General Aviation Alliance

UK Private Pilot Licence and National Private Pilot Licence Medical Requirements - CAP 1284

Introduction

The GA Alliance is a group of associations representing, as far as possible, UK General Aviation (GA) and particularly Sports and Recreational Aviation (SRA) interests. The Alliance coordinates some 72,000 subscription-paying members of these bodies. These members represent the owners/operators of around 60% of the UK registered aircraft fleet, rising to over 70% when unregulated aircraft are included. Activities cover parachuting, hang gliding, gliding, ballooning, plus sport and recreational flying in light and microlight aircraft and in helicopters. The objective of the GA Alliance is to co-operate and engage with government departments and other relevant organisations on regulatory and directly-related matters, to support and progress the activities of SRA.

This invited late response to the public consultation on CAP 1284 was prompted by some process concerns about the last stages of the CAA consultation, and by our ambition to present a more definitive and co-ordinated opinion from the SRA stakeholder community. This response has been agreed by the relevant member bodies of the GA Alliance (with the exception of PPL/IR which chose to stand aside on this primarily SRA matter). It uses elements of the individual association responses already submitted, but seeks to present a more nuanced view, to guide the CAA in their final decision making.

In several places the views expressed in this document differ substantially from those expressed by the individual associations, but where this is the case we explain the differences and the associated context and reasoning. Because we were able to use the CAA data from individual responses to the CAP 1284 questionnaire, we were in a position to contrast these responses with the submitted views of our member association responses, and this has informed our stance, especially on the questions of age limitations and passenger carriage. On one subject (carriage of passengers) there was a difference of views which has meant that we have not expressed a joint opinion.

We should emphasise that the GA Alliance generally supports the proposals put forward in CAP 1284 and believes that these represent an enlightened and positive approach to GA deregulation.

The international context

We note that the UK CAA has played a pivotal role in the development of medical requirements for the EASA LAPL, ensuring as far as possible a proportionate light-touch approach. There are other current examples of substantial deregulation of SRA medical requirements. For example in France, a microlight licence requires a medical declaration at licence initiation and thereafter on on-

going self-assessment without oversight. In the USA, the Light Sport Licence medical is based on the possession of a current driving licence and has no age limitation. There are proposals to extend that medical principle to non-commercial VFR below 14,000 ft in aircraft up to 2,772 kg (6,000 lbs), five passengers and less than 250kts; a more ambitious proposal than CAP 1284. We believe that successful deregulation in the UK and USA will also influence EASA, towards the adoption of proportionate medical requirements for SRA.

The need for an NPPL self-declaration

There was a substantial concern raised by the BMAA, that the specific requirement to hold a driving licence would disadvantage some existing and potential pilots, by requiring them to take an EASA Class 2 or LAPL medical examination, instead of an NPPL self-declaration.

The BGA response to CAP1284 is described in their original response to the consultation (as agreed by the BGA Executive Committee). The BGA strongly supports the GA Alliance view that the NPPL medical Groups 1 and 2 should be retained for use where it is inappropriate to use a driving licence to demonstrate medical fitness.

GA Alliance is grateful for the opportunity offered by our late submission to clarify for the CAA our common view on this topic, which we believe must now be re-visited. This response is given on the basis that the current NPPL Self-Declaration of Fitness is retained without change to standards or process.

If a pilot does not have a driving license, an equivalent NPPL health declaration must be available. Retaining the NPPL medical declaration opportunity may also have benefits for older pilots and those who wish to carry passengers. If formal self-certification is required by a pilot, using a NPPL document, the revalidation/renewal criteria and validity periods should be aligned with DVLA requirements to avoid anomalies.

Answers to CAP 1284 specific questions

Question 1: Do you agree that private pilots do not generally take part in recreational flying if they feel unwell? Please answer yes or no. If you do not agree, please explain why.

Answer: YES. Pilots have to make a judgement of many factors prior to a flight, weather, airfield state, aircraft serviceability etc., and personal fitness is yet another consideration. Most pilots understand that fitness to fly is a legal requirements and part of their pre-flight assessment, but will informally rule out flying several times a year, perhaps on the basis of a heavy cold or other minor condition that would nevertheless prejudice their flying skills and hence flight safety. It is our experience that recreational pilots are not usually under the same pressures to fly as commercial pilots. They act responsibly and do not fly when feeling unwell. The vast majority (99%) of individual respondents

to this question agree with this view.

Question 2: Do you agree that the probability of private pilot incapacitation in flight is extremely low? Please answer yes or no. If no, please provide evidence.

Answer: YES. The evidence provided in the consultation (as well as other data such as that submitted by the BGA) provides clear indication of the very low probability of private pilot incapacitation. The vast majority (99%) of individual respondents to this question agree with this view.

Question 3: Do you believe that we should proceed with the proposal to allow private pilots with the UK PPL or NPPL to fly provided they meet DVLA Group 1 Ordinary Driving Licence medical standards, with no GP or AME involvement in the process? Please answer yes or no. If no, please provide evidence.

Answer: YES. The vast majority (96%) of individual respondents to this question agree with this view, that the ODL standard is sufficient for PPL and NPPL. However, opinion among our member associations differ (see later remarks in this document at Question 7), as to whether this answer should be qualified by some limitation regarding passengers.

Question 4: To minimise the risk of private pilots not being fit to fly (through illness or degeneration of senses) do you believe that we should require private pilots to self-certify themselves through, for example, signing a form? Do you believe they should submit this information to us at regular intervals aligned with the validity of current medicals? (e.g. five, two or one year, dependant on age)? Please answer yes or no to both points.

Answer: YES, except where a driving license is held. We note that 75% of individual respondents were happy to self-certify their medical fitness at appropriate intervals, but self-certification in every case would, we believe, be an unnecessary bureaucratic burden with little safety benefit. The simple possession of a driving licence is sufficient evidence of fitness to DVLA Group 1 standard.

However, a NPPL self-declaration approach must be available where a driving license has not been held or is not current. If a driving license has been held but has been surrendered on health grounds, or for example a driver has been banned from driving due to substance misuse, a GP assessment should be required.

In terms of submission of self-certification information to the CAA, our answer is **NO**. Again there would be an unnecessary bureaucratic burden and cost, on both the CAA and the pilot. In this, we are at variance with the majority (70%) of individual respondents. However, we would like to see the renewal requirements of NPPL self-certification aligned with the DVLA driving license

requirements and not aviation medical examination requirements.

Question 5: Based on the evidence presented, or other evidence which you can reference, do you believe an upper age limit should be included on the proposed change to the medical requirements for private pilots? Please answer yes or no. If you do believe an age limit should be imposed on this new requirement, what do you think the age limit should be? Please give an exact figure and rationale.

Answer: NO. Among individual responses, the great majority (73%) rejected an upper age limit (which is, as noted above, the case in French microlight, US LSA licence and the current FAA proposals). The third-party risk from pilot incapacitation in light aircraft is so low as to indicate that no limitation should be necessary on that score.

Although it is expected that fitness is likely to reduce with age, the rate at which it does so cannot be predicted and so for as long as a pilot is able to comply with the requirements there should be no age-related bar to continuing to act as a pilot.

We do not expect many pilots to continue flying into advanced old age, under the proposed self-certification system. Pilots are generally responsible in their approach. The typically tendency is to increasingly limit the operational envelope, as confidence in personal capabilities reduces. Flying only with other qualified pilots is also a common practice. It is our experience that people know when to stop flying alone, even when no specific illness or disability is involved. It should be noted that the Biennial Review process provides a regular opportunity for an instructor to observe a pilot's competence and capabilities. It is not unknown for such a review to trigger a pilot's decision to cease flying

Opinion differs among our member associations about age limitations, and the issue of passengers (Question 7) is relevant to those who preferred a 'Yes' answer. There is evidence of increased incapacitation risk with age. The BGA response indicated that for a healthy population, the risk of pilot incapacitation exceeds the 2% level required by the DVLA for Group 2 professional drivers by the age of 75, but that at no age does the incapacity risk level exceed that required for Group 1 drivers. The BGA operate rules on age and passenger carriage in their specific environment, which they will continue to apply.

DVLA require Group 1 (ODL) driving licence renewal at three year intervals from the age of 70 with a medical self-assessment, including a mandatory self-declaration covering key conditions that can reduce driving capability. The DVLA also publish a comprehensive guide to medical fitness standards for driving, with reporting requirements and medical reporting forms for GP use. In the current NPPL medical system, solo flight (or with competent passengers only) requires DVLA Group 1 (ODL) standards and this approach has been successful for many years. GA Alliance considers that it is appropriate for pilots of any age who carry a driving license and that an NPPL declaration must

remain available for those who do not.

Question 6: Do you believe that private pilots who have a history of significant psychiatric condition (i.e. that requires medication) should be assessed by their GP rather than use a self-certification system? Please answer yes or no and provide reasons.

Answer: YES. Some pilots who have such a history might lack insight into their condition, be in denial or be unable to objectively assess their health. A GP assessment (rather than an AME medical) allows a better opportunity to assess the medical history including previous psychiatric problems and also substance abuse issues. The great majority of the individual responses (83%) answered YES to this question.

Question 7: If the medical requirements are changed as proposed, should the number of passengers a private pilot carries be restricted? Please answer yes or no. If yes, do you think this should be restricted to a)one, b)two, c)three, d)four or e)five.

Answer: See below. We note that a small majority (56%) of individual respondents supported the "No" response and that of the 44% that responded "Yes" the majority (46%) supported a restriction of 3 passengers. Again we note that the French microlight and US LSA licence medical arrangements as well as US current proposals are liberal in this area.

The primary issue for light aircraft is the impact of pilot incapacitation on passengers. A search of the AAIB database for the ten years between 2004 and 2014 provides evidence of 9 GA and SRA fixed wing fatal crashes, for which the probability (or more often the possibility) of pilot incapacitation is mentioned as a causal factor. In four of these, a single passenger died in addition to the pilot. Two of these occurrences involved pilots flying with NPPL licenses, two with ATPLs, the other pilots were flying on a PPL or CPL. To this list we must add the 2013 occurrence in which a pilot died in flight but an unqualified passenger landed the aircraft safely. These data, limited through they are, conform much anecdotal evidence showing that incapacitation is rare, but can occur with pilots under all levels of medical scrutiny.

There are two relevant issues: firstly, informed passenger consent and secondly, the capability of a passenger to land safely in the event of pilot incapacitation.

Informed consent to passenger flying in the SRA domain is a valuable and valid concept that can properly apply to pilot, as well as aircraft and operational elements of the risk scenario. All informed passengers (even nowadays those on CAT flights) will be aware of the increased risk in a single pilot situation. It is important that SRA passengers should be informed that a pilot is flying with DVLA medical standards if that is the case, just as they should be informed as to an aircraft's airworthiness status (e.g. Permit rather than C of A).

The BGA and the BMAA are concerned with a single passenger only, due to the nature of their aircraft. The BGA requires that pilots flying with DVLA Group 1 (ODL) medical standards should fly only with someone "competent to recover the aircraft in the conditions of the proposed flight", and in a typical gliding club setting they will be in a position to ensure that this happens.

Other than BGA clubs, where flight operation are a core feature of club activities, GA Alliance member associations are generally not involved in operational matters.

The BMAA considers that for holders of medical certification to DVLA Group 1 (ODL) standards the current restrictions on passenger-carrying as applied to the NPPL Group 1 (i.e. 'competent' passengers only) are appropriate. Pilots with medical certification to DVLA Group 2 (PDL) standards should not have a passenger number restriction.

LAA aircraft include an increasing number of aircraft with more than two passenger seats. The LAA response suggested that pilots should hold a valid GP medical declaration (or an EASA Class 2 or LAPL medical certificate), if they wish to carry more than one passenger.

GA Alliance notes the individual and association responses to the CAA on passenger carriage, but because of differences in member views (including that DVLA Group 1 (ODL) is adequate for 3 passengers) cannot express a joint opinion concerning passenger carriage with the medical requirements changed as proposed.

Question 8: Do you believe that private pilots taking advantage of our proposed change to medical requirements should have to fly with a safety pilot? Please answer yes or no.

Answer: NO. The vast majority (96%) of individual respondents also took this view. A DVLA Group 1 drivers license will allow pilots to fly solo when the only person at risk is themselves (other than the very minimal risk to third parties outside the aircraft). As indicated above, we do not express a GA Alliance joint opinion on the carriage of passengers with a DVLA ODL drivers license or NPPL medical declaration to Group 1 standard.

Question 9: Do you believe that the medical requirements for flight instructors should be changed from the current system? Please answer yes or no.

Answer: NO. Student pilots and the public rightly expect that paid flight instructors' medical fitness should be established by aeromedical examination, or alternatively in some cases by a GP-countersigned medical self-declaration to NPPL (DVLA Group 2) standard. A strong majority (66%) of individual respondents agreed that no change was required in this area.

However, the situation is different for PPL Instructors and coaches such as those involved in the LAA's Pilot Coaching Scheme, who are flying only with qualified pilots to conduct Biennial Reviews, class ratings and differences training, etc. These coaches should be able to use a driving license or self-certify their own medical fitness to NPPL (DVLA Group 1) standard when their services are not remunerated.

Question 10: Do you believe that the UK PPL holder wishing to take advantage of the proposed new medical requirements should be limited to flying aircraft with a Maximum Take-Off Mass of 5,700kg or less? Please answer yes or no.

Answer: YES. Larger aircraft have much more kinetic energy in the event of a crash, and hence can cause more damage to people and property on the ground. The BGA response provided compelling supporting evidence, from a published analysis of military crashes. Setting a reasonable limit such as 5,700kg shows a clear intent to protect the public from possible pilot incapacitation. The great majority (74%) of individual respondents agreed.

Question 11: Do you believe that the UK PPL holder wishing to take advantage of the proposed new medical requirements should be limited to the licence privileges of an NPPL holder? Please answer yes or no.

Answer: NO. The license privileges of an NPPL holder are relatively limited and exclude many aircraft under 5,700kg that a UK PPL holder might reasonably wish to fly. The great majority (72%) of individual respondents also disagreed with this proposal.

Question 12: Do you believe that the medical requirements for the CPL(B) should be changed? Please answer yes or no. Please also provide reasons for your answer.

Answer: NO. Commercial passengers in any type of recreational aviation have a right to expect that their pilot is fully competent and has been assessed as medically fit. There are several scenarios in balloon flight where pilot fitness is potentially an issue. 82% of individual respondents agreed that the medical requirements for the CPL(B) should remain unchanged.

Question 13: Do you believe the proposal to change the medical requirements for UK PPL and NPPL holders should be extended to EASA PPL holders flying non-EASA aircraft in the UK? Please answer yes or no.

Answer: YES. There are numerous EASA PPL holders (many having recently changed from a UK PPL) who may in due course find difficulty in maintaining a Class 2 or LAPL medical certificate, but who would wish to continue to fly light

non-EASA aircraft using a self-certification medical approach. This measure would avoid them having to apply for a new national license. The vast majority of individual responses (93%) agreed with this position.

Question 14: Do you have any other specific comments which you would like to be considered as part of this consultation?

Answer: Aviation medicine has its roots in military and commercial aviation, whose pilots must be as fit and healthy as possible, to protect national security and the travelling public. Recreational pilots have been drawn into this domain on doubtful grounds, to be assiduously examined and charged for the privilege. When analysing the results of this consultation, it is important that any negative responses of producer interests (including AMEs) are not assigned undue weight on the basis of 'special expertise'. The evidence of low risk presented in the consultation document is compelling.

Question 15: Do you believe that the figures used to describe the time and cost benefits are accurate for the average private pilot? Please answer yes or no. If no, please provide your view on what realistic figures would be.

Answer: NO. The figures given are representative of the nominal cost of medical examinations (as evidenced by the 94% of individual respondents who agree with them) but underestimate the considerable travel and opportunity costs of attending for an AME medical examination. They also omit the costs of any follow-up investigations. When further tests are required, for example to investigate cardiovascular symptoms, the pilot will typically pay for these, often costing hundreds or thousands of pounds.

Question 16: Can you identify any other specific benefits of this proposal?

Answer: A key benefit of this proposal will be to reduce the barriers of entry for new participants whilst not increasing the overall level of risk to the general public. This proposal will also benefit UK SRA by allowing private pilots to have a greater degree of control over the later stages of their flying 'career'. An abrupt cessation on medical grounds is a harsh end, of what may have been a lifelong passion for flight. Self-certification should allow a pilot to better manage the transition process.

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