



# AUSTRALASIAN SOCIETY OF AEROSPACE MEDICINE

Incorporated  
ABN 50 713 393 083

Aviation Safety Regulation Review  
Department of Infrastructure and Regional Development  
Canberra ACT 2601

## *A comment on the Aviation Safety Regulation Review from the Australasian Society of Aerospace Medicine*

The Australasian Society of Aerospace Medicine (ASAM) is a special medical interest group whose 800 plus members are predominantly CASA Designated Aviation Medical Examiners (DAMEs) and CASA Designated Aviation Ophthalmologists (DAOs). The aims of ASAM are to cultivate and promote aviation medicine and related sciences; to provide an authoritative body of opinion on matters of aviation medical significance; and to increase the awareness of the aviation industry, government, and the general public of the importance of aviation medicine to flight safety.

The ASAM committee commends the Panel's strategic and systemic approach to the review of aviation medicine issues. It is laudable that the Panel recognised the current medical practice of evidence-based medicine and its importance in the role of aeromedical decision making, as distinct from the past practice of eminence-based medicine. On this same note, the ASAM committee recently had a letter published in the May-June 2014 edition of Australian Flying magazine explaining the role of DAMEs, the Regulator, aeromedical decision making and the importance of CASA training and oversight.

It was noted that the Panel compared systems and processes with the United Kingdom, New Zealand and the USA. One unique aspect of Australia is the vastness of the country, which can make access to medical services, especially DAMEs to be difficult in rural areas. The vast majority of DAMEs are General Practitioners (GPs) who incorporate their aviation medicine practice into a busy consulting schedule, often as the only DAME in a medical practice and sometimes not seeing many aircrew in a year. Recent CASA data found that that 77% of DAMEs performed less than 50 medicals per year. An ASAM member survey in 2012 found that 62% of DAMEs who responded said that aviation medicine comprised less than 5% of their medical practice. That is, the majority of DAMEs perform few medicals per year, which encompass a very minor part of their medical practice.

The skill sets and time required for assessing a pilot's fitness to fly and for evaluating complex cases are very different to performing a routine medical and the ASAM committee supports the Panel's recognition that DAMEs under a devolved certificate issuance system would need to be ".....appropriately skilled, accredited and oversighted". The ASAM committee contends that DAMEs in a devolved certificate issuance system should undergo appropriate initial and recurrent training and education beyond what is currently required to be a DAME (which is to attend an aerospace medicine meeting once every 3 years). Specifically, The ASAM committee contends that DAMEs would need to undergo an initial training program in the principles of aeromedical decision-making, aviation risk management and the practice of evidence-based medicine as it applies in aviation medicine. They would then need to engage on a regular basis in a structured Quality Improvement and Continuing Professional Development (QI & CPD) program. This initial training and ongoing QI&CPD currency will be costly and onerous for CASA and for DAMEs compared with the current requirements.

Doctors are obliged to maintain QI & CPD for their medical registration; this QI&CPD is not discretionary. However, aviation medicine QI & CPD that will be mandated by CASA under any devolved certificate issuance system will be optional for a doctor who is also a DAME. When aviation medical work comprises only a small part of a doctor's workload, a rigorous new QI & CPD program (which ASAM recognises to be of vital importance to aviation safety and fully supports) is unlikely to be considered to be a worthwhile commitment in term of time, finances and convenience for many DAMEs. A DAME might perform aviation medicals for many reasons such as a break from the constancy of seeing sick patients, because they fly themselves, or because they wish to provide a community service in a remote location, etc. There is a real danger that if the Panel's recommendation for the devolution to DAMEs to renew aviation medical certificates is accepted, some DAMEs may relinquish their CASA delegation to perform aviation medicals altogether because the costs to them outweigh the rewards. This will restrict access to DAMEs, particularly in rural and remote areas.

We do not think the ongoing training, quality improvement and CPD requirements should be diminished for those DAMEs who might balk at the CASA requirements (yet to be determined) to issue all classes of certificates, but recommend that any changes to the issuances of aviation medical certificates includes an option for CASA aviation medicine to process and issue certificates to accommodate those DAMEs who perform few medicals or who choose not to step up to the next level of training. Such flexibility would support continuing access to DAMEs especially in rural and remote areas of Australia.

The Panel should note that ASAM continues to partner collaboratively with CASA Aviation Medicine to provide ongoing CPD requirements that are currently required by DAMEs, by way of ASAM's annual scientific meeting and State-based meetings. However, we recognise that busy DAMEs and particularly rural DAMEs still have difficulty accessing these meetings.

The ASAM committee believes it is essential that CASA Aviation Medicine be allocated adequate resources and funding to implement the Panel's recommendations in terms of ongoing training, education, and quality improvement for DAMEs and for the CASA recruitment of aviation medical specialists (this should also apply to CASA Aviation Medicine's current structure and role).



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It was also noted that the Panel recognised that risks to safety should be mitigated in a devolved system. However, the Panel appeared to ignore the paradoxical situation of the “Drivers Licence Medical” (DLM) where GPs (who do not have to be DAMEs) without any aviation medicine training can issue a DLM. Even though there are medical restrictions based on the Austroads “Assessing fitness to drive for commercial and private vehicle drivers: medical standards for licensing and clinical management guidelines”, the flaw in the system is that a pilot who does not meet the medical standards for a Class 2 certificate can present to any GP and self-declare to be healthy. Also, few GPs are familiar with the Austroad AFTD guidelines as they would apply to the aviation medicine, risk and safety context.

While a similar DLM certificate exists in the United Kingdom, a key essential difference is that patients in the UK are allocated to a specific GP who have their full medical history, whereas in Australia we can see any GP anywhere who does not have access to one’s complete medical history.

The ASAM committee believes that medicals required for assessing pilot fitness to fly should be conducted by doctors trained in aviation medicine and who maintain CPD in aviation medicine (ie DAMEs). This is not a declaration of self-interest by ASAM because as stated earlier, aviation medicine comprises less than 5% of a medical practice for the majority of DAMEs and they are busy enough without having to rely on aviation medicals as part of their income.

The ASAM committee considers the DLM removes a layer of safety and we are opposed to the DLM continuing as the minimum requirement for a private pilot licence and recreational pilot licence under the guise of the recreational aviation medical practitioner’s certificate (RAMPC) under the proposed CASR Part 61. While there are flying restrictions with a RAMPC, pilots will still be able to fly in controlled airspace and share the skies with commercial airlines carrying up to 500 passengers.

In summary, if the Panel’s recommendation for devolution of medical certificate issuance for all classes to DAMEs is implemented, the ASAM committee contends it is essential that DAMEs are trained and continued to be educated to a standard beyond what is currently required by CASA; that DAMEs are suitably indemnified by CASA; that CASA Aviation medicine is fully funded and resourced to implement the Panel’s recommendation; and that options are considered and implemented so that not all DAMEs are compelled to issue certificates to ensure equality of access and affordability especially in remote and rural areas. In addition,

consistent with the Panel's recognition of risks to safety, the RAMPC should not be conducted by GPs without any training in aviation medicine. Alternatively, the minimum requirement should be a Class 2 medical certificate for a private pilot's licence.

Yours sincerely

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The Committee of the Australasian Society of Aerospace Medicine  
per Dr Ian Cheng, President  
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Disclosure: four of the eleven Committee members have had previous or current affiliation with CASA.