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Mental Health and Pilots – Changing the Narrative

*By Susan Northrup, MD, MPH
Federal Air Surgeon*



Two college-level aviation students took their own lives in 2021. We will never know all the reasons they took this tragic action. However, the myth that pilots can't admit to having mental health issues because they fear that they will never get a medical certificate again didn't help. In fact, that myth is a barrier to pilots' getting help when it is desperately needed. As an aviation community, we need to change the narrative from "never admit to mental health challenges because the FAA will ground you forever" to "get the help you need early before the symptoms progress to major depression or anxiety."

Per the National Institutes of Health, in 2020 an estimated 21 million adults in the US have had at least one major depressive episode in their lives. This represents 8.4% of all US adults and it is worse in 18-to-25-year-olds, with 17% reporting a major depression event. The numbers are even higher in adolescents.

The numbers are similar for anxiety disorders. Pilots and people who want to be pilots are affected, too. Most people's symptoms do not start with major depression. They start with milder symptoms that progress over time. There is an opportunity for early intervention.

So, why are there barriers to pilots seeking help? At one time, most mental health conditions led to permanent grounding for civilian and military pilots, but that has not been the case for some time. In fact,

in 2020, there were 1,510 pilots flying on antidepressant medication that would not have been flying prior to 2010. There were 1,719 pilots flying with a diagnosis of substance dependence in remission who would not have been flying prior to 1970.

Unfortunately, not every pilot is given a Special Issuance. Typically, their illnesses required multiple medications to effectively manage their symptoms; their past symptoms were severe; or they continue to be at a high risk for symptoms to recur. The aeromedical [disposition table for psychiatric conditions](#), which is reviewed and updated frequently, may be found in the Guide for Aviation Examiners.

In addition to severe depression and anxiety, conditions that interfere with judgment, impulse control, and cognition could make airman medical certification challenging. Anyone with an active mental health illness or whose mental status would impair performance or safety should not fly. The last place someone with focus problems or intrusive thoughts should be is in the air.

While people with a history of psychosis, schizophrenia, bipolar disorder, previous suicide attempts, or personality disorders with multiple overt acts are seldom granted waivers, the FAA will carefully review every case on its own merits for consideration. Most people with a history of adjustment disorders, bereavement, dysthymia, mild or moderate depression, personality disorders without overt acts, or substance abuse/dependence, as well as people using an approved SSRI medication -- who are in remission and recovered -- have been granted a special issuance and are eligible to fly again if they meet the requirements for renewal. In some cases, AMEs can even directly issue their medical certificate.

The Office of Aerospace Medicine (AAM) constantly reviews its policies for mental health conditions and processing time frames. Of note, Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) policies are under review as current science seems to indicate childhood and adolescent ADD/ADHD can be “outgrown.” The FAA SSRI program has been active for just over 10 years. A team is looking at the data to see if the follow up neuropsych testing for renewal requirements can be streamlined or reduced. Further, AAM is considering authorizing additional medications for treatment of pilots. Due to acknowledged delays in processing of mental health cases at the Federal Air Surgeon’s level, the Behavioral Health team has been expanded and now includes six professional staff members and a support team.

Here’s the myth buster: the FAA has made significant strides to grant airman medical certificates to people with successful treatment of past mental health diagnoses. While we can’t approve all of them, we do issue special issuances to many pilots.

Now, we need your help to change the narrative. We can’t afford to lose even one more life that could be saved with early treatment that helps that individual successfully recover from their mental health condition. Early treatment is a win-win: the person gets help more quickly; typically the symptoms are less severe; and obtaining a special issuance is more likely to be successful.

Once the illness progresses past mild or moderate to severe, it can be very difficult to obtain a waiver. As an aviation community, we need to get the message out that mental status is a performance and safety issue. When there is impairment, pilots need to take action – and the sooner, the better before impairment progresses to frank illness. Mental health is health, and getting treatment means getting back to a long future of flying.

One final note: if you are having anxiety, depression, or any other mental health issue, please seek help through your primary care provider or a mental health professional. Get the help you need to get healthy and fit. It is never too late to get assistance.

– Susan

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Alcohol and Drug Abuse and Dependence in the Aviator – A Guide to Cockpit Return

By David A. Hardy, DO, MPH

Alcohol and Drug Abuse and Dependence are not uncommon for Aviation Medical Examiners (AMEs) to be confronted with when doing a Medical Certification Exam. For the FAA, both alcohol DEPENDENCE and Alcohol ABUSE (in the last two years) are specifically disqualifying for all classes of pilots.



The FAA defines *Dependence* as at least **ONE** of the following:

- Increased tolerance,
- Manifestation of withdrawal symptoms,
- Impaired control of use, or
- Continued use despite damage to physical health or impairment of social, personal, or occupational functioning.

The FAA defines *Abuse* as:

- Use of a substance in a situation in which that use was physically hazardous, if there has been at any other time an instance of the use of a substance also in a situation in which that use was physically hazardous;
- A verified positive drug test result, an alcohol test result of 0.04 or greater blood alcohol concentration, or a refusal to submit to a drug or alcohol test required by the U.S. Department of Transportation or an agency of the U.S. Department of Transportation; or
- Misuse of a substance that the Federal Air Surgeon -- based on case history and appropriate, qualified medical judgment relating to the substance involved:
- Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held, or
- May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

Very often, a telltale sign of alcohol Dependence and Abuse is a drunk driving (DUI) conviction. The [DUI disposition decision-making tool](#) provides information on when it is acceptable to issue and when the AME must defer.

If the AME determines he/she cannot issue a medical certificate and defers the case to the FAA, we may require the pilot to see a Human Intervention Motivation Study (HIMS) AME. The pilot will need to have several items submitted from both the HIMS and (possibly) a psychiatrist. Review the [HIMS Drug and Alcohol certification aid](#) for a complete list.

If the FAA requires separate psych and neuropsych testing, they will use the [list of items](#) that must be addressed provided in the AME Guide.

When I was a Military AME, I worked a few cases where the FAA didn't require ALL the items above, and some where they required MORE. It is case-dependent, but the requirements above are ballpark for 90% of the cases. As an example of when the FAA didn't require everything listed above, I helped a recently retired Air Force pilot who completed the Air Force's Drug and Alcohol program (ADAPT) and for 10 years ran the local AA meetings on base. He had an Air Force flying waiver since 2009. In this case, the FAA only required his AME to submit driving records, a personal statement, treatment and ADAPT notes, and reference letters from his commanders.

Expectation management is always an important part of dealing with pilots who need a Special issuance, and substance Abuse and Dependence is no exception. The entire process can take months if everything runs smoothly. Once in the program, there is a step-down process that takes years to complete. Of note, many pilots choose to never leave the program, as it motivates them to remain sober. The [step down process](#) is described in the AME Guide.

I hope this helps you better understand the process involved in obtaining a Special Issuance for pilots who have substance Abuse or Dependence issues. As always, if you have questions, you can reach out to your Regional Flight Surgeon or the Certification Division.

Dr. Hardy is the Regional Flight Surgeon of the International, Military, and Federal Region and the manager of the AAM-400 division at the FAA's Civil Aerospace Medical Institute.

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Case Report: Post-Traumatic Stress Disorder in a Student Pilot *by Major Alex Jobrack, USAF, DO, MPH*

A 25-year-old female who separated from active-duty military service presents to her Aviation Medical Examiner (AME) for a Third-class medical certification. She says that since separating from the Air Force, she has been pursuing her dream to fly. She currently has 50 hours of flight time with an instructor and now wants to fly solo. Upon review of her questionnaire, you discover she was separated from service due to a diagnosis of Post-Traumatic Stress Disorder (PTSD). She otherwise has no medical conditions.

She seems to blow off her PTSD diagnosis as a misunderstanding and states she is "fine since leaving the military." Further questioning shows that the Airman worked as a Security Forces Airman and was sexually assaulted during a deployment five years ago by another Security Forces Airman. Since this incident, she had to be moved three times to different bases because she was having difficulty coping with her trauma. She states she saw a mental health professional initially but didn't find that it helped her, so she stopped going after six months. She states that her trigger was being alone at night patrolling the flight line and fearing that someone would sneak up on her. This thought process was often distracting and prevented her from performing her duties properly as she kept reliving the trauma. Due to this, she was placed on a duty-limiting work schedule that only allowed her to work daylight hours. It was determined she was non-deployable since she couldn't work nights, and she was medically separated from the Air Force.

Since her separation 18 months ago she denies having any trouble with reliving her trauma. She states she feels great and goes out all the time with her friends and is in a stable relationship. She denies taking any medications for anxiety or depression. She even states that her flight instructor is a male and she did not have any issues while she was alone in the cockpit with him.

Her physical examination was unremarkable. She had normal mood and affect. She was very pleasant to work with and is excited to keep flying.

Do you certify the airman today? Do you deny her? Or do you defer to the FAA?

When evaluating this prospective pilot for medical certification the AME must pay particular attention to psychiatric conditions that are known to do any of the following:

- Cause sudden incapacitation,
- Impede proper judgment and emotional control, and

- Diminish mental capacity with loss of behavioral concern.

PTSD is characterized by:

- Intrusive thoughts, nightmares and flashbacks of traumatic events;
- Avoidance of reminders of trauma;
- Hypervigilance; and
- Sleep disturbance leading to dysfunction in everyday life.

Individuals diagnosed with PTSD have a higher prevalence of other psychiatric disorders when compared to the general population. Hence, the AME should also screen for depression, which is the most common comorbid condition -- affecting nearly 50% of both men and women with PTSD -- as well as anxiety disorders that are three times more prevalent in this population¹. If a pilot has severe anxiety, this can reduce the ability to focus on the tasks at hand. If they experience flashbacks, this can be incapacitating.

Having a traumatic event does not automatically result in a diagnosis of PTSD. Studies by Stein, et al. and Koenen, et al. showed that among patients from a primary care community clinic, around 65% experienced severe trauma, yet only 12% went on to develop PTSD^{2,3}. This is important to consider, as sometimes a diagnosis of PTSD can be given incorrectly, and the AME should be aware of other disorders that may exist to explain the symptoms.

When an AME is presented with a case such as this, be aware of any red flags that appear whether in the past or the present. This student pilot may appear well and functional today, but this may be a façade, as she wants to fly and can present well at the time of the exam.

Always be willing to ask for more information. The AME should gather all information regarding the diagnosis, how severe it is, what treatments were performed, and the specific symptoms experienced and address all questions listed in the [PTSD Disposition Table](#).

If even one concerning answer on the decision tool is given, the AME must defer to the FAA for a decision. On the referral, the AME should note what aspect caused the deferral and explain any “yes” answers. If all answers are negative, the AME may issue with explanations in Block 60. Other important items the AME should look for are what the specific triggers the airman may have, whether they are still exposed to these triggers, and what the likelihood is of being exposed to these triggers when in flight or in everyday life. Once again, if there exist any concerns, the AME should defer noting the reason in Block 60.

Once a deferral is sent for FAA review, the AME should refer to the [PTSD Disposition Table](#) in the online AME guide to help the pilot provide the required medical records. These requirements should be discussed in detail with the Airman. These include:

- An Airman Personal Statement, which is a typed statement that includes:
 - The incident,
 - Triggers,
 - Impact,
 - Modifications,
 - Medications, and
 - Counseling);
- A current evaluation by the treating psychologist or psychiatrist (a detailed clinical summary);
- A medication list;
- Copies of PTSD screening tools; and

- Copies of psychological testing, including:
 - Raw data,
 - Veterans Administration records (if applicable), and
 - Previous medical/hospital records.

The AME should stress the importance of obtaining and returning all these documents, as any missing items can delay decisions made by the FAA or result in denial of certification.

It is important that the AME clearly explains to the pilot that a mental health diagnosis does not equate to a denial of certification; each case is reviewed independently; and once a pilot has achieved stability per their treating provider, they should apply for certification.

Outcome

After having a long discussion with the AME about her diagnosis, this student pilot decides to resume necessary care. She returns to the AME six months later with all the required documents needed and is deferred to the FAA. Upon full review, she is given a Special Issuance for her Third Class certification.

Dr. Jobrack is an occupational medicine resident at Harvard University.

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2. Koenen KC, Ratanatharathorn A, Ng L, et al. posttraumatic stress disorder in the World Mental Health Surveys. *Psychol Med* 2017; 47:2260.
3. Stein MB, McQuaid JR, Pedrelli P, et al. Posttraumatic stress disorder in the primary care medical setting. *Gen Hosp Psychiatry* 2000; 22:261.

(Special thanks to Dr. Steven Altchuler for his help and guidance writing this Case Study.)

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Military Aerospace Medicine Residents Participate in First-Ever Combined FAA CAMI Educational Experience

By David A. Hardy, DO, MPH and Racquel D. Crisp, PMP

The Civil Aerospace Medical Institute (CAMI) hosted their first-ever combined two-week FAA educational experience for Aerospace Medicine Residents. The event brought together physicians from three branches of the US military, along with medical officers from the US Air Force's Advanced Aerospace Medicine for International Medical Officers (AAMIMO). They represented four strategically important partner nations and included physicians from both the Mayo Clinic and Harvard University.

Altogether, not only did the event host 25 physicians who received 70 hours of education, but it also laid the groundwork for future combined efforts. Combining the rotation cut CAMI workload by 75%, but it more importantly allowed crosstalk among the participants and a greater understanding of aerospace medicine similarities and differences between the different services and our partner nations.



Residents in Aerospace Medicine (RAM) - 4/21/2022

Participants were joined by FAA Deputy Federal Air Surgeon Brett Wyrick, DO, the first week, and both the Federal Air Surgeon Susan Northrup, MD, and CAMI Director Melchor Antuñano, MD, the second week. They provided future aerospace medicine leaders a unique opportunity to interact with FAA leadership and better understand both the depth of the CAMI mission and the policy development process. Dr. Northrup remarked how happy she was with the program and stated she looks forward to seeing the long-term benefits that come from cross-department engagement and education. Dr. Antuñano said he was excited to have students back at CAMI after the COVID pandemic. He noted that plans are already underway to expand the experience in 2023.

Colonel Paul Newbold, MD, the senior Flight Surgeon at Tinker AFB in Oklahoma City, served as the liaison linking the military and FAA during course development. He said he could not be happier with the final product. He stated, "I am very pleased that our first-ever combined CAMI/DoD rotation was a huge success. Many thanks to Dr. Northrup, Dr. Wyrick, and Dr. Antuñano for their resolve to make this an in-person experience." Colonel Newbold went on to single out the efforts of Ms. Cammey Kasper in AAM-400 who coordinated the event, noting how wonderfully everything came together under very trying circumstances.

The event was also lauded by Army leadership who joined the rotation and were impressed with the depth and variety of speakers who shared their knowledge with the resident physicians. Colonel Dan Porter, Director of Aviation Medicine at Fort Rucker's Medical Center of Excellence, expressed his gratitude for the combined program, stating, "We greatly appreciate all of the hard work and collaboration across both the DoD and DoT that goes into this educational effort."

Dr. Hardy is the Regional Flight Surgeon of the International, Military, and Federal Region and the manager of the AAM-400 division at the FAA's Civil Aerospace Medical Institute.

Mrs. Crisp is the Manager of Program Management Staff (AAM-6) at the Civil Aerospace Medical Institute (CAMI).

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Survival Signaling – Part Two "Because You Just Can't Seem to Holler Loud Enough"

By J.R. Brown

Aircraft Radio

Another electronic device to consider is your aircraft radio. Obviously, you know the importance of radio distress procedures. Who you are, where you are, and where you are heading are the very basics. The nature of emergency and your intentions are vital bits of information that could facilitate a fast rescue. Description of the aircraft, souls on board, and survival equipment available can also be very helpful. Remember to try the aircraft radio after the forced landing. If there is no risk to your personal safety, then try to activate the Master Power Switch and transmit out on 121.5 MHz. Transmit blind even if you don't get a reply; you have nothing to lose.

Cellular Phone

Cellular phones are now as common as the air we breathe. Cell coverage is nearly nationwide. There is a good chance that even in remote areas, you may be able to get a signal that could be used for rescue even if you can't dial 911. Simply having your phone powered on could be enough.

Lt. Col. John Henderson, vice commander of the Civil Air Patrol's National Radar Analysis and Cell Phone Forensics Team, explained the role the cellphone played toward a rescue.

He said the Civil Air Patrol team was activated for a missing Beechcraft Bonanza flying a distance of 800 miles. A member of the National Cell Phone Forensics Team was able to locate clues from the phones on the Beechcraft that narrowed the search area from six states to a single county in Tennessee. Cell phone clues then produced a final recommended search area of only 2.6 square miles. The crash site and one survivor were located 1½ miles from the final radar hit.¹

You may still find dead zones with zero coverage. Keep your cell phone fully charged and on your person. Additionally, you can put a non-active cell phone in your survival kit. Even though it is not active, it will still be able to dial 911 or help you start a survival fire!

Ground Communication

Now, we are on the ground or we have executed a ditching and are in a life raft. How do we holler now? The way we do this is by using all available resources. The first resource you should never discount is the actual airframe itself. The rule here is simple: ***always stay with the aircraft!***

The aircraft has many items that not only help with survival but also make for great signals. Always remember that rescue parties aren't looking for you; they are looking for the aircraft. If you are near the aircraft when it is found, then you too will be found. Also, whatever type of ELT you have is now transmitting your aircraft location. Remember, they are looking for the aircraft. So, stay calm and stay put!

Lights on the aircraft could be used in conjunction with an aircraft battery. If you inspect the battery for cracks and leaks and ensure there are none, then it may be safe to flip on the master electrical switch and see what can be used. Not only the lights and strobes but also the aforementioned aircraft radio could be used. The aircraft itself is a big, visible target that will leave many telltale signs of its presence. Other resources offered by the aircraft are shelter, first aid, and useful improvised survival tools. They are there for the taking. It's basically a giant piece of survival equipment. So, ***stay near the aircraft.***

Now it's time to talk about signaling devices that you have in your kit or on your person to help you get noticed. Let's speak the language of light. One of the most effective signaling devices is a survival signal mirror. It can be carried with you in a pocket or in a survival kit. On bright sunny days, the flash can be spotted up to 25 miles away. They work even on cloudy days, albeit not as effectively. Reflectors and

mirrors don't need batteries or any intensive training to use. A little "show and tell" and you are ready to go.

Remember to use it even when you don't see or hear other aircraft. Every 30 minutes for five minutes, shine the reflection 15 degrees above the horizon in a wide sweeping motion. You never know! First, it has line of light as opposed to pinpoint. This line will be one mile long if you are 16,000 feet from target. It's easier to sweep a line across the face of the aircraft as opposed to hitting it with a pinpoint of light. Next, it's at a wavelength that will not cause eye damage to those who receive the signal. Lastly, it works really well with Night Vision Goggles (NVGs) that may be used to find you.

Let's now speak the language of fire and flame. One of the most effective signals is fire. A good campfire can be spotted many miles away. A campfire should be just big enough to keep you warm and protected. But when it's converted to a signal fire, then the bigger the better (within safety limits). When you hear aircraft approaching, make the fire bigger. Have dry and flammable materials ready to go on the fire immediately to make it bigger and brighter. Internationally, three fires in a triangle is a sign of distress. But maintaining three fires is impractical. How about one fire seen 360 degrees in view? That may be all you need.

Another way to speak with fire is to use its associated smoke. Smoke may be a better signal during the day than fire. But look around. If you are in a light-colored environment, then you will need dark-colored smoke. When you hear aircraft approaching, burn evergreens with their pitch-containing resin to produce a soot-black smoke. Most rubber and petrol products will also make a dark-colored smoke. But avoid breathing in this dark smoke. It's releasing compounds that haven't completely combusted. Hydrogen sulfide, hydrogen cyanide, and carbon monoxide are just a few of the toxic byproducts that could be possibly inhaled.

White smoke is best for green and darker environments. White smoke has a high content of water vapor. So, burning wood and material that has a high moisture content will produce white smoke. One trick to make white smoke to speak even more loudly is to activate an orange smoke flare and let it mix with white smoke within the fire. It gives off a unique color, and the heat from the fire will cause it to rise straight up and not hug the ground.

Ballistic signals will typically send a flare anywhere from 250 to 1,400 feet above ground level. They must be shown the respect that one would show any firearm. They are very effective but must be handled with kid gloves. Never point them directly at search aircraft. Aim for them to stay directly over your position when activated, letting the aircraft know your relative position.

CLASS

C is for **Contrast**. It must stand out from the surrounding environment. It has to stand out in color and shape and look manmade.

L is for **Location**. Location is simple. Can it be seen from above and from 360 degrees? As you construct it, you want it to orient east to west so that it will cast a shadow most of the day, which allows the signal to have depth and stand out even more.

A is for **Angularity**. Sharp angles aren't common in nature. So, any improvised signal should have hard 45- and 90-degree angles to stand out.

S is for **Size**. A 6-to-1 ratio of length to width should be the minimum. Elevate it a foot or so off the ground and cause it to cast a shadow to stand out even more. And the bigger, the better; 16 feet long by three feet wide should be the minimum.

S is also for **Surface-to-Air Rescue symbols**, which are letters of the alphabet that have specific meanings. These codes have been around for many years. The one that most readily comes to mind is

“SOS”. This of course traditionally means “Save Our Souls.” But it doesn’t have to be that elaborate. Generally, any letter of the alphabet will do. But use a letter with hard angles. “T”, “X”, “L”, and “A” are all good examples.

So now, how well do you speak this language called “Signaling”? Are you fluent? Can you speak with the accent of smoke and flame? How about the subtle dialect found in the various electronic devices? Can you speak ballistically without hurting yourself and others? Can you speak by using “sign language” in the form of smoke or Surface-to-Air Rescue Symbols?

If the answer is “no,” then you best brush up and learn to holler good and loud.

Mr. Brown is a training specialist with the Airman Education in the Civil Aerospace Medical Institute (CAMI).

References:

1. Civil Air Patrol/U.S. Air Force Auxiliary. Radar cell phone analysis lead to discovery of downed plane in Tennessee. <https://www.cap.news/cap-radar-cell-phone-analysis-lead-to-discovery-of-downed-plane-in-tenn/>
Accessed April 20, 2022

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MedXPress: Application Status Updates Launched

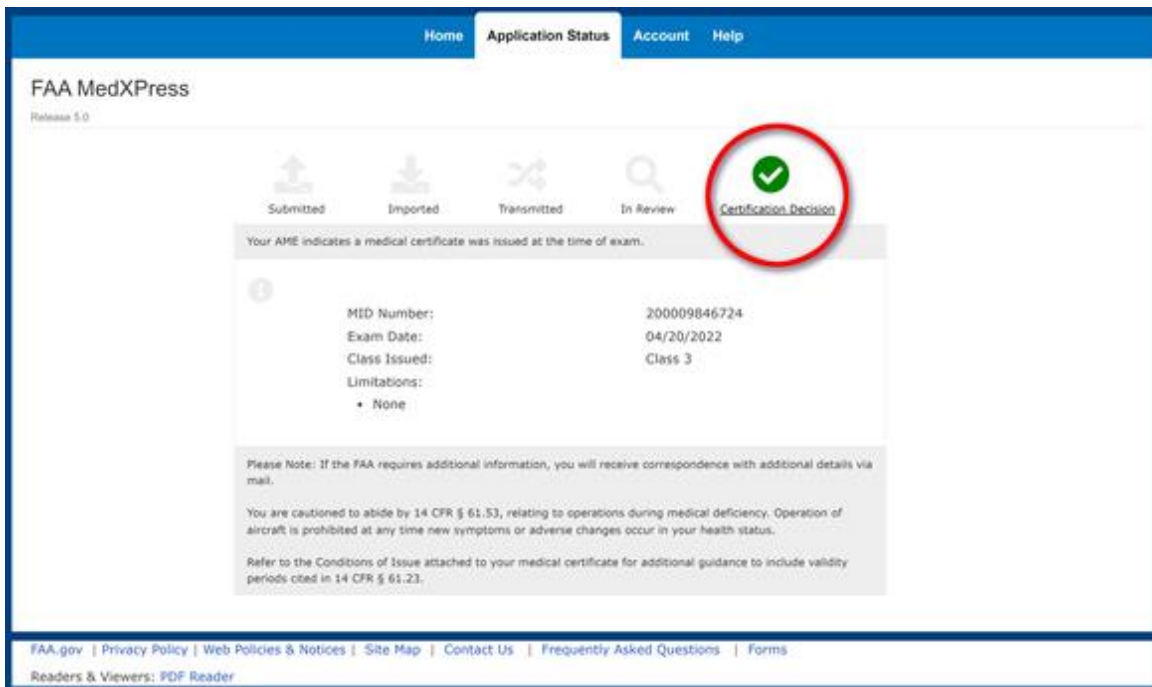
By Jana Weems

We are excited to announce a major update to MedXPress! Now pilots can log in to MedXPress and click the *Application Status* tab to see the status of their most recent application.

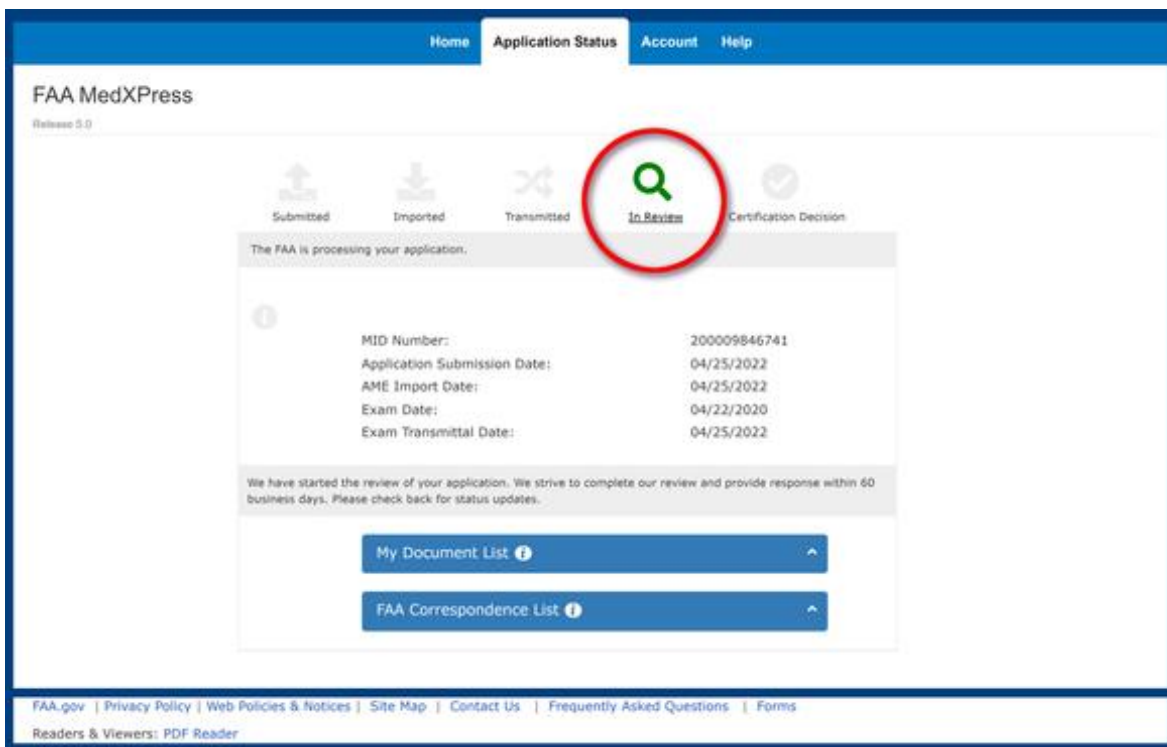
There are five available states on the MedXPress *Application Status* screen:

- *Submitted*,
- *Imported*,
- *Transmitted*,
- *In Review/Action Required*, and
- *Certification Decision*.

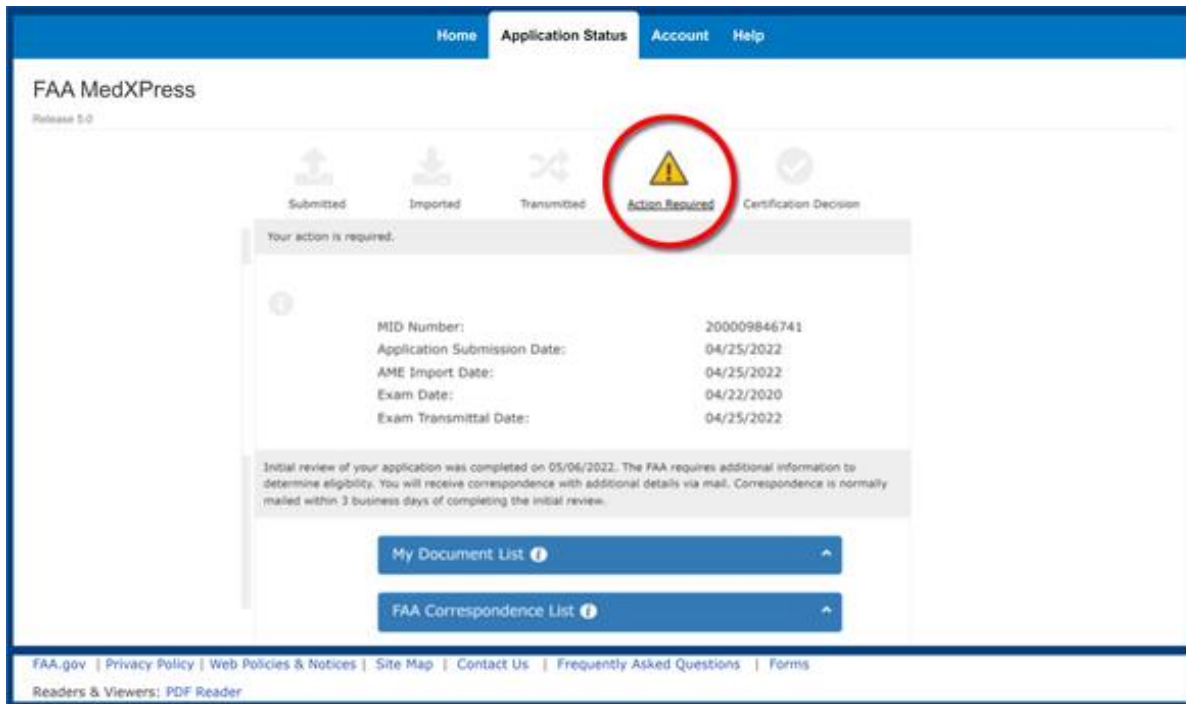
When a pilot submits a MedXPress application, the first status of *Submitted* will display. The application will stay in this state until the Aviation Medical Examiner (AME) imports the application into the Aerospace Medical Certification Subsystem (AMCS). At that time, the application status will change to *Imported*. For most pilots, their status will move directly from *Imported* to *Certification Decision*, which shows information related to the medical certificate status. Also, the *Certification Decision* screen will show for most pilots the details from their medical certificate to include exam date, class of certificate, and any limitations.



If a pilot is deferred by their AME, the MedXPress *Application Status* tab will provide information regarding the processing of their case on the *Transmitted* tab. The *Transmitted* status will provide an estimated time for the initial review to be completed. Once the review process is initiated, the application will move to the *In Review* status. This will indicate to the pilot that the FAA has begun working on their case.



If, after review, the FAA determines more information is required to make a determination, the application status will update to *Action Required*. MedXPress will also display a list of any supporting documentation or official FAA correspondence related to the deferred application. (Due to security and privacy requirements, the contents of supporting documentation and FAA correspondence cannot be released in MedXPress.)



Once a determination has been made, the application will reach the final state on the *Certification Decision* screen.

The MedXPress Application Status updates are intended to provide clear, concise, and accurate information to the pilot. We are excited for these updates and believe the changes will be beneficial to the pilot community.

Ms. Weems is a medical certification specialist with AVS Program Support.

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Recent Policy Updates

By Judith Frazier, MD, MBA

For the past six months, the Policy and Standards branch has focused on helping Aviation Medical Examiners (AMEs) more easily obtain the information they need to make a medical certification decision. Policy changes and update highlights from November 2021 to April 2022 are below. The full list of changes is hyperlinked in the [Archives and Updates](#) section of the AME Guide.

Detailed Clinical Progress Note

One of the most difficult and time-consuming activities in medical certification -- for an AME, pilot, or AAM -- is to obtain the information necessary to make an aeromedical decision. In the past, the AME Guide and letters to pilots requested a current status or current status report from the treating physician. While this terminology was familiar to AMEs and AAM, the terminology is used differently by treating physicians.

When a physician is asked for a current status, the physician will tell you how the patient is doing at that moment in time. When the FAA asks for a current status or a current status report, the treating physician is being asked to provide a detailed clinical summary of:

- the status of the patient and the medical condition,

- what has already been tried and the outcome,
- physical exam findings,
- tests performed and results, and
- assessment, treatment plan, and follow-up.

In other words, the FAA's current status is synonymous with what most physicians know as a **Progress Note**. However, for FAA purposes, it must also be **detailed** and describe **clinical** findings. Whatever terminology is used, the FAA needs a complete summary of the medical status that will allow FAA physicians to understand the specific details of the pilot's condition.

For clarity, this terminology was changed in the AME Guide and is making its way into letters to your pilots. While we are transitioning, if your pilot has a letter requesting a current status, let the pilot know that what the FAA needs their physician to provide is what the physician would call a [Detailed Clinical Progress Note](#).

After Visit Summary

In the haste to get their information to the FAA, pilots sometimes go to their patient portal and print an After [Visit Summary \(AVS\)](#). Unfortunately, this patient information does not contain the details needed to make a medical certification decision. Even worse, the pilot thinks they have submitted the requested information -- but they have not.

Medications

Have you tried the new shortcut [meds link](#)? It will help you and your pilots identify what meds may be considered and any required wait times. The list contains common medications, a Do Not Issue – Do Not Fly list, and the OTC meds list (accessed in one location).

In addition, our pharmacist is adding new medication pages almost every month. The most recent additions include **COVID medications**, **eye medications**, and **cholesterol medications**, as well as DMARDS to certain CACI conditions (arthritis and colitis).

CACI changes

To issue under [CACI](#), the AME must review detailed information from the treating physician. The updated instructions on each CACI page state that the AME should review a detailed clinical Progress Note. If you have been successful in obtaining the necessary CACI information from your local treating physicians, continue to use that process. The most important part is to verify you have all the information required to issue under CACI.

CACI wording Option #2 has changed from ***Not CACI qualified Condition Name, Issued per valid SI/AASI*** to ***Has current OR previous SI/AASI but now CACI qualified***. This change lets the FAA know you have identified this pilot as currently under Special Issuance, but they now meet the CACI criteria.

COVID Questions

What do I do if my pilot had COVID?

Can they take a vaccine?

If they get sick, can they take a COVID medication?

- Yes, pilots can take medication to treat COVID.
- No, they cannot take the medication and fly or perform safety-related duties until they have met the four criteria listed on the COVID-19 page.

Diabetes (Insulin Treated - CGM)

[Recent changes](#) include:

- reduced submission requirements,

- added graphic examples, and
- a list of currently allowed CGM devices added to complement the existing list of required functions for a CGM.

All 1st and 2nd class ITDM cases will continue to be reviewed at the FAS office.

Remind your pilots to continue to submit required information while their cases are pending review. This process will assure the information reviewed is current.

Premature Atrial Contractions (PACs)

[Recent changes](#) include:

- an updated disposition table,
- a removed number of PACs to generate an evaluation, and
- the fact that valuation is no longer required unless the pilot is symptomatic or required treatment.

As an AME, make sure and note in Block 60 whether the pilot has symptoms.

The following conditions have new disposition tables:

- [Anosmia](#)
- [Barrett's Esophagus](#)

The following shortcut links are added for easy access:

- faa.gov/go/hims -- link to HIMS Drug and Alcohol section
- faa.gov/go/bbb --link to updated RBBB and LBBB protocols.

Dr. Frazier is Manager of the Policy and Standards Branch in the Office of Aerospace Medicine.

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