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New York Law Journal

Litigating MedFlight Crashes: Continuing Trends and Legal Issues

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May 9, 2025

On Jan. 31, an air ambulance airplane crashed in a Philadelphia neighborhood killing all on board and two ground victims.

The tragic crash, caught on film, generated much deserved media attention because aviation was top-of-mind after the first fatal U.S. commercial airline crash in 17 years had taken place 2 days before on Jan. 29 in Washington DC, and because of the dramatic crash sequence that played out in Philadelphia.

The Learjet 55 air ambulance took off from Northeast Philadelphia Airport and only reached approximately 1,275-foot in altitude before plummeting to the ground. The plane nose-dived into a parking lot near Roosevelt Mall travelling about 11,000 feet per minute and exploded, causing a large fireball and post-crash fire.

Videos circulated on social media and news sites of shrapnel from the plane narrowly missing patrons in nearby businesses, and of witnesses rushing to the crash site as it burned.

The Jan. 31 Philadelphia crash was a reminder of the huge increase in medflight transport over the last 20 years, and the attendant increase in medflight crashes and fatalities. While helicopter medflight safety concerns have received the most attention, fixed-wing medflight crashes like the one in Philadelphia have increased as well.

This article will provide a brief overview of the medflight industry and the legal issues that often crop up in litigating medflight crashes on behalf of both injured patients and passengers, as well as injured flight and medical crew members.

Medflight Industry: A Brief Background

Before diving into legal issues, it is helpful to understand some background about the medflight industry and its growth up until recently.

Air medical transport falls into four categories: (1) scene response; (2) interfacility transfers; (3) specialty care and organ delivery; and (4) repatriation from outside the U.S. (the last category of which is not well documented in statistics).

As of 2020, about half of all domestic medflights were inter-facility transport, and about one-third were scene response. *See* Lance Sherry & Charlie Wang, *A Statistical Overview of Fixed Wing Air Medical Transportation Operations in the*

United States (2019-2020), 41 Air Med. J. 359, 359 (2022).

Inter-facility transport is mostly handled by fixed-wing aircraft (as was the case with the Philadelphia crash), whereas scene response is handled by helicopters. Despite handling the smaller share of medflights overall, helicopters make up a larger share of fatal crashes. Still, there are significant numbers of fixed wing medflight crashes as well.

Two factors have driven the increase in fixed-wing medflight transport (such as the one that crashed in Philadelphia): (1) the shuttering of many smaller regional hospitals and consolidation of level 1 trauma centers in larger metropolitan areas; and (2) Medicare's decision in 2002 to cover the reasonable cost of air ambulance services. *See* Sherry & Wang, *Statistical Overview*, *supra*, at 359-60.

These two trends provided both a need to transport more patients farther from rural areas to city hospitals, and a chance for substantial profits for the companies performing the transports.

While there are risks to any aviation operation, the business model of medflight transport poses significant challenges. Medflights often only get paid if the medical transport ends up being necessary and they complete the transfer. A helicopter may arrive at an accident scene only to find out the first responders misevaluated the situation and an air medevac was not needed.

The flight will be a waste unless they find a reason to take the patient anyway. For fixed wing air ambulance transport, this creates a pressure to accept and complete the flight regardless of operational issues (fatigue, staffing, equipment, etc.) or situational factors (weather, airport capabilities, etc.).

This financial pressure to take questionable flights and transport patients who may not need or be medically stable enough to tolerate transport impacts safety and is likely part of the reason studies of accident data see higher fatal outcomes in medical flights compared with non-medical flights. *See, e.g.*, Daniel A. Handel & Thomas R. Yackel, *Fixed-Wing Medical Transport Crashes: Characteristics Associated with Fatal Outcomes*, 20 Air Med. J. 3, 149 (2011).

Because of these risks, and the volume of fatal helicopter crash cases, the National Transportation Safety Board issued recommendations to improve medflight safety, and the Federal Aviation Administration adopted special regulations for helicopter air ambulances. *See* 14 C.F.R. Part 135, Subpart L – Helicopter Air Ambulance Equipment, Operations and Training Requirements; FAA Advisory Circular No. 135-14B.

The FAA regulations and guidance set out specific, heightened requirements for certifying helicopter air ambulance operations. It requires specialized equipment, risk management, training and operational rules that helicopter air ambulances must comply with.

While the FAA has issued similar guidance for fixed-wing air ambulance operations, the guidance is older and nonbinding. *See* FAA Advisory Circular No. 135-14A. These regulations and guidance can often be a helpful standard to reference in negligence cases to demonstrate a violation of the standard of care.

The aircraft used as air ambulances are often heavily modified general aviation aircraft, such as the Pilatus PC-12 and Beech King Air. Many of these aircraft have been long in service, having been converted to air ambulances only later in their service life. In 2019-2020, for instance,

the average age of air ambulance aircraft was 26 years old, and the median age was 25 years. *See* Sherry & Wang, *Statistical Overview*, *supra*, at 362.

The Philadelphia crash demonstrates why it is so important for operators to follow the stringent operating standards for medflight. The National Transportation Safety Board is still investigating the crash, but the massive fireball is a reminder of the primary reason that medflight crashes are so rarely survivable – air ambulance aircraft carry oxygen tanks on board for patient care, which explode in crashes and post-crash fires.

The crash also occurred right after takeoff and the full fuel tanks added to the conflagration. The data bears this risk out: there were significantly more aircraft fires in medical flight crashes and those fires significantly increased the odds of a fatal outcome. *See* Handel & Yackel, *Fixed Wing Medical Transport*, *supra*, at 150-151.

Frequent Legal Issues

Patient, Crew or Bystander? – General Aviation Revitalization Act

Victims of medflight crashes often must contend with the General Aviation Revitalization Act (GARA), a federal statute that sets an 18-year statute of repose on products liability claims related to general aviation aircraft and components. *See* Pub. L No. 103-298, 108 Stat. 1552 (reprinted in notes for 49 U.S.C. §40101).

Since many air ambulances are converted general aviation aircraft and the median age of the medflight fleet is older than 18 years, GARA can pose a problem for claimants seeking to pursue a products liability claim concerning a medflight crash.

GARA contains an exception, however, that specifically benefits medflight patients injured or killed in medflight crashes:

> 2. if the person for whose injury or death the claim is being made is a passenger for the purposes of receiving treatment for a medical or other emergency…
>
> GARA provides a further exception for ground victims of a crash, like the two Philadelphians who died in the Jan. 31st crash:
>
> 3. if the person for whose injury or death the claim is being made was not aboard the aircraft at the time of the accident …

These exceptions remove the GARA statute of repose as an issue for the patient and ground victims of a medflight crash. They do not, however, apply to any pilots or medical crew transporting the patient.

Since fatal medflight crashes nearly always involve multiple fatalities of both patients and passengers or crew, as well as ground victims, claimants may face different legal options that need to be carefully evaluated and may lead to very different litigation strategies.

Even for those claimants whose claims are subject to GARA, there is often a viable products liability case. While air ambulances are often older than GARA's 18-year statute of repose, aircraft components are frequently life limited, needing replacement or overhaul significantly more often than 18-years.

Any product liability claim evaluation must therefore go much deeper into the aircraft's history and maintenance than just the age of the overall airframe.

Can the Crew Sue?

In a non-products liability case against operators or maintainers of an air ambulance aircraft for their operational negligence, the crew of a medflight crash must also confront whether their tort claims are barred by worker's compensation exclusivity.

If the pilot or medical crew were employed by the same company that owned and operated the aircraft, then workers' compensation is almost certainly their only remedy. Medflight operations, however, are often not so simple.

Many medflight operators are part of large conglomerates or structured as multiple different companies. It is not unusual for the medical providers on board a medflight aircraft (i.e., nurses, paramedics, etc.) to be employed separately from the pilot(s). Part of this stems from the history of the medflight industry.

Years ago, most medflight operators were hospital affiliated. *See* Sherry & Wang, *Statistical Overview*, *supra*, at 360. They provided all the medical services, staff, and equipment. They either owned and operated their own aircraft or contracted an independent operator.

When Medicare began covering the reasonable cost of medflights, the economics of medflight changed drastically and independent operators proliferated. While hospital affiliated medflights are usually not-for-profit, independent operators are almost always for profit. Usually, independent medflight companies employ both medical and flight crews, and own and operate their own aircraft.

The significant profits available in the medflight space also attracted private equity investors and a wave of consolidation.

As of 2017, two private equity owned helicopter air ambulance companies made up 64% of the Medicare market, and the same two companies plus another smaller private equity owned company represented 62% of the Medicare market for fixed wing air ambulances. *See* Loren Adler, Kathleen Hannick and Sobin Lee, *High air ambulance charges concentrated in private equity owned carriers*.

Despite the increase in independent medflight operators and the wave of consolidation, there remains a decent chance that different entities employ the medical and flight crews involved in a medflight crash.

This might be because it involved an older hospital affiliated operator that has contracted out the aviation part of its operation. It could also be a historical quirk of an independent operator's organization due to a past acquisition or merger, absorbing one independent operator into a larger private equity owned conglomerate.

There are also independent operators who have always kept their medical and aviation businesses separate, perhaps to simplify regulatory compliance or gain other benefits from separation, since both medicine and aviation are heavily regulated in their own unique ways. The structure of the potential defendants and the employment of all potential claimants needs to be carefully evaluated.

Just because the medical crew is employed by a separate entity from the aircraft operator or pilots' employer does not mean the workers' compensation bar is no longer a concern. Whether medical crew member victims are still within the scope of a medflight operator's workers' compensation immunity will depend on the applicable state's workers' compensation law.

Since many medflight transports cross state lines and involve medical and flight crews who commute from one state to another for work, the first step in evaluating this question will be determining the venue for your claims and what state's workers' compensation law will apply under that venue's choice of law principles.

Once the applicable state law is determined, how that law applies to the facts at hand must be determined. Many states allow more than just

the direct employer of a claimant to take advantage of workers' compensation immunity. The tests and rationale vary.

In Nevada, for instance, an entity other than the direct employer can still be immune from a tort suit under the workers' compensation statute if the separate entity is considered a "statutory employer" or "statutory co-employee" of the injured worker.

Nevada law often affords sub-contractors and independent contractors the same status as "employees" for the purpose of determining the scope of workers' compensation immunity. Just as a worker could not sue their employer if a co-worker injured them on the job, the injured worker often cannot sue an independent contractor who is a "statutory co-employee" in Nevada.

To determine whether the separate entity qualifies as a "statutory co-employee" in non-construction contexts, the Nevada courts utilize the "normal work" test from *Meers v. Haughton Elevator*, 101 Nev. 283, 701 P. 2d 1006 (1985). In short, the test is whether the work done for the direct employer by the separate sub- or independent contractor entity "is, in that business normally carried on through employees rather than independent contractors.."

In the air ambulance context, if the medical crews are employed by a separate entity from the aviation crews that operate the aircraft, then the aviation entity is not performing the same "normal work" as the medical crew's employer. Instead, each entity has specialized and does not perform the same "normal work" as the other. There, separately employed medical crews have a strong tort claim against a separate aviation entity.

Some other state laws follow this theme, but add other elements or factors to consider, such as whether the company seeking immunity exercised supervision or control over the work performed by the injured worker. *See, e.g.*, *Alsadi v. Intel Corp.*, 519 F. Supp. 3d 611, 633-34 (D. Ariz. 2021).

Again, the analysis must be closely evaluated under the controlling law and employment facts confronted by each injured party in any medflight crash. With the proper analysis, however, the varied corporate structures and employment arrangements used by medflight companies can often leave open a tort remedy for medical crew members who may have appeared barred by workers' compensation.

In conclusion, medflight aviation has unique risks that result in high accident rates. Medflight victims face significant challenges in seeking justice after the crash. Workers' compensation rules may shield the operator from negligence claims, including those arising from pilot negligence.

Under federal law, aircraft manufacturers are protected by the General Aviation Revitalization Act for aircraft older than 18-years. A patient killed or injured in a medflight accident and ground victims do not face these same hurdles and have a much better chance of success in civil litigation.

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