

THE AVIATION COMMUNITY MEDICAL LIAISON GROUP
– *Meeting Minutes*



DATE: Tuesday 11 March 2014

LOCATION: Civil Aviation Authority, Level 15, Asteron House, 55 Featherston Street, Wellington, Room 15.04

TIME: 1000-1500

PRESENT:

- § Bruce Burdekin, Representative - Sport and Aircraft Association NZ Inc
- § Claude Preitner, Senior Medical Officer - Civil Aviation Authority of NZ
- § Desrae Martin, Administrator, Aviation Infrastructure and Personnel - Civil Aviation Authority of NZ
- § Dougal Watson, Principal Medical Officer - Civil Aviation Authority of NZ
- § Herwin Bongers, Medical Director - NZ Airline Pilots Association
- § Ian Andrews, President - Aircraft Owners and Pilots Association of NZ
- § John Byers, Representative – Sport and Aircraft Association NZ Inc
- § John McKinlay, Manager – Personnel and Flight Training
- § Judi Te Huia, Team Leader, Medical Certification – Civil Aviation Authority of NZ
- § Rajib Ghosh, Senior Medical Officer - Civil Aviation Authority of NZ
- § Richard Small, Representative – Flying NZ, Royal New Zealand Aeroclub, NZ Aviation Federation
- § Samantha Sharif, Chief Executive – Aviation New Zealand
- § Scott Cursons, Representative – Balloon Association
- § Tim Sprott, Representative– Aviation Medical Society of NZ

APOLOGIES:

- § Mike Groome, Representative - Flying New Zealand
- § Martyn Stacey, Representative – Balloon Association

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AGENDA

Welcome and Introduction

John McKinlay

John welcomed attendees and thanked them for their input into the Terms of Reference, presented at the last meeting. He welcomed new members joining the group. He covered the objectives of the Aviation Community Liaison Group and the role, and reiterated that this is a living document and any feedback to enhance the document is welcomed.

ACTIONS FROM THE PREVIOUS MEETING

All actions have been completed.

CASA WORKSHOP (held 10 March 2014 at CAA)

What is the value of attending CASA workshops? Those who attended from this Group found it helpful for understanding medical perspective topics and gaining useful knowledge for the organisations future planning eg; OSA. The Group agreed to continue being sent invitations to the 6 monthly CAA- CASA workshops in New Zealand and wish to receive invitations to the CAA- CASA invitation in Australia. CAA will liaise with CASA to seek an extension of the invitation as it is a CASA initiated meeting.

AIRWAYS AND CAA MEETINGS

Rob Griffiths

Rob explained that issues reported by Air Traffic Controllers had led to liaison meetings with CAA. A common complaint was with **time lag** in processing medical AMCs (Accredited Medical Conclusion). There were outcomes on both sides; process improvements, better understanding of the systems in place. This led to a change in Airways processes. Airways is now sending email reminders to employees, 30 days prior to expiry, to leave time for extensions on a current medical certificate. This change reduces down-time. Also implemented is a **Case Management System** for people off work and a hotline for queries of fitness. The solutions were mainly around communication. Airways had also created a 'preferred ME provider' list. The regular medical meetings with CAA and Airways has been very effective. Knowledge of the 60 day extension has also assisted.

Richard asked about Advocacy for organisations who can't afford Case Managers – how can they get that type of support? Communication to the applicant is slow and he didn't know about the extension option. Dougal advised that individual applicants cannot be discussed with organisations without permission from the applicant.

The Group highlighted issues around disclosure. Medical Examiners carry delegation from CAA and can provide advocacy for an applicant, however this may not feel 'safe' for the applicant. It could be an option to contact the Aviation Medical Society for advice from someone who is not an ME.

CAA suggested that organisations could find an ME with an interest to be an advisor to answer questions. Alternatively the applicant can contact the Help desk phone 04 560 9466 or email med@caa.govt. Dougal explained that CAA do not provide a preferred provider list and it is up to the organisation to choose their MEs.

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Rajib explained why there is sometimes a **time lag** in processing. When information arrives to the SMO/PMO they may be waiting on information from the client. This leaves the file unable to be processed (black hole) until the information is received. We encourage the applicant to engage with CAA and we can explain to them what we are waiting on. They may also need to contact their ME.

Ian raised the issue of ME1 vs ME 2 **time lag**. If an applicant could go directly to ME1 they would avoid delay of information being passed from one to the other. Dougal advised that this situation may not be able to change as it is purely a geographical issue in the smaller regions.

Bruce asked whether a read receipt in emails would help any of these issues? Dougal explained that the process within CAA is at a minimum of two reminders are sent for AMC. There can be email issues caused by CAA not having the most current email address on file. Follow ups are sent and there are delays in getting that information. Chasing applicants is very time consuming.

Richard asked what would be a good timeframe to expect a decision when all documentation is received? Dougal said that is usually within a couple of days. However, if the paperwork is emailed directly to a PMO/SMO who is out of office, this will again cause delay. Judi asked that reports and documents need to be clearly identified as to who it is for (applicants name and CAA ID as we do not work from NHI numbers), and emailed to med@caa.govt.nz

APPENDIX III TOPICS ISSUES FOR CONSIDERATION (from the previous minutes)

The Group agreed that the list should be prioritised under Diagnosis/Assessment/Rehab.

Regarding common health issues, the Aviation Industry may not be any different to general population, co-morbidities can occur eg: drugs/alcohol/depression. Psychological issues, CV diseases and neurological disorders are the big three. Disclosure is an issue. Members are fearful of putting their hands up, although support advocates would help here, creating a degree of separation from the ME and their delegation role. It would be useful to add statistical reporting to the CAA system in the future to address the most prevalent issues.

It was discussed that most issues arise in between the medicals. It is important for the applicant to understand the importance of reporting, and that they have a good relationship with their Medical Examiner. Education is needed to understand the processes and timelines. Also documentation must use plain english to simplify legal jargon.

Is a Peer support network/advocates beneficial to members to feel safe in disclosing information? NZALPA is an example of a system that has improved over the past two years due to more collaboration. Human Factors are a major component of safety. Samantha is happy to take part in such a group via the Aviation NZ website. The group agreed that a neutral person for members to have a conversation with, without threat, will help this cause. A good Medical Examiner can act as a conduit. Another option is to educate applicants to feel less fearful to raise queries. CAA gives the delegated Medical Examiner authority to place and lift suspension for certain conditions eg: fractures.

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In Summary, the Potential Priorities for the Group from the discussions as recorded on the Whiteboard, were:

- Drugs and alcohol
- Depression
- Cardiovascular issues
- Psychological issues
- Fatigue Management
- Education
 - Medical issues in general
 - Understanding processes and timelines
 - Simplifying legal jargon
- In between medicals
 - Fear of reporting
 - The need for support advocates

This Priority List now appears in Appendix III

AvKiwi Seminars – CAA encourage the Group and its members to attend these sessions. They are approached from a practical Pilot/Air Traffic Controller aspect. Covering topics such as fatigue, drugs and alcohol. http://www.caa.govt.nz/avkiwi/pers_preflight/pers_preflight.html

MBF upcoming seminar on Depression 20 March 2014 (members of the Aviation Medicine Team were attending)

Medical Application Fee

AOPA members wondered why has OMCS been dropped? Why are we paying for things outside certification? AOPA were not successful in their appeal to the Aviation Safety Regulation Review panel. They thought a statute had been breached. The Group feels that we will lose pilots and lose aeroclubs due to the high CAA medical fee. Pilots shouldn't be paying for the bigger picture.

THE FUTURE OF THE CURRENT MEDICAL TEAM

John presented the CAA AvMed diagram which covers existing and potential areas of business for the team. Efficiency issues have been identified within the Aviation Medicine team and these are being worked through.

John also presented the 2014-2015 Business Plan. The plan includes training, education and communication.

RPL and Microlight Certification? Who is responsible for the overview? Balloons and Sports Assn feel cost is a huge issue. John advised that it falls under rules CAR Part 61 (RPL & Balloon) which is currently in review. The process at present includes the SMOs, PMOs, or independent consultants, to become involved if an issue arises within the Personnel and Flight Training Unit, depending on the certification. For RPL applications, a GP who is authorized by NZTA performs the assessment (not a Medical Examiner). The Group agreed it is important to introduce

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younger people into aviation to avoid a diminishing aviation population. Interest in aviation needs to be built upon and the downstream effects are obvious.

ONLINE MEDICAL CERTIFICATION SYSTEM (OMCS)

John read out the notification from Chris Ford (24 December 2013), advising that the OCMS initiative was not being implemented. In its place is a proposal to upgrade the Aviation suite of Safety Management systems (ASMS), a CAA wide project and could integrate the two systems to reduce overall cost, rather than OCMS being a standalone system. All the previous work will be carried over to into the ASMS project.

Ian Andrews wanted it noted that in November 2012 Hon Jerry Brownlee stated that 'CAA is implementing an online portal system'. Was he given the wrong information? The CAA team was unable to answer this. The cost to all ACMLG members and Airlines is high. The outcome is disappointing for the group, including CAA, everyone wanted it to happen ASAP. John read out a time line which indicated a proposed initiation date to be after 31 October, post approval in July.

Herwin Bongers requested, and the meeting agreed, that a recommendation be taken from the meeting, to the Director, requesting the OMCS project be reinstated as a stand-alone project with a high priority and emphasising the concern of the meeting that the OMCS has been dropped and bundled in with the ASMS project.

John confirmed that was an option that was considered but one that CAA decided against. There was a general discussion on the process for Government organizations in terms of acquiring new systems, compared to the private sector where systems could be implemented without the need for such a vigorous process. The group would like to see the costs lowered. They also commented that there was a lack in communication after giving user stories, and that they need to go back to their members and let them down. They stated that they represent 4500 pilots – not one would say they are happy with the fee.

John outlined that that there may be benefit in exploring the private good vs public good argument when the group discusses the issues, or makes submissions to the Director or the Authority Chairman. This may be an area where common ground is identified.

All felt there is a mismatch of private and public good, with the funding review being a year away, they were keen on interim solutions. They feel the split should be based more on passenger levy.

Members of the Group felt the potential risk of avoiding the fee would be that people may choose to fly without valid license. This will have a direct effect on safety.

Comments included CAA exists to protect the public. The user pays for a system they have very little say over. The process costs time and money and a quick win would be better than waiting for a completed system. Samantha (Aviation NZ) suggested a modular approach. The Group understood that an online system needs the ability to pick up anomalies and be robust.

The Group suggested an off the shelf system like Healthlink and another system for a practice management (MedTech) as an interim solution. John communicated that this option does not

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have great potential to be accepted as the decision was already made not to go to an interim system, but would pass the comments on.

GENERAL DIRECTIONS COLOUR VISION DEFICIENCY – Appendix II

Dougal discussed his handout. It was taking a long time for the consultation to conclude due to the GD extension periods. Dougal had written a paper in the Blue Journal (the Official Journal of the Aerospace Medical Association) which looks at variation and disposition throughout the world. Colour vision deficiency can be caused by injury, congenital disease or surgery. The wide range of deficiencies result in different outcomes making it a complex issue. Colour vision issues may not need to come through AMC and therefore could be handled by the Medical Examiner.

PREGNANT PILOTS

Dougal referred to the handout. When is it a decision on safety or one that is seen as discrimination? The Risk profile for pregnant pilots is high in the first and third trimester, lower in the second. The study hopes to provide CAA with a formal check on the current requirements and answer the question - who is safe in an Aviation context? Pregnant passengers have varying restrictions placed on them by different airlines. Another question asked is – how much risk does a pregnant passenger possess? This is outside of CAA's rules and regulation. The practices vary greatly.

MEDICAL MANUAL PROJECT STATUS

The Medical Manual can be found on the website, although not all chapters have been completed. It contains the General Directions. Claude referred to Power Point presentation. Ophthalmology has been sent for editing (industry reviewed and internally reviewed). ENT drafted, under review (industry, internal and ME reviewed), Migraines/headaches, melanoma, kidney stones; first draft completed . Respiratory is being added to from the CASA workshop. The website also has links to CASA and ICAO Medical Manuals. We are writing our own because our legislation is different. It fits within our regulatory system.

Below are forms in review (these were also handed out in draft form):

In flight hearing assessment report: reviewed by Airline Examiners and Flight Examiners.

Headache report (includes Migraine) will help make the call as to aeromedical significance.

Special Eye report post refractive surgery: aging pilots are increasing having this type of cataract operations. We did not have this form before. Some cases of Laser eye surgery may be able to return to flying after 6 weeks. We need good information up front.

Diabetes: awaiting feedback in review.

Assessing against the standard of aeromedical significance. In the example of OSA (obstructive Sleep Apnoea) this does mean more screening or using CV risk to go down that path. As yet, no decision has been made (CASA has a different approach). It was agreed that we need to ensure a fatigue risk management system is in place, easy to diagnose, easy to treat. There are a significant number of OSA cases seen and once diagnosed and treated the buy in is excellent.

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This is due to the transformation of their life post treatment. Once diagnosed it is usually an effective fix.

The Group discussed the difficulty in screening everybody with a BMI of 30, 32 or 40. **Is there a problem with people falling asleep in the aircraft?**

The Group proposed a Collection of data to support OSA being of aeromedical significant based on accident statistics.

Dougal suggested that analyzing in this way is problematic because the OSA may not be the sole reason for an accident. This correlates with the road statistics and co morbidity conditions.

Claude concluded that scoring systems could be an option eg; neck circumference, present symptoms, etc. Presently this is not in any guidelines and it would require consistency.

Tim advised that at Emirates, any pilot with a BMI over 35 is grounded (based on 75% risk of OSA). Benchmark of normal BMI is around 25.

GENERAL DIRECTIONS PROCESS

Judi presented her handout.

LETTER TEMPLATE REVIEW AND DELIVERY PROGRAMME

Letters

Review of letter handout – easier, simpler and clearer to improve communication with all parties. There has been good feedback received on this project by all. The project started in November but due to resource issues it has been delayed. Legal input at the start will hopefully decrease legal jargon issues currently experienced by applicants and organisations.

Notification service

Judi advised this service is available on the website. She encourages the Groups memberships to subscribe to the service. Included are changes in rule parts, medical matters, occurrence reporting, etc.

GENERAL DISCUSSION

Fatigue Management –Herwin suggested that changes to ICAO Annex 6 were not reflected in Rules or AC's. There were a number of recommendations (2006) on flight and duty time limits. 119/2 119/3 part K prescriptions – showing analysis of fatigue – **has this model been incorporated in the branches at CAA?** There is a need for good organizational structure to monitor fatigue, and scientific evidence.

Scott advised the Group that there are engineers working 76 hours a week. There is no medical standard for Aircraft engineers.

ECGs – John B asked whether there is any **tolerance on ECGs?** Dougal confirmed that most machines have inbuilt artificial intelligence. A normal report is accepted if not reviewed by a

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cardiologist. The age of machines can affect the read out and individual circumstances, for example, a young marathon runner would have a slower heart rate than normal with a long interval.

CONCLUSION

John McKinlay thanked all the participants for their input and commitment to the Group. The next meeting will prioritise where time is best spent.

He invited “round the table” comments from the attendees.

Comments:

- Educational
- Recommendations to go to the director ASAP
- useful work for members
- good to see the other industries and similar views and would like to keep it simple
- raised issues, produced solutions, keep moving and motivating
- great forum for communication, initiative and challenges for interim solutions to be looked at would be helpful
- a good day, there were issues that we could spend more time on (OMCS)
- appreciate CAA's input, understanding
- act on removing suspicions and promoting open reporting systems (a big thing that this system suffers from). Grey area is difficult for members and the not good for CAA's image

PROPOSED DATE FOR THE NEXT MEETING

17 June 2014

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Actions Sheet

WHO	WHAT	WHEN	OTHER INFORMATION
Judi Te Huia	Review the option of a gap booklet recommending what an applicant does when a medical issue arises Liaise with CASA to seek an extension of CASA biannual workshop	If accepted, as soon as possible June 2014	
John McKinlay	Recommendation from the Group to have an interim solution that provides immediate relief from the costs of the current certification system. A modular system which can be carried over to the new ASMS	As soon as possible	Tim Sprott may be able to give further information on Healthlink and Medtech. John McKinlay communicated to the Group that this option does not have great potential to be accepted. He would communicate this to the Director and AIP Group Manager
Group Members and John McKinlay	Recommendation from the Group that CAA looks immediately at the public private good split for the medical application fee.	As soon as possible	John suggested to the Group that exploring this area may identify common ground and a potential solution with their subsequent communication to the Director and Chairman.
Group Members	Provide any feedback on the forms while they are in draft	As soon as possible	Email feedback to Claude Preitner for collation
John McKinlay	CAA to actively identify and take part in keeping Fatigue Management as a highlighted issue (ICAO Annex 6)	Completed	Herwin to email relevant referenced documentation to John. Information to then be forwarded to Stephen Hunt for his consideration.
Scott Byers	Fatigue Management issues with Engineers		Email Mark Boyle, CAA
Group Members	Appendix III to be prioritised	June 2014	
Group Members	Provide feedback on Topics for next meeting and consideration to a suitable chair for the Group as John McKinlay was to chair the meeting	Early June 2014	Email feedback to Desrae Martin Desrae.Martin@caa.govt.nz

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	in the establishment phase		
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Appendices

Appendix I: Draft Reports for Review

Appendix II: Review of Letter Templates Project

Appendix III: Topics and Issues for Consideration

Appendix IV: General Directions – Colour Vision Deficiency and Pregnant Pilots

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Appendix I: Draft Reports for Review



DRAFT RESPIRATORY FUNCTION REPORT v10

1. Name:		2. CAA Client No.:																						
3. Postal Address:		4. Date of Birth:																						
5. Certificate(s) applied for: Class 1 <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 3 <input type="checkbox"/>																								
6. ASTHMA PAST HISTORY		c: Date of most recent symptoms: Duration: Frequency:																						
a. Age at first diagnosis: <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>																						
b. In the last 5 years or since the last assessment have you had the following symptoms:		Date you last used your reliever puffer: State any time off work:																						
<table border="0" style="width:100%;"> <tr> <td></td> <td align="center">Yes</td> <td align="center">No</td> </tr> <tr> <td>Recurrent or nocturnal cough</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Exercise-induced wheeze</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Chest tightness</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Cold or infection related wheeze</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Atopy</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Work related chest problems</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> </table>			Yes	No	Recurrent or nocturnal cough	<input type="checkbox"/>	<input type="checkbox"/>	Exercise-induced wheeze	<input type="checkbox"/>	<input type="checkbox"/>	Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	Cold or infection related wheeze	<input type="checkbox"/>	<input type="checkbox"/>	Atopy	<input type="checkbox"/>	<input type="checkbox"/>	Work related chest problems	<input type="checkbox"/>	<input type="checkbox"/>	Has hospital/Accident & Emergency/casualty treatment been necessary? Please give length of stay and treatment needed. <input style="width:100%; height:40px;" type="text"/>	
	Yes	No																						
Recurrent or nocturnal cough	<input type="checkbox"/>	<input type="checkbox"/>																						
Exercise-induced wheeze	<input type="checkbox"/>	<input type="checkbox"/>																						
Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>																						
Cold or infection related wheeze	<input type="checkbox"/>	<input type="checkbox"/>																						
Atopy	<input type="checkbox"/>	<input type="checkbox"/>																						
Work related chest problems	<input type="checkbox"/>	<input type="checkbox"/>																						
If YES, please describe symptoms in "c". →																								
7. ASTHMA MEDICATION (Name):	STRENGTH	DOSE (?Puffs):	FREQUENCY PRESCRIBED: Intermittent <input type="checkbox"/> OR Daily <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																					
8. Applicant's Declaration: I confirm that all the information entered onto this form in response to questions 1 to 8 is true and complete.																								
Applicant's Signature: To be signed in presence of examining doctor.			Date: / /																					
9. EXAMINATION: Does the applicant have:																								
		Yes	No																					
Expiratory Wheeze	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please give details or provide report: <input style="width:100%; height:80px;" type="text"/>																					
Atopic features	<input type="checkbox"/>	<input type="checkbox"/>																						
PF Diary (>15% diurnal variation)?	<input type="checkbox"/>	<input type="checkbox"/>																						
Spirometry pre and post SABA (attach) (FEV1>12% OR >200ml increase)	<input type="checkbox"/>	<input type="checkbox"/>																						
Respiratory Physician's report requested (if PF and Spirometry suggest instability)	<input type="checkbox"/>	<input type="checkbox"/>																						
IMPORTANT: Please attach above results with this report.																								
10. ADDITIONAL REMARKS: What further actions have you taken/recommended to the applicant? <input style="width:100%; height:40px;" type="text"/>																								
11. CLASSIFICATION (Refer xxx): Excellent Control <input type="checkbox"/> Good Control <input type="checkbox"/> Moderate Control <input type="checkbox"/> Poor control <input type="checkbox"/> Indeterminate <input type="checkbox"/>																								
12. Print Examiner's Name and Address (Practice Stamp Preferred)		13. Client's ID: Indicate the type of photographic ID sighted, serial number and expiry date.																						
<input style="width:100%; height:40px;" type="text"/>		<input type="checkbox"/> Client's photographic ID sighted at the medical examination.																						
		14. Examiner's Declaration: I hereby certify that I personally identified and examined the applicant named on this medical report and that this report, with any attached notes, embodies my examination completely and correctly.																						
Telephone Number:		Examiner signature: Date: / /																						
Facsimile Number:																								

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CAA **DRAFT**

IN FLIGHT HEARING ASSESSMENT REPORT

To be completed by a Category A or B Flight Instructor or Airline Flight Examiner

1. Name:		2. CAA Client No.:	
3. Postal Address:		4. Date of Birth:	
5. Licence Held		6. Experience (hours)	
7. Medical Certificate(s) applied for: Class 1 <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 2-No IFR <input type="checkbox"/>		8. Applicant's Signature: To be signed in front of the instructor / examiner Date / /	

9. AIRCRAFT OR SIMULATOR TYPE:		10. HEADSET TYPE USED:	
a. Aircraft Type?	<input type="text"/>	a. Active Noise Reduction (ANR) Yes <input type="checkbox"/> No <input type="checkbox"/>	
b. Registration	<input type="text"/>	b. Make	<input type="text"/>
c. Simulator Type?	<input type="text"/>	c. Model	<input type="text"/>
Simulator to be Category D, set at maximum noise level.			
11. HEARING AID USE: on the ground		12. HEARING AID USE: in flight	
Yes	No	Yes	No
Left ear <input type="checkbox"/>	Right ear <input type="checkbox"/>	Left ear <input type="checkbox"/>	Right ear <input type="checkbox"/>

13. TEST FLIGHT DETAILS	
a. Airport of Departure <input type="text"/>	b. Route <input type="text"/>
c. Duration of flight <input type="text"/>	
d. Controlled Airspace: Yes <input type="checkbox"/> No <input type="checkbox"/>	

15. SATISFACTORY / SAFE PERFORMANCE?			14. Comments: Must include interaction with an ATS provider, or a simulated interaction in the case of flight simulator.	
	Yes	No		N/A
a. Communication within cockpit with intercom	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
b. Communication within cockpit without Intercom	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
c. Automatic Terminal Information Service (ATIS)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
d. NAVAIDS (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
e. ATS Communication – Standard Phraseology	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
f. ATS Communication – Non Standard Phraseology	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
g. Cockpit Auditory Warnings	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
h. Traffic Awareness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
i. Overall impression on hearing performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

16. CONTEMPORARY ADDITIONAL INFORMATION: Please attach if any: (i.e. PPL / CPL / BFR / IFR flight test report).

17. Instructor / Examiner's Flying Organisation and Address (Stamp if any)	18. Instructor / Examiner's CAA ID, license and rating
19. Instructor / Examiner Declaration: I hereby certify that I personally identified and assessed the applicant named on this report and that this report, with any attached notes, embodies my examination correctly.	
Tel: <input type="text"/>	Signature: <input type="text"/> Date: <input type="text"/>

Please forward this form to the Medical Team, CAA, PO Box 3555, Wellington 6140, with a copy to the ME, if known.

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CA

DRAFT

HEADACHE REPORT v4

1. Name:		2. CAA Client No.:																												
3. Postal Address:		4. Date of Birth:																												
5. Certificates applied for: Class 1 <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 2-No IFR <input type="checkbox"/> Class 3 <input type="checkbox"/>		6. Applicant's Signature: <i>(To be signed in front of examiner)</i> Date: / /																												
7. HISTORY Date of first attack: <input type="text"/> Date of most recent attack: <input type="text"/> No. of headaches in last year: <input type="text"/> How long does an attack last? <input type="text"/>		8. MEDICATION For symptoms: <input type="text"/> <i>(List all medication and dose)</i> For prevention: <input type="text"/>																												
9. DESCRIPTION OF THE HEADACHE <i>(in applicant's own words)</i> 																														
10. SEVERITY CRITERIA: Pain intensity 1 _____ 10 <i>(pl mark on line)</i> (Mild) (Severe) <table border="0"> <tr> <td></td> <td align="center">Yes</td> <td align="center">No</td> </tr> <tr> <td>Avoidance of routine activity</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Distracting</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Nausea</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Vomiting</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Photo / phonophobia</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Motor or sensory features</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Aura</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Acute medical / hospital treatment needed</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> </table>			Yes	No	Avoidance of routine activity	<input type="checkbox"/>	<input type="checkbox"/>	Distracting	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Photo / phonophobia	<input type="checkbox"/>	<input type="checkbox"/>	Motor or sensory features	<input type="checkbox"/>	<input type="checkbox"/>	Aura	<input type="checkbox"/>	<input type="checkbox"/>	Acute medical / hospital treatment needed	<input type="checkbox"/>	<input type="checkbox"/>	Please give details of any positive answers and degree of incapacity: 	
	Yes	No																												
Avoidance of routine activity	<input type="checkbox"/>	<input type="checkbox"/>																												
Distracting	<input type="checkbox"/>	<input type="checkbox"/>																												
Nausea	<input type="checkbox"/>	<input type="checkbox"/>																												
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>																												
Photo / phonophobia	<input type="checkbox"/>	<input type="checkbox"/>																												
Motor or sensory features	<input type="checkbox"/>	<input type="checkbox"/>																												
Aura	<input type="checkbox"/>	<input type="checkbox"/>																												
Acute medical / hospital treatment needed	<input type="checkbox"/>	<input type="checkbox"/>																												
IMPACT ON ACTIVITY: Minor Distracting <input type="checkbox"/> Distracting (able to continue but may impair performance) with NO severity features.		Major Distracting <input type="checkbox"/> Continue activity but distracting, plus ONE severity criterion.																												
		Incapacitating <input type="checkbox"/> Unable to continue routine activity.																												
11. PREDICTABILITY FACTORS Patterns Premenstrual <input type="checkbox"/> Yes <input type="checkbox"/> No Contraceptive Pill <input type="checkbox"/> Yes <input type="checkbox"/> No Weekends <input type="checkbox"/> Yes <input type="checkbox"/> No Triggers Foods / drinks / other <input type="checkbox"/> Yes <input type="checkbox"/> No Warning signs (pain/vision/tingling etc): Do you have warning of the headache? <input type="checkbox"/> Yes <input type="checkbox"/> No How long before the attack? <input type="text"/>		Please give details of any positive answers: Describe the warning: 																												
12. ADDITIONAL INFORMATION – please attach to this questionnaire. GP Records <i>(required if obtainable)</i> <input type="checkbox"/> Neurologist <input type="checkbox"/> Special Eye Report <input type="checkbox"/> Other <input type="checkbox"/> <i>(please specify)</i>																														
13. Print Examiner's Name and Address <i>(Practice Stamp Preferred)</i> Fax: Tel:		14. Client's ID: <i>(Indicate the type of photographic ID sighted, serial number and expiry date.)</i> 15. Examiner's Declaration: I hereby certify that I personally identified and examined the applicant named on this medical report and that this report, with any attached notes, embodies my examination completely and correctly. Examiner signature: _____ Date: _____																												

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CAAF DRAFT

SPECIAL EYE REPORT – Post Refractive Surgery

To be completed in addition to the special eye report on the first occasion the applicant presents post operatively

1. Name		2. CAA Client No							
7. Operation undertaken (Please attach copy of operating report). Date: / /									
	Right eye	Left Eye							
	Right eye	Left Eye							
Radial Keratotomy	<input type="checkbox"/>	<input type="checkbox"/>	Cataract Extraction						
PRK	<input type="checkbox"/>	<input type="checkbox"/>	IOL monofocal						
LASIK	<input type="checkbox"/>	<input type="checkbox"/>	IOL multifocal						
LASEK	<input type="checkbox"/>	<input type="checkbox"/>	Other intra-ocular procedure						
Other corneal procedure	<input type="checkbox"/>	<input type="checkbox"/>							
(Please describe the other procedures)									
8. PRE OPERATIVE VISUAL ACUITY									
	Distance			Intermediate (100 cm) Class 1 and 3			Near (30-50 cm) Class 1, 2 and 3		
	Right	Left	Both	Right	Left	Both	Right	Left	Both
Uncorrected VA	6/ <input type="text"/>	<input type="text"/>	<input type="text"/>	N <input type="text"/>	<input type="text"/>	<input type="text"/>	N <input type="text"/>	<input type="text"/>	<input type="text"/>
Required if this is a first application									
9. REFRACTIVE CORRECTION APPLIED									
	Right				Left				
POST OPERATIVE CORNEAL THICKNESS (for refractive corneal surgery of more than 3 dioptres correction)									
	Right				Left				
12. SERIAL VISUAL ACUITY SINCE THE OPERATION (Must be completed if the operation was undertaken in the last 6 months):									
Date	Right eye	Left eye	Comments / Stability						
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>						
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>						
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>						
14. STABILITY OF REFRACTION, EYE MEDICATION, ADDITIONAL COMMENTS, SURVEILLANCE PROPOSED. (Please attach copies of any correspondence or reports to other health professionals)									
17. Examiner's Declaration: I hereby certify that I personally identified and examined the applicant named on this medical report and that this report, with any attached notes, embodies my examination completely and correctly.									
Telephone Number				Examiner signature			Date / /		
Facsimile Number									

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DRAFT

1. Name:	2. CAA Client No.:
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8. EXAMINATION							
a.		b. Pulse	Yes	No	c. Peripheral Nervous System	Yes	No
Weight (kg)	<input type="text"/>	Peripheral pulses present	<input type="checkbox"/>	<input type="checkbox"/>	Microfilament sensation (Feet)	<input type="checkbox"/>	<input type="checkbox"/>
Weight change (kg)	<input type="text"/>	Absence of Bruits	<input type="checkbox"/>	<input type="checkbox"/>	Vibration sense (Feet)	<input type="checkbox"/>	<input type="checkbox"/>
BMI	<input type="text"/>	Blood Pressure (Standing)	<input type="text"/>		Reflexes (Legs)	<input type="checkbox"/>	<input type="checkbox"/>
		Blood Pressure (Lying)	<input type="text"/>		Evidence of Neuropathy (Hands)	<input type="checkbox"/>	<input type="checkbox"/>

INVESTIGATIONS					
Albumin/creatinine ratio	<input type="text"/>	Fasting Lipids	Date: / /		Hba1c
Micro Albumin	<input type="text"/>	Cholesterol	<input type="text"/>		1. <input type="text"/> Date: / /
Uric acid	<input type="text"/>	Triglyceride	<input type="text"/>		2. <input type="text"/> Date: / /
		Date: / /	<input type="text"/>		3. <input type="text"/> Date: / /
Creatinine	<input type="text"/>	HDL-cholesterol	<input type="text"/>		4. <input type="text"/> Date: / /
eGFR	<input type="text"/>	Chol/HDL chol	<input type="text"/>		
		LDL-Chol (calc)	<input type="text"/>		
Comments on self-monitored glucose tests (i.e. hypos / stability etc) If on Sulphonylurea or Insulin, please include a print out of all the self-monitoring readings for the past one year.					

10. SUMMARY – OPINION					
Prescription <input type="checkbox"/> Diet <input type="checkbox"/> Sulphonylurea <input type="checkbox"/> Glitazones <input type="checkbox"/> Insulin <input type="checkbox"/> Metformin <input type="checkbox"/> Other	Control <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Sub Optimal	Cardiovascular Risk Yes No >10% at 5 years <input type="checkbox"/> <input type="checkbox"/> Target Organs Damage <input type="checkbox"/> <input type="checkbox"/> Stress ECG Date: / /			
Full tracing and report to be provided					

11 ADDITIONAL REMARKS: (Comments or further action recommended.)

12. Print Examiner's Name and Address (Practice Stamp Preferred)	13. Client's ID: Indicate the type of photographic ID sighted, serial number and expiry date. Client's photographic ID sighted at the medical examination.
Telephone Number: Facsimile Number:	14. Examiner's Declaration: I hereby certify that I personally identified and examined the applicant named on this medical report and that this report, with any attached notes, embodies my examination completely and correctly. Examiner signature: _____ Date: / /

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Appendix II: Review of Letter Template

Review of Letter Templates and Delivery Programme Applicants, Participants and Medical Examiners				
Providing Quality, Informative and Easy to Read Information Delivered through Technology	Vision Medical will have high quality information resources that meets the CAA Plain English Standard and adaptable to environmental changes.	Objective To provide applicants, participants and Medical Examiners with information that leaves them with clear, concise, connected and confident messages delivered in a timely manner.	Supported By Medical Business Plans contribution to the CAA Strategic Priorities	
	The Business Drivers - Why Change?	Who will this change affect?	What is the plan?	Identify the Risks
	Future Technological Changes - A proposed CAA Online Medical Certification System - A proposed Aviation Safety Management System	Applicants - Receive clear communications - Remove the receipt of duplication (email & post) - Receive information electronically Participants - Receive clear communications - Remove the receipt of duplication (email and post) - Receive information electronically - Encouraging up to date contact details Medical Examiners - Time Reduction handling paper based documents - Eliminate receiving additional paperwork - Remove receipt of duplication (email & post) - Reduce paper storage Medical Team - Reduce repetition of information being sent out from Medical (email & post) - Reduce electronic storage CAA Management/Corporate - Reduced postage costs - Reducing returned mail costs Organisations - Faster Notification	Involves: - Subject Matter Experts - CAA Legal Representative - CAA Approved Write it Right Assessor Consult with: - Medical Team - Consultation Group (representatives from ME's) - Manager, Personnel and Flight Training - Manager, Records and Information Management Timeframe: January 2014 – June 2014 Process: PDCA Key Deliverables: - Letter Templates Review - see attached schedule - Email Protocol development and implementation -see attached schedule Communications: Internal - Team Meetings, Emails, Subject meetings External - Consultation Group, Notification to the ACLMG	No ownership - No buy in or engagement from internal or external parties Lack of Training - Not all staff have attended the "Write it Right" programme Consultation - Not enough consultation with the appropriate people Timeframes - Are too tight and progress is not managed or reviewed.
	Environmental - National and International business changes e.g. New Zealand Post's reduction in street postal deliveries - Implementation of the CAA Write it Right Programme Process Review - Reduce time wastage - Elimination of repetition - Simplified process - Clear messages - Use of current technology - Future proofing Stakeholders - Communication is largely by email - Most Medical Examiner practices work electronically - Of the assessments sampled, 80% of participants have consented that their preferred method of written contact is by email			Risk Mitigation <ul style="list-style-type: none"> Acceptance, approval by management Assign responsibility Staff Training Communication and change management Effective monitoring and managing progress
			Drafted by Team Leader, Medical Certification Approved By Manager, Personnel and Flight Training November 2013 updated 26/03/2014	

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Appendix III: Topics/Issues Prioritised for Consideration (summarised from Page 4)

- Drugs and alcohol
- Depression
- Cardiovascular issues
- Psychological issues
- Fatigue Management
- Education
 - Medical issues in general
 - Understanding processes and timelines
 - Simplifying legal jargon
- In between medicals
 - Fear of reporting
 - The need for support advocates

Additional Topics from the Inaugural Meeting for considerations in the Future

- Efficiency
- Benchmarking with CASA (Rajib – on-going medical discussions)
- Cost – overall medical costs – downtime – all specialist costs
- Pre-approved CAA specialists e.g. cardiologist, for AMC
- Performance measurements / metrics – AMCs (numbers) – reduce fear factor – fair
- Renewals – periods 6 months, 2 years, 5 years- different to CASA single pilot over 40
- CPL (B) Class 2?
- Risk levels 1,2,5% - trigger point for further investigation
- Health and safety
- Geographic locations of MEs
- Is the current system, delivering what was intended? – Coroner? Minister? MoT?
- Flight training – aged instructors with Class 1? Policy issue?
- Away from paper base to online = clarity? Better efficiency? Get out there and enjoy it
- ATC downtime with decision, difficult pressure from ATC and Manager's perspective
- Consistency, procedural consistency – people not isolated but treated as others
- MEs – online certifications – Act – consistency, education, performance, monitoring – ambiguity standards/system – flexibility - Medical Manual, guidance on common conditions
- Claude – CA Act, simple, review
- Customer service survey – perception

Appendix IV: General Directions – Colour Vision Deficiency and Pregnant Pilots

2014.03.11 Status

General Directions: Colour Vision Deficiency

Several previous rounds of public consultation.

Delays and changes during that periods => Revision and another round of public consultation

04 July 2013: Draft GD (http://www.caa.govt.nz/medical/gd_colour_vision.pdf) opened for public consultation

Several submissions received.

Currently scheduled consultation closure 31 March 2014

Cochrane Review: Pregnant Pilots

The issue of pregnant pilots, as well as pregnant passengers, came to the fore late in 2012 and early in 2013.

CAA decided to seek for a formal review of the medical knowledge base on matters related to pregnancy.

Auckland University Cochrane Group was contacted and initial exploration of the issues and options was undertaken.

Pregnant professional pilots: literature review

Objectives:

To summarise current medical evidence relating to the effects and complications of pregnancy that may relate to aviation safety and that may result in reduced functional capacity, incapacitation, or unsafe behaviour.

Methods

Inclusion criteria:

- Studies that report the incidence of common effects and complications of pregnancy
- Include (in order of preference) systematic reviews, registry data, prospective population-based cohort studies.
- Include lower-level studies (e.g. retrospective, case-control) if no data available from studies with higher level of evidence
- Include any relevant NZ data
- Exclude unpublished and ongoing studies, studies without at least abstract in English

Search:

- Online databases (including MEDLINE/PubMed, Cochrane Library, CINAHL, PsycINFO, Web of Science, TRIP, EMBASE)
- Google keyword search
- reference lists of articles retrieved

[Search designed in consultation with Cochrane review group information specialist]

Review outcomes

Likelihood and manifestation profile of common complications of pregnancy, including:

- miscarriage

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- fatigue
- nausea and vomiting
- other systemic changes related to pregnancy (e.g. discomfort, back pain, increased abdominal girth/mobility problems)
- bleeding
- venous thrombosis
- mental health disorders
- pre-eclampsia and eclampsia
- premature labour

Format of report

- Summary of objectives, methods and search strategy
- Table of findings of eligible studies grouped by outcomes (ref, design, sample size, findings (incidence and manifestation profile), effect estimates if reported in studies, quality rating for evidence)
- Narrative summary of findings, organized by outcomes
- Interpretation of findings, discussion of any discrepant findings
- References

PDFs of included studies to be supplied

14 October 2013 CAA joined in a contract with Uniservices Auckland, for ...

Services Description

A review

The purpose of this project is to obtain, analyse, and report on the current medical evidence relating to the risks and manifestations of pregnancy that may relate to aviation safety. This review should include consideration of complications and manifestations that may result in reduced functional capacity, incapacitation, or unsafe behaviour. This should include, but not be limited to, the following:

- Miscarriage – likelihood and manifestation profile;
- Fatigue, nausea, discomfort, and general systemic features;
- Abdominal girth and mobility;
- Pre-eclampsia / eclampsia;
- Premature labour - likelihood and manifestation profile.

The report should include a full reference list (any widely used formal publication citation format) and copies of the references reviewed.

The report should, wherever possible, focus on population data that best relates to New Zealand but should also not be blind to data relating to other cultures. The majority of pilots licensed and certificated by the CAA are from New Zealand but a significant number are from elsewhere.

Where possible statistics and their confidence ranges should be referenced. Where interpretation of data invites differing conclusions the likely sources / causes (e.g. subject selection criteria) of those differences should be discussed.

The report should avoid attempting interpretation of the data in an operational aviation context. For example, the implications of increasing abdominal girth may vary widely with differing types of aviation activities.

The protocol for the report will be submitted to the CAA by the 20th of December 2013 to which any comments or feedback can be provided.

The final report will be submitted to the CAA by the 30th of March 2013

Status: Draft report has just arrived and is currently under review. Feedback anticipated by the end of this week, and contract fulfilment looks likely to be on time (30 March 2014 is the correct date).