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The Legal Consequences of Undisclosed Medical Conditions on Aircraft Operator Liability

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**THE LEGAL CONSEQUENCES OF UNDISCLOSED
MEDICAL CONDITIONS ON AIRCRAFT
OPERATOR LIABILITY**

DOUGLAS H. AMSTER*

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I. INTRODUCTION

AVIATION IS A UNIQUE undertaking that presents a multitude of risks and the potential for catastrophic consequences when problems arise during flight. It is an undertaking that requires the coordination of many people and many disciplines. The ultimate responsibility, however, for the safety of every flight lies with the pilot in command (PIC). One aspect of this heavy responsibility is the set of requirements for pilots to be licensed, to maintain currency, and to ensure that they meet the physical and mental requirements necessary, both to obtain and maintain their licenses and to execute their assigned duties.

Like most areas of aviation law, the legal consequences of a pilot's failure to disclose a medical condition involve fact-sensitive investigations, and they are dependent upon which state's substantive laws apply to the issues presented. For example, a pilot who is in perfect physical condition but allows his or her medical certificate to lapse may lose insurance coverage in one state but not another under the same set of circumstances, even if the crash was caused by a mechanical failure or a factor that is

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unrelated to his or her medical certificate. The same pilot might be foreclosed, as a matter of law, from pursuing a third-party claim in a state where a violation of a statute or regulation is deemed negligence per se. Likewise, in the insurance coverage context, a pilot's failure to disclose a medical condition might void or suspend his policy in states that do not require a causal connection between the misrepresentation and the loss.

This article will explore three principal topics. First, it will address the regulatory framework that governs how pilots obtain and maintain their medical certificates and what types of conditions or events trigger the obligation to report or to ground oneself. Second, it will discuss legal issues arising out of a pilot's failure to disclose a medical condition that would affect the validity of his or her medical certificate and/or ability to pilot an aircraft. Third, it will raise questions regarding the magnitude of the problem and discuss policy considerations arising out of the current regulatory framework, which substantially relies upon the pilot to candidly self-report.

II. THE REGULATORY FRAMEWORK

In order to operate an aircraft legally, one must possess a valid pilot certificate and a valid airman medical certificate for flight.¹ The Federal Aviation Administration (FAA) requires that a pilot periodically renew his or her medical certificate in order to ensure that the pilot satisfies current FAA medical requirements and that he or she is medically fit for the rigors of flight.² The grade or "class" of a medical certificate depends upon the type of operation undertaken by the pilot.³ For example, a "first-class medical certificate" is required to exercise the privileges of the "airline transport pilot" license, whereas a "third-class medical certificate" is required to exercise the privileges of a private pilot or student pilot.⁴ The duration of the medical certificate also varies depending on the age of the pilot and the type of operation being conducted.⁵

FAA medical certificates are obtained from a designated aviation medical examiner (AME), who conducts the periodic medi-

¹ Requirements for Certificates, Ratings, and Authorizations, 14 C.F.R. § 61.3(a)-(c) (2011).

² FAA, AERONAUTICAL INFORMATION MANUAL: OFFICIAL GUIDE TO BASIC FLIGHT INFORMATION AND ATC PROCEDURES ch. 8, § 1-1 (2012) [hereinafter FAA AIM].

³ Medical Certificates: Requirement and Duration, 14 C.F.R. § 61.23 (2011).

⁴ *Id.* § 61.23(a).

⁵ *Id.* § 61.23(d).

cal evaluations depending upon the type of certificate sought.⁶ The evaluation begins when the pilot completes an application form for the medical certificate (FAA Form 8500-8).⁷ FAA Form 8500-8 requires the pilot to disclose information about, *inter alia*, medical history, medical conditions, medications, alcohol or substance abuse, hospitalizations, and visits to healthcare professionals.⁸ The form also requires the disclosure of convictions relating to driving while under the influence of alcohol or drugs and the impairment of one's driver's license.⁹ The application contains a questionnaire regarding the applicant's medical history, which is then followed by a medical examination.¹⁰ The medical certificate is issued based upon the results of the exam and medical information provided by the applicant.¹¹ The breadth and scope of the airman medical examination varies, depending on the applicant's responses on the FAA Form 8500-8 and the AME's observations.¹² Most AMEs check blood pressure and pulse, perform a vision test and "a routine urine test,"¹³ but generally do not perform blood tests.¹⁴ Thus, the FAA's medical certificate program relies in large part on the applicant's voluntary self-disclosure of medical information on the applicant form.

The FAA medical applicant form requires a certification from the applicant that the information provided is true and correct to the best of the applicant's knowledge.¹⁵ Federal Aviation Regulations (FARs) prohibit an applicant from making any incorrect, fraudulent, or intentionally false statements on the application for the medical certificate.¹⁶ The FARs declare that an incorrect statement may be the basis for suspension or revocation of the medical certificate, and that a fraudulent or intentionally false statement on a medical application may be the

⁶ FAA AIM, *supra* note 2, ch. 8, § 1-1.

⁷ FAA, FORM NO. 8500-8, APPLICATION FOR AIRMAN MEDICAL CERTIFICATE OR AIRMAN MEDICAL AND STUDENT PILOT CERTIFICATE (1999) [hereinafter FAA FORM 8500-8].

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*; see FAA, GUIDE FOR AVIATION MEDICAL EXAMINERS 46 (2012) [hereinafter AME GUIDE].

¹¹ See AME GUIDE, *supra* note 10, at 46.

¹² See *id.*

¹³ *Id.* at 56, 165, 167, 191.

¹⁴ See *id.*

¹⁵ FAA FORM 8500-8, *supra* note 7.

¹⁶ Applications, Certificates, Logbooks, Reports, and Records: Falsification, Reproduction, or Alteration; Incorrect Statements, 14 C.F.R. § 67.403 (2011).

basis for suspension or revocation of all of the pilot's airman certificates.¹⁷ Nevertheless, despite this prohibition, pilots can, and occasionally do, provide incorrect or false information to the FAA in their applications for medical certificates.¹⁸

Beyond the periodic requirements to obtain and possess a medical certificate, FAA regulations require pilots to monitor and assess their own physical and mental conditions before each flight.¹⁹ The PIC is "the final authority" for determining the safety of flight.²⁰ This broad mandate requires the PIC to ensure that he or she is physically and mentally competent to undertake each flight.²¹ The FARs prohibit flights when a condition is known to the pilot that would render the pilot unable to meet the standards for the required medical certificate.²² These known conditions include both the medical issue itself and the adverse effects of any medication used to address the medical condition.²³ Furthermore, regulations prohibit flight when "under the influence of alcohol," or "[w]hile using any drug that affects the person's faculties in any way contrary to safety."²⁴

In the intervening period between medical exams, pilots are not explicitly required to report to the AME each instance where the pilot is medically unfit for flight.²⁵ However, in many instances, pilots may not have enough information to ascertain whether a particular malady or its treatment may render them unfit for flight.²⁶ In those questionable cases, pilots are directed by the Aeronautical Information Manual (AIM) to contact the FAA or an AME for more guidance.²⁷ The FAA urges pilots to err on the side of caution.²⁸ For example, regarding any illness, the AIM states that "[t]he safest rule is not to fly while suffering from any illness. If this rule is considered too stringent for a

¹⁷ *Id.*

¹⁸ *See, e.g.,* Cooper v. FAA, 622 F.3d 1016, 1025 (9th Cir. 2010), *rev'd*, 132 S. Ct. 1441 (2012).

¹⁹ Prohibition on Operations During Medical Deficiency, 14 C.F.R. § 61.53 (2011).

²⁰ Responsibility and Authority of the Pilot in Command, 14 C.F.R. § 91.3 (2011).

²¹ 14 C.F.R. § 61.53.

²² *Id.*; FAA AIM, *supra* note 2, ch. 8, § 1-1.

²³ 14 C.F.R. § 61.53(a)(1)–(2).

²⁴ Alcohol or Drugs, 14 C.F.R. § 91.17(a) (2011).

²⁵ *See* FAA AIM, *supra* note 2, ch. 8, § 1-1.

²⁶ *See id.* ch. 8, § 1-1(b).

²⁷ *Id.* ch. 8, § 1-1(b)(2).

²⁸ *See id.*

particular illness, the pilot should contact an [AME] for advice.”²⁹ Further, regarding the use of medication, the AIM states that “[t]he [FARs] prohibit pilots from performing crewmember duties while using any medication that affects their faculties in any way contrary to safety. The safest rule is not to fly as a crewmember while taking any medication, unless approved to do so by the FAA.”³⁰

The AIM provides a list, though not exhaustive, of medical conditions that disqualify a pilot from obtaining or maintaining a medical certificate.³¹ These “conditions include personality disorders manifested by overt acts, a psychosis, alcoholism, drug dependence, epilepsy, an unexplained disturbance of consciousness, myocardial infarction, angina pectoris and diabetes requiring medication for its control.”³² Other medical conditions may temporarily disqualify a pilot, “such as acute infections, anemia, and peptic ulcers.”³³ Pilots who suffer from these types of conditions may still qualify “under special issuance provisions or the exemption process,” which may require providing additional medical information and diagnostic testing or conducting practical flight tests.³⁴

The FAA’s “Special Issuance” program provides a process whereby a pilot, whose application has been denied or deferred, is given the opportunity to gather information and present data to the FAA to issue the medical certificate at a later date.³⁵ The decision whether to issue a medical certificate under these circumstances depends upon the medical issue and its treatment, the results of diagnostic tests, and the effect the condition and its treatment have on the airman’s ability to pilot his or her aircraft.³⁶

The AIM provides practical guidance to pilots as to what conditions might constitute a medical deficiency pursuant to 14 C.F.R. § 61.53, such that they are prohibited from acting as a PIC or in any other capacity as a flightcrew member.³⁷ According to the AIM, these types of conditions may include illnesses,

²⁹ *Id.*

³⁰ *Id.* § 1-1(c)(2).

³¹ *See id.* § 1-1(a)(2).

³² *Id.*

³³ *Id.*

³⁴ *Id.*

³⁵ Special Issuance of Medical Certificates, 14 C.F.R. § 67.401 (2011).

³⁶ *Id.*

³⁷ FAA AIM, *supra* note 2, ch. 8, § 1-1(b).

even minor ones, which can seriously degrade the performance of piloting tasks vital to safe flight.³⁸ These illnesses can produce symptoms, such as a fever, that can impair judgment, memory or alertness, and the ability to make calculations.³⁹ Medication, alcohol, fatigue, stress, and emotional issues are all factors that can impair a pilot's performance or make him or her more susceptible to the effects of altitude.⁴⁰

Most recently, the FAA promulgated new regulations entitled "Flightcrew Member Duty and Rest Requirements."⁴¹ These FARs became effective as of January 4, 2012, and they apply to passenger operations conducted by Part 121 operators under Part 91.⁴² The new FARs attempt to address the issue of pilot fatigue and contain the following definitions:

Fatigue means a physiological state of reduced mental or physical performance capability resulting from lack of sleep or increased physical activity that can reduce a flightcrew member's alertness and ability to safely operate an aircraft or perform safety-related duties.

* * *

Fit for duty means physiologically and mentally prepared and capable of performing assigned duties at the highest degree of safety.⁴³

The purpose of the new FARs is to ensure to the extent possible that flightcrew members receive adequate rest prior to flight operations.⁴⁴ "Deadhead transportation" is a defined term, and it classifies this type of transportation as "duty and not rest . . . [f]or purposes of determining the maximum flight duty period."⁴⁵

The new FARs require a flight crew member to report to duty "rested and prepared to perform his or her assigned duties," and they prohibit a certificate holder from assigning (and a flightcrew member from accepting) an assignment "if the flightcrew member" is "too fatigued to safely perform his or her assigned duties."⁴⁶ The FARs also require the certificate holder to

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.* § 1-1(c)-(g).

⁴¹ Flightcrew Member Duty and Rest Requirements, 77 Fed. Reg. 330 (Jan. 4, 2012) (to be codified at 14 C.F.R. pts. 117, 119, 121).

⁴² *Id.* at 338.

⁴³ *Id.* at 330, 398 (emphasis added).

⁴⁴ *Id.* at 330.

⁴⁵ *Id.* at 398.

⁴⁶ *Id.* at 399.

create an FAA-approved “Fatigue Risk Management System” and to provide a “fatigue education and awareness training program.”⁴⁷

These new FARs present both objective and subjective criteria for determining a flightcrew member’s fitness for a particular flight relative to fatigue.⁴⁸ There are objective minimum standards for rest periods and maximum flight time limitations on a per-flight and cumulative basis.⁴⁹ However, if a flightcrew member reports that he or she is “too fatigued to safely perform” the flight duties assigned, then he or she is disqualified from them.⁵⁰ In fact, the new FARs require that “[a]s part of the dispatch or flight release . . . each flightcrew member must affirmatively state he or she is fit for duty prior to commencing flight.”⁵¹

III. LEGAL CONSEQUENCES OF A FAILURE TO DISCLOSE

The legal consequences of a pilot’s failure to disclose a medical condition depend upon the context in which they arise, which include, inter alia, civil litigation, insurance coverage, and even criminal exposure if a pilot knowingly misrepresents his medical status to fraudulently obtain or maintain his pilot’s certificate. As one would expect, the cases are fact specific and are subject to the substantive law of the forum.

In the insurance coverage context, the issue of whether an insurer can disclaim coverage for a claim when the pilot fails to disclose a medical condition requires an analysis of the policy terms, the materiality of the non-disclosure, and whether the underlying condition or failure to disclose is causally related to the claim.⁵² As a threshold matter, however, one must determine which state’s law will apply to the interpretation of the policy and whether that state has statutes and/or case law that govern its interpretation and application.⁵³

For example, some jurisdictions have laws that require that the non-disclosure, misrepresentation, or medical condition be

⁴⁷ *Id.*

⁴⁸ *See id.* at 399–401.

⁴⁹ *See id.*

⁵⁰ *Id.* at 399.

⁵¹ *Id.*

⁵² *See, e.g.,* S.C. Ins. Co. v. Collins, 237 S.E.2d 358, 359–62 (S.C. 1977).

⁵³ For an excellent fifty-state survey of insurance coverage issues in this context, see Jon Kettles & Ashley Sissell, *The Causal Connection Question in Aviation Insurance Coverage*, 75 J. AIR L. & COM. 829 (2010).

causally related to the loss.⁵⁴ On the other hand, the majority of states have no such requirement.⁵⁵ To illustrate, if a pilot fails to disclose type 2 diabetes that is well-controlled with diet and exercise and that has no physical manifestation, would a failure to disclose that condition disqualify the insured from coverage if an ensuing crash was caused by a mechanical breakdown and had nothing to do with the pilot's health or the manner in which the aircraft was piloted? In a state requiring a causal connection, it is likely that the carrier would be compelled to cover the loss, pending expert-intensive litigation over whether the pilot's undisclosed condition was causally related to the loss. In states that do not require a causal connection but instead hold the parties to the strict terms of the policy and the risks underwritten when it was issued, then the insured may very well be disqualified from recovering under the policy.

Likewise, some states have statutes or case law providing that a material misrepresentation or an omission to an insurer in an application for an insurance policy is a disqualifying event.⁵⁶ Other states justify a departure from the terms of the policy by focusing on the reasonable expectations of the insured and in some instances the insurer.⁵⁷ Most jurisdictions will scrutinize the terms of the policy to determine if its provisions are too general or ambiguous to permit a carrier to disclaim coverage, such as an exclusion for the "violation of any [government] regulation," whether or not the violation or regulation has any relation to the loss.⁵⁸

In analyzing a coverage question, a policy is likely to be construed against an insurer and in favor of coverage if its language is deemed ambiguous.⁵⁹ In the case of a pilot who has failed to disclose a medical condition, such that his or her medical certificate would otherwise be invalidated, once the applicable law is determined, then the policy terms must be analyzed to determine if possession of a valid medical certificate is a condition of coverage.⁶⁰

⁵⁴ *Id.* at 832.

⁵⁵ *Id.*

⁵⁶ *Id.* at 837.

⁵⁷ *Id.* at 848-49.

⁵⁸ *Id.* at 858.

⁵⁹ *Id.* at 838-39; see *Woods v. Ins. Co. of N. Am.*, 38 Cal. App. 3d 144, 145-52 (Cal. Ct. App. 1974).

⁶⁰ See *Ins. Co. of N. Am. v. Maurer*, 505 S.W.2d 931, 933 (Tex. Civ. App.—Austin 1974, writ ref'd n.r.e.).

For example, most aviation insurance policies require that pilots be properly certificated as a condition of coverage, which seems self-evident.⁶¹ Historically, what constituted a “properly certificated” pilot was the source of great debate, especially in older policies.⁶² In *Woods v. Insurance Co. of North America*, a pilot allowed his medical certification to lapse twenty-five days prior to a crash, but he was found to be in otherwise exemplary physical condition, having passed all of his prior medical examinations.⁶³ The questions in that case were whether the pilot was properly certificated and rated for flight and whether the lapse in his medical certification justified the carrier’s declination of coverage.⁶⁴ The policy did not expressly state that the pilot was required to have a current medical certificate in order to qualify for coverage, and the California appellate court viewed the lack of such language as creating an ambiguity.⁶⁵ Similarly, in *Insurance Co. of North America v. Maurer*, a Texas appellate court held that an insurance policy requirement that a pilot have a valid pilot’s certificate was not the equivalent of requiring a current medical certificate.⁶⁶ As a result, the court there ruled that coverage was triggered even though the pilot did not possess a current medical certificate.⁶⁷

Other courts have avoided the issue by interpreting the policy provision that a pilot be “properly certificated, qualified, and rated” as requiring an administrative decision rescinding an existing medical certificate before the requirement could be construed in such a manner as to exclude coverage.⁶⁸ In *Mather*, the pilot failed to disclose a significant cardiac condition at his last examination conducted by an AME prior to a fatal crash that killed him and three passengers.⁶⁹ The court refused to “graft” the requirement of a valid medical certificate into the policy and ruled that it lacked jurisdiction to challenge the award of a medical certificate because that type of ruling would be the province of an FAA administrative process.⁷⁰

⁶¹ See, e.g., *id.*

⁶² See, e.g., *Woods*, 38 Cal. App. 3d at 145–52.

⁶³ *Id.* at 146.

⁶⁴ *Id.* at 147.

⁶⁵ *Id.* at 149–52.

⁶⁶ 505 S.W.2d 931, 933 (Tex. Civ. App.—Austin 1974, writ ref’d n.r.e.).

⁶⁷ *Id.* at 932–33.

⁶⁸ See, e.g., *Ins. Co. of Pa. v. Mather*, 37 Pa. D. & C.3d. 115, 117–23 (Pa. Com. Pl. 1985).

⁶⁹ *Id.* at 116, 130.

⁷⁰ *Id.*

As a result, a modern trend developed whereby a clarification was made in the drafting of policy language between a properly certificated, qualified, and rated pilot, as opposed to a pilot having a valid and current medical certificate.⁷¹ Depending upon the type of policy and operation, the modern trend in policies requires pilots to possess: (1) a current and proper medical certificate; and (2) the necessary ratings required by the FAA for each flight.⁷² The court in *U.S. Specialty Insurance Co. v. Skymaster of Virginia, Inc.* upheld the insurer's denial of coverage because the pilot, who survived the crash, failed to disclose diabetes on at least two separate applications for a medical certificate.⁷³ Thus, even a healthy pilot who allows his medical certificate to lapse may very well be disqualified from being covered for a loss at least until such time as he corrects the deficiency.

Once it is determined that the policy requires, *inter alia*, a valid medical certification, battle lines become drawn over whether a causal connection is required between the failure to disclose and the loss.⁷⁴ The first step in addressing this type of situation is to determine whether or not the state in question requires such a causal connection as a pre-requisite for declining coverage.⁷⁵ In states that require a causal connection between the failure to disclose and the loss, the following types of arguments have been made in contravention of the applicable policy terms and in support of requiring a causal connection. First, requiring a causal connection injects an element of materiality into the basis for the declination of coverage, such that it fulfills the reasonable expectations of the insured.⁷⁶ Second, it offsets the unequal bargaining power between the parties.⁷⁷ Third, it injects an element of fairness into the issue of coverage

⁷¹ See *U.S. Specialty Ins. Co. v. Skymaster of Va., Inc.*, 123 F. Supp. 2d 995, 999–1002 (E.D. Va. 2000), *aff'd on other grounds*, 26 F. App'x 154 (4th Cir. 2001).

⁷² See, e.g., *id.* at 998.

⁷³ *Id.* at 999; see also *Ranger Ins. Co. v. Bowie*, 574 S.W.2d 540, 541–42 (Tex. 1978) (where a pilot's failure to disclose a cardiac condition and prescription medication contravened a policy's requirement that he hold "valid and effective pilot and medical certificates").

⁷⁴ See *Skymaster*, 123 F. Supp. 2d at 1002–03.

⁷⁵ See *id.* (determining "that the law in Virginia [did] not require a causal connection").

⁷⁶ *Kettles & Sissell*, *supra* note 53, at 842–49 (citing *S.C. Ins. Co. v. Collins*, 237 S.E.2d 358, 361–62 (S.C. 1977) for the proposition that such a requirement fulfills the reasonable expectations of the insured).

⁷⁷ *Id.* at 849–50.

and avoids forfeitures based upon technicalities.⁷⁸ Fourth, a technical breach of a policy provision that has nothing to do with the loss does not prejudice the carrier or frustrate its reasonable expectations.⁷⁹

Consequently, in states that require a causal connection between the medical condition (i.e., and lack of a valid medical certificate) and the loss, a fact-intensive investigation will be required as to the precise nature of the medical condition, whether it was material to the issuance of the policy, and whether it was a factor in the loss.⁸⁰ This type of dispute inevitably unleashes a battle of medical and technical experts, with attendant *Daubert* and in limine motion practice, to determine if the pilot was suffering from a known undisclosed medical condition that was a causal factor in the crash.⁸¹

By contrast, if the coverage issue is subject to the laws of a state that does not require a causal connection in order for a declination in coverage to be upheld, then the carrier will have a much easier path to the declination of coverage.⁸² There are several arguments advanced in support of not requiring a causal connection. First, the breach of a policy condition supersedes coverage “[w]hile the proscribed activity continues . . . as if [the policy] had never been in force.”⁸³ Second, an insurance policy “should be enforced as written” in order to effectuate the expectations of both parties.⁸⁴ Third, a carrier has a right to limit its coverage to the risk it assumed.⁸⁵ Any activity that increases the

⁷⁸ *Id.* at 850–53 (citing *AIG Aviation, Inc. v. Holt Helicopters, Inc.*, 198 S.W.3d 276, 280–81 (App. Tex.—San Antonio 2006, pet. denied) (Texas anti-technicality statute precluded carrier from declining coverage when loss had nothing to do with the technical ground for carrier’s decision); *AVEMCO Ins. Co. v. Chung*, 388 F. Supp. 142, 151 (D. Haw. 1975) (carrier could not decline coverage for lapsed medical certificate when it had nothing to do with the cause of the crash)).

⁷⁹ *Id.* at 853–54 (citing *Bayers v. Omni Aviation Managers, Inc.*, 510 F. Supp. 1204, 1207 (D. Mont. 1981)).

⁸⁰ *See Collins*, 237 S.E.2d at 359–62.

⁸¹ *See, e.g., In re Jacoby Airplane Crash Litig.*, No. 99-6073 (HAA), 2007 WL 5037683, at *11 (D.N.J. Aug. 27, 2007); *see also Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993).

⁸² *See U.S. Specialty Ins. Co. v. Skymaster of Va., Inc.*, 123 F. Supp. 2d 995, 999–1003 (E.D. Va. 2000), *aff’d on other grounds*, 26 F. App’x 154 (4th Cir. 2001).

⁸³ *Kettles & Sissell*, *supra* note 53, at 854 (quoting *Hedges Enter., Inc. v. Fireman’s Fund Ins. Co.*, 225 N.Y.S.2d 779, 784 (N.Y. Sup. Ct. 1962)).

⁸⁴ *Id.* at 855–56 (citing, among other cases, *O’Connor v. Proprietors Ins. Co.*, 696 P.2d 282, 285 (Colo. 1982)).

⁸⁵ *Id.* at 856–57.

risk and hence the scope of coverage is prohibited.⁸⁶ Fourth, the lack of a causal connection requirement encourages insureds to comply with safety regulations.⁸⁷

The majority view is that no causal connection is required between the medical issue and the loss; however, the split between jurisdictions is not overwhelming, and there are any number of variations.⁸⁸ For example, in some states a causal connection is considered but not required when the condition breached is material to the underwriting and issuance of the policy.⁸⁹ Other states require that the breach of the policy be the “efficient” cause of the loss.⁹⁰ Thus, in determining whether a pilot’s failure to disclose a medical condition invalidates coverage, such an analysis must begin with a careful scrutiny of the policy terms and the applicable state’s coverage laws.

In the third-party liability context, a pilot’s failure to disclose a medical condition can have serious consequences on the outcome of the case.⁹¹ These issues will be subject to a battery of medical and other experts seeking, for example, to blame the accident on the pilot’s physical condition on one hand, and the mechanics of the aircraft or air traffic controllers on the other.⁹² One of the first considerations is whether the applicable state’s substantive tort laws view the violation of statutes and regulations as negligence per se or merely evidence of negligence.⁹³ If the non-disclosure of a medical condition is viewed as negligence per se, then that regulatory breach might very well be dispositive of the case at a relatively early stage.⁹⁴ Thus, an early determination must be made as to whether the pilot’s violation of the applicable FARs is dispositive of the case.

⁸⁶ *Id.* at 857 (citing *Aviation Charters, Inc. v. Avemco Ins. Co.*, 784 A.2d 712, 714 (N.J. 2001)).

⁸⁷ *Id.* at 857–58 (citing *Sec. Ins. Co. of Hartford v. Andersen*, 763 P.2d 246, 250 (Ariz. 1988)).

⁸⁸ *Id.* at 834–36.

⁸⁹ *Id.* at 895–96, 907–08 (citing *Am. Cont’l Ins. Co. v. Estate of Gerkens*, 591 N.E.2d 774, 777 (Ohio Ct. App. 1990); *McAllister v. Avemco Ins. Co.*, 528 A.2d 758, 759 (Vt. 1987)).

⁹⁰ *Id.* at 870 (citing *Chase v. State Farm Fire & Cas. Co.*, 780 A.2d 1123, 1129–30 (D.C. 2001)).

⁹¹ See *In re Jacoby Airplane Crash Litig.*, No. 99-6073 (HAA), 2007 WL 4557654, at *16 (D.N.J. Dec. 21, 2007).

⁹² See *In re Jacoby Airplane Crash Litig.*, No. 99-6073 (HAA), 2007 WL 5037683, at *13–41 (D.N.J. Aug. 27, 2007).

⁹³ See *In re Jacoby Airplane Crash Litig.*, No. 99-6073 (HAA), 2007 WL 559801, at *5 (D.N.J. Feb. 14, 2007).

⁹⁴ See *id.*

A 1999 crash of a single-engine, propeller-driven airplane in New Jersey, a state where violations of statutes and/or regulations are evidence of negligence, provides a detailed analysis of the types of issues that can arise when a pilot fails to disclose a medical condition that would have compromised the validity of his or her medical certificate.⁹⁵

In *In re Jacoby Airplane Crash Litigation*, Dr. Jacoby took off from Linden Airport in New Jersey on the morning of November 26, 1999 under Instrument Flight Rules (IFR) conditions in a single-engine aircraft.⁹⁶ The entire flight lasted approximately six minutes.⁹⁷ Dr. Jacoby was initially instructed to climb to 5,000 feet, but a few seconds later the air traffic controller (ATC) handling his flight instructed him to maintain an altitude of 2,000 feet due to the presence of air traffic at nearby Newark and Teterboro Airports.⁹⁸

Shortly thereafter, the ATC instructed Dr. Jacoby to turn left to a heading of 270 degrees.⁹⁹ After several attempts to communicate with Dr. Jacoby, he reported a momentary gyroscope problem, which appeared to have been corrected.¹⁰⁰ The ATC reissued the instruction several more times, and Dr. Jacoby finally responded with his last transmission: "I have a problem."¹⁰¹ During Dr. Jacoby's exchanges with the ATC, he requested clearance to climb to a higher altitude but was denied due to separation issues involving air traffic at Newark and Teterboro Airports.¹⁰²

The last thirty seconds of radar data indicated that the aircraft reached a maximum altitude of 2,800 feet and air speed of 161 knots, before beginning a final descent that reached approximately 10,000 feet per minute (a vertical speed of 98.7 knots).¹⁰³ There was a dispute between the parties as to whether Dr. Jacoby was beginning to pull out of his descent when his aircraft hit a chimney, resulting in a crash that killed Dr. Jacoby, his wife, his thirteen year-old daughter, and a ground victim.¹⁰⁴ Approximately twenty-five ground victims claimed personal injuries

⁹⁵ *In re Jacoby*, 2007 WL 5037683, at *1-2.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.*

ranging from severe burns to post-traumatic stress disorder.¹⁰⁵ There were also claims for property damage, and the City of Newark claimed that it expended approximately \$1,200,000 in response to the crash.¹⁰⁶

After the personal injury cases involving ground victims were resolved, litigation ensued against the United States for the alleged negligence of its ATCs and against the manufacturer of the autopilot system alleging a defect in the turn coordinator while the autopilot was engaged.¹⁰⁷ An investigation into Dr. Jacoby's medical history revealed that starting as early as 1972, he was taking Fiorinal, a drug containing butalbital (a barbiturate), for migraine headaches.¹⁰⁸ From 1994 through 1999 (the accident year), Dr. Jacoby's records disclosed that he had been prescribed approximately 6,000 pills, with approximately 800 pills being prescribed in the accident year.¹⁰⁹

Dr. Jacoby's medical file revealed that every year from 1988 through 1999, he completed his application of a medical certificate by checking "no" in response to whether he suffered from frequent or severe headaches, and "no" in response to whether he was taking non-prescription or prescription medication (the last certification being one month before the crash).¹¹⁰ Dr. Jacoby's AME from 1996, 1997, 1998, and 1999 testified that had Dr. Jacoby reported his medical history and medication, then he would have deferred issuing Dr. Jacoby a medical certificate.¹¹¹

The litigation that ensued involved a complicated eight-year battle of experts, including dispositive motions, in limine motions, and an eight-week trial consisting of thirty-four live witnesses and several by deposition.¹¹² As to the medical issues, defendants sought a dismissal of all claims by way of a motion

¹⁰⁵ Robert Hanley, *Problems Began Instantly in Newark Plane Crash*, N.Y. TIMES (Dec. 1, 1999), <http://www.nytimes.com/1999/12/01/nyregion/problems-began-instantly-in-fatal-newark-plane-crash.html>.

¹⁰⁶ *The Federal Aviation Administration's Oversight of Falsified Airman Medical Certificate Applications: Hearing Before the Subcomm. on Aviation of the H. Comm. on Transp. & Infrastructure*, 110th Cong. xiii (2007) (report by the majority staff of the H. Comm. on Transp. & Infrastructure for Rep. James L. Oberstar, Chairman, H. Comm. on Transp. & Infrastructure) [hereinafter FAA Oversight Report].

¹⁰⁷ For the trial court's findings of fact and conclusions of law as to the claims against the United States, see *In re Jacoby Airplane Crash Litig.*, No. 99-6073 (HAA), 2007 WL 4557654, at *1 (D.N.J. Dec. 21, 2007).

¹⁰⁸ *Id.* at *4.

¹⁰⁹ *Id.*

¹¹⁰ *Id.* at *5.

¹¹¹ *Id.*

¹¹² *Id.* at *1.

for summary judgment, arguing that Dr. Jacoby's repeated non-disclosures on his medical applications and in his examinations barred his claim as a matter of law.¹¹³ The court denied the motion and ruled that under New Jersey law, a violation of a statute or regulation is merely evidence of negligence, and there was a genuine dispute of material fact as to whether Dr. Jacoby was under the influence of Fiorinal at the time of the crash.¹¹⁴

The practical effect of this ruling is that it guaranteed a trial, absent a settlement.¹¹⁵ It also helped pave the way for the defendants to introduce evidence of the magnitude of Dr. Jacoby's violation of the FARs applicable to the validity of his medical certificate, provided the defendants with a green light to develop arguments that Dr. Jacoby was impaired at the time of the accident, and allowed the defendants to show that his impairment was the proximate cause of the accident.¹¹⁶ There was also a dispute over whether Dr. Jacoby's failure to disclose his condition would have prevented him from obtaining a medical certificate.¹¹⁷

The battle lines in this case were drawn as follows: the plaintiff set out to prove that Dr. Jacoby was a careful pilot who experienced mechanical problems with an autopilot system that failed to adequately warn him of a gyroscope failure in the turn coordinator.¹¹⁸ The plaintiff also set out to prove that Dr. Jacoby was a careful and highly skilled pilot who responsibly monitored his intake of Fiorinal such that it was taken in quantities and at times where it would be out of his system while flying and have no impact on his ability to pilot his aircraft.¹¹⁹ Ironically, the plaintiff argued that Dr. Jacoby's use of Fiorinal was of such duration that he developed a tolerance to it so its effect on his nervous system was negated.¹²⁰ Finally, the plaintiff sought to prove that Dr. Jacoby was in the process of overcoming the effects of his turn-coordinator failure, and that had he been given

¹¹³ *In re Jacoby Airplane Crash Litig.*, No. 99-6073 (HAA), 2007 WL 2746833 at *17-21 (D.N.J. Sept. 19, 2007).

¹¹⁴ *Id.*

¹¹⁵ *See id.*

¹¹⁶ *Id.* at *20.

¹¹⁷ *Id.*

¹¹⁸ Plaintiffs' Response in Opposition to Defendant S-TEC Corp.'s Motion for Summary Judgment Based on Violation of Public Policy at 5, *In re Jacoby*, 2007 WL 2746833 (No. 99-6073 (HAA)).

¹¹⁹ *Id.* at 6.

¹²⁰ *Id.*

clearance to climb to a higher altitude, he would have missed the chimney and avoided the accident altogether.¹²¹

By contrast, the defendants sought to prove that Dr. Jacoby was an incompetent pilot, who misjudged and overestimated his ability given the weather conditions, lost control of his aircraft, and ultimately crashed as a result thereof.¹²² The defendants further sought to prove that Dr. Jacoby was a pilot who lied annually every time he completed his application for a medical certificate and submitted to an examination with his AME, and that had he been truthful, as required by the applicable FARs, then he would not have been issued a medical certificate at his annual examinations.¹²³ The defendants further alleged that Dr. Jacoby was under the influence of a prohibited barbiturate at the time of his flight, such that he became spatially disoriented and could not respond to simple ATC commands.¹²⁴ Finally, the United States sought to prove the ATC handling Dr. Jacoby's flight properly exercised his judgment and was not negligent in declining to allow Dr. Jacoby to climb to a higher altitude due to separation issues involving other aircraft from Newark and Teterboro Airports.¹²⁵

Dr. Jacoby's autopsy revealed the presence of butalbital in his urine, kidneys, spleen, heart, and muscle tissue.¹²⁶ Blood samples were not available due to the accident.¹²⁷ The defendants hired, *inter alia*, a toxicologist and an AME as experts to support their arguments that Dr. Jacoby in fact had butalbital in his blood system at the time of the crash, that it affected his ability to pilot the aircraft, and that it was a substantial contributing factor to the crash.¹²⁸

One of the defendants' toxicologists was the Director of the Forensic Toxicology and Accident Research Laboratory at the Civil Aerospace Medical Institute (CAMI).¹²⁹ After the National Transportation Safety Board (NTSB) received the result of the autopsy, it sent tissue samples to CAMI and asked that entity to

¹²¹ *In re Jacoby*, 2007 WL 2746833, at *2.

¹²² Defendant S-TEC Corp.'s Memorandum of Law in Reply to Plaintiffs' Response in Opposition to S-Tech's Motion for Summary Judgment Based on Violation of Public Policy at 9, *In re Jacoby*, 2007 WL 2746833 (No. 99-6073 (HAA)).

¹²³ *Id.* at 4-6.

¹²⁴ *In re Jacoby*, 2007 WL 2746833, at *19.

¹²⁵ *Id.* at *2.

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Id.* at *3.

¹²⁹ *Id.*

perform an investigation as to whether Dr. Jacoby was under the influence of barbiturates at the time of the accident (i.e., whether he had levels of the barbiturate in his blood sufficient to support an inference of impairment).¹³⁰ The defendant's expert testified that he was able to measure the levels of barbiturate in Dr. Jacoby's organ tissue samples and extrapolate using a distribution coefficient to estimate the level of barbiturates in Dr. Jacoby's bloodstream.¹³¹ The defendants' toxicologist claimed he was able to determine that Dr. Jacoby had a therapeutic level of barbiturate in his bloodstream at the time of the crash, such that it would have slowed "his response times, diminished his muscle control, and reduced cognitive function," consistent with the known effects of that drug.¹³²

The defendants' AME expert used these conclusions to support an opinion that Dr. Jacoby was not legally exercising his flight privileges at the time of the accident due to his failure to disclose his condition and treatment to his AME.¹³³ The AME expert further opined that Dr. Jacoby was impaired due to the levels of butalbital that were estimated to be in his system based upon the sedative effects of that drug.¹³⁴ Finally, the defendants' AME expert opined that the sedative effect of the barbiturate in Dr. Jacoby's bloodstream and acute lack of sleep resulted in his inability to respond to the mechanical problem, as well as spatial disorientation.¹³⁵

The defendants also hired an accident reconstruction expert, who reviewed, inter alia, radar returns, transcripts of radio communications, and the results of test flight recreations of certain aspects of the flight in question.¹³⁶ The defendants' accident reconstructionist was careful not to offer an opinion as to what caused Dr. Jacoby's impairment, as that type of opinion would have been beyond his area of expertise.¹³⁷ The defendants' accident reconstruction expert did opine that Dr. Jacoby was impaired at the time of the flight due to his inability to respond to

¹³⁰ *Id.* at *6.

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *In re Jacoby Airplane Crash Litig.*, No. 99-6073 (HAA), 2007 WL 324390, at *1-4 (D.N.J. Nov. 1, 2007).

¹³⁷ *In re Jacoby Airplane Crash Litig.*, No. 99-6073 (HAA), 2007 WL 5037683, at *20-21 (D.N.J. Aug. 27, 2007).

ATC instructions and to the flight conditions presented to him.¹³⁸

Dr. Jacoby's estate countered on several grounds.¹³⁹ It hired its own toxicologist, who offered an opinion directly contrary to those of the defendants' experts, and he criticized the methodology of the defendants' toxicologist experts; the estate also presented an editorial authored by Dr. Jon Jordan, a doctor, an attorney, and the Federal Air Surgeon from 1991 to 2006,¹⁴⁰ stating that "[Dr. Jacoby's] use of butalbital was probably not a major contributor to the accident."¹⁴¹ The estate also hired a battery of experts laying blame on a defective aspect of the turn coordinator and autopilot system and on the ATC for not allowing Dr. Jacoby to climb to a higher altitude.¹⁴²

Daubert and in limine motions ensued, the substance of which are discussed at length in the decision of the court.¹⁴³ The practical result is that evidence of Dr. Jacoby's history of barbiturate usage and his violations of FARs, relative to his medical certificate, were introduced to the jury, no doubt playing a large role in the ultimate outcome—a no cause.¹⁴⁴

In contrast to New Jersey, there are jurisdictions where a violation of safety-related FARs is presumed to be negligence as a matter of law.¹⁴⁵ In some jurisdictions where such a violation is negligence per se, an exception to this rule exists where the violation is related to licensing as opposed to safety.¹⁴⁶

IV. THE MAGNITUDE OF THE PROBLEM

There is a disturbing dispute within the aviation community as to how pervasive the problem of pilots' failures to disclose medical conditions is, how much of a threat it is to aviation, and whether expending resources to better police pilots is a wise use

¹³⁸ *Id.*

¹³⁹ *In re Jacoby*, 2007 WL 2746833, at *3–15.

¹⁴⁰ *Id.* at *3–8.

¹⁴¹ *Id.* at *4.

¹⁴² *Id.* at *15.

¹⁴³ *See generally id.*

¹⁴⁴ *In re Jacoby Airplane Crash Litig.*, No. 99-69073 (HAA), 2007 WL 4557654, at *16 (D.N.J. Dec. 21, 2007).

¹⁴⁵ *See, e.g.*, *Associated Aviation Underwriters v. United States*, 462 F. Supp. 674, 680 (N.D. Tex. 1978) (citing *Gatenby v. Altoona Aviation Corp.*, 407 F.2d 443 (3d Cir. 1969); *Gas Serv. Co. v. Helmers*, 179 F.2d 101 (8th Cir. 1950)).

¹⁴⁶ *See, e.g.*, *Duty v. E. Coast Tender Serv., Inc.*, 660 F.2d 933, 947–49 & n.1–2 (4th Cir. 1981) (en banc) (Hall, J. dissenting) (collecting cases from twenty jurisdictions that have licensing exceptions).

of government resources.¹⁴⁷ It is undisputed that the regulatory system relies upon the honesty and self-reporting of pilots in large part.¹⁴⁸ Equally evident is that the current system penalizes honest pilots by subjecting them to intensive scrutiny and the real possibility that their application for a medical certificate will be denied if they complete FAA Form 8500-8 honestly.¹⁴⁹ There is a view within the aviation community that the number of aviation accidents involving impaired pilots is so “negligible” that resources should not be devoted to fixing a system that is not broken.¹⁵⁰

However, objective studies tell a different story.¹⁵¹ The U.S. House of Representatives Committee on Transportation and Infrastructure conducted a study and prepared a report entitled *FAA Oversight of Falsifications on Airman Medical Certificate Applications* (FAA Oversight Report).¹⁵² The March 27, 2007, report revealed that “[i]n July 2005, the [U.S. Department of Transportation (DOT)] Inspector General found egregious cases of airmen lying about debilitating medical conditions on their applications for [a]irman [m]edical [c]ertificates.”¹⁵³ “In a sample of 40,000 [a]irman certificate-holders, the Inspector General found more than 3,200 airmen holding current medical certificates while simultaneously receiving Social Security disability benefits, including those with medically disabling conditions.”¹⁵⁴ U.S. Attorney Offices in California identified forty-eight of these cases for prosecution and forty-five of them were actually prosecuted.¹⁵⁵ Four of these cases involved pilots with air transport pilot licenses, six cases involved pilots with commercial licenses, twenty-eight cases involved pilots with private pilot licenses (“including [two] board-certified medical doctors”), and seven pilots held student pilot licenses.¹⁵⁶ Two pilots

¹⁴⁷ See generally FAA Oversight Report, *supra* note 106, at x–xxiii.

¹⁴⁸ See Prohibition on Operations During Medical Deficiency, 14 C.F.R. § 61.53 (2011); FAA FORM 8500-8, *supra* note 7.

¹⁴⁹ See *id.*

¹⁵⁰ See FAA Oversight Report, *supra* note 106, at xii.

¹⁵¹ See generally *id.* at x–xxiii.

¹⁵² This report was printed in the official documents for a hearing by the same name. See *id.*

¹⁵³ *Id.* at xii (internal quotation marks omitted).

¹⁵⁴ *Id.*

¹⁵⁵ Memorandum from Kenneth M. Mead, Inspector Gen., U.S. Dep’t of Transp., to the Sec’y & Deputy Sec’y of Transp. & the Fed. Aviation Adm’r, Falsification of FAA Airman Medical Certificate Applications by Disability Recipients 2 (July 22, 2005) [hereinafter Mead Memorandum].

¹⁵⁶ FAA Oversight Report, *supra* note 106, at xvi.

were not prosecuted because they died during the process, including one from the disability that he failed to disclose to the FAA.¹⁵⁷ The conditions identified included “schizophrenia . . . , drug or alcohol addiction, and disabling heart . . . conditions.”¹⁵⁸ Two-thirds of the pilots involved were under the age of sixty.¹⁵⁹ The number of cases prosecuted was limited due to a lack of resources.¹⁶⁰

According to the FAA Oversight Report, the committee staff identified hundreds of fatal accidents where pilots failed to disclose potentially disqualifying medical conditions on their medical certificate applications.¹⁶¹ The research team found toxicology evidence of serious medical conditions in nearly ten percent of all pilots involved in fatal accidents during a ten-year period (fewer than ten percent of these medical conditions, or medications used to treat them, were disclosed to the FAA).¹⁶²

The FAA Oversight Report indicated that the FAA acknowledged that it had no process to check for medically-related falsifications, and the FAA did not pursue the Inspector General’s recommendations because it took the position that the process would be too “labor intensive” and the safety risk would not justify the resources it would consume.¹⁶³

The FAA Oversight Report indicated that there were “approximately 650,000 foreign and domestic pilots holding current FAA [a]irman [m]edical [c]ertificates.”¹⁶⁴ If ten percent of pilots failed to disclose medical conditions, that would translate into 65,000 pilots having non-disclosed medical issues.¹⁶⁵ The Inspector General recommended that the FAA “work with [the Social Security Administration (SSA)] and other disability benefits providers to expedite development and implementation of a strategy to carry out” cross-checks “and take appropriate enforcement action where falsifications are found.”¹⁶⁶ The Inspector General also recommended that FAA Form 8500-8 be revised

¹⁵⁷ Mead Memorandum, at 2–3.

¹⁵⁸ *Id.* at 2.

¹⁵⁹ *Id.*

¹⁶⁰ FAA Oversight Report, *supra* note 106, at xvi.

¹⁶¹ *Id.*

¹⁶² *Id.* at xvi–xvii.

¹⁶³ *Id.* at xvii–xviii.

¹⁶⁴ *Id.* at xviii.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

“to require applicants to explicitly identify whether they are receiving medical disability benefits from any provider.”¹⁶⁷

The FAA Oversight Report indicated that by January 2007, the FAA had not followed up on any of the Inspector General’s recommendations to address the problem.¹⁶⁸ Among others, “the Federal Air Surgeon, the Deputy Associate Administrator for Aviation Safety, and the Assistant Chief Counsel for Enforcement reiterated their beliefs that the magnitude of the problem was not sufficient to warrant implementing the Inspector General’s recommendations.”¹⁶⁹ The proffered justification by the FAA was that according to its calculations, which the FAA Oversight Report described as “inexplicable,” the Inspector General’s “recommendations would prevent just two fatalities a year.”¹⁷⁰ According to the FAA Oversight Report, the FAA’s response seemed inconsistent with its safety regulations, which have “the strictest medical fitness requirements in the world because” the FAA freely acknowledges “that medically unfit pilots pose a real danger to themselves and the public.”¹⁷¹

The numbers generated in the FAA Oversight Report suggested that ten percent of pilots fail to disclose medical conditions on their medical certificate applications and that eight percent of pilots are receiving disability benefits from the SSA.¹⁷² The latter number was the by-product of a cooperative effort between the Inspectors General of the DOT and SSA entitled “Operation Safe Pilot.”¹⁷³ That program resulted in costly and protracted litigation that in turn resulted in a U.S. Supreme Court decision.¹⁷⁴ In *Cooper*, the pilot had a long-standing medical condition.¹⁷⁵ His failure to disclose the medical condition on his application carried with it a criminal exposure.¹⁷⁶ Mr. Cooper was diagnosed HIV-positive in 1985 and began taking, inter alia, antiretroviral medication, which automatically disqualified him from renewing his medical certification.¹⁷⁷ He

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.* at xii.

¹⁷³ *Id.* at xii, xv.

¹⁷⁴ See *Cooper v. FAA*, 622 F.3d 1016, 1025 (9th Cir. 2010), *rev'd*, 132 S. Ct. 1441 (2012).

¹⁷⁵ *FAA v. Cooper*, 132 S. Ct. 1441, 1443–44 (2012).

¹⁷⁶ *Id.* at 1444.

¹⁷⁷ *Id.* at 1446.

voluntarily grounded himself until 1994, when he deliberately failed to disclose his condition and the medications he was taking.¹⁷⁸ He was able to renew his medical certificate four times between 1998 and 2004—each time failing to disclose his condition and his pharmaceutical regimen.¹⁷⁹

In 1995, he applied to the SSA for long-term disability.¹⁸⁰ In 2002, the DOT authorized Operation Safe Pilot, whereby the FAA would release the names of active, certified pilots to the SSA for purposes of identifying pilots who were receiving federal disability benefits.¹⁸¹ Mr. Cooper was identified as such a pilot.¹⁸² He was indicted on three counts of making false statements to the government and pleaded guilty to one count of making and delivering a false official writing, a misdemeanor.¹⁸³

This case provides an interesting example of the difficulties in deciding whether and how to reform the system, courtesy of the Ninth Circuit.¹⁸⁴ Mr. Cooper sued the FAA, the SSA, and the DOT for violating his rights under the Privacy Act.¹⁸⁵ He sought damages arising out of the stigma associated with the intentional disclosure of his HIV status and sexual orientation.¹⁸⁶ The Northern District of California dismissed the case on summary judgment, holding that plaintiff's damages were of a non-pecuniary nature and that the limited waiver of sovereign immunity set forth in the Privacy Act required actual damages.¹⁸⁷ The Ninth Circuit reversed, holding that a plaintiff may recover for both pecuniary and non-pecuniary damages if the plaintiff can show that a federal agency intentionally or willfully fails to uphold its record-keeping obligations under the Privacy Act.¹⁸⁸ The U.S. Supreme Court granted the government's petition for certiorari, and ultimately reversed the Ninth Circuit.¹⁸⁹

The notion that a pilot is physically and mentally able to fly but not to work (such that he or she is receiving disability benefits) is an insult to the aviation community. Even worse, govern-

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ *Id.* at 1446–47.

¹⁸² *Id.* at 1447.

¹⁸³ *Id.*

¹⁸⁴ *See id.*

¹⁸⁵ *Id.*; *see also* 5 U.S.C. § 552 (2006).

¹⁸⁶ *Cooper*, 132 S. Ct. at 1447.

¹⁸⁷ *Id.*

¹⁸⁸ *Id.* at 1447–48.

¹⁸⁹ *Id.* at 1448.

ment agencies tasked with the investigation of this issue in the interest of public safety have been subjected to the expenses and rigors of litigation arising out of their efforts. One would think that a pilot waives his or her right to medical privacy when he or she places a medical condition at issue by way of attempting to secure a medical certificate.

As a result of the foregoing—the DOT Inspector General’s investigation, the hearing that followed, and problems like the one in *Cooper*—the FAA agreed to several changes to FAA Form 8500-8.¹⁹⁰ The recommendations included adding a question to the form as to whether the airman “has ever received any form of disability compensation” from any source.¹⁹¹ It also sought to “[a]dd a notice similar to the National Driver Register notice on the current form, which authorizes the [FAA] to compare the data . . . with other agencies that might be providing disability benefits.”¹⁹²

Finally, suggestions have been made to enhance quality control and AME oversight processes.¹⁹³ However, entities such as the Aircraft Owners and Pilots Association (AOPA) and the Experimental Aircraft Association (EAA) are lobbying to relax the standards for medical oversight and place more reliance on pilot self-reporting.¹⁹⁴ The recommendation in this regard is to reduce or eliminate the “burdens” associated with requirements for third-class medical certificates.¹⁹⁵ The AOPA and the EAA propose that pilots would have the option of either obtaining a third-class medical certificate or: (1) holding a valid driver’s license; (2) completing an online education course on medical self-certification; (3) flying only under Visual Flight Rules (VFR) conditions, at 10,000 feet or below, with a maximum of one passenger, in a fixed-gear, single-engine aircraft of 180 horsepower or less, with a maximum of four seats; and (4) not flying for hire.¹⁹⁶

¹⁹⁰ Fred Tilton, Editorial, *Operation Safe Pilot Revisited*, FED. AIR SURGEON’S MED. BULL. (FAA, Washington, D.C.), 2007, at 2.

¹⁹¹ *Id.*

¹⁹² *Id.*

¹⁹³ See FAA Oversight Report, *supra* note 106, at xix.

¹⁹⁴ Petition from Aircraft Owners & Pilots Ass’n & Experimental Aircraft Ass’n, to U.S. Dep’t of Transp., Petition for Exemption from Federal Aviation Regulation Sections 61.3 and 61.23 to Allow AOPA and EAA Members to Conduct Certain Operations Without Having to Hold an FAA-Issued Medical Certificate 3 (June 12, 2012).

¹⁹⁵ *Id.*

¹⁹⁶ *Id.* at 5.

The purpose of the petition is to allow certain pilot-members of the AOPA and the EAA to conduct the above flight activities without a third-class medical certificate, so long as they take a course designed to train them to self-diagnose medical conditions material to their ability to pilot aircraft and/or self-certify themselves as being medically fit to fly.¹⁹⁷ In other words, the AOPA and the EAA seek to create a new class of pilots who might be otherwise medically unfit to fly under the FAA's current regulatory framework or unwilling to go through the current medical certification process.¹⁹⁸ The course and proposed exemption from the applicable FARs, however, are available for their members only.¹⁹⁹ This proposal would remove the threshold requirement of these pilots undergoing a medical evaluation and certification by an FAA-approved AME and thereby make each pilot-member the gatekeeper of his or her medical fitness to fly.²⁰⁰

With all due respect to the AOPA and the EAA, the aviation community does not know the magnitude of the problem associated with pilots who fail to disclose known conditions that would otherwise disqualify them from obtaining a medical certificate consistent with the aforementioned study on this topic. In light of the studies demonstrating the magnitude of pilots who fail to disclose medical conditions, one must question the wisdom of allowing pilots to become gatekeepers of medical conditions with no oversight. To compound the problem, one must question who these medically unsupervised pilots might be. Are they pilots who are otherwise medically unfit to fly under the current regulatory framework? Are they pilots who are otherwise unwilling or unable to assume the relatively modest cost of the medical certification process? One of the clear consequences of the AOPA's and the EAA's petition, if granted, would be to open the skies to a new class of pilots who are marginal at best from a medical standpoint.

Respectfully, it would appear that more work needs to be done to determine the magnitude of the problem. The DOT Inspector General, using FAA data, estimated that nine to ten percent of fatal crashes over a ten-year period revealed pilots with medical conditions that raised questions as to the validity of

¹⁹⁷ *Id.*

¹⁹⁸ *See id.*

¹⁹⁹ *Id.* at 3.

²⁰⁰ *See id.*

their medical certificates.²⁰¹ Operation Safe Pilot revealed that eight percent of the pilots sampled were receiving disability benefits from the SSA for conditions they failed to disclose.²⁰² Consequently, one must question the heavy reliance that the current system places on self-reporting and whether cost-effective strategies can be implemented to inject more oversight and objectivity into the process.

²⁰¹ *Id.* at 6.

²⁰² *Id.*

