



# Federal Air Surgeon's Medical Bulletin



**Aviation Safety Through Aerospace Medicine**

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For FAA Aviation Medical Examiners, Office of Aerospace Medicine Personnel,  
Flight Standards Inspectors, and Other Aviation Professionals.

U.S. Department of Transportation  
**Federal Aviation Administration**

## Resources for Aviation Medical Examiners

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A new information brochure for medical certification applicants will soon be available to aviation medical examiners that describes the various services the Office of Aerospace Medicine provides to the aviation community. The brochure advises your applicants how to:

- Obtain a medical certificate
- Locate the nearest aviation medical examiner



- Appeal if denied
- Obtain a duplicate medical certificate or complete file
- Request a full review of records or special issuance
- Report a change of address
- Locate the nearest Regional Flight Surgeon's office

The new brochure will be available by May 3, 2004. Several copies of the brochure will be sent to each

*Continued on page 7*

## QUICK FIX

### *Pilot Medical Certification Information*

By Richard F. (Dick) Jones, MD

**Problem:** Airmen sometimes do not understand the FAA's medical certification process. If a medical certificate has been denied or deferred, the affected airman often does not know his/her rights regarding appeals, how to obtain information on the status of a certification decision, or how to expedite a determination.

**Result:** Many pilots do not view the FAA as being friendly. This perception taints their relationship with their AMEs and is compounded when they encounter difficulty in obtaining guidance when a certificate has not been issued. Considerable frustration is generated in airmen trying to navigate our system without being able to find the appropriate office. Likewise, FAA and AME staff members use significant amounts of time rerouting calls from airmen that have been directed to the wrong person. These airmen are usually not pleased with the FAA or their AMEs and can be unpleasant, causing staff dissatisfaction. In short, everyone is unhappy with the situation.

**Solution:** A brochure, *Pilot Medical Certification*, has been resurrected and revised. The new brochure provides information to the aviation community regarding contacts within the FAA, finding the nearest AME, locating and changing FAA medical records, special issuance, and the appeals process. We will send a few copies of the brochure to each AME as soon as we get them. We do not want to risk wasting them by sending more than a few to everyone at first, since almost half of our nearly 5,000 AMEs perform 25 or fewer FAA examinations a year, and we can't predict how many your practice is likely to use. If you think they will enhance your practice, you should order as many as you will need for the year. Instruction on ordering more will accompany the mailing. We suggest you make these brochures available to all your pilots and strongly recommend you give at least one to each applicant you deny or defer. We hope the use of this tool will improve our relationships with aircrew and enhance the working conditions and efficiency of our staffs.

*Dr. Jones manages the Office of Aerospace Medicine's Aerospace Medical Education Division.*

## 'Same-Day' Certification: Elusive Dream

*While technology is not the answer to every question, the appropriate use of technology will bring us closer to achieving our goals*

Editorial, by **Jon L. Jordan, MD, JD**

**I**T WASN'T ALL THAT long ago that my management team and I were sitting around a hotel table in New Orleans, developing a vision for the future that included a dream of "same-day certification" for airmen. While all of us thought the concept was ideal, few believed that for many airmen it would ever come to pass. Elusive as this dream is, it has lived on in the minds of the leadership of the Office of Aerospace Medicine.

In the several years that have passed since the New Orleans meeting, significant changes have been made in the airman medical certification process. The medical qualification regulations have been modified to facilitate the certification of airmen, certification policies have become more flexible, and in many cases,

certification processes have been simplified. At the same time, however, we have experienced an increase in the quantity and complexity of medical cases requiring resolution. While for many airmen these changes have produced "same day certification" that could not have been provided years ago, a significant number of airmen must still wait prolonged periods for their certification decisions.

Trying to keep ahead of the delays in medical certification decision-making has been a difficult struggle. Perhaps it is unlikely that we will ever achieve our goal of "same-day certification" for every airman. With the remarkable advances being made in technology, however, we are experiencing greater opportunities to push closer to this goal, as well as to many other goals of the Office of Aerospace Medicine.

Just as one example, in the area of aeromedical education and management of the Aviation Medical Examiner (AME) system, the ability to communicate electronically has significantly simplified our tasks. We currently provide remote education for AMEs, thereby reducing the need for time-consuming and expensive travel to attend seminars. When required, AMEs can register on-line for seminar attendance, and our library at the Civil Aerospace Institute can rapidly fill requests electronically for medical journal information.

Perhaps, however, the greatest advantage in the use of new technology relates to the establishment of comprehensive pools of data that are being used to improve and manage our programs. This is especially true in the case of the Document Imaging Workflow System (DIWS), which is now the "backbone" of our medical certification process. It is through the DIWS that we expect to come closer to attaining our goal of "same day certification."

As most of you know, the DIWS is an electronic system that stores medical certification case material on every applicant for airman medical certification by the Federal Aviation Administration. This system allows our staff in Oklahoma City

### The Federal Air Surgeon's Column



By **Jon L. Jordan, MD, JD**

to electronically process cases. Benefits include improved quality and quantity of available medical certification data and expediting the retrieval of those data when necessary. It is through the use of these data that we are able to monitor and assess the performance of AMEs and identify errors that demand correction.

One part of our current processing system that results in frequent errors relates to the transmission by AMEs (or their staffs) of data from the history portion of the form. All too frequently, the data are transmitted inaccurately. While education is a partial answer to this problem, knowledge of human nature leads us to believe that education alone won't solve the problem. It is in our plan, therefore, to once again turn to technology.

For the future, we are pursuing a modification of DIWS that would allow airman applicants to electronically complete the medical certification at sites remote to the AME's office and transmit the information to the AMCD. At the time of the examination, the AME could access the information for use in the conduct of the examination and would not, as now, be required to enter that data into DIWS. Convenience for the airman, reduction in workload for the AME, enhancement of the quality of data in our system, and reduction in the need to correct errors would be the outcomes.

Technology is not the answer to every question. It is clear, however, that the appropriate use of technology will bring us closer to meeting all of our goals. Facilitating the medical certification process is simply one example.

*JLJ*

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## Changing the World



**T**ODAY IS A DAY FOR HEROES. Today is a day for America. Today is a day when we celebrate our ingenuity and the dream of flight — a dream realized by two men on the windy, sandy shores of

Kitty Hawk 100 years ago. Orville and Wilbur Wright knew their work was extraordinary, but did they know that they were changing the world?

But these visionaries did just that. They spurred a revolution that brought together continents, countries, and cultures. With a powered flight that lasted less than a single minute, they created a ripple that still resounds today.

In less than three score and ten years, the Wright's flight spurred man's eventual conquest of the moon. On this hundredth anniversary of that first flight in North Carolina, more than 500 million Americans will take to the skies this year for business and pleasure. What mankind once never could have envisioned — spanning these United States in a single week — now takes place in a matter of hours.

Aviation has become the lifeblood of commerce, a cornerstone of transportation on which we have come to depend. We herald the Wright Brothers and their gift to all of mankind: the ability to fly.

We also take a moment reflect on a job well done by all the men and women of the FAA. We strive every day to maintain and operate the world's safest and most efficient aviation system. We take rightful pride in our achievements. Our day-to-day accomplishments are second to none, and I am proud to serve with you in keeping America flying.

— FAA Administrator Marion C. Blakey

*A Message to FAA Employees  
December 17, 2003*



...A GREAT AMERICAN JOURNEY that began at Kitty Hawk continues in ways unimaginable to the Wright brothers. One small piece of their Flyer traveled far beyond this field. It was carried by another flying machine, on Apollo 11, all the way to the Sea of Tranquility on the Moon.

These past hundred years have brought supersonic flights, frequent space travel, the exploration of Mars, and the Voyager One spacecraft, which right now is moving at 39,000 miles per hour toward the outer edge of our solar system. By our skill and daring,

America has excelled in every area of aviation and space travel. And our national commitment remains firm: By our skill and daring, we will continue to lead the world in flight....

—President George W. Bush

*Remarks to Commemorate First Flight  
Kill Devil Hills, N.C.  
December 17, 2003*



## Certification Update

Information About AME-Assisted Special Issuances

By Warren S. Silberman, DO, MPH

Well, we now have all our physicians back at work. The most recent gain is Dr. **Larry Wilson**, who returned from his tour of duty in Bosnia (see photo, page 15). He has been back at work since November 4, 2003, and has been busy learning all the changes in our certification practices and the upgrades to the DIWS system.

Rather than quizzing you about certification issues, I will inform you of recent changes in our certification practices and discuss the program for AME-Assisted Special Issuances. I shall resume the case presentations with the next issue of the *Bulletin*.

### Updates

□ *Zetia* is now generally acceptable for use in the treatment of hyperlipidemia.

□ *Levitra* (vardenafil): FDA approved on 8/19/03. Due to the additional warning in individuals with prolonged QT interval we withhold certification of persons using this medication for at least another 6 months.

□ *Crestor* (rosuvastatin calcium): This is a new HMG-CoA reductase inhibitor to lower cholesterol and is generally acceptable.

□ *Hip resurfacing replacement*: An operation primarily intended for use in younger people who require hip replacement is now considered generally acceptable and not contraindicated in the certification of airmen.

□ *Zelnorm* (tegaserod maleate): Indicated for treatment of women with irritable bowel syndrome, now generally acceptable as long as the applicant has no side effects and the underlying condition does not present a safety problem

□ *Humira* (adalimumab): Used to manage signs and symptoms of rheumatoid arthritis, is not acceptable for use by airmen.

**Oral hypoglycemic agents.** One of the cases I presented in the last *Bulletin* [*Federal Air Surgeon's Medical Bulletin*, Vol.41, No. 3, Issues and Answers, p.3] stirred up some discussion. Since the Food and Drug Administration has not approved metformin for weight loss, we do not believe it should be considered acceptable for aviation under those circumstances. However, if metformin is being used for "insulin resistance," the FAA permits its use.

The way the Aerospace Medical Certification Division (AMCD) administers these cases is that the airman will have to demonstrate that diabetes was not present prior to the initiation of treatment. We will accept several blood sugars (2) and a statement denying any symptoms compatible with diabetes. We will also require an HgA1C level prior to treatment. If a physician, prior to any of the above being accomplished, started the airman on this treatment, we will require that the medication be discontinued for 30 days and the airman have two fasting blood sugar levels and an HgA1C level. For recertification, the airman must provide us with the same clinical statement and testing as for diabetes treated with oral hypoglycemic agents. If the blood sugar level is 126 mg% or greater, Type II diabetes will be assumed.

**AME-Assisted Special Issuances.** If you have been at any of our recent AME seminars, you heard us promote what was initially referred to as our *Quick-Cert Program*. This program was initially presented in the spring 2002 *Federal Air Surgeon's Medical Bulletin* [pp. 1,3]. I am surprised how many AMEs are still unaware of its existence.

This program came about as a result of a suggestion by the Aircraft Owners and Pilots Association to assign more responsibilities to the aviation medical examiner. It was estimated that this would serve to reduce the workload in medical certification. The crux of the problem is that, by regulation, AMEs

may not grant Authorizations for special issuance medical certificates. They must get permission from the Federal Air Surgeon, a regional flight surgeon, or the manager of the AMCD (that's me!) to issue medical certificates to a person who has a medical condition that requires an Authorization. Other FAA physicians, acting on behalf of these officials, may also give permission to an AME to issue a medical certificate under these circumstances. The diseases that we chose to use for this process are in the top 75 medical conditions seen in AMCD. We came up with 20 medical conditions that we would allow for this medical certification process.

As you should already know from the 2003 electronic *Guide for Aviation Medicine Examiners*, an AME may issue medical certificates to airmen with hypertension, asthma, and a single kidney stone that has passed. Granting of medical certification for these three conditions assumes that the AME has and provides the medical information and testing as outlined in the 2003 *AME Guide*.

As for AME-Assisted Authorization for Special Issuance, only third-class airmen may be certified using this process—until the AMCD can review enough cases to warrant recommending to the Federal Air Surgeon that we expand this to second- and first-class airmen.

Airmen will not be able to take advantage of this process until their medical conditions are initially assessed by the Federal Air Surgeon, the AMCD, or a regional flight surgeon and it is determined that an Authorization for a special issuance medical certificate should be granted. Following receipt of an Authorization, follow-up medical assessments required under the Authorization may be evaluated by AMEs and continuation certification decisions made based upon the availability of all required information and in accordance with FAA guidance. Airmen who have these conditions are informed in their Authorization letters that AMEs have been given authority

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*Dr. Silberman manages the Civil Aerospace Medical Institute's Aerospace Medical Certification Division.*

*Continued on page 7*

**TABLE 1. REQUIREMENTS FOR AME ASSISTED SPECIAL ISSUANCE (AASI)**

CONDITION	INCLUDE IN STATUS REPORT	DEFER TO REGION OR AMCD IF
1. Arthritis	<ul style="list-style-type: none"> <li>Type of arthritis</li> <li>General assessment of condition and effect on daily activities</li> <li>The name and dosage of medication(s) used for treatment and/or prevention with comment regarding side effects</li> <li>Comments regarding range of motion of neck, upper and lower extremities, hands, etc.</li> </ul>	<ul style="list-style-type: none"> <li>The applicant has developed any associated systemic manifestations</li> <li>If new joints becomes involved</li> <li>If the applicant is placed on medication(s) such as: Plaquenil, oral chemotherapy – type medications, Methotrexate, steroids &gt;20 mg of Prednisone per day, or Gold therapy</li> </ul>
2. Asthma	<ul style="list-style-type: none"> <li>The applicant's current medical status addresses frequency of attacks and whether the attacks have resulted in emergency room visits or hospitalizations</li> <li>The Examiner should caution the applicant to cease flying with any exacerbation as warned in § 61.53</li> <li>The name and dosage of medication(s) used for treatment and/or prevention with comment regarding side effects</li> <li>Results of Pulmonary Function Testing (PFT), if deemed necessary, performed within last 90 days</li> </ul>	<ul style="list-style-type: none"> <li>The symptoms worsen</li> <li>There has been an increase in frequency of emergency room, hospital, or outpatient visits</li> <li>The FEV1 is less than 70% predicted value</li> <li>The applicant requires 3 or more medications for stabilization</li> <li>The applicant is using steroids in dosages equivalent to more than 20mg of Prednisone per day</li> </ul>
3. Atrial Fibrillation	<ul style="list-style-type: none"> <li>A summary of the applicant's medical condition since the last FAA medical examination, including a statement regarding any further episodes of atrial fibrillation</li> <li>The name and dosage of medication(s) used for treatment and/or prevention with comment regarding side effects</li> <li>A report of a current 24-hr Holter Monitor performed within last 90 days</li> </ul>	<ul style="list-style-type: none"> <li>There is a recurrent episode of atrial fibrillation</li> <li>The airman develops chronic atrial fibrillation</li> <li>The airman is placed on anticoagulation therapy</li> </ul>
4. Chronic Lymphocytic Leukemia	<ul style="list-style-type: none"> <li>A clinical followup report from the treating physician that includes an update of the condition of the applicant since the last examination</li> <li>The results of any applicable laboratory results, including a complete blood count performed within the last 90 days</li> </ul>	<ul style="list-style-type: none"> <li>The condition currently requires treatment with a chemotherapeutic agent</li> <li>The white blood cell count has risen above 80,000</li> </ul>
5. Chronic Obstructive Pulmonary Disease	<ul style="list-style-type: none"> <li>A statement regarding symptomatology of the condition</li> <li>A statement addressing any associated illnesses, such as heart failure</li> <li>The name and dosage of medication(s) used for treatment and/or prevention with comment regarding side effects</li> <li>A pulmonary specialist evaluation that includes the results of a current pulmonary function test performed within last 90 days</li> </ul>	<ul style="list-style-type: none"> <li>The FEV1 or FEV1/FVC is less than 70%</li> <li>The applicant has been placed on a steroid dose equivalent to greater than 20 mg of Prednisone per day</li> <li>The applicant has developed an associated cardiac condition</li> </ul>
6. Colitis (Ulcerative or Crohn's Disease)	<ul style="list-style-type: none"> <li>A statement regarding the extent of disease</li> <li>A statement regarding the frequency of exacerbation (the applicant should cease flying with any exacerbation as warned in § 61.53)</li> <li>The name and dosage of medication(s) used for treatment and/or prevention with comment regarding side effects</li> </ul>	<ul style="list-style-type: none"> <li>There is a current exacerbation of the illness</li> <li>The applicant is taking medications such as Lomotil, steroid doses equivalent to more than 20mg of Prednisone per day, antispasmodics, and anticholinergics</li> <li>The pattern of exacerbations are increasing in frequency or severity; or applicant underwent surgical intervention</li> </ul>
7. Colon/ Colorectal Cancer	<ul style="list-style-type: none"> <li>An update of the status of the malignancy since the last FAA medical examination, to include the results of a current (performed within last 90 days) carcinoembryonic antigen (CEA), if a baseline value is available</li> </ul>	<ul style="list-style-type: none"> <li>There has been any progression of the disease or an increase in CEA</li> </ul>
8 Diabetics Mellitus - Type II (oral diabetes medication(s))	<ul style="list-style-type: none"> <li>A statement attesting that the applicant is maintaining his or her diabetic diet</li> <li>A statement regarding any diabetic symptomology</li> <li>The results of a current HgA1c level performed within the last 90 days</li> </ul>	<ul style="list-style-type: none"> <li>The applicant has been placed on insulin</li> <li>The HgA1c level is greater than 9.0 mg %</li> <li>The applicant has developed cardiovascular, neurological, renal and/or ophthalmological disease</li> </ul>
9. Glaucoma	<ul style="list-style-type: none"> <li>Certification only granted for open-angle glaucoma and ocular hypertension</li> <li>FAA Form 8500-14, Glaucoma Eye Evaluation Form is filled out by the treating eye specialist</li> <li>A set of visual fields measurements is provided</li> </ul>	<ul style="list-style-type: none"> <li>The FAA Form 8500-14 Glaucoma Eye Evaluation Form demonstrates visual acuity incompatible with the medical standards</li> <li>There is a change in visual fields or adverse change in ocular pressure</li> </ul>
10. Hepatitis C	<ul style="list-style-type: none"> <li>Any symptoms the applicant has developed</li> <li>The name and dosage of medication(s) used for treatment and/or prevention with comment regarding side effects</li> <li>A current liver function profile performed within last 90 days</li> </ul>	<ul style="list-style-type: none"> <li>The applicant has developed symptoms</li> <li>There has been a change in treatment regimen or the applicant has been placed on alpha-interferon</li> <li>Any side effects from required medication</li> <li>An adverse change in liver function studies</li> </ul>

Continued next page ➤

**AASI Table (continued)**

CONDITION	INCLUDE IN STATUS REPORT	DEFER TO REGION OR AMCD IF
11. Hyperthyroidism	<ul style="list-style-type: none"> <li>The name and dosage of medication(s) used for treatment and/or prevention with comment regarding side effects</li> <li>Current thyroid function studies performed within last 90 days</li> </ul>	<ul style="list-style-type: none"> <li>The thyroid function studies are elevated, suggesting inadequate treatment</li> <li>The applicant developed an associated illness, such as dysrhythmia</li> </ul>
12. Hypothyroidism	<ul style="list-style-type: none"> <li>The name and dosage of medication(s) used for treatment and/or prevention with comment regarding side effects</li> <li>A statement regarding any other associated problems, such as cardiac or visual</li> <li>A statement regarding the current thyroid stimulating hormone (TSH) level performed within last 90 days</li> </ul>	<ul style="list-style-type: none"> <li>The applicant develops a related problem in another system, such as cardiac</li> <li>The TSH level is elevated</li> </ul>
13. Lymphoma and Hodgkin's Disease	<ul style="list-style-type: none"> <li>An update of the status of the disease from the last FAA medical examination and any testing deemed necessary by treating physician</li> </ul>	<ul style="list-style-type: none"> <li>There has been any recurrence of the disease progression</li> </ul>
14. Migraine Headache	<ul style="list-style-type: none"> <li>A statement regarding the frequency of headaches and/or other associated symptoms since last followup report</li> <li>A statement regarding if the characteristics of the headaches changed</li> <li>The name and dosage of medication(s) used for treatment and/or prevention with comment regarding side effects</li> </ul>	<ul style="list-style-type: none"> <li>The frequency of headaches and/or other symptoms increase since the last followup report</li> <li>The applicant is placed on medication(s) such as isometheptene mucate, narcotic analgesic, tramadol, tricyclic-antidepressant medication, etc.</li> </ul>
15. Mitral or Aortic Insufficiency	<ul style="list-style-type: none"> <li>A summary of the applicant's medical condition since the last FAA medical examination, including a statement regarding any further episodes of atrial fibrillation</li> <li>A current 2-D echocardiogram with Doppler performed within last 90 days</li> </ul>	<ul style="list-style-type: none"> <li>The gradient across the valve reaches 40mm HG</li> <li>New symptoms occur</li> <li>An arrhythmia develops</li> <li>The treating physician or Examiner reports the murmur is now moderate to severe (Grade III or IV)</li> </ul>
16. Monocularity	<ul style="list-style-type: none"> <li>A complete evaluation by an eye specialist, as reported on FAA Form 8500-7, reveals no pathology of non-involved eye</li> <li>A statement indicating that uncorrected distant visual acuity in the better eye is 20/200 or better and is corrected to 20/20 or better by lenses of no greater power than plus or minus 3.5 diopters spherical equivalent</li> </ul>	<p>Any applicant eligible for a medical certificate through special issuance under these guidelines shall pass a medical flight test, which may be arranged through the appropriate AMCD or RFS. While waiting to complete a medical flight test, an applicant who is otherwise qualified for certification may be issued a medical certificate, which must contain the limitation "Valid for Student Pilot Privileges Only." A statement indicating that a 6-month period has elapsed to allow for adaptation to monocularity.</p> <p><b>NOTE:</b> If the applicant's distant vision in the poorer eye corrects to 20/200, no uncorrected vision limitation or refractive error limitation will be applied to either eye of a first-, second-, or third-class applicant with significant flight experience (250 hours or more of flight time). This allows consideration for useful peripheral vision in the poorer eye and flight experience.</p>
17. Paroxysmal Atrial Tachycardia	<ul style="list-style-type: none"> <li>A statement regarding any recurrences since the last FAA medical examination</li> <li>The name and dosage of medication(s) used for treatment and/or prevention with comment regarding side effects</li> </ul>	<ul style="list-style-type: none"> <li>There have been one or more recurrences</li> <li>The applicant has received some treatment that was not reported in the past, such as radiofrequency ablation</li> </ul>
18. Prostate Cancer	<ul style="list-style-type: none"> <li>A current status of the medical condition to include any testing deemed necessary</li> <li>A current prostate specific antigen (PSA) level performed within last 90 days</li> </ul>	<ul style="list-style-type: none"> <li>The PSA rises at a rate above 0.75ng/ml per year</li> <li>A new treatment initiated</li> <li>Any metastasis has occurred</li> </ul>
19. Renal Calculi	<ul style="list-style-type: none"> <li>A statement from your treating physician regarding the location of the retained stone(s), estimation as to size of stone, and likelihood of becoming symptomatic</li> <li>A current report of appropriate imaging study (IVP, KUB, Ultrasound, or Spiral CT scan) and provide a metabolic work-up, both performed within last 90 days</li> </ul>	<ul style="list-style-type: none"> <li>If the treating physician comments that the current stone has a likelihood of becoming symptomatic</li> <li>If the retained stone(s) has moved when compared to previous evaluations</li> <li>If the stone has become larger when compared to previous evaluation</li> </ul>
20. Sleep Apnea	<ul style="list-style-type: none"> <li>A current report (performed within last 90 days) from the treating physician that references the present treatment, whether this has eliminated any symptoms and with specific comments regarding daytime sleepiness. If there is any question about response or compliance with treatment, then a MWT will be required</li> </ul>	<ul style="list-style-type: none"> <li>There is any question concerning the adequacy of therapy</li> <li>The applicant appears to be non-compliant with therapy</li> <li>The MWT demonstrates sleep deficiency</li> <li>The applicant has developed some associated illness, such as right-sided heart failure</li> </ul>

## CERTIFICATION from page 4

to issue new medical certificates so long as all requirements are met. Decisions by AMEs are reviewed and are subject to reconsideration by the FAA. The Authorization letters inform airmen that they can go to either their AME for recertification or continue to submit their required follow-up information directly to the FAA.

Airmen are also being informed that their AME will likely charge a fee for this service, because in many instances, the follow-up testing is necessary before a new medical certification examination is required. This process requires the AME to have a supply of blank medical certificates (obtained through Aerospace Medical Education Division). The AME will review the provided material, complete the medical certificate, fill out a cover sheet that is stapled to those documents, and forward them to the AMCD for review.

When we decided on the medical conditions that could be managed in this manner we also determined the specific guidance that would have to be followed, and we are including that guidance with our Authorization letters. The specification sheets inform the airman what the treating physician needs to provide and also informs the AME when the decision should be deferred to us. You will note that some of comments on the specification sheets suggesting deferral are conservative. If you have a question, however, or think there is a reason that the guidance should not apply in a particular case, a phone call to the regional medical office or the AMCD may result in a decision to modify the guidance in that case.



*See Table 1 for information about what we require from you and your applicant for special issuance on each of these conditions.*

## Medical Conditions Amenable to AME-Assisted Special Issuances

1. Arthritis (most often, this will be rheumatoid arthritis and its variants)
2. Asthma (this will generally be *complicated* asthma because, as mentioned above, *uncomplicated* asthma can be certificated by the AME)
3. Atrial Fibrillation
4. Chronic Lymphocytic Leukemia
5. Chronic Obstructive Pulmonary Disease
6. Colitis (Ulcerative or Crohn's Disease)
7. Colon/Colorectal Cancer
8. Diabetes Mellitus- Type II (oral diabetes medication(s))
9. Glaucoma
10. Hepatitis C
11. Hyperthyroidism
12. Hypothyroidism
13. Lymphoma and Hodgkin's Disease
14. Migraine Headaches
15. Mitral or Aortic Insufficiency
16. Monocularity
17. Paroxysmal Atrial Tachycardia
18. Prostate Cancer
19. Renal Calculi
20. SleepApnea

## RESOURCES from page 1

aviation medical examiner's office. If you need more copies, you can order them by writing or calling:

FAA Civil Aerospace Medical Institute  
Aerospace Medical Education Division  
AAM-400, P.O. Box 25082  
Oklahoma City, OK 73125  
(405) 954-4831

### Other useful brochures for aviation medical examiners

1. Alcohol and Flying
2. Altitude Decompression Sickness
3. Disorientation
4. Hearing and Noise in Aviation
5. Hypoxia
6. Laser Eye Surgery
7. Over-the-Counter Medications
8. Physiological Training Courses for Pilots
9. Pilot Vision
10. Prevention of Controlled Flight Into Terrain
11. Seat Belts and Shoulder Harnesses
12. Smoke
13. Spatial Disorientation: Visual Illusions
14. Spatial Disorientation: Why You Shouldn't Fly By the Seat of Your Pants
15. When There Are Questions About Your Medical Certification

### Civil Aerospace Medical Institute Web Site Resources

A wide variety of aviation-related information is available on the Office of Aerospace Medicine's Web site ([www.cami.jccbi.gov](http://www.cami.jccbi.gov)) Here is a sample of what you can find there:

- 2003 *Electronic Guide for Aviation Medical Examiners* (complete) — [www1.faa.gov/avr/aam/Game/Version\\_2/03ammanual/home/home.htm](http://www1.faa.gov/avr/aam/Game/Version_2/03ammanual/home/home.htm)
- Physiological challenges of the aviation environment(16topics)— [www.cami.jccbi.gov/aam-400A/brochure.html](http://www.cami.jccbi.gov/aam-400A/brochure.html)
- Physiological stressors, for travelers and pilots — [www.cami.jccbi.gov/aam-400/PassengerHands.htm](http://www.cami.jccbi.gov/aam-400/PassengerHands.htm)
- Severe Acute Respiratory Syndrome— [www.cami.jccbi.gov/aam-400/SARS.htm](http://www.cami.jccbi.gov/aam-400/SARS.htm)
- Aerospace medicine research reports on a broad range (more than 970 reports) of aviation-related topics — [www.cami.jccbi.gov/aam-400A/index.html](http://www.cami.jccbi.gov/aam-400A/index.html)



## Education Division Announces New E-Mail Addresses

### *Division's Contract Employees Converted*

By Richard F. (Dick) Jones, MD

A wonderful thing happened on the first of October this year: The six ladies who have provided contracted support to the Aviation Medical Examiner Program, some for as long as 15 years, were converted to government employees. I'll bet few aviation medical examiners and staff members knew these were contract personnel because they were integrated so well into the Aerospace Medical Education Division.

Most of you working in the private sector probably don't understand the significance of this change to each of these individuals, but it is profound. Every five years they would suffer through contract negotiations, which could result in a new contractor being chosen, causing them to start fresh with a new employer-if they were lucky enough to be rehired.

Contract personnel normally lose benefits, such as affordable health insurance, upon retirement, and do not receive predictable raises. These are all concerns government employees don't have. So, join us in congratulating our newest government employees!

An unintended consequence of this conversion is a change in E-mail addresses for each of these ladies. We have asked the Center Information Systems folks to forward E-mail sent to their old addresses to their new ones, but they will only do this for a few weeks, after which time automatic forwarding will discontinue. The names, major responsibilities, phone numbers, and new E-mail addresses of those affected are listed below. Please update any directories you may have.



**Leah Olson**



**Sharon Holcomb**



**Deanie Davis**



**Gail Gentry**



**Bobby Ridge**



**Denise Patterson**

**List of contract employees who were converted to FAA employees. Please note: All share a common Fax number: (405) 954-8016.**

NAME	TITLE/RESPONSIBILITIES	E-MAIL ADDRESS	PHONE (405)-
Deanie Davis	<b>AME Program Assistant</b> • AME records	Deanie.Davis@faa.gov	954-4257
Gail Gentry	<b>Supply Clerk</b> • Distribution of all FAA AME forms and brochures	Gail.Gentry@faa.gov	954-4831
Sharon Holcomb	<b>Training Assistant</b> • All Distance Education (MCSPT, CAPAME, & MAMERC) for AMEs	Sharon.Holcomb@faa.gov	954-4829
Leah Olson	<b>Training Assistant</b> • Theme AME Seminars	Leah.Olson@faa.gov	954-4258
Denise Patterson	<b>Training Assistant</b> • Basic AME Seminars	Denise.Patterson@faa.gov	954-4830
Bobby Ridge	<b>Program Analyst</b> • International and Military/Federal Regions	Bobby.Ridge@faa.gov	954-4832

*Dr. Jones manages the Aerospace Medical Education Division.*

## AME Seminars at Aerospace Medical Association Meetings

### *Simplifying Difficult Choices When Attending AsMA Meetings*

By Richard F. (Dick) Jones, MD

**A**VIATION MEDICAL EXAMINERS (AMEs) have historically had difficulty deciding which fee to pay when attending an annual Aerospace Medical Association (AsMA) scientific meeting. The fee schedule for the May 2004 AsMA meeting in Anchorage will be no exception. A new American Board of Preventive Medicine requirement for maintenance of certification (MOC) credit to renew Board certification has further complicated the issue. I will attempt to explain all of the choices, so any of you planning to attend this meeting can pick the appropriate fee (see Table 1).

The FAA will offer a Cardiology Theme Seminar in conjunction with the AsMA meeting in Alaska. The registration fees paid by AMEs all go to AsMA to offset the costs of meeting rooms and audiovisual equipment. **NONE OF THE MONEY COMES TO THE FAA.**

As at past AsMA meetings, registrants are welcome to attend all or part of the seminar, whether or not they are AMEs. The FAA seminar schedule has been arranged to permit AMEs to attend some of the scientific sessions and to visit exhibits. It is this flexibility that causes confusion about charges.

If you want seminar credit to satisfy AME training requirements, you should select the FAA AME Seminar rate, which is \$220 this year. Credit for attending the seminar will only be given if you attend **ALL** classes listed as "CORE" on the seminar schedule, since missing any of these means you did not receive all of the information we feel is important. **NOTE: YOU MUST BE PRESENT AT THE FIRST FAA SESSION TO ENROLL FOR SEMINAR CREDIT AND TO GET A SCHEDULE, WHICH WILL LIST WHICH SESSIONS NOT TO MISS!!** You will automatically be given Continuing Medical Education (CME) credits on an hour-per-hour basis, as indicated on the course documents you submit at the end of the seminar. Any AME who submits course documents to us will also automatically have maintenance of certification credits annotated in our computer system, should they be needed later.

The AsMA pre-registration and registration forms also have a choice of a \$350 fee for AMEs desiring CME credit to be given by AsMA. Clearly, AMEs paying for CME should only do so if they plan to attend AsMA scientific sessions and either don't intend to ask for FAA

seminar credit or desire to supplement FAA credit. Those who expect to attend none or only part of the FAA seminar and want to maximize maintenance of certification credit should consider this option. If you elect the FAA rate without AsMA continuing medical education credit, you will not receive credit from AsMA, even if you attend some of their sessions.

There is a final category of fees for those not needing CME credits, such as some of our international physicians. These member (\$225) and non-member (\$310) fees should only be chosen by those needing no CME and not planning to attend enough of the FAA course to qualify for seminar credit.

I know this sounds very confusing, but it's not different than in past years. The simplest solution is to elect the FAA-AME seminar fee of \$220 and attend the entire seminar. This will give you full seminar credit—19-plus hours of CME credit and 19-plus hours of maintenance of certification credit.

The American Board of Preventive Medicine mandates we give at least three test questions for each hour of instruction and to keep precise records of attendance and testing to qualify classes for MOC credit. This will cause us all to be more business-like in our practices and to police attendance for everyone more closely than in the past.

On the positive side for those electing to attend the FAA seminar in Alaska, you should enjoy the same high-quality educational experience you have come to expect from your FAA, in a spectacular setting, surrounded by old friends. I hope to see you in Anchorage!



*Dr. Jones manages the Office of Aerospace Medicine's Aerospace Medical Education Division.*

**Table 1.** Fees charged for various options.

Attendance Options	Registration Fees \$	
	Advance	At-the-Door
Member and No AMA Cat 1 CME Credit	225	250
Member MD/DO and AMA Cat 1 CME Credit	350	375
Non-member and No Cat 1 CME Credit	310	335
Non-Member MD/DO and AMA Cat 1 CME Credit	450	500
Residents	150	150
Students	75	75
FAA AME Seminar	220	220
FAA AME and AsMA Cat 1 CME Credit	350	350
Alaskan Non-Medical Pilots	65	65

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## Raising the Bar—What to Do When Corporate Requirements Exceed the FAA Requirements for Physical Fitness

*What should the AME do when a pilot's employer or corporate medical director, requests additional testing or a higher-class medical certificate than clinically indicated?*

By Donato J. Borrillo, MD, JD

ACCORDING TO THE *Guide for Aviation Medical Examiners*, “The applicant may ask for a medical certificate of a higher class than needed for the type of flying or duties currently performed. For example, a student pilot may ask for a first-class medical certificate to see if he or she qualifies medically before entry into an aviation career.”<sup>1</sup> The aviation medical examiner (AME) then applies the standards appropriate for the class, not duties.

The AME should also recall that, “regardless of whether an applicant holds an airman certificate that permits the exercise of a high level of airman duties, it is only necessary for the applicant to have a medical certificate of a class appropriate to the airman privileges exercised.”<sup>2</sup>

*At issue in the present article is what should the AME do when a pilot's employer or corporate medical director, requests additional testing or a higher-class medical certificate than clinically indicated?*

It has been this senior AME's anecdotal experience that many corporate flying departments mandate a higher-class medical certificate as an annual screen for the airman. Typically the airman states, “My company wants me to have a first-class medical, but lets me fly the second half of the year with a second-class.” Or, “My corporate medical director wants us to have all the blood work, a stress test and an EKG.” Some corporate aviation departments bundle these additional tests as part of an annual “executive” exam. In effect, the company has “raised the bar” for this pilot's flying requirements.

First and foremost, the AME should remember that the FAA certification function is separate from any corporate health responsibility. The examiner is a *designated representative of the FAA Administrator* with important duties and responsibilities. This is one reason that the FAA recommends the airman's family physician not also be the airman's AME.<sup>3</sup>

Second, if additional testing is clinically indicated by the airman's history and exam, the question is moot; however, a false positive found in a test not required by the FAA can have a significant impact on an aviator's career, and the use of medical screening for hiring or retention can be illegal.

Employment examinations must be in accordance with the Americans with Disabilities Act.<sup>4</sup> One simple question that the AME should ask is, “Does everyone in your corporate flight department take part in this type of annual medical health screen?”<sup>5</sup> Does the aviation mechanic; administrative assistant, and scheduler all get the same annual stress test? If the answer is *no*, then perhaps the pilot will feel singled out.<sup>6</sup>

Certainly a pilot must be able to perform essential job functions<sup>7</sup> and be at a decreased risk for sudden incapacitation; however, that is precisely the intent of having three levels of medical certification. In order to “raise the bar” on medical requirements, according to the ADA, an individual must pose a “direct threat” without “reasonable accommodation.”<sup>8</sup>

*Continued on page 12*

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*Dr. Borrillo is the Medical Director of Occupational and Hyperbaric Medicine, The Toledo Hospital, ProMedica Health System. He is also a senior aviation medical examiner, an attorney, and a pilot with a Commercial rating.*

<sup>1</sup> Item 1-2, page 18.

<sup>2</sup> *Guide for Aviation Medical Examiners*, Para 8, page 6.

<sup>3</sup> Another major reason is to avoid conflicts of interest and impartiality.

<sup>4</sup> Title I of The Americans with Disabilities Act of 1990.

<sup>5</sup> Similarly, airlines have drifted away from “flight attendant” weight standards, if they have no bearing on safety.

<sup>6</sup> In addition to the traditional definition of disability, namely an individual with a physical or mental impairment that substantially limits one or more major life activities, the ADA Title I also covers: Medical Examinations and Inquiries. Employers may not ask job applicants about the existence, nature, or severity of a disability. Applicants may be asked about their ability to perform specific job functions. A job offer may be conditioned on the results of a medical examination, but only if the examination is required for all entering employees in similar jobs. Medical examinations of employees must be job related and consistent with the employer's business needs.

<sup>7</sup> The U.S. Equal Employment Opportunity Commission has issued enforcement guidance on pre-employment medical inquiries falling under Title I of the Americans with Disabilities Act (ADA). According to EEOC guidance, once a conditional job offer is made, the employer may ask disability-related questions and require medical examinations as long as this is done for all entering employees in that job category. If the employer rejects the applicant after a disability-related question or medical examination, investigators will closely scrutinize whether the rejection was based on the results of that question or examination. If the question or examination screens out an individual because of a disability, the employer must demonstrate that the reason for the rejection is job-related and consistent with business necessity.

<sup>8</sup> In Fiscal Year 2002, The U.S. Equal Employment Opportunity Commission (EEOC) received 15,964 charges of disability discrimination from all lines of work. The EEOC resolved 18,804 disability discrimination charges in FY 2002 and recovered \$50.0 million in monetary benefits for charging parties and other aggrieved individuals (not including monetary benefits obtained through litigation).

## Melanoma: Certify or Deny?

By Jerome W. Tiefert, MD

*Summary: Melanoma is a relatively common skin malignancy with the capacity to produce sudden incapacitation due to CNS metastases. The case history presented here describes an airman who had an initially localized melanoma but who later developed a lymph node metastasis. Should his first-class certificate be denied or approved?*

**H**istory. This 55-year-old airman presents to the AME with a request for a first-class medical certificate. A melanoma with Breslow thickness of 0.9 mm had been removed from his back nine years ago. No other disease was found at that time. A CT scan of the chest was performed two-and-a-half years ago because a nodule was found on a chest X-ray. The scan did not confirm a pulmonary nodule; however, it did demonstrate an enlarged lymph node in the right axilla. A month later, surgeons removed a two-cm. axillary lymph node that was positive for metastatic melanoma and 12 regional lymph nodes that were free of disease. The airman was placed on a 48-week course of alpha-interferon, which was completed one-and-a-half years ago.

The airman tolerated these treatments well, with only episodic weakness and fatigue during interferon therapy. Periodic CT scans of the abdomen and chest, liver function tests, CBCs, chemistry panels, and semiannual MRIs of the brain all remained normal. Regular physical examinations were negative for disease.

**Aeromedical Concerns.** The aeromedical concerns about melanoma center around the potential for cerebral metastasis. Interferon therapy is associated with fatigue, fever, leucopenia, and depression side effects, which are all of aeromedical significance (4).

The FAA guidelines employ five levels of disease involvement to quantify risk and guide an aeromedical disposition.

1) Breslow < 0.75 mm: standard issuance.

- 2) Breslow  $\geq$  0.75mm, negative nodes: Special issuance with annual brain MRIs and status reports.
- 3) Breslow  $\geq$  0.75 mm, positive local nodes: Special issuance *after completion of treatment* - negative history for other metastasis, negative brain MRIs, and status reports every 12 months.
- 4) Metastatic disease beyond local nodes (not CNS): Special issuance three years after completion of treatment with brain MRIs and status reports required every six months.
- 5) CNS metastasis: Special issuance five years after completion of treatment, with brain MRIs and status reports every three months.

The intervals between follow-up brain MRIs for limited second- and third-class applicants may be doubled at the discretion of the Federal Air Surgeon.

**To grant or not to grant?** For the present case, we must first decide whether the axillary node is “local” or “distant” (is it Category three or four?). An axillary node is “local” with respect to the upper back; therefore, one would expect that this airman could be issued a certificate after completion of therapy. However, the guidelines advise that special issuances can be *considered* in this case, but other factors must be included in that consideration. The prognostic features of positive lymph nodes generally refer to the *initial* evaluation of a patient, not for late recurrence of disease. In addition, a primary lesion on the back carries a somewhat worse prognosis than one on the extremities. These factors suggest a more conservative approach.

### MELANOMA

The incidence of melanoma has been increasing rapidly this past century, possibly due to an increased exposure to UV radiation by people with fair skin. It is the leading cause of cancer in Australians aged 15-44, probably because of Australia's equatorial location and the fair skin of many of the inhabitants (1).

One important correlate of prognosis is the Breslow thickness of the melanoma. Melanomas less than 0.76mm have a generally good prognosis, while those greater than 4mm have a poor prognosis. Other important prognostic signs include the presence of ulceration, the presence and location of involved lymph nodes, and anatomical location (the limbs are better; 2,3). Systemic metastasis, such as to liver or brain, is associated with a less favorable prognosis.

Treatment is usually by wide local excision with sentinel node biopsy for deeper melanoma. Interferon alpha-2b may be used as adjuvant therapy for higher-risk patients. Radiation and chemotherapy are uncommonly used.

What is to be considered “completion of treatment” in applying the guidelines? The airman's consultant believed that interferon was only “adjuvant therapy,” not really “treatment,” thus justifying an earlier return to flying. However, the guidelines do not specify whether a treatment is adjuvant or not in setting the three-year treatment rule. One would be justified, therefore, in setting a three-year, post-interferon period of observation before providing a special issuance.

*Continued on page 12*

**Conclusion.** The airman was granted a special issuance to resume his flying career, despite not waiting for three years after the completion of interferon therapy. This case represents a common problem in special issuance cases; the patient's disease does not fit neatly into the prognostic categories found either in the literature or in the FAA guidelines. The crucial issue is not necessarily the category but the potential for CNS metastasis. The brain MRI constitutes a powerful enough safeguard against sudden incapacitation to justify the decision to permit a return to aviation duties.

#### Are Pilots at Increased Risk?

Some studies suggest that pilots may be at higher risk for melanoma because of increased UV exposures at altitude (5). However, it appears unlikely that cockpit exposure is the reason. Pilots have increased exposure to solar radiation because of increased time spent at more equatorial locations, and many may expose themselves to more solar radiation than the general population during recreational activities. The answer? Protect from prolonged solar exposure during down-time by covering exposed areas and using effective sun blockers.

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Dr. Tiefert was a Wright State University resident in aerospace medicine when he wrote this case report at the Civil Aerospace Medical Institute.

## Regional Flight Surgeon Returns From Military



**Capt. Salazar at Baghdad Airport gun placement during his recent military deployment.**

Dr. **Bill Salazar**, Southwest Regional Flight Surgeon, returned to the Fort Worth FAA office January 20, 2004, after being on active duty with the Navy for almost two years. Dr. Salazar holds the rank of Captain in the Naval Reserve. As a reservist, he has been assigned to Marine Aircraft Group 41 at the Fort Worth Naval Air Station since 1997. Dr. Salazar was recalled to active duty February 1, 2002, and was assigned to VMGR-234, a Marine Corps C-130 squadron from Fort Worth.

In the two years he was assigned to the unit, Dr. Salazar deployed on three separate occasions to the Middle East and Horn of Africa. Among other duties, he was the senior flight surgeon for a 600-person Marine C-130 aircraft group in Bahrain. In that capacity, he participated in Operation Iraqi Freedom, flying 25 combat missions to support casualty evacuations and logistics during the conflict. He also served for a period of time as the 3<sup>rd</sup> Marine Aircraft Wing (Forward) Surgeon in Kuwait.

Dr. Salazar joined the FAA in 1990 and was appointed to the top regional post in July 1992.

### RAISING BAR from page 10

If the airman's employer requires additional testing, the burden of reviewing the tests should be on the employer's medical director. The AME's clinic may provide the diagnostic service or collect the sample, but the AME should not order additional unrelated testing under the auspices of an FAA exam.<sup>9</sup> In other words, if a full-body CT scan isn't indicated for a second-class medical, then the AME can't tell the pilot it is required by the FAA.

Medical information provided to the airman by his medical department or primary care provider may require self-removal from flying.<sup>10</sup> However, placing the burden of working up a false positive on the requesting party decreases the potential for needless grounding, deferral, or denial by the AME.

Finally, direct guidance for FAA examination by a non-AME corporate medical director is unacceptable.<sup>11</sup> A corporate medical director may not

conduct an FAA exam, by agency or proxy.<sup>12</sup> If the corporate medical director is an AME, she or he may conduct FAA exams on pilots as delineated by their FAA certification.

In sum, it is certainly within the purview of a pilot to request any class of medical certification. The AME may remind the airman of the various classes and what privileges they allow. Additional testing, although financially lucrative, should be deferred to the airman's corporate physician, family physician, or internist. Alternatively, the AME should recommend that the requesting party review and workup non-clinically indicated and non-FAA mandated testing. "Raising the bar" on an airman's medical requirements may seem innocuous and well intended; however, the practice of medical screening to limit employment raises the AME's liability. The corporate medical director should not influence the AME's decision to screen for disease that is not clinically indicated by the FAA guidelines.

<sup>9</sup> Aerospace Medicine is a board-certified specialty under the auspices of the American Board of Preventive Medicine; therefore, preventive health screening is certainly considered important. However, we have also seen the "executive annual screening" boom, to include shotgun testing and full-body scans. "Clinicians should be selective in ordering tests and providing preventive service," a principal finding of the US Preventive Services Task Force. *Guide to Clinical Preventive Services*, 2<sup>nd</sup> ed., US DHHS; 1996: Chap. XXIX-XXXII.

<sup>10</sup> Title 14 CFR, 61.53, operations during medical deficiency, also FAR 61.23(b)

<sup>11</sup> The regulations specifically prohibit an "alternate" examiner.

<sup>12</sup> As AMEs, we should know our chain of command, regionally and on the national level. ➔

## Dr. Guy Baldwin Named Oklahoma Aviator of the Year

*Dr. Baldwin is a senior aviation medical examiner who practices in Tulsa, Okla.—Ed.*

By Mike Huffman

**J**oe Cunningham started publishing *The Oklahoma Aviator* in the early 1980s. Shortly thereafter, in 1984, he began an annual tradition that would continue until he died in 1999, that of honoring an outstanding supporter and promoter of aviation in the state.

He called his award the “Oklahoma Aviator of the Year.” Previous award winners include names well known around Oklahoma.

Since Joe’s death, no *Aviator of the Year* awards have been made. However, [wife and co-publisher] Barbara and I have long intended to continue the tradition, and what better year could there be than 2003, this glorious centennial of flight year?

This year’s Oklahoma Aviator of the Year Award winner, presented as part of the Oklahoma Aeronautics Commission’s 40<sup>th</sup> Anniversary party, is Dr. **Guy D. Baldwin**. Guy lives with his wife, **Felice**, and his children, **Brittney** and **Hunter**, in Tulsa and maintains a family medical practice there. The entire family enjoys aviation; they put in many volunteer hours at aviation events.

Guy learned to fly over 30 years ago between college and medical school. His first airplane was an 85-hp Aeronca Champ. “When I think back to the things we did in that airplane, we are lucky to have survived,” says Guy.

Since then, he has amassed over 4000 flight hours in airplanes, seaplanes, gliders, helicopters, and aerobatic airplanes. He holds Air Transport Pilot (ATP), Commercial Pilot, and Instrument ratings. He also holds Certified Flight Instructor-Instrument and Multi-Engine Instructor ratings, as well as helicopter and glider ratings. He is also an Aerobatic Competency Evaluator rating. He currently flies an Extra 300 aerobatic airplane, a North American Harvard/T-6, and a Cessna 210.



**Dr. Baldwin (left) receives Okla. Aviator of the Year award from Mike Huffman.**

Dr. Guy Baldwin is one of the most active aviation medical examiners in the nation, providing medical exams to over 2000 airmen each year and maintaining a close working relationship with the FAA Aeromedical Branch. He writes monthly aeromedical columns for *The Oklahoma Aviator* and *General Aviation News* and has written for other publications including *Flying*, *Sport Aviation*, and *The Flying Physician*.

He sits on the Experimental Aircraft Association’s aeromedical council, the Spartan School of Aeronautics advisory board, the Tulsa Air and Space Museum board, the Will Rogers airshow board in Claremore, and the Airshow Oklahoma board in Muskogee. Guy was instrumental in reactivating the International Aerobatic Club Chapter 10 in Tulsa, with its regular aerobatic practice sessions at Claremore Regional Airport and participation in IAC-sponsored aerobatic competitions around the region.

Guy performs air shows in his Extra 300 aerobatic airplane, donating the acreage of his wing to advertising the Make-A-Wish Foundation. “I am most excited to work with the Make-A-Wish Foundation in bringing awareness to their work or fulfilling a dream to fly with a child.”

He enjoys giving media rides in addition to mingling with the audience and signing autographs. “It is truly rewarding when you can talk to young children that dream to fly someday and to new pilots that are filled with excitement and questions,” says Guy.

Most of all, Guy Baldwin promotes wherever he is—with patients, friends, and total strangers. He is always ready to give someone their first airplane ride, buy them a logbook, and log their first flight. He is very enthusiastic and is always coming up with new ideas for aviation events and fun. In fact, some people have said the most dangerous words that can come from his mouth are, “Hey, I’ve got an idea!” because somebody (generally Guy’s wife) is in for a lot of work!

We asked Guy what might be next on his wish list of accomplishments. “Why, to fly an aerobatic performance at Oshkosh. Last year they featured a group of young acro performers—maybe this year they’ll give old guys like me a chance to show off!”

Congratulations, Guy, Felice, and family for a well-deserved award!



*Mike Huffman is the co-editor/publisher of THE OKLAHOMA AVIATOR, a monthly publication for pilots. His wife, Barbara, is the other half of the team. The article is reprinted with permission.*



Dr. Linnebach (left) receives award from Bernd Westphal, Consul General of the German Consulate in San Francisco.

**AVIATION MEDICAL EXAMINER  
RECOGNIZED FOR SERVICE**

Dr. **Wolfgang D. Linnebach**, a San Francisco, Calif.-based aviation medical examiner, has earned some international recognition for his efforts during the past half-century on behalf of German-Americans. Dr. Linnebach was awarded the Order of Merit of the Federal Republic of Germany by the Hon. **Bernd Westphal**, Consul General of the German Consulate in San Francisco. Dr. Linnebach emigrated from Germany to San Francisco in 1952, and the award was timed to coincide with the 50<sup>th</sup> anniversary of his arrival in this country.

An internal medicine practitioner since 1957, Dr. Linnebach has been an aviation medical examiner since 1960. He joined the faculty at the University of California's Department of Medicine as an Associate Clinical Professor of Medicine, and he has taught physical diagnosis courses to fourth-year medical students for more than 40 years. From 1964 to 1999, he served as local physician for Lufthansa German Airline.

In a quote accompanying the award, Dr. Linnebach was cited for his "devoted service to the welfare and health of the German community" and his aviation medical activities.

*Dr. David Millett, Southern Regional Flight Surgeon, contributed this information. —Ed.*



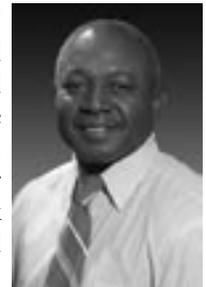
**HUMAN FACTORS SEMINAR HELD IN  
BRAZIL**

Dr. **Melchor Antuñano**, Director of the Civil Aerospace Medical Institute (CAMI), participated as a speaker in the 2<sup>nd</sup> Brazilian Seminar on Aviation Human Factors organized by the Núcleo do Instituto de Ciências da Atividade Física da Aeronáutica (Aeronautics Physical Activity Science Institute), in Rio de Janeiro, Brazil. The purpose of this seminar was to discuss scientific developments and research initiatives in Aviation Human Factors. Seminar participants included aerospace medicine specialists, pilots, flight attendants, aviation maintenance personnel, air traffic controllers, human factors researchers and students, and other personnel in safety-related positions. Dr. Antuñano lectured on Human Factors in Cockpit Automation, Alcohol and Drugs in Civil Aviation, Pilot Fatigue in Aviation Operations, and Medical Aspects of Manned Commercial Space Transportation. In addition, Dr. Antuñano signed a Memorandum of Agreement between CAMI and the Núcleo do Instituto de Ciências da Atividade Física da Aeronáutica (NUICAF) to provide FAA educational opportunities to NUICAF students and researchers at CAMI.

**NUICAF SEMINAR.** Shown (left to right) are Col. Paulo Roberto Nascimento Saraiva, Director of the Brazilian Air Force's Aerospace Medicine Center; Dr. Antuñano, Brig. Gen. Wilmar Terroso Freitas, Commander of the Brazilian Air Force's Aviation Academy; and Francisco da Costa e Silva Junior, NUICAF Program Coordinator.

**COMPUTER SPECIALIST CAMI  
EMPLOYEE OF THE YEAR**

**Lorrenza "Lo" Snyder** is the Civil Aerospace Medical Institute's Employee of the Year for 2003. He was honored for his exemplary work ethics, interpersonal skills, dependability, and professionalism in his work as a computer specialist in the Aerospace Medical Research Division. He has worked at the Institute for more than 33 years.



"When faced with complex computer issues," reads Mr. Snyder's citation, "Lo finds solutions to the problems so they will not impact his customers and is always working to find new ways to improve division computer capabilities."

Each year, employees at the Institute nominate deserving fellow workers for the annual employee-of-the-year award; an employee committee reviews the nominations and selects the winner.

**IN MEMORIAM**  
**ROY VAN GOWDY**

**18 DEC. 1950 – 10 DEC. 2003**

Personnel at the Mike Monroney Aeronautical Center, Civil Aerospace



Medical Institute, and aviation safety researchers through out the world are saddened by the death of a long-time friend, coworker, and outstanding research engineer, Mr.

**Van Gowdy.** Van's 30-year FAA career started in 1973 upon his graduation from the University of Oklahoma with a degree in electrical engineering. His career quickly progressed to a position of universal acceptance in the aviation world as a leading expert in aircraft crash dynamics and aircraft occupant protection.

His lifetime of research in the FAA led to the development of safer aircraft passenger seats for transport aircraft, energy-absorbing seats for military and civilian helicopters, the uniform acceptance of dynamic test and certification procedures for all aircraft seat and restraint systems, and the certification of child safety seats for use in aircraft. Van shared his knowledge and discoveries with the aviation world through numerous scientific papers and lectures to the aviation safety medical, engineering, and lay communities. He was the senior author of six Office of Aerospace Medicine technical reports and the co-author of two.

Van's work in aviation safety was recognized through numerous awards and commendations, including the DOT Secretary's Award for Meritorious Achievement. Survivors include his wife, Barbara; a son, three daughters, and a grandson.

He also leaves a legacy of outstanding accomplishments, engineering expertise, hard work, and integrity.

For FAA and industry coworkers, this legacy will be remembered every time we fly—Van Gowdy was instrumental in making our trip safer.

—Robert Shaffstall



**FULLY STAFFED.** With the return of Dr. Larry Wilson (2nd from left) from military deployment, the AMCS now has its full physician compliment. Shown are: Brian Johnson, MD; Larry Wilson, MD; Henry Boren, DO; Bill Mills, MD; Jim Bernardini, PhD; Richard Carter, MD; and (seated) Warren Silberman, DO. Absent: Steve Carpenter, MD.

### Aviation Medical Examiner Seminar Schedule

#### 2004

- April 23–25 ----- Dallas, Texas ----- AP/HF (2)
- May 3–6 ----- Anchorage, Alaska (AsMA) ----- CAR (3)
- June 21–25 ----- Oklahoma City, Okla. ----- Basic (1)
- July 9–11 ----- Denver, Colo. ----- AP/HF (2)
- August 6–8 ----- McLean, Va. ----- OOE (2)
- September 13–17 ----- Oklahoma City, Okla. ----- Basic (1)
- November 5–7 ----- Tampa/Ft. Lauderdale, Fla., area N/NP/N (2)
- November 15–19 ----- Oklahoma City, Okla. ----- Basic (1)

#### CODES

- AP/HF Aviation Physiology/Human Factors Theme
  - CAR Cardiology Theme
  - OOE Ophthalmology - Otolaryngology - Endocrinology Theme
  - N/NP/P Neurology/Neuro-Psychology/Psychiatry Theme
- (1) A 4½-day basic AME seminar focused on preparing physicians to be designated as aviation medical examiners. Call your regional flight surgeon.
  - (2) A 2½-day theme AME seminar consisting of 12 hours of aviation medical examiner-specific subjects plus 8 hours of subjects related to a designated theme. Registration must be made through the Oklahoma City AME Programs staff, (405) 954-4830, or -4258.
  - (3) A 3½-day theme AME seminar held in conjunction with the Aerospace Medical Association (AsMA). Registration must be made through AsMA at (703) 739-2240. A registration fee will be charged by AsMA to cover their overhead costs. Registrants have full access to the AsMA meeting. CME credit for the FAA seminar is free.

The Civil Aerospace Medical Institute is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

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