CAMA leads discussion with FAA leadership on designating Centers of Specialized Aeromedical Excellence

The CAMA working group focused on providing input on streamlining the process of reviewing complex medical cases requiring Special Issuance Authorization met with FAA leadership April 26th in Atlantic City to discuss strategies for speeding up the process.

The concept of designating specialized centers to assist in evaluating pilots and collating data to work cases 

*en masse* was introduced. This, combined with expanding criteria for CACI (Conditions AMEs Can Issue) qualification, would be one step toward helping the FAA expand its bandwidth utilizing private sector resources without costing taxpayers additional funds and would help address case backlogs. It would also provide an educational opportunity for Aerospace Medicine trainees to research interesting medical cases, as residents and fellows could be tasked to do the background research for individual cases to be presented to the FAA.

Much like a Planning Commission presents data to a city council, a Center for Specialized Aeromedical Excellence would review and collect all supporting material for a specific pilot condition and present the case at a prescheduled date (or “panel”) to FAA physicians or other external consultants who would, in turn, make a final aeromedical decision on each case or defer a decision pending additional data or discussion. A Specialized Center would be designated to be an access point for pilots who wished to come for evaluations in an effort to reduce backlogs of cases and expedite processing of aeromedical application requiring Special Issuance.

CAMA will now submit a formal report to FAA Federal Air Surgeon Dr. James Fraser by next month. FAA leadership would then review and potentially propose a trial if the proposal can garner internal approval.
Where’s the “Public Bill of Rights II?”

It’s rare to find anything in Congress upon which legislators can agree. That’s why it is curious that there are 167 co-sponsors in the U.S. House of Representatives for H.R. 1062 “The Pilot’s Bill of Rights II” that was recently wedged into the FAA Reauthorization Act that was passed by the Senate (S. 2658) and is now being reviewed by the House as H.R. 4441.

Most of the media attention of the Reauthorization Bill has been focused on privatization of air traffic control services. The House has votes to support it. The Senate version passed without privatization of the air traffic control system, so it is expected that more attention and focus will be on this aspect of the bill and it is likely it will pass once the differences of opinion regarding this issue are addressed.

But, pressed way down in Subpart F of the bill is the Pilot’s Bill of Rights II, a piece of legislation written by Senator James Inhofe (R-OK) that will change the entire Class III medical process, allowing pilots to become medically eligible to fly if they have a valid state driver’s license, take an educational course on-line every two years on medical risks for flying, keep proof of participation in their logbooks, and if deemed to have a medical condition that could potentially affect safe flying (nothing in the legislation indicates who is supposed to designate who determines that), would need to have any physician who holds a state medical license to sign off on a checklist of medical items (taken from the FAA Form 8500-8) and attest that the pilot is “good to go” from an aeromedical perspective. The provider could very well be a golfing buddy, or a friend of a friend, as there is no requirement that the provider who signs off have any training whatsoever in aeromedical aspects of operating an aircraft — as long as they hold a valid state medical license.

CAMA supports general aviation and streamlining the aeromedical certification process -- but not by dropping safety standards. It is perplexing as to how one federal agency regulating commercial truck and bus drivers (the Federal Motor Carrier Safety Administration) has used rulemaking to tighten the reins of medical safety for professional drivers in the past two years, when at the same time Congress is busy attempting to abandon a process (granted, a process that is sometimes broken for certain types of complex evaluations and medical conditions, but a mostly successful process regardless), that is managed by the Federal Aviation Administration.

What are the issues of the bill as currently written?

The covered aircraft are large and complex – Covered aircraft may be up to 6,000 pounds, may carry six occupants, allows single pilot operation, flight to an 18,000 foot MSL ceiling, include IFR or VFR flight, and up to 250 knots. These would include aircraft that require significant executive function, often involve travel into very busy airspace, and take passengers into environments in which the pilot with undiagnosed or unmonitored cardiopulmonary conditions could result in potentially dangerous territory.

No definition of who determines if a pilot has a medical condition – The least reliable source for determining if a pilot has a medical condition that could negatively impact flying is the pilot himself. Pilots do not perform their own aircraft annual inspections. Why should they be doing their own medical assessments? For many conditions, the pilot is the last to know or recognize a medical condition, and for all of us who have resources and time invested in aircraft, we are all inherently conflicted towards not reporting medical conditions.

No requirements for physicians who sign off on pilots have any aeromedical training – CAMA members know and understand that the knowledge base for making aeromedical dispositions is significant and requires training and maintenance of proficiency. All of us are required by the FAA every three years to update our personal cache of knowledge toward being up to date in the field. CAMA hosts an annual educational and scientific meeting designed to serve this role as well. Having any provider sign off on the medical proficiency of a pilot is like asking a radiologist to perform an appendectomy.

There is no tort protection for providers who do decide to sign off on pilots – Unlike AMEs who are designated by the FAA and must follow a pathway for training and certification to perform aeromedical examinations, as pilots ask their treating provider to sign a statement that they have examined the pilot,
physicians who elect to do so should understand that the legislation provides absolutely no legal protection if an event occurs thereafter that involves damage to property or persons.

The legislation does nothing to improve aviation safety – Proponents of the legislation state that the bill will not affect aviation safety and cite lack of large data sets or statistics to show current use of the “sport pilot” certification shows no change in crash or fatality incidence. However, the denominator data for a very small cohort such as light sport aircraft will always make calculating statistically significant claims for fatality or serious injury challenging, if not impossible. Even if we agree that there is no change in safety from a probabilistic standpoint (which it is not), the legislation will not increase aviation safety. The real issue is that, for the individuals involved in a medically-induced in-flight incapacitation, the statistics are either zero percent or 100 percent – they are dead or alive.

Reviewing a pilot’s medical data every four years is too infrequent – Current legislative language is such that a physician is only required to sign off on a pilot every four years, regardless of age. For our pilots older than age 50, four years is a long time, and medical conditions tend to become multiple and more frequent. Making a “one size fits all” requirement of four years will assure that many aero-medical conditions are unaccounted for.

Aviation Medical Examiner manpower shortages will become worse – The FAA presented data at the International Academy of Aviation and Space Medicine last fall in Oxford, England, that showed the average age of AMEs had climbed to 60.9 years. With the total numbers of AMEs declining to nearly 3,000 nationally, the population of AMEs is literally dying off. Younger physicians considering becoming an AME do not see any upside for becoming an AME when the role for the examiner could be minimized with passage of the legislation. In other words, there is no incentive for AMEs to spend time and resources to obtain training when the number of examinations to do is potentially minimal if Class III medical assessments are reduced to a trickle.

Insurance premiums for all pilots will likely increase – Complex aircraft covered in the legislation carrying a pilot and five passengers with little or no medical supervision will cause insurance actuaries and adjustors to do the math. While FAA regulations may change, for many older pilots and for those with known medical conditions, most insurers will not stand by idly. They will require either these pilots obtain standard medicals more frequently or undergo assessments that will satisfy risk managers and have the potential to increase aviation insurance premiums to cover potential additional losses.

Regardless of the outcome of the legislation, CAMA’s goal is to focus on maintaining the highest levels of aviation safety for pilots we see on the ground and in the air.

Clayton T. Cowl, MD, MS is CAMA President and serves as the Chairman of the Division of Preventive, Occupational & Aerospace Medicine at Mayo Clinic in Rochester, Minnesota. He is an FAA Senior Aviation Medical Examiner, a pulmonologist, and altitude physiology researcher.

Casa Palmera is a free standing residential treatment center that provides 12-step, evidenced based treatment combined with an integrated traditional/holistic component to individuals and families needing treatment for the disease of addiction, eating disorders, and trauma/mood disorders. We offer a continuum of care that includes residential treatment, partial hospitalization with and without boarding, intensive outpatient program and continuing care. Our staff includes qualified professionals that include physicians, registered nurses, licensed vocational nurses, mental health workers, social workers, licensed master’s level clinicians, PhD and clinical psychologists, dietitian and nutritionist, recreational therapist, acupuncture therapist, massage therapist, spiritual therapists, and substance abuse counselors.

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WWW.CASAPALMERA.COM
CAMA had a very successful presence at the AsMA meeting in Atlantic City, NJ, in late April. Our table had a constant flow of visitors and inquiries regarding our 2016 Annual Scientific Meeting to be held at the Mayo Clinic, Rochester, MN. Dr. Robert Haddon, CAMA VP of Education, and Dr. Clayton Cowl, CAMA President, produced a beautiful brochure about the meeting (see Pages 7 and 8 of this publication) that was a very popular souvenir for AsMA participants. We had 11 CAMA members renew their memberships during AsMA, and 7 new members joined our organization, three of whom reside outside of the USA. (See the New Members listed on Page 17 for a full listing.)

CAMA Sunday was a great success, with an overall rating of “Excellent” from the participants. Many thanks to Dr. Robert D. McBane and Dr. Warren S. Silberman for their outstanding lectures on “Review of DVT and Pulmonary Embolism Assessment and Therapies” and “Aeromedical Implications of Thrombotic Episodes (DVT and PE)” The presentation slides have been sent to the web master to be placed onto the CAMA web site.

Dr. Robert Haddon was a very entertaining and informative speaker at the CAMA Luncheon. His lecture entitled “Handling the Risk of Rare Events in Everyday Life: Or Why Bob Lives on a Cul-de-sac” received excellent reviews from luncheon attendees.

As many of you may know, we have been working on the logistics to have a CAMA Annual Scientific Meeting in Anchorage, Alaska, in the near future. In April, we received information that the University of Washington now has a branch of their medical school in Anchorage, providing a rich source of specialists and researchers from which we might draw for lecturers for the educational portion of the annual meeting. Dr. Petra Illig and several other CAMA members from Alaska have indicated their support to ensure that a meeting in their state would be a great success! Dr. Michael Berry, Deputy Federal Air Surgeon, also indicated that the FAA would plan to support and participate in a CAMA meeting in Alaska. Therefore, we are already in contact with the Anchorage Visitors Bureau, “Visit Anchorage,” to solicit bids from local hotels. We will keep you posted as negotiations progress.

Registration for the 2016 Annual Scientific Meeting is now open, and Dr. Robert Haddon is finalizing the educational portion of the meeting program. The theme of this year’s meeting is “Anatomy of the Complex Aeromedical Exam.” On the Home page of the CAMA web site (www.civilavmed.com) is a Word fillable registration form with active links to the hotels in which CAMA has blocked rooms—the Kahler Grand Hotel and the Marriott Mayo Hotel. A form is also available on Page 6 of this publication.

Old CAMA publications, photos, and records are being sent to be archived at Wright State University. If you are in possession of CAMA memorabilia, please let the Home Office know so that we might arrange for it to also be placed into the archives.
Registration for the 2016 CAMA Annual Scientific Meeting is now open. This year’s meeting is the 51st consecutive CAMA Annual Scientific Meeting. The meeting will be held at the Mayo Clinic in Rochester, Minnesota, September 8-10, 2016. The theme for the meeting is “Anatomy of a Complex Medical Case.” The registration form is on Page 6 of this publication and can also be found on the CAMA web site at www.civilavmed.com.

CAMA has contracted for guest rooms at both the Kahler Grand Hotel, 1-800-533-1655, and at the Rochester Marriott Mayo Clinic, 1-877-623-7775. Room rates at the Kahler Grand Hotel are $99.00 (plus applicable taxes) for a Standard room and $159.00 (plus applicable taxes) for an Executive King room. The room rate at the Marriott is $159.00 (plus applicable taxes) for a Standard room. Both hotels are connected to the Mayo Clinic where the meeting will be held. The CAMA negotiated hotel rates quoted above are good until the deadline of August 8, 2016. Rooms reserved after that date are on an availability only basis and may be subject to additional charges.

Please use one of the following links to make your hotel reservations, depending upon the hotel at which you prefer stay—you may need to click “Control” then the link to activate it, or copy/paste the URL following the link into your browser:

**CAMA - Kahler Grand Hotel**  

**CAMA - Rochester Marriott Mayo Clinic**  
http://www.marriott.com/meeting-event-hotels/group-corporate-travel/groupCorp.ml?resLinkData=Civil%20Aviation%20Medical%20Association%5Erstmc%60camcama%60159.00%60USD%60false%606%609/7/16%609/12/16%6008/18/16&app=resvlink&stop_mobi=yes

The deadline for registering with CAMA for the meeting is **August 10, 2016**. Late registration after the deadline will be subject to an additional $50.00 late charge. The registration fees are the same as last year—$675.00 for CAMA members, $350.00 for guests, and $825.00 for non-members. If you are not currently a CAMA member and wish to register at the member rate, please complete a membership form (see Page 20 or the CAMA web site for a copy of the form) and return it along with your registration document. A guest is considered to be a spouse, significant other, or child. If you are bringing a member of your office staff who will not be seeking CME, that person may also be considered a guest. CME is offered to guests who are spouses and significant others and are also medical professionals. Only registered attendees and their registered guests (ID credentials will be issued by CAMA to all registered individuals) will be allowed to attend the meeting and/or join the registered professional for meals and other activities. Tickets for the field trip and/or banquet are not sold separately. A $50.00 processing fee will be withheld from any refunds of registration payments.

A directory will be prepared for distribution at the meeting with the names and addresses of all registered professionals. Therefore, please use the street or postal address you wish to share. (No email addresses or telephone numbers will be in the directory.) We encourage each attendee to share their cell phone number with us, in case of an emergency. Last year someone left a vital document at the hotel and we had no way to reach him before his flight. We will not release the number to anyone else and will not use the cell number except in an emergency.

Our field trip and catered dinner out on Thursday, September 8th, will take place at Hormel Foods Corporation in nearby Austin, MN. This is Hormel’s 100th anniversary, so there will be lots of special exhibits and activities. We will have our Honors Night Banquet at the Landow Atrium in the Mayo Clinic on Friday, September 9th.

If your organization or company is a corporate member of CAMA, and you wish to host an exhibit at the Annual Scientific Meeting, please let us know, so that we may arrange for exhibition space for you.

If you have any questions, please contact the CAMA office at 770-487-0100 or by email at
CIVIL AVIATION MEDICAL ASSOCIATION  
ANNUAL SCIENTIFIC MEETING  
MAYO CLINIC, SEPTEMBER 8-10, 2016

ATTENDEE NAME & TITLE: ____________________________ AME NUMBER: ____________________________
(MD, DO, BC PhD, etc.)

ARE YOU BRINGING A SPOUSE OR GUEST(S) WHO WILL PARTICIPATE IN THE MEETING, WILL BE EATING MEALS WITH YOU, GOING ON THE FIELD TRIP?  YES: __________  NO: __________

SPOUSE/GUEST NAME: ____________________________

NOTE: There is a $350.00 registration fee for each participating guest to cover eight meals and the field trip. (Tickets to the field trip and/or banquet will not be sold separately.)

ATTENDEE ADDRESS: ____________________________
(Please use the address you wish to be used in the participant roster that will be given to all in attendance)

CITY: ____________________________  COUNTRY: ____________________________  STATE/PROVINCE: ____________________________  PHONE: ____________________________

ZIP: ____________________________  (For emergency use during meeting only)  CELL: ____________________________

EMAIL (REQUIRED): ____________________________

ANY SPECIAL DIETARY NEEDS? PLEASE DESCRIBE: ____________________________
(VEGAN, VEGETARIAN, GLUTEN INTOLERANT, FOOD ALLERGIES, ETC.)

REGISTRATION FEE MAY BE PAID BY CHECK (U.S. DOLLARS) OR CREDIT CARD

CREDIT CARD TYPE: VISA: ____________________________  MASTER CARD: ____________________________
CREDIT CARD NUMBER: ____________________________
EXPIRATION DATE: __________  SECURITY CODE (CVV) __________  BILLING ZIP CODE __________
SIGNATURE: ____________________________

AUTHORIZED CHARGE AMOUNT (U.S. DOLLARS): $ ____________________________
CHECK ENCLOSED (U.S. DOLLARS): CK # ____________________________  CHECK AMOUNT: $ ____________________________

PERSONS REGISTERING TO ATTEND THE CAMA ANNUAL SCIENTIFIC MEETING—PLEASE MAKE YOUR HOTEL RESERVATIONS ONLINE BY USING ONE OF THE FOLLOWING LINKS FOR YOUR PREFERRED HOTEL:

CAMA - Kahler Grand Hotel  CAMA - Rochester Marriott Mayo Clinic

THIS IS A SPECIAL LINK EXCLUSIVELY FOR CAMA MEETING ATTENDEES TO USE TO RECEIVE THE SPECIAL CAMA ROOM RATE, PLUS APPLICABLE FEES AND TAXES, FOR 1 OR 2 PERSONS). ALL RESERVATIONS MUST BE MADE BY AUGUST 8, 2016, TO RECEIVE THE CAMA RATE.

CAMA MEMBER REGISTERED ON OR BEFORE AUGUST 10, 2016 — $675.00 U.S. DOLLARS
CAMA MEMBER REGISTERED AFTER AUGUST 10, 2016 — $725.00 U.S. DOLLARS
SPOUSE/GUEST OF ATTENDEE — $350.00 U.S. DOLLARS
*NON-MEMBER REGISTERED ON OR BEFORE AUGUST 10, 2016 — $825.00 U.S. DOLLARS
*NON-MEMBER REGISTERED AFTER AUGUST 10, 2016 — $875.00 U.S. DOLLARS

NOTE: Registration and guest fees include 6 meals — Buffet breakfast and lunch on Thursday, Friday, and Saturday, a field trip with a catered dinner on Thursday night, and the Honors Night Banquet at Mayo Clinic Landow Atrium on Friday Night. No activities are scheduled for Saturday evening.

*NON-MEMBERS—IF YOU WISH TO REGISTER AT THE LOWER MEMBER RATE, YOU MAY BECOME A MEMBER OF CAMA BY REQUESTING A 2016 MEMBERSHIP FORM. YOU MAY COMPLETE AND RETURN IT AND YOUR 2016 DUES PAYMENT WITH YOUR REGISTRATION FORM.

RETURN REGISTRATION FORMS BY EMAIL, FAX, OR REGULAR MAIL TO:
CIVIL AVIATION MEDICAL ASSOCIATION
P. O. BOX 2382, PEACHTREE CITY, GA 30269
PHONE: 770-487-0100
FAX: 770-487-0080
EMAIL: civilavmed@aol.com

Registration forms may be returned by FAX or eMail (civilavmed@aol.com) if you are using a credit card (VISA or MasterCard preferred) for payment or registration fee(s). All registrations received will be acknowledged by email, so an email address is required. If you do not receive a confirmation email that your registration has been received, please contact CAMA. We do not share email addresses with any other groups or individuals — the email address is strictly for our use in communicating with you with regard to CAMA activities.

THIS MEETING IS APPROVED FOR FAA-AME PERIODIC TRAINING AND CME HAS BEEN APPLIED FOR.
ANNUAL SCIENTIFIC & EDUCATIONAL MEETING
of the
Civil Aviation
Medical Association

MAYO CLINIC
Rochester, Minnesota
September 8–10, 2016

“Anatomy of the Complex
Aeromedical Exam”
FAA UPDATES

- Federal Air Surgeon Dr. James Fraser
- AME performance parameters
- Legal aspects of AME performance
- Guest lectures by FAA personnel

CLINICAL PEARLS AND MUCH MORE!

Some topics include…

- Evaluating color blindness and other ophthalmologic conditions
- Overview of sleep apnea and circadian disturbances
- Infectious Diseases Update for the AME
- Cognitive impairment assessments using various screening instruments
- Valvular heart disease and the airman
- Review of mood disorders and updates on drug addiction
- Lipid evaluation and therapies

GROUP LEARNING OPPORTUNITIES

- Case-based simulations (Group review and critique)
- Back by popular demand…..
  Game Show: “So You Wanna Be an AME”
- Deciphering the Complex Special Issuance Evaluation

REGISTER AT:

www.civilavmed.com

Register by August 10, 2016 to take advantage of early registration discounts!
Alien Flight Student Program (AFSP)

After the March edition of “The Flight Physician” discussed how AMEs are to now handle Student Certificates, we received a question from Dr. Dalbir Singh Sagoo, an AME in Kuala Lumpur, Malaysia. Dr. Sagoo asked, “How do we International AMEs perform or follow the new procedures on this issue? We have no FSDO in this part of the world. Your kindly advice will be most appreciated.”

Answer:
The International AMEs may see a delay in the program, however the AMCS software will preclude issuing a student pilot medical certificate. International AMEs will still be able to issue a regular medical certificate.

Please feel free to share this information widely: http://www.faa.gov/about/office_org/field_offices/ifo/

Subject: Alien Flight Student Program (AFSP)

Starting 1 April 2016 no AMEs, even those in the USA, will be able to issue a Student Pilot Certificate to any student pilot, however for International students wishing to pursue an FAA pilot certificate there is a program run by the Transportation Security Administration. There are some exemptions so read carefully the TSA processes.

https://www.flightschoolcandidates.gov/afsp2/?acct_type=p$ion=FQ##C2

What is the Alien Flight Student Program (AFSP)?
The mission of the Alien Flight Student Program (AFSP) is to ensure that foreign students seeking training at flight schools regulated by the Federal Aviation Administration (FAA) do not pose a threat to aviation or national security. Section 612 of the Vision 100 - Century of Aviation Reauthorization Act (Public Law 108-176, December 12, 2003) prohibits flight schools regulated by the Federal Aviation Administration (FAA) from providing flight training to a foreign student unless the Secretary of Homeland Security first determines that the student does not pose a threat to aviation or national security. Vision 100 transferred responsibility for conducting security threat assessments for foreign students seeking flight training from the Department of Justice to the Department of Homeland Security. On September 20, 2004, the Transportation Security Administration (TSA) issued an interim final rule establishing the Alien Flight Student Program (AFSP).

Who must participate in the Alien Flight Student Program?

Persons seeking flight training must submit a request if they are not citizens or nationals of the U.S. and:

They wish to receive flight training in the U.S. or its territories, regardless of whether training will lead to an FAA certificate or type rating; and/or

They wish to receive flight training from an FAA-certificated facility, provider, or instructor that could lead to an FAA rating whether in the U.S. or abroad.

(NOTE-Certain exemptions to AFSP published in 2004 and 2005 are still in effect. To view those exemptions, please see When is a flight student exempt from the TSA security threat assessment? in the Candidate Frequently Asked Questions section.)

The Aircraft Owners and Pilots Association has some helpful guidance also.


Dear CAMA members!

I want to thank you for your participation in my mental health aviation survey. It continues to gather responses, so if you haven’t submitted you may do so! The survey link is at the end of the article on Page 11.

For purposes of this preliminary review, I pulled data as of April 27th, 2016. There is a ton of information to correlate, so I have only taken a snapshot look some things that stand out. Some of the information appeared straightforward and is consistent with anecdotal knowledge and even a few pieces of information the FAA has found through internal surveys. Other data appears to suggest further areas of exploration. And, of course, there were pieces of information that were eye-opening.

Baseline demographics of the data-pull included N=199 responses. Of these, 69% were U.S. and 31% were non-U.S.

The latter were world-wide from every continent except Antarctica (30 countries). 17% of the total was specific to thirteen European countries, with no country having more than 5 responses. The top three specialties or areas of expertise noted (bear in mind responders could “Mark all that apply”) were Aerospace Medicine (47% of responses), Aviation Medical Examiner (46%), and Family Medicine or General Practitioner (34%). Not counting the ‘Other’ group, the bottom four specialties or areas of expertise noted included Social Work (0.5% or N=1), Neuropsychology (1% or N=2), Psychiatry (5%), and Psychology (20%).
I found the following question, the first one on my survey, quite interesting: “What service(s) do you perform for pilots with mental health and/or substance use concerns? (Mark all that apply.)” Here is how individuals answered:

I was struck by how many responses included referral (59%) in addition to evaluation (57%), and even what percentage endorsed performing treatment and management (25%). This is definitely an area of further exploration, and analysis with regards to individual backgrounds (correlation).

Another question asked about specialty training for those that see pilots with mental health or substance abuse issues. At least 50% of responders endorsed some sort of training in this area, and of these 69% were HIMS-specific. It was also interesting to find over 50% reported a wide-variety of non-HIMS type of training or certification. This included country-specific training, courses provided by the FAA, military, seminars, residency, employee assistance program training, other aviation medical society training, and the Airline Pilots Association.

When it comes to personal aviation experience, 80% reported some type, with 55% reporting obtaining a minimum of their private pilot certificate.

I was surprised by the percentage of participants who reported their pilots as self-referred: 72%. Apparently this was not too surprising when at least 65% of participants stated the method was by word of mouth/another pilot. There was also a wide-variety of payment methods by pilots, ranging from no charge (likely military), self-pay/cash, insurance, to union and even the pilot’s employer (reimbursing the pilot). The comments about insurance require further exploration, and I will have to correlate this with the countries and see if a pattern emerges, since using insurance for coverage of these types of exams in the U.S. can be problematic at best. For example, airline pilots may have no difficulty having mental health evaluations covered by their employer, pilot union, or disability insurance. However, recreational pilots being prescribed an SSRI by their primary care doctor may need to pay out-of-pocket to see a psychiatrist, even with a referral (since the FAA may review their psychiatric consultant’s note and require the airman to see a psychiatrist trained in HIMS).

One preliminary data point that struck me was the use of electronic means to submit data on pilots to an aviation medical authority, for example. While 48% endorsed still using postal mail, 77% reported using electronic means – a higher number than I would have expected. Again, this will need further correlation of the data in term of countries, but I could easily see how in the U.S. both of these numbers would be elevated. This is because initial AME exams are submitted electronically, but those requiring special consideration for flying after a mental health diagnosis must provide a lot of documentation that is snail mailed to the FAA, where it then is scanned in for official review. Note, at this time the FAA only allows online scanning/submission of an electrocardiogram, but not scanning and online submission of other treatment records; there is a team in Oklahoma City that performs this very task.

When asked if they had concerns about a specific pilot, 70% reported they would discuss these concerns with a governmental agency. This is not a surprise, given the nature of regulatory medicine. However, the range of possible individuals to consult was also interesting:

Another baseline piece of data that did not come as a huge surprise, but remains important when it comes to insight into these processes and relationships, had to do with the action(s) an individual would take when a pilot with mental health concerns first
approached him or her. The two most reported actions included reviewing the aeromedical guidelines with the pilot and providing a referral for treatment.

Systems processes also highlighted some fascinating facts. 28% of participants stated they provided both (emphasis added) treatment and evaluations for fitness for duty for the same individual pilot(s). Of these individuals, 57% thought that it was ethical to do so, while 43% thought it was not ethical. Only 8% of respondents stated it was not possible to separate the person who performs the fitness for flying evaluation from the person performing the treatment. A word of caution (which I will delve into more below): More analysis is necessary to clarify how many of these respondents were potential military, since this is already known in the U.S. military, but the intent of my question was more for civilian participation of pilot certification.

In terms of progressive thinking regarding mental health and aeromedical certification, I was startled by the percentage of responses(31%) that agreed with the question “Should pilots with a history of bipolar disorder or psychosis, with maintenance treatment and a favorable prognosis, be considered for waiver or special consideration to return to flying?”

Another question asked of respondents concerned the willingness of pilots to share treatment records with their AME. 9% pilots were not willing at all, 48% stated their pilots were stated their somewhat willing, and 34% stated their pilots were very willing (10% were not applicable). I am not at all surprised that almost half of respondents stated pilots were only ‘somewhat’ willing, but I am surprised that even a third of respondents thought their pilots would be ‘very’ willing. Based upon my own military experience in the Guard – and of course perception – these were interesting responses!

There was a question related to the perception of how respondents felt regarding pilots’ privacy. 85% of those surveyed were concerned about honoring a pilot’s privacy, while only 15% were not concerned. More specifically, 50% were ‘very’ concerned and 35% were ‘somewhat’ concerned. This gets to core issues that surround the relationship between pilots and their AMEs, as well as relationship between pilots and their treating clinician, especially because many mental health notes have heightened privacy protections in the health care system.

One question asked point-blank: “Do you think providers in your country should be required to report any pilot diagnosed with mental health/substance abuse, or undergoing treatment, to the aviation medical authority and be protected under the law if they do so?” The vast majority, 85%, stated in the affirmative. As a side note, this is written into Canada’s legislation and covers all clinicians in the country, including community physicians.

Lastly, I will note my survey asked questions relating to whether their respective country’s aviation medical authority had a database to capture mental health/substance abuse history or diagnoses in aviators. 41% of respondents reported that their country did not (but 15% reported it was being considered, planned, or in the process of implementation).

Again, I thank you for your time in responding to my survey. If you have not, and wish to do so, the survey will continue to collect submission through at least July, and possibly August. I am shooting for more responses from at least 2-3 European countries, to increase the power available for statistical analysis (compare and contrast). If you have any European friends that have not heard of my survey please encourage them to fill it out, thank you!

The links were initially available in the March edition of “The Flight Physician” and were emailed to CAMA members and other interested parties. The links are repeated below for your convenience—You may need to hold the “Control” button as you click the link if the link does not activate with a simple click. If you have not yet taken the survey, please take a moment to do so.

Mental Health and Flying Survey
https://src.co1.qualtrics.com/SE/?SID=SV_0xLGAkp4CATv36d
How far do you have to go, or how right are you expected to be, when you’re trying to make a medical diagnosis and give treatment recommendations over the phone? A federal court may soon be deciding that exact issue in the context of a medical emergency that occurred on an airliner in flight.

In this case, a passenger was hurrying to catch his flight from a northern European city to a city in the southwest United States, and he boarded the aircraft experiencing chest pain and shortness of breath. The passenger reported this to the crew and continued to complain to the crew after takeoff. The crew administered oxygen and aspirin, but the passenger’s symptoms did not stabilize or improve, but worsened. Three hours later, the crew contacted the medical consulting company that was under contract with the carrier to provide medical advice in the event of in-flight medical emergencies.

The physician on duty advised the crew to determine if there was a doctor on board, which they were able to do. The consultant doctor directed the crew and the on-board doctor to administer nitroglycerin to see if the passenger’s vitals stabilized. Thirty minutes later, the on-board physician reported the passenger’s blood pressure and pulse and that he had “crackles” in his left chest. The consultant doctor advised the crew not to administer more nitroglycerine, because the blood pressure readings were too low but to continue oxygen and monitoring. Three hours later, because there was no improvement, the crew called the consultant doctor. He had gone off-shift, so another doctor with the company answered the call and told the crew to administer nitroglycerine.

Neither of the two consultant doctors recommended a flight diversion, and the flight landed in Phoenix 10 hours and 41 minutes after takeoff. The passenger was immediately taken to the hospital where it was determined that he had suffered a heart attack 6 to 8 hours earlier, causing significant coronary damage. About three months later, the passenger passed away while waiting for a heart transplant.

The passenger’s widow sued the medical consulting company and its physicians, claiming that the consultant doctors “negligently failed to provide adequate and appropriate medical assessment, advice, information, instructions and treatment options … causing [the passenger] to sustain severely aggravated personal injuries and ultimately fatal injuries to his body.” The medical consulting company filed a motion to dismiss the case on the pleadings, essentially arguing that there was no factual issue necessary to resolve at a trial to find that there was no legal liability under the “Good Samaritan” provision of the Aviation Medical Assistance Act of 1998. In particular, the medical consulting company argued that the law shielded the consulting doctors from liability for damages that arise from actions or omissions in providing or attempting to provide assistance for an in-flight medical emergency (except in the instance of gross negligence or willful misconduct). The court found this defense unavailing for the reasons that the company and its physicians were not volunteers and they were not on the airplane, thus the Act did not apply to them. The flight crew and the on-board physician who provided medical assistance would be shielded under the law, but not the consulting doctors providing the on-ground medical advice for hire.

The interim court decision doesn’t go into extensive detail of the facts beyond what we’ve reported here, such as the qualifications of the physician on board, the details of the information being reported, the duties expected under the contract between the carrier and the medical consulting company, and why it took so long for the crew to call the physicians, but those will likely come out in the litigation over any liability stemming from the actions of the consulting doctors.

Ms. Kathleen Yodice has been representing aviation legal interests for almost 30 years, beginning her career as an FAA prosecutor and regulatory lawyer, before moving into private practice defending air carriers, commercial operators, repair stations, pilots, and mechanics against FAA enforcement actions and assisting entities and individuals in aviation compliance matters, medical certification concerns, and aviation-related business and transactional issues.

Ms. Yodice received her law degree from the University of Maryland School of Law and a BA Degree from Frostburg State University, where she concentrated her studies on psychology and mathematics. She is admitted to practice in Maryland and the District of Columbia, as well as the U.S. Courts of Appeals and the U.S. Supreme Court. She is an active member of the Maryland and D.C. Bar Associations, the Lawyer Pilots Bar Association, and the International Air & Transportation Safety Bar Association. Ms. Yodice is a Past President of the Lawyer-Pilots Bar Association and currently sits on their Board, and she served on AOPA’s Board of Aviation Medical Advisors. She was appointed to, and continues to serve on, the Editorial Board for the ABA Forum on Air and Space Law, and she is a former long-time panel member in the Transportation Research Board’s Airport Cooperative Research Program.

A CASE IN FLIGHT— WHAT WOULD YOU DO? A Case Study for Thought

Kathleen Yodice, Attorney at Law

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CAMA now has a Facebook page! In order to provide the best options for communication with our members and other interested parties, we have established a Facebook page. If you are already on Facebook, you may find our page by entering “Civil Aviation Medical Association” into the search box. We will post current events, photos, and other pertinent information about our organization. You are invited to ask questions or to post comments or photos on our page (inappropriate remarks/photos or advertisements will be removed). The page is monitored several times daily, and we will strive to answer your questions promptly. Please contact the CAMA home office if you have any questions, suggestions, or comments about the Facebook page.
BLAST FROM THE PAST!!

While preparing Dr. Millett’s cache of old CAMA Bulletins and Flight Physician publications to be sent for archiving at Wright State University, we ran across this wonderful bit of memorabilia from the Autumn 1988 CAMA Bulletin—A letter of congratulations to CAMA from President Ronald Reagan for FOUR DECADES of service to aviation!! What a fantastic tribute to the work CAMA has been performing for the past 68 years to support and educate Aviation Medical Examiners and to contribute to the overall safety and excellence of the aerospace/aviation industry!

In future editions of “The Flight Physician,” we will share other interesting articles, photos, and bits of history we encounter in CAMA history.

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I am proud to salute the members of the Civil Aviation Medical Association for your four decades of service to aviation.

Since its foundation 40 years ago, your fine organization has grown alongside the rapidly expanding aviation industry providing services absolutely critical to aviation safety. Our Nation’s air travelers rely on pilots who are fully fit to fly, and they, in turn, rely on your careful examination to assure their readiness. The record shows that you have helped to make American aviation the very best in the world.

On behalf of all Americans, I extend my appreciation for your excellent work and my congratulations on this special anniversary. God bless you.

Ronald Reagan
Civil Aviation Medical Association
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The financial resources of individual member dues alone cannot sustain the Association’s pursuit of its broad goals and objectives. Its fifty-plus-year history is documented by innumerable contributions toward aviation health and safety that have become a daily expectation by airline passengers worldwide. Support from private and commercial sources is essential for CAMA to provide one of its most important functions: that of education. The following support CAMA through corporate and sustaining memberships, and we recognize the support of our lifetime members:

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CAMA is very pleased to announce a number of new members to our organization since our last publication. We welcome the following physicians and organizations into CAMA, and we look forward to working with them.

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2824 Inverness Drive
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AME, Occupational Medicine

David J. Glatt, MD
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