AM-92/15

Survey of Aviation Medical Examiners
Information and Opinions
Concerning Employment and Training Programs

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March 1992

Final Report

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U.S. Department
of Transportation
Federal Aviation

Doc
FAA
AM
92/15

Technical Report Documentation Page

1. Report No.	2. Government Accession No.	3. Recipient's Catalog No.
DOT/FAA/AM-92/15		

4. Title and Subtitle	5. Report Date
SURVEY OF AVIATION MEDICAL EXAMINERS: INFORMATION AND ATTITUDES ABOUT THE PRE-EMPLOYMENT AND PRE-APPOINTMENT DRUG TESTING PROGRAM	March 1992
	6. Performing Organization Code
7. Author(s)	8. Performing Organization Report No.
Jennifer G. Myers, Ph.D.	
9. Performing Organization Name and Address	10. Work Unit No. (TRAIS)
FAA Civil Aeromedical Institute P. O. Box 25082 Oklahoma City, OK 73125	11. Contract or Grant No.
	13. Type of Report and Period Covered
12. Sponsoring Agency Name and Address	
Office of Aviation Medicine Federal Aviation Administration 800 Independence Avenue, S.W. Washington, D.C. 20591	14. Sponsoring Agency Code

15. Supplementary Notes

This work was performed under task AM-C-90/91-HRR-122.

16. Abstract

Aviation medical examiners who are designated to collect urine specimens were surveyed to collect information and assess attitudes about different aspects of the pre-employment and pre-appointment drug testing program. Fifty-seven percent of the sample responded to the survey. Respondents were generally positive about the custody and control form, the amount of information received about the collection kits and the drug testing program, and the contacts they had with the agency medical staff. However, only about half reported they had been informed of drug testing program changes. Accurate completion of custody and control forms and lack of training were cited most often as causal factors in the occurrence of errors in the specimen collection process and few had actually received information on their error rate in specimen collections. Recommendations were made to 1) review the custody and control form for possible improvements that may reduce errors, 2) restrict the number of AMEs designated to collect specimens, 3) provide training classes, materials, or videotapes, especially for newly designated AMEs, and 4) clarify the alcohol and drug abatement program manager's position prior to making a decision about the organizational location of the manager.

17. Key Words	18. Distribution Statement
Dimensionality Validity Perceptions of Organizational Politics Scale (POPS)	Document is available to the public through the National Technical Information Service, Springfield, Virginia 22161

19. Security Classif. (of this report)	20. Security Classif. (of this page)	21. No. of Pages	22. Price
Unclassified	Unclassified	42	

Form DOT F 1700.7 (8-72) Reproduction of completed page authorized

SURVEY OF AVIATION MEDICAL EXAMINERS: INFORMATION AND ATTITUDES ABOUT THE PRE-EMPLOYMENT AND PRE-APPOINTMENT DRUG TESTING PROGRAM

INTRODUCTION

In early 1990, the Associate Administrator for Human Resource Management (HRM) and the Federal Air Surgeon requested that the Deputy Associate Administrator for Appraisal (AAD-2) evaluate the pre-employment and pre-appointment drug testing program for applicants to FAA safety-critical positions. Some of the issues to be addressed included: the relative cost effectiveness of using a contractor rather than Aviation Medical Examiners (AMEs) for the collection of urine specimens, the potential impact of changing the organizational location of the FAA point of contact for the drug testing program, the error rate in urine specimen collection and factors thought to influence the error rate, and the custody and control form.

AAD-2 requested the Human Resources Research Division participate in the evaluation by assisting in the development, administration, and analysis of a survey to obtain factual and attitudinal data from AMEs who are designated to collect urine specimens for the pre-employment and pre-appointment drug testing program. The survey results were only a part of the overall evaluation which included interviews with the regional medical division and HRM personnel (Gray, Romaine, Bryan & Martin, 1991).

PROCEDURE

Subject Population

The population of AMEs who collect urine specimens for the pre-employment and pre-appointment drug testing program was identified by records maintained by the Aeromedical Education Division (AAM-400) and confirmed by aviation medical division staff in each of the regions. Flight Surgeons in the air traffic en route facilities can collect urine specimens under this program, but were not included in the survey because these Flight Surgeons were interviewed as FAA employees in the evaluation effort. We identified 726 AMEs, ranging from 22 AMEs in the Alaskan Region (AAL) to 152 in the Great Lakes Region (AGL). The number of AMEs within a region who are designated to conduct specimen collections varies widely, even for same-sized regions, because the regional aviation medical divisions set their own policy for designating AMEs to conduct the specimen collections. For example, they can designate any AME who conducts annual physical exams or they can hand pick a select group of AMEs to collect the specimens.

Survey Development

The staff from AAD-2 and AMS-550 submitted questions for inclusion in the survey. The questions were revised and formatted for ease of responding and clarity. The survey was pretested with several AMEs; no problems were encountered requiring additional revision. The final survey consisted of 30 items. The general areas we investigated were: the number of and charges for specimen collections; the types of office staff that collect the specimen and complete the custody and control form; attitudes about the collection kits, custody and control forms and receipt of information about aspects of the drug testing program; factors that influence lab cancellations (errors); frequency and satisfaction with FAA contacts; the organizational location of the regional point-of-contact; and involvement of a contractor in specimen collection.

We distributed the survey on June 12, 1990, with August 1 as the final cutoff date for inclusion in the data analysis. A commercially-available optical mark reader form was used for respondents to record their answers. Appendix A contains the cover letter and AME survey.

RESULTS AND DISCUSSION

Subject Returns

The usable response rate for the total sample was 57% (370 surveys; see Table 1). Of the

respondents, 72 (16% of the total number of returns) reported that they did not collect urine specimens for the FAA pre-employment and pre-appointment drug testing program and were excluded from further analysis. It is possible that although the AMEs were *approved* to conduct the specimen collection, they have not had to do so and therefore answered "no" to the question. Nonetheless, the response rate was sufficiently high to assure representativeness of this survey. The calculated bound on the error of estimation indicated that the results of the survey questions were within $\pm$ 1.5% of the true population proportion.

TABLE 1. RESPONSE RATES BY REGION

REGION	DISTRIBUTED	RETURNED	RESPONSE RATE
	N	N	%
AAL (Alaskan)	22	8	36
ACE (Central)	37	27	73
AEA (Eastern)	129	68	53
AGL (Great Lakes)	152	69	45
ANE (New England)	27	14	52
ANM (Northwest Mountain)	100	52	52
ASO (Southern)	122	51	42
ASW (Southwest)	103	62	62
AWP (Western-Pacific)	34	15	44
DID NOT REPORT REGION		4	
OVERALL	726	370	57

Number of Specimen Collections

Over half of the respondents (58%) reported that they collected 10 or fewer specimens during the past 12 months and 23% of the respondents conducted between 11 and 25 collections. Very few AMEs collected 100 or more specimens. There were some differences among the regions. Only AEA, AGL, ASO, and AWP regions had AMEs who reported they collected 100 or more specimens in the past 12 months. Only in two regions - ASO and AWP - did less than half of the AMEs collect 10 or fewer specimens in the past year. (See Appendix B for item responses for the entire sample and Appendix C for item responses by region).

Table 2 shows the total number of samples processed in CY-89 for each region. The average number of collections per designated AME is fairly similar across regions, with two exceptions: AAL (average=6) and AWP (average=42). The large average number of collections per AME in the AWP reflects that region's policy of careful selection and designation of AMEs to perform the annual physical examinations for air traffic control specialists (personal communication, Dr. Bill Davis, 1990). These AMEs also conduct all the specimen collections for the pre-employment and pre-appointment drug testing program. The number of urine samples collected, and examined in conjunction with respondents' information on the number of collections, suggests that a few AMEs within each region conduct most of the specimen collections.

TABLE 2. SAMPLES PROCESSED IN CY-89 AND NUMBER OF AMEs

REGION	NUMBER OF SAMPLES	AVE.NUMBER OF AMES	PER AME
AAL	138	22	6
ACE	484	37	13
AEA	1490	129	12
AGL	1671	152	11
ANE	360	27	13
ANM	1124	100	11
ASO	2223	122	18
ASW	2085	103	20
AWP	1443	34	42

Charges for Specimen Collections

Nationwide, most AMEs reported that they charged between $11 and $20 for the specimen collection. A significant minority (23%) did not charge for the collection, whereas only 3% charged $30 or more. This pattern was essentially similar to the results identified for each of the regions. Two exceptions were noted; half of the Alaskan Region AMEs reported they did not charge for the collection and the majority of AMEs in ACE charged $10 or less. We analyzed the factors which might influence the charge for the specimen collection and found that the amount charged was unrelated to the number of specimens collected, the type of office staff that collect the specimen, or the type of person who usually completes the custody and control form. It is possible that fees for collection are established by local area rates for this type of service, rather than any of the factors we examined.

Very few of the respondents indicated that the collection of fewer specimens or specimens collected separately from the physical exam would affect their charge. Overall, two-thirds of the AMEs stated that the FAA is not charged for collecting another specimen if the contractor conducting the urinalysis rejects the specimen because of errors in the collection process (lab cancellation). However, over half of the AMEs who conducted 51 or more collections during the past 12 months *do* charge for another collection (see Appendix D for item responses by number of collections). It is possible that only those AMEs who conduct a large number of specimen collections have had sufficient experience to develop a policy about charging for additional collections resulting from lab cancellations.

Payment for Specimen Collections

Most of the AMEs reported they were paid for their services within 2 to 4 weeks (40%) or 5 to 8 weeks (42%) after they submitted a bill to the FAA. Among Alaskan and Central Region AMEs, the majority stated they were paid within 2 to 4 weeks. The majority of ANE, ANM, and AWP respondents reported payment within 5 to 8 weeks. The remaining regions were split fairly evenly between these two categories (see Appendix B). The differences between the regions are most likely the result of slightly different procedures for processing payments in each of the regions.

Staff Completing Collections and Forms

Respondents were asked to identify all office staff who collect the urine specimens. Almost three-fourths of the AMEs reported only one staff person collects the specimen. Of this group of AMEs, the office staff most often reported was the doctor (26%), followed by other (25%), registered nurse (20%), LPN (15%), and physician's assistant (14%). Among AMEs who indicated two office staff collected urine specimens, the doctor and nurse were most often identified. Few AMEs identified more than two office staff who collected the specimens (see Figure 1). Overall, the highest percentages of AMEs reported that specimen collections were conducted by the doctor (34%) and registered nurse (31%).

Table 3 shows the responses of AMEs to the question regarding who completes the custody and control form for a specimen collection.

Although the doctor *or* nurse collected the specimen, the nurse was identified by slightly more AMEs as the primary person for completing the form. Of those who were identified as part of the office staff who collect the specimens, the large majority also complete the custody and control forms.

TABLE 3. PRIMARY STAFF WHO COMPLETE CUSTODY AND CONTROL FORMS

	COMPLETE FORMS	COLLECT SPECIMENS AND COMPLETE FORMS
DOCTOR	22%	85%
NURSE	26%	93%
LPN	16%	93%
PHYS ASS'T	13%	98%
OTHER	23%	93%

Attitudes about the Custody and Control Form

Approximately one-fourth of the respondents felt the custody and control form was too long. A majority of the AMEs (61%) felt the instructions were clear and that they received sufficient information from the FAA on how to complete the form (73%).

A higher percentage of positive responses about the length of the form and the clarity of the instructions came from those who collected 26 or more specimens during the past year. Most likely, those who collected more specimens have greater familiarity with the form, and thus may feel more comfortable about its length and are able to complete the form easily. However, over 80% of the respondents collected 26 or fewer specimens, and thus should be considered more representative of the attitudes of the AMEs (see Appendix D for item responses by number of collections).

The item which asked who is the primary person for completing the custody and control form was compared with other items dealing with attitudes about the custody and control form. Only the item regarding the length of the form had a significant relationship with the type of primary person identified ($\chi^2=37.47$, $df=16$, $p<.002$). Of those who felt the form was too long, just over one-fourth said the doctor was the primary person who completed the form. Of those who disagreed that the form was too long, approximately one-third reported "other" as the primary person completing the form (see Table 4).

TABLE 4. ATTITUDES ABOUT THE FORM BY TYPE OF PERSON COMPLETING THE FORM

TYPE OF PRIMARY PERSON COMPLETING FORM	THE DRUG TESTING CUSTODY AND CONTROL FORM IS TOO LONG					
	DISAGREE		NEITHER		AGREE	
	N	%	N	%	N	%
SELF (DOCTOR)	25	20	22	19	33	27
NURSE	25	20	42	36	28	23
LPN	11	9	19	16	28	23
PHYS. ASS'T.	21	17	12	10	13	10
OTHER	40	33	22	19	22	18

*Percentages may not sum to 100 due to rounding

Information on Collection Kits

Almost 80% of the AMEs agreed that they received collection kits from the FAA in a timely manner. Approximately three-fourths of the respondents felt they received sufficient information from the FAA on how to use the kits. The majority said they had been informed by the FAA on how to order the collection kits. In general, the use and receipt of the collection kits

were not problematic areas for the AMEs.

Information About the Drug Testing Program

Just under two-thirds of the AMEs reported that they received sufficient information from the FAA on the drug testing program and that they understood the federal guidelines for the program. However, less than half (45%) reported they had been informed about changes in the drug testing program. Only 14% reported that they had received information on their error rate, i.e., the percentage of their total specimen collections that had been rejected by the contractor conducting the urinalysis. The process of tracking down rejected specimens to specific AMEs is a difficult paper process. It may be that, given the difficulty of the task, only those AMEs with suspected problems with the specimen collection process are tracked and contacted.

AMES who felt they had received sufficient program information were compared with AMEs who felt they *did not* receive sufficient information on several items. Higher percentages of the "informed" group reported having received information on changes in the drug testing program, the availability of training, and how to order drug testing kits than did the "uninformed" group (see Table 5). The "uninformed" group cited shipment of the specimen to the lab as a factor contributing to errors in the specimen collection process more often than did the "informed" group. It is possible that this is one aspect of the specimen collection process that the "uninformed" group does not understand clearly and could benefit from additional information, resulting in a decrease in the number of specimens that cannot be analyzed by the contractor.

TABLE 5. RECEIPT OF GENERAL AND SPECIFIC DRUG TESTING PROGRAM INFORMATION

		RECEIVE SUFFICIENT INFO ON DRUG TESTING PROGRAM		
		DISAGREE	NEITHER	AGREE
13. RECEIVE SUFFICIENT INFO ON FORM	DISAGREE	65%	17%	18%
	NEITHER	41%	48%	11%
	AGREE	5%	16%	79%
14. RECEIVE SUFFICIENT INFO ON KIT USAGE	DISAGREE	68%	10%	22%
	NEITHER	35%	50%	15%
	AGREE	8%	16%	76%
22. INFORMED ABOUT PROGRAM CHANGES	YES	11%	15%	74%
	NO	24%	24%	52%
23. INFORMED ABOUT TRAINING	YES	8%	8%	84%
	NO	23%	24%	53%
24. INFORMED ABOUT ORDERING KITS	YES	12%	19%	69%
	NO	33%	21%	46%

Correlations Among the Items. We examined the items regarding receipt of sufficient information on the form, collection kits, and the drug testing program for statistical relationships to help understand the survey results. Items were moderately to highly correlated (See Table 6). Thus, it appears that if sufficient information was received in one area, it was also received in other areas. We thought that the more experienced AMEs, that is, those AMEs who collect 50 or more specimens per year, might be the most informed group. However, the number of collections over the past year was unrelated to the information items. Receipt of information was also unrelated to the frequency of contact with FAA representatives. It could be that information is received through distribution in the mail, rather than phone or personal contact with

FAA representatives. Those AMEs who felt they received sufficient information on the program also felt they understood the federal guidelines (Items 15 and 16, $r = .65$, $p < .001$). AMEs who actually *read* the guidelines might be better informed and receive "sufficient information" from the federal guidelines. Responses to Item 16 ("I fully understand the federal guidelines for the pre-employment/pre-appointment drug testing program") were positively - and significantly - related to items about receipt of information regarding the use of the collection kit and completion of the custody and control form.

TABLE 6. CORRELATIONS AMONG ATTITUDE ITEMS

	Q10	Q11	Q12	Q13	Q14	Q15	Q16
Q10	*						
Q11	-.34	*					
Q12	-.09	.25	*				
Q13	-.20	.62	.43	*			
Q14	-.24	.61	.50	.84	*		
Q15	-.16	.46	.36	.68	.64	*	
Q16	-.23	.43	.33	.55	.50	.65	*

N = 344 (Listwise Deletions)

All correlations significant at $p < .001$ except Q10 with Q12 where $p > .05$

Training for the Drug Testing Program

Although no formal FAA training on the drug testing program has been conducted, 28% of the respondents reported they had been informed about training and 23% indicated they had received training on the FAA drug testing program. Because some AMEs are also medical review officers (MROs) for companies covered by the aviation industry drug testing program, those AMEs may have received training at an FAA, Department of Transportation, or other federal agency drug testing seminar.

Error Rates

The number of billable lab cancellations represents the errors incurred by the AME, resulting in the contractor lab's inability to conduct the urinalysis and an additional charge to the FAA. The error rates were computed by dividing the number of billable lab cancellations by the total number of analyzed specimens. The national error rate was 8%, with error rates for regions ranging from 4% to 11% (see Figure 2). These rates are considerably higher than the industry standard of less than one percent.

Factors Contributing to Errors

Almost half of the respondents reported that the doctor/staff not being adequately trained in specimen collection contributed to errors in the specimen collection process. Only 31% of the respondents indicated that the shipment of the specimen to the lab was problematic, while 70% of the respondents stated that accurate completion of the custody and control form contributed to the errors in the process. Of the few AMEs who reported "other" factors, their comments on that item indicated that they believed that the receiving lab was scapegoating the AME for the lab's carelessness and mistakes (see Appendix E for the comments made by AMEs to the survey items).

Experienced AMEs, i.e., those who conduct 50 or more specimen collections per year, were specifically examined for their potentially different perspective on the causal factors in lab cancellations. The perceived impact of the shipment of the specimen to the lab and the lack of

trained medical office staff on errors was unrelated to the number of collections conducted. A majority of AMEs attributed errors in the collection process to the accurate completion of the forms, regardless of the number of collections the AMEs had made (see Appendix D). Inaccurate completion of the forms can be problematic, especially since the receiving lab can cancel the specimen test as a result of these inaccuracies.

Contact with FAA Representatives

The majority of AMEs stated they were in contact with an FAA representative regarding the pre-employment and pre-appointment drug testing program only once a year or less. Just over half of the AMEs identified the Regional Flight Surgeon as their primary contact, while only 4% listed the Air Traffic Flight Surgeon as their primary contact for the drug testing program. The regions were similar to the overall results in their pattern of primary FAA contacts. The Regional Flight Surgeon was the primary contact for a majority of AMEs in all the regions. Identification of the ADAP manager as the primary contact ranged from zero (AAL) to 18% (ASO). The frequency of contact was compared for each of the categories of primary FAA contacts; approximately 70% or more of the respondents for each category of FAA contacts reported three or fewer interactions per year.

Overall, the majority of respondents were satisfied with their contacts with FAA representatives. AMEs were satisfied with their FAA contacts, regardless of the frequency of those contacts. A higher percentage of those with yearly or less frequent contact reported they were neither satisfied nor dissatisfied, as compared with those having more frequent contact. Given their infrequent contact with FAA representatives, it is likely that they were unable to be positive or negative about their FAA interactions. AMEs were also fairly uniform in their satisfaction without regard to the type of primary FAA contact they had.

The majority of AMEs (60%) stated that they would not experience any problems if the regional FAA point-of-contact was changed to a nonmedical office. Only 7% felt they would experience problems "to a very great extent" if this change occurred. The extent to which problems would be experienced was unrelated to the type of primary FAA contact AMEs had identified (see Table 7). Although a higher percentage of those that are in frequent contact with an FAA representative (once every 3 months or more often) stated they would experience problems to a greater extent than did those with less frequent contact, this group represents only 2% of the total respondent sample.

TABLE 7. PRIMARY FAA CONTACT AND PROBLEMS ASSOCIATED WITH A CHANGE IN LOCATION OF POINT OF CONTACT

TO WHAT EXTENT WOULD YOU EXPERIENCE PROBLEMS IF YOUR REGIONAL POINT OF CONTACT FOR DRUG TESTING CHANGED TO A NONMEDICAL OFFICE IN YOUR REGION?

TYPE OF PRIMARY FAA CONTACT	NOT AT ALL		LIMITED EXTENT		MODERATE EXTENT		CONSID EXTENT		VERY GREAT EXTENT	
	N	%	N	%	N	%	N	%	N	%
Regional Flight Surgeon	107	62	20	12	24	14	11	6	10	6
Flight Surgeon-At Field	7	58	2	17	2	17	0	0	1	8
ADAP Manager	25	64	5	13	4	16	3	8	2	5
Medical Div Admin	44	52	18	21	10	12	4	5	8	9
Other	19	58	10	30	1	3	1	3	2	6
Overall	201	60	55	16	41	12	19	6	23	7

Changes in the Pre-employment and Pre-appointment Drug Testing Program

AMEs were asked whether they felt the drug testing program should be conducted by a contractor. Slightly over half (51%) said "no", with the remainder of the respondents fairly evenly split between "yes" (24%) and "not sure" (25%). The pattern of responses among the regions was very similar to the overall results (see Table 8). Although there were a variety of comments regarding this question, in general, those AMEs not wanting the specimen collection to be conducted by a contractor indicated a concern for the convenience of the patient and the need for a medical person to be involved (see Appendix E for the written comments).

TABLE 8. SPECIMEN COLLECTION CONDUCTED BY CONTRACTOR

REGIONS	YES	NO	NOT SURE
AAL	25%	50%	25%
ACE	30%	48%	22%
AEA	26%	58%	17%
AGL	26%	46%	29%
ANE	23%	46%	31%
ANM	28%	34%	38%
ASO	21%	62%	17%
ASW	17%	57%	26%
AWP	13%	47%	40%
OVERALL	23%	51%	25%

SUMMARY AND RECOMMENDATIONS

As of August 1990, the majority of AMEs designated for collecting urine specimens collected fewer than 10 specimens per year. Most AMEs charged $20 or less for the specimen collection and were paid within 8 weeks of submitting their bills to the agency. For most of the AMEs, primarily one staff person collected the specimen; that same staff person tended to complete the custody and control form. A majority of the respondents was positive about the custody and control form and received sufficient information about collection kits. Almost two-thirds of the AMEs felt they received sufficient information on the drug testing program and also understood the federal guidelines, but less than one-half had been informed of program changes. In addition, few of the AMEs reported having received information on their error rate in specimen collections.

Accurate completion of the custody and control forms was cited by a majority of AMEs as a causal factor in the occurrence of errors in the specimen collection process. Almost one-half of the respondents also cited the lack of training for the doctor and staff in the occurrence of errors. In general, AMEs reported infrequent contact with the agency, but were satisfied with their contacts. About one-fourth of the AMEs thought they would experience some problems if their agency point-of-contact changed to a non-medical office. Overall, just over one-half did not want the specimen collection to go to an outside contractor.

Although responses to the attitudinal questions about the custody and control forms were generally positive, the accurate completion of the form was cited most often as a contributor to lab cancellations. Without information on the types of errors that result in lab cancellations, it is difficult to determine if incomplete custody and control forms are the real culprit. Given the number of AME concerns identified by the survey and comments, further review of the contribution of the custody and control forms on the occurrence of lab cancellations appears warranted. Although the Office of Management and Budget (OMB) created a custody and control form to standardize the information obtained with each specimen collection, contractors are not required to use the OMB form. Rather, they can use any form that requests the same information required on the OMB form. These other custody and control forms may have problems in the clarity of instructions for collection procedures

and completing the form that are contributing to errors. It may be useful to establish a mechanism for feedback to the contractor on the forms that they use and possible revisions that may reduce errors.

The regions should consider further restricting the number of AMEs who are designated to collect specimens. Restricting the number of AMEs would more easily allow targeting individuals for training and program materials. In addition, those AMEs who are designated would likely collect a greater number of specimens, thus increasing their familiarity with the custody and control form, as well as the overall drug testing process. This increase in familiarity could result in a reduction in the overall error rate.

Training for AMEs who conduct specimen collections should be initiated. AMEs who are newly designated for specimen collections should be specifically identified for orientation training and/or program information. If types of errors that occur in the drug testing process can be identified through the contractor currently conducting the urinalysis, these errors should be used as the subject of training sessions or special materials for AMEs. Although only about 12% of the AMEs are involved in specimen collection, there may be some utility in offering training or question and answer sessions on the drug testing program during regular AME seminars. Because the type of information to be obtained with the specimen collection has been standardized (through the OMB form), a training videotape could be created that addresses those areas of information and their collection, and prevent problems associated with office staff turnover.

The decision on the organizational location of the ADAP manager requires further study. There appears to be some ambiguity and inconsistency regarding the roles and responsibilities of the ADAP manager, in comparison to those of the Regional Flight Surgeon, for the training and technical assistance provided to AMEs involved in the pre-employment and pre-appointment drug testing program. These roles and responsibilities should be clarified so that potential changes in roles resulting from organizational relocation can be examined for their impact - positive or negative - on the drug testing program. The lack of contact with the ADAP manager by most of the AMEs suggests limited utilization of that staff person for implementation of the drug testing program.The limited contact may reflect the inability of the ADAP manager to answer AME questions, the lack of understanding of the role of the ADAP manager on the part of the AME, or the absence of contacts initiated by the ADAP manager. Clarifying the ADAP manager's role, as well as ensuring adequate credentials for operating the program, may enhance the effectiveness of that position and the drug testing program as a whole. As noted before, this process will help in making an informed decision about the organizational location of the ADAP manager.

REFERENCES

Gray, T.A., Romaine, J.E., Bryan, C.W., & Martin, S.A. FAA Pre-Employment and Pre-Appointment Drug Testing (Deputy Associate Administrator for Appraisal, No. 91-2, August 5, 1991).

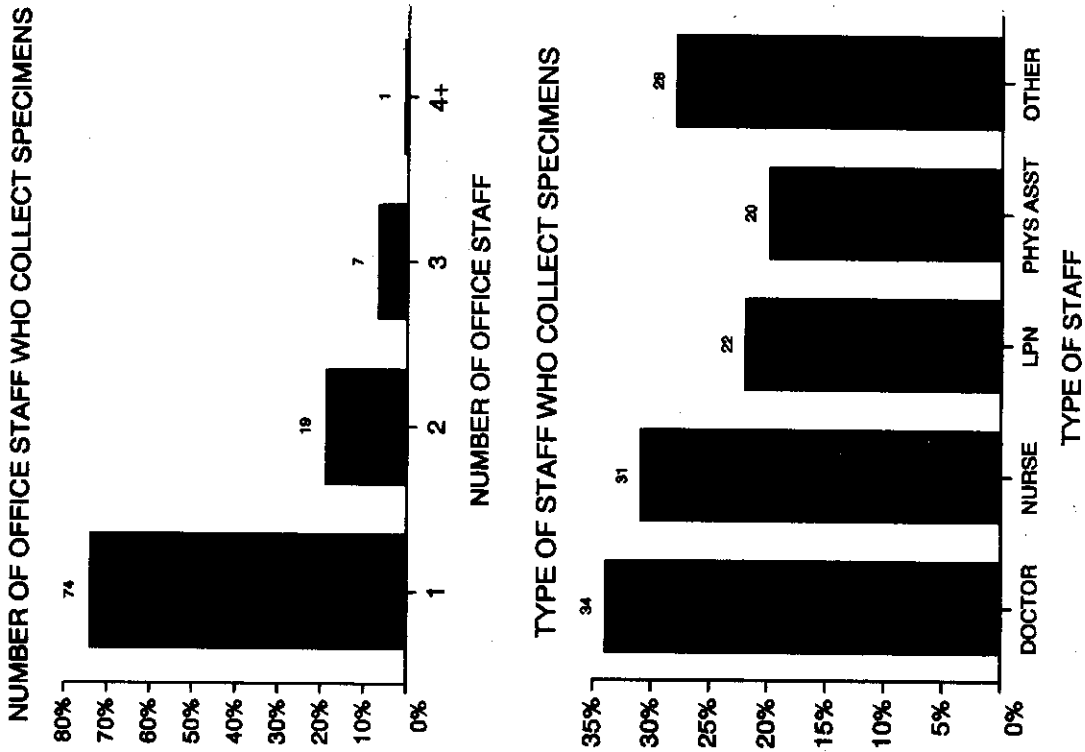

FIGURE 1. NUMBER AND TYPE OF STAFF WHO COLLECT SPECIMENS

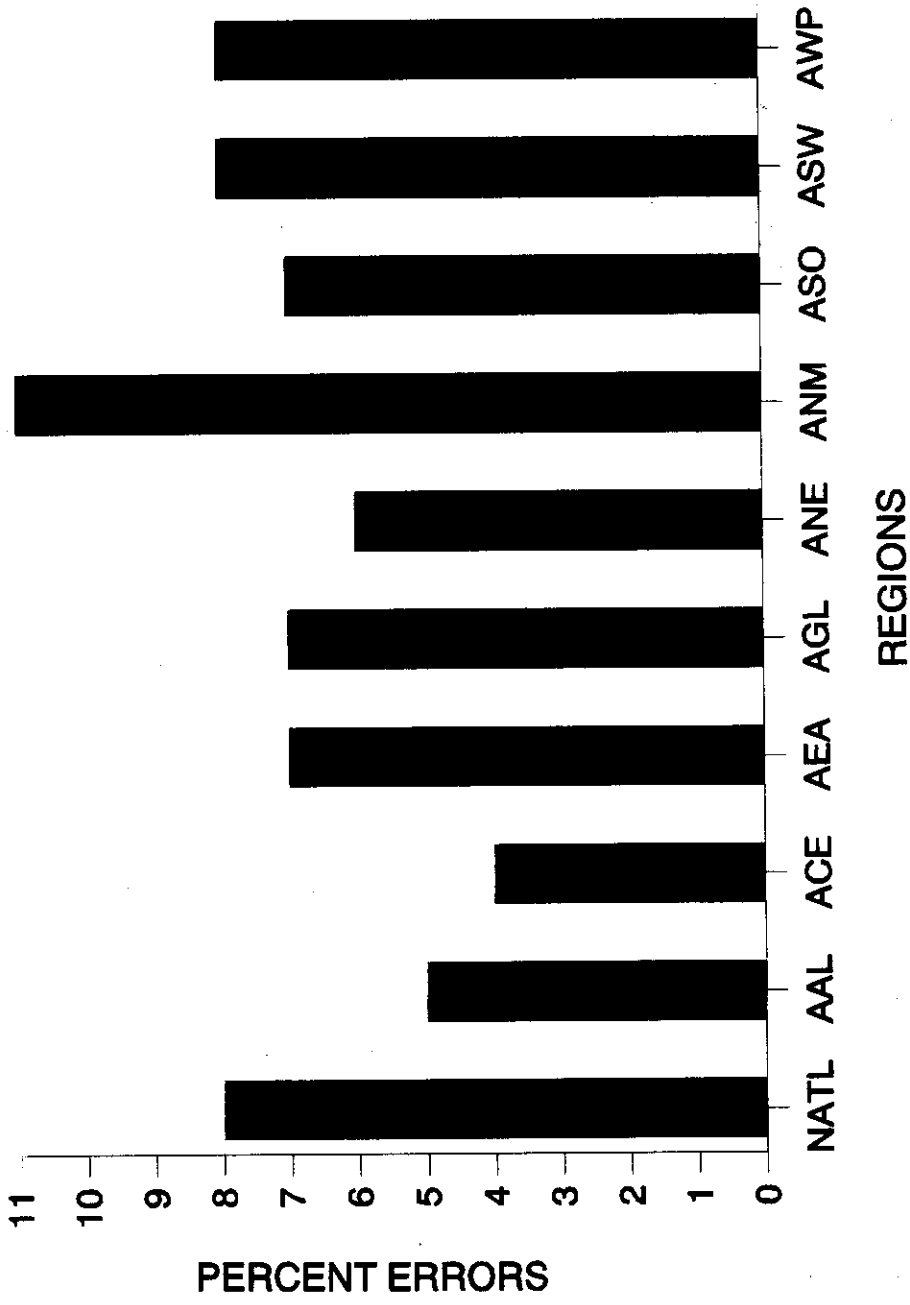

FIGURE 2. CY-89 ERROR RATES

AVIATION MEDICAL EXAMINER SURVEY

GENERAL SURVEY INSTRUCTIONS

The following questions ask about your experiences and opinions regarding the urine specimen collection process that is a part of the FAA's pre-employment and pre-appointment drug testing program. Even though you may believe that you do not have enough information to answer some of the questions, select the response alternative that comes closest to your opinions or feelings. Space for comments is included on the last page of the survey for any other remarks or suggestions you may wish to make regarding the drug testing program. Your participation in this survey is voluntary and anonymous; your individual responses to these questions cannot be identified in any way.

Your answers should be recorded on the scannable answer sheet that is enclosed with this survey. There are spaces for including your name and an identification number on the answer sheet. DO NOT COMPLETE THAT PART OF THE ANSWER SHEET. Mark the circle on the answer sheet that corresponds to the response that you have selected. Because your responses will be read by an optical mark reader, it is important that you follow a few simple rules:

* Do not bend, cut or fold the answer sheet in any way.

* Use a Number 2 lead pencil (Not a ball point, ink, or felt tip pen).

* Make a heavy, dark mark that fills the circle representing each response.

* Erase completely when changing any answer and make sure that all stray pencil marks are also erased.

The completed answer sheet and comment sheet should be mailed to:

CAMI, AAM-522
Mike Monroney Aeronautical Center

P.O. Box 25370
Oklahoma City, Ok 73125

For your convenience, a pre-addressed return envelope is included with this survey.

1. Are you an Aviation Medical Examiner who collects urine specimens for pre-employment or pre-appointment drug testing for FAA employees?

   A Yes
   B No

IF YOU ANSWERED NO, PLEASE DO NOT COMPLETE THE QUESTIONNAIRE. RETURN THE QUESTIONNAIRE AND SCAN FORM IN THE ENVELOPE PROVIDED.

2. In which FAA Region do you reside?

   A Alaska
   B Central
   C Eastern
   D Great Lakes
   E New England
   AB Northwest Mountain
   AC Southern
   AD Southwest
   AE Western-Pacific

   *
   *--> for these regions,
   * please make sure you
   * mark the TWO circles.

3. How many collections under the FAA's pre-employment/pre-appointment drug testing program have you administered within the past year?

   A Less than 10 collections
   B 11-25 collections
   C 26-50 collections
   D 51-100 collections
   E 100 or more collections

4. How much do you charge for a specimen collection, excluding the cost of the physical?

   A No charge
   B $10 or less
   C $11-$20
   D $21-$30
   E $30 or more

5. Would the charge for a specimen collection be different if you collected:
   (MARK ALL THAT APPLY)

   A Fewer specimens
   B Specimens separate from the physical exam
   C Neither of the above would affect the charge

6. Is the FAA charges if another specimen collection is required due to a lab cancellation?

   A Yes
   B No

7. On the average, how long does it take to receive your payment after you have submitted a bill?

   A Less than 2 weeks
   B 2-4 weeks
   C 5-8 weeks
   D More than 8 weeks

8. Who in your office collects the urine specimens for FAA employees? (MARK ALL THAT APPLY)

A Yourself
B Registered Nurse
C LPN
D Physician's Assistant
E Other

9. Who is the PRIMARY person for completing the form which accompanies the specimen collection? (CHOOSE ONLY ONE)

A Yourself
B Registered Nurse
C LPN
D Physician's Assistant
E Other

PLEASE INDICATE YOUR AGREEMENT OR DISAGREEMENT WITH THE FOLLOWING STATEMENTS:

	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
10. The drug testing custody control form is too long.	A	B	C	D	E
11. The instructions for completing the drug testing custody and control form are clear.	A	B	C	D	E
12. I receive an adequate number of collection kits from FAA in a timely manner.	A	B	C	D	E
13. I receive sufficient information from the FAA on how to complete the drug testing custody and control form.	A	B	C	D	E
14. I receive sufficient information from the FAA on the use of the kit for specimen collection.	A	B	C	D	E
15. I receive sufficient information from the FAA on the pre-employment/pre-appointment drug testing program.	A	B	C	D	E
16. I fully understand the Federal guidelines for the FAA pre-employment/pre-appointment drug testing program.	A	B	C	D	E

SOME AMES HAVE EXPERIENCED PROBLEMS WITH LAB CANCELLATIONS DUE TO ERRORS IN THE SPECIMEN COLLECTION PROCESS. WHICH OF THE FOLLOWING FACTORS DO YOU THINK CONTRIBUTE TO ERRORS IN THE PROCESS?

	YES	NO
17. Doctor/staff not trained adequately in specimen collection	A	B
18. Shipment of specimen to lab	A	B
19. Accurate completion of custody and control form	A	B
20. Other (please explain on the Comments Sheet).	A	B

HAVE YOU BEEN INFORMED BY AN FAA REPRESENTATIVE ABOUT....

	YES	NO
21. The error rate in your office for the collection of urine specimens?	A	B
22. Changes in the drug testing program?	A	B
23. Available training on the drug testing program?	A	B
24. How to order drug testing kits?	A	B

25. Have you attended any training on the FAA pre-employment/pre-appointment drug testing program?

A Yes
B No

26. Approximately how often are you in contact with regional FAA representatives regarding the pre-employment/pre-appointment drug testing program?

A Once a month or more
B Once every 2 months
C Once every 3 months
D 2-3 times a year
E Once a year or less

27. Which regional FAA representative do you primarily have contact with regarding the pre-employment/pre-appointment drug testing program?

A Regional Flight Surgeon
B Flight Surgeon at an Air Traffic field facility
C Aviation Drug Abatement Program Manager
D Medical Division Administrative Staff
E Other

28. Overall, how satisfied are you with the contacts you have had with Regional FAA representatives regarding the pre-employment/pre-appointment drug testing program?

A Very dissatisfied
B Dissatisfied
C Neither satisfied nor dissatisfied
D Satisfied
E Very satisfied

**If you indicated you were dissatisfied, please give your reasons why on the Comment Sheet.

29. In your opinion, should the specimen collection for the FAA pre-employment/pre-appointment drug testing program be conducted by a contractor (e.g., UpJohn)?

A Yes
B No
C Not sure

**Please explain your answer on the Comments Sheet.

30. To what extent would you experience problems if your regional FAA point-of-contact for drug testing changed to a nonmedical office in the region?

A Not at all
B To a limited extent
C To a moderate extent
D To a considerable extent
E To a very great extent

**If you foresee problems if your regional FAA point-of-contact was changed to a nonmedical office, please explain those problems on the Comments Sheet.

COMMENTS SHEET

Thank you for taking the time to complete this questionnaire. If you have other comments or suggestions regarding the FAA's pre-employment/pre-appointment drug testing program, please use the front and back of this page to make your comments. Tear the page off from the questionnaire and return your comments with the scannable answer form in the pre-addressed envelope that we have provided.

	PERCENT	NUMBER
9. WHO COMPLETES FORM		
SELF	22	80
RN	26	96
LPN	16	58
PA	13	46
OTHER	23	84
10. FORM TOO LONG		
STRONGLY DISAGREE	8	31
DISAGREE	26	94
NEITHER	32	119
AGREE	20	72
STRONGLY AGREE	14	53
11. FORM INSTRUC CLEAR		
STRONGLY DISAGREE	8	30
DISAGREE	15	55
NEITHER	16	58
AGREE	48	177
STRONGLY AGREE	13	49
12. REC ENOUGH KITS		
STRONGLY DISAGREE	3	10
DISAGREE	7	27
NEITHER	11	42
AGREE	57	211
STRONGLY AGREE	21	79
13. SUFFICIENT INFO ON KITS		
STRONGLY DISAGREE	5	17
DISAGREE	10	37
NEITHER	12	44
AGREE	58	213
STRONGLY AGREE	16	58
14. SUFFICIENT INFO ON KITS		
STRONGLY DISAGREE	4	14
DISAGREE	7	27
NEITHER	13	48
AGREE	62	228
STRONGLY AGREE	14	52
15. SUFFICIENT PROG INFO		
STRONGLY DISAGREE	6	22
DISAGREE	12	45
NEITHER	20	73
AGREE	50	185
STRONGLY AGREE	12	44
16. UNDERSTAND FED GUIDE		
STRONGLY DISAGREE	7	17
DISAGREE	12	46
NEITHER	19	70
AGREE	50	184
STRONGLY AGREE	14	51

	PERCENT	NUMBER
CONTRIBUTIONS TO ERRORS:		
17. DR/STAFF NOT TRAINED	48	176
YES	52	189
NO		
18. SHIPMENT TO LAB	31	112
YES	69	251
NO		
19. COMPLETION OF FORM	70	257
YES	30	108
NO		
20. OTHER	14	48
YES	86	286
NO		
INFORMED ABOUT:		
21. ERROR RATE	14	51
YES	86	316
NO		
22. PROGRAM CHANGES	45	166
YES	55	200
NO		
23. AVAILABLE TRAINING	28	103
YES	72	261
NO		
24. ORDERING KITS	71	260
YES	29	105
NO		
25. ATTENDED TRAINING	23	84
YES	77	280
NO		
26. FREQ OF FAA CONTACT	7	24
ONCE/MO	6	23
ONCE/2 MOS	5	18
ONCE/3 MOS	27	97
2-3 X YEAR	56	203
ONCE/YR		
27. PRIMARY FAA CONTACT	51	181
REG FLT SURGEON	4	14
FLT SURGEON-FIELD	12	41
ADAP MGR	25	88
MED DIV ADMIN	10	34
OTHER		

	PERCENT	NUMBER
28. SATIS WITH FAA CONTACTS		
VERY DISSATISFIED	10	35
DISSATISFIED	6	20
NEITHER	25	89
SATISFIED	43	155
VERY SATISFIED	17	62
29. COLLECT BY CONTRACTOR		
YES	24	83
NO	51	181
NOT SURE	25	90
30. PROBS WITH CONTACT CHG		
NOT AT ALL	60	207
LIMITED EXTENT	16	56
MODERATE EXTENT	12	41
CONSIDERABLE EXTENT	6	19
VERY GREAT EXTENT	7	23

APPENDIX C

ITEM RESPONSE PERCENTAGES BY REGION

	AAL	ACE	AEA	AGL	ANE	ANM	ASO	ASW	AWP
NO. OF RESPONDENTS	8	27	68	69	14	52	51	62	15
3. NO. OF COLLECTIONS									
LESS 10	88	52	62	60	50	67	43	64	33
11-25	12	30	22	22	36	26	33	14	13
26-50	0	14	10	2	14	4	14	14	26
50 +	0	4	4	14	0	2	10	6	26
4. AMOUNT CHARGED									
NO CHARGE	50	11	30	23	8	8	28	32	6
< $10	12	59	28	26	23	25	21	16	33
$11-$20	25	26	36	44	54	50	37	24	40
$21-$30	0	4	4	4	15	14	10	23	6
$30 +	12	0	2	1	0	4	4	3	13
5. CHARGE FACTORS									
A. FEWER SPECIMENS									
YES	12	0	2	2	0	0	0	0	0
NO	88	100	98	97	100	100	100	100	100
B. SEPARATE SPECIMENS									
YES	62	33	32	20	7	21	26	37	20
NO	38	66	68	80	92	78	74	62	80
C. NEITHER									
YES	25	66	62	76	86	78	74	62	80
NO	75	33	38	23	14	21	26	37	20
6. CHARGE FOR NEW COLLECT									
YES	25	40	36	36	54	30	42	20	40
NO	75	60	64	63	46	70	58	80	60
7. RECEIVE PAYMENT									
< 2 WKS	0	12	6	12	0	0	2	2	0
2-4 WKS	83	50	40	42	16	36	42	47	8
5-8 WKS	16	26	42	36	58	62	48	32	54
> 8 WKS	0	12	11	10	25	2	8	18	38

	AAL	ACE	AEA	AGL	ANE	ANM	ASO	ASW	AWP
8. WHO COLLECTS SPECIMEN									
A. SELF									
YES	62	18	36	26	50	30	35	44	26
NO	38	82	63	74	50	69	64	56	73
B. RN									
YES	38	26	26	38	42	28	24	34	46
NO	62	74	74	62	57	71	76	66	53
C. LPN									
YES	25	33	19	12	21	21	31	30	6
NO	75	67	80	88	78	78	68	69	93
D. PA									
YES	0	14	20	17	28	12	31	18	33
NO	100	85	79	82	71	88	68	82	66
E. OTHER									
YES	25	30	20	40	7	38	20	22	26
NO	75	70	80	59	92	62	80	77	73
*COULD MARK MORE THAN 1									
9. WHO COMPLETES FORM									
SELF	38	14	28	20	36	16	18	24	21
RN	25	14	20	32	36	26	20	32	42
LPN	12	30	14	8	7	20	22	20	0
PA	0	14	16	10	14	4	22	8	21
OTHER	25	26	20	30	7	35	20	14	14
10. FORM TOO LONG									
STRONGLY DISAGREE	0	0	10	16	14	2	2	11	13
DISAGREE	25	41	32	23	14	25	30	19	6
NEITHER	25	40	24	39	28	34	20	34	53
AGREE	25	7	14	13	28	21	31	24	13
STRONGLY AGREE	25	11	18	8	14	17	18	11	13
11. FORM INSTRUC CLEAR									
STRONGLY DISAGREE	0	14	12	1	0	11	8	4	13
DISAGREE	25	7	18	13	28	19	16	11	0
NEITHER	0	18	10	22	14	17	18	14	13
AGREE	62	52	40	42	50	48	51	56	53
STRONGLY AGREE	12	7	19	22	7	4	8	12	20
12. REC ENOUGH KITS									
STRONGLY DISAGREE	0	4	6	2	0	0	0	0	13
DISAGREE	12	11	9	6	7	8	6	8	0
NEITHER	0	14	6	7	28	14	18	12	6
AGREE	75	63	50	56	64	46	58	64	60
STRONGLY AGREE	12	7	28	28	0	32	18	14	20
13. SUFFICIENT INFO ON FORM									
STRONGLY DISAGREE	0	4	9	2	0	2	2	4	6
DISAGREE	12	18	14	7	0	10	10	8	6
NEITHER	0	14	12	11	14	12	12	11	20
AGREE	75	59	43	55	71	65	66	60	46
STRONGLY AGREE	12	4	20	23	14	12	10	16	20

	AAL	ACE	AEA	AGL	ANE	ANM	ASO	ASW	AWP
14. SUFFICIENT INFO ON KITS									
STRONGLY DISAGREE	0	4	9	1	0	2	2	2	6
DISAGREE	12	4	9	4	7	12	6	10	0
NEITHER	0	18	13	13	14	14	16	10	13
AGREE	75	70	50	58	71	64	68	64	66
STRONGLY AGREE	12	4	19	23	7	10	8	14	13
15. SUFFICIENT PROG INFO									
STRONGLY DISAGREE	0	11	12	3	0	2	8	3	6
DISAGREE	25	7	16	12	21	15	6	10	13
NEITHER	25	22	14	29	7	15	28	16	13
AGREE	50	59	36	46	64	58	50	54	53
STRONGLY AGREE	0	0	20	10	7	10	10	16	13
16. UNDERSTAND FED GUIDE									
STRONGLY DISAGREE	0	4	2	4	7	2	10	4	6
DISAGREE	25	11	10	17	0	17	12	8	13
NEITHER	12	22	20	16	21	30	16	12	20
AGREE	62	63	50	42	64	38	54	56	40
STRONGLY AGREE	0	0	16	20	7	12	8	18	20
CONTRIBUTIONS TO ERRORS:									
17. DR/STAFF NOT TRAINED									
YES	25	40	46	54	42	52	47	50	40
NO	75	59	53	46	57	47	52	50	60
18. SHIPMENT TO LAB									
YES	75	40	28	29	23	34	28	26	33
NO	25	60	72	70	76	65	72	74	66
19. COMPLETION OF FORM									
YES	38	65	80	71	57	75	70	72	46
NO	62	34	20	29	42	25	29	27	53
20. OTHER									
YES	42	13	12	8	33	16	8	18	23
NO	57	87	87	92	66	83	91	82	76
INFORMED ABOUT:									
21. ERROR RATE									
YES	0	33	19	2	0	14	8	19	26
NO	100	66	80	97	100	86	92	80	73
22. PROGRAM CHANGES									
YES	38	48	42	44	36	54	39	45	66
NO	62	52	58	56	64	46	60	54	33
23. AVAILABLE TRAINING									
YES	14	26	24	31	42	19	31	29	46
NO	86	74	76	68	57	80	68	71	53

	AAL	ACE	AEA	AGL	ANE	ANM	ASO	ASW	AWP
24. ORDERING KITS									
YES	88	70	68	67	57	73	72	76	73
NO	12	30	32	32	42	26	28	24	26
25. ATTENDED TRAINING									
YES	25	18	18	20	57	21	20	21	46
NO	75	82	82	79	42	78	80	78	53
26. FREQ OF FAA CONTACT									
ONCE/MO	0	4	8	3	7	10	4	8	20
ONCE/2 MOS	12	11	4	3	0	10	8	6	6
ONCE/3 MOS	0	4	2	3	14	4	8	8	6
2-3 X YEAR	38	30	32	20	42	36	16	21	20
ONCE/YR	50	52	54	70	36	40	64	56	46
27. PRIMARY FAA CONTACT									
REG FLT SURGEON	75	64	54	54	71	34	44	49	60
FLT SURGEON-FIELD	0	0	4	0	0	2	14	3	6
ADAP MGR	0	8	3	9	14	15	18	14	13
MED DIV ADMIN	25	20	28	32	0	32	12	28	6
OTHER	0	8	10	4	14	15	12	5	13
28. SATIS WITH FAA CONTACTS									
VERY DISSATISFIED	14	4	10	6	7	17	14	8	0
DISSATISFIED	28	4	6	3	7	2	8	3	13
NEITHER	14	33	27	27	14	25	26	23	6
SATISFIED	14	44	46	42	42	42	45	43	40
VERY SATISFIED	28	14	10	21	28	14	8	22	40
29. COLLECT BY CONTRACTOR									
YES	25	30	26	26	23	28	20	17	13
NO	50	48	58	46	46	34	62	56	46
NOT SURE	25	22	16	28	30	38	16	26	40
30. PROBS WITH CONTACT CHG									
NOT AT ALL	62	59	59	58	41	64	54	57	86
LIMITED EXTENT	12	14	17	10	8	26	14	23	0
MODERATE EXTENT	0	11	9	12	33	4	20	10	14
CONSIDERABLE EXTENT	25	7	6	6	0	6	6	2	0
VERY GREAT EXTENT	0	7	7	12	16	0	4	7	0

APPENDIX D

ITEM RESPONSE PERCENTAGES BY NUMBER OF COLLECTIONS

	LESS 10	11-25	26-50	51 +
NO. OF RESPONDENTS	212	86	38	31
4. AMOUNT CHARGED				
NO CHARGE	24	20	16	22
< $10	27	26	26	26
$11-$20	34	42	34	48
$21-$30	12	8	13	3
$30 +	2	4	10	0
5. CHARGE FACTORS				
A. FEWER SPECIMENS				
YES	0	2	2	0
NO	100	98	97	100
B. SEPARATE SPECIMENS				
YES	28	32	16	22
NO	71	67	84	77
C. NEITHER				
YES	70	66	78	68
NO	30	34	21	32
6. CHARGE FOR NEW COLLECT				
YES	29	37	40	52
NO	70	62	60	48
7. RECEIVE PAYMENT				
< 2 WKS	4	6	6	10
2-4 WKS	50	28	22	32
5-8 WKS	37	56	48	28
> 8 WKS	8	8	22	28
8. WHO COLLECTS SPECIMENS				
A. YOURSELF				
YES	40	30	26	16
NO	60	70	74	84
B. RN				
YES	34	32	26	22
NO	66	68	74	77
C. LPN				
YES	20	23	26	22
NO	79	76	74	77
D. PA				
YES	18	20	26	22
NO	82	79	74	77
E. OTHER				
YES	22	30	26	58
NO	78	70	74	42

*COULD MARK MORE THAN 1

	LESS 10	11-25	26-50	51+
9. WHO COMPLETES FORM				
SELF	28	18	10	3
RN	28	27	26	20
LPN	14	18	21	10
PA	10	9	21	24
OTHER	18	27	26	41
10. FORM TOO LONG				
STRONGLY DISAGREE	5	9	10	26
DISAGREE	22	18	44	42
NEITHER	34	30	28	26
AGREE	22	24	5	3
STRONGLY AGREE	15	17	10	3
11. FORM INSTRUC CLEAR				
STRONGLY DISAGREE	6	8	18	12
DISAGREE	14	24	5	6
NEITHER	21	10	2	10
AGREE	48	46	66	29
STRONGLY AGREE	11	10	8	42
12. REC ENOUGH KITS				
STRONGLY DISAGREE	2	1	5	13
DISAGREE	7	8	2	12
NEITHER	13	8	16	3
AGREE	55	66	63	38
STRONGLY AGREE	22	16	13	38
13. SUFFICIENT INFO ON FORM				
STRONGLY DISAGREE	4	0	13	10
DISAGREE	10	12	2	12
NEITHER	14	9	10	3
AGREE	58	64	58	42
STRONGLY AGREE	14	14	16	32
14. SUFFICIENT INFO ON KITS				
STRONGLY DISAGREE	2	0	13	10
DISAGREE	7	10	2	
NEITHER	16	12	5	3
AGREE	62	61	66	52
STRONGLY AGREE	12	15	13	29
15. SUFFICIENT PROG INFO				
STRONGLY DISAGREE	6	4	16	3
DISAGREE	13	15	2	10
NEITHER	20	16	16	32
AGREE	48	56	50	45
STRONGLY DISAGREE	12	9	16	10
16. UNDERSTAND FED GUIDE				
STRONGLY DISAGREE	4	4	8	3
DISAGREE	15	12	5	6
NEITHER	20	20	18	12
AGREE	48	55	50	48
STRONGLY AGREE	12	9	18	29

	LESS 10	11-25	26-50	51 +
CONTRIBUTIONS TO ERRORS:				
17. DR/STAFF NOT TRAINED				
YES	48	48	47	52
NO	52	52	52	48
18. SHIPMENT TO LAB				
YES	32	32	24	23
NO	68	67	76	76
19. COMPLETION OF FORM				
YES	67	72	74	80
NO	32	27	26	19
20. OTHER				
YES	14	11	24	17
NO	86	88	76	82
INFORMED ABOUT:				
21. ERROR RATE				
YES	13	12	18	19
NO	86	88	82	80
22. PROGRAM CHANGES				
YES	46	47	50	36
NO	54	54	50	64
23. AVAILABLE TRAINING				
YES	28	28	34	26
NO	72	72	66	74
24. ORDERING KITS				
YES	64	78	81	87
NO	36	22	18	12
25. ATTENDED TRAINING				
YES	18	22	36	38
NO	81	78	63	61
26. FREQ OF FAA CONTACT				
ONCE/MO	2	7	13	22
ONCE/2 MOS	5	6	10	10
ONCE/3 MOS	3	4	16	3
2-3 X YEAR	24	34	18	36
ONCE/YR	64	48	42	29
27. PRIMARY FAA CONTACT				
REG FLT SURG	56	50	44	23
FLT SURG FIELD	2	4	6	6
ADAP MANAGER	8	12	22	16
MED DIV ADM	26	22	14	36
OTHER	6	12	14	16

	LESS 10	11-25	26-50	51 +
28. SATIS WITH FAA CONTACTS				
VERY DISSATISFIED	12	4	13	6
DISSATISFIED	7	2	2	6
NEITHER	28	18	24	19
SATISFIED	40	56	44	26
VERY SATISFIED	14	18	16	42
29. COLLECT BY CONTRACTOR				
YES	26	24	13	16
NO	43	50	76	74
30. PROBS WITH CONTACT CHG				
NOT AT ALL	64	60	47	50
LIMITED EXTENT	16	14	21	10
MODERATE EXTENT	9	18	13	10
CONSIDERABLE EXTENT	6	2	5	6
GREAT EXTENT	4	4	13	23

APPENDIX E

COMMENTS BY ITEM

1. ARE YOU AN AVIATION MEDICAL EXAMINER WHO COLLECTS URINE SPECIMENS FOR PRE-EMPLOYMENT OR PRE-APPOINTMENT DRUG TESTING FOR FAA EMPLOYEES?

I used to do them for ATC but refused when it became burdensome and disruptive.

I started to fill out this form, but can't really answer everything required. I have agreed to perform the service, but we have seen no FAA employees. We do this for the fixed base operators here in Syracuse.

5. WOULD THE CHARGE FOR A SPECIMEN COLLECTION BE DIFFERENT IF YOU COLLECTED A) FEWER SPECIMENS B) SPECIMENS SEPARATE FROM THE PHYSICAL EXAM?

I would like to charge for collections in addition to the charges for a physical exam, but was not told I could do this. How about a standard fee in each region?

Our fee collection is that offered by the FAA. We never thought to make an alternative offer.

6. IS THE FAA CHARGED IF ANOTHER SPECIMEN COLLECTION IS REQUIRED DUE TO A LAB CANCELLATION?

Never happened.

We have never had to recollect a specimen due to a lab cancellation.

7. ON THE AVERAGE, HOW LONG DOES IT TAKE TO RECEIVE YOUR PAYMENT AFTER YOU HAVE SUBMITTED A BILL?

On payment-would appreciate knowing who payment is for. As of May 9, 1990, we receive a payment and we don't know if it's for FSS, Tower, New Hire, and sometimes it's marked as payment for "various".

Our major problem is slow payment. Have only had one or two lab cancellation repeats.

I am not sure how long it takes us to get a payment in after we have completed the physical because the receptionist marks the payments when they come in.

Marked over 8 weeks, but we work and bill via purchase order with the FAA.

8. WHO IN YOUR OFFICE COLLECTS THE URINE SPECIMENS FOR FAA EMPLOYEES?

Here in this office, whoever starts with the patient finishes him from the start of the physical to mailing the physical reports and findings in.

10. THE DRUG TESTING CUSTODY AND CONTROL FORM IS TOO LONG.

Your forms are too long. If you keep it simple, you have less mistakes. To collect a urine for this procedure it takes 15 minutes to do just this. TOO LONG. To put color in toilet and wash bowl--really. The only way to send this form is to fold it. Love your instructions.

I think if the forms were cut down it might help. There is so much signing that has to be done, and put this information here and that information there it seems so complicated. This is my personal opinion on all drug screen forms.

The lab form does not require the social security number but the security tape does. Second, the security tape is difficult to write on and even good quality ink pens will and frequently do smear making reading the info labels difficult.

I am satisfied with the FAA procedures and have used them for several years (since program began). I am less pleased with the airline procedures as each is a little different. If the forms could be standardized it would be helpful. Our only rejected specimen in 3 years was from a regional airport pilot-using Compuchem but with a somewhat different form than that of ATC. I have no problem with different labels or couriers--it's the form (and much fewer printed instructions) that could be simplified.

11. THE INSTRUCTIONS FOR COMPLETING THE DRUG TESTING CUSTODY AND CONTROL FORM ARE CLEAR.

I find the forms to fill out complicated. Doing the procedure takes too much time. The specimen must be refrigerated while maybe waiting a day or two for the designated shipping company to pick it up.

Color code all blanks to be initialed or signed by the testee and the testor (yellow testee/red testor). Standardize and shorten the chain of command format.

12. I RECEIVE AN ADEQUATE NUMBER OF COLLECTION KITS FROM FAA IN A TIMELY MANNER.

Not always, but recently better.

13. I RECEIVE SUFFICIENT INFORMATION FROM THE FAA ON HOW TO COMPLETE THE DRUG TESTING CUSTODY AND CONTROL FORM.

Every time we have called to find out any information about these physicals the representatives have always gotten smart with us. It's like they make me feel like I don't know anything at all. To a certain extent they are right, because like I told you before, when the other assistant left she didn't have time to go with me step by step. But we have come a long way with these physicals.

This office did not receive adequate information from the FAA at the time the urine drug screen form was changed. We had to solicit this information.

SOME AMES HAVE EXPERIENCED PROBLEMS WITH LAB CANCELLATIONS DUE TO ERRORS IN THE SPECIMEN COLLECTION PROCESS. WHICH OF THE FOLLOWING DO YOU THINK CONTRIBUTE TO ERRORS IN THE PROCESS?

17. DOCTOR/STAFF NOT TRAINED ADEQUATELY IN SPECIMEN COLLECTION.

Previous instructions inadequate and ambiguous--now corrected.

18. SHIPMENT OF SPECIMEN TO LAB.

Originally with Federal Express-no problems; when changed to new Air Express-many problems so we switched to Postal Service (mail) and have had no problems at all.

A driver once refused to sign off custody forms.

19. ACCURATE COMPLETION OF CUSTODY AND CONTROL FORM.

Only problems have been with patients printing names which they do as their legal signatures and testing company refusing specimen as not a legal signature.

Formerly a problem--now corrected.

Only one initial.

20. OTHER.

No obvious reason at all-signature possible not exactly the same as printed name.

I think the lab makes errors and then blames it on the AME.

We have had no problems with lab cancellations.

I feel all FAA-ATC or any drug-testing kit should be standard, ALL THE SAME! It would cause less confusion for doctor and employee and shipment and lab mistakes, less questions and time spent on each kit performed.

When forms are changed, new ones need to be issued to all participating AME offices; along with any changes in filling out the forms.

When the program first started, the instructions were difficult to interpret-also some of the specimen labels did not contain all the data blanks requested by the FAA.

I have had no lab cancellations--so I don't know why they have.

I believe the lab discards specimens inappropriately but this is rare and has to do with the initials of the individual being different than their sequenced initials, i.e., their official initials are really different from sequenced initials.

Lab errors.

No template labeling on specimen container.

I think lab errors are often blamed on AME or staff. Compuchem is consistently unresponsive and should participate in training-,i.e., training video, explain common errors, etc. -surely their profit on FAA contract would justify such a small financial investment in training the numerous staff involved. Need to know "error rate" and comparison with region and national "error rate".

All forms for drug screening are so different. I think a lot of the problem is just oversight, some part of form may be overlooked, or some place not signed.

Lack of definitive answers to questions addressed to regional office.

My experience with re-collecting of specimens may be the lab's problem as they state that the forms aren't done correctly but having a copy of the form and checking it--in no way was there any error from this end--how many of these specimens are spilled, mixed-up, mishandled, etc., at the lab--then blamed on the collectors? I'd check with the lab on errors also!

No problems to date in this area.

It has been our feeling that our office does not make the errors in specimen collection or on the forms. We think Compuchem spilled the specimen, makes a testing error, etc., and then claims the AME office did not complete the chain-of-custody form correctly. We always have our copy of the forms and can never find any errors.

Receiving lab carelessness.

Information on proper completion of the form was not accurate in the beginning and errors were made because rules seem to be made on a daily basis.

The problem we have is the signature by the employee. They are not consistent with using either all three initials or just two, i.e., CPS or CS. On bottle seal, it says SS# but you want the identification number off the custody form. It showed and stated this!

Applicant's or employee's lack of understanding of the process.

We sometimes feel our facility is being the "scapegoat" for lost or fouled up lab work. It is easy for the lab to just say "improper chain of custody".

Lab unable to read applicants handwriting, specimen refused.

Have not had any problems with lab cancellations.

21. HAVE YOU BEEN INFORMED BY AN FAA REPRESENTATIVE ABOUT THE ERROR RATE IN YOUR OFFICE FOR THE COLLECTION OF URINE SPECIMENS?

When a urine specimen is returned from the lab with an error, please notify the collector with what type of error so we can correct ourselves.

26. APPROXIMATELY HOW OFTEN ARE YOU IN CONTACT WITH REGIONAL FAA REPRESENTATIVES REGARDING THE PRE-EMPLOYMENT/PRE-APPOINTMENT DRUG TESTING PROGRAM?

I have received a rare letter concerning the drug testing program.

Region slow to respond, often hesitant. Communication is in the form of non-personalized flyers which are easy to mistake for advertising.

27. WHICH REGIONAL FAA REPRESENTATIVE DO YOU PRIMARILY HAVE CONTACT WITH REGARDING THE PRE-EMPLOYMENT/PRE-APPOINTMENT DRUG TESTING PROGRAM?

None.

Regional Flight Surgeon's office refers questions to various individuals--only some of whom seem to have answers.

Contact made by local control tower secretary.

Principal contact is with administrative personnel in local tower.

28. OVERALL, HOW SATISFIED ARE YOU WITH THE CONTACTS YOU HAVE HAD WITH REGIONAL FAA REPRESENTATIVES REGARDING THE PRE-EMPLOYMENT/PRE-APPOINTMENT DRUG TESTING PROGRAM?

There simply have been no contacts.

No FAA representative has ever contacted me regarding this program. I presume that the Regional Flight Surgeon is my "contact man". All information that I have received has been with written directives through the mail and through conversation with ATC personnel.

We have no contacts with the Regional FAA. And in the past when we did, they didn't know anything about the drug testing either.

Inconsistent advice, unavailability after 4:00 p.m.

Other AMEs in this area refused to participate. I did this as a favor to our local ATC and FSS personnel. It has been a continual headache. The personnel in the Atlanta Regional Office have been "pushy" and difficult to deal with, especially on repeat samples. I have requested that I be relieved of this responsibility.

Little information obtained from this source.

No contacts with Regional FAA representative.

Contact with FAA representatives has been poor simply because they did not get current information on a timely basis. Many times we would have to check up on rules or changes that we heard by grapevine through employees of FAA.

No effective contact, ONLY CRITICISM!

I have worked as an RN in this office for nearly 2 years. I have never had a representative from the FAA contact me about any changes in drug testing, or any seminars on drug testing. What I have learned is from reading literature sent to our office and by calling the regional FAA office.

Rude, supplies not updated, directions often confusing.

Put on hold, busy, passed from person to person in agency. Most of our testing is done as part of the ATC program.

Initially was passed from one person to another, till finally we know who we can get answers from. System improving.

29. IN YOUR OPINION, SHOULD THE SPECIMEN COLLECTION FOR THE FAA PRE-EMPLOYMENT/PRE-APPOINTMENT DRUG TESTING PROGRAM BE CONDUCTED BY A CONTRACTOR (e.g., UPJOHN)?

YES:
Drug testing is complicated enough that the "middle men" (re-the physicians) should be eliminated from the process.

It would seem to me that a totally disinterested party (e.g., Upjohn) would be preferable as we AMEs are a little too close to the personnel involved.

I see no problem with a contractor if properly qualified, responsible, etc.

I have the impression that Upjohn would do a better job, but this is not substantiated.

The whole procedure is too time and energy consuming than the $10.00 fee we receive.

I personally do not wish to spend time on the NON-MEDICAL aspect of the pre-employment evaluation.

With all the variables in correct collections of specimens, sometimes the doctor's office is not as well equipped as an independent contractor whose sole job is to handle this task.

More objective.

Consistency and accountability are higher.

If all drug testing was done by a contractor, I think there would be less chance of error. As it is now, there are different kits with different instructions and more room for error.

A facility who collects specimens often would do a more standardized and consistent job.

Would prefer a private contractor--would release myself and staff of responsibility in drug testing.

We do so few screens that it is difficult to remember the procedure and therefore it takes a great deal of staff time.

It would be much simpler if the drug screen testing was not done at the same time as their physical. Most of the patients forget they're having the urine drug screen and can't give enough of a specimen, prolonging their stay at the doctor's office.

Our laboratory personnel collect the specimens. They say it takes a long time, and would rather not do it. We have not collected any specimens for the FAA as of yet, as there have been no applicants, but we have collected for other agencies.

Larger volume of tests would promote standard collection procedure which would be more efficient and less prone to "break" in procedure. Of course, the applicant would be inconvenienced by separate visits for physical and drug screen.

NO:
My reason for the "B" answer (no) is prompted by the fact that generally the applicant for employment is undergoing a medical examination for such employment in connection with the specimen collection. Therefore, it seems to me it would be an imposition on the applicant to be forced to visit two separate facilities to complete his required tests. The specimen collection can be done at my facility in conjunction with the medical examination conducted by my office; thereby saving the applicant additional time and expense traveling between two separate locations.

We can do our own drug testing.

Too easy for fraud if big non-interested company does the job.

On testing at non-medical facility--I think it would be more convenient for client.

Have only heard horror stories from pilots who have had to go to a contracted lab. The second time around they get permission to come to me.

I do not feel that a contractor should conduct the specimen collection. The entire pre-employment and pre-appointment examination and all necessary testing should be conducted at one site to assure continuity.

At this point, I believe the AME is best qualified for this service. Also, many pilots have expressed this opinion to me.

Since I do the physicals, I don't want any outside personnel involved.

Let the AME continue to have personal contact with the controllers from the very first.

Convenience at time of exam.

Collection at exam site is more convenient for the subject.

Waste of time--two appointments, two visits, two places--too little trouble to collect at time of examination.

I could do it for a lot less than the $100/specimen Upjohn gets paid! Most of their collections in Tampa fluctuate between inadequate and ludicrous, and could not withstand a defense lawyer's review--based on personal observation.

If the applicant is going to have his physical done here; why not do it here.

We have no problems assisting with this program.

No problem with collections in office. Saves time for applicant. Saves a lot of time for on board FAA employees--everything done in one office.

Inconvenient for examinee to have to go to two locations for drug test and physical.

As long as all FAA facilities are knowledgeable in drug screen collection, I see no need for a contractor.

Feel that current system is more unified and personal.

We'd do it happily. Need to be able to ship promptly and not have too much detail work. Collect and send.

At the present time I have no complaint about the drug screen collecting system as it goes fine in our office.

The MRO is in a better position to certify a positive test if the specimen is collected in his office under his supervision.

No, because I feel it would be more efficient for the airman to be able to take care of both medical and drug testing at one site.

Service should be optional at time of physical exam, or widely available.

Seems unnecessary trip for applicant.

Believe not practical in this area due to the limited numbers done--would increase cost to government.

I do the physicals--I can do the collection.

A separate contractor for drug testing would mean an extra trip for the candidate and might complicate what is now a pretty good system.

I feel hiring a contractor to conduct drug testing will be much more costly. We have never charged extra for the additional service, but I feel there should be a minimal allowance for the additional staff time involved. Our number of tests is low; however, those with a large volume would have additional problems.

Complication. Too many people involved. Responsibility is mine.

Diversification costs more (gasoline), takes more time, inconvenient, more chance of error. KEEP IT SIMPLE.

I would like to continue to do the drug testing as a physician.

Feel that the drug screening program of the FAA should be kept in the AME system! If there is a financial consideration I feel that this could be handled within the system. If the FAA allowed only a maximum fee, I'm sure most of us would honor it.

I feel only a doctor should collect the specimen, and be FULLY responsible for the ATC-as this could totally ruin the life of a person if it is not done correctly and no error.

We have tried it at both hospitals and it was a total failure-some sent the person alone to the restroom, some had them bring in a specimen (who knows whose it was). Also, I examine for 31 companies and it must be done one way only--the right way--clothes off and watch the person urinate in the bottle and then seal it. I have people bring in urine in hats, in cowboy boots, in rectum, under a hat, under the arm, taped between the leg or in a baby bottle in the vagina. All females are escorted to bathroom in a gown and my nurse acts as an observer. We have never had a false positive.

NOT SURE:
Only if error rate warrants change.

Wouldn't random tests be more conclusive? I have non FAA patients who come for drug testing prior to an employer's exam to see if they are negative before enduring the employer's exam.

Not sure--I don't care who does the testing or runs the program as long as it remains straightforward.

I don't know--I am willing to do the collecting myself.

30. TO WHAT EXTENT WOULD YOU EXPERIENCE PROBLEMS IF YOUR REGIONAL FAA POINT-OF-CONTACT FOR DRUG TESTING CHANGED TO A NON-MEDICAL OFFICE IN THE REGION?

We find in our office it is much easier to communicate with medically trained personnel concerning any problems which might arise during the medical examination or urine collection than it is to communicate and receive meaningful information from non-medically trained personnel.

Non-medical personnel have no business or knowledge to be involved.

Loss of medical perspective.

If one is seeking medical advice, a medical "person" is needed to give the answer.

For 7 years I was Center Flight Surgeon, FAA, and all my contacts are in Regional Medical Office and we have a very good working relationship that would be hard to duplicate in a non-medical office.

It would depend on the efficiency of the non-medical office, wouldn't it?

Hypothetical--if it works, great. If it does not--I'll yell.

There can be real problems when non-medical people are handling medical-type situations. These people will need to be well trained and know what they are doing.

I have enough trouble getting through to an FAA physician already without another level of administration.

We have difficulty enough keeping up with regulations getting our information from the FAA. It seems that communication would be impossible if lay people handled the situation.

No part of medical care should be turned over to a "non-medical" office. We must keep medical care in the control of medical personnel.

Medical offices have better insight than office operations.

GENERAL COMMENTS:

On collection a client comes in fasting for bloodwork--and then has to produce urine for drug screen. A conflict of body functions.

No problems.

You did not ask my opinion but I think the whole program falls into the same category as the Salem Witch Hunts and with probably even lower benefit to the country as a whole.

The entire program is invalid because the collection of specimens is not chaperoned. It is clear to me that anyone who wishes to avoid detection can do so by taking a warm drug free sample from their pocket in the privacy of the restroom and substitute it for the test specimen.

Have no problems with specimen collection in this office.

Although I am a very active AME, I do not believe I have done more than one pre-employment in the past year. My comments are of little or no value to your survey.

We have done so few drug screening tests it nearly terrifies me when one comes in that we may have to do, because we do so very few. I wasn't really trained from the other assistant that used to be here so we (me and the other assistants) are having to learn this the best that we can. On any other drug screens we have done, our biggest errors were not having everything filled out or not having it shipped right from not fully understanding how to do these. BUT WE ARE TRYING HARD!

We are not for sure you all should have these drug screens done. We have mostly decided it is for new ATC only. Which we don't see that often.

I think the program is working OK, but that may be because I'm AMRO for a consortium and also do DOT truck drivers and have considerable experience.

This is easy compared to the Navy program.

Easier.

Please send results of survey. They would be interesting to know.

AMEs need 1-800 numbers for phone calls.

Activity is very labor intensive requiring more time of medical assistants and supervisors for the $35 we bill for testing.

We have yet to send in a urine specimen for drug testing. We are ready to do this when requested; however, no answers reflect our present opinions and experience.

I am an MRO and anti-drug consortium manager for air carriers. I am not experiencing lab or collection problems, but am not being asked to collect for ATC applicants.

I have never examined for pre-employment/pre-appointment purposes. I examine a few employed ATC's each year and find the FAA protocol superior to the tangled, complex systems imposed on us by most employers for their pre-employment protocol.

We only do 3 or 4 a year. I know of no problems. As is usually the case the more you do the more familiar you are with the forms and it becomes easier. We do 250 collections a month for other businesses and DOT. I can't knowledgeably answer most of the questions because we do so few--we would be willing to do more.

Main problem is the collection of specimens. Recommend collect the same as we did for the PanAm athletes: Go in bath room and observe collection. No one in PanAm games (athletes) objected to this method (men observe men-women observe women). This eliminates all the problems in collection. Also--select one carrier and one lab. Every time either is changed, the complicated paper work multiplies.

The drug testing program is a farce--get back to good health exams including chest x-rays -- blood work (cholesterol screening, etc). The money spent on drug testing would be spent much more wisely.

*U.S.GPO:1992-661-063/40043