THE AVIATION COMMUNITY MEDICAL LIAISON GROUP
– Meeting Minutes 17 February 2015

DATE:	Tuesday 17 February 2015
LOCATION:	Civil Aviation Authority, Level 15, Asteron House, 55 Featherston Street, Wellington, Room 15.04
TIME:	0900-1400

PRESENT:

- Ben Johnston, Medical Officer – AMSNZ
- Bruce Burdekin, Representative - Sport and Aircraft Association NZ Inc
- Claude Preitner, Senior Medical Officer - Civil Aviation Authority of NZ
- Desrae Martin, Administrator - Civil Aviation Authority of NZ
- Dougal Watson, Principal Medical Officer - Civil Aviation Authority of NZ
- Herwin Bongers, Medical Director – NZ Airline Pilots Association
- John McKinlay, Manager – Personnel and Flight Training
- Judi Te Huia, Team Leader, Aviation Medicine – Civil Aviation Authority of NZ
- Kim Smith, Airways NZ
- Richard Small, Representative – Flying NZ, Royal New Zealand Aeroclub, NZ Aviation Federation
- Stephen Brown, Medical Executive Member – Aircraft Owners and Pilots Association of NZ

APOLOGIES:

- Cam Lorimer, Representative - NZ Airline Pilots Association
- Ian Andrews, President - Aircraft Owners and Pilots Association of NZ
- Karen Groome – Flying NZ
- Lew Jenkins and Connie Nicholson-Port - Airways
- Rajib Ghosh, Senior Medical Officer - Civil Aviation Authority of NZ
- Rob Griffiths – Otago University
- Samantha Sharif, Chief Executive – Aviation New Zealand
- Simon Ryder-Lewis, Specialist Occupational Medicine – ATC Mutual Benefit Fund
- Sue Telford, President – NZ Women in Aviation

AGENDA

Welcome and Introduction

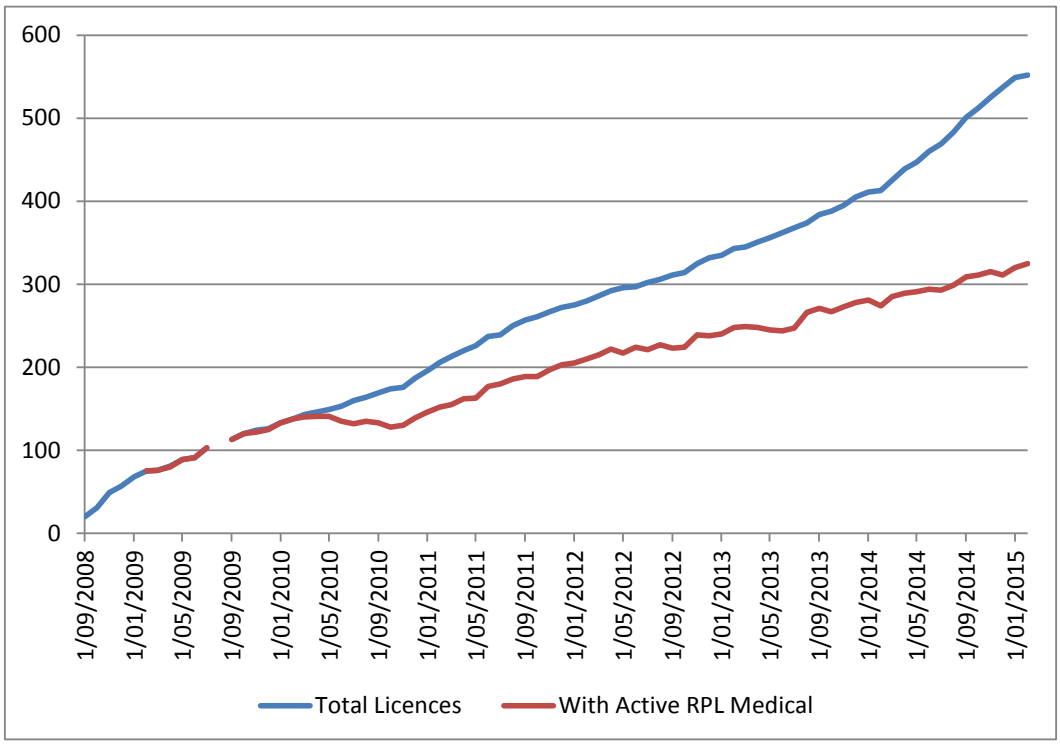
John welcomed attendees, no new members attended.

ACTIONS FROM THE PREVIOUS MEETING

All actions were updated on the Actions Sheet.

RPL Stats presented. There is a trend in pilots moving to RPL licences. CAA advised that Stats will become limited when the DL9 is no longer required to be sent to CAA. The priority for CAA is towards risk based regulation; microlight and RPL applicants do not require a CAA Medical. The graph shows the change where the medical fee was introduced and affected the number of active RPLs.

The graph below depicts the **total number of RPLs** issued to date. Of interest is the growing trend of RPL holders not recorded as holding a current NZTA medical. Also of interest is the increase rate of RPL applications with the introduction of the new CAA medical fees for PPL, CPL, and ATPL.



TOPICS FOR CONSIDERATION - Updates

DRUGS AND ALCOHOL

A Consultation process will begin across the transport sector initiated by the Ministry of Transport. The ACMLG membership list has been forwarded as a potential interest group**.** Consultation is likely to occur March/April 2015.

Herwin indicated information on drugs and alcohol within the HIMS Group is leading to better understanding in this area. He looks forward to implementing external resources such as a bookmark (in discussions with Peter Singleton) advertising HIMs on one side. He mentioned that when events are publicised on this topic relating to a pilot, on the front page of the Newspaper, sales go up by 6%. ALPA is implementing a professional standards programme to be launched in May. It is hoped that

this will modify behaviours towards drugs and alcohol. It is based on an adoption of the US ALPA Professional Standards Programme and Royal College of Surgeons Code of Conduct.

Stephen raised the need for better education and understanding regarding the application form and drink driving convictions. Herwin confirmed the ALPA policy is infringement based. Members are encouraged to call and discuss where to from here, assistance can then be applied. Ben said Air NZ acts similarly. The MIS mentions 'drink driving episode' and 'a discussion with the ME'.
Is infringement an issue for the application form? Dougal has noted this and will look into it further.
Ben said engagement with an honorary ME or ME advisers could attend clubs to help educate.
Richard was concerned there could be a conflict of interest, and thought that a lay person/retired ME could relay questions, where to go for help and answer general questions. Ben may be able to refer to resources.

DEPRESSION

Ben and Herwin discussed the Pilot Assistance Network which combines union and employer interests. It is envisaged that volunteers will be given supervised training and the process will allow them to hand over to professional consultation where required.
Dougal suggested that co-morbidities can create complex recovery. Rehabilitation can be delayed as a person could feel that their career is over and they lack the ability to seek further information.
Herwin suggested promotion of available information could be provided by MIS being displayed or discussed routinely, as these are written for medical certificate holders in plain English. The group discussed that small organisations have limited resources. Medical Health Liaison Officers or retired MEs, active MEs or interested lay people could also promote information.

CARDIOVASCULAR ISSUES

The Aviation Medicine Team has recruited another cardiologist consultant who will spend some time with the current cardiologist. This will remain a contracted position. Both cardiologists will operate for a period of time. Ben wanted clarification when actions are required from the recommendation by the cardiologist. He had experienced reports where aspects were commented on outside of the MAR. Is the recommendation just an FYI. Dougal stated that if it is forwarded it is FYI, if there is a requirement for action the SMO/PMO will be more direct with follow up. In some cases 27I/27H could occur. In most cases a copy is forwarded for future consideration. John said we could look at this as an area for improvement regarding QA. Stephen suggested that MEs do not feel that their opinions are being taken in shared decision making. Ben was concerned that cardiology reports are given retrospectively on the issued certificates and requirement for future surveillance is not very clear. Dougal said that it is the responsibility of the ME or SMO/PMO to come up with the best decision. John suggested that the reports could be communicated better.

PSYCHOLOGICAL ISSUES

Dougal indicated that rates of diagnosed Aspergers had increased in the 2015 flying school intakes, along with Obsessive type personalities (which the Group agreed the industry attracts). Bruce asked whether this condition is being over-diagnosed. Dougal advised that some cases do not meet the formal diagnostic criteria. When CAA is assessing a medical application, verification of where the diagnosis came from can indicate whether the diagnosis is correct, as labelling can be harmful.

Ben reiterated any medical issue can be over diagnosed. Dougal used the example of PTSD which became a very popular diagnosis in healthcare and insurance documentation, is being seen more and more.

Learning disabilities and dyslexia were also discussed as issues. When does a regulator defer to operational advice? A raft of criteria needs to be met; learning to fly, passing the medical, mounting financial obligations in an uncertain career, possibly requiring a reader/writer to sit exams and the possibility of ongoing issues such as confusion over left turn/right turns. CAA has been discussing this subject. Bruce said that dyslexia can be a real danger in aviation due to the amount of text, instruction and calculation required. Some pass, some do not, where is the cut off point?

FATIGUE RISK MANAGEMENT PROJECT

The link was shared here
A number of resources are available and John confirmed that the project is not a 'one size fits all' due to the diversity of the aviation industry. Please sign up to the Notifications if you would like to be kept up to date.

EDUCATION

From CAAs perspective this is ongoing. ME education could cover two separate days. AMSNZ this year is 5th and 6th September in Auckland, Claude is in dialogue with Ben.

FREQUENCY OF MEETINGS

The group is happy to stay with current duration and frequency. Also John was happy for anyone else to Chair the meetings, the Group are happy with the status quo.

DRAFT MEDICAL INFORMATION SHEET – *You must advise the CAA*

Kim is concerned that the document suggests all sick leave needs to be reported to CAA. Airways Manual of Air Traffic Services and MATs advisory circular wanted to address this subject. The Policy and Standards team have had lengthy discussions around 'exclusions for the need to report'. Airways publications have been delayed due to the H & S unit changes. In addressing the various responsibilities, is an individual to report to CAA, for Airways to tell CAA and the GP to tell CAA? Airways feel it is a subjective decision to be made by the individual. If a person is not at work, surely they are not a risk? The practicality of notifying CAA of this on a daily basis will be immense, who at CAA will receive this information and what do they do with it? Dougal provided background information, the Statutory obligations were established in 2002 and had a tiered system of reporting, this document attempts to clarify this provision. The ME is the delegate for the Director (CAA). Coroner cases have identified the need for reporting. Herwin suggested there are issues in reporting. The MIS could have unintended consequences of unscrupulous employer pressure being applied upon pilots at a GA level as NZALPA has had complaints of, and the likelihood of driving behaviours of some pilots to work when unfit with a minor illness whereas before they would have stood themselves down for a day or two.

An example was given by the Group, where someone used being 'tired' as the reason for not showing up to work, in this case they would need to report this to CAA. Is this individual sick or suffering stress? Telling CAA becomes an employment issue. The MIS requires self-assessment in not being fit for work. This example highlights that fatigue can be an Ops type issue. Airways will be making a submission by the closure on 5 March 2015.

Stephen finds that the vast majority of his organisation would be non-compliant to this, mainly due to it being open to pilot interpretation. The GA sector practicality is questionable, rises in communications and possible ongoing fees for communications (if MEs were to charge for emails). He confirmed being comfortable with the Act but not this MIS. The Medical Protection Society would not sanction correspondence by email on patient information.

Ben would not have the capacity within Air NZ to deal with this. It seems at odds with previous discussions around Temporary Medical Conditions which do not need reporting which could reduce the level of unnecessary reporting, whereas this draft will increase it. He agreed it is an important document, as something is needed. Air NZ supports their pilots well, they contract a medical provider who can stand down a pilot until an ME can assess the situation. Ben pointed out that the MIS on 'Your doctor must advise the CAA' is half the length of the 'You Must Advise the CAA' MIS.

There is a provision in the Act for Temporary Medical Conditions which do not need Reporting, which Dougal sees as an important adjunct to this. This would cover true minor issues to fit into the safety legislation.

Bruce was concerned that a lack of disclosure will occur in non-reporting to GPs or MEs. The document appears negatively focused; could the same result be achieved in a positive way? The CAA is Public Safety First as the Regulator. John reiterated we need to comply with the Act and improve the reporting culture.

Richard suggested publishing the GD for Temporary Medical Conditions which do not need Reporting, in conjunction with this document, to create balance between the white list/black list to achieve a cultural change.

NEW ISSSUES

Bruce highlighted that **FAA is probably moving Class 3 licences to a Vehicle Standard.** He asked whether CAA were making any changes? John said that there was no position at this stage to adopt it but encourages any communications. Some states stay at a National Standard instead of ICAO or other International Standards. RPL is being extended to being able to go solo. Bruce asked when this will be completed but CAA couldn't give a firm date.

Bruce asked about progress in **Online Medical Processes** these were discussed in the open actions under RCP.

Herwin asked about **Insulin Protocols**. Dougal confirmed ICAO hadn't brought in on that issue. FAA provide detailed Protocol for private pilots. The French are opposed to insulin in the cockpit and CAA may never have a set Protocol, it could be assessed on a case by case basis. Could research benefit

this topic? ICAOs engagement would be beneficial. Claude outlined that the treatment and management is always evolving and therefore this area may change. Dougal suggested the Group members use the constituent Groups to get buy in from ICAO.

RESEARCH TOPIC

Dougal suggested a Cochrane style research project (Literature Review), initially he anticipated Stroke and TIAs as good topics but CASA has started a project on those with Monash University. The Spectrum of Migraine Disorders is a good option. CAA are seeing a diversity of **Migraine Disorders**.

Herwin requested for consideration as a research project, the **Recovery from Traumatic Brain Injury risk of seizure**. Dougal responded that the regulators risk is fairly well documented in this area. Risk of a seizure is of aeromedical significance, and all parties want a good functional outcome.

Bruce is interested in **Hydration** (and Dehydration features) as conflicting advice is given.

Going forward, a wish list for future topics is to be tabled, eg; above topics and **surveillance for Melanoma** (Ben). If stroke is covered by CASA then we could move towards Migraine Disorder research**.**

AVIATION MEDICINE TEAM UPDATES

Temporary Medical Conditions which do not require Reporting

CAA are rewriting the legal stance and the least conditions are to be written first. We will then seek feedback from the ACMLG. It is important for CAA to have this in place.

GENERAL DIRECTIONS - MEDICAL MANUAL STATUS can be found on the CAA website

http://www.caa.govt.nz/medical/Medical_Manual.htm

Opthalmology some feedback received, basically completed
ENT very little feedback received and about to go on the Website no longer as draft
Respiratory draft chapter on the website
Neurology draft chapter on the website
Cardiology chapter started.
Hearing Loss Guidelines produced and the GD will be taken off. A newsletter will be prepared for MEs.

Colour Vision consultation has been extended to 1 April 2015. Feedback has been dependent on the ongoing hearing in Australia which is awaiting delivery of a decision and the outcome may effect this issue.

Medical Application form

The administration portion will change, with a general tidy up and legal have proposed some changes. The doctors need to look at some of the clinical data in the form (CAA internal feedback due date 27 February and then to this Group).

GENERAL DISCUSSION

CASA CAA Medical meeting has no firm date. Claude considers July as being a good date for a NZ Meeting and possibly a November meeting in Australia. He needs to discuss this further with Michael Drane. Currently there are no topics other than possibly the Stroke TIA but any topic suggestions can be sent to Claude.

SUMMARY

The Group provided vigorous discussions on this Agenda. Updates on progress can be provided at the next meeting;

- Topics for consideration
- Draft Medical Information Sheet and Temporary Medical Conditions which do not need Reporting
- Research Topic (CASA/Monash University topic going ahead?)
- CASA CAA Medical Meetings dates

DATE FOR THE NEXT MEETING

2 June 2015

Actions Sheet

WHO	WHAT	WHEN	OTHER INFORMATION
John McKinlay/Bill MacGregor	RPL Colour Vision question about possible changes to the application form. John advised there has only been one issue in the last year relating to this and presented Licence Stats.	ongoing	The RPL revision continues.
John McKinlay/Judi Te Huia/Dougal Watson	**Education –** Demystifying processes. CAA begin assessments at the lowest level of cost for tests (ECG to Stress to Perfusion, etc). If this could be placed in Vector, it would show that the CAA cardiology process is clear (demystified) and fair.	2015	Vector –information on the Cardiovascular process would be a good place to start. There is a 'disconnect' between the applicant and Aviation Medicine Team in understanding processes. CAA team to discuss with Peter Singleton. Options are a flow chart or outline of Principles rather than specifics
Steve Pawson/Roger Shepherd	**Education**: Steve Pawson and Roger Shepherd are to place an item in Vector outlining the process of reporting issues to the CAA with the view to enhance reporting culture. Aiming for May/June edition	June 2015	Vector article to be published
John McKinlay/Rob Scriven	**Regulatory Craft Programme:** Online Systems for CAA are top priority.	ongoing	Options are being reviewed and this also links into the Funding Review (below in Medical Fee)
John McKinlay	**Medical Fee**: Any changes are subject to the Funding review passing through all phases. Phase 1 is complete, Phase 2 will be released for further consultation in mid 2015	ongoing	Information and Summaries are available on the below links http://www.caa.govt.nz/funding/ http://www.caa.govt.nz/funding/funding_seminars_summary.pdf
Group Members	**Feedback** welcomed on the draft forms	ongoing	Inflight Hearing Tests
John McKinlay	**Fatigue** Management Project started. A Steering Group and Working Groups are being formed. All resources are placed on the website.	closed	Please sign up for Notifications if you are interested in this topic. http://www.caa.govt.nz/fatigue/fatigue_risk_management.html