A E R I A L A P P L I C A T I O N A S S O C I A T I O N O F A U S T R A L I A L T D .

ABN 13 002 501 886 • ACN 002 501 886

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30 March 2017

AAAA Submission

CASA Medical Certification Standards Discussion Paper

Introduction
AAAA recommends a significant overhaul of the aviation medical system in Australia that will deliver a similar level of safety outcomes, but which will significantly boost the efficiency of the avmed system, reduce costs, anxiety and delay and greatly improve the transparency of the process and the use of the best expert opinion in resolving more complex cases.

There are five core areas for reform:

- Improved alignment and simplification of aviation medical certification classes/requirements against the classification of operations, and consequently relevant to risk and consequence.

- Significant improvements in the management of the Aviation Medicine Branch - howsoever called - including cultural realignment to a 'client' model, case management and tracking, reporting and management of delays and the prioritisation of commercial licences.

- Reinforcement, increased delegation and support of the DAME system.

- Establishment of a transparent and credible appeals process, including the ability of the candidate to nominate an expert to argue on their behalf.

- A need to consider how relevant medical information can be made available to Chief Pilots to help them fulfil their responsibilities.

Medical Certification, the Classification of Operations and Risk
The evidence in the DP, including from the ATSB and international sources, is that the low level of pilot medical incapacitation calls into question the relevance of the current complex, expensive, low-trust structure and functioning of the CASA aviation medicine rule-set and branch.

This is particularly evident when pilot incapacitation in the recreational aviation cohort is compared (with the cohort currently required to have Class 1 or 2 medicals), where it is likely there is an additional skewing of the pilot population towards pilots with pre-

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existing conditions as they are, in many cases, self-selecting into recreational aviation as they are unable to secure a Class 1 or 2 medical.

The risk and likely consequence of medical incapacitation of pilots must be considered in context - is medical incapacitation a prime cause of accidents in a particular sector of operations?

Certainly, in the case of aerial application operations, this is not the case (see ATSB Report - *Aerial Application Safety, 2015-16 year in review*').

There is clear anecdotal evidence from AAAA members - CASA may have better data - that the number of pilots in the aerial application sector being excluded on medical grounds is comparatively low - further calling into question the relevance of the current system in contributing to safety.

If CASA or AAAA were selecting any area to make a significant difference to safety in aerial application, it would certainly not be in aviation medicine certification.

There is a need to match risk - and especially potential consequence - to a category of operations to ensure that pilots are not handicapped by the need, cost and inconvenience of having to meet a higher medical standard than absolutely necessary on safety grounds.

For example, if a pilot is only involved with aerial application operations in single seat aircraft and in rural or generally remote areas, then the requirements of a Class 1 medical are unlikely to be relevant in reducing the risk to the same level as an ATPL operating a commercial airliner.

In addition, the chronic inefficiency created by the CASA medical system points to the need for a significant overhaul of the strategy that drives the system, with there being significant potential for great efficiencies by better matching of risk and controls to category of operations.

While AAAA understands the need for international licences to be compliant with ICAO Annexes and SARPs, there is still considerable scope for Australian domestic aviation licences and medical requirements to be simplified.

AAAA recommends that CASA implement a medical system based on the following requirements:

- Private and sport aviation - driver's licence standard medical (ie removal of current Class 2 requirement)

- Aerial work operations - domestic only - a Class 2 medical standard if passengers are not carried during commercial operations (eg aerial application)

- Aerial work operations - international only - a Class 1 medical, but with the Class 1 medical validity period out to 3 yearly.

- Charter - domestic only - a Class 1 medical, but with the Class 1 medical validity period out to 3 yearly.

- RPT - Class 1 medical

If CASA is to honour the sound principles outlined in *DAS Directive 01/16*, then it must review the current system, especially in light of international practice - and not only for private or sport aviation.

Key Challenges in Managing AvMed Branch Better
While there has been some improvement in the performance of the Aviation Medicine Branch over recent years, the branch is still not performing at an acceptable level of fairness or efficiency.

While changing the system of medical classes required will go a long way to reducing demands on the Branch and allow improved workflow management, this alone will not achieve significant change in attitudes and performance.

In addition to the recommended realignment of Avmed classes to operational risks, the branch must also undergo significant reform of processes, greater delegation to DAMES and the introduction of a transparent appeals mechanism to lift performance and confidence in fairness of the Avmed system.

The range of challenges includes:

- Cultural realignment to focus on outcomes and fairness
- Stronger client focus and ethics which must include an understanding of the importance of medicals to pilots' livelihoods
- Improved processes, workflow management, tracking and case management
- Improved relationships with and support of the DAMEs and a recognition of their important role by greater delegation of powers to them.

Avmed cultural change
The attitude of the CASA Aviation Medicine Branch (or 'team' as it has been repackaged) is central to any discussion of lack of trust of DAMES, the inefficiency of current systems and the ongoing conflict and difference of opinion with specialists.

The branch appears to adopt a 'we know better than you' attitude which was the subject of considerable discussion in the ASRR Report - putting themselves above other processes, demonstrating little care concerning getting pilots back to their livelihood, and a level of arrogance in treatment of 'clients'.

Case management and workflow
It will be critical for improved 'whole-of-life' (ie 'life' referring to the time CASA is considering an issue before cancelling or issuing a medical) case management to ensure

the absence of any single individual within the Avmed branch does not compromise the movement of a case to completion.

AAAA has been provided with many examples of urgent - in the eyes of pilot unable to earn a living - medical cases stalling because a person in the branch has gone on recreation or longer term leave and there does not appear to be an effective system to identify that a case folder is sitting on someone's desk and not being progressed.

This is not an 'aviation' or 'medical' problem - it is the complete absence of sensible 'practice' management and robust systems within the branch.

Similarly, the stalling of cases because of administrative errors on the part of CASA is at the same time a cultural and management challenge. This problem is characterised by failures and excuses reported by AAAA members including:

- lost files
- misplaced records
- rejected forms for minor errors
- errors or omissions that could easily be remedied over the phone
- unreturned phone calls
- requests for multiple copies of the same document
- lack of acknowledgement of receipt
- lack of timely follow-up
- refusal of staff to directly contact candidates to problem solve and
- a comprehensive lack of care for the candidates' predicaments.

While cultural change relies on leadership and very clear messages about what is and is not acceptable - backed up by action and attention to priorities, many of the shortcomings of the branch can only be attributed to administrative slackness that has been allowed to be perpetuated by a lack of robust systems, lack of regular reporting on achievements or delays and other KPIs and management action.

It appears that new management of the branch may be necessary to kick start such processes with an air of urgency.

Case prioritisation, equity/justice

CASA medical branch does not appear to assign any priority to addressing issues with commercial pilot licence medicals - even though that may be the pilot's sole source of income and livelihood.

AAAA would strongly support a 'fast-track' system being developed for those candidates who rely solely or principally on their aviation licence for their livelihood.

Initial 'triaging' of cases as they come in and assignment of higher priority to cases involving commercial pilots should be an integral part of the avmed system.

The recommended new alignment of medical class to operational use would likely result in a significant reduction in workload for the branch and a greater capacity to deal with

commercial licences in a fair timeframe. However, the second part of reform of processes and workflow management will still be critical.

CASA Staff qualifications and experience

AAAA questions the current ability of CASA staff - with comparatively 'junior' qualifications - to over-rule nationally and internationally recognised experts and specialists.

CASA's dogmatic support and defence of decisions in the face of evidence and experience to the contrary simply serves to underscore industry's already low opinion of the avmed branch.

AAAA is also concerned at the apparent willingness of CASA medical staff to pursue 'fads' that have been otherwise discredited - eg use of BMI to trigger sleep apnoea reviews despite DAME assessment of the candidate in person - or which simply have been proven to have no basis in safety - eg pursuit of colour deficient pilots in spite of decades of safe operations.

A quality-driven organisation would reconsider its position after numerous losses in jurisdictions such as the AAT, but this level of introspection does not seem to apply to the aviation medical branch - or for that matter the CASA legal branch.

It would clearly be advantageous to CASA to establish systems of quality assurance, review and appeal that serve as a discipline on these long-standing concerns.

Damage to the DAME system and Repair

It is incongruous to establish and succour a system of Designated Aviation Medical Examiners, and then do everything possible to undercut trust in them by removing their ability to issue medical certificates on the spot, or to extend to them greater responsibility and flexibility in managing medical issues.

CASA must start to reengage with the DAME community to find out what it needs to do to re-earn their trust and to re-establish a system that works for both the DAMEs and CASA and the industry.

While failure of the new CASA online systems to marry up payments with certificate approval from DAMEs, leading to considerable frustration, anxiety and delay for both DAMEs and pilots could be written-off by CASA as 'teething problems' it underscores a much deeper problem.

The electronic system of medical licencing is essentially a failed experiment. It is simply too complex for the task it is trying to achieve and more thinking and less reliance on IT - often non-functional in rural and remote areas - would result in a far more robust, quicker and more efficient system.

If CASA simply wants DAMEs to become form-fillers rather than aviation doctors actually managing the health of the pilots who come to them, then it will continue to

antagonise a group who make a very valuable contribution to the health and well-being of the pilot population.

By continually pulling more power to the centre, CASA is making the position of the DAME less valuable. To achieve this has taken considerable effort on CASA's part and it will take equally considerable effort for CASA to win back the trust of DAMEs after this treatment.

A starting point for CASA is to humbly re-engage with the DAME community, to develop a system based on the DAME issuing the pilot medical on the spot immediately following successful completion of a medical and to develop more creative ways of putting the DAME at the centre of the aviation medical system.

Quality assurance and appeals

The avmed branch has clearly struggled - and failed - with continuous improvement over a long period of time. The branch is inward looking, apparently impervious to suggestions for improvements or complaints, and treats people in such a way as to erode their patience or their confidence in the system.

Delays continue, there appears to be little workflow planning or case management systems in place to manage the inevitable gaps created by people taking leave or being otherwise absent from the Branch.

CASA appears only too happy to draw out interactions with aggrieved pilots trying to win back their livelihood, and is clearly affronted when it is suggested that leading medical specialists in areas including cardiology probably know more about the issue than CASA staff who may only hold base-level qualifications.

Examples are plentiful of questionable rulings on pilot medicals that fly in the face of genuine expert opinion (for example in cardiology) and result in the trashing of careers for no safety purpose. The ability of the branch to hide behind a facade of medical qualifications is well known in industry and under current systems, is an almost unassailable position that has drifted far from actual safety issues, or the leading non-CASA advice on medical issues.

Of greatest concern is the apparent active resistance from the Branch leadership to the establishment of quality assurance processes and transparent appeal processes. The current system is simply not adequate.

CASA must address this ongoing cultural resistance to improvement if the Aviation Medicine Branch is to be made more responsive and responsible.

AAAA strongly recommends the establishment of an expert review panel that would be comprised of a CASA nominee, a nominee of the candidate (preferably their specialist) and the candidates' DAME.

Industry would be greatly concerned with any panel that would suffer from capture by the CASA Avmed Branch or which would not be more independent than CASA making the decision itself.

The Chief Pilots 'Need to Know' vs Privacy
A critical shortcoming in current aviation medical arrangements is the lack of a notification link between pilots, their medical advisors, CASA and the Chief Pilot (or HoFO under CASR Part 137).

Where pilots may be suffering, for example, from a psychological issue or a substance abuse issue, it is currently impossible for a Chief Pilot to discover the problem through means other than their own observations.

While some pilots are very conscientious and include their Chief Pilot in their confidence regarding medical issues, there is a strong incentive in protecting their career to not include the Chief Pilot.

Consequently, CASA should investigate a fair means of including Chief Pilots in a system of notification where the medical issue could result in operational implications, especially for safety. There is a range of provisions under privacy legislation that would enable such an approach.

Further Information

For further information or clarification on any issues raised in this submission, please do not hesitate to contact the CEO of AAAA, Mr Phil Hurst on 02 6241 2100.