IJMS INTERNATIONAL JOURNAL of MEDICAL STUDENTS

Experience

Is There A Doctor Onboard?

Holly Cathryne Brownlee.[1]

The Experience

I was 35,000 feet in the air and 90 minutes into an early morning flight to mainland Europe when the call alarm began to sound. As I moved towards the accumulating cluster of the flight crew, I saw that a woman was slouched back into her chair, seemingly unresponsive. I stated that I was a medical student and asked if anyone was more qualified onboard; they put out a call and received no response. So, I proceeded with my ABCDE approach, as has been dutifully drilled into me by my medical school. Thankfully she was breathing, and her airway wasn't compromised; she was unresponsive to voice but did respond to pain. A and B were assessed for now. I considered laying her down in the aisle and elevating her legs, suspecting vasovagal syncope, but this was not feasible given her size and the limitations within the cabin. Onto C, her heart rate was slightly high at around 90 beats per minute, and her capillary refill was less than 2 seconds. I did not have a sphygmomanometer to hand, nor was there a stethoscope anywhere onboard; however, I did manage to acquire a smartwatch that enabled me to monitor her heart rate and even provided an electrocardiogram, showing her to be in sinus rhythm. Her Glasgow Coma Scale (GCS) was 9 when I arrived,[1] and her pupils were equal but sluggish to react.

I then asked them what medical equipment they had onboard giving her oxygen supplied by the cabin crew. Essentially: plasters and a defibrillator. I proceeded to take a collateral history from her husband and ascertained that she felt faint and nauseous and then proceeded to lose consciousness. She was in her early 50s with no medical history of note. She had eaten that morning and had not been drinking alcohol. I then checked her GCS again, which was down to 8. It had now been over 5 minutes and I feared it was a possibility she may lose her airway. However, I was also acutely aware of my own lack of competencies if this were the case. There was a discussion between myself, the pilot, and the crew regarding the diversion of the plane. I presume the pilot was in contact with the medical crew on the ground; however, I was not made aware of this.

In the meantime, I continued to monitor the vital signs that I could and her neurological status and after some time, the lady began to regain consciousness. Her GCS quickly returned to 15; she was orientated to time and place and neurologically intact with the exception of a slight tingling sensation in her left arm. She remained stable for the rest of the flight, and I attempted to keep her and her husband as calm as possible and answering any questions but making sure they understood I was not yet a qualified doctor. I asked the aircrew to ensure an ambulance was waiting when we landed and wrote down a record of what had occurred for the paramedics, and the lady took a picture of my notes to show her General Practitioner. I then enjoyed a complimentary chocolate bar and chatted with her about her holiday plans until we landed, and I handed over to the paramedics and said goodbye. Disembarking the flight into the early morning sunshine, I began to reflect on the morning's events, questioning my actions and decisions and calling the most experienced doctor I knew, my Mum, to go over what had happened.

I am aware that many people have had a similar experience and have reflected on the legal risks and obligations involved alongside the logistics of attending to an inflight medical emergency.[2-4] I have discovered through research that as a medical student I was under no legal obligation to assist, however, the law varies internationally in this regard concerning qualified physicians. I made it clear that I was not a qualified doctor and made sure to act within my own competencies. I was aware at the time that I was not legally permitted to administer prescription medication but did not know what the legal implications may be regarding any wrong decision I made. The Good Samaritan law would protect me somewhat, however, the legislation varies between countries.[5-6] Referring to The Good Medical Practice guidelines from the General Medical Council, which state the responsibility of a doctor to assist in an emergency is always of relevance. However, this does not apply directly to medical students.[7]

Another aspect of my experience was the limited equipment I was provided and what equipment may have been useful. Upon research, there is no standard set of medical equipment European airlines carry and no set guidelines or consensus leading to a variation in what is available on any given flight.[8-9] For example, the reduced partial pressure of oxygen must be considered in the use of a pulse oximeter, and the sound of the engines makes the use of a stethoscope impractical. Airway adjuncts should be included in a medical kit for emergencies. However, these must be used only by those who are qualified to do so. If my patient had lost their airway, I would not have been competent to establish a definitive airway however, I could have opened her airway and used a bag valve mask if needed. Finally, in a medical landscape dominated by algorithms and proforma, it felt unusual to be in a situation without these tools for guidance. A standardized handbook containing guidelines for common medical emergencies onboard aircraft would be a useful tool for all onboard, including medical practitioners and the cabin crew. This would provide standardized guidance for those assisting in the challenging environment of a commercial aircraft and is certainly something I would have been grateful for.

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Editor: Francisco J. Bonilla-Escobar
Student Editors: Mohamed Fahmy Doheim, Purva Shah, Vinson Chan
Copyeditor: Nguyen Tran Minh Duc
Proofreader: Anna-Maria Chantaliyska
Layout Editor: Sushil Dahal

Submission: Sept 9, 2020
Revisions required: Dec 14, Dec 29, 2020
Received in revised form: Dec 25, 2020
May 4, 2021
Acceptance: May 4, 2021
Publication: Jun 30, 2021
Process: Peer-reviewed

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Acknowledgments

None.

Conflict of Interest Statement & Funding

The Author has no funding, financial relationships or conflicts of interest to disclose.

Author Contributions

Conceptualization, Project Administration, Resources, Supervision, Validation, Visualization, Writing – Original Draft Preparation, Writing – Review and Editing: HCB.

Cite as

Brownlee HC. Is There A Doctor Onboard? Int J Med Students. 2021 May-Jun;9(2):174-5.

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ISSN 2076-6327

This journal is published by the University Library System, University of Pittsburgh as part of the Digital Publishing Program and is co-sponsored by the University of Pittsburgh Press.

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