The FAA’s Mental Health Standards: Are They Reasonable?

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THE FAA’S MENTAL HEALTH STANDARDS: 
ARE THEY REASONABLE?

KATIE MANWORREN*

I. INTRODUCTION

IN 2015, A PILOT FOR GERMANWINGS (an airline based in Germany) purposefully crashed a plane into a mountain in France while en route to Düsseldorf, Germany. Germany is one of thirty-two member nations whose aviation industries fall under the jurisdiction of the European Aviation Safety Agency (EASA).1 The Bureau d’Enquetes et d’Analyses (BEA), the French agency charged with investigating the crash, launched its inquiry with the goal of recommending ways to improve safety and prevent similar future incidents.2 While the requirements for a first-class pilot’s license are the same in Europe as in the United States,3 the monitoring of mental health conditions may not be as consistent in Europe due to strong privacy protection standards.4 The American counterpart to EASA, the Federal Aviation Administration (FAA), has strict requirements for pilot mental health, and at least partially because of this vetting, there

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4 See, e.g., Luftansa Says It Was Not Obligated to Report Pilot’s Medical Records, AL JAZEERA AM. (Apr. 6, 2015, 3:13 PM), http://america.aljazeera.com/articles/2015/4/6/lufthansa-not-obligated-to-report-pilots-record.html [perma.cc/V94F-7Z4E]. “Privacy is fiercely guarded in Germany . . . . Under German law, employers cannot access employees’ medical records and sick notes excusing a person from work do not specify their medical condition.” Id.
is a very low incidence of airplane accidents, especially intentional ones.5

The international reaction to the Germanwings crash is emblematic of the skewed public perception of aviation safety.6 For example, in an attempt to explain how the crash happened, an American journalist referred to “layers of safety in aviation [being] peeled away,” ignoring the fact that passenger aviation has actually become increasingly safer over the decades.7 Just days after the crash, several European airlines, including all German carriers, announced the official implementation of a procedure already being used by U.S. carriers which requires two people to be in the cockpit at all times.8 The tamper-proof locking cockpit door that prevented anyone on board from stopping the Germanwings crash was implemented in reaction to the September 11th terrorist attacks in an attempt to prevent hijackers from entering the cockpit.9 The United States decided that “a terrorist was [a] greater risk” than a suicidal pilot.10

Concerns for passenger and flight crew safety have spurred strict testing requirements issued by the FAA that pilots must satisfy in order to become certified. Physical or mental health problems may prevent applicants from obtaining the documents


9 Id.

10 Id.
required to become a certified pilot. At the same time, the rate of mental health diagnoses is increasing, precluding more people from this career path. To make matters worse, the aviation industry is growing as well; 2017 brought a 3% increase in air traffic over 2016. If these trends continue, the world will need more pilots but will have fewer qualified candidates to choose from.

This comment seeks to provoke discourse regarding the balance between public safety—and perception of safety—and ensuring that major airlines’ demand for pilots can be met. Part II will discuss the relevant statutes and regulations pertaining to pilot medical certification. Part III provides an analysis of the current state of mental health and psychiatric diagnosis as well as the implications of these practices on a prospective pilot’s ability to obtain certification. Part IV compares and contrasts the mental health requirements for pilots to those of other comparable professions. It then discusses the pros and cons of adjusting the FAA’s current medical requirements to accommodate future flight volumes—after all, so many potential pilot candidates are excluded from flying for commercial air carriers due to disqualifying mental health problems. Finally, it contemplates whether the National Transportation Safety Board is appropriately equipped to rule on pilots’ appeals of FAA denials of pilot medical certificates.

II. LEGAL AND HISTORICAL BACKGROUND

Pursuant to the Federal Aviation Act of 1958, the FAA has the authority to promulgate rules pertaining to aviation safety. The Act also gives the FAA the power to both grant and revoke different types of pilot’s certificates. Under the Federal Aviation Regulations (FARs), which comprise Title 14 of the Code of Federal Regulations, there are minimum medical requirements for pilots. Part 61 states that all pilots must obtain some level of

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15 Id. § 44702(a).
16 Id. § 44709(b).
17 14 C.F.R. § 61.23(a) (2018).
medical certification, but different classes of pilots are required to get different types of certificates, the stringency increasing relative to the potential harm that could result from pilot error.18

For example, sport pilots can fly with just a U.S. driver’s license instead of a formal medical certificate, unless the pilot “know[s] or [has] reason to know of any medical condition that would make [a] person unable to operate a light-sport aircraft in a safe manner.”19 On the other hand, a first-class medical certificate is required for airline transport pilots (ATPs), who serve as captains on scheduled airliners, including passenger airline pilots.20 While co-pilots on these planes are technically only required to have a second-class medical certificate, “[m]ost, if not all, U.S. airlines require a first class medical certificate for all of their pilots.”21 All classes of medical certificates require an Aviation Medical Examiner (AME) to conduct a thorough physical exam and review of the applicant’s medical history.22 The AME evaluates an applicant’s eyes, ears, nose, throat, equilibrium, mental health, neurological status, cardiovascular health, and general medical condition.23

Medical standards for all certifications are explained in Part 67 of the FAR.24 The requirements for a First-Class Medical Certificate are laid out in Subpart B25 of Section 67, while those for Second- and Third-Class certificates are in Subparts C26 and D,27 respectively. The whole medical evaluation must be conducted again upon the certification’s expiration if the pilot wants to continue to fly. The last update to most of these provisions was

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18 Id. § 61.23(d).
19 Id. § 61.23(c)(2)(iv). However, if the pilot’s most recent request for a medical certificate was denied or revoked, this option is not available. Id. § 61.23(c)(2)(ii)–(iii).
20 Id. § 61.23(d); see also Airman Medical Certification, AIRCRAFT OWNERS AND PILOTS ASS’N, https://www.aopa.org/go-fly/medical-resources/airman-medical-certification (last updated Mar. 2017) [perma.cc/8N9T-RQRF].
24 Id. § 67.
25 Id. §§ 67.101–.113.
26 Id. §§ 67.201–.215.
27 Id. §§ 67.301–.315.
passed in 1996.28 Courts have repeatedly upheld regulations regarding medical and mental health as being reasonably related to the governmental interest in promoting aviation safety.29

A. CURRENT ALTERNATIVES TO THE STANDARD FIRST-CLASS MEDICAL CERTIFICATE

While a First-Class Medical Certificate is generally required for an ATP license, there are actually three ways a pilot can be certified to fly when the highest clearance would normally be required: (1) unrestricted certificates;30 (2) restricted certificates;31 and (3) an Authorization for Special Issuance of a Medical Certificate (SI).32 An unrestricted certificate is the standard first-class certificate and is issued to applicants with no concerning medical conditions.33 These expire after twelve months for pilots under forty years old and are valid for six months for pilots over forty years of age.34

Restricted certificates, called Statements of Demonstrated Ability (SODA), are granted to those who are not eligible for an unrestricted first-class certificate but whose health conditions are relatively minor.35 The AME must either defer these applications to the Federal Air Surgeon (FAS) for consideration or deny them outright.36 Applicants are required to provide documentation regarding the relevant maladies showing that the problems are “static or non-progressive,” but the certification process is still fairly simple, as are renewals.37 Renewals are sim-

28 Historical FARs, Fed. Aviation Admin., http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgFAR.nsf/HistoryFARPart!OpenView&Start=1&Count=200&Expand=33#33 [perma.cc/3RBL-U8QF]. Section 67.107(b)(2) was updated in 2006 to modify the definition of "substance abuse" slightly, and a reference to another provision was deleted from Section 67.3. Id. Additionally, the phrasing of Section 67.413 was updated for clarity in 2008. Id.
30 14 C.F.R. § 61.23(a) (2018).
31 Id. § 67.401(b).
32 Id. § 67.401(a).
33 Id. § 61.23(a).
34 Id. § 61.23(d).
36 14 C.F.R. § 67.401(b) (2018); AME GUIDE, supra note 35, at 10.
37 AME GUIDE, supra note 35, at 22.
ple in that as long as the pilot’s condition has not changed for the worse, the AME may renew the SODA without FAS approval. SODAs are “valid for an indefinite period or until an adverse change occurs that results in a level of defect worse than that stated on the face of the document,” or until the underlying certification expires.

Finally, SI certificates may be approved for applicants with otherwise disqualifying medical conditions that are sufficiently managed to the extent that the pilots do not pose a danger to those in their care. Like SODAs, the AME must refer SI applications to the FAS. SIs can expire when the first-class certificate would expire, but the period may be shortened at the FAS’s discretion, or additional requirements such as periodic psychiatric evaluations may be added.

B. Special Issuance Certificates and SODAs

The application process for a pilot requesting a Special Issuance has many additional requirements. First, the AME refers the application to the FAS. The AME sends the relevant information to the FAA for review. The FAS may require additional tests, such as a “medical flight test, practical test, or medical evaluation” when considering whether to grant the SI. Additionally, the FAA may request more information, in which case the pilot must “[f]urnish that information . . . or . . . [a]uthorize any clinic, hospital, physician, or other person to release to the FAA all available information or records concerning that history.” An applicant’s failure to provide the requested information can result in denial of the SI.

If the FAS approves the certification, the pilot receives an SI Authorization letter that details what is required from both the pilot and his or her treating physicians in order to maintain certification. This can include additional periodic exams, letters from treating physicians, and any other supplemental records.

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38 See 14 C.F.R. § 67.401(b) (2018); AME Guide, supra note 35, at 22.
40 14 C.F.R. § 67.401(a).
42 14 C.F.R. § 67.401(a); AME Guide, supra note 35, at 11.
45 Id. § 67.413(a).
46 Id. § 67.413(b).
the FAS believes necessary. For example, a pilot was allowed to fly as a First-Class pilot, provided that he obtain a psychiatric evaluation semi-annually, despite the fact that he had threatened to commit suicide during an argument with his wife and was subsequently diagnosed with a personality disorder. Until the SI expires, the AME can certify the pilot as long as requisite medical records are provided.

C. Problematic Medical Conditions

The FAA created two categories of conditions to which AMEs must pay special attention: Conditions AMEs Can Issue (CACI) and per se disqualifying conditions. CACIs are conditions such as arthritis, asthma, hypertension, and several types of cancer, to name a few. For applicants with these disorders, the AME can issue an unrestricted certificate as long as “the applicant meets the parameters of the CACI Condition Worksheet,” which is a detailed checklist that guides the AMEs’ decision. The AME is not required to submit any documents to the FAA for CACI approvals, but if the certification “requirements are not met, the AME must defer the exam and send the supporting documents to the FAA.”

Conditions that are considered automatically disqualifying are listed in the FARs, which state that there can be “[n]o established medical history or clinical diagnosis.” In other words, the applicant cannot have a specific disorder. AMEs are not authorized to grant certification if an applicant reports a history of any of these diagnoses. Under the FAA’s rules, the physician must either deny the application or submit it to the FAS for review. The pilot does not have an opportunity to present evidence at a hearing for the FAS to consider before making a

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49 Witter v. Delta Airlines, 966 F. Supp. 1193, 1195–96 (N.D. Ga. 1997). Note that Witter’s original diagnosis was bipolar disorder, but another psychiatrist subsequently determined his true “problem . . . might be considered a personality disorder” while a third doctor diagnosed the pilot with “an Adjustment Disorder with Mixed Emotional Features.” Id. at 1196.
55 See, e.g., id. §§ 67.107(b)–(c).
The decision is based solely on documentation provided to the FAS by the pilot and the AME outside of a hearing setting.59

A wide variety of conditions are listed throughout Part 67 of the FARs as unacceptable:60 several heart conditions, such as cardiac valve replacement, heart replacement, myocardial infarction, and pacemakers;61 diabetes mellitus;62 “disturbance of consciousness” or “transient loss of . . . nervous system function(s) without satisfactory medical explanation of the cause”;63 epilepsy;64 “personality disorder that is severe enough to have manifested itself by overt acts”;65 psychosis;66 and substance abuse and dependence.67 Specifically regarding mental health abnormalities, the Guide for AMEs provides that the following conditions require certificate denial or deferral: attention deficit/hyperactivity disorder (ADHD), bipolar or personality disorder, psychosis, substance abuse or dependence, or suicide attempt.68 Other conditions, ranging from adjustment disorder and dysthmic or minor depression to bereavement or use of psychotropic drugs to quit smoking, allow the AME to exercise more discretion in either approving or deferring to the FAS.69

Additionally, several medications are classified as “Do Not Issue,” meaning the AME must submit a pilot’s application to the FAA if the pilot is using any such categorized drugs.70 This classi-

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58 49 C.F.R. §§ 821.24(b), (d) (2018) (stating that the appeal may "contain a complete but concise statement of the reasons why the petitioner believes the certificate denial was erroneous" and that "[t]he Board lacks the authority to review requests for special issuance . . . medical certificates"); see 14 C.F.R. § 67.401(c) (stating that the FAS can only consider "[t]he combined effect on the person of failure to meet more than one requirement of this part; and (2) [t]he prognosis derived from professional consideration of all available information regarding the person").
59 14 C.F.R. § 67.401(c) (2018).
60 Id. § 67.101.
61 Id. § 67.111(a).
62 Id. § 67.113(a).
63 Id. §§ 67.109(a)(2)–(3).
64 Id. § 67.109(a)(1).
65 Id. § 67.107(a)(1).
66 Id. § 67.107(a)(2).
67 Id. § 67.107(a)(4).
68 AME GUIDE, supra note 35, at 156.
69 AME GUIDE, supra note 35, at 156.
fication is based on the medications’ performance-impeding side effects, such as blurred vision, drowsiness, hallucinations, and memory impairment.\textsuperscript{71} Do Not Issue drugs include: any drugs approved less than twelve months ago by the FDA; psychiatric or psychotropic medications; seizure medications; smoking cessation aids; and high-dose steroids.\textsuperscript{72} These medications force applications to be deferred, even when they are prescribed for conditions other than those they were created to treat.\textsuperscript{73}

The psychiatric and psychotropic category includes some widely-prescribed types of drugs such as “antidepressants . . .[,] antianxiety drugs . . .[,] antipsychotics[,] [medications for] attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) . . .[,] mood stabilizers[,] sedative-hypnotics[,] stimulants[,] and tranquilizers.”\textsuperscript{74} Because drugs like antidepressants and ADHD medications are so prevalent, and the prescription rate is growing,\textsuperscript{75} it may become increasingly difficult to find potential pilots who do not use these medications.

D. An Exception to the “Do Not Issue” Rule

The FAA did create some leeway regarding four specific antidepressant medications that are selective serotonin reuptake inhibitors (SSRIs).\textsuperscript{76} A pilot who has been taking one of these particular SSRIs\textsuperscript{77} for at least six months prior to certificate application and wishes to continue to use the prescription may do so under certain prescribed circumstances.\textsuperscript{78} The pilot must have “been clinically stable as well as on a stable dose of medication without an aeromedically significant side effects” in order to be eligible for an SI Authorization with continued use of the

\begin{footnotesize}
\begin{enumerate}
\item Id.
\item Id.
\item Id.
\item Id.
\item AME GUIDE, supra note 35, at 156.
\item The applicable SSRIs are fluoxetine, sertraline, citalopram, and escitalopram. AME GUIDE, supra note 35, at 157.
\item AME GUIDE, supra note 35, at 157.
\end{enumerate}
\end{footnotesize}
SSRI. This applies to those diagnosed with (1) mild to moderate “[m]ajor depressive disorder; [(2)] [d]ysthymic disorder; [(3)] [a]justment disorder with depressed mood; or [(4)] [a]ny non-depression related condition for which the SSRI is used.” If the applicant has a history of “[p]sychosis[,][s]uicidal ideation[,] [e]lectro convulsive therapy[,] [t]reatment with multiple SSRIs concurrently, [or] . . . prior use of other psychiatric drugs in conjunction with SSRIs,” the pilot is not eligible for the SSRI exception.

There is an onerous burden on a pilot trying to obtain an SSRI exemption. The applicant is required to present in-depth medical history regarding mental health, including when symptoms started and what the symptoms were, what treatment was sought, any current or previous treatments and providers, and the current status of the pilot’s depression. The applicant must also provide statements from his treating physician and his psychiatrist and a report from a neuropsychologist addressing the results of a cognitive screening and neurocognitive evaluation. The SSRI Initial Certification form states that this information is the “absolute minimum information required” for the FAA to consider a Special Issuance while the pilot is taking one of these SSRI drugs. Moreover, the form requests clinic notes from the providers consulted and states that the reports must be from within the last ninety days. In addition to all of this medical information, the pilot must send the FAA reports from his chief pilot or airline management designee if he has been “employed by an air carrier within the last 2 years.”

If the pilot is granted an SI with an SSRI exemption, he is required to see a Human Intervention Motivation Study (HIMS) AME every six months to ensure the condition is still under control and that there have been no adverse changes in mental health. This includes review of a report by the treating physician (or by the psychiatrist) before every AME visit; an annual report regarding neurocognitive testing from the neurop-

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79 AME GUIDE, supra note 35, at 157.
80 AME GUIDE, supra note 35, at 157.
81 AME GUIDE, supra note 35, at 157–58.
82 AME GUIDE, supra note 35, at 164.
84 AME GUIDE, supra note 35, at 164–68.
85 AME GUIDE, supra note 35, at 164–68.
86 AME GUIDE, supra note 35, at 164–68.
87 AME GUIDE, supra note 35, at 169–70.
psychologist; a report from the chief pilot every three months; and any additional reports required by the SI authorization letter. If everything checks out, the HIMS AME can recertify the pilot. But if any item on the HIMS AME’s checklist is questionable, the recertification must be deferred and reviewed by the FAA.

The pilot may also decide to discontinue the SSRI, in which case the applicant must be off the medication for at least sixty days, and his physician must report that his mood has been stable and there has been no evidence of “aeromedically significant side effects.” In either case, the decision must still be “made on a case-by-case basis” by the FAA after the applicant sees both an AME and a specialized AME. Any pilot diagnosed with minor depression and taking another formulation of an antidepressant goes through the same SI application process as any other applicant taking a “Do Not Issue” medication.

Another exception to the purported disqualifying conditions is substance abuse and dependence. Pilots with drug or alcohol problems are offered the option of entering a HIMS, which aims to “effectively treat the disease of chemical dependency.” The program involves individualized treatment plans with oversight from a specialized AME, and it allows pilots to return to flying after successfully completing treatment, provided they attend all required follow-ups and meetings. HIMS treats substance abuse as a disease rather than simply a lack of willpower. These pilots are issued a special type of SI, so they are subject to close supervision just like pilots with other types of medical conditions.

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92 As previously discussed, severe depression is disqualifying even if the pilot is taking an SSRI to treat the disorder. See AME Guide, supra note 35, at 157.
95 Id.
96 Id.
97 Id.
E. Disqualifying Conditions, “Do Not Issue” Medications, and Issuance of SIs and SODAs

While the FAA providing discretionary options for a pilot to be granted ATP privileges seems reasonable, the reality is much more inflexible than it seems. As of May 2017, only fifty First Class pilots had been authorized for a Special Issuance based on use of approved SSRIs.98 Only 1,361 pilots with neuroses, anxiety, hypochondria, or a phobia have been certified.99 Merely eleven pilots with major affective disorder, depression, or mania have been certified.100 Additionally, only forty-six pilots with a history of seizures have been approved to fly, and only thirty-two with a diagnosis of multiple sclerosis, chronic brain syndrome, or degenerative nerve disease have been approved.101 Heart conditions other than hypertension also have low certification numbers, ranging from zero to nearly 850, depending on the severity of the condition.102 However, 14,000 pilots with hypertension are licensed.103 Regarding substance abuse and dependence, more than 10,000 pilots have been approved to fly as First-Class airmen after being convicted of an alcohol-related offense, and more than 600 have been certified despite a drug-related offense.104 Additionally, 2,085 pilots reporting alcohol abuse or dependence, and 807 who report drug abuse or dependence, have been allowed to fly as ATPs.105

F. Appealing Denials of First-Class Medical Certificates and Alternatives

According to the FAA, “[96%] of pilots receive their medical certificates at the time of their AME physical examination” when considering all classes of certificates.106 The agency has stated than only 0.05% of applications are ultimately denied.107 In 2015, the FAA granted a total of 33,604 Special Issuance Medical Certificates.108 Nearly 16,000 of those were for First-Class Medi-

99 Id.
100 Id.
101 Id.
102 Id.
103 Id.
104 Id.
105 Id.
106 Pilot Mental Fitness Fact Sheet, supra note 21.
107 Pilot Mental Fitness Fact Sheet, supra note 21.
108 Pilot Mental Fitness Fact Sheet, supra note 21.
If the pilot does not have any of the disqualifying conditions, yet his medical certificate is denied, he has the right to appeal that denial. The application must be reconsidered by a Regional Flight Surgeon (RFS) or a physician at the Aerospace Medical Certification Division (AMCD). If the RFS or AMCD denies the application, the pilot can then appeal to the FAS. Once the FAS issues a final denial, the pilot may then appeal to the National Transportation Safety Board (NTSB). An Administrative Law Judge (ALJ) will review the application, and the ALJ’s decision is subject to review by the full NTSB. If the NTSB’s decision is appealed, it is heard by a federal circuit court.

If the FAA denies an SI or SODA, there is effectively no appeal process. According to the FAA website, “the denial is final.” According to the FAA’s Guide for AME’s, the NTSB does not have jurisdiction to review the denial of a special issuance authorization or a SODA. Although medical opinions can differ, especially when it comes to mental health, which involves far more subjective diagnoses than physical ailments, even if a pilot can present an expert stating that the original diagnosis was incorrect, the NTSB is likely going to defer to the FAA’s decision. The NTSB may only override the FAA’s denial if the applicant can prove the condition does not exist because “the granting of a special issue certificate . . . is completely within the [FAA] Administrator’s discretion and, thus, not subject to [NTSB] review.”

Under the Administrative Procedure Act, courts reviewing administrative action must apply a deferential standard of review and may disrupt the agency finding only if the decision was “ar-

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109 Pilot Mental Fitness Fact Sheet, supra note 21.
112 Id.
113 Id.
114 Id.
115 Id.
116 Id.
117 AME GUIDE, supra note 35, at 23.
118 Reder v. Admin’r of FAA, 116 F.3d 1261, 1262–63 (8th Cir. 1997).
bitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.” 119 In other words, a court cannot substitute its judgment for that of the agency and may overturn the agency decision only if it was made without a reasonable basis.120

If a medical certificate applicant appeals the NTSB’s denial to a federal circuit court, the court must apply this deferential standard.121 However, the federal courts have more discretion than the NTSB. The D.C. Circuit has held that if a pilot’s medical certificate is denied based on a “disputed issue of fact,” such as whether the pilot actually suffers from a dangerous mental health condition, the NTSB’s action may be considered arbitrary and capricious if the pilot is not allowed to present evidence on his behalf.122 For example, in Dickson v. FAA,123 Dickson argued that he should be issued a SI authorization because a doctor cleared him for flight based on his current medical condition.124 He claimed that, when reviewing his application, the FAS only considered his history and not his current health.125 The Fifth Circuit held that it is permissible for the FAS, in considering an application for SI, to rely on the applicant’s medical history as a whole.126 There is no requirement for the FAS to solely consider a pilot’s current medical state, therefore the decision was not arbitrary when based upon Dickson’s complete medical record.127 This procedure creates uncertainty for pilots with disqualifying mental health conditions, and it also puts an incredible obstacle in pilots’ paths for resuming flight duties.

III. MENTAL HEALTH

Of the health problems that are automatic disqualifiers for receiving a First Class Medical Certificate, many are related to mental health. On the medical history form, if a pilot has an affirmative response to any of the mental health questions, an “investigation through supplemental history taking” is re-

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121 Reder, 116 F.3d at 1263.
123 480 Fed. App’x 263 (5th Cir. 2012).
124 Id. at 267.
125 Id.
126 Id.
127 Id.
required.128 According to the National Institute of Mental Health, in 2016, nearly 20% of adults in the United States had a diagnosable mental illness within the past year.129 This rate was highest for those in the eighteen to twenty-five age range, with the rate decreasing as the group age increases.130 Even more jarring is the prevalence for adolescents, defined as children ages thirteen to eighteen.131 Around 49.5% of this age group was found to have mental illness in the same year.132 The increase in incidence is concerning because, if the trend continues, even if some of the adolescents with mental health diagnoses are later found to be stable, a large portion of the population will be automatically excluded from obtaining a medical certificate from the FAA.

A. SOURCES OF OVER-DIAGNOSIS AND MISDIAGNOSIS

It is commonly suggested that more people are qualifying for mental and psychiatric disorders not due to physiological change, but rather because of the criteria laid out in the Diagnostic and Statistical Manual of Mental Disorders (DSM).133 The DSM is “an authoritative volume that defines and classifies mental disorders in order to improve diagnoses, treatment, and research.”134 The DSM is created by the American Psychiatric Association and is relied upon by mental health professionals “to diagnose and classify mental disorders.”135 The DSM aims “to facilitate an objective assessment of symptom presentations in a variety of clinical settings,”136 but “[t]he experts who establish the DSM criteria . . . worry more about missing cases than about

128 AME GUIDE, supra note 35, at 34.
129 Mental Illness Statistics, supra note 12.
130 Mental Illness Statistics, supra note 12. The rate for eighteen- to twenty-five-year-olds is 22.1%, while the rates for twenty-six- to forty-nine-year-olds and those fifty years of age or older are 21.1% and 14.5%, respectively. Mental Illness Statistics, supra note 12.
131 Mental Illness Statistics, supra note 12.
132 Mental Illness Statistics, supra note 12.
133 See, e.g., Allen J. Frances, Psychiatric Fads and Overdiagnosis, PSYCHOL. TODAY (June 2, 2010), https://www.psychologytoday.com/blog/dsm5-in-distress/201006/psychiatric-fads-and-overdiagnosis [perma.cc/VZG9-2Y47] (stating that the criteria are “fairly easy to meet” and that “[t]he definitional thresholds may be set too low”).
135 Id.
136 Id.
casting too wide a net and capturing people who do not require a diagnosis or a treatment.”

While the stated purpose is to be objective, studies have found, even when basing diagnoses on the DSM, that there is an incredible disparity in diagnoses between doctors. One psychotherapist even went as far to say that “[t]here [is] not a single diagnosis in DSM that lives up to the standards of medical diseases.” The rate of misdiagnosis is even greater when general practitioners, rather than specialized doctors such as psychiatrists, are the ones making the diagnosing decisions. This discrepancy between diagnoses is found in doctors treating both adults and children. One study reveals that a quarter of pediatricians use the criteria laid out in the DSM to make diagnosis decisions for patients with potential mental health disorders. Another study found that mental health specialists stuck to guidelines more closely and therefore are “less liberal” with the associated disorder labels and diagnoses than other physicians also certified to make these findings. Because different disorders (even ones that seem related) frequently require vastly different treatment methods, it is imperative that they are diagnosed correctly, otherwise patient care could suffer.

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137 Frances, supra note 133.
138 The Dangers of Mental Health Misdiagnosis, BRIDGES TO RECOVERY (Aug. 4, 2017), https://www.bridgestorecovery.com/blog/the-dangers-of-mental-health-misdiagnosis-why-accuracy-matters [perma.cc/4NPS-FJCU]. The article cites two studies. In one, “57% of adults diagnosed with bipolar disorder did not meet diagnostic criteria upon more comprehensive diagnostic review,” and in the other, it was “found that general practitioners correctly identified depression in patients in 47.3% of cases.” Id.
140 Id.
141 Id.
142 Id.
143 Id.
Even when mental health professionals diagnose patients, the rate of error can be high. One study found that 40% of people who met criteria for bipolar disorder were misdiagnosed as having Bipolar Type 2 (likely due to similarities between symptoms).\textsuperscript{145} Additionally, lack of treatment availability leads physicians (again, especially those less trained in mental disorders) more likely to “err on the side of diagnosing the disorder that is medication-responsive.”\textsuperscript{146}

The influence of “cultural and ethnic factors” on providers’ opinions of patients’ mental states provides another source of provider error.\textsuperscript{147} While this problem most often leads to misdiagnoses, or even missed diagnoses, it contributes to overdiagnoses as well. African-Americans are more likely than other races to be inappropriately diagnosed with schizophrenia, for example.\textsuperscript{148} Because schizophrenia is a disqualifying condition under the FARs,\textsuperscript{149} those misdiagnoses can significantly impact African-American pilots’ medical certification. If the patient was diagnosed with depression instead, he or she would have a greater chance of receiving an SI medical certification because antipsychotic medications are disqualifying, while exceptions are made for some types of antidepressants.\textsuperscript{150} These types of errors create considerable problems in providers’ diagnosis determinations.\textsuperscript{151}

Patients’ inaccurate descriptions or non-disclosures of their symptoms may lead to misdiagnosis as well. These information-gathering errors\textsuperscript{152} are especially problematic for patients suffering from bipolar disorder. Most people do not understand that manic phases are actually symptoms that increase the likelihood of misdiagnoses of depression or another disorder.\textsuperscript{153} Another specific area of concern is diagnosis in children. It is more diffi-

\textsuperscript{145} Id.
\textsuperscript{146} The Dangers of Mental Health Misdiagnosis, supra note 138.
\textsuperscript{147} The Dangers of Mental Health Misdiagnosis, supra note 138.
\textsuperscript{149} Though not specifically listed in the Guide for Aviation Medical Examiners, schizophrenia is a type of psychosis and is therefore considered a disqualifying condition. See Schizophrenia Diagnosis and Treatment, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/schizophrenia/diagnosis-treatment/drc-20354449 [perma.cc/KC7B-X3G2].
\textsuperscript{150} AME GUIDE, supra note 35, at 156.
\textsuperscript{151} Cathcart, supra note 141.
\textsuperscript{152} Cathcart, supra note 141.
\textsuperscript{153} The Dangers of Mental Health Misdiagnoses, supra note 138.
cult for children to describe or acknowledge their symptoms, and their parents and teachers are not always accurate reporters.\textsuperscript{154}

\textbf{B. THE ADHD AND ANXIETY “EPIDEMICS”}

The influx of recent headlines asserting an “epidemic” of one mental health disorder after another in the United States is hard to ignore.\textsuperscript{155} However, in this context, the term “epidemic” is perhaps being applied too loosely. The CDC’s definition of “epidemic” is intended to apply “to actual cases of disease—not to changing rates of diagnosis, which are subject to many sociocultural variables.”\textsuperscript{156} This discrepancy speaks to the subjective nature of mental health, which makes psychological disorders so difficult to diagnose. When a diagnosis can drastically impact a patient’s future—such as eliminating possible job opportunities—it is important for physicians to take extra care when making decisions.

While mental health diagnoses have been on the rise across the globe, “[a]nxiety disorders are the most common” in the United States.\textsuperscript{157} Approximately 31.1\% of adults will experience some type of anxiety disorder at some point in their lives, and 19.1\% “had [an] anxiety disorder in the past year” according to a study in 2005.\textsuperscript{158} Considering anti-anxiety medications are Do Not Issue drugs\textsuperscript{159} and only 1,361 pilots with neuroses, anxiety, hypochondria, or a phobia have been granted an SI,\textsuperscript{160} this high prevalence rate keeps a lot of potential pilots grounded.

Diagnoses of attention deficit disorders, especially ADHD, are also becoming increasingly common. The CDC monitored

\textsuperscript{154} Cathcart, supra note 141.
\textsuperscript{159} Pharmaceuticals (Therapeutic Medications), supra note 70.
\textsuperscript{160} FAA Medical Certification Statistics, supra note 98.
childhood ADHD diagnosis rates from 2003 to 2012 and found that the rate of diagnosis increased from 7.8% in 2003 to 9.5% in 2007 and 11.0% in 2011.161 Sadie Cathcart’s article, previously mentioned, discussed a study about childhood mental health disorders.162 In that study, the authors listed potential reasons for increases in ADHD diagnoses.163 One important factor was “[c]hanges in diagnostic criteria lead[ing] to reduced thresholds for diagnosis,” meaning the prevalence rate of many disorders increases each time the DSM is re-released (including ADHD and autism spectrum disorder).164 Additionally, doctors do not always “strictly adhere to diagnostic criteria” leaving “their clinical judgment . . . affected by heuristics and biases.”165 Moreover, diagnosticians sometimes ignore or fail to notice less significant exclusion criteria—an error especially likely to lead to diagnoses in cases where there potentially should have been none.166 The study also found an alarmingly high rate of changed diagnoses and low agreement between providers.167 Considering the potential effect of these diagnoses, even a slight tendency to over-diagnose presents a problem. Diagnoses follow children through schooling and into adulthood. Sometimes, misdiagnosis can lead to a worsened condition or future problems resulting from improper treatment and medication. The consequences of misdiagnosis can harm the aviation industry because merely a history of a disqualifying condition, or even of taking a Do Not Issue drug, presents an obstacle to obtaining FAA medical certification.

IV. DISCUSSION

The FAA released a Fact Sheet in June 2016 stating that the agency wants to “work with airlines . . . to reduce the stigma


162 Cathcart, supra note 141.


164 Id.

165 Id. For example, psychotherapists were given nearly 500 cases to review. 16.7% of the doctors gave an ADHD diagnosis despite diagnostic criteria not being met, while only 7% did not diagnose when criteria were met. Id. at 6.

166 See id. at 8.

167 See id. at 4–5.
around mental health issues by increasing awareness and promoting resources to help resolve mental health problems. However, whether the agency has actually accomplished that goal is questionable considering the very small number of pilots with mental or behavioral health issues who are able to fly.

A. A COMPARISON: PILOTS, POLICE OFFICERS, AND FIRE FIGHTERS

Pilots, especially those in major airlines, hold the safety of hundreds of lives in their hands every time they go to work. Therefore, it is undeniably important for a pilot to be appropriately vetted prior to being certified to fly a plane. Other high-stress or dangerous jobs also have certain mental health requirements that must be met before a person is allowed to step into that role. Police officers, firefighters, and other first responders have some of the most mentally demanding jobs, and the application processes for such positions are typically highly selective. Unlike pilot certification, the licensing of these professions is controlled on a state or local level. For illustration and comparison purposes, this article will discuss the requirements for first responders in Texas, but states across the country have similar provisions for their police and fire departments.

The Texas Occupational Code requires that a licensed psychologist or psychiatrist evaluate any prospective law enforcement officer before applicants can be officially hired. However, under the Americans With Disabilities Act (ADA), the exam must come after a conditional employment offer. Additionally, the candidates must not show signs of illegal drug de-

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168 Pilot Mental Fitness Fact Sheet, supra note 21.

169 Pilot Mental Fitness Fact Sheet, supra note 21.


172 42 U.S.C. § 12112(d) (2018). Subsection 3 allows employment entrance examinations related to features that may qualify as disabilities, but it requires that these exams take place after a conditional job offer has been extended. Id. Additionally, every employee must be required to take the exam, and the information
pendency or use. The Dallas Police Department includes a psychological written exam and an in-person evaluation in the second phase of its hiring process to comply with this statutory provision. The Houston Police Department includes these tests in its fifth hiring phase and estimates that the psychological exam will take four to five hours. The San Antonio Police Department lists the psychological exam as the seventh hiring step and states that the goal is to ensure that “the applicant’s psychological and emotional health is appropriate for the duties and functions” to be performed. If the licensing commission reasonably believes the hiring law enforcement agency contravened the statutorily imposed rules, the commission can order the applicant to see a psychiatrist, psychologist, or physician of its choosing for re-testing.

While the Occupational Code contains no specific mandate for firefighters to submit to a psychological exam prior to service, San Antonio and Austin both require some type psychological assessment as a condition of employment. Dallas and Houston do not list any similar screenings on their respective fire department recruiting websites, but the departments still order drug testing. Holding first responders to high mental health standards is logical considering the level of job-related stress their jobs entail.

The Texas Local Government Code provides that, once a firefighter or police officer is employed by a department, there is an “exclusive procedure” for ordering an assessment of

must be kept as a confidential medical record and only made available to those who need to be informed about the employee’s condition. Id.

174 TEX. OCC. CODE ANN. § 1701.306(a)(2).


178 TEX. OCC. CODE ANN. § 1701.306(d).

179 Applicant to Candidate Phase, SAN ANTONIO FIRE DEP’T, http://www.sanantonio.gov/SAFD-Recruiting/BecomingAFirefighter/ApplicantCandidatePhase [perma.cc/N9Z3-36UC].


181 Recruiting, DALL. FIRE-RESCUE, http://www.dallasfirerescue.com/training_support_recruiting.html [perma.cc/CBL3-FHH7].

mental fitness. At this provision, the department head must submit a written order to the police officer or firefighter. At that point, the employee may see a personal psychiatrist or psychologist for examination. If any party contests the results of the report, the certification commission appoints a doctor to carry out a new evaluation. If the first and second reports contain different findings, the commission appoints a three-member board to conduct a third mental fitness examination. The results of the third report are binding on the commission's determination regarding the firefighter or police officer's mental fitness.

While both pilots and first responders are required to undergo a mental fitness exam prior to employment, there are differences in the two processes. First, if a pilot has any history of a disqualifying condition, the pilot is not eligible for AME medical certification approval and must seek FAS review of his or her application. If the FAS approves the applicant's certification, the FAS issues an SI and the pilot must be evaluated regularly by an AME and a personal psychiatrist to ensure any relevant conditions do not change. Similarly, every police officer (and in some jurisdictions, every firefighter) undergoes a psychological evaluation. However, in contrast to pilot medical certification, a police recruit who fails the initial evaluation may retake it during the next hiring session and pass without further questions. While there may not be an appeal process for a police applicant who does not pass the mental fitness screening, a failed exam does not disqualify the person indefinitely.

A police officer's duty is to protect and serve his or her community. As such, many lives are in their hands on a daily basis. The job frequently puts officers in stressful situations that re-

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184 Id. § 143.1115(b).
185 Id.
186 Id. § 143.1115(c).
187 Id. § 143.1115(d).
188 Id. Note that this section only applies to cities with a population of 1.5 million or more people. Id. § 143.1115(a). The process for smaller cities is laid out in Section 143.081 and is substantially the same, except that, rather than the commission making a decision based on the board's findings, the board's findings completely control. Id. § 143.081(d).
quire quick thinking. Pilots are faced with similar situations where they must remain calm and make level-headed decisions in order to protect others’ lives. Additionally, both professions run the risk of needlessly injuring those they are meant to protect if the employees report to work while in an unstable condition. It appears equally important for pilots and police officers to be mentally sound in order to ensure the safety of their communities.

Moreover, there are significant differences between treatment of police officers and pilots who are already employed. ATP-certified pilots see an AME at least once a year to maintain their ability to fly commercial passenger airplanes. A police officer is required to be re-evaluated only if a supervisor orders the test based on the officer’s problematic actions. Police officers and firefighters have the benefit of contesting the findings of these “fit for duty” exams, and supervisors may dispute the results, as well. The mere existence of this review procedure points to a government acknowledgement of mental health subjectivity. The Texas legislators who drafted the code recognized that different providers frequently reach different conclusions about the state of a person’s mental health. Conversely, the FAA seems unwilling to acknowledge the proven fallibility of providers making mental health diagnoses by taking an applicant’s psychiatric history at face value rather than providing more room for review.

The lack of meaningful appeals beyond the FAA level compounds this problem. Because the NTSB and federal courts are so deferential to the FAS’s determinations, pilots who believe their medical certificates were improperly denied or revoked do not have a legitimate opportunity to alter the outcome. These pilots cannot contradict the FAA’s denial or revocation with reports from other doctors attesting to the pilot’s mental health. The NTSB will overturn the adverse decision only if the pilot can prove that he was never diagnosed with the specific disorder.

194 Id. § 143.1115(c)–(d).
195 See id.
196 See Reder v. Admin’r of FAA, 116 F.3d 1261, 1262–63 (8th Cir. 1997).
in the first place.\footnote{Denial of Medical Certification, NAT’L TRANSP. SAFETY Bd. (Mar. 2012), https:/\
/www.ntsb.gov/legal/alj/Pages/medical_denial.aspx [perma.cc/7PAW-N3LZ].} Even if the FAA does not change its method for dealing with or classifying disqualifying conditions, having a different appellate standard may be beneficial to the aviation industry.

\section{Subjectivity of Diagnosing Mental Disorders}

Unlike physical medical issues, or even certain mental health problems like substance abuse, there is no reliable, accurate way to test for most mental health and psychiatric disorders.\footnote{Scutti, supra note 139 (“If I as a therapist tell you (that) you have a mental disorder, it’s not the same thing as my telling you [that] you have diabetes or cancer because diabetes and cancer are diseases that can be confirmed through biochemical findings.”).} While somatic disorders can “be detected by genetic, neuronal, or physiological correlates,” mental disorder diagnosis relies on a patient’s accurate disclosure of symptoms and the doctor’s accurate application of the DSM.\footnote{Merten et al., supra note 163.} This process is complicated by the fact that symptoms do not manifest in the same way for everyone; one person’s experience of a particular disorder may differ significantly from that of another person.\footnote{Lindsay Holmes et al., Mental Health Treatment Can Save Lives, but the Right Diagnosis Can Take Years, HUFFINGTON POST (May 15, 2017, 10:03 AM), https://www.huffingtonpost.com/entry/mental-health-treatment-misdiagnosis_us_590751dae4b05c397680cb4a [perma.cc/ZS4N-9UFH].}

In \textit{Witter v. Delta Airlines}, the plaintiff received four different diagnoses by four different doctors over the course of his employment with the airline: bipolar disorder; a “characterological problem that might be considered a personality disorder”; an adjustment disorder; and Narcissistic Personality Disorder with possible cyclothymia.\footnote{Witter v. Delta Airlines, 966 F. Supp. 1193, 1195–97 (N.D. Ga. 1997).} Is it wise to have life-altering decisions based on such amorphous criteria? The FAA has taken a “better safe than sorry” approach. By default, those who have any history of these types of disorders are excluded from eligibility. The excluded pilots must then show that they are “[able] to safely perform the duties or exercise the privileges of the airman certificate applied for.”\footnote{See 14 C.F.R. § 67.107(c)(1) (2018).} This approach, while over-inclusive, may be the best way to draw the line between fit-to-fly and unfit-to-fly with the diagnostic practices currently available.
Under the Americans with Disabilities Act (ADA), employers (including airlines) cannot mandate an employee to submit to any medical exam “unless such examination . . . is shown to be job-related and consistent with business necessity.”\textsuperscript{205} Because the FARs require pilots to be “able to safely perform the duties [and] exercise the privileges of the airman certificate applied for,”\textsuperscript{206} airlines can order a pilot to undergo a psychological evaluation if the airline is given reason to believe that the pilot is suffering from mental illness and that illness may affect work performance. It is a business necessity that pilots are able to safely transport their passengers, and while many mental disorders do not present a safety threat when well-controlled, there is always a risk of an adverse reaction. This risk, however small, makes it less advisable to permit those with a history of most mental health disorders to fly airplanes.

\section*{C. \textsc{The Effects of High Mental Fitness Standards on the Aviation Industry}}

Between 1992 and 1997, the Aviation Medicine Advisory Service (AMAS) received 1,200 phone calls from pilots asking for advice regarding depression diagnoses.\textsuperscript{207} Sixty percent of those pilots said “they would refuse medication and continue to fly,” while 15\% disclosed that they planned to “take the medications and continue their flying duties without informing the FAA.”\textsuperscript{208} Only 25\% wanted to “take sick leave, undergo the recommended treatment and return to work when aeromedically cleared to do so.”\textsuperscript{209} Additionally, between 1990 and 2001, sixty-one pilots using SSRIs died in the performance of their jobs; of those, only seven had reported disqualifying psychological conditions to the FAA, and only one of those seven admitted to continued SSRI use.\textsuperscript{210}

These statistics do not instill much confidence in the system as it currently exists. The data suggests that pilots would rather not disclose their medical and psychiatric conditions to the FAA in order to avoid the risk of losing their licenses. One pilot, in a blog post, disclosed that he was sick enough to need an ambulance but hesitated to call one for fear of being grounded by the

\begin{thebibliography}{9}
\bibitem{206} See 14 C.F.R. § 67.107(c)(1).
\bibitem{207} \textsc{Bureau d’Enquetes et d’Analyses, supra} note 2, at 41.
\bibitem{208} \textsc{Bureau d’Enquetes et d’Analyses, supra} note 2, at 41.
\bibitem{209} \textsc{Bureau d’Enquetes et d’Analyses, supra} note 2, at 41.
\bibitem{210} \textsc{Bureau d’Enquetes et d’Analyses, supra} note 2, at 41.
\end{thebibliography}
FAA. He explains that “[m]aintaining [his SI] is time consuming and expensive,” and that he could have avoided the need for an SI by refraining from disclosing his health information to the FAA. He also confirms that “the FAA medical certificate procedure discourages seeking help.” A pilot who has not yet been diagnosed and is not taking a banned medication has nothing to disclose to the FAA and therefore has nothing to lie about. The pilot also opines that media reaction to perceived safety concerns creates political pressure, leading to new rules that “merely create the illusion of additional safety.”

The apparent minority of affected pilots that do disclose their disqualifying conditions do technically have a chance of being approved for a medical certificate. That being said, based on the paltry number of SIs granted for such conditions as of May 2017, their odds of approval are slim. In light of this, it is no wonder that pilots would rather lie by omission and risk a fine from the FAA or try to manage their mental health issues without professional or pharmaceutical help.

The problems created by the FAA’s current mental health policy have a direct correlation to the potential issue of pilot shortage. Strict regulation of the piloting profession has always made it “difficult for the industry to meet the ebbs and flows of demand.” Much of that difficulty is the result of stringent training requirements. The minimum qualifications for co-pilots were heightened in 2013. However, sticter training standards

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212 Id.

213 Id.

214 Id.

215 See FAA Medical Certification Statistics, supra note 98. Only fifty pilots have been approved to fly while using SSRIs, and a mere eleven who suffer from major affective disorder, depression, or mania have been approved. Id. Meanwhile, 1,361 pilots with neuroses, anxiety, hypochondria, or a phobia have been certified. Id. Approval rates for those with substance abuse disorders are even higher. Id.

216 See 18 U.S.C. §§ 1001, 3571 (2018). Both the pilot and the AME may be criminally prosecuted if they fail to report a disqualifying medical condition. Section 1001 imposes criminal liability for making false statements to the government, while § 3571 lays out the punishment for a violation of § 1001. See id.

are not the only cause of the narrowing stream of new pilots.218 The current trend of increasing diagnoses of disqualifying mental conditions will result in even fewer applicants eligible to fly for commercial airlines, regardless of their ability to complete the required training programs.219

Meanwhile, Oliver Wyman’s Airline Economic Analysis for 2016 predicts that “the number of commercial aircraft in service in the U.S. [will] rise 7.7[%]” between 2016 and 2026, while “the number of commercial aircraft in the global fleet” will increase by 40% over the same time period.220 Taking retiring pilots into account, U.S. airlines will need an estimated 95,000 pilots over the next twenty years, and the European and Asian markets will require at least as many.221 A pilot shortage—whether caused by training obstacles, inability to obtain medical certificates, or both—could lead to “constrained airline revenue, higher fares, or both.”222 To try to satisfy demand for pilots, the FAA may benefit by reevaluating its stringent mental health requirements. Still, mere increase in the applicant pool may not solve the supply problem since only a limited number of training pilots are permitted to be in the air at one time. Under the increased training hours requirement, “[e]ven a perfectly efficient system could only provide the experience required for two-thirds of the pilots needed in the U.S.”223 The current training program is on pace to produce a maximum of only 64,000 pilots in the same span that the United States is expected to require 95,000.224

D. IS THE NTSB THE PROPER APPELLATE FORUM?

Rather than changing the mental fitness standards themselves, the FAA could solve this problem by adjusting the appellate process.225 Currently, a pilot may appeal an adverse decision from the FAS to the NTSB, but the NTSB’s highly deferential standard of review makes it very difficult for the pilot to prevail.226 Despite the statutory requirement that NTSB hearings be

218 Id.
219 Id.
220 Id.
221 Id.
222 Id.
223 Id.
224 Id.
225 See generally Armstrong, supra note 198.
226 See generally Armstrong, supra note 198.
conducted in an “impartial manner,” the NTSB may only change an FAA decision if “safety in air commerce or air transportation and the public interest do not require an affirmation of the order.” The considerable deference afforded to FAA decisions has severely limited the NTSB’s discretion and autonomy in the appeals process.

Federal district courts may serve as a more appropriate venue to hear pilots’ appeals. Courts have not hesitated to overrule the NTSB’s affirmations of FAA decisions upon the determination that the NTSB failed to properly apply relevant law and precedent. As far back as 1954, the Supreme Court admonished the NTSB for reaching a final decision before even hearing the parties’ evidence. Similar claims of due process violations and other procedural errors by the NTSB have been brought before federal circuit courts repeatedly. Despite judicial indication that its standard of review for FAA actions should be adjusted, the NTSB has continued to afford extreme deference to FAA revocation or denial of medical certificates. The NTSB’s refusal to change, combined with an apparent tendency to ignore its own precedent, has led some to call such decisions arbitrary and capricious.

Because the NTSB may have trouble balancing the duty to protect the public and the rights of the pilots under its jurisdiction, federal district courts could serve as a more impartial forum. On the other hand, this solution could also lead to potential problems similar to those associated with an alteration of the mental fitness requirements. There is a legitimate ques-

229 See generally Armstrong, supra note 198.
231 See, e.g., Moshea v. Nat'l Transp. Safety Bd., 570 F.3d 351–52 (D.C. Cir. 2009) (holding that the NTSB must decide whether the suspension of a pilot's license was appropriate under applicable rules rather than merely deferring to the FAA's determinations); Hart v. McLucas, 535 F.2d 516, 520 (9th Cir. 1976) (holding that the NTSB cannot adopt an interpretation of a regulation that goes against principles of statutory construction, specifically that there is a scienter requirement where the statute uses the word “intentional”).
232 See, e.g., Admin't v. Sue, NTSB Order No. EA-3877, 1993 WL 157467 (Apr. 28, 1993) (holding that intent can be projected onto a pilot based on inattention, seemingly eliminating the requirement set out in Hart).
233 See, e.g., Alan Armstrong, Call for Congressional Inquiry into the Arbitrary and Capricious Decisions of the National Transportation Safety Board, 75 J. Air L. & Com. 3 (2010).
234 See generally Armstrong, supra note 198.
tion as to whether it is preferable to prioritize the welfare of the public as a whole over the right of a pilot to fly a plane, even if it comes at the expense of airlines’ ability to meet the predicted demand for commercial flight.

V. CONCLUSION

One reality is clear regarding how the FAA should treat pilots with mental health disorders—there is no easy answer. Pilots are held to an extremely, maybe impossibly, high standard. It is a standard arguably even higher than that to which police officers and other first responders are held. Carriers have a legitimate interest in ensuring that passengers are as safe as possible. That being said, pilots are just normal people, and “normal” people commonly have some form of mental illness. As Patrick Smith aptly summarized, “[p]ilots are human beings, and no profession is bulletproof against every human weakness [:] [a]ll the medical testing in the world isn’t going to preclude every potential breakdown or malicious act.”235 Still, it is not necessarily dangerous to trust a person with a well-managed mental illness to care for others. However, with the high standards to which the aviation industry is held, the FAA and the airlines have a legitimate interest in ensuring pilots are as fit to fly as possible.

Considering the objective safety of modern commercial flight, the Germanwings incident, while perhaps avoidable, should not have led to the type of public response that followed. Any chance that the FAA might relax its mental health requirements likely went out the window after Germanwings. Airlines and regulatory agencies are doing whatever they can to rebuild consumer trust, and notice of repealed mental health requirements after a highly-publicized pilot mass murder-suicide would not be well-received.

U.S. airlines may experience a pilot shortage in the near future, and while allowing more flexibility for pilots with disqualifying mental conditions may alleviate this supply and demand issue to some extent, such changes are unlikely to provide an effective solution due to the other factors contributing to the shortage. Allowing more pilots with minor, well-managed mental illnesses does provide benefits to the pilots, but the benefits to the industry are minimal. Therefore, considering the serious potential costs associated with relaxing mental health standards, the FAA should probably stay its current course until

235 Smith, supra note 6.
there is a more predictable method of diagnosis and management of psychiatric and other mental disorders. Still, it may be beneficial to vest appellate power in a body more able to act objectively\textsuperscript{236} and provide more room for discretion.

\textsuperscript{236} See generally Armstrong, supra note 198.