Comment on: What to do during inflight medical emergencies? Practice pointers from a medical ethicist and an aviation medicine specialist

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Dear Sir,

Inflight medical cases pose various ethical problems that are different in magnitude from ethical problems 'on the ground'. This subject has not been explored much in bioethics literature; thus, the article by Ho et al[1] allows for some novel discussion.

The authors made several controversial claims. First, they believe that the doctor should always support the crew and pilot. This is true in most cases, but the physician should not support the pilot if the pilot prioritises the interests of the airline over the patient's. Second, they seemingly believe that all physicians have a duty of care toward inflight patients; however, one must consider what it is about physicians that confers this duty on them. A wealth of literature addresses this ethical issue, particularly in the context of extreme situations.[2-4] It may be argued that it is physical competence, rather than qualifications or the Hippocratic oath, that obliges the physician to provide care in a particular circumstance. An emergency medicine physician has an obligation to assist an inflight patient with chest pain, but there is less or no obligation if the physician is a plastic surgeon, or a retired physician who passed Advanced Life Support training 40 years ago. If this argument holds true, a student who just finished an emergency medicine rotation may be deemed to possess a stronger obligation of care than a plastic surgeon.

I would like to add nuance to this discussion of ethics in inflight medical cases by providing two examples based on my personal experience. In one situation, a 50-year-old woman on a transatlantic flight presented with what seemed to be heartburn with low pretest probability of being a true medical emergency. I asked the flight attendants and the patient for antacids, but they had none. For lack of a better option, I went around the plane to ask other passengers for antacids. I finally found one and handed the drug to the patient.

My intention in this case was good, but did I do the right thing in asking the other passengers for the drug? Aside from safety concerns such as fake drugs, what I did unwittingly revealed the patient's condition to other passengers. Without seeking the patient's consent, I had implicitly assumed that the patient would be more concerned about her condition rather than her privacy. In retrospect, I should have asked the patient for permission before approaching the other passengers. Making value judgments for patients is risky business.

The other situation occurred during a trans-Pacific flight. A 24-year-old woman suffered from a panic attack, so I stayed with her until she felt better. When I met the patient and her friend after the flight, I learnt that they were going to tour the downtown area. I had an eight-hour layover before my next flight and wondered whether it would be appropriate to join them. If this had taken place within the hospital, I would not have joined them for fear that it would compromise doctor-patient relations. But in such a situation, where do doctor-patient relations end and passenger-passenger relations begin? Emergency medicine often does not allow us to contemplate ethical dilemmas in real time, perhaps more so than other fields of medicine; ethics training thus becomes paramount.

Yours sincerely,

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References

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Editor's note: The authors, Ho et al, have declined to respond to the above letter.