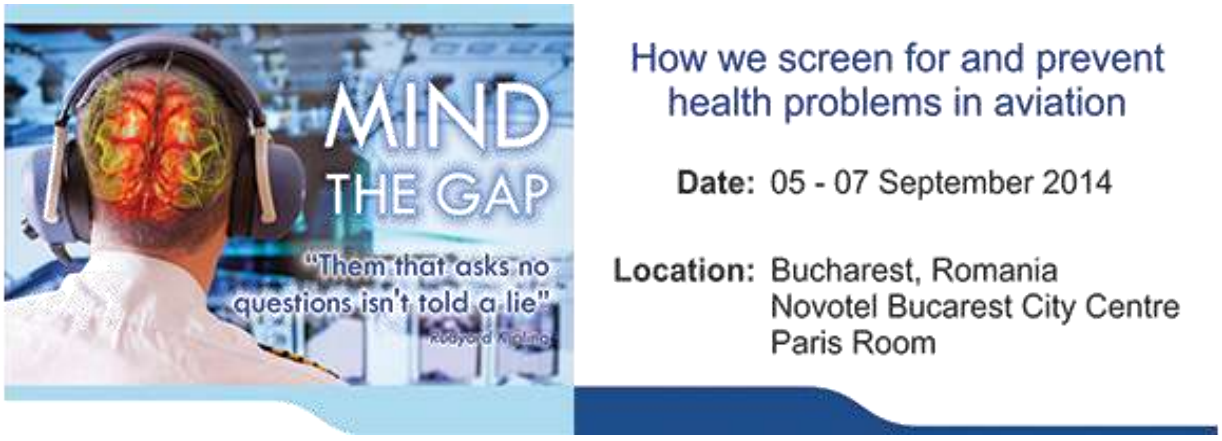
ESAM Scope Meeting

February 1st

2014

ESAM Meeting on the future of the Aeromedical Examination
Valetta, Malta.

Minutes



European Society of Aerospace Medicine

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ESAM Meeting on the future of the Aeromedical Examination

Corona Room,
Radisson Blu Hotel,
Valetta, Malta.
Saturday 1st February 2014.

Scope Meeting

Attendees:

Kevin Herbert President	**Anthony Wagstaff** 1st Vice-President	**Vincent Fieuille** 2nd Vice-President	**Declan Maher** Secretary General
Carla Ledderhous Treasurer	**Cristian Pannait** Director		
Ries Simons Chair Advisory Board Committee	**Stefan Dreschel** Secretary to Advisory Board Committee	**René Maire** Co-opted member Advisory Board Committee	
Roland Vermeiren ESAM, Vice President AsMA	**Hans Ponsgraff** ESAM Representative at AsMA	**Lars Tjensvol** Nominations Committee Chair	**Claudia Stern** Nominations Committee Member
Alfred Bonnici Founding member AAME, AME Malta	**Paul Sciriha** CMO Malta	**Alexander Usachev** Russian Representative	

Apologies from Elena Cataman who was unable to attend due to logistical problems.

Minutes

Welcome.

Alfred extended a very warm welcome to the ESAM representatives and wished us a very successful meeting. He suggested that February is not the fairest month in Malta and reminded us that St. Paul found himself ship wrecked on the island as a result of storms. A storm raged outside the meeting room with the waves lashing the seafront 20 metres away and the poolside furniture danced in the wind and torrential rain as if flung about by poltergeists. Kevin thanked Alfred for his kindness and opened the meeting at 09:50.

As everyone in the room was known to each other, Kevin presented a synopsis of the theme of this meeting. He began by referencing his draft document on the need for a debate on the procedure, content and decision making around the aeromedical examination. We were all in agreement as to the need for change.

A debate followed. It is important that any invitation to the debate must be free of implied solutions or pre-set pathways and must be seen to be open to novel ideas and a move away from the status quo.

Anthony was invited to outline the background for where this meeting. He explained that he had been approached by Dr. Tony Evans at the AsMA meeting last spring he had asked for ESAM to join with ICAO to look at the issues that are relevant in the medical assessment of those requiring certification. At present, it appears that the regulators are at the sharp end of the sword in terms of the implementation of medical standards. A problem arising from the current system is the lag between medical advances and the application of medical standards at the point of certification.

It is imperative that if there is to be change, the change must be sanctioned and ideally as a result of collaboration and consultation with all the stakeholders.

The AME Pilot Interface.

At the moment, there is a power gradient from the AME to Pilot. The AME has the "power" to grant or deny the pilot the privileges of their licence. It is a decision with immediate effect. The pilot enters the AME interface and leaves either with the retention of their current privileges at best, or losing them completely. There is no sense of gain to the pilot in the engagement with the AME.

Instead of a power gradient, there needs to be a partnership. As part of the partnership, the AME must be seen to be a part of the programme that will keep the pilot flying in the long term and maintaining the health and performance of the pilot. The maintenance of health in the medium term, for example a decade, by identifying factors that might have a negative health impact in the future.

Some feel that we need to move away from the current rule making and legal framework to a more diverse output based system, while others feel a strong need for the application of rules and guidelines which constantly require change and to find a mechanism that can incorporate that change into the decision making process. Rules allow the identification of probability and therefore can improve the strength of a decision.

Some AME's are already practicing this change, involving the pilot in the decision making process. The Norwegian Military system, the "care of the flyer" programme, uses a board including the pilot in forming a decision which is at the Competent Authority level.

Involvement of the pilot in the decision making process increases the level of trust with the AME. It is imperative that the pilot is included and represented in this conversation and in any change that is proposed. People and organisations that are interested in being a part of the debate and being proactive are needed for any change to have value.

A historical review followed. In this part, the role of psychological assessment and testing was described from the past in both the JAR and Eastern Europe. European harmony will come about over a long period, probably over the next fifteen to twenty years.

Currently, we overestimate the strength of our decision making process. There is a need for a fair and transparent system all the way from the level of the AME to the AMS. We not only need to look at existing realms of operation but need to include areas such as space medicine. At present there are no clear structures in place for decision making apart from the considered opinion of two doctors. Here we have a clean slate on which to develop a decision making process in the absence of a clear regulation and then extend this process to the area of general aviation.

Another model similar to this might be the South African system where they were required to develop an aeromedical system from a base without reference as they had been ostracised during the era of apartheid.

Consider starting with an international board system. Step one would include the concept where the AME is not required to make a decision but simply advise. Step two

would include decision making, where necessary. Each assessment would be individual to the pilot.

Some small states have a limited resource of AMEs and experts in aerospace medicine. There they can have networks that come together to answer certain challenges and issues. This is done in an informal manner. Perhaps developing this model might be of value.

The Canadian's Aviation Authority employs a management oversight policy when a pilot is going through a difficult phase. But there are problems such as litigation and the concept of medical migration when the underlying regulatory system softens. So, as part of this process, we will need to not only engage with the pilot, but also the unions and ultimately, the politicians.

Psychiatry and Psychology.

Psychiatry deals with the individual and the mental health relating to one person. Psychology best deals with the health an performance of the group, rather than the individual. Fitness involves the application of psychology to prevent loss using guidance and supportive material. Unfitness applies a list of exclusions (pathologies) to the process. Ideally the AME should be working on building supportive advice rather than simply applying exclusions after the event.

We need to avoid the blunt instrument of the formal psychology test. Experience has not served either the pilot or the AME well in this area. Many saw the tool as a soft option when trying to remove a pilot and many pilots distrusted and feared the implications of the test.

Resistance to Change.

An example of resistance to change was experienced recently by the FAA. They proposed obstructive sleep apnoea screening on pilots with a BMI >40. There was an immediate and very strong voice of opposition to the proposal. As a result the FAA was forced to withdraw the proposal. What this highlights is the failure of the system. No child is born with a BMI >40. It had to develop over time. It should be possible to advise and direct towards the healthy option of a normal BMI.

Partnership.

Trust is required between the AME and the pilot. Fear of loss of licence prevails for the pilot. We need to talk to the AME and ask them to look at how they go about their work. There needs to be a change in the attitude of the AME away from simply

being an instrument of the state and becoming an advocate for the health and well being of the pilot. The position of AME is somewhere between an Occupational Health Physician and a General Practitioner. Currently, a lot of AMEs act in this fashion, but it is not the paradigm.

This element of trust might be easier to build in smaller communities where the pilot and the AME are known to each other and have built a relationship over time. Even where there has been medical migration, a call from one AME to another can quickly shed light on why migration might have occurred.

Much of what has been talked about relates to the commercial pilot, but there is a need to consider the GA pilot both in Class 2 and LAPL. We also need to include ATCO in the discussion.

Where do we start?

We start with the Facts:

- Aviation has changed from the days of glamour to the tough environment where pilots work.
- Reasons for loss of licence. What are they?
- The increase in diffuse factors in incapacitation.
- Changes in the pilot's levels of stress including work/life balance, doubling of flight hours in the past two decade.
- The need to focus on Prevention.

Summary.

Kevin summarised the first part of the meeting with bullet points as follows:

1. Preventive Medicine, Long term outlook.
2. Trust.
3. Psychosocial wellbeing.
4. Multi-disciplinary team based decision making.
5. Safety impact.
    - Acknowledge the change in aviation.
    - Increased work based demands on pilots.
    - Increased stress on pilots.
    - Decrease in impact of medical pathologies.

Coffee Break 11:40

At 12:00 Kevin re-convened the meeting.

Engagement.

There are three main groups that will need to be addressed:

- Civilian commercial.
- Military.
- Recreational.

We started a broad discussion of the stakeholder and whom we should invite initially as part of the debate process. It was agreed that people and organisations would be added as time passed and as the layers of complexity evolved.

ECAM 4 in Bucharest this September will be the location of the initial engagement.

There will be a need to include the Regulators from the beginning as well. A discussion followed as to who would invite whom and which groups should be included ab initio. Over the following period a number of political issues were addressed and explored. The contacts were assigned to the members present.

It was clear that we need to contact Elena and call on her networking skills and experience.

The Space medicine working group was spoken of. Dr. Rupert Gerzer of the DLR was mentioned as a point of contact. On the American side of the ocean we could invite Melchor Antunano from the FAA.

The list below should give a broad sense of the scope of this project. It is not an inclusive list and will remain dynamic.

Preliminary List of Invited Attendees to ECAM 4

AsMA
ATCO
Australian Air Force Tracy Smart
CAMA
Canadian Air Transport Canada
CASA
China CAA
CIMP
CMO Forum
EASA
Easi Jet
European Air Group (ES FR IT NL UK)
European Air Sports
European Society of Aviation Psychologists
European Cockpit Association
FAA
FAI
Head of the Norwegian CAA ex military
Hungarian Flight Surgeon
IAASM
IAC

IATA
Ibero-American Association
ICAO
IFACTA
IFALPA
International Academy of Astronauts
Luftwaffe. Chief Pilot of the Air Force
NAA Regulators
NATO European Air Group
Richard Branson
Romanian Chief Cabin Crew
Russian Air Force Representative
Ryanair Chief Pilot Terry O'Neill
Singapore CAA
South African CAA
Space Medicine Group
Surgeons General of the Air Forces
US Head of training Chris Boland
US Surgeon General Tom Travis
USAF Chief Flight Surgeon

How?

ESAM will develop a project applying principles of preventive medicine called for by several stakeholders, including ICAO. We will invite the above listed group. Other organisations will be invited/encouraged to attend on the basis of a briefing that will outline the five principles detailed on page 6.

"We will be engaging with a wide group of stakeholders in September, where you are one of them. If you are interested, we would like you to attend the conference."

That would be backed up by a personal contact from this group.

The Scope document needs to be a very carefully constructed brief message that is free of ambiguity. A discussion of that content followed. Kevin said that he would draft a notice and circulate it for opinion.

Gary Kay will be invited as a key note speaker.

Kevin asked about the article that he had written being put on the website. A discussion followed about the content. It was agreed that the Diabetes component be removed as we need to have a common platform. There was a fear that there might be a concern that a local agenda was being pushed.

A summary of the issues follows:

- We need as many views as possible to come forward and be included, avoiding the risk of closing down the options.
- Forward a pilot representative or a member for a working group.
- Stay away from hard rules.
- Make a case for the need for change. This change in mind set will be far beyond ECAM 4. It will take up to twenty years.
- It was agreed that we need to sell the idea of a need for change not of the idea of the need for "providing" solutions.
- The change must come from within Europe and be in keeping with the ICAO goal.

A short paragraph of non-contentious text outlining the Scope of the project will be sent to these parties. This will be supported by an article which will flesh out the concept. At a later point people can add position paper and then publish. At this point we need to send out a "teaser" to entice a response and engagement.

- This is bigger than ECAM.
- This is bigger than ESAM.
- This is a long term project with the potential for a better system to manage wellbeing.

Final remarks and close.

Kevin thanked all present and invited them all for lunch. The meeting was closed at 13:00.

Declan Maher.
Secretary General.
ESAM.