

“Is there a doctor onboard?”



Travel insurance is all well and good, but what if you fall ill during your flight? Diana Bentley looks at how well prepared airlines are in case of medical emergency and where responsibility for onboard health actually lies



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Onboard medical incidents can be an anxious experience for an afflicted passenger, their companions and crew alike. A stricken passenger at 30,000 feet is not what any airline wants and the quality of care that can be given is limited. Rules regarding training of crew, necessary onboard medical kits and treatment procedures are well established in most countries, and continue to be monitored and improved upon. But with the development and imminent arrival of two new aircraft – the Airbus A380, which will carry 550 passengers, and the A350, which will have a longer flight capacity than existing aircraft – onboard health is an issue that is likely to be again in the public eye.

Who governs?

Much sickness onboard is thankfully minor. British Airways (BA), which carries about 34 million passengers a year on about 400,000 flights, reports that the most common medical problems encountered onboard are fainting, diarrhoea, vomiting, bruises and sprains. The most common potentially serious problem is chest pain or other suspected heart problems, while other, more serious problems, like deep vein thrombosis (DVT) can surface later.

But who governs the conduct of onboard health and what rules apply? Generally, airlines must comply with the rules of the authority with whom they are registered. In the UK, for example, the Civil Aviation Authority (CAA) regulates aircraft registered in Great Britain. "Rules relating to onboard health are laid down in Europe by the Joint Aviation Authorities (JAA) operations manual, known in the industry as JAR-OPS 1," explains Dr Raymond Johnston, head of the CAA's Aviation Health Unit. "This sets out medical standards for fitness for cabin crew and provides general guidelines for cabin crew on the treatment of passengers." Countries' individual regulators, like the CAA, can subsequently build on

these minimum standards and enforce their own additional requirements for members.

An association of representatives of the civil aviation authorities of various European states who have agreed to cooperate on safety standards – known as the European Aviation Safety Agency (EASA) – will soon take over some of the JAA's work, Dr Johnston explained. As a European Union body, the EASA will have the power of the EU's lawmaking capacities behind it.

"Currently, cabin crew must have basic first aid training that is tailored with specific reference to what can occur on an aircraft," says Dr Johnston. Some airlines, however, provide additional training to that which is required as a minimum standard. BA says its cabin crews undergo rigorous first aid training, above and beyond statutory requirements, as part of their entrance training. Five days are devoted to learning life-saving





procedures as well as more general first aid skills, and refresher courses must be completed annually. Cabin crews of Singapore Airlines undergo a four-month training programme that includes health and safety. Crews will have specific training for the new double-decker A380 craft, including medical and health programmes. Under JAA rules, two different sorts of equipment must be used on airlines: a first aid kit that includes basic medical supplies like bandages and antiseptic cleaner, and a medical kit that contains more complex equipment and drugs, which can only be used under the supervision of a qualified person such as a doctor or a nurse. Many airlines exceed the minimum requirements laid down by their relevant regulator, however.

In the UK, semi automated external defibrillators – used in cases of sudden cardiac arrest – do not have, by law, to be carried onboard an aircraft, but some airlines stock them by choice. Low-cost or short haul airlines may not. Since 2004, the Federal Aviation Administration of the US has required that all planes in the country carry defibrillators, though some airlines already did. “Some airlines like Qantas and Virgin Atlantic used them before the US rules came into force,” says Joan Sullivan Garrett, founder and Chairman of MedAire, the US-headquartered global telemedicine company. “We regard them here not as medical equipment but as part of first aid.”

Medical standards, however, evolve with medical developments and with what regulators consider desirable for passenger safety. Presently, the JAA is reviewing what needs to be carried onboard and its conclusions are expected later this year.

Handling cases onboard

As to who may be especially at risk on a flight, the CAA’s Dr Raymond Johnston says: “The (US-based) Aerospace Medical Association (ASMA) has general guidelines on fitness to fly, but each airline has its own rules, and passengers with health problems should ask their airline for advice if they think they need it.” According to BA, most people with existing medical conditions can fly on a commercial aircraft without any difficulty, but when cabin air pressure is equivalent to an altitude of 6,000 to 8,000 feet, special care is sometimes needed. “Passengers with problems like heart disease or breathing difficulties should discuss their journey with their doctor before booking, and if they are flying with us they or their doctor can speak to our Passenger Medical Clearance Unit,” says BA’s Dr Mark Popplestone.

Onboard, apart from crew training and basic supplies that may be stipulated by regulators, how airlines respond to a passenger’s illness is up to them. When the crew does not feel they can handle an incident alone, a call is put out for a ‘Good Samaritan’ – a doctor or nurse who may happen to be onboard and who may offer to help. Such

passengers may fear subsequent legal problems, although airlines like BA indemnify their Good Samaritans against any legal proceedings that may arise following the assistance of a passenger. Many airlines now use the services of telemedicine companies, which provide immediate advice by satellite telephone or high frequency radio from doctors who are particularly knowledgeable of airborne conditions. One of the most renowned is Phoenix-based MedAire, which provides a range of support through its MedLink service – from first aid

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and medical kits, staff and crew training, airport and in-flight medical advice – for around 90 airlines including Aer Lingus, Air Canada, British Airways, Cathay Pacific, Delta Airlines, Qantas Airways, Thomas Cook Airlines and Virgin Atlantic Airways. “All of our doctors are active practitioners and also undergo specific training in altitude physiology,” says Sullivan Garrett. MedLink’s medical advice, she says, can be given in over 140 languages through interpreters: “Most pilots and crew speak English but their proficiency varies. Also, not only do crew and anyone else helping onboard sometimes need interpreters, but the interpreters must be familiar with medical terminology.” One dilemma that can arise, points out Sullivan-Garrett, is that an airline may be carrying equipment that only medical professionals can use, but no such professional may be onboard, or those that are may not want to use it. Before taking on clients, therefore, telemedicine companies generally discuss with airlines what they are confident and comfortable about doing in medical emergency cases. If telemedicine doctors believe an ill passenger needs to be hospitalized or needs urgent medical attention, it identifies the closest hospital in case the plane needs to be diverted, though in some more isolated parts of the world, finding adequate medical facilities nearby can be a challenge.

Cost-effectiveness

Not all airlines have telemedicine services that require expensive onboard satellite communications systems. Easyjet, the UK-based low-cost airline, is one airline that sees no need presently to have such facilities. “We’re a short haul airline,” says an Easyjet spokesperson. “We don’t have equipment like defibrillators onboard, though we do have standard

first aid kits. And we don’t use a telemedicine service as our planes are usually very close to airports where we can land if we have a medical emergency.”

This may be reasonable in the case of a short haul airline and it remains the decision of the airline as to what it will carry onboard. “It’s up to the airline what kind of backup they need and want but a lot of airlines use telemedicine services and a lot are looking at them,” says the CAA’s Dr Johnston. But should telemedicine services be compulsory? “It’s like any other new treatment or procedure,” he says. “You have to consider the accumulated evidence before you make anything mandatory or decide whether something is an effective – and a cost-effective – way to intervene.”

Some insurers, too, it seems, are not so concerned about telemedicine services. “We only expect people to receive minimal treatment onboard anyway,” says a spokesperson for BUPA’s travel insurance arm. “Our policies cover people for being hospitalized after a diversion, and in cases where they can’t get proper treatment we can send a doctor or nurse or an air ambulance.” Norwich Union – also a travel insurer – has a similar approach: “Our experience is that airlines take the safety of their passengers seriously so they will make the decision that is right for them,” says the company’s David Ross.

Flight diversion

However minor most onboard illnesses may be, there may well come a time when a passenger may need immediate treatment not available onboard. Around one in every 1,000 BA flights is diverted for a medical emergency. “Ultimately, the decision on whether to divert rests with the captain; however, they’ll take advice from our telemedicine service and, potentially, any medical professional onboard,” says BA’s Dr Popplestone. Where a plane decides to

land depends on many factors, such as distance from the planned destination, airport facilities – including fuel availability and ground support – and available medical facilities, on which telemedicine companies also advise. “We have data on 15,000 medical facilities in 5,000 cities,” says MedLink’s Joan Sullivan Garrett. “So we help the captain with which airport would be closest to the best facilities for the patient, but their ground operations people also advise about the airport’s capabilities and other factors. It’s not just the health of the ill passenger that’s at stake but the safety and health of all of the others.” Once the passenger has been handed over to the care of the airport and local emergency medical service providers, airlines consider that the patient is no longer under their care.

Bigger planes and those with longer flight capacity may naturally see an increase in the number of onboard health incidents. “[Such flights] may be a problem for those with cardio-vascular problems or problems like asthma,” says Sullivan-Garrett. Larger planes also have less ability to make diversions, as certain airports are too small to accommodate them or do not have the facilities to service them. Recent developments in the aviation world may increase the need for a review of the treatment of onboard illness, but airlines, thankfully, have a variety of advisers apart from their own staff, consultants and regulators. The International Air Transport Association (IATA) has a Medical Advisory Group, and the ASMA and the International Academy of Aerospace Medicine (IASM) are also considering the issues presented by new aircraft.

Advances in medicine too – including better methods of diagnosis – may help in future. “There are devices being developed that in the next five years may be able to help with the rapid diagnosis of, for instance, heart attacks,” says Sullivan Garrett. “And these may well be able to make a difference to onboard treatment.”

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