

BGA RESPONSE TO THE LAPL MEDICAL CRD – 3rd DRAFT

This response will be submitted on behalf of the British Gliding Association.

1. Context

The British Gliding Association (BGA) is the UK governing body of sport gliding and an association of 85 clubs with some 9000 full member participants and 21 000 occasional participants. The BGA clubs operate approximately 2400 gliders and light aircraft. The BGA has been specifically delegated a wide range of authorities by the UK CAA for many years, including for medical matters affecting gliding. Pilots are not licensed by the State but are certified by the BGA. All gliding activity is supported by personal taxed income with no government funding.

In 1967 (following a fatal accident with an epileptic instructor who held a PPL) the BGA required a General Practitioner holding medical records to endorse the medical declaration of instructors and those pilots authorized to carry passengers. At that time and for these pilots the then PPL medical standard was required. Solo pilots made a self declaration and had to meet the private driver medical standard. In 1998 following a proposal by AOPA and a review of the safety record for BGA instructors a similar procedure using an endorsed medical declaration was adopted by the CAA for the UK national PPL although the Group 2 (professional) driving licence medical standards were followed for all pilots, these being closer to ICAO than the 1997 JAR-FCL Class 2. If a pilot could not meet the full standard, solo flying (OPL limitation) was permitted so long as they met the Group 1 (private) driver licence standard. These standards and associated process have become known as the 'NPPL medical'.

The safety record of the 'NPPL medical' and the prior BGA instructor medical declaration has met the 1% aeromedical risk level as defined by the JAR-FCL 3. It should also be noted that several of the aeromedical accidents during BGA gliding operations were suffered by pilots holding a valid Class 2 or 1 medical certificate. In the UK, it is estimated that one GA medical related fatality can be expected every two years. 50% of medical related fatalities are alcohol/drug related (usually linked to depression) and 50% are cardiovascular related. There has been one NPPL medical related fatality since 1998.

Some 15 000 pilots in the UK utilize the NPPL medical standard. These pilots fall into two groups; youngsters and those with no ambition to become commercial pilots, and older and experienced pilots who have become less fit and now hold only a restricted (OPL) NPPL. Because of their experience these latter pilots contribute greatly to safety at club level but the requirements proposed in the CRD could result in approximately 10% (1500) of the pilots who utilize the NPPL medical being prevented from flying as pilot in command with the resultant personal impact as well as the impact on general aviation clubs and industry.

2. The LAPL Medical Proposals

The BGA believes that the LAPL medical proposals within the CRD do not comply with either the spirit or the letter of the Basic Regulation (216/2008) or provide sufficient latitude or flexibility to match the varied health care systems that exist in Member States. The CRD proposals differ significantly from those published for consultation and on which EU citizens based their responses. The BGA is extremely concerned that;

1. The LAPL medical proposals are unduly stringent within the intentions of the Basic Regulation (216/2008). As a consequence, they are significantly less flexible than current arrangements for the assurance of medical standards and will therefore unnecessarily reduce pilot numbers.
2. The LAPL proposals are, perhaps unknowingly, far more restrictive than current systems. At best this will significantly raise costs (by a factor of x5 to x6 in the UK) with the potential to reduce pilot numbers further for no good reasons.
3. The LAPL proposals identify that EASA is relying on the opinion of groups, some of whom have a vested interest in the outcome and, therefore, a potential conflict of interest. There is a substantial body of direct evidence that supports a far more pragmatic and less unnecessarily damaging set of implementing measures that, in many cases, maintain current approaches that have been demonstrated to work perfectly well over many years.
4. Given that there are very obvious detrimental impacts on pilot numbers (for no demonstrated benefits) it is imperative that EASA takes a full RIA into account before finalising the medical proposals.
5. EASA has omitted to describe mitigation measures that would permit pilots to fly with a limited role.

The Basic Regulation (216/2008) required proportionate medical measures for recreational aviation, it permitted GMPs to assess recreational pilots where national rules allowed, and provided for mitigating limitations when individual pilots could not meet the full medical standard. EASA claimed to understand the success of national arrangements and the need for a proportional approach. However the outcome of the CRD has not met these aims. Critically, during the process of considering the Regulation (EC) 216/2008, the medical 'assessment' by a GMP was transcribed or translated as 'examination' by a GMP.

The LAPL proposals within NPA 2008-17c in turn were clearly written by EASA having interpreted the 'assessment' as a physical examination rather than a medical review, but did also recognize the additional control provided by an available medical history. This resulted in a proposed LAPL medical requirement within NPA 2008-17c of a physical examination by a GMP (refer to NPA 2008-17c MED.B.90).

The CRD notes that changes to the LAPL medical proposals as originally published in NPA 2008-17c, including those relating to the 'examination' element, have been made on the basis of opinion by NAA's and AME's. Identical proposals for these changes have been published on the web site of the European Society of Aerospace Medicine (EASAM) where the members of the ESAM Advisory Board are listed and their report is available; these were also published in a scientific journal by the same authors. It should be noted that ESAM opposes any lower and limited pilot medical standard. This is contrary to the provision of the Basic Regulation. No opinion from GMP's was sought and it can be assumed that these doctors are unaware of the EASA rulemaking process. The term 'best practice' is misused within the CRD text. 'Best practice' in the medical certification of GA and sporting pilots includes, evidentially, the GP medical process used in a small number of Member States. The CRD text erroneously infers that the GMP medical is poor practice.

Moreover, NPA 2008-17c presented to EU citizens allowed this medical assessment to be carried out either by a GMP who has completed postgraduate training or by a GMP trained in aviation medicine, thus satisfying the varying medical regimes throughout the community. The regulation presented with the CRD now requires GMPs to have postgraduate training and training in aviation medicine but it is most unlikely that any GMP who is not also an AME will be able to satisfy that requirement. By changing the word structure of this part of the regulation EASA has denied GMPs the opportunity to carry out this function and restricted it to AMEs but without stating that specifically in the regulation. This appears to have been done to deny this work to GMPs but without making a clear and open statement to that effect so that citizens could raise their objections.

The LAPL medical requirements as proposed in the CRD will result in a serious negative impact on stakeholders because the requirements are such that GMP's will be unwilling to either qualify or invest the time required to carry out a LAPL medical (*BGA opinion based on a sample of practicing GP's*). A typical GMP will have only one or two pilots among their patients, so it is unlikely to be worth their effort to qualify. Whether the physical examination is conducted by a GMP or an AME, the proposed requirements will increase the cost per medical in at least one Member State by approximately x10 because of the increase in medical time required to carry out a physical examination as compared to that required to carry out an assessment or examination of records (*reference - British Medical Association recommended fees*)

3. Evidential Based Rulemaking

Regulators tend towards developing regulations that aim to control the tiny minority who do not conform to good practice or even hard law. Unfortunately, unless mitigated by a democratic process, this results in over-regulation of the majority while usually failing to achieve the aim. Dishonest or psychotic applicants will continue to hide adverse pathology from their AMEs, regardless of JAA medical or EASA FCL medical requirements. Organizations whose members benefit commercially may encourage over-regulation because it maximizes their interests. As a non-commercial democratic organization with 79 years of experience of developing and maintaining safety standards under derogation by the NAA, the BGA believes that it is entirely appropriate to consider the expert opinion of both NAA's and AME's when considering the LAPL medical requirements. However, the BGA believes very strongly that accepting opinion from vested interests without considering counter evidence is inappropriate for a democratic society.

4. Proposal

The BGA proposes that;

- a. The CRD proposed LAPL medical requirements in their entirety must be reconsidered by EASA and resubmitted for full stakeholder consultation by taking into consideration;
 1. The intent of the basic regulation
 2. Proportionality
 3. That fully functioning GP medical systems for GA and air sport pilots currently exist in a small number of Member States

- b. That in resubmitting an evidentially based LAPL medical NPA and CRD, a detailed RIA is presented to stakeholders

MED.A.055

Comment

Regulation (EC) 216/2008 Annex III - referring to 7(1) notes that;

"...All pilots must periodically demonstrate medical fitness to satisfactorily execute their functions, taking into account the type of activity".

The CRD proposes LAPL medical validity periods up to the age of 45 that are significantly increased from those proposed in NPA 2007-17c. This change is partially explained within the CRD as follows;

'The NPA proposed to limit the initial period of validity of the medical certificate to age 45 of the pilot. This was considered as a safety issue by AMEs and NAAs as it could cover a period of almost 30 years. Medical conditions that are not compatible with the safe exercise of a pilot licence, specifically for the higher end of the LAPL, could develop during this period of time and comments asked for a defined and overseeable period of validity...'

Cardiovascular disease is the major cause of aeromedical incapacity but is rare before the age of 45. That was the obvious reason for the earlier periodicity. In published reports ESAM has argued that the onset of psychotic diseases in early adult life should be a reason for reducing validity intervals. However the experience of the BGA is that mental illness is never detected by doctors during a short office visit, but results in problems that have to be reported to doctors. The CRD does not indicate whether evidence to counter the opinion of AME's and NAA's has been considered by EASA. Acceptance of the subjective views of commercially interested groups without challenging those views is unacceptable. MED.A.60 requires LAPL holders to report changes in health status. It is not explained in the CRD why this is no longer accepted as an adequate explanation for the original LAPL medical validity periods.

Gliding across Europe and beyond is enjoyed by pilots of all ages. This includes many young and inevitably low income pilots. Aviation provides an environment in which young people learn responsibility and gliding provides healthy outdoor exercise. The proposed change will require a LAPL pilot who flies solo at 16 and continues into middle age to be subject to at least six times as many medical assessments than would have been the case under the original text. The economic impact on end users is adverse and the cost of medical assessment becomes a significant proportion of their total budget. For some, participation will therefore be unaffordable. However, the CRD does not include a regulatory impact assessment.

Proposal

The BGA proposes that EASA must reconsider MED.A.055 taking into consideration;

- A Regulatory Impact Assessment
- The experience of Member States that use medical validity periods similar to those proposed in NPA 2008-17c

MED.D.001

Comment

Regulation (EC) 216/2008 notes that “..in the case of a leisure pilot licence a general medical practitioner who has sufficient detailed knowledge of the applicant's medical background may, if so permitted under national law, act as an aero-medical examiner, in accordance with detailed implementing rule...”

Neither the earlier NPA nor the CRD clarifies why a GMP must have completed post graduate training prior to issuing a LAPL medical certificate. This requirement for completion of post graduate training is curious when trainee GMPs under supervision can carry out every other professional function. Less than 0.1% of the general population hold or has held a pilots licence. Therefore it is unlikely that more than 0.2% of GMP's are so qualified. It would have been more apt, would have provided greater aeromedical understanding and would have complied with the basic regulation if AMEs were required to hold a pilot licence. The unavailability of GMP's qualified to issue a LAPL medical certificate will have an adverse economic and social impact on recreational pilots.

Proposal

The BGA proposes that EASA follows the Basic Regulation and does not impose additional requirements on GMPs.

Further, the BGA proposes that EASA should consider the desirability for AMEs to hold a pilot licence thereby meeting the requirement of the Basic Regulation in respect of knowledge and experience of aviation.

MED.B.090

Comment

Regulation (EC) 216/2008 Article 7 states that;

‘...in the case of a leisure pilot licence a general medical practitioner who has sufficient detailed knowledge of the applicant's medical background may, if so permitted under national law, act as an aero-medical examiner, in accordance with detailed implementing rules adopted pursuant to the procedure referred to in Article 65(3); these implementing rules shall ensure that the level of safety is maintained.’

During the development of NPA 2008-17c, EASA and industry medical experts developed the following proposal;

MED.B.90 Medical examination of applicants for LPL medical certificates

Aeromedical examination and assessment of applicants for a LPL medical certificate shall consist at least of the following:

- (1) evaluation of their medical history;*
- (2) examination of vision;*
- (3) urine test;*
- (4) blood pressure test;*
- (5) whispered voice test;*
- (6) examination of musculoskeletal system.*

Subsequent NAA and AME opinion during the NPA consultation process has resulted in the following proposal within the CRD;

MED.B.90 Medical examination of applicants for LAPL medical certificates

(a) An applicant for a LAPL medical certificate shall be assessed based on aeromedical best practice.

(b) Special attention shall be given to the applicant's complete medical history.

(c) The aero-medical examination shall include at least the following:

(1) clinical examination;

(2) blood pressure;

(3) urine test;

(4) vision;

(5) hearing ability.

(d) Notwithstanding (c), after the first issue of a LAPL medical certificate the aeromedical examinations until the age of 50 can be reduced with due regard to the evaluation of the applicant's medical history.

This CRD proposes that the LAPL GMP medical will be assessed based on aeromedical 'best practice' – which in fact does not assess medical records - rather than an assessment of a lifetime medical record. In practice a medical examination never exposes a previously unknown and asymptomatic condition of such seriousness that it will cause an aeromedical hazard. Diseases are either of slow onset and will be in the clinical record, or of sudden onset and not predicted by examination. The requirement does not provide sufficient latitude or flexibility to permit alternative methods of maintaining an equivalent level of safety in Member States 'where records exist and permissible under National law'. The CRD proposal effectively prevents the implementation of the relevant element of Regulation (EC) 216/2008 as intended by Parliament.

Proposal

The BGA proposes that EASA must reconsider the examination required under MED.B.90, taking into consideration;

- The intent during the drafting of Regulation (EC) 216/2008 to certify pilot medical fitness by assessment by a GMP who has sufficient detailed knowledge of the applicant's medical background
- Medical evidence
- A Regulatory Impact Assessment