Årgang 25 -2
MARS 2017

Flyvebladet

MEDLEMSBULLETIN FOR NORSK FLYMEDISINSK FORENING

Innhold:

Mer om kurset, skisse av programmet + **info om påmelding**

Innkalling til generalforsamling

EASA krav om Peer support også for AME ++

Brukerforum

Kursprogrammet foreligger nå i en skisse i og med at alle foredragsholdere ikke er helt på plass. Det vil bli vekt på flygeledere på torsdag for å sørge for at vi kan oppfylle kravene for å utføre medisinske undersøkelser for klasse 3.

EASA forbereder ytterligere endringer og krav, særlig til flyleger som ønsker å være godkjent for utføre klasse 1 og 3 legeattester. Dette som et ledd i en ønsket profesjonalisering av flylegene. Noe mer om dette i neste punkt.

Foreløpig kursprogram – det er søkt godkjent:

Torsdag 20 april

1630-1700	Part-ATCO.MED
1700-1900	Operativt arbeidsmiljø for flygeledere (ved Avinor)

Fredag 21 April
Kan være at kurset starter 0800, se endelig program

0830-0915	Innledning og praktisk informasjon ved Luftfartstilsynet (Terje)
0930-1015	Diagnostikk av rusmiddelproblemer
1030-1115	Diagnostikk av rusmiddelproblemer
1130-1215	Biologisk prøvetaking for å avdekke rusmiddelbruk
1215-1300	Lunsj
1315-1400	Kommunikasjonsteknikk
1415-1445	Kommunikasjonsteknikk
1445-1500	EMPIC (Lasse og Hege)
1515-1545	AME-veileder (Terje)
1545-1600	AME quiz (Kahoot!)

Stedet er Thon Hotel Opera, Storkvinten.

Etter programmet på torsdag vil det umiddelbart følge Årsmøte/generalforsamling for NFF og deretter middag for kursdeltakerne.

Kursavgift og medlemskontingent NFF: 2800,-
Kursavgift ikke medlem: 3100,-
Kursavgift og medlemskontingent inkludert middag: 3400,-
Kursavgift inkludert middag ikke medlem: 3700,-

(Festmiddagen koster 600,- inkluderer 3 retter og inntil 3 glass vin.
Kontingent i 2017 er 400,- for deg som ikke kan komme på kurset.)

Påmelding skjer kun gjennom innbetaling av kursavgift med medlemsavgift for 2017 og middag på NFFs konto nr. 9235.17.93505. Det er veldig viktig å skrive hvem påmeldingen gjelder. Påmelding kan starte nå!

Innkalling til Generalforsamling i NFF Torsdag 20 april 2017, sted Storkvinten, Thon Hotel Opera, tid: rett etter kursavslutning – ca kl 1900

Saker: Godkjenning av innkalling, Årsberetning fra Leder og kasserer, Eventuelt. Det er ikke valg i år.

Peer-Support - kollegastøttegrupper!

Vedlagt, som egen .pdf fil, er EASA rapport etter Germanwings ulykken (**Task Force on Measures Following the Accident of Germanwings Flight 9525**) og det er foreslått flere tiltak som skal iverksettes forholdsvis snart. Det som er viktig for oss er kapittel 4: "Aeromedical Checks" som jeg anbefaler at dere leser i sin helhet. Det er litt lettere å lese i det ved lagte originaldokumentet, men all tekst er også gjengitt under. Det er ikke alt som vil berøre oss direkte, men det er viktig at vi vet hva som skjer når vi møter pilotene. Vi bør jo helst være like godt orientert som det de er.
Alkoholtesting er allerede i gang og vil bli et av temaene på kurset.

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4 Aeromedical Checks

The pilot of the Germanwings accident underwent an initial Class 1 medical assessment and psychological evaluation by a pilot training organisation prior to being selected for flight training. He developed mental ill-health which manifested itself during ab-initio training.
The overall number of aviation accidents with a medical cause or contribution is small but they have the propensity to result in rare, catastrophic accidents. Not all medical events are predictable.

4.1 The initial and continuous assessment of pilots

The Task Force analysed the current assessment system. The current process foresees that candidates for flight training undergo medical screening and airline and pilot training organisation selection procedures:
Medical screening: An initial Class 1 medical assessment includes the taking of a medical history, examination and several tests, among which a general mental health assessment. If the medical history or discussion raises concerns about psychiatric or psychological ill-health, the candidate is referred to a psychiatrist or a clinical psychologist for review prior to their fit status being decided
The system puts emphasis on the ability of the aero-medical examiners to detect disorders in all fields of medicine, including psychiatric and psychological disorders. Sometimes these disorders are difficult to detect, for example because no early symptoms exist, or when an individual is not open about their symptoms, thoughts or behaviour.
Airline and pilot training organisation selection procedures: Psychological evaluation of self-sponsored candidates and airline cadets is undertaken through pilot training organisations, under the direction of a psychologist. Currently, some entrants into commercial flying will never undertake an initial psychological evaluation due to their training path.

If undertaken, the psychological evaluation includes an assessment of cognitive capacity to be an airline pilot, as well as performance aspects, checking abilities such as multi-tasking, psycho-motor coordination, attention, concentration, memory, reaction times and stress tolerance. Pilot training organisations tend to use their own customised tests.
The psychological evaluation at the selection stage may include an evaluation of the personality of the candidates. The aim of these tests is to identify applicants who are balanced and do not show any signs of behavioural instability, and to exclude applicants whose personality factors elevate the risk of later behavioural problems.
After having been accepted for Air Transport Pilot License training, currently candidates who experience difficulties in terms of performance or behavior during training (e.g. from fatigue, intense workload, depression, substance misuse) may be reported by flight instructors or other students to the pilot training organisation management. For some pilot training organisations, those difficulties trigger a meeting between the student and the chief pilot or the Head of Training of the pilot training organisation and in the case of depression, anorexia, addiction, etc. with a clinical psychologist and/or psychiatrist.
Psychological evaluation of applicants for airline pilot training (self-sponsored and state/airline sponsored) is essential but evidence to date does not support the idea that recurrent evaluation brings added value.
Aero-medical examiner advice between medicals: A pilot who is determined to hide a medical condition, which is not detectable on examination, may currently seek medical advice and treatment in another country and is able to purchase medication abroad or over the internet.
The role of aero-medical examiners in giving aeromedical advice to pilots between medicals is essential and is not always sufficiently emphasised in the rules or well understood by pilots and there is very little EASA guidance material on aeromedical matters.
Based on these observations, the Task Force recommends to emphasise, in the rules and in aero-medical examiner training, the role of aero-medical examiners in giving aeromedical advice to pilots between medicals and promote this to pilots. Issues potentially affecting flight safety are reported by aero-medical examiners to the licensing authority.
Continuous aeromedical assessment: Regarding the continuous assessment, aero-medical examiners learn most of the information through pilots giving information about their past medical history, current and past medication, and answering questions directed by the doctor depending on their psycho-social situation and

"Recommendation 2: The Task Force recommends that all airline pilots should undergo psychological evaluation as part of training or before entering service. The airline shall verify that a satisfactory evaluation has been carried out. The psychological part of the initial and recurrent aeromedical assessment and the related training for aero-medical examiners should be strengthened. EASA will prepare guidance material for this purpose."

4.2 Drugs and alcohol testing

The use/abuse of drugs and alcohol4 is one of the few disorders that has the potential to affect the mental health of pilots, for which screening by means of biochemical tests is available.
From 1980 to 2011, there were 31 medical-cause commercial air transport accidents of which 20 were of psychiatric cause. The highest proportion of the psychiatric causes (60%) was due to drugs or alcohol5.
Drugs and alcohol can lead to errors, slow or incorrect judgement and decisions, poor cognitive function, slow reaction times, mood changes, poor coordination, tracking or concentration and risk-taking behaviour or inappropriate action. All these have clear implications for flight safety. In contrast to most other medical causes of flight crew impairment or incapacitation, the impairment of a pilot due to drugs and alcohol is

often difficult to recognise and is likely to affect the whole of a flight duty period6. Side effects from certain types of medication can also lead to a flight safety risk.
Early recognition of drugs and alcohol problems is more likely in a company that has an active, clear, accessible and open reporting system, which promotes fair management of pilots with medical issues and has a good safety culture. Positive support and active rehabilitation is essential to encourage declaration of drugs and alcohol problems. The demonstration of a robust company stance differentiating between strong support for pilots who self-declare and intolerance of pilots who don't declare and put their and others' lives at risk is of paramount importance.
Drugs and alcohol testing is mandated by legislation in a number of States and also undertaken by a number of airlines in States where there is no statutory requirement to test. It is currently being considered by a number of aviation authorities and airlines. The Task Force reviewed evidence from safety regulators and airlines undertaking drugs and alcohol testing, all employer led rather than mandated by legislation. The Task Force also took account of legislation and practices related to drugs and alcohol testing in the road and rail areas.
Different scenarios were considered for the drugs and alcohol testing: pre-employment, with due cause (e.g. post incident/accident, whistleblowing report, on suspicion), periodic, random and follow-up (after tests).
A number of elements to be considered for a drugs and alcohol testing programme were identified and analysed, including policy, training of staff, testing principles and implementation, quality assurance and issues for employers.
Based on the analysis carried out, the Task Force recommends to mandate drugs and alcohol testing as part of a random programme of testing by the operator and at least in the following cases: in conjunction with the initial Class 1 medical assessment or when employed by an airline, post incident, post-accident, with due cause, as part of follow-up and after a positive test result. All operators' Safety Management System should include a drugs and alcohol policy and organisations should be required to report the results of testing to the competent authority.
The following considerations and guidelines might be taken into account for the implementation of the recommendations:

– The test shall comply with the best practice including "B samples" to avoid false positives.

– It may be appropriate to obtain a complete EU-wide picture of national drugs and alcohol legislation that affects pilots by surveying the competent authorities.

– International experience should be taken into account.

– Require the competent authority to collate the results of testing and to amend the percentage of pilots required to be tested the subsequent year according to the proportion of positive results obtained in the previous period.

– Require the competent authority to approve accredited organisations to undertake drugs and alcohol testing for licensing purposes.

– Legislation should avoid mandating a list of drugs to be tested to allow for local variation in usage and the introduction of new drugs. Guidance will need to be updated regularly.

– Any publicity campaign to introduce the concept of drugs and alcohol testing to the aviation community should include safety information about potential side effects of medication, both prescribed and purchased directly from a pharmacy or online.

– It might be considered to extend the target group for the random testing programme to other safety critical professionals.

4 Drugs' is used in this report to refer to illicit drugs. Medication is used to refer to substances either prescribed or bought over the counter, or internet, to treat symptoms or a medical condition.

5 Medical Cause Fatal Commercial Air Transport Accidents: Analysis of UK CAA Worldwide Accident Database 1980-2011 (Abstract). SJ Mitchell, M Lillywhite Aviat Space Env Med: 2013; 84(4)p346
6 'Impairment' is used to signify reduced functioning. 'Incapacitation' is used to signify complete inability to function.

Recommendation 3: The Task Force recommends to mandate drugs and alcohol testing as part of a random programme of testing by the operator and at least in the following cases: initial Class 1 medical assessment or when employed by an airline, post-incident/accident, with due cause, and as part of follow-up after a positive test result.

4.3 The aero-medical examiner framework

The Task Force reviewed the current European aeromedical system, including the regulatory framework and the roles and relationships of the different actors including the authorities, aeromedical centres, aero-medical examiners and pilots.

4.3.1 Aviation medicine capability

The current rules require that, in the case of Class 1 medical certificate applicants and holders, difficult, contentious and borderline decisions shall be referred to the licensing authority. In these cases, the authority medical assessor needs the right level of experience to take a leading role and decide on the fitness of the applicant. However, it is difficult for aero-medical examiners without a profound clinical background to deal with pilots having health problems but not having reached a critical threshold. This problem is further aggravated by the fact that many aero-medical examiners work in relative isolation, alone or as part of medical practises without the support of colleagues facing the same issues.
The authorities play an important role in ensuring a cooperative relationship with aero-medical examiners, including in sharing detailed information on the latest medical developments and rule changes.
The Task Force discussed the creation of networks of aero-medical examiners as a way to address these issues. These networks could be coordinated through the national authorities and grouped according to geographic or work environment criteria. They would provide peer support and ensure that aero-medical examiners are not isolated in their daily activities. However, aero-medical examiners will remain responsible for their decisions. Training for aero-medical examiners should be complemented by additional training in psychological disorders and patient communication skills.
A complementary way to mitigate aero-medical examiners isolation would be for aeromedical centres to play the role of network coordinators.

4.3.2 Aviation medicine process oversight

The Task Force analysed the oversight of the aviation medicine system and highlighted the importance of evaluating the quality of pilot medical assessments. The Task Force identified the main following issues:

– There are presently no requirements for EASA to approve or audit aero-medical examiner training providers to ensure the level and consistency of training provided.

– The rules overseeing the auditing of aero-medical examiners and visits by medical standardisation teams are compliance based and concentrate on written processes and facilities.

Moving to a performance based audit and oversight system would bring strong benefits by showing the tangible issues faced by aero-medical examiners in their decision making, when making judgments on pilot fitness. This assessment of medical examiner performance should demonstrate how their knowledge is applied in practice. To support this change, authority medical assessors should receive training in performance-based audit techniques and the regulations should support this.
The main recommendation from the Task Force in this domain is to switch the focus of aeromedical audits to the assessment of aero-medical examiners performance including the application of their knowledge in practice. The Task Force also recommends that:

– EASA approves and audits the training of aero-medical examiners.

– When introducing a performance based auditing system of aero-medical examiners, authorities are able to undertake some routine elements of the audit by videoconference.

– Changes to requirements take into account the different situations across Europe, as some States have only a very small number of aero-medical examiners, all trained by a single organisation.

– A high level of aviation medical competence should be ensured within the Authorities and the aeromedical centres.

– The merits of a periodic assessment in an aeromedical centre should be further explored.

Recommendation 4: The Task Force recommends the establishment of robust oversight programme over the performance of aero-medical examiners including the practical application of their knowledge. In addition, national authorities should strengthen the psychological and communication aspects of aero-medical examiners training and practice. Networks of aero-medical examiners should be created to foster peer support.

4.4 Aeromedical data

The introduction of pan European medical certification has given pilots freedom to apply to an aero-medical examiner certificated by any EASA State. A system to share aeromedical information in an efficient manner is important to minimise the risk of non-declaration introduced by this freedom.
The Task Force identified the following main issues:
– The implementation of data protection rules should balance the need to protect patient confidentiality with the need to protect public safety. Unless national rules are changed, this will continue to be a risk.

– Pan European medical certification has opened the potential for medical tourism as the States do not share a common medical data system. The authorities and aero-medical examiners do not have access to the past medical history of the individual, nor information on whether a pilot has been denied a medical certificate if previously assessed in another State, nor the reason for denial.

– Pilots are increasingly mobile. Some choose to undertake their medical examinations in States where the costs are lower and there may also be a tendency to go to aero-medical examiners who have a reputation for having a less rigorous approach to examinations. Some may choose to shop around with an intention not to declare one or more aspects of their medical history. A history of psychiatric disease like depression or personality disorders as well as issues including drugs and alcohol misuse is particularly vulnerable to this type of non-declaration as there may be no clinical signs that can be elicited on examination. Many operators are still insisting on pilots changing their licences to the State in which the operator is based when they start working for them.

– Also, in the case of a revalidation or renewal application in a different State, procedures have had to be created by the authorities to ensure the medical information report is sent to the authorities of the State responsible for issuing the licence. The procedures are not legislated, are difficult to apply in some States and very difficult to control and oversee. The volume of manual data handling and data loading is large.

The Task Force reviewed the feasibility of a European aeromedical data repository containing basic medico-administrative information and of a comprehensive aeromedical records management system to supersede national systems. The practicality of implementing a full pan-European aeromedical records management system at this time was questioned. Significant issues include cost, lengthy implementation time, data security and difficult buy-in from stakeholders.

A European repository containing medico-administrative information, limited to Class 1 medicals, would deliver a significant benefit and be more readily accepted by aero-medical examiners and other stakeholders. It would include basic personal information (name, date of birth), State of License Issue (or to which the pilot has applied for a medical certificate if yet to achieve a licence) and details of the aero-medical examiner who issued the last medical certificate and current fit status. While acknowledging the limitations of the repository, it could as an act as interim measure to a future full aeromedical records system.

The Task Force recommends the creation of a European aeromedical data repository as a first step to facilitate the sharing of aeromedical information and tackle the issue of pilot non-declaration. EASA will lead the project to deliver the necessary software tool, including the analysis of costs and data protection related issues.

Recommendation 5: The Task Force recommends that national regulations ensure that an appropriate balance is found between patient confidentiality and the protection of public safety.
The Task Force recommends the creation of a European aeromedical data repository as a first step to facilitate the sharing of aeromedical information and tackle the issue of pilot non-declaration. EASA will lead the project to deliver the necessary software tool.

Flyselskapene har fått det same kravet om Peer Support groups. Mange selskaper har det allerede, men for å hjelpe det hele i gang så var vår europeisk flymedisinske paraplyorganisasjon (ESAM) en av initiativtakerne til å få startet dette opp på europeisk plan og jeg anbefaler dere å ta ek kort titt på nettstedet: http://eppsi.eu

Styret kommer til å jobbe med denne saken og se på ulike løsninger, alt fra at man kan møtes lokalt eller bruke videokonferanser av ulike slag. Fra EASA er det ikke et krav – ennå.

Vi har startet opp vårt diskusjonsforum, registrer deg! Vi håper at diskusjonsforumet kan revitalisere foreningen. Vi håper at alle medlemmer blir med fordi vi tenker oss at dette blir en måte å sende ut forespørsler, få inn ideer og tanker til saker styret bør ta tak i, sende info om kurs og møter – men aller viktigst: bli en plattform for diskusjoner om saker som opptar oss alle.

Bruksanvisning for hvordan forumet kan brukes følger her!

Velkommen til NFF sitt brukerforum!

Hvordan komme i gang første gang!

Velg Brukertilgang fra hovedmenyen!

Velg: **opprett ny konto**

Velg deg et brukernavn og epostadresse og fullt navn. Navnet ditt fremkommer når du poster i forumet. **Det er altså ikke mulig å være anonym**.

Du må bekrefte tall og bokstaver i CAOTCHA og trykk til slutt på ”Opprett konto”.

Administrator må nå godkjenne deg og det kan ta litt tid, avhengig av at administrator er tilgjengelig. Når du er godkjent, får du en mail som inneholder en link der du blir bedt om å generere ditt eget passord og du før mulighet til å legge inn bilde, osv. Når du er ferdig, blir du logget ut og deretter må du gå til Brukertilgang på menyen. Der blir du bedt om å skrive inn brukernavn og passord. Da har du tilgang til Forumet og dine personlige opplysninger som du kan endre på.

Alle må delta under fullt navn. Pseudonymer blir blokkert og/eller ikke godkjent.

Hvordan logge deg inn hvis du er registrert og godkjent:

Velg: **Logg på** Der skriver du brukernavnet og passord, trykk deretter **Logg på.**
Forum er et av valgene i hoved menyen! Du må altså løfte blikket opp og se ved siden av Brukertilgang feltet!

I Forumet kan du få e-post varslinger. Du kan lage nye diskusjonsemner under de enkelte kategorier eller underkategori. Synes du det er en kategori som mangler kan forslag postes i forumet ”Administrasjon og Brukerhjelp”
Har du andre spørsmål, trykk på **?Hjelp**

Lars Tjensvoll

Redaktør