The Medical Examiner

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A Newsletter from the
Civil Aviation Authority
Central Medical Unit

17 December 2004

In this issue:

Enclosures:

1. NZ Medical Council statement
2. Case notes for competition

CAA Medical Help

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Welcome to this issue of the Medical Examiner!

Welcome to this issue of the *Medical Examiner*. The purpose of this newsletter is to share with you at the *"frontline"* some of the issues that face us all in New Zealand regulatory civil aviation medicine.

This issue actually started in January 2004 as the first issue for that year. Alas we have all been caught up with a lot of other matters and have not been able to devote the time necessary to have this important newsletter published in a timely manner. Hopefully *better late than never* applies. Thank you all for your patience, forbearance, and support during the last year. Overall we have been very pleased with the continuing transition into the new system.

This issue of the *Medical Examine*r contains update information concerning the regulatory system that we're all working within as well as information concerning some of the problems we face. This edition of the Medical Examiner newsletter also includes a new section titled Medical Education. We will try and use this section to provide you with snippets of (hopefully) interesting medical information from the literature as well as a new "You're the expert" competition. Please do let us know of any discussion topics that we could include in these newsletters that would be particularly useful to you.

Last year, as many of you will be aware, the Medical Council of New Zealand published a statement concerning non-treating doctors performing medical assessments of patients for third parties. This is a very important document for us all. Further information can be found in the *Questions, Comments, and Notices* section of this newsletter (p11).

Also, if you have **any** uncertainty about **any** aspect of your ME role and responsibilities, please do not hesitate in contacting the CAA Central Medical Unit. We are working hard to provide a very responsive 'help desk' facility to provide prompt advice and information in response to telephone, email, fax, and letter queries.

The People in the System

There have been a few changes in respect to the roles, responsibilities, and requirements relating to the people in our system since the last issue of *The Medical Examiner*.

CAA Central Medical Unit

Drs Pooshan Navathe and Claude Preitner swapped roles at the start of this year. Pooshan now deals primarily with matters related to Medical Examiners and Claude with applicant certification matters.

Dr Michael Drane has been working with us, on a full-time basis, since the start of this year.

Amy Butters, one of our advisers, has left the unit to pursue another exciting employment opportunity. Many of you will have dealt with Amy, as a part of the Accredited Medical

Conclusion process, and will doubtlessly share our mixture of sadness at the loss and excitement at the new prospects for Amy.

Sue Holliday joined us, to replace Amy, in August this year. Sue comes to the CAA from the NZ Rural General Practice Network so already has many of the skills necessary to keep the CMU doctors in line.

The structure and responsibilities of our Adviser staff have recently been modified in an effort to maintain the highest level of real-time support for your efforts … in response to phone calls, emails, faxes, and letters.

Medical Examiners

How many doctors?

At the moment we have 34 ME1s and 47 ME2s operating in New Zealand and 14 ME1s and 10 ME2s operating internationally.

We also have domestic ME1s providing 'roving' services at more than one location.

Continued transition

As you know we are continuing the three-year transition to our new regulatory medical system. This was discussed at length and in detail with industry groups, including AMSANZ (NZ) Inc, during late 2001 and early 2002. Some details of the intended transition can be found in back issues of the *Medical Examiner* newsletter on the CAA website.

One important aspect of this ongoing transition is the requirement for our MEs to have aviation medical training as well as the regulatory aviation medical training provided by CAA. You will recall the previous newsletters, and the sessions at the training courses, where this matter was discussed.

This is not a peculiar local notion, in fact there are very few, if any, other countries who do not require their medical examiners to be trained in aviation medicine. Australia's DAMEs, who have much less certification responsibilities, are required to have undertaken at least the Monash University ACCAM (Australian Certificate of Civil Aviation Medicine) course or equivalent.

As you know New Zealand is also a signatory nation to the Chicago Convention which contains the international law in relation to civil aviation. As a member state we have international legal obligations. The International Civil Aviation Organisation (ICAO) is the governing body that manages and publishes these international civil aviation standards in documents called *Annexes* to the Chicago Convention.

Annex 1 deals with Personnel Licensing matters and contained within that annex is the ICAO standard 1.2.4.4.1 which states "Medical examiners shall have had, or shall receive, training in aviation medicine". ICAO is presently in the process of amending Annex 1 and the proposed amendment to standard 1.2.4.4.1 states "Medical examiners shall have received training in aviation medicine and shall receive refresher training at regular intervals. Before designation, medical examiners shall demonstrate adequate competency in aviation medicine."

New Zealand is unable to comply with this international standard without requiring our MEs to be trained in aviation medicine.

Our continued shift to the new civil aviation regulatory medical system brings with it a number of changes. One of the most fundamental changes

is that virtually all MEs will be able to provide one-stop certification services. This means that the same doctor examines and assesses (certificates) an applicant. This is different from the previous system where, in many cases, one doctor examined an applicant and another assessed and, where appropriate, certificated the applicant. The structure of this new system very closely parallels the regulatory system used by the US FAA and is intended to reduce double-handling, administrative effort, errors, and hopefully end-user costs.

The new system also seeks both aviation medicine training and regulatory training of involved MEs. All of the MEs in the system have now undertaken initial regulatory aviation medicine training.

All MEs who have delegations that enable them to issue medical certificates have also undertaken formal aviation medicine training.

Some MEs who have not undertaken formal aviation medicine training have been provided with an opportunity to continue during a transition period in a limited *examination-only* capacity. It is our continued hope that these MEs will decide to undertake aviation medical training and so increase their future involvement.

Regulatory Training

It's been a busy year for CAA regulatory aviation medicine training. Two-day (initial) courses were held on the weekends of 14 – 15 March (Christchurch), 12 – 13 June (Wellington), and 30 – 31 October (Auckland). One-day (update) courses were held in late March (Wellington), and late September (Christchurch). Courses for international MEs were held early in May (Anchorage) and September (Pretoria). These courses were well attended and the feedback was very positive. The course timings for 2005 are outlined below.

We have scheduled our regulatory aviation medicine courses for 2005 as follows:

19 – 20 March 2005. Two-day initial course. South Island, in Christchurch, Dunedin, or Queenstown depending on demand.

06 or 13 May 2005. International ME course in association with Aerospace Medicine Association (AsMA) annual scientific meeting 2005 (Kansas City).

28 May 2005. One-day update course. Auckland.

27 August or 02 September 2005. International ME course in association with International Congress of Aviation and Space Medicine (ICASM) 2005 (Warsaw).

15 September 2005. Possible one-day update course. Possibly, depending on number of attendees and levels of interest, in association with the 2005 AMSANZ-NZ conference. (Gold Coast)

15 – 16 October 2005. Two-day initial course. North Island, in Auckland or Wellington depending on demand.

12 November 2005. One-day update course. South Island, in Christchurch, Dunedin, or Queenstown depending on demand.

We would also be happy to try and provide on-demand one day regulatory updates if groups of MEs wish to get together for the purpose. If you'd like to arrange such a session please let us know.

<u>Requirements</u>

Regulatory aviation medical training is a requirement of becoming and remaining an ME.

To date applicants who have successfully completed the two-day CAA regulatory aviation medicine training course have been designated as

medical examiners.

We are presently exploring the future recertification regulatory aviation medical requirements for MEs. Your feedback and thoughts on possible training requirements would be helpful.

As mentioned above we are scheduling one-day update courses to be held at-least twice a year in New Zealand, including once in association with the AMSANZ-NZ conference.

Aviation Medicine Training

Formal aviation medical training is an important component in attaining the competencies required for full ME function. The training requirements are now significantly less expensive and easier to achieve than in days-gone-by when a full post-graduate Diploma of Aviation Medicine was required for you to become an AMA.

This training is provided by various tertiary academic facilities, not the CAA, and there are a number of courses available within New Zealand that may cater to the training needs of different MEs.

Auckland University

The University of Auckland runs a *Certificate of Proficiency* course in Aviation Medicine which is offered by the Faculty of Medical and Health Sciences.

The course has been designed to meet the competencies for CAA Medical Examiners Grades 1 and 2 as outlined in the Aviation Medical Transitional Criteria Notice 2002 from the Minister of Transport.

The CAA medical unit also tries to schedule a "Regulatory Aviation Medicine" training course for Certificate of Proficiency students in conjunction with this course.

The course is taught as a combination of distance learning with a residential block requirement by some of New Zealand's leading occupational health practitioners and aviation professionals. The focus is on the practical application of aviation medicine and lectures are supplemented by field trips. Course content is based on the Australasian Faculty of Occupational Medicine training programme. Successful completion of the course will provide evidence that the following competencies have been met: Clinical competence; Aviation environment; Critical appraisal and research methods; Management; Communication; Regulatory and medico-legal matters; Rehabilitation.

While the Certificate of Proficiency is a stand-alone qualification it can also be used (depending on subjects taken) to continue studying towards further postgraduate qualifications at the University of Auckland.

For further information and a Preselection Application Form, please contact the Course Coordinator: Jessica Rorich

Telephone: 09 373-7599 extn 88489

Fax: 09 3082379

Email : occmed@auckland.ac.nz

Full information on courses and admission regulations is available in the

University of Auckland Calendar or http://www.auckland.ac.nz

Otago University

The Otago University post-graduate *Diploma in Aviation Medicine* (DAvMed) continues to be

available for part-time distance education studies in aviation medicine.

Otago University is also offering two of the DAvMed papers, Aviation Physiology and Clinical Aviation Medicine for the new Postgraduate *Certificate in Civil Aviation Medicine*.

For further information on these courses you should contact Dr Robin Griffiths, Senior Lecturer in Occupational & Aviation Medicine, Wellington School of Medicine:

Email: rfgriffiths@wnmeds.ac.nz

Tel: +64–4–385 5999 ext 6749

Fax: +64-4-389 5427

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Requirements

To date the following levels of completed aviation medical training have been accepted in respect to ME1s:

- Diploma of Aviation Medicine (Otago or Royal College of Physicians);
- Certificate of (aviation medicine) competency (Auckland);
- Certificate of Civil Aviation Medicine (Otago).

These qualifications or equivalent are expected to remain acceptable levels of aviation medical training for initial-entry ME1s.

To date the following aviation medical training has been accepted in respect to ME2s:

- Part completion of and ongoing training in the courses mentioned above for ME1s;
- Australian Certificate of Civil Aviation Medicine (Monash);
- The basic FAA AME introductory course held at the FAA Civil Aerospace Medical Institute.

These qualifications or equivalent are expected to remain acceptable levels of aviation medical training for initial-entry ME2s.

We are presently exploring the future ongoing aviation medical requirements (CME) for MEs. Your feedback and thoughts on these training requirements would be helpful.

GP CME

The CAA CMU is now accredited by the NZ College of General Practitioners as a Special Interest Registered Provider of endorsed Continuing Medical Education (CME). This means that we will be able to directly award GP CME points to GP MEs in respect to the training we provide. We have also been subject to our first audit, as a registered provider, and were very pleased with the feedback from the College auditors.

The Paper in the System

The Act

We continue to be working under the Civil Aviation Act 1990 (the Act). The Act was amended by the Civil Aviation (Medical Certification) Amendment Act 2001.

A copy of the Act can be found on the CAA website (www.caa.govt.nz).

The Rules (Part 67)

The Act is supported by the Civil Aviation Rules, primarily Part 67 for our purposes. The MoT has also issued the *Aviation Medical Transitional Criteria Notice 2002* which provides further supplementary information and requirements concerning the new medical system.

The MoT has been developing a new Part 67 and it is anticipated that this new rule will be

completed early in 2005.

A copy of the current Rule Part 67, the Transitional Criteria can be found on the CAA website (www.caa.govt.nz) and a copy of the Part 67 NPRM (Notice of Proposed Rule Making) can be found on the MoT website (www.transport.govt.nz).

The General Directions

The Act provides for the Director to issue General Directions (GDs) in a number of circumstances.

Our intent is that the GDs will, in conjunction with the Medical Standards in Part 67, provide the road-maps that will allow MEs to directly certificate the vast majority of applicants without having to resort to the flexibility provisions of section 27B(2) of the Act. Of course those applicants who lie outside the coverage of the Medical Standards (having regard to the GDs) would still need to be considered under flexibility and utilising an Accredited Medical Conclusion.

GDs are going to be a very important component of the new medical certification system as the transition continues. Because there are presently no GDs issued many of you are carrying a higher-than-hoped-for administrative load. Our intent is that many of the medical conditions that are presently handled via AMC and flexibility will be covered by GDs.

Because of the interplay between Part 67 and the majority of the GDs it has not been appropriate to publish any GDs until we are confident about the wording of Part 67. This means there are presently no published GDs.

If you have **any** uncertainty about **any** aspect of your ME role please do not hesitate in contacting the CAA Central Medical Unit by phone, email, fax, or letter. We are putting a lot of effort into ensuring our administrative and medical staffs provide you with a highly responsive ‘help desk’ facility.

The Medical Manual

The Medical Manual is undergoing significant revision. The old volume 1 is no longer valid. A new volume 1 will be published soon after the new Part 67 comes into existence.

The old volume 2 is also invalid although still represents a potentially useful source of guidance.

The function of the old volume 2 will be largely replaced by the various ‘clinical’ GDs included in the new medical manual.

Once again if you have **any** uncertainty about **any** aspect of your ME role please do not hesitate in contacting the CAA Central Medical Unit by phone, email, fax, or letter.

Forms

The forms necessary for CAA medical certification are all available online on the CAA web site (www.caa.govt.nz).

While we acknowledge that some of the forms are not yet perfect they are reasonably functional in their present iteration. A review of these forms is planned and will probably be undertaken on a form-by-form basis with the first form reviewed being the application form. We will let you know when this review starts and welcome your suggestions.

Thank you, also, to those MEs who have provided helpful feedback in respect to the new ‘Special Eye’ and ‘Audiometry’ forms. Those comments

have lead to some very helpful revisions of these new forms.

Of course we'll advise you, via the CAA Medical Examiner mailing list, when new versions of any forms are posted on the website.

Old system documents

The 201

As advised in previous issues of this newsletter we can no longer accept old '201' forms for consideration of the issue of a new system Medical Certificate and suggest all MEs destroy, or return to the CAA, any old stock 201 forms you hold.

All of the forms that are needed can be downloaded from the CAA web site (www.caa.govt.nz).

AC67

As has also been previously advised the old Advisory Circular 67 (AC67) was withdrawn on 01 April 2002. Please do not refer to this document for requirements or guidance in respect to the functions and processes of the new system. This old document has no validity in respect to the new certification system.

Communications

The Email Mailing List

Most of you will have now received email from the CAA Medical Examiner mailing list, formerly called 'Aimie'. This mailing list has been established for our medical certification functions and allows us to expeditiously advise you of issues and changes within the system.

The Medical Examiner Newsletter

This newsletter is intended as our primary regular communication with the Medical Examiners who work within our regulatory aviation medical system. Despite our recent difficulties in doing so we hope that we can keep to a quarterly schedule with this newsletter and use the Aimie list for more sporadic communications.

Comments, questions, and suggestions concerning this newsletter would be welcome.

Other periodic communications

We are exploring the possibility of sending-out brief, one-page, news-sheets on a monthly basis as well as other, more focussed and issue-specific communications, when problems arise. The desirability of these communications options must be balanced against the time required to develop them.

Your thoughts and ideas would be appreciated.

The CAA web site

The medical section of the CAA web site has been significantly improved. Our intent is to make all the information you need to function as an ME available on the web site. Back-issues of this newsletter will also be made available on the web site.

Again suggestions and comments are welcome.

Meetings & Consultation

Sporadic and regular meetings with individual MEs and representative groups are another important aspect of our communications with you.

A number of MEs have visited us while in the Wellington area and we welcome such visits and the opportunity to discuss the system, the processes, and any problems experienced.

CMU staff also welcome the opportunity to visit

with you on your home ground. So if there are any problems or other matters where the personal touch may help please do not hesitate in calling us.

The Processes in the System

Our medical certification process certainly differs from that in force prior to 01 April 2002. Please don't hesitate in phoning the Central Medical Unit anytime you are uncertain of how to proceed with an examination or assessment. Many MEs are still finding that a short telephone call is saving them a lot of unnecessary hassles and, in turn, making the certification process easier and more economical for the licence holder or student.

Accredited Medical Conclusion (AMC)

The AMC process is now running very smoothly and efficiently at the CAA end and most MEs have established reliable systems to handle flexibility and AMCs. There are usually 120 – 150 AMCs opened and closed each month. The vast majority of current AMCs see the Director identify the ME as the AMC-expert. This means turnaround is very quick. Approximately 80% of all AMCs are closed within 6 days of CAA receiving the application for experts to be identified.

Of course the more complex or difficult AMCs, which usually see a higher degree of direct involvement by CAA staff, do take longer. The record to date (not necessarily one to be proud of) is 365 days … and that applicant was very appreciative of the time taken and effort made on their difficult case.

Occasionally we still come across an applicant who is not adequately aware of the meaning of flexibility and how the AMC process works. If you think you're going to need to use the flexibility option please do make sure that the applicant you're working with understands what it means and what happens.

Questions, Comments, & Notices

Questions and Answers

This section responds to some of the questions we've received since the last issue of the *Medical Examiner*.

Can I still use the pink 201 form?

No. The old, pink, General Medical Examination form (CAA24067/201) cannot be used for CAA medical certification.

Can I still refer to AC67?

No. There is no current Advisory Circular 67 (AC67). This document was withdrawn on 01 April 2002 and, given the role and scope of the GDs, there is no immediate plans for its replacement.

Can I re-use an AMC?

No. An AMC cannot be re-used for a subsequent certification assessment, even if the main medical factors have changed little.

Why so many AMCs?

There are presently many more AMCs than we feel appropriate for the structure of our certification system. Unfortunately many of these are a result of the wording of the medical standards in the current Part 67. In several sections of those medical standards an AMC is specified and so must be undertaken to comply with the legislation.

The Part 67 NPRM, upon which the MoT has now

twice consulted, has all of these AMC references removed. This change, coupled with the planned detailed clinical GDs, will result in a dramatic reduction in the numbers of applicants whose certification is processed via flexibility and AMC.

Why no GDs?

Initially it was thought that GDs could quickly replace the function of the old medical manual. Because of the structure of the current Part 67 this has not been the case so we are waiting for the new Part 67 to enable the intended function of the GDs.

Some of you will have seen the *Temporary Medical Conditions* GD. This document is still under review to clarify some legal issues.

Three, possibly four, more GDs are planned to accompany the next draft of the Part 67 NPRM into public consultation later this year. These three GDs are *Routine Examination Periodicity*, *Examination Procedures*, and *Hearing Impairment*. The possible fourth relates to *Refractive Vision Impairment*.

The periodicity GD is intended to describe the requirements with respect to when routine examinations (including tests and investigations) are to be performed … such as when an ECG or audiometry is required. The procedures GD is intended to describe the actual performance and interpretation of routine and non-routine examinations (including tests and investigations). This GD is expected to be revised quite frequently to begin with as each new 'clinical' GD will require new examination procedures to be added. The hearing GD is intended to describe the interpretation of results, and the investigation pathways, for applicants whose hearing is impaired. This hearing GD is expected to be the first 'clinical' GD which describes the clinical processes and requirements in relation to a particular condition or group of conditions. The second such clinical GD is intended to relate to refractive visual errors.

Why no new Medical Manual?

There is no new medical manual for much the same reason that there are no GDs. Firstly much of the new medical manual will be the GDs and secondly the new Part 67 has not been published and we cannot reliably develop the administration section of the medical manual until we know what that Rule says.

We are working on the administration portion of the medical manual but will not be publishing this document until we are confident of the contents of the new Part 67.

When does the validity period of a medical certificate start?

Any medical certificate that you issue must commence its validity on the day it is issued. You cannot pre- or post- date medical certificates.

If delays are anticipated, and you are satisfied that there is no jeopardy of flight safety, then you might consider using the extension provisions of the Act (Section 27E).

The Part 67 NPRM contains new rules to provide a buffer period of 30 days so that, in most circumstances, applicants do not lose time with each subsequent issue of a medical certificate. Until the new rule comes into force, however, we are obliged to continue as outlined above.

How can I handle any surveillance requirements I might want to impose on an applicant?

Subject to your delegations, and any conditions that may apply to them, you are able to impose conditions, restrictions, and endorsements on medical certificates. As there are no specific medical surveillance provisions under the Act or Rule Part 67 you have two avenues to achieve this 'surveillance'.

The first is to issue a medical certificate that expires when the surveillance you require is due. This approach is relatively fail-safe but imposes extra costs on the applicant because you would have to repeat the whole examination and assessment process for the issue of the next certificate.

The second option is to apply conditions to the medical certificate that you issue. You could, for example, issue a twelve month certificate with a condition requiring, say, a psychiatric review every three months. If the certificate holder fails to comply with the condition that has been applied this renders their medical certificate non-current. You should, of course, advise them of the process and the implications of failing to comply with the conditions.

You do not have a third avenue that was practised by some in the old system. You cannot issue a short-duration medical certificate, say for three months, and then undertake to issue a full duration medical certificate when you receive a particular report. The certification system within which we operate requires an application, a full examination, any additional examinations or tests required, and an assessment for every medical certificate issued. In circumstances where you might have taken this approach in the old system the best option in the new system is the second one described above … issue a full duration medical certificate carrying an appropriately worded endorsement. This approach also requires less work on your part; you don't have to issue another certificate, and so is likely to be more economical for the applicant.

Can I modify an entry on the 'Application for a Medical Certificate' form?

No! Form CAA24067-001 *Application for Medical Certificate* is to be completed and signed by the applicant. The ME should not make any entry on this form other than to witness the applicant's signature.

If you notice any irregularities with the completed form you should ask the applicant to remedy them. If faced with an irregular or incomplete application form you should give serious thought as to whether you are able to issue a certificate at all. If you do need to comment about entries in the application form then make your comments on your form CAA24067-002 *Medical Examination Report*.

What do I tell an applicant who wants to appeal a decision?

The CAA website contains information concerning review of medical decisions (www.caa.govt.nz Medical / Review of Medical Certification Decisions / Options if denied a medical certificate / What are my Review Options?).

You may wish to print this document and hand to all, or some, of the applicants you deal with. You should pass this document on to any applicant who is being denied a medical certificate or who you feel is likely to be dissatisfied with a decision.

Helping us to help you

This section details issues that have caused our staff some extra and unnecessary workload. We ask your consideration of these in helping us to run the system as smoothly as possible and, therefore, to be better able to help you.

Forms

All of the forms you need can be obtained from the CAA website. You can use the online document or a hardcopy master to copy your own forms.

When a form is updated you will be notified via the Medical Examiner mailing list.

Info accompanying AMC requests

Another matter that will help our advisers keep the wheels turning smoothly. The turnaround times for AMCs will be further improved if MEs ensure that every AMC request is accompanied by the application and examination forms.

This provides us with dates (etc) for our monitoring processes (especially relevant wrt 90-day expiries) and provides the Director with some additional information upon which the identification of suitable (AMC) experts can be reasonably made.

Request for reports or ECGs etc

If you need a copy of something from an applicants file, such as a past psychiatry report or ECG, please make your request as simple as possible. Some requests we receive explain, in depth, the clinical reason for wanting such a document. This can lead to our advisers missing the point of your request in thinking that the complex medical discussion is a matter for one of the doctors … with resultant delays in response to your request.

If you're examining or assessing an applicant you are perfectly entitled to information from their files and do not need to justify your request. A simply worded request will save you time, save us time, and make a prompt response much more likely.

Notices and other information

NZ Medical Council

Last year the Medical Council of New Zealand published a statement titled Non-Treating Doctors Performing Medical Assessments of Patients for Third Parties.

This is a very important document for Medical Examiners to read and be aware of. The document provides guidelines which the Council states is good medical practice for those undertaking third party assessments.

The statement can be downloaded from the Medical Council website (www.mcnz.org.nz). A copy is also attached to this newsletter.

If you have any doubt about the applicability of this document to your practice as an ME then you should contact the Medical Council of New Zealand to seek clarification.

Aviation medical positions vacant

The ICAO *Chief, Aviation Medicine Section* position, currently held by Dr Claus Curdt-Christiansen, was advertised earlier this year. Although various rumours have circulated throughout the aviation medical world no advice has been received as to who the new ICAO chief doctor.

The Australian Civil Aviation Safety Authority

(CASA) has recently advertised their PMO position. The position was advertised on 02 December 2004, applications close on 14 January 2005, and details can be found on the CASA website at http://www.casa.gov.au/jobs/index.htm.

Education & Training

This new section contains details about conferences, seminars, workshops, and other training opportunities as well some snippets from the medical and aeromedical literature and a new "You're the expert" competition.

Conferences, seminars, workshops, and other education / training opportunities

Joint regulatory workshops

CAA hosted two very successful joint (CAA / CASA / Industry) workshops to consider civil aviation regulatory issues in relation to drug and alcohol use (02 April 2004) and depression and anti-depressant therapies (05 November 2004). These workshops were attended by CAA, CASA, various industry groups, and several specialist consultants. Our guests at the April workshop included Dr Don Hudson from US ALPA, Dr Gary Kohn the Medical Director of United Airlines, and Dr Bart Paykell previously from FAA and responsible, to a large extent, for establishing their HIMS accelerated alcohol rehabilitation program for airline pilots.

CASA also hosted a joint workshop, in Canberra, on 14 September 2004. The topic for discussion was aviation gastro-enterology.

We have scheduled joint clinical workshops for 2005 as follows:

04 February 2005. To be hosted by CAA in Wellington area. Civil aviation regulatory considerations of disorders of glucose metabolism.

01 March 2005. To be hosted by CASA in Canberra. Civil aviation regulatory considerations of orthopaedic and rheumatological disorders.

04 November 2005. To be hosted by CAA in Wellington area. Topic TBA, possibly cardiovascular risk assessment.

There may be an additional CASA-hosted workshop TBA.

Medical Examiners are more than welcome to attend any of these joint seminars although prior notice is essential.

Aerospace Medicine Association (AsMA)

This years AsMA annual scientific meeting (ASM) was held in Anchorage, Alaska. Abstracts of the conference's 679 presentations and panels can be found in the supplement to the April 2004 issue of the *Aviation, Space, and Environmental Medicine* journal.

Next year the AsMA ASM is to be held in Kansas City MI during 09 – 12 May 2005 and then the subsequent meetings are held: 2006 in Orlando FL during 14 – 18 May 2006; 2007 in New Orleans during 13 – 17 May 2007; and 2008 in Boston MA during 11 – 15 May 2008. Each year the AsMA ASM is preceded by the one-day ASM of the Airline Medical Directors Association.

Australasian Society of Aerospace Medicine (ASAM)

The Australasian Society of Aerospace Medicine (ASAM) held their 2004 conference / ASM in Adelaide, South Australia. ASAM is the reinvented and renamed Aviation Medical Society of Australia and New Zealand which presently boasts a membership of approximately 840.

With the name and identity change comes a new

peer review journal to replace AVMEDIA. The first issue of *The Journal of the Australasian Society of Aerospace Medicine* was published in April.

The 2005 ASAM ASM is scheduled for the Gold Coast QLD during 15 – 18 September 2005 and is being held in conjunction with the Asia Pacific Federation of Aerospace Medical Associations (APFAMA).

Aviation Medical Society of Australia and New Zealand (NZ) Inc

The Aviation Medical Society of Australia and New Zealand (New Zealand) Inc (AMSANZ-NZ) again joined forces with the Australia and New Zealand Society of Occupational Medicine (ANZSOM) for their annual conference. This year the theme is "medical risk management in the transport industries" and the conference was held in Christchurch during 23 – 26 September 2004.

As previously mentioned the CAA hosted a one-day regulatory aviation medical update ("CAA day") in association with this meeting on 23 September 2004.

It is understood that discussions are underway with a view to co-locating the 2005 AMSANZ-NZ with the 15 – 18 September 2005 ASAM meeting on the Australian Gold Coast.

International Academy of Aviation and Space Medicine (IAASM)

The venue for the 52nd International Congress in Aviation and Space Medicine (ICASM) was the Sun City conference facility in the North West Province of South Africa. ICASM 2004, the 52nd ICASM, was hosted by the South African National Defence Force and the South African Society for Aviation and Environmental Medicine in conjunction with the International Academy of Aviation and Space Medicine, during the period 05 – 09 September 2004.

The 53rd ICASM is scheduled for Warsaw, Poland for the period 28 August – 01 September 2005 and the 54th for Banagalore, India with dates to be advised.

International Civil Aviation Organisation (ICAO)

ICAO is planning on hosting a regional seminar on aviation medicine (and personnel licensing), in Bangkok sometime during the second half of 2005. The ICAO Asia and Pacific regional office is located in Bangkok.

If you're interested in attending this seminar please keep in touch and we can let you know any actual dates as they are advised.

From the journals

Below are two brief items-of-interest from the medical literature. The complete papers discussed, in PDF form, can be viewed up until 01 April 2005, at www.aeromed.info/articles.php.

During the year CAA staff made presentations at conferences and some of that material has been submitted for publication. It is hoped that some of this material will be featured in the next "from the journals" section.

Pre-test probabilities and stress-ECGs

In asymptomatic (CVS) individuals the pre-test probability of a cardiovascular event has a powerful influence on the implications of a stress exercise electrocardiogram. Table 1 in the

Greenland and Gaziano (2003)[1] paper shows the pre-test and post-test (exercise electrocardiography) probability, within 10 years, of a coronary event. An excerpt of this table is reproduced below. Much of the Greenland and Gaziano analysis is based on data published by Gibbons et al (2000)[2].

Pre-test probability of a coronary event within 10 years	Probability within 10 years according to results of exercise electrocardiography	
	Abnormal	Normal
1.0	4.0	0.4
2.0	8.0	0.9
3.0	12.0	1.3
4.0	15.0	1.9
5.0	19.0	2.3
6.0	22.0	2.8
7.0	25.0	3.3
10.0	33.0	4.8
15.0	44.0	7.4
20.0	52.0	10.0

These findings may have some very interesting potential implications in a regulatory environment that utilises a 10% five-year screening CVS risk threshold in a process that attempts to ascertain that an applicant has an incapacitation risk of less than 1% per annum in respect to CVS asymptomatic individuals.

Discrimination power of CVS risk prediction

In a pair of papers in the NZ Medical Journal Milne et al (2003)[3] analyse the NZ Heart Foundation CVS risk assessment tool. The areas under the ROC (Receiver Operator Characteristic) curves illustrate the utility of the multi-factorial method recommended by the NZ Guidelines Group[4]. It will also be no surprise that the multi-factorial method is superior and that, of the factors analysed, age is the most powerful single predictor.

Below is a simplified version of the ROC curves shown in Figure 1 of that paper (these curves apply to men only). The NZGG evidence-based publication can be downloaded from their website at www.nzgg.org.nz.

[1] Greenland, P. and J. Gaziano (2003). "Selecting asymptomatic patients for coronary computed tomography or electrocardiographic exercise testing." New England Journal of Medicine, 349(5): 465-473.

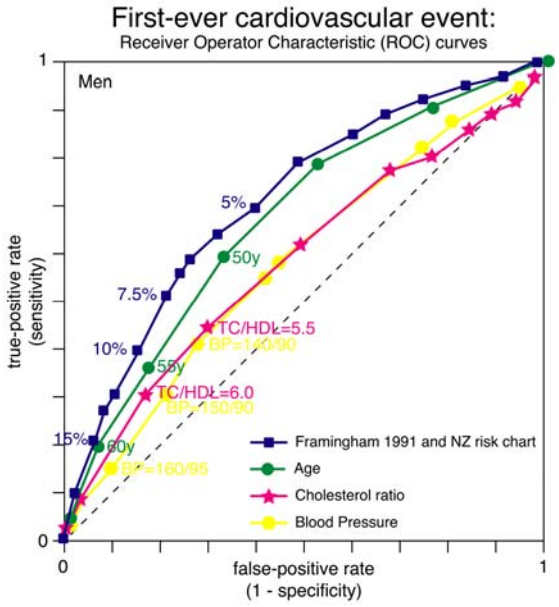
[2] Gibbons L W et al, Maximal exercise test as a predictor of risk for mortality from coronary heart disease in asymptomatic men, American Journal of Cardiology 2000, 86:53-58

[3] Milne R et al, Discriminative ability of a risk-prediction tool derived from the Framingham Heart Study compared with single risk factors, NZ Medical Journal 2003, 116(1185).

Milne R et al, Framingham Heart Study risk equation predicts first cardiovascular event rates in New Zealanders at the population level, NZ Medical Journal 2003, 116(1185).

Williams M (Editorial), Risk assessment and management of cardiovascular disease in New Zealand, NZ Medical Journal 2003, 116(1185).

[4] The assessment and management of cardiovascular risk: Evidence-based best practice guideline, New Zealand Guidelines Group 2003 (www.nzgg.org.nz).



You're the expert

This is a competition! The author of the best answer, as judged by CMU medical staff, will have their analysis published in the next edition of *The Medical Examiner* and will receive a suitable reward from the PMO's cellar. Entries close on 31 March 2005.

The scenario is that you are the expert undertaking an AMC for the applicant described. The information you have available to you is limited to that provided and any medical or scientific literature you can find … and, of course, your own wisdom and expertise.

The winning analysis will attempt to take an evidence-based risk management approach to determine whether this applicant can be reasonably issued a class 1 medical certificate. The risk criteria utilised in this risk assessment should be a 1% per annum incapacitation risk for single-pilot operations and a 2% per annum incapacitation risk for multi-pilot operations. The quality of the medical evidence utilised will be an important factor in the quality of the final decision.

The applicant is a 63 year old male ATPL pilot who, on 01 January 2005, applies for CAA class 1 medical certificate. He has approximately 20,000 hours of flight time logged and flies domestic and international non-passenger transport operations (freight).

The medical details for use in this case are attached to this newsletter.

Who is doing what?

The CAA Central Medical Unit comprises:

Principal Medical Officer Dr Dougal Watson;

Senior Medical Officers Drs Pooshan Navathe and Claude Preitner;

Registrar / Medical Officer Dr Michael Drane;

Executive Officer Judi Te Huia;

Medical Advisers Sue Holiday, Christine Kirker, Dianne Lassche, Hedy Mulholland., Dianne Parker, Julia Reed, and Vanessa Sales (nee Calnon).

Claude Preitner has the primary responsibility for applicant certification matters and Accredited Medical Conclusion. Accordingly Claude is also responsible for the processing of queries directed to us by and about applicants.

Pooshan Navathe has responsibility for the non-CAA medical officers. Pooshan is managing the review and audit processes as well as any educational activities we undertake.

Earlier this year Pooshan was awarded both full membership (*Academician*) of the International Academy of Aviation and Space Medicine and Fellowship of the Aerospace Medicine Association. These prestigious awards recognise Pooshan's huge past and ongoing contributions to

the world of aviation medicine. To the best of our knowledge Pooshan is now one of only three doctors in New Zealand to hold both of these honours. Congratulations Pooshan.

Judi Te Huia is responsible for our administrative support and the support provided to us, and you, by the CAA Medical Adviser staff..

Contacting us.

The CAA Medical Help Line number is +64 (4) 560-9466. This number should be used as the primary contact for virtually every civil aviation medical regulatory matter.

The CAA web site (www.caa.govt.nz) has a "Medical" button on the main page. This will make it much easier for you to find information and other resources to help you with your ME activities … as well as this issue, and back issues, of the *Medical Examiner*.

Enclosures:

1. Medical Council of New Zealand statement, of June 2003, titled Non-Treating Doctors Performing Medical Assessments of Patients for Third Parties.
2. Case notes for the "You're the expert" competition.

CAA Medical Help

Tel: +64–4–560 9466 **Fax:** +64–4–560 9470
Email: med@caa.govt.nz **web site:** www.caa.govt.nz

Medical Council of New Zealand

Non-Treating Doctors Performing Medical Assessments of Patients for Third Parties

Doctors who are employed by a third party to perform medical assessments of patients are required to maintain a professional standard of care within the framework of the assessing relationship and are expected to meet the standards of practice outlined in this statement.

Introduction

1. Medical assessments for third parties are a common feature in medical practice. The purpose of a medical assessment varies depending upon the role of the third party. Examples include assessment for employment suitability, and eligibility for health services or compensation. Medical assessments may be performed by the patient's own doctor or by a non-treating doctor.

2. In some circumstances the patient's own doctor will be asked to provide a medical assessment of the patient for a third party. Insurance companies and employers tend to use this form of assessment. Non-treating doctors may be employed or contracted when the third party requires an independent assessment or second opinion. Examples include expert advisors (used in legal proceedings), doctors employed by organisations like ACC, insurance companies or the patient's employers.

3. An assessment by a doctor may take several forms that include a consultation with the patient, possibly a physical examination or a file review of the patient's medical history.

Performing medical assessments

4. If a doctor who is asked to perform a medical assessment does not consider him or herself suitably qualified, or identifies that a conflict of interest exists, the doctor must decline the referral. An explanation does not have to be provided to the third party.

5. If the third party considers a physical examination is not required the assessing doctor must be satisfied (and be able to justify) that he or she has all the information necessary without performing a physical examination or speaking with the patient, before providing an accurate professional opinion or recommendation.

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The role of the non-treating doctor

6. The role of the non-treating doctor is to perform a medical assessment and provide an impartial medical opinion. The recipient of the medical opinion is the third party who has employed or contracted the non-treating doctor. As the title indicates, the non-treating doctor does not provide any form of treatment to the patient.

The non-treating doctor and patient relationship – the professional standard of care within the framework of the assessing relationship

7. The basis of the relationship between the patient and assessing doctor is not the same as an established doctor-patient relationship, however the doctor is still required to maintain a professional standard of care within the framework of the assessing relationship. The Council requires that non-treating doctors adhere to the principles in the Code of Health and Disability Services Consumers' Rights.

8. As such, the patient should be treated with respect, be free from coercion, discrimination, harassment and exploitation. If there is a meeting with the patient, the non-treating doctor is required to respect the patient's dignity and ensure that he or she communicates with the patient in a manner that enables the patient to understand the information provided and the role of the non-treating doctor.

Effective communication and consent

9. The Council has identified some recurring problems in medical assessments performed by non-treating doctors. The common issue is poor communication with the patient. This leads to unmet expectations, misunderstandings and confusion about the non-treating doctor's duty of care to the patient. The following information must be clearly communicated to the patient by the non-treating doctor:

    - If the non-treating doctor is required to consult the patient he or she must ensure the patient understands the purpose of the medical assessment and the non-treating doctor's role. Although the patient will usually be informed of this by the third party before visiting the non-treating doctor, it is the responsibility of the non-treating doctor to confirm this and if necessary, provide any further explanation. This explanation should include discussion about the differences between the non-treating doctor's role and the patient's own doctor.

    - The non-treating doctor must explain what will happen during the assessment and also ensure that the patient is aware of what he or she is doing throughout the consultation. This includes explaining the scope of the consultation and any tests that the assessment may require.

    - As with any health service, informed consent must be obtained before any service is provided. The non-treating doctor should ensure the patient understands that any aspect of the medical assessment may be included in the report to the third party. If the patient does not consent to this the assessment

shall not proceed. The patient also has the right to withdraw from the assessment at any time. In either of these circumstances the non-treating doctor should record in his or her report to the third party at what point the assessment was terminated and why.

- The non-treating doctor must explain and ensure that the patient understands what will happen after the consultation. Specifically, the non-treating doctor should ensure the patient understands that the report will be the property of the third party. A request for a copy of the report and any further communication should be directed through the third party.

Recording a consultation

10. A patient may want to record the consultation by video or audio tape. Arrangements should be made prior to the consultation and with the consent of the doctor. The Council recommends that third parties make the arrangements with the patient and doctor and if the doctor selected to perform the medical assessment does not consent to recording the consultation, an alternative doctor is located.[i]

Reports for the third party

11. Once the medical assessment has been completed it is standard practice for the doctor who performed the assessment to provide a written report to the third party with his or her medical opinion. The report must be accurate and objective. The doctor should not speculate or base recommendations on insufficient or flawed evidence and if he or she is not satisfied that a medical opinion can be accurate, based on the information provided in the file, he or she must clearly state this in the report. The doctor may choose to recommend further methods of investigation if appropriate (i.e. medical tests, x-rays etc).

12. If the non-treating doctor has been provided with any documentation or information from the third party this should be listed as part of the report. This ensures that all the information available to the non-treating doctor is recorded and can be referred to again if there are any issues or questions in the future.

13. If the third party has requested that the non-treating doctor make recommendations (e.g. suitability for an employment position) the recommendations must not compromise the patient's safety. The non-treating doctor is contracted to make a medical judgement and the third party's decision will be influenced by the medical opinion. The Council does not accept that making recommendations is a step back from implementing them. Therefore the non-treating doctor has some responsibility for the outcome by ensuring his or her professional opinion and recommendation are appropriate to protect or enhance the patient's health.

14. It is inappropriate for the assessment report to include comments on any policy or legislation pertaining to the third party because it is not relevant to the non-treating doctor's role.

15. If the non-treating doctor becomes aware of another medical condition as a result of the assessment the doctor should inform the patient and refer the patient back to his or her own doctor (the patient's general practitioner/specialist) for further investigation.

Medical Assessments by the patient's own doctor

16. In some circumstances the patient's doctor will be requested to perform a medical assessment that would otherwise be performed by a non-treating doctor. This is usually because the patient lives in an isolated area where a non-treating doctor is unavailable. It is imperative that the doctor clearly explains the difference in his or her role in this circumstance, so that the patient understands that the usual dynamics of the doctor-patient relationship are different.

17. Doctors must ensure that any medical assessment of a current patient to a third party is based on objective and clinical findings.

18. When the patient's own doctor is requested to perform a medical assessment for a third party on a current patient, the doctor has the same duty and requirements to report all of the relevant findings accurately to the third party.

File assessments by non-treating doctors

19. A non-treating doctor may be employed or contracted to perform a medical assessment based solely on information in the patient's file. As with any other form of medical assessment the non-treating doctor must be satisfied that he or she has all the information necessary and a physical examination is not required before providing an accurate professional opinion or recommendation.

20. The Council reminds non-treating doctors in this role that the documented findings of another doctor have been based on physical examinations and direct communication with the patient. If a non-treating doctor performing a file medical assessment concludes that the documented cause of a medical condition or diagnosis is incorrect, the non-treating doctor needs to be confident that his or her conclusion can be supported with clinical evidence and is based on all the necessary information. It is not acceptable to include such conclusions in the report to the third party unless the non-treating doctor is confident that consulting with the patient or the patient's own doctor is not necessary.

Financial influences for the non-treating doctors

21. A doctor must not allow the financial interests of either the patient or the third party to influence the medical assessment of the patient, the medical opinion or recommendations.

Review of medical assessment opinions

22. Any challenge by a patient or representative of the patient to an opinion in a medical assessment report should be done through the third party.

23. In past cases, the Health and Disability Commissioner has concluded that a non-treating doctor is not providing a health service to the patient. Instead, the service is provided to the third party. As a result the Commissioner is likely to refer any complaint to the third party in the first instance because the Commissioner's jurisdiction is restricted to services provided directly to a patient by a health provider.

Notes:

- The Medical Council of New Zealand has released guidelines on medical certification that outline the general requirements and duties of a doctor when signing any form of certificate or medical report. This is available from the Council's website (www.mcnz.org.nz), or the office.

- A doctor who performs a medical assessment is not responsible for the actions of the third party. The only responsibility the doctor has is to competently perform a medical assessment within the scope identified by the third party, and provide a professional, ethical report based on his or her impartial medical assessment.

Approved June 2003

[i] Jackson v ACC (Wellington District Court, Decision No. 168/2002 dated 25 June 2002).
A doctor has the "privilege" to decide in what lawful way a medical examination will be conducted and the patient also has the "privilege" to ask for a tape-recorded consultation. It is then a question of balancing the reasonableness of the exercise of the mutual privileges. In this particular case the doctor had not put forward any worthy arguments to refuse to tape the consultation and given the patient's perception of her dealings with ACC and specialists appointed by it, her request to tape the examination was a reasonable exercise of her privilege to do so.

You're the expert!

The applicant is a 63 year old male ATPL pilot who, on 01 January 2005, applies for CAA class 1 medical certificate. He has approximately 20,000 hours of flight time logged and flies domestic and international commercial freight operations. He is very fit, running and playing squash regularly.

History: Relatively uneventful class 1 medical certification January 2004. Flexibility utilised due to high frequency hearing loss. Medical certificate issued for maximum duration and carrying "004" endorsement (half spectacles must be readily available). Five-year CVS risk (NHF methodology) of 8%.

Comments on June 2004 application for a medical certificate (Q20.46 and Q20.48) that he's had a swollen right ankle but is still very active and plays squash regularly. Medical certificate issued for maximum duration and carrying "004" endorsement. One week later he presents to his medical practitioner complaining of increasing shortness of breath with exercise. Respiratory physician observes that there is "no specific diagnosis forthcoming" but notes the possibility of a pulmonary vascular abnormality or occult ventilation abnormality and orders a number of investigations. Investigation results indicate: Normal spirometry; Normal chest x-ray; Normal ECG; Elevated D-dimer; CT pulmonary angiography and HR CT showing bilateral moderate-volume pulmonary embolism; Normal echocardiography. No aetiology identified for pulmonary embolism. Warfarin therapy instituted.

Suspension, and then disqualification, of CAA medical certificate.

Application for class 1 medical certificate (01 January 2005) accompanied by the following:

> Oximetry results. 96-98% spO_2 at sea level. 96% at 8,500ft cabin altitude. 93% at 10,000ft cabin altitude.
>
> Further investigation results. Thrombophilia screen negative, normal PSA, negative lupus anticoagulant, negative ANCZ, normal protein electrophoresis, and normal urine chemistry and mircoscopy. Lower limb ultrasonography revealing old thrombus in recanalised right superficial femoral vein.
>
> Daily / alternate-daily INR assay results between 1.0 and 3.4 during first month on Warfarin, weekly 1.8 – 3.1 during subsequent three months, and weekly 2.0 – 3.2 during most recent two months.
>
> Normal resting ECG.
>
> Audiogram showing bilateral high frequency hearing loss. Does not meet the medical standards: 70 – 75 dB at 3kHz and higher in right ear. 70 – 110 dB at 3kHz and higher in left ear. Speech audiometry 90% at 80 dBSPL and 97% at 110 dBSPL. Results stable over last five years.

Examination normal. Corrected 6/6 distant, N12 intermediate, and N5 near vision acuity in each eye in isolation and together.

ME applies for the Director to identify experts for the purpose of an Accredited Medical Conclusion. YOU are identified as the AMC expert.