

Response to
Consultation on the Future Structure of the
CAA's Medical Department
CAP 1214

The Honourable Company of Air Pilots

The Company was established as a Guild in 1929 to ensure that pilots and navigators of the (then) fledgling aviation industry were accepted and regarded as professionals. From the beginning, the Guild was modelled on the lines of the City of London Livery Companies, which were originally established to protect the interests and standards of those involved in their respective trades or professions. In 1956 the Guild was formally recognised as a Livery Company and in 2014 it was granted a Royal Charter in the name of The Honourable Company of Air Pilots.



Today, the Company's principal activities are centred on sponsoring and encouraging action and activities designed to ensure that aircraft are piloted and navigated safely by individuals who are highly competent, self-reliant, dependable and respected. The Company fosters the sound education and training of air pilots from the initial training of the young pilot to the specialist training of the more mature. Through charitable activities, education and training, technical committee work, aircrew aptitude testing, scholarships and sponsorship, advice and recognition of the achievements of fellow aviators world-wide, the Company keeps itself at the forefront of the aviation world.

The Company is honoured to have this opportunity to respond to the Consultation on the Future Structure of the CAA's Medical Department CAP 1214. This response has been prepared following debate in our Education and Training Committee and our Technical and Air Safety Committee and consultation with our members who are practicing Aeromedical Examiners. Our response takes the form of general comments, followed by answers to the specific questions posed at paragraph 53 of CAP1214. For completeness, those questions are also repeated below with our comments.

GENERAL COMMENTS

The Air Pilots' believe that proposals to cease or to outsource the non-mandatory parts of the current CAA aeromedical capabilities:

- Would diminish unacceptably the UK's aviation medicine competency, research capability and global reputation for excellence and leadership.
- Would over time diminish the robust and cohesive implementation and maintenance of pilot medical status oversight, leading to an inevitable reduction in AME standards and knowledge. That would impact adversely aviation safety and the safety of air passengers and the over-flown population.
- Will have an adverse impact on flight safety. Over the last 10-20 years, there has been a significant change in the pilot/AME relationship. Historically, pilots would avoid an AME at all costs because any medical variance seemed to result in automatic suspension of flight duties; indeed, pilots preferred not to report medical problems rather than seek qualified assistance. Under CAA Medical Department leadership, that relationship has changed to a supportive one and UK AME's are now seen as part of a pilot's support network rather than a threat to continued employment. That transition has been driven in part by CAA Medical Department initiatives and research enabling insulin-dependent pilots to continue flying and the rationalization of colour vision standards.
- Threatens the current approach of AMEs in facilitating pilots to return to flying duties will be threatened whenever an outsourced organisation reviews its risks and potential liabilities.
- Will have an adverse impact on the UK economy not addressed within CAP1214; the cost of training a commercial pilot who becomes unable to fly burdens the UK economy through increased operator costs feed through to the cost of travel and loss of tax income as well as disadvantaging the individual and his/her family.

SPECIFIC QUESTIONS FROM CAP1214

1. What are your views on the proposition that the CAA ceases to be a service provider, via its AeMC, that is regulated by the CAA as a competent authority under the EASA rules?

As long as human pilots are part of the aviation safety chain, it is essential that their fitness to operate is monitored and supported by an expert community without fear of or bias from commercial pressures.

A central research capability remains essential to sustain and improve aeromedical knowledge and that needs to be linked to those who implement medical standards in the pilot population. There is no evidence that these aspects would be sustained through dismantling parts of its medical organisation; history shows that where such areas have been dismantled in other sectors (e.g. defence research establishments) the UK's ability to remain at the forefront atrophies.

The Air Pilots see no conflict in the CAA's regulation of its own AeMC that, notwithstanding EASA viewpoint, reflects established and effective practice in other aviation areas.

2. What are your views on the current situation by which the costs of the functions performed by the CAA Medical Department exceed its income?

This question assumes that the CAA Medical Department has to be financially self-sufficient.

This ignores the CAA global activity as a leader in aeromedical matters and expertise.

This ignores the beneficial impact that services provided by and through that department have in the continued employment of medically challenged individuals. Alternative options do not offer the same support and would exist in a different commercial environment where the Company believes pilots would receive less support and be less likely to retain the appropriate medical certificates necessary for continued employment. Losing those individuals from the pilot profession would then have two adverse effects:

- First, airlines would face an increased recruitment and training cost in replacing pilots lost through failure of a medical.
- Second, the experience levels within airlines would become diluted as fresh trainees replace those more experienced pilots.
 - Loss of experienced individuals from the professional piloting community through natural demographics already poses a safety risk. Increased wastage of experienced pilots exacerbates that risk, especially when airline expansion suggests there will be a global shortage of pilots.

Furthermore, the financial evidence in CAP 1214 is not compelling because it lacks supporting detail. Even if the headline numbers are correct, it is impossible to construct a view of the possible corrective actions or likely benefits or disbenefits of the alternatives proposed. One of our members has asked for a detailed financial breakdown to assist with this analysis but the information provided was little more than already contained in CAP1214. The Company finds it difficult to support embarking on a major change programme on the grounds of income/cost imbalance (or to make properly informed decisions on the Options proposed) without a full understanding of the current financial status.

The Company is also aware that where medical functions have been outsourced elsewhere, actual costs have increased as much as eight-fold while the level of service, including the time that qualified medical expertise is available to staff, has decreased.

3. What are your views on the manner in which the costs referred to in Question 2 are currently distributed? How they should be distributed in the future?

The service provided by the CAA Medical Department benefits the (professional and leisure) aviation communities, the aviation industries and the general public whether as fare paying passengers or as part of the over-flown population. All beneficiaries should play a part in funding the Department.

More broadly, the UK's knowledge, research and global credibility in the aeromedical sector benefits UK industry and UK government's standing with aviation. The fiscal benefits arising from this would be difficult to quantify but should be reflected in any funding arrangement.

4. Do you agree that the CAA, which is funded by industry, should continue to retain and develop the expertise necessary to take an effective role in developing aeromedical policy and practice in the years ahead?

For the reasons already mentioned in answer to questions 1 and 2, the Company sees no viable alternative to CAA retaining and developing its aeromedical expertise. It does not believe the alternative proposals safeguard either the sustainment of necessary pilot aeromedical standards or satisfy individual, company or UK economic needs.

5. What are your views on each of the options considered in this consultation?

For reasons already stated, based on the information provided within CAP1214 the Air Pilots believe only Option 1 is viable and safe.

6. Which of the options outlined in this consultation should the CAA prefer for the future of the Medical Department?

Option 1.

➤ **What are your reasons for this view?**

The financial case for Options 2 and 3 has not been made, nor have the risks identified in answer to questions 1 and 2 been addressed.

➤ **Why have you rejected the other options?**

As stated in answers to questions 1-4.

7. Are there any alternative options that meet the CAA's core criteria, and which you think the CAA should consider?

CAA should review how it makes aeromedical information available outside the UK and whether the costs of that service could be recovered from the recipients.

CAA should review whether Medical Department costs should be borne solely by the aviation communities/industries or whether a general taxation income would also be appropriate.

8. In your view, what risks should the CAA seek to manage and pay special attention to as part of the implementation of any option for its services?

CAA must address flight safety and the safety of air passengers and the overflowed public through ensuring that only pilots of appropriate medical fitness are permitted to fly; this applies similarly to Un-manned Air System operators and to Air Traffic Controllers.

CAA must ensure that unnecessary safety, personal and economic (personal, industry, UK) damage does not occur through the unnecessary loss of pilots from professional or leisure flying due to medical conditions that a more robust, informed and up to date aeromedical community might otherwise have kept flying and in employment. This concept applies equally to Un-manned Air System operators and to Air Traffic Controllers and is further expanded in bullet points within the answer to question 2.

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