

Licensing of Pilots in the Autistic Spectrum – A Comparative Study

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Abstract: The licensing of pilots diagnosed with autism spectrum disorder (ASD) reveals a pervasive regulatory ambiguity across the United States, Europe, Canada, and the international framework established by ICAO. None of these jurisdictions has produced authoritative jurisprudence or explicit statutory guidance that directly addresses autism in the context of aeromedical certification, thereby leaving a vacuum in both legal doctrine and administrative practice. In the United States, the body of case law concerning mental-health assessments and medication use offers analogies but no direct engagement with ASD, while Europe's policy projects—such as MESAFE—advance conceptual reforms without generating judicial precedent. Canada's functional "medical fitness" standard permits discretionary assessment yet remains untested in autism-specific litigation. ICAO, for its part, provides only general mental-health criteria within Annex 1, declining to enumerate autism or any neurodevelopmental condition, thereby reinforcing the primacy of national discretion. The cumulative effect is a regulatory silence that leaves the treatment of autistic pilots to case-by-case clinical judgment rather than harmonized norms. This absence of clarity underscores the tension between safety-driven precaution and the equitable recognition of neurodiverse individuals, and it signals an urgent need for more transparent, evidence-based, and consistent frameworks in global aviation medicine.

Keywords: Autism Spectrum Disorder, Aeromedical Certification, Regulatory Discretion, Neurodiversity, Pilot Licensing.

1. INTRODUCTION

The licensing of pilots diagnosed with autism spectrum disorder (ASD) raises a central legal question that has thus far escaped precise doctrinal articulation: whether existing aeromedical regulatory frameworks, grounded in broad discretionary standards, are capable of accommodating neurodevelopmental diversity while remaining faithful to the overriding imperative of aviation safety. The issue is not merely clinical or administrative; it is fundamentally juridical, engaging principles of regulatory reasonableness, evidentiary sufficiency, and non-discrimination within safety-critical domains.

Across the United States, Europe, Canada, and the international regime shaped by the International Civil Aviation Organization, there exists a conspicuous absence of authoritative jurisprudence or explicit statutory articulation addressing ASD within aeromedical certification. This silence creates a structural ambiguity. While regulators consistently invoke safety as the governing principle, the lack of defined criteria for assessing ASD transforms what ought to be a rule-based system into one largely dependent on individualized discretion. The doctrinal question that emerges is whether such discretion, in the absence of articulated benchmarks, satisfies the

requirements of transparency, consistency, and fairness that underpin modern administrative law.

A review of regulatory materials reveals that certain psychological conditions and pharmacological dependencies are explicitly disqualifying. Autism, however, occupies an indeterminate position. The Federal Aviation Administration does not classify ASD as an automatic exclusion but instead subjects it to functional evaluation. Advisory guidance, including that attributed to Elizabeth R. Anderson-Doze, reflects a measured shift toward individualized assessment. It acknowledges that individuals with Level 1 ASD may, under appropriate circumstances, satisfy certification requirements, provided that their functional capacity is demonstrably consistent with the demands of aviation.

This approach signifies a broader legal evolution. The regulatory focus is no longer on diagnosis as a categorical determinant, but on demonstrable operational capacity. Such an approach aligns with the fundamental principle that administrative decisions must be grounded in evidence rather than presumption.

The Federal Aviation Regulations, particularly 14 CFR Part 67, do not enumerate ASD as a disqualifying condition. Instead, ASD is subsumed under general mental-health provisions that prohibit certification where a condition may reasonably be expected to compromise safety. This formulation, while flexible, confers substantial discretion upon the regulator. The question that follows is whether such discretion is exercised within legally defensible bounds.

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Applicants who seek to enter the formal ranks of aviation must first present themselves before a certified Aviation Medical Examiner, whose task it is to determine eligibility for a First- or Second-Class Medical Certificate. Only after this step is completed does the candidate, armed with the medical certificate alongside identity documents such as a birth certificate and any other requisite records, proceed to an instructor authorized to guide them through the process of applying for a student pilot license.

During this interaction, the instructor generally undertakes a brief inquiry into the applicant's background, examines the medical certificate with deliberate care, and ensures that any limitations noted therein are clearly understood by the aspiring aviator. It is a moment of initiation into the broader regulatory culture of aviation, where personal aspiration meets structured oversight.

It is at this juncture that an insidious difficulty often reveals itself, particularly for those on the autism spectrum. A cursory search through publicly available regulatory materials shows that certain conditions—such as attention deficit disorders, anxiety disorders, or the use of particular psychotropic medications—are explicitly identified as incompatible with safe flight operations. Autism, however, does not appear in the United States Federal Aviation Administration (FAA)'s catalogue of automatic exclusions.

Instead, one is directed to a distinct advisory circular that discusses autism spectrum disorder in some detail, reflecting the administration's attempt to move beyond reductive classification and into a more nuanced understanding of neurodevelopmental diversity within aviation.

An advisory, authored by Colonel¹—whose credentials in family medicine and aerospace medicine lend particular authority to her observations—draws upon familiar diagnostic descriptors and presents a single illustrative case. While the document inevitably relies on generalizations that have become culturally associated with autism, its practical conclusion is more measured. It recognizes that individuals with Asperger's syndrome or what is presently understood as Level 1 autism spectrum disorder may, under certain circumstances, be considered fit for certification.

This consideration is not automatic; it must be grounded in the endorsement of a psychiatrist or physician well acquainted with the applicant and supported by a persuasive professional assessment of the individual's capacity to function safely and reliably in the aeronautical environment.

In its final effect, the guidance suggests a pathway—narrow but not barred—for autistic applicants whose functional abilities align with the demands of flight. It reflects an emerging willingness within aeromedical practice to acknowledge individual capability rather than rely solely on categorical diagnosis, thereby offering a measure of dignity to those who seek not exemption from scrutiny, but a fair appraisal of their competence.

The question whether a person diagnosed with autism spectrum disorder may lawfully and safely occupy the cockpit of an aircraft touches the delicate interface between individual aspiration and the uncompromising demands of public safety. Aviation, by its very nature, admits no margin for error, and every applicant who seeks the privilege of flight must do so under a regulatory framework designed to protect not only the airman but the travelling public and the integrity of the aviation system. An ASD diagnosis, in itself, is not a categorical bar to pilot certification; however, it inevitably invites a more searching inquiry into the applicant's functional capacity. The essence of regulatory philosophy is neither punitive nor exclusionary; rather, it is grounded in the principle that any medical condition with the potential to impair judgment, communication, stress tolerance, or cognitive adaptability must be examined with the utmost care. Whether certification is ultimately granted turns not on medical labels but on demonstrable evidence that the individual possesses the full measure of faculties required to command an aircraft with reliability.

The insistence that every pilot holds a valid Aviation Medical Certificate is the principal mechanism through which aviation authorities discharge their duty of preserving safety in the air. The certificate is not a mere formality; it is a jurisdictional threshold, ensuring that no one assumes the role of pilot without first exhibiting the physical and mental soundness essential to managing the dynamic, sometimes unforgiving, environment of flight. The Federal Aviation Administration has structured this medical oversight into three classes, each corresponding to a different level of operational responsibility. The First-Class

¹Elizabeth R. Anderson-Doze, Medical Certification of Pilots With Autism spectrum disorder- Asperger's Type, *Federal Air Surgeon's Medical Bulletin*, vol. 53, no.3 2015, at 6.

certificate, required of Airline Transport Pilots, represents the highest standard, reflecting the heavy burden placed upon those who carry passengers for hire on scheduled flights. The Second-Class certificate governs those who fly commercially in non-airline capacities such as charter or corporate aviation, while the Third-Class certificate affords greater latitude and is required of individuals flying for recreation, training, or personal purposes. Regardless of the class sought, the regulatory lodestar is constant: no person may act as pilot if any identifiable medical or psychological condition could reasonably lead to sudden incapacitation or a subtle erosion of judgment while in flight.

Within this framework, the treatment of autism spectrum disorder warrants particular attention. The federal medical standards, codified in 14 CFR Part 67, do not enumerate ASD as a per se disqualifying condition. Instead, the condition falls under the broader mental and neurologic provisions that require the regulator to examine any disorder that could interfere with safe performance of pilot duties. The assessment, therefore, is functional rather than diagnostic. In the language of the regulations, ASD is appraised under the general prohibition against any mental condition that may “reasonably be expected” to compromise the safe exercise of the privileges of a pilot certificate. Aviation medicine specialists are alert to the possibility that ASD may manifest in ways that bear upon critical piloting task sustained attention, rapid assimilation of information, adaptive decision-making, or seamless communication under pressure. Yet the regulatory concern is not with autism as a categorical state of being; it is with identifiable limitations that could, in the operational context of aviation, translate into risk. For this reason, the Aviation Medical Examiner is not empowered to issue a certificate independently to an applicant with a known history of ASD. Instead, such cases are referred to the FAA for a more comprehensive, individualized analysis intended to balance the aspirations of the applicant with the inviolate principle of safety.

The question of whether pilots on the autism spectrum may obtain or renew an airman medical certificate in the United States must be approached with a measured equilibrium between regulatory prudence and the evolving understanding of neurodiversity. Under U.S. aviation law, no categorical bar exists that automatically precludes individuals with autism spectrum disorder from certification; rather, the Federal Aviation Administration (FAA) evaluates such

applicants under the general medical standards of Title 14 of the Code of Federal Regulations, assessing whether any functional manifestation of the condition may pose a risk to the safe operation of an aircraft. Thus, the determination rests not on the diagnosis alone, but on the demonstrable capacity of the airman to exercise sound judgment, effective communication, and operational reliability—qualities integral to aviation safety and central to the regulatory purpose.

2. A CASE STUDY

The informative advisory² published on the subject discussed an interesting case study. The narrative concerns a young undergraduate in aeronautics who, in seeking the renewal of his second-class medical certificate, presented himself before his local aviation medical examiner. At twenty years of age and already amassing 210 hours of flight time—with fifty of those hours accrued in the preceding half year—he exemplified the diligence and aspiration typically associated with those preparing for a vocation in aviation. His childhood diagnosis of Asperger’s syndrome had not led to protracted therapeutic intervention; apart from a brief hospitalization three years earlier due to suicidal ideation, for which later psychiatric evaluation attributed the cause to a transient adjustment disorder, his developmental history had been largely unremarkable. A short course of *Concerta* was prescribed following that episode, discontinued after several months for lack of efficacy.

Despite the early diagnostic label, his academic journey unfolded without impediment. His teachers repeatedly described him as cooperative, meticulous, and earnest in his studies—attributes consistent with cognitive assessments that placed him above the average intellectual range, an outcome not uncommon among those who had once fallen under the Asperger’s subtype of autism spectrum disorder. At no point did he exhibit characteristics suggestive of attention-deficit conditions.

His aptitude allowed him to gain admission to a university aeronautics program, with his ambitions firmly oriented toward a future as a commercial and eventually transport-category pilot. In due course, he obtained a second-class airman medical certificate through a one-year Special Issuance granted by the FAA. In aeromedical terms, autism spectrum disorder

²*Ibid.*

raises questions not of diagnosis but of function. ASD is often associated with challenges in communication, insight, and adaptive decision-making—qualities that, when diminished, could have profound implications in an operational environment demanding rapid, coordinated responses to unanticipated contingencies. Even individuals with high cognitive ability, such as those formerly categorized under Asperger's syndrome, may demonstrate rigidity of thought or difficulty interpreting subtle contextual cues. Such characteristics may impair performance during emergent situations where swift decision-making is indispensable. Moreover, a predisposition toward social detachment may pose concerns in the cockpit, where interpersonal coordination and situational awareness are inseparable from operational safety. Cognitive abilities within ASD can also be unevenly distributed; strong academic or procedural learning does not always translate into consistent real-time judgment under pressure.

Yet it is equally important to acknowledge the strengths identified in literature. Lorenz and Heintz³ observe that individuals with Asperger-type traits often excel in sustained concentration, logical reasoning, pattern recognition, factual retention, and visual processing—skills that, when appropriately channeled, lend themselves to fields requiring analytic precision rather than interpersonal fluency. This cognitive orientation explains their success in engineering, information technology, and related disciplines where intellectual clarity often takes precedence over emotive engagement.

Autism spectrum disorder, according to the Centers for Disease Control, affects approximately one in sixty-eight children in the United States, spanning a wide range from profound disability to exceptional intellectual capability. Asperger's syndrome represents one subset of this spectrum. Long-term data regarding the occupational functioning of adults with ASD remain limited. Available evidence, however, suggests that individuals with this profile often face challenges in professions requiring heightened communication, social intuition, and team coordination—although research also demonstrates that targeted coaching and structured support can enable such individuals to harness their cognitive strengths while mitigating the social limitations that may accompany the condition.

Within this regulatory landscape, the aviation medical examiner operates under delegated authority to determine whether an applicant for an airman medical certificate satisfies the medical standards prescribed in the FAA Guide for Aviation Medical Examiners. These standards, grounded in Title 14 of the Code of Federal Regulations Part 67.213, prohibit certification where a functional disease or defect creates a risk to aviation safety—whether presently active or likely to recur prior to the expiration of the certificate. It is notable that neither ASD nor Asperger's syndrome is discussed explicitly in the AME Guide, thereby requiring the examiner to evaluate the applicant's functional capacity in light of the overarching mandate to safeguard the public interest in air safety.

In this case, the young airman's diagnosis—present since childhood—had never hindered his academic performance nor required sustained clinical supervision. His cognitive assessments indicated average to superior ability, and he accordingly received a second-class certificate through Special Issuance. The AME, exercising appropriate caution, referred the matter to the FAA Aerospace Medical Certification Division for final disposition. Upon review, the AMCD issued an "Unable to Establish" notice requesting evidence attesting to the stability of his condition during the preceding year. As he had not been under psychiatric care since his brief hospitalization three years earlier, documentation from his primary pediatric provider was accepted in lieu of a psychiatrist's report. On this basis, the AMCD issued another second-class medical certificate through a one-year Special Issuance, enabling the airman to continue his pursuit of a professional future in aviation.

The FAA's advisory material presents an illustrative case of a young aeronautics student diagnosed in childhood with Asperger's syndrome, who sought renewal of a second-class medical certificate. His academic and operational record demonstrated competence and stability, and he was ultimately granted certification through Special Issuance.

In aeromedical terms, ASD raises questions not of diagnosis but of function. While concerns may arise regarding communication, adaptability, or decision-making under stress, it is equally recognized that individuals with ASD may possess strengths in concentration, pattern recognition, and analytical reasoning. The regulatory challenge lies in reconciling these dual aspects within a safety-critical framework.

³Timo Lorenz, Kathrin Heintz, Aspergers— Different, Not Less: Occupational Strengths and Job Interests of Individuals with Asperger's Syndrome, See <https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0100358&type=printable>

The case illustrates both the potential and the limitation of the current system. While individualized assessment permits capable candidates to proceed, the process itself—characterized by repeated evidentiary demands and provisional approvals—reveals the absence of a standardized legal pathway. It is a system that accommodates success but does not guarantee predictability.

3. UNITED STATES

A. Regulatory Requirements

The Federal Aviation Regulations offer no dedicated provision dealing expressly with autism spectrum disorder or its Asperger phenotype. Rather, the regulatory guidance relevant to such conditions is dispersed within the general mental-health standards set out at 14 C.F.R. §§ 67.107(c), 67.207(c), and 67.307(c), which—uniform across the first, second, and third classes of certification—serve as the regulatory “catch-all.” These provisions articulate the broad mental standards expected of an airman, providing that an applicant must not suffer from any personality disorder, neurosis, or mental condition that, in the judgment of the Federal Air Surgeon, and having regard to the applicant’s history and appropriate medical evaluation, either renders the individual unable to safely discharge the privileges of the certificate sought, or may reasonably be expected to do so during the full tenure of its validity. In the absence of a bespoke protocol addressing ASD or Asperger’s syndrome, the regulatory burden accordingly shifts to the airman: the applicant must satisfy the Authority that he or she is fit to operate an aircraft without posing a hazard to aviation safety.

Experience in ASD-related cases demonstrates that the FAA’s concerns tend to center on matters fundamental to operational judgment—insight, decision-making capacity, cognitive flexibility, response speed, and the overall coherence of the individual’s cognitive functioning. Within this evaluative framework, evidence of successful engagement in flight training can be particularly persuasive. A letter of assessment from a Certified Flight Instructor, attesting to the applicant’s performance, adaptability, and conduct in the cockpit, may carry significant probative weight. Likewise, demonstrations of consistent functioning in academic or professional settings can further reinforce the argument that the applicant possesses the stability and cognitive reliability necessary for safe flight operations.

Nevertheless, it has become the FAA’s usual practice to require that an applicant with a history of Autism undergo a neuropsychological evaluation conducted by a HIMS-qualified neuropsychologist. Neuropsychological assessment in this context remains far from standardized. No test battery has been crafted specifically for applicants with ASD; in practice, neuropsychologists often rely on the FAA’s attention deficit hyperactivity disorder (ADHD) test battery, supplementing it with additional measures tailored to the applicant’s cognitive profile. Such evaluations typically encompass attention and vigilance, processing speed, visuospatial capacity, auditory and visual memory, linguistic competence, psychomotor performance, executive functioning—including reasoning, problem-solving, and cognitive flexibility—personality structure, and academic achievement. Strong performance across these domains, combined with supportive contextual evidence demonstrating stability and effective functioning, can provide a persuasive foundation for establishing medical eligibility.

Cases involving Autism underscore the necessity of informed legal guidance when navigating the FAA certification process. The Federal Aviation Regulations require not merely the submission of medical evidence but the presentation of evidence that meaningfully satisfies the regulatory threshold: namely, that the applicant’s condition does not compromise—and is not reasonably expected to compromise—aviation safety. This demands a careful synthesis of fact and law, and an understanding of how clinical findings must be framed to meet the statutory and regulatory expectations of the FAA.

Although no jurisprudence directly addresses ASD, analogous cases involving mental health and medication provide important doctrinal guidance.

In *Solondz v. FAA*⁴, the court rejected a denial of certification grounded in inconsistent reasoning, emphasizing that administrative decisions must demonstrate a rational connection between evidence and outcome. Similarly, in *Bulwinkle v. FAA*⁵, the court vacated a decision that relied on categorical exclusion without sufficient engagement with the applicant’s functional capacity.

⁴*Infra*, note 7.

⁵*Infra*, note 8.

The legal significance of these decisions lies in the principles they articulate. They confirm that the FAA's discretion, though broad, is constrained by the requirement of reasoned decision-making. Administrative determinations must be supported by coherent analysis and evidentiary justification. By implication, any future adjudication involving ASD would be assessed on whether the regulator relied on demonstrable impairment rather than diagnostic generalizations.

B. MEDICAL EXAMINATION

There are specific guidelines issued by the FAA on medical examinations on this subject⁶. The medical examiner, when presented with an airman seeking certification, is entrusted with a responsibility that transcends routine clinical assessment. The examiner must furnish a report that captures, with clarity and precision, the full neurological landscape of the applicant, enabling the FAA to arrive at a considered judgment on medical eligibility. This report is reviewed not in abstraction but by a physician versed in the rigours of aerospace medicine. It is therefore not expected that the clinician address the aeromedical implications of neurological findings; rather, the task is to present the clinical facts, the documented history, the course of symptoms, and the professional interpretation of any neurological condition that may bear on the airman's capacity to operate an aircraft safely.

In accordance with established federal expectations, the neurological assessment must observe the documentation standards promulgated by the Centers for Medicare and Medicaid Services in 1997. These requirements ensure that the evaluation is sufficiently comprehensive to delineate both the nature and the extent of any neurological disorder, along with the limitations it may impose. The report, at its most fundamental level, must identify the neurologist conducting the examination, together with the date of assessment, and then set out a chronological narrative of the condition from its first manifestation to the present day. This history must include a careful account of symptoms, the occurrences in which they have arisen, and the relevant positive and negative findings that inform clinical understanding. For the FAA, the cognitive and functional dimensions of the

applicant's history are as vital as the physical manifestations of disease; accordingly, the sources of historical information—whether from the patient, witnesses, or documentary review—must be identified to preserve the integrity of the narrative.

The evaluation must also record the treatments undertaken in the past and their outcomes, as well as the applicant's broader medical, surgical, and psychiatric background. A full account of medications is required, spanning herbal supplements, over-the-counter remedies, and prescribed pharmaceuticals, each noted with dosage, frequency, therapeutic purpose, side effects, and any recent changes in regimen. The examiner must also describe the applicant's current academic or occupational functioning, habits or exposures involving caffeine, alcohol, tobacco, or other substances, and any family history bearing upon neurological conditions of potential relevance, such as migraine, seizure disorders, stroke, or degenerative disease.

A thorough physical examination must be undertaken, capturing vital signs, an ophthalmoscopic evaluation, a focused cardiovascular assessment, and a neurological examination in all its dimensions—cranial nerves, motor and sensory systems, reflexes, gait, coordination, and praxis. Cognitive screening must be conducted using a standardized instrument such as the Montreal Cognitive Assessment, the Kokmen test, or the SLUMS evaluation, unless a recent and comprehensive neuropsychological assessment has already furnished that information. Copies of score sheets must accompany the report, and the examiner must clearly describe all material findings and functional limitations detected during the assessment.

Any diagnostic procedures—imaging studies, laboratory testing, EEGs, or other specialized investigations—must be summarized alongside their clinical significance. The examiner must then set out the primary diagnosis, any secondary or contributory diagnoses, and the condition's underlying etiology. Where differential diagnoses were considered and excluded, the analysis supporting those exclusions should be provided. A treatment plan must also be delineated, indicating forthcoming investigations, medication changes, therapeutic interventions, and the proposed timetable for follow-up.

The examiner's professional judgment regarding prognosis is of great value, even though the ultimate

⁶See 2025 GUIDE FOR AVIATION MEDICAL EXAMINERS (Updated 12/03/2025) at https://www.faa.gov/ame_guide/media/ame_guide.pdf

aeromedical determination rests with the FAA. The clinician is asked to reflect on the likelihood of sudden incapacitation—such as seizure or stroke—or more subtle forms of impairment that could compromise aviation safety, including slowed reaction times, diminished memory, or reduced capacity for multitasking. The FAA also requires copies of all pertinent medical records reviewed during the evaluation, which must include actual clinical notes rather than summaries intended for the patient's personal use.

In addition to the comprehensive neurological report, the FAA expects the submission of earlier treatment records, including office notes from previous physicians and copies of any diagnostic studies such as EEGs, CT scans, MRIs, and laboratory tests. Where imaging is involved, the interpretive reports must be accompanied by the actual images provided on a compact disc. Electroencephalographic assessments must include full recordings—awake, asleep, and during provocation using hyperventilation or photic stimulation.

For every hospitalization or emergency department encounter related to a neurological concern, the FAA requires the corresponding records: emergency transport documentation, emergency room notes and investigations, admission histories, discharge summaries, consultant evaluations, operative or procedural reports, pathology findings, laboratory records, imaging, and EEG material. If the airman reached the hospital by private means rather than emergency transport, a memorandum clarifying the mode of arrival must accompany the submission.

In sum, the FAA's expectations rest on the premise that the medical examiner's report must illuminate every clinical contour of the applicant's neurological health, enabling an informed determination of safety in flight. It is a process grounded in meticulous documentation, clinical discernment, and a deep awareness of the obligations owed to the safety of the aviation system.

Although the United States has not produced jurisprudence directly concerning the refusal of a pilot's license on the basis of an ASD diagnosis, the contours of the regulatory landscape can be discerned through analogous cases involving mental-health conditions and the use of psychotropic medication. The American legal system has indeed generated decisions in which psychological diagnoses, behavioral profiles, or the

administration of certain medicines have shaped the outcome of aeromedical certification, yet none of these judgments explicitly engage with autism as such. Consequently, there remains no established body of public precedent that addresses autism spectrum disorder within the framework of FAA licensing. Nevertheless, the limited cases in which the FAA's determinations have hinged upon mental-health status, cognitive functioning, or the effects of prescribed treatment reveal that the agency's discretion, while broad, is not immune from judicial scrutiny, and that adjudicative challenge remains a viable mechanism when regulatory reasoning lacks coherence or evidential alignment.

In the matter of *Solondz v. FAA*⁷, the Court of Appeals for the District of Columbia Circuit confronted an instance where a commercial pilot, having been diagnosed with anxiety and effectively treated with mirtazapine, sought the restoration of his medical certification only to encounter a categorical prohibition grounded in regulatory rigidity rather than nuanced assessment. The Federal Aviation Administration denied his request on multiple grounds—including the use of mirtazapine, a history of anxiety, sleep apnea, optic neuritis, and atrial fibrillation—despite the applicant demonstrating stable control of these conditions and an absence of adverse effects. The court observed that the agency's own practice permits conditional approval of other antidepressants through a structured, evidence-based review process, thereby rendering its blanket exclusion of mirtazapine both inconsistent and insufficiently justified. In vacating the denial and remanding the matter, the court underscored the necessity for the regulator to articulate a coherent and rational explanation, one that accords with the evidential record rather than contradicting it, and thereby reaffirmed the principle that aeromedical decision-making must be grounded in reasoned analysis rather than categorical presumption.

In *Bulwinkle v. FAA*⁸ The Federal Aviation Administration grounded Benton Bullwinkel on the premise that the lithium he ingested daily to stabilize his bipolar disorder rendered him incapable of safely exercising the privileges of a pilot. By declining to renew his third-class medical certificate—an indispensable credential for operating a private aircraft—the agency effectively barred him from the

⁷No. 24-1105 (D.C. Cir. 2025).

⁸23 F.3d 167 (7th Cir. 1994)

cockpit. Confronted with this administrative determination, Mr. Bullwinkel sought review before the National Transportation Safety Board, yet despite the favorable recommendation of the administrative law judge, the Board upheld the FAA's denial. The matter then reached this Court pursuant to the statutory avenues provided under 49 U.S.C. §§ 1486(a) and 1903(d), whereupon the Court, recognizing the gravity of the issues involved, vacated the Board's decision and remanded the case for further consideration.

The architecture of the Federal Aviation Act is founded upon the imperative of safeguarding air traffic, a principle articulated in 49 U.S.C. § 1421(a), and reinforced by the requirement that a pilot be physically capable of performing his duties. The statutory scheme obliges applicants to secure a medical certificate as a precondition for licensure, with the class of certificate corresponding to the nature of the operational responsibilities. Thus, a commercial captain must obtain a first-class certificate, a co-pilot a second-class, and an individual such as Mr. Bullwinkel, who merely seeks to operate a private aircraft, a third-class certificate. Where an applicant cannot satisfy the unrestricted standard, the Federal Air Surgeon possesses the discretion to issue a special-issuance certificate, conditioned by limitations and periodic examinations designed to preserve aviation safety. These regulatory provisions, entrenched in 14 C.F.R. §§ 61.3 and 67.17, have long been understood as permissible constructions of the Act, and the dispute in *Bullwinkel* therefore centred not upon their validity but upon the reasonableness of the Board's interpretation.

In its review, the Court demonstrated a sensitivity to the tension between safety-driven regulatory discretion and the requirement for rational, evidence-based decision-making. The Court recognized that while the FAA is entrusted with safeguarding the skies, such authority must be exercised through a process that is both transparent and grounded in medical and factual coherence. The categorical rejection of an applicant on the basis of a stabilizing medication—without a nuanced engagement with the evidence of functional capacity—risked elevating precaution into presumption. By vacating and remanding the Board's decision, the Court underscored that administrative adjudication in aviation medicine must remain tethered to reasoned explanation, not merely to the invocation of risk. In doing so, the judgment reaffirmed a fundamental principle: that the balance between safety and fairness is best maintained when regulatory conclusions are supported by lucid reasoning, rigorous assessment,

and an openness to the possibility that individuals managing chronic conditions may still meet the demands of safe flight.

4. EUROPE

Aviation safety regulation comes under the purview of The European Union Aviation Safety Agency (EASA)'s regime on medical examination and licensing proceeds from a foundational principle that aviation safety is inseparable from the physical and mental wellbeing of those entrusted with the control of aircraft. Within this framework, the assessment of an applicant on the autism spectrum does not arise from a predetermined prohibition but from a broader regulatory command that the airman must be demonstrably capable of performing the functions of flight without compromising safety. The rules, found chiefly in Regulation (EU) No. 1178/2011 and its medical annexes, do not single out autism as a category warranting special treatment. Rather, they subsume all mental, behavioral, and neurodevelopmental conditions within a comprehensive evaluative process aimed at determining functional fitness. The examination therefore turns not on the label of the condition, but on its operational effect: whether it impairs judgment, coordination, communication, or the ability to manage workload and stress in the unforgiving environment of the cockpit.

The system obliges every applicant—whether seeking a First-, Second- or Third-Class medical certificate—to undergo an assessment of mental health and psychological stability. Where there is a disclosed or known history of a psychiatric or behavioral condition, the applicant must satisfy the licensing authority through psychiatric or psychological evaluation that the condition does not detract from the safe performance of aviation duties. The inquiry necessarily extends beyond mere diagnostic categories and includes an examination of how the individual responds to operational pressures, interacts with crew, and exercises decision-making authority. This holistic method reflects the recognition that aviation safety is a continuum of human performance, and that the cockpit demands cognitive suppleness, situational awareness, and emotional equilibrium.

In this context, applicants with a history of autism spectrum disorder are neither pre-judged nor summarily excluded. They are instead subject to a deliberative case-by-case review, directed at determining whether any features of their

neurodevelopmental profile might reasonably interfere with essential piloting functions. Functional capacity therefore becomes the touchstone: whether the applicant can manage rapid shifts in operational tempo, communicate effectively within a multi-crew environment, and adapt judgment to dynamic circumstances. The absence of a prescribed ASD-specific protocol means that the assessment often depends on psychiatric opinion and the professional judgment of medical examiners, resulting in variability of outcomes across EASA Member States.

This variability and the inherent subjectivity of current assessments have drawn the attention of the European aviation system itself. Through its research initiative known as MESAFE—Mental Health for Aviation Safety—EASA has acknowledged that existing aeromedical evaluations lack a standardized, scientifically validated battery of mental-health tests suited to the particularities of aviation. The project seeks to construct a harmonized framework for evaluating mental-health conditions, including neurodevelopmental profiles, with a view to establishing transparent and evidence-based procedures that avoid the pitfalls of ad hoc and inconsistent decision-making. Its work recognizes that neurodiversity, properly understood and fairly assessed, need not be at odds with aviation safety, provided that the applicant's capabilities demonstrate stability and operational reliability.

MESAFE, an initiative conceived under the auspices of the European Union in 2022, represents a conscious shift toward re-examining the way mental health is treated within the architecture of aviation safety. Its essence lies in questioning whether present aeromedical practices adequately reflect the realities of modern psychology, neurodiversity, and the complex operational demands placed upon pilots and air traffic controllers. The project's mandate is not merely to catalogue deficiencies but to reimagine a system in which mental well-being is regarded as a central pillar of safe flight rather than a peripheral administrative formality. By subjecting longstanding assumptions to critical scrutiny, MESAFE signals an intention to bring coherence and scientific rigor to a domain that has long relied on fragmented methods and discretionary judgment.

One of the most striking observations to emerge from this inquiry is the absence of a standardized evaluative framework for mental health in aviation. What exists instead is a mosaic of interviews of varying

depth, self-reported questionnaires, and occasional psychological assessments conducted largely on an ad hoc basis. Many evaluations are performed under significant time constraints, sometimes in windows scarcely long enough to permit more than a cursory impression of the applicant. Predictably, this has produced substantial divergence in practice across European jurisdictions; the discretion afforded to individual examiners has created a landscape where method, quality, and even philosophical approach vary widely. It is therefore unsurprising that many aviators report a sense that the current system does not adequately detect mental-health vulnerabilities that might influence judgment, stress tolerance, or susceptibility to incapacitation.

In response to these deficiencies, MESAFE advances the concept of a structured, graduated methodology for assessing the risk of mental incapacitation. This model contemplates a measured analysis of probability, severity, and appropriate mitigation, thereby introducing a discipline of proportionality into a field that has often oscillated between insufficient scrutiny and overly cautious exclusion. The project also urges that existing regulatory frameworks be recalibrated to accommodate more systematic and recurrent mental-health monitoring, coupled with enhanced collection of psychosocial histories. For such reforms to take root, examiners must be better equipped through training that deepens their understanding of mental-health indicators, and closer collaboration must be cultivated between aeromedical examiners and mental-health professionals. The intention is to anchor mental-health oversight not in suspicion but in informed, compassionate vigilance.

These reforms bear particular relevance for individuals on the autism spectrum and others with neurodevelopmental conditions. Although MESAFE does not isolate autism as a focal point in its public analyses, the project's broad attention to comorbidity, diagnostic nuance, and functional evaluation inevitably touches upon this population. The present absence of a validated diagnostic battery tailored for aviation means that neurodiverse applicants encounter uneven treatment: some are certified on the strength of demonstrated functional stability, while others are deferred or denied based largely on the examiner's subjective interpretation. Should the recommendations of MESAFE achieve regulatory expression, they may help cultivate a more transparent and equitable environment—one in which applicants are assessed on

concrete evidence of operational capability rather than on preconceptions or inconsistent national practices. For individuals with ASD who exhibit stable functioning and present no identifiable risk of incapacitation, such evolution could yield a more dignified and predictable certification process.

MESAFE's significance therefore extends well beyond the confines of aeromedical procedure. It marks the first concerted effort to replace a patchwork of mental-health practices with a coherent, evidence-based standard that serves both safety and fairness. For scholars of air law and policy, the project offers fertile ground for examining how regulatory systems can evolve to reconcile the imperatives of aviation safety with the ethical obligation to avoid unjust discrimination against the neurodiverse. In doing so, it illuminates a path toward a more humane and scientifically grounded vision of aviation regulation—one that affirms that safeguarding the skies begins, in no small part, with understanding the minds entrusted to navigate them.

In the long term, implementation of MESAFE's recommendations may usher in a more balanced and equitable approach, one that removes uncertainty for neurodiverse applicants and strengthens the legitimacy of the certification process. Until such reforms are integrated into Part-MED and related instruments, the fate of an applicant with ASD will continue to rest on an individualised inquiry into functional competence, guided by established mental-health standards and the overarching imperative of safeguarding the travelling public.

Within the framework of the European Union Aviation Safety Agency, ASD is not treated as a distinct category but is assessed under general mental-health standards contained in Regulation (EU) No. 1178/2011.

The emphasis is on functional capacity rather than diagnosis. Applicants must demonstrate the ability to perform safely under operational conditions, including communication, decision-making, and stress management.

However, the absence of standardized evaluation criteria has resulted in variability across Member States. The MESAFE initiative represents an attempt to address this deficiency by promoting structured, evidence-based assessment.

From a legal perspective, MESAFE signals a movement toward constraining administrative

discretion through standardized methodology. Should its recommendations be codified, they may provide the foundation for a more coherent and predictable regulatory framework

5. CANADA

Under the Canadian Aviation Regulations, the medical fitness of pilots is governed by a framework that is deliberately broad, a framework which entrusts the assessment of both physical and mental health to accredited medical authorities rather than to rigid diagnostic lists. The applicable regime, embodied in Standard 424, insists that no pilot shall possess any medical condition or history which, in the judgment of competent medical experts, may compromise the safe exercise of aviation privileges. This formulation is capacious and functional rather than classifying; it does not enumerate particular disorders but instead demands a demonstration that the applicant can operate without impairment. In this respect, the Canadian law does not single out Autism spectrum disorder, nor any neurodevelopmental condition, as an automatic bar to licensing. Instead, it situates such diagnoses within a general principle that any condition capable of undermining safe flight must be scrutinized with rigor and precision.

The responsibility for this scrutiny lies with the Civil Aviation Medical Examiner, a physician designated to conduct examinations that extend beyond mere physical inspection to encompass the complex terrain of behavior, cognition, and psychological functioning. Where questions arise concerning mental health or behavioral conditions, the examiner is obliged to report and to initiate further evaluation. In this architecture, certification is neither a mechanical nor a purely clinical act; it is a process in which evidence, judgment, and risk-assessment converge. The regulatory authority, Transport Canada, retains discretion to impose limitations or to defer certification where uncertainty remains, thereby ensuring that safety considerations prevail over administrative convenience.

Because ASD is not mentioned as a disqualifying condition, applicants with ASD are not excluded *ab initio*. Their eligibility depends instead on a case-specific inquiry into functional capacity: whether the individual's cognitive, behavioral, and adaptive profile allows safe piloting under the demanding conditions of aviation. In principle, this functional approach accords with contemporary understandings of neurodiversity, insofar as it resists categorical exclusion and

emphasizes actual capability rather than diagnostic labels. Yet, in practice, such an open-textured standard inevitably produces variability. Decisions may diverge depending on the interpretation of the examiner, the quality of the documentation, and the perceived risk profile.

This variability, while legally defensible, creates uncertainty. In the absence of a standardized protocol for evaluating neurodevelopmental conditions within aviation medicine, applicants may encounter divergent outcomes in different jurisdictions or even between different examiners. Moreover, because the regulations reference broad concepts such as “established neurosis” or “behavioral disorders,” an examiner might, in a conservative interpretation, view certain manifestations of ASD as falling within these categories, thereby triggering restrictions or denial. Thus, the law’s flexibility—intended to capture safety risks not foreseen by the drafter—may, in certain circumstances, translate into precautionary exclusion.

Ultimately, the Canadian system reflects a tension inherent in aviation regulation: the need to guard the integrity of flight safety while avoiding unjustified discrimination against individuals whose conditions do not, in fact, impair their operational performance. For applicants on the autism spectrum, the pathway remains open but contingent, resting upon the ability to demonstrate stable function, sound judgment, and an absence of incapacitation risk. In such cases, the legal and medical assessment becomes a sophisticated interplay between evidence and regulatory prudence, a process demanding both scientific clarity and juridical sensitivity.

Under the regime administered by Transport Canada, medical fitness is governed by a broad and functional standard. ASD is not identified as a disqualifying condition, and eligibility is determined through individualized assessment.

This approach reflects a commitment to flexibility and recognition of neurodiversity. However, it also introduces variability. In the absence of standardized criteria or jurisprudential guidance, outcomes may differ depending on the interpretation of individual examiners.

The Canadian model thus illustrates a classic tension in administrative law: flexibility enables individualized justice, yet excessive reliance on discretion may undermine predictability. The balance between safety and fairness remains contingent rather than defined.

6. CONCLUSION

Across the jurisdictions of the United States, Europe, and Canada, the existing body of judicial and administrative material reveals a notable paucity of precedent concerning the treatment of autism spectrum disorder within the context of pilot medical certification. In the United States, while courts and administrative tribunals have adjudicated cases where medical certificate denials rested upon mental-health conditions, behavioral abnormalities, or the use of psychotropic medications, none of these decisions directly engage with autism -spectrum diagnoses. The jurisprudence thereby illuminates the contours of regulatory discretion without providing guidance on neurodevelopmental conditions as such.

In Europe, discourse has been driven more by policy innovation and scholarly inquiry than by litigation. Initiatives such as MESAFE have undertaken a comprehensive re-evaluation of mental-health assessment in aviation and have acknowledged the significance of neurodiversity, yet these contributions remain situated within the realm of research and regulation rather than judicial pronouncement. No publicly available court decisions have emerged in which autism has been the focal point of a licensing dispute.

Canada exhibits a similar pattern. Its regulatory scheme, grounded in the broad and functional notion of “medical fitness,” affords considerable discretion to aviation medical authorities; however, this discretion has not been tested in litigation involving autism or any comparable neurodevelopmental condition. No documented cases address the refusal or granting of certification on such grounds.

The consequence of this tripartite silence is that there exists no authoritative, published case law that elucidates how regulators interpret and apply standards to individuals diagnosed with autism spectrum disorder in the domain of pilot licensing. This absence is itself jurisprudentially significant, for it underscores both the uncertainty inherent in the regulatory frameworks and the need for clearer, more transparent interpretive structures in an era increasingly attentive to neurodiversity.

It must be mentioned that the International Civil Aviation Organization, despite its central role in harmonizing the medical standards that underpin pilot

licensing, has not promulgated any guidance that expressly addresses autism spectrum disorder or related neurodevelopmental conditions. The framework established in Annex 1 and elaborated in the Manual of Civil Aviation Medicine⁹ operates through broad, functional criteria rather than diagnostic specificity, requiring that a pilot not suffer from any condition likely to impair safe operation, yet eschewing any categorical reference to autism. In this regulatory silence, the Organization leaves the interpretation and application of these general principles to the discretion of individual Contracting States, each of which must assess the functional capacity of applicants on a case-by-case basis. The absence of autism -specific standards is therefore not merely a gap in the documentation; it reveals a deeper reliance on national discretion and clinical judgment rather than uniform international norms. This lacuna underscores the need for greater clarity and coherence in the global aeromedical regime, particularly at a time when neurodiversity is increasingly recognized and understood.

The foregoing analysis reveals a conspicuous legal lacuna. Across the United States, Europe, and Canada, there exists no authoritative doctrinal framework addressing autism spectrum disorder within aeromedical certification. This silence is not merely descriptive; it constitutes a normative deficiency in the law.

At the international level, the International Civil Aviation Organization reinforces this ambiguity by articulating general principles without diagnostic specificity, thereby leaving interpretation to national authorities.

What emerges is a system characterized by regulatory indeterminacy. While all jurisdictions adopt a functional approach, none provides precise criteria for evaluating ASD. The result is a convergence in principle but divergence in application, underscoring the absence of harmonized legal standards.

This ambiguity must be understood as a matter of legal consequence. It reflects an overreliance on discretion in a domain where transparency and consistency are essential. The development of harmonized, evidence-based guidelines—whether through regulation, international standard-setting, or judicial interpretation—is imperative.

Until such clarity is achieved, the certification of pilots with ASD will remain governed less by settled doctrine than by administrative judgment, and less by articulated law than by discretionary assessment.

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⁹Doc 8984.