This was going to be a no-holds-barred-related trip. We were heading to a meeting in Cleveland on March 27, 2013, aboard an American Airlines 767 to Dallas-Fort Worth, where we would change planes. It was about an hour-and-a-half into the flight, crossing over eastern New Mexico, and we were working on our laptops, when there was a tremendous thud.

We looked down at the floor next to us and into the pale face of a man in his 60s who had collapsed in the aisle. He regained consciousness after a moment, and we asked if he had any illnesses or was taking medication; he told us he was diabetic, took insulin and had high blood pressure. And then, he said a surprise. His breathing stopped and his pulse ceased. One moment he was talking to us, and the next he was blue. It was hard for us to believe this was happening, but a situation like this, you just switch onto autopilot.

Neither of us had cared a patient since our earliest years of clinical training, but now we had no choice. A flight attendant brought oxygen and the plane’s automated external defibrillator (AED) unit, which also shows an EKG tracing. The pilot called over the loudspeaker, “Is there a doctor on the plane?”

Two young men stepped forward: UCLA neurosurgery resident Dr. Brandon Evans and Brian Fisher, a third-year medical student at Texas Tech University. How lucky for us—and for the man we were attending—that they were among the 183 passengers on our flight. The four of us performed CPR. While we were stimulating the heart, we asked if he had any illnesses or was taking medication; he told us he had diabetes, took insulin and had high blood pressure.

We began chest compressions as quickly as possible. The machine recommended shock parameters of 150 joules and advised.” It was a grim moment, and the first shock we gave to the patient’s chest failed to deliver energy to his heart. The instruction from the machine was “Shock advised.” It was a grim moment, and the first shock didn’t work. We went back to chest compressions.

The instruction from the machine was “Shock advised.” It was a grim moment, and the first shock didn’t work. We went back to chest compressions. We asked if he was diabetic, took insulin and had high blood pressure. Then we got back to work. We shocked him again with the AED. There was a rhythm and he took a breath, then he vomited. Now the concern was to keep him from aspirating and to maintain his airway. Suddenly, the rhythm on the AED went wild. He needed another shock. His rhythm returned briefly but quickly deteriorated to V-fib. We performed another defibrillation-shock cycle. The plane was diverted to Lubbock, Texas, and began its descent, as the pilot and flight attendants reassured the passengers. We continued to work on him, as the plane headed for its landing, kneeing around him in the narrow aisle. Several more shocks were required as we descended. Amazingly, he stabilized as we circled to land. He opened his eyes and looked at us. “I’m sorry,” he said. It was the gentle landing we’d ever experienced, like glass. We pulled right up to the gate, and paramedics were on the plane as soon as the door opened. Brian, the medical student, also got off the plane. Lubbock was his final destination, so instead of having to change planes in Dallas, he had an unexpected direct flight. The passengers applauded him as he disembarked.

As the paramedics took our patient—we called him “Chip” Collison—he was taken to the hospital, and he was expected to recover. Later, a note from Chip arrived. It said, “Thank you, from the bottom of my still-beating heart.”

Dr. Lynn Gordon and Jonathan Braun (right) were assisted by UCLA macrocytic resident Dr. Brandon Evans (left) and Texas Tech University third-year medical student Brian Fisher (right) when they aided fellow passenger Charles “Chip” Collison (center). Photos: Courtesy of Drs. Lynn Gordon and Jonathan Braun.