

Pilot Fitness Aviation Rulemaking Committee Report

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TABLE OF CONTENTS

Executive Summary	1
1.0 Recommendations	2
1. Enhance AME Training.....	2
2. Psychological Testing.....	2
3. Pilot Assistance Programs.....	2
4. Air Carrier Education	3
5. Informational Material on Pilot Support Programs	3
6. Medical Professional Reporting	3
7. Two Persons on Flightdeck and Flightdeck Access.....	3
8. Aircraft Design Standards.....	4
2.0 Pilot Fitness ARC Background.....	4
Pilot Fitness ARC Charter	4
3.0 ARC Data and Research	5
Tasks and Inputs	5
4.0 Estimated Costs	23
Appendix A—Pilot fitness ARC Members	A-1
Appendix B—Definitions	B-1
Appendix C—Acronyms	C-1
Appendix D—Pilot Support Program Descriptions	D-1
Contract Aeromedical Advisors	D-1
Air Carrier Employee Assistance Programs	D-1
Air Carrier-Specific Pilot Assistance Programs.....	D-1
Crew Resource Management.....	D-2
Critical Incident Response Program	D-2
Formal Pilot Mentoring Programs	D-2
Human Intervention Motivation Study.....	D-2
Professional Standards Program.....	D-3
Appendix E—Charter	E-1
Appendix F—Medical Privacy Laws Overview.....	F-1
Introduction.....	F-1
Americans with Disabilities Act (“ADA”).....	F-1
Family Medical Leave Act of 1993.....	F-3
Aviation and Transportation Security Act.....	F-4
Health Insurance and Portability Accountability Act.....	F-5

EXECUTIVE SUMMARY

The Pilot Fitness Aviation Rulemaking Committee (ARC) was chartered by the Federal Aviation Administration (FAA) on May 11, 2015, to consider specific objectives and tasks in a forum for the U.S. aviation community to discuss and provide recommendations to the FAA on pilot mental fitness for duty. The ARC was chartered after the Commercial Aviation Safety Team (CAST) considered the circumstances surrounding the Malaysia flight 370 and Germanwings flight 9525 events. CAST ultimately determined it did not have all of the needed expertise to examine pilot mental fitness issues (that is, issues affecting a pilot's emotional state, mental health, or cognitive ability to safely conduct their duties), and a committee of medical and aviation industry professionals with expert knowledge on pilot mental fitness issues was best suited to explore the topic.

The ARC membership and working groups consisted of a broad representation of people including aerospace medicine, psychiatric, and psychological medical experts from the FAA, FAA Flight Standards Service, U.S. aviation industry trade associations, pilot representative organizations, and international aviation industry associations. The working groups examined individual issues in detail. ARC meetings were held in person in Washington, DC, and working group meetings were held on an ad hoc basis in person or through teleconferences.

The ARC developed eight recommendations that are found in the next section of this report. Several of these recommendations suggest actions the FAA and air carrier community could take to address pilot mental fitness issues through education, outreach, and training initiatives. Others address reporting mental health issues, operational procedures, and aircraft design.

The ARC believes the best strategy for minimizing the risks related to pilot mental fitness is to create an environment that encourages and is supportive of pilot voluntary self-disclosure. However, even within a supportive environment the group identified many barriers to voluntary self-disclosure. It is clear even when symptoms are recognized, pilot mental fitness issue self-reporting may be perceived as a high risk situation. There may be misperceptions that all mental illness is career ending. Financial and career implications for professional pilots can be significant even for short-term medical disqualification. Therefore, it is critical that the pilot community receive healthcare and support information that is timely, accessible and accurate. The best approach to address misperceptions is to expand the use of pilot support programs, educate the air carrier and pilot communities on mental fitness for duty issues, and ensure pilots experiencing such issues are cared for in a confidential, non-stigmatized, and safe environment.

Additionally, the ARC believes a risk mitigation process built on Safety Management System (SMS) principles should be used by air carriers and pilot representative organizations to create an environment where early reporting, appropriate treatment, and rapid return to the flightdeck are the expectation. Early identification of mental fitness issues leads to better results. A holistic approach to educating and addressing pilot mental fitness issues offers the best opportunity for a positive outcome.

1.0 RECOMMENDATIONS

1. ENHANCE AME TRAINING

The Federal Aviation Administration (FAA) should ensure all Aviation Medical Examiners (AME) demonstrate knowledge in assessing basic mental health concerns, and enhance AME training on this topic.

Rationale: Most AMEs have limited psychiatric education and experience. This may be as little as 3 weeks in medical school and 2 hours in AME basic training, of which 1 hour is entirely devoted to substance abuse and dependence. It is desirable to expand general knowledge regarding mental status assessment and mental health. This could be accomplished by restructuring the AME basic and refresher curricula, with the goal to enhance the AME's ability to identify warning signs and refer the pilot for evaluation and appropriate intervention.

2. PSYCHOLOGICAL TESTING

The ARC does not recommend mandating formal psychological testing during the pilot hiring process nor as part of routine FAA aviation medical examinations beyond those which already exist.

Rationale: The Aviation Rulemaking Committee (ARC) found no convincing data to conclude that adding psychological testing to the hiring process or to the routine medical examinations enhance the ability to assess the mental fitness of the pilot workforce.

3. PILOT ASSISTANCE PROGRAMS

Air carriers should develop effective pilot assistance programs.

Rationale: An environment needs to be created where pilots feel comfortable disclosing mental fitness issues. Pilot support programs should provide the opportunity for a pilot to disclose a mental fitness concern and if appropriate, receive temporary relief from flight duties and be referred to professional resources. The successful implementation of pilot support programs benefits from a joint collaboration between the air carrier to include senior management support, its pilot representative organization, and pilot peer volunteers. The trusting relationship with a fellow pilot in a peer-supported program may provide the best opportunity to identify and engage an individual requiring assistance. To encourage use, pilots must be handled in a confidential, non-stigmatized, and safe environment. If a culture of mutual trust and cooperation is maintained, pilots are less likely to conceal a condition, and more likely to report and seek help for mental health issues.

4. AIR CARRIER EDUCATION

Air carrier operators should be encouraged to implement mental health education programs for pilots and supervisors that improve awareness and recognition of mental health issues, reduce stigmas, and promote available resources to assist with resolving mental health problems.

Rationale: Improved mental health literacy is associated with earlier reporting and improved treatment outcomes.

5. INFORMATIONAL MATERIAL ON PILOT SUPPORT PROGRAMS¹

The FAA should assemble and disseminate information on benchmark pilot support programs, which includes pilot assistance programs, to serve as a resource for air carriers to develop new or improve existing programs.

Rationale: There is a need for more opportunities for sharing best practices among air carriers. Providing the basic description, function, and benefits of pilot support programs will encourage air carriers to implement some or all of these programs. Implementation of the full complement of these programs is considered a best practice.

6. MEDICAL PROFESSIONAL REPORTING²

Encourage advocacy for a uniform national policy on mandatory reporting of medical issues that affect public safety.

Rationale: In the United States, medical professional reporting responsibilities are unclear. Reporting requirements and guidelines vary by State and by licensing boards. The perceptions of adverse legal consequences of reporting appear to be greater than not reporting. AMEs are expected to report issues potentially affecting public safety, but among medical professionals at large, concerns exist about professional and legal liability for violating patient privacy.

It should be noted there exists a concern that universal implementation of mandatory reporting requirements may deter individuals from seeking treatment. Also, because of the current uneven legal landscape, and medical ethics considerations notwithstanding, it is important that existing or future pilot support programs and policies continue to raise pilot awareness and encourage voluntary self-disclosure in a confidential and safe environment.

7. TWO PERSONS ON FLIGHTDECK AND FLIGHTDECK ACCESS

The ARC recommends no changes to the guidance found in FAA Order 8900.1, “Procedures for Opening, Closing, and Locking Flight Deck Doors” concerning two persons on the flightdeck and flightdeck access.

¹ See appendix D.

² For purposes of this report, this term includes physicians, physician assistants, nurse practitioners, psychologists, and clinical social workers or substance abuse specialists (all “health professionals” as defined on FAA Form 8500, the medical application form).

Rationale: The ARC notes that mental health episodes have occurred even with two persons in the cockpit, and no single safety practice can address all possible hypothetical events and other civil aviation authorities may have different procedures best suited to their regulated air carriers and operating environments.

8. AIRCRAFT DESIGN STANDARDS

The ARC believes existing aircraft and flightdeck door design standards are adequate and no changes are required by the FAA.

Rationale: No additional design requirements or pending technologies have been identified that would reduce risk more than those systems currently in place.

2.0 PILOT FITNESS ARC BACKGROUND

PILOT FITNESS ARC CHARTER

The Pilot Fitness ARC was chartered by the FAA on May 11, 2015. The full charter, appendix E, includes purpose, background, and objectives and tasks for the ARC to consider, which formed the basis of the committee's work. The objectives and tasks were:

The Pilot Fitness ARC will provide a forum for the United States aviation community to discuss and provide recommendations to the FAA and is tasked to review the following questions and provide findings and, if appropriate, recommendations to the Associate Administrator for Aviation Safety.

- a. What does data show us about changes in awareness and reporting of emotional and mental health issues in the general population?
- b. If the review completed under Task a demonstrates a change in awareness and reporting of mental health issues in the general public, can we determine whether a similar change is reasonably expected to have occurred in the pilot community? If not, why not?
- c. If so, do the changes in the awareness and reporting of emotional and mental health issues reflected in the pilot community indicate increased risks to aviation safety? If so, does that suggest that further review is valuable?
- d. What methods are used to evaluate the emotional and mental health of pilots today? Do those methods differ depending on the level of certification held by the pilot? If so, are those differences appropriate?
- e. What methods are used to encourage pilots to report medical conditions, including emotional and mental health issues? What steps are taken when emotional and mental health conditions are reported--either by the pilot or by family, friends or co-workers who are concerned about the pilot?

- f. Are there barriers that prevent pilots from reporting medical conditions, including emotional and mental health issues?
- g. Given the findings under Tasks a through f; are there gaps in the methods used today to evaluate the emotional and mental health of pilots?
- h. If there are gaps in current methods of evaluation, what would the ARC recommend to address those gaps?
 - i. Are there medical methods that could be employed to address the gaps?
 - ii. Are there aircraft design improvements that would mitigate the gaps?
 - iii. Are there policies and/or procedures that would mitigate risk during flight?
 - iv. Are there pilot training and/or testing improvements that would mitigate the gaps?
 - v. Are there actions by professional standards groups or other airline or union actions that would mitigate the gaps?
 - vi. Are there training or other improvements for AMEs that would mitigate the gaps?

3.0 ARC DATA AND RESEARCH

To address the ARC charter tasks and objectives, the ARC formed 10 working groups of ARC members, observers, and subject matter experts (SME) to address each of the areas. The ARC recognized early in its deliberations that the failure to get information where it needed to be was a critical element in the Germanwings event, therefore, the ARC created a Task x, Organizational Cross-Communication Working Group, to examine impediments to information flow. The working groups were tasked with researching their given subject, analyzing existing policies and procedures, and presenting their findings to the ARC. They only applied the charter tasks and objectives to Title 14, Code of Federal Regulations (14 CFR) part 121 certificated air carriers. The working groups drafted potential recommendations if their findings warranted. The inputs of working groups to each task follow.

TASKS AND INPUTS

Task a. What does data show us about changes in awareness and reporting of emotional and mental health issues in the general population?

Although data is limited, there is some evidence of an increase in both awareness and reporting in both the general U.S. population as well as other developed countries. It is noteworthy that a significant portion of the literature reviewed comes from research in Germany and Australia. In terms of the scientific literature, awareness is studied as “mental health literacy” and reporting is reflected as “help-seeking.”

Anthony Jorm and colleagues coined the term “mental health literacy” which refers to knowledge and beliefs about mental disorders which aid in their recognition, management, or prevention.³ He further developed several components of mental health literacy: a) the ability to recognize specific disorders or different types of psychological distress; b) knowledge and beliefs about risk factors and causes; c) knowledge and beliefs about self-help interventions; d) knowledge and belief about professional help available; e) attitudes that facilitate recognition and appropriate help seeking; and f) knowledge of how to seek mental health information.⁴ Schomerus, et al. conducted a meta-analysis of six studies from different countries, including the United States through 2011. They concluded that there was a coherent trend to greater mental health literacy over the time period studied.⁵

The working group believes that increased awareness may be related to increased media attention on mental health issues in recent years. Congress and President George H.W. Bush designated the 1990s as the “Decade of the Brain” to enhance public awareness of the benefits of brain research. Some believe that a more biologically based public understanding of mental illness parallels greater acceptance of professional treatment.⁶

Willingness to seek help can be considered a surrogate for self-reporting. Mojtabai examined Americans’ attitudes toward seeking mental health treatment over the period 1990-1992 and 2001-2003. He concluded that over these periods, Americans indicated more willingness to seek professional help for mental health problems, were more comfortable talking with a professional about personal problems and would be less embarrassed if others found out they had sought professional help.⁷ Schomerus, et al. likewise found population based time-trend studies show that public attitudes towards help-seeking have improved over the last decade.⁸ A body of literature exists on reporting mental health issues in the workplace.^{9 10} The consistent theme is that individuals are more likely to report if they do not have fears about their job.

The working group noted the general population is not good at recognizing mental disorders in other people. Given a typical case scenario, studies found only 39–72 percent of respondents recognized depression and 75–84 percent recognized schizophrenia.^{11 12} This is unfortunate

³ Jorm AF, Korten AE, Jacomb PA, Christensen H, Rodgers B, Pollitt P. "Mental health literacy": a survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. *Med J Aust.* 1997 Feb;166(4):182-6

⁴ Jorm AF. Mental health literacy. Public knowledge and beliefs about mental disorders. *Br J Psychiatry.* 2000 Nov;177:396-401.

⁵ Schomerus G, Schwahn C, Holzinger A, Corrigan PW, Grabe HJ, Carta MG, Angermeyer MC. Evolution of public attitudes about mental illness: a systematic review and meta-analysis. *Acta Psychiatr Scand.* 2012 Jun;125(6):440-52

⁶ Ibid.

⁷ Mojtabai R. Americans' attitudes toward mental health treatment seeking:1990-2003. *Psychiatr Serv.* 2007 May;58(5):642-51.

⁸ Schomerus G, Matschinger H, Angermeyer MC. Traces of Freud--the unconscious conflict as a cause of mental disorders in the eyes of the general public. *Psychopathology.* 2008;41(3):173-8.

⁹ Brohan E, Henderson C, Wheat K, et al. Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. *BMC Psychiatry.* 2012;12:11.

¹⁰ Ellison ML, Russinova Z, MacDonald-Wilson KL, Lyass A. Patterns and correlates of workplace disclosure among professionals and managers with psychiatric conditions. *Journal of Vocational Rehabilitation.* 2003;18:3-13

¹¹ Jorm AF, Korten AE, Jacomb PA, Christensen H, Rodgers B, Pollitt P. "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Med J Aust.* 1997 Feb;166(4):182-6.

¹² Lauber C, Nordt C, Falcato L, Rossler W. Do people recognize mental illness? *European Archives of Psychiatry and Clinical Neurosciences.* 2003;253:248-251.

because individuals are more likely to seek professional help if someone else suggests it. Yap concluded that improved recognition of mental health signs and symptoms may facilitate help-seeking.¹³

It is a significant concern that although mental health literacy and willingness to seek help are improving, the same studies suggest that no changes or changes to the worse were observed regarding attitudes towards people with mental illness. Schomerus, et al. states, “Increasing public understanding of the biological correlates of mental illness seems not to result in better social acceptance of persons with mental illness.”¹⁴ Others have also demonstrated that stigmatization is alive and well.¹⁵

Difficulties with early reporting and help seeking remain. There is evidence that mental health symptoms are frequently underestimated or mischaracterized by patients. Patient recollection of past symptoms (whether physical or mental) is poor. Even after mental health symptoms are recognized, patients may delay months to years before seeking treatment.¹⁶

Task b. If the review completed under Task a. demonstrates a change in awareness and reporting of mental health issues in the general public, can we determine whether a similar change is reasonably expected to have occurred in the pilot community? If not, why not?

The working group attempted to locate published studies to determine whether there has been a similar increase of awareness and reporting within the pilot community. The group concludes that scientific data is not readily available to support whether or not changes in awareness or reporting of mental health issues have occurred in the pilot community. The group noted the gradual increase of pilot assistance programs, and the increase in the number of subscribers to aviation medical assistance services in both air carrier and business aviation communities. This may point to an increase in mental health awareness and reporting among pilots; however, the number of mental health consultations within these programs has not been compiled.

Task c. If so, do the changes in the awareness and reporting of emotional and mental health issues reflected in the pilot community indicate increased risks to aviation safety? If so, does that suggest further review is valuable?

In general, the working group agreed the more information and the more awareness, the better. The point was made however, that focusing increased scrutiny on mental health issues may decrease reporting.

¹³ Yap MB, Reavley NJ, Jorm AF. The associations between psychiatric label use and young people's help-seeking preferences: results from an Australian national survey. *Epidemiol Psychiatr Sci.* 2014 Mar;23(1):51-9.

¹⁴ Schomerus G, Schwahn C, Holzinger A, Corrigan PW, Grabe HJ, Carta MG, Angermeyer MC. Evolution of public attitudes about mental illness: a systematic review and meta-analysis. *Acta Psychiatr Scand.* 2012 Jun;125(6):440-52.

¹⁵ Pescosolido BA, Medina TR, Martin JK, Long JS. The "backbone" of stigma: identifying the global core of public prejudice associated with mental illness. *Am J Public Health.* 2013 May;103(5):853-60.

¹⁶ Jorm A. The population impact of improvements in mental health services: The case of Australia. *British Journal of Psychiatry.* 2011;199(6):443-444

Given that the ARC cannot ascertain with certainty whether changes in the awareness and reporting of emotional and mental health issues reflected in the pilot community indicate increased risks to aviation safety, the working group reached consensus that the ARC should continue its work in the spirit of continuous improvement based on the mantra of “What can we collectively do to make it better?”

Task d. What methods are used to evaluate the emotional and mental health of pilots today? Do those methods differ depending on the level of certification held by the pilot? If so, are those differences appropriate?

In the United States, initial and periodic medical examinations are completed by AMEs who are designees of the FAA. Pre-employment exams may include some psychological exams or testing but this is variable and deferred to the hiring subgroup.

The working group found before applying to an air carrier, most pilots have gone through career steps that tend to eliminate candidates with significant personality and/or skills deficiencies that will prevent them from effectively performing as a pilot. These steps include, but are not limited to education, military service, flight schools, and employment at smaller companies.

The working group found during the air carrier industry downturn of the 2000s, pilot hiring plunged. Thousands of pilots were furloughed and air carrier workforces shrunk. The group noted at some air carriers, no new pilots were hired for 10 years or more, and many of the pilots hired during this period were highly experienced pilots on furlough from other air carriers. Consequently, any data on new hires during this period may be somewhat skewed in favor of a strong group of candidates.

The working group noted while hiring practices and interview steps vary from one air carrier to another, the similarities are quite striking. The group found this true regardless of whether the hiring air carrier is a major, midsize, or regional air carrier.

The working group found hiring practices have been largely unchanged for over 20 years. A review of the 1999 Aviation Rulemaking Advisory Committee¹⁷ (ARAC) report on Pre-Employment Screening shows similar processes were employed in the 1990s.

The working group found during the hiring process, all air carriers conduct extensive background checks and in-depth interviews. Air carriers are typically looking for candidates who have appropriate aviation knowledge and skills. In addition, candidates are screened for leadership traits and strong interpersonal and communication skills that will enable the candidate to work effectively with fellow crewmembers.

The working group found no statistical data measuring whether different hiring protocols produce better pilot performance at one air carrier over another, for either an extended career or during the pilot’s early years at an air carrier. The group noted new hire pilots are closely scrutinized during their initial training and qualification period, as well as during their first year or probationary period.

¹⁷ Aviation Rulemaking Advisory Committee, “Report to Congress: Air Carrier Pilot Pre-Employment Screening Standards and Criteria Study,” US Department of Transportation: Federal Aviation Administration, 1999

The working group conducted a teleconference, during which four participating major U.S. air carriers all reported that very few new hire pilots experience voluntary or involuntary terminations during initial training or their probationary period. None of the major air carriers interviewed could recall any recent incident of a probationary pilot departing for mental health reasons, involuntarily or voluntarily.

The working group noted low termination rates at major air carriers are consistent with the findings of the 1999 ARAC¹⁸ report, which stated: “Regardless of the selection criteria utilized, all major air carriers surveyed report strong safety records and exceedingly low failure rates by probationary pilots during initial training.”

The working group found that at midsize and regional air carriers, resignations, or involuntary terminations during the first year are higher: ranging from 1 percent to as high as 40 percent, with a mean of approximately 10 percent. With regards to involuntary terminations, most are for training failures, along with disciplinary and behavioral matters. Resignations are usually financially related, such as obtaining a better paying job or over business uncertainties at the air carrier. Three air carriers reported pilots departing because of stress issues usually related to personal or family illness or divorce. The 1999 ARAC¹⁹ report showed a similar pattern of first year departures at regional air carriers, ranging from 1 percent to 55 percent, with a mean of 12.4 percent.

The working group also found that none of the 19 carriers, regionals and majors, surveyed reported any instance of a pilot being unable to complete their initial operating experience (IOE) and/or training period because of mental health issues. This zero failure rate may be a reflection of several factors that greatly reduce the likelihood for a pilot with significant health issues—mental or physical—to enter into the pool of candidates for pilot hiring. While a pilot applying to an air carrier may be “new” to that air carrier, he/she is generally not “new” to the career path and has been subject to medical and professional evaluation at earlier stages. The applicants are generally working at smaller companies, or serving in the military. In those environments, their behavior is being scrutinized by co-workers and supervisors, and they are already subject to FAA and military medical examinations.

The working group found no statistical studies on the long term outcomes of different hiring protocols and emotional/mental health stability of the pilot workforce. Consequently, there is no statistical basis to conclude that adding psychological evaluations to the hiring process either enhances or detracts from the quality of the new hires.

The working group did not address differences in evaluating the emotional and mental health of pilots depending on the level of certification held by the pilot. The ARC only applied the charter tasks and objectives to part 121 certificated air carriers which require a first class medical certificate for pilots

¹⁸ Ibid.

¹⁹ Ibid.

Task e. What methods are used to encourage pilots to report medical conditions, including emotional and mental health issues? What steps are taken when emotional and mental health conditions are reported—either by the pilot or by family, friends or co-workers who are concerned about the pilot?

The working group found a myriad of pilot support programs available through pilot representative organizations and air carriers working in conjunction with flight operations departments that offer a safe environment for a pilot to report medical, emotional and mental health issues. In most cases these programs and departments provide the opportunity for the pilot to identify a need, if appropriate receive temporary relief from flight duties, and if necessary be referred to a professional resource to address medical, emotional, and mental health issues.

The working group also found the air carrier industry has developed a comprehensive network of flight operations support departments and programs to continually evaluate pilots' cognitive and behavioral performance and offer support for any identified deficiencies. Although these oversight programs and procedures may have aspects of confidentiality, they are generally used to openly evaluate aviation knowledge, skill levels, crewmember interactions, and stress management.

The working group noted some company and pilot representative initiatives provide mental health education in an effort to counter negative stigma associated with emotional and mental health problems. In addition, in some aviation organizations, senior company and pilot representative leaders offer direct support through media or written communication encouraging crewmembers to seek help for emotional and mental health issues.

The working group found when an emotional or mental health concern is reported, the pilot is engaged in a timely manner to investigate the situation and to be offered support and assistance. Informal mental health triage is provided and the pilot is assisted in assessing his or her problem and fitness for duty. Potential resources for help are discussed with the individual, some of which may include a referral to a medical or mental health professional.

The working group noted all visits to medical and mental health professionals are required to be reported to an AME through FAA Form 8500-8,²⁰ Application for Airman Medical Certificate or Airman Medical & Student Pilot Certificate during the medical certificate examination. In addition, in cases where the medical or mental health condition is of potential concern, the crewmember must be evaluated through FAA protocols.

The working group examined how an event is handled in which air carrier management receives a report concerning the emotional or mental health of a pilot. In those cases, an investigation is initiated to determine the credibility of the report. After this evaluation, if management determines additional research into the report is necessary, the pilot will be removed from flying status and a mandatory fitness for duty exam may be required.

²⁰ FAA Form 8500-8 (9-08) Application for Airman Medical Certificate or Airman Medical and Student Pilot Certificate

Task f. Are there barriers preventing pilots from reporting medical conditions, including emotional and mental health issues?

Self-reporting of mental health issues may be perceived by the pilot as a high risk situation.

Studies have shown that a clear disincentive for reporting mental health concerns is fear of negative action on one's career. This concern is reported to be especially high in the transportation industry. The myth that all mental health conditions are career ending may be widely believed.

A closely related barrier is concern about adverse financial impact. This can include substantial or total loss of income, as well as the added cost of treatment. There are fewer opportunities to offset the costs of mental illness than medical illness. Paid leave may not be available. There is disparity between disability benefits for mental health and other medical conditions. Insurance coverage, even in good plans, is typically limited for mental health diagnoses. Length of medical grounding is difficult to predict.

Lack of trust that the "system," be it employers or regulators, will treat pilots in a fair, enlightened, and expeditious manner is also a major barrier.

Data cited earlier in this report shows that stigmatization regarding mental illness is still highly prevalent in the general population. There is no reason to think this is less true for pilots and may contribute to barriers in reporting and barriers based in denial of a problem.

The mental illness itself may be a barrier to reporting. Individuals with certain diagnoses may not recognize their symptoms or signs of mental illness and view their behavior as normal. Studies show it is common for people to minimize or miscategorize their symptoms and have poor recollection of them. Accurate psychiatric "labeling" may facilitate reporting/help seeking according to some studies.

Schomerus and Angermeyer report²¹ that an individual is less likely to seek help if they do not believe that professional treatment will do any good. The extent to which this is true among pilots is unknown.

Task g. Given the findings under Tasks a. through f.; are there gaps in the methods used today to evaluate the emotional and mental health of pilots?

All identified gaps are addressed by the recommendations and rationales that suggest actions the FAA and air carrier community could take to address pilot mental fitness issues through education, outreach, training initiatives, and the reporting of mental health illness affecting public safety.

²¹ Schomerus, G and Angermeyer, M. Stigma and its impact on help-seeking for mental disorders: what do we know? *Epidemiologia e Psichiatria Sociale*, 17 (1) 31-7. 2008

Task h. If there are gaps in current methods of evaluation, what would the ARC recommend to address those gaps? Specifically,

i. Are there medical methods that could be employed to address the gaps?

The working group determined it is essential to first identify which of the identified gaps may be amenable to medical intervention, as no evaluation or combination of evaluations is perfect. Most evaluations rely on honest reporting by the pilot, and it is important to note the nature of mental illness is such that failure to disclose symptoms may be a result of lack of awareness and insight as well as a deliberate decision to conceal.

The working group noted the medical community did not miss the pathology in Germanwings pilot Lubitz. Reporting and disclosure failed because critical information did not get where it needed to be. The working group found in the United States, reporting responsibilities of the AME are clear, they are expected to report. Among medical professionals at large, concerns exist about professional and legal liability for violating patient privacy. Reporting requirements/protections vary by State and by licensing board. In Canada, reporting is required nationally.

Even when symptoms are recognized, reporting may be perceived by pilots as a high-risk situation. Financial and career implications can be significant even for short-term medical disqualification. Misinformation, anecdotes, and hearsay propagate the misperception that all mental illness is career-ending. In the United States and Canada, less than 0.5 percent of airmen have their medical certificates denied once they have provided all requested information.

The working group believes a risk mitigation process built on SMS principles should be used by air carriers and pilot representative organizations to create an environment where early reporting, appropriate treatment, and rapid return to the flightdeck are the expectation. Early identification of mental fitness issues leads to better results. A holistic approach to educating and addressing pilot mental fitness issues offers the best opportunity for a positive outcome.

Some air carriers have elected to perform psychological testing as part of their hiring practices. The working group endorses the inclusion of medical professionals in that process.

Because one third of individuals with substance abuse also have coexisting mental health diagnoses, the Medical Working Group supports the current efforts by the Office of Drug Control Policy (ONDCP) and the Department of Health and Human Services, to expand the five drugs the National Institute of Drug Abuse (NIDA) currently tests for on random, reasonable suspicion and other mandated Department of Transportation (DOT) tests by including synthetic opioids. This should aid in identifying individuals who could benefit from mental health treatment.

ii. Are there aircraft design improvements that would mitigate the gaps?

The working group found significant improvements have been made to aircraft and avionics design over time that have increased the safety of flight. With respect to pilot mental fitness issues, however, the working group found aircraft design and technology have no easy fixes or ready technology. The group did not identify additional design requirements or pending technologies that would reduce risk more than those systems in place.

While examining events related to pilot mental fitness, this working group worked with the Policy and Procedures Working Group to determine if any design or hardware change might have been helpful in preventing or limiting the outcome of such events. No such change was found.

The work of this group was focused solely on the issue of events or incidents related to pilot mental fitness that occurred outside of the United States involving non-U.S. operators. Hardware or design changes have been discussed in other initiatives related to aircraft safety and security. Such issues are beyond the scope of this ARC and working group and were not addressed.

This working group examined the Policy and Procedures Working Group's work to see if any changes in procedures would mitigate any risk arising from methods of evaluating pilot mental fitness and whether any aircraft design changes could further mitigate risk.

Three potential design issues were identified by the working group as the focus of its work. These areas include:

- The hardened flightdeck door and possible use of a secondary barrier,
- Changes to the flightdeck locking mechanism, and
- Any other aircraft design changes or technologies.

These issues are summarized below.

Existing FAA Requirements For Hardened Cockpit Doors

Following the terrorist attacks of September 11, 2001, Congress enacted Public Law 107-71, the Aviation and Transportation Security Act (the Act), which specifies that improved flightdeck security must be applied to aircraft operating in passenger or intrastate air transportation. Section 104 of the Act directed the FAA to issue a final rule, without seeking public comment before adoption, addressing security requirements for flightdeck doors. As a result, the FAA issued a series of Special Federal Aviation Regulations (SFAR) and four final rules without notice. Actions of note include:

- FAA SFAR 92 (66 FR 51546, October 9, 2001; 66 FR 52835, October 17, 2001; 66 FR 58650, November 21, 2001; and 67 FR 12820, March 19, 2002; Docket No. FAA-2002-10770) first allowed, and then required, the installation of internal locking devices on the flightdeck doors.

- In January 2002, the FAA amended 14 CFR § 25.795 to set standards for reinforcing flightdeck doors. The new standards required them to resist forcible intrusion and ballistic penetration. Section 121.313(f) was amended to mandate installation of the reinforced doors on certain airplanes not later than April 9, 2003. Affected airplanes included transport category all-cargo airplanes operated under part 121 which had flightdeck doors installed on or after January 15, 2002.
- In June 2002, the FAA amended 14 CFR part 129 to apply similar standards to foreign operators operating into the United States. Section 129.28 required installation of the reinforced door not later than April 9, 2003.

The reinforced cockpit door has served as a deterrent to unauthorized flightdeck entry since its introduction. The working group noted the possible addition of a second installed barrier has been discussed outside of this ARC as a potential security enhancement, preventing or further deterring unlawful or unauthorized entry to the flightdeck. The working group agreed however, such a change in aircraft design or in FAA regulations would not mitigate risks arising from any gaps in current methods of pilot mental fitness screening.

Possible Changes to the Cockpit Door Locking Mechanism

The Policy and Procedures Working Group discussed various original equipment manufacturer (OEM) guidance and flight manual information on flightdeck door/design during both manual and automatic operation, determining no modifications to policy and procedures were necessary. This working group reached a similar conclusion with respect to any necessary design changes in the locking mechanism.

Other Aircraft Design Changes or Technologies

The working group discussed various other design changes or technologies that could be employed to mitigate any gaps in fitness screening, but no known design changes or technology could be found to meet the goal. Included in those discussions were, among others, the use of additional cameras in the aircraft and remote aircraft control mechanisms.

As noted in the report section by the Policy and Procedures Working Group, and based on their survey, cameras are already widely used by a number of international air carriers to monitor the area immediately outside of the flightdeck door during crew transition. This working group believes using these cameras as a tool to mitigate gaps in screening, or during an inflight incident involving a crewmember would be limited.

The working group noted remote operation of aircraft during an inflight emergency, or during an act of unlawful interference, has been discussed in some media circles following recent events and during past hijackings. The group did not investigate the technical feasibility of installing such technology on civil passenger aircraft. Nonetheless, providing the ability to control an aircraft from a remote location not only would present a major security concern with respect to hacking of the system or operation by unauthorized persons, but would also be prohibitively expensive. For a system that is

highly unlikely to ever be used, and introduces entirely new security concerns, the working group believes it does not make operational or economic sense to investigate further.

After discussing the possible uses of such technologies in various scenarios, the working group determined none would mitigate any gaps in pilot or crew screening or feasibly enhance any required response by other crewmembers.

iii. Are there policies and/or procedures that would mitigate risk during flight?

The working group's deliberations were conducted within the following scope statement:

The Policy and Procedures Working Group will provide recommendations to the ARC on policies and/or procedures used in flight that would mitigate risks caused by current methods of evaluating fitness. This may include review of pilot training, cockpit resource management, cockpit operational procedures/discipline, use of installed equipment such as the hardened cockpit door, and integration with programs such as Federal Flight Deck Officer (FFDO).

The working group identified five areas as the focus of its work. A working group member served as the lead for each research area. These areas include:

- Prescriptive vs. outcome based approach to closing identified gaps,
- Existing FAA guidance related to occupying the cockpit in flight,
- Existing international guidance related to occupying the cockpit in flight as benchmarks,
- Procedures used for opening/closing the hardened cockpit door during manual operation, and
- Procedures used for opening/closing the hardened cockpit door during automatic operation.

Each area of work is summarized below. The working group's findings introduce each research area.

Prescriptive vs. Outcome Based Approach to Closing Identified Gaps

During the course of its deliberations, the working group examined options available to the FAA to close unforeseen or future gaps and minimize risks. The options ranged from collaboratively developing a compendium of best practices to issuing prescriptive changes through 14 CFR. The working group acknowledged while best practice guidelines could be used to close some gaps, others would require the FAA to issue new regulations to all aircraft operators.

The working group examined previous regulation involving other areas of safety and pilot certification and analyzed whether one size fits all regulation, which is appropriate in some cases, would be suitable for issues involving pilot mental fitness. Because of the rarity of such events and the resulting lack of data sets, frequency tables, and risk modeling, the working group determined that prescriptive regulation in this case may

introduce more vulnerabilities and gaps than it closed. The working group believes the FAA should identify desired outcomes through regulation and allow operators within the context of their own unique operational circumstances, to develop compliance solutions.

The working group believes performance-based solutions allow air carriers, who have the best knowledge of their operations and flightcrews, the latitude to develop tailored solutions and the incorporation of industry standard crew resource management (CRM) risk mitigation measures.

Existing FAA Guidance Related to Occupying the Cockpit in Flight

The working group recognized that mental health episodes have occurred even with two persons on the flightdeck, and no single safety practice can address all possible hypothetical events. The group recommends no change to FAA Order 8900.1, Procedures for Opening, Closing, and Locking Flight Deck Doors, guidance for two persons on the flightdeck and flightdeck access, but believes foreign aviation authorities should have the option to adopt the flightdeck practice(s) that best suits their regulated air carriers and operating environments; no change to part 129 is suggested.

Existing international guidance related to occupying the cockpit in flight as benchmarks

The working group conducted a survey of 28 global air carriers carrying 16 percent of world traffic. The results of survey responses indicated the following:

- There is a menu of options across the industry that aircraft operators use to maintain the integrity of the flightdeck.
- Only a minority of regulators (7 of 28) mandate a second person in the cockpit.
- Various air carriers have chosen to voluntarily implement the “Four Eyes” practice.
- Cameras are widely used to monitor the area immediately outside of the cockpit door during transition.

Procedures Used For Opening/Closing the Hardened Cockpit Door During Manual Operation

The working group discussed various OEM guidance and flight manual information on flightdeck door/design during manual operation. This is defined as the use by flightdeck personnel to open and close the hardened door using the door handle and latching of manual bar/latches/strike plates. The working group is satisfied that these procedures are safe and reliable and no modifications are necessary. The group notes aircraft operators should continually verify they have documented policies and procedures in place.

The working group discussed the issue of flightdeck door secondary barriers. The group is satisfied that these procedures are safe and reliable in existing installations, and no modifications to procedures are necessary. Additional commentary on the construction and performance of secondary barriers was referred to the Aircraft Design Work Group.

Procedures Used For Opening/Closing the Hardened Cockpit Door During Automatic Operation

The working group discussed various OEM guidance and flight manual information on flightdeck door/design during automatic operation. This is defined as the use of the keypad and pedestal unlock/override switch used by flightdeck personnel to open and close the hardened door using electronic means. The working group is satisfied that these procedures are safe and reliable, and no modifications are necessary. The group noted air carriers should continually verify that they have documented policies and procedures in place.

iv. Are there pilot training and/or testing improvements that would mitigate the gaps?

The working group found air carrier pilots complete rigorous training and testing programs throughout their careers. These programs are intended to ensure safe, compliant, standardized pilots, adequately trained and prepared to face many situations. Through training and testing, there are programs and processes that help in the determination of issues associated with a pilot's mental fitness.

The working group believes one of the most critical air carrier training programs is the CRM program. CRM ensures a constant flow of communication between the pilots on the flightdeck, and between the pilots and the rest of the crew. CRM also ensures that pilots understand the need to communicate, the duties of each position, such as pilot flying, monitoring, or flight attendant, and methods to interact with crewmembers who do not seem to be performing at an appropriate level. This is a program that is continuously trained, evaluated, and emphasized to all crewmembers. The level of communication and awareness required by this program helps highlight any concerns or issues and in that way, helps to mitigate gaps.

The working group noted there are other programs to ensure pilot performance, and through observation, help ensure pilot mental fitness. These programs include but are not limited to:

- Recurring simulator training and evaluations,
- Line flying evaluations,
- Ground training through classrooms and other means,
- Flight Operation Quality Assurance (FOQA) programs (which would highlight anomalies in flying performance),
- Line Operation Safety Audits (LOSA) which monitor crew performance from a safety and CRM standpoint—usually without the stress of a flight evaluation, and
- Aviation Safety Action Programs (ASAP) which allow pilots to self-disclose any issues associated with a flight.

The working group determined all of these programs, whether administered through the safety, flight operations, or specifically through the training department provide the opportunity for air carrier personnel to determine the ability of an individual to perform their duties in various environments and with various levels of stress. The working group noted pilot fitness issues have been highlighted by instructors and crews based on these and similar programs. This type of continuous scrutiny of pilots helps mitigate gaps.

Because pilot training is performed initially upon hiring and then on a recurring basis throughout a pilot's career, the training program is an excellent forum for ensuring that the pilot understands fitness requirements and the programs available to the crewmember if he or she is encountering a pilot mental fitness issue (either personally or a fitness issue observed in another crewmember).

v. Are there actions by professional standards groups or other airline or union²² actions that would mitigate the gaps?

The working group addressed mitigating the gaps based on its members' operational experience and its opinion as air carrier pilots.

The working group summarized known information about pilot support programs and gathered additional data on operating pilot support programs within the U.S. air carrier industry through an email and telephone survey to determine the prevalence of these programs. This information is in appendix D. Working group members contributed information about the variety of pilot support programs for discussion. Based on these discussions the group formed recommendations to address the gaps.

Professional Standards and Pilot Support Groups

The working group determined that the reference to "Professional Standards Groups" found in the assigned task question is meant to extend to the full complement of pilot support programs available to support pilot mental fitness, not specifically "professional standards" programs that are designed to address pilot professionalism. The full complement of pilot support programs include air carrier employee assistance programs (EAP), CRM, critical incident response programs (CIRP), the Human Intervention Motivation Study (HIMS), professional standards, formal mentoring programs, and aeromedical support programs.

The working group found that the interpretation of the word "methods" in the fundamental question, "Are there gaps in methods of evaluation...?" had a bearing on its conclusion. The working group viewed the definition of the word from two perspectives and answered for each perspective.

²² Pilot representative organizations as defined in Appendix B.

When defining “methods” as “the way pilot mental fitness issues are detected and addressed”, the working group concluded that while some existing pilot support programs were not specifically developed for the purpose of detecting pilot mental fitness issues, when the full complement of those programs are available at an air carrier, they are mostly effective in doing so.

The working group conducted both telephone and email surveys with U.S. air carriers. Data from this survey was combined to form a picture of how many air carriers participate in which pilot support programs.

The survey data shows that access to a variety of pilot support resources is available to the vast majority of air carrier pilots, because major U.S. air carriers, which employ a majority of the air carrier pilot workforce, have most, if not the full complement of pilot support programs in place at their companies. Those air carriers that have no in-house services have access to most services through their pilot representative organization or other sources.

The working group found the survey data revealed that the majority of air carriers provide an EAP. Of the air carriers that provide an EAP, the majority do not provide a separate EAP for pilots; there is a single EAP for all employee groups. The working group also found that a majority of air carriers and/or pilot representative organizations also provide HIMS programs.

Additionally, the working group found that the majority of air carriers do not provide a pilot peer-supported assistance program; however, there are programs such as the Pilot Assistance Network (PAN) or Project Wingman (PW) provided by pilot representative organizations and their air carriers. The group noted that although gaps exist in access to some in-house resources, these gaps affect a relatively small number of air carrier pilots and are well mitigated by access to programs available through their respective pilot representative organizations.

When “methods” are defined as “the way a pilot’s mental fitness is determined after a deficiency is detected,” the working group discussed streamlining communication between some pilot support program volunteers and mental health professionals, but gaps were not identified.

Mitigating Actions by Air Carriers

The working group found in some cases, pilots will not self-disclose perceived fitness issues because of potential adverse consequences in medical certification and licensing. The group believes because of the attendant loss of short or long-term income, even loss of career, it is critical that EAPs and other pilot support programs provide as much confidentiality as reasonably possible to foster participation.

The working group believes major air carriers that have implemented effective EAPs serve as a model to the industry. Often, effective EAPs are employee-group-specific, and in the case of air carrier pilots, understand the pilot’s work environment, the regulatory

environment, and the consequences of how interactions with pilots are best conducted and reported. EAPs serving an air carrier's entire employee group frequently lack this pilot group specificity. As a consequence, such EAPs are often unable to gain the trust, reputation, and rapport required to serve as a viable pilot resource. The working group believes that employee-group-specific EAPs are preferred by pilots and maximize the potential for effectiveness.

Mitigating Actions by Others

The working group considers access to the full complement of pilot support programs as a best practice in maintaining pilot mental fitness.

The working group investigated the concept of developing a pilot mental fitness-focused ASAP-like program as one potentially effective method to bridge any existing gaps between existing pilot support programs, such as CIRP, HIMS, or professional standards. Consensus among the group as to the ability to implement such a program was not found.

The working group notes that the Air Carrier Safety and Pilot Training ARC²³ identified participation in five volunteer peer programs as an air carrier industry best practice. The five programs enumerated in that recommendation are among the eight programs the working group has identified in its proceedings.

The working group identified a number of programs and points of observation available to assist in identifying pilots suffering from mental and emotional health issues and provide support and if necessary, referral into treatment. These include the following:

- Aeromedical Advisory Programs;
- Air carrier Specific Pilot Assistance Programs such as PW and PAN;
- CIRP;
- CRM;
- EAP;
- Formal pilot mentoring programs;
- HIMS, substance abuse program; and
- Professional standards programs.

²³ Federal Aviation Administration Task Force on Air Carrier Safety and Pilot Training: Report from the Air Carrier Safety and Pilot Training Aviation Rulemaking Committee, 31 July 2011

The working group noted all of these pilot support programs were developed based on a specific need; however, all of the pilot support programs work in unison and overlap as far as mental fitness is concerned. The group found that most air carriers have at least a small number of these programs in place, but some smaller or newly established air carriers do not have any of the programs in place, which creates a significant void. The working group believes one of the reasons for lack of implementation is lack of knowledge regarding the existence and benefits of the programs. The working group noted that where these pilot support programs have been established, they have been predominately successful.

vi. Are there training or other improvements for AMEs that would mitigate the gaps?

The working group found that AME-pilot encounters are not optimized to detect mental health issues. These encounters are generally brief and infrequent, ranging anywhere from a single visit to once every 6 months to 1 year. The group noted there is both an economic and personal incentive for the AME to assume an advocacy role. The group members shared many anecdotes of AMEs encouraging airmen to not report significant items of history or to minimize items which were reported. The working group believes the AME regulatory role should be reemphasized versus the trend toward advocacy.

The working group found most AMEs have limited psychiatric education and experience. This may be as little as 3 weeks in medical school and 2 hours in AME basic training, of which 1 hour is entirely devoted to substance abuse and dependence. The group believes it is desirable to expand general AME knowledge on mental status assessment and mental health issues. The working group suggests this could be accomplished by restructuring the AME basic and refresher curricula, with the goal of enhancing the AME's ability to identify warning signs and refer the pilot for evaluation and appropriate intervention.

The Aerospace Medical Association (AsMA) is a professional organization of over 2,500 physicians, nurses, and scientists engaged in the clinical practice of Aerospace Medicine and related research and education activities. On September 21, 2015 the organization sent FAA Administrator, Michael Huerta a list of recommendations²⁴ from their Pilot Mental Health Work Group. One of those recommendations stated, "AsMA believes that in-depth psychological testing for detecting serious mental illness as part of the routine periodic pilot aeromedical assessment is neither productive nor cost effective and therefore not warranted." The working group feels the same.

The working group members' opinions were divided over the value of standardized rapid assessment tools, such as the Patient Health Questionnaire for Depression and Anxiety (PHQ-4), and the Columbia Suicide Severity Rating Scale (C-SSRS). The group believes it should be noted that the U.S. Preventive Services Task Force has issued a recommendation to conduct routine screening for depression in the primary care setting for public comment.

²⁴ Aerospace Medical Association Ad Hoc Working Group On Pilot Mental Health. *Pilot mental health: expert working group recommendations*. Aviation, Space, and Environmental Medicine 2012; 83:1184-5

Task x. Organizational Cross-Communication Working Group

Early in the ARC's deliberations, it was suggested that communication between and among the several parties who may have an interest in ensuring that pilots are mentally fit for duty, may be either inadequate or otherwise impeded not only by a pilot's reluctance to self-report, but by potential organizational, institutional, and legal considerations that further impede communication. This suggestion was rooted, in part, over concerns based on media accounts and the Bureau d'Enquêtes et d'Analyses (BEA) preliminary report, that German medical privacy laws may have precluded private medical doctors from disclosing Mr. Lubitz's condition to his employer or the German authorities. Although not specifically addressed in the ARC charter, the ARC determined this consideration to be highly relevant to its inquiry. An additional task was created and assigned to the Organizational Cross-Communication (OCC) Working Group.

As the various working groups developed their analyses and reported out to the entire ARC, it became apparent that significant overlap existed between the OCC Working Group's objective and several other working groups, except in the area of legal considerations. Accordingly, the OCC Working Group narrowed its scope to an overview of relevant Federal and State laws that may impact on the disclosure of personal health information for the purpose of protecting public safety.

Medical information privacy laws are rooted in a strong public policy concern that seeks to protect the confidentiality of personal health information. The underlying rationale is that a patient's interests are best served where open and candid dialogue with a medical provider is encouraged. Consequently, Congress and State legislatures have enacted statutes, and some State courts have recognized common law actions that protect the confidentiality of personal health information. A countervailing policy concern arises, however, when a patient communicates a threat of harm that, if acted upon, would pose a serious threat to public safety. Recognizing this competing policy, Congress, many State legislatures, and some State courts have carved out narrow exceptions to medical information privacy laws.

An initial review of Federal and State law suggests that the balance tips in favor of protecting medical information, except where there exists specific or direct threats of imminent physical harm against specific victims or a reasonably identifiable victim or victims. The challenge for medical professionals who provide medical services from which they may obtain confidential medical information may be choosing between disclosing a confidential communication that proves to be a hollow threat, and thereby undermining the trust of that patient (and potential patients) thus deterring the future seeking of medical help where needed, and risking liability to the patient; or failing to disclose a confidential communication that later proves to be a credible threat and possibly incurring liability to the victim and the victim's family.

Additionally, the legal and regulatory interests in protecting public safety cannot be overlooked. Under the system, pilots and AMEs are required under 14 CFR and statutory authority to disclose instances where the pilot has sought treatment for mental health issues.

The group drafted an overview of Federal and State law that bears on the issue of a pilot's mental fitness for duty, which is found in appendix F.

4.0 ESTIMATED COSTS

The ARC was tasked with estimating costs associated with improvements to aircraft design and pilot training and testing. There are no costs associated with changes to aircraft design standards or pilot psychological testing, because the ARC recommended no changes. The ARC's recommendation to enhance AME training can be incorporated in current initial and recurrent training, resulting in no additional cost. The ARC was unable to estimate neither a cost associated with its recommendation for air carriers to voluntarily develop and implement effective pilot assistance programs nor the cost of air carrier education and for the FAA to assemble and disseminate informational material for pilot support programs.

APPENDIX A—PILOT FITNESS ARC MEMBERS

ARC Members

Name	Affiliation
Michael Berry, M.D. M.S.	Co-Chair, FAA Office of Aerospace Medicine (AAM-2)
Paul Morell	Co-Chair, Airlines for America
Les Smith	Co-Chair, FAA Flight Standards Service (AFS-200)
Stacey Bechdolt	Regional Airline Association
Charles Chesanow, D.O.	FAA Office of Aerospace Medicine (AAM-200)
Rob DeLucia	Airlines for America
Joe DePete	Air Line Pilots Association, International
John Duncan	FAA Flight Standards Service (AFS-1)
Ken Dunlap	International Air Transport Association
Claudia Gerstle	Airlines for America
Peggy Gilligan	FAA Aviation Safety (AVS-1)
Penny Giovanetti, D.O.	FAA Office of Aerospace Medicine (AAM-200)
Keith Hagy	Air Line Pilots Association, International
Katie Haley	FAA Office of Rulemaking (ARM-203)
Carl Johnson	FAA Flight Standards Service (AFS-800)
Ken Lee	Coalition of Airline Pilots Associations
John Linsenmeyer	FAA Flight Standards Service (AFS-800)
Tom McSpadden	Coalition of Airline Pilots Associations
George Novak	Aerospace Industries Association
George Paul	National Air Carrier Association
Brad Sheehan	Regional Airline Association
Tim Steeds	International Air Transport Association
Peter Stein	Flight Safety Foundation

ARC Observers

Name	Affiliation
Charlie Curreri	Airlines for America
Maryanne DeMarco	Coalition of Airline Pilots Associations
Jeff Hamlett	Airlines for America
Thomas Mickler	European Aviation Safety Agency
Jeff Miller	Airlines for America

Name	Affiliation
Chris Puckett	Airlines for America
Di Reimold	International Air Transport Association
David Salisbury, M.D.	Transport Canada Civil Aviation

Medical Working Group

Name	Affiliation
Penny Giovanetti, D.O.	FAA Physician, Aerospace Medicine, Working Group Chair
Steven I. Altchuler, M.D., PhD.	Physician, Psychiatrist
David Altman, M.D.	Physician, Psychiatrist
Charles Chesanow, D.O.	FAA Chief Psychiatrist
Robert Elliott, Ph.D.	Neuropsychologist
Tony Evans, M.D.	Physician, Aerospace Medicine–ICAO CMO
Chris Front, Psy.D.	FAA Clinical Psychologist
Gregory Pinnell, M.D.	Physician, Family Medicine–AME
David Salisbury, M.D.	Physician, Aerospace Medicine–Transport Canada CMO
Quay Snyder, M.D.	Physician, Aerospace Medicine
Claude Thibeault, M.D.	Physician, Aerospace Medicine–IATA CMO
James Vanderploeg, M.D.	Physician, Aerospace Medicine–AME

APPENDIX B—DEFINITIONS

Term	Definition
<i>Aeromedical advisor</i>	An aeromedical professional who assists pilots with health concerns by providing specialized aeromedical advice, and works as a liaison with the Federal Aviation Administration (FAA) to help pilots maintain or regain their medical certification.
<i>Air carrier</i>	A business that undertakes directly by lease, or other arrangement, to engage in air transportation.
<i>Aviation Medical Examiner</i>	An FAA-designated physician authorized to receive airman medical certificate applications, perform airman physical examinations, and to issue airman medical certificates.
<i>Medical professional</i>	Physicians, physician assistants, nurse practitioners, psychologists, and clinical social workers or substance abuse specialists (all “health professionals” as defined on FAA Form 8500, the medical application form).
<i>Mental health literacy</i>	Knowledge and beliefs about mental disorders which aid their recognition, management or prevention.
<i>Mental illness</i>	Disorders generally characterized by dysregulation of mood, thought, and/or behavior.
<i>Meta-analysis</i>	A systematic method of evaluating statistical data based on results of several independent studies of the same problem.
<i>Pilot assistance program</i>	A pilot-specific program at an air carrier designed to address specific mental fitness issues.
<i>Pilot mental fitness</i>	Issues affecting a pilot’s emotional state, mental health, or cognitive ability to safely conduct their duties.
<i>Pilot Representative Organizations</i>	An official or ad hoc organization representing pilot interests at an air carrier such as labor unions, nonunion organized pilot groups, or professional associations.
<i>Pilot support programs</i>	A network of programs at an air carrier available to assist pilots and other employee groups with mental fitness issues.
<i>Public safety</i>	The welfare and protection of the general public.

APPENDIX C—ACRONYMS

Acronym	Definition
ADA	Americans With Disabilities Act
AME	Aviation Medical Examiners
ARAC	Aviation Rulemaking Advisory Committee
ARC	Aviation Rulemaking Committee
ASAP	Aviation Safety Action Programs
AsMA	Aerospace Medical Association
ATP	airline transport pilot
ATSA	Aviation and Transportation Security Act
CAST	Commercial Aviation Safety Team
CBA	collective bargaining agreement
CIRP	critical incident response programs
CRM	crew resource management
C-SSRS	Columbia Suicide Severity Rating Scale
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
EAP	employee assistance programs
FAA	Federal Aviation Administration
FFDO	Federal Flight Deck Officer
FMLA	Family Medical Leave Act of 1993

Acronym	Definition
FOQA	Flight Operation Quality Assurance
HIMS	Human Intervention Motivation Study
HIPAA	Health Insurance and Portability Accountability Act
IOE	initial operating experience
LOSA	Line Operation Safety Audits
NTSB	National Transportation Safety Board
OEM	original equipment manufacturer
PAN	Pilot Assistance Network
PHI	personal health information
PHQ-4	Patient Health Questionnaire for Depression and Anxiety
PW	Project Wingman
SFAR	Special Federal Aviation Regulations
SME	subject matter expert
TSA	Transportation Security Administration

APPENDIX D—PILOT SUPPORT PROGRAM DESCRIPTIONS

CONTRACT AEROMEDICAL ADVISORS

Contracted aeromedical advisors provide confidential, but not anonymous, assistance to pilots with the full range of aeromedical concerns. These physicians and their staffs work as case managers and provide specialized aeromedical advice as well as liaison with the Federal Aviation Administration (FAA) to help pilots maintain or regain their medical certification. These physicians may or may not be FAA Aviation Medical Examiners (AME), and do not act as treating physicians, although they may refer the pilot for appropriate evaluations and treatment. Pilots typically self-refer. Frequently these services are provided at no cost to the pilot. One large service reports utilization of around 1,000 pilots per month.

AIR CARRIER EMPLOYEE ASSISTANCE PROGRAMS

Air carrier employee assistance programs (EAP) are employee benefit programs that provide consultation, information and referral services to air carrier employees and their eligible family members at many, but not all, air carriers. They provide confidential help on a 7-day, 24-hour basis to address a variety of personal and professional challenges. Programs vary among air carriers. They may be run by the company or a contract service. Most offer referral assistance and provide payment for limited medical and counseling services. Some provide legal and financial counseling. Employees are encouraged to self-refer and to refer others.

AIR CARRIER-SPECIFIC PILOT ASSISTANCE PROGRAMS

Two air carrier pilot representative organizations, in cooperation with management, operate air carrier-specific pilot assistance programs (Pilot Assistance Network (PAN) for Delta Air Lines, Inc. and Project Wingman (PW) for American Airlines, Inc.). These programs were developed to help pilots with “life’s mental health challenges” or “physiological, psychological, or medical” issues that may adversely impact their piloting career, but do not fall into the category of substance abuse, post-traumatic stress, ethical and professional standards, or maintenance of medical certification. These programs are staffed on a 24/7 basis and are contacted via a toll-free number. Staff may consist of mental health professionals or peer pilot volunteers. This service is generally available at no cost to the pilot. Some data shows that utilization of these programs exceeds EAP participation.

CREW RESOURCE MANAGEMENT

Originally known as cockpit resource management, crew resource management (CRM) has expanded to include a wide variety of individuals or groups who are involved in decisions required to operate a flight safely. These may include pilots, aircraft dispatchers, flight attendants, maintenance personnel, air traffic controllers, and additional crewmembers. CRM training was developed to improve aviation safety through better communication, crew coordination, teamwork, workload management, fatigue and stress mitigation, and decision making. The goal is to optimize the human/machine interface and accompanying interpersonal activities. It refers to the effective use of all available resources: human, hardware, and information. There is formal initial and recurrent training as well as continual reinforcement on the job. Poor CRM performance may be an indicator of a deeper individual problem, and mechanisms exist for reporting anomalous occurrences.

CRITICAL INCIDENT RESPONSE PROGRAM

The purpose of critical incident response programs (CIRP) is to mitigate the adverse psychological impact of work-related traumatic events such as an incident or accident, and aid in the recovery from these events before harmful stress reactions affect job performance, careers, families, and health. A “critical incident” is any event which has a stressful impact sufficient to overwhelm the usually effective coping skills of an individual or a group. Pre-event education and post-event crisis intervention is provided by specifically trained and certified peer crewmembers either from within or from another air carrier. Licensed mental health professionals may also be involved. Participation is voluntary and no records are kept.

FORMAL PILOT MENTORING PROGRAMS

Formal pilot mentoring programs are company programs which pair highly experienced pilots with newly employed pilots, pilots upgrading to captain, or transitioning to different equipment. Mentors are a personal resource for answering questions and addressing concerns, and a source of sound advice and guidance covering not only training and flying skills, but also professionalism, air carrier pilot culture, ethics, leadership, regulatory and policy compliance. The Airline Safety and Federal Aviation Administration Extension Act of 2010 directed the FAA to convene an Aviation Rulemaking Committee (ARC) to develop procedures for each Title 14, Code of Federal Regulations part 121 air carrier to establish flightcrew member mentoring programs.

HUMAN INTERVENTION MOTIVATION STUDY

The Human Intervention Motivation Study (HIMS) provides a structure within which pilots with substance abuse or dependence can be identified, referred for treatment and if in recovery, safely returned to the cockpit. HIMS program education and training is funded by the FAA and administered via contract. The program involves the coordinated efforts of air carrier managers, peer pilot volunteers, pilot unions, healthcare professionals and the FAA. HIMS training is available to all interested parties but is required for healthcare professionals and highly recommended for pilot peers. Pilots with substance abuse problems may be identified through peer intervention, employee drug and alcohol testing programs, law enforcement encounters such

as DUI arrests, coworker and family referrals, and less often, self-reporting. Treatment in an inpatient program is preferred followed by long-term aftercare, participation in a 12-step program, frequent unannounced follow-up drug/alcohol testing, abstinence and close monitoring by supervisors, sponsors, peers, AMEs and other medical professionals. HIMS may be the mechanism to identify other mental health problems as mood disorders are twice as common in persons with addiction disorders compared to the general population. The HIMS program has established an impressive track record of success and safely returned over 5,400 pilots to flying since its inception.

PROFESSIONAL STANDARDS PROGRAM

Professional standards programs (ProStans) are volunteer, peer, conflict/behavior resolution programs which address allegations of misconduct or conflicts between crewmembers. Their purpose is to promote and maintain the highest degree of professional conduct among crewmembers and maintain the positive image of the air carrier pilot profession. Direct resolution between parties is encouraged. The ProStans volunteer attempts to arbitrate a resolution and reach a verbal agreement between a pilot and another individual. No records are maintained.

APPENDIX E—CHARTER



U.S. DEPARTMENT OF TRANSPORTATION
FEDERAL AVIATION ADMINISTRATION
Aviation Rulemaking Committee Charter

Effective Date: 05/11/2015

SUBJECT: Pilot Fitness Aviation Rulemaking Committee

1. **PURPOSE.** This charter establishes the Pilot Fitness Aviation Rulemaking Committee (ARC), according to the Administrator's authority under Title 49 of the United States Code (49 U.S.C. § 106(p)(5)). It also establishes a working group composed of medical professionals reporting to the ARC. The sponsor of this ARC is the Associate Administrator for Aviation Safety and this charter outlines the committee's organization, responsibilities, and tasks.
2. **BACKGROUND.** Because of two recent events, Malaysia 370 and German Wings 9525, the Commercial Aviation Safety Team (CAST) is interested in the question of pilot fitness. Because the safety professionals on CAST do not have sufficient expertise to examine the question, the FAA has determined that an ARC and a working group of medical professionals reporting to the ARC will provide the most complete and expeditious review of this issue.
3. **OBJECTIVES AND TASKS OF THE ARC.** The Pilot Fitness ARC will provide a forum for the United States aviation community to discuss and provide recommendations to the FAA and is tasked to review the following questions and provide findings and, if appropriate, recommendations to the Associate Administrator for Aviation Safety.
 - a. What does data show us about changes in awareness and reporting of emotional and mental health issues in the general population?
 - b. If the review completed under Task a. demonstrates a change in awareness and reporting of mental health issues in the general public, can we determine whether a similar change is reasonably expected to have occurred in the pilot community? If not, why not?
 - c. If so, do the changes in the awareness and reporting of emotional and mental health issues reflected in the pilot community indicate increased risks to aviation safety? If so, does that suggest that further review is valuable?
 - d. What methods are used to evaluate the emotional and mental health of pilots today? Do those methods differ depending on the level of certification held by the pilot? If so, are those differences appropriate?
 - e. What methods are used to encourage pilots to report medical conditions, including emotional and mental health issues? What steps are taken when emotional and mental health conditions are reported -- either by the pilot or by family, friends or co-workers who are concerned about the pilot?
 - f. Are there barriers that prevent pilots from reporting medical conditions, including emotional and mental health issues?
 - g. Given the findings under Tasks a. through f.; are there gaps in the methods used today to evaluate the emotional and mental health of pilots?

Initiated By: AFS-200
AAM-200

- h. If there are gaps in current methods of evaluation, what would the ARC recommend to address those gaps?
 - i. Are there medical methods that could be employed to address the gaps?
 - ii. Are there aircraft design improvements that would mitigate the gaps?
 - iii. Are there policies and/or procedures that would mitigate risk during flight?
 - iv. Are there pilot training and/or testing improvements that would mitigate the gaps?
 - v. Are there actions by professional standards groups or other airline or union actions that would mitigate the gaps?
 - vi. Are there training or other improvements for AMEs that would mitigate the gaps?

Recommendation Report. If the Pilot Fitness ARC identifies that there are gaps, it shall make recommendations that may be used by the FAA to improve the emotional and mental health training and certification of pilots in the United States and any improvements to aircraft design. The report should include:

- a. An explanation of the data and research found as a result of the tasks
- b. Proposed mitigation of identified risks for aircraft design and pilot training and testing
- c. Provide revised regulatory language based on identified gaps
- d. Any additional information the ARC considers, associated with the tasks, that would help the FAA further understand the recommendation
- e. Estimated costs associated with improvements to aircraft design and pilot training and testing

4. ARC PROCEDURES.

- a. The Pilot Fitness ARC acts solely in an advisory capacity by advising and providing written recommendations to the Associate Administrator for Aviation Safety and the Director of the Office of Rulemaking.
- b. The Pilot Fitness ARC may propose additional tasks as necessary to the Associate Administrator for Aviation Safety for approval.
- c. **Status Reports.** The Pilot Fitness ARC will provide a status update to the Associate Administrator for Aviation Safety every month.
- d. **Recommendation Report.** The Pilot Fitness ARC will submit a report detailing recommendations within six months from the effective date of the charter.
 - i. The Industry Co-Chair sends the recommendation report to the Associate Administrator for Aviation Safety and the Director of the Office of Rulemaking.
 - ii. The Associate Administrator for Aviation Safety determines when the recommendation report is released to the public.
- e. The ARC may reconvene following the submission of the recommendation report for the purposes of providing advice and assistance to the FAA, at the discretion of the Associate Administrator for Aviation Safety, provided the charter is still in effect.

- 5. **ARC ORGANIZATION, MEMBERSHIP, AND ADMINISTRATION.** The FAA will set up a committee of members of the aviation community. Members will be selected based on their familiarity with emotional and mental health, certification analysis and regulatory compliance.

Membership will be balanced in viewpoints, interests, and knowledge of the committee's objectives and scope.

The provisions of the August 13, 2014 Office of Management and Budget guidance, "Revised Guidance on Appointment of Lobbyists to Federal Advisory Committees, Boards, and Commissions" (79 FR 47482), continues the ban on registered lobbyists participating on Agency Boards and Commissions if participating in their "individual capacity." The revised guidance now allows registered lobbyists to participate on Agency Boards and Commissions in a "representative capacity" for the "express purpose of providing a committee with the views of a nongovernmental entity, a recognizable group of persons or nongovernmental entities (an industry, sector, labor unions, or environmental groups, etc.) or state or local government." (For further information see the Lobbying Disclosure Act of 1995 (LDA) as amended, 2 U.S.C 1603, 1604, and 1605.)

The Pilot Fitness ARC membership is limited to promote discussion. Attendance, active participation, and commitment by members is essential for achieving the objectives and tasks. When necessary, the Pilot Fitness ARC may set up specialized and temporary task groups that include at least one Pilot Fitness ARC member and invited subject matter experts from industry and government.

The Pilot Fitness ARC will consist of senior safety officials from the airlines, pilot unions, manufacturers and FAA. A working group, made up of medical experts from the organizations on the ARC, will be established at the same time.

- a. The Associate Administrator for Aviation Safety will:
 - 1) Select and appoint industry and the FAA participants as members to the Pilot Fitness ARC,
 - 2) Select an Industry Co-Chair from the membership of the Pilot Fitness ARC,
 - 3) Select the FAA Co-Chair from the FAA line-of-business,
 - 4) Provide the FAA participation and support from all affected lines-of-business,
 - 5) Provide administrative support for the Pilot Fitness ARC, through the Office of Flight Standards Service and the Office of Aerospace Medicine, and
 - 6) Receive all status reports and the recommendations report.
- b. Once appointed, the Industry Co-Chair will:
 - 1) Coordinate required ARC (and task group, if any) meetings in order to meet the objectives and timelines,
 - 2) Provide notification to the members of the time and place for each meeting,
 - 3) Establish and distribute meeting agendas in a timely manner,
 - 4) Keep meeting notes, if deemed necessary,
 - 5) Perform other responsibilities as required to ensure the objectives are met,
 - 6) Provide status reports in writing to the Associate Administrator for Aviation Safety, and
 - 7) Submit the recommendation report to the Associate Administrator for Aviation Safety.

6. **COST AND COMPENSATION.** The estimated cost to the Federal Government for the Pilot Fitness ARC is approximately \$2,500. All travel costs for government employees are the responsibility of the government employee's organization. Non-government representatives, including the Industry Co-Chair, serve without government compensation and bear all costs related to their participation on the ARC.
7. **PUBLIC PARTICIPATION.** Meetings are not open to the public. Persons or organizations outside the Pilot Fitness ARC who wish to attend a meeting must get approval in advance of the meeting from either the Industry Co-Chair or the FAA Co-Chair.
8. **AVAILABILITY OF RECORDS.** Consistent with the Freedom of Information Act, Title 5, U.S.C., section 552, records, reports, agendas, working papers, and other documents that are made available to or prepared for or by the ARC will be available for public inspection and copying at the FAA Office of Flight Standards Service, 800 Independence Ave SW, Washington, D.C. 20591. Fees will be charged for information furnished to the public according to the fee schedule published in Title 49 of the Code of Federal Regulations, part 7.

You can find this charter on the FAA Committee Database website at:
http://www.faa.gov/regulations_policies/rulemaking/committees/documents/.
9. **DISTRIBUTION.** This charter is distributed to the Office of Flight Standards Service, the Office of Aerospace Medicine, the Office of Aircraft Certification Service, and the Office of Accident Investigation and Prevention, the Office of the Associate Administrator for Aviation Safety, the Office of the Chief Counsel, the Office of Aviation Policy and Plans, and the Office of Rulemaking.
10. **EFFECTIVE DATE AND DURATION.** The Pilot Fitness ARC is effective upon issuance of this charter and will remain in existence for twelve months, unless the charter is sooner suspended, terminated, or extended by the Administrator.

Issued in Washington, D.C. on May 11, 2015.



Michael P. Huerta
Administrator

APPENDIX F—MEDICAL PRIVACY LAWS OVERVIEW

INTRODUCTION

The following report provides a general overview of Federal and state law that bears on the issue of a pilot’s mental fitness for duty.

AMERICANS WITH DISABILITIES ACT (“ADA”)

The ADA provides that “[n]o covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees.”²⁵ To establish a prima facie case of disability discrimination under the ADA, a plaintiff must show that: (1) he is disabled; (2) he is a qualified individual; and (3) he was subjected to unlawful discrimination because of his disability.²⁶

I. Federal medical qualification standards insulate air carriers from ADA liability in cases where pilots have a mental disability.

The highly regulated and stringent qualification standards placed on commercial pilots means that from both a legal and practical standpoint, air carriers have very limited liability under the ADA. The ADA recognizes a defense to liability where: “a challenged action is required or necessitated by another Federal law or regulation, or that another Federal law or regulation prohibits an action (including the provision of a particular reasonable accommodation) that would otherwise be required....”²⁷ The Supreme Court described the relationship between Government mandated standards for physical qualifications and the elements of an ADA claim as follows:

When Congress enacted the ADA, it recognized that Federal safety rules would limit application of the ADA as a matter of law. The Senate Labor and Human Resources Committee Report on the ADA stated that ‘a person with a disability applying for or currently holding a job subject to [DOT standards] must be able to satisfy these physical qualification standards in order to be considered a qualified individual with a disability’ under [the ADA].²⁸

Put simply, a pilot with a mental illness, or other medical condition that will not allow him or her to hold a medical certificate cannot satisfy the qualification element of a prima facie ADA case.²⁹

²⁵ 42 U.S.C.A. § 12112(a).

²⁶ *Holly v. Clairson Indus., L.L.C.*, 492 F.3d 1247, 1255–56 (11th Cir. 2007).

²⁷ 29 C.F.R. § 1630.15(e)

²⁸ *Albertson's, Inc. v. Kirkingburg*, 527 U.S. 555, 573 (1999) (holding that federal safety rules would limit application of the ADA as a matter of law)

²⁹ *Martin v. Lennox Intern. Inc.*, 342 Fed. Appx. 15 (5th Cir. 2009) (Employee, who lacked the required Federal Aviation Administration (FAA) certification, failed to establish that he was qualified for pilot position with employer, as required to establish prima case that his termination violated the ADA); *Johnson v. Board of Trustees of Boundary County School Dist. No. 101*, 666 F.3d 561 (9th Cir. 2011) (Teacher who failed to complete professional development training required for renewal of her teaching certificate because of major depressive episode was not qualified for a teaching position, and thus the school district's board of trustees was not required by the ADA to accommodate the teacher's disability); *Levinger v. Mercy Medical Center, Nampa*, 75 P.3d 1202 (Idaho

Moreover, under the ADA a “[q]ualified individual with a disability means an individual with a disability who satisfies the requisite skill, experience, education and other job-related requirements of the employment position such individual holds or desires, and who, with or without reasonable accommodation, can perform the essential functions of such position.”³⁰ “Essential functions” are defined as the “fundamental job duties of the employment position the individual with a disability holds or desires.”³¹ It can therefore be argued that passing an appropriate FAA medical exam and holding an airman’s medical certificate are essential functions of any commercial pilot’s job. Thus, a pilot with a mental disability that would prevent him from holding an airman’s medical certificate cannot perform an essential function and is not qualified.³²

II. The ADA contains confidentiality provisions.

Like the myriad of state and federal laws designed to protect medical privacy, the ADA also contains confidentiality provisions. The ADA provides that information regarding an applicant or current employee shall be collected and maintained on separate forms and in separate medical files and shall be treated as confidential medical records, except that: (1) supervisors and managers may be informed regarding necessary restrictions on the work or duties of the employee and necessary accommodations; (2) first aid and safety personnel may be informed when appropriate, if the disability might require emergency medical treatment; and (3) government officials investigating compliance with the ADA shall be provided relevant information on request.³³

At present, the courts are divided on whether a plaintiff seeking relief under the ADA for misuse of medical information must also demonstrate that he is a qualified individual with a disability. The courts holding that no cause of action exists unless the plaintiff is qualified with a disability have relied mainly on plain text interpretations of the statute that require the employer to misuse the collected information to discriminate on the basis of a disability.³⁴ In contrast, the courts that disagree conclude that the plain text reading makes little sense because requiring a plaintiff to

2003) (An anesthesiologist whose medical privileges and medical license were suspended was not a “qualified individual with a disability” for the purposes of the ADA).

³⁰ 29 CFR § 1630.2(m)

³¹ 29 CFR § 1630.2(n) (1)

³² *Jones v. Nationwide Life Ins. Co.*, 696 F.3d 78 (1st Cir. 2012) (Holding a registered investment advisor license, as required to sell securities products offered by employer, was an essential function of the employee’s job); (Holding a commercial driver’s license and passing the Department of Transportation (DOT) medical examination were essential functions of a technician position conditionally offered to a job applicant); *Knutson v. Schwan’s Home Serv., Inc.*, 870 F. Supp. 2d 685, 691 (D. Minn. 2012) *aff’d*, 711 F.3d 911 (8th Cir. 2013) (Holding that DOT qualification to drive delivery trucks was an essential function of the job).

³³ 42 U.S.C.A. § 12112(d)(3), 29 C.F.R. § 1630.14(b)(1) (applicants); 29 C.F.R. § 1630.14(c) (current employees).

³⁴ *Wetherbee v. Southern Co.*, 754 F.3d 901, 904 (11th Cir. 2014) (Joining the Seventh and Tenth Circuits in holding that an individual seeking relief under § 12112(d)(3)(C) must demonstrate that he is a qualified individual with a disability); *O’Neal v. City of New Albany*, 293 F.3d 998, 1010 n. 2 (7th Cir.2002) (“If the applicant is not disabled, ... then the applicant cannot recover under § 12112(d)(3)(C).”); *Garrison v. Baker Hughes Oilfield Operations, Inc.*, 287 F.3d 955, 960 n. 4 (10th Cir.2002) (“[T]o recover under subsection 12112(d)(3)(C) a plaintiff must show the employer used collected medical information to discriminate on the basis of a disability.”)

show that he is qualified with a disability would completely negate the privacy protections written into the ADA.³⁵

Although the courts are currently split, any employee involved in the review or handling of personal health information at any stage of a pilot's career should take great care to ensure that the information is kept confidential. While it is most likely that an air carrier will come into possession of a pilot's personal health information as part of a fitness for duty process, however it happens, the air carrier should ensure that the information is sealed off in a secure location and that only a small defined group with a need to know should have access. These steps will mitigate any risk that the pilot's personal health information will be used inappropriately.

FAMILY MEDICAL LEAVE ACT OF 1993

The Family and Medical Leave Act of 1993 (FMLA) provides eligible employees with up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons. FMLA is also intended to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women.

FMLA applies to all public agencies, all public and private elementary and secondary schools, and companies with 50 or more employees. The foregoing employers must provide an eligible employee with up to 12 weeks of unpaid leave each year for any of the following reasons: (1) for the birth and care of the newborn child of an employee; (2) for placement with the employee of a child for adoption or foster care; (3) to care for an immediate family member (spouse, child, or parent) with a serious health condition; (4) when the employee is unable to work because of a serious health condition; or (5) because of an exigency arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on covered active duty in the armed forces.³⁶

Unique eligibility requirements apply to pilots, flight attendants, and other crewmembers. The Airline Flight Crew Technical Corrections Act of 2009 modified the original legislation to provide that an air carrier flightcrew member is eligible for FMLA leave if he or she has worked (1) at least 504 hours during the previous 12-month period for the employer and (2) at least 60 percent of the minimum number of hours that the employee was scheduled to work in any given month or, for an employee who is in "reserve status," at least 60 percent of the hours that an employee was paid for any given month. The hours that a flightcrew member works include not only the hours spent in flight, but also the hours that a crewmember is on duty.³⁷

In cases where a pilot is suffering from depression or other serious mental health condition, the protections offered by FMLA may make the affected individual more inclined to temporarily cease flying in order to seek appropriate assistance. On the other hand, certain FMLA eligibility

³⁵ *Fredenburg v. Contra Costa County Dep't of Health Servs.*, 172 F.3d 1176, 1182 (9th Cir.1999) (requiring plaintiffs to prove that they have disabilities would defeat the privacy protections set forth in the ADA); *Cossette v. Minnesota Power & Light*, 188 F.3d 964, 969 (8th Cir. 1999) (holding that "to required proof of disability would obliterate much of [the confidentiality provisions] usefulness.").

³⁶ See 29 U.S.C.A. § 2601(a)(1).

³⁷ PL 111-119, December 21, 2009, 123 Stat 3476. See also 29 U.S.C. 2611(2)(D).

requirements may have the effect of deterring or preventing individuals from taking leave to address personal health issues. For example, employees may be reluctant to pursue FMLA leave because of real or perceived uncertainty as to whether a mental health condition rises to the level of a “serious health condition” under FMLA.³⁸ Another potential inhibiting consideration is that a portion of an employing air carrier’s pilot population may be ineligible for FMLA; a pilot who does not qualify for FMLA leave and is not otherwise afforded similar protection from his or her employer may choose to refrain from seeking treatment for a mental health condition out of fear of compromising his or her employment status. Notwithstanding the potential impact on non-qualifying individuals who are unable to work because of a serious medical condition or other enumerated reason under the statute, Congress recognized the entitlements provided under FMLA must be balanced against “the legitimate interests of employers.”³⁹ Accordingly, the statute was intentionally crafted to limit an employer’s obligations under FMLA to full-time employees who have demonstrated a commitment to the organization by meeting the time and hour threshold requirements.⁴⁰ Any future efforts to modify the statute to relax the prescribed eligibility requirements could prove burdensome and costly to employers.

AVIATION AND TRANSPORTATION SECURITY ACT

The Aviation and Transportation Security Act (ATSA) provides that any air carrier or any employee of an air carrier who makes a voluntary disclosure of any suspicious transaction relevant to a possible violation of law or regulation, relating to air piracy, a threat to aircraft or passenger safety, or terrorism to any employee or agent of the Department of Transportation, the Department of Justice, any Federal, State, or local law enforcement officer, or any airport or air carrier security officer shall not be civilly liable to any person under any law or regulation of the United States, any constitution, law, or regulation of any State or political subdivision of any State, for such disclosure. Immunity under the ATSA is not available, however, if (1) the disclosure was made with actual knowledge that the disclosure was false, inaccurate, or misleading, or (2) the disclosure was made with reckless disregard as to the truth or falsity of that disclosure.⁴¹

The immunity offered by the ATSA may provide an incentive for air carrier personnel to report an individual who they believe, because of a mental condition or otherwise, poses an immediate threat to the safety of the traveling public. While ATSA has not been extensively tested or challenged, two relatively recent Federal cases affirm the notion that reporting threats to passenger safety without fear of liability override the growing trend to protect personal reputations and privacy interests.

Air Wisconsin Airlines Corp. v. Hoepfer involved a pilot who reacted angrily after repeatedly failing required simulator training. Considering the pilot’s outburst, as well as his impending termination and the potential he might be armed by virtue of being a Federal Flight Deck Officer,

³⁸ See e.g., *Price v. City of Fort Wayne*, 117 F.3d 1022 (7th Cir. 1997) (finding that that job-related stress manifesting itself in physical symptoms may constitute a serious medical condition under the FMLA). *But see e.g., Deleva v. Real Estate Mortgage Corp.*, No. 1:04cv1299 (N.D. Ohio June 21, 2007) (finding that stress, without any evidence of mental illness cannot constitute a serious health condition under FMLA).

³⁹ 29 USCA § 2601(b)(4).

⁴⁰ 29 U.S.C. 2611(2)(D).

⁴¹ 49 U.S.C.A. § 44941(b).

the air carrier decided to notify the Transportation Security Administration (TSA). The TSA detained, searched and questioned the pilot upon his arrival at the airport to board a flight home. The pilot subsequently sued Air Wisconsin for defamation. After a verdict in the pilot's favor at jury trial, the pilot recovered a judgment for more than \$1 million in compensatory and punitive damages against the air carrier. The case was appealed all the way to the Supreme Court, where the damages award was vacated. The court upheld the application of ATSA immunity after finding that the statements by the air carrier employee were substantially true.⁴²

Another relevant case recently was decided by the Second Circuit. In *Baez v. JetBlue Airways Corp.*, an air carrier passenger who made reference to a hypothetical bomb in her checked luggage, which had been loaded onto an airplane that the passenger was not permitted to board, brought action against the air carrier and an air carrier employee, alleging negligence, defamation, false arrest, and intentional infliction of emotional distress, in connection with employee's relaying of the passenger's statements and passenger's subsequent arrest. The court held that: (1) the air carrier employee and the air carrier were entitled to immunity under the ATSA, and (2) the employee was not stripped of ATSA immunity by the fact that she initially relayed passenger's statements to her supervisor, rather than to law enforcement.⁴³

HEALTH INSURANCE AND PORTABILITY ACCOUNTABILITY ACT

The protection and exchange of health-related information is controlled to a large extent by the Health Insurance Portability and Accountability Act (HIPAA).⁴⁴ HIPAA, among other things, addresses the rights of individuals with regard to their protected health information, the procedures by which individuals may exercise these rights, and how protected health information may be used and disclosed.⁴⁵ While HIPAA provides Federal protections for health information held by health providers and gives patients an array of rights with respect to that information, it also considers and balances the need in certain instances to disclose health information to protect the interests of individuals and the public.

HIPAA applies to covered entities that include the following groups: (1) health care clearinghouses, (2) health plans, and (3) health care providers that conduct certain transactions in electronic form. As a general rule, a covered entity must obtain an individual's written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations.⁴⁶

Absent express written authorization from an individual, HIPAA regulations permit covered entities to disclose personal health information to third parties in twelve narrowly defined categories aimed at advancing national priority purposes.⁴⁷ The twelve categories include:

⁴² See *Air Wisconsin Airlines Corp. v. Hoepfer*, 134 S. Ct. 852, 187 L. Ed. 2d 744 (2014), 134 S. Ct. 1575, 188 L. Ed. 2d 582 (2014).

⁴³ See generally *Baez v. JetBlue Airways Corp.*, 793 F.3d 269 (2d Cir. 2015).

⁴⁴ PL 104-191, August 21, 1996, 110 Stat 1936 (codified at 42 U.S.C. §§ 1320d-1320d-8).

⁴⁵ See 45 CFR Part 164.

⁴⁶ 45 C.F.R. § 164.508. Assuming an aviation medical examiner, as a representative of the Federal Aviation Administration, is considered a covered entity, he or she is required to treat a pilot/patient's medical information in accordance with the requirements of HIPAA regulations, in addition to any applicable FAA-imposed obligations.

⁴⁷ 45 C.F.R. § 164.512.

(1) uses and disclosures required by law; (2) uses and disclosures for public health activities; (3) disclosures about victims of abuse, neglect or domestic violence; (4) uses and disclosures for health oversight activities; (5) disclosures for judicial and administrative proceedings; (6) disclosures for law enforcement purposes; (7) uses and disclosures about decedents; (8) uses and disclosures for cadaveric organ, eye or tissue donation purposes; (9) uses and disclosures for research purposes; (10) uses and disclosures to avert a serious threat to health or safety; (11) uses and disclosures for specialized government functions; and (12) disclosures for workers' compensation.⁴⁸

When discussing pilot fitness, the tenth category—uses and disclosures to avert a serious threat to health or safety— is pertinent while the others have little or no relevance. Under the health or safety category, a health provider may use or disclose protected health information if the provider in good faith believes the use or disclosure (1) is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and (2) is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.⁴⁹ This may include, depending on the circumstances, disclosure to law enforcement, family members, the target of the threat, or others who the covered entity has a good faith belief can mitigate the threat. For example, if a provider knows a patient is not taking medication as prescribed and without the medication the patient is at an increased risk of suicide, then the provider may disclose this information to a family member or friend who is in a position to avert the threat, if the provider has a good faith belief that disclosure is necessary to prevent or lessen the threat of harm to the health or safety of the patient. Another example, specific to the aviation industry, is if a provider has a good faith belief that a pilot/patient intends to commit an act that compromises the safety of the traveling public. While the appropriate recipient of the disclosure will depend on the specific facts and circumstances, the employing air carrier may be best suited to take immediate action to prevent or lessen the threat (by relieving the individual of flying duties, restricting access to secured areas, etc.).

A disclosure to avert a serious threat is a permitted disclosure—not a required disclosure—under HIPAA, but State law may impose affirmative reporting requirements on health providers. HIPAA rules are consistent with (but do not affirmatively prescribe) the “duty to warn” third persons at risk, which has been established through case law.⁵⁰ In *Tarasoff v. Regents of the Univ. of California*, the Supreme Court of California found that when a therapist’s patient had made credible threats against the physical safety of a specific person, the therapist had an obligation to use reasonable care to protect the intended victim of his patient against danger, including warning the victim of the danger.⁵¹ Many states have adopted, through either statutory or case law, versions of the Tarasoff duty to warn. While HIPAA rules are not intended to create a duty to warn or disclose, they also do not prohibit states from imposing mandatory disclosure requirements.⁵² Accordingly, covered entities must remain cognizant of the state law disclosure requirements that may vary from HIPAA rules.

⁴⁸ *Id.*

⁴⁹ 45 CFR § 164.512(j)(1).

⁵⁰ 65 Fed. Reg. 82538 (Dec. 28, 2000).

⁵¹ *Tarasoff v. Regents of Univ. of California*, 17 Cal.3d 425 (1976).

⁵² 65 Fed. Reg. 82538 (Dec. 28, 2000).

Medical Information Privacy under State Law

I. Introduction

The protection of medical information privacy under state law varies widely and lacks uniformity. The public policy underlying the protection of medical information is rooted in the patient-physician privilege, which seeks to serve the patient's best interests through open and candid disclosure of personal health information. Because of this strong policy concern, employers and third-party medical providers encounter not only strong federal protections surrounding personal health information (for example, HIPAA⁵³) but a broad landscape of State law protections.

An exhaustive analysis of potential State law claims for the unlawful disclosure of personal health information is beyond the scope of this report because of the vast geographical diversity among pilot residences, third party medical providers, and employer domiciles. The purpose of this report is to provide the reader with a general understanding of how state law may prevent or impede a medical professional from disclosing an employee's personal medical information to an employer, regulatory agency, or law enforcement; or may encourage or require disclosure and reporting.

Under State law, claims for the unlawful disclosure of personal medical information may be founded upon state constitutions, common law causes of action, and state statutes. Statutory claims may be brought under statutes that specifically protect mental health records, medical records generally, privacy rights, and a mental health provider's duty to protect or warn.

II. State Constitutions

Unlike the United States Constitution, many State constitutions explicitly recognize a right to privacy.⁵⁴ In the absence of governmental action, however, it is unlikely that an employee would prevail in a state constitutional claim for unlawful disclosure of personal information.⁵⁵ California, however, recognizes a private constitutional right of action against a private entity as well as the government.⁵⁶

III. Common Law Actions

The unlawful disclosure of an individual's personal health information may also give rise to common law actions. Examples of such actions include the following:

- Invasion of privacy,⁵⁷
- Breach of duty of confidentiality,⁵⁸

⁵³ Health Insurance and Portability Accountability Act of 1996, 42 U.S.C. 1320d *et seq.*

⁵⁴ Shaman, *Right of Privacy In State Constitutional Law*, Rutgers Law Journal Vol. 37:971,988; *see, e.g.* ILCS Const. Art. 1 § 6 (Illinois); West's F.S.A. Const. Art. 1 § 23 (Florida); West's Ann.Cal.Const.Art. 1, §1 (California); *People v. Stritzinger*, 34 Cal.3d 505, 511 (1983)(Patient-psychotherapist privilege is part of a patient's constitutional right to privacy).

⁵⁵ *See, e.g. Kelly v. Mercoird Corp.*, 776 F. Supp. 1246(N.D. Ill. 1991).

⁵⁶ *Hill v. National Collegiate Athletic Association*, 7 Cal.4th 1, 16 (1994).

⁵⁷ *See, e.g., Darcangelo v. Verizon Commc'ns, Inc.*, 292 F.3d 181, 186 (4th Cir. 2002)(disclosure of medical information where employer sought to declare employee a "direct threat" to co-workers).

- Publicity of private facts,⁵⁹
- Wrongful disclosure of medical information,⁶⁰ and
- Intentional and negligent infliction of emotional distress.⁶¹

Meeting evidentiary burdens and individual State pleading requirements will ultimately determine an employee's success in prevailing on a common law action rooted in an unlawful disclosure of personal medical information. To the extent that the existence of common law actions would have a chilling effect on a medical provider's disclosure of personal medical information to an employer, regulatory agency, or law enforcement is uncertain.

IV. State Statutes

A likely ground for bringing a claim based on an alleged unlawful disclosure of personal medical information would be for violation of a State statute, or such a claim may be brought in conjunction with other state law claims. There is considerable variation among statutory protections. Broadly speaking, statutory protections can be broken down as follows:

- Mental health information statutes;
- Medical records statutes;
- Right to privacy statutes; and
- Duty to protect or warn statutes.

A. Federal Preemption – HIPAA & Railway Labor Act

As a threshold matter, the question arises whether federal law would preempt a State law claim. In the context of the ARC, two questions arise with respect to an alleged unlawful disclosure of personal medical information: (1) whether HIPAA would preempt a State law claim; and (2) whether the Railway Labor Act⁶² would preempt a State law claim where a collective bargaining agreement (CBA) is in place.

⁵⁸ See, e.g., *Byrne v. Avery Ctr. for Obstetrics & Gynecology, P.C.*, 314 Conn. 433, 102 A.3d 32 (2014)(breach of duty alleged against health care provider for complying with subpoena).

⁵⁹ *Davis v. Monsanto*, 627 F.Supp. 418 (S.D. W.Va. 1986)(employer's limited disclosure of information insufficient to constitute publication necessary to establish cause of action for public disclosure of private facts).

⁶⁰ See, e.g., *R.K. v. St. Mary's Med. Ctr., Inc.*, 229 W. Va. 712, 721, 735 S.E.2d 715, 724 (2012) (common-law tort claims based upon the wrongful disclosure of medical or personal health information not preempted by HIPAA).

⁶¹ See, e.g., *Fanean v. Rite Aid Corporation of Delaware, Inc.*, 984 A.2d 812 (Del. 2009)(allegations in complaint sufficient to allege common law action for intentional and negligent infliction of emotional distress related to providing sensitive medical information to third party).

⁶² 45 U.S.C § 151 et seq.

HIPAA and its regulatory progeny expressly recognize that it may not entirely preempt State law.⁶³ “[I]f ... [t]he provision of State law relates to the privacy of individually identifiable health information and is more stringent than a standard, requirement, or implementation specification adopted under [HIPAA],” HIPAA will be preempted.⁶⁴ Accordingly, a case-by-case analysis is necessary to determine if a State law claim is preempted by HIPAA.

Where a collective bargaining agreement is in place, the RLA may preempt a State law claim against an employer. In *Carmack v. National R.R. Passenger Corp.*, a railroad engineer alleged, among other things, an invasion of privacy based upon his employer’s request for a comprehensive psychiatric evaluation and psychological testing.⁶⁵ The court held that the RLA preempted the employee’s claim because his employer’s right to demand the evaluation and testing “hinge[d] upon” an interpretation of the CBA.⁶⁶ Discussing RLA preemption generally, the court stated that if a plaintiff’s claim is tantamount to a minor dispute, it must be resolved only through the “mechanisms established by the RLA.”⁶⁷ If, however, a claim involves rights and obligations that exist independent of the CBA, the RLA will not preempt the State law claim.⁶⁸ Accordingly, a fact-intensive inquiry will be required to determine whether a state law claim is preempted by the RLA.

B. Mental Health Information Statutes

Some States expressly protect mental health information from disclosure.⁶⁹ For example, the Texas Mental Health Records statute provides, in part, as follows:

“(a) Communications between a patient and a professional, and records of the identity, diagnosis, evaluation, or treatment of a patient that are created or maintained by a professional, are confidential.

(b) Confidential communications or records may not be disclosed except as provided by Section 611.004 or 611.0045.

(c) This section applies regardless of when the patient received services from a professional.”⁷⁰

⁶³ 42 U.S.C. § 1320d-7(a); 45 C.F.R. § 160.203.

⁶⁴ *See*, 45 C.F.R. § 160.203; *see, e.g., Nat’l Abortion Fed’n v. Ashcroft*, No. 03 CIV. 8695 (RCC), 2004 WL 555701, at *3 (S.D.N.Y. Mar. 19, 2004)(State law did not control under Federal question jurisdiction but would control in a State proceeding)

⁶⁵ *Carmack v. National Railroad Passenger Corporation*, 486 F.Supp.2d 58 (D.Mass 2007).

⁶⁶ *Carmack*, 486 F.Supp. at 80.

⁶⁷ *Carmack*, 486 F.Supp. at 75.

⁶⁸ *Carmack*, 486 F.Supp. at 74, *citing, Hawaiian Airlines v. Norris*, 512 U.S. 246, 261 (1994).

⁶⁹ *See, e.g.* V.T.C.A. Health & Safety Code § 611 et seq. (Texas); MD Code, Health § 4-302 and 4-307 (Maryland); IC 16-39-2-3 (Indiana); 50 P.S. §7111 (Pennsylvania); SDCL §27A-12-26 (South Dakota).

⁷⁰ Tex. Health & Safety Code Ann. § 611.002 (West)

The Texas statute does enumerate a list of exceptions to the general prohibition under certain circumstances.⁷¹ Two notable exceptions are when the patient consents to disclosure, or a disclosure to medical or law enforcement personnel if the professional determines that there is “a probability of imminent physical injury by the patient to the patient or others or there is a probability of immediate mental or emotional injury to the patient.”⁷²

C. Medical Records Statutes

Some states provide broad statutory protections to medical records generally, which may encompass mental health information.⁷³ For example, in *Pettus v. Cole*, an employer and two employer-hired psychiatrists violated California’s Confidentiality of Medical Information Act for the unauthorized release of medical information in conjunction with an employee’s request for disability leave.⁷⁴ The psychiatrists violated the CMIA when they provided the employer with detailed reports of the employee’s psychiatric evaluations.⁷⁵

D. Right to Privacy Statutes

In addition to statutes that protect mental health information and medical records generally, a claim may also be brought under a general right to privacy statute.⁷⁶ In *Kornved v. Advanced Healthcare, S.C.*, a lab technician accessed a patient’s medical records and then disclosed information to her husband. The plaintiff filed suit against the health care provider and lab technician alleging, among other things, that Wisconsin’s general privacy statute was violated. The court ultimately ruled in favor of the health care provider on the ground that the lab technician was not acting within her scope of employment, but commented that the plaintiff may have a viable claim against the lab technician.⁷⁷

E. Duty to Protect or Warn Statutes

In the seminal *Tarasoff v. Regents of Univ. of California*, the California Supreme Court held that when a psychotherapist determines that his patient presents a serious danger of violence to another, he has a duty to protect the intended victim against such danger.⁷⁸ In response to the *Tarasoff* decision, many states, including California, enacted statutes that addressed a psychotherapist’s obligation to warn or protect third parties. For example, the California statute provides limited immunity from monetary liability where a psychotherapist fails to protect “from a patient’s threatened violent behavior or failing to predict and protect from a patient’s

⁷¹ V.T.C.A., Health & Safety Code § 611.004 et seq.

⁷² V.T.C.A., Health & Safety Code § 611.004(2)(4).

⁷³ See, e.g., 735 ILCS 5/8-802 (Illinois); Cal. Civ. Code §56.10 (California); 49 Pa. Code § 25.213 (Pennsylvania).

⁷⁴ *Pettus v. Cole*, 49 Cal.App.4th 402, as modified on denial of reh’g (1996).

⁷⁵ *Pettus*, 49 Cal.App.4th at 425.

⁷⁶ See, e.g., W.S.A 995-50 (Wisconsin); R.I. Gen. Laws 1956 § 9-1-28(a)(3)(Rhode Island).

⁷⁷ *Kornved v. Advanced Healthcare, S.C.*, 286 Wi.2d 499, 513 (2005); see also, *Lisnoff v. Stein*, 925 F.Supp.2d 233 (D. R.I. 2013)(A physician’s use of a patient’s medical information for a book stated the claim for violation of right to privacy under State statute).

⁷⁸ *Tarasoff v. Regents of Univ. of California*, 17 Cal.3d 425 (1976).

violent behavior *except* if the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.” (Emphasis added.)⁷⁹

Although variability exists between and among the various State statutes, they can generally be divided into those that (1) impose an affirmative duty⁸⁰; or (2) are permissive.^{81 82} Additionally, a few states have not enacted Tarasoff statutes, and one state found the Tarasoff rationale “unpersuasive.”⁸³ It should be noted, however, that even among jurisdictions with a like-kind statute (for example, affirmative duty), variations exist. Therefore, before considering a statute’s effect within a particular jurisdiction, a careful reading of the applicable statute and its interpretive case law is essential.

Two examples, one from an affirmative duty jurisdiction and another from a permissive jurisdiction, illustrate how state courts have interpreted their Tarasoff statutes. In Colorado, a mental health provider is “not liable for damages in any civil action for failure to warn or protect a specific person or person ... against the violent behavior of a person receiving treatment ... except where the patient has communicated to the mental health provider a serious threat of imminent physical violence against a specific person.” (Emphasis added).⁸⁴

Interpreting its statute, Colorado courts have held that a health care provider had no duty to warn where a patient reported suicidal thoughts and ultimately committed suicide⁸⁵ and a patient’s communicating of thoughts and homicidal fantasies without stating an intent to act did not constitute to a threat.⁸⁶ The court did find that the “imminent threat” requirement was satisfied when a patient called his psychologist in the middle of the night, and told him about his strong negative feelings toward his supervisor and expressed concern that he might not be able to control his anger.⁸⁷ Similarly, a California court held that a psychotherapist had no duty to warn, in the absence of concrete threats of violence, victims who were injured during a shooting spree by a deranged gunman who subsequently committed suicide.⁸⁸

In Texas, a state with a permissive-type Tarasoff statute, the Supreme Court refused to impose a common-law duty on mental health professionals to warn third parties of their patient’s threat.⁸⁹ In reaching its conclusion, the court considered the Legislature’s intent to protect from disclosure communications during the course of mental health treatment, except in the narrow

⁷⁹ Cal.Civ.Code § 43.92 (West).

⁸⁰ See, e.g., Colo. Rev. Stat. Ann. § 13-21-117 (West)(Colorado); Cal. Civ. Code Ann. § 43.92 (California); M.C.L.A 330.1946 (Michigan); N.H. Rev. Stat. § 329-B:29 (New Hampshire).

⁸¹ See, e.g., V.T.C.A, Health & Safety Code § 611.004(a)(2)(Texas); 740 ILCS 110/11 (Illinois).

⁸² Herbert & Young, *Tarasoff at Twenty-Five*, J Am Acad Psychiatry Law 30:275-81 (2002)

⁸³ *Nasser v. Parker*, 249 Va. 172 (1995)(Absent control, there is no duty to warn a victim of possible harm), distinguished by *Delk v. Columbia/HCA HealthCare Corp.* 259 Va. 125 (2000).

⁸⁴ Colo. Rev. Stat. Ann. § 13-21-117 (West).

⁸⁵ *Sheron v. Lutheran Medical Ctr.*, 18 P.3d 796, 800 (Colo.App. 2000)(The statute applies only to threats directed to third persons).

⁸⁶ *Fredericks v. Koehn*, No. 06-CV-00957-MSK-KLM, 2009 WL 765876, at *4 (D. Colo. Mar. 20, 2009) *aff’d sub nom. Fredericks v. Jonsson*, 609 F.3d 1096 (10th Cir. 2010)

⁸⁷ *McCarty v. Kaiser-Hill Co.*, 15 P.3d 1122, 1125 (Colo.App. 2000); see also, *People v. Kailey*, 333 P.3d 89, 98 (2014)(Non-threatening statements remain privileged).

⁸⁸ *Calderon v. Glick*, 131 Cal.App.4th 224 (2005)

⁸⁹ *Thapar v. Zezulka*, 994 S.W.2d 635, 640 (Tex. 1999).

circumstance, among others not relevant to the discussion here, where the professional determines that “there is a probability of imminent physical injury by the patient/client.”⁹⁰ The court rejected the notion that the statute imposed a mandatory duty on mental health professionals to disclose threats by patients. The court stated that it was permissive.⁹¹

In the context of the ARC, and based upon a cursory examination of Tarasoff statutes, it is unlikely, regardless of jurisdiction, that merely communicating thoughts of depression or suicide to a mental health provider would trigger either an affirmative or permissive duty to warn or protect third parties. Moreover, as pointed out in *Thapar*, and is likely elsewhere, mental health professionals find themselves between two competing interests: (1) disclose a confidential communication that proves to be a hollow threat and risk liability to the patient; or (2) fail to disclose a confidential communication that later proves to be a credible threat and incur liability to the victim and the victim’s family.⁹²

⁹⁰ *Thapar*, 994 S.W.2d at 639, *citing*, Texas Health & Safety Code §611.004(a)(2).

⁹¹ *Thapar*, 994 S.W.2d at 639.

⁹² *Thapar*, 994 S.W.2d at 640.