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Flight Physician

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In this issue:

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2018 Anchorage, Alaska, Annual Scientific Meeting Recap

This year's annual scientific meeting was a resounding success in beautiful Alaska! There were 100 medical professionals and 30 guests registered for the event. The hotel, the food, and the program received terrific reviews!

The field trip was to the Alaska Aviation Museum where we enjoyed the exhibits and the cuisine provided to us by Impressions Catering. Teri Toothman from David Green Premier Furriers brought a fabulous selection of coats, hats, scarves, pins, and other goodies for us to try on. Several prizes were awarded, and the ladies were invited to tour the fur vault after lunch on Friday.

The Honors Night Dinner Keynote Speaker was Don Lee of Alaska Floats & Skis in Talkeetna, AK. Mr. Lee spoke about his adventures as a bush and glacier pilot since his arrival in Alaska in the 1970's. Some of the stories were hair-raising and others were told with such humor and detail that we often felt we were along for the ride! Mr. Lee has flown more than 20,000 hours, and his planes have floats or wheels for landing on a multitude of surfaces. "Flying is one thing, but the access to the wilderness is really where it's at," he said. "It's cool to preflight my airplane, jump in, fly 30 miles and not see a road, a cabin, a light…to catch a fish right off the float on the first cast. It's awesome."

It's that type of adventurous lifestyle that Mr. Lee said leads dozens of pilots to contact him each year looking for advice. "They call me all the time and say 'I want to be a bush pilot,' and I tell them it's not a job, it's a lifestyle," he related. This is a fun business, he encourages, "but this is a serious business." Which is why students at his training outfit not only learn advanced flying skills, but also how to develop the right mental approach to off-airport success.

An exciting part of Honors Night is the awards given out for the year. This year, five CAMA Fellows were awarded. The recipients were:

Stephen D. Leonard, MD
Richard Ronan Murphy, MBChB
Leigh L. Speicher, MD
Stephen J. H. Veronneau, MD, MS
Kathleen A. Yodice, Esq., JD (not pictured)

The Forrest and Pamela Bird Recognition Award was presented to Donald R. Lee for his exceptional contributions to Aviation Safety as an expert and teacher of aviation principles as applied to aircraft operations under severe conditions. As an educator, he has instructed thousands of pilots on the techniques of operating safely in the Alaskan frontier. As an active pilot with over 30 years of experience in the bush, many of his thousands of glacier landings and float plane operations have resulted in life-saving missions.

The Jim and Sammie Harris Award was presented to Gregory A. Pinnell, MD, for his years of devoted service to CAMA and its ideals as a Trustee and a leader in the development and execution of new promotional ideas to increase the visibility and reputation of CAMA. His efforts have always demonstrated the highest degree of excellence.

The President's Commendation was given to Marcel V. Dionne, MD, MPH, the Alaska Regional Flight Surgeon, in recognition of his enthusiasm and his dedication to the field of Aerospace Medicine and his support of CAMA, along with his concentrated efforts to make the 2018 Annual Scientific Meeting a success.

The Audie and Bernice Davis Award, sponsored by Harvey Watt and Company, was presented to Andrew H. Miller, MD, FACC, in recognition of his duties as an Aviation Medical Examiner (AME) and cardiovascular consultant in the Dallas/Fort Worth area. Dr. Miller always provides exceptional service to his airmen in order to assure their longevity and safety in their aviation duties.

Our most recent Corporate Member, T. J., Waggoner, of Waggoner Diagnostics, provided two medical services that were given out free at a drawing during the annual scientific meeting in Anchorage, Alaska—the Waggoner PIP24 (value $195), and the Waggoner Computerized Color Vision Test (value $795). Congratulations to Dr. William G. Schultz and Dr. John E. Freitas as the winners of these great products!

Following are some photos taken during the meeting. Many thanks to those who shared their pictures and to Dr. John Perry for capturing shots of the activities during the educational portion of the meeting, the lunches and dinners, and the field trip!

CAMA President Warren Silberman enjoying the flight simulator at the Aviation Museum

Deann King, Leah Hale, and Lisa Veronneau on the field trip, enjoying the David Green Furriers' display

Field trip dinner among the museum displays

Tools of the trade for bush and glacier pilots

Dinner at the Alaska Aviation Museum

Debra & Jeff Sventek at AsMA display

Field trip dinner among the old airplanes

Bacon! The breakfast of champions!

Everyone enjoyed networking and visiting during the lunches

Medical Education begins

Richard Wien, Alaska Bush and Rescue Pilot

Concentrating in the classroom!

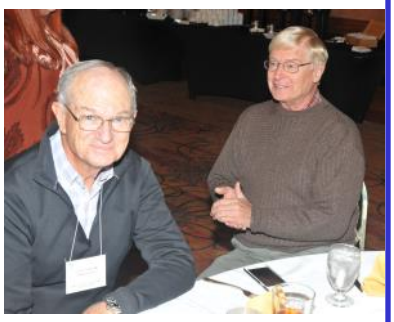
THE FACES OF CAMA'S MEETING IN ANCHORAGE

Deann King of the FAA always ready to

Dr. Scott Rossow, FAA (L)

Dr. Daniel Danczyk, Psychiatry & Addiction Lecturer (R)

Dr. David Glatt & Dr. David Schall



Dr. John Freitas & Dr. Donald Taylor

Dr. J. Russell Bowman, USCG (ret), Director of SEARHC

Dr. Geir Pasi Gilje of Norway

Dr. Michel and Janice Plechas

Dr. William and Betty Collignon

Dr. Denise Baisden, SW Regional Flight Surgeon

Lisa Veronneau when the CAMA Fellows were announced

Dr. Stephen Veronneau, FAA

Dr. Joseph and Linda Laguna

LeftSeat.com Corporate Member and Exhibitor

Dr. Jeffrey Gold, Dr. Gerald Marketos, and Dr. Milo Farnham

Warren S. Silberman, DO, MPH
CAMA President, 2018-2019

Warren S. Silberman, DO, MPH, is from Philadelphia, PA, and now resides in Oklahoma. He was the Manager of the Aerospace Medical Certification Division at the Civil Aerospace Medical Institute for 14 years. He was in the United States Army Medical Corps and was a Flight Surgeon in the U.S. Army for 12 years. While working as the Chief of Aerospace Medical Certification, he joined the Oklahoma Air National Guard and served as the State Air Surgeon for approximately 5 years.

Dr. Silberman received his BA from Temple University in 1971 and his DO from Des Moines College of Osteopathic Medicine & Surgery in 1974. He served a 1-year internship at Lancaster Osteopathic Hospital in Lancaster, PA, then a residency at Community General Osteopathic Hospital in Harrisburg, PA, from 1975-1978. After his residency, he practiced Internal Medicine in Phoenix Arizona from 1978 to 1985. He then joined the United States Army.

He earned an MPH at the University of Texas Health Sciences Center of Houston in 1991 and then served a residency in Aerospace/Preventive Medicine at the USAF School of Aerospace Medicine at Brooks AFB, TX, from 1991-1992. Dr. Silberman is Board Certified in Internal Medicine and Preventive/Aerospace Medicine. He is a Fellow of the American Osteopathic College of Internists, American Osteopathic College of Occupational and Preventive Medicine, the Aerospace Medicine Association, and the Civil Aviation Medical Association.

CAMA President's Editorial

I think all of us need to express our deepest condolences for our Executive Vice President and great friend, David Millet, MD. I have known David since June of 1997 when I first came to the FAA. He was a fine fellow! We spoke many times over the years discussing medical certification cases for which he needed a sounding board. I am not sure that you all know it was David who paved the way for the FAA to provide AME credit for our annual meeting. For those members who were not at our meeting in Anchorage, David was there and we all had a chance to spend time with him. We shall all miss that "radio personality voice" of his!

The Board of Trustees of CAMA has thrown its support to Sherry Sandoval to continue as the Executive Vice President. According to our Bylaws, the EVP does not have to be a physician. Recall, James Harris, the EVP prior to David was an educator and not a physician.

Some reminders for our FAA AME members. The Office of Aerospace Medicine sponsored an Oncology Summit in the Washington, DC, FAA Headquarters building about 2 months ago. They had many experts of the common types of cancers present and heard the up to date diagnostic methods and treatments. Over the next months, expect policy changes in the ways certification manages the different malignancies.

I really do not want to sound like a broken record, but I am still seeing AMEs who obtain the required stress testing and Holter monitoring, but do not provide proper documentation. We want you to provide all the computer print outs and 12-lead electrocardiographic tracings with stress tests and the computer print-outs and representative tracings with Holter monitor tests. This is especially upsetting when we made an AME minute on this very topic. For those of your who are unaware of what an "AME Minute" is, I will tell you! Every month the Aerospace Medical Education Division puts out a one-minute educational video on a topic that we notice has been causing problems. Last month there was a continuation of examples of the "normal variant" ECGs. This next month, we are doing a reminder on Block 17b. That question on "near-vision contact lenses". If you go to the www.faa.gov/GO/AME site and click on the envelope on the top right-hand side of the page, it will prompt you to place your email address. You will then be sent our AME minutes. These are scripted by Dr. Susan Buriak, Instructional Analyst in the Education Division, along with one of the certification docs, and professionally produced by the Enterprise Service Center here at the Aeronautical Center. We have about 1600 of our AMEs who have signed up to receive these. (See the picture below)

It is with deep regret that we report that David P. Millett, MD, MPH, the Executive Vice President of CAMA, passed away October 4, 2018, in his home in Peachtree City, Georgia. He was born in New York City in 1941, and spent his first 12 years in Leonia, New Jersey. The family then moved to Oxford, Ohio, where his father, John D. Millett, was President of Miami University from 1953 to 1964. David graduated from Talawanda High School in Oxford, Ohio, in May, 1959.

David received his undergraduate degree from Denison University in 1963 with a major in Biology and entered the Yale School of Medicine in the fall of that year. After graduating from the Yale School of Medicine in 1968, he spent two years as an assistant resident in surgery at the Yale-New Haven Medical Center. He married Joyce K. Gorlach, a graduate of Vassar, in July, 1968. Upon graduation from medical school, he joined the U. S. Air Force and attended the USAF School of Aerospace Medicine, graduating in April 1971. His daughter Cathleen Millett Thomas was born in August of 1971.

David served on active duty in the U.S. Air Force from 1970-1978, achieving the rank of lieutenant colonel in the Medical Corps. He stayed in the Air Force Reserves until his retirement in 1990, and was called to active duty during the first Gulf War. From 1973-1975 he served as the Assistant Air Attaché and post medical officer at the U.S. Embassy in Moscow. He was Chief of Aviation Medicine at Shaw AFB from 1975-78, and in 1978 was designated a Senior Aviation Medical Examiner. That year he became Director of Flight Medicine for Eastern Air Lines, serving in that position until 1987. He received his Masters Public Health (MPH) from Florida International University in 1987.

After several years of private practice in the Miami, Florida area, he was chosen to be the FAA Regional Flight Surgeon for the Southern Region in 1990, a position he held for 16 years. He joined the Airlines Medical Directors Association (AMDA) in 1979 and served as the President of that association from May 2015 to May 2016. He also served as chairman of the AMDA membership committee for the last ten years.

David was widowed in October, 2006. He retired from the FAA in December, 2006, and in 2008 became the Executive Vice President of the Civil Aviation Medical Association (CAMA) where he devoted the majority of his time to the management of the organization. CAMA, aviation, the arts, and sports were David's passions. He loved to recount his experiences in the Air Force when he flew as a Weapons Officer in F-4 squadrons, along with his adventures while living and working in Moscow. He spoke fluent Russian and loved to converse with anyone who knew that language (taxi drivers, waiters, grocery store clerks, etc.)

Dr. Millett was a Diplomate of the National Board of Medical Examiners, a Fellow of the Aerospace Medicine Association (AsMA), a Trustee, Fellow, and Executive Vice President of the Civil Aviation Medical Association (CAMA), a member of the International Academy of Aviation and Space Medicine, and Past President of the Airlines Medical Directors Association (AMDA, 2015–2016). He had served on many AsMA committees for 35 years. He was chairman of the Air Transport Medicine Committee for 5 years and chairman of arrangements twice. He was the chair of the program and arrangements for the AMDA meeting three times.

Dr. Millet's awards include the John A. Tamisiea Award from AsMA, a President's Commendation and the Harris Award from CAMA, the Joint Services Commendation Medal, the Air Force Commendation Medal, the FAA Flight Surgeon of the Year, the FAA Regional Employee of the Year, the FAA Spirit Award, several FAA Superior Accomplishment Awards, the CAMA President's Award, and an Honorary Membership in Birds of a Feather. He presented and authored numerous scientific papers on aviation medicine, including the memorable presentation on the "Mystery of the Red Sweat" at the AsMA meeting in 1983. In recent years, he has represented CAMA at AsMA meetings, often presenting the Tamisiea Award. His larger than life presence at AsMA meetings will be sorely missed.

David became one of the original Friends of Spivey Hall at Clayton State University in nearby Morrow, GA, when the music hall was built, and he attended the very first concert held there. He attended many performances each year and sponsored several concerts and receptions in recent years. The last concert he sponsored took place the weekend after his death. His companion, Sherry Sandoval, his daughter, Cathleen Millett Thomas, Sherry's younger daughter Lianne Carpenter, and other family friends attended the performance of Joshua Bell, famed concert violinist, in David's honor. A

beautiful tribute was given by Samuel C. Dixon, Executive & Artistic Director, and the concert performance was dedicated to David.

The family does not have any current plans for a public service. If anyone wishes to honor David with a memorial, in lieu of flowers, the following institutions would be excellent recipients:

(1) Spivey Hall (where David sponsored a number of concerts and whose music programs he enthusiastically supported). The link for gifts to Spivey Hall is: https://www.clayton.edu/giving-to-spivey-hall. Please annotate that your contribution is in memory of Dr. David P. Millett.

(2) Denison University, Granville, Ohio, where David received his Bachelor of Science *Cum Laude* in 1963. The link to the general Denison giving web site is https://unlock.denison.edu/give. However, David started a scholarship at Denison University in the name of Dr. Gail R. Norris, the biology professor who inspired him to enter the medical profession. To contribute specifically to this scholarship, mail a check made out to Denison University, P.O. Box 716, Granville, OH 43023-0716 with "Dr. Gail Norris Endowed Scholarship Fund in memory of David P. Millett, MD" marked in the memo portion of the check.

(2) The John D. and Catherine L. Millett Scholarship Fund at Miami University in Oxford, Ohio. The Miami University web site is www.miamioh.edu. David's father was the President of the university from 1953 to 1964 and was the first chancellor of the Ohio Board of Regents, 1964-1972. David was very proud of his parents' contributions to the field of education and to Miami University in particular.

David would be thrilled to be remembered by contributions to any of these worthy causes.

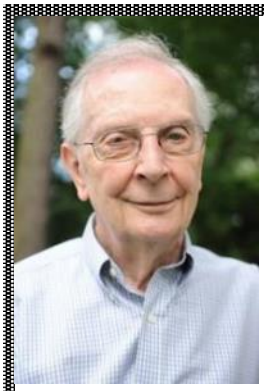
Sherry Sandoval and David Millett at Dr. Forrest Bird's 90th Birthday party, Sandpoint, ID, June 2011

David Millett (L) enjoying lunch with friends and colleagues during the Anchorage annual meeting

David enjoying a dinner of enormous king crab legs in Anchorage

Photo taken on field trip by Dr. John Perry on 09-27-18

David loved fishing for salmon and halibut in Alaska.



IN MEMORIUM
ALLEN DUANE CATTERSON, MD, OBITUARY

June 26, 1929 - August 20, 2018

We recently received the sad news that Allen Duane Catterson, MD, Space Medicine pioneer, passed away on August 20, 2018. Duane had been living at the time with his daughter and son-in-law in Ponte Vedra, Florida.

Dr. Catterson was born in Denver, Colorado in 1929 and graduated from the University of Colorado Medical School in 1955. He served his internship in the United States Air Force and became a flight surgeon. He attended Ohio State University to earn his Masters in Aerospace Medicine in 1961 and went to work at the newly-formed Manned Spacecraft Center in Houston, Texas. He served as the Deputy Director of Aerospace Medicine for NASA through the Mercury, Gemini, and Apollo programs, caring for the astronauts and their families. He left NASA in 1972 to form his own company near the newly-built Houston Intercontinental Airport, serving as a flight surgeon for the airlines. In his later career, Duane joined the Kelsey-Sebold Clinic as a physician in Preventive Medicine. When retired, Duane mentored second-year medical students at the UT Medical School and was active in the Retired Physicians Organization with its First Response Task Force.

Duane was preceded in death by Charlene, his wife of 64 years, and his eldest son, Donald. Duane is survived by his daughter, Mary Carol, son-in-law, Marc Stearns, son, Allen Catterson, six grandchildren, and two great-grandchildren. He will be remembered for his steadfast calm, his sense of humor, and his quiet dignity.

His family asks that he be remembered through prayer and acts of kindness. Any memorial donations may be made to the Houston Humane Society to honor Duane's love of animals at the following link: https://www.houstonhumane.org/(Give)/giving/general-donation.

Dr. Catterson served as the President of CAMA from 1996-1997 and remained as a CAMA Board emeritus member until his death. The following links will take you to some fascinating interviews and a transcript of an oral history from Dr. Catterson, conducted for the Johnson Space Center Oral History Project in February, 2000:
https://www.jsc.nasa.gov/history/oral_histories/CattersonAD/CattersonAD_2-17-00.htm
https://www.jsc.nasa.gov/history/oral_histories/CattersonAD/ADC_BIO.pdf

1963 Press Photo of A. Duane Catterson, MD, Assistant Chief of Medical Operations, NASA

The FAA Federal Air Surgeon Hosts Oncology Summit

The Federal Aviation Administration (FAA) has received medical certificate applications from more than 7,000 airmen with new cases of malignancy, just since 2013. As clinicians are aware, few specialties can rival oncology in terms of recent treatment advances. Our understanding of the pathogenesis and cytogenetics of cancer seems to improve every day, and new, targeted therapies have brought exciting results and clinical outcomes that could never have been anticipated even a decade ago.

Recognizing these advances, and with an eye to keeping aerospace medicine policy in the oncology area on the cutting edge, the Federal Air Surgeon invited ten leading oncology specialists from across the nation to participate in a summit to review areas for potential policy updates. Specialists in the areas of melanoma, colon cancer, breast cancer, lung cancer, blood malignancies, thyroid cancer, new cancer drugs, and cognitive impacts of cancer and cancer therapy participated in a 3-day session with the Federal Air Surgeon and key FAA physicians involved in medical certification decision making.

The Federal Air Surgeon's policymaking division is still reviewing the large volume of information gathered during Summit discussions. Aviation Medical Examiners (AMEs) can anticipate policy updates as a result of the meeting itself, and from follow-on FAA collaboration with oncology experts. We will be looking at malignancy in some cases as a chronic disease that may be able to be aeromedically managed in such a way that the FAA can grant a special issuance medical certificate, and still assure the safety of the National Air Space.

NOTE: The articles published in this newsletter are presented for informational purposes and topics of discussion and do not necessarily represent the opinions or recommendations of the Civil Aviation Medical Association.

CAMA Refund Policy

As of 01/01/2018, the cancellation/refund policy with regard to Annual Scientific Meeting registration fees and guest fees is as follows:

1) If a refund is requested due to cancellation of attendance **prior** to the catering guarantee date (*normally 2-3 weeks prior to the first day of the meeting – it varies by hotel, caterer, and location*), 10% of the total registration fee amount, or $50.00, whichever is greater, will be withheld to cover bank and service processing fees.

2) If a refund is requested due to a cancellation of attendance **after** the catering guarantee date, the cost of the meals will be withheld from the refund, plus 10% of the total registration fee to cover bank and service processing fees.

3) **Dire** or **unusual** circumstances which require cancellation/refund (attendee and/or guest fees) after the guarantee date will be determined on a case by case basis (death in the immediate family, accidents, emergency surgery, etc.), but the 10% fee will be applicable in all cases.

4) The cutoff date for the guarantees will be shown on the registration form for each year, so that there will be no misunderstandings.

Reprinted from the September/October 2018 edition of the FAA Safety Briefing with permission from the FAA. See original article on FAA web site: 1.usa.gov/FAA_ASB

Aeromedical Advisory

MICHAEL BERRY, M.D.
FEDERAL AIR SURGEON

Building the Right Team

Medical certification is a process, not a sheet of paper. While pilots are understandably concerned with the end result, they sometimes neglect building a partnership that will serve them better in the long run. You should think of obtaining your medical certificate as a process that involves three team members: You, your Aviation Medical Examiner (AME), and your Regional Flight Surgeon (RFS). Of those three, the only one you can really Choose is your AME. Therefore, your AME becomes one of the biggest variables in how smoothly your medical certification goes.

AMEs are like any large group of professionals, all with different strengths and weaknesses. In my AME days, it wasn't unusual for me to spend significant time preparing an airman's application and supporting documents to ensure smooth passage with the FAA. Not all AMEs expend that much energy on FAA exams, because most cases don't require it.

My practice was exclusively Aerospace Medicine and primarily special issuances, but many AMEs also practice another specialty. This means that any time spent on aerospace medicine is time away from their primary focus. This arrangement works when you Are in generally good health. But should you encounter a challenge in your certification, this AME may not be as up to date in the latest FAA policy, or willing to spend the time required to work your specific case, all of which could result in your medical certificate being deferred or denied unnecessarily. We see a number of cases where the AME could have issued the medical certificate, but unnecessarily deferred it to the FAA. We also see cases where the AME could have been very helpful with obtaining the correct medical documentation but was not. This means delays for you and more work for the FAA. It's a lose-lose situation. There are two ways to prevent this situation.

Who You Gonna Call?

If you are in generally good health, start building a relationship with an AME who is familiar with current FAA policy, willing to spend the time necessary, and can provide you with the best possible certification experience. One organization that can help locate these AMEs is the Civil Aviation Medical Association (CAMA). CAMA is a professional organization for FAA AMEs across the world. They can recommend member AMEs in your area. AMEs who are CAMA members are more likely to be up to speed on the latest FAA policies and aerospace medicine advances. You can find them at **http://civilavmed.org**.

Getting Dialed In

Do you have a specific medical issue that either is, or could be, a future hindrance to your medical certification? If so, your RFS could also be very helpful. RFSs know which AMEs in your region are most current in the special issuance process for a given condition. Even if you don't currently have a problem, it can be good to work with someone who may be able to help you avoid problems with certification. Call the Regional Flight Surgeon's office; they should be able to help. This advice also applies if your medical certificate is deferred. The RFS can access you case file and, in some cases, they can review and issue without having to forward it to Oklahoma City. This saves time for you and can allow the FAA to be more efficient in working your case and coming to a certification decision.

Start building a relationship with an AME who is current with FAA policy and can provide you with the best possible certification experience.

I hope that these tips can help you have a better experience during your next exam.

Dr. Michael Berry received an M.D. from the University of Texas Southwestern Medical School, and an M.S. in Preventive Medicine from Ohio State University. He is certified by the American Board of Preventive Medicine in Aerospace Medicine. He served as an FAA Senior Aviation Medical Examiner and Vice-President of Preventive and Aerospace Medicine Consultants for 25 years before joining the FAA. He also served as both a U.S. Air Force and NASA flight surgeon.

Home Office Activities and Information

Sherry Sandoval
CAMA Operations Manager

With the loss of the inimitable David Millett, who served as the CAMA Executive Vice President from 2008 through the Annual Scientific Meeting in Anchorage in September, 2018, I will be continuing the management of CAMA in the style in which he and Jim Harris before him established. David was an amazing mentor and teacher and prepared me well to fill his shoes. The CAMA telephone number has been converted to a cell phone in order to make our communications more accessible at all times. The great advantage is that, no matter where I go, CAMA will always be available by telephone. Furthermore, you can now text the CAMA number with questions or information. Please be sure, especially at first, that you identify yourself in your text in case your number is not yet in the contact list for the CAMA number. The Post Office Box and FAX number remain unchanged.

Membership renewal for 2019 is now open. See the last pages of this publication for both the regular membership form and the Corporate membership form. Dues for 2019 remain unchanged at $125.00 per year, with special pricing for retired individuals or for medical students.

With regard to Federal Air Surgeon Dr. Michael Berry's article regarding finding the a CAMA AME in your area, please bear in mind that it is not a requirement that every AME be a member of CAMA. So, if you contact us for a referral for a CAMA educated AME in your area, and our records do not show one available at this time, please contact your Regional Flight Surgeon for an AME recommendation or referral.

2019 Annual Scientific Meeting in Cleveland, Ohio

Our 2019 annual scientific meeting will take place at the Metropolitan at the 9, part of the Marriott Autograph Hotel series, which will be an excellent place in which to hold our annual meeting! The hotel is located in the middle of shops, restaurants, and activities in downtown Cleveland, a short cab or Uber ride from the airport.

Meal and activity planning has already begun for the 2019 meeting, so please keep an eye on the CAMA Home Office postings in the newsletter so that you do not miss any exciting news!

Mark your calendars and save September 26-28, 2019, to join us for the CAMA Annual Scientific Meeting in Cleveland at the interesting and unusual Metropolitan at the 9!!

2020 Annual Scientific Meeting in Albuquerque, New Mexico

The Hotel Albuquerque Old Town has been selected as the site of the 2020 Annual Scientific Meeting! The hotel is situated right in the middle of the Albuquerque, New Mexico, Old Town shopping and restaurant area, with various museums and points of interest within a short walking distance of the hotel. The hotel rooms are being updated in January 2019, so will be ready and comfortable for our meeting!

During the Albuquerque site visit, my daughter Lisa and I took a hot air balloon ride to view the city and surrounding desert and mountains from the air. The view was absolutely spectacular! Our pilot was Troy Bradley, the premier, record-setting international balloon pilot, who has done multiple transoceanic balloon crossings and has more than 7255 piloting hours in the air. Mr. Bradley has consented to give a presentation during our annual scientific meeting and his company, Rainbow Ryders, will provide discounts to CAMA attendees who wish to check a balloon flight off their bucket lists while in Albuquerque! Stay tuned for additional information in future editions of "The Flight Physician."

The Albuquerque CAMA annual scientific meeting will be held from Thursday 09/24/20 through Saturday 09/26/20. This is the weekend prior to the 2020 annual International Balloon Fiesta in Albuquerque, so those who attend the meeting may wish to block off some days after the meeting to participate in the balloon festivities, sightseeing, shopping, hiking, or indulging in the amazing New Mexico cuisine!

Long Range Planning Committee Report
26 September 2018

Following is a discussion initiated by the Long Range Planning Committee and begun at the CAMA Fall Board Meeting in Anchorage. In the coming year, each of the Six Objectives, the CAMA Mission Objectives, and suggested initiatives for each of the objectives will be the subject of much of our organizational work during 2019. Much of the history of CAMA has been archived at the Wright State University in Dayton, Ohio, and is available and searchable online. Dr. Dodge has been combing through the archived information to compile an extensive CAMA history. Volunteers to research and/or address the objectives and initiatives are hereby solicited from CAMA membership, committee members, and board members. If you wish to volunteer to assist in any of these areas, or if you have suggestions or comments, please let the CAMA Home Office know as soon as possible.

Committee members:
Gerald W. Saboe, DO, MPH – Chair

Robin Dodge, MD
Robert J. Gordon, DO
Katherine A. Helleur, MD
Gregory A. Pinnell, MD
Russell B. Rayman, MD, MPH
Reddoch E. Williams, MD

CAMA Six Objectives:

1) History of Civil Aviation Medicine – Safety
   Tell the story of why what we do as AMEs is important

2) Civil Aviation Medicine Standards of Practice
   Detail current AME practice guidelines

3) Civil Aviation Medicine CME
   Offer high quality education for performing AME exams

4) Civil Aviation Medicine Contacts/Experts
   Provide a network of AME experts to CAMA members

5) Civil Aviation Medicine Networking Ideas/Jobs
   Sharing of AME practice initiatives/ideas/job availability

6) Civil Aviation Medicine Benchmark Practice Methods
   Model “turn-key” office practice methods offered for reuse

Using the six CAMA Objectives, plan and solicit future initiatives to be completed, to continually add new content into each of the six structured areas.

CAMA BYLAWS
ARTICLE II. MISSION

Section 1. CAMA is an organization dedicated to civil aviation safety. CAMA, working on behalf of physicians engaged in the practice of aviation medicine and other professionals in the field of civil aviation safety, aims to achieve the following objectives:

A) To promote the best methodology for the assessment of mental and physical requirements of civil aviators.

B) To actively enlarge our scientific knowledge.

C) To advocate, through continuing education, both basic and advanced civil aeromedical knowledge.

D) To promote professional fellowship among our colleagues from allied scientific disciplines.

E) To bind together all civil aviation medical examiners into an effective, active medical body to promote aviation safety for the good of the public.

Suggested initiatives within each of the categories are:

1) History of Civil Aviation Medicine – Safety

- Have an ongoing list compiled to post to CAMA website of previously written history articles regarding the medical selection of aircrew.
- Have a history of aviation medicine speaker selected annually to make a presentation at the Annual Scientific Meeting.

2) Civil Aviation Medicine Standards of Practice

- Solicit members for Clinical AME topics to be prepared for presentation and/or Flight Physician publication, with posting to website.
- Solicit members for previous year's updated aeromedical standards to be prepared for presentation and/or Flight Physician publication, with posting to website.

3) Civil Aviation Medicine CME

- Solicit an ongoing Member's Only listing of CAMA members on website, with identified medical specialties and areas of aviation expertise. Secondary use would be to canvas members for potential CME presentations and Flight Physician articles.
- Solicit VP for Education candidates when needed.

4) Civil Aviation Medicine Contacts/Experts

- Task a member (or committee) to complete and maintain a secured Member's Only listing area on website.
- Task a member (or committee) to provide expanded current CAMA member detailed information for CAMA member/expert listings.

5) Civil Aviation Medicine Networking Ideas/Jobs

- Establish an AME forum within the Member's Only section of the CAMA website.
- Establish an AME job opening forum within the Member's Only section of the CAMA website (Useful for military returning to civilian practice, as well as, new civilian RAMs).

6) Civil Aviation Medicine Benchmark Practice Methods

- Task a member (or committee) to solicit information from practicing AMEs regarding their practices and request information regarding automated scheduling providers, website design recommendations, unique office forms created, billing schedules, etc., to compile for the educational use and/or reuse by other CAMA members.
- Task a member (or committee) with compiling a listing of example "best practices" AME websites for listing in CAMA Member's Only section of website. List contact information to obtain additional details from the owner.

John E. Freitas, MD
Senior AME
St. Joseph Mercy Hospital
Ypsilanti, MI

John E. Freitas, MD, received his undergraduate degree in 1967 from the University of Notre Dame, and his medical degree from the University of Michigan in 1971. He completed an Internal Medicine residency (1971-1974) and a Nuclear Medicine fellowship (1976-1978) at University Hospitals, Ann Arbor, MI. From 1974-76, Dr. Freitas served in the US Navy at NAS Miramar, San Diego, CA. He is a retired thyroidologist and Director of Nuclear Medicine Services for the St. Joseph Mercy Health System. He is a practicing AME, a Clinical Professor Emeritus of Radiology at the University of Michigan Medical School and, for almost four decades, an active participant in medical student and residency education. Dr. Freitas is a long –time member of CAMA and also a member of the Flying Physicians Association (FPA), previously serving as the President of the Great Lakes Chapter. He serves on the FPA Board of Directors and chairs the FPA Samaritan Committee, where he has initiated close working relationships with Bahamas Habitat, AeroBridge, and other aviation service agencies involved with patient transportation and those working to meet emergency needs. Dr. Freitas and his wife, Beth, own a 1972 Beech Bonanza F33A, and he has over 3900 PIC hours and ratings for IFR, COMM, MEL, SEL, and SES.

Tales of An AME

By John E. Freitas, MD

My father was a World War II Naval Flight Surgeon who engendered in me a desire to fly. As a Berry Plan participant since 1967 at the University of Michigan Medical Center, the U.S. Navy finally came calling for me in early 1974, despite President Nixon's non-renewal of the "Doctor Draft" in 1973. After some negotiations with my detailer, I was pleasantly surprised to be assigned to NAS Miramar, San Diego, CA, as a General Medical Officer at the completion of my Internal Medicine Residency in June 1974. Upon arriving at my duty station and getting my haircut, I discovered that the nearest Navy Flying Club was at NAS North Island, the birthplace of Naval Aviation, 15 miles to the south. Ove the next 2 years, I earned my private and commercial pilot certificates. On a daily basis, I worked with multiple Flight Surgeons at the base dispensary who told me how much they enjoyed working with their pilots. I was hooked, but with a wife and 2 kids, extending my naval career as a flight surgeon was not going to work, so I returned to Ann Arbor for Nuclear Medicine fellowship training, contacted the Federal Aviation Administration (FAA) and eventually received my aviation medical examiner (AME) designation in Washtenaw County, MI, in January, 1977. I was now one of more than 7,000 FAA AMEs worldwide (40% were pilots) charged with the FAA Mission: "To provide the most efficient aerospace system in the world". My AME philosophy for the past 40 years has been threefold: my medical and flight knowledge interact to maintain and promote aviation safety; a high level of physician and airman integrity is required to validate the aerospace medical certification system (Figure 1); and meticulous attention to detail maximizes the likelihood of "ticketing" in the shortest time. As a serious aviator who has been "medically grounded" on several occasions, I know personally how aggravating that can be, not to speak of the career and financial distress incurred for a professional pilot.

Figure 1:

Avmed, Inc
John E. Freitas, MD
5301 E. Huron River Dr.
Ypsilanti, MI 48197

Dear Joseph Blo M **March 10, 2007**

Thank you for giving me the opportunity to be your AMEfor the past several years. I have valued our relationship, and I hope that you continue to prosper in your aviation career. However, as we discussed at some length during your recent visit, your failure to divulge to me and the FAA your recent cardiology visit and subsequent cardiac catheterization has broken the bond of trust that must exist between us for this relationship to continue. Thus, I am severing our relationship and can no longer act as your AME. For your future medical certification needs, I am providing you with the contact information of the other First Class AMEs practicing in Washtenaw County.

Daniel Chapman, M.D., 1500 E. Medical Center Drive, Ann Arbor, 734-998-8788

Martin Gleespen, M.D., 1290 S. Main St., Chelsea, 734-475-1107

Sincerely yours in aviation,
John E. Freitas, M.D.
AME #15169

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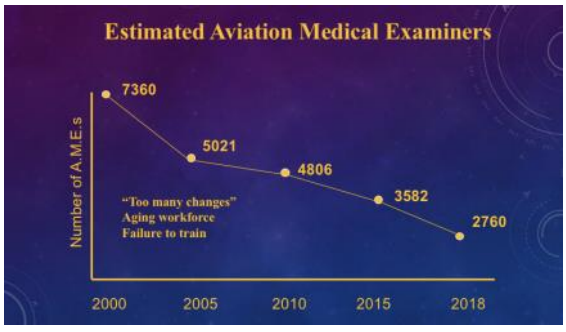
Currently in 2018, there 2760 AMEs assigned to 9 FAA regions, taking care of 406,612 pilots, 23,240 Air Traffic Controllers, and performing 384,000 exams per year. The FAA designates AMEs by county through the Regional Flight Surgeon (RFS) office providing roughly one AME for every 150 aviators domiciled in that county. In Michigan, there are 73 AMEs (30% are pilots) providing exams for 12,216 pilots and roughly 1,100 Air Traffic controllers. As we all know from reading the aviation publications and our local newspapers, there has been progressive decline in the number of certificated pilots for more than 30 years. Over a 20-year period, the number of general aviation pilots declined by more than 40% from 1995 to 2015 (Figure 2).

Figure 2: Estimated Airmen Certificates Over a Twenty Year Span

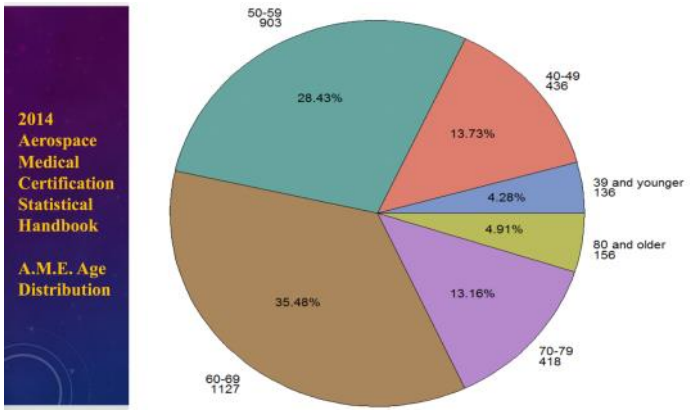
While the number of professional pilots declined less dramatically, there is now a dearth of professional pilots in the burgeoning aviation transportation system. As the number of pilots declined, the number of AMEs took an even more precipitous drop of >60% (Figure 3).

Figure 3: Estimated Aviation Medical Examiners



Why has this happened? Let's look at how an AME's practice has evolved over the past 30 years. Initially, medical certificate applicants would complete the paper FAA Form 8500-8 in the office. The AME would review the form, perform the exam, and complete the form on the trusty office typewriter and send the airman on his way with (or occasionally without) the paper certificate in hand. The typewritten form with the EKG (if needed) was deposited in the local mailbox and off it went to Oklahoma City. In the late 1990s, things began to change. Starting in 1998, the AME had to transpose the information from both the front and back of the 8500-8 into the FAA's Digital Imaging Workflow System (DIWS) for transmission to OK City. An EKG had to be transmitted electronically (access to such a device required in 1999), and even later attached to the internet-transmitted Form 8500-8. As the number of medical certificate applicants dropped, many AMEs were unable to meet the minimum numbers of exams required per year (10) to maintain their designation. Others did not wish to go along with further modernization of the Aerospace Medical Certification System (AMCS), such as the introduction of the AME Assisted Special Issuance (AASI) Program in 2002 (Third Class Airmen initially) and its expansion in 2004 (for all airmen), followed by the monthly changes in the internet version of the AME Guide (2003). In 2012, the paper 8500-8 was finally eliminated by mandatory introduction of electronic completion online for all medical certificate applications in 2012. In 2013, the Conditions an AME Can Issue (CACI) Program was added. AMEs lost their designation by a failure to adapt to these changes or to train at 3-year intervals as required. At the same time, the AME workforce was aging in place and by 2014, more than 50% of examiners were over 60 years of age (Figure 4) with some leaving practice and not being replaced. Lastly, an AMEs performance was scrutinized more carefully and designations were rescinded for failure to perform effectively. So now, when the question is raised: "How many AMEs are there?". The answer is "Not enough."

Figure 4: Aviation Medical Examiner Age Distribution



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My AME practice has also evolved with time. It is now a "one-man shop" consisting of a hospital-based office rental, online website scheduling (Figure 5), limited hours, approximately 130 exams/ year, a truly low budget operation.

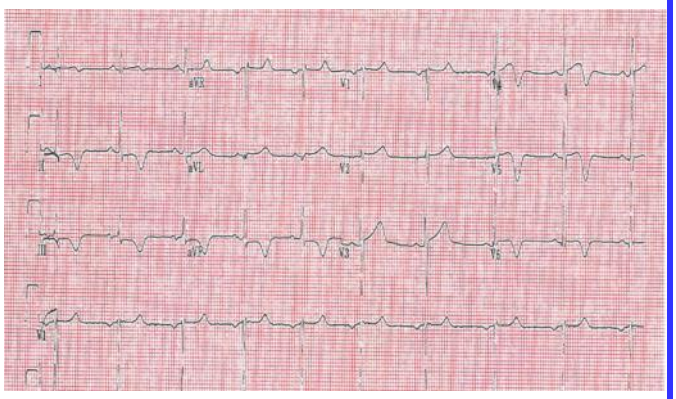
Figure 5: Online website featuring medical certificate application information and self-scheduling by the airman.

Let's now look at a series of airmen presenting with medical issues that need to be addressed before their medical certificate can be issued:

A 20 year old (y.o.) commercial pilot with 188 hours is an Aviation Technology (AT) student in a Restricted ATP certification program who received a First Class medical at his initial FAA exam 2 years prior. My exam demonstrated severe red-green color deficiency and, upon first questioning, the student confirmed that the initial AME had used non-authorized color vision testing to "pass" him after he initially failed standard testing. I contacted the prior AME's office and verified the airman's description of the procedure followed and then reported this procedure deviation to the RFS office. With this degree of color deficiency, it is highly unlikely that the student could even pass the Farnworth Lantern test, the most lenient color vison testing authorized by the FAA. I issued the airman a First Class medical certificate with the restriction "Not valid for night flying or by color signal control" and referred the airman for an Operational Color Vision Test (OCVT) which he failed both the day and night testing. The airman was dropped from his AT program, the prior AME lost his designation, and successful litigation ensued. Adherence to procedure performance standards is imperative to prevent such disappointing outcomes.

This 35 y.o. First Class Air Transport Pilot (ATP) with 3800 hours presents for his first FAA exam after age 35. On Lansoprazole for gastroesophageal reflux disease (GERD), his physical exam is normal, but his required EKG demonstrates marked QT and T wave changes (Figure 6).

Figure 6: Abnormal EKG



The airman denied chest pain, shortness of breath, substance abuse, or significant family history, but stated that he had 2 prior EKGs interpreted as normal in South America. A "curbside cardiology consult" suggested a cardiomyopathy as the most likely diagnosis, and the airman was deferred to the FAA since it was unlikely that the required Cardiology evaluation could be completed within the "14 day window" before my evaluation must be transmitted. However, I initiated the cardiology evaluation and testing that I knew the FAA would require and asked the airman to obtain the prior EKGs. The airman had a normal cardiac exam by the cardiologist, a normal rest and stress echocardiogram, and a "No evidence of disease" letter from the cardiologist within 3 weeks. The prior EKGS demonstrated similar, but less impressive findings. I was able to transmit this information to the RFS who issued the First Class medical certificate with no follow-up requirements within days of receiving the cardiology evaluation. The airman was given an EKG copy to show to the next examiner when an EKG was required again in 5 years.

A 32 y.o. Third Class private pilot with 485 hours had CACI-qualified hypertension on Lisinopril and had passed a kidney stone requiring an ER visit a few weeks prior to this exam. He is now asymptomatic. The FAA's Nephrolithiasis Worksheet (Figure 7, next page) is the guide to whether the AME can issue or not. Perusal shows that, if a single stone passed, and there are no retained stones, we can issue. However, the Kidney-Ureter-Bladder (KUB) radiograph that I obtained on the day of his visit showed several retained stones in the

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Figure 7: FAA Nephrolithiasis Guide Sheet

Nephrolithiasis Evaluation Sheet

DISEASE/CONDITION	EVALUATION DATA	DISPOSITION
A. Most recent event/diagnosis **5 or more years ago.**	No symptoms or current problems. Renal function has returned to normal. No ongoing treatment or surveillance needed.	**ISSUE** Summarize this history in Block 60.
B. Single stone that passed **Less than 5 years ago** with no complications*	If a **single stone passed** or is in the bladder with no further problems and imaging (such as a KUB) verifies **no retained stones**:	**ISSUE** Summarize this history in Block 60.
C. Multiple or **Retained** asymptomatic stone(s) **Less than 5 years ago** with no complications* **Note:** Use this for incidental findings.	See CACI worksheet	Follow the CACI – Retained Kidney Stones Worksheet. Annotate Block 60.
D. All others Complications* Symptomatic Underlying cause for recurrent stones	Submit the following to the FAA for review: ☐ Current status report from the treating urologist with treatment plan and prognosis; ☐ If underlying cause is identified, the status report should include diagnosis, treatment plan, prognosis and adherence to treatment for this condition; ☐ List of medications and side effects if any; ☐ Operative notes and discharge summary (if applicable);and ☐ Copies of imaging reports and lab (if already performed by treating physician).	**DEFER** Submit the information to the FAA for a possible Special Issuance. **Follow up Issuance** Will be per the airman's authorization letter.

***Complications** include the following:
- Hydronephrosis (chronic).
- Metabolic/underlying condition requiring treatment/surveillance/monitoring
- Procedures (3 or more for kidney stones within the last 5 years)
- Renal failure or obstruction (acute or chronic).
- Sepsis or recurrent urinary tract infections due to stones

Figure 9: CACI Retained Kidney Stone Worksheet

CACI Retained Kidney Stone Worksheet

AME MUST REVIEW	ACCEPTABLE CERTIFICATION CRITERIA
A current status report from the treating physician that notes the airman's condition is: • Asymptomatic; • Stable (**no increase in number or size of stones**); • Unlikely to cause a sudden incapacitating event; • If surgery has been performed, the airman: o Is off pain medication(s); o Has made a full recovery; and o Has a full release from the surgeon; • No history of complications (including chronic hydronephrosis; metabolic/underlying condition; procedures (3 or more in the last 5 years); renal failure or obstruction; sepsis; or recurrent UTIs due to stones.)	[ ] Yes
Is there an underlying cause for stone recurrence?	[ ] No
Current or recommended treatment After a single stone event - if follow up imaging verifies no further stone(s) present, annotate this in Block 60. No further follow up is required unless there is a change in condition.	[ ] None Supportive treatments such as hydration or medications (such as thiazides, allopurinol, or potassium citrate) to decrease recurrence **(with no side effects)** are allowed.

AME MUST NOTE in Block 60 one of the following:

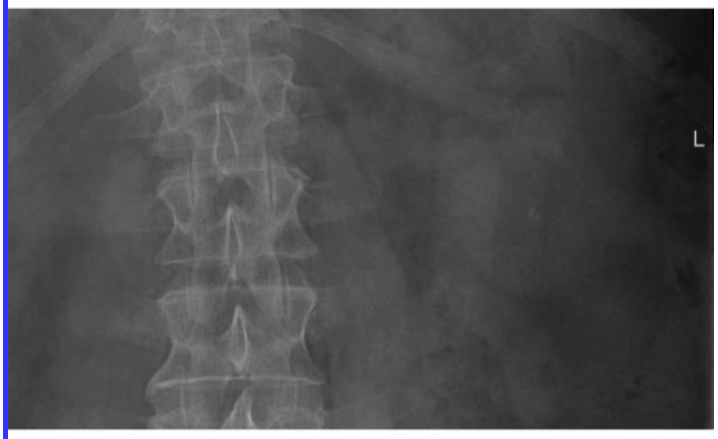
[ ] CACI qualified Retained Kidney Stone(s).

[ ] Not CACI qualified Retained Kidney Stone(s). Issued per valid SI/AASI. (Submit supporting documents.)

[ ] NOT CACI qualified Retained Kidney Stone(s). I have deferred. (Submit supporting documents.)

left kidney (Figure 8) requiring an evaluation for an underlying cause of stone recurrence. Since I had not imported his file in the AMCS and had not performed an exam, I was able to refer him for an appointment with a urologist the following week. No cause for stone recurrence was found and his urologist provided a letter that fulfilled Acceptable Certification Criteria for the CACI Retained kidney Stone Worksheet (Figure 9). He returned to my office for his FAA exam 2 weeks later and I was able to issue his "ticket" that day.

Figure 8: Kidney-Ureter-Bladder Radiograph



This 34 y.o. Third Class private pilot with 385 hours had hypertension treated with Lisinopril that had developed since his FAA exam 5 years prior. With his permission, I accessed his medical records online to see if he had CACI-qualified hypertension that I could issue. To my surprise, I found that a Total Serum Calcium 2 years prior was elevated but not followed up, apparently. I obtained a repeat Serum Calcium that was elevated and an intact Parathyroid Hormone (PTH) confirmed a diagnosis of Primary Hyperparathyroidism 2 days later. This requires a deferral to the FAA. I contacted the airman's treating physician, relayed what I had discovered, and helped arrange for a successful one gland parathyroidectomy 3 weeks later. The RFS issued a Third Class medical certificate 6 weeks after my initial exam.

A 22 y.o. Third Class applicant with 7 hours was an Aerospace Engineering student with a "clean" Form 8500-8. My exam noted a "steppage gait", spindly lower legs, and decreased ankle dorsiflexion. Family history revealed similar findings in his mother and a brother. The likelihood of a neurologic disorder requires deferral to the FAA, and I referred the applicant to a neurologist who confirmed a diagnosis of Charcot-Marie-Tooth disease, most likely an autosomal dominant inheritance pattern. The FAA issued a Third Class medical certificate with a Medical Flight Test requirement. Subsequently, he received a Special Issuance and not a Statement of Demonstrated Ability (SODA) since this condition can worsen with time.

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This 52 y.o. First Class ATP with 12,300 hours was ticketed by law enforcement for driving his car while intoxicated 2 weeks prior to his already scheduled aviation medical examination. His Blood Alcohol Content (BAC) was 0.12 after approximately 60 oz. of beer consumed over 3-4 hours. He had no prior history of alcohol-related suspensions or convictions. He contacted me after already notifying FAA Security and Investigations Division. The airman and I briefly reviewed the FAA DUI/DWI/Alcohol Incidents Worksheet (Figure 10) over the phone and I then e-mailed the airman the FAA Certification Aid (Figure 10) and Alcohol Worksheet, so he knew what documents that he must obtain along with completing his Drug and Alcohol Personal statement.

Figure 10: FAA Certification Aid, Drug& Alcohol

FAA Certification Aid Drug and Alcohol

REPORT FROM	MUST SPECIFICALLY ADDRESS OR STATE THE FOLLOWING (Drug and Alcohol)
AIRMAN Drug and alcohol (D&A) Personal statement	1. Detailed typed personal statement from you that describes the offense(s): a. What type of offense occurred? b. What substance(s) were involved? c. State or locality or jurisdiction where the incident occurred d. Date of the arrest, conviction and/or administrative action. e. Description of circumstances surrounding the offense. f. **Describe the above for each alcohol incident. If no other incidents, this should be stated.** 2. Your past, present and future plans for alcohol or drug use. a. When did you start drinking? How much? How often? b. How much, how often were you drinking at the time of the incident(s) c. How much, how often do you drink now? If abstinent, state date. d. Any negative consequences (legal complications, medical complications such as blackouts, pancreatitis or ER visits) e. Include any other alcohol or drug offenses, (arrests, convictions, or administrative actions) even if they were later reduced to a lower sentence. 3. Treatment programs you attended ever in your life **(if none, this should be stated)** a. Dates of treatment b. Inpatient, outpatient other c. Name of treatment facility 4. Current recovery program (if any) If you attend AA or other, please list and frequency. **If no recovery program, this should be stated.**
BAC Blood Alcohol Content	1. Blood Alcohol Concentration (BAC) from any alcohol offense. It may be listed in a hospital report, a police report or investigative report. a. This will be either a breathalyzer test or a blood test. b. Attach copies of any drug testing that was also performed.
Court Records	1. Police/investigative report from dates of incident(s). It should describe the circumstances surrounding the offense and any field sobriety tests that were performed. 2. Court records if applicable. 3. Military records if events occurred while the applicant was a member of the U.S. armed forces. (It should include military court records, records of non-judicial punishment, and military substance abuse records).
Driving record DMV Records (Department of motor vehicles)	1. List every state/municipality/location and dates you have held a driver's license in the past 10 years. 2. Submit a complete copy of your driving records from each of these for the past 10 years.
Evidence of treatment	1. Treatment records and Copy of certificate (if any) 2. If no program was recommended or if treatment was started but not completed, that should be stated.
Substance Abuse Evaluation	Not required for all airmen. If one is required, the type of provider required to perform the evaluation should be in the letter sent to the airman from the FAA. This will be either a Substance Abuse Professional (SAP), HIMS AME, Psychiatrist or a HIMS psychiatrist If the evaluation submitted is not adequate or does not meet the specified parameters, a higher level evaluation may be required.

Three weeks later he had all the documents ready for my review. His physical examination was unremarkable, and I was able to complete my Alcohol Event Status Report (Figure 11) and issue his medical certificate. He continues to drink socially.

Figure 11: DUI/DWI/Alcohol Incidents Worksheet

DUI/DWI/Alcohol Incidents

CONDITION	EVALUATION DATA	DISPOSITION
A. History of alcohol related event(s) OR alcohol dependence Previously **reported to FAA and written proof from the FAA** that monitoring is not required.	The airman should bring his/her letter(s) from the FAA (for this condition) for the AME to review. The AME should review the letter and **obtain any additional history necessary from the airman to verify no subsequent events have occurred.** If the airman is required to remain abstinent, the AME, based on their clinical assessment, should note in Block 60 if the airman is adhering to this requirement.	**ISSUE** Annotate Block 60 with the mm/yyyy of the most recent event and if there have been no further events or changes in condition. If changes, consult with AMCD/RFS or Defer
B. **Single** event **5 or more years ago** **with Blood Alcohol Content (BAC) less than 0.15**	The AME should gather information regarding the incident including date, events surrounding the incident, history of other events, or any prior treatment programs (it is highly recommended that the AME obtain all items on the AIRMAN Drug and Alcohol Personal Statement. If AME determines, through exam and interview, there is no current or historical evidence of a substance abuse or dependence problem.	**ISSUE** Summarize this history, annotate Block 60 including date (mm/yyyy) of the offense. Submit Airman Drug and Alcohol Personal Statement and copy of BAC (if available) to the FAA for retention in the file.
C. **Single** event **less than 5 years ago** OR Single event **at any time** with **Unknown BAC, Refused BAC/breathalyzer or BAC .15 or above**	The AME must complete the Alcohol Event Status Report for the AME OR write a summary report that includes all of the items on the Alcohol Event Status Report. If the single event was 10 or more years ago, the BAC or court records are unavailable, and the AME has no concerns, call AMCD at 405-954-4821 or the RFS to discuss.	Follow the instructions on the Alcohol Event Status Report for the AME. Submit the information to the FAA for review. Follow up Issuance will be per the airman's authorization letter.
D. **Two or more** events in the airman's lifetime Or **History of dependence or substance use disorder**	Submit the following for FAA review: ☐ Airman's personal statement ☐ The Alcohol Event Status Report for the AME along with the supporting information used to review. Additional information may be required after review of this documentation.	**DEFER** Submit the information to the FAA for review. Follow up Issuance will be per the airman's authorization letter.

60 y.o. First Class ATP with 24,900 hours has had CACI-qualified hypertension for several years on Hydrochlorothiazide and hyper-cholesterolemia controlled with Lovastatin. His urine glucose screen showed 4+ and a confirmatory Hgb A1c was 9.8% on the same day confirming Diabetes Mellitus Type II. His physical exam showed no diabetic complications. New onset Diabetes Mellitus requiring other than diet therapy must be deferred to the FAA for an Initial Special Issuance. I consulted with his treating physician and Metformin 500 mg b.i.d. was started that day, increasing to 1000 mg. b.i.d. one week later. I provided him with the Diabetes or Hyperglycemia on Oral Medications Status Report (Figure 12) to give to his physician for completion after he had been on Metformin treatment for a minimum of 14 days. Three weeks later his Hgb A1c was 9.1 %, his status report was completed by his treating physician and he subsequently received his Special Issuance 3 weeks later returning him to flight status. My follow-up exams demonstrated the development of diabetic retinopathy with no treatment indicated yet and stable Hgb A1c values.

Figure 12: Alcohol Event Status Report for the AME

Alcohol Event Status Report for the AME
(Updated 05/27/2017)

Name: [redacted] Birthdate: [redacted]
Appl: [redacted] Pat: [redacted]

Airmen - See the FAA Certification Aid - Drug and Alcohol INITIAL to identify what information you should give the AME.

AME Instructions:
- Address the following items based on your in-office exam and documentation review:
- **Submit this Checklist** (it must be signed and dated by the AME); and
- Submit the **supporting documentation reviewed** to complete this checklist **within 14 days to:**

Federal Aviation Administration
Civil Aerospace Medical Institute, Bldg. 13
Aerospace Medical Certification Division, AAM-313
PO Box 25082, Oklahoma City, OK 73125-9887

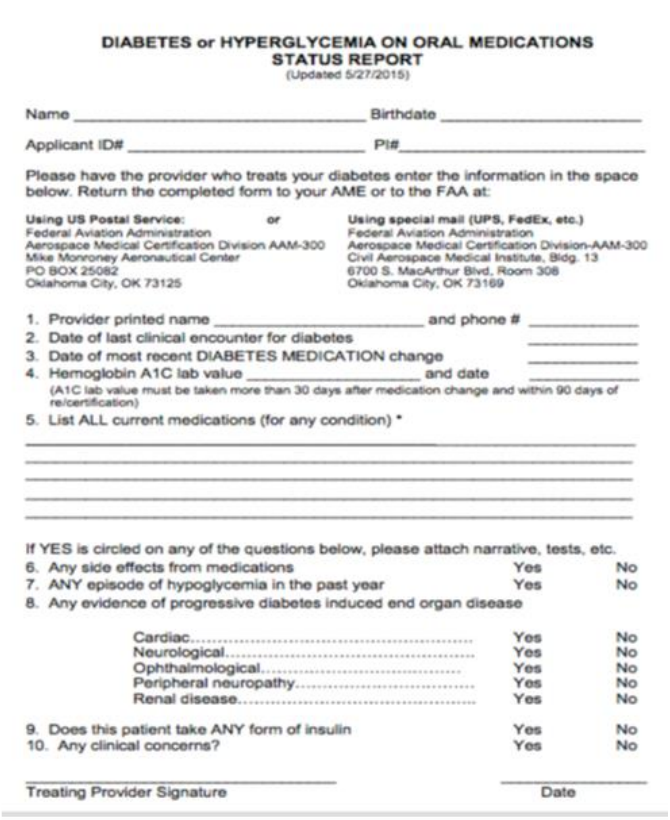
1. List DATE(s) of any arrest, conviction or administrative action here. 11/10/17
2. Number of alcohol related events in the airman's lifetime? ..... One / Two or more
3. **AIRMAN's STATEMENT** Do you find any evidence of current or previous alcohol abuse, dependence or other concerning behaviors? ..... No / Yes
4. **BLOOD/BREATH ALCOHOL CONTENT (BAC)** from all offenses:
   Did the airman ever **REFUSE TO TEST** ..... No / Yes
   Missing records of test performed (per the airman)? ..... No / Yes
   Any BAC in the records of **0.15 g/dl or HIGHER** ..... No / Yes (.15 or higher)
   List the highest BAC found on report(s) here: 0.12
5. **COURT RECORD(s) AND ARREST RECORD(s)**: (including military records)
   Did the airman **fail to provide** a copy of the narrative police/investigative report from all offenses and complete copies of all court records associated with the offense(s) including court-ordered education? ..... No / Yes
6. **DRIVING RECORD** AME must review a complete Department of Motor Vehicles (DMV) record. List all states the airman held a driver's license for the past 10 years.
   1. MICHIGAN 3.
   2. 4.
   Any additional driving offenses involving alcohol or other concerns not listed in #1? ..... No / Yes
7. **EVIDENCE OF TREATMENT**: Did the airman attend any inpatient or outpatient rehabilitation or treatment? (Do not include court-ordered education programs.) ..... No / Yes
8. Is there any history or evidence of any DRUG (illicit, Rx, etc.) offense at any time? ..... No / Yes
9. Do you have ANY concerns regarding this airman? If yes, notate in Block 60 ..... No / Yes

John S. Tilton MD — AME Signature
12/8/17 — Date of evaluation

If ALL items fall into the clear column, the AME may issue with notes in Block 60 but must submit all documents to the FAA.

(Continued on Page 19)

Figure 13: Diabetes or Hyperglycemia on Oral Medications Status Report



DIABETES or HYPERGLYCEMIA ON ORAL MEDICATIONS STATUS REPORT
(Updated 5/27/2015)

Name _____ Birthdate _____

Applicant ID# _____ PI#_____

Please have the provider who treats your diabetes enter the information in the space below. Return the completed form to your AME or to the FAA at:

Using US Postal Service: or **Using special mail (UPS, FedEx, etc.)**
Federal Aviation Administration
Aerospace Medical Certification Division AAM-300
Mike Monroney Aeronautical Center
PO BOX 25082
Oklahoma City, OK 73125

Federal Aviation Administration
Aerospace Medical Certification Division-AAM-300
Civil Aerospace Medical Institute, Bldg. 13
6700 S. MacArthur Blvd, Room 308
Oklahoma City, OK 73169

1. Provider printed name _____ and phone # _____
2. Date of last clinical encounter for diabetes _____
3. Date of most recent DIABETES MEDICATION change _____
4. Hemoglobin A1C lab value _____ and date _____
   (A1C lab value must be taken more than 30 days after medication change and within 90 days of re/certification)
5. List ALL current medications (for any condition) *

_____
_____
_____
_____
_____

If YES is circled on any of the questions below, please attach narrative, tests, etc.

6. Any side effects from medications Yes No
7. ANY episode of hypoglycemia in the past year Yes No
8. Any evidence of progressive diabetes induced end organ disease

Cardiac	Yes	No
Neurological	Yes	No
Ophthalmological	Yes	No
Peripheral neuropathy	Yes	No
Renal disease	Yes	No

9. Does this patient take ANY form of insulin Yes No
10. Any clinical concerns? Yes No

_____ _____
Treating Provider Signature Date

Like many AMEs, I have airmen who inquire about BasicMed. Which airmen benefit the most from BasicMed? Currently, there are roughly 19,000 airmen on a Special Issuance, with more than 15,000 of them having cardiac or diabetic conditions. Airmen on a Special issuance for a medical condition that is more likely than not to deteriorate over the next several years would benefit the most going the BasicMed route, if they are now qualified to do so. In summary, being an AME is fun, if you enjoy interacting with pilots. The AME's meticulous attention to detail facilitates the medical certification process. Having a good working relationship with your RFS is paramount to expedite medical certification of pilots with medical issues.

Waggoner Diagnostic's suite of color vision tests is the only cross-platform suite of color vision products available on the market today. Waggoner Diagnostics is able to satisfy anyone interested in performing color vision tests, both screening and diagnostic, by providing traditional booklets (PIP), computerized color vision tests (App), and Internet-based testing (Web) with several of their products accepted by the U.S. Navy, Army, Navy, Coast Guard, and FAA. There is a product that aligns with each potential customer's needs perfectly by providing products between $110 and $2,395. Please note, Waggoner Diagnostic's online testing can have a higher priced depending on the number of individuals being tested annually.

Daniel Glover is a writer-editor for the Federal Aviation Administration.

K. Daniel Glover has three decades of experience as a writer, editor and social media strategist, most of that time as a journalist covering Congress for leading Washington news outlets. He has written and edited news stories, features, columns, blogs, speeches, broadcast scripts and more — both under his own byline and as a ghostwriter. While Glover's editorial emphasis has been in text, he also has experience editing photos, audio and video.

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Daniel Glover is a writer-editor for the Federal Aviation Administration, which published a version of this article in September 2018. CAMA thanks him and the FAA Office of Communications for permission to reprint this very interesting presentation. We hope to have regular contributions from Mr. Glover in future editions of "The Flight Physician."

A Generation of 'Flying Fools'

Clockwise from top left: A Time magazine cover about skyjacking; infamous "parajacker" D.B. Cooper; a hijacker holds a gun to the head of TWA pilot John Testrake; and a courier delivers ransom to a Delta plane that was hijacked (Photos via Google Images)

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When Americans think of hijacking these days, one date sticks in their minds—Sept. 11, 2001, the day that 19 terrorists coordinated the hijacking of four airplanes and killed nearly 3,000 people. But there was a time in aviation history when "skyjackings" were so common that they were a topic of great concern at the FAA.

Stretching from the early 1960s into the mid-1970s, this "golden age of hijacking" featured the hostile takeover of more than 150 aircraft. The outbreak of lawlessness in the air led to new laws, regulations, executive orders and treaties. In addition to experts inside the FAA, pilots, aircraft designers, law enforcers and others brainstormed ways to address the threat domestically, and the International Civil Aviation Organization played a key role globally.

A scene from 9/11 as captured by an FAA employee

"Hijacking—or what to do about hijacking—confronts the government of the United States with serious challenges that require the harnessing of its technological, political and legal skills," State Department official Frank Loy said in 1969.

The FAA deployed "peace officers" on select flights. It tested a system that combined behavioral profiling of passengers with technological screening and occasional interviews by U.S. marshals. And by the mid-1970s, the foundation of today's passenger and baggage screening system had been laid in airports across the country.

The Cuban Connection

It didn't take long after the first successful flight of a powered airplane for the new technology to become a target of criminality. As noted in the 2017 book *Violence in the Skies: A History of Aircraft Hijacking and Bombing*, the first known theft of a plane was in 1911, followed by another incident in 1917 that ended with the two scofflaws dying in a crash.

While the earliest unverified accounts of skyjacking date back to 1919 in Hungary and 1929 in Mexico, the incident officially recognized as the first occurred Feb. 21, 1931, in Peru. A rebellion led by Lt. Col. Luis Miguel Sanchez Cerro was the impetus for that crime. Some disenchanted followers of his commandeered a Pan American Airways tri-motor plane for a flight from Arequipa to Lima to drop leaflets on the city. The captive mail pilot, Capt. Byron Dague Rickards, later received a *Chicago Daily News* award for his daring during that rebellion. It took another 30 years—and the rise of Fidel Castro in Cuba—for skyjacking to surface as a major concern in the United States. Several Cuban aircraft were hijacked to the United States and elsewhere before and after the Castro-led Cuban revolution, but those defections from a newly communist neighbor didn't stir much angst in America.

Then on May 1, 1961, Antulio Ramirez Ortiz forced a National Airlines pilot to take a detour to Havana, not the United States. Three more such attempts, including the first on U.S. soil, occurred between July 24 and Aug. 9.

Najeeb Halaby after being sworn in as administrator of the FAA in 1961 (Photo: JFK Presidential Library)

The threat materialized just weeks after Najeeb Halaby took over the then-Federal Aviation Agency, which was created in 1958. Under his leadership, the FAA started imposing the maximum penalties for drunken and disorderly conduct on aircraft. More significantly, he spearheaded the Kennedy administration's push for a law to make skyjacking a

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federal crime. “This bill provides very simply that air drunks and flying fools and spies in the sky will face not just local police or a defenseless girl or a preoccupied crew but the full power of your federal government,” Shaffer told the Senate Commerce Aviation Subcommittee. In what the *Virginia Law Review* characterized as “an extraordinary exhibition of congressional speed,” the House and Senate cleared the bill to President Kennedy, who signed it into law Sept. 5.

The statute defined air piracy as a crime subject to at least 20 years in prison and potentially the death penalty. Interfering with an aircraft crew could result in fines up to $10,000 and jail time up to 20 years, with a life sentence as an option for a threat made with a dangerous weapon. The law also imposed penalties for assault, robbery and carrying concealed weapons aboard aircraft, and for giving false reports about any of the newly defined crimes.

The administration supplemented this legislative deterrent to air piracy with a groundbreaking executive action—the deployment of armed guards on civilian planes. The initial guards were deployed from among the ranks of U.S. border patrol a day after the third successful skyjacking in 1961. The FAA gained its own corps of “peace officers” six months later, fulfilling that duty only when airlines or the FBI requested it.

The birth of airport screening

The crackdown had the desired effect for a while. In five of the six years from 1962 to 1967, no U.S.-registered aircraft were targeted—the exception being 1965, which saw one successful hijacking and three failed attempts, according to a 1975 FAA report. But manmade turbulence returned to the air with unprecedented intensity at the tail end of the decade.

Skyjackings in the 1960s prompted the FAA to test airport screening. (Photo: FAA)

Seventeen skyjackings in 1968 eclipsed the previous annual record of five in 1961, and that total paled in comparison to the 40 in 1969. Another 25 aircraft were commandeered each year in 1970, 1971 and 1972. “An atmosphere of hopelessness existed, and few workable solutions emerged from testimony presented by government and private industry,” the Task Force on Deterrence of Air Piracy recalled in its final report in 1978.

The FAA created that eight-member task force in February 1969, and it spearheaded the federal response to skyjacking over the next few years. Led by Federal Air Surgeon H.L. Rheigard and FAA Chief Psychologist John Dailey, the task force met almost daily and worked full time to identify tactics for preventing skyjacking.

The experts ultimately settled on a two-step screening process at airport gates. Airline personnel analyzed passengers for various undisclosed behaviors that had been identified as matches for 82 percent of past hijackers. Passengers also walked through weapons-screening devices. U.S. marshals interviewed those who fit the behavioral profile and/or who carried items identified as potential weapons.

The FAA worked with Eastern Air Lines, a victim of multiple hijackings in the 1960s, to test the system in August 1969. One-day tests were held at Eastern gates in Atlanta, Dallas, New Orleans, New York, Miami, St. Louis, Tampa, the Washington, D.C., area and Puerto Rico. The airports featured signs to alert passengers to the screening, and the FAA held press conferences and videotaped passengers at each site to get public feedback.

Rep. Jim Wright hailed the program as a success in a June 1970 article he wrote about anti-hijacking efforts for *Airways* magazine. As proof, he described what officials found in a single planter near an Eastern gate in New Orleans—two pistols, a sawed-off shotgun and several knives that people presumably dumped there upon realizing they would be screened. David Brown, the public affairs representative on the FAA task force, said that of the dozens of articles written about the program, only three were negative. Air travelers concerned about the rise of skyjacking also voiced their approval directly to the FAA. “We couldn’t find anybody who objected or refused to fly,” Brown said. “Not one.”

‘Guns for everybody’

Americans shared their opinions in another way, too, flooding the FAA with anti-hijacking ideas of

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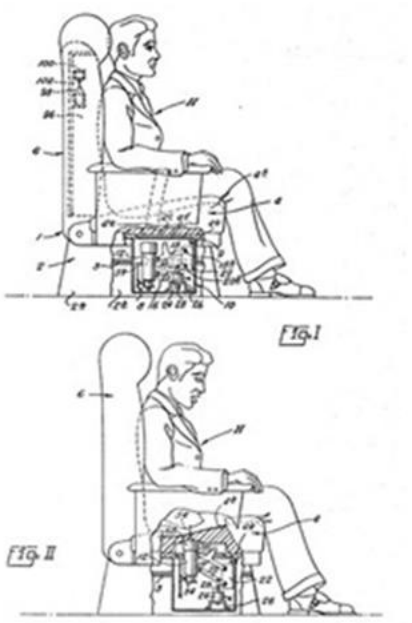
their own. “Mayors, bank presidents, civic club members, teachers, whole classrooms of students write in,” Al Butler, assistant chief of the air-carrier research branch of the Flight Standards Service, told Associated Press. “We read them all and acknowledge every one.”



Patent illustrations for an airplane injection seat (Photo: Escapenet)

Some people contacted the FAA directly, while others channeled ideas through their members of Congress. The editor of *The Nation* raised the idea of screening all passengers, sent a copy of his editorial to the FAA and asked for a response on the record. Syndicated columnist Norton Mockridge recapped suggestions made by celebrities like cartoonists Chester Gould and George Wunder, authors Arthur Hailey and Mickey Spillane, and watercolor artist Dong Kingman.

AP characterized the proposals as “some serious, some frivolous and most pretty unusual.” A dive into the FAA archives and news coverage of the day revealed more impractical and bizarre ideas than thoughtful ones. The suggestions ran the gamut from capitulation (free travel to Cuba for anyone who wanted it) to confrontation.

A Miami Beach man who regularly commuted to Boston by plane proposed adapting the “riding shotgun” approach from the Old West to modern aviation. The weapon in this case could have fired darts, tranquilizers, tear gas or anything else that would have worked well within a few feet. “A north end Boston boy would solve this problem in 10 seconds—shoot the first man who approached a restricted or unauthorized section,” he wrote in a telegram. “… A few people shot would clean up this mess.”

Talk of how to deter skyjacking was so pervasive that a similar off-the-wall pitch made it into a 1972 episode of “All in the Family.” Archie Bunker shared it in a “guns for everybody” broadcast editorial that still gets laughs today. “If that was up to me, I could end the skyjackings tomorrow,” Bunker said. “All you gotta do is arm all your passengers. … They just pass out the pistols at the beginning of the trip, and they pick them up again at the end. Case closed.”

Here are some of the other unusual recommendations the FAA received:

- Install double-door cockpits and airtight compartments between the two doors to trap and gas hijackers.
- Install trap doors or ejection seats in planes to get rid of hijackers.
- Build a needle apparatus into seats to sedate or kill hijackers.
- Require passengers to wear only robes or to wear smocks over their clothes, inhibiting their access to weapons.
- Equip all passengers with boxing gloves so they couldn’t wield guns.
- Lock passengers’ legs to their seats.
- Gas everyone on the plane during refueling stops on the ground so law enforcers could board and apprehend the hijackers.
- Depressurize the cabin until the hijackers (and everyone else except the pilots) passed out from hypoxia.
- And play the Cuban national anthem before takeoffs, arresting all who stood for it.

Jack Shaffer headed the FAA from 1969 to 1973 (Photo: Wikimedia)

The Cuban connection to skyjacking inspired another pitch the FAA heard several times a day—building a decoy airport in Florida to look like Jose Marti International Airport in Havana. Writing in *Family Weekly* in July 1969, FAA Administrator Jack Shaffer exposed the obvious flaw in that plan: “Using a fake airport would work once, and that’s all.”

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From 'parajacking' to terrorism

Cuba remained a popular destination for hijackers through the 1960s, but criminals began to see airplanes as a means to other nefarious ends. Italian-American Rafael Minichiello forced a Trans World Airlines flight from Los Angeles to Rome so he could escape his obligations as a U.S. Marine. And D.B. Cooper, the first "parajacker," held a Northwest Orient Airlines flight hostage until he collected a $200,000 ransom, then jumped out of the plane, never to be found. Media coverage of such events tended to glorify the hijackers unwittingly, a development that caused concern in the FAA. The agency refused to help a documentary filmmaker tell the story of Minichiello's hijacking for that very reason. The FAA couldn't even be swayed by Rome-based Carlo Ponti Production's vow to let the agency review and approve the script.

Rafael Minichiello, who forced a flight from L.A. to Rome, became a folk hero. (Photo: 99% Invisible)

Shaffer warned that such a film would "evoke both sympathy and heroic images," and it could encourage more hijackers to adopt Minichiello's unprecedented approach of requiring pilots to land and refuel multiple times for long-distance hijackings. Transportation Secretary John Volpe urged the filmmaker to ditch the idea altogether.

"The risk of exposing innocent passengers is always present and could never be explained away should a disaster occur," Shaffer said in a letter to the law firm representing the production company. "As the agency responsible for safety, we cannot condone anything that would expose passengers to such risks, nor could we endorse the concepts in such a film."

The risks endemic to skyjacking became clear days after Shaffer penned those words. On March 17, 1970, suicidal hijacker John Divivo shot the pilot and co-pilot of Eastern Air Lines Flight 1320. Capt. Robert Wilbur Jr. survived and landed the plane safely, but co-pilot James Hartley died—after wresting the gun from Divivo and killing him.

The tragedy marked a turning point in the government's thinking about what motivated hijackings. They were no longer seen as being primarily about political escape but instead as driven by psychological problems. "The trend now is toward the hijacker who is emotionally deranged, stunt oriented, or possibly intent on suicide or under the influence of drugs, or one or more, even all of these," Shaffer said in a letter to an industry group.

The FAA reacted to the Flight 1320 hijacking by expanding airport screening. The agency initially let airlines decide whether to use the system that was tested in 1969, and four U.S. carriers had employed it by the summer of 1970. In a trial run after the shooting, the FAA expanded the program to all passengers at then-Moisant Field in New Orleans. The agency also replaced its temporary anti-piracy task force with the permanent Office of Air Transportation Security and expanded the mission to encompass sabotage, bomb threats and air-cargo theft.

A hijacker shot pilots James Hartley (left) and Bob Wilbur Jr. in 1970. Wilbur landed the plane; Hartley died after shooting the hijacker. (Photos: Eastern Air Lines)

President Nixon had his own 9/11 moment months later. He proposed a series of anti-hijacking initiatives after the Popular Front for the Liberation of Palestine hijacked or attempted to hijack four jets headed to the United States. Nixon's proposals included screening at all U.S. airports and for U.S. carriers abroad when possible, deployment of armed guards on U.S. commercial flights, and ratification of a treaty on extraditing and punishing hijackers.

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"We can—and we will—deal effectively with piracy in the skies today," he said. Four years later, in one of his last acts before resigning as president, Nixon signed the Anti-Hijacking Act into law. Among other steps, it required nationwide passenger and baggage screening, allowed the FAA to deploy personnel for airport security programs (this led to the creation of the Civil Aviation Security Service), and authorized the president to suspend airline services to and from countries that aided terrorist hijackings.

The early 1970s also saw the ratification and implementation of two treaties through ICAO. The Convention for the Suppression of Unlawful Seizure of Aircraft took effect in 1971, followed by the Convention for the Suppression of Unlawful Acts against the Safety of Civil Aviation two years later. Together they required signatory countries to extradite or prosecute people who hijacked, sabotaged or destroyed aircraft, or interfered with air navigation facilities.

The world after 9/11

The number of U.S.-related skyjackings fluctuated in the ensuing decades but never rose to the same intensity of danger as in the late 1960s and early 1970s. Major events continued to spur government action domestically and globally. The efforts included creative research pursuits like Project Gerbil. After eight hijacking attempts of U.S.-registered aircraft in 1978, the FAA awarded a $100,000 research grant to study the possibility of using the rodents as part of a bomb-sniffing patrol in airports.

One of the more dramatic hijackings in the 1980s lasted two weeks in Beirut. Two Lebanese Shiite Muslims aboard TWA Flight 847 forced pilots to go to that destination and held passengers hostage while demanding that Israel release hundreds of Shiite prisoners. The terrorists murdered U.S. Navy diver Robert Stethem and held a gun to the head of pilot John Testrake, a defining photographic moment of hijacking as a means of terror.

The mid-air bombing of Pan Am Flight 103 near Lockerbie, Scotland, led to new aviation security measures. (Photo: FBI)

That incident and two others involving Pan American World Airways in 1987 and 1988—the hijacking of Flight 73 in Karachi, Pakistan, and the mid-air bombing of Flight 103 near Lockerbie, Scotland—contributed to new agency initiatives. The agency deployed explosives-detection systems, imposed tough baggage-screening requirements on U.S. carriers in Europe and the Middle East, required computer systems to control access to secured airport areas, and appointed civil aviation security liaison officers at key international locations.

Security measures implemented after the terrorist attacks in 2001, including the expansion of the air-marshal program, the reinforcement of cockpits and the creation of the Transportation Security Administration, have made skyjackings rare. The Aviation Safety Network has tallied only about 50 of them worldwide since then.

Most recently, two incidents in 2016—the hijacking of an EgyptAir flight in March and of an Afriqiyah Airways flight in December—were bookended by years with no hijackings in 2015 and 2017. This past April, a mentally ill passenger threatened a China Air flight attendant with a fountain pen and forced an emergency landing.

The closest thing to a skyjacking in the United States since 9/11 occurred this past Aug. 10. An airline employee stole a Q400 turboprop from Seattle-Tacoma International Airport and flew around the area for about an hour before crashing into Puget Sound. FAA air traffic controllers earned praise for their interactions with that man.

"There was a time when there was no security and we had this awful, awful crisis," Brendan Koerner, author of the 2013 book *The Skies Belong to Us*, told CNN. "And I think it would be even worse today if we stripped away a lot of security."

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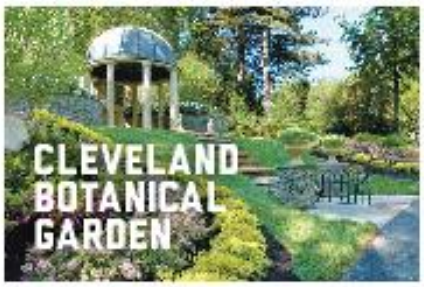

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CAMA CORPORATE MEMBERSHIP FOR 2019

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, American Express, and checks only.

Payment Options:

Check Enclosed #_____ MasterCard _____ VISA _____ AMEX _____

Credit Card Number: _____

CVV/CVC Security Code: _____

Zip Code of Billing Address: _____

Expiration Date: _____ **Authorized Amount $** _____

Print Name on Card: _____

Signature: _____

Return form to: CAMA
P. O. Box 2382
Peachtree City, GA 30269
FAX: 770-487-0080
Telephone: 770-487-0100
email: civilavmed@aol.com

PLEASE PRINT (* required information)

***Contact Person(s) Name:** _____

***Specialty/Type of Business:** _____

_____

***Phone: # ( )** _____

Cell # of Contact Person(s): ( ) _____

Fax: # ( ) _____

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

_____

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