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NTSB Order No. EA-5222

UNITED STATES OF AMERICA
NATIONAL TRANSPORTATION SAFETY BOARD
WASHINGTON, D.C.

Adopted by the NATIONAL TRANSPORTATION SAFETY BOARD
at its office in Washington, D.C.
on the 10th day of May, 2006

_____)	
Petition of)	
)	
SCOTT J. PIAS)	
)	
)	
for review of the denial by)	Docket SM-4637
the Administrator of the)	
Federal Aviation Administration)	
of the issuance of an airman)	
medical certificate.)	
)	
_____)	

OPINION AND ORDER

Petitioner has appealed from the written initial decision of Administrative Law Judge William A. Pope, II, issued on July 29, 2005, following an evidentiary hearing.¹ The law judge affirmed the Federal Air Surgeon's (FAS) denial of an unrestricted third-class medical certificate sought by petitioner. The FAS determined that issuance of the medical certificate was barred by Federal Aviation Regulations (FARs) 14 C.F.R. 67.307(c) and

¹ The initial decision is attached.

67.313(c).² We deny petitioner's appeal. The law judge's decision aptly addresses many of the facts and the issues, and we will repeat them only as necessary to an understanding of our decision.

Petitioner first sought psychiatric help on January 6, 1993. He saw Dr. James Anderson. He appeared for treatment after his daughter had been seen by another psychiatrist. Petitioner realized he had many of the same symptoms reported by his daughter and told Dr. Anderson on his first visit that he had dysthymia. Transcript (Tr.) at 39.³ Over the course of 4 years,

² Section 67.307(c) provides that mental standards for a third-class airman medical certificate include: (c) no other personality disorder, neurosis, or other mental condition that the FAS, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds - (1) makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or (2) may reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

Section 67.313(c) provides that the general medical standards for a third-class medical certificate include (c) no medication or other treatment that the FAS, based on the case history and appropriate, qualified medical judgment relating to the medication or other treatment involved, finds - (1) makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or (2) may reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

³ Dysthymia is defined as a low grade depressive disorder. It literally means "bad mood." Tr. at 39. It is characterized by at least 2 years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet the criteria for a Major Depressive Episode. The diagnostic criteria for dysthymic disorder include the presence, while depressed, of two or more of the following: (1) poor appetite or
(continued...)

petitioner tried a number of antidepressant medications to counteract his symptoms of unhappiness, trouble concentrating and difficulty making decisions, overeating, hopelessness, hypersomnia, and tenseness.⁴ Either the medicine had unacceptable side effects or it stopped working after a time.

In 1998, petitioner switched to Celexa, also an antidepressant. Dr. Anderson testified that petitioner had had no adverse side effects from it and, although he could develop side effects that would adversely affect flying capability, the risk of that was slim. In reaching his conclusion that there had been no side effects, Dr. Anderson relied on petitioner's representations.

Petitioner took Celexa until October 2004, shortly after the FAS denied his application. However, after just a few days he resumed taking Celexa. At the hearing, he testified that he was still taking it, and had had no side effects. He has stated that his dysthymia is controlled by this medication. Dr. Anderson testified that if petitioner stopped taking Celexa his symptoms would return and that he has responded well over the last 7 years of taking it. Tr. at 110, 114, 138. Dr. Anderson saw no reason why petitioner should not receive a medical certificate.

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overeating; (2) insomnia or hypersomnia; (3) low energy or fatigue; (4) low esteem; (5) poor concentration or difficulty making decisions; and (6) feelings of hopelessness. Exhibit A-2, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) at 377.

⁴ The law judge thoroughly discussed the numerous medicines.

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The FARs state that a certificate will not be issued to an individual who has a mental condition that the FAS, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds - (1) makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or (2) may reasonably be expected, for the maximum duration of the airman medical certificate applied for or held (here, 2 years), to make the person unable to perform those duties or exercise those privileges. Petitioner admittedly has a mental disorder described in the *Diagnostic and Statistical Manual of Mental Disorders* issued by the American Psychiatric Association. Petitioner has admitted to having, absent medication, many of the symptoms of dysthymia - low energy, poor concentration, hypersomnia, sadness, depression,⁵ worthlessness or guilt, nervousness, anxiousness, and irritability most of the time.

Dr. Myron Almond, who is Board-certified in aerospace medicine and was accepted as an expert in aviation psychiatry, testified for the Administrator. He testified, and we agree, that certain of these symptoms could easily adversely affect aviation safety. For example, poor concentration, questionable decision-making ability in complex tasks, nervousness,

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Initial Decision at 3.

⁵ The record shows that petitioner reported to Dr. Anderson that his depressed state made it difficult to function. Tr. at 208.

anxiousness, irritability, sadness, depression, and feelings of worthlessness clearly would adversely affect a pilot's attention and capability to fly and to prepare for flight in even the most routine circumstances. He also testified that it was just as likely that petitioner had "major depressive disorder," as opposed to dysthymia, a more serious malady in which at least 4, as opposed to 2, of the symptoms listed in footnote 3 are present. The evidence indicates that dysthymia can often develop into a major depressive disorder.

Although petitioner might want it so, the FARs do not provide an exception to the rule for cases where medication is controlling an individual's symptoms. The FAA cannot monitor and cannot be expected to monitor individuals to ensure that they stay on their medication, that they are having no adverse side effects from it, and/or that the medication is continuing to be effective.

Further, we disagree with petitioner's claim that the Administrator (and the law judge) did not look at his medical history but rather that they have decided that the certificate should be denied because the condition and the medication can have aeromedically adverse effects.

Both of the Administrator's expert witnesses carefully reviewed the medical history evidence presented by petitioner. It is true that the Administrator offered considerable medical evidence against any pilot's use of Celexa and the law judge discussed it at length. But in doing so they extensively

discussed the properties that made the drug either an actual or potential problem. The experts also discussed all the record evidence of petitioner's medical history. Both were concerned that Dr. Anderson's conclusions were not reliable because he had not given petitioner cognitive tests and had not spent enough time with him. Even if a patient says he is doing wonderfully, testified the Administrator's experts, they may have concentration problems and problems processing information that can only be seen by cognitive testing (i.e., testing by visual stimuli). Further, Dr. Anderson had not seen petitioner since 2002 and before that, not since 1998 - twice in 8 years. Tr. at 105-106. His 2004 appointment with petitioner was by phone. Thus, the argument that Dr. Anderson's testimony is more reliable because he saw petitioner, and the Administrator's experts did not, has little weight. Further, Dr. Anderson has considerably less knowledge in these areas, and no specialized aviation knowledge.

In addition, as the Administrator's expert witnesses testified, self-reporting is not reliable not only because of its self-serving nature but also because a patient may not recognize adverse effects on his behavior or performance. It is necessary for the physician to observe the patient often and closely to discern whether there are side effects. For all the foregoing reasons, we decline to rely on Dr. Anderson's conclusions or petitioner's argument that flying while taking Celexa would not compromise aviation safety.

Accordingly, petitioner has failed to demonstrate by a preponderance of the evidence that the FAS was not reasonable in concluding based on, "the case history and appropriate, qualified medical judgment relating to the condition involved," that sections 67.307(c) and 67.313(c) prevented issuing an unrestricted medical certificate to petitioner.

Petition of Bullwinkel, NTSB Order No. EA-4273 (1994), on remand from Bullwinkel v. FAA and NTSB, 23 F.3d 167 (1994); and Petition of Selbach, NTSB Order No. EA-4267 (1994), do not compel a different result. The posture of these cases is different from the one before us. In Bullwinkel, the Board found on remand that the Administrator's evidence regarding petitioner's medical condition (mild bipolar disorder) was not adequate to rebut petitioner's showing of lack of adverse effect to aviation safety. In declining to issue an unrestricted medical certificate, the Administrator had relied primarily on the medicine that controlled the condition rather than the condition itself. In fact, the Administrator's expert testified that the underlying condition would not be disqualifying. The Seventh Circuit held that the over-reliance on the use of a particular medication as disqualifying rather than the condition being disqualifying was improper under the wording of the rules at the time (they were subsequently changed to accommodate the court's opinion). The decision on remand was on the same record and, given the court's decision, the testimony by the Administrator's expert that the underlying condition would not be disqualifying

was controlling.

Selbach was decided after the remand in Bullwinkel but with a record developed before the court decision and again focusing on the medication rather than the ailment. In Selbach, petitioner was diagnosed with primary dysthymia, early onset, which in contrast to the evidence in this case presented only as an inability to enjoy life. Id. at 4-5. The Board found that the inability to enjoy life was not sufficient to deny the application. Here, in contrast, the expert testimony clearly shows that petitioner's underlying diagnosis and case history make him unfit to hold a medical certificate now and in the future 2 years. Petitioner's evidence is not sufficient to demonstrate that the FAS was wrong in declining to issue the certificate.

Finally, petitioner's claim that the Administrator's rules violate federal discrimination statutes is not cognizable by this Board. Administrator v. Ewing, 1 NTSB 1192, 1194 (1971) ("it is well settled that the Board does not have authority to pass on the reasonableness or validity of FAA regulations, but rather is limited to reviewing the Administrator's findings of fact and actions thereunder.").

ACCORDINGLY, IT IS ORDERED THAT:

Petitioner's appeal is denied.

ROSENKER, Acting Chairman, and ENGLEMAN CONNERS, HERSMAN, and HIGGINS, Members of the Board, concurred in the above opinion and order.