

BRITISH AIRWAYS HEALTH SERVICES

YOUR PATIENT AND AIR TRAVEL

A GUIDE TO PHYSICIANS

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Introduction

Commercial air travel is a comfortable, speedy and safe means of transport and is now accepted as a part of everyday life for many people in the developed world.

It is affordable and accessible to all sectors of the population and it is easily forgotten that the individual is travelling in an unfamiliar and physiologically unusual environment.

For the fit, healthy and mobile individual there is no problem but for the passenger with certain pre-existing conditions or developing an acute medical problem in flight, the cabin environment may exacerbate the condition.

In-flight medical problems can result from the exacerbation of a pre-existing medical condition or can be an acute event occurring in a previously fit individual. Although the main problems relate to hypoxia and expansion of trapped gases, the stress and physical challenge to passengers of the complex airport environment should not be overlooked (e.g. carrying baggage, walking long distances and dealing with unexpected delays).

Cabin Crew receive training in advanced first aid and basic life support and in the use of the emergency medical equipment, including automated external defibrillators which are carried on board all British Airways aircraft. In the future, British Airways intends to install air-to-ground cardiac monitors to assist with diagnosis. In serious cases assistance will be requested from the airline's medical advisers via the air-to-ground link or a medical professional who may be travelling as a passenger.

In a medical emergency, other (non-medical) factors need to be taken into account when considering whether a diversion is appropriate, including:

- suitable convenient airport
- appropriate medical facilities
- terminal facilities for the number of passengers
- sufficient hotel accommodation for passengers and crew

Most airlines provide services for those passengers requiring extra help but these can be made available only if the airline is advised of the need for special assistance by the passenger or his/her medical practitioner prior to the flight. Most airlines also have a medical adviser to assess the fitness for travel of those with medical needs. The information needed for provision of appropriate assistance depends upon an understanding of the practicalities of air travel as well as an understanding of the basic physics of the flight environment and its effect on human physiology.

The operational effect of the use of equipment such as wheelchairs, ambulances and stretchers must be taken into account and the possibility of aircraft delays or diversion to another airport must be considered. It may be necessary to change aircraft and transit between terminals during the course of a long journey and land-side medical facilities will not be available to a transiting passenger. At London's Heathrow Airport, for example, transfer traffic accounts for more than 40% of all passengers.

Deterioration on holiday or on a business trip of a previously stable condition such as asthma, diabetes or epilepsy or accidental trauma frequently gives rise to a request for medical clearance for the return journey. A stretcher may be required, together with medical support and this can incur considerable cost. Hence the importance of adequate travel insurance which includes the provision of a specialist repatriation company.

Aside from the considerations specific to flying, thought should, of course, also be given to immunisation and anti-malarial prophylaxis where appropriate, adverse effects of the destination climate, inadequate health resources and the potential impact of lost or stolen medication.

Pre-flight Assessment and Medical Clearance

The ideal traveller is one who is fully vaccinated, insured, taking appropriate protection measures, aware of potential risks, prepared for the demands of the journey (both on the ground and in the air) and fully conversant with their destination. (For example, Mexico City with its high pollution levels and an altitude above 9,500 feet should not be contemplated by those with respiratory impairment.)

Objective

The objectives of medical clearance are to provide safe, healthy travel, high levels of customer satisfaction and to prevent delays and diversions to the flight as a result of a deterioration in the passenger's well-being. It depends, however upon self-declaration by the passenger and upon the attending physician having an awareness of the flight environment and how this might affect the patient's condition.

Mechanism

Early notification to the airline is essential to ensure communication to operational areas for pre-board and baggage assistance, provision of buggies or wheelchairs for distances, special diets and seating.

The Aerospace Medical Association has published guidelines on fitness for travel and the International Air Transport Association (IATA) publishes a recommended Medical Information Form (MEDIF) for use by member airlines. This is available from the airlines directly or from travel agents.

Part 1 of the MEDIF is completed by the agent and/or passenger and Part 2 by the passenger's medical representative. It should then be passed to the airline at the time of booking to ensure timely medical clearance. It is **essential** that the form is fully completed as delays can result if information is omitted.

The need for Medical Clearance

Medical clearance is required when:

- **fitness to travel is in doubt** as a result of recent illness, hospitalisation, injury, surgery or instability of an acute or chronic medical condition
- **special services are required** e.g. oxygen, stretcher or authority to carry or use accompanying medical equipment.

- passengers are contemplating overseas diagnostic or hospital treatment in specialist hospitals. There is still the need to conform to airline requirements for medical clearance.

Assessment

Physiological Considerations

Basic principles of physics, physiology and pathology should be used in determining the passenger's fitness to fly.

Modern commercial airliners fly with a cabin altitude of between 4000 and 8000 feet when at cruising altitude, which means a reduction in ambient pressure of the order of 20% compared with sea level and a consequent reduction in blood oxygen saturation of about 10%. Consideration must be given therefore to the effects of the relative hypoxia encountered.

Any trapped gas will expand in volume by up to 30% at the normal aircraft cabin cruise altitude, potentially leading, for example to pain and perforation of the ear drum if the Eustachian tubes are blocked by infection or to stretching of suture lines following recent abdominal surgery.

The cabin air is relatively dry which can lead to a sensation of dryness in the mouth and extremities, though studies have shown that it does not lead to central dehydration and plasma osmolality is unchanged.

The potential for the development of traveller's thrombosis, particularly on long haul routes, should be borne in mind. Many airlines (including British Airways) promote lower limb exercise in the in-flight magazine and encourage mobility within the cabin. However, those passengers known to be vulnerable to DVT (for example with clotting disorders, recent surgery or trauma and those with certain types of malignancy) should undergo appropriate medical evaluation, and consideration given to the use of compression stockings, aspirin or anti-coagulants.

In addition to the effect of the condition upon the sick passenger, account must be taken of the effect or potential effect on other passengers or crew members. It is important to recognise that the filters for re-circulating cabin air remove bacteria and most viruses, so that any risk of transmission of infection in the cabin is remote and usually confined to those passengers seated near to the infected passenger. However, it is an International Health Regulation that an individual should not fly during the infectious stage of a contagious disease.

Practical Considerations

The best time to establish the fitness of the prospective passenger for a commercial airline flight is in the weeks prior to the intended departure.

The pre-flight evaluation should focus on the passenger's medical condition with special consideration given to possible infectivity, the dosage and timing of any medication and the need for special assistance requests.

The physician can achieve much by simply reminding passengers to hand carry life-line medication and by endorsing the need for valid travel insurance which includes adequate health cover.

Criteria

Examples of conditions requiring particular evaluation include cardiovascular disease, deep vein thrombosis, upper and lower respiratory tract disease (e.g. sinusitis, asthma, chronic obstructive airways disease, emphysema), recent surgery, cerebro-vascular disease, unstable psychiatric illness, diabetes and infectious diseases.

Assessment is often relatively simple. For example, a knowledge of the passenger's exercise tolerance can be a useful indication of fitness to fly. If someone is unable to walk a distance greater than 50 metres without developing dyspnoea, there is a risk that they will be unable to tolerate the relative hypoxia of the pressurised cabin. More specific information can be gained, if necessary, from a knowledge of the passenger's blood gas levels and oxygen saturation.

Operational airline crew are familiar with the risk of otic barotrauma from flying with an upper respiratory tract infection, hay fever or sinusitis but passengers may need to be reminded of this potential hazard. It is also considered unwise to travel by air with otitis media unless appropriate antibiotics have been administered for at least 36 hours and the patency of the Eustachian tubes assessed by a health professional.

It is advisable to carry written confirmation of non-infectivity, for example when jaundiced. Similar documentation is wise if carrying medication to satisfy customs at ports of entry.

One other important point is to avoid prescribing a medication for in-flight use unless the would-be traveller has used it before, is familiar with its primary effects and has no undue side effects.

Waivers and disclaimers are inappropriate and are not recommended practice.

Medical Criteria for Fitness to Fly

There are a number of contraindications to flying that are absolute, many more of which are relative. The following guidelines are in use in **British Airways**, which are, in turn, based on those issued by IATA (the International Air Transport Association). It is impossible to give definitive advice for every condition and the information provided is for guidance only and may be varied for reasons such as complications or multiple pathology.

Medical escorts may be required if there is a high level of dependency or if there is a significant risk of deterioration. In all cases, passengers must be reminded to carry into the cabin with them any medication that might be required in flight.

Some Medical Conditions Requiring Pre-Flight Medical Evaluation:

Cardio-Vascular Disease

Examples include recent **myocardial infarction**, **coronary artery bypass grafting**, **angina pectoris** and **congestive cardiac failure**.

Most cardiac patients on medication can tolerate cabin air if stable, with the use of supplementary oxygen in some cases.

Following an uncomplicated **myocardial infarction**, passengers should not fly for at least 7 days. **Angina**, if stable with infrequent attacks, is not usually a problem.

Coronary artery bypass grafting and other **chest surgery** should pose no risk providing the passenger has made a normal uncomplicated recovery. Air travel can be contemplated, if necessary, at 10 days post surgery, thus allowing time for the air introduced into the chest to be reabsorbed. The situation following the relatively new procedure of **angioplasty** (with or without stent) is less clear because of the risk of early re-occlusion. In most cases travel can be contemplated within 3 to 5 days but individual assessment is required.

Respiratory Disease

Passengers with **asthma** and **chronic lung disease** (including **chronic obstructive pulmonary disease (COPD)** and **pulmonary fibrosis**) are usually able to travel safely if the condition is stable and there has been no recent deterioration.

One method for use by the physician when making an assessment is to check whether the passenger **can walk 50 metres on the flat or up one flight of stairs** without becoming severely dyspnoeic. If the answer is “yes” then the passenger is likely to be fit to fly; if “no” most of the passengers may be transported safely and without incident providing that supplemental oxygen is available during the flight as standby or for continuous use. Individuals who are markedly breathless at rest should be advised not to fly.

For borderline cases or when oxygen is required on the ground (and the trip is essential), measurements of oxygen saturation and/or blood gas analysis can be useful. Although the **percentage** of oxygen remains constant at around 21% whatever the altitude, the **partial pressure** of oxygen in the cabin at the highest cruising altitude can be considered to be **equivalent** to an oxygen concentration of approximately 17% at sea level. Some respiratory physicians therefore, have assessed oxygen saturation levels on patients whilst breathing 16-17% oxygen as a definitive test of fitness to fly. More information on the provision of in-flight oxygen can be found below.

There is no specific risk to passengers with **asthma** in the aircraft cabin, the most significant problem encountered is when medication is inadvertently packed in the hold. For travellers to areas of the world where health care provision may not be readily available, it may be prudent for all but the mildest asthmatics to be advised to take a course of steroids with them for use in an emergency.

Pneumonia should be resolved, with no residual infection and satisfactory exercise tolerance as above. If the passenger also has existing pathology (such as **COPD**) it is often prudent to delay travel for a few weeks if possible.

Under conditions of reduced pressure, gas trapped in the body cavities will expand and this must be considered following a **pneumothorax**. Generally, it should be safe to travel by air two weeks after successful drainage.

Blood Disorders

For passengers with **anaemia** special consideration should be given to anyone with a haemoglobin below 7.5gm/dl as it reduces the tolerance to hypoxia. If there is any doubt oxygen should be considered.

Those with **chronic renal failure** and other **conditions predisposing to anaemia**, usually tolerate a lower haemoglobin level at cabin cruising altitude than someone with a recent haemorrhage.

Those with **sickle cell anaemia** should travel with supplemental oxygen and should defer travel for 10 days following a sickling crisis.

Sickle cell trait has not been associated with problems at normal cruising altitude.

Central Nervous System Disorders

Following a **stroke** or **cerebrovascular accident**, passengers can usually travel after 3 days if stable or recovering, though formal medical clearance should be sought if travel is required within 10 days. For those with **cerebral artery insufficiency**, hypoxia may lead to problems and supplementary oxygen may be advisable.

Travel should be delayed for 24 hours after a **grand mal seizure**. The passenger with stable **epilepsy** may be more prone to seizures during a long flight; mild hypoxia and hyperventilation are known precipitating factors, in addition to the aggravation of fatigue, anxiety and irregular medication. Whilst it would not be appropriate to change medication immediately prior to a trip, consideration should be given to providing extra anti-convulsant medication. If nothing else, the passenger with **epilepsy** must ensure that they have sufficient medication in their hand baggage for the duration of the flight and also for any unexpected delays.

Deep Vein Thrombosis (DVT)

Those with a **DVT** of the leg can travel once the condition is stabilised on an appropriate anti-coagulation regime with resolution of the clot.

Prolonged immobility is a known risk factor for **thrombo-embolic disease** and all passengers should keep mobile whilst in flight. It is recommended that they stand in their seat area and stretch their arms and legs every couple of hours, walk around the cabin whenever they can and follow an in seat exercise programme. Such as that contained in the British Airways in flight magazine, High Life.

Passengers with intrinsic risk factors, such as a history of **DVT** or **pulmonary embolism**, **post thrombotic syndrome**, **chronic venous insufficiency**, **malignancy**, **coagulopathy**, **heart disease** or **pregnancy**, should, in addition, seek medical advice and take appropriate precautions. Prophylaxis with low molecular weight heparin or aspirin may be appropriate.

ENT Disorders

Otitis media, sinusitis and any other condition leading to **blockage of the Eustachian tube** may lead to problems because of gas expansion. Pain, perforation of the tympanic membrane and sinus barotrauma can result and flying should be delayed until the condition has resolved.

Passengers can fly 10-14 days after **tonsillectomy** or **middle ear surgery**. If the jaw has been wired for any reason, a passenger may only travel if there is an escort equipped with wire cutters or a self quick release mechanism is fitted.

Fractured Limbs

Following application of a **plaster cast**, British Airways restricts flying for 24 hours for flights under 2 hours and 48 hours for longer flights. However, these restrictions do not apply if the cast has been bi-valved which helps to avoid harmful swelling, particularly on long flights.

Full length, above the knee plasters or those who require **leg elevation** are required to purchase appropriate seating (First, Club World or extra seats in World or Euro Traveller) in order to obtain the necessary leg room. Fractures of the **hip** or **femur** will almost certainly require a stretcher. Safety regulations preclude the use of Emergency Exit rows for any passenger with a medical condition.

Gastro-Intestinal Disease

Passengers who have had **abdominal surgery** in which hollow viscus has been sutured are at risk of perforation or haemorrhage as a result of gas expansion at altitude. Air travel should be discouraged for 10 days following any **abdominal surgical procedure**. In addition stretching gastric or intestinal mucosa may result in haemorrhage from **ulcer** sites although travel may be permitted if there is clear endoscopic evidence of healing.

Travellers with **colostomies** are not at increased risk during air travel although intestinal distension may increase faecal output. The use of a large **colostomy** bag is recommended. More frequent changes may be necessary for smaller bags and extra supplies should be carried in the cabin hand baggage.

Passengers may experience abdominal discomfort because of gas expansion in flight but this is not of significant medical concern.

Infectious Diseases

In common with other public transport systems, an airline cannot accept passengers with infectious conditions until the risk to other passengers has passed.

Diabetes Mellitus

As long as they can administer their own medication passengers with **diabetes mellitus** can usually travel without difficulty and medical clearance is not required. It is important that they are aware of problems caused by time zone changes. It is recommended to remain on one time system during the flight and only attempt to readjust to local time on arrival at their destination.

For flights over 8 hours a specialist doctor or nurse should advise regarding an insulin regime.

Diabetics also need to be reminded that insulin does not generally require refrigeration. The **British Diabetic Association** recommend carriage of insulin in the hand baggage and not in the aircraft hold where it is possible that the insulin may be frozen and so become inactivated. Needles should be disposed of safely and never in seat pockets or toilets. Further information on diabetes and travel is available on the British Diabetic Association website at www.diabetes.org.uk.

Special diets can be requested at the time of making a reservation. It is often sensible to specify what the dietary requirements are rather than just asking for a “diabetic meal”.

Ophthalmological Procedures

Procedures for **retinal detachment** can involve the intra-ocular injection of gas in order to temporarily increase intra-ocular pressure. This gas bubble needs to be fully absorbed prior to any flight. This takes approximately 2 weeks if sulphur hexafluoride is used and 6 weeks with the use of perfluoropropane.

For other **intra-ocular procedures** and **penetrating** eye injuries, one week should elapse before flying. There is no specific restriction on flying after **cataract surgery** and **corneal laser surgery**.

Pregnancy

Whilst **pregnancy** is not a “medical condition”, flying whilst **pregnant** is a frequently raised topic. Normally pregnancy is a happy event for all concerned but delivery in flight it is not without risks to the mother and baby. For this reason British Airways, along with many airlines, refuses to carry women in the latter stages of pregnancy, typically after 36 weeks for single pregnancies, 32 weeks for multiple.

A certificate is normally required to be carried after 28 weeks confirming the estimated date of delivery, that there are no complications and, in the view of the doctor or midwife, the passenger is fit to fly.

Passengers should be reminded that health travel insurance in the latter stages of pregnancy can be difficult to obtain.

Psychiatric Disorders

Because of the safety implications, **psychiatric disorders** need to be stable and controlled. Generally any acute severe condition (such as an **acute psychosis**) would need to have an appropriately trained medical escort (RMN) plus suitable sedation which can be administered by the escort. Medical clearance must be sought well in advance of intended travel.

For passengers with other disorders, such as **anxiety** or **depressive neurosis**, the airport environment and the flight itself may have a significant impact. Small doses of anxiolytics *may* be helpful in passengers who are familiar with their effects and side effects. However, great care must be taken to avoid over sedation (which could be misinterpreted by cabin crew as serious illness) and mixing with alcohol which can lead to unpredictable behaviour.

A variety of courses is available to help those with a **fear of flying** and passengers will usually find cabin and flight crew extremely supportive if they are aware of the problem.

Terminal Illness

Not infrequently airlines are asked to carry passengers with terminal illness with only a matter of days or weeks to live, usually in circumstances where the passenger has expressed a desire to die in their native country. Whilst recognising the need to deal sympathetically with such requests, the airline medical department will need to evaluate very carefully the risk of in-flight death or unexpected deterioration. While a proportion of such passengers can be accommodated with special arrangements such as a stretcher with a qualified escort, the treating physician needs to be mindful of how distressing it can be to relatives (and indeed airline cabin crew) should the passenger die in flight and the subsequent burden of regulatory requirements at the destination.

Summary of Contra-Indications

It should be noted that a passenger with a medical condition will be assessed as an individual and any complications or additional medical problems may extend the period for which they are unable to fly.

- **Anaemia** - with haemoglobin less than 7.5g/dL
- **Cardiac Failure** - uncontrolled
- **Cerebral Infarction** - within the last 3 days
- **Contagious or Communicable** diseases
- **DVT** - acute
- **Fractures** - unstable/untreated
- **Haemorrhage** - recent gastro-intestinal
- **Jaw** - fractured with fixed wiring
- **Myocardial Infarction** - within last 7 days
- **Operations** - depending on the nature of the surgery, within 5 to 10 days.
- **Otitis Media** - with loss of Eustachian tube function
- **Pneumothorax** - suspected or confirmed
- **Pregnancy** beyond the 36th week of gestation
- **Psychiatric Disorders** and those whose behaviour is unpredictable, aggressive or may disrupt the flight or endanger other passengers
- **Respiratory Disease** - with marked breathlessness at rest
- **Sickling crisis** - recent
- **Sinusitis** - severe
- **Any Conditions** which may be exacerbated by the flight environment
- **Unstable Conditions** with a risk of deterioration prejudicial to the passenger or the flight

Oxygen

In addition to the main ventilation system, all commercial aircraft carry an emergency oxygen supply for use in the event of failure of the pressurisation system or during emergencies such as fire or smoke in the cabin. The passenger supply is delivered via drop down masks from

chemical generators or emergency reservoir and the crew supply is from oxygen bottles strategically located within the cabin.

Sufficient first aid oxygen bottles are carried to allow the delivery of oxygen to a passenger in case of a medical emergency in flight.

Specific arrangements for a premeditated supply of oxygen for a passenger needs pre-notification to the airline at the time of booking the ticket. Flow rates of 2 litres or 4 litres per minute are available on many flights, but on some, generally long haul routes, only 4 litres per minute is available so it is wise to check with the airline concerned when booking oxygen. A standard oxygen mask is normally provided. Other types would usually need to be supplied by the passenger (e.g. nasal cannulae, infant/child masks, tracheal etc.).

The supplementary oxygen provided for use by the sick passenger may be delivered from gas bottles or it may be delivered by tapping into the aircraft ring-main system. Some carriers provide molecular sieve concentrators although these can be expensive to service and maintain. Most airlines, including British Airways, make a charge to cover the cost of its provision for which there is not a refund should the pre-arranged oxygen not be used. It should be noted that the charge contributes to the cost of provision (whatever the mechanism of supply) and British Airways does not make a profit from the service.

Passengers and their physicians should be aware of those airlines which do provide oxygen usually do so for in flight use only and any ground requirements, including transit, would need to be made by the passenger or their representative.

It is not generally permissible for the passenger to use, or carry, his/her own oxygen system in flight. All equipment used on board must meet the regulatory standards including the specification for aviation oxygen, which is higher than that for medical oxygen in terms of permissible water content to prevent freezing and the type of valve which needs to be able to cope with varying cabin pressures.

Stretchers

All equipment used on board a commercial aircraft must comply with the safety and compatibility requirements of both the regulatory authority and the airline. This applies to a stretcher, which must be securely fixed in the cabin, must not impede normal or emergency egress and must provide adequate restraint for the sick passenger. There is an assessment and approval system for all aircraft equipment and the airline itself will normally arrange for the stretcher provision.

A suitable attendant, whether nurse, doctor or family member, must be responsible for all care and attention to the passenger throughout the journey, including toileting and disposal of catheter bags. Consideration must be given to factors such as disposal of biohazardous waste and the effect on other passengers and crew members of carrying the sick passenger. Any supporting equipment must be approved by the airline and any equipment which requires electrical power must be operated by dry cell batteries. This equipment, generally, cannot be

used during the crucial phases of take off and landing. Pre and post flight ground handling of the stretcher must be arranged in advance of the flight.

There are specialist medical assistance and repatriation companies established throughout the world and these work closely with the major airline medical departments and with air ambulance companies. These companies also have links with the travel insurance industry and there is much inter-dependency.

Stretcher cases have potential practical and organisational difficulties inherent in the operation so arrangements by specialist companies are usually preferred. Specialist air ambulance facilities are, in some cases, more appropriate.

Other precautions

The relatively dry cabin air can lead to the sensation of dryness in the mouth, though evidence suggest that it does not lead to actual dehydration. Passengers should therefore be encouraged to maintain their normal intake of food and fluid, but alcohol consumption should be no more (and preferably less) than the passenger's normal intake.

Established treatment regimens should not be altered.

Ensure valid Travel and Health Insurance is purchased, that the passenger has had relevant vaccinations and has a supply of appropriate anti-malarial medication.

Considerations of Physical Disability or Immobility

As well as the reduction in ambient pressure and the relative hypoxia, it is important to consider the physical constraints of the passenger cabin.

Passengers with a disability (of sight, hearing or mobility etc.) do not require medical clearance although special needs, such as wheelchair assistance or assignment of seats with lifting arm rests, must be identified to the airline at the time of reservation.

As part of their training Cabin Crew members gain an awareness of the needs of passengers with disabilities. In addition to the provision of normal in-flight service they can assist passengers, for example, with the use of the on board wheelchair (on wide bodied aircraft) or describing where items are on the meal tray to those with visual impairment. They are unable, however to provide individual special assistance (e.g. lifting/toileting) to passengers due to varying health and safety regulations. Those who are unable to look after their own personal needs during the flight will be asked, therefore, to travel with an accompanying adult who is able and willing to provide all necessary assistance, including assistance in the toilet, if necessary.

There is limited leg space in an economy class seat and thus a passenger with an above-knee leg plaster or an ankylosed knee or hip may simply not fit in. The impact of a long period of immobility in an uncomfortable position must be remembered and even in the premier class cabins with more available leg room there are limits on space.

To avoid impeding emergency evacuation immobilised passengers with medical conditions or with disabilities will not be seated adjacent to emergency exits, despite the availability of increased leg room at many of these positions. Similarly, a plastered leg cannot be stretched into the aisle because of the conflict with safety regulations.

The challenge of the complex airport environment should not be under-estimated and must be considered during the assessment of fitness to fly. The formalities of check-in and departure procedures are demanding and can be compounded by illness and disability as well as by language difficulties or jet lag.

There may be a long distance between the check-in desk and the boarding gate. Not all flights depart or arrive from/to jetties and it may be necessary to climb up or down stairs and board transfer coaches. It is thus important to specify the level of assistance required when booking facilities such as wheelchairs.

Conclusion

The passenger cabin of a commercial airliner is designed to carry the maximum number of passengers in comfort and safety, within the constraints of cost effectiveness. It is incompatible with providing the facilities of an ambulance, an emergency room, an intensive care unit, a delivery suite or a mortuary.

Specialised air ambulances are required for unstable cases such as those with active bleeding needing surgery, dependency on life support equipment or ventilator dependent cases as these are all unsuitable for carriage by scheduled airline.

The ease and accessibility of air travel to an ageing population inevitably means that there are those who wish to fly who may not cope with the hostile physical environment of the airport or the physiological environment of the pressurised passenger cabin. It is important for medical professionals to be aware of the relevant factors and for unrealistic public expectations to be avoided.

British Airways, in common with other airlines, has a medical department which can be consulted prior to flight to discuss the implications for a particular passenger. Such pre-flight notification can prevent the development of an in-flight medical emergency which is hazardous to the passenger concerned, inconvenient to fellow passengers and expensive for the airline.

For those with disabilities, but not a medical problem, pre-flight notification of special needs and assistance will reduce the stress of the journey and enhance the standard of service delivered by the airline.

Additional Information - Contact Details

For further information regarding British Airways passengers please contact:

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