Convincing Our International Colleagues

Some of our international colleagues have concerns about the adequacy of our medical standards and the required scope of our routine medical examinations: What they ought to consider.

Editorial, by Jon L. Jordan, MD, JD

Several years ago I wrote an article for the Bulletin focusing on world leadership in aviation [FASMB, fall 1996, p. 3]. I wrote how we in the Office of Aerospace Medicine develop and implement aeromedical standards, airman medical certification, aviation physiology, and accident investigation research.

I wrote the article because of questions raised by an aviation medical examiner as to why we should place emphasis on international involvement. The AME's point was that resources might be better spent on solving some of our own domestic issues.

As you might imagine, I pointed to the rapid worldwide growth of travel by air and that American citizens find themselves dependent on foreign air carriers, foreign aviation systems, and foreign-manufactured airplanes to reach their destinations in other words, worldwide safety for the flying public. What I did not mention is the objective of ensuring, in so far as possible, that airmen found qualified under our medical standards and certification practices are accepted internationally as being medically qualified.

Some of our international colleagues have concerns about the adequacy of our medical standards and the required scope of our routine medical examinations. Admittedly, other than resting electrocardiograms for first-class certificate applicants and urine examinations for all classes of certificates, no special routine medical testing is required under our medical standards. Finding pathology, therefore, is dependent on the historical information provided by the applicant and the general physical examination conducted by the aviation medical examiner. One might ask whether this is enough? I believe our excellent safety record answers the question.

In addition, there is the issue about the flexible approach we take in determining the medical competence of an airman who has a history of a significant medical condition and, therefore, does not meet the requirements of the established medical standards. Airmen with a wide variety of medical conditions are evaluated on an individual basis, and we exclude relatively few medical conditions from consideration.

Experience has validated the appropriateness of our medical certification practices. Our

accident data indicate that airmen granted Authorizations and special-issuance medical certificates are significantly less likely to be involved in accidents than airmen who have not. On the whole, medically related accidents are rare, whether in relationship to the scope of our medical examinations or the issuance of certificates to persons with a history of known pathology.

All physicians have an inclination to apply preventive medicine practices when dealing with people. I believe that this may drive some of the thinking in countries that have established standards more comprehensive than ours. Promoting health is an appropriate thing for physicians to do but, as persons with regulatory oversight responsibilities, I think that so long as the individual's health does not compromise safety, he or she should be permitted to fly.

The same is true when making medical certification decisions concerning persons with medical conditions that we know are likely to be progressive. If we can (without compromising aviation safety) provide the opportunity for these persons to participate in aviation activities, we ought to do so. Recognizing that an individual eventually will be unable to meet our safety criteria should not influence us in arriving at a favorable decision.

We have developed one of the most, if not the most, comprehensive systems in the world for assuring the medical qualifications of airmen. Our AMEs are carefully selected, trained, and monitored. We provide centralized oversight of their work through a sophisticated electronic processing system that guarantees correct decision-making. We have staffs here in Washington, in our regional offices, and in Oklahoma City that are trained and highly qualified to administer the system. I believe this comprehensive oversight more than compensates for any value that might be realized through more comprehensive routine medical testing of applicants.

In hopes of arriving at greater commonality in medical standards and certification practices, we will continue to interact with medical representatives from the international community, sharing our experiences in certification of airmen and administration of our standards. While I am convinced that our medical standards are appropriate and effective, and our certification decisions are correct, convincing certain segments of the international community presents a challenge.

JLJ