II. SOME SPECIAL ISSUES PECULIAR TO AIR CARRIER PILOTS

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Introduction

The arbitration of alcohol and substance abuse cases involving professional pilots employed by U.S. carriers is distinguished from the arbitration of such cases in most other industries by the regulatory framework established by the Federal Aviation Act of 1958, as amended. While an arbitrator or a System Board of Adjustment may properly establish that a grievant has fulfilled his requirements under the contract and render a final binding award thereunder, the airman is still subject to regulations external to and independent of company rules. It was the impact of the Federal Aviation Regulations (FAR) on the ability of airmen to be licensed and medically certificated that led the Air Line Pilots Association (ALPA) to undertake its Human Intervention and Motivation Study (HIMS) in 1974. The majority of U.S. carriers consider the Federal Aviation Administration (FAA) standards for medical certification to be the guiding standards for continued carrier medical qualification. Hence, FAA certification is tantamount to carrier medical clearance.

The loss of intensively trained and experienced pilots is costly in human and economic terms. We believe such losses to be preventable and maintain that the reduction of those losses has been demonstrated to be the most effective way to manage substance abuse and a variety of behavioral problems. The system described herein neither pampers pilots nor covers up the problems, and it does not negate the ultimate question of responsibility, on the part of either the involved airman, the carrier, or the government.

We confine our remarks here to our area of experience, the airline pilots represented by ALPA. While our medical case experience encompasses use and abuse of a variety of drugs, it is primarily alcohol, as the drug of abuse, that has been the sub-

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stance resulting in problems of dysfunction and violation of company rules, FAA regulations, and civil law.

The Regulatory Framework

The paramount feature distinguishing airline pilots from other professional and nonprofessional employees with regard to use and abuse of alcohol and drugs is the regulatory framework established pursuant to the Federal Aviation Act of 1958, as amended, 49 U.S. Code 1301, et seq. Section 601 of the Act empowers and obligates the FAA Administrator to prescribe and revise from time to time regulations "to promote safety of flight of civil aircraft in air commerce," including "such reasonable rules and regulations, or minimum standards, governing . . . practices, methods, and procedure, as the Administrator may find necessary to provide adequately for national security and safety in air commerce." Section 601(b) of the Act specifies that, "in prescribing standards, rules, and regulations, and in issuing certificates under this title, the Administrator shall give full consideration to the duty resting upon air carriers to perform their services with the highest possible degree of safety in the public interest. . . ."

Pursuant to that authority, the Administrator has promulgated and adopted a voluminous set of FAR, 14 CFR Parts 1-199.

Medical Certification Procedures

The Act specifies that:

> "If the Administrator finds, after investigation, that . . . [the applicant] possesses proper qualifications for, and is physically able to perform the duties pertaining to, the position for which the airman certificate is sought, he shall issue such certificate, containing such terms, conditions, and limitations as to duration thereof, periodic or special examinations, tests of physical fitness, and other matters as the Administrator may determine to be necessary to assure safety in air commerce." (Section 602(b))

Section 67.1 of the FAR "prescribes the medical standards for issuing medical certificates for airmen." These standards are implemented through a detailed structure providing for application for licensure with required disclosure of medical information, examination by FAA designated physicians serving as

Aviation Medical Examiners (AMEs), and internal agency review through an established hierarchy of FAA medical personnel, and they are policed through enforcement action by FAA. In addition to those other certificates issued by the Administrator attesting to his experience and ability, each airline pilot is required to possess a currently effective airman medical certificate issued by the FAA.

Three classes of certificates are available—First Class, Second Class, and Third Class. To assume any cockpit position in an air-carrier aircraft, pilots must possess at least a Second Class medical certificate which has a nominal duration of 12 months. First Class certification has the most stringent standards and the shortest duration—six months. At the end of six months, a First Class certificate lapses to a Second Class certificate for the ensuing six months. Whether a pilot requires a First or Second Class certification depends initially on his flight deck position and secondarily on his employer's job requirements. Thus, the regulations specify that to serve as pilot-in-command (captain), he must hold a First Class certificate, while a Second Class certificate is adequate for any other cockpit position (copilot, flight engineer). However, many carriers require, by house rules or provisions of applicable labor agreements, that all of their pilots possess currently effective First Class medical certificates. Semiannually or annually, as appropriate, each pilot therefore must apply for medical certification and prove his fitness to the FAA. He does so by completing appropriate portions of the FAA's standard "Form 8500" application, submitting the form to a designated AME, and undergoing a physical examination by such examiner in accordance with the FAA's established protocol for such examinations.

Form 8500 requires the applicant to disclose, under penalty of perjury, whether he now has or ever has had, among 23 specific items, "any drug or narcotic habit," "excessive drinking habit," "admission to hospital," "record of traffic convictions," and "record of other convictions." Another portion of the form requires the applicant to disclose his "medical treatment within the past five years," describing the nature of the treatment as well as the provider of the medical services.

By way of illustration, an applicant who had been treated in a hospital for alcoholism would have to disclose to the AME, on his Form 8500 application, his hospitalization and treatment. Failure to disclose would subject him to prosecution for perjury,

as mentioned above, and action by the Administrator pursuant to Section 67.20 of the Federal Aviation Regulations which proscribes making "any fraudulent or intentionally false statement on any application for a medical certificate," and authorizes the Administrator to suspend or revoke any airman or medical certificate held by the maker of such a statement. The FAA has vigorously pursued cases of fraudulent nondisclosure or intentional falsification by applicants for medical certificates, particularly where the facts concealed may be determinative of whether the applicant meets the minimum acceptable medical standards.[1] The usual penalty sought by the FAA in such cases is revocation of any medical certificate issued and, in certain circumstances, revocation of any other airman certificate the applicant possesses, on grounds that his actions demonstrated his lack of the integrity and credibility which are prerequisites for qualification for any airman certificate.

After completing his examination of the applicant, the AME is authorized to issue a certificate if he finds the applicant meets the minimum acceptable standards, to deny the application if he finds the pilot plainly disqualified, or to forward the application for consideration by the next level up the ladder in the FAA's medical hierarchy—the Aeromedical Certification Branch in Oklahoma City. Even if the AME issues the certificate, the Administrator has 60 days within which to review and reconsider that action before it becomes a final action of the FAA. If the Administrator questions the applicant's qualifications within the 60-day period, the burden will be upon the applicant to demonstrate his fitness.

The Administrator, acting through his designated medical officers, may at any time request additional medical information pursuant to Section 67.31 of the regulations, which provides:

> "Whenever the Administrator finds that additional medical information or history is necessary to determine whether an applicant for or the holder of a medical certificate meets the medical standards for it, he requests that person to furnish that information or authorize any clinic, hospital, doctor or other person to release to the Administrator any available information or records concerning that

[1] *See, e.g., Administrator* v. *Howard,* 2 NTSB 222 (1973) (failure to disclose use of FAA prohibited medication); *Administrator* v. *Cochran,* 1 NTSB 136 (1967) (excessive drinking habit, suicide attempt); *Administrator* v. *Sorenson,* 1 NTSB 1919 (1972) (traffic convictions, admission to mental hospital).

history. If the applicant or holder refuses to provide the requested medical information or history or to authorize the release so requested, the Administrator may suspend, modify, or revoke any medical certificate that he holds or may, in the case of an applicant, refuse to issue a medical certificate to him."

The ability to request additional medical information is available to the FAA at any level of its medical hierarchy. Of course, the pilot may challenge the request as being arbitrary under his particular circumstances.

The Aeromedical Certification Branch may affirm or override the AME's action, or may forward the application to the FAA's highest medical authority, the Federal Air Surgeon in Washington, D. C. Applicants who, in FAA's opinion, do not meet the medical standards may nevertheless be granted medical certification through the "special issuance" procedures established under the recently revised provisions of Section 67.19 of the regulations. If the Administrator, acting through the authorized medical representatives of the FAA, deems that the individual pilot's medical circumstances warrant certification, subject to such additional tests and procedures on such periodic basis as may be appropriate, it may be forthcoming even though the pilot suffers from an otherwise disqualifying medical problem.

For example, the medical standards for all three classes of certification provide that in the normal course, an applicant is ineligible for certification under the "mental and neurologic" standards if he has an

". . . established medical history or clinical diagnosis of any of the following: . . .

"*(c)* Alcoholism, unless there is established clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence from alcohol for not less than the preceding 2 years. As used in this Section, 'alcoholism' means a condition in which a person's intake of alcohol is great enough to damage his physical health or personal or social functioning, or when alcohol has become a prerequisite to his normal functioning.

"*(d)* Drug dependence. As used in this section, 'drug dependence' means a condition in which a person is addicted to or dependent on drugs other than alcohol, tobacco, or ordinary caffeine-containing beverages, as evidenced by habitual use or a clear sense of need for the drug."[2]

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[2]Section 67.13, 67.15, 67.17 (d)(1)(i)*(c), (d).* The first sentence of paragraph *(c)* was adopted in May 1982 by Amendment 67-11 which changed the former language permanently denying medical certifications, all classes, for an "established medical history or

Drug and alcohol abuse are thus defined as medical conditions, and the established clinical diagnosis or history of either is cause for denial of FAA medical certification.

Federal Aviation Regulations were designed, no doubt, to remove potentially dangerous addicted persons from the cockpit. Current regulations are different from those that became effective in 1959. The 1959 regulations, in effect until mid-1982, permanently disqualified persons with an established clinical diagnosis or history of alcoholism or drug addiction. In 1981, however, a federal appeals court decision applied Public Law 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (Hughes Act) to the FARs.[3] The court held that no person, including a pilot, could be denied a federal license merely because of a history of alcoholism. The FAA then amended (May 1982) the regulation (FAR, Part 67) to delineate the factors that would be considered in establishing eligibility for an airman's medical certificate after rehabilitation from alcoholism.[4] No change was effected for the drug dependence definition, which remained disqualifying by the original 1959 language.

This change in the alcoholism regulation provided pilots with some hope of eventual certification after treatment and rehabilitation. The watershed November 10, 1976 policy statement of the Federal Air Surgeon concerning "Alcoholism and Airline Flight Crewmembers" evolved as a result of the tripartite HIMS program (described elsewhere). The policy continued to be one of waiving the mandatory denial rule existing before the May 1982 amendment. The current rule allows certification for air carrier pilots successfully demonstrating their rehabilitation, with special proviso that all such "exemptees" ("special issuances" under new language) submit to monthly monitoring by company and union officials and periodic reevaluations by aftercare programs from treatment centers and specially designated psychiatrists and/or psychologists.

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clinical diagnosis" of "alcoholism" to: "Alcoholism, unless there is established clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence from alcohol for not less than the preceding 2 years . . . ."

[3]*Jensen* v. *Administrator,* 741 F.2d 797 (9th Cir. 1981).

[4]It should be noted that Jensen was granted a second class medical certificate, the regulation was amended, and the court's order was vacated. *Jensen* v. *Administrator,* 680 F.2d 593 (9th Cir. 1982).

Dispute Resolution Mechanisms

Internal avenues of review are available within the established FAA medical hierarchy for an applicant who has been denied licensure by the AME or at some other level of the FAA's medical establishment. First, he may request reconsideration by the next higher level. For example, if his AME found him disqualified, the applicant could request reconsideration by the Aeromedical Certification Branch. The wise applicant would provide additional medical documentation in support of his request in order to rule out, if possible, the disqualifying condition found by the AME.

Denial by the Aeromedical Certification Board does not foreclose a pilot from requesting reconsideration by the Federal Air Surgeon. Denial by the Aeromedical Certification Board, the Federal Air Surgeon, or any one of the nine Regional Flight Surgeons, geographically scattered throughout the United States, does constitute a "final agency action" by the FAA. The applicant is then entitled, pursuant to Section 602(b) of the Federal Aviation Act, to petition the National Transportation Safety Board (NTSB) "for review of the Administrator's action." The Act provides that the petition will be assigned "for hearing at a place convenient to the applicant's place of residence or employment." Hearings are conducted by NTSB administrative law judges, also geographically decentralized. The NTSB has adopted "Rules of Practice in Air Safety Proceedings" that detail procedures for the conduct of such hearings and appeals therefrom to the NTSB in Washington, D. C. The rules provide that, in proceedings brought under Section 602(b) of the Act, "the burden of proof shall be upon the petitioner."[5] He must carry that burden "by a preponderance of reliable, probative, and substantial evidence."[6]

Section 602(b) of the Act specifies that "in determining whether the airman meets the pertinent rules, regulations, or standards, the Board shall not be bound by findings of fact of the Administrator." Consequently, hearings before the NTSB administrative law judge are de novo. The rules provide for the FAA to answer the petition, and in so doing, the issue is gener-

[5]Section 821.25, 49 CFR, Part 821.25. *See Administrator* v. *Journic,* NTSB Order No. EA-1705 (Nov. 16, 1981).

[6]*See* Section 821.49 of the Board's Rules of Practice.

ally framed by identifying the specific medical condition or conditions in issue. Discovery is available at the discretion of the administrative law judge. In practice, the petitioning pilot will need expert medical testimony and precise medical documentation establishing his fitness in order to carry his burden. Of course, the Administrator will be represented by counsel and supported by his medical experts and medical documentation. The sole question at bar will be whether the petitioner meets the applicable standards of Part 67 of the regulations.

The rules permit the administrative law judge to issue an oral decision at the conclusion of the hearing, but frequently written briefs are filed and the law judge takes the case under advisement, rendering a published written decision at a later time. The administrative law judge may affirm, reverse, or modify the final action of the FAA which gave rise to the petition for review. Thus, he may order the Administrator to issue the certificate for which the petitioner has applied. Conversely, he may sustain the Administrator's denial of such certificate.

Either party may appeal from the administrative law judge's decision. That appeal is perfected by written brief to the NTSB. Oral argument is available in only very limited circumstances. The NTSB is not bound by the findings of its administrative law judge, and the Board may affirm, reverse, or modify the law judge's decision. If the Board's decision is adverse to the petitioner, he may seek review in an appropriate U.S. court of appeals. This latter course is not available to the FAA if they lose the case before the Board.

Enforcement of Medical Standards

Each pilot is personally obligated to comply with the applicable medical standards. In this regard, Section 61.53 of the FAR provides: "Operations During Medical Deficiency. No person may act as a pilot-in-command, or in any other capacity as a required pilot flight crewmember, while he has a known medical deficiency, or increase of a known medical deficiency, that would make him unable to meet the requirements for his current medical certificate."

A pilot who has reason to believe he does not meet the medical standards need not automatically surrender his certificate; however, he is obliged not to exercise the privileges of that cer-

tificate by performing flight duty until such time as it is determined that he meets the medical standards.

Section 1002 of the Federal Aviation Act specifies that "any person may file with the Administrator . . . a complaint in writing with respect to anything done or omitted to be done by any person in contravention of any provision of this Act, or of any requirement established pursuant thereto." The FAR specify that each reported violation will be investigated by FAA personnel "to determine the nature and type of any additional investigation or enforcement action the FAA will take" (Section 13.1). In practice, then, an anonymous complaint to the FAA about a pilot's drinking behavior or alleged use of drugs could make his medical condition the subject of an FAA investigation with potential enforcement action against that pilot's medical certificate.

Where the FAA has reason to believe a pilot does not meet the medical standards (that is, is not qualified for the medical certificate issued to him), and provided more than 60 days have elapsed since his certificate was issued by the AME, the FAA may seek to revoke, suspend, or modify that certificate only through appropriate enforcement action authorized under Section 609 of the Federal Aviation Act. The pilot whose certificate is the subject of such action by the Administrator is entitled to appeal the Administrator's order of suspension or revocation to the NTSB and challenge the propriety of the FAA action.

In such cases, "the burden of proof shall be upon the Administrator"[7] to establish by a "preponderance of reliable, probative and substantial evidence"[8] that "safety in air commerce or air transportation and the public interest" requires affirmation of the Administrator's order.[9] In proceedings under Section 609 of the Act, the FAA acts as prosecutor. The pilot is entitled to defend with documentary and testimonial evidence before the NTSB administrative law judge, who has authority to affirm, dismiss, or modify the Administrator's order attacking the pilot's certificate in issue. Appeal procedures mirror those available in Section 602(b) proceedings described above.[10]

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[7]Section 821.32 of the NTSB Rules of Practice in Air Safety Proceedings, 49 CFR Part 821.32.

[8]*See* Section 821.49 of the Board's Rules of Practice.

[9]Section 609 of the Federal Aviation Act of 1958, as amended.

[10]The FAA has the option to seek to redress regulatory violations through an entirely different scheme. Section 901(a) of the Federal Aviation Act renders any person who violates any rule, regulation, or order issued under the Act "subject to a civil penalty of not to exceed $1000.00 for each violation . . . ." Authority to attempt to compromise

Rules Regarding Consumption of Alcohol and Drugs

Section 91.11 of the FAR concerns "liquor and drugs" and specifies that "(a) No person may act as a crewmember of a civil aircraft—(1) Within 8 hours after the consumption of any alcoholic beverage; (2) While under the influence of alcohol; or (3) While using any drug that affects his faculties in any way contrary to safety." The FAA rigorously enforces these rules through certificate action—often revocation—brought under Section 609 of the Federal Aviation Act. Circumstantial evidence is adequate to prove consumption of alcohol.[11]

Air Carrier Rules and Regulations on Consumption and Use of Alcohol and Drugs

Federal Aviation Regulations provide the minimum safe standards, leaving carriers free to impose higher or more stringent standards. Virtually all carriers have exercised their rights in this area when it comes to specifying rules regarding the length of the period of time prior to duty during which their pilots are prohibited from consuming alcohol or drugs. The rules vary not only in their nominal duration—8, 10, 12, and 24 hours—but also by whether the prohibited period ends with actual flight duty or merely report for duty. The 24-hour rule has survived attack as being arbitrary and unreasonable, with one arbitrator holding:

> "In my opinion, the drinking of any alcoholic beverage by a cockpit crewmember in violation of the 24-hour rule is an egregious offense of such magnitude and gravity as to destroy that employee's future usefulness, value and entitlement to continued employment. It need not be buttressed by prior misconduct nor offensive behavior. Nor is it excused or minimized by the amount of the intoxicant consumed or by the fact that the offender was neither drunk nor stupefied."

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a civil penalty action is granted to the Administrator, but the FAA has no self-enforcing powers in the event the pilot declines to settle. Consequently, if FAA is unable to reach a satisfactory accommodation with the pilot against whom the civil penalty is proposed, the matter must be turned over to the U.S. Department of Justice for enforcement action by bringing complaint against the pilot in federal district court. In such proceedings, the burden of proof is, of course, upon the complainant, and the pilot is entitled to all the protections of a civil trial. It should be noted that certificate action rather than civil penalty action is the expected FAA response to alleged violations of Section 91.11.

[11] *Sorenson* v. *NTSB*, 684 F.2d 683 (10th Cir. 1982); *Administrator* v. *Goodyear*, 2 NTSB 1264 (1975); *Administrator* v. *Horvath*, NTSB Order No. 1548 (1981).

The award in that case specified:

> "The 24-hour rule is a reasonable rule and regulation and its violation by a cockpit crewmember whether captain, first officer, or second officer is a grievous offense of such magnitude and severity as to destroy the offender's further usefulness and entitlement to continued employment and constitutes just cause for discharge standing alone.
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> "The gravity of misconduct of this nature by a cockpit crewmember and the culpability inherent therein is so egregious in and of itself as to require no associated incident or happenstance of any kind or nature to support or buttress the just cause of the discharge of the offender." (Burton Turkus, 1975, unpublished)

When combined with the obvious prohibition against consumption of alcohol or drugs while on duty, the 24-hour rule applied at many airlines may drastically reduce those periods during the month when a pilot is free to consume alcoholic beverages.

Company rules commonly prohibit pilots from consuming alcoholic beverages while in uniform, whether on or off duty. These generally apply on and off the employer's premises. Penalties for infractions of these rules usually have been severe. Historically, discharge was almost universally imposed for a proven violation of the drinking rules, even for the first offense. More recently, however, more liberal approaches are being taken, particularly where consumption was remote from flight duty and no other misconduct was present, or where there were compelling, extenuating circumstances. In such cases, arbitrators have found the imposition of a disciplinary suspension to be a more rational and just response to a single episode of consumption in violation of applicable rules. For example, in 1963 Arbitrator Sam Kagel reduced a pilot's discharge to an eight-month disciplinary suspension, observing:

> "Understandably, the Company must take a firm position on the type of case involved in this arbitration where there was an admitted violation of the 24-hour rule. And particularly when the entire crew was involved in the violation. It can do no less with respect to its responsibility to the public. It can do no less with respect to making it clear to all of its pilot employees that this rule is meant to be observed and will be enforced by the Company. . . .
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> "The violation of the rule by [grievant] having occurred, disciplinary action is in order. If it is to be something less than discharge, it must be disciplinary action which is severe and heavy. If it is to be something less than discharge, it must be considered on an individual basis. The record in this case, by a very small margin, supports a finding that the action against [grievant] be modified.

"The fact remains that the 24-hour rule must be observed. This decision and award is not meant in any way to affect that requirement.

"[Grievant] was discharged as of August 6, 1962. He has been off the payroll more than eight months. A return to his employment without backpay represents a loss of $10,000 to $12,000, a very substantial fine for two or three drinks. During this period [grievant] has paid heavily, no doubt, in worryment in throwing away a lifetime career for two or three drinks. Under the circumstances and because of the nature of the 24-hour rule, it is not an excessive disciplinary action for violating it." (Unpublished)

On another airline property, Arbitrator Mark Kahn in 1971 summarized the parties' evolutionary response to the 24-hour rule:

"I consider this background of prior Board decisions to be relevant to interpreting the meaning of what the parties agreed to . . . in relation to the 24-hour rule, although the language used to express their understanding largely speaks for itself. It is my view that the Company, having noted that the System Board was prepared to reinstate violators (although with substantial penalties) where compelling extenuating circumstances were present, agreed to recede from its policy of automatic discharge. The Company would now 'separately and independently' consider each [no-drinking] rule case and act upon each case in accordance with its 'merits and circumstances,' provided that any penalty the Company then decided to impose would not constitute a precedent. In other words, the Company agreed to anticipate the System Board in a consideration of extenuating circumstances, but only on a non-precedent basis." (Unpublished)

In a 1977 decision involving the discharge of a pilot who admittedly drank intoxicants within 24 hours prior to assigned schedule, Arbitrator Arthur Stark adopted a similar rationale:

"This infraction would normally constitute just and sufficient cause for discharge under [the Agreement]. In this instance, however, the majority of the Board believes that an exception should be made, although a severe penalty is warranted. We are convinced that at the time of the incident the grievant was suffering from a very painful condition which caused him to become physically and emotionally overwrought (corrective surgery was performed two weeks later) and unable to exercise good judgment. The net result, unintended and unanticipated, was that he failed to report off sick and, in fact, went to the airport in an inebriated condition.

"The grievant has an exemplary ten-year record of service and there is no indication that he has ever had a drinking problem. The episode of November 8 was an aberration which, we are convinced, will not recur.

"The seriousness of the infraction, however, was such as to justify a one-year suspension without pay . . . . Moreover, in view of the unique facts and unusual circumstances in this case, it is the Board's opinion that this decision should not be considered a precedent for handling of infractions of the rule concerning the use of intoxicants." (Unpublished)

Until recently, the fact that a pilot who breached rules regarding consumption of alcohol was suffering from alcoholism at the time was no defense to severe discipline, including discharge. This harsh result is typified by the 1975 decision of the late Father Leo C. Brown in a case involving a pilot who boarded the aircraft and commenced operations in an inebriated condition, observed by passengers. Prior to discharge, the pilot had requested a medical leave, and by the time of the arbitration hearing, he had undergone treatment for his alcoholism and was doing well in recovery. The brief opinion portion is quoted in its entirety:

"It is to be observed that we are not here confronted with a case where a pilot, aware that he is unable or becoming unable to cope with this problem, voluntarily and before any serious overt infraction of Company rules, seeks a medical leave to undergo treatment. Ours is a case where a pilot reported for his flight intoxicated and unable to perform his duties.

"The first question that I must answer is whether Grievant's condition and actions constituted cause for discharge. I am able to come to only one conclusion. I am convinced that they did.

"Any other holding, it seems to me, could make it impossible for the Company to effectively enforce its 24-hour rule. For if the Company cannot discharge an employee on the first occasion that he reports for his flight in a state of intoxication, how can it discharge an employee for a first violation of the 24-hour rule? If drinking to the stage of intoxication is not cause for discharge, can drinking that stops before that stage is reached be considered such a cause? So if reporting for a flight in a state of intoxication is not cause for discharge, no other single violation of the 24-hour rule can be considered cause for discharge. And if that is the case, the Company will be compelled to adopt a policy of progressive discipline in administering the 24-hour rule. Should that come about some employees, knowing that they cannot be discharged for first violations of the rule, will surely tend to disregard it. For these reasons, I am convinced that a holding that reporting for duty in a state of intoxication is not cause for discharge will seriously weaken the 24-hour rule.

"And I do not see how it could be possible for the Company to have one standard for alcoholics and another for non-alcoholics: the alcoholic who reports intoxicated, if it is his first such offense, will not be discharged; but the non-alcoholic will be discharged.

> "I agree as the Association contended, that an alcoholic is a sick man and should be treated as such. But an airplane pilot, by the nature of his profession, must take a responsible attitude toward illnesses that can impair his ability to fly safely. Such an attitude should cause a pilot who suffers from alcoholism to seek timely treatment. In my judgment there is no proof that a rule that pilots who are alcoholics will not be discharged for their first instance of reporting for duty in a state of intoxication will encourage them to seek timely treatment for their problem. It could have the opposite effect." (Unpublished)

In a similar vein, Arbitrator Mark Kahn opined in a 1976 case:

> "I do not see how an airline can safeguard the public's right to air safety by permitting alcoholics to violate the pertinent policies, with sick or medical leave as the consequence, where non-alcoholics would be discharged for the same misconduct. And, based on the record of this case, I am concerned about the implications for other alcoholic pilots—currently on duty—of believing that even if they drink while on duty in the cockpit they might not be discharged, at least not the first time." (Unpublished)

The situation is markedly different, however, where an alcohol rehabilitation program or an employee assistance program is established. While the program language usually reflects that the carrier waives neither its right to discipline nor its rules regarding consumption or use of alcohol (and drugs), in practice, the philosophy is rehabilitative rather than punitive. Consequently, where the alcoholic pilot has been caught violating rules regarding consumption of alcohol, referral for professional evaluation, treatment, rehabilitation, and eventual medical certification in accordance with applicable FAA policies and procedures described above, rather than severe discipline or discharge, more often follows. Privately, between the parties, the pilot's alcoholism has been recognized as a defense for his misconduct. The focus thereafter is upon successful rehabilitation and the pilot's cooperation in the rehabilitation process. Of course, return to active duty is conditional upon medical recertification through the previously described FAA procedures. Experience shows that alcoholic airline pilots have an 85 percent chance of successful long-term recovery.

One writer found it

> "questionable whether *airline pilots,* truck drivers, bus drivers, locomotive engineers, ships' pilots, interns, residents, physicians, pharmacists, police officers, forklift operators, and other employees whose job entails duties which, if performed in an intoxicated state,

will in all probability jeopardize life and/or property of significant value, possess the same right to return to their previous title when certified as rehabilitated or 'cured,' and in the same manner and for the same reasons as employees who have been on paid or unpaid leave for a year because of a disabling accident or illness, or because of a disabling mental illness not connected with addiction."[12] (Emphasis added).

It should be apparent, however, in light of an 85-percent success rate, the multifaceted certification procedures of the FAA, the employer, and the pilot's peer group, that alcoholic airline pilots should not be lumped in with other employees who have no such rehabilitative support structure available.

Occupational Programs

Substance use and abuse, including the use and abuse of addictive drugs and alcohol, is endemic in the general population. Statistics descriptive of the enormity of the problem are frequently quoted in the lay press and various official publications, but the fact is that no one really has exact figures on incidence or prevalence.[13] This uncertainty results in part from the diverse and redundant agencies, both private and public, involved in dealing with the problem. Other factors include the large number of users and abusers, the very significant proportion of covert use, the failure or reticence of observers to report problems until they are flagrant, the long period of latency, or dormancy, from the beginning of use until it becomes abuse, the inconstancy of predicting which use will ultimately lead to abuse, and the lack of consistent social policy for resolving problems. Our society appears to be unable or unwilling finally to decide whether punishment or rehabilitation is the way to deal with alcohol and drug problems. Little wonder, then, with the confusion in all of our minds, that there is a wide spectrum of arbitral opinion.[14]

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[12]Simons, *Alcoholism, Drug Abuse and Excessive Absences,* Proceedings of the New York University 32nd Annual National Conference on Labor (1980).

[13]*Alcohol and Health: Fourth Special Report to the U.S. Congress on Alcohol and Health,* U.S. Department of Health and Human Services, Public Health Service, NIAAA, January 1981.

[14]It has happened that the FAA has taken apparently inconsistent positions, on the one hand with the enforcement branch moving to revoke the airman certificate held by a pilot for violation of Section 91.11, while on the other hand the medical branch acts to recertify him medically following treatment for his alcoholism.

The recognition, management, and rehabilitation of alcoholic persons have become, in knowledgeable circles in our society, relatively straightforward and systematized. The long and tedious development of techniques has been facilitated by their integration into the work site, thus merging motivating forces with the means for intervening in and correcting addictive behavior. Occupational programs, now often known as employee assistance programs, grew from their narrow focus on alcoholism to encompass drug addiction and behavioral and emotional problems affecting work performance. In the early 1970s, no method had been applied industrywide to airline pilots. Some air carriers had recognized the need and had rudimentary in-house programs, but none had professional substance abuse counselors on property and few, if any, professional pilots had availed themselves of these meager early programs.

The public image problems faced by all segments of the industry served as a potent damper, and cases were kept hidden. There was a wonderfully synergistic relationship between the disease of alcoholism, a supreme manifestation of which is denial, and the fears of pilots, companies, and the FAA manifesting as denial that such problems existed. So, the industry continued for many years in a behavior pattern not unlike a conspiracy of silence and denial, unwilling and unable to admit that alcoholism was a disease that no more spared pilots than any other segment of our alcohol-using society. This massive denial actually made the problem worse, as persons in need of help were driven underground, where they might get no, or an inferior level of, professional assistance.

It is not for humanitarian reasons alone that large numbers of employers have turned to programs designed to encourage recognition, treatment, and rehabilitation of alcoholic workers. The economic benefits are well documented,[15] and nowhere are these benefits more persuasive than in the rehabilitation of airline pilots. Hoover and others have shown that the direct economic cost to an airline for the loss of a single captain is in excess of $500,000.[16] Notwithstanding the economic folly of discharging or otherwise prematurely terminating the career of

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[15]Royce, Alcohol Problems and Alcoholism, A Comprehensive Survey (New York: Free Press, 1981).

[16]Hoover, Hutchings, Masters, and Kowalsky, *A Cost-Benefit Analysis of an Occupational Program for Professional Pilots,* prepared for 8th Annual ALMCA meeting, Detroit, October 1979.

a pilot, it simply is not in the interests of society or the victims of addiction to throw them on the trash heap—literally sentencing them to lives of continued addiction, personal and social degradation, illness, and death.

The Resolution of Problems

Federal Aviation Regulations firmly establish the prohibition of the use of alcohol or drugs within certain periods of time prior to or during the operation of any aircraft (FAR Part 91.11), and, as mentioned above, most airlines have rules that either affirm or are more stringent than the FAR. Prior to 1972, the FAA had never made an exception to the rule permanently denying medical certification to diagnosed alcoholics. Only a few pilots had achieved recertification by 1974, when ALPA, recognizing as unacceptable the loss of careers resulting from a regulation that was in effect punitive and without constructive purpose, established a program intended to encourage treatment, rehabilitation, and return to effective functioning. Sharing the aims of the program, the FAA and the carriers cooperated. The program, referred to as the Human Intervention and Motivation Study (HIMS), was funded largely by a government grant and has resulted in hundreds of airline pilots now flying who might have been permanently grounded without the tripartite program.[17]

A special program for airline pilots was mandated by the controlling FARs, regulations to which other occupational groups were not subject. Air traffic controllers are under the jurisdiction of the FARs, but do not have an externally developed program; rather, theirs is an in-house activity of the FAA. Flight attendants, represented by several unions, are covered by some emerging programs, but are not under the FARs to the same extent as the pilots. Basically, FARs require air carriers to maintain the highest degree of safety. The regulations apply primarily to pilots, as the operating crewmembers, but some case law applies to cabin crew as well.

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[17]Gilstrap, Masters, and Hoover, *Preventing Alcohol Abuse,* Air Line Pilot 28-29 (April 1975); Pakull, *Alcoholism and Aviation Medical Certification,* in Alcoholism: Clinical and Experimental Research, Vol. 2 (1978). For a detailed description of the HIMS program, *see* Hoover, Kowalsky, and Masters, *An Employee Assistance Program for Professional Pilots (An Eight Year Review)* (Denver: Air Line Pilots Association Human Intervention Study, 1982).

The basic assumption of the ALPA program included acceptance of alcoholism as a primary treatable disease and recognition that an occupation-based program would be more effective than other alternatives, that total abstinence is essential to successful rehabilitation, that the intense job motivation could result in higher rehabilitation rates than those in many other occupational programs, and, most important, that a peer identification system was needed. The program, which has developed, applied, and refined a model for early detection, prevention, intervention, and treatment and rehabilitation, has a long-term recovery rate of about 85 percent. That is, of all pilots who went through the program since 1974 and received FAA medical recertification, 85 percent are still abstinent and flying. This rate compares quite favorably with occupational programs which are deemed quite successful if they maintain an 80 percent recovery rate in one year. To date, the FAA has certificated nearly 500 pilots after treatment.

Although we have experienced some multiple or "polydrug" abuse in cases identified as alcoholism, rarely have there been cases of single or polydrug abuse not involving alcoholism. When cases are found, ALPA's approach has been to intervene in much the same manner as for alcoholism. The rehabilitation effort involves diagnostic evaluation and referral to treatment programs of the highest quality, subsequent detailed aftercare participation, and psychiatric and psychologic evaluations attesting to the stability or resolution of underlying problems. Whereas FAA certification procedures for alcoholism are accomplished relatively rapidly, treatment for drug abuse is likely to be more protracted. The average time for recertification for alcohol cases, in our experience, is about five months from the start of treatment. Drug abuse cases take well over a year, on average, to resolve.

In general, street drugs such as heroin and cocaine are not commonly seen in our group of pilots, but we are not so naive as to think that professional pilots are immune. Also, it has been noted that the flower children of the 1960s are the middle-class, middle-aged citizens of today, and their experience with drugs in the sixties will perhaps enhance the social acceptability of marijuana and cocaine today. The FAA attitude toward casual or occasional social use of marijuana is tempered by the proximity of use to on-duty time. Use of marijuana is not compatible with flight safety if it is within 24 hours of flight time, in our

opinion. But, this opinion notwithstanding, a blood or urine test that is positive for the presence of cannabinoids should not be the grounds for loss of careers, reputations, or privileges. It must be shown that the person was adversely affected or that all persons with similar test results are impaired.[18]

Conclusion

Job performance decrement or obvious impairment may form the basis for action against employees, but the interests of safety preclude delaying the intervention until such a late manifestation of abuse is apparent. So, ALPA representatives have been instructed in the methods of peer observation and early identification, which are as valid with behavioral and drug problems as with alcoholism. Referral for professional evaluation and possible treatment of any problem opens to management personnel the identifying information and thus exposes the employee to potential harm unless there is agreement between the union and management that these problems can and will be handled medically. Herein lies the key to programs that will preserve careers and be mutually beneficial to pilots and companies.

Responsibility for one's acts is often cited as a normal expectation in our society. Arbitral decisions have referred to the necessity of holding the individual responsible. We do not claim that that responsibility is unimportant. Rather, it can be applied at a point in a case other than with termination at discovery, when the afflicted individual often is unable to discern, because of the very nature of his illness, that he is in trouble or has a problem. Rather, through the process of intervention, a concept developed by Dr. Vernon E. Johnson,[19] the individual is brought face-to-face with reality in a language he can understand. The message is delivered jointly by union and management. The recommendation for treatment is firm and without reasonable alternatives (discharge if no treatment), and at that point, confronted with hard evidence of an illness needing treatment, the individual must make a responsible decision. If he accepts the recommendation, treatment and probable return to work en-

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[18]McBay, Dubowski, and Finkle, *Urine Testing for Marijuana Use* (Letter to the Editor), 249 JAMA 881 (February 18, 1983); Law, Pocock, and Moffat, *An Evaluation of a Homogeneous Enzyme Immunoassay (EMIT) for Cannabinoid Detection in Biological Fluids,* 22 J. Forensic Sci. Soc. 275-81 (1982).

[19]Johnson, I'll Quit Tomorrow, rev. ed. (New York: Harper & Row, 1980).

sue. If he does not elect treatment, disciplinary action follows.

Contrary to attitudes which hold that rigid rules of discharge are necessary to maintain discipline and to prevent other employees from similar violations on duty, the program that treats drug and alcohol abuse and behavior abnormalities as recoverable conditions that should receive professional handling will, in the long run, enhance employee-management relations and encourage employees to help their troubled fellow workers get help. There is no gain in enforcement attitudes that punish or discharge when these programs ignore the very essence of the illness—that afflicted persons are unable to regulate their consumption by mere dint of self-control. Telling a drug addict or alcoholic to stop using or drinking is akin to telling a hemophiliac to stop bleeding.

III. AN INDUSTRIAL RELATIONS PERSPECTIVE

JOHN D. WILLIAMSON*

Tia Denenberg, in her presentation here today, has raised a number of questions on the issue of arbitration of drug cases which are challenging your profession. I'd like to comment on them from my perspective in industrial relations, and I'll offer some observations on why my perspective is what it is.

First of all, where am I coming from? I am Manager of Industrial Relations for Carpenter Technology Corporation's Bridgeport, Connecticut, plant. This is a fully integrated steel mill. We make specialty steel bar and billet products. Specialty steel is steel which is used in critical applications—stainless steel, tool steel, and high temperature alloys. Our steel is used in such things as jet engine parts, nuclear components for the U.S. Navy that have to go many feet under the surface of the sea, human implants such as the metal piece that goes into a hip joint replacement, and high strength fasteners. I'll relate a story that might put some of our responsibilities in perspective. You remember several years ago out in Chicago there was a tragic crash of a DC-10 when it lost an engine. After the crash, everybody was asking why. The first thing that came over the news was that a bolt, broken into pieces, was found on the runway

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