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THE NEED FOR REGULATION OF
AIR AMBULANCE SERVICES

D. PAUL DALTON

IN JULY OF 1977, the Federal Aviation Administration (FAA) published an advance notice of proposed rulemaking (ANPR) to amend Part 135 of the Federal Aviation Regulations to establish standards for Air Ambulance Services. These proposals would apply not only to those Part 135 registrants who hold themselves out to the public as operating air ambulances, but also to every Part 135 certificate holder who carries any patient. The stated purpose of these regulations is to establish definitive standards for air ambulances regardless of whether the aircraft is so characterized. This all-encompassing application is "predicated not only on the personal safety of the person being carried, but also on the risk of inflight emergencies that could occur if the aircraft does not have proper medical equipment and personnel." This will prevent a certificate holder from avoiding compliance merely by not advertising itself to be an air ambulance. The proposed regulations would establish separate criteria for general, intensive care and rescue air ambulance services. This article will examine the scope of these proposed regulations and consider whether they adequately meet the problems of providing air ambulance services.


2 For the purpose of this discussion, Part 135 registrants or certificate holders means persons whose operations are regulated under 14 C.F.R. § 135 (1978). These rules govern (among other things): "The carrying in air commerce by any person, other than an air carrier, of persons or property for compensation or hire (commercial operations) in small aircraft; and . . . each person who is on board an aircraft being operated under this part." Id. at 135.1(a)(3) and (4).

3 Id. at 37,825.

4 "Patient" is defined in proposed § 135.283(b)(5) as "a person who is sick, injured, wounded, or otherwise incapacitated or helpless." Id. at 37,826-27.

5 Id. at 37,825.

6 Id. at 37,825-26.

7 Id. at 37,826.

8 Id. at 37,826.

9 Id. at 37,826-28.
I. THE PROPOSED REGULATIONS

A. The FAA Proposal

The basic format of the regulations would be additive, that is, the minimum required equipment and services for all levels of air ambulance care would be set forth under proposed § 135.285.10 If a certificate holder knows that a patient will need intensive care or life support measures while aboard the aircraft, § 135.287 (Intensive Care Air Ambulance Service) would require that the aircraft contain all items listed in § 135.285 and additionally that there be a medical attendant11 aboard assigned only to that patient.12 Moreover, § 135.291 would prohibit providing intensive care air ambulance service "unless a physician is available, either in person or by telephone or radio communication, to advise the certificate holder with regard to the transportation of the patient."13

Any aircraft used for rescue air ambulance service would, under § 135.289 (Rescue Air Ambulance Service), be required to contain the equipment necessary for intensive care air ambulance service14 as well as an auxiliary medical oxygen unit15 and a poison kit.16 Furthermore, at least one medical attendant would be re-

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10 Minimum requirements would include a basic stock of: plastic trash bags, flashlight, batteries, and disposable face masks. Additionally, a blanket and a pillow would be required for each patient. A third category of basic equipment is designated as required only when the certificate holder knows or has reason to know that such equipment may be needed by the patient. Under § 135.285(c), this equipment would include litters, locking hooks for intravenous packages, ventilation units or resuscitators, emesis basins, urinals, bedpans, sphygmomanometers, medical oxygen units, and portable suction units. Id. at 37,827.

11 Medical attendant is defined in § 135.283(b)(6) as "a physician, registered nurse, registered physician's assistant, or a person either registered by the National Registry of Emergency Medical Technicians or certified by a State, territory or possession of the United States as meeting standards acceptable to the Administrator." Id. at 37,827.

12 Id. at 37,827.

13 Id. at 37,828.

14 An exception is that the requirement of a specific medical oxygen unit and a portable suction unit would not apply unless there were an anticipated need of such for the patient. Id. at 37,827-28.

15 Standards for a "medical oxygen unit" would be different from those for an "auxiliary medical oxygen unit." The standards for each would appear in 14 C.F.R. § 135.295. Id. at 37,828.

16 Additionally, the aircraft would be required to have the following equipment readily available but on board only if necessary to meet the anticipated needs of the patient: sterile obstetrical kit, padded boards, specific splints for legs and arms, backboards, traction splints, and sterile burn sheets. Id. at 37,828.
quired to be aboard any aircraft used for rescue air ambulance service.\(^7\)

In addition to the requirements for each category of air ambulance service, the proposed regulations would establish the following: continuing minimum educational requirements for medical attendants,\(^8\) regulations regarding the specifications, use and placement of litters in the aircraft,\(^9\) regulations for carriage and maintenance\(^10\) of medical equipment and supplies, aircraft interior lighting and electrical power supply requirements,\(^11\) requirements for an air ambulance manual\(^12\) and for an emergency medical care kit.\(^13\) An emergency clause allows a certificate holder to deviate from the proposed regulations if there is a medical emergency and no other practicable means of transportation is reasonably available.\(^14\) This deviation would then have to be reported in detail to the FAA Flight Standards District Office within ten days.\(^15\)

**B. Reactions To The Proposal**

The FAA’s move to consider regulation of air ambulance serv-

\(^{17}\) Proposed Regulations § 135.289(c). *Id.* at 37,828.

\(^{18}\) Every person to serve as a medical attendant on an air ambulance under the proposed regulations must have received training within the preceding 12 months in attendant responsibilities, airway obstruction, pulmonary arrest and resuscitation, bleeding and shock, wound care, fractures of the upper and lower extremities, injuries of the head, face, neck and spine, injuries of the eye, chest, abdomen, pelvis and genitalia, childbirth and care of newborn infants, lifting and moving patients and environmental emergencies. Proposed Regulations § 135.293. *Id.* at 37,828.

\(^{19}\) Proposed Regulations § 135.299. *Litter Patients. Id.* at 37,828.

\(^{20}\) Proposed Regulations § 135.301. *Carriage of Medical Equipment. Id.* at 37,828.

\(^{21}\) Proposed Regulations § 135.303. *Maintenance of Medical Equipment and Supplies. Id.* at 37,828.

\(^{22}\) Proposed Regulations § 135.305. *Aircraft Requirements. Id.* at 37,828.

\(^{23}\) Proposed Regulations § 135.307. *Manual Requirement.* This would include: identification of responsibilities and persons charged with same, patient handling procedures, flight crew members’ responsibilities to patients and emergency procedures. *Id.* at 37,828.

\(^{24}\) Proposed Regulations § 135.297. *Emergency Medical Care Kit.* Every certificate holder’s aircraft carrying any patient would be required to be equipped with a kit meeting the specifications proposed as Appendix B to 14 C.F.R. § 135. These include first aid items such as gauze dressings and pads, adhesive tape, scissors, tongue depressors, ammonia inhalants, eye covers, constricting bands, airways, triangular bandages and mouth gags. *Id.* at 37,828-29.

\(^{25}\) Proposed Regulations § 135.309. *Medical Emergencies. Id.* at 37,828.

\(^{26}\) Proposed Regulations § 135.309(b). *Id.* at 37,828.
ices has sparked varied, but generally favorable, reactions. Equipment manufacturers have been understandably supportive, because specific items of equipment would be required which those companies could supply. The Aerospace Medical Association is strongly in favor of the concept of regulation, although its proposal contained some material differences from that of the FAA.

Specifically, the Aerospace Medical Association's proposal would have applied only to those Part 135 certificate holders who hold themselves out as Air Ambulance Operators. This particular element was expressly rejected by the FAA and has been characterized as essentially an attempt at industry advertising restrictions. In other areas, the Aerospace Medical Association proposal would require: greater educational requirements for medical attendants, air ambulance responsibility for patient ground transportation between the air ambulance and the hospitals, codification of specific procedures peculiar to air transportation of patients, more

37 Another type of reaction to the regulations has arisen within the government itself. There has been speculation about the authority of the FAA to issue such regulations. Specifically, the Department of Health, Education and Welfare (HEW) may claim authority over air ambulances as health care providers and urge that the FAA's authority over flight safety would therefore not extend to air ambulance standards. Telephone conversation with Mr. Gubler, FAA Flight Standards, Washington, D.C. (July 6, 1978). Although the outcome of such a Cabinet-level struggle is unknown, it is submitted by this author that the extent of regulation, if assumed by HEW, would be greater than that proposed by the FAA. This postulation is based on the nature of the FAA as an agency generally considered to be primarily concerned with the impact of a program on the air industry and secondarily with the impact on the "public good." See note 32 infra. This is in opposition to the pervasive program inclinations of the HEW, such as Medicaid and Medicare, which tend to subordinate the interests of industries and professions to the "public good" of the social program in question.

38 Telephone interview with Henry Felhouse, President of First Ambulance Center of Tennessee (July 7, 1978). This company supplies equipment for land ambulances and is interested in the proposed regulations as possibly establishing a new market for their services and equipment.


40 Id. at 3.

41 Proposed Regulations, supra note 1, at 37,825-26.

42 Interview with Bill Block, President of Alpha Aviation, Inc., in Dallas, Texas (July 11, 1978).

43 Aerospace Medical Association Resolution, supra note 29, at 4.

44 Id. at 5.

45 See, e.g., id. This would include prohibition of intravenous fluids in glass
extensive basic air ambulance equipment, specific life support and electronic monitoring equipment for Intensive Care Air Ambulance Service, higher standards for medical oxygen units, pressurized cabins for critical care patients, non-smoking regulations, special fueling requirements when patient onboard, special air ambulance flight plan codes with FAA priority, five-year maintenance of patient records, and filing of medical incidence reports with the FAA.

Most of these items and services are currently being used by large air ambulance services. At least one such company has even gone beyond both the FAA and the Aerospace Medical Association proposed standards to develop and equip their air ambulances with modular care units. Moreover, they maintain an on-call staff of specially trained, critical care unit (CCU) experienced, registered nurses.

bottles, indwelling retention balloon devices using expandable filling media such as air, etc.

This would include almost all of the items required in the FAA proposal for Rescue Air Ambulance Service, including the Emergency Medical Kit items, as well as many other items including emergency medications. Id. at 5-6.

The equipment required would be a cardiac monitor with tapewriter and supplies, defibrillator with supplies, electric and portable suction units and supplies, nasogastric tube, aspirating syringe and one critical care registered nurse for each intensive care patient. Id. at 6-7. Critical care registered nurse is defined as a Registered Nurse with at least two years experience in critical care nursing. Id. at 4.

Each unit would be required to supply 60 minutes of oxygen rather than 20 minutes as proposed by the FAA. Id. at 7.

No smoking would be permitted in the aircraft at any time, nor could anyone smoke within 50 feet of it when on the ground. Id.

Complete reports would be filed following an in-flight death or any significant patient deterioration which required alteration of the flight plan. Id.

Interview with Alice Gaul, Head Flight Nurse, Alpha Aviation, Inc., in Dallas, Texas (July 11, 1978) (taped).

Alpha Aviation, Inc. has developed an “Airborne Critical Care Unit” which includes the stretcher, cardiac monitor, defibrillator, oxygen supply, sphygmomanometer, intravenous fluid hangers, suction, ventilators, and power supply in one unit. The patient is placed in the unit at the hospital and then the entire unit is placed onto the aircraft. This reduces the possibility of trauma or aggravation of injury to the patient. Id.

Id.
In its decision not to include these elements of the Aerospace Medical Association proposal in its proposed regulations, the FAA may have balanced cost considerations against the ideals desired by the involved health professions. Nevertheless, the FAA standards still would be expensive to implement. The required costs would likely be beyond the means of small rural air taxi certificate holders. Moreover, the aircraft necessary to carry the amount of equipment required would be too large to land at many small rural airstrips, thus either denying these areas the benefits of air ambulance services or forcing certificate holders to turn to more expensive aircraft with low takeoff and landing requirements.

For certificate holders in areas without a substantial demand for air ambulance services, there is the additional problem of aircraft utilization. The proposed regulations do not state whether the aircraft would have to remain constantly equipped for air ambulance service. Such a requirement could preclude an aircraft's use for other air taxi functions or at the very least, significantly reduce its passenger and cargo carrying capacity due to the substantial aircraft modifications which would be necessary. As a practical matter, therefore, the certificate holder would have to keep one aircraft out of regular service for the sole purpose of handling air ambulance calls. In areas where the demand for air ambulance service is low, this situation could either cause the certificate holder to abandon his program entirely or to charge an inordinately high rate for air ambulance services.

In the event that the FAA decides to promulgate the regulations for air ambulance services, United States Senator George McGovern has drafted and will submit to Congress a bill to establish a financial assistance program for small certificate holders for acquisition of

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48 It is estimated that the cost of equipping an aircraft to meet the proposed FAA regulations could be as much as $20,000 and that the cost of modifying the aircraft to accept the required equipment could be as much as $17,500. Letter from Frank M. Drew, Executive Director of the South Dakota Hospital Association to United States Senator George McGovern (June 16, 1978).

49 Id.

50 Id.

51 Telephone interview with Robin Carpenter, Assistant to United States Senator George McGovern (June 7, 1978).

52 Id.
the necessary equipment. The bill will provide for grants to emergency medical facilities to purchase required equipment to be used by those small air ambulance services which would otherwise be unable to purchase such equipment. The equipment would be owned and maintained by the facility and loaned on request and without charge to the specified air ambulance services. The funds to be appropriated for this program would be $200,000. Because of the high cost of outfitting the aircraft for air ambulance service, this amount has been questioned as being inadequate and should probably be increased. The principle of the legislation, however, would strike at the heart of the only strong opposition to the regulations—cost.

Considering the expense of medical equipment in relation to the expansive proposals of the Aerospace Medical Association, the FAA's proposed regulations are a realistic compromise, both economically and professionally. When supplemented by Senator McGovern's legislation, quality ambulance services should be readily available throughout the country. These equipment and service regulations alone, however, may sow the seeds of destruction for the very services they are intended to standardize. Specifically, no mention has yet been made of how air ambulance services are to fit into the health care system in relation to the current problems of liability for malpractice and negligence.

II. LIABILITY BASED ON NEGLIGENCE PER SE

Before considering the malpractice implications of the proposed regulations, the effect they would have on negligence actions in general should first be analyzed. In an action against an air ambu-

53 Draft of A Bill To Authorize Assistance to Small Air Ambulance Operators in Acquiring Necessary Medical Equipment by Senator George McGovern. Received with a letter from Robin Carpenter, Assistant to United States Senator George McGovern (July, 1978).

54 Id. at 3.
55 Id. at 3.
56 Id. at 4.
57 Letter from Frank M. Drew, supra note 48.
58 Telephone Interview with Robin Carpenter, supra note 51.
59 This article is not concerned with the potential liability of an owner-lessee for the acts of a lessee who may be operating an air ambulance service. For a discussion of these problems see Hilliker, Vicarious Liability for Aircraft Owners
lance service for negligence in which no federal or state safety regulations exist, the plaintiff is ordinarily required to establish four basic elements. First, he must show a duty requiring the air ambulance service to conform to a certain standard of care. Second, he must show a failure to conform to that duty on the part of the air ambulance service. The third and fourth required elements are a causal connection and actual loss or damage.

When a statute regulating the activities of the defendant is in effect, however, the first two elements, duty and breach, may be established as a matter of law. Under these circumstances, the trier of fact is left to decide only whether the requisite causal connection existed between the established breach of the defendant and the plaintiff’s alleged damages and whether in fact there were actual damages. This concept is referred to as negligence per se.

If, therefore, a statute were passed regulating air ambulance services and an action against an air ambulance service subsequently arose which involved a failure to comply with the statute, the courts of most states would treat it as an action based on negligence per se. If it were established that the statute was violated, those courts could find negligence as a matter of law and move directly to the factual issues of damages and causal relationship. In some states, however, violation of a statute is treated as only evidence of negligence, leaving the jury to decide negligence as a fact issue. California, moreover, has taken a different approach


Id. at 143.

Id. at 143.

Id. at 200.


and treats a violation of a statute as creating merely a rebuttable presumption of negligence. Regardless of which of these methods is used, violation of a statute will usually place a much greater burden on the defendant.

Questions remain, however, as to whether the same state court results will occur when it is a regulation promulgated by a federal administrative agency rather than a statute which is violated. The answer generally appears to be in the affirmative, qualified only by the requirements (generally applicable to state and federal statutes as well) that the regulation was intended to prevent the harm which is being complained of and that the plaintiff was within the class of persons intended to be protected by the regulation. More specifically, FAA regulations have provided the foundation for successful negligence actions in states such as Massachusetts, Pennsylvania, Ohio, California, Washington and Minnesota. Furthermore, in California, where statutory violations raise only a presumption of negligence, at least one court has combined the negligence per se presumption with concepts of comparative negligence to produce a conceptual morass.

It is apparent that the mere existence of the regulations will have an appreciable impact on the potential liability of air ambulance services for injuries to patients. This is so even without regard to overt acts of negligence by the air ambulance service or its agents. When an overt act does occur, rather than merely alleg-

67 Prosser, supra note 60, at 192-97.
69 Rudelson v. United States, 431 F. Supp. 1101 (C.D. Cal. 1977). In this case a violation by U.S. Government personnel of an FAA safety regulation concerning air traffic control systems was found to constitute negligence per se. Each of three pilots was also found by the trier of fact to be negligent. The complexity arises in that the trier of fact is required to determine the proportional allocation of negligence between the person whose negligence was established as a matter of law by the court and the other parties whose negligence was established as a matter of fact. This overlap clouds the division of duties between the court and the trier of fact in negligence per se cases.
being negligence per se, a plaintiff might elect to pursue a malpractice claim.

III. Malpractice Problems of Air Ambulance Services

Prior to the movement for regulation, carriers providing air ambulance services were generally regarded by health care professionals and the public as being analogous to "good samaritans." Of course, given the opportunity, courts would probably have treated air ambulances as any land ambulance service for purposes of negligence or malpractice liability. But apparently because of this general sentiment, as well as questions of medical responsibility, no cases have yet been decided involving liability for the well-being of a patient in an air ambulance.

By establishing minimum standards for equipment and services, the FAA may unintentionally be exacerbating the problem of the proliferation of medical malpractice litigation which exists in many courts. These minimum standards may well lay the predicate for a "minimum standard of care" to be used as the basis for malpractice claims against air ambulances. An understanding of the reasons for this hypothesis will require an examination of: first, the way in which land ambulances have traditionally been treated in cases of negligence; second, the possible allocation of responsibility between involved health care professionals and land ambulance services; and finally, whether these relationships would continue for air ambulance services.

A. Traditional Ambulance Services

Ambulance services have been categorized as an anomaly in that, although they may or may not be classified as common carriers, they are neither taxi services nor hospitals, but something in between the two categories. Those questions involving ordinary negligence in providing non-professional services, such as mere transportation, have been clear-cut. Ordinary negligence, if proven, is generally actionable. Thus, in the common carrier or taxicab-like cases, recovery may be allowed against the ambulance

70 Interview with Bill Block, supra note 32.
72 Id. at 912.
73 Id.
service predicated on ordinary negligence, even if the ambulance belongs to a charitable institution. Moreover, ordinary negligence is the usual standard of conduct for ambulance attendants in transporting the patient to and from the vehicle.

More difficult questions may arise, however, concerning the standard of professional health care due the patient by the ambulance service. As ambulance services undertake, or are required, to provide a greater degree of care to the patient, the nature of their liability begins to approach that of a hospital. Just as hospitals are no longer considered to be mere providers of beds and basic services, ambulances are assuming a responsibility greater than just safe driving and the proper loading and unloading of patients. Therefore, when an ambulance service employs trained medical personnel, the ambulance service may be held liable for the acts and omissions of these skilled persons under the doctrine of "respondeat superior." Liability could arise, for example, in rescue and accident situations wherein the ambulance is called to the scene by non-medical personnel and the attendants have no contact with a physician. Liability for the ambulance service may

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77 Cf. Brook v. Vancil, 340 Ill. App. 432, 92 N.E.2d 526 (1950) (where infant patient was burned by defective incubator in ambulance, fact that incubator was owned and maintained by the state and under the direct supervision of hospital-employed nurse at time of fire precluded finding of liability for the ambulance based on doctrine of res ipsa loquitur because ambulance service or its employees had neither management nor control of the incubator.)
80 These might include nurses, emergency medical technicians, ordinary ambulance attendants or others.
continue, however, even in those situations in which a physician has instructed the ambulance attendants as to the specific care to be given to a specific patient before departure or when a physician is in, or in communication with, the ambulance.

B. Liability Allocation Theories

There are several different theories used by state courts to allocate liability between a hospital, its employee, and the physician where the patient’s injury results from an act or omission of the employee. Depending on the jurisdiction, the liability may fall totally on the physician, totally on the hospital, or on the physician with provisions for indemnity against the hospital.

When the physician takes command of or controls the patient’s care in an ambulance, his responsibility, and thus his liability, is the same as if he were performing an operation in a hospital assisted by a surgical team or if he were on call in a hospital emergency room. Although he has primary responsibility, and thus liability, those same theories of liability allocation between physicians and hospitals might be used to exculpate or find liability for either him or an ambulance service.

1. Borrowed Servant Doctrine

The oldest of these doctrines is that of the “borrowed servant.” This is a permutation of the doctrine of “respondeat superior” in that it finds liability for a “master” based on the actions of a “servant.” It distinguishes, however, between a “general master” (hospital) and a “special master” (physician). When the servant is under the control of or subject to the right of control of the special master, the special, but not the general, master is responsible for the negligent acts of the servant. In its most frequent application, the servant is a hospital employee assigned to assist a physician, usually in a surgical procedure. The factual question

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83 See Holman, Emergency Room Care, 188 J.A.M.A. 1165 (1964), quoted in Ficarra, The Hospital Emergency Room and the Law, supra note 81, at 239-40.

84 See Aderhold v. Bishop, 94 Okla. 203, 221 P. 752 (1923).

85 Payne and Mayes, supra note 82, at 373-74.
presented is whether the hospital has surrendered control or the right to control to the physician. If it has, vicarious liability attaches to the physician. Under the "borrowed servant" doctrine, "right to control" has generally been construed as an immediate right of control. "Immediate" means some realistic connection of the physician in time or place with the acts for which he is to be held responsible. At the same time, it is recognized that when the physician is exercising actual control and direction over the servant, even though the physician is not physically present, the "borrowed servant" doctrine will still impute liability to the physician.

The implications of the "borrowed servant" doctrine for the ambulance service are predictable. If the physician is physically present in the ambulance and in control of the attendants regarding the patient's care, he and not the ambulance service would be held vicariously liable for the negligent acts of the attendants. This is analogous to the operating room surgeon and the assistants working under his supervision. Although technically employed by the hospital, the assistant is considered to be the "borrowed servant" of the surgeon. For that reason, the surgeon is held liable for the assistant's negligent acts. Thus with a physician present and in command, the ambulance service probably would be exculpated. If the physician maintained continuous radio or telephone supervision of the patient's care by the attendants, his physical absence would not preclude a finding of immediate control and, as outlined above, liability would again fall on the physician, not on the ambulance service, for the negligent acts of the attendants under his supervision.

When, however, the absent physician merely gives general care instructions to the attendants prior to departure, or even signs standing orders, the attendant's situation becomes more analogous

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86 Id. at 380.
87 Id. at 374.
88 Id. at 374, 376.
89 Id. at 376. It is not really clear whether the doctor was originally singled out over the hospital because he was actually in complete control or whether it was because most hospitals at that time enjoyed charitable immunity.
90 Standing orders are usually a form listing procedures to follow if the patient begins to develop certain symptoms. Although specific procedures are listed, the determination of when to start such procedures is, within general parameters, left up to the nurse or attendant. See ALPHA AVIATION, INC., MEDICAL
to that of a hospital's nurse who negligently executes a doctor's orders for a patient's care. In such a case, the physician has directed an act, but he has not directed or supervised the method of performance nor did he have an immediate right to control such performance. Under these circumstances, the hospital (ambulance) has not actually surrendered right of control to the physician, even though he is available to advise the nurse (ambulance attendant) by telephone (radio) whenever the nurse (ambulance attendant) chooses to seek such advice. Until that physician is so contacted and assumes control of the situation, he lacks the requisite connection of either time or place upon which the "borrowed servant" doctrine would predicate his liability.

2. "Captain Of The Ship" Doctrine

A second concept for allocation of liability is known as the "captain of the ship" doctrine. Based on the "borrowed servant" doctrine, it holds the physician vicariously liable for the acts of all persons under his control. Because his right to control is complete, he is analogized to a ship's captain and the operating room and assistants to the ship and its crew. This doctrine differs from the "borrowed servant" concept in that the physician's liability may continue in his absence, even when he is exercising no control over the servant whatsoever. At the same time, the hospital is exculpated from liability as having surrendered control of the "ship" to the "captain."

The impact of this doctrine upon the ambulance service is clear. The ambulance service needs either to have a physician sign a list of general standing orders for attendants to execute, or to advise the physician of the particular patient and secure his agree-

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92 Payne and Mayes, supra note 82, at 374.
93 See McConnell v. Williams, 361 Pa. 355, 65 A.2d 243 (1949). This case is generally considered to be the birthplace of the "Captain of the Ship" doctrine.
95 Note, Borrowed Servant Doctrine Rather Than Captain of the Ship Doctrine Determines Vicarious Liability of Surgeon in Operating Room in Texas, supra note 91, at 203.
ment to be available for any radio call from the ambulance. If this is done, the physician will be the recipient of the vicarious liability, not the ambulance service itself.

Unfortunately for the ambulance services, use of the "captain of the ship" doctrine is diminishing. Although it is still recognized, the scope of its application varies such that, as a practical matter, its result may be unpredictable in those jurisdictions which still use it.

3. Other Theories

Some jurisdictions have modified the concept of the "borrowed servant" doctrine. One modification would require "indemnification" by the general master for liability predicated on the unfitness of the servant provided. Another would impose a responsibility on the special master for the "finished product" while excusing him from liability for the servant's acts over which he had no real control.

The "indemnification" concept deals with the relationship between the two masters. The theory is that the hospital (ambulance) owes the physician a duty to provide him with assistants (ambulance attendants) skilled and competent to perform the specific task. If the physician proves that the active, or primary, negligence was that of the assistant provided by the hospital (ambulance), indemnification may lie against the hospital (ambulance) for the passive, or secondary, liability of the physician. The gravamen of this theory is that, as in the "borrowed servant" doctrine, the physician is still held liable as the special master over the ambulance attendant. However, if the physician can prove that the active negligence was that of the attendant and that the ambulance service owed him a duty to furnish a qualified attendant, the physician is entitled to indemnity from the ambulance service for damages assessed against him based on his vicarious liability for the acts of that attendant. This would be true even if the physician

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97 Pennsylvania may be the only state which still recognizes this doctrine. Payne and Mayes, supra note 82, at 386.

were present in the ambulance. The result would be total, not shared, liability for the ambulance service.

The "finished product" theory blunts the "borrowed servant" doctrine but imposes a burden on the physician analogous to that of inspection of a finished product. The "borrowed servant" doctrine is weakened by the practical recognition that a mistake may be made by the servant which is not discoverable by the physician even in the exercise of reasonable supervision. Under such circumstances, the physician's duty is to exercise reasonable care in supervising the servant. Having fulfilled that responsibility, the vicarious liability for the acts of the servant will return to the general master—the hospital. However, an additional duty is imposed on the physician to exercise that reasonable supervision throughout the entire procedure. Assume, for example, that a surgeon leaves the operating room after surgery but before he has verified that the patient is breathing properly. His failure to remain and exercise reasonable care in supervising the assistants until the patient is breathing properly will result, under this theory, in his vicarious liability for the negligent acts of the assistants, whether otherwise discoverable or not.

The result of this "finished product" doctrine would be that if the physician exercises reasonable care in supervising the attendants, the vicarious liability for the undiscoverable acts of the attendants falls on the ambulance service. On the other hand, if the physician has assumed control and supervision of the attendants, he may not relinquish that control until the procedure (safe transportation of the patient) is completed, on penalty of full vicarious liability. In such event, the ambulance service would be exculpated.

C. Liability For Air Ambulances

Under the proposed regulations, air ambulances would feel the

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99 Such indemnity is possible even when both the physician and the assistant are working simultaneously within the same surgical cavity in a patient. Id.

100 For example, a nurse negligently left a sponge in a patient's body. Before closing the cavity, the physician asked for a sponge count and was told by the nurse that it was correct. He additionally made a visual inspection of the operating field. The court held that no more was required of him unless a sponge was known to be missing. Olander v. Johnson, 258 Ill. App. 89 (1930).


102 Id. at 261-62.
impact of each of these theories more severely than land ambulance services. The category of patients (intensive care) required to have the most attention is also the only category which involves the physician as a requirement. Furthermore, that involvement only goes to the physician's being "available, either in person or by telephone or radio communication, to advise . . . with regard to the transportation of the patient."

The implications of this provision in terms of liability for the air ambulance service could be substantial and would vary in interstate travel. If the physician assumed active control and supervision by radio of the management of the patient, under the "borrowed servant" and "captain of the ship" doctrines he would be solely liable for the acts of the medical attendants (air ambulance exculpated). Under the "indemnification" theory, the physician would be vicariously liable, but the ambulance service might be made to indemnify him (air ambulance service exculpated only if the primary negligence was that of the attendant). Finally, under the "finished product" concept, the physician would be only vicariously liable for whatever acts might be discoverable by reasonable supervision, unless he terminated that supervision before the trip was concluded (air ambulance might be exculpated).

If, however, the physician did not assume actual control and supervision, but merely remained "available," only the "captain of the ship" doctrine would impose vicarious liability on the physician. Because the "borrowed servant" requires an immediate right of control not present under such circumstances, it would not free the ambulance service of liability. As the "finished product" and "indemnification" theories are also predicated upon the immediate right of control, they also would be of no avail to the air ambulance service in this situation. Under these last three concepts, however, if the attendant exercised the option of contacting the physician and the physician took control of the situation, the same morass of liability questions arises. Under such legal con-

103 One Medical Attendant would be required per patient. Proposed Regulations, supra note 1, at 37,827.
104 Id. at 37,828.
105 Id.
106 It is uncertain (and beyond the scope of this article) what degree of supervision might be considered reasonable based on radio contact alone.
straints, a physician might well be hesitant to respond to a call from the attendant.

These distinctions may be of little consequence or interest to land ambulance services as they generally operate within a limited range and therefore would not be expected regularly to undertake interstate transportation of patients. Air ambulances, however, are frequently called upon for the express purpose of making such interstate trips with patients. It is conceivable that the air ambulance could depart from a "borrowed servant" state (Texas), refuel in a "finished product" state (Illinois) and then end the trip in a "captain of the ship" state (Pennsylvania). If a negligent act was committed by the medical attendant and the physician had assumed control of the patient's care in Texas, but predictably lost radio contact before the Illinois stop, how would the liability be allocated? Endless permutations of such problems in conflict of laws are imaginable.

IV. CONFLICT OF LAWS: THE NEED FOR FEDERAL COMMON LAW PRINCIPLES

In the event that all of the parties involved in a lawsuit of the nature described above resided in the same state and if the entire flight was conducted within that state, no problems of competing rules and laws would exist. The entire matter would be resolved in that state's courts applying its own laws. As elements of the case begin to involve interests of other states, such as parties who are non-residents of the forum state or an interstate flight, decisions would have to be made as to which state's substantive laws should apply. If the action were one in a state court, that court would apply its conflict of laws rule to determine whether to apply substantive law of the forum state or that of another state. In situations involving residents of different states, however, lawsuits frequently either begin in, or are removed to, federal court based upon diversity of citizenship. For these cases, the Supreme Court held in *Erie R. Co. v. Tompkins* that the law to be used is that which would be applied by a state court of the state in which the federal district court sits. Therefore, the forum state's choice of

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107 Interview with Alice Gaul, *supra* note 45.
laws rules would be used to determine which of several involved states' substantive law to apply. 109

Numerous choice of law standards have been devised and applied by state courts. In aviation tort litigation, however, courts frequently use one of two basic conflict of laws standards. The first is the *lex loci delicti* rule which applies the law of the state in which the tort was committed. 110 This standard would be particularly difficult to apply for the interstate trips of air ambulances, as the determination of exactly which state the aircraft was over at the time of the injury could well be a matter of sheer speculation. In the example mentioned in the preceding section, the defendants (air ambulance, attendant and physician) would be collectively advocating that the state of occurrence be found as that with the law most favorable to them as defendants generally. At the same time, however, they would each be seeking application of the law of that state which recognizes the liability allocation theory most likely to exculpate that particular defendant. The combination of uncertainty at the outset with that type of disharmony makes it very unlikely that any consistency could possibly result.

A second standard commonly used is the "most significant relationship" test which applies the law of that state which has the most significant relationship to the occurrence and the parties. 111 The method of determining the relationships is to consider the contacts which each state has with the occurrence and the parties. Included are such factors as: (1) domicile, nationality, place of incorporation, place of business of the parties; (2) place where the relationship, if any, between the parties centered; and (3) issues and character of the tort and relevant purposes of the tort rules of interested states. 112 While this test may appear to be more logically applicable, the complex relationships generally found in the aviation industry (such as domicile of the aircraft owners and passengers, place of departure and arrival, or place where the agree-

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ment was entered into) and the absence of any physical evidence of the location of the incident can prevent conclusive determination not only of just which states are interested, but also of which state in fact really has the most significant relationship. The determination of applicable state law may therefore turn on factors otherwise totally unrelated to the negligent act itself, such as domicile of the parties or place where the relationship centered. The very nature of air ambulance services is such that it would not be out of the ordinary for a Texas air ambulance to pick up in Arkansas a patient (a Pennsylvania resident on vacation) to be carried to a specialist in Illinois. If an injury occurred in flight, use of the "most significant relationship" test might result in an application of one state's law predicated only upon findings that the carrier was a Texas business, the patient was a Pennsylvania citizen, they first encountered each other in Arkansas and that sometime before the air ambulance arrived in Illinois, an in-flight negligent act occurred. In this type of case, the state found to be most significantly related could in fact have only a very tenuous or even a passive relationship to the incident.

Clearly, incongruous judgments will result from the battles over applicable state law under either conflicts rule. The interstate nature of air ambulance services, however, demands that these carriers be similarly treated throughout the country to insure that no geographical area is without air ambulance services simply because the relative potential liability is greater in one state than in another. This possibility offers a compelling reason for the establishment of a uniform basis for malpractice actions which, by necessity, would be a federal cause of action. The easiest and most effective method would of course be legislation. A possible vehicle for such federal legislation might be Senator McGovern's bill discussed in Part I(B) above. However, Congress has not responded favorably to previous suggestions that they legislate a federal remedy for aviation tort litigation. Another possibility for uniform treatment would be the formulation of a federal common law remedy. This would avoid both the imposition of state laws and the

113 Id.
conflict problems mandated by the *Erie* doctrine for diversity cases.\(^{115}\)

Creation of a federal common law remedy by the courts is not unprecedented in cases involving the aviation industry. In *Kohr v. Allegheny Airlines*,\(^{119}\) the Seventh Circuit imposed a federal law of contribution and indemnity in an action involving a mid-air collision of two aircraft. The basis for finding this federal common law remedy was the predominant federal interest in regulating airways.\(^{117}\) The court quoted from Justice Jackson's opinion in *Northwest Airlines v. Minnesota*,\(^{118}\) including the following:

> Federal control is intensive and exclusive. . . . Planes . . . move only by federal permission, subject to federal inspection, in the hands of federally certified personnel and under an intricate system of federal commands. . . . Its privileges, rights, and protection, so far as transit is concerned, it owes to the Federal Government alone and not to any state government.\(^{119}\)

Other courts have similarly found federal common law remedies in aviation tort litigation.\(^{120}\) Although *Kohr* has been distinguished by some courts in their decisions not to imply a federal cause of action,\(^{121}\) this generally has been either because the incident occurred outside of the United States,\(^{122}\) because it was a totally intrastate incident,\(^{123}\) or because an agent of the United States was a defendant which required application of the Federal Tort Claims Act.\(^{124}\) Likewise, the advisability of judicially estab-

\(^{115}\) See *Erie R. Co. v. Tompkins*, 304 U.S. 64 (1938).

\(^{116}\) 504 F.2d 400 (7th Cir. 1974), cert. denied, 421 U.S. 978 (1975).

\(^{117}\) Id. at 403.

\(^{118}\) 322 U.S. 292 (1944).

\(^{119}\) Id. at 303.


lishing a federal common law for aviation tort litigation in general has been addressed by several articles encouraging action by the Supreme Court to validate the practice. However, even when asked to imply a private right of action based upon a federal statute, the Supreme Court has required that such implied federal causes of action meet a four part test. In Cort v. Ash, the Court set out four requirements for implying a private remedy under the Federal Election Campaign Act of 1971: first, whether the plaintiff is a member of the class sought to be protected by the statute; second, whether there is any evidence of Congressional intent to either create or deny a remedy; third, whether implication of such a remedy would be consistent with the underlying purpose of the statutory scheme; and finally, whether implication of a federal remedy would be inappropriate because this is a cause of action traditionally relegated to state law or involving an area of state concern. Without attempting to predict what the Court's exact disposition of either suggested federal common law remedies or implied private rights of action based upon the Federal Aviation Act or FAA regulations would be for aircraft litigation generally, or air ambulance litigation specifically, it seems unwise to anticipate that the Court will eagerly embrace the concept.

It seems, therefore, that the litigation difficulties caused by different laws, rules and interpretations throughout the country are certain to plague air ambulance services. If state laws are to apply, the problem of determining which state arises. If a federal common law or an implied private remedy lies, it must be determined whether it will be uniformly applied throughout the industry or will only be applied to interstate flights. Whether by action of Congress on a vehicle such as Senator McGovern's bill or by decision of the Supreme Court, this confusion should be resolved if air ambulance services are to be regulated effectively. Unquestionably, it would be preferable to have just one rule apply to an


128 Id. at 78.
air ambulance flight whether the act occurs over Texas, Illinois, Florida or Pennsylvania.128

V. CONCLUSION

The FAA's proposed regulations for air ambulances would certainly be of value in helping to insure quality air ambulance service throughout the country. The FAA has done a commendable job of weighing cost factors against idealistic professional desires. Furthermore, Senator McGovern's proposed legislation, as presently drafted, will help to moderate the economic impact of the regulations for the small certificate holders.

Nevertheless, regulation may create serious new problems of tort liability and corresponding questions of application of state or federal remedies. If some action is not taken to deal with a federal liability allocation concept, those certificate holders who attempt to provide air ambulance services may be thrown into a quagmire of disputes over applicability of conflicting states' tort laws, a federal common law or an implied federal right of action. Under these circumstances, it would seem that proposal of uniform principles of liability allocation would be the best way for the FAA both to protect the air ambulance industry and to insure the availability of affordable air ambulance service throughout the country.

128 "Moreover, insurers would be better able to predict their liability and premium rates if a single rule is applicable." Hilliker, Vicarious Liability For Aircraft Owners Under State Laws, supra note 59, at 1045.