THE AVIATION COMMUNITY MEDICAL LIAISON GROUP
– Meeting Minutes

DATE: Tuesday 21 October 2014

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

TIME: 1000-1500

PRESENT:

- Ben Johnston, Medical Officer – AMSNZ
- Bruce Burdekin, Representative - Sport and Aircraft Association NZ Inc
- Claude Preitner, Senior Medical Officer - Civil Aviation Authority of NZ
- Cam Lorimer, Representative - NZ Airline Pilots Association
- Desrae Martin, Administrator - Civil Aviation Authority of NZ
- Dougal Watson, Principal Medical Officer - Civil Aviation Authority of NZ
- Herwin Bongers, Medical Director – NZ Airline Pilots Association
- Ian Andrews, President - Aircraft Owners and Pilots Association of NZ
- John McKinlay, Manager – Personnel and Flight Training
- Judi Te Huia, Team Leader, Medical Certification – Civil Aviation Authority of NZ
- Kim Smith, Airways NZ
- Rajib Ghosh, Senior Medical Officer - Civil Aviation Authority of NZRichard Small, Representative – Flying NZ, Royal New Zealand Aeroclub, NZ Aviation Federation
- Stephen Brown, Medical Executive Member – Aircraft Owners and Pilots Association of NZ
- Samantha Sharif, Chief Executive – Aviation New Zealand
- Simon Ryder-Lewis, Specialist Occupational Medicine – ATC Mutual Benefit Fund

APOLOGIES:

- Sue Telford, President – NZ Women in Aviation

AGENDA

Welcome and Introduction

John McKinlay

John welcomed attendees, no new members attended.

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ACTIONS FROM THE PREVIOUS MEETING

All actions were updated on the Actions Sheet.

TOPICS FOR CONSIDERATION

EDUCATION

Peter Singleton (Editor and Webmaster) answered questions from the floor.

Herwin represents HIMS and employer groups referencing drugs and alcohol. Could a reminder about HIMS be inserted with *Vector* magazine to raise awareness – is this open for discussion?

Peter said that this has been discussed with the HIMS group. Originally he thought that the pilot bookmark for logbooks could not be used, but said this is now a possibility when it comes up for reprint, using one side for the HIMS message. Inserts should only be used occasionally, or they lose their impact, but this could be a suitable use for an insert with *Vector*.

Peter also said that *Vector* has carried articles promoting HIMS, and would be happy to do this from time to time.

Ian would like the CAA to take out paid advertising in the AOPA New Zealand magazine. He suggested using the "I'm Safe" poster for this. He believes it would be better advertising than a fridge magnet and that it would be nice to get something back from CAA. Links and newsfeeds would be available via their web site also. He recently attended a conference where promotional information is becoming more digital than written. The CAA could be contributing to some of the costs Ian said.

Bruce would like something similar on their (AOPA) back page. He doesn't see *Vector* magazines lying around offices visited (Ian agreed), although *Sport Flying*, *Kiwi Flyer* and *Aviation News* are visible indicating a wide readability.

Peter said that this has been discussed before on several occasions. Safety Promotion has no budget for advertising. *Vector* is sent to every aviation document holder, and that includes every New Zealand registered aircraft owner, so he believes that audience is covered. He said that if they had any budget for additional promotion, how it was used would be carefully scrutinised to make sure that there was value for money.

Peter thanked the group for suggesting additional links to the information on the CAA web site about pregnancy. The links were done as soon as the suggestion was received.

ACT REVIEW UPDATE

Felicity Steel (Senior Policy Advisor) discussed the Act Review she is co-ordinating CAA's response to the Act review. Here is a link from the CAA website to MoT http://www.transport.govt.nz/air/caa-act1990-aa-act1966-review-consultation/ Public consultation ends 31st of October. We will be making submissions. MoT led this review of both CAA and the Airport Authority Acts. This is a once in 25 year opportunity. Open forums have been held and it is a five part document with Medical

Certification issues in Pt B of the document. Medical is the most recent part of the Act (Part 2a of the Act)

1. **Certification pathways and stable conditions** – ordinary pathway and use of flexibility pathway. Eg; Loss of a finger – without the need to go through the AMC process or a long term condition which has subsequently been resolved. We welcome comments on these, please make a submission.

   Feedback

   a. Ian Andrews raised PRNC and SODA are potential solutions, a submission will be made. If we can support this it is a useful way to go.
   b. Ben discussed conditions no longer of aeromedical significance; he is concerned about PRNC, the way that AMCs are used by MEs. Could additional pathways make this more difficult? Felicity advised the Group to place submissions for all concerns.
   c. Dougal said we need to see what the MoT produce, as the devil is in the detail.
   d. Felicity discussed that the Board is providing a submission and it will be available publicly after the 31st of October. We do support changes with flexibility within the Act. We need clear feedback.
   e. John asked whether we do this individually or via our organisations. CAA is bound by legislation which diminishes our latitude.
   f. Ian advised that consultation is great although with other consultations occurring simultaneously it can be difficult. Get your submissions right.

2. **Other State Recognition** - Policy work on this is quite difficult but the Director is very keen to discuss this to reduce compliance costs.

   Feedback

   a. Herwin raised differences in Colour vision standards with other ICAO States
   b. Felicity identified questions such as how do we monitor someone who enters the system this way? There is a floodgate potential, it's big.
   c. Herwin said that the Gatekeeping stage is CAAs role. At what point do we know that there is an element of oversight? Would contracting-out be an option?
   d. Dougal advised again that the devil will be in the detail.

3. **Medical Convener**- CAA would like to keep the process and this is supported by the board.

   Feedback

   a. Ian would like to see the convener role improved to be more as a tribunal before you get to the court process. Felicity replied that the cost will be extremely expensive and the solution may be across all transport modes.
   b. Stephen asked about conflicts of interest and will submit a response.
   c. Bruce said that everything resides with the Director. Dougal did not agree, it is extremely transparent process and a review can be held at any time. The District court can replace the decision. Ian identified feedback from his group is that it is difficult for the decision to be overturned.
   d. Felicity discussed that MoT are looking at redrafting and we are unsure as to the extent of this, it would be a really big job. We would keep an eye on this regards no change in intent.
   e. Dougal said that the select committee looked widely at other models in use and this system has been going for about 12 years. It is very cost effective (no direct cost to the applicant) and quite responsive with conclusions resolved in about 6 months.

f. Ben asked how the convener is funded? John replied that the Convener has a three yearly appointment and needs aviation medicine experience. The MoT invoice CAA. The Convener makes the decisions and a deputy peer reviews.
g. Richard advised that technology changes impact rules. Rules in areas where we are performance based will be more flexible for longer.

FATIGUE MANAGEMENT

John presented the Fatigue Management Issue Assessment Paper (Appendix with additional information on http://www.caa.govt.nz/rules/Rule_Dev_Process/IAG_3_Fatigue.pdf). A Risk Management system initially developed by the Policy and Systems Interventions teams. A CAA Fatigue Management Working Group will be formed. Terms of reference will be written. ALPA have volunteered representatives who experts in the field. The first objective is to work on the revised Advisory Circular. Overseas documentation will be incorporated into the system and the first meeting is in November with documentation out within the month.

Feedback

a. Ben offered input from Air NZ. John is still looking into Working Group members and invitations are to be sent.
b. Stephen asked about GA non-commercial? John said it does allude to GA and private in the documentation, CAA welcomes any views or thoughts.
c. Bruce asked whether we are reinventing the wheel? MoT (for bus drivers) has a good fatigue management system in place (some members of the group did not agree with this statement.)
d. John reflected that the Working Group will deal with issues in manageable chunks, perhaps airline and transport first. Again, he welcomed any suggestions.
e. Herwin suggested that Vincent Aviation's work in the Air Ambulance scope, based on FRMS, would help. OSA is subservient to a proper fatigue system. In Appendix 2, CAR 172 is identified as a low risk? Evidence in employment contracts contradicts this. John replied that CAA look forward to gaining more information as we work through this.
f. Kim asked what is covered by the phrase 'potential for fatigue to affect flight safety?' Ian and Mike Groom (ACAG) are working on system and will share it around AOPA, where they will start publishing actual documentation. John was keen to get as much on the CAA website as soon as possible.

OBSTRUCTIVE SLEEP APNOEA (OSA)

Dougal presented the MIS (http://www.caa.govt.nz/medical/Med_Info_Sheets/MIS022.pdf). He had also hosted and attended a harmonization workshop on this recently.

Feedback

a. Ben commented that OSA can be taken as an accusation of weight issues and can be a difficult discussion with the applicant. He would like the rules to be more prescriptive to avoid comments such as 'Where does it say that I have to do this?' Stephen said that some thin people have OSA. Dougal advised that the MIS document balances all of the medical information.
b. Richard asked whether any hard data is being produced to indicate who requires CPAP in conjunction with a sleep medicine specialist? Dougal replied that there are

no hard and fast numbers, CAA are not using neck circumference, and BMI is used on a case by case basis.

c. Does an applicant need to reach and certain point and have to have testing? Stephen added that the document has a wide range of interpretation. FAA and perhaps CASA have brought in such a requirement.
d. Going forward, Claude added that the Respiratory Chapter in the Medical Manual also covers this, based on guidelines from the MoH. Dougal added that there is no simple measurement for fatigue/OSA such as a blood test. Sleep deprivation can be measured biochemically but there are a wide variety of issues with OSA.

CARDIOVASCULAR MATTERS

Ian discussed that the roadshow raised issues of Medical costs in relation to CVR and a retired cardiologist hired as consultant. He reiterated his previous example on costs (previous meetings) to a pilot flying 100 hours per year $11784. Questions raised were whether there is a need to bring in other cardiologists? Could all tests done by one CAA approved cardiologist? Or a list of acceptable cardiologists? Could a pool of cardiologists be used for initial consultation to avoid the review process? The costs are high for pilots. Are we over-regulating for recreational private pilots? Stephen asked for input from this group. He was concerned about the advice given from a non-active specialist. Feedback from other groups using long in the tooth cardiologists is that they are not making good decisions. There are vast differences between a licensed Bus driver carrying 45 children (under MoT) vs a licensed Pilot visiting mother in his private plane (CAA Medical.) MoT look at cross mode comparisons. A Parliamentary Rule put cardiovascular risk into aviation. The NZTA handbook indicates a taxi driver is almost the same as a PPL license holder. What is different is interpretation. The Class 2 Medical is very costly. Ben thought we are over testing. Ian reflected on previous years (when Dougal first started) where potential for a lower standard of medical (Class 4) was raised. It was prior to RPL.

Feedback

CAA doctors replied that review is part of the process and part of how we do business. Review meets the standards (independent body to review), and Dougal is responsible for the advice given from the Medical Team.

Rajib provided feedback from CAA. We do not disqualify on age, our consultant cardiologist remains current and active. There are many examples of his skill and domain expertise. There is a process in place to contract a larger team of cardiologists. CAA has complete confidence in their current cardiologist. CAA process is to use the least expensive tests in the first instance, only 1% of cases need a stress myocardial perfusion scan in addition to the regular process of a stress ECG, followed by a stress echo, to requiring a stress perfusion scan. FAA directs a stress perfusion scan from the outset.

Dougal referred to feedback from the Coroner, court cases and review feedback as always being superb. Claude had many examples of lives being saved. There have also been many

cases where our consultant cardiologist confirms a normal report from an abnormal. The review process creates consistency.

Discussions followed on possible study topics the Group thought would be useful:

- Statin (drop dead) statistics in aviation (Stephen)
- Pilot incapacitation due to cardiovascular reasons (accidents have not been caused in decades (Ben)
- Societal risk acceptance project for CAA (Rajib). Class 1 Agricultural but potential to extend to others. National and International acceptable risk in aviation. Clinical condition converted to risk percentage, you need an understanding/definition of acceptable risk beforehand.
- Class 2 (Stephen)
- Multi-tiered system, society's tolerance for risk (Herwin)
  It is a changing world. We are too risk averse. The cycle of risk is changing all the time. The group would like cardiovascular risk, reducing the number of tests and a lower risk level between commercial pilots and class 3 certificate holders. To be placed for discussion on the next agenda.

AVIATION RELATED CONCERNS

Roger Shepherd and Steve Pawson presented an overview of the ARC process.

The data is qualitative not quantitative. The process is designed to capture information on a potential risk prior an incident occurring. An ARC is separate to Part 12 mandatory reports and can be wide ranging in nature. Upon receipt they are recorded, tracked and feedback provided where possible. Recommendations are provided to relevant units and stakeholders.

Feedback

Samantha asked what action is taken on spurious complaints? The operational perspective is recorded as inconclusive – guilty until proven innocent. We are worried about complaints where people may not have done anything wrong. We need to ensure the process is carried out acceptably. The outcome of inconclusive vs dismissed needs to be recorded and communicated.

Roger confirmed CAA applies the principals of natural justice and is careful to convey to the person that it stops there. Otherwise we "keep lifting the rocks to see what is underneath". The submitter is contacted where applicable and advised CAA was unable to prove the accusation. If further information comes to light it will be reviewed, as this may be relevant from another perspective.

Bruce raised concern over direct complaints where wind and light may have created a situation which was not the way the complainant perceived it.

What happens with drug and alcohol complaints? Steve advised that if an ARC is raised CAA will investigate these concerns under the usual process, normally in consultation with the Principal Medical Officer. Medical records may need to be reviewed and this is handled on a case by case basis. If a concern is raised anonymously, the submitter cannot be contacted as to outcome. Not all complaints become ARCs, and this consideration is aided by the triage process. Some issues may be raised directly to other units.

AVIATION COMMUNITY

Discussion by Richard Small – Misconceptions. Removing mystery and suspicion.

How many specialist reports do you require a year? Dougal was unable to answer this but estimated a fraction of a percent. Cardiology, neurology and psychology are CAAs main reports. Only complex cases are requested. Feedback can be skewed as complaints are generally more verbalized than compliments.
Richard asked that CAA starts at the lowest level of cost for tests (ECG to Stress to Perfusion, etc). If this could be placed in Vector, it would show that the CAA cardiology process is clear (demystified) and fair.
Approximately 90% of certificates are issued by the Medical Examiners at assessment. 10% are sent to us for AMC, of that 90% of AMCs are ME expert and 10% of AMCs are Director Expert.
Communicate a reminder to Applicants to use Med@caa.govt.nz for emails not a specific person in Medical (there have been instances where no reply is received due to conferences, etc). CAA will discuss this with the Webmaster. Richard will be reiterating this in his newsletters.

GENERAL DIRECTIONS

MEDICAL MANUAL PROJECT can be found on the CAA website
http://www.caa.govt.nz/medical/Medical_Manual.htm

Opthalmology consultation closed with very few comments. Pathways for the ME to decide whether to make an AMC application.
ENT chapter is under consultation. The amended version will possibly go live on line by Christmas.
Respiratory chapter is awaiting feedback by a respiratory physician.
Neurology chapter is at the internal review stage.
Cardiology chapter is being started.

TEMPORARY MEDICAL CONDITIONS WHICH DO NOT REQUIRE REPORTING. The Legal team have taken up this challenge. We need to identify a number of conditions which do not need reporting, this will be beneficial to all, eg; hernia, vasectomy, off work for a couple of weeks, grounded for this time and then no longer required. Currently the Act does provide for this, but the general direction is yet to be formalized.

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GENERAL DISCUSSION

ICAO – Ian discussed Dougal's Paper (Tony Evans, Dougal Sally Evans) on SMS. Does CAA back this? Dougal suggested to raise this issue with ICAO. The paper is not law, only advisory.

SUMMARY

Ian suggested that this Agenda focused on presentations on too many non-medical issues. Focus on medical only as the cost is high for attendees.

Bruce would like clarity on refunds for those pulling out of medical application fee. John replied that work is being done in this area and he will provide feedback.

Stephen asked about FPP assessments, which are done for every document holder. John advised it is not a one size fits all. Assessments are done by the Unit responsible in an attempt to prevent future issues. DICs were discussed briefly by Ian and requested to be on the next agenda. They do not always require CDT testing.

- Subjects to be discussed further at the next meeting:
  - Fatigue Management (update from the Working Group – John McKinlay)
  - DIC (as raised by Ian Andrews in the summary)
  - Refunds of the Medical Application Fee (update by John McKinlay)
  - Society Risk Tolerance (from CVR discussion and study topic)

DATE FOR THE NEXT MEETING

17 February 2015

Actions Sheet

WHO	WHAT	WHEN	OTHER INFORMATION
John McKinlay/Bill MacGregor	RPL Colour vision question form Stephen from the last minutes– GPs do not read Advisory Circulars. Could this be an appendix on the actual application form?	Feb 2015	Amendment to the Application form. John to action as part of RPL revision which has started. We will try and conclude before next meeting
John McKinlay/Richard Small	**Communication to demystify processes –** CAA start at the lowest level of cost for tests (ECG to Stress to Perfusion, etc). If this could be placed in Vector, it would show that the CAA cardiology process is clear (demystified) and fair.	Feb 2015	Vector –information on Cardiovascular process and AMC process. Use med@caa.govt.nz on the website (for all queries)

	Approximately 90% of certificates are issued by the Medical Examiners at assessment. 10% are sent to us for AMC, of that 90% of AMCs are ME expert and 10% of AMCs are Director Expert. Reminder to Applicants to use Med@caa.govt.nz for emails not a specific person in Medical (there have been instances where no reply is received due to conferences, etc). CAA will discuss this with the Webmaster. Richard will be reiterating this in his newsletters.		
Judi Te Huia	**Education**: Review options (including pull outs in Vector) which recommend what an applicant does when a medical issue arises (Post-script. The Current Vector Magazine for July/August, includes Personal Preflight Check information and Fatigue Risk Factors)	ongoing	Peter Singleton replied to the issues – see minutes. Is there a general process outline that can be published in the Vector to enhance a reporting culture.? Steve Pawson and Roger Shepherd are keen to place an item in Vector in the coming months.
John McKinlay/Rob Scriven	**Regulatory Craft Programme (previously OMCS)**: The option of a stand alone system for Medical services was rejected. The RCP decision will sit with the Board once the RFI, RFP process and presentations from Vendors are received in the coming months	Dec 2014	Request for Proposal advertised vendors have until Oct 30 to provide proposals https://www.gets.govt.nz/ExternalIndex.htm?orderBy=type
John McKinlay	**Medical Fee**: John Kay advised John McKinlay that a Government Consultation includes the Funding Review. This may provide opportunity for submissions from the Group to express Public Good over Private Good charges	ongoing	The Group would like an accurate description of what the Consultation will cover as soon as it is available. Is a fuel levy an option? http://www.caa.govt.nz/funding/ Link sent with the last minutes. Further meetings held with ACAG in the last week. MoT meeting was also held in which Ian Andrews attended. http://www.caa.govt.nz/funding/funding_seminars_summary.pdf

Group Members	**Feedback** welcomed on the draft forms in Appendix I of March meeting. This is similar to the Blood Pressure form and will information to improve decisions	as soon as possible	Specialist feedback has been received.
John McKinlay	**Fatigue** Management issues with Engineers. Update at the next meeting	ongoing	A new working Group is being formed and John will continue to update the Group
COMPLETED ITEMS			
Judi Te Huia	**Education**: Liaise with **CASA** to seek and extend invitations of CASA biannual workshop	Completed	Judi Te Huia emailed CASA to confirm invitations can be extended to the ACMLG. An email was received by CASA advising they're not able to extend invitations further.
John McKinlay/Jack Stanton	**Report** on Pilot License Statistics over the past year	Completed	To provide an overview of whether the numbers are dropping since the implementation of the medical fee. See Appendix
John McKinlay/Steve Pawson	**ARCs and health concerns from a third party** based on the ARC policy	Completed	Steve Pawson and Roger Shepherd to outline the ARC process at this meeting.
John McKinlay/Peter Singleton	**Pregnancy Information and Search function** could be placed in better locations on CAA website?	Completed	**Pregnancy** Information included in the A-Z search on the website and feedback provided on location of the Search functions http://www.caa.govt.nz/admin/alphaindex.htm **Search function** queries or general feedback can be sent to info@caa.govt.nz
Group Members	Appendix III to be prioritised	Completed	Appearing in Priority Topics at every meeting
John McKinlay	**Fatigue:** CAA to actively identify and take part in keeping Fatigue Management as a highlighted issue	Completed	Herwin emailed relevant referenced documentation to John. Information was then forwarded to

	(ICAO Annex 6)		Stephen Hunt for his consideration (who will be asked to attend the October meeting). A new working Group is proposed- John will update the Group