Traveller Assist details an operationally and logistically challenging medical repatriation from La Paz, Bolivia to Perth, Australia

On 8 January 2017, the Traveller Assist Assistance Center was activated to assist with a complex medical case in Bolivia, which would later evolve into an operationally and logistically challenging repatriation of a 57-year-old male adventure traveller, who was cycling on a treacherous pass in Northern Bolivia, affectionately known as 'Death Road'. After striking a boulder, the patient suffered life-threatening injuries, including a perforated and collapsed lung, broken and displaced ribs, a fractured shoulder blade, a fractured collarbone and severe bruising. The initial transportation of the patient to the hospital took over five hours. Despite the fact that the clinic itself was relatively nearby, the unmaintained conditions of the road made it difficult to quickly transport the patient. In addition, the most rapid source of transportation was via a public taxi.

Extracting information

Twenty-four hours later, the patient contacted his travel insurance company to inform them of his accident. As the medical assistance and cost containment provider in Latin America for World Nomads Group, Traveller Assist was activated to obtain a medical report. This is where this case became administratively challenging. The clinic where the patient was being treated operated using contract doctors through an external agency. This agency collects hand written reports from the doctors, then types them up and submits them to the clinic. We were told that this process happens once a week. Unfortunately, the day that we requested a medical report was not that day, or the day after.

As the medical director at Traveller Assist, I contacted the clinic and, after speaking with seven different clinic employees, I was able to speak with the treating medical officer (TMO). A verbal medical report was written up and sent to the World Nomads Emergency Assistance Team in Perth, Australia. This opened a direct communication channel that allowed us to request regular verbal updates. It's worth noting here that the patient ended up being hospitalised for four weeks, and only one written medical report was provided by the clinic in that time. Two days after the patient was admitted, it was reported that the patient's chest tube was removed, and the lung had successfully re- inflated. We were then informed by the clinic that they wanted to discharge the patient as they were not a long-term care facility. This created a problem: we could not repatriate the patient home to Australia as the TMO would not issue a Fit-to-Fly declaration until 14 days after the chest tube had been removed. The patient could not sit, stand or lay down for extended periods of time, and had become somewhat dependent on positive pressure oxygen, which required ongoing medical supervision for potential complications, including pneumonia. There was also the added complication of being at an altitude of 12,000 feet.

Considering the options

We provided World Nomads with two options. the first was to book the patient into a hotel and have a Traveller Assist nurse stay in an adjoining room to continue to medically monitor him as required. The second was to transfer the patient to a long-term care facility of which there was one in the local area that would accept him. At the same time, we began negotiations with that clinic to allow the patient to remain there until he was able to make the lengthy flight home to Australia. The clinic agreed to let the patient stay; however, this created further challenges, mainly the fact that long-term care at this clinic literally meant that a bed and food was provided, and a nurse was provided to check on the patient once daily. No medical reports were provided, and communication from the clinic eventually all but stopped.

World Nomads requested that we send our nurse practitioner, Alice Proia, who was the case manager for this patient, to conduct a full medical assessment of the patient and write a full medical report, with recommendations. Ten days after the patient was admitted to the clinic, Alice arrived and immediately found that the medical reports that had been submitted were not accurate. Three separate medical reports from the clinic's system reported that the chest tube had been removed on three separate dates. This information was critical for two reasons. Firstly, if the date of the chest tube removal was incorrect, we had to assume that other information in the reports was not accurate. Secondly, we knew that the TMO could only provide a Fit-to-Fly declaration after 14 days of the tube being removed, as per hospital guidelines. After some investigation, we found that the tube had been removed on 13 January, which meant the earliest the patient could fly was 26 January.

Determining Fitness-to-Fly

On 21 January, we informed World Nomads that seat availability in business class was quickly filling up. As an assistance company who regularly escorts patients via commercial flights from Latin America to Australia and New Zealand, we are constantly monitoring flight

availability. We recommended to World Nomads that we held seats for 26 January or just after. Taking a proactive approach and wanting to avoid any further delays, we contacted the three airlines on which we would potentially fly the patient, and provided them with a summary of the case. Two of the airlines advised that their policy was that they would only accept a pneumothorax patient after 21 days of a chest tube being removed, and only then with an x-ray proving full lung inflation 48 hours prior to the flight, and a full fit-to-fly declaration from the TMO. World Nomads activated us on 25 January to plan the non-medical escort (NME) of the patient on or after 2 February. We booked the last two business class seats with Qantas on the 2 February and discussed the case with our liaison at the airline to ensure we had all of the documentation we required. We were then informed by the TMO that he would not issue the fit-to-fly declaration until 4 February. At the same time that we were informing World Nomads of this issue, the patient was also emailing them directly to tell them that the TMO had issued a fit-to-fly and cleared the patient for the original date of 2 February. This miscommunication led to more confusion. I called the clinic once again and was informed that the TMO would definitely not issue the fit-to-fly until 4 February. This situation not only created confusion between World Nomads, the patient and ourselves, but also created another logistical challenge with rescheduling flights, hotels and transportation. Our head of assistance, Danny Kaine, requested a call with World Nomads' head of assistance Lisa Fryar to discuss the issues, to explain the complexities of the case, and discuss communications. It was primarily conveyed that the information we had provided was from a medical doctor to a medical doctor and should

THE PATIENT WAS KEEN TO RECONNECT WITH HIS FAMILY AFTER HIS ORDEAL

take precedence over information that a patient was providing. Understandably, the patient was eager to get home, but perhaps did not understand the operational and logistical requirements to make that happen. It was further confirmed that the NME would be delayed until the 4 February in line with the airline's guidelines and the treating doctor's recommendations.

Homeward bound

Our nurse arrived in La Paz on 2 February and prepared for the forthcoming repatriation by ensuring all documentation was present and correct. She was also tasked to review all medical expenses. We had issued a guarantee of payment to the clinic for the full medical bill, but upon discharge of the patient, the clinic requested payment in full, and held all documentation until this was made. We have the ability to do this, but the clinic did not accept visa payments nor did they know how to receive an electronic transfer. This meant a co-ordinated effort involving our head of claims, who attended the branch of our corporate bank account, while our nurse attended the branch of the clinic in La Paz with a clinic employee. After some exhaustive communication, we successfully paid the medical expenses in full via transfer and the documents were released. As arranged, the patient was discharged and transported via ground ambulance to the airport with oxygen on standby as a precautionary measure, as the airport is an additional 1,000 feet higher than the clinic. Due to the patient overstaying his visa, our nurse had arranged a meeting with immigration authorities to extend it and avoid any issues. All documentation was then submitted to the airline, and the patient was successfully escorted to his home address in Perth, Australia without issue, where he was reunited with his family. Needless to say, the patient was keen to reconnect with his family after his ordeal and speaks highly of the assistance and coverage that World Nomads and Traveller Assist were able to provide.

Author

Dra Natalia Reyes is a medical director at Traveller Assist. With extensive experience providing remote medicine in mountain regions, Natalia has been solely responsible for providing emergency medicine, including control of chronic pain, prenatal attention, and emergency first aid and evacuations. At Traveller Assist, Dra Reyes is responsible for assessing treatment strategies, overseeing medical transportation and working with insurance underwriters and corporate travel departments.