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THE DEMON ON THE FLIGHT DECK: A PROPOSAL FOR SUBSTANTIVE AND PROCEDURAL REFORM IN AVIATION MEDICAL REGULATIONS

Brendan J. Keegan

"The tragedy of our day is the climate of fear in which we live, and fear breeds repression."[1]

I. INTRODUCTION

Joseph Heller's 1961 satire, *Catch-22*, follows a World War II fighter pilot faced with a dilemma: if he shows a concern for his safety in the face of a dangerous mission, then he is presumed sane; after all, concern for flying dangerous missions during wartime is the process of a sane mind.[2] If he is presumed sane, then he must fly the mission.[3] Accordingly, the book coined

[1] Adlai E. Stevenson II, U.S. Presidential Candidate, Address to the Am. Legion Convention (Aug. 27, 1952) (transcript of speech at http://society3rdid.org/3rd-division-history/2-uncategorised/14-adlai-stevenson-speech).

[2] JOSEPH HELLER, CATCH-22 46 (Simon & Schuster Paperbacks 1996).

[3] *Id.*

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the term "Catch-22," which highlights a non-zero-sum game—a problematic situation for which the only solution is denied by a circumstance inherent in the situation. Today, pilots in the United States experience a similar dilemma, engendered by the superannuated policies and regulations of the Federal Aviation Administration (FAA): pilots are being forced to manage depressive symptoms, without the possibility of treatment, due to the fear of negative career impacts.[4]

Throughout the world, nearly one in eight pilots meets the threshold associated with clinical levels of depression.[5] A recent survey found that at least seventy-five pilots reported having suicidal thoughts within the preceding two weeks.[6] From 1960 to 2015, there have been eighteen cases of homicide-suicide on aircraft, with pilots perpetuating thirteen of these events.[7] While there may be several explanations for these statistics, it is generally regarded among pilots that medical diagnoses of conditions that could potentially ground a pilot should be avoided, at all costs, in order to remain medically qualified.[8] Mental health is no exception to the rule.

In March 2015, the issue garnered international attention when Germanwings Flight 9525 crashed into the French Alps, killing all 150 passengers and crewmembers on board.[9] The First Officer had a history of being denied medical certificates as he suffered from depression, which worsened in the weeks leading up to the crash.[10] On the day of the crash, when the Captain left the First Officer alone in the flight deck, First Officer Andreas Lubitz decided to commit suicide and deliberately descended the aircraft into mountainous terrain.[11] After the crash, the French investigators determined that a contributing factor to the accident was "the co-pilot's probable fear of losing his ability to fly as a professional pilot if he had reported his decrease in medical fitness to [the regulatory authorities]."[12]

To be sure, aviation is inherently safe.[13] Air travel has become

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[4] Alexander C. Wu et al., *Airplane Pilot Mental Health and Suicidal Thoughts: A Cross-Sectional Descriptive Study Via Anonymous Web-Based Survey*, 15 ENVTL. HEALTH 121 (2016) [hereinafter *Airplane Pilot Mental Health and Suicidal Thoughts*].

[5] *See* Lisa Rapaport, *One in Eight Airline Pilots May Be Clinically Depressed*, REUTERS (Dec. 14, 2016, 8:10 PM) https://www.reuters.com/article/us-health-depression-pilots-survey/one-in-eight-airline-pilots-may-be-clinically-depressed-idUSKBN144047.

[6] *Id.*

[7] Christopher Kenedi et al., *Suicide and Murder-Suicide Involving Aircraft*, 87 AEROSPACE MED. & HUM. PERFORMANCE 388, 389 (2016).

[8] Michael L. Slack, *Early Thoughts on the Safety Implications of Germanwings Flight 9525*, 33 WESTLAW J. AVIATION, no. 11, July 29, 2015, at 1, 4.

[9] *Id.* at 1.

[10] *Id.* at 2, 4.

[11] *Accident on 24 March 2015 at Prads-Haute-Bleone (Alpes-de-Haute-Provence, France) to the Airb.us A320-211,* BUREAU D'ENQUETES ET D'ANALYSES POUR LATJIS SECURITE DE L'AVIATION CIVILE, 96 (2016).

[12] *Id.* at 97.

[13] *Annual Report*, INT'L AIR TRANSP. ASS'N, 22 (2009) (stating that "air continues to be the safest form of travel").

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increasingly safer; incidents and fatalities have fallen significantly in recent years.[14] Following the Germanwings accident, regulations in the United States, Europe, Canada, Japan, and Australia now require that at least two crewmembers be in the cockpit at all times, enabling intervention in the case of an emergency (the "two-crewmember rule").[15] Peer support programs have been created to allow a network of volunteer pilots to support other pilots facing various stressors.[16] Even pilot disability insurance plans are being underwritten to offset the socio-economic effects of losing medical certification.[17] Nevertheless, each of these present their own drawbacks.

While the two-crewmember rule may be a visible means to deter future incidents, there is evidence that it may not be efficient enough. In *United States v. Calloway*, a FedEx flight engineer attacked flying crewmembers with a hammer in an attempt to hijack the aircraft and commit suicide.[18] Although the flight engineer was ultimately unsuccessful in his hijacking attempt, perhaps the two-crewmember rule is not sufficient enough to prevent future acts of homicide-suicide.[19] Similarly, although peer support programs should be applauded, they are staffed by non-medical volunteers; these programs simply are not an adequate alternative to seeking professional medical attention when needed.[20] Finally, pilot disability insurance rarely pays anywhere near the average pilot salary, thus failing to alleviate the monetary support net that would eliminate the airman's need to withhold information.[21] The only proper solution is a shotgun-style approach which

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[14] Peter Dizikes, *Study: Commercial Air Travel Is Safer Than Ever*, MIT NEWS (Jan. 23, 2020), https://news.mit.edu/2020/study-commercial-flights-safer-ever-0124 (stating that the fatality "rate is now one death per 7.9 million passenger boardings, compared to one death per 2.7 million boardings during the period 1998-2007, and one death per 1.3 million boardings during 1988-1997.").

[15] Holly Watt, *Germanwings Crash Prompts Airlines to Introduce Cockpit 'Rule of Two'*, THE GUARDIAN (Mar. 26, 2015, 2:49 PM), https://www.theguardian.com/world/2015/mar/26/germanwings-crash-prompts-airlines-to-introduce-cockpit-rule-of-two; Andrew Greene, *Germanwings: Australia Tightens Cockpit Safety Laws in Wake of French Alps Plane Crash*, ABC NEWS (Mar. 30, 2015, 4:40 AM), https://www.abc.net.au/news/2015-03-30/federal-government-announces-new-cockpit-safety-standards/6358474;
Japan Airlines to Have At Least Two People in Cockpit at All Times After Alps Crash, THE STRAITS TIMES (Apr. 28, 2015, 2:35 PM), https://www.straitstimes.com/asia/east-asia/japan-airlines-to-have-at-least-two-people-in-cockpit-at-all-times-after-alps-crash.

[16] *Pilot Peer Support*, AIR LINE PILOTS ASS'N, INT'L, https://www.alpa.org/resources/pilot-peer-support
(last visited Feb. 1, 2023).

[17] *See generally* AIR LINE PILOTS ASS'N, INT'L, ALPA NATIONAL DISABILITY INSURANCE: EXCLUSIVE DISABILITY INSURANCE COVERAGE FOR ALPA MEMBERS (2022-2023) [hereinafter ALPA INSURANCE BROCHURE].

[18] United States v. Calloway, 116 F.3d 1129, 1131, 1132 (6th Cir. 1997); Woody Baird, *Suicide Note Found on FedEx Plane After Attack*, AP NEWS (April 14, 1994), https://apnews.com/article/4e24c6c40de55f8048350bff56f67a9f.

[19] *Calloway*, 116 F.3d at 1132.

[20] Harold M. Pinsky et al., *Psychiatry and Fitness to Fly After Germanwings*, 48 J. AM. ACAD. PSYCHIATRY L. 65, 74 (2020).

[21] *Compare* ALPA INSURANCE BROCHURE, *supra* note 17, *with American and Commercial Pilots*, U.S. BUREAU OF LABOR STATISTICS, https://www.bls.gov/ooh/transportation-and-material-moving/airline-and-commercial-pilots.htm (last visited Feb. 6, 2023) (stating that "the median annual wage for airline pilots . . . was $202,180 in May 2021").

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combines all these changes with a regulatory system that incentivizes—not penalizes—airmen to report visits to mental health practitioners.

This Comment proposes reform in the Federal Aviation Regulations ("FARs")[22] and in the United States Code to make way for much needed changes in the procedures for airman medical appeals as well as in substantive regulations pertaining to airman mental health. Part II-A provides the relevant regulations pertaining to airman medical certification. Part II-B explains alternative pathways to certification. Part II-C discusses the appeals process for airman medical certificates and how courts apply deference to the actions of the FAA. Part III provides an analysis of the regulations and systems in place and discusses why they are failing and proposes several ways of reforming the airman medical standards. Finally, this Comment proposes a change to the procedures for appeal.

II. BACKGROUND

A. Regulations Pertaining to Airman Medical Certification

In 1958, Congress passed the Federal Aviation Act, creating the FAA and delegating the FAA the authority to create rules and regulations that enhance aviation safety.[23] Since then, the FAA has promulgated the FARs, which can be found in Title 14 of the Code of Federal Regulations.[24] With limited exceptions, 14 C.F.R. Part 61 requires all pilots certified by the FAA to obtain a medical certificate if they seek to operate a civilian aircraft.[25] While the pilot's airman certificate (layman terms "pilot license") itself never expires, airman medical certificates are only valid for specified periods of time.[26] Therefore, in almost all cases, regardless of whether a pilot has obtained a certificate to operate an aircraft, they must still be granted an airman medical certificate from the FAA periodically in order to exercise the privileges of their pilot certificate.[27]

In the Federal Aviation Act of 1958, Congress delegated authority to the FAA for granting, denying, and revoking airman certificates, including airman medical certificates.[28] The FAA has designated three separate classes of medical certificates.[29] Depending on the nature of the pilot activity, a pilot needs either a first, second, or third-class medical certificate.[30] For example,

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[22] 14 C.F.R. § 1 *et seq*.
[23] *See* 49 U.S.C. § 44701. *A Brief History of the FAA*, FEDERAL AVIATION ADMINISTRATION, https://www.faa.gov/about/history/brief_history (last visited Jan. 28, 2023).
[24] *See* 49 U.S.C. § 44701.
[25] 14 C.F.R. § 61.3.
[26] *Id*. §§ 61.19–61.23.
[27] *See id.* § 61.23.
[28] *See* John W. Gelder, *Air Law – The Federal Aviation Act of 1958*, MICH. L. REV. 1214, 1216–1220 (1959); *see* 49 U.S.C. §§ 44702, 44703, 44709.
[29] 14 C.F.R. § 61.23.
[30] *Id.*

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a pilot operating as captain of a commercial airliner must have a valid first-class medical certificate, a pilot operating a banner tow aircraft must have a valid second-class medical certificate, and a pilot operating as a pilot for recreational or hobby purposes must have a valid third-class certificate.[31] There are a few operations that do not require a medical certificate, but airline operations is not one of them.[32] Each medical certificate's valid period is different, but in no case may a commercial airline pilot fly without having first received a medical certificate in the preceding twelve calendar months.[33] Similarly, recreational or hobby pilots must have received a medical certificate in the preceding sixty calendar months.[34] Regardless of class, the pilot must see a specialized physician ("Aviation Medical Examiner" or "AME"), with the proper authority delegated to them by the FAA, to receive an airman medical certificate.[35]

The standards for issuance of an airman medical certificate are found in 14 C.F.R. Part 67 ("Part 67").[36] The standards for some conditions vary between classes; however, the standards for mental health do not.[37] In all cases, a pilot must not have an "established medical history or clinical diagnosis of": a personality disorder, psychosis, bipolar disorder, substance dependence or abuse, or any other "or other mental condition that the Federal Air Surgeon [finds,] based on the case history and appropriate, qualified medical judgment relating to the condition involved, . . . [m]akes the person unable to safely perform [the duties of a pilot]."[38]

In addition to an established medical history of the above conditions, the FAA has established numerous policies listing certain medications as disqualifying.[39] Examples of disqualifying medications are antidepressants such as Remeron, antianxiety drugs such as Xanax, and even attention deficit disorder or attention deficit hyperactivity disorder medications such as Ritalin and Adderall.[40] Recently, a push for relaxation of these strict standards has resulted in the FAA approving certain medications; however, the AME still cannot issue a medical certificate to the airman without approval from the

[31] *Id.*; Medical Certification Standards for Commercial Balloon Operations, 87 Fed. Reg. 224, 71226 (Nov. 22, 2022) (to be codified at 14 C.F.R. pts. 61, 68).

[31] *See* § 61.23(b)(1)(i) (excepting sport pilots from the requirement to obtain a medical if they meet certain criteria).

[33] *See* § 61.23(d) (requiring a second-class medical if operating as second-in-command).

[34] *Id.* (requiring a third-class medical if operating as a recreational pilot under age 40).

[35] § 67.401(b); *see also* § 67.407(a).

[36] *See generally* § 67 (subparts B, C, and D).

[37] *See* § 67.103(a) (requiring distant visual acuity of 20/20 or better); *cf.* § 67.303(a) (requiring distant visual acuity of 20/40 or better); *see generally* §§ 67.107, 67.207, 67.307.

[38] §§ 67.107, 67.207, 67.307.

[39] *Guide for Aviation Medical Examiners*, FED. AVIATION ADMIN. 420, 445–46 (2023) [hereinafter *AME Guide*].

[40] *Id.*; Peter M. Hartmann M.D., *Mirtazapine: A Newer Antidepressant*, 59 AM. FAM. PHYSICIAN 159 (1999); *Ritalin and Adderall Abuse*, UNITED BRAIN ASS'N., https://unitedbrainassociation.org/brain-resources/ritalin-and-adderall-abuse/ (last visited Feb. 1, 2023).

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Federal Air Surgeon.[41]

As part of this push for relaxed standards, today, a potential pilot who is currently taking, or in the past has taken, one of four antidepressants—Celexa, Zoloft, Lexapro, and Prozac—may request special consideration from the FAA.[42] An airman with a medical history of these prescribed medications can apply for regular issuance of a certificate if they have stopped taking the medication for at least sixty days prior to application for the medical certificate.[43] If they are still taking the medication, the potential pilot must establish a period of six months of clinical stability and meet with a specialized AME.[44] Nevertheless, a pilot who currently takes one of these medications will not receive their medical certificate from the AME, but must have their application sent to the FAA for review and decision.[45] While this review process seems reasonable, the reality is much more inflexible than it seems. As of January 2022, less than 250 commercial pilots have been authorized under this process.[46] Comparatively, over 27,000 pilots with hypertension are granted either a first-class or second-class medical certificate.[47]

While the text of the mental health regulations under Part 67 have changed several times over its history, the substance of the regulations has remained significantly unchanged since they were introduced under the guidance of the Diagnostic and Statistical Manual of Mental Disorders, third edition ("DSM-III").[48] The DSM-III is a classification of mental health disorders published in 1980 by the American Psychiatric Association, replacing two previous versions, with the first being published in 1952.[49] These manuals were created and amended in response to the need for a classification of mental disorders for psychiatrists and psychologists to use in diagnosing and treating mental disorders.[50] Since 1952, there have been several significant changes to each subsequent edition.[51] Today, only the fifth edition ("DSM-V")—published in 2013—is used in clinical settings, as the

[41] *See AME Guide, supra* note 39, at 475.
[42] *Id.* at 241.
[43] *Id.*
[44] *Id.*; *See generally infra* Part III.D.
[45] *See AME Guide*, *supra* note 39, at 244.
[46] *FAA Medical Certification Statistics*, PILOT MED. SOL., INC., https://www.leftseat.com/faa-medical-certification-statistics/ (last visited Feb. 2, 2023).
[47] *Id.*
[48] *See generally* Revision of Airman Medical Standards and Certification Procedures and Duration of Medical Certificates, 61 Fed. Reg. 11, 241 (Mar. 19, 1996) (as codified at 14 C.F.R. pt. 67).
[49] *DSM History*, AM. PSYCHIATRIC ASS'N https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm (last visited Feb. 3, 2023).
[50] *Id.*
[51] *See generally* Shelly Yeats, *Significant Changes from the DSM-IV To The DSM-5,* TEX. DIST. & CNTY. ATT'YS ASS'N (Nov.–Dec. 2013), https://www.tdcaa.com/journal/significant-changes-from-the-dsm-iv-to-the-dsm-5/; *see also* Shadia Kawa et al., *A Brief Historicity of the Diagnostic and Statistical Manual of Mental Disorders: Issues and Implications for The Future of Psychiatric Canon and Practice,* PHIL., ETHICS, & HUMANITIES IN MED. at 1–2 (2012).

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older editions are considered by most mental health professionals to be completely obsolete.[52]

Use of the DSM's diagnoses has become problematic in the regulatory scheme set forth by the mental health standards of Part 67. When the current regulatory standards were instituted in 1996, the FAA and key industry stakeholders regularly referenced the DSM-III or its successor—the DSM-IV—as the guidance they were attempting to parallel.[53] However, the implementation of catch-all provisions allows the Federal Air Surgeon to conduct an inquiry into an airman's mental health history that *might* be disqualifying.[54] In this manner, individuals diagnosed with a disorder that is not recognized by the DSM-V could be disqualified due to the broad overreach of these catch-all provisions.

Consider an applicant presenting with a clinical history of "neuroticism." Although not a diagnosis in the DSM-V, neurotic behavior is a personality trait characterized by behavior that "[may] interfere with [one's] personal, professional, and romantic lives."[55] One who has experienced infidelity in a past relationship might be characterized as "neurotic" because they regularly ask their new partner if they are cheating on them, and then constantly blame themselves for driving their new partner away.[56] The closest possible mental health diagnosis to this kind of behavior is neurosis, which was abandoned by the DSM-III in 1980.[57] Of particular consequence, the same applicant who presented with a clinical history of "neuroticism," may have been diagnosed by a marriage and family health counselor without any clinical expertise in psychiatry or psychology. Nevertheless, this applicant would be barred from holding a medical certificate under Part 67.[58]

Surely not everyone that has been jaded in the past and has had their views affect romantic relationships should be clinically disqualified from holding an airman medical certificate. Unfortunately, the current aeromedical

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[52] *See* Kristalyn Salters-Pedneault, *Why Multiaxial Diagnosis Is Outdated*, VERYWELL MIND (Sept. 17, 2020), https://www.verywellmind.com/what-is-multi-axial-diagnosis-425180.

[53] Revision of Airman Medical Standards and Certification Procedures and Duration of Medical Certificates, 61 Fed. Reg. 11, 246 (Mar. 19, 1996) (as codified at 14 C.F.R. pt. 67) (stating that "[the mental health standards] language change was proposed to be consistent with the diagnostic terminology and classification of mental disorders, published in the DSM III and its successor DSM IV.").

[54] 14 C.F.R. §§ 67.107(c), 67.207(c), 67.307(c).

[55] Alyson Powell Key, *What Is Neurotic Behavior?,* WEBMD (June 14, 2021), https://www.webmd.com/mental-health/neurotic-behavior-overview.

[56] *Id.*

[57] John Townsend et. al., *Whatever Happened To Neurosis? An Overview*, 14 PRO. PSYCH.: RSCH. & PRAC. 323–329 (1983). *But see International Statistical Classification of Diseases and Related Health Problems*, 1 WORLD HEALTH ORG. (5th ed. 2016) (The 10th edition of the International Statistical Classification of Diseases and Related Health Problems, the World Health Organization's version of the DSM, which still classifies Neurosis as a disorder).

[58] §§ 67.107(c), 67.207(c), 67.307(c) (Rendering any "other mental condition that the Federal Air Surgeon . . . finds: (1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or (2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.").

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standards allow for an individual to be diagnosed by a non-mental health professional and be disqualified from ever flying again.

B. Alternatives to Regular Issuance of Airman Medical Certificate

According to the FAA, 96% of applications are approved at the time of physical evaluation by the AME.[59] Implicitly, this shows that roughly 4% of applicants either follow an alternative process, appeal the FAA's findings, or seek no further action—letting the denial stand. Alternatives available are by way of the AME either denying the certificate at the outset or deferring the decision to the Federal Air Surgeon, who will consider the applicant for a Statement of Demonstrated Ability ("SODA") or Authorization for Special Issuance of Medical Certificate ("SI").[60]

A SODA may be granted to pilots who are unable to meet the standards for medical certification, but whose conditions are minor or stagnant.[61] Applicants must provide documentation to the FAA showing that the conditions are "static or nonprogressive."[62] Examples of such conditions are an applicant presenting with color blindness or a prosthetic limb. After a SODA is granted to the pilot by the FAA, an AME may issue a medical certificate to the pilot so long as the condition has not changed.[63] A SODA is valid indefinitely so long as no adverse change occurs.[64] Due to the non-static nature of mental health disorders, these conditions rarely, if ever, qualify for a SODA.

However, an SI may be approved for conditions that are otherwise not eligible for a SODA or regular medical certificate, so long as the applicant "shows to the satisfaction of the Federal Air Surgeon that the duties authorized by the class of medical certificate applied for can be performed without endangering public safety . . . ."[65] SIs are valid for a defined duration and are renewed only at the discretion of the FAA.[66] Most mental health disorders are recognized as non-static.[67] Therefore, an applicant affected by a mental health disorder may be granted an SI.

Two mental health disorders that have been recognized by the FAA as deserving special consideration for SIs are substance dependence and

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[59] *Medical Certificate Questions and Answers*, FED. AVIATION ADMIN. https://www.faa.gov/pilots/safety/pilotsafetybrochures/media/Checklist.pdf (last visited Apr. 11, 2023).
[60] § 67.401.
[61] *Id.* § 67.401(b).
[62] *AME Guide*, *supra* note 39, at 25.
[63] *Id.*
[64] *Id.*
[65] § 67.401(a).
[66] *Id.*
[67] *See, e.g.*, Administrator v. Matthews, NTSB Order No. EA-5918, Docket No. SM-30217, 2022 NTSB LEXIS 3, slip op., 18 (NTSB Jan. 26, 2022) (explaining that the Chief Psychiatrist at the FAA, Dr. Charles Chesanow, testified that "most mental illnesses are chronic conditions that require monitoring and may recur, rather than conditions that may be 'cured.'").

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substance abuse.[68] In the early 1970s, industry stakeholders and the FAA collaborated to create a program known as the Human Intervention Motivational Study ("HIMS").[69] HIMS is an occupational substance abuse treatment program that coordinates treatment and the return-to-work process for airmen.[70] Today, HIMS is recognized as a potential incentive for airline pilots to be upfront with the FAA about their chemical dependencies.[71] Although the program was created exclusively for airline pilots, specialized AMEs under this program ("HIMS AMEs") have extended its opportunities to other airmen, including recreational and student pilots.[72] Over 10,000 pilots with alcoholism or other addictions have been granted SIs through this program.[73] Unfortunately, this program has been criticized as being overinclusive, representing multiple pilots with other significant disorders who have no other means of returning-to-work than to enter HIMS.[74]

Finally, the FAA has created a process that allows AMEs to issue medical certificates for some conditions that would otherwise be disqualifying: Conditions AMEs Can Issue ("CACI"). Under this process, AMEs can issue certificates to individuals affected by various maladies, such as arthritis and many forms of cancer.[75] During the physical evaluation, an AME can issue the airman medical certificate so long as the applicant fits the standards in the CACI Condition Worksheet given to the AMEs.[76] The AME is not required to submit documentation to the FAA for a CACI.[77]

C. Denials and the Appeals Process

For the 0.05% of medical certificates that are ultimately denied by the FAA, the FARs and statutes describe an appeals process.[78] If an applicant's certificate is denied by an AME, they may apply in writing within thirty days to the FAA for reconsideration of the denial.[79] There is no requirement for the FAA to respond in a timely fashion.[80] If the Manager of the Aeromedical Certification Division denies the application due to a mental health condition, the applicant may again appeal to the Federal Air Surgeon.[81] Under current

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[68] Ian Fries, *Alcohol, Antidepressants and the FAA*, FLYING MAG. (Nov. 4, 2011), https://www.flyingmag.com/pilots-places/pilots-adventures-more/alcohol-antidepressants-and-faa/.

[69] *Id.*

[70] *About HIMS*, HUM. INTERVENTION MOTIVATIONAL STUDY, https://himsprogram.com/about-hims/ (last visited Mar. 18, 2022).

[71] *See id.*

[72] *See AME Guide*, *supra* note 39, at 18–19.

[73] *FAA Medical Certification: Statistics*, *supra* note 46.

[74] *See, e.g.,* RANDALE PATRICK MURPHY, THE HIMS NIGHTMARE: A PILOT'S GUIDE TO SURVIVING SUBSTANCE ABUSE RE-EDUCATION (2019).

[75] *AME Guide*, *supra* note 39, at 330.

[76] *Id.*

[77] *Id.*

[78] 14 C.F.R. § 67.409.

[79] *Id.*

[80] *Id.*

[81] *Id.*

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practice, the Federal Air Surgeon convenes a panel of physicians with expertise in the area of concern to review documentation submitted and guide the Federal Air Surgeon in her determination.[82] The panel conducts their analysis behind closed doors, neither the airman, nor his counsel, are given the opportunity to testify, present evidence, or otherwise persuade the panel other than their previously submitted written statements.[83] The applicant is not given the opportunity to respond to the denial on the merits.[84]

Once the Federal Air Surgeon issues their denial, it is reviewable by the National Transportation Safety Board ("NTSB").[85] A hearing is normally conducted first by an Administrative Law Judge ("ALJ") where an applicant may present evidence and examine witnesses.[86] Despite the airman's opportunity to present their case, ALJs give a great deal of deference to the decisions of the Federal Air Surgeon.[87] If the ALJ does not reach a favorable outcome for the applicant, the applicant may appeal again to the full board of the NTSB.[88] Full NTSB board appeals are not hearings and only written briefs may be submitted.[89] Similar to the hearing by the ALJ, the board rarely overturns the decisions of the Federal Air Surgeon.[90]

Under Title 5 of the United States Code, courts may review the final agency action of either the NTSB full board or the FAA.[91] In reviewing the case, the federal courts will disrupt the finding only if it was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."[92] The federal courts will not overturn the decision of the NTSB or FAA unless it was made without reasonable basis.[93]

The process for a denied SI or SODA does not follow this process. Instead, the applicant is left in limbo, with no recourse whatsoever, as the

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[82] *See, e.g.*, Witter v. Delta Airlines, 966 F. Supp. 1193 (N.D. Georgia 1997).

[83] § 67.409(a).

[84] *Id.*

[85] 49 C.F.R. § 821.24(a); *see also* 49 U.S.C. § 44703(d); *see also How Does the Appeal Process Work?*, FED. AVIATION ADMIN., https://www.faa.gov/faq/how-does-appeal-process-work (last visited Feb. 2, 2023).

[86] 49 U.S.C. § 44703(a) (requiring that proceedings before the NTSB Administrative Law Judges relating to denial of an airman certificate are required to "be conducted, to the extent practicable, in accordance with the Federal Rules of Civil Procedure and the Federal Rules of Evidence."). Pilot's Bill of Rights, 112 P.L. 153, 126 Stat. 1159, 1159 (2012); s*ee also* 49 C.F.R. § 821.38 ("The Federal Rules of Evidence will be applied in these proceedings to the extent practicable.").

[87] *See, e.g.*, Administrator v. Matthews, NTSB Order No. EA-5918, Docket No. SM-30217, 2022 NTSB LEXIS 3, slip op., 36 (NTSB Jan. 26, 2022); Administrator v. Choure, NTSB Order No. EA-5829, Docket No. SM-30091, 2017 NTSB LEXIS 16, 30–31 (NTSB Oct. 11, 2017); Administrator v. Dickson, NTSB Order No. EA-5517, Docket No. SM-4892, 2010 NTSB LEXIS 34, 55 (NTSB Apr. 9, 2010).

[88] 49 CFR § 821.47.

[89] *See id.* § 821.48(e).

[90] *See, e.g.*, Administrator v. Matthews, NTSB Order No. EA-5918, Docket No. SM-30217, 2022 NTSB LEXIS 3 slip op., 36–37 (NTSB Jan. 26, 2022).

[91] *See* 5 U.S.C. § 706.

[92] Dustman v. Huerta, 2014 U.S. Dist. LEXIS 76020, at 1* (N.D. Ill. May 30, 2014).

[93] Katie Manworren, *The FAA's Mental Health Standards: Are They Reasonable?*, 83 J. AIR L. & COM. 391, 403–04 (2018).

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NTSB has repeatedly found that the decision whether to grant an SI under 14 C.F.R. § 67.401 is within the discretion of the Federal Air Surgeon and, thus, not subject to Board review.[94] 49 U.S.C. § 44703(d) clearly grants the NTSB jurisdiction, but only after the Federal Air Surgeon "has issued a *final* denial of a medical certificate which is not a special issuance."[95] Because the FAA has not denied a regular certificate, the NTSB lacks jurisdiction to review decisions related to airman SIs.

III. ANALYSIS AND PROPOSED CHANGES

In late 2020, the issue garnered congressional attention when Senator Diane Feinstein requested a Department of Transportation audit of FAA mental health recertification policies.[96] In conducting the audit, the Department of Transportation Office of Inspector General identified objectives of "(1) evaluating the psychological health of airline pilots and (2) mitigating potential threats to aviation safety from pilots with psychological health issues."[97] Perhaps inevitable, the first objective is likely to result in a less than favorable finding.[98] Even in the event that the audit returns only a small number of airline pilots are affected by psychological health, the focus should turn primarily on the second objective: mitigating potential threats to aviation safety. Due to a lack of incentives for applicant honesty, a comprehensive overhaul of the regulatory system, as well as further changes for administrative oversight, are needed to ensure the safety of the traveling public.

A. The Stick Approach: Forced Compliance Through Punishment

The FARs themselves provide for "suspending or revoking a medical certificate; withdrawing an [SI] or SODA; or denying an application for a medical certificate or request for an [SI] or SODA [when an applicant makes a]n incorrect statement, [on] an application for a medical certificate."[99] Thus, an airman caught falsifying an answer about their mental health on their airman medical application (Form 8500-8) *could* face administrative action and the revocation of their flying privileges. But when the alternative is an *automatic* denial of their flying privileges because they reported a disqualifying condition, this is hardly an adequate deterrent.

Indeed, the statistics provide that many airmen do not perceive this

[94] Administrator v. Harris, NTSB Order No. EA-5676, Docket No. NA-110, 2013 NTSB LEXIS 57, 7–8 (NTSB Aug. 27, 2013); *See* Administrator v. John Doe, 5 NTSB 41, 43 (1985).

[95] Administrator v. Harris, NTSB Order No. EA-5676, Docket No. NA-110, at 5.

[96] *See Memorandum: Audit Announcement, Review of FAA's Evaluation of Pilot Mental Health,* 1 U.S. DEP. OF TRANS. OFF. OF INSPECTOR GEN. (Nov. 17, 2020), https://www.oig.dot.gov/sites/default/files/FAA.

[97] *See id.* at 2.

[98] *See generally Airplane Pilot Mental Health and Suicidal Thoughts*, *supra* note 4.

[99] *See* 14 C.F.R. § 67.403(c).

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as an adequate threat to their livelihoods. When FAA researchers looked at every fatal accident between 1993 and 2003, toxicological evidence revealed that of the roughly 4,000 pilots involved in fatal accidents, more than 300 pilots had a serious medical condition that went unreported on their airman medical applications.[100] If this 7.5% lie-factor were not enough, in March 2007, a Department of Transportation Office of Inspector General investigation called Operation Safe Pilot revealed "egregious cases of pilots failing to disclose debilitating medical conditions on their applications for [a]irman [m]edical [c]ertificates."[101] From a sample of 40,000 pilots, Operation Safe Pilot found evidence that over 3,200 medically certificated pilots were receiving Social Security disability benefits that would otherwise be aeromedically disqualifying.[102] Many of these pilots "may have [flown] with debilitating illnesses that should have kept them grounded, such as schizophrenia, bipolar disorder, drug and alcohol addiction and heart conditions."[103] These statistics make apparent that at least 7.5% of pilots are lying on their medical applications.

Perhaps the biggest possible deterrence from lying on an airman medical application is the possibility of criminal liability.[104] When the FAA discovers that a pilot has lied on their application, it will usually refer the matter to the Department of Justice, which may bring criminal prosecution for concealment.[105] Prosecution under this statute may find a pilot in jail for five years or fined $250,000.[106] However, these prosecutions are rare. Of the more than 3,200 pilots identified as having disqualifying conditions, only forty-five were prosecuted for concealment.[107] This number was limited by resource and personnel constraints in the United States Attorney's Office.[108] Hundreds more pilots could likely have been prosecuted.[109]

Ensnared by Operation Safe Pilot for concealment, one pilot filed suit for violation of the Privacy Act of 1974.[110] In *FAA v. Cooper*, a pilot was able

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[100] *See* Susan Parson, *Truth or Consequences*, FAA AVIATION NEWS, 11 (Jan./Feb. 2009), https://www.faa.gov/news/safety_briefing/2009/media/janfeb2009.pdf.

[101] *See The Federal Aviation Administration's Oversight of Falsified Airman Medical Certificate Applications, Hearing Before the Subcomm. on Aviation of the H. Comm. on Trans. & Infrastructure*, 110th Cong. 1 (2007) (opening remarks of Jerry F. Costello, Chairman, H. Subcomm. on Aviation) [hereinafter *The Federal Aviation Administration's Oversight Of Falsified Airman Medical Certificate Applications*].

[102] *See id.* at 2.

[103] *See Pilots Claimed Disability but Kept Flight Status*, WASH. POST, https://www.washingtonpost.com/archive/politics/2005/07/20/pilots-claimed-disability-but-kept-flight-status/ (last visited Jan. 30, 2023).

[104] *See, e.g.*, United States v. Culliton, 328 F.3d 1074 (9th Cir. 2003).

[105] *See* 18 U.S.C. § 1001.

[106] *See id.*; *see also* Alyssa Miller, *Pilot Sentenced to Jail for Lying on Medical Application*, AOPA NEWS (Mar. 25, 2008), https://www.aopa.org/news-and-media/all-news/2008/march/25/pilot-sentenced-to-jail-for-lying-on-medical-application.

[107] *See The Federal Aviation Administration's Oversight Of Falsified Airman Medical Certificate Applications supra,* note 100.

[108] *See id.* at 10 (testimony of Calvin L. Scovel, Inspector General, U.S. Department of Transportation).

[109] *See id.*

[110] *See* FAA v. Cooper, 566 U.S. 284, 289 (2012).

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to successfully petition the Supreme Court of the United States, which held that the FAA could be liable for actual damages for violating the provisions of the Privacy Act by sharing the pilot's confidential medical information with the Social Security Administration.[111] As a result, the FAA sought to change the 8500-8 so that airmen would implicitly "authorize[] the agency to compare the data on [the] 8500-8 with other agencies that might be providing disability benefits to the individual."[112] Because this change never occurred,[113] questions still remain as to the financial feasibility—both personnel-wise and in unknown litigation—of inter-agency investigations into pilot's medical records. Consequently, agencies may be reluctant to implement similar investigations with the FAA.

It is possible that the FAA may go to a life insurance or health insurance clearinghouse in order to determine eligibility. Insurance clearinghouses like the Medical Information Bureau ("MIB") provide insurance companies with fraud protection for underwriting of insurance policies.[114] According to the MIB, "only those insurance companies that are members of MIB may access MIB's database and report information to MIB and they may only do so when they have obtained a written authorization from the consumer."[115] Thus, the FAA would need to receive written authorization from the airman in order to access an airman's medical record through a national clearinghouse. Currently, an airman's signature on the 8500-8 only permits the FAA to request information pertaining to an airman's driving record.[116] As a result of the Supreme Court's ruling in *Cooper*, any reluctance on the FAA's part to seek information from the MIB is well-founded.

Setting aside an inter-agency investigation like Operation Safe Pilot, or access to an insurance clearinghouse, other notable prosecutions of pilots for concealment stem from in-flight emergencies or lawsuits. In 2002, a commercial airline pilot suffered a diabetic seizure in flight and forced an emergency landing.[117] He received a sentence of sixteen months in federal prison.[118] Another pilot was convicted of knowingly providing false statements to a federal agency after he brought a personal injury lawsuit against a manufacturer but failed to report his injuries on his medical

[111] *See id.* at 287.

[112] Douglas H. Amster, *The Legal Consequences of Undisclosed Medical Conditions on Aircraft Operator Liability*, 77 J. AIR L. & COM. 221, 243 (2012) (citing Fred Tilton, *Operation Safe Pilot Revisited*, 45 THE FEDERAL AIR SURGEON'S MEDICAL BULLETIN, 2007-3, at 2).

[113] *See AME Guide*, *supra* note 39, at 42.

[114] *MIB Responds to Misleading Statements by AnnualMedicalReport.com*, MIB (April 4, 2016), https://www.mib.com/webcontent/mib_responds_annualmedicalreport.pdf.

[115] *Id.*

[116] *AME Guide*, *supra* note 39, at 42.

[117] *Ex-Cape Air Pilot Gets Jail After Emergency*, BOSTON HERALD (Nov. 17, 2018), https://www.bostonherald.com/2008/03/22/ex-cape-air-pilot-gets-jail-after-emergency/.

[118] *Id.*

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application.[119] The pilot received a $5,000 fine.[120] Needless to say, examples like these are few and far between for pilots. To a pilot, whose livelihood depends on medical clearance by the FAA, the current approach of penalizing wrongdoers does not provide an adequate mechanism for deterring falsification of the application for airman medical.

In 2016, over 300,000 first-class and second-class airman medical certificates were processed by the FAA.[121] Considering the 7.5% lie-factor described above, at least 22,500 pilots are lying on their medical applications. Given the lack of perceived threat of enforcement, it is likely that this number is far greater and deterrence has tragically failed. It is imperative that changes be made to cure this issue.

B. The Carrot Approach: Amnesty for Airmen who Previously Falsified Applications

Previously, the FAA made significant progress in seeking to bring pilots back to a position of complete honesty on their medical applications. In an early 2010 agency action, the FAA announced that it would change its enforcement policy, allowing pilots to disclose previous falsification on application for airman medical certification without the risk of enforcement action by the FAA.[122] Thus, a pilot whose depression was controlled by the antidepressants Celexa, Zoloft, Lexapro, or Prozac could self-disclose their previous falsifications without risk of losing their pilot's licenses.[123] However, the action was limited only to falsifications of Serotonin Self Reuptake Inhibitor ("SSRI") antidepressant use.[124] As a consequence, an airman who was successfully managing symptoms of the same disorder with a non-SSRI was exempt from the policy and could still be prosecuted. In other words, the FAA unwittingly created a policy that singled out medications instead of the underlying root cause for using the medications.

Increasing in popularity, Serotonin and Norepinephrine Reuptake Inhibitors ("SNRIs") have been reported to have a greater efficacy at treating depression than some SSRIs.[125] Some studies consistently suggest that one particular SNRI, Venlafaxine, may have an even greater efficacy than the SSRIs as a class at managing depressive symptoms.[126] Nevertheless, the

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[119] United States v. Culliton, 328 F.3d 1074, 1076–78 (9th Cir. 2003).
[120] *Id.* at 1078.
[121] FED. AVIATION ADMIN., 2016 AEROSPACE MEDICAL CERTIFICATION STATISTICAL HANDBOOK 12 (May 2018).
[122] Compliance and Enforcement Bulletin No. 2010–1, 75 Fed. Reg. 17,200 (Apr. 5, 2010) (not codified in the C.F.R.). [Hereinafter Compliance and Enforcement Bulletin 2010-1].
[123] Special Issuance of Airman Medical Certificates to Applicants Being Treated with Certain Antidepressant Medications, 75 Fed. Reg. 17,047, 17,049 (Apr. 5, 2010) (not codified in the C.F.R.).
[124] *Id.*
[125] *See* Michael Thase, *Are SNRIs More Effective Than SSRIs? A Review of The Current State Of The Controversy*, 41 PSYCHOPHARMACOLOGICAL BULLETIN 58, 59 (2008).
[126] *Id.*

FAA's amnesty policy did not apply to medications that could possibly have a greater efficacy of managing depressive symptoms than those it approved.

Still, the FAA should be commended for implementing such a policy that incentivizes pilots to compliance. Unfortunately, the amnesty policy ended on September 30, 2010.[127] In order to effectively remove the threat of prosecution and loss of livelihood from any future pilots who have previously failed to disclose their conditions, an essential starting place would be to revisit and reissue this policy. If deterrence theory did not work in practice, an effective way to increase compliance is to incentivize pilots into compliance, rather than disincentivizing pilots from non-compliance.

Such a move is not unprecedented in the history of the FAA. Prior to 2015, the FAA developed a reputation of strict liability enforcement.[128] Under this regime, if a pilot were accused of wrongdoing, the FAA would commence enforcement action.[129] Thirty day suspensions were the norm, with occasional violations far-exceeding thirty days.[130] As a result, many pilots were—and some still are—reluctant to speak out about otherwise unassuming incidents for fear that what they said would turn into a violation.[131] In 2015, the FAA changed its approach significantly and instituted a philosophy of compliance.[132] Under this philosophy, the FAA has embraced the concept of a "just culture," a culture that has "both an expectation of, and an appreciation for, self-disclosure of errors."[133] Today, a pilot who is willing and able to comply and who is cooperative in taking the steps necessary to get back into compliance will not be prosecuted.[134] Strict enforcement is reserved only for those who are unwilling or unable to comply.[135] Reissuing the 2010 amnesty policy is not only a necessary step toward a solution, but is harmonious with the current enforcement policy of the FAA and the concept of a "just culture."

What remains is the necessary duration of the amnesty policy and its proper scope. Absent good reason otherwise, amnesty for falsification of an airman medical application should be extended indefinitely. Such a policy ensures a "just culture" throughout all aspects of aviation, without the exemption of the FAA airman medical application process, enabling the ability to maintain the safest airspace system in the world. In furtherance of that goal, if a review of an airman's application for medical certification

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[127] Compliance and Enforcement Bulletin 2010-1, *supra* note 122, at 17,201.

[128] Scott Williams, *FAA's Compliance Program: Kinder and Gentler?*, CIRRUS OWNERS & PILOTS ASSOC. (Aug. 17, 2020), https://www.cirruspilots.org/Publications/Articles/faas-compliance-program-kinder-and-gentler.

[129] *Id.*

[130] *Id.*

[131] *Id.*

[132] *See* FED. AVIATION ADMIN., COMPLIANCE PROGRAM & AIRMAN RIGHTS (May 12, 2020).

[133] *Compliance Program*, FED. AVIATION ADMIN. (Sept. 20, 2022), https://www.faa.gov/about/initiatives/cp.

[134] *See* John Duncan, *Getting a Fix on Safety*, FAA SAFETY BRIEFING, Jan. 2016, at 1.

[135] *Id.*

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becomes necessary, regulatory medicine practitioners, as factfinders, should review only the airman's current application for medical certificate. Such a practice would be effective at eliminating any bias a practitioner might have for an airman's past practices of falsification. Instituting this policy would also alleviate any concerns about the scope of the amnesty policy, which should extend to all previously undisclosed medical conditions. Of course, not every medical condition would be *per se* qualifying. The amnesty policy would not seek to eliminate standards for aeromedicine but would only serve as an effective measure to ensure that pilots seeking to be forthcoming with the FAA will not be prosecuted for past indiscretions.

Nevertheless, the amnesty policy is only as good as the opportunities it provides. Indeed, since the original amnesty period in 2010, less than 500 pilots have received an SI for use of SSRIs.[136] This seems to suggest that less than 500 pilots took advantage of the amnesty program, or more likely, the SSRI protocol proved to be too stringent and many pilots effectively stopped flying indefinitely. Without further changes, an amnesty program would be only a mere incremental step towards a solution in solving pilot mental fitness and would not solve the problem.

C. Economic Incentives: Reducing Financial Disincentives

At the outset, it would seem apparent that a simple change to the aeromedical regulations might be sufficient to incentivize those pilots afflicted with mental health problems in coming forward. Such an assessment falls short of the mark. Pilots may still be disincentivized from reporting due to possible adverse effects financially.

The median annual salary for all commercial pilots (airlines, corporate aviation, government contracting) is $99,640.[137] In the airline industry, wages begin at roughly $65,000 per year, with the potential of reaching between $350,000 and $400,000 per year as a captain for a legacy airline.[138] While these numbers may seem more than sufficient to support temporary changes in income due to a denied application for medical certificate, consider also that airline pilots, like lawyers and doctors, are professionals who experience a significant financial barrier to entry.[139] A pilot without a four-year degree will likely incur at least $96,000 in debt while in

[136] *FAA Medical Certification Statistics*, *supra* note 46.

[137] *American and Commercial Pilots*, U.S. BUREAU OF LAB. STAT., https://www.bls.gov/ooh/transportation-and-material-moving/airline-and-commercial-pilots.htm (last visited Feb. 9, 2023).

[138] *Regional Airline Pilot Salary*, ZIPRECRUITER, https://www.ziprecruiter.com/Salaries/Regional-Airline-Pilot-Salary (last visited Feb. 9, 2023). *United Airlines Captain Salaries*, GLASSDOOR, https://www.glassdoor.com/Salary/United-Airlines-Captain-Salaries-E683_D_KO16,23.htm (last visited Feb. 9, 2023).

[139] *See Airline Career Pilot Program*, AIRLINETRANSPORTPROFESSIONALS, https://atpflightschool.com/airline-career-pilot-program/ (last visited Feb. 9, 2023).

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flight school.[140] As many large airlines have long required a four-year degree, most commercial airline pilots incur significantly more debt than this, with some pilots incurring well over $300,000 in debt.[141] Given this debt load, an individual will need to make in excess of $2,000 per month to pay their student loan debt.[142] When wages begin at roughly $65,000, an individual's monthly take home after Federal Insurance Contributions Act deductions, federal taxes, and loan payment is less than $2,300. A temporary gap in income, let alone completely foregoing any earnings at all, for medical certification or further examinations is one disincentive that must be addressed. It simply is not feasible for individuals to afford such a high debt load without some sort of safety net. This income gap is a strong factor on why pilots might not be willing to be forthcoming with the FAA on their medical applications.

By the same token, the opportunity cost of foregoing the lucrative career outcomes of the upper end of the pay scale is also a large disincentive. Imagine being an attorney or doctor, having just graduated law or medical school, with offers at major firms or hospitals which will set you up for a lucrative career in your profession. However, shortly after entering the profession, you are forced to retire due to a medical condition that is entirely controllable with medication. This is effectively what pilots are facing. The lost potential earnings and potential career thus present another significant obstacle: one of missed opportunity. Thus, the two most significant obstacles to faithful reporting on an airman's medical application are the income gap and the cost of missed opportunity.

In order to offset the income gap, many airlines provide disability insurance.[143] Additionally, unions have begun offering multiple disability insurance plans that seek to offset these costs as well.[144] The Air Line Pilots Association ("ALPA") offers two different types of plans for members: a base plan which provides up to $4,800 per month up to a maximum duration of five years, and a plus plan that offers a percentage of salary up to retirement.[145] Indeed, many airlines that provide this benefit to their pilots pay the premiums

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[140] *Id.*

[141] Ethan Klapper, *Delta Removes a Big Barrier to Getting Hired There as a Pilot*, THE POINTS GUY (Jan. 10, 2022), https://thepointsguy.com/news/delta-air-lines-college-requirement/ ("Delta becomes the last major U.S. airline to drop the college degree requirement."). *See e.g.*, *Tuition and Estimated Costs: Fall 2023-Spring 2024*, EMBRY-RIDDLE AERONAUTICAL UNIV., https://daytonabeach.erau.edu/admissions/estimated-costs (last visited Mar. 18, 2022) (reporting a yearly cost of attendance in excess of $90,000 for Embry-Riddle Aeronautical University); *Flight Course Track*, EMBRY-RIDDLE AERONAUTICAL UNIV., https://daytonabeach.erau.edu/-/media/files/daytona-beach/college-of-aviation/flight/flight-tracks-2021.pdf (last visited Feb. 9, 2023) (reporting median flight costs of $74,200 at the same school).

[142] Assuming an interest rate of 6% with a 20-year repayment period.

[143] SPIRIT AIRLINES MASTER EXEC. COUNCIL, SPIRIT PILOTS' CONTRACT COMPARISON 55–57 (2021).

[144] *See generally* ALPA INSURANCE BROCHURE.

[145] *Id.* at 1.

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for this plan at no cost to the pilot.[146] However, these airline-provided policies routinely limit the maximum benefit duration to less than three years for conditions related to substance abuse or mental illness.[147] Therefore, pilots are still left without meaningful incentives.

To close this gap, it becomes necessary to insure pilots against losses for a longer period of time and not specifically limit the maximum duration of long-term disability insurance as an exception. A statutory change should be effected to preempt insurers from excluding these conditions from full coverage. Such a statutory change need not be limited to pilots, as it represents sound public policy. In the alternative, a statutory change could allow for individuals to obtain social security disability assistance if they have been deemed medically disqualified by the FAA. Such a change may be costly, so it may be necessary to offset these costs by having pilots pay a higher rate into the social security net.

Regardless, the financial disincentive for pilots to come forward and be honest about any adverse mental health symptoms must be repudiated. Failure to remove this barrier would only prove to solve the current climate of fear among pilots for only a relatively short period. Half measures in this area would achieve little. Therefore, these disincentives must be addressed through legislation in order to offer a holistic solution to the aviation community.

D. Human Intervention Motivational Study: A Bypass with Drawbacks

Changing the regulations might seem an arduous task. Nevertheless, the FAA has already proven a willingness to work with airmen who might otherwise be ineligible for medical certification due to a small subset of mental health conditions: addiction.[148] Prior to 1974, "[t]he notion that alcoholism could be a bona fide disease was alien to . . . decision-makers in the air transport industry . . . as a result, alcohol-addicted pilots stayed in the closet."[149] All too often, the only way to determine if a pilot was addicted was if they were struck by seizures on duty.[150]

Stepping in to stage an intervention, the new Aeromedical Advisor to ALPA, Dr. Richard Masters, received unanimous approval from the union's board to establish a program to address alcoholism.[151] Dr. Masters worked closely with the National Institute for Alcohol Abuse and Alcoholism to obtain funding for his Human Intervention Motivational Study ("HIMS") for

[146] *See* SPIRIT AIRLINES MASTER EXEC. COUNCIL, *supra* note 143, at 55–56.
[147] *Id.* at 56.
[148] *See* Esperison Martinez, *HIMS: Addressing Alcohol Abuse*, AIR LINE PILOT 17 (2004).
[149] *Id.*
[150] *Id.*
[151] *Id.*

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returning affected pilots to flight duty with approval of the FAA.[152] Within ten years, the study was implemented industrywide, returned 1,200 pilots to active flight status, and boasted a surprisingly effective 90% recovery rate.[153] Since then, despite several major changes to the program, HIMS has been used as a benchmark for other occupational recovery programs.[154]

Today, a pilot who identifies as being affected by the disease of addiction must follow a regimented pathway ("the HIMS Protocol") in order to be deemed certifiable under aeromedical policies. The pilot begins the process by undergoing thirty days of inpatient residential treatment and upon release from treatment, establishes with a HIMS AME.[155] The HIMS AME serves as the pilot's liaison with the FAA and also helps to develop the recovery program for the airman.[156] Simultaneously, the pilot will attend daily recovery meetings (AA, NA, etc.) for a period of ninety days and establish a sponsor and homegroup.[157] The HIMS AME will also begin a random testing regime to verify abstinence compliance.[158]

Once the pilot is established in recovery, they complete a psychiatric interview and a neuropsychological evaluation.[159] The psychiatric interview includes a ninety minute office visit, which includes a comprehensive psychiatric and substance use disorder evaluation conducted by a qualified psychiatrist who is board-certified by the American Board of Psychiatry.[160] During the neuropsychological evaluation, a board-certified neuropsychologist will put the pilot through twelve neuropsychological tests: the Wechsler Adult Intelligence Scale Revised (WAIS-R); the Trail Making Test (parts A and B); the Booklet Category Test; the Rey Osterrieth Complex Figure Test; the Rey Auditory-Verbal Learning Test; the Wisconsin Card Sorting Test; the Boston Naming Test; the Wechsler Memory Scale-Revised; the Controlled Oral Word Association test; the Manual Finger Tapping Test; and the FAA Computerized Cognitive Screening Battery (CogScreen-AE).[161] These tests are used to establish the pilot's lack of cognitive disability and

[152] *Id.*
[153] *Id.*
[154] *Id.* (stating that "HIMS elements . . . are the blueprint for successful recovery programs for professionals, nationwide.").
[155] *Milestones and Timelines for a Sample HIMS Case*, HIMS PROGRAM, https://himsprogram.com/wp-content/uploads/2021/04/Milestones-and-Timelines-for-a-Sample-HIMS-Case-1.pdf (last visited Mar. 18, 2022).
[156] *See generally id.*
[157] *Id.*
[158] *Id.*
[159] *Id.*
[160] Matthew Goldenberg, *HIMS Psychiatric Evaluation Q & A*, DOC GOLDENBERG, https://www.docgoldenberg.com/contents/services-additional/hims-psychiatric-evaluation-for-the-faa (last visited Mar. 18, 2022); *see also AME Guide*, *supra* note 39, at 412.
[161] *See* Adm'r v. Hoover, NTSB Order No. EA-4094, Docket No. SE-13417, 1994 NTSB LEXIS 35, 4-5 (NTSB Feb. 18, 1994).

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their ability to safely perform the functions of a pilot.[162]

Once these evaluations are complete, the HIMS AME will submit all applicable records to the FAA for final determination.[163] In 2014, the average time for the FAA to render a decision to grant an SI of the pilot's medical was within sixty days.[164] As a result, a pilot can disqualify themselves from operating an aircraft under 14 C.F.R. Part 61.53(a), seek help through the HIMS Protocol, and be back to flying status within five to eight months.[165]

The FAA has recently expanded the HIMS Protocol to other mental health disorders. Under the new SSRI protocol, a pilot will follow a similar process to the HIMS Protocol, establishing with a HIMS AME, completing the neuropsychological evaluation, attending the psychiatric interview, and having regular meetings with additional providers.[166] Thus, the FAA seems willing to certify those affected by some mental health disorders if they submit similar documentation to that of a pilot going through the HIMS Protocol, hinting that it is an adequate framework for further expansion.

Nevertheless, the HIMS Protocol has its disadvantages. First, the packet must be sent to the FAA for final determination.[167] With the current atmosphere of government shutdowns, it is possible that a pilot could wait several months—if not years—for the FAA to render a final decision on medical certification. Additionally, having the document sent to regulatory medicine practitioners is a significant barrier to effective medicine: the aeromedical doctors with decision-making authority at the FAA are merely looking at a series of documents and are not evaluating the patient in the first instance. Making matters worse, these doctors may decide that they do not have all the information necessary and send the pilot a request for further information, which only delays the certification process by placing the pilot at the back of the line.

Second, and perhaps the most important, is the financial drawback. Inpatient treatment may be covered by a pilot's medical insurance, but there are some cases where an insurer may not cover treatment for addiction because they do not find it medically necessary.[168] The strict aeromedical

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[162] *Milestones and Timelines for a Sample HIMS Case*, HIMS PROGRAM, https://himsprogram.com/wp-content/uploads/2021/04/Milestones-and-Timelines-for-a-Sample-HIMS-Case-1.pdf (last visited Mar. 18, 2022).

[163] *Id.*

[164] *Id*.

[165] *See generally id.*

[166] *AME Guide*, *supra* note 39, at 173.

[167] *Id.* at 245.

[168] *Medical Necessity*, LAHACIENDA, https://www.lahacienda.com/resources/articles/medical-necessity-addiction (last visited Jan. 25, 2023) (stating that "[m]ost insurance companies operate by the following definition of medical necessity: . . . services that a medical practitioner, exercising prudent clinical judgment, would provide to a Covered Individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are . . . in accordance with generally accepted standards of medical practice . . . .").

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standards of the FAA define substance dependence as "(A) Increased tolerance; (B) Manifestation of withdrawal symptoms; (C) Impaired control of use; or (D) Continued use despite damage to physical health or impairment of social, personal, *or* occupational functioning."[169] By contrast, the DSM-V has completely eliminated the antiquated distinction between substance abuse and dependence but has instead established a need for at least two of these criteria to issue diagnoses.[170] Thus, a pilot who exhibits only an increased tolerance for alcohol would be disqualified from medical certification by the letter of the law but would otherwise not meet the criteria set by most insurers for medical necessity. In some cases, inpatient treatment can cost $60,000, making this cost a significant barrier to recertification under HIMS.[171]

The financial drawbacks do not end with inpatient treatment. While daily recovery meetings may be free, the cost of the psychiatric interviews and neuropsychological evaluations can be astronomical. At the time of writing, some professionals conducting these evaluations advertised flat rates of $1,200 to $2,800 for the psychiatric interview and $2,500 to $4,500 for the neuropsychological evaluation.[172] Additionally, the HIMS AME may require frequent visits which may not be covered for medical necessity and the cost of routine drug tests to verify the pilot's sobriety may be significant. Under the FAA's current policy guidelines for the HIMS Protocol, there are virtually no adjudicated limits on what these practitioners can charge the pilots.[173] Although once a beacon of hope for pilots affected with mental health disorders, HIMS has recently come under fire for disincentivizing pilots to speak up about their addiction due to the exorbitant financial drawbacks.[174]

E. The Modern Medicine Approach: Empowering the Clinician

Despite its critics, the HIMS Protocol seems to be a moderately effective way of returning a pilot to active flight status. However, regulators should consider several minor tweaks to create a safer aeromedical system.

At the outset, the FAA should empower their AMEs to spearhead the team for all mental health related aeromedical issues. The FAA does not need to take a hands-off approach in the system but should create a support net for

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[169] 14 C.F.R. §§ 67.107(a)(4)(ii)(a–d), 67.207(a)(4)(ii)(a–d), 67.307(a)(4)(ii)(a–d) (emphasis added).

[170] Deborah Hasin et al., *DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale*, 170 AM. J. PSYCHIATRY 834, 336–37 (2013).

[171] Jeffrey Juergens, *Understanding the Cost of Rehab*, ADDICTION CTR. (Jan. 18, 2023), https://www.addictioncenter.com/rehab-questions/cost-of-drug-and-alcohol-treatment/.

[172] *See e.g.*, Michael Morris, *Fees Transparency Matters*, https://friscopsychology.com/fees (last visited Jan. 27, 2023); *Neuropsychological Evaluation Rates*, PAC. NEUROBEHAVIORAL CLINIC, PC, https://www.neuropacific.com/rates/ (last visited Jan. 22, 2023).

[173] *See generally Guide for Aviation Medical Examiners*, FED. AVIATION ADMIN. (Nov. 23, 2022, 1:03 PM), https://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide/dec_cons/disease_prot/ppevals/ (excluding any mention of the cost for evaluations).

[174] *See generally* Murphy, *supra* note 74.

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its AMEs. If the AME's primary purpose is to serve the FAA and the flying community by medically certifying pilots, it follows that the AME should be able to accept delegated authority from the FAA for many situations.

Many pilots meet with their AMEs and do not understand that the traditional doctor-patient relationship does not exist. The doctor-patient relationship is one of vulnerability and trust. If the FAA consistently overrules, or worse yet, does not allow the practitioner to meet the needs of the patient, the relationship between doctor and patient only serves to be eroded significantly into a relationship of regulator and citizen. If this is the case, why have certified medical professionals serve as FAA doctors in the first place? It would be far simpler to administer a system in which individuals could go through specialized training about medical conditions and render decisions for the FAA without due regard to the current practices of medicine. In other words, the FAA should trust the trained medical professionals that they empowered to make decisions, rather than consistently second guess these clinical decisions.

It is with this in mind, that the first implemented solution should be to allow the AME to serve as the primary decision-maker, relying on reports from trained psychiatrists, neuropsychologists, and other practitioners that the pilot regularly sees, such as therapists, psychologists, and even the pilot's primary care physician. In this manner, the AME might even serve as the pilot's primary care physician and get to understand the pilot better as a patient, which only leads to a safer aeromedical system. Who better to understand when a pilot should be disqualified from flight status than the doctor who has an established relationship with him?

It is in this manner that the FAA can serve an advisory role to the AMEs, as part of a team of other qualified diagnosticians. Should the AME encounter a difficult situation, he can always defer the decision to the FAA doctors who can make the ultimate decision for certification. The FAA's doctors would serve effectively as part of a team, rather than as the final arbiter of medical decisions when others may better know the circumstances of the case.

It might be argued that the FAA should retain ultimate authority of the decision-making process. Indeed, they still could maintain ultimate authority through an additional review process or an AME termination process. The first process, additional review, might allow the FAA regulatory practitioners to review airman medical records and determine that the airman should not have been granted a medical in the first place. In this sense, there would be no changes to current practice: the FAA currently conducts "quality control" reviews of issued medicals to ensure eligibility for medical

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certification.[175] Thus, the only thing that needs change is the guidance for the AMEs who would issue a medical certificate if they deemed the pilot's clinical history aeromedically insignificant or properly controlled.

Nevertheless, in another sense, it makes more sense to remove this review power from the FAA and to only allow the FAA to solve improper grants of certificate by suspending or terminating the AME from service. Under this method, the FAA would exercise control over the process by ensuring that only the most qualified AMEs are selected to remain in service as AMEs.

Perhaps a middle ground can be struck. Instead of removing the power from the FAA to conduct quality control reviews of granted medicals, the FAA could still conduct these reviews but would refer the case to an impartial medical review board for determination of outright denying the airman's certificate. This is no novel practice, as currently, the Federal Air Surgeon regularly convenes a panel of medical specialists to determine a pilot's eligibility.[176] However, under this proposal, the medical review board would be independent of the FAA and would serve as an impartial decision-maker in the case of both referrals from the FAA and in the course of appeals.

Such an independent medical review board could serve under the NTSB and could serve to alleviate the docket of current NTSB ALJs as well as growing caseloads of those officials in the Aeromedical Certification Division of the FAA. Appeals to such a medical review board could be as a matter of right when a pilot is denied their medical by an AME, or initiated by the FAA when a pilot is granted an SI by their AME when an FAA review post-certification encounters an error by the AME in granting the pilot's certificate.

The independent medical review board could hear arguments from both the pilot and the FAA, and both sides could be represented by attorneys (or even a doctor of their choice). Such board should be staffed by a team of AMEs and other board-certified specialists in the area of concern, and the financial burden should be instilled upon the party that initiated the hearing, with a reasonable cap on hearing costs not to exceed two to three hours of each doctor's billable rate. Similar to 90% of the nation's administrative hearings, these hearings could take place via telephone or video conference.[177] Additionally, there should be no exclusion for those seeking an SI for board

[175] *See* Gary Crump, *The Faa Sent A Letter About My Medical. Now What?*, AOPA (Jan. 28, 2013) https://www.aopa.org/news-and-media/all-news/2013/january/28/the-faa-sent-a-letter-about-my-medical-now-what.

[176] *Pilot's Guide to Medical Certification*, AOPA, https://www.aopa.org/training-and-safety/students/presolo/special/pilots-guide-to-medical-certification (last visited Jan. 28, 2023).

[177] Steven Wise, *Trends in Administrative Law: Telephone Hearings*, THE NAT'L JUD. COLL. (Feb. 19, 2015), https://www.judges.org/news-and-info/trends-in-administrative-law-telephone-hearings/.

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review: virtually any individual seeking a medical certificate should be entitled to the board's review. The hearings conducted by the board should be reviewable by the full board of the NTSB and then by the federal courts through the process outlined in the APA.

These changes would need codification. The Pilot's Bill of Rights 2, a bill that died in the House of Representatives, could be amended and reintroduced to allow for these much needed changes.[178] Reintroducing the Pilot's Bill of Rights 2 would provide the appropriate mechanism for making these changes as its text already addresses other reforms in the FAA medical certifications process.

F. Effective Recourse through Judicial Review

As explained, the fear of negative career impact is perhaps the strongest motivation for a pilot to avoid seeking professional help for a mental health condition. Previously, the NTSB appeals process rarely reversed a decision of the FAA. In 2010, the NTSB's ALJs held sixty-one hearings on emergency revocation actions and only five of these cases resulted in a reversal of the FAA's orders.[179] This so called "rubber-stamping" of the FAA's decisions only served to intimidate pilots who were arguably justified in believing that there was no effective recourse through appeal of the FAA's determinations.[180] It was against this backdrop that Senator Jim Inhofe introduced the Pilot's Bill of Rights in the Senate, attempting to change the appellate landscape for pilots.[181]

With sixty-five co-sponsors, the bill was unanimously passed by the Senate, passed by the House of Representatives by a voice vote, and enacted by President Obama in August 2012.[182] As enacted, the text of the law called for "full independent review" by a district court.[183] Aviation attorneys believed this term required a "de novo trial on a newly-created evidentiary record."[184] Nevertheless, the only court to address this standard of review issue found that the term was not sufficiently clear, and thus did not abrogate the APA's judicial review provisions.[185] In essence, the case of *Dustman v. Huerta* has inadvertently become pseudo-precedent for the applicable

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[178] *S. 571 (114th): Pilot's Bill of Rights 2*, GOVTRACK https://www.govtrack.us/congress/bills/114/s571 (last visited Jan. 22, 2023).

[179] Sen. Jim Inhofe, *Preview of the Pilots Bills of Rights*, YOUTUBE (Jul. 5, 2011), https://www.youtube.com/watch?v=roXiaGt4qek.

[180] 157 Cong. Rec. S4400 (daily ed. Jul. 6, 2011) (statement of Sen. Jim Inhofe).

[181] *See generally S.1335 – Pilot's Bills of Rights*, CONGRESS.GOV, https://www.congress.gov/bill/112th-congress/senate-bill/1335 (last visited Jan. 22, 2023) (providing a summary of the bill).

[182] Jim Inhofe, *Inhofe's Pilot's Bill of Rights Becomes Law*, VOTE SMART (Aug. 3, 2012), https://justfacts.votesmart.org/public-statement/733047/inhofes-pilots-bill-of-rights-becomes-law.

[183] Pilot's Bill of Rights, Pub. L. No. 112-153, § 2(e), 126 Stat. 1159, 1161 (2012).

[184] Dustman v. Huerta, No. 13 C 3565, 2013 WL 5747079, at *4 (N.D. Ill. Oct. 23, 2013).

[185] *Id.* at *5.

standard of review in cases where a pilot appeals an NTSB decision to a district court.[186] Fundamentally, this has resulted in language within the Pilot's Bill of Rights being rendered redundant and inoperative.

The *Dustman* court got it wrong. First and foremost, the United States district courts are trial courts, and appeals on administrative records should be heard solely by various circuit courts of appeals, the courts most adequately suited to hear cases involving complex appeals. An appellate court already exists that is adequately suited for appeals in complex, technical, and specialized areas of law, the Federal Circuit, but pilots need not be limited to review in this circuit alone. Additionally, under the Pilot's Bill of Rights, a pilot may elect "not to file an appeal in a United States district court, [but] may file an appeal in an appropriate United States court of appeals."[187] It strains logic that the text of a law might allow separate means of appealing an administrative record to two separate courts that are legally obligated to apply the same standard of review. Why would one willingly appeal an administrative record to one judge when they could have the opportunity to appeal to, at a minimum, a three-judge panel? Appeals on the administrative record below should be taken to the proper courts: the circuit courts of appeals. Accordingly, as trial courts, the United States district courts are the courts that are most adequately prepared to conduct a fact-finding hearing *de novo*.

Moreover, the *Dustman* court's interpretation of "full independent review" renders multiple sections of the law inoperative. In any exercise of statutory interpretation, "[t]he starting point . . . 'is the language of the statute itself.'"[188] But with the language of the term "full independent review" being unclear, courts should construe a term's meaning "to give effect, if possible, to every clause and word of a statute."[189] The Supreme Court is "'reluctan[t] to treat statutory terms as surplusage' . . . especially . . . when the term occupies . . . [a] pivotal . . . place in the statutory scheme."[190] The court in *Dustman* took extra care to explain that the Pilot's Bill of Rights does not establish a clear intent by Congress to depart from the clearly established APA norms of "arbitrary, capricious, . . . abuse of discretion, or otherwise not in accordance with law," but in so finding, the term "full independent review" is virtually meaningless.[191] Surely, Congress intended to give a less

[186] *See e.g.* Creighton v. Dep't of Transp., No. 6:13–cv–907–Orl –18TBS, 2014 WL 1364495, at *3 (M.D. Fla. 2014).

[187] Pilot's Bill of Rights § 2(d)(1).

[188] Kaiser Aluminum & Chem. Corp. v. Bonjorno, 494 U.S. 827, 835 (1990) (quoting Consumer Prod. Safety Comm'n v. GTE Sylvania, Inc., 447 U.S. 102, 108 (1980)); *accord* McNeil v. United States, 563 U.S. 816, 819 (2011).

[189] *See* Dustman, 2013 WL 5747079, at *5; Inhabitants of Montclair v. Ramsdell, 107 U.S. 147, 152 (1883); *see also* Williams v. Taylor, 529 U.S. 362, 404 (2000) (describing this rule as "a cardinal principle of statutory construction"); Duncan v. Walker, 533 U.S. 167, 174 (2001).

[190] Duncan, 533 U.S. at 174 (quoting Babbitt v. Sweet Home Chapter, Cmtys for Great Or., 515 U.S. 687, 698 (1995)).

[191] 5 U.S.C. § 706(a)(2); *Dustman*, 2013 WL 5747079, at *5–6.

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deferential scope of review than that afforded by the APA.

Further, if "full independent review" is given the same meaning as the ordinary arbitrary and capricious standard, why did Congress find it necessary to single out the district courts in the Pilot's Bill of Rights?[192] Nowhere in the text of the Pilot's Bill of Rights is the standard of review dictated for the circuit courts of appeals—because it is clear that those courts should apply the arbitrary and capricious standard that is normally afforded to appellants of administrative decisions before those tribunals. Therefore, contrary to the *Dustman* court, the text of the statute establishes Congress's intent to depart from the APA.

Perhaps recognizing the *Dustman* court's illogical conclusion, Senator Inhofe introduced a bill to expand the Pilot's Bill of Rights: the Pilot's Bill of Rights 2.[193] In this improved bill, a section was added to clarify that district courts must apply *de novo* review:

> In an appeal . . . in a United States district court with respect to a denial, suspension, or revocation of an airman certificate by the Administrator the district court shall review the denial, suspension, or revocation *de novo*, including by conducting a full independent review; permitting additional discovery and the taking of additional evidence; and making the findings of fact and conclusions of law required by Rule 52 of the Federal Rules of Civil Procedure without being bound to any findings of fact of the Administrator or the National Transportation Safety Board.[194]

While this bill was never passed into law, these provisions can still be included in another bill and enacted to give full effect to Senator Inhofe's intended meaning when the original Pilot's Bill of Rights was passed in 2012. Absent recognizing that the original text of the law requires *de novo* review or passing a law that clarifies such, pilots may neglect coming forward about their mental health conditions.

IV. CONCLUSION

There is no one-size-fits-all approach to fixing the failed policies of the FAA. Multiple measures must be adopted to empower pilots to come forward about their depressive symptoms. The appropriate starting point is amnesty for those pilots who have previously lied on their medical applications, which removes any fear of repercussions for falsification of government documents. Subsequently, the disability insurance industry or

[192] Pilot's Bill of Rights § 2(e)(1).
[193] Pilot's Bill of Rights 2, S. 571, 114th Cong. (2015).
[194] *Id.* (emphasis added).

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social security system must be obligated to provide for those pilots who are in the process of re-obtaining their medical certificates, which would serve to remove any financial disincentive that a pilot would face by being honest. Additionally, regulations should be enacted that empower the FAA's contracted doctors to make certification decisions on behalf of the pilots they see for most—if not all—of their medical certifications. Finally, district courts should find that appeals from the NTSB require *de novo* review and afford pilots an ability to have their cases heard by an impartial judiciary. Absent such findings, Congress must act swiftly in ensuring that the standard of review language from the original Pilot's Bill of Rights is given its full, intended meaning.

Joseph Heller's novel concludes with the protagonist unable to accept the conditions of an arrangement that would turn his back on the men of his squadron.[195] Similarly, the aeromedical regulatory system should not be in a position that turns its back on pilots, causing them to make the choice of hanging up their wings or continuing to falsify each medical application. The status-quo remains unsustainable. Together the aviation community and the FAA can solve these problems through proactive legislation and creative policymaking. While the pilots in a fictional story may be forced to face a Catch-22 situation, the systemic practice of 21st century aeromedicine need not be.

[195] HELLER, *supra* note 2, at 427.

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