105TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
105–456

AVIATION MEDICAL ASSISTANCE ACT OF 1998

MARCH 20, 1998.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. SHUSTER, from the Committee on Transportation and Infrastructure, submitted the following

REPORT

[To accompany H.R. 2843]

[Including cost estimate of the Congressional Budget Office]

The Committee on Transportation and Infrastructure, to whom was referred the bill (H.R. 2843) to direct the Administrator of the Federal Aviation Administration to reevaluate the equipment in medical kits carried on, and to make a decision regarding requiring automatic external defibrillators to be carried on, aircraft operated by air carriers, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Aviation Medical Assistance Act of 1998".

SEC. 2. MEDICAL KIT EQUIPMENT AND TRAINING.

Not later than 1 year after the date of the enactment of this Act, the Administrator of the Federal Aviation Administration shall reevaluate regulations regarding (1) the equipment required to be carried in medical kits of aircraft operated by air carriers, and (2) the training required of flight attendants in the use of such equipment, and, if the Administrator determines that such regulations should be modified as a result of such reevaluation, shall issue a notice of proposed rulemaking to modify such regulations.

SEC. 3. REPORTS REGARDING DEATHS ON AIRCRAFT.

(a) IN GENERAL.—During the 1-year period beginning on the 90th day following the date of the enactment of this Act, a major air carrier shall make a good faith effort to obtain, and shall submit quarterly reports to the Administrator of the Federal Aviation Administration on, the following:

(1) The number of persons who died on aircraft of the air carrier, including any person who was declared dead after being removed from such an aircraft as a result of a medical incident that occurred on such aircraft.

(2) The age of each such person.

(3) Any information concerning cause of death that is available at the time such person died on the aircraft or is removed from the aircraft or that subsequently becomes known to the air carrier.

(4) Whether or not the aircraft was diverted as a result of the death or incident.

(5) Such other information as the Administrator may request as necessary to aid in a decision as to whether or not to require automatic external defibrillators in airports or on aircraft operated by air carriers, or both.

(b) FORMAT.—The Administrator may specify a format for reports to be submitted under this section.

SEC. 4. DECISION ON AUTOMATIC EXTERNAL DEFIBRILLATORS.

(a) IN GENERAL.—Not later than 120 days after the last day of the 1-year period described in section 3, the Administrator of the Federal Aviation Administration shall make a decision on whether or not to require automatic external defibrillators on aircraft operated by passenger air carriers and whether or not to require automatic external defibrillators at airports.

(b) FORM OF DECISION.—A decision under this section shall be in the form of a notice of proposed rulemaking requiring automatic external defibrillators in airports or on aircraft operated by air passenger carriers, or both, or a recommendation to Congress for legislation requiring such defibrillators or a notice in the Federal Register that such defibrillators should not be required in airports or on such aircraft. If a decision under this section is in the form of a notice of proposed rulemaking, the Administrator shall make a final decision not later than the 120th day following the date on which comments are due on the notice of proposed rulemaking.

(c) CONTENTS.—If the Administrator decides that automatic external defibrillators should be required—

(1) on aircraft operated by air passenger carriers, the proposed rulemaking or recommendation shall include—

(A) the size of the aircraft on which such defibrillators should be required;

(B) the class flights (whether interstate, overseas, or foreign air transportation or any combination thereof) on which such defibrillators should be required;

(C) the training that should be required for air carrier personnel in the use of such defibrillators; and

(D) the associated equipment and medication that should be required to be carried in the aircraft medical kit; and

(2) at airports, the proposed rulemaking or recommendation shall include—

(A) the size of the airport at which such defibrillators should be required;

(B) the training that should be required for airport personnel in the use of such defibrillators; and

(C) the associated equipment and medication that should be required at the airport.

(d) LIMITATION.—The Administrator may not require automatic external defibrillators on helicopters and on aircraft with a maximum payload capacity (as defined in section 119.3 of title 14, Code of Federal Regulations) of 7,500 pounds or less.

(e) SPECIAL RULE.—If the Administrator decides that automatic external defibrillators should be required at airports, the proposed rulemaking or recommendation shall provide that the airports are responsible for providing the defibrillators.

SEC. 5. LIMITATIONS ON LIABILITY.

(a) LIABILITY OF AIR CARRIERS.—An air carrier shall not be liable for damages in any action brought in a Federal or State court arising out of the performance of the air carrier in obtaining or attempting to obtain the assistance of a passenger in an in-flight medical emergency, or out of the acts or omissions of the passenger rendering the assistance, if the carrier in good faith believes that the passenger is a medically qualified individual and not an employee or agent of the carrier.

(b) LIABILITY OF INDIVIDUALS.—An individual shall not be liable for damages in any action brought in a Federal or State court arising out of the acts or omissions of the individual in providing or attempting to provide assistance in the case of an in-flight medical emergency unless the individual, while rendering such assistance, is guilty of gross negligence or willful misconduct.

SEC. 6. DEFINITIONS.

In this Act—

(1) the terms "air carrier", "aircraft", "airport", "interstate air transportation", "overseas air transportation", and "foreign air transportation" have the meanings such terms have under section 40102 of title 49, United States Code;

(2) the term "major air carrier" means an air carrier certificated under section 41102 of title 49, United States Code, that accounted for at least 1 percent of domestic scheduled-passenger revenues in the 12 months ending March 31 of the most recent year preceding the date of the enactment of this Act, as reported to the Department of Transportation pursuant to part 241 of title 14 of the Code of Federal Regulations; and

(3) the term "medically qualified individual" includes any person who is licensed, certified, or otherwise qualified to provide medical care in a State, including a physician, nurse, physician assistant, paramedic, and emergency medical technician.

BACKGROUND

Current regulatory status

In 1986, the Federal Aviation Administration (FAA) first established regulations requiring air carriers to place medical kits on board their aircraft. These regulations (51 FR 1223, January 9, 1986) applied to air carriers carrying passengers under FAA's rule Part 121 (more than 30 seats) and those operating aircraft with more than 19 passengers seats under Part 135.

Prior to this, air carriers were required to have first-aid kits for treatment of injuries or medical emergencies that might occur during flight time or in minor accidents. First aid kits are required to have such items as bandages, antiseptic swabs, splints, adhesive tape, and scissors. Equipment placed in medical kits are more comprehensive and include such items as a stethoscope, blood pressure measuring device, airways, drugs for allergic reactions, and the basic instruction for use of the drugs.

Federal Aviation Regulations addressing medical kits were not amended until October 18, 1994. This amendment required the addition of disposable latex gloves to the medical kits. On January 19, 1996, these regulations were further amended to require commuter aircraft that have passenger configurations of 10 to 30 seats to carry medical kits on board.

Recent studies and actions

In recent years, there has been growing debate outside and within the aviation industry as to whether or not current medical kits are adequate. Several foreign air passenger carriers have extensive medical kits, including defibrillators, on-board their overseas flights.

American, United, Delta, Alaska Airlines, and American Trans Air have recently announced that they will place defibrillators on some flights. The other carriers that carry these systems include Qantas Airlines from Australia, Virgin Atlantic from England, and Air Zimbabwe from Africa.

An Automated External Defibrillator (AED) is a device that when placed on the chest of a person suffering from ventricular fibrillation can shock that person's heart back into the proper rhythm. Although they used to be bulky and complex, recent technology improvements in these defibrillators has made them portable, compact, and easy to use. This has enabled air carriers to con-

sider installing them on their aircraft in order to address cardiac emergencies.

Although there have been a number of short-term data collections and assumptions from various sources, there does not appear to be enough historical data on the number and types of medical emergencies to determine trends that would be helpful in assessing the scope and extent of in-flight emergencies.

According to the FAA, at the present time, there is no way to actually monitor the incidence of in-flight medical emergencies because airlines are not required to report them. The FAA receives reports of accidents, incidents, and diversions; however, the diversion information is only maintained for a 30-day period. The available data for air carriers are from multiple sources, are collected and classified differently and often use different categorizations.

The FAA's Civil Aeromedical Institute issued a report in February 1997, which noted the difficulties mentioned above, stating that the in-flight medical emergency rate appeared to have nearly doubled between 1990 and 1993, the interval covered by the study.

According to a study of 120 airlines conducted from 1977 to 1984 and published in the Journal of the American Medical Association in 1988, about 72 deaths occur aboard aircraft each year. In many years, this is more than the number of deaths from airline crashes in the U.S. The study states that about 63% of the deaths were due to sudden, unexpected cardiac problems, and that the most likely victims were middle-age men.

Qantas Airlines placed defibrillators on all of its 53 international route airplanes and throughout Qantas airport terminals in 1991. From September 1991 to August 1996, the defibrillators were used on 87 occasions; 47 times for monitoring an acutely ill passenger, and 40 times for cardiac arrest; 22 episodes of cardiac arrest occurred on the airplanes. Qantas aircraft diverted on 17 occasions during this five-year period.

Most airlines do not keep records of passenger deaths. However, according to American Airlines, cardiopulmonary resuscitation is a good indicator as to when a defibrillator would be necessary.

From 1991 through 1996, American Airlines indicated that CPR related incidents on board aircraft have almost tripled. In 1991, there were 12 reports of CPR being administered while in 1996 there were 33 cases reported. Moreover, the Chicago Tribune reported that American Airlines recorded 4,800 in-flight medical emergencies over the last two years and, in 1994 and 1995, Northwest Airlines made 171 emergency medical landings and American Airlines made 285.

The most common in-flight medical occurrences for American Airlines from 1991 through 1996, by percentage, are as follows:

	Percent
cardiac events	40
unconscious	17
seizures	14
unknown	9
psychiatric	7
gastrointestinal	7
bleeding	6
obstetrical	6
asthma	3
turbulence	3

	Percent
diabetes	2
infections	1

Crew medical training

Some question the current medical training of flight attendant personnel as well as the liability concerns of the airlines and their employees. There are also debates about the level of medical training flight attendants should receive or be held responsible for during flights.

Under current Federal Aviation Regulations, crew member training programs must provide instruction in first-aid equipment and its proper use and familiarization with the emergency medical kit.

Subcommittee hearing

On May 21, 1997, the Subcommittee held a hearing on Medical Kits aboard Commercial Aircraft. At that hearing, the new smaller defibrillator was demonstrated. The Subcommittee was impressed with its ease of use. However, it was apparent that there was still a lack of data to determine the extent of medical problems aboard commercial aircraft. It was also unclear whether defibrillators could safely be used on all sizes and types of aircraft. There were indications that there could be problems if these devices were installed on smaller aircraft. The Subcommittee was also concerned about the minimal training airline crews seemed to be receiving in dealing with medical emergencies.

It has been reported that cardiac arrest kills an estimated 350,000 to 400,000 Americans each year. To be effective, defibrillation must usually occur within the first few minutes of the event. It will usually not be possible to land that quickly and obtain medical help when the plane is at 20 or 30 thousand feet. And the cost to divert is not inconsequential to the airline involved.

Legislation

Therefore, on November 6, 1997, Aviation Subcommittee Chairman Duncan introduced H.R. 2843, the Aviation Medical Assistance Act. Congressmen Lipinski, Blunt, Fox, Cooksey, and Congresswoman Kennelly are cosponsors of this bill. The American Medical Association (AMA) has announced that it supports it.

The bill would require major airlines to report their on-board medical incidents to the FAA. The FAA would then use the data to decide whether to require defibrillators aboard passenger aircraft, and if so, which types of passenger aircraft. Cargo aircraft are not affected.

There was testimony at the hearing indicating that defibrillators would only be appropriate for long flights and only on large aircraft although there was some disagreement over what exactly would constitute a large enough aircraft. The reported bill specifies that this equipment cannot be required on helicopters or aircraft with payload capacity of 7,500 pounds or less (about 30 seats or less). With respect to aircraft of more than 7,500 pounds, the Committee has chosen to leave it to the detailed analysis by the FAA as to where to draw the line.

However, the Committee is aware that there are many aircraft in regional service with payloads of more than 7,500 pounds. Most

have only a single flight attendant. The typical characteristics of these aircraft are relatively narrow aisles and limited open floor space at the entry door and in the service areas. The lack of open floor space could make positioning of the sick person and the application of the defibrillator difficult. In addition, most of the regional aircraft involved have between 32 and 50 passenger seats. At typical load factors of about 55%, it is less likely that there will be a medical professional on board. Moreover, most of these smaller aircraft require less runway to land safely and are able to divert more quickly into many more airports than larger jet aircraft in the event of an onboard medical emergency. The Committee urges the FAA to consider these factors in deciding where to draw the line.

The time periods in this bill will enable that agency to consult with aerospace medicine practitioners, other clinical specialists, airlines, and the public before making its decision. The Committee does note with approval that some major U.S. airlines with narrow body aircraft have already chosen to equip their fleet with the new defibrillators.

The reported bill gives the FAA authority to require defibrillators at airports. As with airlines, the FAA must decide the size of the airport at which defibrillators should be required, the training that should be required of airport personnel, and the related equipment and medication that should be required at the airport. The Committee would expect FAA to take a similar judicious approach in drawing the line with respect to airports as it does with airlines and not require them at airports which are too small to justify the expense such as general aviation airports or small commercial ones that do not have crash/fire/rescue equipment. If the FAA does require defibrillators at airports, the reported bill makes clear that it is the airport owner or operator and not the airlines operating there that will be responsible for providing the equipment.

The reported bill would also direct FAA to consider upgrading the medical equipment on aircraft and improving flight attendant training. The FAA now requires carriers to instruct flight attendants in the location, function, and operation of first aid equipment and first aid oxygen. The Committee is concerned that FAA rules do not mandate a standard training program that will ensure that flight attendants can perform first-aid procedures necessary to effectively deal with the medical emergencies that occur aboard aircraft. The Committee expects the FAA, in the reevaluation of flight attendant training required by this bill, to consider making changes to address this issue.

Finally, the bill includes a "Good Samaritan" provision to protect those who help in a medical emergency. The provision protects an individual (such as a passenger, pilot, or flight attendant) from legal liability for helping in a medical emergency unless that individual is guilty of gross negligence or willful misconduct. The provision also protects the airline from liability for the negligence of a passenger who volunteers to help in a medical emergency but only if (1) that passenger is not an employee of the airline and (2) the airline in good faith believed that that passenger was qualified to provide that help (such as where the crew believed that the passenger was a doctor, nurse, or was otherwise experienced in dealing with medical emergencies).

Nothing in the good Samaritan provision should be construed to affect the liability of an air carrier with respect to harm caused to a passenger by that carrier's employee or agent who provides or attempts to provide assistance during an in-flight medical emergency. The provision is intended to limit the liability only of individual passengers and employees, not the vicarious liability of the airline they may work for. The airline is not a good Samaritan but rather is a common carrier that, by law, has a duty to provide safe transportation to those who have paid for it.

Also, this provision should not affect situations such as the one that arose in *Krys* v. *Lufthansa German Airlines,* 119 F.3d 1515 (11th Cir. 1997). The provision in the reported bill ensures that airlines will not be held liable for the acts or omissions of passengers who are not its employees and who they do not control. However, in *Krys,* the airline was held liable there not because of acts or omissions of the passenger rendering assistance but rather because the airline's employees failed to divert the flight and land when its own policy as well as standard industry practice indicated that it should have done so.

SECTION-BY-SECTION SUMMARY

Section 1 is the short title.

Section 2 gives the FAA 1 year to reevaluate its rules regarding the contents of aircraft medical kits on commercial aircraft and the training required in the use of that equipment and, if warranted, to propose changes in those rules.

Section 3 requires major airlines to provide quarterly reports over a 1-year period to the FAA that include the following information—

The number of people who died on their aircraft.;

The age of that person;

Any available information about the cause of death;

Whether the aircraft was diverted as a result of the death or incident; and

Such other information as the FAA may require.

This section also permits FAA to specify a format for the quarterly reports. However, airlines must still file the reports quarterly with the required information even if FAA has not specified a format. If FAA chooses to specify a format, the Committee suggests the following:

Date	Flight	Passenger ID & age	?Divert	Medical/death info

Section 4 requires FAA to make a decision on whether automatic external defibrillators should be required in airports and on commercial passenger aircraft. The FAA is given 120 days after receiving the airline quarterly reports to make the decision on the defibrillators. This decision could take the form of either the issuance of a notice of proposed rule-making (NPRM), a recommendation to Congress, or a notice that no further action should be taken. If FAA takes the NPRM approach, it would have 120 days after comments are received to issue a final rule. If FAA decides that defibrillators should be required, the agency would be ex-

pected to decide the size of the aircraft on which defibrillators should be required, the type of flights (domestic, international), the training that should be required of flight attendants, and the related equipment and medication that should be carried in the aircraft medical kit. Similar decisions would have to be made with respect to airports.

Section 5 is the Good Samaritan provision. It protects the airline against liability for the actions of a passenger rendering assistance in an in-flight medical emergency if the passenger is not an employee or agent of the airline and if the airline in good faith believed that the passenger was qualified to render such assistance. It also protects an individual (such as a passenger or member of the crew) from liability for rendering assistance unless that person engaged in gross negligence or willful misconduct.

Section 6 defines terms.

HEARINGS AND LEGISLATIVE HISTORY

The Subcommittee on Aviation held a hearing on "Medical Kits on Commercial Airlines" on May 21, 1997 (Committee document 105-23). H.R. 2843 was introduced on November 6, 1997. The Committee has not held hearings on the reported legislation.

COMMITTEE CONSIDERATION

On March 5, 1998, the Subcommittee on Aviation reported the bill, by unanimous voice vote, to the Committee on Transportation and Infrastructure. On March 11, 1998 the Committee met in open session and ordered the bill reported, with an amendment, by voice vote with a quorum present. There were no recorded votes taken during Committee consideration of H.R. 2843.

ROLLCALL VOTES

Clause 2(l)(2)(B) of rule XI requires each committee report to include the total number of votes cast for and against on each rollcall vote on a motion to report and on any amendment offered to the measure, and the names of those members voting for and against. There were no recorded votes taken in connection with ordering H.R. 2843 reported. A motion by Mr. Duncan to order H.R. 2843 reported to the House was agreed to by voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

With respect to the requirements of clause 2(l)(3)(A) of rule XI of the Rules of House of Representatives, the Committee's oversight findings and recommendations are reflected in this report.

COSTS OF THE LEGISLATION

Clause 7 of rule XIII of the Rules of the House of Representatives does not apply where a cost estimate and comparison prepared by the Director of the Congressional Budget Office under section 403 of the Congressional Budget Act of 1974 has been timely submitted prior to the filing of the report and is included in the report. Such a cost estimate is included in this report.

COMPLIANCE WITH HOUSE RULE XI

1. With respect to the requirement of clause 2(l)(3)(B) of rule XI of the Rules of the House of Representatives, and section 308(a) of the Congressional Budget Act of 1974, the Committee references the report of the Congressional Budget Office included below.

2. With respect to the requirement of clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, the Committee has received no report of oversight findings and recommendations from the Committee on Government Reform and Oversight on the subject of H.R. 2843.

3. With respect to the requirement of clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives and section 403 of the Congressional Budget Act of 1974, the Committee has received the following cost estimate for H.R. 2843 from the Director of the Congressional Budget Office.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 18, 1998.

Hon. BUD SHUSTER,
Chairman, Committee on Transportation and Infrastructure, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 2843, the Aviation Medical Assistance Act of 1998.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts for this estimate are Victoria V. Heid (for federal costs), Pepper Santalucia (for the state and local impact), and Jean Wooster (for the private-sector impact).

Sincerely,

JUNE E. O'NEILL, *Director.*

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

H.R. 2843—Aviation Medical Assistant Act of 1998

Summary: H.R. 2843 would direct the Administrator of the Federal Aviation Administration (FAA) to reevaluate regulations regarding equipment in medical kits carried on certain aircraft and the training required of flight attendants in the use of such equipment. Specifically, the bill would direct the FAA to consider whether automatic external defibrillators should be required. H.R. 2843 also would direct the FAA to evaluate whether the agency should require such equipment in airports. The bill would require the FAA to announce its decisions within 19 months of enactment.

In addition, the bill would direct major air carriers to provide information to the FAA about medical incidents occurring on aircraft for the purpose of assisting the FAA in reevaluating the current regulations. The bill also would limit the liability of air carriers and individuals when assisting passengers in an in-flight medical emergency.

CBO estimates that enacting H.R. 2843 would have no significant impact on the federal budget. Because H.R. 2843 would not af-

fect direct spending or receipts, pay-as-you-go procedures would not apply.

H.R. 2843 contains both intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act of 1995 (UMRA), but the expected costs of complying with those mandates would be well below the statutory thresholds established in UMRA.

Estimated cost to the Federal Government: Under current law, the FAA has the authority to regulate the medical equipment carried on aircraft; however, the agency does not have the authority to regulate medical equipment at airports, and it is unclear whether enacting H.R. 2843 would give the FAA authority to do so. CBO estimates that the FAA would incur no significant costs to reevaluate medical equipment required on aircraft. Assuming that enacting H.R. 2843 would give the FAA authority to regulate medical equipment at airports, CBO estimates that additional discretionary outlays for the FAA to study and review whether such regulations should be proposed would total less than $250,000, assuming appropriation of the necessary amounts.

Estimated impact on State, local, and tribal governments: The bill contains at least one intergovernmental mandate as defined in UMRA. By limiting the liability of air carriers and individuals who provide medical assistance during an in-flight emergency, the bill would preempt the liability laws of state and local governments. CBO estimates that this preemption would not impose any significant costs on state or local governments.

The bill would also direct the FAA to consider whether automatic external defibrillators should be required at airports, most of which are publicly owned. If imposed, such a requirement would be an intergovernmental mandate. Based on information from airports and the FAA, CBO estimates that the direct costs of such a requirement would be well below the statutory threshold for intergovernmental mandates ($50 million in 1996, adjusted annually for inflation).

Estimated impact on the private sector: H.R. 2843 would impose a new private-sector mandate, as defined by UMRA, on major domestic air carriers. The bill would require approximately 10 air carriers to make a good faith effort to obtain information on their onboard medical incidents and to submit a quarterly report for a one-year period to the FAA. CBO estimates that the direct cost of complying with this mandate would fall well below the statutory threshold for private-sector mandates ($100 million in 1996, adjusted annually for inflation).

The bill would also direct the FAA to consider whether automatic external defibrillators should be required on aircraft and at airports, but this would not be a new private-sector mandate. The FAA Currently has the authority to require medical equipment on aircraft, and CBO expects that no private airports would be affected by such a requirement.

Estimate prepared by: Federal Costs: Victoria V. Heid. Impact on State, Local, and Tribal Governments; Pepper Santalucia. Impact on the Private Sector: Jean Wooster.

Estimate approved by: Robert A. Sunshine, Deputy Assistant Director for Budget Analysis.

APPLICABILITY TO THE LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act (Public Law 104–1).

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of the Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act (Public Law 104–4).

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause (2)(l)(4) of rule XI of the Rules of the House of Representatives, committee reports on a bill or joint resolution of a public character shall include a statement citing the specific powers granted to the Congress in the Constitution to enact the measure. The Committee on Transportation and Infrastructure finds that Congress has the authority to enact this measure pursuant to its powers granted under Article I, Section 8 of the Constitution.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

H.R. 2843 does not amend any existing Federal statute.

EXCHANGE OF LETTERS

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE JUDICIARY,
Washington, DC, March 20, 1998.

Hon. BUD SHUSTER,
Chairman, Committee on Transportation and Infrastructure, House of Representatives, Washington, DC.

DEAR BUD: I am writing to you regarding the "Aviation Medical Assistance Act of 1997" (H.R. 2843), legislation that was ordered reported by the Committee on Transportation and Infrastructure on March 11, 1998.

Section 5 imposes limitations on the liability of air carriers and individuals for injuries caused in the course of providing in-flight medical emergency services. This provision falls within the Rule X jurisdiction of the Committee on the Judiciary.

The Judiciary Committee does not object to the terms of this provision, and for this reason, I am not requesting a sequential referral of the bill. However, this should not be deemed to be a waiver of this Committee's jurisdiction over the subject matters contained therein, or our right to be appointed as conferees should this bill go to conference with the Senate.

Sincerely,

HENRY J. HYDE, *Chairman.*

HOUSE OF REPRESENTATIVES,
COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE,
Washington, DC, March 20, 1998.

Hon. HENRY J. HYDE,
Chairman, Committee on the Judiciary, Rayburn House Office Building, Washington, DC.

DEAR HENRY: Thank you for your letter of March 20, 1998 concerning the Aviation Medical Assistance Act of 1997, H.R. 2843. I appreciate your assistance in expediting House consideration of this legislation and your comments on section 5 of the bill which limits the liability of air carriers and individuals for injuries resulting from in-flight medical emergency services. As you correctly point out, this provision falls within the jurisdiction of the Committee on the Judiciary.

As you have requested, it is my intention to insert your letter and this response in the report accompanying H.R. 2843. Further, I would be pleased to support the representation of your Committee in any Conference on H.R. 2843 on matters within the jurisdiction of the Committee on the Judiciary.

With warm personal regards, I am

Sincerely,

BUD SHUSTER, *Chairman.*

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