Consortium of Aviation Groups Gather in Fort Worth

Prior to the annual educational and scientific meeting in Fort Worth on October 7, CAMA initiated discussions with a variety of aviation interest groups and pilot unions to discuss a variety of common interests and to find ways to collaborate in the future. Representatives from the Aircraft Owners and Pilots Association (AOPA), Experimental Aircraft Association (EAA), Allied Pilots Association (APA), Airline Pilots Association (ALPA), Aviation Medicine Advisory Service (AMAS), the Law Offices of Yodice Associates, and Aerospace Medical Association (AsMA) attended the session, which featured focused time to identify issues for which each organization could agree and attempt to provide constructive suggestions to the FAA and/or other agencies moving forward.

One common theme identified was that, for certain medical conditions, delays by the FAA in making a final certification determination were a sentinel factor in reduced satisfaction by airmen and medical examiners alike. Cases involving use of anti-depressants, prior substance abuse, and psychiatric cases were singled out as particularly problematic, but certain neurological cases and pilots with certain cardiac conditions were also discussed.

Minutes from the meeting have been distributed to all representatives, and edits and comments have been solicited. The plan now is to draft a white paper that will be delivered to the FAA by January, followed by an in-person briefing provided to FAA Aeromedical Certification leadership by the consortium group in the spring. It is hoped that the FAA will be willing to work together with the consortium group to help solve aeromedical certification backlogs in a collaborative fashion with the goal of preserving aviation safety while improving certification system satisfaction from its users.
Since its inception in 1948 as the Airline Medical Examiners Association, the Civil Aviation Medical Association (CAMA) has been focused on providing outstanding continuing education to aviation medical examiners and health care professionals from a variety of disciplines on topics of aviation safety. It has also served as a voice for examiners for interfacing with the Federal Aviation Administration (FAA), including partnering to promote examiners who are current on aeromedical implications of medical conditions and who perform examinations correctly, competently, and efficiently. The demographics of the examiner population have changed dramatically since that time, just as the makeup of the pilot community has aged and changed. Data from the FAA indicates that there are now slightly more than 3,000 designated examiners and that the average age of the aviation medical Examiner (AME) has climbed to 60.9 years. It signals a concerning potential impending shortage of examiners in the coming years.

How will we as an organization address the issues facing AMEs as physician advocates for aviation safety?

- **Continue to provide outstanding educational programs** – CAMA has produced world class opportunities for its members and all AMEs to remain current on relevant topics that provide updates not only on aeromedical certification but also on medical conditions that allow members to stay on top of the rapidly changing clinical environment. In April, 2016, we will again feature “CAMA Sunday” at the Aerospace Medical Association Meeting (April 24) in Atlantic City. Thromboembolic disease with focus on new novel oral therapeutic agents will be discussed and the aeromedical implications will be reviewed.

- **Recruit younger members to become involved** – As examiner ranks age and colleagues pursue retirement, it will become critical to recruit and retain younger members to articulate the importance of excellent aeromedical examinations and to participate in organizational activities. Each member should take on the challenge of encouraging younger colleagues and other professionals to become CAMA members and get involved. Together we can make a difference in aviation safety.

It is a great honor to be serving as your President in the coming two years. Together with our executive leadership team and Board of Directors, we look forward to providing a voice for AMEs and serving as a center point for quality education.

Clayton T. Cowl, M. D., MS
President, CAMA

Clayton T. Cowl, MD, MS is the incoming 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 and commercially-rated pilot.
The Annual Scientific Meeting in Fort Worth, Texas, in October was a resounding success! On Wednesday afternoon, CAMA held a meeting of representatives and officials from several aviation-related organizations to discuss issues of common interest and to develop potential solutions for common problems. The regular Fall CAMA Board meeting later on Wednesday was very productive in planning for 2016 activities and meetings.

We had 102 registered aeromedical professionals at the Annual Meeting with 23 registered guests, nine additional lecturers, three exhibitors, numerous FAA representatives from CAMI and the Southwest Regional Flight Surgeon’s office, and the CAMA Home Office staff. We had thirteen doctors from seven countries outside of the United States. The FAA reported 80 AMEs recertified during the course of the meeting. Dr. Mark C. Eidson, CAMA President for 2014 and 2015, passed the gavel to incoming President Dr. Clayton T. Cowl for the 2016-2017 term. A new slate of CAMA Trustees were appointed for terms expiring in October, 2018.

The educational program for this year’s meeting received rave reviews! All of the presentation slides used during the educational portion of the CAMA Annual Scientific Meeting are posted to the CAMA web site for viewing and download. All are in pdf format and optimal file size for downloading.

The program for CAMA Sunday, April 24, 2016, at Harrah’s in Atlantic City, NJ, has been set. Dr. Robert D. McBane, Vascular Medicine Specialist from Mayo Clinic, Rochester, MN, will speak on “Review of DVT and Pulmonary Embolism Assessment and Therapies,” followed by Dr. Warren S. Silberman, Former Manager, Aeromedical Certification Division, FAA, and Senior AME, speaking on “Aeromedical Implications of Thrombotic Episodes (DVT and PE)”

The CAMA Luncheon on Monday April 25th will feature Dr. Robert Haddon speaking on “Handling the Risk of Rare Events in Everyday Life: Or Why Bob Lives on a Cul-de-sac.” We have applied for CME for CAMA Sunday and the CAMA Luncheon. If you plan to attend the AsMA Annual Meeting, please join us for CAMA Sunday and the CAMA Luncheon. There is no charge for CAMA Sunday. Tickets for the CAMA Luncheon may be purchased from AsMA prior to the event.

We are now actively working on the 2016 Annual Scientific Meeting, scheduled for September 8-10, 2016, at the Mayo Clinic in Rochester, Minnesota. The 2016 CAMA Vice President of Education, Dr. Robert Haddon, is already developing an outstanding educational program for the meeting!! Mark your calendars and save the dates to attend what is shaping up to be another outstanding meeting.

You may begin paying your 2016 CAMA dues this month. A 2016 dues form is included on page 20 in this edition of “The Flight Physician” for your convenience.

The CAMA family was saddened by the news that Pamela Riddle Bird died in an airplane accident in the Idaho mountains on October 8, 2015. She was an outstanding supporter of CAMA and of the Bird Honorarium. I will always remember her as the most gracious hostess for events at the Bird Ranch and the Bird Aviation Museum and Invention Center. Without her leadership and devotion to Forrest and to aviation, there would not have been these monuments to aviation and the Bird medical equipment that exist today. We wish her a safe journey as she travels West to join Forrest.
Past President’s Message

It has been an honor to have served as CAMA's president for the past two years. During this term we have seen CAMA become more involved with the politics of aviation medicine: assisting the U.S. General Accounting Office on the FAA Medical Certification process, issues concerning Obstructive Sleep Apnea, the Third Class Medical issue, and the initiation of a consortium of organizations to help solve common medical/aviation issues.

CAMA continues to be a leader in great educational meetings with the annual CAMA scientific meetings and the popular CAMA Sunday programs in conjunction with the annual Aerospace Medical Association (AsMA) meetings. These meetings offer numerous CME credits and recertification opportunities for the Aviation Medical Examiners and others.

The Annual CAMA Scientific Meeting this past October was ruled as excellent by most attendees and I feel was a great success. My wife, Sarah, and 15 other spouses/guests had a fun and interesting time at the Kimbell Art Museum. The Bar-B-Q, catered by Mesquite Pit, the Montagu Wines, and Dr. Russell Rayman's piano playing made for a great social event at the Milan Gallery in downtown Fort Worth. Everyone appeared to enjoy it all, and I only wish more social events were possible.

During the past two years, we have mourned the loss of several very active members and/or their spouses. I look back at these unique individuals with admiration and as mentors.

I wish again to express my appreciation to all CAMA members, the CAMA Board, our Executive Vice President, Dr. David Millett and our Executive Assistant, Sherry Sandoval, for all their support and help.

Dr. Clayton Cowl will serve CAMA well and continue this organization as "the voice of the AME".

Your Past President,

Mark C. Eidson, MD

We understand the responsibility in serving as an Aviation Medical Examiner.
By caring for airmen, you make sure our skies are safe.

When an airman is faced with obstructive sleep apnea, rest assured there is a team of board certified experts ready to help. At FCCI, our two convenient sleep laboratories are fully accredited by the American Academy of Sleep Medicine (AASM), ensuring our sleep medicine services have met the highest standard in the healthcare field.

We offer a range of services for the diagnosis and management of obstructive sleep apnea as well as other sleep disorders. Our services include:

- Diagnostic testing
- Titration testing including C-PAP, Bi-pap
- Maintenance of Wakefulness Test (MWT)
- Multiple Sleep Latency Test (MSLT)
- Home Sleep Test
- Follow up with Sleep Medicine Specialist

First Coast Cardiovascular Institute
Serving Northeast Florida as well as patients from Southern Georgia with convenient offices in Duval, Clay, St. Johns and Putnam counties
www.firstcoastcardio.com I 904.493.3333
We are very sorry to inform members and friends of CAMA that Dr. Pamela Bird, 59, widow of Dr. Forrest M. Bird, of Sandpoint, Idaho, lost her life on Thursday, October 8, 2015, in a tragic airplane accident in the Cabinet Mountains near Hope, Idaho.

Pamela was born on Aug. 19, 1956, in Rolla, Missouri to Albin and Julia Nicklyn Hudek, the youngest of eight children.

Pamela was an internationally recognized commercialization expert. She was the founder and CEO of Innovative Product Technologies, Inc. (IPT, Inc.), a product- and technology-based market commercialization corporation in Gainesville, Florida, with a branch office in Sandpoint. Pamela has been on the forefront of commercializing innovation and technology for the last three decades. She opened the third publicly-funded innovation center in the U. S.

Pamela was a “key player” in the technology-transfer process and was a liaison between inventor organizations, venture capital organizations, entrepreneurial networks, and research park facilities. Pamela was interviewed by and has served as a consultant to the ABC television show “20/20” as a national new product development and commercialization expert. She worked diligently with her clients (independent inventors) to bring new products to the end consumer with hands-on work with national buyers in retailing, pricing, promoting, packaging, and distributing products. She also worked with manufacturers regarding production of new products and investors to capitalize new business ventures.

Pamela served as the president of the United Inventors Association, a national organization comprised of inventor organizations, as well as independent inventors and corporations. She helped found various inventor organizations in Florida and Idaho, including the Inventors Association of Idaho.

Pamela is the author of over 70 publications and has been quoted and featured in numerous newspapers throughout the country, including the New York Times, Wall Street Journal, Barron’s, The Dow Jones Business and Financial Weekly, Forbes Magazine, and the Miami Herald. She has appeared as a guest on numerous television shows including “Golden Lifestyles”. Dr. Bird was the author of “Inventing for Dummies,” published by Wiley Publishing Company, owner of the “Dummies” series.

Pamela was the founder of the Inventors Educational Foundation non-profit public charity. The charity’s purpose is to assist people by helping them bring their ideas and products to market.

Pamela and her late husband, Dr. Forrest Bird, were the founders of the Bird Aviation Museum and Invention Center. This is the world’s only aero-medical and innovation museum featuring a collection of more than 21 aircraft, rare vintage cars, and a unique display of inventions from some of the greatest inventors in history. The museum’s motto is, “One person can change the world and it can be you!”

Pamela was a licensed building commercial and residential construction contractor. She was a licensed pilot and competed in the Women’s Air Classic Races. Other interests included horseback riding, hiking, snow skiing, traveling, gardening, card-making, cooking and boating. Pamela’s favorite things were taking care of her beloved husband and great love, Forrest, and spending time with her 3 amazing granddaughters.

Pamela Bird is survived by her daughter, Rachel (husband Nathan) and granddaughters, Julianna and Autumn Schwam of Sandpoint, Idaho; her son, Brandon (wife Chanity) and granddaughter Loralye of Gainesville, Florida; her brothers, Robert Hudek, Ronald Hudek, Frank Hudek, Elaine Pingle, Kathleen Gerard, and Margaret Williams; as well as countless cousins, nieces, nephews, great-nieces and great-nephews; her beloved Labrador, Wizard; and the friends and organizations she cared so much about.

If you would like to send a thought, memory or photo of Dr. Pamela Bird, please send them to Bird Aviation Museum, Attn: Rachel Schwam, P.O. Box 1200, Sagle, Idaho 83860.

Family and friends are invited to sign Pamela’s online guest book at www.coffeltfuneral.com.
CAMA 2015 Honors Night Banquet Photos

The Bird Award—
Col. Elmo Baker

The Harris Award—
Dr. Russell Rayman

President’s Commendation—

The Audie Davis Award—
Dr. Warren Silberman

President Service Award—
Dr. Mark Eidson

2015 Fellow—
Dr. John Raniolo

Passing of the Gavel
Dr. Mark Eidson to
Dr. Clayton Cowl

Dr. Clayton Cowl Announces
The 2016 Slate of Officers
and Trustees

Honors Night Banquet
Dr. Mark Eidson & Sarah Eidson
Col. Elmo Baker & Honey Baker

Honors Night Banquet
Col. Elmo Baker & Honey Baker

AME Humor

I DON’T ALWAYS GET SUCKED INTO A JET ENGINE
BUT WHEN I DO, I USE ICD-10 CODE: V97.33XD

AME Humor

Honors Night Banquet
Featured Speaker
Col. Elmo Baker
CACI UPDATE:

I sure hope you all know what the acronym “CACI” stands for? The Conditions AME’s Can Issue (CACI) have undergone some revisions and additions over the past several months. I am going to summarize them for you in this article.

The most recent addition was the inclusion of kidney stones to the group. They should have made note that this CACI is mainly for retained kidney stones that up until now was an AME Assisted Authorization for Special Issuance (ASSI) after medical certification initially reviewed the material. Please note that a single stone event where the stone has passed and there are no retained ones does require the AME to obtain a history and proof that there are no retained stones. This necessitates annotation in block 60, but there is no special issuance.

If the follow up films demonstrate retained stones, the airman needs to provide records that show the stone(s) to be asymptomatic, stable in size and number, unlikely to result in a sudden incapacitating event, and no hydro-nephrosis, underlying metabolic condition, 3 or more events in past 5 years, obstruction, renal failure, sepsis, or recurrent urinary tract infections. The airman can be receiving treatments including hydration, thiazide diuretics, allopurinol, or potassium citrate. If this is so, the AME is to annotate on the 8500-8 “CACI qualified kidney stones.”

There has been some simplification to the hypertension CACI. It is now a requirement for 7 days of stability after initiation of a new medication rather than to 2 weeks as previously required.

Instead of just a mention in the decision protocols that prostate cancer treated with surgery and no pathology or evidence that the cancer had spread beyond the confines of the capsule; there is now a formal CACI worksheet.

The airman must provide a letter from the treating urologist that the condition is stable with no spread or recurrence. There should be no evidence of recurrence or history of metastatic disease. All treatments must be completed with no further treatments at that time and the airman is off all pain medications and has been released by the surgeon. The airman needs to provide a PSA performed within the last 6 months that is either 20 ng/dl or less, if no prostatectomy, and 0.20 ng/dl or less, with prostatectomy. Current treatment should be only brachytherapy or no active treatment.

During this past CAMA Annual meeting, the FAA noted that not annotating the proper statement (for example: CACI qualified HTN) in Block 60 was one of the most common errors made by AMEs.

NOTE: Please submit any AME-related questions you wish answered to civilavmed@aol.com for Dr. Silberman. Please indicate in your emailed question your city and state or city and country, and state whether or not you wish to have your real name used in the column. Dr. Silberman will answer your question in his column and may also contact you directly via email to provide a timely personal answer.
Obstructive Sleep Apnea in Aviation

Obstructive sleep apnea (OSA) is also called “obstructive sleep apnea syndrome.” It occurs due to repeated episodes of complete or partial blockage of the upper airway during sleep. During an obstructive apnea episode, the diaphragm and chest muscles work hard to open the obstructed airway. Breathing usually resumes with a loud gasp or snort. Oxygen levels drop due to blocked airways and these episodes can interfere with sleep and occur many times throughout the night. Oftentimes, the patient has no recognition of the problem.

Common symptoms include loud snoring, pauses in breathing at night and excessive daytime sleepiness. Obstructive sleep apnea can adversely affect the patient’s quality of life, decrease concentration and memory and increase the risk of many other health problems including hypertension, stroke, diabetes, depression, automobile accidents due to drowsy driving, and even sudden death.

Popular treatment options for this dangerous health condition include continuous positive airway pressure (CPAP) and continuous open airway therapy, also known as COAT.

CPAP is a mask that is connected to a mechanical blower. The mask is strapped over the nose or mouth and pushes positive pressure into the back of the airway splinting the soft tissues open. A Mandibular Advancement Device, also known as continuous open airway therapy (COAT), is a precisely manufactured custom dental appliance that the patient wears on the upper and lower teeth and it is fitted by a trained dentist. The device works by pulling the mandible, or lower jaw, forward which opens up the airway. Surgery is also an option that is occasionally used to treat OSA if there are obvious anatomically correctable problems.

Many large randomized studies have demonstrated that CPAP and COAT are equally effective in treating mild to moderate obstructive sleep apnea. They both similarly improve sleepiness and quality of life. For severe sleep apnea, CPAP is usually the better starting choice. However, studies show that only approximately 50-60% of patients are actually able to continue using CPAP long-term, while the remaining patients are simply unable to tolerate this treatment. COAT devices are an approved option for patients with severe OSA who fail to tolerate CPAP.

Regulatory agencies that oversee public safety, including the FAA and FMCSA, recommend that commercial drivers and pilots be screened for obstructive sleep apnea. The regulations also require compliance monitoring to ensure that the patient is being adequately treated.

Although patients overwhelmingly prefer the comfort of a COAT device, CPAP is often the only choice offered for patients who fall under FAA or FMCSA guidelines. This is due to the fact that, until recently, CPAP had the advantage of objective compliance monitoring. This is the ability to precisely monitor the number of hours that the device is worn.

Although compliance monitoring capability has previously been limited to CPAP devices, innovation has expanded making compliance recording available in COAT devices, thus expanding the choices for more comfortable, highly effective treatment that meets compliance monitoring guidelines.

This new development is an important advancement in technology, as physicians and dentists now have a way to reliably ensure that patients are actually reaching prescribed levels of compliance, because we know that the more compliant the patient is, the more effective the treatment.

The compliance monitor is the future standard for COAT treatment, and as an increasing number of physicians discover the ease of prescribing COAT, more patients will experience effective OSA treatment. This development will also lead to more dentists collaboratively working with the patients and their physicians, as well as more employers of transportation workers, including commercial drivers and pilots, having an option comparable to CPAP in reliably monitoring compliance.
Hepatitis C Virus
“Only the Tip of the Iceberg”

Last month’s column was devoted to update our CAMA members about preventable diseases through vaccination. Clearly, the development of the vaccine theory and the extensive armamentarium that is currently available to us has prevented countless of infections both viral and bacterial across the globe.

Diseases states such as Small Pox and Polio are essentially eradicated from our planet and other infections such as Acute Hepatitis B or Tetanus here in the United States are reportable and extremely rare.

Unfortunately, a vaccine for the Hepatitis C Virus (HCV) has not been developed and despite a significant research and development process an immune-effective HCV vaccine has been impossible to manufacture as of this writing.

At least 3½ million people in the US have been infected with HCV and most are impacted by the chronic form that the majority of those infected will have unless treated effectively. Epidemiologic data documents that the largest cohort of interest is the “Baby Boomer” age group, thus the CDC recommends that the age group with birth years between 1945 and 1965 be screened at least once time for HCV independent of stated risk factors from that individual in your office’s exam room. At least 75% of those infected are SLOWLY developing some form of liver damage that may not be seen on routine liver function tests either.

The modality of transmission of HCV is well known. It is a blood borne pathogen. Transfusion years ago before blood bank screening assays were available were a huge reservoir of contagion. Now with well designed blood product surveillance this almost never occurs. Sexual contact is a risk factor according to the CDC, but in practice one almost never sees that lifelong partner of a HCV patient also positive unless they shared a common habit...i.e...IV drug abuse...now better known as IDU...injecting drug use. Overwhelming support exists that concordant with the rise of body art in the US (i.e. tattoos) and the professional and non-professional ink injection involved in this growing phenomenon has an contributing factor in the ever increasing epidemic level of new HCV cases here is the US. It hard to go to the gym, the playground or just the workplace without seeing more than half of the younger cohorts and some of the grandma and grandpa age set without seeing some ink being flaunted on a bare deltoid area or an ankle local. In my own private practice I can honestly say that I think I’ve seen everything pierced or inked short of a hemorrhoid!!

The HCV screening assays are now widely available thru almost any commercial or large hospital lab. I usually order a Hepatitis Profile (which gets you A, B, C relatively easy and inexpensively) but one can stay more directed and just order a Hepatitis C Virus Screen assay. If positive one then can order a Hep C RNA PCR assay to confirm active infection. If the HCV PCR RNA assay is negative then your patient has either cleared the infection long ago on his or her own...some 30% might or more often is the case that if the HCV RNA PCR results as a negative then the initial HCV antibody screen was a “false positive”.

When counseling the HCV positive patient even before specialty referral for possible antiviral therapies you should advise them:

A: No sharing of toothbrushes, dental or shaving equipment.

B: Strict infection control hygiene in regards to any bleeding cuts or wounds.

C: Stop illicit drug use (i.e. IVDA and IDA) and certainly no needle sharing!

D: They should not change to barrier sexual protective practices in my opinion. Strong data states that penile vaginal contact without
coexistent ulcerative STDs is a an extremely low risk subgroup for any partner to partner transmission. Non-longstanding sexual partners should be practicing safe-sex anyway!!

Most importantly however, new treatment options for the most common genotypes of the HCV virus are now available and albeit not cheap are well tolerated and very effective in curing these patients; that is, achieving a sustained viralogic response once treatment is completed. This cure called a sustained viralogic response is other wise known as achieving “SVR” once off therapy that usually incorporates an all oral combination regimen fro 8-12 weeks.

The new treatment options now exclude interferon in many of the regimens, thus making them well tolerated and all oral more often than not. It is far beyond the scope of this brief update to go over all of these therapeu tic advances for HCV. One might even argue that this arena is changing so quickly by the time this column goes to “print” any treatment algorithms might be out of date.

The FAA Medical Certification process for Hepatitis C patients that are without cirrhosis is still evolving but will require a deferral until the data base is reviewed in detail, but may eventually lead to the airman still getting his medical.

While the lengthy process of the HCV positive host is underway, you can provide additional benefits to the patients long term health by vaccinating them for Hep A and Hep B if not already immune, have them off alcohol and Tylenol, and screening them as well for HIV co-infection.

The CDC has a wealth of information to assist you on the latest epidemiologic data and good patient information sheets as well. The website is: www.cdc.gov/hepatitis

Unfortunately an ever increasing burden to the already spiraling costs to our US healthcare system has correlated directly with the emphasis on HCV testing in so many people that we may just be seeing the tip of the iceberg here in the total numbers of patients and pilots that we care for with Hepatitis C Virus.

---

### ADDICTION TREATMENT OPTIONS FOR PILOTS

The Addiction Treatment Program for Pilots at Talbott Recovery Campus addresses not only the medical, psychological and social aspects of the disease of chemical dependence but also the most efficient pathway for the pilot’s return to work. The program is directed by senior clinicians who thoroughly understand the disease of chemical dependence.

**Talbott Recovery Campus**  
5448 Yorktowne Drive  
Contact Us to Schedule an Assessment:  
(800) 445-4232  
www.talbottrecovery.com
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, dietician and nutritionist, recreational therapist, acupuncture therapist, massage therapist, spiritual therapists, and substance abuse counselors.

FOR MORE INFORMATION CALL 858-481-4411 OR 888-481-4481
WWW.CASAPALMERA.COM

Daniel Danczyk MD, is a fellow in aerospace medicine at Mayo Clinic. He is also a flight surgeon in the Air National Guard and completed his psychiatry residency and boards in 2013. If there is a particular subject you wish for Dr. Danczyk to address, please notify the CAMA Home Office by email or by telephone.

General Aviation advocacy: What’s it really all about?

As a pilot and *hopeful* future aircraft owner, it seemed like a no-brainer to join AOPA back in 2012 when I was wrapping up my private certificate. Not only did I need decent renter’s insurance to reserve the 172 from my FBO, but the Flight Training magazine provided fun and interesting articles with tidbits of useful info for a budding private pilot.

Now, three years later, with my instrument qualification under my belt, and recent high-performance rating, I’m less sure about what my AOPA membership means. I am conflicted: I do not necessarily agree with AOPA’s push to end the 3rd class medical. As a military flight surgeon, and now with experience performing FAA medicals half-way through fellowship, I see a lot of pathology that can easily ground pilots. I also see the pathways to resumption of flying as onerous in some cases (I’m talking both Air National Guard and FAA).

On one hand, I understand clearly why GA pilots hate medicals: It can be a bureaucratic maze few pilots and AMEs alike navigate with ease. Not to mention the waivers: A Special Issuance is not the easiest thing in the world to obtain when multiple specialist and AME visits may be required. On the other hand, some of the very things that ground pilots, from chronic conditions to intermittent side effects from a medication, are not always the most straightforward medical issues for a pilot to address when it comes to the I.M. S.A.F.E checklist. While most pilots would make reasonable judgments to self-ground while having symptoms, others may not, or they may make a risk assessment calculation on a flight-by-flight basis, assuming they don’t get the symptoms checked out right away (not an uncommon thing for patients to do, we doctors being even worse!).

Am I biased wanting to keep the 3rd class medical? Of course, how could I not be? It provides me a form of business, and keeps me connected with pilots as a physician, not just as a pilot. On the flip side, I could see a valid argument, at least for recreational pilots, that the public safety risk differs from that of the commercial side. And why not have the PIC in charge of the liability when she or he is already responsible for everything else? God forbid we have a cottage industry grow out of creating a separate medical “POH” with checklists and flow sheets for PICs to decide their own medical status.

However, even with the latter argument of putting all the liability at the hands of the PIC, I’m deeply disturbed by the proposal to substitute a state driver’s license as a medical. That would just further the false belief by some that their driver’s license serves as a ‘checks & balances’ on their individual medical status.

What do you think as a physician and AME? How does one assess AOPA’s push objectively?

Cama
Dr. Jay Weiss is the Medical Director of the Palmetto Addiction Recovery Center, a 100 bed inpatient addiction treatment Center in Rayville, Louisiana. He retired from the U.S. Air Force after 30 years of military service in 1997 after service as a Navigator and a Psychiatrist. He began working at Palmetto in 2000. He is board certified in Psychiatry, Addiction Psychiatry, Geriatric Psychiatry, Addiction Medicine and Psychosomatic Medicine. He is a consultant to the Federal Aviation Administration and holds Airline Transport Pilot, Flight Navigator and Flight Instructor certificates. He is also a consultant to the FAA.

Aviation Psychiatry, Addictions in Aviation, and PTSD

This article is a synopsis of a presentation given at the Civil Aviation Medical Association meeting in early October, 2015. It discusses the duties and responsibilities of the Aviation Medical Examiner with regard to psychiatric and drug problems that may be discovered during a routine airman flight physical.

The Airline Pilots Association (ALPA) has a good bead on the personality profile of a typical pilot. It published an article in which it noted that pilots are distinct segment of the general population. Pilots tend to be physically and mentally healthy as well as reality based. They tend to be self-sufficient and may have difficulty functioning in team situations without cockpit resource management and other training. They have difficulty trusting anyone to do the job as well as they can. Pilots tend to be intelligent but not intellectually oriented. They are good at taking things apart, if not putting them back together. Pilots are concrete, practical, linear thinkers rather than abstract, philosophical, or theoretical thinkers. They are reality and goal oriented. They like to make lists of concrete problems which can be quickly resolved as they go down the list. They are short-term as opposed to long-term oriented. They tend to be bimodal. They think in terms of on/off, black/white, good/bad, safe/unsafe, and legal/illegal.

Pilots are inclined to modify their environment rather than their own behavior. They are very competitive and do not handle failure very well. They have a low tolerance for personal imperfection, and they demand high standards of themselves and others. They tend to scan people as if people were instruments to be rapidly analyzed with a glance rather than processed in a long and emotion laden conversation. Pilots avoid introspection and have difficulty revealing, expressing, or even recognizing their own feelings. Being unemotional helps pilots deal with crises, but this quality can be counterproductive in terms of intimate relationships. Pilot personalities are very much like surgeon personalities. Both professions require quick and accurate decisions with little margin for error. Both require strong egos. Both activities select and train for high performance capability under great pressure.

The great majority of pilots who present to the Aeromedical Examiner’s office requesting an FAA Flight Medical Certificate will walk out with a certificate in hand, because the AME finds no evidence of medical conditions that would be disqualifying under current FAA rules. The FAA flight medical form guides the pilot through a thorough history and review of systems that will reveal any of the 15 disqualifying conditions listed in part 14 CFR Part 67. The brief screening interview and examination done by the AME is designed to identify an airman who has developed one of the 15 disqualifiers. The Aeromedical Examiner must decide whether the applicant meets standards and then issue, deny, or defer the medical certificate. The Examiner has a fiduciary responsibility to the public and to flight safety. He can also advocate for the pilot and guide the pilot through the certification process, but the examiner’s primary responsibility is to the public.

Aeromedical decisions must consider the flyer and the flight environment. Additional factors involve the effect of the disorder on the flyer and the effect of the environment on the disorder. The key question is whether the pilot can fly safely with the medical condition in question. The disqualifying conditions have in common the potential for sudden or subtle incapacitation. They are a risk to flying safety within the context of the aviation environment. The five psychiatric conditions that would disqualify an airman include personality disorder, psychosis, bipolar disorder, substance dependence, and depression if sufficient to warrant antidepressant medications or the depression is sufficiently severe to precipitate suicidal or psychotic thought processes. Discretionary denials include other forms of depression, neurosis, psychotropic medications, organic brain syndrome, and any other psychiatric or medical condition if it affects the pilots ability to fly safely. Discretionary denials involve FAA decisions at the Regional Flight Surgeon and Federal Air Surgeon levels.

Personality disorders are disqualifying if manifested by overt actions that could affect aviation safety. All of us have some combination of the 13 personality features identified by Psychiatry, and these involve our world view and our interactions with other people. When personality features become a maladaptive pattern of behavior first evident by late teens and early 20s, a personality disorder can be diagnosed. The disorder by itself is
not disqualifying unless manifested by overt actions that threaten flying safety. A personality disorder diagnosis should be confirmed by appropriate psychological testing administered by a Clinical Psychologist who is familiar with the aviation environment.

Personality disorders fall into three separate clusters. Cluster A (weird, strange, and different) includes paranoid, schizotypal, and schizoid personalities. Paranoid personalities tend to be naturally suspicious, schizotypal personalities may engage in some magical thinking short of frank hallucinations or delusions, and schizoid personalities have little need for personal contact or relationships. Cluster B personalities (flamboyant and dramatic) include antisocial, borderline, narcissistic and histrionic personality features. Antisocial personalities have little remorse for the damage done to others, borderline personalities tend to be volatile and emotional, narcissistic personalities tend to place an inordinate importance on self, and histrionic personalities tend to be dramatic. Cluster C personality features (shy and awkward) include obsessive, compulsive, avoidant, and dependent features.

Psychosis is disqualifying for flight duties. Psychotic thought processes require delusions, hallucinations, or bizarre and disorganized behavior well outside the norms of the culture in question. Schizophrenia is the prototype for psychosis, but psychotic thought processes can also occur in the affective disorders (bipolar disorder and major depression). The only exception to disqualification for flight duties with psychosis is a temporary psychosis with a logical medical explanation not likely to be repeated. For example, a blow to the head with resultant concussion can result in transient hallucinations which resolve as the concussion resolves. An airman with such history may qualify for medical certification with Federal Air Surgeon approval.

Bipolar disorder is also disqualifying under current Federal Air Regulations. The key to a diagnosis of bipolar disorder is a history of mania or hypomania not caused by a medical problem such as trauma, drugs, or disease. Manic characteristics include grandiose or expansive presentations, decreased need for sleep, rapid and pressured speech or thoughts, high distractibility, poor judgment, and an engagement in risky activities without concern for consequences.

Depression is disqualifying for flight duties if it requires medication, presents with suicidal ideation, intent or plan, or is accompanied by psychotic symptoms to include delusions, hallucinations, or bizarre behavior. Symptoms of depression include decrements in sleep or excessive sleep, decreased interest, increased guilt, decreased energy, decreased concentration, decreased or increased appetite, decreased psychomotor activity, and suicidal ideation, intent or plan.

Discretionary denials include severe anxiety, panic attacks, severe phobias, claustrophobia, fear of flying, or acrophobia (fear of heights). Additional discretionary denials include physical conditions affecting mental function (organic brain syndrome) due to toxic, metabolic, infectious, tumor, trauma, or encephalopathy.

There are a number of clues available to the Aeromedical Examiner during the examination. Consider the applicant’s reputation in the community, frequent appearance on a police blotter, staff concern over the applicant’s behavior, or missing data on the FAA form. Additional flags include incomplete prior examinations, medication history, over-the-counter medications, and an applicant that does not live or work locally. Scars, injuries, surgeries, and needle track marks or tattoos provide additional information. Spider nevi, palmar erythema, and hepatomegaly raise the possibility of an alcohol problem. Over-the-counter medications and herbal medications can create adverse reactions, especially at altitude. Evasive and incomplete answers, dress, grooming, odor, and behavior provide opportunity for additional questions.

The Aeromedical Examiner is expected to perform a screening mental status examination (not a full psychiatric evaluation). Basics of this examination should include appearance, sensorium, orientation, presence or absence of psychosis, behavior, speech, mood, expression of mood (affect), and cognition, judgment, and insight. These should all be normal on the typical pilot applicant with no significant psychiatric problems.

When finished with the examination, clarify your data with any additional questions, consider consultation if necessary, mention equivocal items in the comments section of the FAA exam form, and if in doubt call your Regional Flight Surgeon for a brief telephone discussion. After consultation with the Regional Flight Surgeon, defer the decision if still in serious doubt. Ask the question, "Would I fly with this pilot?"

Substance dependence is a mandatory denial on an FAA Flight Medical Examination except where there is established clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence from the substances in question for not less than the preceding 2 years. Substances common in our society today include alcohol, cannabis, hallucinogens, inhalers, opioids, sedatives, stimulants, club drugs.
and designer drugs. There are three separate sets of criteria for diagnosing substance dependence and abuse, as well as the more recent category of substance use disorder.

DSM-IV TR requires 3 of 7 equal criteria for the diagnosis of substance dependence, and 1 of 4 criteria for the diagnosis of substance abuse. FAA criteria for substance dependence and abuse are slightly different from the DSM-IV criteria. We have recently switched from DSM-IV TR DSM 5, and DSM 5 eliminates substance dependence and abuse, and replaces both of these terms with substance use disorder, mild, moderate, or severe. There are 11 criteria for substance use disorder outlined in DSM 5, and the more of these criteria an individual meets, the higher he progresses up the scale of severity, from mild to moderate to severe.

It is important when diagnosing a substance problem to deal with professionals who are aviation savvy and understand that an Aerospace Medical Examiner is required to use FAA criteria, not DSM-IV TR or DSM 5 criteria. DSM-IV TR and DSM 5 criteria are similar but not identical to FAA criteria. FAA criteria mandate a diagnosis of substance dependence if anyone of the following criteria are met: increased tolerance, manifestation of withdrawal symptoms, impaired control abuse, or continued use despite damage to physical health or impairment of social, personal, or occupational function. FAA criteria for substance abuse require only one of the following criteria: Use in a physically hazardous situation, a positive drug test of 0.04 on a breathalyzer or refusal to test, or misuse of a substance in a way that could affect aviation safety (this would be determined by the Federal Air Surgeon).

FAA, medical board, nursing board, and pharmacy board programs for substance dependent professionals are remarkably similar. All involve formal evaluation, participation in some level of education and training on substance abuse and recovery, participation and sponsorship in the Alcoholic Anonymous program, strict monitoring, frequent alcohol and drug screens, and participation in a monitoring program as a consideration for licensure. The FAA program is called the HIMS program (Human Intervention Motivational System). This program is AA for pilots in a Nutshell PTSD is also an FAA and CAMA item of interest. PTSD involves exposure to unusual and dangerous experience, intrusive symptoms, avoidance symptoms, altered cognition, and altered arousal. Symptoms must be present for more than one month. PTSD involves a direct experience either witnessed in person or experienced through a close family member or friend involving extreme exposure to a traumatic experience outside the norm of the culture in question.

Lifetime prevalence of PTSD in the United States is about 7%. Men experience PTSD at a prevalence of around 3.6% and women at around 9.7%. Male veterans experience PTSD with a lifetime prevalence of 31% and women veterans 27%. During Vietnam, the prevalence of PTSD in returning veterans as of 1988 was 15.2% in men and 8.1% in women. Returning gulf war veterans in 1997 experienced PTSD at a rate of about 10-12%. The average incidence of PTSD for returning combat veterans from all conflicts is around 25%.

Recurrent, involuntary, and intrusive memories, dreams, flashbacks, distress, and physical reactions are common. A person with PTSD may engage in avoidance of distressing memories or reminders of the trauma and question. Cognition and mood disturbance involve inability to remember important aspects of the trauma, negative beliefs or expectations as result of the trauma, distorted beliefs, negative emotions, diminished interest and participation in usual activities, detachment, estrangement, and inability to experience positive emotions.

Arousal and activity symptoms include unusual irritability and anger, reckless or self-destructive behavior, hypervigilance, and exaggerated startle response, problems with concentration, and problems with sleep disturbance.

PTSD treatment involves medications to include SSRI and atypical antipsychotic medications, cognitive behavioral therapy, group therapy, and family therapy. Treatment in our VA system lasts around 3-6 months.

Remember that the AME part to this complex puzzle involves a regular screening examination not unlike triage, in that the goal is to sort applicants into two categories: Those who do not have disqualifying conditions and those who do have disqualifying conditions. The first group walks out of the examiner’s office with a time-limited flight medical certificate in hand. The second group will require a decision at a higher level than the AME.
BACKGROUND

The Civil Aviation Medical Association (CAMA) is an organization dedicated to aviation safety and is comprised of FAA-designated aviation medical examiners and physicians engaged in the practice of aviation medicine and other professionals in the field of civil aviation safety. CAMA aims to achieve the following objectives: (A) promote the best methodology for the assessment of mental and physical requirements of civil aviators; (B) actively increase its scientific knowledge; (C) advocate, through continuing education, both basic and advanced civil aeromedical knowledge; (D) promote professional fellowship among our colleagues from allied scientific disciplines; and (E) bind together all civil aviation medical examiners into an effective, active medical body to promote aviation safety for the good of the public. Although CAMA is not primarily an advocacy organization and does not engage lobbying personnel or pursue a specific political agenda, current legislation being considered (S. 571) deserves comment and consideration.

CAMA’s Board of Directors opposes S.571 as drafted currently, but recognizes that there have been several compromises and/or proposed changes to the original bill.

A. Adding private sector “bandwidth” to the FAA’s ability to review cases will help to ease review backlogs and improve pilot satisfaction.

The FAA processes more than 350,000 medical applications each year, but less than 1% of airmen final denials are due to a disqualifying medical condition. Despite this, there are significant delays in making certification determinations for pilots being considered for medical waivers. Conditions such as coronary artery disease, certain neurologic conditions, substance abuse in remission, and use of antidepressant medications may require weeks or even months before a certification decision is made, and these decisions may be further delayed if additional testing or review by an outside medical consultant is deemed necessary by physician reviewers at the FAA. The delays seem to hinge on lack of resources and limited manpower to review the high volume of cases, often complex in nature, in a more timely fashion. Partially decentralizing the review process and allowing private sector solutions to expand the bandwidth of reviewing complex medical cases would be one way to help address the backlog of cases to review.

Expanding the use of Conditions AMEs Can Issue (CACIs) is the first step to improving turnaround time. Allowing designated Aviation Medical Examiners (AMEs) the ability to use a checklist approach to ensure an airman is meeting pre-designated medical criteria currently helps to expedite a variety of cases that previously required medical waivers to be reviewed by the FAA.

CAMA proposes establishing Centers of Specialized Aeromedical Excellence that would allow for medical centers or clinics that meet certain criteria to be designated by the FAA to assist the agency in assessing and reviewing cases involving pilots with complex medical conditions. Centers, particularly those with an educational mission and/or training programs in Aerospace and Aviation Medicine (e.g. Mayo Clinic, University of Texas Medical Branch at Galveston, and Wright State University in Dayton, OH, as well as other private clinics with significant experience handling complex cases) could be designated by the FAA to serve as specialized centers to evaluate multiple cases that would be presented to FAA medical reviewers for aeromedical certification decisions after all supporting data were collected and collated. Subspecialty experts could be pre-scheduled to provide their opinions and discuss current medical literature applicable to making a medical certification decision as needed. Designating centers would serve to add additional cases to assist in training future medical specialists in Aerospace & Aviation Medicine, assist the FAA in preparing cases for presentation to a reviewer panel at no cost to the taxpayers or pilots.
(other than traveling to a regional center of excellence for testing and aeromedical reviews which would not be required but would be at the pilot’s discretion), and allow pilots to seek care at medical institutions with specialized expertise in aviation physiology and environmental factors unique to aviation in order to expedite medical certification review.

B. Future state should maintain use of screening all airmen in the national database for prior legal arrests, convictions or administrative history.

Each pilot who applies for a medical certificate undergoes a cross check of the national database for prior arrests, convictions, or administrative actions that may not have been reported by the airman. This should be maintained regardless of the future state of private pilot medical certification.

C. Civil aviation medical groups should work with the FAA to determine specific medical conditions to be covered under Special Issuance Authorization.

As most pilots know, the aviation environment has unique characteristics that differ considerably from the motor vehicle driving environment. These include specialized factors such as spatial disorientation, executive function and complex decision-making that include multitasking with navigation and radio operations, and cognitive function associated with hypoxia at altitude. These factors play an even more critical role as aviators age, and decrement is experienced in the special senses such as vision and hearing, as well as chronic subclinical illnesses and subtle cognitive decline may emerge. Having groups like CAMA work with the FAA to determine specific conditions that require additional scrutiny should be pursued rather than legislate specific conditions. Requiring airmen to undergo evaluations by individuals who have received training and are audited in the ability to appropriately perform FAA medical evaluations remains important as the average age of the pilot continues to escalate in the United States. Even if the frequency of certification is altered, pilots should be assessed by AMEs.

D. Pilots with progressive diseases should continue to be screened in a future state.

Screening requirements for airmen with Special Issuance Authorizations (i.e. a medical waiver), have resulted in early detection of progressive diseases that have likely saved lives. Many airmen who have been required to undergo annual functional testing for progressive conditions such as coronary artery disease, have had new onset subclinical myocardial ischemia identified, findings that likely would not have been identified without a pattern of regular medical screening that provided a baseline that could be followed. But without a requirement for testing, it is unlikely that the individual pilot would pursue it. The FAA has allowed for AME-assisted Special Issuance Authorizations to expedite renewal of medical waivers for airmen with Class III medicals given no complicating factors involving a specific case. Multiple pilots have been diagnosed early in the process of coronary artery disease progression. Similarly, many pilots with recurrent cancer have been diagnosed as a result of careful surveillance required to maintain a Class III medical certificate. This practice should be continued as part of compromise legislation.

E. We support having private pilots who have not been assessed for 10 years or more be evaluated by an AME. Elimination of the current rigidity of the Class III medical examination will undoubtedly invite pilots to fly with known medical conditions who likely would not have applied for a medical certificate in the first place if required to be assessed by an aviation medical examiner.

An unintended consequence of eliminating the Class III medical certificate for operations outlined in the legislation is the possibility that pilots with known complex medical conditions who have avoided flying larger, more complex aircraft because of fear of applying for a medical certificate will now become eligible to fly despite these known medical conditions. Individuals with seizure disorders who have retained their driving license, advanced coronary artery disease, and those with metastatic cancers would not be subjected to an FAA medical examination. Therefore, it is
critical that legislation address entry into the aeromedical certification system by requiring pilots to see an AME if the airman has not held a medical certificate in 5 years or more.

F. Removal of the Class III medical certificate may result in increased insurance rates for all pilots flying for business or recreation.

Aircraft are expensive to own, operate, and maintain. Accidents with serious or fatal injuries or property damage may result in major claims against insurance companies and the policy owners or their estates. Elimination of the Class III medical examination for operations described in S.571 may result in the requirement for pilots by their insurers to undergo physical examinations at frequencies the same or more frequent than current practice in order to maintain a discounted premium, or to qualify for insurance at all. For example, many pilots older than age 70 are now required to undergo annual physical examinations by their insurers, not the FAA, regardless of whether or not they hold a medical waiver.

RECOMMENDATIONS

A. CAMA opposes the legislation as written currently but is open to compromise language that preserves a system of periodic preventive surveillance assessments, particularly for pilots with complex medical conditions.

B. CAMA recommends that the legislation be amended to include designation of Centers of Specialized Aeromedical Excellence to assist the FAA in processing applications associated with pilots who have been diagnosed with complex medical conditions.

C. CAMA encourages the FAA to further expand use of CACIs for a variety of medical conditions, and decentralize the process of medical decision-making for medical condition for which specific criteria can be followed by the AME.

D. CAMA urges Senate members to include language that would compel the FAA to work with civil aviation safety organizations to determine what medical conditions require special surveillance as part of a compromise proposal.

E. CAMA suggests that if frequency of medical certification is altered, that evaluations occur with AMEs or providers that can demonstrate specific training or knowledge of the aviation environment.

F. CAMA supports efforts to improve education to pilots on the importance of medical fitness as a critical component of aviation safety.

RAYMAN’S CLINICAL AVIATION MEDICINE

NOW AVAILABLE FROM
THE CAMA HOME OFFICE!!

The 2013 fifth edition of “Rayman’s Clinical Aviation Medicine” is a 485 page rewrite of the classic text. Seven physicians well experienced in aviation medicine provide aeromedical disposition guidelines for civil and military aviation, making it an indispensable reference for the aviation medical examiner or flight surgeon practicing in an operational or regulatory role. (The authors receive no royalties.)

The price for the book is $50.00, plus $7.00 postage, payable by check, VISA, or MasterCard. Call or email CAMA for your copy! 770-487-0100 or civilavmed@aol.com
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:

**Corporate Members & Sponsors**

Allied Pilots Association  
14600 Trinity Boulevard  
Suite 500  
Fort Worth, TX 76155  
www.alliedpilots.org

Ashgate Publishing Company, Inc  
Suite 3-1, 110 Cherry Street  
Burlington, VT 05401  
www.ashgate.com

Behavioral Health of the Palm Beaches  
631 U.S. Highway 1, Suite 304  
North Palm Beach, FL 33408  
www.bhpalmbeach.com

Casa Palmera, HTC, LLC  
14750 El Camino Real  
Del Mar, CA 92014  
www.casapalmera.com

First Coast Cardiovascular Institute  
3900 University Boulevard, S.  
Jacksonville, FL 32216  
www.firstcoastcardio.com

Harvey Watt & Company, Inc,  
P. O. Box 20787  
Atlanta, GA 30320-9990  
www.harveywatt.com

Percussionaire Corporation  
P. O. Box 817  
Sandpoint, ID 83864  
www_percussionaire.com

SomnoMed, Inc.  
7460 Warren Pkwy, Suite 190  
Frisco, TX 75034  
www.somnomed.com

Talbott Recovery Campus  
5448 Yorktowne Drive  
Atlanta, GA 30349  
www.talbottcampus.com

University of Texas Medical Branch  
Aerospace Medicine Center  
301 University Boulevard  
Galveston, TX 75555-1110  
http://pmch.utmb.edu/clinics/services/aerospace-medicine-center

**Life Members**

Michael Boyer, MD  
John R. Capurro, MD  
George H. Coupe, DO  
Bill B. Curtis, MD  
Andrew J. Davis, MD  
M. Craig Delaughter, MD, PhD  
Mark C. Eidson, MD  
Mohammed Elaia, MD  
Tony Evans, MD  
Donna Ewy, MD  
Edmond Feeks, MD, MPH  
Aynalem Gebremariam, MD  
Robert Gordon, DO  
Dottie Hildebrand-Trembley, RN  
Ernst J. Hollman, MD  
Joseph Kearns, DO  
Atsuo Kikuchi, MD  
Stephen M. Kirkland, MD  
Ernest J. Meinhardt, MD  
Andrew H. Miller, MD  
David P. Millett, MD  
Story Musgrave, MD  
Thomas Nguyen, MD  
Michael G. Nosko, MD, PhD  
Hugh J. O’Neill, MD  
Rob G. Parrish, MD, PhD  
Michael A. Pimentel, DO  
Jeffrey P. Powell, MD, DDS.  
Sean Kevin Roden, MD  
Robert M. Roeshman, MD  
Mark S. Rubin, MD  
Gerald W. Saboe, DO  
Philip Sidell, MD  
Sergio B. Seoane, MD  
Kazuhito Shimada, MD  
Brian Smalley, DO  
E. Warren Stadler, Jr., MD  
Ruth Steward, RN  
Shepard B. Stone, MPS, PA  
Salil C. Tiwari, MD  
Lars Tjensvoll, MD  
Harold N. Walgren, MD.  
Alex M. Wolbrink, MD

**Sustaining Members**

James R. Almand, Jr., MD  
Raymond S. Basri, MD  
Forrest M. Bird, MD, PhD  
A. Duane Catterson, MD  
DeWayne E. Caviness, MD  
Gary Crump, AOPA  
Harold H. Haralson, II, MD  
James N. Heins, MD  
Reddoch Williams, MD  
Sir Rodney E. L. Williams, MD
New Members

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

Jeral L. Ahtone, MD
333 Throckmorton Street
Fort Worth, TX 76102
Emergency Medicine/Aerospace Medicine

Steven J. Altchuler, PhD, MD
Mayo Clinic, 200 First Street, SW
Rochester, MN 55905
Pilot, Psychiatrist, Addiction Psychiatry, Sleep Medicine

James M. Brauer, MD
3848 Barrett Drive
Hood River, OR 97031
AME, Family Medicine

Gabriel Fried, MD, MPH
13740 Midway Road, Suite 610
Dallas, TX 75244
Senior AME, Aviation Medicine

David G. Hess, MD
485 East 900 North
Brigham City, UT 84302
Senior AME, Pilot, Anesthesiology

Howard Alan LaGrone, MD
2311 Mustang Drive, Suite 300
Grapevine, TX 76051
Psychiatry

Rocco Anthony Lombardi, MD
104 Cawker’s Cove Road
Port Perry, Ontario, Canada L9L 1R6
AME, Family/Emergency Medicine

James McKeith, MD
1323 Sealy Street
Galveston, TX 77550
Chief Medical Officer, Polar Medical Operations, UTMB, Emergency Medicine

Col. Robert M. Monberg, MD
2165 Ermine Drive
North Pole, AK 99705
AME, Pilot, Aerospace Medicine

David C. Murdy, MD
3211 E. Racine Street
Janesville, WI 53546
Senior AME, Pilot, Internal Medicine

Milton A. Padgett, DO
165 Chestnut Drive, Suite D
Madison, AL 35758
AME, Internal Medicine

David G. Schall, MD, MPH
Regional Flight Surgeon, FAA Great Lakes Region
2300 E. Devon Avenue
Des Plaines, IL 60018
Pilot, Senior AME, HIMS, Aerospace Neurotologist

Basil P. Spyropoulos, MD
P. O. Box 764
Lake Geneva, WI 53147
Pilot, HIMS, Psychiatry

2016-2017 CAMA Officers:

President
Clayton T. Cowl, MD, MS

President-Elect
Warren S. Silberman, DO MPH

Immediate Past President
Mark C. Eidson, MD

Secretary Treasurer
John S. Raniolo, DO

Executive Vice President
David P. Millett, MD, MPH

Vice President for Education
Robert Haddon, MD

Vice President for Communications And Representation
Andrew H. Miller, MD

Vice President for Management
Gerald W. Saboe, DO, MPH

CAMA Trustees:

Term Expiring 2016:
Robert Gordon, DO
Richard S. Roth, MD
Sergio B. Seoane, MD
Harold N. Walgren, MD
Rodney Williams, MD

Term Expiring 2017:
Edmond F. Feeks, MD
Fred A. Furgang, MD
John D. Hastings, MD
Sean K. Roden, MD
Alex Wolbrink, MD

Term Expiring 2018:
Steven Altchuler, MD, PhD
Petra Illig, MD
Richard Ronan Murphy, MBChB
Russell B. Rayman, MD
CAMA MEMBERSHIP DUES NOTICE FOR 2016

*Member Name and Address:

Name & Title: ___________________________________________

Address: ___________________________________________

*AME Number: ___________________________________________

*Senior AME?: ___________________________________________

Please complete and return with your payment.

NOTE: Membership is from January 1st through December 31st of each year

Membership dues: ........................................... $ 125.00 U.S. Dollars
Sustaining Membership dues (optional): .................. $ 250.00 U.S. Dollars
Membership dues for Retired Members: ................. $ 35.00 U.S. Dollars
Membership dues for Students: .......................... $ 35.00 U.S. Dollars
Life Membership: ........................................... $1250.00 U.S. Dollars

Payment Options: CAMA Accepts checks, MasterCard and VISA only.

Check Enclosed #_________________ MasterCard_________ VISA_________

Credit Card Number: ___________________________________________

Expiration Date: ____________ Total Amount/Authorized Charge $_________

Print Name: ___________________________________________

Signature: ___________________________________________

__________________________________________

PLEASE PRINT (* required information)

Spouse/Significant Other Name: ________________________________

Check if you are a member of: AOA Yes_____ No_____

*Pilot: Yes____ No____ AOPA Yes____ No_____

*AME: Yes____ No____ EAA Yes____ No_____

*AMA Yes____ No____ AAFP Yes____ No_____

*HIMS Yes____ No____ AsMA Yes____ No_____

*Specialty: ___________________________________________

*Phone: # ( ) __________________________

Cell #: ( ) __________________________

Fax: # ( ) __________________________

*E-Mail Address: ________________________________

(E-mail address required – all CAMA correspondence, registrations, notifications, and publications are sent via email. Please notify CAMA of any email address changes so you will not miss any important information! CAMA does not share your information with any other entity or organization.)
CAMA CORPORATE MEMBERSHIP FOR 2016

Corporation/Business Name and Address:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Please complete and return with your payment.

NOTE: Membership is from January 1st through December 31st. Corporate Membership dues $300.00 U.S. Dollars. CAMA accepts MasterCard, VISA, and checks only.

Payment Options:

Check Enclosed _______ MasterCard ______ VISA _______

Credit Card Number: __________________________

Expiration Date: ___________ Authorized Amount $ ___________

Print Name on Card: __________________________

Signature: __________________________________

PLEASE PRINT (* required information)

*Contact Person(s) Name: __________________________

*S specialty/Type of Business: __________________________

*Phone: # (________) __________________________

Cell # of Contact Person(s): (________) __________________________

Fax: # (________) __________________________

*E-Mail Address of Contact Person(s):

*Email address required – all CAMA correspondence, registrations, notifications, and publications are sent via email. Please notify CAMA of any email address changes so you will not miss any important information! CAMA does not share your information with any other entity or organization.

Return form to: CAMA
P. O. Box 2382
Peachtree City, GA 30269
FAX: 770-487-0608
Telephone: 770-487-0100
email: civilavmed@aol.com