

# HIMS: A RESTORING FORCE

Thanks to its therapeutic approach rather than a punitive approach, more than 3500 pilots are flying today after loss of their medical certificate to a disease that once kept all affected pilots out of their cockpits.

By Esperison Martinez, Contributing Editor

ACARS, TDR, CAS, DFDR, SIGMETS, FDR, FMS, GPS, HIMS, ARTS, HUD, TCAS, , CVRCP,...in a profession that depends so heavily upon a safety web whose countless links are mostly identified by acronyms, it is difficult for the seldom used to be quickly recalled. And that seems to be the case with HIMS whose contributions to restoring good pilots to the cockpit by helping them overcome the insidious disease known as alcoholism has produced increased safety margins. Many pilots have forgotten or may not even be aware of ALPA Human Intervention and Motivation Study (HIMS), which has returned more than 3500 pilots to the cockpit since its inception 29 years ago on Oct. 1, 1974.

Also probably forgotten is that HIMS was initiated, fashioned, and developed for airline pilots by airline pilots. It happened because a thoughtful, frank, in-your-face-physician had the intrepidity to stand before an assembly of the 1972 ALPA Board of Directors, made up of many grizzled, tenacious, heavy year experienced pilots, and open the very taboo subject of alcoholism in the cockpit. Back then no reliable or system wide method existed to provide help to airline pilots with alcohol problems. In the early Seventies, the term "alcoholism" equated with "drunks." And when discovered in the cockpit, "drunks" were summarily fired from their jobs, lost their FAA medical certification and literally were forever banned from the airline piloting profession. The notion that alcoholism could be a bona fide disease was alien to most laypersons and decision makers in the air transport industry; the prevailing attitude was "once a drunk, always a drunk." The dark side safety effect of this was that addicted pilots, stayed in the closet. "Too often, the only way we would discover an alcoholic pilot, was when withdrawal seizures struck while on-duty," said an FAA official.

The enlightened physician who faced the BOD, Dr. Richard L. Masters, knew differently. He had been appointed in 1969 to the new ALPA role of Aeromedical Advisor to the union's governing bodies and was charged with advising such bodies about pilot health and welfare problem areas. Dr. Masters was not suggesting an epidemic of pilot alcoholism. He just wanted Board members to recognize that any pilot who drank, and many did, might be susceptible to the illness. He emphasized that existing attitudes of management and the FAA were incompatible with early identification and treatment. For example, from 1960 to 1971 eight pilots petitioned the FAA for alcoholism exemptions; all were denied. Further, FAA granted only 10 of 15 submitted from 1971 to 1974.

Dr. Masters received unanimous approval to establish a health program to address the illness. Working with him were two pilots, Captains R. W. Gilstrap (UAL), and G.S. Chase (CAL/UAL). Two years later they introduced a program they believed would be trusted and accepted by pilots; would convince management and the FAA about the need for such a program; would not tarnish the pilots image; and would be funded by an outside source. The program elements were: Education -general education and ALPA/supervisory training seminars; Program Format Structure -policy, procedures and program evaluation; and Interim Assistance Program -peer identification/intervention, professional diagnostic and referral services, and FAA declaration and aftercare monitoring.

The developed program was a pilot-specific model that provided for recognition of the illness by all parties, intervention, evaluation, referral to treatment, rehabilitation and recertification of airman medical licensure by the FAA. The National Institute for Alcohol Abuse and Alcoholism (NIAAA) worked closely with the pilot team that developed the program, which became the Human Intervention and Motivation Study, and provided three years' funding for it. Eventually, because of HIMS' overwhelming and continuing success, NIAAA renewed the funding twice, for a total of 10 years.

## **Proven assumptions**

The mix of two pilots and a doctor proved ideal for the task at hand. The assumptions they used to develop program mechanisms have proven themselves over 29 years and remain at the core of HIMS today.

- \* Acceptance of alcoholism as a primary treatable disease.
- \* Recognition of FAA and American Medical Association definitions of alcoholism.
- \* Occupational alcoholism programs are expected to have a higher success rate than non-work related programs.
- \* The intensity of job motivation characteristic of airline pilots would be expected to yield a greater recovery rate.
- \* Total abstinence is essential to successful rehabilitation.
- \* Alcoholism readily fits the disease prevention model.
- \* Education can be a factor in changing drinking behavior.
- \* Airline pilot professionalism and the ALPA Code of Ethics promote periodic review of performance.
- \* Knowledgeable and trained individuals are required to staff the program.
- \* An open, honest approach toward recovery is basic to quality sobriety and is consistent with pertinent FARs.
- \* An alcoholic pilot deserves individual professional attention.
- \* Unsuccessful repeated efforts at treatment for alcoholism warrant cessation of flying on medical grounds.
- \* Education of the membership is crucial to the success of the program.

In 1984, at HIMS' zenith, there were full featured HIMS programs on most all the major properties; by then it had returned 1200 pilots to the cockpit, and achieved a 90 percent recovery rate. Unfortunately, budget cutbacks forced NIAAA funding to cease. ALPA, feeling it had achieved its goal of establishing a pilot alcohol intervention program and having it accepted by all, withdrew from its role as "administrator." The program continued under supervision of FAA, independent medical sponsors and air carrier medical officers.

At that time, pilots and the industry were caught in the upheavals of deregulation: jobs were being lost, airlines filed bankruptcy, mergers prevailed and upstart airlines filled the airways. Many persons who had adopted the

teachings of HIMS, were either gone or were leaving the industry. The elements of the HIMS program began to be incorporated into locally developed programs and were given a new name. Encouraging this shift away from the program methodology was the thinking of many that past teaching would carry over and that new upcoming drug and alcohol testing provisions would act as inhibitors to any growth of alcoholism in the cockpit. Attentiveness and interest in HIMS elements and activities began to slacken.

In the early 1990's, which saw some blistering news media coverage of pilots violating the alcohol regulations, it was apparent that hybrid recovery programs were not working nearly as well as had HIMS. Each segment of the industry, labor, owners, regulators examined itself and its program or lack thereof. Consequently in 1992, the FAA funded a resurrection of HIMS. By that time the effects of Deregulation had caused a major makeover of the air carriers. The once dominate major carriers had given way to countless regional and commuter carriers, changing the makeup of the pilot and management force as well; thus forcing "new thinking" in the recreation of HIMS.

"When HIMS originally started it was thought that there would be one program for the entire industry and that it would function the same on all the properties. In its early years, it seemed to follow that pattern, But over the years, what has happened, is the while each property used the HIMS program as a blueprint, they don't follow it exactly; each property has a separate corporate culture and an ALPA culture, together these forces influence what the program on that property looks like," said Dr. Hudson, who joined the ALPA group in 1987 and was "groomed" to fill the Aeromedical Advisor role following Dr. Masters retirement in January 1992.

Contributing to this shift in how HIMS is being executed was the program void between 1984-1992, which led to the new training tack HIMS II took with its new funding by the FAA. The education aspect of the program was designed as a 42-month training and education program consisting of seminars and development of training material for all air carriers, with emphasis on newly established airlines and regional carriers. A Delta retired pilot, Capt. Richard Stone who had served the union as its ECAR (Executive Chairman for Aeromedical Resources) was tagged to serve as the Program Manger for HIMS II. The program shift in emphasis to "education" saw a mass mailing program about alcohol and alcoholism as a family disease that reached 57,000 pilots at 46 airlines, development of a video depicting how to make HIMS elements effective, and development of an outline of a model program to deal with alcoholism for use by air carriers. Mini-1 day seminars were added to the 3-day "national" seminar HIMS conducted. Perhaps owing to the lessons learned from the program break of 1984 to 1992, HIMS has enjoyed continued funding and programming ever since.

## **Demographics shift**

Dr. Hudson says, "The fact that the demographics had shifted then and continues today towards a younger pilot base means that HIMS itself has to continue to focus more on its education role. There are more people coming into the industry now who have never heard of HIMS. To people under 40 this is a new concept. As a result, on many of the properties that fact has really shifted the emphasis to education rather than on maintenance of the committees and that kind of thing. It is the kind of program that you really have to get out and sell every two years on your property, because of the changeover."

That clearly was the case in 1998 at the start of the third renewal of the program. The annual seminar held then, thought planners, would serve as a "refresher" for the attendees. But much to their surprise, almost 80% of those attending were new to the subject and to the program. The same numerical balance held for the most recent HIMS seminar held in the Renaissance Hotel, in Denver, Colorado on Sept. 23, 2003; but this time, the

HIMS planners had expected it and were well prepared.

Dr. Audie Davis, HIMS program manager opened the program. He is now in his second contract term with HIMS. He formerly headed the FAA agency that for 30 years made the decision on which pilots were "fit" to fly. Although he was always an advocate of "keeping pilots flying as long as it could be done safely," he was, for years, unable to overcome the FAA culture that held to the belief that recovered alcoholic pilots should never return to the cockpit. But working together with Dr. Masters in developing what would become HIMS, he became the "most effective force" within the FAA for eliminating the belief.

What was once a seminar, intended only for a pilot audience, and designed to make the attendees "fully ready" to do program work on their property has over the years been honed to a crisp, detailed two-and-half-day education program "...to train peer pilot committee members, airline managers, and physicians in dealing with substance abuse among the pilot profession,"

Dr. Davis, told the assembled crowd of 138 in welcoming them to the seminar. He emphasized, "... this seminar is only the first step in qualifying you to work in this field. Experience in assisting with identification, intervention and continuing care must come from other trained and experienced members in the system."

By the time the data laden program was over, attendees would clearly understand the role they would play in the triad of cooperation between management, union and FAA that allows the methodology of the HIMS program to succeed (see adjacent sidebar HIMS Program Elements) . Unlike those at some earlier seminars, this audience was more familiar with the declarations that "alcoholism is not self induced;" and that "alcoholism is a disease." Here, they would learn the "Why" of those facts.

In providing a broad national overview of the addiction/alcohol problem, Dr.Davis noted the contrasting statistics between illicit drug use and alcohol use:

\*19.5 million Americans used illicit drugs in 2002 -- 8.3 % of the population over age 12.

\*54 million involved in binge drinking, more than 5 drinks on one occasion, in 1 month.

\*16 million involved in heavy drinking, 5 or more drinks a day for at least 5 days in a month.

\*7.7 million people...need treatment for diagnosable drug problem

\*18.6 million need treatment for alcohol problems.

\*1.4. million received treatment for illicit drug problems.

\*1.5 million for alcohol problem.

And what is the statistic for the pilot force? Dr. Davis says, "As in any other professional occupation, about 7 to 10 percent will develop the disease in their professional life time. On an annual basis the number of pilots in a HIMS program ranges from 110 to 130 per year, although for one three year period it fell to 105, 97, and 87. In 2002 the FAA made 80 special issuance and as of mid-September 2003, 61 had been approved." Regarding alcohol testing he noted that in 2001, nine pilots tested positive for alcohol, but the next year 22 tested positive, reducing to 9 by mid-September last year.

Dr. Hudson says that the relapse rate remains low for the pilot force. "From the beginning, our 24 month rate has been 10 to 15 per cent, meaning 85 to 90 percent will remain sober if they make the two year mark. After the 2 year mark, we look at a 10 per cent relapse." He adds that the rate is well above the rate of most programs in existence, except that some of the professional programs, such as for physicians, are also at the 90% mark. "HIMS elements," he said "remains the blueprint for successful recovery programs, nationwide."

## Brother's Keeper

- "*Are you or are you not willing to become your brother/sister's keeper?*" That penetrating question came at the end of an excellent video presentation that demonstrated all the elements of a HIMS program in action: program initiation, identification, intervention, referral, evaluation, treatment, recertification, and continuing care. The question was asked by the man who would take the audience deeply into the subject of "Chemical Dependency: Is it Really a Disease?"

Lynn Hankes, MD, FASAM, Director of the Washington [state] Physicians Health Program and a HIMS Advisory Board member, has been with the program for more than 15 years and is among the 100 pioneer physicians in the nation who passed the first certification exam in addiction medicine.

The Doctor's subject is the core of the HIMS educational effort. Understanding that chemical dependency is truly a disease state is critical to working with those afflicted with it. He began with the basics by stating that alcoholism and any other drug dependency constitutes chemical dependency. A chemical is addictive if it is mind altering/mood changing, reinforcing (taking the chemical stimulates taking more of the chemical), and euphorogenic, (produces intense pleasure). Relative to alcoholism, "Ethyl Alcohol is the active chemical ingredient and it is indeed a drug," the Doctor said.

He reviewed the classes of drugs and noted that contrary to popular opinion, the mortality rate of about 300 per day for alcohol related deaths is higher than the 10 per day from illegal drugs.

Addiction, noted Dr. Hankes, is characterized by three core elements: 1) loss of control, 2) compulsive use; and 3) continued use despite adverse consequences. Loss of control is better described as loss of predictability. Faced with the drug, these individuals cannot predict 3 things: 1.) Whether or not they will use; 2. If they do, how much they will use, and 3. What behavior will follow.

Dr. Hankes further explains that a "Compulsion arises from something called an obsession which is an omnipotent thought that takes precedence over all other powerful thoughts including survival thoughts." He told the audience, "You must understand 'denial,' or waste the next three days: Denial is a distorted relationship between individual and the chemical. Denial is not lying. Lying is a conscious attempt to distort the truth. Denial is a subconscious defense mechanism. It is a little trick the mind plays on itself to protect it from hearing overwhelming bad news. "

He said, "Denial catalyzes a person's continued drinking which causes problems, but the drinking continues because the chemically dependent person can't see the cause and effect connection between the drinking and the problems. The bottom line for the attendees to carry away is that alcoholics and addicts *do not drink or drug the way they do because they want to; they drink or drug the way they do because they **have to!***

To answer the question, 'Is chemical dependency really a disease?' Dr. Hankes turned to medical science. "A

disease is a dysfunctional state with a characteristic form . Certain medically established criteria must be met in order to qualify as a disease state. In order for a condition to qualify as a disease, it must have: a cause; a specific defect (the pathology); diagnostic symptoms, signs and laboratory confirmation; a predictable course; uniform treatment; and a similar response. Chemical dependency has those and therefore qualifies as a disease which is chronic, primary, predictable, and contagious.

As for alcoholism he said: "Like many other diseases, the root cause is not known. The defect appears to be a combination of a brain chemical imbalance and certain psychological traits or lack thereof; Alcoholism is a chronic condition, meaning it is permanent and prone to relapse. It is primary, that is, it stands alone independent of other conditions.; It is often progressive through early, middle, and late stages. It follows this same predictable pattern in all afflicted individuals; Lastly, it is contagious in that the stress of living with an alcoholic produces a condition similar to post traumatic stress syndrome in anyone emotionally bonded to the individual."

In normal brain function, all systems are in balance and its chemical messengers act fast to transmit bursts of data quickly. Alcohol and drugs alter the balance of the brain's systems and change its messengers. They become slower, their actions are prolonged, and responses are diminished. Through a series of Power Point images he showed where different drugs affected various brain areas. Images obtained from spect/pet scans showed how chemical dependency alters brain blood flow, increasing it to areas required for drug use and decreasing blood flow to areas of thinking, learning and memory. Brain glucose (70 to 80 percent of brain energy) is also reduced resulting in decreased brain function. "Once altered," said Dr. Hankes "the brain does not return to normal.

## **Full agenda**

The seminar's full agenda presented 22 speakers, many were veterans of previous seminars, but all recognized it was a "first time" audience and presented their material simply and without undue use of unfamiliar medical terms and language. Dr. Hudson gave a high-grade primer on illegal drugs, before turning to the relationship between airline culture and the drug of choice, alcohol. While virtually every society may encourage "appropriate use" of alcohol as stress relief, airline industry rules about when it can be used are very specific. All pilots are aware of the consumption parameters; but because of the rigidity of the rules, Dr. Hudson says that it is not strange to find that binge drinking, consuming a lot of drinks very quickly, is a common pilot behavior.

The caution that attendees need to convey to their pilot group, he indicated, is that binge drinking may make it possible for a pilot to stay within company drinking rules, but owing to the body's metabolism rate for alcohol, a pilot would most likely break the FAA legal limits of between .02 and .039 of a drug test. He cited as an example four high profile incidents in 2002, in which the pilots involved all tested over .06 BAC (blood alcohol concentration), after consuming 8 to 14 drinks the evening before, all within legal time limits.

He explained that an empty stomach more quickly absorbs the alcohol into the blood stream than does one with food in it. Once the alcohol is absorbed, the blood stream sends it to the brain and it metabolizes primarily into the liver and secondarily into the kidney. In 90 percent of the people, the body metabolizes alcohol approximately at the rate of .015 milligram percent per hour, about .3 fluid ounces. So, a person may stop drinking within the confines of the drinking rules, but if more alcohol has been consumed than the body can metabolize in the hours before the flight (read alcohol test), the person will test positive.

Two long term HIMS connected pilots, Captains Chris Storbeck (DAL) and Chris Behl (AWA) provided

hands-on practical information about working committees. Capt. Storbeck, Delta Pilots Assistance Committee Chairman, stressed that intuition should be trusted when involved in identifying cases of substance abuse: "If it walks like a duck....," he reminded his audience. He informed attendees that most initial information about a pilot that may be having problems usually comes from fellow flight deck and cabin crewmembers. Other sources include the more obvious: on duty DOT tests, security screening reports, hotel incident reports. But calls from a family member concerned about behavior patterns also occur. On rare occasions a self-referral will happen. He further described the need for, and how to provide a supportive atmosphere, the criteria for information to be obtained, the workings of a confidential investigation, and the methodology of the various interventions used at Delta.

Captain Chris Behl, speaking from experiences of a smaller carrier, covered similar subjects. In addition to stressing the need for "long term commitment by committee members," to give meaning to the "Rehabilitate Don't Terminate" goal of AWA's program, he discussed the "bubble theory." He noted that pilots function in a corporate bubble (CB), the working environment, and a private bubble (PB), the living environment. In CB, should the pilot begin to falter, a means exist to gain that information, but in the PB getting any information is extremely difficult, Captain Behl said. Another factor in the bubble theory is that in the CB an affected pilot can appear "Sky King" clean, but the family may have an entirely opposite view. "How does one operate under those conditions?" he asked. "We are here to learn what help to offer and how to have that offer accepted. He went on to describe the working of his group's program.

## **Not a policing action**

Crewmembers unfamiliar with HIMS may look upon it and associated programs as a policing action, but that is way off the mark, says Dr. Hudson. "Our concern lies in the medical aspects of the addiction and how to help the pilot recover," he said. Still, he understands the reluctance to report something that can easily be put aside with the rationalization that "it's none of my business; it's personal behavior. It's not my place to be the alcohol police."

In the recovery business, that type of thinking is associated with the "Snitch Factor."

Dr. Hudson explains: "The piloting profession is a brotherhood, sisterhood, in the sense that all pilots share a common bond and from that comes a reluctance of not wanting to place anyone's career in jeopardy. The fear that exposure will lead to punitive action is what really figures into the snitch factor and the reluctance to report. HIMS pilots, with the training they receive, can credibly give assurance that an affected pilot won't lose his job if his name is put forward or if he is identified by a crewmember." Crewmembers self-debating a report can look upon the 3500 pilots already returned to the cockpit for assurance that the program is intended to assist not jeopardize a career.

Attendees received a perceptive look at "Alcoholism and Family Dynamics" from Nancy Hay, herself a longtime spouse victim, and a qualified family counselor on the subject. Her descriptions of the trauma a family experiences, of how individual family members are affected, and the "rules (don't talk, trust, or feel)" in an alcoholic family system captured audience attention. Lastly, she cautioned "Take care of yourself." Committee members, she said, can all too often become so caught up in their committee work that their own family-life begins to suffer, as well as often creating stress for themselves.

Dr. Jon Jordan, Federal Air Surgeon, FAA, also addressed the group, but opted to forgo his formal presentation

regarding substance abuse in favor of an extemporaneous talk covering the operational aspects of medical certification and the issues facing HIMS committee representatives. He commented on how well the peer alcohol identification system has worked

over past years, but noted an upswing in violation cases. "Education," he said, "is a necessary tool, but it doesn't always work." Nonetheless, he encouraged the continued revitalization of HIMS.

He shortened his presentation to allow time for a Q&A session, which proved to be a lengthy one, as pilots in the audience queried what they believed, was a "new" FAA policy of emergency revocation of the Medical and the Airman's Certificate, on a universal basis, upon failure of an on duty alcohol test. Dr. Jordan responded that while people may see it as a draconian approach and as a change in policy, FAA's Flight Standards Department has always had the authority to revoke a pilot's medical certificate and Airman's Certificate for violations. He cited the "past year's surge" of violations when talking about current practice of automatic imposition of "emergency" revocation and the change in the past practice of selective imposition based on the facts of the case.

Dr. Nicholas Lomangino, FAA's, acting manager of the Office of Aerospace Medicine, later clarified the status of a pilot entering the HIMS program. He said that any pilot **voluntarily** entering a recovery program, such as HIMS, is only required to surrender the medical certificate. In such cases, a pilot is not considered to have violated pertinent FAA regulations and is, therefore, able to retain the Airman's Certificate.

The seminar education process moved on, speaker after speaker supplying practical, hands-on type information to the people who would return to their property and become engaged in sharing what they learned with their pilot group to encourage peer reporting, when necessary, and in working with identified pilots to help restore them to their professional apex and rid them of the addiction directing their lives. Paul Hoover, American Airlines Employee Assistance manager, who helped shape early HIMS seminars and Debra Reynolds, CAL director Employee Health Services, taught the methodology of intervention, first through lecture, then using role playing techniques. Suzanne Kalfus, ALPA attorney spoke at length about, and how to, manage the legal parameters and landmines HIMS volunteers can encounter in fulfilling the many roles associated with the work. Those roles include: providing information, receiving reports, staging interventions, monitoring peers, assisting pilots returning to work and providing feedback to the MEC.

Other presentations covered an overview of how FAA handles addiction issues in medical certification cases; The assessment and treatment aspects of psychological evaluations; a panel discussion on working programs; how cases are prepared for the FAA certification process; a frank talk on Alcoholic Anonymous (AA) as to what it is, and what it isn't; and closing the seminar was a detailed discussion on the rules of drug and alcohol testing.

How did the attendees take to this profusion outpouring of information? First time attendee, Sue Konig, NWA, flight attendant and chemical dependency nurse found the quality to be "... magnificent. It is a wonderful, wonderful seminar and a huge reinforcement of what we are doing and that we are doing it right. The reading materials provided are phenomenal." She is a co-chair for a newly formed flight attendant program.

Bernie Kiambao was another first time attendee, only from the operator's side. "We are establishing an entirely new program for the airline. Formerly the service was contracted out, but it was decided to bring it in-house to establish a positive approach in helping people," she said. She is the Drug and Alcohol program administrator for Hawaiian Airlines and said of the seminar: " It is just awesome. I didn't expect the quality and such a diversity of information.

Is the program content as significant to a second-time attendee as a first? Captain William Noyes, (HAL) answered the question like this: "We need to hear HIMS many times and I find it very helpful to be here a second time. I am absorbing more and after having a year under my belt, I am able to better absorb the tools that I am gaining here." Regarding the intervention role-playing session in which an unintentional "accusatory" tone was heard, he noted, "If there is a tendency to sound accusatory rather than conciliatory it may be because pilots tend to address a problem directly and normally...but that is not the intent. Anybody that may become involved in an intervention is doing it with the best intentions and warmth of the heart; it is not an easy thing to do and it is being done out of genuine concern and compassion."

Lynn Eddy, FAA, Office of Aviation Medicine, expresses her opinion from having served as the FAA's contracting representative for HIMS over the past five years. "The program in my opinion is incredible. People that work on this program are almost all volunteers, all having other jobs. The emotion and camaraderie and the brotherhood they show to this program is like nothing I have ever seen before. It is truly amazing and I think it helps more people than we can ever imagine."

Dr. Collin Howgill, UK Civil Aviation Authority, was one of a dozen physicians attending the seminar. At the CAA, equivalent to the FAA, he serves as the Senior Medical Officer responsible for the certification of pilots with drug and alcohol problems. He was also a first time attendee, but has been associated with certification issues for sometime. He doesn't believe any program similar to HIMS exist within the carriers in the U.K. His opinion of HIMS?

"I think it is absolutely fascinating. Having read the literature provided to us who attended, I have been thinking that it may be a very good idea to set up something similar in the UK. The beauty of the HIMS system is that you are actually being proactive in trying to stop people, before they are found drunk in the cockpit, before they run into problems. That's got to be a good thing."

Alcoholism began to be recognized as a disease in the U.K. about the same time that it began in the U.S., he said, "Amongst the pilot community there are some that would say 'you got a problem, sort it yourself, and if you don't then you are irresponsible and you shouldn't be a pilot.' But, I don't come across that attitude too frequently. And the pilot managers I meet really appear to be very supportive and understanding. I think that has to be the way to go. If one is going to be too draconian, then all that is going to happen is that the matter will again be driven underground and that really doesn't promote flight safety, and we go back to the 'bad old days' and we achieve nothing.

By the close of the education seminar, the thick program agenda booklet and the supplied heavy reference manual had been well thumbed. Not only had the attendees been exposed to detailed statistical data, and new concepts such as "denial being the greatest detriment to treatment," they also had added to their vocabulary terms and meanings peculiar to addiction, such as, recidivism, intervention, constructive confrontations, and craving, to name a few. But even with all that, Dr. Davis' opening caution remained a constant in this effort to restore pilots to their cockpits, "... this seminar is only the first step in qualifying you to work in this field. Experience in assisting with identification, intervention and continuing care must come from other trained and experienced members in the system."

## **HIMS Program Elements**

The below menu of elements constitute a comprehensive HIMS program. Readers should know that for some

carriers the menu might be too encompassing. However a minimal program would include: identification, intervention, assessment, treatment and medical clearance and essential support systems. HIMS operates under a contract with the FAA, which receives program funds from Congress. ALPA expends no funds to maintain HIMS.

- **Written Structure:** mission statement; policy, procedures.
- **Treatment Continuum:** identification, intervention, diagnostic assessment, treatment, continuing care.
- **FAA Medical Certification:** rehabilitation standards, pre-special issuance procedures, post special issuance treatment/monitoring
- **Education & Training:** training specific groups, educating the line pilot, promoting the program
- **Program Evaluation**

## HIMS Advisory Board

The membership of the HIMS Advisory Board reflects the triad of management, union and FAA that directs the program.

### Members:

- First Officer Hal Schichtel, ALPA, HIMS Chairman
- Captain Chris Behl, America West Airlines
- David Berg Esq., Air Transport Association
- Audie Davis, M.D. Program Manager
- Lynn Hankes, M.D. Washington Physicians Health Program
- Wayne Kendall, M.D., Aviation & Preventive Medicine Associates
- Gary Kohn, M.D., Medical Director, United Airlines
- Captain Dexter Tutor, Federal Express
- Ex-Officio Members
- Lynn Eddy, FAA
- Donald Hudson, M.D. ALPA, Aeromedical Advisor
- Jon Jordan, M.D., Federal Air Surgeon, FAA
- Suzanne Kalfus, ALPA Legal Department
- Nestor Kowalsky, M.D. FAA
- Barton Pakull, M.D.