GAA COMMENT IN RESPONSE TO CRD 2008-17c RE THE LAPL MEDICAL

Introduction

The GA Alliance is a group of organisations representing, as far as possible, all UK General Aviation (GA), and Sports and Recreational Aviation interests (S&RA). The Alliance coordinates about 72,000 subscription-paying members of these bodies. It is estimated that in total more than 100,000 people are involved in GA. This covers ballooning, parachuting, hang gliding, gliding, sport and recreational flying in light and microlight aircraft and helicopters. The GA Alliance objective is to co-operate and consult with government departments and other relevant organisations to support and progress these interests.

General Comment

A proportion of GAA member body pilots fly Annex 2 aircraft and for the immediate future will be unaffected by EASA FCL requirements. Some of these Annex 2 aircraft carry more than 2 people and are equivalent to or exceed the MTOM of some EASA aircraft. The proven medical risk as currently mitigated by National licensing medical requirements is satisfactory for these pilots and will continue to be so following the introduction of EASA FCL. It is illogical and totally disproportional for a pilot of, for example, a 300kg EASA aircraft to be required to be subject to a more complex and costly medical standard than that required by the pilot of a 300kg Annex 2 aircraft.

A high proportion of GAA member body pilots fly EASA aircraft and therefore the LAPL medical proposals as described within the CRD 2008-17c will have a significantly negative impact on their activities. The NPPL medical standard is relied on by approximately 15 000 pilots. We estimate that approximately 10% (1500) of these pilots will be prevented from flying as pilot in command. This includes a number of disabled pilots who currently enjoy life enhancing freedoms associated with flying as pilot in command, but who will be unfairly disadvantaged under the proposed EASA FCL medical requirements.

The GAA is extremely concerned that;

- The LAPL medical proposals in this CRD are significantly different to the proposals published for earlier consultation and on which EU citizens based their responses
- The LAPL medical proposals are far more restrictive than those originally proposed in NPA 2008-17c
- EASA has justified the additional restrictions based on AME opinion but has not considered counter-evidence
- EASA has not carried out an RIA despite the significant cost increase associated with the CRD proposed LAPL medical requirements

UK National Medical Requirements

In 1998 following a proposal by AOPA 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' meets the 1% aeromedical risk level as defined by the JAR-FCL 3. It should also be noted that several of the aeromedical accidents in GA flight have been suffered by pilots holding a valid JAA 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.

CRD 2008-17c - Key Issues

1. Excluding GMP's

The European Parliament Resolution of 3 Feb on an agenda for a sustained Future in General and Business Aviation (2008/2134(INI) no 4 states "Calls on the Commission when adopting implementing rules on aviation safety, to ensure that they are proportionate and commensurate with the complexity of the respective category of aircraft an operation." The Basic Regulation (216/2008) requires proportionate medical measures for recreational aviation, it permits GMPs to assess recreational pilots where national rules allowed, and provides for mitigating limitations when individual pilots do not meet the full medical standard. However the outcome of the CRD has not met these aims. Critically, NPA 2008-17c as presented by EASA to our members and all other interested EU citizens allowed this medical examination 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 objections to the Commision.

2. Evidential Based Rulemaking

Regulations are frequently developed with the aim of controlling a small number of people who do not conform with good practice or societal norms. Without mitigation associated with democratic process, this results in over-regulation of the majority and usually fails to achieve the aim. By way of example in the pilot licensing context, dishonest or psychotic applicants will continue to hide adverse pathology from their AMEs, regardless of JAA medical or EASA FCL medical requirements. Commercially motivated organisations may encourage over-regulation to maximise their interests.

The GAA asserts that accepting opinion from vested interests without considering counter evidence is highly inappropriate and must be questioned.

3. Complexity and Cost

NPA 2008-17c described a medical examination that had been developed by medical experts. CRD 2008-17c proposes are far more complex examination. Other than a comment regarding 'AME opinion', the CRD does not justify why the requirement has increased in complexity. Additional complexity will result in GMP's having to spend additional time in each case. This will result in unnecessary cost to individuals and, potentially, will reduce the numbers of available GMP medicals.

Evidence published in the Journal of American Medical Association on April 1, 1998 (Vol 279, No. 13) regarding balloon accidents contains the statistic that only one death over 30 years of ballooning resulted from medical incapacitation (with the two passengers in the balloon surviving).

Though the article does not predict a denominator, it can be calculated that during those 30 years there were 3,000,000 balloon flights (average length of flight 1 hour so equating to 3,000,000 flight hours). Thus with pilots flying with a driving licence as the only medical qualification there was 1 death in 3,000,000 flight hours. If the pilot population had undergone ICAO compliant medical

certification this would have cost the pilot population close on £10,000,000 (in today's terms) during that time.

Likewise in the UK during the last 45 years there would have been an estimated 1,000,000 balloon flight hours with no reported cases of medical incapacitation. Again, if pilots would have needed an ICAO compliant medical certification this would have cost the pilot population approximately £3,000,000 (in today's terms) during that time.

The cost of obtaining a LAPL medical rather than an NPPL medical will increase by a factor of x10 in the UK (*Reference UK BMA recommended fees*).

4. Periodicity of LAPL Medical to age 45-50

NPA 2008-17c required a single LAPL medical up to the age of 45. The NPA increases the requirement to every 60 months to age 50. The stated justification is 'AME opinion' rather than medical evidence.

Cardiovascular disease is the major cause of aeromedical incapacity but is rare before the age of 45 and was the obvious reason for the periodicity described in the NPA. In published reports ESAM (an association of AME's) 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 UK's 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.

MED.A.60 identifies that LAPL holders are 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.

The proposed LAPL medical periodicity will require a pilot who flies at aged 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. There is a significant resulting economic impact on end users and for some will be a barrier to participation. Despite these important issues, EASA has chosen not to present a Regulatory Impact Assessment.

Proposal

The GAA proposes that the CRD proposed LAPL medical requirements must be reconsidered in light of stakeholder's comments, modified appropriately and be resubmitted for full stakeholder consultation. In particular, EASA must take into full consideration the intent of the basic regulation and the need for proportionality.

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18 Aug 10