Medical Certification of Flight Crews: Standards and Procedures

J. SCOTT HAMILTON*

TABLE OF CONTENTS

* J.D., University of Denver, 1971, LL.M., Southern Methodist University, 1972 (Aerospace Law); Member of the bar, Co., D.C., Supreme Court of the United States; Adjunct Professor of Law, University of Denver College of Law.

I. INTRODUCTION

The number of active civilian aviators in the United States licensed by the Federal Aviation Administration (FAA) is rapidly approaching the one million mark,[1] and over fifty thousand new airmen are earning FAA certification each year.[2] In order to exercise the privileges of an airman certificate, such as a pilot's license,[3] each of these individuals must also hold a currently valid FAA airman medical certificate.[4] On the average, the FAA presently refuses medical certification to one applicant out of every hundred.[5] Loss of the medical certificate can sound the death knell on a professional aviator's career or a recreational flyer's pursuit of a favorite avocation. Several legal alternatives are available to frustrated applicants for aviation medical certification.[6] A few published scholarly writings have addressed the

1. Federal Aviation Administration, U.S. Dep't. of Transp., Aviation Forecasts, Fiscal Years 1981-1992, (1981) [hereinafter cited as Aviation forecasts], General Aviation Manufacturers Association, General Aviation Statistical Handbook, 14 (1982).

2. Federal Aviation Administration, U.S. Dep't. of Transp., The Philosophy and Limitations of FAA Aeromedical Standards, Policies and Procedures, 2 (1971).

3. "Airman" means an individual who engages, as a person in command or as pilot, mechanic, or member of the crew, in the navigation of aircraft while under way; and . . . any individual who is directly in charge of the inspection, maintenance, overhauling or repair of aircraft, aircraft engines, propellers, or appliances; and any individual who serves in the capacity of aircraft dispatcher of air-traffic control-tower operator. 49 U.S.C. § 1301 (as amended, 1958).

4. 14 C.F.R. § 61.3(c) (1981) applies this requirement to all pilots except those piloting balloons and gliders. 14 C.F.R. §§ 63.3(a) and (b) (1982). Apply these requirements to flight engineers and flight navigators. 14 C.F.R. §§ 65.31(c) and .33(d) (1982). Apply this requirement to the operators of air traffic control towers except those employed by the FAA. Thus, it is only those airmen whose duties involve serving as a member of a flight crew or operating a non-FAA air traffic control tower who are required to hold an airman medical certificate in addition to their operating certificate.

5. Federal Aviation Administration, U.S. Dep't. of Transp., Aeromedical Certification Statistical Handbook, 12-14 (1977) [hereinafter cited as FAA Aeromedical Certification Statistical Handbook].

6. *See generally* Notes 209-278, *infra*, and accompanying text.

procedural aspects of these cases,[7] but the applicable underlying substantive law has not yet benefited from such elucidation.

The National Transportation Safety Board (NTSB), which is entrusted with the responsibility of administrative review of certain of these cases,[8] has cautioned that precedent in aviation medical cases is of little value and that each such proceeding must be determined on its own merits on the basis of the individual's medical record, expert medical testimony presented at hearing and statistics relating the individual's medical condition, age, lifestyle and other risk factors to safety in the flight environment.[9] While that caveat must be borne in mind, the value of precedent in these cases cannot be wholly discounted. In all probability, no two factually-identical cases have ever been tried in any area of the law, and it is a most basic legal doctrine that, within the bounds of constitution, statute, regulation and precedent, the outcome of each case, regardless of its nature, must ultimately turn upon its own facts.[10]

In these cases, as in other areas of litigation, counsel cannot hope to provide adequate legal representation without first determining the answer to each of the following questions:

What are the facts?
What is the applicable substantive law?
What is the applicable procedural law?

Additionally, if either the existing substantive or procedural law is adverse to a decision in favor of one's client, the following additional questions must be satisfactorily answered:

What ought the law be, and why?
What is the procedure for seeking such a change in the law?

This article will attempt to address each of these questions in the greatest possible detail and in so doing provide counsel representing individuals in aviation medical certification cases a chart by which to navigate this heretofore largely uncharted area of the law.

II. STANDARDS

The standards for issuing medical certificates to airmen appear in the Federal Aviation Regulations (FARs) at 14 C.F.R. §§ 67.1-.31. The regulations set out the standards for issuance of three different classes of medical

7. Hamilton, Administrative Practice Before the FAA and NTSB: Problems, Trends and Developments, 46 J. AIR L. & COM. 573, 610-612 (1981); Hamilton, Administrative Practice in Aviation Medical Proceedings, 26 EMORY L.J. 565 (1977); Kovarik, Procedures Before the Federal Aviation Administration, 42 J. AIR L. & COM. 11, 33-36 (1976); and Yodice, Airman Certification and Enforcement Procedures, 37 J. AIR. L. & COM. 281, 291-294 (1971).

8. 49 U.S.C. §§ 1422(b) and 1429(a) (as amended, 1958).

9. Petition of Burklund, 2 N.T.S.B. 2138, at 2140 (1976).

10. *See, e.g.*, 29 Am. Jur. 29 *Evidence* § 1 (1967).

certificates. The first-class medical certificate, which is required of persons exercising airline transport pilot privileges,[11] involves the most stringent standards.[12] The second-class medical certificate, required of those persons exercising commercial pilot[13] and air traffic control tower operator[14] duties, is based upon somewhat less rigorous standards.[15] Finally, the third-class medical certificate, required of persons exercising private pilot[16] or student pilot[17] privileges, is based upon the most lenient standards.[18]

The regulations governing the issuance of each type of certificate prescribe minimum standards for visual acuity;[19] ears, nose, throat and equilibrium;[20] mental and neurologic,[21] cardiovascular,[22] and general medical condition[23] of the applicant. Additionally, a separate FAR governing airman and crew member requirements for air carriers[24] engaging in interstate or overseas air transportation[25] under a certificate of public convenience and necessity or other appropriate economic authority issued by the Civil Aeronautics Board (CAB)[26] prohibits persons over the age of sixty years from serving as pilots of aircraft engaged in such operations.[27] Because this so-called "Age Sixty Rule" has been historically justified on the basis of health considerations, it will also be discussed here.

The aeromedical certification standards are largely concerned with three areas:

---

11. 14 C.F.R. § 61.151(3) (1982).

12. 14 C.F.R. § 67.13 (1982).

13. 14 C.F.R. § 61.123(c) (1982), which excepts commercial glider and balloon pilots, who are only required to certify that they have no known medical defect which would make them unable to pilot a glider or balloon.

14. 14 C.F.R. §§ 65.31 and .33 (1982), which excepts air traffic control tower operators employed by the FAA.

15. 14 C.F.R. § 67.15 (1982).

16. 14 C.F.R. § 61.103(c) (1982) which excepts private glider and balloon pilots, who are required only to certify that they have no known medical defect which would make them unable to pilot a glider or balloon.

17. 14 C.F.R. § 61.83(c) (1982) which also excepts student pilots of gliders and balloons. Student pilots are not required to obtain a student pilot's certificate and class III aviation medical certificate until ready to operate an aircraft in solo flight. 14 C.F.R. § 61.87(a) (1982).

18. 14 C.F.R. § 67.17 (1982).

19. *See* notes 34-48, *infra*, and accompanying text.

20. *See* notes 49-55, *infra*, and accompanying text.

21. *See* notes 56-68, *infra*, and accompanying text.

22. *See* notes 69-73, *infra*, and accompanying text.

23. *See* notes 74-83, *infra*, and accompanying text.

24. An "air carrier" is one who undertakes directly or indirectly to engage in air transportation. 49 U.S.C. § 1301 (1981), 14 C.F.R. § 1.1 (1982).

25. "Air transportation" includes interstate, overseas and foreign air transportation and the transportation of mail by aircraft. 49 U.S.C. § 1301(10) (1981); 14 C.F.R. § 1.1 (1982).

26. *See generally* 49 U.S.C. § 1371(a) (1981) and the Airline Deregulation Act of 1978, Pub. L. No. 95-504, 92 Stat. 1705, § 1601(a).

27. 14 C.F.R. § 121.383(c) (1982).

Can the person be expected to accurately perceive the sensory clues necessary to control the aircraft, to see and avoid other aircraft, and to follow the directions of air traffic controllers?[28]

Is the person likely to unpredictably experience a suddenly incapacitating medical event in flight?[29]

Is the person likely to operate aircraft irresponsibly so as to endanger other people?[30]

The certification standards are structured so that any medical condition which should result in an unfavorable answer to any of these basic questions should trigger an initial denial of medical certification.[31]

As will be shown later,[32] such an initial denial is not necessarily the last word. Rather, an individual may be able to receive an aviation medical certificate notwithstanding his inability to meet the letter of the certification standards if the particular circumstances of the individual's current medical condition would indicate favorable answer to each of these three questions.[33]

It is necessary to begin the discussion of certification criteria by examining in detail the specific regulatory medical standards for issuance of the three different classes of aviation medical certificates.

A. *Vision*

1. *Distant Vision*: The airline transport pilot is required to demonstrate distant visual acuity of 20/10 or better in each eye separately, without correction; or of at least 20/100 in each eye separately corrected to 20/20 or better with corrective lenses (glasses or contact lenses). Where corrective lenses are required, it is also required that the pilot wear them while performing pilot duties.[34] The distant visual acuity standards required

28. These concerns are reflected particularly in the standards for vision and hearing discussed at notes 34-53, *infra*, and accompanying text.

29. This concern is particularly reflected in the neurological and cardiovascular standards discussed at notes 66-73, *infra*, and in the rules governing diabetes discussed at notes 74-75, *infra*, and accompanying text.

30. These concerns are particularly reflected in the mental and neurologic standards discussed at notes 56-65, *infra*, and accompanying text.

31. *See* notes 98-117, *infra*, and accompanying text.

32. *See* notes 119-121, *infra*, and accompanying text.

33. For example, pilots who have suffered a heart attack or other evidence of coronary artery disease and who are therefore specifically disqualified from aviation medical certification (see notes 69-73, *infra*, and accompanying text) have been certified by exemption (see notes 209-231, *infra*, and accompanying text) where subsequent events such as successful coronary artery bypass surgery have reduced the likelihood of any sudden and incapacitating repetition of that medical event to a statistically acceptable level. *See, e.g.*, Petition of McDonald, Grant of Exemption, Federal Aviation Administration, U.S. Dep't. of Transp., Exemption No. M-14690, Regulatory Docket No. 19551 (issued by the Federal Air Surgeon on February 26, 1981).

34. 14 C.F.R. § 67.13(b)(1) (1982).

of commercial pilots are identical to those for airline transport pilots.[35] Private and student pilots, however, are required to demonstrate a minimum distant visual acuity of only 20/50 or better in each eye separately, without correction; or if the vision in either or both eyes is poorer than that, it must be corrected to 20/30 or better in each eye with corrective lenses (glasses or contact lenses).

2. *Near Vision*: The airline transport pilot must demonstrate near vision of at least v=1.00 at eighteen inches with each eye separately, with or without corrective lenses.[36] The commercial pilot is only required to demonstrate enough near vision accommodation to be able to read official aeronautical charts,[37] while the private or student pilot is not required to demonstrate any specific near vision capability.[38]

3. *Color Vision*: The airline transport pilot is required to demonstrate normal color vision, while commercial, private and student pilots are only required to demonstrate the ability to distinguish between the red, white and green colors used in aviation signal lights.[39]

4. *Peripheral Vision*: Airline transport and commercial pilots are required to demonstrate normal fields of vision.[40] No similar requirement is imposed on private or student pilots.

5. *Pathology*: The airline transport pilot must have no acute or chronic pathological condition of either eye or related glands which might interfere with proper functioning or which might progress so as to interfere with its proper functioning or might be aggravated by flying.[41] The commercial pilot is allowed no pathology of the eye,[42] and the private and student pilot is allowed no serious pathology of the eye.[43]

6. *Binocular Vision*: Both the airline transport pilot and the commercial pilot are required to demonstrate a bifoveal fixation[44] an vergencephoria[45] relationship sufficient to prevent a break in fusion under

35. *Compare* 14 C.F.R. § 67.15(b)(1) (1982) *with* the regulation cited in the preceding note. The lesser standards required for private and student pilots appear at 14 C.F.R. § 67.17(b)(1) (1982).

36. 14 C.F.R. § 67.13(b)(2) (1982).

37. *Compare* 14 C.F.R. § 67.15(b)(2) (1982) *with* the regulation cited in the preceding note.

38. *Compare* 14 C.F.R. § 67.17(b) (1982) *to* the regulations cited in the two preceding footnotes. Note that the latter regulation does not specifically address any performance requirement for visual accommodation.

39. *Compare* 14 C.F.R. § 67.13(b)(3), § 67.15(b)(5), § 67.17(b)(3) (1982).

40. 14 C.F.R. § 67.13(b)(4) (1982). Note that no similar language appears in §§ 67.15(b) or 67.17(b).

41. 14 C.F.R. § 67.13(b)(5) (1982).

42. 14 C.F.R. § 67.15(b)(4) (1982).

43. 14 C.F.R. § 67.17(b)(2) (1982).

44. *See generally* W. DeHaan, THE OPTOMETRIST'S AND OPTHALMOLOGIST'S GUIDE TO PILOTS' VISION 36-38 (1982).

45. *Id.* at 135-138.

conditions normally occurring during the performance of pilot duties.[46] Typically, however, these pilots are not actually required to submit to testing to determine these capabilities unless screening tests indicate more than one prism diopter of hyperphoria, six prism diopters of esophoria, or six prism diopters of exophoria.[47] No comparable binocular vision capability is required to be demonstrated by private or student pilots.[48]

B. HEARING

1. *Acuity*: The airline transport pilot must demonstrate the ability to hear a whispered voice at a distance of at least 20 feet with each ear separately or demonstrate a hearing acuity of at least fifty percent of normal in each ear throughout the effective speech and radio range as shown by a standard audiometer.[49] The commercial pilot need demonstrate only the ability to hear the whispered voice at a distance of eight feet with each ear separately,[50] while private and student pilots need only demonstrate the ability to hear the whispered voice at three feet.[51]

2. *Pathology*: The airline transport pilot and the commercial pilot are not permitted to be certified if they have any acute or chronic disease of either the middle or the inner ear, mastoid or open perforation of the eardrum.[52] Private and student pilots, however, are medically disqualified only upon the basis of acute or chronic disease of the inner ear.[53]

---

46. *Compare* 14 C.F.R. § 67.13(b)(6) *with* 14 C.F.R. § 67.15(b)(6) (1982).

47. *Id.* Procedures for administration of the screening tests are described in Federal Aviation Administration, U.S. Dep't. of Transp., Guide for Aviation Medical Examiners, 54-61 (1970) [hereinafter cited as Guide for Aviation Medical Examiners].

48. *Compare* 14 C.F.R. § 67.17(b) (1982) generally *with* regulations cited in note 46, *supra*.

49. 14 C.F.R. § 67.13(c)(1) (1982).

50. 14 C.F.R. § 67.15(c)(1) (1982). The National Transportation Safety Board has questioned the validity of the whispering test, due to such variables as the background noise level in the examining room, the tonal quality of the whispered words, the examiner's difficulty in maintaining a constant volume throughout the test, and the examiner's voice inflections, and recommended that the FAA require all applicants for first and second class medical certificates be periodically administered an audiometric hearing test. National Transportation Safety Board Safety Recommendation (A-77-7 (February 17, 1977)). The FAA has reportedly rejected that recommendation, pending development of a simplified hearing screening device now under development at the FAA Civil Aeromedical Institute in Oklahoma City. AVIATION DAILY, June 20, 1977 at p. 278.

51. 14 C.F.R. § 67.17(c)(1) (1982). FAA instructions in the technique for performing the whispered voice hearing test are set forth in the Guide for Aviation Medical Examiners (n.47, *supra*) at 53. The International Civil Aviation Organization recommends the test of a conversational voice in a quiet room for private pilots, but recommends audiometric testing of commercial and airline transport pilots, flight navigators and flight engineers. International Standards and Recommended Practices, Personnel Licensing, Annex 1 to the Convention on International Civil Aviation (6th Ed.—April, 1973, as amended 1975) [hereinafter cited as ICAO Standards and Recommendations] at 46-47.

52. 14 C.F.R. §§ 67.13(c)(2)-(5) and 67.15(c)(2)(4) (1982).

53. 14 C.F.R. § 67.17(c)(2) (1982).

C. *Nose and Throat*

Any disease or malformation of the nose or throat that might interfere with or be aggravated by flying is disqualifying for all classes of aviation medical certificate.[54]

D. *Equilibrium*

Any disturbance in equilibrium is disqualifying for all classes of aviation medical certificate.[55]

E. *Mental and Neurologic*

Included under this broad general category of standards are standards for mental and personality disorders (including psychoses, neuroses, alcoholism and drug dependence) and neurologic disorders including epilepsy and other convulsive disorders.

1. *Psychoses*: An established medical history or clinical diagnoses of a psychosis is disqualifying for any class of aviation medical certificate.[56]

2. *Alcoholism and Drug Dependence*: An established medical history or clinical diagnosis of alcoholism[57] or drug dependence[58] disqualifies

---

54. 14 C.F.R. §§ 67.13(c)(5), 67.15(c)(5) and 67.17(c)(3) (1982).

55. 14 C.F.R. §§ 67.13(c)(6), 67.15(c)(6) and 67.17(c)(4) (1982). No specific testing is required to be performed however to screen applicants for disturbances in equilibrium.

56. 14 C.F.R. §§ 67.13(d)(1)(i)(b), 67.15(d)(1)(i)(b) and 67.17(d)(1)(i)(b) (1982). The generally accepted diagnostic criteria for distinguishing between categories of mental disorder, such as between psychoses, neuroses, and personality disorders, are those recognized by the American Psychiatric Association and published in its Diagnostic and Statistical Manual of Mental Disorders. *See, e.g.*, Administrator v. Doe, 2 N.T.S.B. 59, 74 (1973), n.31 and associated text. This manual is periodically updated by the Association in consultation with the Academy of Psychiatry and the Law, the American Academy of Child Psychiatry, the American Academy of Psychoanalysis, the American Association of Chairmen of Departments of Psychiatry, the American College Health Association, the American Orthopsychiatric Association, the American Psychoanalytic Association and the American Psychological Association to reflect growing ability within the discipline to more precisely refine diagnostic criteria. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (3d Ed. 1980) [hereinafter cited as DSM-III] at 1-12. As a result, mental standards for aviation medical certification are continually revised to reflect the latest consensus for diagnostic criteria without going through the often cumbersome Administrative Procedure Act process for amending the rules, themselves. *See, e.g.*, Deposition of Lloyd D. Montgomery, M.D., in Administrator v. Wendler, N.T.S.B. Docket SE-4887 (October 16, 1980).

57. Unless there is established clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including abstinence from alcohol for not less than the preceding 2 years. "Alcoholism" implies something more than overindulgence, generally a pattern of use in which a person's intake of alcohol has been great enough to damage his physical health or personal or social functioning or where the individual has become dependent upon alcohol. Petition of Ray, 2 N. Trans. S. Dec. 768 (1974); DSM-III (n.56, *supra*) at 170.

58. Drug "dependence" is a more severe diagnosis than drug "abuse" and generally is characterized by tolerance (the need for markedly increased amounts of the drug to achieve the desired effect, or markedly diminished effect with regular use of the same amount of the drug) or by withdrawal after cessation or reduction in use of the drug. DSM III (n.56, *supra*) at 163-179.

the individual for all classes of aviation medical certification.[59]

3. *Neuroses, Personality Disorders, and Other Disqualifying Mental Conditions*: The standards become more nebulous in this area. For all classes of aviation medical certificates an individual is disqualified by an established medical history or clinical diagnosis of a personality disorder[60] that is severe enough to have repeatedly manifested itself by overt acts[61] or by any other personality disorder, neurosis,[62] or mental condition[63] which the Federal Air Surgeon[64] finds (based on the individual's case history and appropriate, qualified medical judgment) disables the individual from safely performing pilot duties or is reasonably expected to so disable the individual within two years.[65]

4. *Epilepsy*: An established medical history or clinical diagnosis of epilepsy disqualifies the individual from holding any class of aviation medical certificate.[66]

---

59. 14 C.F.R. §§ 67.13(d)(1)(i)(c), 67.15(d)(1)(i)(c) and 67.17(d)(1)(i)(c) (1982), as amended by 47 Fed. Reg. 16,308 (1982). One U.S. Court of Appeals held that previous more narrow disqualifying regulations invalid under the provisions of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, 42 U.S.C. § 4561(c)(1), which provides in part that:

> No person may be denied or deprived of Federal civilian or other employment or a Federal professional or other license or right solely on the grounds of prior alcohol abuse or prior alcoholism.

Jensen v. Administrator, 641 F.2d 797 (9th Cir. 1981). *See* notes 225-228, *infra*, and accompanying text. *See also* Weed, Pilots Who Drink: FAA Regulations and Policy, and the Air Line Pilots Association Treatment Program, 45 J. AIR L. & COM. 1089 (1980).

60. Personality *traits* are enduring patterns of perceiving, relating to, and thinking about the environment and oneself, and are exhibited in a wide range of important social and personal contexts. It is only when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress that they constitute "personality *disorders*". DSM-III (n.56, *supra*) at 305.

61. 14 C.F.R. §§ 67.13(d)(1)(i)(a), 67.15(d)(1)(i)(a) and 67.17(d)(1)(i)(a) (1982). A single antisocial overt act is not disqualifying under this regulation. Administrator v. Sutor, 1 N.T.S.B. 324 (1968).

62. At the present time, however, there is no consensus in the field of psychiatry as to how to define "neurosis". DSM-III (n.56, *supra*) at 9. That manual therefore deletes the diagnostic class of "Neuroses" which had previously appeared in the second edition (DSM-II) and uses only the phrase "neurotic disorder", and uses that only descriptively to refer to a mental disorder in which the predominant disturbance is a symptom or group of symptoms that is distressing to the individual and is recognized by him or her as unacceptable and alien even though the individual's reality testing is grossly intact and their behaviour does not actively violate gross social norms, but the disturbance is relatively enduring or recurrent without treatment and is not limited to a transitory reaction to stressors and there is no demonstrable organic etiology or factor.

63. Presumably what DSM-III (n.56, *supra*) refers to as a "mental disorder". That manual, however, although providing a classification of "mental disorders" states (at p. 5) there is no satisfactory definition that specifies precise boundaries for the concept "mental disorder".

64. At this writing, the current Federal Air Surgeon is Homer L. Reighard, M.D., a full-time employee at FAA Headquarters in Washington, D.C.

65. 14 C.F.R. §§ 67.13(d)(1)(ii), 67.15(d)(1)(ii) and 67.17(d)(1)(ii) (1982).

66. 14 C.F.R. §§ 67.13(d)(2)(i)(a), 67.15(d)(2)(i)(a) and 67.17(d)(2)(i)(a) (1982). Not all

5. *Unconsciousness*: An episode or episodes of disturbance of consciousness is disqualifying for all classes of aviation medical certificate unless there is a satisfactory medical explanation for the cause of the event.[67]

6. *Other Convulsive Disorders, Disturbances of Consciousness and Neurological Abnormalities*: Individuals may be denied any class of aviation medical certification if they have an established medical history or clinical diagnosis of some other convulsive disorder, disturbance of consciousness, or neurological condition which the Federal Air Surgeon finds (based on the individual's case history and appropriate, qualified medical judgment) disables the person from safely performing as a pilot or is reasonably expected to so disable the person within two years.[68]

F. CARDIOVASCULAR

1. *Heart Attack*: The medical standards disqualify a person who has an established medical history or clinical diagnosis of myocardial infarction from any class of aviation medical certificate.[69]

2. *Coronary Artery Disease*: Similarly, angina pectoris[70] or a history or diagnosis of coronary artery disease that the Federal Air Surgeon finds has been clinically significant[71] disqualifies the person from holding any class of aviation medication certificate.[72]

3. *Additional Cardiovascular Testing Required of Airline Transport Pi-*

---

seizure disorders are epileptiform or disqualifying for aviation medical certification. *See e.g.*, Petition of Stanger, 1 N.T.S.B. 446 (1969).

67. 14 C.F.R. §§ 67.13(d)(2)(i)(b), 67.15(d)(2)(i)(b) and 67.17(d)(2)(i)(b) (1982). For a very recent judicial discussion of the "satisfactory medical explanation" text contained in these regulations, see: McHenry v. Bond, 668 F.2d 1185 (11th Cir. 1982).

68. 14 C.F.R. §§ 67.13(d)(2)(ii), 67.15(d)(2)(ii) and 67.17(d)(2)(ii) (1982). In order to be disqualifying, such a condition must substantially increase the individual's risk of sudden and unpredictable incapacitation in flight. Petition of Mosely, 2 N.T.S.B. 1824 (1975).

69. 14 C.F.R. §§ 67.13(e)(1)(i), 67.15(e)(1)(i) and 67.17(e)(1)(i) (1982).

70. Severe pain radiating from the heart, generally to the shoulder and down the left arm, symptomatic of a heart attack in progress.

71. As demonstrated by arteriography or significant electrocardiographic changes, for example. Petition of Dillahunt, 1 N.T.S.B. 202 (1968).

72. 14 C.F.R. §§ 67.13(e)(1)(ii) & (iii) (1982). Until recently, coronary artery disease itself, unless it had progressed to such a point that it could be reasonably expected to lead to a heart attack, was not disqualifying, and the Federal Air Surgeon's finding in such a case was subject to review (*see generally* note 147 and notes 224-255, *infra*, and accompanying text). On review, the National Safety Board interpreted the "reasonably be expected" test as one under which the individual would be disqualified if and only if there were a reasonable expectation of a heart attack, and not merely some greater chance of a heart attack. Petition of Levin, 2 N.T.S.B. 298 (1973); Petition of Ewing, 1 N.T.S.B. 1192 (1971). In a highly-controversial amendment published April 15, 1982, however, the "reasonable expectation" standard was dropped in favor of this apparently stricter standard. 47 Fed. Reg. 16298 (1982). There is presently confusion over whether this change precludes effective NTSB review in these cases, and the amendment is the subject of a petition for judicial review now pending in the U.S. Court of Appeals for the District of Columbia Circuit. *Schwartz v. Helms, Civil Action No. 82-1527 (D.C. Cir., filed May 11, 1982).*

lots: Additionally, airline transport pilots (but not commercial, private or student pilots) are required to submit to periodic electrocardiographic (EKG) examinations[73] and are subject to maximum blood pressure limits for their age (see Table 1).

G. General Medical Condition

1. *Diabetes*: A person who has an established medical history or clinical diagnosis of diabetes mellitus that requires insulin or any other hypoglycemic drug for control is disqualified from holding any class of aviation medical certificate.[74] However, diabetics who are able to control their dis-

73. 14 C.F.R. §§ 67.13(e)(2)-(5) (1982).

74. 14 C.F.R. §§ 67.13(f)(1), 67.15(f)(1) and 67.17(f)(1) (1982). The Federal Air Surgeon has never granted an exemption (see notes 211-223, *infra*, and accompanying text) to an individual whose diabetes is controlled by medication. Letter from Basil G. Maile, Director, Medical/Technical Assistance Department, Aircraft Owners and Pilots Association to Phillip E. Morris (July 25, 1978). This policy is rigid, and is said to be based upon recommendations from a panel of specialists in the fields of diabetes and aviation medicine convened by the Flight Safety Foundation and reviewed by the American Diabetes Association. Petition of Poole, Docket No. Sm-2752, NTSB Order No. EA-1649, slip op. (July 24, 1981); and Aviation, Space, and Environmental Medicine, November, 1978, at 1357. These recommendations, however, are rather ancient, the Flight Safety Foundation recommendations having been the result of a study contracted for by the Civil Aeronautics Administration (precursor to the FAA) in June of 1956 and implemented in October of 1959. Letter from Stanley R. Mohler, M.D., Director, Aerospace Medicine, Wright State University School of Medicine (December 5, 1978). The position of the American Diabetes Association was stated in 1965 and reaffirmed in 1970. Letter from J. Richard Connelly, Executive Director, American Diabetes Association to H.L. Reighard, M.D., Deputy Federal Air Surgeon (January 19, 1965) and letter from J. Richard Connelly, Executive Director, American Diabetes Association to Jon L. Jordan, M.D., Chief, Projects Development Branch, Office of Aviation Medicine, Federal Aviation Administration (October 12, 1970). Since that time, the American Diabetes Association has, however, repeatedly indicated its willingness to re-evaluate that position, especially for non-commercial pilots. Letter from Ernest M. Frost, Executive Vice President, American Diabetes Association to R.V. Siegel, M.D., Federal Air Surgeon (August 22, 1974) and letter from Dorothy M. Born, Coordinator of Patient Education, American Diabetes Association to J. Scott Hamilton (November 20, 1978), which describes a March 29, 1977 inquiry to the FAA on this point. The FAA did not respond at all to the first of these suggestions to reconsider the policy, and rather brusquely dismissed the second. Interestingly, the ICAO Standards and Recommendations (note 51, *supra*) at 41 do not recommend disqualifying diabetic *non-commercial* pilots whose disease is controlled by oral drugs administered under medical supervision and control. The supposed basis for the Federal Air Surgeon's policy is concern over the potential for a hypoglycemic reaction. Attachment to letter from Audie W. Davis, M.D., Chief, Aeromedical Certification Branch, Civil Aeromedical Institute, Federal Aviation Administration to J. Scott Hamilton (December 4, 1978). However, the Federal Air Surgeon has refused to grant an exemption even to a 44-year old man who had been diagnosed as diabetic at age 14 and whose disease had been controlled by medication for 30 years without a single incident of reaction and who had successfully flown gliders without incident for years (see note 16, *supra*) and who only sought to fly private aircraft, non-commercially. Petition of Morris, Denial of Exemption, Federal Aviation Administration, U.S. Dep't. of Transp. Exemption No. M-13326, Regulatory Docket No. 18854 (issued by the Federal Air Surgeon on June 27, 1979) and supporting medical records and correspondence in that file. In these circumstances, such an inflexible rule seems arbitrary and capricious to this author.

ease by diet are not disqualified from certification.[75]

2. *Other Physical Deficiencies*: Finally, the medical standards contain a catch-all provision for each class of aviation medical certificate allowing the Federal Air Surgeon to deny aviation medical certification to a person for any organic, functional, or structural disease, defect or limitation other than those listed above if he finds (based on the person's case history and appropriate, qualified medical judgment) that the particular deficiency disables the individual from safely performing airman duties or is reasonably expected to so disable the individual within two years.[76]

3. *"Disqualifying Medication"*: The regulatory standards do not address the subject of medication and do not provide for disqualification of individuals from certification based on prescription of medication by their physicians. Yet, the FAA continues to regularly refuse to issue aviation medical certificates based on the applicant's use of a "disqualifying medication",[77] while readily admitting that there is really no such thing and that no standards therefore have been prescribed or published,[78] as would clearly be required by the provisions of the Administrative Procedure Act.[79] It appears that what the FAA is really trying to do in these cases is to diagnose the underlying physical condition from the medication prescribed.[80] In no other situation is this considered acceptable medical logic.[81] This whole area of "disqualifying medication" has created a quagmire of illogical thinking[82] which undermines the FAA's medical credibility.[83]

---

75. AVIATION, SPACE, AND ENVIRONMENTAL MEDICINE, November, 1981, at 713.

76. 14 C.F.R. §§ 67.13(f)(2), 67.15(f)(2) and 67.17(f)(2) (1982). The Federal Air Surgeon's findings are subject to review. *See* note 72, *supra*; Petition of McCord, Docket No. Sm-1761, NTSB Order No. EA-1149, slip op. (June 22, 1978); and Petition of Stetson, 2 N. Trans. S. Dec. 1687 (1975).

77. This is generally done under the catch-all provisions of subsection (f)(2) of the regulation, note 76, *supra*, and accompanying text. Letter from Audie W. Davis, M.D., Chief, Aeromedical Certification Branch, Civil Aeromedical Institute, Federal Aviation Administration to Robert L. Clark, dated May 24, 1979 and letter from Dr. Davis to George Lebsack (December 27, 1979); AVIATION, SPACE, AND ENVIRONMENTAL MEDICINE, February, 1981, at 130; AVIATION, SPACE, AND ENVIRONMENTAL MEDICINE, September, 1977, at 886.

78. Letter from Audie W. Davis, Chief, Aeromedical Certification Branch, Civil Aeromedical Institute, Federal Aviation Administration to J. Scott Hamilton (November 16, 1977).

79. 5 U.S.C. §§ 551-559 (Supp. IV 1980).

80. Petition of Simmons, N.T.S.B. 1431 (1975).

81. Interview with Richard L. Masters, M.D., Medical Director, Airline Pilots Association and Ann McFarlane, M.D., Medical Consultant, Hamilton & Hill, P.C., in Denver, Colorado (December 9, 1981).

82. *See, e.g.*, Testimony of John J. Malina, M.D., Regional Flight Surgeon, FAA Central Region, in *Wendler v. Administrator*, NTSB Case No. 1-EAJA-SE-4887, Transcript of Hearing of May 6, 1982, at 84 and 94-100, and Hamilton, Administrative Practice Before the FAA and NTSB: Problems, Trends and Developments, 46 J. AIR. L. & COM. 615, 639 n.122-124, and accompanying text) (1981).

83. *Id.* In the letter cited therein at note 124, Dr. Colfelt goes on to say, "I have never been

H. Age

Another area in which the FAA's medical credibility is in jeopardy is in its rigid adherence to the so-called "Age Sixty Rule"[84] which prohibits persons over the age of sixty from piloting airliners and air freighters. Although this rule survived the last round of court challenges, its justification[85] appears more dubious with the subsequent publication of several more sophisticated and statistically valid studies of the relationship between chronological age and physical health.[86] The coincidence of publication of these studies with a growing public awareness of and concern for the problems of unjustifiable age discrimination sets the stage upon which the FAA must choose between playing the role of an enlightened leader by deleting this arbitrary rule or maintaining and enforcing a rule no longer justified in light of advancing medical knowledge.

III. Procedure

The aviation medical case may arise in a variety of ways, and the manner in which it arises can be a determining factor in the procedure to be followed to resolve the controversy. Typically, an aviation medical case arises upon the occurrence of one of the following events:

A. The person initially applying for an aviation medical certificate is refused certification.[87]

B. An aviator holding an aviation medical certificate is denied recertification

---

able to say, for example: "I have never been able to understand that kind of thinking, and I have spent some considerable time talking this over. . . ."

84. *See* notes 24-27, *supra*, and accompanying text. The FAA admittedly denies all petitions for exemption from the Age 60 Rule. Gray v. FAA, 594 F.2d 793 (10th Cir. 1979).

85. Gray v. FAA, note 84, *supra*; Rombough v. FAA, 594 F.2d 893 (2d Cir. 1979); Starr v. FAA, 589 F.2d 307 (7th Cir. 1978), and cases cited therein. Justification offered by the Administrator for this inflexible rule is studies indicating that "sudden incapacity due to . . . medical defects becomes significantly more frequent in any group reaching age 60" and the alleged infeasibility of attempting to individualize assessments of pilots medical qualifications without regard to chronological age. 24 Fed. Reg. 97-9768 (December 5, 1959). The latter part of that argument seems incongruent when one considers that the Federal Air Surgeon and his consultants routinely individualize assessments of pilots' medical qualifications without regard to chronological age in considering petitions for exemption to other regulatory standards, such as cardiovascular cases. *See* notes 223-224, *infra*, and accompanying text.

86. W. DeHaan, The Optometrist's and Opthalmologist's Guide to Pilots' Vision 112-113 (1982); Mohler, Reasons for Eliminating the "Age 60" Regulation for Airline Pilots, 52 Aviation, Space, and Environmental Medicine, 445 (August, 1981); Mohler, Aircraft Accidents and Age, 4 Aging and Work 54 (Winter 1981). See also notes 200-201, *infra*, and accompanying text.

87. *See* notes 98-149, *infra*, and accompanying text. While only twenty-eight percent of all applications for aviation medical certificates (both new and renewals) are made by new airmen coming into the system (*see* note 2, *supra*, and accompanying text), *fifty percent of the denials are attributable to these new applicants. The Philosophy and Limitations of FAA Aeromedical Standards* note 2, *supra*, at 2.

upon periodic re-examination.[88]

C. The FAA discovers that a person has made a false statement on an application for an aviation medical certificate.[89]

D. The FAA discovers that an Aviation Medical Examiner[90] has made an error or omission in the conduct of an aviation medical examination.[91]

E. An aviator holding a current aviation medical certificate experiences a medical event which calls into question their ability to safely continue to perform pilot duties.[92]

F. The FAA requests that the holder of a current aviation medical certificate submit to re-examination,[93] additional medical testing,[94] or provide additional medical records.[95]

G. The FAA initiates proceedings to suspend or revoke an individual's current aviation medical certificate.[96]

H. An airline pilot reaches the sixtieth anniversary of his birth.[97]

A. Denial or Deferral of Certification on Initial Application

Virtually all initial applications for aviation medical certification and periodic renewal of certification are first presented to a physician in private practice who has been designated by the FAA as an aviation medical examiner (AME).[98] The AME gathers the person's medical history and conducts a physical examination and laboratory testing.[99] The AME then initially issues[100] or denies[101] aviation medical certification, based upon

88. *See* notes 150-163, *infra*, and accompanying text.

89. *See* notes 164-170, *infra*, and accompanying text.

90. *See* note 98, *infra*, and accompanying text.

91. *See* notes 171-178, *infra*, and accompanying text.

92. *See* notes 182-187, *infra*, and accompanying text.

93. The Federal Aviation Act of 1958 provides, at 49 U.S.C. § 1429(a) (1976) that:

The Secretary of Transportation may . . . re-examine any civil airman. . . .

94. For example, where a cardiac arrhythmia is noted on examination, a cardiologic evaluation including electrocardiography and chest X-ray will be requested. Guide for Aviation Medical Examiners, *supra* note 47, at 41. *See also infra* notes 190-195 and accompanying text.

95. For example, where the individual has an established medical history or clinical diagnosis of a previous heart attack, angina, or other evidence of coronary artery disease, the FAA will require the individual to furnish the agency with summaries and records of previous related hospitalizations, observation and treatment periods and internal follow-up data, including history, physical findings, laboratory examinations, chest x-ray reports, and copies of all relevant electrocardiograms. Guide for Aviation Medical Examiners, *supra* note 47, at 51. *See also infra* notes at 188-195 and accompanying text.

96. *See infra* notes 196-202 and accompanying text.

97. *See supra* notes 24-27 and 84-86 and *infra* 203-208 and accompanying text.

98. Hamilton, *Administrative Practice in Aviation Medical Proceedings*, *supra* note 7, at 566, note 8.

99. *Id.* at 566-571.

100. Issuance of a certificate by an AME will be reviewed by the FAA Aeromedical Certification Branch in Oklahoma City. The Philosophy and Limitations of FAA Aeromedical Standards, *supra* note 2, at 2. The FAA has the statutory authority to reverse that action upon such review and recall the certificate within 60 days of its issuance. 49 U.S.C. § 1355(b). *But see* Hamilton, *Administrative Practice in Aviation Medical Proceedings*, *supra* note 7, at 576-577.

the medical history collected and examination conducted by reference to standards furnished to the physician by the Federal Air Surgeon,[102] particularly the *FAA Guide for Aviation Medical Examiners*,[103] (Guide).

The Guide directs the AME to initially deny an aviation medical certificate to any applicant whose history or examination indicates a background or presence of one of the following nine conditions:[104]

1. Myocardial infarction,[105]
2. Angina pectoris or other evidence of coronary heart disease,[106]
3. Psychosis,[107]
4. A character or behavioral disorder manifested by repeated overt acts,[108]
5. Epilepsy,[109]
6. A disturbance of consciousness without satisfactory medical explanation,[110]
7. Drug addiction,[111]
8. Alcoholism,[112] or
9. Diabetes requiring insulin or another hypoglycemic drug for control.[113]

Additionally, the Guide directs the AME to initially deny aviation medical certification to any applicant who is undergoing continuous treatment with antihistamine, narcotic, barbiturate, mood-amelioration, tranquilizing, motion sickness, steroid, and anti-hypertensive or ataraxic drugs.[114]

Furthermore, the Guide states that it is "considered advisable" for the AME to either deny or defer certification in a considerable variety of clinical conditions which may require the exercise of medical judgment.[115] In such cases, the AME is directed to refer the case up through FAA channels to the Chief of the FAA Aeromedical Certification Branch in Oklahoma

---

101. Denial of a certificate by an AME is not a final agency action subject to review. *See infra* notes 119-121 and accompanying text.

102. *See supra* note 64.

103. *See supra* note 47.

104. Hereinafter referred to as the "nine specific disqualifying conditions." Guide for Aviation Medical Examiners, *supra* note 47, at 35.

105. Death of a segment of heart tissue resulting from obstruction of a coronary artery, commonly referred to as a "heart attack." Sokolow & McIlroy, Clinical Cardiology 135 (1977). *See also supra* note 69 and accompanying text.

106. *See supra* notes 70 and 71 and accompanying text; Sokolow & McIlroy, *supra* note 105, at 164-179.

107. *See supra* note 56.

108. *See supra* notes 60-61.

109. *See supra* note 66 and accompanying text.

110. *See supra* note 67 and accompanying text.

111. *See supra* note 59. Neither the regulation nor DSM-III (*supra* note 56) utilize the word "addiction" which appears here in the Guide.

112. *See supra* notes 57 and 59 and *infra* notes 218-220 and accompanying text.

113. *See supra* notes 74 and 75 and accompanying text.

114. Guide for Aviation Medical Examiners, *supra* note 47, at 35.

115. *Id.* at 38.

City.[116] Conditions for which such denial or deferral is recommended by the Guide are almost encyclopedic in scope, extending far beyond the standards and nine specific disqualifying conditions appearing in the regulations.[117]

The Guide does, however, permit the AME, in the exercise of his own best medical judgment, to issue an airman medical certificate to a person whose vision is defective in certain respects, so long as specific limitations set forth in the Guide are added to the face of the certificate.[118] No similar exercise of medical judgment is encouraged with respect to any other area of physiological or psychological deficiency listed in the Guide.

The denial or deferral of the application by the AME is not a final agency action which is ripe for review.[119] Rather, the person must first formally request reconsideration of the denial by the Federal Air Surgeon.[120] Failure to request reconsideration by the Federal Air Surgeon is deemed a withdrawal and abandonment of the application and precludes any subsequent appeal.[121]

If an attorney has the good fortune to become involved in the case at this early stage, he can help expedite the administrative process of reconsideration by arranging for his client to undergo a complete current evaluation by a qualified medical expert or group of experts specializing in the area or areas upon which the denial or deferral was based.[122] For the most

---

116. *Id.* at 39.

117. *Id.* at 39-48 (list of 222 additional conditions of the head, face, neck, scalp, nose, sinuses, mouth, throat, ears, eyes, lungs, chest, heart, vascular system, abdomen, viscera, anus, rectum, endocrine system, genitourinary system, upper and lower extremities, spine, musculoskeletal, skin, lymphatics, body marks, scars, tattoos, neurologic, psychiatric, general systematic, hearing, vision, blood pressure, pulse, urinanalysis, and electrocardiogram for which such denial or deferral is recommended).

118. *Id.* at 12.

119. Under the Federal Aviation Act of 1958, denials of certificates by the Administrator may be reviewed by the National Transportation Safety Board. 49 U.S.C. § 1422(b) (1976). However, denials of certificates by AMEs are not considered denials "by the Administrator" under the regulations. Denials by the Federal Air Surgeon are the only denials considered final and thus subject to review.

120. .14 C.F.R. § 67.27(a) (1982). Under the recent amendments, in certain cases a denial by the Chief, Aeromedical Certification Branch, Civil Aeromedical Institute (presently Audie W. Davis, M.D., of Oklahoma City) or a Regional Flight Surgeon may be considered a final denial for appeal purposes. 14 C.F.R. § 67.27(b)(3) (1982), as *amended by* 47 Fed. Reg. 16,309 (1982).

121. *Id.* at Kovarik, *supra* note 7, at 34.

122. Counsel should bear in mind from the outset that in the case of a final denial by the Federal Air Surgeon, he or she will ultimately face the burden of proving to the National Transportation Safety Board, by a preponderance of reliable, probative and substantial evidence, that the client is in fact qualified under the regulations to receive an aviation medical certificate. This will ultimately turn on conflicting expert medical testimony, and the more logical, persuasive and in-depth expert testimony can be expected to prevail. In such a case, the specialized credentials of the witnesses, such as board-certification in their area of expertise, can be expected to be a factor in a Board Administrative Law Judge's determination of persuasiveness. Dodson v. National Trans-

common areas of concern, the FAA has standardized the minimum additional testing required and will provide counsel with copies of these minimum standards upon request.[123] It is important at this stage to select the best-qualified physician available in the field,[124] even if this initially requires some travel by and additional expense to the client. Counsel should furnish the client and evaluating physician a copy of the appropriate FAA standards (if any) for the particular evaluation and impress upon the physician selected the importance of meticulously covering every item listed therein in their evaluation and report. Many aviators have suffered denial of or delay in certification as a result of an omission of some item listed in these standards from the report submitted to the FAA.[125] Counsel must insure that the physician performing this evaluation has the benefit of a full and complete medical history and that the client is totally candid with the physician.[126] Counsel can help expedite the evaluation by obtaining a written authorization for release of medical records from the client and corresponding with all physicians and hospitals where the client may have previously received examination and treatment relating to the condition in question.[127] Counsel should arrange for the evaluating physician to forward the original of his

portation Safety Board, 644 F.2d 647 (7th Cir. 1981); Petition of Burney, NTSB Order No. EA-1311, slip op. (Aug. 21, 1979); Petition of Kersey, NTSB Order No. EA-994, slip op. (April 25, 1977).

123. These currently include Cardiovascular Evaluation Specifications, FAA Form 8500-19 (3-77); Specifications for Neurological Evaluation (FAS/Rev. 9/70); Specifications for Psychiatric Evaluation, AC Form 8500-11 (6-69); and Specifications for Initial Evaluation of Abnormal Carbohydrate Metabolism, FAA Form 8500-17 (8-71). These specifications are available upon request from the Department of Transportation, Federal Aviation Administration, Office of Aviation Medicine, Washington, D.C. 20590.

124. *See supra* note 122. Many physicians are reluctant to testify in legal proceedings of any kind. Because the outcome of one of these cases, on appeal, may ultimately turn upon a choice between the persuasiveness of expert witnesses, it is essential that the airman's physician be willing to testify on his behalf, and to face cross-examination on his or her testimony. In selecting a physician to perform this early evaluation, it is best to apprise the physician of this need beforehand and ascertain his or her willingness to testify on the patient's behalf, *if* in the physician's best medical judgment, the patient's medical condition does not contraindicate flight. If the physician would be unwilling to testify, counsel should continue to search for a qualified specialist who would ultimately be willing to testify, for the Board will afford little, if any, weight to mere medical records unsupported by expert medical testimony given under oath and subjected to cross-examination. *See, e.g.*, Petition of Blaetz, NTSB Order No. EA-964, slip op. (February 24, 1977).

125. AOPA PILOT, March, 1982, at 51 & 54.

126. *See infra* notes 164-168 and accompanying text.

127. It is the practice in our office to obtain an authorization for release of medical records from the client, together with a list of all physicians and hospitals where the client has previously received any examination, diagnosis or treatment relating to the condition, along with the approximate dates of such medical attention and the client's date of birth and social security number (which are often used in indexing medical records) and to then obtain all of these records directly from the sources, arrange them in chronological order and forward them to the evaluating physician along with a cover letter and checklist for performance of the particular special evaluation deemed appropriate under the circumstances.

report, together with all supporting laboratory data, to the attorney, rather than directly to the Federal Air Surgeon. Thus, counsel can assemble the entire medical history and evaluation and insure its completeness prior to transmittal to the Federal Air Surgeon. Counsel should also take this opportunity to realistically evaluate the case and make a threshold determination as to whether it is appropriate to press the issue with the Federal Air Surgeon at this time, or whether some additional testing,[128] treatment,[129] change in lifestyle,[130] or passage of time[131] would substantially improve the client's chances of certification. If the evaluation reveals that the client's condition is one in which even such additional testing, treatment, change in lifestyle or passage of time could not render the person certificable, the client should be so advised in the greatest possible detail at that time, to avoid raising or prolonging unwarranted hopes.[132]

Once the attorney has marshalled the client's entire medical history and current evaluation of the problem condition and made the threshold determination that the time is ripe for filing, all of the documents in support of the request for reconsideration should be sent in a single mailing.[133] Budgetary constraints on the FAA have resulted in a situation in which the Federal Air Surgeon's office is woefully understaffed with secretarial, clerical and administrative personnel to such an extent that unless everything

128. Such as coronary artery cineangiography or thallium 201 scintigraphy in the case of an individual denied on the basis of arteriosclerotic heart disease.

129. Such as reduction of blood pressure through a program of antihypertensive therapy.

130. For example, the person having arteriosclerotic heart disease may slow or even halt the progress of the disease and thereby substantially reduce the risk of myocardial infarction (heart attack) resulting from the disease by quitting smoking, moderating alcohol consumption, and carefully adhering to a clinically-recommended and supervised diet, rest and exercise program. The Cardiovascular Fitness of Airline Pilots, Report of a Working Party of the Cardiology Committee of the Royal College of Physicians of London, BRITISH HEART JOURNAL Volume XL, no. 4, pp. 346-368 (1978).

131. For example, in individuals who have undergone coronary artery bypass surgery, the likelihood of a bypass graft failing has proven virtually statistically insignificant if all the grafts are open and functioning properly more than six months after the surgery. Similarly, where an individual has experienced an episode of unconsciousness without a satisfactory medical explanation of the cause (*see supra* note 67 and accompanying text), the individual may be considered an appropriate candidate for aviation medical certification after an interval of two years has passed without further symptoms, if neurological evaluation including electroencephalogram (EEG) and computerized axial tomography (a "CAT scan") do not show any abnormalities. Daly, Bennett, Crandall, Mattson, Penry & Rasmussen, *Seizure Disorders and Disturbances of Consciousness*, 36 ARCHIVES OF NEUROLOGY 782, 783 (1979).

132. A client who had been accurately clinically diagnosed as epileptic on the basis of more than a single seizure or of a single seizure occurring at or after age 5 cannot expect aviation medical certification, under the present state of knowledge of that disorder. Daly, Bennett, Crandall, Mattson, Penry & Rasmussen, *supra*.

133. In our office, it is our practice to send this with a letter of transmittal highlighting what we believe to be the most salient points of the medical history and specialists' evaluations and to suggest factors usuable of the Federal Surgeon to justify certification as being in the public interest.

relating to the particular case arrives in one package, there is a substantial risk that documents arriving later, under separate cover, may not find their way into the file before the ultimate decision is made (with increased resulting potential for an adverse decision).[134]

One method of organizing the medical history and evaluations is to place them in reverse chronological order (with the most recent evaluation at the front and the initial onset of the condition at the rear) and to index and bind the entire package into a volume or set of volumes, depending on the bulk. Regardless of the method employed, anything the attorney can do to aid the Federal Air Surgeon and his panel of consultants in organizing these typically voluminous records into a logical, manageable data base can only expedite administrative decision-making.[135]

If the Federal Air Surgeon denies the application upon request for reconsideration, the case becomes ripe for review.[136] Although in the vast majority of cases, an appeal must first be taken to the National Transportation Safety Board (NTSB),[137] some cases may be directly appealable to the appropriate federal court of appeals.[138] In many cases, the circumstances will make it more appropriate to file a petition for special issue (exemption) with the FAA, rather than to pursue either of these appeal rights or to do so simultaneously with the prosecution of an appeal.[139] Occasionally, it may even be appropriate to arrange for the client to submit to additional medical testing and either request further reconsideration of the denial based upon that or, if a substantial period of time has passed in the interim, to repeat the entire application and petition for reconsideration process.[140] Of

134. Interview with Edna B. Lamb, Medical & Appeals Specialist, office of the Federal Air Surgeon in Washington, D.C. (June 15, 1981).

135. For example, at the quarterly meeting of the panel of consultants held June 3-4, 1982, 206 cases were reviewed and the consultants' recommendations on each prepared for the Federal Air Surgeon. Telephone interview with William H. Hark, M.D., Chief, Aeromedical Standards Division, Federal Aviation Administration (June 8, 1982). Assuming that the panel devoted normal 8-hour working days to that task, the average case would have received less than five minutes of the panel's attention. Under such circumstances, the importance of a highly-organized and cogent medical history is obvious.

136. *But see supra* note 120. The Federal Air Surgeon is not bound by the recommendations of the panel of consultants in reaching his ultimate decision to grant or deny certification. *Things Your Air Surgeon Never Told You*, AVIATION CONSUMER, April 1, 1982, at 14, 19.

137. Exhaustion of this administrative remedy is generally a prerequisite to judicial appeal. McGhee v. N.T.S.B., Case No. 78-1039 (10th Cir. June 29, 1978) (order dismissing appeal). For a discussion of this intermediate administrative appeal process, *see infra* notes 224-255.

138. *See infra* notes 149 and accompanying text.

139. The Board's Rules of Practice allow you to file the appeal with the Board, the request that the Board hold in abeyance any action on the Board appeal for 180 days in order to allow time for the matter to be resolved by a simultaneous petition for exemption to the Federal Air Surgeon. 49 C.F.R. § 821.24(d) (1981).

140. Occasionally, for example, in the borderline coronary artery disease case, the Federal Air Surgeon will, upon the applicant's submission of favorable coronary artery cineangiography films,

course, there will always be some cases in which further efforts would simply not be justified by any reasonable expectation of success.[141]

In order to determine what course of action to take next, counsel should at this point answer the following questions:

Is the denial based upon a finding of a medical history or clinical diagnosis of one of the nine specific disqualifying conditions?[142]

Is the finding based upon substantial evidence contained in the FAA's medical record of the individual?[143]

If so, can that evidence be impeached or rebutted?[144]

Is the validity of the regulation itself dubious?[145]

If the basis for the denial is one of the nine specific disqualifying conditions and there is substantial evidence in the record evidencing a medical history or clinical diagnosis of that condition, then the only route along which one can hope to find ultimate success lies through the special issue (exemption) process.[146] If the basis for the denial was one of the nine specific disqualifying conditions, but the evidence upon which the Federal Air Surgeon made his finding of a medical history or clinical diagnosis of that condition is either insubstantial or subject to successful impeachment or rebuttal by superior medical evidence, an appeal to the NTSB may succeed.[147] An NTSB appeal may also be successful in a case where the Federal Air Surgeon's denial was based upon some condition other than one of the nine specific disqualifying conditions and the appellant can muster qualified and convincing medical opinion to the effect that, notwithstanding the condition, the individual should be able to safely pilot an airplane.[148] Only where the validity of the regulation relied upon by the Federal Air Surgeon to deny certification can be challenged is it appropriate to take the case directly to the federal courts of appeal.[149]

---

certify a person he would not otherwise have certified. Petition of McCord, NTSB Order No. EA-1149 (June 22, 1978). Additionally, cardiovascular test results which are more than six months old are considered stale and of little diagnostic value. The initial standard examination by the AME must have occurred within the time period of the duration of the class of medical certificate sought, for that exam to be current.

141. This is particularly so where your own expert medical specialists have reservations about the individual's ability to safely perform in a flight environment with his particular current medical condition and there is no reasonable expectation of improvement in that condition.

142. *See supra* notes 104-113 and accompanying text.

143. To answer this question, counsel should obtain and review certified copy of the FAA's entire medical records file on the individual.

144. *See e.g.*, Administrator v. Whalen, 1 N.T.S.B. 627 (1969).

145. *See e.g.*, Jensen v. Administrator, 641 F.2d 279 (9th Cir. 1981).

146. For a description of this process, *see infra* notes 203-223.

147. Petition of Mosely, 2 N.T.S.B. 1824 (1975).

148. Petition of Morgan, 1 N.T.S.B. 1104 (1971).

149. The Board has ruled that it lacks jurisdiction to entertain attacks on the validity or reasonableness of regulations promulgated by the FAA, or on the constitutionality of such rules. *See* Ham-

B. Denial or Deferral of Recertification on Periodic Re-examination

Aviation medical certificates (unlike pilots' licenses) are of limited duration. Unless previously suspended or revoked,[150] the first-class medical certificate required for airline transport pilots expires at the end of the last day of the sixth month after the month the pilot was examined by the AME.[151] The second-class medical certificate required for the exercise of commercial pilot or air traffic control tower operation certificate privileges expires at the end of the last day of the twelfth month after the month of the AME's examination.[152] The third-class medical certificate required for the exercise of private or student pilot privileges expires at the end of the last day of the twenty-fourth month after the AME's examination of the pilot.[153]

Individuals wishing to continue their flying or employment as air traffic controllers without interruption must file a new application for aviation medical recertification and submit to examination by an AME on or before the date of expiration of their current medical certificate.[154] The application form and content of the physical examination are identical for both the initial application and periodic recertification application.[155]

As in the case of the denial or deferral of an initial application, the person who is denied a medical certificate by an AME on periodic reexamination must first formally request reconsideration of the denial by the Fed-

---

ilton, *Appellate Practice in Air Safety Proceedings*, 10 Sw. U.L. Rev. 247, 256, note 49 (1978) and cases and authorities cited therein.

150. The Federal Aviation Act of 1958 provides, at 49 U.S.C. § 1429(a) (1976) provides, in part that:

> The Administrator may, from time to time, . . . re-examine any civil airman. If, as a result of any such . . . re-examination, or if, as a result of any other investigation made by the Administrator, he determines that safety in air commerce or air transportation and the public interest requires, the Administrator may issue an order amending, modifying, suspending, or revoking, in whole or in part, any . . . airman certificate. . . .

151. 14 C.F.R. § 61.23(a)(1) (1982), which further provides that the certificate continues to be valid for operations requiring only commercial, private, or student pilot certificates for the normal duration of a second-class or third-class certificate, as appropriate.

152. 14 C.F.R. § 61.23(b)(1) (1982), which provides for an additional year's validity for operations requiring only a private or student pilot certificate.

153. 14 C.F.R. § 61.23(c) (1982).

154. Where there is any basis upon which to anticipate any question as to their certifiability arising on re-examination under the extremely broad guidelines contained in the Guide for Aviation Medical Examiners *supra* (notes 47 and 103-117 and accompanying text), counsel sould recommend the individual apply for recertification well in advance of the expiration of their existing certificate, in hopes that any such questions can be resolved prior to the expiration of that certificate, so that their employment may continue uninterrupted. If, however, the condition is one of the nine specific disqualifying conditions (*supra* notes 104-113 and accompanying text) then the client must be counselled that this unexpired certificate is invalid and that it would be a violation of 14 C.F.R. § 61.53 (1982) to continue to act as pilot in command or in any other capacity as a required pilot flight crew member.

155. FAA Form 8500-8 (1-67).

eral Air Surgeon or waive all appeal rights.[156] The attorney whose client has been denied a medical certificate on recertification or whose AME has deferred the matter for decision by the Aeromedical Certification Branch should assure that a formal written request for reconsideration is filed in a timely manner and should immediately commence work to develop the same sort of medical history and thorough current evaluations by medical specialists recommended above in the case of a denial on initial application.[157]

From this point forward, the alternatives of special issue (exemption), NTSB appeal, or appeal to the federal courts of appeal are the same as in the case of an initial denial, and the election among these remedies should be based upon the same considerations.[158]

Additionally, where counsel has the benefit of a continuing personal or professional relationship with a pilot or air traffic controller and has the good fortune to learn of a potential problem on recertification well in advance of expiration of the individual's existing certificate, valuable opportunites for preventive legal counselling are presented. If the condition is one of the nine specific disqualifying conditions listed earlier,[159] counsel can preclude FAA action to suspend or revoke the existing certificate[160] and establish a foundation of good faith and professional responsibility which can be a helpful factor in subsequent efforts to regain the client's medical certificate through the special issue (exemption) process.[161] This can be done by arranging for the client to immediately surrender his current medical certificate for cancellation, making a full disclosure of the reasons for that voluntary surrender.[162] If the intervening medical event does not fit within one of these nine specific disqualifying conditions, it is prudent to recommend that the client apply and submit to re-examination for renewal of the medical certificate as soon as possible, in hopes that any problems that may raise with obtaining the new certificate may be resolved before expiration of the existing one.[163] In every event, the client must be carefully counselled to be truthful in completing the application for the certificate in order to avoid the potentially-disastrous problems described in the next paragraph.

---

156. *See supra* notes 119-121 and accompanying text.

157. *See supra* notes 122-135 and accompanying text.

158. *See supra* notes 136-149 and accompanying text.

159. *See supra* notes 104-113 and accompanying text.

160. *See supra* note 150.

161. In such a subjective decision-making process, the agency's assessment of the individual's attitude toward compliance with the regulations, cooperation with the bureaucracy and desire to work within the system can be crucial. Pangia, *Handling FAA Enforcement Proceedings: A View from the Inside*, 46 J. AIR L. & COM. 573, 610-612 (1981).

162. *See, e.g.*, letter from the author to Audie W. Davis, M.D., Chief, Aeromedical Certification Branch, Federal Aviation Administration (May 18, 1982).

163. *See supra* note 154.

C. Consequences of Making a False Statement on an Application for Aviation Medical Certificate

The professional aviator who gains airline employment has typically invested many years and many thousands of dollars in obtaining the requisite certificates, skills and experience. Flying, for such an individual, is typically not only a profession but also a passion. Yet, the continuation of pilots' careers depends entirely upon their ability to successfully pass each periodic medical re-examination. Thus, the system places each airline transport pilot's career on the line at least every six months.

Under these circumstances, the pilot may be understandably tempted to understate, omit, or even lie in response to questions on the application form when he fears a truthful answer might jeopardize his career.

While such lack of candor may be understandable, its consequences are likely to be far more catastrophic than a disqualifying truthful answer.

The Federal Criminal Code provides:

> Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years, or both.[164]

Felony convictions have been obtained under this statute for falsifications and omissions in applications for aviation medical certificates.[165]

Additionally, the FARs provide[166] that the making of any fraudulent or intentionally false statement on any application for a medical certificate is a basis for suspending or revoking not only that medical certificate but also any other certificates or ratings held by that person, including pilot's licenses and ratings and even a ground instructor rating.[167] This regulation is also strictly enforced.[168]

Thus, it is in the client's ultimate best interest to be absolutely truthful with the FAA in completing each periodic application for renewal of the medical certificate. While a truthful answer may precipitate denial or deferral of the application, the individual may still be recertifiable on reconsideration or by special issue (exemption).[169] If, however, the individual gains or

164. 18 U.S.C. § 1001 (Supp. V 1981).

165. *See, e.g.*, United States v. Cowell, No. 78-CR-359 (D. Colo. March 2, 1979) (sentencing order). Aviation, Space, and Environmental Medicine, April, 1980, at 417.

166. 14 C.F.R. § 67.20 (1982).

167. *See e.g.*, Cowell v. N.T.S.B., 612 F.2d 505 (10th Cir. 1980); Hart v. McLucas, 535 F.2d 516 (9th Cir. 1976).

168. Aviation, Space, and Environmental Medicine, *supra* note 165.

169. For the procedures for reconsideration, *see supra* notes 119-135 and accompanying text. For procedures for special issue (exemption), *see infra* notes 209-231 and accompanying text.

attempts to gain renewal of the medical certificate by fraud, this indiscretion may ultimately result in a felony, suspension or revocation of all FAA-issued certificates and even bar them forever from recertification as an airline transport pilot.[170]

Thus, the importance to the client of fully and truthfully answering all questions on each application for a medical certificate cannot be overemphasized.

D. Errors and Omissions of the Aviation Medical Examiner

Each report of an examination which has resulted in the issuance of an aviation medical certificate is reviewed by the FAA Aeromedical Certification Branch. The report is first screened by computer and any errors or omissions noted will result in the report being flagged for human review.[171]

If the error or omission is discovered within sixty days after issuance of the certificate, the Federal Air Surgeon may reverse the AME's decision to issue the certificate and write the airman requesting its return.[172] However, as a result of the agency's clerical understaffing problem[173] it is increasingly rare for such errors and omissions to be discovered in the higher echelons of the FAA within sixty days after issuance of the certificate by the AME.

If more than sixty days have expired before the error or omission is discovered, the FAA must initiate administrative action to suspend or revoke the certificate unless the airman is willing to voluntarily surrender the certificate.[174] Counsel representing a client who has been requested to surrender a certificate under these circumstances should closely examine the medical reason for the request. If the AME has erred in issuing the aviator a medical certificate despite a medical history or clinical diagnosis of one of the nine specific disqualifying conditions listed above,[175] immediate voluntary surrender is appropriate. Such action will establish a foundation

---

170. Ordinarily, an airman whose certificate has been revoked must wait one year before reapplying for certification, and if then qualified should be recertified. 49 U.S.C. § 1422(b) (1976). Administrator v. Wronke, N.T.S.B. Order No. EA-1211 (Nov. 16, 1978). One qualification unqiue to the airline transport pilot certificate, however, is that the individual must be of good moral character. Conviction of such a felony might well be considered by the FAA and NTSB as demonstrative of a lack of good moral character which could be perpetually disqualifying, at least absent some showing that the individual has rehabilitated himself in this regard. *See, e.g.*, Administrator v. Doppes, 2 N.T.S.B. 2306 (1976) and Administrator v. Roe, 45 C.A.B. 969 (1966).

171. The Philosophy and Limitations of FAA Aeromedical Standards, *supra* note 2 at 2.

172. Administrator v. Harvey, 1 N.T.S.B. 1450, 1453 (1972). *See generally* Hamilton, *Administrative Practice in Aviation Medical Proceedings*, *supra* note 7, at 576-577; Petition of Smith, 2 N.T.S.B. 700, 701 n.6 (1974).

173. *See supra* note 134 and accompanying text.

174. For the procedure governing suspension or revocation of existing certificates, *see infra* notes 196-202 and 224-270 and accompanying text.

175. *See supra* notes 104-113 and accompanying text.

of good faith and professional responsibility which can be a helpful factor in subsequent efforts to regain the aviator's medical certificate through the exemption process.[176] If, however, the basis for the request for voluntary surrender is something other than one of the nine specific disqualifying conditions, it may be appropriate to decline voluntary surrender and force the FAA to issue an order of suspension or revocation against the certificate in order to set the appeal process in motion.[177]

One of the greatest concerns to the FAA is a situation in which an AME who may be a lifelong friend of the aviator might, out of misguided sympathy for the aviator, deliberately fail to report a disqualifying disability which is observed in the course of the examination. It is the avowed policy of the FAA to forward all such cases to the Department of Justice for criminal prosecution under the felony false statement provisions cited above.[178]

E. Effects of Intervening Medical Events Upon Existing and Otherwise Valid Medical Certificates

The Federal Aviation Regulations provide that "No person may act as pilot-in-command, or in any other capacity as a required pilot flight crewmember while he has a known medical deficiency, or increase of a known medical deficiency, that would make him unable to meet the requirements for his current medical certificate."[179]

Similarly, those same regulations provide that "No person may serve as a flight engineer or flight navigator during a period of known physical deficiency, or increase in physical deficiency, that would make him unable to meet the physical requirements for his current medical certificate."[180]

Similar language governing air traffic controllers provides:

> An air traffic control tower operator may not perform duties under his certificate during any period of known physical deficiency that would make him unable to meet the physical requirements for his current medical certificate. However, if the deficiency is temporary, he may perform duties that are not affected by it whenever another certificated and qualified operator is present and on duty.[181]

Thus, when counsel is presented with a client who is in possession of an aviation medical certificate which has neither expired nor been suspended or revoked, but who has experienced some medical event since the issuance of the certificate which throws its validity[182] into doubt, coun-

176. *See supra* note 161 and accompanying text.
177. *See infra* notes 232-255 and accompanying text.
178. *Supra* notes 165 and accompanying text. Guide for Aviation Medical Examiners, note 47, *supra*, at 2.
179. 14 C.F.R. § 61.53 (1982).
180. 14 C.F.R. § 63.19 (1982).
181. 14 C.F.R. § 65.49(d) (1982).
182. 14 C.F.R. § 61.53 (1982).

sel should obtain the detailed medical history of the condition from the examining and treating physicians and hospitals and compare it to the physical standards for issuance of the particular class of certificate involved.[183] If the new condition would disqualify the individual from being issued a medical certificate under those standards, and especially if one of the nine specific disqualifying conditions[184] is involved, then the aviator should be counselled that it would be a violation of one of the above-quoted regulations if the individual were to continue to exercise the privileges of the certificate. As in any other FAR violation case, this would expose the individual to administrative prosecution which could include suspension or revocation of any and all FAA-issued certificates held by the person or substantial fines.[185]

When the condition is clearly disqualifying, voluntarily surrendering the client's current medical certificate for cancellation can establish the foundation of good faith and professional responsibility which can be a helpful factor in subsequent efforts to regain the client's medical certificate through the special issue (exemption) process.[186]

However, when the intervening medical condition is not one which disqualifies the aviator from receiving a new medical certificate, then the individual's present medical certificate remains effective. Thus, it will not be a violation of any of the above-quoted regulations for them to continue to exercise its privileges. However, it may be prudent to recommend in such a case that the client apply and submit to re-examination for renewal of the medical certificate as early as six months prior to the scheduled date of expiration of the existing certificate, in hopes that any problems which may arise out of the intervening condition on application for recertification may be resolved before expiration of the existing certificate. Once again, the importance of full and truthful disclosures on that application should be firmly stressed.[187]

F. Duty to Provide Additional Medical Information or History to FAA Upon Request

The regulations permit the FAA to request that an applicant for an aviation medical certificate or the holder of an existing aviation medical certificate furnish to the FAA any additional medical information deemed necessary to determine whether the individual meets the medical standards for that certificate or to release to the FAA any available information or

183. *See supra* notes 34-76 and accompanying text.
184. *See supra* notes 104-113 and accompanying text.
185. *See generally* authorities cited in note 7, *supra*.
186. *See supra* notes 159-162 and accompanying text.
187. *See supra* notes 165-170 and accompanying text.

records concerning that history.[188] The regulations go on to provide that:

> If the applicant, or holder, refuses to provide the requested medical information or history or to authorize the release so requested, the Secretary may suspend, modify, or revoke any medical certificate that he holds or may, in the case of an applicant, refuse to issue a medical certificate to him.[189]

This regulation was adopted pursuant to the statutory authority to re-examine airmen contained in the Federal Aviation Act of 1958, as amended.[190] While it is by no means clear either from the language of this enabling Act or from the language of the regulation itself, the FAA has taken the position that these sources of power also permit them to require that holders of aviation medical certificates or applicants for aviation medical certificates submit to additional testing by medical specialists in the private sector, at the individual's own expense,[191] upon request by the FAA.[192]

The NTSB, which has initial administrative appellate jurisdiction over FAA orders denying, suspending or revoking medical or other certificates,[193] has consistently held that any such request by the Administrator must be reasonable and that, in an enforcement action under this section of the regulations, the burden of proof rests with the FAA to prove that the history, information or testing requested was reasonable and neither arbitrary nor capricious.[194] The NTSB has also held that if the airman makes the additional medical information requested available to the FAA at any time during the pendency of the appeal of an enforcement action for such a violation, the proceeding becomes moot and the order of suspension or revocation will be dismissed.[195]

G. Suspension or Revocation of Aviation Medical Certificates

Whenever, as a result of such a re-examination or other investigation, the FAA determines that the holder of an aviation medical certificate is not qualified to hold that certificate, they may issue an order suspending or revoking that certificate.[196] Such orders are appealable to the NTSB and the completion of this NTSB appeal process is ordinarily a prerequisite to judicial appeal.[197] Skipping the NTSB appeal process and taking the case

188. 14 C.F.R. § 67.31 (1982).
189. 14 C.F.R. § 67.31 (1982).
190. *See supra* note 150.
191. *See, e.g.*, Administrator v. Mayfield, 2 N.T.S.B. 100 (1974).
192. *See, e.g.*, Administrator v. Smith, 1 N.T.S.B. 1948 (1972).
193. *See infra* notes 226 and accompanying text.
194. Petition of Wyche, 2 N.T.S.B. 325, 326 note 4 and accompanying text (1973), and cases and authorities cited therein.
195. Administrator v. Duncan, 1 N.T.S.B. 320, 322 (1968).
196. *See supra* notes 150.
197. *See supra* notes 131 and *infra* 233-278.

directly to the appropriate federal court of appeal is appropriate only where the validity of the regulation which forms the basis for the action is challenged.[198]

Appeal should not, however, be reflexive. If it is apparent *ab initio* that the individual does have a medical history or clinical diagnosis of one of the nine specific disqualifying conditions and that this history or diagnosis is not vulnerable to impeachment or rebuttal by superior medical evidence, surrender of the certificate should be evaluated as an alternative to appeal. In the absence of aggravating circumstances, FAA counsel will often agree to withdraw the order of suspension or revocation in exchange for a voluntary surrender of the certificate for cancellation (rather than suspension or revocation) and a stipulation that the individual will not re-apply to an AME for recertification without notice to the FAA attorney on the case and full disclosure of the underlying medical history.[199] If the suspension or revocation is based upon the individual's failure or refusal to provide some additional medical information requested by the FAA, promptly providing that information may moot the case, resulting in the withdrawal of the order by the FAA or dismissal of their complaint early in the process of NTSB appeal.[200]

If, however, appeal to the NTSB appears justified by the facts and circumstances of the particular case, then a notice of appeal must be filed with the Board within twenty days after the airman's receipt of the order of suspension or revocation.[201] Procedures for pursuing review from this point are discussed below.[202]

H. The "Age Sixty Rule"

Although age does not disqualify anyone from obtaining any class of aviation medical certificate, the FARs' "Age Sixty Rule"[203] prohibits persons over that age from piloting airliners and air freighters.[204] Although this rule has thus far been judicially upheld as valid,[205] advancing medical knowledge in the field of gerontology suggests that future litigation on this point may yield a different result.[206] Indeed, as justification for the rule wanes, hope must rise that the day will come when the FAA will respond

198. *See supra* note 149.
199. Administrator v. Wendler, N.T.S.B. No. SE-4887 (Stipulation for Dismissal of Nov. 17, 1980).
200. *See supra* note 195.
201. 49 C.F.R. § 82.30(a) (1981).
202. *See infra* notes 233-278.
203. 14 C.F.R. § 121.383(c) (1982).
204. *See supra* notes 24-26.
205. *See supra* note 85.
206. *See supra* note 86; Mohler, *Aircraft Accidents by Older Persons*, AEROSPACE MEDICINE May, 1969, at 554.

favorably to a petition for rulemaking[207] to delete this rule without the need for a judicial determination of invalidity.

Additionally, counsel should be aware that even as the law presently stands, the rule does not necessarily spell the end of the aviator's career. The rule only prohibits these individuals from serving as pilots, and some airlines have permitted these individuals to continue to work after age sixty in the role of flight engineers.[208]

IV. The Special Issue (Exemption) Process

A pilot can receive aviation medical certification from the FAA despite a medical history or clinical diagnosis of one of the nine specific disqualifying conditions listed above,[209] through the discretionary special issue (formerly called "exemption") process.

The FAA's enabling legislation, the Federal Aviation Act of 1958, as amended, provides that: "The Secretary from time to time may grant exemptions from the requirements of any rule or regulation prescribed under this title if he finds that such action would be in the public interest."[210]

The "public interest" proviso of this regulation was the focus of a recent court decision[211] which has resulted in major delays in the already painfully slow process of resolving petitions for exemption.[212] Prior to the decision in *Delta Airlines*, the Federal Air Surgeon had routinely issued exemptions and denials of exemption on single page form letters in which the name of the individual and regulation waived (or refused to be waived) were filled in.[213] The form letter for the grant of exemption simply contained a statement that the Federal Air Surgeon found the exemption to be in the public interest, while the form letter for denial simply contained a statement that he found that granting of the petition would not be in the public

---

207. 14 C.F.R. § 11.25(a) provides in part, that:

> Any interested person may petition the Administrator to issue, amend, or repeal a rule. . . .

The FAA has issued an advance notice of proposed rulemaking to solicit comments relating to the "Age 60 Rule." 47 Fed. Reg. 29782 (1982).

208. Morgan, *The Young and the Restless*, Flying, April 1982, at 112, 113.

209. *See supra* notes 104-113 and accompanying text.

210. 49 U.S.C. § 1421(c) (1976).

211. Delta Airlines v. United States, 490 F. Supp. 907 (N.D. Ga. 1980).

212. As a direct result of this decision, the number of exemptions granted in 1980 decreased to 205, compared to 316 granted in 1979. Federal Aviation Administration, U.S. Dep't. Transp., Aeromedical Certification Statistical Handbook 25 (1981). The process was already averaging 4-8 months from petition to decision. *Things Your Air Surgeon Never Told You*, Aviation Consumer, April 1, 1982, at 14, 20. There is presently a backlog of approximately 700 petitions awaiting decision. Telephone interview with William H. Hark, M.D., Chief, Aeromedical Standards Division, Federal Aviation Administration (June 8, 1982).

213. *See e.g.*, Bosso v. Helms, No. 81-1311 (10th Cir. March 24, 1982) (Denial of Exemption, Exhibit A to Petition for Review).

interest.[214]

In neither case would the Federal Air Surgeon divulge any factual basis or findings of fact to support the grant or denial of the exemption. An effort to persuade the Federal Air Surgeon to make a practice of including such disclosures in the decision letters was rejected as it was feared that it would create an intolerable bureaucratic workload.[215] Where efforts at reasoned persuasion had failed, however, litigation prevailed, for the Court in *Delta* enjoined the FAA, its Administrator, and the Federal Air Surgeon from issuing any medical certificates by the exemption that is considered to be in the public interest.[216] An excerpt from the decision on that point merits reproduction here:

> By the plain wording of the regulation, the Administrator can grant exemptions to airmen possessing any of the absolutely disqualifying conditions, and this court so holds. However, the court further holds that any exemption granted must be done with strict adherence to the FAA's own regulation that the exemption be "in the public interest." This requirement assures that the objec-

---

214. *Compare* Petition of Ackerson, F.A.A. Regulatory Docket No. 19309, Exemption No. M-13711 (Grant of Exemption, Nov. 5, 1979) *with* Petition of Bosso, F.A.A. Regulatory Docket No. 10845, Exemption No. M-14482 (Denial of Exemption Dated Sept. 17, 1980).

215. Correspondence between the author and H.L. Reighard, M.D., Federal Air Surgeon, Federal Aviation Administration.

216. *See supra* notes 211. The FAA recently amended its medical certification rules in response to this and the *Jensen* decision (*supra* note 59 and *infra* notes 225-228 and accompanying text). Ironically, the effective date of the amended regulation was two years to the day from the date of the District Judge's order in the *Delta* case. 47 Fed. Reg. 16,308 (1982) (to be codified in 14 C.F.R. §§ 67.13-.27). The essence of the changes to the procedural rules there appears to be no more than a re-naming of the process from "exemption" to "special issue," and appears to be a rather blatant and transparent effort to avoid the effect of the *Delta* and *Jensen* decisions by enshrining in the regulation the unbridled discretion previously enjoyed by the Federal Air Surgeon, but under a different name. In its summary of the new rule, the FAA states that the practice of granting relief through the exemption procedures will be discontinued in favor of the new "discretionary special issuance" procedures. 47 Fed. Reg. 16,298 (1982). The purpose of this is ostensibly to avoid the "complex administrative procedure . . . involved in processing a formal petition for exemption from the medical standards of the Federal Aviation Regulations." *Id.* at 16,299. Motivation aside, the rule change appears of dubious legality. While the authority to grant exemptions appears clearly in the agency's enabling act (*see supra* note 210 and accompanying text), authority to accomplish the same purpose through a more informal, simple and discretionary process under a different guise ("special issuance") does not clearly appear in the agency's enabling act. The most that can be surmised from the amendment (*Id.* at 16,309) is that the agency believes this power is included in the vague general grant at 49 U.S.C. § 1354(a) (196), which provides that:

> The Secretary of Transportation is empowered to perform such acts, to conduct such investigations, to issue and amend such orders, and to make and amend such general or special rules, regulations, and procedures, pursuant to and consistent with the provisions of this Act, as he shall deem necessary to carry out the provisions of, and to exercise and perform his powers and duties under, this Act.

That appears to be grasping at semantic straws. Because of this uncertainty (which will hopefully be resolved in the pending action of *Schwartz v. Helms*, *supra* note 72) I will, throughout this paper, use the phrase "special issue (exemption)" to describe this process as it has existed since May 17, 1982, and simply "exemption" to describe the same process prior to that date.

> tive of the Act and the Regulations (to promote air safety) will not be defeated and further assures that the Regulations themselves will not be rendered meaningless by virtue of constant and pro forma exemptions. See *Utah Agencies v. CAB*, 504 F.2d 1232 (10th Cir. 1974), and *Island Airlines, Inc. v. CAB*, 363 F.2d 120 (9th Cir. 1966), wherein the courts noted that exemptions should be used sparingly and only in very limited and unusual circumstances.
>
> This court finds that the defendants have been improperly granting exemptions in two very significant ways: (1) the grants of exemption routinely recite that they are "in the public interest" with no supporting facts whatsoever for that determination and (2) the Federal Air Surgeon has totally misconceived what is meant by the "public interest."
>
> It is basic to judicial review of administrative action that the agency "must find what the statute [or regulation] requires it to find, not in conclusory fashion in the statutory language but in such fashion that a reviewing court can test the validity of the finding." *American Airlines, Inc. v. CAB*, 235 F.2d 845, 853 (D.C. Cir. 1956). "The necessity for administrative agencies to provide a statement of reasons, especially in cases . . . where the public interest demands close scrutiny of an agency action, is a fundamental principle of administrative law." *Brooks v. Atomic Energy Commission*, 476 F.2d 924, 926-27 (D.C. Cir. 1973). See also *SEC v. Chenery Corp.*, 332 U.S. 194 (1947).
>
> Mere recitation that a grant of exemption is in the public interest gives the court no basis by which to judge the FAA's action and falls far short of the requirement of *Chenery* that the basis for an agency's decision must be set forth with such clarity that the court is not left to speculate as to the theory, rationale, or facts underlying the agency's determination. For the FAA to grant an exemption to the medical standards promulgated in the Regulations it must specify why such exemption is in the public interest.[217]

A. The Petition for Special Issue (Exemption)

Counsel representing airmen seeking aviation medical certification through the special issue (exemption) process should marshal medical history and opinion to substantiate the proposition that the client, notwithstanding a history of one of the nine specific disqualifying conditions, does not pose an unacceptable risk to flying safety.[218] The petition for special issue (exemption)[219] should also furnish the Federal Air Surgeon with persuasive language suitable for incorporation into a grant for exemption showing why it is in the public interest to grant a special issuance (exemption) to the

217. *Delta*, 490 F. Supp. at 916-17.

218. For example, a third-class airman medical certificate was issued under the new special issuance procedures to an individual who had a history of myocardial infarction and other evidence of coronary artery disease which required triple-vessel coronary artery bypass surgery. The surgery was successful and effectively bypassed all of the diseased areas, providing adequate blood circulation within the heart muscle, rendering it no more likely that the individual would suffer another heart attack than would the average man of his age (fifty-seven) not having his medical history. Letter from H.L. Reighard, M.D., Federal Air Surgeon, to James F. Glenn (June 28, 1982).

219. New procedures for special issuance of medical certificates are described at 47 Fed. Reg. 16,308 (1982) (to be codified at 14 C.F.R. § 67.19).

particular individual under the facts and circumstances of the case.[220]

The documented medical history should be as thorough, detailed, and organized as possible,[221] and ideally should accompany the petition in a single package to minimize the clerical workload on the Federal Air Surgeon's office and the concomitant risk of some portion of the supporting documentation simply not getting into the file.[222]

B. THE DECISION PROCESS

At this point, all similarity to the familiar adversary "due process" method of decision-making abruptly ends. When the petition and supporting medical information are received in the Federal Air Surgeon's office, the file is referred to a panel of consulting physicians for review and recommendation. While these consultants are said to be specialists who have a high degree of personal interest in the medical aspects of aviation safety,[223] the agency will not divulge their identity, nor will it allow the petitioner to be present during the panel's deliberations or to have any type of hearing.[224]

---

220. In the interim between the *Delta* decision and the recent rule amendment, the Federal Air Surgeon was going to considerable effort to provide in each grant of an exemption a detailed recitation of the supporting facts and policy considerations upon which he had relied to find the particular grant of exemption to be in the public interest. *See, e.g.*, Petition of Brannon, FAA Exemption No. M-14460, Regulatory Docket No. 21529, Grant of Exemption (April 7, 1981). During that same time, however, the Federal Air Surgeon failed to make findings of fact relied upon in denying exemptions as being not in the public interest, continuing instead to utilize an uninformative form denial, but appending thereto a so-called "Working Paper/Specialists' Recommendation," an unsigned document purporting to be an extract of the medical information reviewed by the Federal Air Surgeon's anonymous consultants and their recommendation to him. This procedure is challenged in several cases now pending in the United States Court of Appeals, *See, e.g.*, Smith v. Helms, No. 82-1629 (D.C. Cir. filed June 7, 1982); Holmes v. Helms, No. 81-7578 (9th Cir. filed September 4, 1981); and Lenhardt v. Helms, No. 81-7740 (9th Cir. filed October 29, 1981). After adopting the recent rule change cosmetically renaming the procedure from "exemption" to "special issuance," the Federal Air Surgeon abandoned his short-lived efforts to recite in grants of medical certificates through this process the factual basis and rationale for arriving at the decision to issue the certificate and has ceased making any findings of or reference to the issuance being "in the public interest." *See, e.g.*, letter from H.R. Reighard, M.D., Federal Air Surgeon to James P. Glenn (June 28, 1982); letter from Dr. Reighard to Robert P. Shallenberger (June 15, 1982).

221. *See supra* notes 122-135.

222. *See supra* notes 133 and 134.

223. Guide for Aviation Medical Examiners, *supra* note 47, at 17.

224. Representing the Medically Disqualified Pilot, address by Mark T. McDermott, Law of Aviation Symposium hosted by the FAA Office of Chief Counsel in Washington, D.C. (December 1, 1981) (an outline of this speech was published in the Syllabus of the Symposium). Recent efforts by the author and physicians working with our law firm to gain entry to panel deliberations for an aviator's treating physician have been ignored by the agency. *See, e.g.*, letter from Richard D. Spangler, M.D. to H.L. Reighard, M.D., Federal Air Surgeon (May 18, 1982).

C. JUDICIAL REVIEW

Although one court has held that this exemption procedure does not comport with the requisites of due process,[225] the Federal Air Surgeon has made no substantive change in the exemption process as a result of that decision.[226] The decision charts a clear course for future judicial challenges to the legality of this secret decision process, and thus, a portion of the court's opinion merits reproduction here:

> The FAA apparently now concedes that the Alcoholism Act applies to the disqualifying regulations. But it contends that although an applicant with a history of alcoholism is automatically disqualified from obtaining a medical certificate, he can apply for an exemption from the rule under the "two-tiered" system. The FAA administrator may grant an exemption from any FAA rule or regulation if he decides that to do so would be "in the public interest," and would not adversely affect safety," 14 C.F.R. § 11.27(e) (1980). The FAA argues that this procedure negates the contention that the Administrator denies certificates solely on grounds of prior alcoholism. This argument is without merit.
>
> First, the decision to deny Jensen's application for an exemption is not before this court because Jensen did not appeal. Second, even if we were in a position to consider the "second tier" exemption procedure as a limitation on the "first-tier" certification process this would not cure the direct conflict between the "first-tier" and the Alcoholism Act.
>
> Third, even if this court accepted the FAA's "two-tier" argument, the exemption procedures do not comport with due process. The FAA need not grant an

---

225. *Jensen v. Administrator*, 641 F.2d 797 (9th Cir. 1981).

226. Minor cosmetic changes made since and attributed to the *Delta* decisions are described and discussed in notes 211-220, *supra*. These recent amendments did, however, contain a substantive change in the standards for disqualification on the basis of alcoholism. The regulatory standard governing alcoholism was itself amended as part of those changes. Whereas previously any history or diagnosis of alcoholism was one of nine specific disqualifying conditions, the amendment makes alcoholism disqualifying only in the absence of established clinical evidence of recovery, including sustained total abstinence from alcohol for not less than the preceding two years. 47 Fed. Reg. 16,308 (1982) (to be codified at 14 C.F.R. §§ 67.13(d)(1)(i)(c), 67.15(d)(1)(i)(9c) and 67.17(d)(1)(i)(c)). The summary and background to those changes further indicate that the Federal Air Surgeon will consider granting a medical certificate by special issuance (exemption) within an even shorter period, and enumerates the factors which he will consider in evaluating such petitions. These include:

1. The period of the applicant's abstention from alcohol;
2. The severity of the problem and how long it has existed;
3. The number of times treatment was sought and relapse occurred;
4. The quality of the final treatment effort;
5. The presence of residual medical complications, especially neurologic manifestations;
6. Progress in marital, social, vocational and educational areas, as appropriate, since rehabilitation began;
7. Commitment to rehabilitation by virtue of continuing contacts with social or professional agencies, or both, and their opinions and recommendations;
8. Any underlying personality difficulties that would either be disqualifying independently or adversely affect sustained abstinence; and
9. The findings of a recent psychiatric and psychologic evaluation.

47 Fed. Reg. 16,301 (1982).

> applicant a hearing before passing on the application, see *Coppenbarger v. FAA*, 558 F.2d 836 (7th Cir. 1977) and the decisions are reviewable under the arbitrary and capricious standard, see *Keating v. FAA*, 610 F.2d 611 (9th Cir. 1979).
>
> Due process requires that for a meaningful review of an agency decision, the agency must have articulated standards governing its determinations. See *Matlovich v. Secretary of the Air Force*, 591 F.2d 852, 857 n.11 (D.C. Cir. 1978).
>
> Here, the FAA's only standards for an exemption are that it would be "in the public interest" and "would not adversely affect safety." These standards do not give the court a sufficient basis for review. Neither do they give the applicant any basis for "planning his course of action (including the seeking of judicial review)." Id. at 857.
>
> In the absence of articulated guidelines, the FAA's statements about Jensen's one year period of abstinence being insufficient to demonstrate a "cure" do not foreclose the ability of the FAA to apply standards other than a period of abstinence. See *Id.*; *White v. Roughton*, 530 F.2d 750, 753-54 (7th Cir. 1976). In *Graham v. National Transportation Safety Board*, 530 F.2d 317 (8th Cir. 1976), the Federal Air Surgeon approved Graham's second-class certificate because he had demonstrated a sufficient period of abstinence by remaining sober for six months. Here, Jensen's one year period of abstinence was considered insufficient. This indicates that the FAA probably considers factors other than the period of remission in the exemption determination.
>
> We hold that the disqualifying regulations are invalid.[227]

The court now has before it at least three cases which present the opportunity to incorporate what was dicta in *Jensen* into *res judicata*.[228]

If the petition for special issue (exemption) is denied, the denial is subject to judicial review in the appropriate federal court of appeals,[229] but the standard of review is the arbitrary and capricious abuse of discretion standard.[230]

A question now before the federal courts is whether the Federal Air Surgeon is required to set forth in a denial of a petition for special issue (exemption) the same qualitative and quantitive basis for that decision as is necessary to allow the reviewing court to test the validity of an issuance under *Delta*.[231]

---

227. Jensen, 641 F.2d at 798-99.

228. *Smith*, *Holmes*, and *Lenhardt*. Smith v. Helms, No. 82-1629 (D.C. Cir. filed June 7, 1982); Holmes v. Helms, No. 81-7578 (9th Cir. filed September 4, 1981); and Lenhardt v. Helms, No. 81-7740 (9th Cir. filed October 29, 1981).

229. Coppenbarger v. FAA, 558 F.2d 836 (7th Cir. 1977).

230. Keating v. FAA, 610 F.2d 611 (9th Cir. 1979).

231. *Smith*, *Holmes*, and *Lenhardt*. Smith v. Helms, No. 82-1629 (D.C. Cir. filed June 7, 1982); Holmes v. Helms, No. 81-7578 (9th Cir. filed September 4, 1981); and Lenhardt v. Helms, No. 81-7740 (9th Cir. filed October 29, 1981).

V. The NTSB Appeal Process

The aviator who has been either denied an aviation medical certificate on reconsideration by the Federal Air Surgeon[232] or who has received an order of suspension or revocation of such a certificate[233] may appeal that decision to the NTSB.[234] The procedure in such an appeal varies according to whether the case originated as a denial (commonly called a "Section 602" case)[235] or a suspension or revocation (commonly referred to as a "Section 609" case)[236] and, if the latter, whether the FAA has also invoked its emergency powers[237] in connection with the order.

A. *Administrative Law Judge Hearing*

In every such case, a hearing will first be held before an administrative

232. *See supra* notes 120-135 and accompanying text.

233. *See supra* notes 196-201 and accompanying text.

234. The National Transportation Safety Board (NTSB) was established by the Department of Transportation Act of 1967, Pub. L. No. 89-670, 80 Stat. 931 (codified at 49 U.S.C. § 1651, *et seq.*) as an agency within the U.S. Department of Transportation. The Board became an independent agency on April 1, 1975, as a result of the Independent Safety Board Act of 1974, Pub. L. No. 93-633, 88 Stat. 2166 (codified at 49 U.S.C. § 1901). The Board has two basic functions: first, it investigates accidents in aviation and other forms of public mass transportation and determines the probable cause thereof and, second, it serves as an administrative appellate review board which is the first level of review of actions by the FAA and Coast Guard revoking, suspending, or denying certificates. The Board's qualifications and procedures have been the subject of considerable controversy. *See, e.g.*, Steenlik, *Reforming Aviation's "Supreme Court,"* Airline Pilot, April 1982, at 6.

235. From this section's number in the Federal Aviation Act of 1958, Pub. L. No. 85-726 (codified at 49 U.S.C. § 1422 (1976)).

236. *Id.* (codified at 49 U.S.C. § 1429 (1976)).

237. U.S.C. § 1485(a) (1976) provides, in part that:

> Whenever the Secretary of Transportation is of the opinion that an emergency requiring immediate action exists in respect of safety in air commerce, the Secretary of Transportation authorized, either upon complaint or his own initiative without complaint, at once, if he so orders, without answer or other form of pleading by the interested person or persons, and with or without notice, hearing, or making or filing of a report, to make such just and reasonable orders, rules, or regulations as may be essential in the interest of safety in air commerce to meet such emergency: *Provided further*, That the Secretary of Transportation shall immediately initiate proceedings relating to the matters embraced in any such order, rule, or regulation, and shall, insofar as practicable, give preference to such proceedings over all others under this Act.

The Board has characterized this as "extraordinary authority" which "it would be irresponsible for the Administrator to invoke . . . unless grounded only through investigations." Administrator v. Air East, Inc., 2 N.T.S.B. 870, 881 (1974). The agency's election to invoke the emergency power makes the suspension or revocation ordered effective immediately, *prior to* a due process hearing on the merits (which must then follow in expedited manner). *See infra* note 249 and accompanying text. The agency's decision to invoke the extraordinary emergency power is subject to judicial review (*see generally infra* notes 264-278 and accompanying text). The standard for review of such emergency determinations, however, is whether the Administrator's finding of an emergency was arbitrary and capricious, an abuse of discretion, or otherwise not in accordance with law. Nevada Airlines, Inc. v. Bond, 622 F.2d 1017 (9th Cir. 1980) and Air East, Inc. v. N.T.S.B., 512 F.2d 1227 (3d Cir. 1975), *cert. denied*, 423 U.S. 863 (1975).

law judge of the NTSB.[238] The Federal Rules of Civil Procedure do not apply to these cases[239] and the Board's Rule of Practice in Air Safety Proceedings (Rules of Practice)[240] make little provision for discovery. Since the Board has stated a policy of encouraging pre-hearing discovery (including both formal and informal discovery),[241] one wonders why the Board has failed and refused[242] to provide by rule for customary civil discovery in these actions, independent from case-by-case exercise of judicial and prosecutorial discretion (especially considering that the FAA maintains the power throughout the action to discover the individual's medical records under the provisions of FAR § 67.31.[243] A pre-hearing conference[244] can be useful to narrow the issues for hearing and to resolve controversies over the scope of discovery.

The NTSB administrative law judge will schedule a hearing at a time and place convenient to the aviator.[245] Where out-of-town medical specialists are involved, counsel may find it more economical and practical to request that an additional hearing or hearings be scheduled in a location or locations convenient to such witness or witnesses.[246]

The hearing before the administrative law judge is in the nature of a trial de novo. In a "Section 602" case, the burden of proof is on the aviator to establish as an affirmative fact that he is qualified under the appropriate medical standards to hold the class of aviation medical certificate which has been denied him on reconsideration by the Federal Air Surgeon.[247] In a "Section 609" case, however, the burden of proof rests with the FAA to prove that the individual is not qualified to hold the class of aviation medical certificate which is the subject of the order of suspension or revocation.[248] In a "Section 609" case, the filing and pendency of the appeal stay the effectiveness of the order of suspension or revocation, unless the FAA has invoked its emergency authority in the issuance of that order.[249]

---

238. At this writing, the Board has three offices of administrative law judges. These are located in Washington, D.C.; Denver, Colorado; and Los Angeles, California. Judges from these offices "ride circuit," traveling extensively to conduct these hearings at locations convenient to those involved. *See infra* notes 245 and 246 and accompanying text.

239. Administrator v. Cockes, 1756, 1758-59 (1975).

240. 49 C.F.R. §§ 821.1-.63 (1981).

241. Administrator v. McClain, 1 N.T.S.B. 1542 (1972).

242. Petition of Hamilton, N.T.S.B. Order No. EA-1615 (June 4, 1981).

243. *See supra* note 188 and accompanying text.

244. 49 C.F.R. § 821.35(b)(8) (1981).

245. 49 C.F.R. § 821.37(a) (1981).

246. 49 C.F.R. § 821.37(b) (1981).

247. 49 C.F.R. § 821.25 (1981).

248. 49 C.F.R. § 821.32 (1981). In either event, the burden of proof is one of a preponderance of reliable, probative, and substantial evidence. 49 C.F.R. § 821.49(a) (1981).

249. The Federal Aviation Act of 1958, as amended, provides, in part, at 49 U.S.C. § 1429(a) (1976):

These hearings typically revolve around a contest between expert witnesses for both sides and are ultimately decided by balancing the weight of conflicting expert medical opinions. Generally, the FAA's expert will not have examined the individual, but only the documented medical history, and the testimony of the airman's attending physician may be entitled to some additional weight (especially where the latter physician's testimony elucidates an incomplete documentary history).[250] Greater weight is given to the testimony of an expert medical witness who testifies at the hearing, subject to cross-examination, than to written reports.[251] All other factors being equal, the testimony of a medical expert who is Board-certified in the area of medical speciality at issue may be afforded greater weight than that of a similar witness not so certified.[252]

In the vast majority of cases, the administrative law judge will render an initial decision orally at the close of the hearings.[253] In unusually complicated cases, however, a ruling may be reserved until a later date and appear only as a written decision.[254] This initial decision must contain findings of fact and conclusions of law, including the grounds therefor, and address issues of the credibility of witnesses and exercises of discretion presented by the case.[255]

B. Full Board Review

The rendering of this initial decision still does not constitute "final agency action" subject to judicial review.[256] Rather, appeal from this decision must next go to the full NTSB (the five political appointees[257] actually constituting the Board).[258] This appeal must be commenced by giving notice of appeal within ten days after an initial oral decision has been rendered or, if no oral initial decision was delivered, after a written decision or order has been served.[259] Timely filing of this notice of appeal continues to stay

---

The filing of an appeal with the Board shall stay the effectiveness of the Secretary of Transportation's order unless the Secretary of Transportation advises the Board that an emergency exists and safety in air commerce or air transportation requires the immediate effectiveness of his order, in which event the order shall remain effective and the Board shall finally dispose of the appeal within sixty days after being so advised by the Secretary of Transportation.

250. Petition of Ewing, 1 N.T.S.B. 1192 (1971).

251. Petition of Byrom, N.T.S.B. Order No. EA-1442 (June 26, 1980).

252. Petition of Spivey, N.T.S.B. Order No. EA-1440 (August 6, 1980).

253. 49 C.F.R. § 821.42(a) (1981).

254. *Id.*, except in cases where the Administrator has exercised his emergency authority, in which case the administrative law judge is required to render his initial decision orally on the record at the termination of the hearing. 49 C.F.R. § 821.56(b) (1981).

255. 49 C.F.R. § 821.42(b) (1981).

256. Because of the general requirement for exhaustion of administrative remedies.

257. Independent Safety Board Act of 1974, note 226, *supra*, at § 303(b).

258. 49 C.F.R. § 821.43 (1981).

259. 49 C.F.R. § 821.47 (1981).

the government's order of suspension or revocation in a "Section 609" case, unless the order was issued under the emergency power.[260]

The issues on appeal to the full Board are narrow,[261] and the appeal is typically decided by the Board solely on the basis of the record and written appeal briefs, although the Board has the authority to grant oral argument where it is deemed necessary.[262] The decision of the full Board is always rendered only in writing as an "Opinion and Order," which is typically quite detailed in its findings of fact, conclusions of law, and supporting rationale.[263]

C. Judicial Review

The issuance of this decision by the full Board finally makes the case ripe for judicial review which, unlike many other administrative appeals,[264] lies within the jurisdiction not of the federal district courts, but of the federal courts of appeal.[265] Only the individual aggrieved by the agency action has standing to pursue judicial appeal of a decision of the full Board; the government lacks such standing.[266] The appeal must be filed within sixty days of the entry of the Board's final order.[267]

While in a non-emergency case brought under Section 609 the pendency of this appeal process will have automatically stayed the effectiveness of the government's order of suspension or revocation, that automatic

260. 49 C.F.R. § 821.43 (1981). However, if the order was issued under the emergency power, it continues in effect during this appeal process, which is accelerated by the Board's rules. In such an emergency case, notice of appeal must be given within 2 days after the oral initial decision, followed by filing of the appeal brief within 5 days after filing the notice of appeal. 49 C.F.R. §§ 821.57(a) and (b) (1981).

261. The Board's Rules of Practice in Air Safety Proceedings provide, at 49 C.F.R. § 821.49 (1981):

Issues on Appeal.
On appeal, the Board will consider only the following issues:
(a) Are the findings of fact each supported by a preponderance of reliable, probative, and substantial evidence?
(b) Are conclusions made in accordance with precedent and policy?
(c) Are the questions on appeal substantial?
(d) Have any prejudicial errors occurred?

262. 49 C.F.R. §§ 821.47(g) and 821.57(b) (1981).

263. *See, e.g.*, Petition of Black, N.T.S.B. Order No. EA-1704 (Nov. 16, 1981).

264. *Compare* 42 U.S.C. § 405(g) (Supp. IV 1980), which provides for judicial review of final decisions of the Secretary of Health, Education and Welfare denying Social Security benefits in the United States District Courts.

265. 49 U.S.C. § 1486 (1976). Venue is proper in the circuit in which the aviator resides or has his principal place of business or in the United States Court of Appeals for the District of Columbia. 49 U.S.C. § 1486(b).

266. Lee v. C.A.B., 225 F.2d 950 (D.C. Cir. 1955).

267. 49 U.S.C. § 1486(a) (1976), which also grants the court discretion to permit filing of a petition after that time period, by leave of court, upon a showing of reasonable grounds for failure to file a petition within the statutory time limit.

stay expires upon issuance of the full Board's order. Counsel must take affirmative action to secure a stay order at this point, if the client's existing medical certificate is to continue to remain in effect during the pendency of the judicial appeal. Application for such a stay order pending judicial review is required to be made first to the Board, if practicable.[268] The Board has the authority to postpone the effective date of its order, pending judicial review, upon a finding that justice so requires.[269] If the Board denies the motion for a stay order, then the Court may grant such an order upon a showing of good cause and after reasonable notice to the Board.[270] The Board typically refuses to grant stays in cases where the appellant's qualifications to hold the certificate are at issue (which is the case in the vast majority of medical certification actions).[271]

Except for challenges to the constitutional validity of the underlying regulation, no objections may be raised upon judicial appeal which were not previously argued before the Board.[272] The Court's scope of review is narrow,[273] and it is bound by the Board's findings of fact, provided they are supported by substantial evidence.[274] Challenges to the sufficiency of the evidence are extremely unlikely to be successful.[275]

The court is empowered, upon review, to affirm, modify, or set aside the Board's order, in full or in part and, if need be, to order further proceedings by the Board or by the FAA.[276]

The judgment and decree of the court of appeals is finally subject to review by the United States Supreme Court but only upon certification or by the grant of a writ of certiorari,[277] which is a most unlikely event.[278]

VI. Equal Access to Justice & Federal Tort Claims Act Aspects

Final resolution of a medical certificate action may take several years and involve attorney fees and expert medical witness fees which are quite burdensome to the individual. Where the individual is a professional aviator

268. Fed. R. App. P. 18.
269. 5 U.S.C. § 705 (1976).
270. 49 U.S.C. § 1486(d) (1976).
271. *See, e.g.*, Administrator v. Bond, N.T.S.B. Order No. EA-1138 (May 5, 1978).
272. 49 U.S.C. § 1486(e) (1976). *See also supra* note 149.
273. The applicable standard of review is whether the Board's decision is supported by substantial evidence. Loomis v. McLucas, 553 F.2d 634 (10th Cir. 1977).
274. 49 U.S.C. § 1486(e) (1976).
275. *See* Hamilton, *Administrative Practice Before the FAA and NTSB: Problems, Trends and Developments*, *supra* note 7, at notes 96-101, and accompanying text, *cf.* Dodson v. N.T.S.B., 644 F.2d 647 (7th Cir. 1981).
276. 49 U.S.C. § 1486(d) (1976).
277. 49 U.S.C. § 1486(f) (1976).
278. This review power has existed at least since passage of the Air Commerce Act of 1926, ch. 344, 44 Stat. 568. The author has found no aviation medical certification case in which the Court has granted certification or certiorari in the ensuing fifty-six years.

who has been without a medical certificate (and therefore without his usual source of income) for that time period as a result of a "Section 602" denial or "Section 609" emergency action, that individual may be financially ruined even if he eventually prevails in regaining his medical certificate.

In cases arising under Section 609, at least, the new Equal Access to Justice Act (EAJA)[279] may provide some recompense.[280] At this writing, the first of these cases is now pending before an administrative law judge of the Board.[281]

While the EAJA appears inapplicable to aviation medical certificate denial cases arising under Section 602, the Federal Tort Claims Act (FTCA) may provide a tenable cause of action for recompense in certain of these cases.[282] In an FTCA action, the burden would be on the aviator to prove negligence on the part of the government (or its designee AME),[283] whereas in an EAJA action, the burden is on the agency to prove its actions were reasonable and its position to have been substantially justified.[284]

VII. Conclusion

Aviation medical certification cases rank among the most hypertechnical cases in which private counsel are called upon to provide advice and advocacy.

A multidisciplinary approach in which the aviator's legal counsel works closely with the aviator's physicians is an absolute prerequisite to ultimate success.

Even then, the unbridled administrative discretion inherent in the highly subjective and secretive off-the-record decision making process, together with the heavy case loads assigned the FAA decisionmakers provides an

279. Pub. L. No. 96-781, 94 Stat. 2325 (1980) (to be codified in scattered sections of 5 U.S.C.).

280. The Act provides for reimbursement of attorney fees and costs to an individual who has been the subject of an adversary adjudicative proceeding brought by an agency, where the agency's position was not substantially justified. Pub. L. No. 96-481, 94 Stat. 2325 (to be codified at 5 U.S.C. § 504). The Act applies to suspension or revocation cases (*see supra* notes 196-202 and accompanying text) but not denial cases (*see supra* notes 98-163 and accompanying text) because the Act excludes from its coverage an adjudication for the purpose of granting or renewing a license. Pub. L. 96-481, 94 Stat. 2325 (to be codified at 5 U.S.C. § 504(b)(1)(C)).

281. Wendler v. Helms, N.T.S.B. No. 1-EAJA-SE-4887 (filed Nov. 25, 1981).

282. See Beins v. United States, Civil Action No. 79-3322, slip op. (D.D.C. Aug. 5, 1981); Dilk, *Negligence of Federal Aviation Administration Delegates Under the Federal Tort Claims Act*, 42 J. Air L. & Com. 575, 579-81 (1976).

283. *Id.*

284. The National Transportation Safety Board has adopted Rules Implementing the Equal Access to Justice Act. These provide, in part, at 49 C.F.R. § 826.5(a) (1981);

> . . . the burden of proof that an award should not be made to an eligible prevailing party is on the agency counsel, who may avoid an award by showing that the agency's position was reasonable in law and fact.

atmosphere conducive to arbitrariness. This has resulted in a situation in which aviators are highly suspicious of the fairness and impartiality of these decisionmakers who wield, in the language of one critic, "an executioner's power over the pilot's legal ability to fly."[285] The seemingly interminable bureaucratic delays and unpredictability of results further aggravate the situation, resulting in a process which may prove extraordinarily, if not prohibitively, expensive to the aviator and ultimately prove a classic and monumental exercise in frustration not only to the aviator, but to his counsel and personal physicians as well.

This is intolerable in what is intended to be a democracy governed by laws, and not by the whims of bureaucrats. Aviation medical standards contained in the FARs should be updated to reflect advances in medical knowledge and treatment capabilities and should reflect the highest possible specificity, both for ordinary certification and for certification in special cases. The decision-making process should be opened to the light of public hearing, on the record, with the opportunity for confrontation and cross-examination.

We have come a long way from the early romantic days of airline flying, when it was said of airline pilots that: "They are the picked men of the country. These men must not only be perfect mentally and physically, but the art of flying a plane must be born in them."[286]

Today, almost a million rather ordinary (though well trained) Americans possessing a rather wide variety of physical imperfections are doing a very presentable job of flying planes. Medical knowledge continues to advance, with increasing precision in diagnosis and new methods of treatment yielding concomitant increases in pilot health and longevity. In such times, the standards and procedures for medical certification of flight crews must also progress to keep abreast of these developments. Indeed, at this writing, such a review has begun.[287] The medical standards and procedures which result from such periodic reviews must always reflect a careful balancing of the public interest in maintaining an air transportation system which provides the highest possible degree of safety for the traveling public against the individual liberties of professional aviators and recreational flyers.

---

285. *Things Your Air Surgeon Never Told You*, *supra* note 136, at 14.

286. Representative John Martin of Colorado, in debate over the proposed Civil Aeronautics Act of 1938, *quoted in* G. Hopkins, *The Air Line Pilots*, 189 (1971).

287. 47 Fed. Reg. 30,795 (1982).

Table 1

Age Group	Maximum readings (reclining blood pressure in mm)		Adjusted maximum readings (reclining blood pressure in mm)[1]	
	Systolic	Diastolic	Systolic	Diastolic
20-29	140	88	—	—
30-39	145	92	155	98
40-49	155	96	165	100
50 and over	160	96	179	100

[1]For an applicant at least 30 years of age whose reclining blood pressure is more than the maximum reading for his age group and whose cardiac and kidney conditions, after complete cardiovascular examination, are found to be normal.