



A PROPOSED PROTOCOL OF MEDICAL NEGLIGENCE ON-BOARD INTERNATIONAL COMMON CARRIER  
FLIGHTS IN THE CONTEXT OF INTERNATIONAL LAW, TREATIES AND/OR INSTRUMENTS.

by

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I will be forever grateful.



## SUMMARY

To determine to whom liability will attach when an act of medical negligence were to occur on-board an international Common Carrier aircraft -

- The airline for not providing / creating adequate conditions for medical assistance / healthcare;
- The medical practitioner, as a good Samaritan, for providing substandard care, albeit in less than ideal surroundings;
- The medical insurer, based on an ethical duty to indemnify / cover its doctors?

The main focus of the study will therefore be to clarify whether either the airline itself or the doctor in their personal capacity providing assistance, could be held liable, alternatively jointly liable, in the event of a procedure being performed on-board a commercial carrier which procedure then does not go according to plan. Any refusal by a medical practitioner to treat a passenger in distress, albeit for a sound reason, would certainly pose an ethical dilemma to the practitioner on board.

In this critical analysis of medical negligence in the context of international law, specifically pertaining to long-distance international airline flights, the focus shall fall on the liability of any medically negligent act as well as the duty of care and such standard of care provided in accordance with such duty.

It will further be to determine whether the passengers' Constitutional right to healthcare in terms of section 27 of the Constitution "trumps" all other rights, including the medical practitioners' right to refusal to provide medical treatment?

## **CHAPTER 1:**

### **Introduction**

#### **1.1 Background**

With the rise in medical negligence claims in the spheres of both public as well as private medical health care in South Africa, it is only a matter of time before medical negligence takes to the national and international air travel, placing in-flight emergency health care diagnosis and treatment under the spotlight.

Following a recent 15 hour intercontinental flight to Italy with a general medical physician by my side, it came to my attention that a certain expectation is placed on both volunteer medical physicians as well as airlines to provide a level of medical assistance to fellow-passengers in mid-air distress.

This led to the question of liability if an act of emergency medical healthcare were to result in negligence, and if so, who would then be liable for such negligence -

- The airline for not providing / creating adequate conditions for medical assistance / healthcare; or
- The medical practitioner, as a good Samaritan, for providing substandard care, albeit in less than ideal surroundings?

In this critical analysis of medical negligence in the context of international law, specifically pertaining to long-distance international airline flights, the focus shall fall on the liability of any medically negligent act as well as the question to whom such negligence shall attach.

The right to emergency medical health care and the corresponding ethical obligation of airlines as well as in-flight volunteer physicians will be discussed in the context of the Constitution of the Republic of South Africa<sup>1</sup> (hereinafter referred to as “the Constitution”) and consideration of international framework:

#### **1.2 Research Question / Problem Statement**

The focus of the study will be to clarify whether either the airline itself or the physician providing assistance could be held liable, individually or jointly, in the event of diagnosis or treatment provided on-board a commercial carrier which falls short of the accepted standard of care. Consideration is also given to any refusal by a medical physician to treat a passenger in distress, albeit for a sound reason such as fear of possible litigation, and the ethical dilemma that this poses.

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<sup>1</sup> Constitution of the Republic of South Africa Act 108 of 1996

Also to determine whether the ailing passengers' Constitutional right to emergency healthcare<sup>2</sup> "trumps" all other rights, including the medical practitioners' right to refuse to provide medical treatment.

The Medical Protection Society (MPS) does extend cover to its clients for Good Samaritan acts, and they can therefore not be considered for any possible liability.

It is further assumed that the airline would take all reasonable steps to ensure that their health and safety procedures on board the flights are up to standard, only insofar as they are capable of ensuring same, considering the availability of financial resources, medical expertise, etc.

The rights contained in the Constitution, more specifically Chapter 2 of the Bill of Rights, are considered to be absolute, subject to the limitation clause contained in section 36 thereof. Therefore, if the physician has a justifiable ground for refusing treatment, then the passenger's right to treatment will not "reign supreme". It is also worth considering whether or not the possibility of being sued is a justifiable ground for a medical physician to refuse medical assistance to a fellow passenger.

It is assumed that, in the absence of overwhelming statutory authority, the main grounds of justification relied upon will be those of emergencies and the *boni mores* / legal convictions of society, considering both the circumstances surrounding and location of the emergency.

The rights protected in the Constitution will be tested and scrutinised in context of the limitation clause.

### 1.3 Methodology

This study will follow a comparative research methodology by completing an analysis of the right to emergency health care rules, both locally and internationally.

This comparison will indicate where the Constitution, the federal Emergency Medical Treatment and Active Labour Act of 1986 (EMTALA)<sup>3</sup>, The Air Carrier Access Act of 1986 and The Federal Aviation Medical Assistance Act of 1998 rules are different. Furthermore, solutions and recommendations will be made where deficiencies need to be addressed.

Sources will include statutes, case law and opinions of academic writers. The following will be used to critically analyse the South African health care law: the Constitution, the National Health Act<sup>4</sup>, rules of interpretation and assumptions that apply to the right to health care in general, case law determining both the duty and standard of health care, ethical considerations as well as International rules and regulations.

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<sup>2</sup> Section 27 of the Bill of Rights of the Constitution of the Republic of South Africa Act 108 of 1996

<sup>3</sup> The federal Emergency Medical Treatment and Active Labour Act of 1986

<sup>4</sup> National Health Act 61 of 2003

#### 4. Proposed Structure

In Chapter 2 the study shall consist of an in-depth discussion of the most common types of in-flight medical emergencies as well as the scenarios in which in-flight medical emergencies occur and the frequency of these incidences. The issue of jurisdiction will briefly be discussed. The Good Samaritan doctrine will also be discussed with reference to different international laws in which volunteer medical physicians provide their in-flight assistance.

Chapter 3 shall address the effect of in-flight medical emergencies on international common carrier aircrafts by analysing the on-board response protocols for the emergency treatment of ailing passengers as well as the standard of the emergency medical kits used and the effects of diverting a common carrier aircraft.

In the next chapter the duty of care will be discussed with reference to case law as well as ethical considerations.

Chapter 5 will consider the standard of care to which physicians are held and whether such standards remain the same when responding to an in-flight medical emergency. Consideration is also given to the defence of *imperitia culpa adnumeratur*.

Chapter 6 will address the Constitution. The importance of the Constitution when interpreting the right to health care will be evaluated. Specific reference shall be made to section 27 of the Constitution which grants every person the right not to be refused emergency medical care. Further in this chapter the grounds on which such rights may be limited will be discussed. Throughout the various discussions and evaluations in this chapter, reference shall be made to applicable case law.

Chapter 7 will discuss the ground for liability of both the in-flight volunteer physician and the airline respectively, in terms of either delict or contract, weighed against the passenger's right to medical care. The onus that lies on airline passengers to limit the occurrence of in-flight medical emergencies will also be discussed.

In chapter 8 of this study, the grounds on which the passenger's right to emergency health care as well as the standard of such health care limitations, will be discussed.

The next chapter will attempt to propose solutions to the prevalent rise of in-flight medical emergencies.

The last chapter of this dissertation will consist of a conclusion where the research shall be placed into perspective and various recommendations shall be made for the best way forward for the South African law of medical negligence and ethics on-board intercontinental airline flights.

#### 5. Delimitations or Delineations:

This study will not include a detailed discussion of the laws of Italy, Greece, Finland, Germany, Israel, China, Canada, France or related legislation.

## **CHAPTER 2:**

### **International Case Discussion**

“Economy air travel has often been described as a sort of midair version of Virchow’s triad: dehydration, immobilization and predisposing factors increasing the risk of deep vein thrombosis<sup>1</sup>.”

#### **2.1 Scenario**

Consider the following situation: Whilst travelling on an Air France international flight out of New York, Doctor Internist responds to an in-flight medical emergency, to assist a US passenger who had briefly lost consciousness but then appeared to recover.

Following the examination, Doctor Internist makes a tentative diagnosis of a transient ischaemic attack, but does not think an immediate diversion is necessary. Based on Doctor Internist’s diagnosis, the pilot does not divert and continues on the original flight plan, landing several hours later in Paris, France. Meanwhile, the passenger’s condition worsened and he expired shortly after arrival<sup>2</sup>.

#### **2.2 Jurisdiction**

It is considered that when a volunteer physician provides in-flight medical assistance to a fellow passenger in medical distress, a doctor-patient relationship with all the attendant obligations and liability is created<sup>3</sup>.

The liability is generally determined under the law of the country in which the aircraft is registered, however the law of the country in which the incident occurs or in which the parties are citizens could arguably apply<sup>4</sup>.

#### **2.3 Frequency of Occurrence**

Based on the data of a study concluded in 2013, it is estimated that 44,000 in-flight medical emergencies occur worldwide each year<sup>5</sup>, with one in-flight emergency per 11,000

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<sup>1</sup> Be Prepared for In-Flight Medical Emergencies <http://www.acep.org/Clinical---Practice-Management/Be-Prepared-for-In-Flight-Medical-Emergencies/>

<sup>2</sup> S. Y. Tan, M.D., J.D *Midair medical emergencies* (Internal Medicine News: 2015)

<sup>3</sup> J. V. Noble, M.D., N. R. P., C. L. Tupe, M.D., B. D. Gehle, J.D., and W. J. Brady, M.D. *In-Flight Medical Emergencies during Commercial Travel* (N Engl J Med: 2015) 373: 939-945

<sup>4</sup> J. V. Noble, M.D., N. R. P., C. L. Tupe, M.D., B. D. Gehle, J.D., and W. J. Brady, M.D. *In-Flight Medical Emergencies during Commercial Travel* (N Engl J Med: 2015) 373: 939-945

<sup>5</sup> Drew C. Peterson, M.D., Christian Martin-Gill, M.D., M.P.H., Francis X. Guyette, M.D., M.P.H., Adam Z. Tobias, M.D., M.P.H., Catherine E. McCarthy, B.S., Scott T. Harrington, M.D., Theodore R. Delbridge, M.D., M.P.H., and Donald M. Yealy, M.D. *Outcomes of Medical Emergencies on Commercial Airline Flights* (N Engl J Med: 2013)



passengers.<sup>6</sup> In-flight medical emergencies are a daily occurrence necessitating the assistance of travelling physicians and other health care providers to aid a fellow ill passenger. However, such incidences are very rare when considered on a per-passenger basis.<sup>7</sup> In fact, the actual figure may be much higher, in the absence of a mandatory reporting system and the underreporting of minor incidences<sup>8</sup>. In addition, the prevalence of in-flight medical emergencies has increased with the advent of airplanes such as the Airbus A380, which is able to carry twice the amount of passengers as current aircrafts<sup>9</sup>.

## 2.4 In-flight Medical Emergencies

Notwithstanding the absence of concrete figures, the reality and expectation is that the number of in-flight medical emergencies is set to increase at least in parallel to air traffic growth<sup>10</sup>.

By its very nature, a common carrier is not an environment in which to expect access to any established health care system. However, the airlines are faced with a dilemma: with an increase in both an aging and more sickly air travel population with more medical problems, that expects a duty of care from the airline, many more passengers are taking to the skies<sup>11</sup>, resulting in an increase in in-flight medical incidences, thus necessitating the airline to reach a good balance between the immediate risk and cost of a diversion, versus the implied risk, or even liability, when deciding to continue a flight with an ill or injured passenger.

Airlines are faced with a further dilemma as prescribed by anti-discrimination law(s) to ensure that individuals with disabilities or chronic illnesses should be accommodated on flights wherever possible.

Following a study of 11,920 in-flight medical emergencies in 2013, an average of 91 in-flight medical emergencies occurred per 604 flights<sup>12</sup>, of which the most common medical conditions likely to result in a diversion are:

1. Heart attacks are responsible for 86% of diversions<sup>13</sup>;

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<sup>6</sup> Be Prepared for In-Flight Medical Emergencies <http://www.acep.org/Clinical---Practice-Management/Be-Prepared-for-In-Flight-Medical-Emergencies/>

<sup>7</sup> Drew C. Peterson, M.D., Christian Martin-Gill, M.D., M.P.H., Francis X. Guyette, M.D., M.P.H., Adam Z. Tobias, M.D., M.P.H., Catherine E. McCarthy, B.S., Scott T. Harrington, M.D., Theodore R. Delbridge, M.D., M.P.H., and Donald M. Yealy, M.D. *Outcomes of Medical Emergencies on Commercial Airline Flights* (N Engl J Med: 2013)

<sup>8</sup> B. Tinker *Sick and dying at 30,000 feet* (2016)

<sup>9</sup> "Management of In-flight Medical Emergencies" by Keith J. Ruskin, M.D., Keith A. Hernandez, M.D., Paul G. Barash, M.D. *Anesthesiology* 4 April 2008: vol 108: 749 - 755

<sup>10</sup> P. Alves, MD, MSc; H. MacFarlane, Med *The Challenges of Medical Events in Flight* (A MedAire-Sponsored Paper: 2011)

<sup>11</sup> C. Gounder *Medical Emergencies at 40,000 Feet* (The Atlantic: 2013)

<sup>12</sup> Drew C. Peterson, M.D., Christian Martin-Gill, M.D., M.P.H., Francis X. Guyette, M.D., M.P.H., Adam Z. Tobias, M.D., M.P.H., Catherine E. McCarthy, B.S., Scott T. Harrington, M.D., Theodore R. Delbridge, M.D., M.P.H., and Donald M. Yealy, M.D. *Outcomes of Medical Emergencies on Commercial Airline Flights* (N Engl J Med: 2013)

<sup>13</sup> S. Perry *In-flight medical emergencies are surprisingly common* (MINNPOST: 2015)

2. Fainting (syncope) accounts for 37%<sup>14</sup>;
3. Difficulty breathing (dyspnea) resulting in 12%<sup>15</sup>;
4. Strokes are responsible for only 2%, the symptoms of which are sometimes mimicked by low blood sugar<sup>16</sup>;
5. Seizures result in 6%<sup>17</sup>;
6. Psychiatric issues result in 3.5%<sup>18</sup>.

Although the majority of in-flight medical emergencies occur due to pre-existing conditions or acute illnesses, the pressurised cabin environment (which causes a 10% drop in blood oxygen saturation in the average traveller<sup>19</sup>), and the physical conditions associated with air travel, such as immobility, cramped seating conditions, drowsiness and gastrointestinal expansion, can hinder the body's response to volume of respiration causing a passenger to become unwell<sup>20</sup>. In addition, the prolonged periods of inactivity by passengers may cause deep venous thrombosis as well as pulmonary embolus, and the varying meal times may hold risks for insulin-dependent diabetics<sup>21</sup>.

In addition, certain airlines have adopted the practice of "pinching the inches" by increasing passenger numbers at the expense of individual space allocations resulting in a decrease in seat space and reduction of cabin air quality. All of which certainly impinge on the comfort, if not the health, of passengers<sup>22</sup>.

## 2.5 Volunteer Medical Professionals / Physicians

Providing emergency medical care at 36,000 feet is a daunting proposition for any medical physician as the environment onboard a common carrier is noisy, with poor lighting, low humidity, low air pressure, cramped spaces, lack of privacy and dropped oxygen saturations as well as possible language barriers<sup>23</sup>.

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<sup>14</sup> S. Perry *In-flight medical emergencies are surprisingly common* (MINNPOST: 2015)

<sup>15</sup> S. Perry *In-flight medical emergencies are surprisingly common* (MINNPOST: 2015)

<sup>16</sup> S. Perry *In-flight medical emergencies are surprisingly common* (MINNPOST: 2015)

<sup>17</sup> S. Perry *In-flight medical emergencies are surprisingly common* (MINNPOST: 2015)

<sup>18</sup> S. Perry *In-flight medical emergencies are surprisingly common* (MINNPOST: 2015)

<sup>19</sup> C. Gounder *Medical Emergencies at 40,000 Feet* (The Atlantic: 2013)

<sup>20</sup> B. Shepherd, D. Macpherson and C. M. B. Edwards *In-flight emergencies: playing The Good Samaritan* (Journal of the Royal Society of Medicine: Dec, 2006) vol. 99

<sup>21</sup> B. Shepherd, D. Macpherson and C. M. B. Edwards *In-flight emergencies: playing The Good Samaritan* (Journal of the Royal Society of Medicine: Dec, 2006) vol. 99

<sup>22</sup> B. Shepherd, D. Macpherson and C. M. B. Edwards *In-flight emergencies: playing The Good Samaritan* (Journal of the Royal Society of Medicine: Dec, 2006) vol. 99

<sup>23</sup> A. Neinstein *Is There A Doctor On The Plane? Dealing With In-Flight Medical Emergencies* (2013)

The study concluded in 2013 determined that medical assistance was provided by physician passengers in 48.1% of in-flight medical emergencies and aircraft diversions occurred in 7.3% of these occurrences<sup>24</sup>.

Although there is no legal obligation to intervene, volunteer medical professionals are often called upon to assist on a moral and professional obligation<sup>25</sup>, notwithstanding the absence of guidelines or best practices to guide their actions<sup>26</sup>.

## 2.6 The Good Samaritan Doctrine

The “Good Samaritan” doctrine<sup>27</sup> is a universal concept intended to encourage emergency assistance, on a voluntary basis<sup>28</sup>, in an emergency situation by removing the threat of liability for damage done by the assistance, provided that the assistance is not made recklessly or in a grossly negligent manner<sup>29</sup>. In general, although the law encourages rescue, it does not affirmatively require doctors to come to the aid of strangers.

Generally speaking, as long as you use reasonable care in voluntarily assisting a person, who does not object to such assistance, during an emergency, *based on the resources that you have available to you at the time* (own emphasis), you cannot be sued for any injuries that the person sustains during the incident<sup>30</sup>. Typically, there is legal immunity against ordinary negligence but not gross misconduct, although California appears to excuse even gross negligence if it was done in good faith<sup>31</sup>.

In order to successfully invoke the protection of the Good Samaritan doctrine, the emergency situation must not be caused by the Good Samaritan and the care provided must be in response to the emergency in a manner that is not grossly negligent or reckless<sup>32</sup>. If the Good Samaritan errs in the rendering of care, no liability will be attached if the care is provided in good faith at the scene of the emergency with no expectation of financial remuneration for

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<sup>24</sup> Drew C. Peterson, M.D., Christian Martin-Gill, M.D., M.P.H., Francis X. Guyette, M.D., M.P.H., Adam Z. Tobias, M.D., M.P.H., Catherine E. McCarthy, B.S., Scott T. Harrington, M.D., Theodore R. Delbridge, M.D., M.P.H., and Donald M. Yealy, M.D. *Outcomes of Medical Emergencies on Commercial Airline Flights* (N Engl J Med: 2013)

<sup>25</sup> Drew C. Peterson, M.D., Christian Martin-Gill, M.D., M.P.H., Francis X. Guyette, M.D., M.P.H., Adam Z. Tobias, M.D., M.P.H., Catherine E. McCarthy, B.S., Scott T. Harrington, M.D., Theodore R. Delbridge, M.D., M.P.H., and Donald M. Yealy, M.D. *Outcomes of Medical Emergencies on Commercial Airline Flights* (N Engl J Med: 2013)

<sup>26</sup> A. Chandra, S. Conry *In-Flight Medical Emergencies* (Western Journal of Emergency Medicine: 2013) 499–504

<sup>27</sup> Also known as “volunteer protection laws”

<sup>28</sup> Good Samaritan Law & Legal Definition <http://definitions.uslegal.com/g/good-samaritans/>

<sup>29</sup> Good Samaritan Doctrine legal definition of Good Samaritan Doctrine <http://legal-dictionary.thefreedictionary.com/Good+Samaritan+Doctrine>

<sup>30</sup> What are Good Samaritan laws? <http://resources.lawinfo.com/personal-injury/what-are-good-samaritan-laws.html>

<sup>31</sup> S. Y. Tan, M.D., J.D *Midair medical emergencies* (Internal Medicine News: 2015)

<sup>32</sup> Good Samaritan Doctrine legal definition of Good Samaritan Doctrine <http://legal-dictionary.thefreedictionary.com/Good+Samaritan+Doctrine>

such services rendered. Charging for services rendered by the volunteer physician would lead to a shift in expectations of the type and standard of care provided.<sup>33</sup>.

## 2.7 Good Samaritan Law: United States

The laws / acts pertaining to Good Samaritans vary by jurisdiction, where some extend protection to medical personnel only, while others extend such protection to lay persons, and a few states don't extend such protection at all.

### 2.7.1 The Air Carrier Access Act of 1986

The Act states that “an individual shall not be liable for damages in any action brought in a 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 wilful misconduct.”

### 2.7.2 The Federal Aviation Medical Assistance Act of 1998

The Act provides that “an air carrier shall not be liable for damages in any action brought in a Federal or State court arising out of the performance of the air carrier in obtaining or attempting to obtain the assistance of a passenger in an in-flight medical emergency, or out of the acts or omissions of the passenger rendering the assistance, if the carrier in good faith believes that the passenger is a medically qualified individual and not an employee or agent of the carrier”<sup>34</sup>.

The Act further states that “an individual shall not be liable for damages in any action brought in a 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 wilful misconduct”<sup>35</sup>.

The Act does not attach any liability to the volunteer medical physician if an ailing passenger receiving treatment suffers harm as a result of the absence of appropriate

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<sup>33</sup> B. Shepherd, D. Macpherson and C. M. B. Edwards *In-flight emergencies: playing The Good Samaritan* (Journal of the Royal Society of Medicine: Dec, 2006) vol. 99

<sup>34</sup> Section 5(a) of the Aviation Medical Assistance Act of 1998

<sup>35</sup> Section 5(b) of the Aviation Medical Assistance Act of 1998

medical equipment, which should be supplied by the airline<sup>36</sup>. However, the volunteer medical physician is not released from the legal duty and standard of care simply because the airline provides the medical resources<sup>37</sup>.

### 2.7.3 The American Medical Association's Code of Medical Ethics 2012 – 2013 edition

The United States common law does not impose a legal duty for any person, even a medical physician, to provide assistance to a stranger. However, doctors are generally held to have an ethical obligation to provide emergency care<sup>38</sup>.

Two Californian Courts, in the civil matter of *Alexandra Van Horn v Lisa Torti*<sup>39</sup>, (incorrectly) interpreted “emergency care” and “medical care” when Lisa Torti pulled her friend, Alexandra Van Horn, from their wrecked car in Topanga, California. Van Horn was left without the use of her legs. “Emergency care” may only be provided by medical personnel. Fortunately, the 1980's Californian Good Samaritan law has since been revised accordingly<sup>40</sup>.

## 2.8 Good Samaritan Law: United Kingdom

English Law protects any persons from liability when rendering emergency assistance provided that they acted rationally, in good faith and in accordance with their level of training, unless their actions were grossly negligent or aggravated the situation.

The English law does not impose an obligation to rescue even if such assistance would be of no effort or difficulty to provide. In the absence of a positive obligation then, no issues of liability can arise. Following from the Hippocratic Oath, all medical physicians have an obligation to act as Good Samaritans<sup>41</sup>. Any physicians who fail to volunteer their services in an emergency situation, risk losing their registration as a practicing professional. However, once a physician provides such assistance, a doctor-patient relationship is created with the attached duty of care and subsequent liability issues<sup>42</sup>.

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<sup>36</sup> Section 5(b) of the Aviation Medical Assistance Act of 1998

<sup>37</sup> J. N. Noble, M.D., N. R. P., C. L. Tupe, M.D., B. D. Gehle, J.D., and W. J. Brady, M.D. *In-Flight Medical Emergencies during Commercial Travel* (N Engl J Med: 2015) 373:939-945

<sup>38</sup> Chapter 1, Paragraph 1.1.2 *Code of Medical Ethics Chapter 1: Opinion on Patient-Physician Relationships* (AMA Principles of Medical Ethics: 2016) 2

<sup>39</sup> *Van Horn v Watson* – 45 Cal. 4<sup>th</sup> 322, 197 P. 3d 164, 86 Cal. Rptr. 3d 350 S152360 (2008)

<sup>40</sup> S. Miller *The Sorry State of “Good Samaritan” Laws* (2015)

<sup>41</sup> Paragraph 9 *Good Medical Practice Guidelines* states that: “in an emergency, wherever it may arise, you must offer anyone at risk the assistance you could reasonably be expected to provide”.

<sup>42</sup> B. Shepherd, D. Macpherson and C. M. B. Edwards *In-flight emergencies: playing The Good Samaritan* (Journal of the Royal Society of Medicine: Dec, 2006) vol. 99

In contrast with the United States' Aviation Medical Assistance Act, airlines registered under and operating out of the United Kingdom have no legal obligation to offer indemnity to Good Samaritans. Each airline exercises its own discretionary powers when deciding whether or not to extend protection out of goodwill. Certain airlines, such as British Airways and Virgin Atlantic, have already undertaken to indemnify medical professionals against legal liability arising from their on-board emergency medical assistance, provided that same was not grossly negligent<sup>43</sup>. It goes without saying that such indemnity will only be extended to medical professionals whose assistance is verbally sought by the airline, and any direct assistance requested by a fellow passenger must be brought to the attention of the airline staff immediately to establish indemnification<sup>44</sup>.

## 2.9 Good Samaritan Law: Australia

Australia<sup>45</sup> (subject to certain requirements) imposes a legal obligation on all persons to provide assistance in emergency situations.

## 2.10 Good Samaritan Law: Ireland

Ireland exempts any Good Samaritan from liability, however does not impose a duty to intervene<sup>46</sup>.

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<sup>43</sup>B. Shepherd, D. Macpherson and C. M. B. Edwards *In-flight emergencies: playing The Good Samaritan* (Journal of the Royal Society of Medicine: Dec, 2006) vol. 99

<sup>44</sup> B. Shepherd, D. Macpherson and C. M. B. Edwards *In-flight emergencies: playing The Good Samaritan* (Journal of the Royal Society of Medicine: Dec, 2006) vol. 99

<sup>45</sup> Section 57(1) of The Civil Liability Act 2002 (NSW)

<sup>46</sup> Section 51D of The Civil Law (Miscellaneous Provisions) Act of 2011

## **CHAPTER 3:**

### **The Effect of in-flight Medical Emergencies on International Common Carriers**

#### **3.1 Introduction**

As true as the adage of “what goes up must come down” is, the same weight may be attached to the principle “if it can happen on the ground, it’s going to happen in the air”.

An appropriate response is required from airlines that pride themselves on passenger safety as a number one priority<sup>1</sup>. In fact, it is already expected by many passengers of both long-haul carriers as well as short-haul flights<sup>2</sup>.

The issues surrounding airline safety and in-flight medical emergencies was placed under the spotlight when Edward-Gilligan, President of American Express, passed away suddenly from a suspected heart attack on-board his corporate jet, which necessitated (failed) resuscitation efforts as well as emergency diversion and subsequent landing<sup>3</sup>.

#### **3.2 On-board Protocols for the emergency treatment of Passengers**

The first in-flight line of care at 35,000 feet is the flight attendants, trained in the delivery of basic first aid. The flight attendants are also the first persons to initiate the process of obtaining further assistance, by notifying the cockpit crew of the medical emergency. The cockpit crew will then establish a connection with medical ground support, such as MedAire<sup>4</sup>.

Although the flight attendants are trained in basic first aid, a medical professional is required when an IV is needed to treat an ailing passenger<sup>5</sup>. Fortunately, in roughly 75% of incidences, a medical professional, such as a nurse, paramedic or physician, will be travelling as a passenger<sup>6</sup>.

It would, however, be ideal for the flight crew to train in specific roles, as well as to identify emergency situations and how to deal with those as well as rare life-threatening situations when time is of the essence<sup>7</sup>.

However, often times the public and airlines forget that travelling physicians are, in fact, just passengers, the same as any other who may require a sedative to sleep or a stiff drink to make the flight more bearable<sup>8</sup>, resulting in a possible refusal to provide assistance.

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<sup>1</sup> B. Tinker *Sick and dying at 30,000 feet* (2016)

<sup>2</sup> P. Alves, MD, MSc; H. MacFarlane, Med *The Challenges of Medical Events in Flight* (A MedAire-Sponsored Paper: 2011)

<sup>3</sup> A. Pawlowski *Medical emergencies in the sky: What happens if you get ill on a plane?* (2015)

<sup>4</sup> J. Taschler *For in-flight medical emergencies, airlines follows detailed game plan* (Journal Sentinel)

<sup>5</sup> J. Taschler *For in-flight medical emergencies, airlines follows detailed game plan* (Journal Sentinel)

<sup>6</sup> J. Taschler *For in-flight medical emergencies, airlines follows detailed game plan* (Journal Sentinel)

<sup>7</sup> P. Alves, MD, MSc; H. MacFarlane, Med *The Challenges of Medical Events in Flight* (A MedAire-Sponsored Paper: 2011)

In addition, volunteer physicians often divert aircrafts for medical events more frequently and unnecessarily than other responders, being a costly decision of \$3,000 for a domestic flight, and \$70,000 to \$230,000 for an international flight<sup>9</sup>, thus reaffirming the need for ground medical support<sup>10</sup>.

For just such an eventuality, a growing number of airline carriers in the United States choose to utilise the services of ground emergency response centers, such as MedAire, to work with the in-flight volunteer physician and cabin crew over radio or satellite telephone to assess, stabilise, treat or assist the passenger in need. These ground-based emergency response centers<sup>11</sup> employ physicians and nurses with experience in emergency care and additional training in aviation medicine who can better evaluate the situation utilising crew members as “eyes and hands”<sup>12</sup>, to help guide the decision whether to divert the aircraft and to organise the medical response teams on the ground in the event of an emergency landing<sup>13</sup>.

The vice-president for aviation and maritime health at MedAire, Dr. Paulo Alves, states that: “these professional services are essential if we hope to provide passengers with a consistent level of care”. To handle an in-flight medical emergency requires more than just a good set of skills, but requires “a good grasp of how to manage a medical situation in a resource-limited environment”<sup>14</sup>.

Unfortunately, the flight crew often fail to inform the in-flight volunteer physician of the ground medical support<sup>15</sup>.

In an effort to relieve on-board assisting physicians of any medico-legal worries, the cabin crew often issues a declaration of assumption of liability, which insures the physician for any claims arising from his or her actions (which must be free from monetary recompense) on-board, except in the case of deliberate harm or gross negligence. Emergency assistance is accepted and insured, however the practice of medicine as an ordinary commercial activity is not<sup>16</sup>.

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<sup>8</sup> C. Gounder *Medical Emergencies at 40,000 Feet* (The Atlantic: 2013)

<sup>9</sup> C. Gounder *Medical Emergencies at 40,000 Feet* (The Atlantic: 2013)

<sup>10</sup> C. Gounder *Medical Emergencies at 40,000 Feet* (The Atlantic: 2013)

<sup>11</sup> Based at centers including MedAire in Phoenix, the University of Pittsburgh Medical Center’s STAT-MD program, the Mayo Clinic Aerospace Medicine Program, and sometimes an airline’s internal medical department.

<sup>12</sup> P. Alves, MD, MSc; H. MacFarlane, *Med The Challenges of Medical Events in Flight* (A MedAire-Sponsored Paper: 2011)

<sup>13</sup> C. Gounder *Medical Emergencies at 40,000 Feet* (The Atlantic: 2013)

<sup>14</sup> C. Gounder *Medical Emergencies at 40,000 Feet* (The Atlantic: 2013)

<sup>15</sup> C. Gounder *Medical Emergencies at 40,000 Feet* (The Atlantic: 2013)

<sup>16</sup> Graf J. Stuben U, Pump S: “In-flight Medical Emergencies” (*Dtsch Arztebl Int*: 2012) 591-602



### 3.3 Emergency Medical Kits

Every aircraft is required to carry a first-aid kit stocked with a variety of emergency medical equipment, medicines, IV fluids (such as an intravenous line, a bronchodilator inhaler and nitroglycerin tablets<sup>17</sup>) as well as an automated external defibrillator (AED)<sup>18</sup>. Furthermore, all flight attendants as well as the pilots are required to have the requisite skill and training in cardiopulmonary resuscitation (CPR) and use of the defibrillator, every two years<sup>19</sup>.

Despite their suspected best efforts, airlines' basic first-aid kits often fall short of including the required equipment, such as a glucometer to measure a passenger's blood sugar. In this instance, airlines rely on the prevalent rise of worldwide obesity and diabetes, that one or more passengers will have this piece of medical equipment on their person. However, this approach is unsustainable as the verification of calibration may not be possible and the cleanliness of the device, as well as potential for transmission of bloodborne pathogens is prevalent<sup>20</sup>.

The Federal Aviation Administration regulations, last updated in 2001, requires all United States registered commercial aircrafts weighing 7,500 pounds or more and serviced by at least one flight attendant<sup>21</sup>, to carry automated external defibrillators (AEDs), as well as an enhanced medical kit containing additional medications (such as a non-narcotic pain killer, IV fluids, an antihistamine, an inhaler, aspirin and nitroglycerin, IV dextrose, epinephrine, atropine and lidocaine), and added equipment (such as a stethoscope and manual blood pressure cuff)<sup>22</sup>.

Any injury or damage resulting from either the non-compliance of the Federal Aviation Administration's regulations (providing that the equipment and medications may be used by a flight attendant only under the supervision of a physician or that the absence of an on-board medical kit or automated external defibrillator will ground any flight), or failure to exercise the expected high standard of care and diligence of a reasonable careful operator, will result in liability for the airline<sup>23</sup>.

In lieu of the prevalent rise of in-flight medical incidences and the Federal Aviation Authority dragging its feet, a consortium of international organisations<sup>24</sup> working alongside experts in emergency medicine, are fleshing out what additions the medical kits require<sup>25</sup>.

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<sup>17</sup> S. Perry *In-flight medical emergencies are surprisingly common* (MINNPOST: 2015)

<sup>18</sup> J. Taschler *For in-flight medical emergencies, airlines follows detailed game plan* (Journal Sentinel)

<sup>19</sup> S. Perry *In-flight medical emergencies are surprisingly common* (MINNPOST: 2015)

<sup>20</sup> J. V. Noble, M.D., N. R. P., C. L. Tupe, M.D., B. D. Gehle, J.D., and W. J. Brady, M.D. *In-Flight Medical Emergencies during Commercial Travel* (N Engl J Med: 2015) 373: 939-945

<sup>21</sup> Be Prepared for In-Flight Medical Emergencies <http://www.acep.org/Clinical--Practice-Management/Be-Prepared-for-In-Flight-Medical-Emergencies/>

<sup>22</sup> C. Gounder *Medical Emergencies at 40,000 Feet* (The Atlantic: 2013)

<sup>23</sup> What is a Common Carrier? <http://injury.findlaw.com/torts-and-personal-injuries/what-is-a-common-carrier.html>

<sup>24</sup> Including the International Civil Aviation Organization, the International Air Transport Association (IATA), and the Aerospace Medical Association.

<sup>25</sup> C. Gounder *Medical Emergencies at 40,000 Feet* (The Atlantic: 2013)

In addition, Telemedicine<sup>26</sup> has advanced to the point where airlines have implemented the use of devices which allow vital signs, ECG and other data to be transmitted to staff on the ground<sup>27</sup>.

The Aerospace Medical Association's air transport medicine committee recommends that the standard emergency medical kit contain a stethoscope, syringes and IV catheters, in a range of sizes, as well as commonly used medications. Although the complete standard emergency kit is carried by most domestic flights, same is not required by international regulations<sup>28</sup>.

The provisions of the European Safety Agency and International Air Transport, which respectively regulate the content of emergency medical kits and mandated automated external defibrillators,<sup>29</sup> remain unenforced. Although purchasing additional medical equipment not prescribed by legislation may be costly, it is far less so that a diversion of a full common carrier flight<sup>30</sup>.

### 3.4 Diversion of a Common Carrier

In addition to the cost of added medical kits and ground control support centres, airlines are further faced with the unexpected costs and disruption to passengers of medical diversions. Diversions are often unnecessary with only 25,8%<sup>31</sup> of passengers transported to hospital and the remainder recovering immediately and flying once more shortly after the in-flight medical emergency and subsequent emergency landing. The costly decision to divert rests with the pilot of the aircraft who is assisted by the occasional presence of a volunteer physician.

This arrangement, however, can by no means be regarded as a permanent solution<sup>32</sup>.

Should the pilot choose to disregard the recommendations of the volunteer physician to divert, no liability will be attached to the volunteer physician, but rather to the pilot and/or airline<sup>33</sup>.

Although medical diversions are, at this stage, few and far in between, the consequences are far-reaching, resulting in delays in reaching final destinations, inconveniencing passengers,

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<sup>26</sup> International Bar Association's Draft International Convention on Telemedicine and Telehealth (1999)

<sup>27</sup> B. Chandler *Medical Emergencies at 30,000ft*

<sup>28</sup> Be Prepared for In-Flight Medical Emergencies <http://www.acep.org/Clinical---Practice-Management/Be-Prepared-for-In-Flight-Medical-Emergencies/>

<sup>29</sup> M. Liao *Handling In-Flight Medical Emergencies: Special care circumstances require creative thinking* (NREMT-P: 2010)

<sup>30</sup> M. Liao *Handling In-Flight Medical Emergencies: Special care circumstances require creative thinking* (NREMT-P: 2010)

<sup>31</sup> Drew C. Peterson, M.D., Christian Martin-Gill, M.D., M.P.H., Francis X. Guyette, M.D., M.P.H., Adam Z. Tobias, M.D., M.P.H., Catherine E. McCarthy, B.S., Scott T. Harrington, M.D., Theodore R. Delbridge, M.D., M.P.H., and Donald M. Yealy, M.D. *Outcomes of Medical Emergencies on Commercial Airline Flights* (N Engl J Med: 2013)

<sup>32</sup> P. Alves, MD, MSc; H. MacFarlane, Med *The Challenges of Medical Events in Flight* (A MedAire-Sponsored Paper: 2011)

<sup>33</sup> J. V. Noble, M.D., N. R. P., C. L. Tupe, M.D., B. D. Gehle, J.D., and W. J. Brady, M.D. *In-Flight Medical Emergencies during Commercial Travel* (N Engl J Med: 2015) 373: 939-945

added costs, increased risk to safety<sup>34</sup>, dumping of fuel before landing and the arrangement of overnight accommodation<sup>35</sup>.

Even domestic airlights cannot avoid the occasional in-flight medical emergency, of which 12% result in an emergency diversion, brought on largely by cardiac events followed by neurologic and respiratory incidents<sup>36</sup>.

Diversion and landing of the aircraft becomes a priority once an in-flight medical emergency is declared. However, the decision to land must take into consideration the liability of the aircraft to land at the closest airport as well as the medical resources available at the chosen airport<sup>37</sup>. The emergency landing is further complicated by time restraints as it takes time to land a large aircraft, made more difficult by the more prevalent use of wide-bodied and super long-haul aircrafts<sup>38</sup>.

“Even if you have someone who needs absolute, immediate medical attention, you can’t just push the ‘down’ button like you’re on an elevator” said Captain Michael Sharpe, pilot and flight instructor for Southwest Airlines in Milwaukee. “It takes at least 25 minutes to get from altitude to the ground”<sup>39</sup>.

In addition to the aforementioned factors, the condition of the passenger will be of primary consideration. Although it may sound more prudent to land at the nearest and first available airport, it would in fact be better to extend the flight to a further airport with medical facilities capable of assessing and treating the ailing passenger<sup>40</sup>.

Understandably, the most common cause of litigation is when the pilot chooses not to divert the aircraft on the recommendation of the volunteer physician, which decision then adversely affects the patient.

Fortunately, thus far, 79% of past incidences indicated agreement between the in-flight and hospital diagnosis, as well as improvement of the passenger’s condition in 60% of cases before arriving at the hospital, suggesting appropriate in-flight treatment<sup>41</sup>. Nonetheless, it is still advised that extreme caution be exercised by the volunteer physician and on-board airline personnel<sup>42</sup>.

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<sup>34</sup> M. A. Gendreau, M.D., and C. DeJohn, D.O., M.P.H. *Responding to Medical Events during Commercial Airline Flights* (N Engl J Med: 2002) 1067

<sup>35</sup> M. A. Gendreau, M.D., and C. DeJohn, D.O., M.P.H. *Responding to Medical Events during Commercial Airline Flights* (N Engl J Med: 2002) 1067

<sup>36</sup> M. A. Gendreau, M.D., and C. DeJohn, D.O., M.P.H. *Responding to Medical Events during Commercial Airline Flights* (N Engl J Med: 2002) 1067

<sup>37</sup> S. Perry *In-flight medical emergencies are surprisingly common* (MINNPOST: 2015)

<sup>38</sup> T. Goodwin *In-flight medical emergencies: an overview* (BMJ: 2000) 321 - 325

<sup>39</sup> J. Taschler *For in-flight medical emergencies, airlines follows detailed game plan* (Journal Sentinel)

<sup>40</sup> Medical Emergencies – Guidance for Flight Crew  
[http://www.skybrary.aero/index.php/Medical\\_Emergencies\\_-\\_Guidance\\_for\\_Flight\\_Crew](http://www.skybrary.aero/index.php/Medical_Emergencies_-_Guidance_for_Flight_Crew)

<sup>41</sup> B. Shepherd, D. Macpherson and C. M. B. Edwards *In-flight emergencies: playing The Good Samaritan* (Journal of the Royal Society of Medicine: Dec, 2006) vol. 99

<sup>42</sup> B. Shepherd, D. Macpherson and C. M. B. Edwards *In-flight emergencies: playing The Good Samaritan* (Journal of the Royal Society of Medicine: Dec, 2006) vol. 99

The situation is further complicated when multiple physicians volunteer their assistance, resulting in disagreement over how best to manage the medical emergency situation<sup>43</sup>. In such a situation, the physician with the relevant speciality, level and skill of training should take the lead in managing a team approach<sup>44</sup>.

Maintaining a standard of care expected by the general travel population requires that the flight crew is properly trained, the aircraft is properly equipped and supported by a medical advisory service via a telemedicine provider<sup>45</sup>, as well as informing the volunteer physician of the available resources at his or her disposal, failing which the airline may be held vicariously liable for any shortcomings by its personnel resulting in gross negligence<sup>46</sup>.

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<sup>43</sup> C. Gounder *Medical Emergencies at 40,000 Feet* (The Atlantic: 2013)

<sup>44</sup> A. Chandra, S. Conry *In-Flight Medical Emergencies* (Western Journal of Emergency Medicine: 2013) 499–504

<sup>45</sup> Paulo Alves, MD, MSc; Heidi MacFarlane, Med *The Challenges of Medical Events in Flight* (A MedAire-Sponsored Paper: 2011)

<sup>46</sup> Mtetwa v Minister of Health 1989 (3) SA 600 (D)

## **CHAPTER 4:**

### **Duty of Care**

#### **4.1 Introduction**

Admittedly, falling ill inside a pressurised metal tube travelling at 500 miles per hour seven miles above the earth, may not be the best place, for some it is unavoidable<sup>1</sup>.

Airlines will often appeal to a volunteer physician's moral sense of duty when requesting their assistance, and only provide a token gesture of appreciation to allow the Good Samaritan rules to apply<sup>2</sup>.

There are certain inherent risks associated with relying on a volunteer physician's assistance, such as a lack of specialist knowledge regarding aviation medicine or the availability of medical resources onboard the aircraft. In fact, many volunteers respond to medical emergencies which they do not see regularly in their practice<sup>3</sup>.

Notwithstanding, volunteer physicians remain comfortable to render their services, however are fearfully hesitant of liability and subsequent litigation. A study concluded in 2002 determined that 69% of all in-flight medical emergencies were attended to by health care professionals, such as physicians (40%), nurses (25%) and paramedics (4%)<sup>4</sup>.

The decision of volunteer physicians to render medical assistance is considered more of an ethical duty than a legal duty, requiring such physician to, *inter alia*, keep his or her professional knowledge and skills up to date as well as primarily<sup>5</sup> act in the ailing passengers' best interest<sup>6</sup>. Failure to abide by these, often codified<sup>7</sup>, standards is unethical<sup>8</sup>.

#### **4.2 Duty of Care**

The Court in *Anns v London Borough of Merton* (1977) 2 ALL ER 492 held that:

"... First one has to ask whether, as between the alleged wrongdoer and the person who has suffered damages there is a sufficient relationship of proximity of neighbourhood such that, in the reasonable contemplation of the former, carelessness on his part may be likely to cause

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<sup>1</sup> J. Taschler *For in-flight medical emergencies, airlines follows detailed game plan* (Journal Sentinel)

<sup>2</sup> Poll: Should doctors be compensated for responding to in-flight medical emergencies by Kevin dated 17 August 2009 <http://kevinmd.com/blog/2009/08/poll-should-doctors-be-compensated-for-responding-to-in-flight-medical-emergencies.html>

<sup>3</sup> C. Gounder *Medical Emergencies at 40,000 Feet* (The Atlantic: 2013)

<sup>4</sup> M. A. Gendreau, M.D., and C. DeJohn, D.O., M.P.H. *Responding to Medical Events during Commercial Airline Flights* (N Engl J Med: 2002) 1067

<sup>5</sup> Dhali & McQuoid-Mason *Bio-ethics, Human Rights and Health Law: Principles and Practice* (Juta: 2011) 7

<sup>6</sup> Rule 27A Guidelines for Good Practice in the Health Care Professions *Ethical and Professional Rules of the Health Professions Council of South Africa as Promulgated in GG R717/2006* (Booklet 2: May 2008) 20

<sup>7</sup> Beauchamp & Childress *Principles of Biomedical Ethics* (6<sup>th</sup> ed.) 7

<sup>8</sup> Beauchamp & Childress *Principles of Biomedical Ethics* (6<sup>th</sup> ed.) 4

damage to the latter, in which case a prima facie duty of care arises. Secondly, if the first question is answered affirmatively, it is necessary to consider whether there are any considerations which ought to negative, or to reduce or limit the scope of the duty of the class of person to whom it is owed or the damage to which a breach of it may give rise<sup>9</sup>. “Thus, a person who is a medical professional, or who holds himself out as ready to give medical advice or treatment, impliedly undertakes that he is possessed of skill and knowledge for the purpose, and when consulted by a patient will owe him a duty of care...”<sup>10</sup>.

In the matter of *Donoghue v Stevenson* (1932) AC 562, speaking of both Scots and English law, Lord Atkins held that:

“The law of both countries appears to be that in order to support an action for damages for negligence the complainant has to show that he has been injured by the breach of a duty owed to him in the circumstances by the defendant to take reasonable care to avoid such injury”<sup>11</sup>.

Giesen submits that a physician is under a duty to use reasonable care when giving advice and that it is entirely irrelevant whether such advice is given in terms of a contract or in the absence thereof and that ... “the only distinction being that in the case of contract this duty arises by reason of a term implied by law and in the case of torts under a duty imposed by law”. It is further submitted that “the legal duty of care sometimes takes the very general form of a duty not to act in such a way as to harm others”<sup>12</sup>.

The Court in *Seema v MEC Gauteng Health Services* 2002 91 SA 771 (T) confirmed that there was a legal duty [...] to protect the general public against [...] wrongful and unlawful conduct [...], and that the defendant had negligently breached the said duty by failing to take proper precautions [...], thereby causing damages.

A medical physician is expected to exercise a fair, reasonable and competent degree of skill when discharging his or her duty of care<sup>13</sup>.

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<sup>9</sup> Giesen *International Medical Malpractice Law* (1988) 79

<sup>10</sup> Giesen *International Medical Malpractice Law* (1988) 81

<sup>11</sup> Giesen *International Medical Malpractice Law* (1988) 77

<sup>12</sup> Giesen *International Medical Malpractice Law* (1988) 73

<sup>13</sup> Giesen *International Medical Malpractice Law* (1988) 90

## CHAPTER 5:

### Standard of Care

#### 5.1 Introduction

The Good Samaritan doctrine gives rise to a standard of care which provides that the Good Samaritan must exercise the same standard of care and / or treatment that he or she would normally be held to in their profession. Although the term “gross negligence” remains universally undefined, the term is frequently equated with wilful, wanton or reckless conduct, for example, an obviously inebriated physician attempting to provide treatment and causing harm to the victim<sup>1</sup>.

Volunteer physicians who assist the flight crew in managing an in-flight emergency must firstly “do no harm” (non-maleficence)<sup>2</sup> and practise within the limits of their training and knowledge<sup>3</sup>.

In contrast, the act of doing good by preventing harm from occurring to others (beneficence)<sup>4</sup>, requires both an acceptable standard of care and appropriateness of that care. Although it may be unreasonable to expect all physicians to be informed of the latest medical developments, it is expected that physicians will make every effort to at least familiarise themselves with the clinical developments that may affect their specific area of practice<sup>5</sup>. “In most instances, illness afflicts people without warning at a time when they least expect it, exposing their vulnerability. Under these circumstances, beneficent care of patients is a non-negotiable obligation that can only be fulfilled with excellent clinical training and skills”<sup>6</sup>.

Thus, a trained medical professional must act according to the medical professional standards<sup>7</sup> within his or her respective skillsets, ability, education and expertise<sup>8</sup>, and any care rendered for which the medical professional has not been trained is regarded as grossly negligent and liability attaches to such care.

However, the Californian Court in the matter of Perkins v Howard, 232 Cal. App. 3d 708 (1991) held that “the goodness of the Samaritan is a description of the quality of his or her intention, not the quality of the aid delivered”<sup>9</sup>.

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<sup>1</sup> S. Y. Tan, M.D., J.D *Midair medical emergencies* (Internal Medicine News: 2015)

<sup>2</sup> Moodley *Medical Ethics Law and Human Rights: A South African Perspective* (Van Schaik: 2011) 65

<sup>3</sup> N. Dowdall *Education and Debate “Is there a doctor on the aircraft?” Top 10 in-flight medical emergencies* (BMJ: 25 November 2000) 321:1336

<sup>4</sup> Moodley *Medical Ethics Law and Human Rights: A South African Perspective* (Van Schaik: 2011) 57

<sup>5</sup> Moodley *Medical Ethics Law and Human Rights: A South African Perspective* (Van Schaik: 2011) 58

<sup>6</sup> Moodley *Medical Ethics Law and Human Rights: A South African Perspective* (Van Schaik: 2011) 62

<sup>7</sup> What are Good Samaritan laws? <http://resources.lawinfo.com/personal-injury/what-are-good-samaritan-laws.html>

<sup>8</sup> J. Olin *Good Samaritan Law – Do They Cover Nurses?* (2011)

<sup>9</sup> <http://law.justia.com/cases/california/court-of-appeal/3d/232/708.html>

## 5.2 Standard of Care

The Court in *S v Kramer and Another* 1987 (1) SA 887 (W) laid down the test for medical negligence by deciding that specialists will be judged by the level of skill and standard of other specialists in the same field.

The Court in *Van Wyk v Lewis* 1924 AD 438, confirming the test for medical negligence, held that:

“The Court must ascertain from the medical profession what is the usual practice adopted in modern hospitals in this country when a surgeon conducts an abdominal operation. The Court cannot lay down for the profession a rule of practice. It must assume that the generally adopted practice is the outcome of the best experience and is that which is best suited to attain the most satisfactory result.”

Justice Innes however cautioned that:

“[...] the testimony of experienced members of the profession is of the greatest value on a question of this kind (reasonable care and skill). But the decision of what is reasonable under the circumstances is for the Court; it will pay high regard to the views of the profession, but it is not bound to adopt them.”

The objective standard of care is applied in relation to the circumstances in which the physician’s conduct took place, thus only attaching liability to the risks reasonably foreseeable in all the circumstances<sup>10</sup>.

It cannot be emphasised enough, that the law does not recognise different degrees of negligence in medical malpractice<sup>11</sup>. Therefore, when a medical professional (whether a general practitioner or a specialist) fails to measure up to that standard in any way, they have acted negligently and should be so adjudged<sup>12</sup>. Any failure by the volunteer physician to exercise the standard of care and expertise expected of their field of speciality will amount to negligence and result in liability in damages for any injury caused as a result thereof<sup>13</sup>.

The Court in *R v Schoor* 1948 (4) SA 349 (C) confirmed that “there are no degrees of negligence, whether the case is criminal or civil. A man is either negligent or he is not”.

The Court in *R v Meiring* (1927) AD 41 considered: “What amount of negligence can be called culpable, is a question of degree for the jury, depending on the circumstances of each case... A man is either negligent or he is not”.

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<sup>10</sup> Giesen *International Medical Malpractice Law* (1988) 96

<sup>11</sup> Giesen *International Medical Malpractice Law* (1988) 102

<sup>12</sup> Giesen *International Medical Malpractice Law* (1988) 103

<sup>13</sup> Giesen *International Medical Malpractice Law* (1988) 104



The Court in *Kovalsky v Krige* 1910 CTR 822 at 823 held that: “A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care, and he is liable for the consequences if he does not”.

The Court further asked: “what can be expected of the ordinary or average doctor in view of the general knowledge, ability, experience, skill and diligence possessed and exercised by the profession, bearing in mind that a doctor is a human being and not a machine and that no human being is infallible”.

Nonetheless, whether the degree of negligence on the doctor’s part is gross or slight makes no difference to their civil liability, but it may affect the quantum of damages awarded or the severity of the punishment imposed<sup>14</sup>.

### 5.3 *Imperitia Culpae Adnumeratur*

The requisite standard of care requires the physician to act with the skill and competence ordinarily expected from a person undertaking his particular role and professing to have his particular set of skills, as per the “Bolam Test”<sup>15</sup>. And a lack of experience will neither excuse a physician from liability nor provide a defence, “for if one holds oneself out as a doctor, even as a junior doctor, must show the same degree of skills as those more experienced, or seek senior help if required”<sup>16</sup>.

The Court in *McDonald v Wroe* unreported case no 7975/03 (CPD) observed that it may be imprudent for a general practitioner to venture onto a field of specialisation without having the necessary qualifications, skill and experience as required of a specialist<sup>17</sup>.

The Court in *S v Mkwetshana* 1965 (2) SA 493 (N) confirmed that ignorance or lack of experience is not a defence.

The important points are whether the procedure carried out was “a practise accepted as proper by a responsible body of medical men skilled in that particular art”, and whether an error made was one that might have been made by “a reasonably competent professional professing to have the standard and type of skill the defendant held himself out as having, and acting with ordinary care”<sup>18</sup>.

Either way, each case of alleged negligence will be dealt with pragmatically<sup>19</sup>, within its own context and based on its own merits and circumstances, due to the fact that the standard of

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<sup>14</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis:2007) 636

<sup>15</sup> *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582 lays down the rule for assessing the appropriate standard of reasonable care in negligence cases involving skilled professionals.

<sup>16</sup> B. Shepherd, D. Macpherson and C. M. B. Edwards *In-flight emergencies: playing The Good Samaritan* (Journal of the Royal Society of Medicine: Dec, 2006) vol. 99

<sup>17</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis:2007) 636

<sup>18</sup> B. Shepherd, D. Macpherson and C. M. B. Edwards *In-flight emergencies: playing The Good Samaritan* (Journal of the Royal Society of Medicine: Dec, 2006) vol. 99

<sup>19</sup> Herring *Medical Law and Ethics* (Oxford University Press: 2008) 32

care required on-board an aircraft in an emergency situation will be very different to that required in a controlled environment<sup>20</sup>.

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<sup>20</sup> B. Shepherd, D. Macpherson and C. M. B. Edwards *In-flight emergencies: playing The Good Samaritan* (Journal of the Royal Society of Medicine: Dec, 2006) vol. 99

## **CHAPTER 6:**

### **The Right of Access to Health care and Emergency Treatment**

#### **6.1 Introduction**

The Constitution of the Republic of South Africa Act 106 of 1998 (hereinafter referred to as “the Constitution”) holds itself out as the supreme law of the Republic and regards any law or conduct inconsistent with it as invalid, and further prescribes that the obligations imposed by it must be fulfilled<sup>1</sup>.

#### **6.2 Right to Health**

The following consortium of rights, when viewed collectively, may be regarded as a right to health:

- The inherent right to dignity and the right to have same respected and protected<sup>2</sup>.
- The right to life<sup>3</sup>.
- The right to bodily and psychological integrity, including the right to security in and control over a person’s body<sup>4</sup>.
- The right to privacy, including the right not to have ones person searched<sup>5</sup>.
- The right to an environment that is not harmful to a person’s health or well-being<sup>6</sup>.
- The right to have access to health care services<sup>7</sup>, which the State must take reasonable legislative steps and other measures, within its available resources, to achieve the progressive realisation of each of these rights<sup>8</sup>.
- The right not to be refused emergency medical treatment<sup>9</sup>.

All natural or juristic persons are bound by the provisions of the Bill only to the extent that it is applicable, after considering the nature of the right as well as any duty imposed thereby<sup>10</sup>.

The State is also obligated to respect, protect, promote and fulfil the rights contained in the Bill of Rights<sup>11</sup>, which rights are subject to the limitations contained or referred to in section 36 or elsewhere in the Bill<sup>12</sup>.

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<sup>1</sup> Section 2 of the Constitution of the Republic of South Africa Act 108 of 1996

<sup>2</sup> Section 10 of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

<sup>3</sup> Section 11 of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

<sup>4</sup> Section 12(2)(b) of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

<sup>5</sup> Section 14(a) of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

<sup>6</sup> Section 24(a) of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

<sup>7</sup> Section 27(1) of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

<sup>8</sup> Section 27(2) of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

<sup>9</sup> Section 27(3) of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

<sup>10</sup> Section 8(2) of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

<sup>11</sup> Section 7(2) of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

In accordance with section 36, the aforementioned rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors including the nature of the right, the importance of the purpose of the limitation, the nature and extent of the limitation, the relation between the limitation and its purpose and less restrictive means to achieve the purpose<sup>13</sup>.

Except for the limitation provided for in section 36 *supra*, no law may limit any right entrenched in the Bill of Rights<sup>14</sup>.

### 6.3 Right of Access to Health care

The right to health care services<sup>15</sup> does not give rise to a self-standing and independent positive right enforceable irrespective of the considerations mentioned in section 27(2). Section 27(1) and (2) must be read together as defining the scope of the positive rights that everyone has, and the corresponding obligations on the State to respect, protect, promote and fulfil such rights. The rights conferred by section 27(1) are to have “access” to the services that the State is obliged to provide in terms of section 27(2).

In addition, the Minister of Health must, within the limits of available resources, ensure the provision of such essential health services, which must at least include primary health services, to the population of the Republic as may be prescribed after consultation with the National Health Council<sup>16</sup>. The Act neglects to define primary health services, in the absence of which it is assumed that these services, at the very least, include a right to emergency medical care.

The Court in *Minister of Health and Others v Treatment Action Campaign and Others (No 2)* 2002 (5) SA 721 (CC) held that not everyone could immediately claim access to such realisation of rights and access to treatment, although the ideal was to achieve that goal. Every effort, however, had to be made to do so as soon as reasonably possible.

Although evidence in a particular case may show that there is a minimum core of a particular service that should be taken into account in determining whether measures adopted by the State are reasonable, the socio-economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them. It is impossible to give everyone access to even a “core” service immediately. All that is possible, and all that can be expected of the State, is that it acts reasonably to provide access to the socio-economic rights identified in, *inter alia*, section 27 on a progressive basis. Where a breach of any right has taken place, including a socio-economic right, a Court is under a duty to grant effective relief.

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<sup>12</sup> Section 7(3) of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

<sup>13</sup> Section 36(1)(a)(b)(c)(d)(e) of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

<sup>14</sup> Section 36(2) of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

<sup>15</sup> Section 27(1) of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

<sup>16</sup> Section 3(1)(d) of the National Health Act 61 of 2003

#### 6.4 Right of Access to Emergency Health care

The basic human rights contained in the Bill of Rights infer a reciprocal duty of realisation, usually by the State, without which the rights would be meaningless.<sup>17</sup> The National Health Act<sup>18</sup> provides that a person may not be refused emergency medical treatment by a health care provider, health worker, or health establishment.

In light of the fact that the Constitution<sup>19</sup> does not define the term “emergency medical treatment” notwithstanding the right entrenched in section 27(3), consideration is given to the federal Emergency Medical Treatment and Active Labour Act of 1986 (EMTALA) to properly interpret the Bill of Rights<sup>20</sup>, which defines “emergency medical condition” to mean –

A. a medical condition manifesting itself by acute symptoms of sufficient severity (...) such that the absence of immediate medical attention could reasonably be expected to result in: (i) Placing the health of the individual in serious jeopardy; (ii) Serious impairment of bodily functions; (iii) Serious dysfunction of any bodily organ or part<sup>21</sup>.

The Gauteng Ambulance Services Bill Notice 2229 in PG 124 dated 8 May 2002 further defines “emergency medical care” as “the rescue, evaluation, treatment and care of an ill or injured person in an emergency care situation and the continuation of treatment and care during the transportation of such patients to or between medical facilities in order to prevent loss of life, aggravation of illness or injury”<sup>22</sup>.

The Court in *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC), considered the right of access to health care and emergency treatment in terms of section 27(3) of the Constitution, and noted that the State has a constitutional obligation to provide *inter alia* health care, within its available resources. The Court held that the right not to be refused emergency medical treatment meant that a person who suffers a sudden catastrophe which calls for immediate medical attention should not be denied ambulance or other emergency services which are available and should not be turned away from a hospital which is able to provide the necessary treatment. It also held that the right not to be refused emergency medical treatment was independent from the right to life and had to be interpreted in the context of the availability of health services generally. The Court proceeded to define an emergency to imply a condition which is sudden or unexpected, for which treatment may be expected to restore a patient to health or at least a better health status, rather than treatment of a condition which had already existed for many years. This judgment correctly reflects the distributive justice whereby patients are treated fairly and limited resources are distributed equally<sup>23</sup>.

The duty to provide emergency medical treatment is further codified in The International Code of Medical Ethics of the World Medical Association 1949 which provides that a physician

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<sup>17</sup> Moodley *Medical Ethics Law and Human Rights: A South African Perspective* (Van Schaik: 2011) 92

<sup>18</sup> Section 5 of the National Health Act 61 of 2003

<sup>19</sup> The Constitution of the Republic of South Africa 108 of 1996

<sup>20</sup> Section 39(1)(c) of the Constitution of the Republic of South Africa Act 108 of 1996

<sup>21</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis: 2007) 167

<sup>22</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis: 2007) 333

<sup>23</sup> Moodley *Medical Ethics Law and Human Rights: A South African Perspective* (Van Schaik: 2011) 37; 39

must give emergency care as a humanitarian duty unless he is sure that others are willing and able to give such care.

However, the beneficent duty of care can only be exercised by the on-board physician to the best of their ability within the availability of resources in the circumstances. This duty conflicts with the availability of resources thus resulting in a moral dilemma<sup>24</sup>, requiring the contravention or compromise of one of the obligations to satisfy the other.

The ethical considerations and legislation must be carefully balanced, as they are intrinsically interwoven and do not stand separately from one another.

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<sup>24</sup> Beauchamp & Childress *Principles of Biomedical Ethics* (6<sup>th</sup> ed.) 10

## **CHAPTER 7:**

### **Grounds for Liability**

#### **7.1 Introduction**

It is confirmed that an on-board volunteer physician has an ethical obligation to render assistance in an in-flight medical emergency. Now the question still remains as to whom liability will attach to in the event of on-board medical negligence.

The Court in *Minister van Polisie v Ewels* 1975 (3) SA (590) A held that:

“It is therefore clear that our law has evolved from its older, highly individualistic stance to a viewpoint reflecting a health social responsibility. A court may now well hold a doctor liable for harm suffered by an injured person, where the doctor was aware of his condition and unreasonably refused or failed to attend. The word ‘unreasonably’ must be emphasised”.

Section 27(1) of the Constitution does not suggest a general obligation to rescue. However, when assistance is requested, either implied or tacitly, any unreasonable refusal to render emergency medical assistance will be in direct violation of section 27(3) of the Constitution<sup>1</sup>.

#### **7.2 Breach of Contract**

A breach of contract occurs where a party to an agreement with another person fails to fulfil a contractual personal right or obligation to perform as agreed upon in the terms and conditions that come into effect by virtue of the will of the parties<sup>2</sup>. The party, who suffers damages as a result of the breach of contract, may sue in delict or contract, for enforcement, fulfilment or execution, provided there is no contractual exclusionary clause<sup>3</sup>. The breach of contract results in wrongfulness, which may be negated by any of the recognised grounds of justification, in both delict and contract.

#### **7.3 Delict: Negligence**

A delict is a breach of a general duty imposed by the law and breaches of constitutional rights may result in delictual actions<sup>4</sup>.

In order to successfully claim for patrimonial damages, an injured ailing passenger is required to prove that the volunteer physician and / or airline by virtue of its in-flight crew, unlawfully

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<sup>1</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis: 2007) 176

<sup>2</sup> Neethling, Potgieter and Visser *Law of Delict* 5<sup>th</sup> ed. (Lexis Nexis: 2006) 5

<sup>3</sup> Dhai & McQuoid-Mason *Bio-ethics, Human Rights and Health Law: Principles and Practice* (Juta: 2011) 52

<sup>4</sup> Dhai & McQuoid-Mason *Bio-ethics, Human Rights and Health Law: Principles and Practice* (Juta: 2011) 52

committed an act or omitted to do something<sup>5</sup>, causing harm to the passenger resulting in patrimonial loss as a result of the volunteer physician and / or airline's actions<sup>6</sup>.

In order to successfully claim for non-patrimonial damages, the passenger must prove that the volunteer physician and / or airline's actions by virtue of its in-flight crew were wrongful thus infringing the passenger's personality rights<sup>7</sup>.

#### 7.4 Airline Liability

"Airlines can no longer hide behind the adage 'It's not an air ambulance. This is a commercial aircraft' when passengers ask why an airplane isn't stocked with everything reasonably required in any medical situation"<sup>8</sup>.

Although passengers are not entering into a contract with the airline for the inclusion of health care services, it would seem that the airlines have already started to prepare for such eventualities in any event. However, there is no possibility that the airline would be able to prepare for every contingency<sup>9</sup>. The airlines are therefore required to act with a heightened degree of care towards passengers, and may be negligent if they fail to provide proper training to airline personnel<sup>10</sup>.

The Court in *Afrox Healthcare v Strydom* 2002 (6) SA 21 (SCA) held that you cannot sign away "gross negligence", as it is contrary to the public interest, and that any exclusionary clause would probably rather have been restricted to exclude gross negligence. The Court found that there was no evidence indicating that Strydom had indeed occupied a weaker bargaining position than Afrox during the conclusion of the contract. The Court found exclusionary clauses in standard contracts were the rule rather than the exception, and that a person who signed a written agreement without reading it did so at his own risk and was consequently bound by the provisions contained therein as if he were aware of them and had expressly agreed thereto.

Similarly, the Court in *Barkhuizen v Napier* CCT72/05 (2007) ZACC 5 found that there was no evidence to indicate that there was unequal bargaining power, or that the contract was not freely entered into<sup>11</sup>.

Under the laws of the United States of America, a passenger, in order to successfully prove a common carrier's fault in a negligence case, must show that the passenger was owed a duty of

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<sup>5</sup> S v Kramer 1987 (1) SA 887 (W)

<sup>6</sup> Dhali & McQuoid-Mason Bio-ethics, Human Rights and Health Law: Principles and Practice (Juta: 2011) 52

<sup>7</sup> Dhali & McQuoid-Mason Bio-ethics *Human Rights and Health Law: Principles and Practice* (Juta: 2011) 53

<sup>8</sup> S. Costa *Is There a Doctor on the Plane? What you should know about in-flight medical emergencies* (2015)

<sup>9</sup> J. Barney *In-Flight Medical Emergencies: What Doctors and Travellers Must Know* (2015)

<sup>10</sup> K. Michon *Airplane Turbulence and In-Flight Injuries* (2015)

<sup>11</sup> B Kuschke *Barkhuizen v Napier case CCT 72/05 (2007) ZACC 5 delivered on 4 April 2008: Constitutionality of a Time Bar Clause in an Insurance Contract* (De Jure: 2008) 466



care and diligence, and that the common carrier breached that duty, causing the passenger's injury, resulting in damages as proven by evidentiary support<sup>12</sup>.

#### 7.4.1 Medical Kits

Complete medical emergency kits are instrumental to the diagnosis and treatment of any in-flight medical emergencies. The common carriers are responsible to ensure that the basic first aid and emergency medical kits are comprehensive and fully stocked to be used at a moment's notice, failing which liability may be incurred if the medical instruments or equipment become defective or dangerous resulting in personal injury or even death. The liability will depend on whether or not the common carrier was aware that the instruments or equipment were defective and whether it could reasonably have been expected to be aware thereof<sup>13</sup>.

#### 7.4.2 Telemedicine

Although still in its infancy, it is considered that, as a result of the extra layers of difficulty, the standard associated with e-health may be lower than that for conventional care<sup>14</sup>.

In the absence of an in-flight volunteer physician, the on the ground personnel are the only medical support to the in-flight crew, to provide adequate and often life saving treatment. In such instances, the liability would then rest with the airline as the airhostesses are the interim physicians.

#### 7.4.3 Volunteer Physicians

Airlines may request volunteer physicians to produce identification of their skill and level of training, failing which the airline may choose to refuse such medical assistance<sup>15</sup>. Under such circumstances, the liability will attach to the airline as "beggars can't be choosers" and disregard medical assistance in an emergency situation.

Furthermore, volunteer physicians board flights as passengers not expecting to be called on duty, who may, in any event, lack the requisite skills necessary to address the

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<sup>12</sup> What is a Common Carrier? <http://injury.findlaw.com/torts-and-personal-injuries/what-is-a-common-carrier.html>

<sup>13</sup> Mitchell v Dixon 1914 (AD) 519

<sup>14</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis: 2007) 823

<sup>15</sup> M. Liao *Handling In-Flight Medical Emergencies: Special care circumstances require creative thinking* (NREMT-P:2010)

medical emergency presented. A volunteer physician's personal bias may influence his recommendations and a fear of liability may push to favour a diversion<sup>16</sup>.

Volunteer physicians often lament the fact that airlines do not offer compensation for their in-flight medical emergency services rendered, not knowing that same is done to preserve the cover of the Good Samaritan doctrine which would be negated by any form of compensation. And quite rightly, any person requiring compensation would no longer be regarded as a volunteer<sup>17</sup>.

#### 7.4.4 Diversion

A great deal of weight is given to the decision to divert the aircraft as well as the inconvenience to the remaining passengers. The airline's financial preference could give rise to liability as it is given preference over the medical emergency of the patient.

#### 7.4.5 Montreal Convention 1999

The Montreal Convention<sup>18</sup> applies to international air travel attaching liability to airlines for, *inter alia*, injury or death to a passenger during an international flight, where such injury is caused by a member of the flight crew or another passenger<sup>19</sup>. Therefore, if a member of the flight crew, in the absence of a volunteer physician, were to incorrectly insert an intravenous line causing harm or death to the ailing passenger, the airline would be liable for such damages resulting thereof.

### 7.5 Physician Liability

Physicians, especially if specifically trained to respond to undifferentiated medical emergencies, have an ethical obligation to volunteer<sup>20</sup>, and any failure to act accordingly will attach negligence<sup>21</sup>.

Briefly, the test for medical negligence requires that the actions of the volunteer physician be measured against the reasonable, average, competent medical practitioner in the same specialist field<sup>22</sup> of practice, and in the same circumstances who could reasonably have

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<sup>16</sup> P. Alves, MD, MSc; H. MacFarlane, Med *The Challenges of Medical Events in Flight* (A MedAire-Sponsored Paper: 2011)

<sup>17</sup> P. Alves, MD, MSc; H. MacFarlane, Med *The Challenges of Medical Events in Flight* (A MedAire-Sponsored Paper: 2011)

<sup>18</sup> Chapter 3, Article 17, Paragraph 1 of The Convention for the Unification of Certain Rules for International Carriage by Air No. 4698 of 29 May 1999

<sup>19</sup> Aeroplane accidents and illness claims <http://www.medic8.com/healthguide/personal-injury/aeroplane-accidents-and-illness-claims.html>

<sup>20</sup> A. Chandra, S. Conry *In-Flight Medical Emergencies* (Western Journal of Emergency Medicine: 2013) 499–504

<sup>21</sup> Giesen *International Medical Malpractice Law* (1988) 104

<sup>22</sup> Van Wyk v Lewis 1924 AD 438

foreseen the harm or death, and taken reasonable steps to prevent such harm or death from occurring. The volunteer physician further has a duty to refer the matter to another in-flight volunteer alternatively the ground support centre, if it falls outside of his or her scope of practice.

A physician may not unreasonably withhold emergency medical treatment. However, in the event that such treatment is withheld, the Court may consider the knowledge of the condition; seriousness of the condition; professional ability of the physician to treat; physical state of the physician; availability of other physicians to assume responsibility for management and a consideration of professional ethics<sup>23</sup>.

The Court in *Seema v MEC Gauteng Health Services* 2002 91 SA 771 (T) confirmed that there was a legal duty [...] to protect the general public against [...] wrongful and unlawful conduct [...], and that the defendant had negligently breached the said duty by failing to take proper precautions [...], thereby causing damages.

The ethical principle of respect for patient autonomy entails the treating physician to inform the patient of his / her field of medicine. Any failure to do so will amount to lack of informed consent and will not negate any wrongfulness.

## 7.6 Patient's right to medical care

Liberal individualism allows the freedom and rights of individuals to be considered the most important moral values. Negative rights refer to a person's entitlement to refuse things, including healthcare. Latching onto the principle of respect for patient autonomy, even in an emergency situation where the patient is *compos mentis*, he / she must be informed of the physician's expertise, level of skill and training. Although no person may be refused emergency medical treatment, same may not be forced, except in the instance of children<sup>24</sup>.

## 7.7 Medical Insurer Liability

The Medical Protection Society (MPS), although not an insurer, provides benefits to a physician who is involved in a claim arising from a Good Samaritan Act anywhere in the world. In the unlikely event that legal proceedings follow, the physician would be entitled to apply for assistance, no matter in which country the legal proceedings are commenced<sup>25</sup>.

## 7.8 Onus on Airline Passengers

It would be unreasonable to expect airlines and volunteer physicians to bear the load alone.

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<sup>23</sup> Moodley *Medical Ethics Law and Human Rights: A South African Perspective* (Van Schaik: 2011) 115

<sup>24</sup> *Hay v B* 2003 (3) SA 492 (W)

<sup>25</sup> MPS Member Guide (2007)

The passengers' rights are accompanied by a consortium of responsibilities, such as to undergo pre-flight medical screenings<sup>26</sup> and behave in a manner that would make it easier for the State, airline and / or volunteer physician to meet its rights and obligations<sup>27</sup> by not skipping out on chronic medication, managing pre-existing conditions<sup>28</sup>, keeping same at hand, as well as additional oxygen if necessary, and avoiding air travel shortly following surgery<sup>29</sup>.

“The passengers have a duty unto themselves as well as all others onboard to ensure their health is up to standard to endure a transcontinental flight.”<sup>30</sup> The Patient's Rights Charter similarly imposes duties on patients to take care of their health<sup>31</sup>. Any failure to comply with these duties may, at best, result in contributory negligence and an apportionment of the damages awarded, if any<sup>32</sup>. I suppose that in the end, one could even go so far as to avert negligence to the treating medical physician who failed to adequately advise and inform the passenger of risks inherent to, and associated with, flying long distance, with the medical condition.

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<sup>26</sup> A. Chandra, S. Conry *In-Flight Medical Emergencies* (Western Journal of Emergency Medicine: 2013) 499–504

<sup>27</sup> Moodley *Medical Ethics Law and Human Rights: A South African Perspective* (Van Schaik: 2011) 103

<sup>28</sup> S. Perry *In-flight medical emergencies are surprisingly common* (MINNPOST: 2015)

<sup>29</sup> S. Costa *Is There a Doctor on the Plane? What you should know about in-flight medical emergencies* (2015)

<sup>30</sup> S. Costa *Is There a Doctor on the Plane? What you should know about in-flight medical emergencies* (2015)

<sup>31</sup> Section 19 of the National Health Act 61 of 2003

<sup>32</sup> Section 1(a) of the Apportionment of Damages Act 34 of 1956; *Wright v Medi-Clinic LTD* (2007) 2 ALL SA 515 C; *Minister of Safety and Security v Rudman* 2005 (2) SA 16 (SCA).

## **CHAPTER 8:**

### **Limitation of Rights: Grounds of Justification**

#### **8.1 Introduction**

Grounds of justification are nothing more than the justifiable limitation of individuals' socio-economic rights.

The Court in *Prince v President, Cape Law Society and Others* 2002 (2) SA 794 (CC) confirmed that the rights conferred by the Bill of Rights are not absolute, and that they may be justifiably limited under certain circumstances. The Court could not sanction the use of cannabis without impairing the State's ability to enforce its legislation in the public interest and to honour its international obligation to do so.

Therefore, the positive right of access to health care services and the right not to be refused emergency medical treatment may be limited in terms of the limitation clause and claimed only subject to the availability of resources<sup>1</sup>. The Court in *Affordable Medicines Trust v Minister of Health* Case no 1908/2004 TPD confirmed that: "to equate a certain degree of inconvenience to the impairment of the right to dignity thus rendering such encroachment as unconstitutional would be to extend the boundaries of patients' rights to an unrealistic Utopia"<sup>2</sup>.

The standard of medical care requires a medical practitioner or medical specialist to perform acts only in the field of medicine in which they were educated and trained and in which they have gained experience, regard being had to both the extent and limits of their professional expertise<sup>3</sup>.

The very nature of a medical emergency dictates that sudden medical care is required, often in circumstances that are less than ideal, thus automatically resonating with the limitations provided for in the Constitution<sup>4</sup>. When the standard of care provided by volunteer medical physicians in a medical emergency situation falls short of the standard of care demanded in the normal scope of practice, the following grounds may be cited as justification -

##### **8.1.1 Unauthorised Administration**

The volunteer physician may avail him or herself to this defence where an ailing passenger is unable to consent to medical treatment / intervention due to incapacitation (delirium, shock, inebriation, coma or unconsciousness), and which consent is urgently required to save his / her life or to preserve his / her health.

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<sup>1</sup> Moodley *Medical Ethics Law and Human Rights: A South African Perspective* (2011, Van Schaik: 2011) 34

<sup>2</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis: 2007) 142

<sup>3</sup> Rule 21 Guidelines for Good Practice in the Health Care Professions *Ethical and Professional Rules of the Health Professions Council of South Africa as Promulgated in GG R717/2006* (Booklet 2: May 2008) 15

<sup>4</sup> Section 36 of the Constitution of the Republic of South Africa Act 108 of 1996

Thus rendering the intervention lawful, provided there is an emergency situation requiring the intervention where the passenger is unable to consent to or expressly prohibit intervention which is in the passenger's best interest<sup>5</sup>.

### 8.1.2 Necessity

This defence will justify the volunteer physician's actions, to protect the ailing passenger's legally recognised interest to health care and life which is threatened by a medical emergency situation which has already commenced and cannot be averted in another way, in society's best interest.

### 8.1.3 Statutory Authority

Statutory provisions may justify a medical intervention in an emergency situation, in which case the justifications of statutory authority and necessity may overlap<sup>6</sup>. Both the Constitution<sup>7</sup> and the National Health Act<sup>8</sup> provide that nobody may be refused emergency medical treatment.

The National Health Act provides that emergency medical treatment may be provided where patients, incapable of giving consent, are faced with death or irreversible damage to their health if such treatment is delayed and they have not refused consent<sup>9</sup>.

### 8.1.4 *Boni mores* / legal convictions of society

Public policy and the law are interwoven, so much so, that all laws are public policy, however not all public policies, which need to be expressly formulated, are law<sup>10</sup>.

Fortunately, the Courts are free to develop these justifications if they can no longer cater for new situations, as illustrated by the Court in *Carmichele v Minister of Safety and Security* 2002 (1) SACR (79) CC which held that: "The common law, especially in the field of delictual liability, has constantly required development, [...] and the provisions of section 39(2) of the Constitution oblige it to have regard to the spirit, purport and objects of the Bill of Rights".<sup>11</sup>

The test to determine whether or not the medical intervention was lawful or wrongful will be whether or not it was contrary to public policy in terms of society's notions of

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<sup>5</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis: 2007) 907

<sup>6</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis: 2007) 918

<sup>7</sup> Section 27(3) of the Bill of Rights in the Constitution of the Republic of South Africa Act 106 of 1998

<sup>8</sup> Section 5 of the National Health Act 61 of 2003

<sup>9</sup> Section 7(1)(e) of the National Health Act 61 of 2003

<sup>10</sup> Beauchamp & Childress *Principles of Biomedical Ethics* (6<sup>th</sup> ed.) 8

<sup>11</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis: 2007) 937

what might or might not be expected of medical practitioners in the circumstances, considering all of the surrounding circumstances of the case.

### 8.1.5 Contributory Negligence

The volunteer physician or airline may allege contributory negligence where the ailing passenger neglected to follow the instructions of his / her general practitioner or specialist physician, failed to adhere to further treatment regimes or by ignoring specific instructions pertaining to post-operative care<sup>12</sup>.

### 8.1.6 Error of professional judgment and medical misadventure

Lord Fraser laid down the requirements for an error of professional judgment as a defence against medical negligence<sup>13</sup>:

“The true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one that would have been made by a reasonable competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that a man, acting with ordinary care might have made, then it is not negligence”.

Instances of medical misadventure / mishap are considered in the particular circumstances by way of expert medical opinion as to whether the patient’s adverse complications (injury or death) were reasonable, foreseeable and preventable in the particular circumstances<sup>14</sup>.

It is submitted however, that a volunteer physician who knowingly lacks the degree of training, knowledge, experience, skill and competence, and chooses to engage in assistance requiring that requisite degree of skill, will not be bound by that standard of care in the case of an emergency situation<sup>15</sup>.

### 8.1.7 Locality of Practice

The locality of the volunteer physician when rendering the emergency medical treatment plays an important role in the assessment of medical negligence<sup>16</sup>, and may

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<sup>12</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis: 2007) 940

<sup>13</sup> *Whitehouse v Jordan* (1981) 1 ALL ER 267 (HL)

<sup>14</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis: 2007) 941

<sup>15</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis: 2007) 628

<sup>16</sup> Carstens & Pearmain *Foundational Principles of South African Medical Law* (Lexis Nexis: 2007) 638

be used to escape liability in the context of the elements of unlawfulness and / or fault, but not as a means to determine the element of causation<sup>17</sup>.

Justice Innes in *Van Wyk v Lewis* 1924 AD 438 held that the “locality” rule does not apply when determining medical negligence, by determining that “the ordinary medical practitioner should, as it seems to me, exercise the same degree of skill and care, whether he carries on his work in the town or the country, in one place or another”.

In contrast, Wessels AJ observed that:

“It seems to me, however that you cannot expect the same skill and care of a practitioner in a country town in the Union as you can expect of one in a large hospital in Cape Town or Johannesburg. [...] It seems to me, therefore, that the locality where an operation is performed is an element in judging whether or not reasonable skill, care and judgment have been exercised”.

The Court in *S v Tembani* 1999 (1) SACR 192 (W) held that “medical negligence must be overwhelming”.

However, later on, Cameron J in *S v Tembani* 2007(2) SA 291 (SCA) held that “In a country where medical resources are not only sparse, but badly distributed [...] Medical negligence, even if it is gross, will not avail assailant provided it was done with good faith [...] improper medical treatment neither abnormal nor extraordinary in South Africa [...]”. “By ‘grading’ medical negligence to ‘overwhelming or gross’ and by ruling that substandard / negligent medical treatment in our State hospitals is to be expected, the Court has [...] created a disproportionate yardstick by allowing too much leverage for unacceptable and even unethical medical standards in our public hospitals to flourish, under a protective veil of policy consideration.”<sup>18</sup>

The Court in *Charles Oppelt v The Head: Health, Department of Health, Provincial Administration: Western Cape* CCT 185/14 held that the department’s employees were negligent in failing to timeously refer Mr. Oppelt to a hospital specialised in spinal injuries to enable him to be treated there for his injury. The Court further found that the unreasonable delays justified the conclusion that the department refused emergency medical treatment to Mr Oppelt as provided for in section 27(3) of the Constitution. Leave to appeal has been granted in the matter.

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<sup>17</sup> Carstens “Judicial recognition of substandard medical treatment in South African public hospitals: The slippery slope of policy considerations and implications for liability in the context of criminal medical negligence” 2008, *SA Public Law*, 168 – 180

<sup>18</sup> Carstens “Judicial recognition of substandard medical treatment in South African public hospitals: The slippery slope of policy considerations and implications for liability in the context of criminal medical negligence” 2008, *SA Public Law*, 168 – 180



## **CHAPTER 9:**

### **Proposed Solution(s)**

#### **9.1 Introduction**

On-board treatment is by its very nature carried out in an isolated setting which is very different from the volunteer physician's usual working environment where the available expert knowledge and specialised equipment on-board are highly limited<sup>1</sup>.

The following solutions are proposed in an effort to limit the liability of both volunteer physicians and airlines as well as negate contributory negligence for the passengers:

##### **9.1.1 Indemnity Forms / Disclaimer / Waiver Agreements**

It is difficult to imagine that a patient may maintain patient autonomy when entering into a metal tube some 35 000 feet in the air, and having a medical emergency with various medical practitioners providing care and an airline pilot who needs to adhere to the interests of the airline as well. Where indemnity forms include, and the passengers agree to, consent to any treatment which the airline is able to offer in an emergency situation, thus negating patient autonomy. This way the airline can contract out of liability for medical negligence, except gross negligence<sup>2</sup>, by way of a permissible disclaimer clause. However, airlines may not refuse travelling passengers and any passenger who refuses to sign the indemnity form. In fact, certain passengers may even refuse such health services, thus indicating a freedom to contract<sup>3</sup>.

##### **9.1.2 On-board Medical Assistance**

Although the in-flight airline crew receive basic first aid training in cardiopulmonary resuscitation (CPR) as well as training in the use of an automated external defibrillator, they are not emergency physicians<sup>4</sup>. Similar to additional travel insurance, it is suggested that perhaps airlines should consider levying an extra charge to provide an in-flight emergency medical physician to monitor the passenger and ensure a healthy arrival at his or her destination.

Or perhaps such extra charge should only be levied against persons with serious pre-existing medical conditions. However, serious medical conditions must then be determined and defined, and such determination would amount to discrimination against certain persons.

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<sup>1</sup> Graf J. Stuben U, Pump S: "In-flight Medical Emergencies" (Dtsch Arztebl Int: 2012) 591-602

<sup>2</sup> *Afrox Healthcare v Strydom 2002 (6) SA 21 (SCA)*

<sup>3</sup> *Barkhuizen v Napier CCT72/05 (2007) ZACC 5*

<sup>4</sup> T. Goodwin *In-flight medical emergencies: an overview* (BMJ: 2000) 321 - 325

Alternatively, airlines should employ a full-time medical physician trained in emergency medicine, at no extra charge to the passenger, to travel with each flight much the same as an American Air Marshall travels on each flight to ensure the safety of all passengers. These physicians are best suited to assist during an in-flight medical emergency as their training provides a breadth across all age groups and organ systems, and their ability to improvise and focus on the diagnosis and immediate care of sick passengers sets them apart as a specialty<sup>5</sup>.

In fact, Lufthansa has already included a patient-transport compartment (PTC) accompanied by one intensive care nurse and one physician<sup>6</sup>, to provide intensive care onboard its commercial long-distance aircrafts on intercontinental routes. The PTC includes backup devices for all vital medical equipment (for monitoring, artificial ventilation, infusions, etc) in case of failure, as well as 13 000L of oxygen in gas volume.

### 9.1.3 Full disclosure of medical history by passenger(s)

With the advent of telemedicine, Carte Blanche intended to air a clip regarding the suggested microchipping of humans which would change the way assistance is received in a medical emergency. The microchip would contain all of the persons medical information which would be instantly available to the medical physician and airline personnel attending to the emergency. It has often happened that the ailing passenger is not in a position to inform the volunteer physician and in-flight crew of any pre-existing medical conditions, chronic medication or allergies, effectively causing the medical assistance to be administered in the dark.

In the alternative, perhaps airlines should insist that passengers provide their complete medical history when reserving their seats on the flight. However, this once more would result in a severe infringement of the right to privacy.

Although the microchip and suggested database would be intended to assist the patient passenger and ensure that he or she receives the best medical diagnosis and treatment (beneficence) in the circumstances, it would be in direct conflict with the principle of patient autonomy as the personal rights to privacy would be directly infringed upon. Every bit of care must be taken to protect the identity of those who are mentioned on the medical database and the consent of patients is needed if the information is accessible to a third party<sup>7</sup>.

In contrast though, once the airline is in possession of each passenger's medical information, they would be able to properly prepare thus ensuring the availability of resources, and accordingly prevent harm from occurring to the passengers which would have resulted from the absence of the necessary equipment and medication.

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<sup>5</sup> Be Prepared for In-Flight Medical Emergencies <http://www.acep.org/Clinical--Practice-Management/Be-Prepared-for-In-Flight-Medical-Emergencies/>

<sup>6</sup> Graf J, Stuben U, Pump S: "In-flight Medical Emergencies" (Dtsch Arztebl Int: 2012) 591-602

<sup>7</sup> The World Medical Association Declaration on Ethical Consideration regarding Health Databases (2002)

#### 9.1.4 Full disclosure of medical practitioner's scope of practice

Volunteer physicians should critically assess their abilities and level of skill prior to volunteering their medical service to the flight crew and passenger. The physician should not volunteer if they are incapacitated in any way from recently ingested alcohol or central nervous depressants. In so far as it is possible, it would be ideal if the volunteer physician could present their medical credentials confirming their level of skill, to both the in-flight crew and passenger. It cannot be emphasised enough that volunteer physicians should stay well within their level of competence, as the protection of the Good Samaritan laws do not extend to gross negligence. The volunteering physician must further obey all instructions received from the in-flight crew<sup>8</sup>.

However, the in-flight personnel have a duty to inform the volunteer physician of the availability of onboard emergency medical kits as well as the content thereof, and the availability of access to on the ground medical support centres, to enable the volunteer physician to provide emergency care within the scope of practice and to the best of their ability. The writer however, submits that it would be unreasonable to expect the volunteer physician to have knowledge of the most common in-flight medical incidents<sup>9</sup>.

It is suggested that the volunteer physician treat the ailing passenger in his / her seat, record all findings and treatments administered, communicate and coordinate with flight crew and ground resources, practice within their field of expertise only, request access to the emergency medical kit, recommend diversion if necessary and use a translator where necessary<sup>10</sup>.

#### 9.1.5 Full disclosure by Airline of possible risks

It has been suggested that passengers undergo a pre-flight examination when considering airtravel to mitigate the occurrence of a medical emergency. However, a corresponding duty should rest with the airline to inform passengers of the most common medical risks associated with air travel and advise that air travel can exacerbate underlying diseases, such as heart problems, diabetes and epilepsy, as well as trigger a new condition<sup>11</sup>.

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<sup>8</sup> "Management of In-flight Medical Emergencies" by Keith J. Ruskin, M.D., Keith A. Hernandez, M.D., Paul G. Barash, M.D. *Anesthesiology* 4 April 2008: vol 108: 754

<sup>9</sup> A. Chandra, S. Conry *In-Flight Medical Emergencies* (*Western Journal of Emergency Medicine*: 2013) 499–504

<sup>10</sup> A. Chandra, S. Conry *In-Flight Medical Emergencies* (*Western Journal of Emergency Medicine*: 2013) 499–504

<sup>11</sup> S. Perry *In-flight medical emergencies are surprisingly common* (*MINNPOST*: 2015)

### 9.1.6 Shorter flights for long-distance destinations with frequent stops

BBC News, on 11 December 2016, reported that the Australian airline, Qantas Air, will be offering a new non-stop 17 hour flight service from London to Australia, covering a distance of 14,498km, as of March 2018. The Boeing 787-9 Dreamliners would carry 236 passengers and make up the longest non-stop passenger route in the world. The current longest non-stop scheduled flight is Emirates Airlines' 14,200 km Dubai-to-Auckland, New Zealand service, which takes 16 hours 35 minutes in an Airbus A380<sup>12</sup>. However, Air India's flight from San Francisco is the world's longest at 15,140 km.

It is suggested that the airlines consider shortening the distances of their international flights to allow passengers to receive intermittent breaks as needed. However, this recommendation would come at a considerable cost to the airlines themselves due to the massive fuel consumption during each take-off.

Airlines would therefore prefer to continue with longer non-stop flights. Granted, space onboard common carriers is at a premium, and it may have been unrealistic to expect that an aircraft be equipped as an emergency room in the past, it is submitted that, with the increase of non-stop flights, the airlines now have a duty to ensure that they are equipped in-flight to handle all medical emergencies short of surgeries<sup>13</sup>.

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<sup>12</sup> Business *Qantas to fly from London to Australia non-stop* (BBC News: 2016)

<sup>13</sup> C. Gounder *Medical Emergencies at 40,000 Feet* (The Atlantic: 2013)

## **CHAPTER 10:**

### **Final Conclusion and Recommendations**

The Court in *Coetzee v Comitis* 2001 (1) SA 1254 (C)<sup>1</sup> held that “...considerations of public policy cannot be constant. Our society is an ever-changing one. We have moved from a very dark past into a democracy where the Constitution is the supreme law, and public policy should be considered against the background of the Constitution and the Bill of Rights”. Although the hard law of legislation and case law are clear on the matter, the difficulty lies with the ethics of a person<sup>2</sup>.

With the advent of increased<sup>3</sup> disabled, more sickly, and older, less healthy passengers flying considerable distances, a corresponding expectation arises that the airlines will take care if problems occur by providing special facilities to make their journeys possible, notwithstanding clear challenges and resource constraints<sup>4</sup>.

In this regard, it is submitted that Lufthansa has, perhaps unintentionally, set the industry standard, to adhere to the passengers’ right to an environment that is not harmful to a person’s health or well-being<sup>5</sup>, for all common carrier aircrafts travelling internationally, and against which standard they will be measured in future medical negligence claims. Just as medical physicians have a duty to remain up to date with their knowledge of treatments in their field of medicine, so too, do airlines have a duty to ensure that they comply with the industry standard.

It is believed that, under the circumstances, both the airlines as well as the volunteer physician have a heightened obligation to ensure that the ailing passenger receives adequate in-flight emergency medical treatment and a right to health care in terms of section 27 of the Constitution, as per the recommendations already made *supra*.

It is submitted that, in the absence of documented cases of a physician or airline being sued for providing assistance during an in-flight emergency, the increase in such occurrences cannot be ignored.

A finding of medical negligence in South Africa requires a value-judgment dependent on expert evidence, circumstance, locality and policy considerations. It is clear that the law is limping and it must be amended to catch up and regulate a travelling society aware of their right to emergency medical health care.

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<sup>1</sup> *Coetzee v Comitis* 2001 (1) SA 1254 (C)

<sup>2</sup> Dhai & McQuoid-Mason *Bio-ethics, Human Rights and Health Law: Principles and Practice* (Juta: 2011) 14

<sup>3</sup> T. Goodwin *In-flight medical emergencies: an overview* (BMJ: 2000) 321 - 325

<sup>4</sup> T. Goodwin *In-flight medical emergencies: an overview* (BMJ: 2000) 321 - 325

<sup>5</sup> Section 24(a) of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996

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