

STATEMENT OF DR. JON L. JORDAN, FEDERAL AIR SURGEON, FEDERAL AVIATION ADMINISTRATION, BEFORE THE HOUSE COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE, SUBCOMMITTEE ON AVIATION, CONCERNING EMERGENCY MEDICAL KITS ABOARD AIRCRAFT.
MAY 21, 1997.

Mr. Chairman and Members of the Subcommittee:

I welcome the opportunity to appear before the Subcommittee this morning to discuss emergency medical kits on board passenger-carrying aircraft.

Before I describe for you FAA's ongoing effort to monitor and evaluate the appropriateness of the requirements setting forth the contents of emergency medical kits, I would like to provide you with some background that I hope will be useful to you in establishing a context for the testimony that you will have heard today.

Current regulations calling for emergency medical kits date back to 1986, when the FAA promulgated a final rule requiring large passenger-carrying aircraft, operating under part 121, to carry such kits beginning in August of that year.

The FAA set a minimum standard for kit contents, requiring:

- a sphygmomanometer, which is an instrument for taking blood pressure;
- a stethoscope;
- 3 different sizes of airways, or breathing tubes;
- syringes;
- needles; and

- latex gloves, which were added to the kit's minimum contents list in 1995.

The emergency medical kit is also required to contain, at a minimum, these basic pharmaceuticals:

- 50% dextrose injection, to be used for treating hypoglycemia or "insulin shock";
- epinephrine, which is used for asthma or acute allergic reactions;
- diphenhydramine, which is used for allergic reactions;
- nitroglycerin tablets, used for cardiac-related chest pain;
- basic instructions for using these drugs.

These supplies are in addition to those contained in the required first aid kit, which include adhesive bandages, antiseptic swabs, ammonia inhalants, bandage compresses, arm and leg splints, roller bandages, adhesive tape, and bandage scissors.

As of January 1996, commuter aircraft with between 10 and 30 seats also have been required to carry emergency medical kits in addition to the first aid kits they have always had. This change came as a result of our ongoing "harmonization" of parts 121 and 135 regulations.

At the time the rule mandating the contents of emergency medical kits was promulgated, there was controversy over what types of instruments and pharmaceuticals the FAA should require they contain. Commenters to the rule, as well as your counterparts in the Senate, in the form of report language, expressed concerns about controlled substances and potentially dangerous weapons being stowed on board any passenger aircraft. These and other

commenters also argued that an aircraft should not be a flying hospital, but that the proper course of action in the event of an on board medical emergency is to put the aircraft down on the ground and get the ailing passenger to the nearest hospital facility.

As a result of these concerns, as well as the views expressed by a substantial number of professional medical organizations that more statistical information on the frequency of occurrence and types of medical emergencies on board aircraft was necessary before requiring additional equipment or pharmaceuticals to be contained in the kit, the FAA scaled down its original proposal in terms of the contents that would be required of medical kits. The rule promulgated was designed to ensure that, at the very least, U.S. aircraft would have the basic, minimum equipment on board to handle medical emergencies. That regulation also required airlines to report to their Principal Operations Inspector, for a period of 24 months after the effective date of the rule, information on each medical emergency occurring during flight time and resulting in the use of the emergency medical kit or the diversion of the aircraft.

That two-year collection of data resulted in the generation of two reports by our medical experts at the Civil Aeromedical Institute, or CAMI, in Oklahoma City. The final, comprehensive report, published in 1991, analyzed the 2,322 in-flight emergencies reported during this period. There were 33 in-flight deaths, with reports indicating that physicians responded to the call for help 85% of the time

the request was made. The report noted that airlines were provided a good deal of regulatory latitude in terms of the data they were required to report, and the form in which they were to report it. The report suggested that, based on the data obtained, the kit's medical contents might selectively be expanded to include analgesics, antiarrhythmics, antiemetics, and bronchodilators to address those symptoms (pain, difficulty breathing, nausea, heart) that occurred most often. The report also suggested that some of the more clinically serious cases might have been helped with a more complete medical kit that included a wider range of cardiovascular diagnostic and treatment tools. The report concluded:

Because the final chapter of consensus building on in-flight medical care has not yet been written, [FAA and the private sector] must continue to explore alternatives for improvement. Ongoing voluntary evaluation of in-flight health care experience by individual carriers will be especially useful as evidence to support action. This pooling of data will be needed to most efficiently meet the joint FAA-industry mandate to refine the "optimal" medical kit and applications.

Over the course of the next several years, FAA did receive cooperation from industry in terms of reporting medical emergencies, however, the data were not sufficient to determine what, if any, changes should be made to the contents of medical kits. Therefore, in late 1995, the FAA convened a working group to coordinate our efforts with industry and the medical community to obtain the information necessary to make an informed decision concerning medical kits. CAMI will have two new sources of data to enable it to more effectively analyze the contents issue. The Aerospace Medical Association (AsMA) has solicited

information on medical emergencies from airlines, in the form of questionnaires that have been provided to CAMI for analysis. The data will include information regarding the usefulness and limitations of existing inflight medical capabilities.

In addition to the AsMA questionnaires, a contract medical assistance company, MedAire, Inc., has agreed to provide anonymous, prospective data to CAMI through October 1997. The MedAire data will include information on the individual having the medical emergency, the medical equipment needed and used, the responding treatment provider or consultant, the final ground-based diagnoses, and the outcome of ground-based medical treatment. These new sources of information should facilitate a report by CAMI expected by the beginning of next year. I anticipate that the working group I have formed will review this information and recommend whether additional rulemaking to require more equipment and/or supplies as part of the emergency medical kit contents is warranted. In the meantime, we recognize the efforts of carriers like American Airlines, which recently elected to equip its overseas aircraft with, and to explore the utility of, automatic defibrillators, and of those other carriers who choose to exceed the minimum regulatory requirements posed by the FAA.

Mr. Chairman, we at the FAA recognize that this issue is important to many people; this morning you and I have heard from the family members of people who, tragically, passed away aboard aircraft. The FAA, in conjunction with industry and the medical community, are committed to resolving this issue. If, at

the conclusion of our current efforts, we find that regulatory action is appropriate, FAA will take that action.

This concludes my prepared statement, Mr. Chairman. I would be pleased to respond to any questions you may have at this time.