

Good samaritan law: 'Is there a doctor on board'?

C Niek Van Dijk

As orthopaedic surgeons, we used to travel a lot. A glance at the conference and meetings calendar showed weekly opportunities for continuous medical education. The COVID-19 pandemic has changed all this from one moment to the other. It has a dramatic impact on all of us, involving all our daily activities and our practices, including our medical education. Conferences have been cancelled or postponed. Webinars, virtual learning and virtual conferencing have taken over the exchange of knowledge and learning, and yes, the field is changing so quickly that we need this lifelong learning. After 10 years of practice, a third of my procedures were new; a third were modifications of what I had learnt during my residency; and only the remainder were—more or less—unchanged. So it continued. We learn from our own experience, but we also gain from others.

Virtual training and webinars will probably remain also in the future but only to a certain extent. However, virtual learning and webinars miss the one-to-one (social) interaction. The personal interaction with teachers, presenters and fellow congress participants cannot be replaced by a webinar. Visiting a conference requires you to force yourself away from your local activities, set yourself to register to find yourself in a place away from your daily environment. An important part of any orthopaedic conference is the industry exhibition, where we may find new tools and which feeds us with new ideas.

Moreover, there are other socioeconomic factors which will drive the return to a full conference and meetings calendar once the COVID-19 pandemic is history. It probably needs a vaccine or effective treatment to achieve this. Billions of dollars are currently spent towards these developments, so it is safe to assume that, somewhere in 2021, we will resume (international) travelling. International Society of Arthroscopy, Knee Surgery and Orthopaedic Sports Medicine (ISAKOS) members are especially prone to travelling

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abroad because of the international character of our society.

As orthopaedic surgeons and other healthcare providers in sports medicine care, we resume flying and, sooner or later, we will hear the announcement: 'Is there a doctor on board? We have an emergency'. It seems that 5% of intercontinental flights have a 'medical incident'¹: mostly cardiovascular, neurological or gastroenterological, although contusions, fractures or distortions may occur as a result of turbulence.² Pulmonary embolisms may occur when leaving the aeroplane.

The call for a doctor happened to me, after an ISAKOS-approved conference in Buenos Aires. On my KLM (Royal Dutch Airlines) flight down from Amsterdam, I had a friendly talk with the purser and the captain about my journey. I explained that I was an orthopaedic surgeon, about to lecture at a Congress. Three days later, on the return flight, it was the same KLM crew. They welcomed me back, and we talked about the importance of continuous education for pilots and for doctors. However, next morning before breakfast, there was this announcement: 'Is there a doctor on board? We have an emergency'.

I was caught! Even if I would have tried to hide behind my newspaper, the purser was already trying for eye contact. So I followed him all the way back to the rear-pantry to find a 65-year-old man. It was not easy to diagnose someone who could not speak and could not understand my directions (he was Spanish). But given his blood pressure and his asymmetric pupillary reflex, and my basic medical knowledge, I was able to diagnose a stroke, although I had not done this for over 40 years. I said that he would benefit from urgent treatment—I seemed to remember that a rapid thrombolysis gives a better prognosis—and the purser said we were close to Madrid. So I advised a landing, and our Boeing 747—with 406 passengers—made an emergency landing, with an ambulance on the runway, waiting to further transport my patient to one of the Madrid hospitals.

The patient was actually a retired surgeon, and accompanied by his wife. After he was dismissed from our aeroplane, of course I was curious to know if my diagnosis was correct. But on the

ground the Rules of Privacy apply, so I will never know.

Anyway an emergency landing, disembarking my patient, handling the formalities and getting a new time-slot—all this delayed us by 4 hours. This almost triggered European Union Aviation Safety Agency rules about the maximum flight times for crew. Because of the delay, many passengers missed their connections and had their plans disrupted.

So there were consequences to my intervention. What if my diagnosis had been incorrect? What if new guidelines—unknown to me—no longer required treatment within 6 hours? What if passengers had sued the airline for disruption? Worse than that, what if they would sue me for medical incompetence? It all began to weigh on my shoulders.

As I left, the captain thanked me for my help and told me he would get the whole crew together for a debriefing. However, back at home, and talking it over with my wife, I felt the unanswered questions, and my sleep was a troubled sleep.

The following were some of the questions.

PROBLEM OF COMPETENCE

Are we obliged as doctors to make ourselves known on 'is there a doctor on board, we have an emergency'? It is most likely that the patient has a disorder outside the field of your own expertise. *What then is the best approach?* Because of our training, we are still competent to make a better decision than the untrained bystander, *but what if we just had a few glasses of wine and a sleeping pill?*

PROBLEM OF LITIGATION

Could the patient sue us for a wrong diagnosis? Could other passengers sue us for their missed-connections and disruption? Could the airline sue us for incompetence?

Are there differences aboard an American airline, a Chinese domestic airline or my KLM flight?

PROBLEM OF CONFIDENTIALITY

When we make a diagnosis, we establish a doctor-patient relationship and cannot share information with civilians, like an aeroplane's purser or captain.

However, if we diagnose in an airplane incident, does that create a doctor-patient relation, with similar confidentiality?

PROBLEM OF CONTINUITY

Imagine a heart-attack patient who needs continuous resuscitation. This must continue until ground professionals can

take over, *but what to do if the fasten-seatbelt sign comes on, and the captain asks the cabin crew (and all other passengers) to resume their seats for landing?*

I searched the literature for answers, but with little success. So I contacted the Airport Medical services (AMS) of KLM and made an appointment for an interview with Dr Brinio Veldhuijzen van Zanten (BVvZ), who is managing director of KLM Health Services and Peter Nijhof (PN), responsible physician of AMS, at Amsterdam's Schiphol Airport.

CNvD: As doctors, are we legally obliged to respond, when we hear "Is there a doctor aboard? We have an emergency", even if we have drunk a few glasses of wine, and taken a sleeping-pill? The surgeons on 17th century warships may have worked better, after they had drunk the rum they used for anaesthesia, but those were the good old days.

PN: For Dutch doctors it is simple. If you are a registered as a doctor, you come under the *BIG Act* (the Dutch Individual Healthcare Professions Act which covers all health-care professionals). And the *BIG Act* obliges you to help. If you refuse, there are legal consequences. The *BIG Act* states that you should only do what you are competent to, and what you are authorized to do. If you are a general-practitioner, for example, you should not operate, because although you are "qualified", you are not "competent". But in an emergency you should act to the best of your ability. If you have been drinking or taking sedatives—and feel less able to help—then you should inform the crew of that.

CNvD: What about other countries' doctors?

PN: There are similar laws across Europe and some other countries. But Common-Law countries—such as England, Canada and America—they follow different rules. You only need to help a patient if it happens to be one of your own patients. So if there is a prior doctor-patient relationship. In all other cases you are not (legally) obliged to help.

CNvD: So that's essentially different from Europe

PN: Yes, but of course there is a moral requirement. If you are the only doctor on board, and you are called to help with a medical-incident, but refuse (by keeping silent), then you have failed your moral-duty. And there may be a civil redress against you.

CNvD: Oh yes? And even for an American doctor?

PN: Yes, I believe so. If you are qualified and competent, you must respond to

an emergency situation, especially if you have been asked. If you fail to do so In Europe, you can be called to account, and disciplined.

But because there is no legal obligation under US Law, they passed the "Good Samaritan Law". This states that, when a doctor offers assistance aboard an American aircraft, he cannot be held responsible (liable) for his medical treatment, provided that he acted in accordance with professional standards (and provided he was not drunk or drugged). If you are qualified and competent, then you are authorized to act, and you will not be held liable for the consequences of your medical-action.

CNvD: Does this Good Samaritan Law only apply to aviation?

BVvZ: Yes, There is a special "Aviation Medical Assistance ACT", (<https://www.govinfo.gov/content/pkg/CRPT-105hrpt456/pdf/CRPT-105hrpt456.pdf>) for US airplanes, with reference to the Good Samaritan Law.

CNvD: And does it only apply to American flights?

PN: It applies to American territory, but if you are inside an American aircraft, you are presumed to be on American territory.

As far as I know—and as far as literature shows—there has never been a lawsuit against a medical professional, who was asked for assistance by the airline. But you must be asked by the airline, that's to say by the Captain. If you are sitting next to a passenger who stops breathing, and you start resuscitation immediately—before you have been asked by the aircrew, then that is your own responsibility.

CNvD: So it's important, that the airline asks you to help?

PN: Absolutely, the Captain (or his representative) should ask you to help. The Cabin Crew is fully trained in resuscitation, and they have a first-aid kit. They must first see the problem, report to their Captain, who -if there is enough time-will contact the airline's medical services on the ground. When Cabin Crew asks: "is there a doctor on board?", the airline requests the help from a passenger-doctor, because obviously they don't have their own doctor on board. The airline however retains control.

CNvD: So if there is a request, there has already been contact between captain and ground medical staff?

PN: Certainly on intercontinental flights. Inside Europe, there may be no direct communication, but only control-tower talking to control-tower. There is no satellite-link. Sometimes we are alerted by our control tower: "an airplane is landing,

and somebody has breathing problems, so get an ambulance to the gate". In these cases there is no direct contact.

With intercontinental flights, there is satellite-linkage, and we will have direct contact with the Captain. And sometimes he will ask a passenger-doctor to enter his cabin, to speak directly with the ground medical staff

CNvD: What about my case? A passenger with possible brain haemorrhage, and my recommendation about emergency landing? I didn't have contact with medical staff on the ground. I didn't even know it was possible.

PN: Probably the Captain had contact: "We have a passenger with a suspected brain-haemorrhage. A doctor-on-board has diagnosed him, and advises landing in Madrid. Do you agree?" Then we would ask about the symptoms: "Our doctor says Hemi-paralysis, a high blood pressure, asymmetric pupillary reflex, the patient is hardly approachable etc., etc" . Then we would approve an emergency landing. But the captains makes the final decision if it safe to make an emergency landing.

CNvD: When I made my diagnosis, I shouldn't really have spoken with the purser. I should have said: "I have medical confidentiality, and cannot share information with a layman".

PN: Yes, strictly speaking, but this was an emergency.

CNvD: So, do the same again next time?

PN: Absolutely. How would you do it differently?

CNvD: Maybe I could say: "I would like to discuss my diagnosis with a doctor on the ground".

Yes, In principle that is possible, but it rarely happens. Of course you don't have to give details to the purser. You only need to say that it's really an emergency, and you advise landing as quickly as possible. Whether that violates your professional secrecy is for lawyers to decide. But you are acting in the patient's best interests and, as I have already mentioned, there hasn't been a problem so far.

Just remember, the Captain is fully responsible for his flight, for everything that happens on his flight. As a doctor, you are giving medical advice to the Captain, who relays it to his ground medical staff.

CNvD: So the overall decision is the Captain's, and not the doctor's?

PN: Yes. The Captain issues his orders, after consulting you.

CNvD: And I cannot be called to account for my advice?

PN: No, the Captain asks for your advice, but he makes the decision. When the passenger-doctor agrees with the

ground-doctor, it's easy for him. It's more difficult—and annoying—when there is a difference of opinion. But in that case he would normally follow the ground-doctor, simply because we deal with these problems on a daily basis.

Returning to your case, where you diagnosed a brain haemorrhage, and urged treatment within 6 hours. Yes, it would have been more convenient—at least for the airline—to continue to Amsterdam, rather than stopping in Madrid, gaining those 90 minutes, but with 400 people in the wrong place.

But that is why the Good Samaritan Law was passed: to overcome the fear of providing medical assistance and to provide treatment advice or advice to make an emergency landing. You provide professional advice, only when the airline asks for it. And they take the responsibility.

CNvD: If you diagnose a patient in an airplane, do you have a doctor-patient relation? Should I have made a report on my findings?

If you diagnose a patient in an emergency situation you do indeed create a doctor-patient relationship. This normally requires written notes, which can be sealed, and accompany the patient to his treating physician.

CNvD: Lastly, what about resuscitation?

PN: The cabin crew is trained to start and continue resuscitation. Of course

physicians on board can assist with this, especially when they are also trained. However, when the fasten seatbelt sign goes on, and cabin crew are asked to resume their seats, then, yes, you need to stop the resuscitation and return to your own seat. Cabin crew will continue the resuscitation.

IN CONCLUSION

Conscience urges we treat all patients, no matter what. We will help, when we are asked. This also applies in the air. The big act—and similar acts across Europe and other continents—state that we should only do what we are competent to. In an emergency, we will act to the best of our ability. In the USA, there is no legal obligation to help; however, the 'Good Samaritan Law' regulates the liability for the medical treatment, provided that it is in accordance with professional standards and provided that medical assistance has been asked for by the airline.

Next time when you are on a flight and you hear 'we have an emergency: is there a doctor on Board?', I hope this editorial made you comfortable that 'Primum non nocere' (*First do no harm*)³ does not translate to *remain seated*.

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REFERENCES

- 1 Graf J, Stüben U, Pump S. In-flight medical emergencies. *Dtsch Arztebl Int* 2012;109:591–602.
- 2 Kleijne I. Dokteren OP dertigduizend voet (doctors at thirty thousand feet). *Medisch contact* 2019;22.
- 3 Hippocrates. Asklepiion, 400 bc.