Medico-legal Aspects of Inflight Emergencies

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Air travel has become the normal method of travel for medium and long distances. With increasing passenger traffic, the incidence of inflight medical emergencies is also on the rise. When a doctor who is a passenger is called upon to attend an inflight medical emergency, he/she may have to be wary of the medico-legal implications. This paper reviews the current state of the problem and calls for a debate to ensure optimum medical care for inflight emergencies without medico-legal entanglements for the attending doctor.

Keywords: Medical emergencies in air, medical litigation, airline passengers.

Speed is directly proportional to advancement. Today's man is always in a hurry and for him time in hand is too less. Air transport has now become the normal method of travel for medium and long distances. Air travel is the third safest mode of mechanised transport in the world. Sophistication in technology, adequate pressurisation, airconditioning, provision of oxygen supply, high quality control of water and food supply and, last but not the least, trained cockpit and cabin crew have made flying safe and enjoyable. Still medical emergencies do occur on board. A fellow passenger who happens to be a doctor is always called upon to tackle the situation and is expected to act with the same professional skill as he would have done on the ground with all facilities available. The medical world is watching these developments with interest and is developing a nagging fear of their medico-legal implications. Till today, we have neither any supportive law to protect the medical man when he is entangled in unnecessary lawsuits nor any authoritative guidelines pertaining to the exact implications of such unavoidable hazards.

The medico-legal problems vary to a great extent between international and domestic flights, particularly when flying in foreign air space and when international passengers are involved. Inflight medical emergencies differ from similar emergencies on ground because in the former the limited space, the noise, the lack of basic equipment and drugs and other inflight conditions impose restrictions. The doctors are invariably exposed to interference by travelling VIPs and fellow passengers. When international passengers are involved, the medico-legal implications are different to which the doctors may not be conversant. To summarise, the following are the basic difficulties associated with inflight emergency management faced by a doctor who is flying as a passenger

Limited space, noise, lack of basic equipment and drugs, unfamiliarity to patient's condition and environment, unpreparedness, personal limitation and Apprehension of medico-legal implications.

Under the circumstances, during any inflight medical emergency if a doctor comes forward to manage the situation, he assumes two major responsibilities. Firstly, he has to act with the same reasonable and professional skill as on the ground; he should judge the situation and act in the best interest of the patient within the limitation of his professional skill, which may not please the fellow passengers. Secondly, he has to decide, judging the urgency of inflight illness, about a premature diversionary landing.

In any inflight medical emergency, the cabin crew announces for a doctor on board and when a doctor volunteers his services, he shoulders all the responsibilities pertaining to the commissions and omissions in the medical management. If he responds to a call from the crew, he acts on behalf of the opeating airline and the latter should be a partner to the responsibility. Though they are not accountable for the doctor's professional skill or any negligence that may arise during the management, they have to ensure the bonafide of the medical practitioner.

Medical emergencies may occur with cockpit crew, cabin crew or passengers. The common problems that are encountered are 'heart attack', incapacitation following diabetic coma or insulin coma, food poisoning, electric shock, incidences following pressurisation failure, epilepsy and fainting attacks, air sickness, bleeding from the nose, and physical injuries including burns and scalds. Travelling sick passengers may require urgent medical attention. Two important factors often contribute towards creating medical emergencies. They are contributory negligence on the part of the

passengers and wilful misconduct on the part of both the passengers and the operators. Contributory negligence includes smoking in toilets, not fastening seat belts when the seat belt sign is on, etc. Wilful misconducts include consumption of alcohol and drugs in the aircraft, opening overhead lockers, and unnecessary movements in the aircraft by the passengers. Poor quality control of food and water is attributed towards the misconduct of the operator.

A doctor, who may be least prepared psychologically and equipmentwise, is called upon to take care of the above emergencies. Today ambulance-chasing lawyers, overenthusiastic journalists and opportunist politicians make a doctor's position more vulnerable to lawsuits. In countries like the United States, lawyers act on a contingency basis, i.e., they take up cases when they believe that the damages may be awarded. They collect their fees on a percentage basis when damages are awarded and naturally nothing when the case is lost. They may try to make cases and drag them to lawsuits, rather than finding them. Today the community in general, and so also the patients, are becoming more litigious and support this contingency system dragging a doctor to unnecessary medical lawsuits when he offers his voluntary services in good faith, remembering the Hippocrates oath. In our country, like in the United Kingdom, when doctors are forced into medical lawsuits under such situations, the judges may show a sympathetic attitude towards them. But in the US, a civil jury assesses these cases and awards damages in which a doctor may lose a fortune. It is needless to say that this plague of medical lawsuits is slowly infiltrating in our country and naturally a medical man becomes quite apprehensive whenever he is asked to tackle medical emergencies. He cannot be blamed under such circumstances if he prefers to remain silent rather than to come forward and tackle the medical crisis thus exposing himself to possible litigation.

Taking into consideration all these factors which lead to non-avalability of doctors at the time of crisis, political pundits and responsible citizens have tried to introduce a 'Good Samaritan Legislation' in the US. This bill intended to protect doctors, registered nurses and aircraft employees who volunteer to manage medical inflight emergencies, except in case of gross professional or wilful negligences, and offered protection from other liabilities. The 'Inflight Emergency Bill', introduced in 1983, took care of two aspects. Firstly, it kept provision for certain standard medical equipment to be carried aboard the aircraft. Secondly, it provided a 'Good Samaritan Clause' to assist the medical and paramedical personnel in the event of medico-legal lawsuits. The Federal Aviation Administration, vide its NPRM (Notice of Proposed Rule Making), has suggested the 'Emergency Medical Equipment Proposed Rule' which requires certificate holders to provide medical kits containing equipment and drugs for use in the treatment of injuries or medical emergencies that might occur during flight time.

Most airlines have observed that proper and rigorous training of the cabin crew in first aid and some basic medical treatment can go a long way to look after the sick and injured aboard aircraft during flight.

Indian Airlines has introduced the following steps to face the medical emergencies :

i. Medical training of the cabin crew.

ii. Refresher courses to keep them updated.

iii. Supply of first aid boxes and physician kits in each flight.

iv. Periodical medical checkup of cockpit crew and cabin crew.

v. Preflight medical test of cockpit and cabin crew.

vi. Record keeping of all inflight emergencies, treatment given, bonafide of the medical practitioner, etc.

When confronted with an inflight medical emergency, a doctor in dilemma must:

i) take the best course of action in the prevailing circumstances, ii) render aid in the best interest of the patient, iii) act with reasonable professional skill, iv) take the cabin crew into confidence, v) make decisions independent of the convenience and advice of the fellow passengers, vi) take consent in writing from the patient if feasible, a relative if present, the commander of the aircraft or from responsible fellow passengers, and vii) prepare a detailed clinical record of the emergency, in duplicate, giving his/her address and registeration number.

Today, the high sounding phrases like 'noble profession', 'service to humanity', 'Hippocrates oath', 'doctor is next to God', etc would not motivate a medical man any longer. He wants legal protection from medico-legal implications which unfortunately are unavoidable occupational hazards. Politicians, judges, lawyers and community as a whole, now should come forward and debate in detail with the medical professionals to find out ways and suitable enactments to protect the latter in order to get the best out of them.