THE AVIATION COMMUNITY MEDICAL LIAISON GROUP
– Meeting Minutes 14 June 2016

DATE:	Tuesday 14 June 2016
LOCATION:	Civil Aviation Authority, Level 15, Asteron House, 55 Featherston Street, Wellington, Room 15.04
TIME:	1000-1430

PRESENT:

- Ian Andrews, President - Aircraft Owners and Pilots Association of NZ
- Herwin Bongers, Medical Director – NZ Airline Pilots Association
- Deborah Symons – CAA Aviation Med Team Lead
- Bruce Burdekin, Representative - Sport and Aircraft Association NZ Inc
- John McKinlay, Manager – Personnel and Flight Training
- Claude Preitner, Senior Medical Officer - Civil Aviation Authority of NZ
- Richard Small, Representative – Flying NZ, Royal New Zealand Aeroclub, NZ Aviation Federation
- Mark Stretch – Manager of performance, Airways
- Josie Sherriff – CAA Admin Support

APOLOGIES:

- Rob Griffiths, Director Occupational and Aviation Medicine Unit - Otago University
- Cam Lorimer, Representative - NZ Airline Pilots Association
- Karen Groome - Royal New Zealand Aeroclub
- Kim Smith, Operations Support Manager - Airways NZ
- Margaret Wright – Representative for NZ women in Aviation
- Dougal Watson – CAA Principal Medical Officer

AGENDA

Welcome and Introduction

John welcomed all attendees and introduced Deborah Symons (CAA Aviation Medical Team Lead). John announced that this will be his last meeting as he will be taking up a new role at the CAA at the end of the month. He explained the objectives of ACMLG meetings, and explained to attendees that frequency and perceived utility of meetings should be reviewed during the meeting.

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ACTIONS FROM THE PREVIOUS MEETING *(held October 2015, as February meeting 2016 was cancelled due to staff illness)*

Summary

1. Medical fee/ Funding Review – this is with the Minister. The funding review may reduce the medical fee. Medical assessments have been on a steady increase (estimated from 6500 annually); although rates are still reduced in comparision to 2012 when 8000 were processed each year. The decline is likely due to international students not going for medicals, a reduction in government funded student pilots and effects of the economic cycle at the end of the last decade. Pilot's requiring six monthly medical assessments have been most affected and concerned with the $313 medical fee.
2. Aviation Medical document group – At this stage we are receiving the information required, and the process is working well.
3. Online ceritification - There has been no progress on setting up online medical certification. Service providers offering their technologies have been put in touch with IT. Due to delays caused by reduced service days from NZ Post, it is preferable to set up an online portal, allowing pilots to access and contribute the information required. There have been consultant sessions in the past, but changes were not approved and the manual system continues.
4. Attendees were in agreement progress on installing an online medical certification has been stagnant since its initial promotion at the first ACMLG meeting in 2013; despite its efficient implementation in Austalia and the US. The view of the aviation community representatives was that the issue must be escalated.
5. Herwin informed attendees about a recent medical practitioner meeting regarding a new ICAO approach. This specifically involved adopting a long-term and holistic approach to medical examinations, considering factors such as well-being and long-term health in medical assessments (e.g. by assessing lifestyle habits etc). This involves the incorporation of SMS guidelines into aviation medicine. Other viewpoints were raised; the international view of the AOPA is that this should be a matter of professional advice as opposed to regulation. While this is fundamentally well intended, advice allows pilots to mitigate their own health risks rather than revoking licences due to future risk potential. Therefore the phrasing is of utmost importance.

ITEMS OF INTEREST

1. RPL(H) and Solo on DL9 – the process is underway and is offering a good alternative option to medical class 2. Future consideration include processing Walsh academy in this process. DL9 is a cheaper alternative to Class 2 medical assessments, costing approximately $50. The next stage is to develop policy work on PPL, which has been proposed to progress this year.
    - Questions were raised about the use of RPL medicals being transferred into PPLs, and asked for clarification about the informational policy involved with this. John agreed to check with Bill MacGregor (CAA Licencing & Flight Training team) and report back to the group. Claude explained the Class 2 medicals need to be of a high standard, as some private operations are long-haul and can hold up to eight passengers. (Bill's reply post meeting: The idea of aligning the RPL with the PPL from scratch and having the syllabi, flight tests and BFR the same is for exactly the situation you ask about. If an RPL holder subsequently gains a Class 2

medical then they can apply to be issued with a PPL. The same applies for any current RPL holder as they have all been Part 61 licence holders previously so have undertaken the training at some stage).

2. Colour vision report update – The colour vision panel met, a report is expected later this year. There was discussion about global variation of colour vision standards, as there are many regional variations (e.g. Canadians landing in New Zealand Airspace with different class 1 standards for colour vision or diabetes). Issue raised of looking worldwide – issue of choosing the highest as opposed to most reasonable standard of adequacy. Simultaenous issue of the priotity of risk management – Context must be considered in relation to medical guidelines.
3. Research directions – we are entering the 2017 financial year, and aim to focus on the Fatigue Risk Management project. Many experts have collaborated on this project, such as Philippa, Leigh, flight operations personnel, pilots, air traffic controllers and engineers. ICAO have helped in developing these standards (founded in scientific reasoning and work with airlines such as Air New Zealand). Fatigue is a health and safety issue and therefore must be escalated. Further funding is needed to complete the project.

    - Herwin mentioned that a tangible benefit is important, and that we should ensure that investment is spent on research.
    - John stated that this project should be a priority, and that SMS rules helps support its escalation

4. Draft revision and medical procedures – Claude Preitner explained that documents are currently being revised. Progress on colour vision is on hold while waiting for the colour vision panel outcome. He discussed a NZ Doctor article which outlined increased reporting of changing medical conditons following the German Wings accident. This has led to increased awareness, as the accident derived from a lack of obligation to report medical changes in Europe. Claude has created a first draft of a GD and is liasing with lawyers
    - Questions were raised about whether others (e.g. managers, coworkers) should report pilot's sick days. According to 27C, operator must report if they are suspicious that pilot is unable. Claude explained that he has created a first draft of a GD and is liasing with lawyers about this, which will soon be reviewed by senior medical officers. This will clarify the issue, and will put set parameters in place (i.e. by giving sensible guidelines) to avoid any ambiguity.

    There has been increased reporting of abnormal behaviours, which serves as evidence of safety progress (specially following the German Wings accident). The lawyers are happy with the documents, and the next step is approval from the PMO, followed by consulation. Meeting are scheduled for July and August, therefore there should be an update at the end of August. Overall, AMC's have been underway in ususal fashion.

John announced that a medical officer 0.8 is being advertised. The medical unit is currently three members down; two licencing advisers will be advertised at a later date. Claude is spending one day a week reviewing manuals and working on the GD.

- Ian raised concerns with the heavy wording used in a recent article stating that it is imperative for medical examiners to report medical issues. He said that the language was negative and implied threat, making bold assertions of

underreporting of conditions and using emotive language to convey the overall message.

- Deborah responded to this, letting the attendees know that she is currently planning a letters project, examining the utility of language used in the letters to laypeople.
- Claude clarified that GP notes can only be requested from the patient, rather than directly from the CAA. The CAA finds these particularly useful as they can provide the information required to resolve many issues. Questions were asked about the relevance of historical GP notes, and Claude explained that relatively recent notes were of priority. Deborah explained that we have rules and protocol regarding the use of patient notes, as it is a privacy matter which must be complied with. The reason for requesting notes from the client is so that they know specifically what is being provided, and they know what is happening with their medical assessment process; ultimately allowing and maintaining trust. Requesting notes from the client does not cost the CAA, and is an overall cleaner process. A case was brought up by Richard to contend the use of recent notes in making medical conclusions, whereby an 18 year old with a history of asthma provided his GP notes to a medical examiner. They observed a fall at age three in the notes and asserted to his mother that he failed his obligation to report this incident.
- Deborah requested to be CC'ed into similar communications in future, so that she can take the steps required to mitigate the issue by contacting the ME, thereby preventing its future occurance.

AVIATION MEDICINE TEAM UPDATES – *Claude Preitner*

As well as the GD (mentioned above), Claude explained that he is currently reviewing and updating Part 3 of the Medical Manual, which is the section that provides clinical guidelines. Four chapters are being revised; and are being corrected and modified. These are guidelines, and not a policy document. He has drafted a cardiology chapter which is under internal review and will soon be put forward for consultation. Psychiatry and oncology are underway and not yet fully structured.

- Ian questioned the NZ medical guidelines in comparison to those from Australia, specifically whether adding to the guidelines would mean that our document is getting too lengthy. Claude explained the the Austalian manual is prescription, and the NZ version involves flexibility. These are based in different legal contexts; and some chapters have been expanded in the NZ medical manual to increase the knowledge of our medical examiners

Claude informed attendees about a successful CASA meeting on 25 May 2016, which was attended by three caridologists, designed to explore the new investigative modality of "calcium scoring". The outcome of this was a new coronary policy, whereby coronary calcium screening via CT scans can be used to screen cononary arteries. Recent cardiological field research and emerging long-term data support it as an efficient mode of screening relative to Stress ECG's. Specifically it is often cheaper, takes less time for pilots, and is only needed once every 5 years (whereas Stress ECG's are needed every 1-2 years). Both tests can successfully show the absence of coronary risk. These specialist tests are often required as a part of the AMC process, and a calcium score of zero would indicate aquequate health.

- Ian asked if other ICAO organisations are using calcium scoring as a screening method. Claude said that he is not sure whether other ICAO countries use this; but that the CASA meeting involved both Australia and NZ, and that letters have

been sent to NZ medical examiners about the new development and are pending approval on their utilisation of the method. Therefore at this stage the timeframe has not been agreed.

RECOMMENDATIONS FOR FUTURE MEETINGS

John opened discussion to the attendees, asking for general feedback about the perceived efficacy of the tri-annual meetings.

John stated that overall, he thought that regular meetings were good as they bridge the gap between the aviation medicine team and the aviation community. He perceived that they were beneficial for the team, allowing insight into what the aviation community are contending with. Overall it has helped build relationships and a forum for communication. Positive outcomes have included the establishment of the fatigue risk management project, completion of the research project, ensuring better communication with respect to implementing extensions at time of medical assessments, which allows leeway for pilots and airways controllers as they await further medical reports, etc. Negative aspects, beyond the control of the group, have involved financial (e.g. cost of an online system) and organisational barriers (e.g. medical officer staffing) which have hindered progress on some initiatives.

As Herwin had to excuse himself from the meeting early, John asked him to contribute feedback or information that he wished to communicate to the attendees. Herwin said that he wanted to thank the CAA for facilitating the inclusion of the HIMS leaflet in the next edition of the Vector. This includes disease model for drugs and alcohol, which the organisation are aiming to make available to the public. HIMS is a referall group which should be recommended to those in need. He referred attendees to a US based video (15mins long), which discussed topics that were synergous with the topics covered by the organisation.The treatment process gives that assistance needed for pilots to later return to flying. More information is available on their website: http://hims.org.nz/

When asked for his feedback on ACMLG meetings in general, Herwin said that the meetings were helpful in developing and maintaining connections and raising FRM. His frustrations regarded the review of medical practices, particularly online medical certification. There is a great need for improvement. He suggested a review of the design of meetings, and that big issues must be elevated and transmitted at a board level. While there has been success in some areas, there has been no outcome for online certification despite all efforts.

- Deborah stated that some issues are out of the medical team's scope, and agreed that general feedback on the meetings is important.
- Michele, who will be taking over John's role next month, needs to be introduced to the liaison group in order to open up communication. Michele has been a squadron leader in the airforce, and has about 20 years experience in the aviation industry

Mark spoke about the impact of medical fees on the aviation community. He acknowledged that without meetings, those in aviation cannot effectively voice their concerns. However, if the ACMLG is achieving little, this negatively affects the future of the liaison group. He noted that while he was aware that the regulatory process is a slow, the long-term inaction on important developments has been frustrating.

Ian said that based on the value-for-money premise (i.e. meeting cost estimated to be $1000), the meetings were not valuable. He said that while it has been useful for opening communication, it has

not been successful in certain areas. He voiced his frustration with the online certification process, and queried the ongoing development of the medical manual (a project which began in 2003) when an efficient solution would be to use an exisiting manual from another country. He was concerned that projects such as updating colour vision guidelines were not valuable as we could easily follow international standards. He stated that the meeting process was expensive, and yielded few results.

Richard said that he has found the meetings beneficial, mainly because they have helped him guide pilot's correspondence with the CAA. He sees value in the meeting forum as it additionally allows for networking outside of the meeting. However he has been disappointed with the lack of progress with online medicals, and believes that the demand is evident as it would suit the aviation community, saving them a lot of time. There needs to be room to do something about this. The time to address and sort medical issues is too long, and pilots are aversely affected due to time away from work. They often suffer while waiting on outcomes.

- Deborah informed the attendees that the AMC process is being assessed in August; and over the next six months other processes will be subsequently reviewed.

Richard said that numbers of attendees need to be increased in order to yield efficiency and influence. He thanked John for allowing for discussion over the past few years, stating that it has been beneficical. He observed that John had maintained a patient and calm demeanour.

Bruce thanked John for his efforts, and remaining patient throughout "spirited" discussions. He too found the lack of progress in online medical certification frustrating, and felt that days and efforts dedicated to this were wasted. The poor turnout for meetings is perhaps due to the lack of outcomes from the liason, and believed that many may be reluctant to travel to the meeting for this reason. He acknowledged that this is not a fault of the medical unit; rather it is relevant to higher levels of the organisation.

Ian stated that the beaurocracy of the CAA system largely leads to inaction. He referred to the effective model used in the US, and contrasted with NZ where two hours are spent per AMC. He is often questioned by people about the fees of medicals. These examinations reveal conditions that can be life-threatening, but the cost is generally problematic.

- Deborah was asked why there has been an increase in AMC's in proportion to medical assessments. She suggested that possible reasons may include an ageing population, and the request for more reporting of medical conditions.
- Ian said that information, such as statistics of increasing AMC's etc. should be communicated to the group.
- John informed Ian that not all AMC's are completed at the CAA, we complete some but refer the rest back to medical examiners. A majority of the AMC cost is due to external specialists. The medical unit may be working more efficiently due to attrition of staff, but AMC's are increasing. ME's do not get paid any extra for AMC's so may prefer to refer them to CAA medical officers.

Bruce raised concerns of the ongoing medical conditions of clients, specifically when the condition has been assessed via AMC, and is continually assessed through AMC's despite no changes in condition. The Act requires clients to go back to the medical unit for further AMC's.

The closing comments from the aviation community representatives present, was that the meetings should continue, and that improved communication with the aviation community was important. John thanked the group for the feedback and agreed to pass on the above comments to the new manager Michele Thomson for review and consideration.

FATIGUE RISK MANAGEMENT UPDATE – Xavier Ruch

The next step for the project involves the need to go to the industry with improvements on FRM. Important principles including the need for sleep, sleep loss, circadian effects, and workload must be considered. The State sets prescriptive limits, whereby operators must use SMS processes to assess ones own individual risk. The development has involved collaboration with policy, insurance, promotion and risk management, and is a data driven process. NZ rules for pilots are about 20 years old.
The project implements a regulatory design, and is founded in scientific knowledge (i.e. limits and criteria), and has clear expectations. Effective management processes are not considered. There is international alignment, but it is not one size fits all as it is a complex issue with a broad range of responses which requires participant and regulator competence. It has been a low-information environment that impairs decision making at organisational and system levels.
The approach has been to engage with the industry and build trust. Rule changes would be a secondary process. In order to promote cultural change, a multi-faceted approach is needed. Human performance capability reduces with fatigue, impairing decision making and judgements.

- Xavier stated that the FRM document is large; and that face-to-face interaction is needed to effectively convey messages and open up communication. CASA published new rule in 2013, and have given their pilots four years to transition
- Bruce claimed that awareness of the associated risks caused by fatigue need to be communicated. Xavier explained that Philippa Ganda (sleep expert from Massey) is speaking about the issue at an upcoming conference to bridge the education gap. Capitalising on circadian rhythm leads to enhanced productivity

Further information on FRM is located on the CAA website:
https://www.caa.govt.nz/fatigue/fatigue_risk_management.html

CLOSING DISCUSSION

The attendees agreed that meeting tri-annually was best suited at this stage. Overall, those that are extended invite should send their apologies as a large proportion failed to do so (so that we can inform caterers, etc).

- Richard emphasised that the chair needs an overview over what is happening in CAA sectors in order to promote efficiency. He brought up the pilots frustrations with continually being directed to the CAA website for information, stating that many find it difficult to navigate. Many have problems with having to contact the CAA for progress on medical decisions and reports. He stated that facilitators in the community would reduce irritation. Bruce said that the site should be simple enough not to need a facililator.
- Deborah agreed that the site should indeed be more helpful, but guidance should be given when needed.
- The issue was raising about not communicating reasons behind the necessity of specialist reports. Phrasing around these matters should be personable in order to reduce negative perceoptions of the medical process.

ADMINISTRATION

John - to report back to the group regarding transfers between RPL and PPL medical assessments. (Bill MacGregor's reply post meeting: The idea of aligning the RPL with the PPL from scratch and having the syllabi, flight tests and BFR the same is for exactly the situation you ask about. If an RPL holder subsequently gains a Class 2 medical then they can apply to be issued with a PPL. The same applies for any current RPL holder as they have all been Part 61 licence holders previously so have undertaken the training at some stage)

DATE FOR THE NEXT MEETING

Tuesday 11 October 2016, 1000 – 1500

Actions Sheet

WHO	WHAT	WHEN	OTHER INFORMATION
CAA	Policy development on PPL	Ongoing (due for completion 2016)	
	Colour vision report	Ongoing (due for completion 2016)	
	Fatigue Risk Management Project	Ongoing	Next stage is consultation with other sectors of the industry https://www.caa.govt.nz/fatigue/fatigue_risk_management.html
	Claude Preitner - GD's project; reviewing medical manual	Ongoing	Update on GD's is due late August.
	Deborah Symons – Letters project	Ongoing	Reviewing the manner of phrasing used in correspondence between the medical team and clients
	Deborah Symons – AMC process review; reviewing other medical processes	Ongoing (due for completion late 2016)	
	Policy regarding use of calcium scoring	Ongoing	Pending approval from medical examiners. See letter to ME's
ACMLG	Introductions and opening communication with Michele Thomson	From July	