In-flight Medical Emergencies

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Introduction: Research and data regarding in-flight medical emergencies during commercial air travel are lacking. Although volunteer medical professionals are often called upon to assist, there are no guidelines or best practices to guide their actions. This paper reviews the literature quantifying and categorizing in-flight medical incidents, discusses the unique challenges posed by the in-flight environment, evaluates the legal aspects of volunteering to provide care, and suggests an approach to managing specific conditions at 30,000 feet.

Methods: We conducted a MEDLINE search using search terms relevant to aviation medical emergencies and flight physiology. The reference lists of selected articles were reviewed to identify additional studies.

Results: While incidence studies were limited by data availability, syncope, gastrointestinal upset, and respiratory complaints were among the most common medical events reported. Chest pain and cardiovascular events were commonly associated with flight diversion.

Conclusion: When in-flight medical emergencies occur, volunteer physicians should have knowledge about the most common in-flight medical incidents, know what is available in on-board emergency medical kits, coordinate their therapy with the flight crew and remote resources, and provide care within their scope of practice. [West J Emerg Med. 2013;14(5):499–504.]

INTRODUCTION

In-flight medical incidents during commercial air travel are common yet poorly understood and studied phenomena. The cramped quarters of an aircraft cabin environment and limited available resources make responding to such events fraught with challenging clinical decisions.

Despite the expansion of commercial air travel over recent decades, there are currently no guidelines for managing ill passengers during commercial flights from the standpoint of volunteer medical professionals. The incidence of these cases is hard to estimate given the paucity of available data. While commercial airlines often collect information on medical events during flight, they do not do so in a standardized format, so it is difficult to compare data across regions.

Equipment stocked in “emergency medical kits” is not mandated by any international aviation body, although the International Air Transport Association (IATA), the Aerospace Medical Association (AsMA), and the International Civil Aviation Organization (ICAO) have agreed upon standardized recommendations. Given the difficulties pertaining to epidemiological data described above, their contents are guided by anecdotal evidence and experts’ opinions.

This paper discusses the unique characteristics of the flight environment, reviews the literature describing aviation medical incidents, and suggests an approach to managing these patients.

Flight Physiology

Air travel is associated with an assortment of potential stressors on the physical and psychological well being of travelers. Altitude changes and resultant fluctuations in cabin pressure in particular can affect susceptible airline passengers. A commercial jet’s cruising altitude typically ranges between 29,000 and 39,000 feet. The Federal Aviation Administration (FAA) requires airlines to maintain cabin pressure below 8,000 feet, and a commercial plane traveling at 39,000 feet will usually maintain a cabin pressure at or below 7,874 feet. When compared to the altitude of Aspen, Colorado, which is approximately 7,800 feet above sea level, it is not surprising
that some passengers experience symptoms of altitude changes when flying.

According to Dalton’s law, the total pressure of a system is equal to the sum of the partial pressures of its components. While the partial pressure of oxygen remains 21% throughout the atmosphere, atmospheric pressure drops at higher altitude resulting in a lower partial pressure of oxygen. At sea level, the partial pressure of oxygen is 160 mmHg, while at 8,000 feet it is 118 mmHg. The partial pressure of oxygen is further reduced when air is inspired into the lungs, which contains high concentrations of water vapor and carbon dioxide. The lower level of inspired oxygen results in less oxygen available for gas exchange and can lead to hypoxia.

The average person is usually able to ascend to a height of 7,800 feet without difficulty. People with cardiopulmonary co-morbidities, however, are more susceptible to changes in altitude. Patients with chronic obstructive pulmonary disease (COPD), interstitial pulmonary disease, or pulmonary hypertension are at an appreciably higher risk of developing symptoms of symptomatic hypoxia. Clinically, patients may appear to have dyspnea at rest, cough, weakness or drowsiness, anxiety or agitation, cyanosis, tachycardia, tachypnea or rales. Other medical conditions may also be exacerbated by high altitude, including congenital and valvular heart diseases, symptomatic coronary artery disease, decompensated heart failure, sickle cell disease and obstructive sleep apnea. While there are no studies on pre-flight medical screening of passengers, many sources advise primary care providers to screen patients for these disorders and provide advice prior to commercial air travel. Patients with relative hypoxia at rest or with minimal exertion at ground level elevation should be advised to avoid air travel or travel with supplemental oxygen.

Incidence studies

We conducted a MEDLINE search in March 2010 using search terms relevant to aviation medical emergencies and extracted incidence studies and high quality topic summaries published between 1980 and 2010. Reference lists of selected articles were reviewed to identify additional relevant publications. The incidence of medical incidents during commercial air travel is unknown. MedAire, a medical assistance company that provides remote assistance to several commercial airlines in the United States, responds to an average of 17,000 cases per year. Given the absence of a national (or international) registry of incidents, reported numbers of cases from individual airlines and telemedicine providers cannot be generalized to an overall estimation of incidence.

Table 1 demonstrates the wide range of estimates generated by analyzing data from single airports or carriers. Most are retrospective cohort studies. Qureshi, et al, in a study published in 2005, retrospectively studied data from a single international carrier and characterized 507 medical incidents reported over a 6-month period in 2002. Dowdall, et al, also performed a retrospective study using a single airline over 1 year and found the incidence of medical incidents to be 1 per 11,000 passengers.

Multiple airline studies include the study by Sand et al, which was a retrospective study of incidents from 2 European airlines over the course of 5 years, demonstrating an incidence of 14 incidents per billion passenger kilometers. This is comparable to the study by Hung et al, a 5-year retrospective
cohort study that demonstrated an incidence of 11.6 cases per billion passenger kilometers. The variation of incidence, flight diversion, and cardiac arrest data underscores the need for standardized, system-wide reporting and data tracking.

Common In-Flight Medical Events

Table 2 provides a breakdown of the types of in-flight medical incidents reported.\(^5\)\(^-\)\(^16\) Once again, the lack of standardized data sources and the overlapping categorizations become evident through the wide-ranging results. The table nevertheless highlights common complaints and alludes to the predominant organ systems affected by the in-flight environment. Syncope, gastrointestinal upset, and respiratory symptoms were among the common medical complaints reported. Chest pain and cardiovascular events were also noted, and these cases were often associated with diversion.\(^7\)\(^,\)\(^9\)

The data presented by Sand et al\(^{11}\) indicated that syncope was the most common type of in-flight medical emergency. Baltsezack et al\(^{12}\) noted that gastrointestinal complaints were the most common. Qureshi et al,\(^{13}\) demonstrated that the exacerbation of pre-existing diseases (usually respiratory) was the most common cause of an in-flight medical emergency, and syncope and respiratory conditions were the most common complaints. A study focused only on pediatric medical consultations requested from a single airline noted a high incidence of infectious disease complaints in addition to respiratory and neurologic symptoms.\(^{17}\) Each incident described was likely the product of a combination of contributing factors, including patient co-morbidities, the flight environment, and alcohol and drug use or withdrawal.

What's Available in Flight?

The FAA requires all American commercial airlines weighing 7,500 pounds or more and serviced by at least one flight attendant to carry an automatic external defibrillator (AED) and an enhanced emergency medical kit. AED use during the commercial flight environment has been validated as safe and effective.\(^{18}\) Flight attendants must be CPR and AED certified every 2 years.

The standard emergency medical kit on American commercial airlines, which is based on recommendations by the Aerospace Medical Association’s (AsMA) Air Transport Medicine Committee, includes a stethoscope, bag valve masks, syringes and intravenous catheters in a range of sizes, and commonly used medications listed in Table 3.\(^{19}\) Several medications are listed as drug types, including “bronchodilator,” “antihistamine,” and “analgesic,” so the specific medication included may vary from one kit to another. Flight attendants are trained to be familiar with the contents of the kit, and its seal is examined during every pre-flight check and restocked after it is used. According to FAA regulations, a flight may not take off if it is missing the medical kit or AED. Flight attendants may only use the equipment and medications under the direction of a licensed medical provider. For minor medical complaints, flight attendants may use a “first aid” kit that is stocked separately. Physicians requiring additional equipment or medications (e.g., a glucometer) can ask flight attendants to make an overhead announcement requesting the items from other passengers.

All United States (U.S.) airlines are required to carry the standard kit and many supplement its contents with additional equipment and medications. There are, however, no international regulations requiring a complete kit to be available overseas. The International Air Transport Association (IATA) does not regulate the contents of emergency medical kits of international airlines, although it...
Table 3. The emergency medical kit.

| Medications                          |
|-------------------------------------|
| Epinephrine 1:1,000                 |
| Epinephrine 1:10,000                |
| Antihistamine, inj.                 |
| Dextrose 50%, inj. 50 ml (or equivalent) |
| Nitroglycerin tablets or spray      |
| Major analgesic, inj. or oral       |
| Sedative anticonvulsant, inj.       |
| Antiemetic, inj.                    |
| Bronchial dilator inhaler           |
| Atropine, inj.                      |
| Adrenocorticoid steroid, inj.       |
| Diuretic, inj.                      |
| Medication for postpartum bleeding  |
| Normal Saline                       |
| Acetyl salicylic acid for oral use  |
| Oral beta blocker                   |

| Equipment                           |
|-------------------------------------|
| Stethoscope                         |
| Sphygmomanometer                    |
| Airways, oropharyngeal              |
| Self-inflating manual resuscitation device with pediatric, small adult, and large adult mask |
| CPR masks (pediatric, small adult, large adult sizes) |
| Syringes                             |
| Needles                             |
| Intravenous catheters & tubing      |
| Antiseptic wipes                     |
| Gloves                              |
| Sharps disposal box                 |
| Urinary catheter                    |
| Venous tourniquet                   |
| Sponge gauze                        |
| Tape adhesive                       |
| Surgical mask                       |
| Flashlight and batteries            |
| Thermometer (non-mercury)           |

| Basic instructions for the use of medications in the kit |

Table 4. General approach to managing in-flight medical incidents.

| Approach                                              |
|-------------------------------------------------------|
| Identify yourself and your training/expertise         |
| Treat in the seat whenever possible; use of the aisle blocks mobility of flight crew |
| Document your findings and treatments administered    |
| Communicate and coordinate with flight crew and ground resources |
| Do not attempt to practice beyond your expertise       |
| Request access to the emergency medical kit            |
| Use a translator if necessary                          |

centers staffed by physicians. If medically trained passengers volunteer their assistance they should coordinate with cabin crew and a response center physician. If a call center physician is not available, the volunteer physician must work with cabin crew and can suggest treatment or diversion options.

Medico-legal Issues

Federal legislation contained in the Aviation Medical Assistance Act of 1998 has provided limited protection and guidance for physicians and other medical professionals who volunteer their services during flight. Volunteers must be “medically qualified” and receive no monetary compensation in order to receive protection.21

The legislation states that “an individual shall not be liable for damages in any action brought in federal or state court arising out of the acts or omissions of the individual in providing or attempting to provide assistance in the case of an in-flight medical emergency unless the individual, while rendering such assistance, is guilty of gross negligence or willful misconduct.” To date there are no documented cases of a physician being sued for providing assistance during an in-flight incident.7,22,23

While physicians have no obligation under U.S. law to volunteer, one can argue that they have an ethical obligation to do so, especially if they are specifically trained to respond to undifferentiated medical emergencies.

Volunteer physicians should document their assessment and interventions administered using a standard airline medical incident form if available, or on a blank sheet of paper if a form is not available. If possible, the volunteer physician should request a copy of the medical document or form for their personal records. If a patient requires ongoing monitoring and therapy, the volunteer may need to stay by their side for the duration of the flight. Once the plane lands, the volunteer can hand over care to on-the-ground medical staff who can transfer the patient to an appropriate facility.

Approach to patient and guidelines

A 2002 article published in the New England Journal of Medicine by Gendreau et al,22 offers recommendations for volunteer physicians faced with an in-flight medical incident. The authors’ key points and others are outlined in Table 4.

Table 5 outlines evaluation and management considerations.
for specific in-flight medical incidents.

If the patient’s condition is unstable and requires immediate formal medical attention, the physician may recommend diversion of the flight to the nearest airport capable of landing the aircraft and with access to appropriate medical facilities. The act of diverting a full aircraft to the nearest city is expensive, estimated to range between $3,000 and $100,000 depending on the size of the plane and costs of additional fuel and passenger re-routing, and has far-reaching consequences.\textsuperscript{22} Diversion is usually made in consultation with ground-based medical expertise and should account for regional medical resources along the flight path. The final decision to make an emergency landing rests with the pilot in command. An article published by Ruskin et al\textsuperscript{7} advised diversion for unremitting chest pain, shortness of breath, or severe abdominal pain. Grendreau et al\textsuperscript{22} add stroke, persistent unresponsiveness, refractory seizures, and severe agitation to this list. A 2010 study reviewing 4 years of flight diversion data from Air Canada revealed that the majority of diversions occurred following cardiac complaints.\textsuperscript{7} Regardless of the presenting symptom, in-flight or ground-based providers must assess a patient’s stability and perceived medical condition based on the limited clinical information available and then make a risk-based recommendation. Factors affecting this decision include the differential diagnosis of the patient’s condition, available in-flight resources, the patient’s response to initial treatments, and ground resources along the flight path. International flights that traverse oceans or large tracts of sparsely populated land may have a lower threshold for diversion before crossing these spaces given the paucity of resources once they are entered.\textsuperscript{7}

In the case of multiple volunteers or a severe incident requiring a team approach, health providers should introduce themselves, their level of training, and their specialty in order to determine who should take the lead role. In some cases, a sub-specialist physician (e.g. a neonatologist) should defer to other personnel (e.g. an ED nurse or advanced paramedic) when responding to incidents beyond the scope of their training and experience.

**DISCUSSION**

An aircraft in mid-flight is a unique environment in which to provide medical care. Any setting, be it a wilderness location, a ship, or at the scene of an accident, is associated with clear challenges and resource constraints that warrant academic study and guideline development. The specialty of emergency medicine focuses on the management, evaluation, and diagnosis of medical emergencies in a variety of environments including resource-limited settings. It is the only recognized medical specialty that takes a health systems approach to emergency care by incorporating the principles of triage, screening for lifethreatening conditions, and pre-hospital emergency medical services. The specialty must therefore take a leadership role in the field of aviation medical emergencies.

Recent decades have witnessed an increase in the ease and accessibility of air travel, with a resultant rise in the number and diversity of aircraft passengers. Patients with chronic medical conditions should be screened by their primary care providers prior to air travel to determine their ability to endure the flight environment. Patients with significant pulmonary or cardiovascular disease should be counseled to avoid air travel when possible. When in-flight medical incidents occur, emergency physicians are ideally suited to respond given the breadth of their training, improvisational skills, and team leadership experience. Volunteer physicians should request access to the on-board emergency medical kit, coordinate their

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**Table 5. Approach to common in-flight medical incidents.**

| Condition                        | Recommendation                                                                 |
|----------------------------------|-------------------------------------------------------------------------------|
| Syncope                          | Assess vital signs, cardiovascular exam, and neurological exam. Recommend diversion for hypotension, arrhythmia, or suspected stroke. |
| Altered Mental Status            | Assess for toxidromes. Administer oxygen, establish intravenous access and administer normal saline and dextrose 50%. |
| Seizure                          | Clear space around passenger. Administer sedative/anticonvulsant (benzodiazepine if available). Provide supportive care during post-ictal period. Recommend diversion for status epilepticus. |
| Chest Pain                       | Assess vital signs. Perform cardiovascular and respiratory exam. Administer oxygen, nitroglycerin, and aspirin. Recommend diversion for arrhythmia, abnormal vital signs, or concern for myocardial infarction. |
| Respiratory                      | a) Administer inhaled bronchodilator and oxygen. Consider intravenous steroid for moderate to severe symptoms. Consider intramuscular epinephrine (0.3 to 0.5 ml of 1:1000 solution) for severe symptoms. b) Perform needle thoracostomy for suspected tension pneumothorax (unequal breath sounds, chest pain, dyspnea). Recommend diversion. c) Administer oxygen, assess vital signs and establish intravenous access. Administer oral nitroglycerin and intravenous diuretic. Recommend diversion. |
| Allergic Reaction                | For mild allergic reaction, administer intravenous antihistamine and corticosteroids. For severe allergic reaction/ anaphylaxis, administer intramuscular epinephrine (0.3 to 0.5 ml of 1:1000 solution). |
| Gastrointestinal                 | a) Administer antiemetic. Establish intravenous access and administer normal saline. b) Establish intravenous access and administer normal saline. |
| Pregnancy Complications          | Assess vital signs and establish intravenous access. Recommend diversion for abdominal pain or vaginal bleeding. |
therapy with the flight crew and remote resources, and provide care within their scope of practice.

Existing data on both the incidence and classification of in-flight medical events are limited by the lack of a central registry with standardized data collection. Such a data collection tool has been advocated for by several international aviation organizations and could inform the development of emergency medical kits, flight crew medical training, and passenger screening protocols.

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REFERENCES

1. Hunt EH, Reid DH, Space DR, et al. Commercial Airliner Environmental Control System Engineering Aspects of Cabin Air Quality. Boeing. May 1995. Available at: http://www.boeing.com/commercial/cabinair/ecs.pdf. Last accessed January 12, 2011.

2. Hackett PH, Roach RC. High-altitude illness. N Engl J Med. 2000;345(2):107–114.

3. Muhm JM, Rock PB, McMullin DL, et al. Effect of Aircraft-Cabin Altitude on Passenger Discomfort. N Engl J Med. 2007;357(1):18–27.

4. Silverman D, Gendreau M. Medical issues associated with commercial flights. Lancet. 2009;373(9680):2067-2077.

5. Tso E. High-altitude illness. Emerg Med Clin North Am. 1992;10(2):231–247.

6. Gallagher SA, Hackett PH. High-altitude illness. Emerg Med Clin North Am. 2004;22(2):329-355.

7. Valani R, Cornacchia M, Kube D. Flight diversions due to onboard medical emergencies on an international commercial airline. Aviat Space Environ Med. 2010;81(11):1037-1040.

8. Ahmedzai S, Balfour-Lynn IM, Bewick T, et al. Managing passengers with stable respiratory disease planning air travel: British Thoracic Society Recommendations. Thorax. 2011; 66:1-30.

9. Dowdall N. Is there a doctor on the aircraft? Top 10 in-flight medical emergencies. BMJ. 2000;321:1336-1337.

10. Hung KC, Chan EY, Cocks RA, et al. Predictors of Flight Diversions and Deaths for In-flight Medical Emergencies in Commercial Aviation. Arch Intern Med. 2010;170(15):1401-1402.

11. Sand M, Bechara FG, Sand D, et al. Surgical and medical emergencies on board European aircraft: a retrospective study of 10,189 cases. Crit Care. 2009;13;R3.

12. Baltsezak S. Clinic in the air? A retrospective study of medical emergency calls from a major international airline. J Travel Med. 2008;15(6):391-394.

13. Qureshi A, Porter KM. Emergencies in the Air. Emerg Med J. 2005;22:658-659.

14. Szmajer M, Rodriguez P, Sauval P, et al. Medical assistance during commercial airline flights: analysis of 11 years experience of the Paris Emergency Medical Service (SAMU) between 1989 and 1999. Resuscitation. 2001;50(2):147-151.

15. Cummins RO, Schubach JA. Frequency and types of medical emergencies among commercial air travelers. JAMA. 1989;261:12959.

16. Delaune EF, Lucas RH, Illig P. In-flight medical events and aircraft diversions: One airline’s experience. Aviat Space Environ Med. 2003;74(1):62-68.

17. Moore BR, Ping JM, Claypool DW. Pediatric emergencies on a US based commercial airline. Pediatr Emerg Care. 2005;21(11):725-729.

18. Page RL, Jogler JA, Kowal RC, et al. Use of automated external defibrillators by a U.S. airline. N Engl J Med. 2000;343:1210-1216.

19. United States Federal Aviation Administration. Advisory circular: Environmental Control System Engineering Aspects of Cabin Air Quality. Boeing. May 1995. Available at: http://www.boeing.com/commercial/cabinair/ecs.pdf. Last accessed January 12, 2011.

20. Sand M, Gambicher T, Sand D, et al. Emergency medical kits on board commercial aircraft: A comparative study. Travel Med Infect Dis. 2010;8(6):388-394.

21. Public Law 105-170: Aviation Medical Assistance Act of 1998 (112 Stat. 47; April 24, 1998). Text from U.S. Government Printing Office, Available at: www.gpo.gov/fdsys/pkg/PLAW.../PLAW-105publ170.pdf. Last accessed May 19, 2011.

22. Gendreau MA, DeJohn C. Responding to Medical Events During Commercial Airline Flights. N Engl J Med. 2002;346:1067-1073.

23. Ruskin KJ, Hernandez KA, Barash PA. Management of In-Flight Medical Emergencies. Anesthesiology. 2008;108:749-755.