COMMENT RESPONSE DOCUMENT (CRD) TO NOTICE OF PROPOSED AMENDMENT (NPA) 2008-17C

for an Agency Opinion on a Commission Regulation establishing the Implementing Rules for the medical certification of pilots

and

a draft Decision of the Executive Director of the European Aviation Safety Agency on Acceptable Means of Compliance and Guidance Material on the medical certification of pilots

"Implementing Rules for Pilot Licensing – Medical Certification"

CRD c. 1 - Comments and Responses to Subparts A, B, C, D

IV. CRD table of comments, responses and resulting text

(General Comments)	-

comment	37	comment by: *Johannes Niesslbeck*
	Bei 65 Einwohner pro Quadratkilometer in Europa ist die Wahrscheinlichkeit eines Absturzes ca. 1 zu 1000 pro Absturz. Flugunfälle (Nicht Abstürze!) passieren nur zu 0,33 % aus medizinischer Ursache. Ob diese medizinische Ursache auch voraussehbar ist und ob der Pilot dann völlig handlungsunfähig und damit ungesteuert auf schlägt, ist völlig spekulativ und das reduziert die Wahrscheinlichkeit, dass ein zweiter, außer dem Piloten zu ernsthaftem Schaden kommt auf unter 0,1 %. Ein solcher Unfall aus medizinischen Gründen hat also eine Wahrscheinlichkeit von unter 0,000 001 %. Lohnt das wirklich einen solchen Aufwand wie eine flugmedizinische Untersuchung? Das Risiko das z.B. ein Motorradfahrer oder ein Autofahrer aus medizinischen Gründen die Herrschaft über sein Fahrzeug verliert ist etwa genau so hoch, wie bei einem Piloten, sein Unfall führt aber im allgemeinen praktisch immer zu einer ernsthaften Gefährdung des übrigen Verkehrs. Trotzdem muss ein solcher Verkehrsteilnehmer kein Medical vorweisen sondern darf auf eigene Verantwortung fahren. Warum also glaubt man das bei Piloten nicht ebenso der Verantwortung des Einzelnen überlassen zu können. Kann das eventuell wirtschaftliche Gründe haben (Flugmediziner könnten empfindliche Einbußen erleiden wenn für Privatpiloten kein Medical mehr erforderlich ist, könnte das einer der Gründe sein?). Mein Plädoyer daher: Kein Medical für Privatpiloten, wohl aber für Militär- und kommerziell tätige Piloten.	
response	*Not accepted*	
	Safety in aviation is ensured by many different measures, one of them being medical fitness. The legal basis for the medical certificate is the ICAO SARPs and the EU Basic Regulation. It is not possible, for safety and legal reasons, to abolish the medical certificate for private pilots.	

comment	41	comment by: *Katja Burkhardt*
	Dear EASA Members! First of all I wanna thank You for the opportunity to comment on this. I am a sailplane - student from Germany and wanna state my comments on the LPL Part of this Paper. In a nutshell: I just do not see any sense in a medical at all for private pilots! It is my free time that I use to fly a sailplane. I do this for fun. In case I feel ill, haven't slept well the night before or something just doesn't feel 100% right, I will not go to the airport and I certainly will not fly a sailplane. All pilot's I know, act the exact same way. And even if they would not do so: There's lots of guys	

around who will stop them from flying.
So what worth is a medical for a private pilot?
Can You predict the time and place of "sudden incapacitation" by means of a medical? Probably not. And even if You could: What is the worsest case that could possibly happen when a private sailplane-pilot experience a sudden incapacitation? Of course this pilot might die. But will anything else happen to noninvolved people around? Let's say the place where the plane crashes on the ground is 15 m2. There is 65 inhabitants per 1000 m2 in Europe. That means the chance of hitting an inhabitant by crashing a sailplane is 1:1000.
According to the AOPA Flight-Incidents (NOT crashes!) happen by only 0.33% because of medical reasons. There is no certainty that these 0.33% medical reasons are predictable at all, and there is no certainty that a single one of these medical reasons causes a sudden incapacitation that makes the pilot crash his plane. This reduces the risk of crashing a plane by medical reasons to less than 0.1%
Combining the chances of a predictable medical issue causing a crash (1:1000) with the chances of hitting an inhabitant with that crashing plane (1:1000) that means a chance of 1:1.000.000 of hitting an nonivolved person due to a sailplane-crash caused by a predictable medical incident. That is a risk of 0.000001% per incident. You need 1 Mio Sailplane incidents to have one that will hurt or kill an uninvolved person by a predictable medical reason.

Is that the reason for a medical?
I cannot believe this. If a car crashes, it is likely to hit the oncoming traffic by 50% and there is no medical required for operating a car.

So what else is the reason? I do not know. As far as I know, my medical has cost me lots of money, but there is other pilots who payed even more. Is that a reason? That Medical Practitioneers want our money? I don't believe this, either. All the doctors I know have enough work to do and they earn enough money by curing the illnesses of people, they don't need pilots for their income.

A medical costs every privat pilot time and money - with no reason at all!

The questionaire that was just designed for the self assesment of the pilot is in my opinion useless.

I'm majoring in psychology and the best way to find out about the personality of a person, for example if they are shy is a One-Item-Test: "Are You Shy" - mark yes or no.
I also believe that a self assessment: "Is Your medical fittness good enough to operate a sailplane?" - mark yes or no, will have the exact same validity as the one-item shyness test.

No private pilot will fly a plane if he's seriously ill! I know the risks of flying a plane, I know I can't stop at the curb if I don't feel well - I have to land this plane. I wanna have fun when I fly - I'm not suicidal!

I don't have to pay hundreds of Euros to AMC's to find out if I'm a risk to noninvolved persons. And I don't even believe that the AMC can ever know that.

So please stop the Medical for private pilots. It costst lots of money and it safes

	absolutely noone. Let the pilots decide for themselves if they feel fit enough to fly or not. Remember the 0.000001%. I think this is worth some more self-determination! Thank You for reading!
response	*Noted*
	Please refer to response to comment No 37 in this segment.

comment	*43*	comment by: *Ulrich RAPPEN*
	As proven in the AOPA Air Safety Foundation analysis of U. S. accidents , medical certificates for glider pilots do not add to air safety with regards to air traffic accidents. Indeed, glider pilots have less (0,33% vs. 0,36%) accidents caused by medical incapacitation than other pilots. Therefore medical requirements for glider pilots should be withdrawn completely.	
response	*Noted*	
	Please refer to response to comment No 37 in this segment.	

comment	*118*	comment by: *Civil Aviation Authority - The Netherlands*

Indeling NPA (punt 27, blz. 11 van 85 van de Explanatory notes)

De CAA - The Netherlands is akkoord met de wijziging in de indeling.
Ten gunste van de duidelijkheid zouden de titels van de onderdelen die zien op de AMC's moeten worden vereenvoudigd. De titels zouden als volgt moeten worden gewijzigd:

- Blz. 31 van 66
  "Subpart B, requirements for medical certificates, section 1, specific requirements for class 1 and class 2 medical certificates, Chapter A, AMC for class 1 medical certificates" zouden moeten worden gewijzigd in:
  "AMC 1 for class 1 medical certificates" en
  "AMC 2 for class 2 medical certificates"
- Blz. 60 van 66
  "Section 2, specific requirements for LPL medical certificates", " zou moeten worden gewijzigd in:
  "AMC 3 for LPL medical certificates"

Reactie van de CAA - The Netherlands op de nieuwe werking van de AMC (Punt 35 van blz. 13 van 85 van de Explenatory notes)
Uit de tekst van de NPA, noch uit de toelichting wordt duidelijk wanneer het moment ingaat waarop van de AMC mag worden afgeweken. Is dat het moment waarop de Inspectie VenW instemt met het verzoek af te wijken van de AMC of is dat het moment waarop EASA de afwijking heeft doorgevoerd in de AMC?
Omwille van de zorgvuldigheid naar de aanvrager toe, verdient het volgens de CAA - The Netherlands de voorkeur dat het moment van afwijken ingaat, wanneer EASA de afwijking formeel in de AMC heeft doorgevoerd. De motivering hiervoor is dat het mogelijk terugdraaien door EASA van een besluit van de Inspectie

	VenW geen nadelige gevolgen mag hebben voor de aanvrager. De CAA-The Netherlands verzoekt om het moment waarop de afwijking van de AMC ingaat, duidelijker in de tekst van de toelichting aan bod te laten komen. **Reactie van de CAA-The Netherlands op introductie LPL** De CAA-The Netherlands is niet akkoord met de introductie van het LPL medisch certificaat, wanneer de eisen van een LPL certificaat beneden ICAO standaard zijn.
response	*Noted*
	The logic behind the numbering system proposed was explained in the Explanatory Note to this NPA. After review of the comments received, and taking into account input received from stakeholders during the Agency's conferences and workshops, it is the Agency's view that the numbering system is now understood and accepted by the vast majority of stakeholders. Member States or stakeholders may propose different ways of compliance with Implementing Rules. In this case alternative Acceptable Means of Compliance have to be developed, they need to be approved by the National Aviation Authority prior to implementation and will be sent to the Agency. The Basic Regulation (Article 7) allows a GMP (if permitted under national law) to issue a medical certificate for a LAPL licence. This has to be taken into account in the implementing rules. The medical provisions for the LAPL were redrafted following comments to this NPA.

comment	*224*	comment by: *Newton Consulting*
	General comments LPL It seems to me that the medical requirements for the LPL and the use of specialist 'AME' are unnecessary. If a pilot is capable of driving safely to an aerodrome he is clearly capable of flying. Driving demonstrably demands higher level skills than flying 'leisure' aeroplanes. Any GP is capable of assessing fitness to drive. The medical demands and use of AME's proposed in these documents are driven by AME's desire to remain employed and remunerated; they have nothing to do with the needs of light aviation.	
response	*Noted*	
	The ICAO SARPs require that medical fitness of pilots is assessed by an AME. However, the Basic Regulation provides the possibility of a GMP to assess the medical fitness for a LAPL applicant /holder, if permitted under national law.	

comment	231	comment by: *Pekka Oksanen*
	Comment: Safety risk levels must be stated Add a paragraph specifying the level of incapacitation risk for the specifed class taking into account all medical factors and the limitations to be applied. Add : **(c) (1) For class 1 medical certificates the maximum acceptable annual risk of incapacitation is 1% for multi-pilot operations and 0.5% for single pilot operations** **(2) For Class 2 medical certificates the maximum acceptable annual risk of incapacitation is 2%.**	
response	*Noted*	
	The risk assessment was included in the Guidance Material of JAR-FCL 3. The text needs to be reviewed and the calculations assessed by a specialist in medical statistics. This will be done and the risk assessment will be included in the future rulemaking task MED.001.	

comment	232	comment by: *Ulrich Mildenberger*
	Dear Madams and Sir, do you really think, that you could prevent exactly one single accident of an sailplane with an expensive, bureaucratically medical? In reality you will force pilots to fly simply illegal without a medical. If the trend with more and more bureaucratically barriers will proceed, then pilots will be spread in two groups: the one with self-response will finish with this great sport (so the commercial aviation wont get enough young talents) and the other ones without any self-response will fly simply without any papers! Turn back! Forget all bureucraticall barriers! Let the pilots get there own decisions. Patronize all pilots to be self-responsible. The humans know best by themselves, when to fly or not to fly. This responsible charakter of any single pilot in our sport is the essence, the nucleus of aviation itself! Kindly regards Uli Mildenberger	
response	*Noted*	
	We presume that the comment suggests that no medical is needed for private pilots. Please refer to the response to comment No 37 in this segment.	

comment	342	comment by: *FOCA Switzerland*
	• Aeromedical Risk Assessment: Aviation medicine is one part of many factors contributing to flight safety. EASA should make definitions, which annual risk of incapacitation (regardless to which medical disorder) is an	

acceptable risk. This risk may be different for various medical categories, but it must be defined, in order to be a general guideline to aeromedical assessments (see JAA Rules: eg 1% rule.

Proposal:
Make similar (or evidence based) levels of acceptable risk for each category: eg: Class 1: the maximum aceptable annual risk of incapacitation is 1% for class 2 the maximum risk is 2 (2-5?)% for LPL the maximum risk is ??% (to be determined or as for class 2).

- FOCA Switzerland agrees basically to align medical standards of Class 2 Medicals with ICAO Class 2 standards, but proposes not to make a special medical category for LPL pilots. We strongly propose to eliminate in the entire 17c NPA this separate medical category for LPL License holders. Specially the questionnaire proposed as medical report for LPL holders in AMC to MED.A.040 is not an usable tool at all. There are too many medical mistakes in it (only some exemples: no 3: numbers of alcohol units inappropriate) no 4: drug and alcohol dependency not detectable if first question is answered with "no" ("no=absence of psychological troubles) no 5: eye surgery is missing , no 7: text not existing , no 10: aneurysmas as described are too dangerous, no 16: colour vision not adressed and many more) . The time to fill in this really inappropriate questionnaire takes more time than the normal time of an aeromedical exam and is therefore more expensive for pilots. In addition, there is no reporting system establised in case of unfitness. Nearly every pilot that fills in the questionnaire correctly will need to be deferred to an AME which creates additional costs for pilots. The whole concept of separate medical requirements for Class 2 and LPL is not in line with ICAO, the dual system is complicated, the questionnaire is full of medical mistakes.

Proposal:
Apply the ICAO Class 2 standards for EASA Class 2 for PPL and LPL-holders. If there should really be a difference between Class 2 and LPL (though they have similar privileges concerning use of airspace and transport of pax), the requirements should be the same but the peridodicity of exams might eventually be different, for instance: (Proposal: for LPL privileges the validity of an EASA class 2 medical certificate is 60 months until age 60 and 24 months thereafter).

response *Noted*

Proposal 1:
The risk assessment will be included in the rulemaking task MED.001.

Proposal 2:
The proposed LAPL medical requirements were redrafted following the comments to this NPA. However, they are still below ICAO class 2 requirements considering the lower risk involved in this type of flying. The purpose of the introduction of LAPL is to make private flying more accessible for applicants.

comment *372* comment by: *European CMO Forum*

Comment:
EASA should include the acceptable level of incapacitation risk per year for each

	class of medical certificate. Safety risk levels should be stated Justification: Standardisation Proposed Text: Add **MED.A.040 (c): 'the level of incapacitation risk is acceptable for the class of medical certificate issued, taking into account any mitigating factors and limitations applied.'** Add **AMC to MED.A.040 (c): '(a) For Class 1 medical certificates the maximum acceptable annual risk of incapacitation is 1% for multi pilot operations and 0.5% for single pilot operations.** **(b) For Class 2 medical certificates the maximum acceptable annual risk of incapacitation is 2%.'**
response	*Noted*
	The risk assessment was in the Guidance Material of JAR-FCL 3 and will be re-introduced in GM to Part Medical during the rulemaking task MED.001 after assessment of the JAR-FCL 3 text and of the statistical calculations. However, it is not planned to include the risk assessment in IRs or AMCs, but in GM.

comment	*373*	comment by: *European CMO Forum*
	Comment: The European Aviation Authorities' Chief Medical Officers' Forum agree with the proposals to base the Class 2 medical assessment on the ICAO Class 2 Standards and Recommended Practices.	
response	*Noted*	
	Thank you for your positive comment.	

comment	*507*	comment by: *British Microlight Aircraft Association*
	1. Medical requirements must be proportionate to the flight tasks undertaken and whilst the medical certification frequency periods are accepted as a level of assurance of fitness no other requirements should prevent the holder of a licence or certificate from exercising any privilege of that licence or certificate. 2. The proposal includes restrictions that limit the holder of a commercial licence to acting only as part of multi-crew operation when they have reached the age of 60 years and prohibits commercial operation completely when they have reached the age of 65 years. The limitations must be changed to recognise that pilots over the age of 60 years who hold a Class 1 medical certificate are fully able to act as pilot in command of single pilot operations and when over 65 can play a valuable role as co-pilot for multi-crew operations. 3. The proposed declaration of health for the Leisure Pilot's Licence has become	

	a medical examination requiring the pilot's GMP to register with the National Authority and maintain records of activity. The proposal moves away from the concept of pilot responsibility and simple confirmation of known history by the pilot's own regular doctor. The procedure for the Leisure Pilot's Licence medical should be redrafted to require a simple self declaration confirmed by the applicant's own doctor. Procedures for recording and notification should be the responsibility of the pilot and not the GMP.
response	*Noted*
	1. The requirements for a medical certificate must be proportionate to the flying activities. Some health conditions are not compatible with flying. It depends on the flying activity of a pilot (commercial, private, leisure) and on what kind of risk can be accepted. 2. The NPA Part Medical is based on JAR-FCL 3 and follow ICAO Annex 1 SARPs. The age limitations are in international law. 3. Thank you for your opinion concerning GMPs to issue medical certificates for the LPL. Knowledge of the medical background of the applicant is a pre-requisite for a GMP to be allowed to issue medical certificates, in accordance with Article 7(2) of the Basic Regulation. But the same article further determines that a medical certificate shall only be issued when the applicant demonstrates compliance with the Essential Requirements in Annex III to the Basic Regulation. Paragraph 4.a.1 of the Essential Requirements determines the following: *'All pilots must periodically demonstrate medical fitness (...). Compliance must be shown by appropriate assessment (...)'.* The Agency's view is that this requirement for an appropriate assessment cannot be satisfied with the analysis of medical records only. There is a need for the GMP to perform a medical assessment. Existing medical records have to be taken into account when performing the assessment, but cannot be the only element. The rules and AMC for an aeromedical assessment of a LAPL holder/applicant have been redrafted following the comments received to this NPA but still less stringent than ICAO Annex 1 SARPS for PPL. However, the new draft is more specific and, again, results in a medical certificate.

comment	*508*	comment by: *British Gliding Association*
	The comments in this response to NPA17c represent the formal response of the UK British Gliding Association	
response	*Noted*	
	Thank you for this statement.	

comment	*638*	comment by: *Siegfried Samson*

	Hiermit bitte ich Sie endlich in Deutschland (Europa) auf ein Medical zu verzichten. Als Pilot einer großen deutschen Luftfahrtgesellschaft und ehemaliger Fluglotse ist mir bewußt das Sicherheit im Luftverkehr an oberster Stelle stehen muß. Allerdings wird dieses Mehr an Sicherheit garantiert nicht mit einem Medical für Segeflieger erreicht. Die Wahrscheinlichkeiten mit einem Segelflugzeug aufgrund medizinischer Gründe einen fatalen Unfall zu haben sind dermaßen gering das ein Medical nicht zu begründen ist. Im gewerblichen Bereich macht es durchaus noch Sinn, wenn auch hier gelegentlich einem Flugkapitän nach 30 Dienstjahren ein epileptischer Anfall widerführt, der durch keine Untersuchung vorherzusagen ist.
response	*Noted*
	Please refer to response to comment No 37 in this segment.

comment	*640*	comment by: *Royal Danish Aeroclub*
	General comments From the Royal Danish Aeroclub we want to comment on the proposed regulations for the licensing and medical certification. As a whole it seems pretty good, but we could recommend a few changes/improvements. As a general rule we suggest a practical medical flight test could be used in case of doubt. The practical medical flight test can determine whether the pilot is able to perform the flight in a safe manner. New medication and treatment are coming and we should not refrain from taking advantage of the new and coming developments. Therefor we do also believe that medical details should be part of the AMC instead of the regulation itself. This makes the change more dynamic, which is needed in this area. The time to change the regulation are several years - but the time to change AMC are much shorter. We strongly support the idea behind this proposal, and believe this a very positive development in the right direction.	
response	*Noted*	
	Thank you for your comment. para 3: The medical flight test is included in AMC to MED.A.045. para 4: Most of the medical requirements of JAR-FCL 3 Appendices (rules) have been moved to AMC for the reason the commenter provides.	

comment	*840*	comment by: *ICAO*
	Thank you for providing the opportunity to provide comments on NPA 2008-17c.	

	This NPA provides a potential opportunity to harmonise the European requirements with the ICAO Standards and Recommended Practices (SARPs), as set out in Annex 1 to the Convention on International Civil Aviation. However, there are differences from Annex 1 in the proposal, some of which are minor whilst others may contribute to important variations in requirements between EASA and other regions or States. The following are provided as examples: • Use of the term 'accredited medical opinion', which is close to the ICAO terminology 'accredited medical conclusion' that is specifically defined in Annex 1 • Automatic disqualification if the applicant is taking anticoagulants • Refractive error limits that could disqualify applicants who have healthy eyes and correct satisfactorily Further, at the request of its member States, ICAO is moving towards performance-based regulation, and away from prescriptive requirements. By inclusion of some medical standards in the implementing rules, rather than in acceptable means of compliance, EASA could be at risk of becoming locked into a prescriptive approach that may over time become outdated.
response	*Noted*
	Thank you for commenting on this NPA. 1. The term 'accredited medical opinion' has been changed to the ICAO wording 'accredited medical conclusion'. 2. The decision on fitness/unfitness while under anticoagulants has been moved from IR to AMC. 3. Refractive error limits have been amended. EASA is closely monitoring the performance based approach presently developed in ICAO in close cooperation with Industry. Once ICAO adopted performance based regulations a review of the EASA rules may occur.

comment	*975*	comment by: *Hans-Joachim AMINDE*
	Ein medical für Segelflieger-/Motorseglerpilot sollte bitte von jedem autorisierten Fliegerarzt in Europa ausgestellt werden können. Einer Freizügigket des Wohnsitz-Freizeit- und Arbeitsortes in Europa sollte bitte auch der freie Standort des Fliegerarztes entsprechen. Alles andere wäre gegen ein offenes und freizügiges Gesamteuropa gerichtet. Hans-Joachim Aminde Privatpilot GLD+ TMG und freier Architekt	
response	*Noted*	
	A pilot can go to any AME in any EU Member State or EASA associated state for his/her medical examination and assessment. The medical certificate is issued by this AME and the report is sent to the licensing authority of the pilot.	

comment	*1023*	comment by: *Andrew Sampson*
	I am resident in the UK. I am an active glider pilot with a particular interest in cross-country soaring, and aerobatics. I am qualified as a "Basic Instructor" under the BGA scheme.	
response	*Noted*	
	Thank you for the comment.	

comment	*1061*	comment by: *Dr Michel Kossowski AeMC Clamart*
	why performing whispered voice test for leisure pilot and testing hear function for class 2 with a conversationnal speech? I think the more discriminant test is the whispered voice test for each ear. One ear is tested while we do a maskage on the other with reperted pression on the tragus. If this test is abnormal thus an audiometry must be done Eustachian tube function is not enaough individualized Insist on the importance of the head shaking test for the vestibular balance	
response	*Partially accepted*	
	Thank you for your input, conversational speech test is the test for both, LAPL and class 2.	

comment	*1075*	comment by: *Nigel Roche*
	I believe that as there is such a link for ATOs between the proposed EASA FCL NPAs 2008-17a,b and c, EASA Management System NPA 2008-22a to d and the very likely affects of the proposed EASA Ops that has yet to be issued will have on ATO's and other operations that all comment periods should be extended to that of the EASA Ops to ensure that all ramifications are found and commented upon. Suggested Action extend NPA2008-17 and 2008-22 to match that of EASA ops when issued	
response	*Noted*	
	NPA 2008-17 was open for comments for 8 months and there was time of overlap with regard to NPA 2008-22 and NPA 2009-02.	

comment	*1123*	comment by: *Danish Balloon Organisation*
	General Comments: We think that the concept of introducing specific requirements for the LPL medical certificate is very good and in line with the intentions in the Basic Regulation. We welcome the proposals for lighter medical requirements for LPL(B) holders and find the requirements adequate and proportionate to the privileges granted the LPL license.	

response	*Noted*	
	Thank you for giving us your opinion.	

comment	*1145*	comment by: *PR Jean Pierre GOURBAT*
response	*Noted*	
	No comment provided under this number 1145.	

comment	*1153*	comment by: *Keith WHITE*
	A general point which applies to all instances in all documents. When using the indefinite article with abbreviations, 'a' may only be used if the first letter of the abbreviation starts with a consonantal sound; i.e. 'a GMP', but 'an LPL'. The abbreviation stands on its own, not to be read in full.	
response	*Accepted*	
	Thank you for your input. Editorial check will be done.	

comment	*1166*	comment by: *Darrell Aldersea*
	2000kg unrealistic for recreational pilots: a Cessna 172 MTOW is 1111kg. What sort of recreational pilot wishes to fly an aircaft almost twice as heavy? The trend is for lighter aircraft and lower horse power. I would have thought EASA would encourage this. 1500kg is more realistic. For medical requirements there should be 2 categories. (1) Not exceeding 750kg and 2 seats. (2) Not exceeding 1500kg and 4 seats. Category (1). Medical requirements same as to drive a car. Risks to general public less for light aircraft than cars. Cars up to 7 occupants rather than two. Passenger in a 2 seat aircraft more of a participant than a passenger. Category (2). Medical requirements should be much less than NPA 2008-17C even if only to reflect less inertia than for 2000kg.	
response	*Not accepted*	
	Basic Regulation, Article 7(7).: ... provisions for ... a leisure pilot licence covering non-commercial activities involving aircraft with a maximum take-off mass of 2000 kg or less ... The implementing rules cannot deviate from the Basic Regulation. (1) Please also refer to response to comment 37 in this segment. (2) Another separation within the LAPL category is presently not plannned but would result in ICAO class 2 standards for the higher segment for safety reasons.	

comment	1185	comment by: *Dr. med Frank Fabian*
	Seit 30 Jahren führe ich Flugtauglichkeitsuntersuchungen für Flieger durch ,zunächst nur Privatpiloten ,seit 10 Jahren alle Klassen, privat sowie kommerzielle Klasse I und Klasse II Piloten. Gemeinsam mit anderen Fliegerärzten sind wir die vorläufigen neuen Regeln durchgegangen, die uns aus dem Internet zur Verfügung standen. Der Fragebogen für die Flugtauglichkeit ist für den Patienten völlig unverständlich und kann nicht ohne Mithilfe des Arztes ausgefüllt werden. Um als Arzt dem Patienten die Fragen verständlich zu machen ist ein Zeitraum von minimal 45 Minuten erforderlich. Der größte Teil der Fragen kann in seiner Bedeutung für die Beurteilung der Flugtauglichkeit nur durch speziell geschulte Ärzte beurteilt werden. Die Fragen beinhalten in ihrer Bedeutung der Einschätzung der Flugfähigkeit eigene Erfahrung in den an Bord eines Flugzeuges herrschenden psychischen und physischen Bedingungen. Diese sind einem "General Praktitioner" in den meisten Fällen nicht bekannt. Die Bestätigung der Flugtauglichkeit von nicht dafür geschulten Ärzten für Piloten, die möglicherweise den allgemein genutzten Luftraum nutzen , bedeutet eine Gefährdung des ohnehin überlasteten Luftraums. Sollte es bekannt werden, dass sich in diesem Europäischem Luftraum kranke Piloten mit ihren Fluggerät aufhalten, würde dies für die Passagiere und Piloten der Verkehrsfliegerei eine enorme Gefährdung und zusätzliche Beeinträchtigung der Sicherheit sorgen. Ich bitte dringend die medizinische Flugtauglichkeitsbeurteilung nur den dafür geschulten Fliegerärzten zu gestatten. Alles andere, was besonders von englischer Seite gefordert wird, ist unverantwortlich und beeinträchtigt die Sicherheit für Piloten und Passagiere. Die bestehende Regelung sollte in verbesserter Form beibehalten werden, ganz besonders auch für die Piloten von Kleinflugzeugen.	
response	*Noted*	
	The Basic Regulation (Article 7) allows a GMP to issue a medical certificate for a LAPL licence (if permitted under national law). This was taken into account in the Implementing Rules. The questionnaire will be withdrawn and the application and examination forms for class 1 and class 2 pilots will also be used for the LAPL, however not all of the items on the forms will be applicable to the LAPL medical certificate.	

comment	1186	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Comment: JAR-FCL has been consistent in using the expressions "applicant" or "licence holder" which are also used in ICAO Annex 1, while the EASA NPA Part Medical sometimes also uses the expression "pilot". This expression "pilot" should be avoided in the regulation to prevent unnecessary amendments of the regulation since cabin crew (in the draft Part OPS) and air traffic controllers (in the draft amendment of Basic Regulation and Part ATM/ANS) will have their medical requirements referred to, or being included in, Part Medical. **Proposal**: In the whole Part MED, replace the expression "pilot" with "applicant" or "licence holder" whenever possible.	

response	*Accepted*
	Thank you for the comment.

comment	*1343*	comment by: *Danish Powerflying Union*
	We are very satisfied with EASA's proposal of introducing specific requirements for LPL medical certificate. Generally we support EASA's proposals in 17C.	
response	*Noted*	
	Thank you for this positive comment	

comment	*1408*	comment by: *Dieter Lenzkes*

General comment
Dieser Teil der Bestimmungen lässt nicht erkennen, dass ihm eine fundierte Risikoanalyse zugrunde liegt, insbesondere nicht für den Segelflug.
Nach DIN EN ISO 14121 wird die Höhe eines Risikos durch die Kombination aus der Eintrittswahrscheinlichkeit eines Schadens und der möglichen Schadenshöhe bestimmt. Im vorliegenden Fall also aus der Eintrittswahrscheinlichkeit eines Unfalles aus medizinischen Ursachen des Piloten und den möglichen Folgeschäden bei diesem Unfall. Ein Risiko kann also hoch sein, wenn entweder die Eintrittswahrscheinlichkeit hoch ist, oder wenn – auch bei geringer Eintrittswahrscheinlichkeit – der mögliche Schaden hoch sein kann, oder beides. Das Ausmaß der Risiko mindernden Maßnahmen muss sich an der Höhe des Risikos orientieren. Im vorliegenden Fall sind dies die medizinischen Untersuchungen und Vorkehrungen.

Nun ist die Wahrscheinlichkeit für einen Unfall aus medizinischen Ursachen bei dem Piloten äußerst gering. Dies zeigen mehrere Untersuchungen (z.B. http://www.aopa.org/whatsnew/newsitems/2003/030116petition.html), auch in Ländern, in denen ein Medical nicht obligatorisch ist. Man kann sicher auch davon ausgehen, dass die Wahrscheinlichkeit für medizinische Unfallursachen bei Motorpiloten und Segelflugpiloten gleich ist. Bedingt durch die Natur des Segelflugbetriebes ist jedoch die mögliche Schadenshöhe bei einem Segelflugunfall wesentlich geringer als bei Motorflugzeugen:

- Bei den weitaus meisten Flügen ist der Segelflugpilot alleine im Flugzeug
- Bei den meisten großen doppelsitzigen Flügen ist auch die 2. Person flugerfahren
- Die relativ wenigen Flüge mit flugunerfahrenen Passagieren sind kurz (im Platzbereich)
- Die Natur eines Segelfluges erfordert es, dass man sich **nie** längere Zeit in niedriger Höhe über dicht bebautem Gebiet aufhält.

Demzufolge ist das Risiko, dass bei einem Unfall ein Folgeschaden an 3. Personen und Sachen auftritt, vernachlässigbar klein. Dieses Risikoniveau dürfte im Straßenverkehr um ein Vielfaches höher sein. Ebenso im Motorflugbetrieb, insbesondere wenn dieser auch kommerziell aktiv ist. Es gibt also eigentlich keinen Grund an einen LPL(S)-Piloten dieselben hohen medizinischen Anforderungen zu stellen wie an einen Motorflugpiloten der evtl. auch kommerziell tätig werden darf.

	Vorschlag: Die medizinischen Anforderungen an Segelflugpiloten sind von denen für (kommerzielle) Motorflugpiloten zu trennen und dem tatsächlichen Risikoniveau anzupassen. Man sollte hierfür allgemeine Sportärzte zu Rate ziehen, die auch andere nicht kommerzielle Sportarten beurteilen. Eine medizinische Beurteilung wie sie auch für andere, alleine betriebene Freizeitbeschäftigungen wie Radfahren, Bergwandern, Tauchen etc. durchgeführt wird, dürfte völlig ausreichend sein. Begründung: Einfacherer und kostengünstigerer Einstieg für Jugendliche in den Segelflugsport, insbesondere in Verbindung mit der „Hausarzt Lösung". Siehe auch Kommentar 1346 Förderung des Segelflugsports als Breitensport und keine Erschwerung der Jugendarbeit der Vereine. Keine Belastung eines Freizeitsports durch Anforderungen die auf einen kommerziellen Betrieb abgestimmt und dort auch sinnvoll sind.
response	*Not accepted*
	Thank you for this analysis. ICAO standards require glider pilots to hold a class 2 medical certificate. The medical requirements for the LAPL, including LPL(S) provide pilots with the option of a less stringent medical certificate.

comment	*1469*	comment by: *richard benham*
	With the additional proposals being put forward regarding a hot air balloon pilot license, I will seriously be giving time to giving up the sport as it will just not be worth the perceived hassle / cost / inconvenience. I fly about 6-10 times per year in this country currently, due to having a young family and work commitments. A further restriction is caused by the poor weather and restrictions of air space imposed in this country by sensitive areas / air space. With these proposed additional RESTRICTIONS on training, currency, experience and the like, I will be forced out my a hobby/sport - I only have about 6-10 flights per year, so if I have got to travel around the country to find an examiner/instructor to have a recency flight, with the hope that the weather holds out, then this will eat into my available flying weekends. The availability of crew for my hobby will further restrict me being able to travel to a qualified instructor. I don't need to go to a special medical person to get a medical - my GP is perfectly able to qualify me as being bit to fly. In addition, when I eventually reach 60, I'll be able to get my GP to confirm again that I'm medically fit - there's absolutely no factual proof that the "over-60's" are more likely to have an accident in a balloon with severe consequences - indeed some of my learned and experienced flying colleagues in the USA are >60 years of age Please, before you kill off the sport of ballooning in the UK, which is already restricted by poor weather, increasing costs, decreasing landing opportunities and other issues, please give serious consideration to the comments added by myself and other balloonists ! There really is NO VALUE being added to the sport, to safety, or to my hobby with the current EASA proposal	

response	*Noted*
	Applicants for or holders of a hot air balloon pilot licence may choose Class 2 or LAPL medical certificate. If permitted under national law, the medical assessment can be done by a GMP.

comment	*1474*	comment by: *Jeremy Hinton*
	This NPA seems very comprehensive in its coverage and requirements. The minimum medical check for a leisure pilot (Balloons) involves a greater input by the AME/GP than is the case in the UK now. This alone may not be a problem, but as part of the increasing effort and cost burden, it will contribute to the decline of general aviation, particularly the low-cost low-risk forms such as ballooning.	
response	*Noted*	

comment	*1503*	comment by: *Wolfgang SCHLISKI*
	first of all: your new laws **do not** fullfill the priziple or conzept of "Keep it simple"! In Germany a simple law exists and worked for 50 year. It was easy to understand for pilots and local administration! Your new law are difficult an very expensive in service, because Jet- and sport-pilot and glider-pilot-regulations are mixed up together!!! Has **Edmund Stoiber** checked these rules??? Edmund Stoiber is responsible for better Laws in Europe! Second: I think, glider pilots do not need medical regulations. I myself do not fly when I am thick or do not feel well!. When a person has leucaemy (or something else) , then he has other problems and will not fly!! The risk for ohter people is so very low (< 1 : 1000000000000), because the area where we can fly, is outside the cities! The big cities have control areas and other ristricted areas, where we are not allowd to fly. There is no reason to be the healthiest man in the country! Sorry: I have to continue in german: Meine Forderung: **kein Mecical** für glider pilots. Bei den Amerikanern gehts auch wesentlich einfacher!!!	
response	*Noted*	
	Please refer to the response to comment No 37 in this segment.	

comment	*1510*	comment by: *Javier CASTRILLON (EGU Spanish Delegate)*
	I support the comments sent by the European Gliding Union (EGU).	

response	*Noted*	
	See response to the comment of EGU.	

comment	*1511*	comment by: *Charles Jarman*
	The current system operated by my Gliding Club - Needwood Forest - is for a medical certificate to be issued by the pilot's GP: the person who is best qualified to determine his or her fitness. This works well and should continue	
response	*Noted*	
	This is also possible under the new regulations, if permitted under national law.	

comment	*1522*	comment by: *Dr Ian Perry*
	For 15 years or so, the JAA/LSST Medical Committee, consisting of the CMO's from the participating Nations and the 5 Industry representatives, commented on, added to, reviewed any changes, to all parts of the medical contribution to the licensing process. Who will review this NPA? Who will decide what comments are appropriate, what changes should be made etc? Should it not be the same Committee, with the same make up, meeting as one group and not in fragmented parts. It will take longer to reach an overall conclusion on the NPA if the decision making is fragmented. Calling a meeting of a group of experts, would be an insult to all those who served on the original committee if they are excluded from such an expert group, as everyone/organisation who has has served the original committee in some way over the years should be included. This will add to the harmony of EASA and satisfy many adverse comments circulating about this NPA.	
response	*Noted*	
	The comments to this NPA have been reviewed by medical specialists in the Agency, an additional review group consisting of 3 CMOs of NAAs and specialists in aviation medicine/pilots representing General Aviation, commercial aviation, disabled pilots and AMEs. Further to this input, 2 meetings were held where invitations had been extended to all CMOs and representatives of Organisation as represented in the former LSST(M).	

comment	*1563*	comment by: *Steve BARBER*
	These comments are the personal comments of S Barber, a sailplane pilot, and relate to the requirements of the LPL as applied to sailplanes. It seems to me that in an attempt to provide consistency of licencing for a wide variety of aircraft, some of the proposed rules are inappropriate to certain types of licence, and in some cases could even lead to a reduction in flight safety - clearly not the desired intention of the proposal. The British Gliding Association has controlled the operation of sailplanes since the 1930s. The rules of operation have evolved to meet the needs of sailplane flying, whilst working successfully with other forms of aviation. The BGA are therefore expert in the field, and their experience and should be recognised and their	

	advice and recommendations heeded.
response	*Noted*
	The Agency acknowledges the experience of the British Gliding Association. However, it was the will of the legislators to introduce common rules in Europe for all activities in aviation. Several EU Member States will have to change their national rules to comply with the new ones, but the advantage of having one licence that is valid all over Europe may outweigh the eventual difficulties of transition from the national system to a European one.

comment	*1598*	comment by: *DGAC FRANCE*
	General comment Reading the full text of the NPA it seems that all pathologies which requires a review and decision by the authority for class 2 have disappeared from the proposed draft in reference to JAR FCL 3.It is the same for some class 1 pathologies. **It is better to keep the decision to be taken by the authority like in JAR FCL 3** Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained. As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid contentious cases with AME's or AMC's which takes a lot of time to treat. It is also important for authorities to have a homogeneous feed back of these kinds of decisions to improve the rules in the future.	
response	*Accepted*	
	Text changes will be made in NPA 2008-17 (c) and NPA 2008-22 to say in the Implementing Rules that in contentious cases: • for class 2 the decision on fitness will be taken by the AME or AeMC in consultation with the licensing authority and that • pilots who apply for a class 1 medical certificate will be referred to the licensing authority.	

comment	*1599*	comment by: *DGAC FRANCE*
	Reading MED A.045(3) (v), MED B. 060 (7), AMC A to MED .B.045, AMC A to MED.B.060 7, AMC B to MED .B 3 and 4 , it seems that fitness for disabled (paraplegic, amputee, neurodegenerative diseases) are covered for a class 1 and 2 fitness. **Is it possible for the Agency to confirm this analysis ? Thus, what's about for deaf and mute class 2 applicants who don't seem to be covered by the NPA ?**	

response	*Noted*
	Your list of paragraphs and some others (e.g. MED.B.045(c)) cover fitness for disabled applicants. In fact, disability may be a result of any abnormality listed in Subpart B. Class 2 IRs regarding hearing problems are proposed in MED.B.075 (a), (b), (c)(1) and AMC to MED.B.075 (1.). Class 2 IRs for mute applicants are proposed MED.B.075(d)(7) and AMC to MED.B.075 (7.).

comment	*1604*	comment by: *Helicopter Club of Great Britain*
	C. Draft Opinion and Decision Part Medical - Annex II to Implementing Regulation. We support the LPL and in particular the medical standards within the LPL proposal. These standards will ensure that few if any people, who should be allowed to fly, will be denied the right to do so. This is fundamental to the **rights** of the European citizen. Further, the ability for a GMP to conduct the medical certification within those member states whose national law allow that (vide: Basic Regulation 216) is a welcome removal of unnecessary restrictions created by the JAA system which limited most countries to having to use an AME. The LPL will be a welcome recognition of the need for an entry level set of qualifications to private civil aviation, so long dominated in many states by the thinking borne out of commercial and military aviation where someone else (the passenger or the military establishment) is paying the costs!	
response	*Noted*	
	Thank you for your positive comment. Please note that the GMP can only issue medical certificates when permitted under national law. The IRs and AMCs covering the fitness of LAPL holders/applicants have been redrafted following adverse comments. However, the amended provisions are still considerably less stringent than the ICAO compliant Class 2 requirements.	

comment	*1628*	comment by: *Roxanna SNOOKE*
	I am a student flying with the Ulster Gliding Club. If this law was accepted, then to fly solo, a very expensive medical certificate would be required, surely a GP endorsed medical certificate should be sufficient? For many people (especially students), including myself this extra expense (with gliding not being a cheap hobby to begin with) would make flying solo extremely difficult and probably not bother.	
response	*Noted*	
	We confirm that a medical certificate for an LPL (S) can be issued by a GP, if	

	permitted under national law.

comment	*1629*	comment by: *Richard McLachlan*
	I strongly support the LPL and in particular the medical standards within the LPL proposal. These standards will ensure that the maximum number of people who wish to fly are enabled to do so commensurate with proper safety standards. Further, the ability of a GMP to conduct the medical certification is a welcome removal of unnecessary restrictions created by the JAA system which limited most countries to having to use an AME. This system has worked well within the UK and the UK NPPL license has been a great success with no increase in the accident record due to its relaxed medical standards.	
response	*Noted*	
	Thank you for your positive comment. Please note that the GMP can only issue medical certificates when permitted under national law.	

comment	*1630*	comment by: *Jonathan Schenck*
	The introduction of an LPL would be very welcome, as it would open up the possibilities of flying to a broader cross-section of ex-pilots and potential pilots. The ability for a GMP to carry out the medical examination rather than an AME would also help and potentially reduce the on-going costs and inconvenience of having to find an AME whenever it's necessary.	
response	*Noted*	
	Thank you for your positive comment. Please note that the GMP can only issue medical certificates when permitted under national law.	

comment	*1634*	comment by: *Paul Arditti*
	Since medical certification for leisure pilots is within the capability of General Medical Practitioners, this proposal will help to avoid the perception that vested intersets have a grip on medical certificaction, without compromising safety.	
response	*Noted*	
	Thank you for your positive comment. Please note that the GMP can only issue medical certificates when permitted under national law.	

comment	*1642*	comment by: *Q Aviation Ltd*
	C. Draft Opinion and Decision Part Medical - Annex II to Implementing Regulation.	

We support the LPL and in particular the medical standards within the LPL proposal. These standards will ensure that few if any people, who should be allowed to fly, will be denied the right to do so. This is fundamental to the **rights** of the European citizen.

Further, the ability for a GMP to conduct the medical certification within those member states whose national law allow that (vide: Basic Regulation 216) is a welcome removal of unnecessary restrictions created by the JAA system which limited most countries to having to use an AME.

The LPL will be a welcome recognition of the need for an entry level set of qualifications to private civil aviation, so long dominated in many states by the thinking borne out of commercial and military aviation where someone else (the passenger or the military establishment) is paying the costs!

response *Noted*

Thank you for your support.

Copy of comment No 1604: Please see response to comment No 1604.

comment *1650* comment by: *jara aviation ltd*

C.Draft opinion and decision Part Medical-anex 11 to implementing Regulation

I support the LPL and the medical standards proposed therein.
The LPL proposal would allow all European citizens of right, given a satisfactory medical by a GMP, to fly light aircraft.
The ability for a GMP to conduct the medical certification within the member states whose national law allow(vide: basic regulation 216)
would be a welcome removal of unnessary restrictions created by the JAA system which limits most countries to having to use an AME.
The LPL would be welcomed by entry level pilots who fly for pleasure and who's finances are limited and encourage growth and progression and invention in the vital aeronautical industry.

response *Noted*

Thank you for your positive comment.

Please note that the GMP can only issue medical certificates when permitted under national law.

The IRs and AMCs covering the fitness of LAPL holders/applicants have been redrafted following adverse comments. However, the amended provisions are still considerably less stringent than the ICAO compliant Class 2 requirements.

comment *1652* comment by: *peter barker*

C. Draft Opinion and Decision Part Medical - Annex II to Implementing Regulation.

	I support the LPL and in particular the medical standards within the LPL proposal. These standards will ensure that few if any people, who should be allowed to fly, will be denied the right to do so. This is fundamental to the **rights** of the European citizen. Further, the ability for a GMP to conduct the medical certification within those member states whose national law allow that (vide: Basic Regulation 216) is a welcome removal of unnecessary restrictions created by the JAA system which limited most countries to having to use an AME. The LPL will be a welcome recognition of the need for an entry level set of qualifications to private civil aviation, so long dominated in many states by the thinking borne out of commercial and military aviation where someone else (the passenger or the military establishment) is paying the costs!
response	*Noted*
	Thank you for your support. Copy of comment No 1604: Please see response to comment No 1604.

comment	*1654*	comment by: *Kevin Cinnamond*
	C. Draft Opinion and Decision Part Medical - Annex 11 to Implementing Regualtion. I concur and support the Leisure Pilots Licence (LPL) and in essence the medical standards within the LPL proposal. These standards will ensure that few if any persons, who should be allowed to fly, will be denied the right to do so. This is essential to the RIGHTS of citizens of the European Union. Additionally, the ability for a General Medical Practisioner (GMP) to conduct the medical certification within those Countries whose national law allow that (e.g: Basic Regulation 216) is a welcome removal of unnecessary restrictions created by the JAA system which limited most Countries to essentially using an AME. The LPL will be a most welcome recognition of the need for an entry level set of qualifications to private civil aviation pilots, for so long dominated in many countries by the establishment bourne out of commercial and military aviation where somebody else (the passenger or the government department) is paying the costs!	
response	*Noted*	
	Thank you for your support. Copy of comment No 1604: Please see response to comment No 1604.	

comment	*1658*	comment by: *Deutscher Aero Club (DAeC)*
	General	comment:

	The German aero club (DAeC) representing 100,000 pilots throughout Germany, strongly supports the FCL proposal to introduce differential medical standards and medical validation processes appropriate to air sport necessities. DAeC is supportive of the principles embodied in the LPL medical standards, which will enable a significant number of air sport pilots to exercise their right to fly, or continue to fly, with absolutely minimal risk to others. This principle is in accordance with the Commission's stated view, endorsed by the Transport Committee of the EU Parliament, of the need for proportionate regulation relative to risk."
response	*Noted*
	Thank you for your positive comment. Please note that the GMP can only issue medical certificates when permitted under national law. The IRs and AMCs covering the fitness of LAPL holders/applicants have been redrafted following adverse comments. However, the amended provisions are still considerably less stringent than the ICAO compliant Class 2 requirements.

comment	*1668*	comment by: *Deutscher Aero Club (DAeC)*
	Absence of a board of Appeal Although the basic law in 216/2008 introduces mechanisms for appeal in other areas of certification, this does not apply to medical decisions. To establish an EASA medical appeal board would reduce the possibility of discontented individuals going to law and the probability of diverse judgments setting unwelcome precedents. DAeC Proposal: That EASA establish an independent medical appeal board and that this be available initially through national escalation process.	
response	*Not accepted*	
	Review procedures are proposed in NPA 2008-22b (Authority Requirements) Subpart MED Section 3. Setting up a European Appeal Board in/by EASA is presently outside the remit of the Agency. The existing Appeal Board in Certification is meant for appeals against EASA decisions in Certification. The decision on medical fitness is taken by the Aeromedical Examiner, an AeMC or the Medical Assessor in the Licensing Authority and any appeal will deal with in the Member State. The expertise in the Member States is such that they will be in a position to evaluate difficult cases correctly. This approach may be reviewed once the new rules are in place and experience has been gained.	

comment	*1669*	comment by: *IGSA*
	The IGSA (Irish Gliding and Soaring Association) represents glider pilots in	

	Ireland. The IGSA is not making a detailed submission, but it does support the detailed submissions made by the EGU (European Gliding Union) of which the IGSA is a member.
response	*Noted*
	Thank you for this information.

comment	*1670*	comment by: *Dr Gill Jenkins*
	I support the LPL and in particular the medical standards within the LPL proposal. These standards will ensure that few if any people, who should be allowed to fly, will be denied the right to do so. This is fundamental to the **rights** of the European citizen. Further, the ability for a GMP to conduct the medical certification within those member states whose national law allow that (vide: Basic Regulation 216) is a welcome removal of unnecessary restrictions created by the JAA system which limited most countries to having to use an AME. The LPL will be a welcome recognition of the need for an entry level set of qualifications to private civil aviation, so long dominated in many states by the thinking borne out of commercial and military aviation where someone else (the passenger or the military establishment) is paying the costs. The UK NPPL works well in the fixed wing field and a similar licence is appropriate for rotary wing pilots.	
response	*Noted*	
	Thank you for your support. Copy of comment No 1604: Please see response to comment No 1604.	

comment	*1672*	comment by: *Dragonfly Aviation*
	We support the LPL and in particular the medical standards within the LPL proposal. These standards will ensure that few if any people, who should be allowed to fly, will be denied the right to do so. This is fundamental to the **rights** of the European citizen. Further, the ability for a GMP to conduct the medical certification within those member states whose national law allow that (vide: Basic Regulation 216) is a welcome removal of unnecessary restrictions created by the JAA system which limited most countries to having to use an AME. The LPL will be a welcome recognition of the need for an entry level set of qualifications to private civil aviation, so long dominated in many states by the thinking borne out of commercial and military aviation where someone else (the passenger or the military establishment) is paying the costs!	
response	*Noted*	

	Thank you for your support. Copy of comment No 1604: Please see response to comment No 1604.

comment	*1673*	comment by: *Nigel Murphy*
	C. Draft Opinion and Decision Part Medical - Annex II to Implementing Regulation. I support the LPL and in particular the medical standards within the LPL proposal. These standards will ensure that few if any people who should be allowed to fly, will be denied the right to do so. This is fundamental to the **rights** of all European citizens. Further, the ability for a GMP to conduct the medical certification within those member states whose national law allow that (vide: Basic Regulation 216) is a welcome removal of unnecessary restrictions created by the JAA system which limited most countries to having to use an AME. The LPL will be a welcome recognition of the need for an entry level set of qualifications to private civil aviation, so long dominated in many states by the thinking borne out of commercial and military aviation where someone else (the passenger or the military establishment) is paying the costs!	
response	*Noted*	
	Thank you for your support. Copy of comment No 1604: Please see response to comment No 1604.	

comment	*1674*	comment by: *Hartmut Hummel*
	Comment NPA 2008 17c Sehr geehrte Damen und Herren Betr. Flugtauglichkeitsuntersuchung für Segelflugzeugführer Es gibt so gut wie keine Aufzeichnung über Flugunfälle mit Segelflugzeugen bei denen gesundheitliche Mängel der Piloten die Ursache waren, oder bei denen auf Grund dieser gesundheitliche Mängel, dritte zu schaden gekommen sind. Ebenfalls gibt es keine Aufzeichnungen über Fälle, wo Segelflugzeugführer verklagt worden sind, weil ihr Gesundheitszustand ursächlich für einen Unfall war. Warum also eine Flugtauglichkeitsuntersuchung für Segelflieger? Die Fakten sprechen eindeutig gegen die Notwendigkeit eines Medicals für Piloten von Segelflugzeugen und deren Derivate. Eine Selbstkontrolle wie in den USA üblich, ist für nicht kommerzielle Flüge mit Segelflugzeugen völlig ausreichend. Die Forderung dass ein Pilot von Segelflugzeugen jeder Zeit physisch in der Lage sein muss, sein Flugzeug sicher zu steuern, dass er über ein normales Hör-, Seh- und Geistesvermögen verfügen muss und keine Krankheiten hat, die eine plötzliche Steuerungsunfähigkeit verursachen, kann jeder Hausarzt bei einem standardmäßigen Gesundheitscheck bescheinigen. Das ist völlig ausreichend! Wer gesundheitlich in der Lage ist, ein Kraftfahrzeug sicher zu steuern, ist auch in	

	der Lage nach entsprechender Ausbildung, ein Segelflugzeug zu fliegen. In der Hoffnung dass diese Argumente zu einer pragmatischen, unbürokratischen Entscheidung beitragen, verbleibe ich, Mit freundlichen Grüßen Hartmut Hummel
response	*Noted*
	Please refer to responses to comments No 37 and 1408 in the segment.

comment	*1705*	comment by: *Deutscher Aero Club*
	The comments in this response to NPA17c represent the formal response of the European Gliding Union. EGU represents the national gliding organisations of 25 countries (Austria, Belgium, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Luxembourg, The Netherlands, Norway, Poland, Serbia, Spain, Slovakia, Slovenia, Sweden, Switzerland & UK)	
response	*Noted*	
	Thank you for the information.	

comment	*1706*	comment by: *Deutscher Aero Club*
	General comment: The EGU, which represents approximately 82,000 glider pilots throughout the EU, strongly supports the FCL proposal to introduce two EU glider pilot licences which are identical in all respects other than the differential medical standards and medical validation processes. The EGU is emphatically supportive of the principles embodied in the LPL medical standards, which will enable a significant number of glider pilots to exercise their right to fly, or continue to fly, with absolutely minimal risk to others. This principle is in accordance with the Commission's stated view, endorsed by the Transport Committee of the EU Parliament, of the need for proportionate regulation relative to risk."	
response	*Noted*	
	Thank you for your positive comment. Please note that the GMP can only issue medical certificates when permitted under national law. The IRs and AMCs covering the fitness of LAPL holders/applicants have been redrafted following adverse comments. However, the amended provisions are still considerably less stringent than the ICAO compliant Class 2 requirements.	

comment	*1713*	comment by: *Deutscher Aero Club*
	General comment: Absence of a board of Appeal Although the basic law in 216/2008 introduces mechanisms for appeal in other	

	areas of certification, this does not apply to medical decisions. To establish an EASA medical appeal board would reduce the possibility of discontented individuals going to law and the probability of diverse judgments setting unwelcome precedents. EGU Proposal: That EASA establish an independent medical appeal board and that this be available initially through national escalation process.
response	*Noted*
	Duplicate of comment No 1668 (same commenter, same comment). Please refer to the response to comment No 1668 in this segment.

comment	*1714*	comment by: *roy targonski*
	C. Draft opinion and decision part medical-annex II to Implementing Regulation. I support the LIGHT (leisure !) PILOTS LICENSE and the less onerous medical standards. One`s G.P. is the best placed person to know your medical history and temprament and so is a far more reliable judge of your health than a Doctor who sees you once a year or less.  It is also getting more difficult and expensive to find an approved AME so if you insist on LPL`s needing an AME, you will have to address the availability of AME`s and the fees charged to bring them in line with the average G.M.P., otherwise, and it seems to be the best solution for everyone concerned and that is to allow your GMP to conduct your medical - as is now - succesfully - with parachuting, microlights, gliders, UK-NPPL etc - no problems - and so I say this is a ` PROVEN ` ! solution to the medical issue - it will certainly apease the ` Public `	
response	*Noted*	
	Thank you for your comment. Please note that the GMP can issue medical certificates for LAPL holders/applicants if permitted under national law.	

comment	*1725*	comment by: *Aero-Club of Switzerland*
	The Swiss Gliding Feeration (SFVS) supports the comments of the European Gliding Union (EGU).	
response	*Noted*	
	Thank you for this information.	

comment	*1746*	comment by: *Bernd Hein*
	Das flugmedizinische Tauglichkeitszeugnis beweist nicht mehr als das, was ein guter Hausarzt auch feststellen kann, es verursacht nur Kosten.	

	Den Ihnen vorliegenden umfangreichen Kommentaren von dem Segeflieger und Arzt Dr. Claus-Dieter Zink schließe ich mich an. Es sollte möglich sein, dass es in Europa die gleiche Regelung gibt, wie in den USA.
response	*Noted*
	Please refer to response to comment No 1408 in this segment.

comment	*1795*	comment by: *Needwood Forest Gliding Club*
	We want to continue the practise where the GMP evaluate whether a glider pilot is medically fit. They have the necessary medical records that you would not expect to be available to a third party. The present process of linking this to the standards for driving licences is simple to understand, seems and seems appropriate. To change will impose an additional financial burden for no benefit and risks some unfit pilots flying.	
response	*Noted*	
	The GMP (where permitted under national law) may assess the medical fitness of LPL (S) licence holders, whereas a Class 2 medical certificate will have to be issued by an AME.	

comment	*1797*	comment by: *Richard Dawson*
	C. Draft Opinion and Decision Part Medical - Annex II to Implementing Regulation. We support the LPL and in particular the medical standards within the LPL proposal. These standards will ensure that few if any people, who should be allowed to fly, will be denied the right to do so. This is fundamental to the **rights** of the European citizen. Further, the ability for a GMP to conduct the medical certification within those member states whose national law allow that (vide: Basic Regulation 216) is a welcome removal of unnecessary restrictions created by the JAA system which limited most countries to having to use an AME. The LPL will be a welcome recognition of the need for an entry level set of qualifications to private civil aviation, so long dominated in many states by the thinking borne out of commercial and military aviation where someone else (the passenger or the military establishment) is paying the costs!	
response	*Noted*	
	Thank you for your support. Copy of comment No 1604: Please see response to comment No 1604.	

comment	*1854*	comment by: *Nigel GREENWOOD*
	I have carefully read the British Gliding Association's comments on medical	

	requirements for glider pilots, as given on the BGA website, & fully endorse the BGA's position as the UK representative of my sport. Nigel Greenwood Cotswold Gliding Club
response	*Noted*
	Thank you for this information.

comment	*1858*	comment by: *reinhardKOHLHAAS*
	Die hohen Anforderungen periodischer Untersuchungen führen zu keiner Erhöhung der Flugsicherheit. Statt Eigenverantwortung bezüglich der Anpassung des Verhaltens in der jeweiligen körperlichen Verfassung zu fördern wird ein falsches Sicherheitsgefühl vermittelt. Dies gilt insbesondere für Segelflieger.	
response	*Noted*	
	Thank you for giving us your opinion.	

comment	*1868*	comment by: *Phil King*
	The following comments are my personal comments but also reflect my view as a long time supporter of the sport of gliding and as a voluntary member of several local and national gliding organisations. I am currently a Regional Safety Officer and a member of the British Gliding Association Saftety Committee.	
response	*Noted*	
	Thank you for this information.	

comment	*1869*	comment by: *ECA- European Cockpit Association*
	Self-medication or taking medicine in any form can be extremely hazardous when flying. ECA considers that employers should educate pilots on the use of medication and local and general dental and other anaesthetics and their compatibility with flying duties. This may be done in the form of a leaflet and should include national legislation on the subject, a list of prohibited medication and whom to contact in case the use of any medication that is not on any of the lists is being considered. The leaflet should also include National and company rules on waiting times after the use of any anaesthetics. IFALPA advises Member Associations to seek contact with Associations of General Practitioners with the purpose of informing GPs on the dangers of the use of some medication and the exercise of flying duties. Note: IFALPA has published a Medical Information sheet on this subject. If this is not introduced in the rules, responsibilities on the pilots about drug consumption cannot be established without clear substances, amounts and criteria list. ECA cannot agree on ANY requirement which is below the ICAO minimums. Taking into consideration that the LPL is also a sub ICAO license, any requirement	

	that is below those standards should be carefully assessed. Any JAR-FCL requirement that is downgraded in this regulation should be accompanied by a safety RIA.
response	*Noted*
	We agree with the opinion that self-medication is hazardous for flight safety. For this reason requirements with regards to this problem are placed in Implementing Rules MED.A.025 (b) and (c), MED.A.060 (a)(3) and MED.A.065 (a)(1) and (2). Initiation of the regular use of any medication may require a period of temporary unfitness, determined by the AeMC or AME, to ensure that there are no side effects that may interfere with the safe exercise of the privileges of a licence. In any case licence holders shall seek the advice of an AME or AeMC when in doubt about possible side effects. The introduction of sub-ICAO Class 2 medical requirements for LAPL is determined in the Basic Regulation. The Agency proposed medical requirements corresponding to the risk involved in this type of flying. However, the provision has been revised after assessing all comments. There was support for the proposed rules for LAPL holders/applicants but the comments giving reasons to review the NPA text were more convincing. Nevertheless, the redrafted rules/AMC for LAPL medical certificates are still below ICAO standard which was a pre-condition from the regulator.

comment	*1908*	comment by: *Tom GARDNER*
	I support the BGA's proposals for the changes to "Subpart D General medical Practitioners (GMPS)"	
response	*Noted*	
	Thank you for this information.	

comment	*1934*	comment by: *Deutsches Zentrum für Luft- und Raumfahrt, Abteilung Luft- und Raumfahrtpsychologie, Hamburg*
	<![endif]--> <![endif]--> The Deutsches Zentrum für Luft- und Raumfahrt (DLR) is the German Aerospace Research Centre founded in 1969 (two of its parent institutions founded in 1907 and 1912) with today more than 5700 employees distributed over 29 research institutes in Germany and Europe. As part of the Institute of Aerospace Medicine, the DLR Department of Aviation and Space Psychology in Hamburg has been involved in psychological evaluations of pilots, flight engineers, air traffic controllers, and astronauts since 1955. Both nationally and internationally the DLR Department has a leading position in examining operational staffmembers working in safety critical socio-technical systems. It has provided professional support to the advantage of a number of recognized Airlines, Air Navigation Service Providers, Space Agencies, and Aviation Authorities in Europe and worldwide, these include Lufthansa German Airlines, Deutsche Flugsicherung, Eurocontrol, ESA, Iberia, Austrian Airlines,	

	Royal Jordanian, Luftfahrt-Bundesamt, Civil Aviation Department of China, Russian Institute of Biomedical Problems. Every year the DLR Department conducts between 5000 and 10000 psychological examinations of pilots, air-traffic controllers, instructors, and astronauts to evaluate their mental fitness to responsibly fulfil the operational safety requirements within the air transport system. The quality of this work is regularly audited and certified according to ISO 9001 standards. When the JAA was established and the Joint Regulations for Flight Crew Licensing were developed, the professional expertise of the DLR Department has served as significant input for determining the psychological requirements of pilots (JAR-FCL 3.240, JAR-FCL 3.360, Appendix 10 and 17 to Subpart B and C). Our strong concern is that the current EASA Draft NPA No 2008-17c for establishing rules and acceptable means of compliance for the licensing and medical certification of pilots would substantially reduce the high safety levels of the current and future air transport system by leaving open the methodical standards and professional qualification for the psychological evaluation of pilots. <![endif]--> Psychological evaluation is not everywhere under the head of Aviation Medicine. The "independent" position of psychology is presently supported by several national authorities (examples Austria, Germany) which already maintain since years a list of certified aviation psychologists for psychological evaluations next to a list of AeroMedical Examiners (AME). In order to provide a clear regulation and legal guidance regarding the future psychological requirements and psychological evaluation for pilots in Europe, DLR completely supports the proposal of the European Association for Aviation Psychology (EAAP) with respect to a revision of the Subparts B.055 Psychology of Part Medical and corresponding AMCs A and B to MED.B.055 (Class 1 and 2, and Leisure Pilot License).
response	*Noted*
	Our proposed rules do not prevent Member States from using already existing professional expertise in the field of aviation psychology. If a Member States want to restrict access to examination of pilots to certain psychologists or professional organisations, e.g. because of specific knowledge that may not be available elsewhere, they will have to defend that at national level. The AME is ultimately responsible for the determination of fitness of a pilot (see ICAO Annex 1). In difficult cases he/she will ask for additional examinations and/or tests and will evaluate the resulting reports before making that decision. These reports may be from e.g. cardiologists, ophthalmologists, neurologists and, also, psychologists.

comment	*1982*	comment by: *EFLEVA*
	The comments logged here are from EFLEVA. EFLEVA is the European Federation of Light, Experimental and Vintage Aircraft. This is a federation representing national associations in the areas of light,	

	amateur build, vintage & classic aircraft from states, which are members of the European Civil Aviation Conference (ECAC). Twelve national associations from eleven countries currently form the federation.
response	*Noted*
	Thank you for the information.

comment	*2000*	comment by: *PPL/IR Europe*
	In respect of EASA Class 1 and 2 medical standards, we do not have the expertise to provide comment in detail. However, as a stakeholder group impacted by the NPA, we have the following general comments 1. JAR-FCL medical standards for Class 1 and 2 are in excess of ICAO standards in a manner which, in practice, denies medical certification to European pilots who would qualify under other ICAO regimes 2. We are aware of the general arguments for "higher European standards" in aviation regulation. However, we believe Medical certification can be evaluated in a highly objective manner. We believe, for example, that comparison of the outcomes of the JAA and FAA medical regimes over the last decade provides such an objective reference, and, in effect, a controlled experiment analogous to the methods used in testing medical practices and treatments, but on a greater scale 3. We do not believe that there is any evidence that the more restrictive JAA medical regime has had any meaningful safety benefit for pilots, passengers or any 3rd party 4. Therefore, we believe that there is a firm case to rescind European medical requirements in excess of ICAO ones, where there is no demonstrable safety case for the higher European standard 5. We believe that over-regulating medical standards is particularly insidious, because it denies career and employment opportunties to European citizens in an unmerited and arbitrary fashion, that contravenes principles of natural justice and equal employment opportunity 6. We therefore urge EASA to ensure that FCL17c does not penalise European citizens in this way As non-expert readers, our impression of the NPA is that many of the prescriptive JAR-FCL requirements have been moved to the AMC section, and that the Implementing Rules offer a suitable degree of flexibility. We firmly support this approach. We are also fully supportive of the NPA in respect of the LPL Medical in its entirety. We believe the NPA proposals are fully in compliance with both the Basic Regulation on this subject, and the interests of the entire stakeholder community. As we have stated, we believe that JAR-FCL medical standards have unnecessarily and unfairly barred applicants for Class 2 medicals who presented no practical risk to themselves or 3rd parties from holding European pilot qualifications. Our view of the current NPA is that it has included a degree of unmerited "gold plating" of the LPL Medical examination, on grounds not demonstrably related to flight safety, in order to satisfy lobbies involved in the development of the NPA. We think the current draft is acceptable, but we do not think any further	

	amendments which make the LPL medical standard, or the process by which LPL medicals may be obtained, more restrictive or costly are acceptable. Where stakeholder lobbies differ in their opinions, we would urge EASA to apply its principle of retaining flexibilty within the Implementing Rules, and to move controversial items to the AMC domain.
response	*Noted*
	The class 2 medical standards were aligned with IACO SARPs. Medical provisions for class 1 medical certificates are based on JAR-FCL 3, which has been in place since 1999. These requirements are slightly more stringent than ICAO Annex 1 SARPS which are minimum standards. It must also be taken into account that the wording in ICAO Annex 1 for medical is very general and ever so often open for interpretation. Once the wording is amended to provide clarity, it often seems that the resulting requirements are more stringent. LAPL: Please note that the IRs and AMCs covering the fitness of LAPL holders/applicants have been redrafted following adverse comments. However, the amended provisions are still considerably less stringent than the ICAO compliant Class 2 requirements.

comment	*2002*	comment by: *Swedish Soaring Federation*
	General comment: "Swedish Soaring Federation, which represents approximately 2,400 glider pilots in Sweden, strongly supports the FCL proposal to introduce two EU glider pilot licences which are identical in all respects other than the differential medical standards and medical validation processes.	
response	*Noted*	
	Thank you for your feedback.	

comment	*2067*	comment by: *Light Aircraft Association of the Czech Republic*
	Light Aircraft Association of the Czech Republic - LAA CR is association of pilots, builders, designers, manufacturers and operators of light aircraft with MTOM up to 450 kg. It has 6 400 members and registers 7 900 aircraft and 10 000 pilots. LAA CR is a competent authority for Certification, Licencing and Operation of microlights in the Czech Republic. This covers paragliding, powered paragliding, hang gliding, gyroplanes, helicopters, weight shift and aerodynamically controlled microlight. As is visible from scope of our activities we represent current AnnexII activities. Hovewer we are interested in EASA rulemaking process because it could have influence to our activities. We will make just comments where we feel that there is relevance to our interests.	

	The LAA CR, generally supports the principles embodied in the LPL medical standards. Hovewer we also request that the current system of medical checks for microlight pilots using dedicated doctors as it is used in Czech Republic could be used as well. We understand that the success of LAPL is determined by success of light simple medical standards - therefore we support this concept. Proposal: LAA CR strongly recommends that EASA should not ignore proven best practice in several EU countries, abandoning systems and processes that have proven over many years to work, just for the sake of EU standardisation. If 'Acceptable Means (plural) of Compliance' is to have its true meaning, then there should be more than one acceptable means of demonstrating compliance with the medical standards.
response	*Noted*
	The proposed medical requirements are not related to Annex II type of activities. As you say in your comment, this activity is subject to national regulation. The GMP will be allowed to issue medical certificates for LAPL holders/applicants, if permitted under national law. This wording in the Basic Regulation takes into account that many Member States oppose to that idea while in others the GMP has been integrated into the system of private pliot licensing for many years. This shows that longstanding processes are not necessarily abolished when EU law comes into force. It is the general understanding that the AMCs as published by the Agency will be used. If alternative AMCs are envisaged by an MS, these AMCs should undergo a risk assessment by the NAA and, if the same level of safety can be reached, the AMC(s) will be sent to the Agency for further processing. It is not foreseen that MS just implement alternative AMCs.

comment	*2106*	comment by: *David PYE*
	I have read, understood, support & reitterate the comments made by the BGA with regards to suggested alterations to this document. Please accept this comment as if it were a copy of the BGA response.	
response	*Noted*	
	Thank you for this information.	

comment	*2107*	comment by: *Light Aircraft Association UK*
	These comments are made on behalf of the Light Aircraft Association, UK, which represents Light Aircraft pilots and owners in the UK.	
response	*Noted*	
	Thank you for the comment.	

comment	2115	comment by: *Direction de l'Aviation Civile Luxembourg*
	Luxembourg believes that the medical requirements should not deviate from ICAO and stay as close as possible to JAR FCL 3 and we cannot accept the additional requirements for a continued validity of an AeMC and medical assessors. These requirements are not in line with JAR FCL 3 and might lead to the collapse of quite a number of aeromedical systems in Europe.	
response	*Partially accepted*	
	Proposed Class 1 requirements are based on JAR-FCL 3, whereas Class 2 requirements have been aligned with the standards in ICAO Annex I. We agree with your comment that the validity period of an AME certificate should remain as it was in JAR-FCL 3 (no longer than 3 years) and the text will be amended accordingly. AeMC: Please see Comment Response Document of NPA 2008-22.	

comment	2121	comment by: *Croft Brown*
	The comments in this response to NPA17c represent the responce from Croft Brown, Bowland Forest Gliding Club. i have mainly copied the resonce from the British Gliding Association.	
response	*Noted*	
	Thank you for this information.	

comment	2137	comment by: *Avon CAYZER*
	Please can we have a more simplified structure with clearer more straight forward criteria and management that means normal U.K General Doctors can undertake and complete the checks, along with a remainder when the check is due every 1,2, or 4 year dependent on age and general health. Kind Regards The Hon Avon Cayzer	
response	*Partially accepted*	
	The form for medical checks for LAPL medical certificates has been abolished following comments to this NPA. The form will be replaced by the application and examination forms for class 1 and class 2 pilots that are easier to handle as they are self-explaining.	

comment	2146	comment by: *ECA- European Cockpit Association*
	ADD REDWIG PROTOCOL Justification: The old JAR-FCL 3.046 REDWIG protocol is missing. This was very useful for the	

	system as whereby we can gain experience of specific certificating certain conditions under close supervision prior to a prospective easing of the Rules. There is no apparent reason to delete it, so I would encourage to get a similar system under the new regulation.
response	*Noted*
	REDWIG protocol has not been included in the current proposal as the task is not under the Agency's remit. However, nothing would prevent MS and Organisations to liaise in order to identify areas where new medication/treatment/assessments become available and propose rulemaking activities as deemed necessary.

comment	*2163*	comment by: *Arno Glover*
	The EASA medical proposals that substantiate the LPL licence holder are welcomed and appear relavent to that type - the LPL licence type is needed and any medical certification process that accompanies this licence should be supported	
response	*Noted*	
	Thank you for your positive comment.	

comment	*2183*	comment by: *Finnish Aeronautical Association - Kai Mönkkönen*
	The Finnish Aeronautical Association supports the proposed system for FCL by having two categories of glider pilot licenses LPL(S) and SPL that are identical in all respect than the differential medical standards. Especially will welcome the principle of medical standards and medical validation for LPL which will enable a larger amount of glider pilots to start to fly and continue to fly with minimal risk to anyone. Justification: This principle is also in accordance with the Commission's stated view, endorsed by the Transport Committee of the EU Parliament, of the need for proportionate regulation relative to risk Proposed text: See comments made by the European Gliding Union (EGU).	
response	*Noted*	
	Thank you for your support. Please note that the GMP can only issue medical certificates when permitted under national law. The IRs and AMCs covering the fitness of LAPL holders/applicants have been redrafted following adverse comments. However, the amended provisions are still considerably less stringent than the ICAO compliant Class 2 requirements.	

comment	*2192*	comment by: *Oxford Gliding Club*

	These comments represent the views of Oxford Gliding Club, a UK club with approx 100 members, 8 club aircraft and 25 private aircraft
response	*Noted*
	No comments to be found in this section.

comment	*2207*	comment by: *Liz SPARROW*
	I support the proposals of the British Gliding Association on this section	
response	*Noted*	

comment	*2219*	comment by: *Adrian Giles*
	I enjoy the sport of gliding. I am worried that the suggested changes to pilot licensing with respect to medical requirements will increase the financial costs of my hobby without bringing a greater benefit in terms of safety for me or other people. I am therefore pleased to see that the proposed Leisure Pilot licence has an appropriate level of medical certification, and hope that this is the licence which will be required for gliding. There does seem to be a long list of "boxes" for a busy GMP to tick, perhaps this list could be shortened without detracting from the basic principles. As a practising pharmacist I appreciate the heavy workload of my medical colleagues. I understand that the British Gliding Association has proposed an alternative and I hope that will receive serious consideration.	
response	*Partially accepted*	
	The application form will be withdrawn from the NPA.	

comment	*2232*	comment by: *Tom Snoddy*
	I fully support the response provided on my behalf by the British Gliding Association.	
response	*Noted*	
	Thank you for this information.	

comment	*2250*	comment by: *Féderation Française de Planeurs Ultralégers motorisés*
	FFPlUM is of the opinion that a medical control is not useful as it was demonstrated by 25 years of practice. All the microlight accidents with a suspicion of medical causes recorded during this period implied pilots who are holding a part medical for heavier class of aircraft ! A self declaration countersigned by a family doctor will be sufficient to insure the level of security.	
response	*Noted*	

	Licences to operate Microlights are not within the Agency's remit and will continue under national regulations.

comment	*2262*	comment by: *Christopher Keating*
	I wish that the views and concerns expressed by the British Gliding Association in response to these proposals by accepted as my views and concerns.	
response	*Noted*	
	Thank you for this information.	

comment	*2263*	comment by: *ECOGAS*
	We are supportive of the content of this document, and find it well-written and appropriate for its task. Substantial requests for change to the NPA should be resisted.	
response	*Noted*	
	Thank you for your positive comment.	

comment	*2273*	comment by: *Julian darker*
	NPA 2008 17c I am in favour of the LPL and the medical standards that are proposed to apply to it. We should all be allowed to fly anywhere in the EU as of right with as few restrictions as possible and the ability of a GMP to conduct a pilot medical would be a very welcome step. Having to use an AME every year at great expense as directed by the JAA system is unnecessary for the type of medical we need for the LPL.It's all very well for commercial and military worlds where fees get paid but in this credit crunch a cheaper and simpler entry level medical would make sense	
response	*Noted*	
	Please note that the GMP can only issue medical certificates when permitted under national law. The IRs and AMCs covering the fitness of LAPL holders/applicants have been redrafted following adverse comments. However, the amended provisions are still considerably less stringent than the ICAO compliant Class 2 requirements.	

comment	*2319*	comment by: *Tim FREEGARDE*
	As in my response to p7, para 1 of NPA 2008-17a, I fully support the proposal to allow medical certificates to be issued by a general medical practitioner. Several cases have demonstrated that the pilot's general practitioner, with a knowledge of the pilot's medical history and access to his/her medical records, is better placed	

	to judge the fitness of the pilot than a separate body of aero-medical examiners. The medical requirements for the leisure pilots licence in particular should be no more stringent than those for, for example, HGV drivers, who represent a greater risk. UK gliding, the UK NPPL, the USA Sport Pilot's Licence and several classes of aviation in European states have happily and successfully operated with either self certification (comparable with private motoring) or general-practitioner certification based upon knowledge of the pilot's medical history. I therefore endorse the BGA proposal that, where adequate records exist, a general practitioner should be able to certify pilots without further examination, and that this certification should be recognized beyond the country of certification. Should international recognition not be achievable, general practitioner certification should nonetheless be acceptable within individual countries.
response	*Not accepted*
	Please refer to the response to comment No 37 in this section. Additional response for this particular comment No 2319: A medical certificate issued by a GMP of a Member State where national law allows GMPs to do so will be accepted in the EU and EASA associated States if that medical certificate has been issued for a pilot who holds his/her licence in that MS. However, a medical certificate issued by that same GMP is not valid if it has been issued for pilots who hold their licence in an MS where national law does not allow GMPs to issue medical certificates.

comment	*2351*	comment by: *Barrie Christie*
	C. Draft Opinion and Decision Part Medical - Annex II to Implementing Regulation. We support the LPL and in particular the medical standards within the LPL proposal. These standards will ensure that few if any people, who should be allowed to fly, will be denied the right to do so. This is fundamental to the **rights** of the European citizen. Further, the ability for an ordinary doctor to conduct the medical certification within those member states whose national law allow that (vide: Basic Regulation 216) is a welcome removal of unnecessary restrictions created by the JAA system which limited most countries to having to use an AME. The LPL will be a welcome recognition of the need for an entry level set of qualifications to private civil aviation, so long dominated in many states by the thinking borne out of commercial and military aviation where someone else (the passenger or the military establishment) is paying the costs!	
response	*Noted*	
	Thank you for your support. Copy of comment No 1604: Please see response to comment No 1604.	

comment	*2361*	comment by: *Bob BOYD*
	This section is so complex that only medical or legal professionals may be able to correctly explain the consequences of these proposals. However, the British Gliding Association (BGA) has obtained such expertise to suggest an appropriate way forward. I very strongly recommend that the BGA response is adopted, especially in regard to the use of certification by General Practitioners. As with other sections, the incorrect conclusions will destroy gliding in the UK for more than half of the participants.	
response	*Noted*	
	See the response to the comment of BGA.	

comment	*2368*	comment by: *Federal Ministry of Transport, Austria (BMVIT)*
	Congratulations on the achievement of drafting this text. We especially appreciate the key concept of moving a significant part of JAR-FCL 3 Section 1 material into the AMC part. A lot of other details are to be commended, such as replacing the legally problematic JAR-term "AeroMedical Section" with licencing authority or the issuance of first Class 1 Medicals by AeMCs.	
response	*Noted*	
	Thank you for sharing your supporting views.	

comment	*2376*	comment by: *Norwegian Air Sports Federation, Gliding Section*
	In general, the Norwegian Air Sport Federation, Gliding Section, agrees with the comments to NPA 2008-17c submitted by the European Gliding Union (EGU) Geir Raudsandmoen on behalf of the Norwegian Air Sport Federation, Gliding Section	
response	*Noted*	
	Thank you for this information.	

comment	*2377*	comment by: *Norwegian Air Sports Federation, Gliding Section*
	The Norwegian Air Sport Federation, Gliding Section, strongly supports the proposal that medical examinations for a LPL may be performed by a General Medical Practitioner. Examination by a GMP for glider pilots licence has been allowed in Norway for more than 20 years, with an examination report form established for this purpose. Geir Raudsandmoen on behalf of the Norwegian Air Sport Federation, Gliding Section	

response	*Noted*
	Thank you for your support. Please note that the GMP can only issue medical certificates when permitted under national law. The IRs and AMCs covering the fitness of LAPL holders/applicants have been redrafted following adverse comments. However, the amended provisions are still considerably less stringent than the ICAO compliant Class 2 requirements.

comment	*2380*	comment by: *Irish Aviation Authority*
	EASA should include the acceptable level of incapacitation risk per year for each class of medical certificate. Safety risk levels should be stated. Justification: Standardisation. Proposed text: Add MED.A.040 (c): the level of incapacitation risk is acceptable for the medical certificate Class 1 or Class 2 taking into account any mitigating factors and limitations applied.' Add AMC to MED.A.040 (c): (a) For Class 1 medical certificates the maximum acceptable annual risk of incapacitation is 1% for multi pilot operations and 0.5% for single pilot operations. (b) For Class 2 medical certificates the maximum acceptable annual risk of incapacitation is 2%.	
response	*Noted*	
	Please see response to comment No 231.	

comment	*2381*	comment by: *Irish Aviation Authority*
	The IAA does fully agree with the proposals to base the Class medical assessment on the ICAO Class 2 Standards and Recommended Practices. (The IAA would also want this for LPL)	
response	*Noted*	
	Thank you for your comment.	

comment	*2422*	comment by: *CMO/AMC and President of Danish Aviation & Marine Medical Association*
	The NPA2008-17C has a large numbers of altered medical requirements compared to JAR-FCL3. In general, it is very clear that no aviation medical experts have evaluated the proposals as most of the proposals have no scientific	

	background. Several topics are inadequate worked up or worked up with intention of decrease aviation safety due to uncertain reasons. Where are the evidences to justify lower standard LPL health examinations, GMPs without aviation medicine knowledge as medical examiners (gate keepers) and the newly introduced extended periods of health examinations for Class 1 and 2 pilots? Why is the workload and duty hours increased despite several scientific papers on the opposite? Instead Rulemakes should take the opportunity to modernize requirements onto today medical standard and modern examinations methods as well as take public expectations into account. May I suggest that Rulemakers consult Manual of Civil Aviation Medicine, ICAO 2008, for a more differentiated opinion?
response	*Noted*
	Medical requirements proposed in NPA 2008-17(c) are based on ICAO Annex I provisions (for Class 2 applicants) and JAR-FCL 3 provisions (for Class 1 applicants). The periods of validity of medical certificates for class 1 and class 2 did not change. Flight duty hours are not included in this NPA. Please refer to NPA 2009-02. LAPL medical requirements were proposed following the principle of proportionality of the rule and are tailored to the risk involved in this type of operations. Provisions allowing GMPs to issue LAPL medical certificates are in Article 5 of the Basic Regulation. Please note that the LAPL rules and AMCs have been redrafted after all comments were reviewed. The rinciple that these provisions should be lower than ICAO class 2 SRAPs has been kept. The rules for medical fitness will be updated in regular intervals. The next rulemaking task for this is MED.001 that will start in the 1st quarter of 2011.

comment	*2444*	comment by: *SANMA Swedish Aeronautical Associatation*
	I den medicinska texten står hela tiden should and may vilket innebär att inget är tvingande och undersökningarna därför blir mycket godtyckliga. Helt oacceptabelt för flygsäkerheten.	
response	*Noted*	
	Implementing Rules are binding which can be seen by the use of 'shall' in the rules. Acceptable Means of Compliance allow some flexibility. For this reason expression 'should' is used in AMCs.	

comment	*2577*	comment by: *UK General Aviation Alliance*
	The UK GAA supports the development of medical certification appropriate to the activity undertaken.	
response	*Noted*	

	Thank you for your support.

comment	*2580*	comment by: *UK General Aviation Alliance*
	GAA support a lower medical certification standard requirement for the LPL. However a self declaration standard as currently used in the United Kingdom with the National Private Pilot's Licence supported by the holder's general practitioner is more appropriate than the medical examination proposed in this NPA and has proved to be successful.	
response	*Noted*	
	Thank you for your support of the possibility of GMPs to issue medical certificates for the LPL. However, your proposal to have the GMP issue the medical certificate without the need for an assessment when the GMP has the medical history of the pilot cannot be accepted. In fact, having knowledge of the medical background of the applicant is a pre-requisite for a GMP to be allowed to issue medical certificates, in accordance with Article 7(2) of the Basic Regulation. But the same article further determines that a medical certificate shall only be issued when the applicant demonstrates compliance with the Essential Requirements in Annex III to the Basic Regulation. Furthermore, paragraph 4.a.1 of the Essential Requirements determines the following: *'All pilots must periodically demonstrate medical fitness (...). Compliance must be shown by appropriate assessment (...)'.* The Agency's view is that this requirement for appropriate assessment cannot be satisfied with the mere analysis of medical records. There is a need for the GMP to perform a medical assessment. Existing medical records may be taken into account when performing the assessment, but cannot be the only element used. The same reason was behind the decision not to allow the system of self-declaration of medical fitness that is used in some Member States. In the Agency's view, a self-declaration cannot fulfil the requirement for an appropriate aero-medical assessment in the Basic Regulation.	

TITLE PAGE p. 1

comment	*1086*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	General: On behalf of the Executive Committee and the Advisory Board of the European Society of Space and Aviation Medicine (ESAM) I submit our comments on NPA 17c.	

	These comments were elaborated by 82 medical specialists nominated by their national aeromedical societies or licensing authorities of 24 European EASA and ESAM member states (see attachment). Comments of those 82 medical specialists were collected and summarized into cluster. 41 corresponding partners were members of 6 working groups during the First European Conference on Aviation Medicine, held in Wiesbaden/Germany, August 23 and 24, 2008. In this conference the comments were harmonized and finalized. The finalized version was sent to all ESAM member states and all corresponding specialists and was agreed. The following comments on different chapters of NPA 17c are proofed by medical specialists and show you the medical opinion agreed by 3400 AMEs and other medical specialists represented by ESAM. The comments are based on medical studies and literature as well as own experience in AMCs, AMS and AMEs offices and shall show what medical experts in Europe can accept as a minimum safety standard in aviation medicine. We all hope that EASA will respect this powerful medical statement and will not go beyond the level of safety standard which is shown in these comments.
response	*Noted*
	We appreciate the effort made by ESAM to pull together the aeromedical expertise available in Europe and to draft a comprehensive set of comments to this NPA.

comment	*1482*	comment by: *Richard FREY*
	The document states in the title page that the document is two opinions, an agency opinion and a director's opinion. There is nothing to say where one ends and the other begins. This vagueness is unnecessary.	
response	*Noted*	
	The title of the document is: 'Draft **Opinion** .... for a Commission Regulation establishing the Implementing Rules .... and Draft **Decision** of the Executive Director .... on Acceptable Means of Compliance and Guidance Material ...' The Draft Opinion on Implementing Rules ends on page 21, last paragraph is MED.D.001. The Draft Decision starts on page 22. The page header is: II Draft Decision AMC and GM for Part-Medical, the first paragraph is AMC to MED.A.015. The mentioning of 'AMC' in the paragraph number indicates that the paragraph contains acceptable means of compliance.	

comment	*1483*	comment by: *Richard FREY*
	The title page makes claim that the document contains the two opinions, one of an agency and one of a function. The document contains no authorisation or empowerment from either.	
response	*Noted*	
	1. Opinion: please see an answer to your comment 1482 above. 2. The task to draft NPAs for Implementing Rules (Draft Opinion) and Acceptable Means of Compliance (Draft Decision) is documented in Articles 17, 18 and 19 of the Basic Regulation (Regulation (EC) No 216/2008 of the European Parliament and the Council of 20 February 2008 on common rules in the field of civil aviation and establishing a European Aviation Safety Agency, and repealing Council Directive 91/670/EEC, Regulation (EC) No 1592/2002 and Directive 2004/36/(EC)).	

comment	*1484*	comment by: *Richard FREY*
	The document contains no statement that it is a controlled document.	
response	*Noted*	
	All Agency's documents published on its website are controlled documents.	

comment	*1656*	comment by: *Leisure and Retail Helicopters*
	C. Draft Opinion and Decision Part Medical - Annex II to Implementing Regulation. I support the LPL and in particular the medical standards within the LPL proposal. As a registered medical practitioner I believe the propopsed standards will ensure that few people, who should be granted the right to fly, will be denied that right. This is a Human Rights entitlement. Further, the ability for a GMP to conduct the medical certification within those member states whose national law allow that (vide: Basic Regulation 216) is a welcome removal of unnecessary restrictions created by the JAA system which limited most countries to having to use an AME. The LPL will be a welcome recognition of the need for an entry level set of qualifications to private civil aviation, so long dominated in many states by the thinking borne out of commercial and military aviation where someone else (the passenger or the military establishment) is paying the costs!	
response	*Noted*	
	Thank you for giving us your opinion on the provisions for the LAPL medical. However, please note that the proposed provisions for a medical certificate for LAPL holders/applicants have been redrafted following comments on the IRs and AMCs for the LAPL. The resulting rules and AMCs are still less stringent and more flexible than ICAO class 2 standards and the GMP will be allowed to issue medical	

	certificates for the LAPL if permitted under national law as foreseen in the Basic Regulation.

comment	*1954*	comment by: *UK Department for Transport*
	The UK Department for Transport supports the medical proposals set out in NPA 2008/17C in general, and in particular the decision to move from JAR to ICAO standards for the Class 2 medical.	
response	*Noted*	
	Thank you for your support.	

comment	*2136*	comment by: *Avon CAYZER*
	Please can we have a more simplified structure with clearer more straight forward criteria and management that means normal U.K General Doctors can undertake and complete the checks, along with a remainder when the check is due every 1,2, or 4 year dependent on age and general health. Kind Regards The Hon Avon Cayzer	
response	*Noted*	
	The provisions for the LAPL have been redrafted following comments in the relevant sections of this CRT. Also see the response to your identical comment 2132 in section 'General Comments'.	

comment	*2189*	comment by: *Lesley ASHBURNER*
	GPs must be allowed to conduct the LPL medical to ensure sufficient numbers are carried out.	
response	*Noted*	
	Thank you for your input.	

comment	*2277*	comment by: *Karsten KNOOP*
	Sehr geehrte Damen und Herren, ich möchte NPA 2008-17c wie folgt kommentieren: Das Medical für Piloten der allgemeinen Luftfahrt ist zu streichen. Begründung: Es sind keine Fälle von medizinisch bedingten Unfällen in der Allgemeinen Luftfahrt in Europa bekannt (nach meinen Informationen). Dies gilt für Länder mit medizinischen Untersuchungen der Piloten wie auch für die Länder, in denen es bisher keine solchen Untersuchungen gab. Daraus folgt, daß fliegerärztliche Untersuchungen nicht zu einen Erhöhung der Sicherheit führen können.	

	Nach europäischem Recht muß eine Vorschrift aber einen Zweckerfüllen, der der Gemeinschaft einen Nutzen erbringt. Aber auch für den Fall, das ein Luftfahrzeug aus medizinisch bedingtem Versagen des Piloten abstürzt entsteht hierbei der Allgemeinheit kein Schaden. Die Fälle, bei denen unbeteiligte Dritte durch ein abstürzendes Luftfahrzeug der allgemeinen Luftfahrt zu Personenschaden kommen sind so gering, dass das gleichzeitige vorkommen beider Fälle (medizinisch bedingter Unfall mit Personenschaden unbeteiligter Dritter) statistisch nicht mehr erfassbar ist. Aus oben geschildertem geht hervor, dass durch Medicals keine Verbesserung der Sicherheit für die Luftfahrt zu erwarten ist. Da aber die Kosten für Piloten durch das Medical in die Höhe getrieben werden besteht die Gefahr, daß die Piloten weniger fliegen. Das wiederum verschlechtert die Sicherheit, denn nur Übung erhöht die Sicherheit weniger Übung verringert die Sicherheit. Ich bitte Sie, dies alles zu berücksichtigen und, wenn mit den Vorgaben der Politik vereinbar, das Medical für Piloten der allgemeinen Luftfahrt zu streichen. Mit freundlichen Grüßen Karsten Knoop 1. Vorsitzender der Segelfluggruppe Giulini e.V.
response	*Not accepted*
	It is not possible, for safety and legal reasons, to abolish the medical certificate for private pilots. Please refer to the response to comment No 37 and 1408 in the Section 'General Comments'.

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comment	*1335*	comment by: *James Carrie*
	Please would EASA clarify when there is a requirement for candidates to undergo intimate examinations. This matter warrants a section in this NPA of its own. Generally medical staff are helpful and professional. However, there is the possibility of abuse. Whilst FCL does not make the requirement clear, Doctors may interpret the general requirement to ensure that a candidate is free from illness to include random testicular examination of males. There has never been any evidence to suggested that I suffered from testicular defect and in the nine years I have held a class one medical I have only once been examined. I have never been asked or guided about inspecting myself. Please, please, please, please would you include a section here to the effect that:- 1) There is normally no requirement for intimate examination of either male of female candidates for class one medicals 2) Where the doctor has reasonable cause to suspect that the candidate may be concealing testicular cancer or other illness he may require an intimate	

	examination before he is able to grant the medical certificate 3) When this is the case the candidate will have the concern explained. The nature of the examination will be discussed with the candidate. The candidate will be asked to consent specifically to an intimate examination. 4) The candidate may request that a second person (a second doctor, a nurse of a person known to the candidate) be present during the examination. 5) A candidate will never be forceably examined or surprised to be examined in this way. I am not a medical expert, but I am training as a psychoterapist and I believe that inappropriate or unnecessary examinations can harm. If I have misunderstood the medical requirement and there is a requirment for intimate examination then the NPA should make this clear. Many thanks for your consideration
response	*Noted*
	Only examinations that are needed to determine fitness to fly are included in the Implementing Rules (IR) and Acceptable Means of Compliance (AMC) of this NPA. On a general basis this excludes intimate examinations. If a GMP or AME sees a clinical indication to go beyond the examinations required in an IR or AMC, he/she has to explain why this is the case and the applicant has to give consent. If the applicant disagrees with the request for an additional examination, the case shall be referred to an AeMC or to the licensing authority.

comment	*1485*	comment by: *Richard FREY*
	The document contains no assessment of the cost to process it as requested, or any confirmation that the benefit accruing from the processing of the document will exceed the cost of so doing.	
response	*Noted*	
	The development of NPAs is one of the tasks of the Agency (see response to your comment No 1483 in the Section 'Title Page' in the CRT). The cost is covered by the Agency's budget which is regulated in several articles in Section IV of the Basic Regulation.	

comment	*1486*	comment by: *Richard FREY*
	The document contains no link to an assessment of need, a consequence analysis, a safety analysis, or a cost-benefit analysis. If these analyses have been undertaken, references should be included in the document. If they have not been undertaken, the persons responsible should be disciplined.	
response	*Noted*	
	Safety, economical, environmental evaluation have been published in NPA 2008-22f - Authority and Organisation Requirements - Regulatory Impact Assessment	

on Flight Crew Licensing (FCL).

C. PART-MED p. 3

comment	*222*	comment by: *Hans-Dieter Weigel*
response	*Noted*	
	No comment appears under Cmt # 222.	

comment	*319*	comment by: *Aero-Club of Switzerland*
	To ease comprehension: Please clarify that you use the "shall" and the "should" as ICAO does. All texts related to class 1 and class 2 medical certificates: The medical specialists of the Aero-Club of Switzerland do not comment all of these sections, a choice was made and the comments proposed hereby are completed by the statements prepared at the 1st European Conference on Aviation Medecine held at Wiesbaden, Germany, on August 23/24, 2008, where several issues were discussed, consensus found and proposals for changes transmitted to the Agency by the organisers of that Conference. We support most of these proposals.	
response	*Noted*	
	The Agency uses 'shall' in Implementing Rules, 'should' is used in Acceptable Means of Compliance and Guidance Material. ICAO uses 'shall' in a standard and 'should' in a recommendation.	

comment	*343*	comment by: *Oliver Brock MD PhD AME*
	Attachment #1	
	See attached file	
response	*Noted*	
	Attachment not visible in the tool.	

comment	*1356*	comment by: *PR Jean Pierre GOURBAT*
response	*Noted*	
	No comment appears under Cmt # 1356.	

comment	1357	comment by: PR Jean Pierre GOURBAT

LE DIRECTEUR
General J.P GOURBAT
Professor at the Val de Grâce
Member of the Medical Council of Civil Aviation
President of the French Society of Aerospace Medicine

I am expressing myself here in the name of the 20 specialist physicians of aerospace medicine who have been working in the French centres of aeronautical expertise for years.

The objective that we all share is to maintain the flight safety.
Nevertheless, the decreasing incidence of the aircraft crashes related to a proven medical cause implies a will of relaxation of the lawful medical requirements, the periodicity of the visits and the qualification level necessary for the doctors in charge of the monitoring of the flight crew of civil aviation.
This will clearly appears in the proposals of the EASA.
The methods of organization of aeronautical medicine which are considered, do not take into account national specificities and existing structures. Their possible implementation will disorganize in a country as France the aeromedical organization without improving the flight safety, quite the reverse.
If a liberalization of requirements is legitimate, a full safety means it must be applied by experienced doctors in solid and adapted structures in every country, i.e. corresponding to the history, the culture and the uses.

The new text suggested by the EASA takes as a starting point various principles :

- Standardization of the practices in the European Union, with adjustment on the Anglo-Saxon practices;
- Will of simplification of procedures with a levelling down;
- Drastic reduction of medical requirements;
- Application of fitness standards by doctors who are little or not qualified in aeronautical medicine.

Two subjects appear essential and deserve to be detailed because they risk to strike a blow at the aeronautical medicine in France if they are applied:
- The possibility that isolated aeromedical examiners to practise the periodical visits of class 1 pilots;
- The appearance of the leisure licence.

The coexistence of AMC (AeroMedical Centres) and AME (AeroMedical Examiners) has existed in the United Kingdom for a long time, but the fact is that this situation is adapted to their culture and their legal system.

In France, the monitoring of professional pilots is carried out in AMC exclusively. Sometimes pilots have to move a lot to get to these centres, their operation can be considered difficult at times, but qualitatively this centralized system presents only advantages.
Unfortunately, nowadays quality is out of place, simplification and economies are more important. To do that, the EASA introduces a possible competition between

the AMC and the AME which appears in a recent history that it is useful to remind.

The medical expertise of the flight crew is governed in France by a decree of January 27th, 2005 relative to the physical and mental fitness of the technical flight crew of professional civil aviation, which was published in the Official Journal of the French Republic on March 13rd, 2005.
This text is the translation in the French law of the JAR FCL 3, which was the result of more than ten years of discussions between the various members of the JAA. The idea was a consensus which allowed every country to adopt a common attitude towards medical expertise problems.
This consensus respected both the organization of the aeronautical expertise medicine and the national specificities. In particular, it was expected that the examination of a professional pilot could be carried out by an AME ('may' and not 'shall' in the English text), letting the national authorities to choose their organization.

The text in the EEC 216 /2008 regulations introduces changes in this approach. It has not been the subject of a preliminary consultation, and there is an ambiguity.
It is written that the medical certificate can be delivered by an aeromedical examiner **or** an aeromedical centre. We will consider the interpretations that we can give to this "or".

The NPA 2008 17 C looks like the application decree of the ECC 216/2008 regulations, and it brings an interpretation to this "or"; thus "may" is turned into "shall", de facto imposing the coexistence of aeromedical centres and aeromedical examiners for the class 1 pilot certification in all countries.
This evolution appears extremely serious to us, it definitely does not take into account of the present situations, the cultural identities and the national methods of organization. Consequently, it imposes to every country, whatever its previous organization, the Anglo-Saxon organization which is not always adapted and shall disorganize the present structures without improving the flight safety.

A legal approach is needed:
The EEC 216/2008 regulations (OJEU 03.19.2008 p L79/1) concerning the medical certificates for pilots, in the article 7, paragraph 2, subparagraph 3, specify that a person is issued with a medical certificate only if this one satisfies the established rules to guarantee conformity with the essential requirements relative to the medical fitness fixed in appendix 3.
This medical certificate can be issued by an examiner **or** a centre.

Are the examiner and the centre equal for the issue of the medical certificate ?
In order that the medical certificate should be issued in a completely equivalent way by the examiner or the centre, it is necessary to be sure that the required guarantees and safety rules are filled exactly the same on both sides.
The necessary conditions that the aeromedical examiner has to meet are very limited: to be allowed with the legal practice of medicine, to have received an initial and permanent training in aeronautical medicine, and to have knowledge and experience of the working conditions of pilots.

The conditions which are planned for the aeromedical centre are much more restrictive, seeing that it has to own means and staff necessary to assume

the whole responsibilities related to its privileges, as well as installations, material equipments, technical tools, documentation, data access and filing system.
Moreover, the centre has to implement a management system relative to the safety and quality of the aeromedical assessments and also to a constant improvement of these systems.
It is also expected that the approval is granted to the aeromedical centre only when this one satisfies the established rules.
No equivalent approval system is discussed concerning the competence of the aeromedical examiner.

It appears that the pilots who will be assessed in an AMC or by an AME will not be treated in the same way. Moreover, the quality, equity and safety-first principles, required to achieve the objective of safety as specified in the Chicago convention, the ICAO and the European regulations, are not respected.

The whole French aircrew has always been selected and followed in the AMC. This system is qualitatively and quantitatively well adapted to our country. Thanks to it, the mission can be carried out with a relatively reduced number of highly specialized physicians in 5 fully equipped centres.
In the Principal Aeromedical Centre of Expertise of Aircrew in Paris, from 80 to 100 initial or renewal examinations for civilian and military crew members are carried out every day. Such a quantity of aeromedical assessments as well normal as abnormal confers a solid experience on medical experts who are used to broaching the limits of normality and the acceptable limits for fitness decisions in a legitimate way.

In such centres, the aeromedical expertise is plural, what offers a guarantee of quality and equity which is not met for isolated examiners.
If one compares the examination in an aeromedical centre and by a simple aeromedical examiner, it appears clearly that the qualitative level is not equivalent.
These questions have been studied in the Kourilsky and Viney report relative to the safety-first principle and in the Lepage commission's work within the framework of the Borloo mission about Grenelle of the environment, which have shown that **plural expertise is greatly higher than individual expertise.**
The problem of training and competence of the physicians in charge of aeromedical examinations is also essential. In France, the physicians working in the military centres have profited from a 5-year special training to rise to a specialist qualification after passing final theoretical and practical exams.
The 10 aeromedical assessments which are daily performed on average by each physician, this specific training and a team work, allow examiners of these centres to answer the safety requirements which are asked by the French authorities and also by the European commission concerning the medical monitoring of class 1 pilots.

In France, the setting up authorization of isolated aeromedical examiners for class 1 pilots (AME), who will coexist with aeromedical centres (AMC), will call into question the present situation without a benefit for the flight safety, because it shall involve an economic competition. The AME shall profit from an asset of proximity and an attractive price (an isolated expertise is obviously less expensive than a plural expertise in a centre) to the detriment of quality, in particular when

one examines the approval conditions for an AME.
In order to obtain this approval, actually you only have to be a present qualified examiner for class 2 pilots, to have carried out 30 aeromedical assessments (clearly a very limited experience), and to have followed an additional training anywhere in a European country. Then you only have to carry out 10 yearly assessments to keep this approval for unlimited period.
In this context, the conditions of practice and attribution of approvals are not equitable between the AMC and the AME, and the quality level suggested to the flight crew is not comparable.
Moreover, we shall witness a decrease of abilities. Indeed, the quality of aeronautical expertise is closely related to the number of examinations carried out, then the decreasing number of examinations in the AMC will affect their quality level, if they purely and simply do not disappear…

The best solution is to let the initiative to the national authorities with regard to the place of the AME in the management of class 1 pilots:

- opportunity of authorizing them,
- adaptation of the number to the needs,
- training and control exams at the national level only.

In France, our aviation medicine is a mature, old and structured medicine with very clear reference marks which are called into question by the EASA proposals.
1 - *The Medical Council of Civil aviation*, with its recognized medical experts who are used to examining the aircrew files in a full neutrality to discuss fitness with a waiver and limitations: in the NPA 2008 17 C, it is proposed that the files concerning class 2 pilots and LPL pilots will not be submitted to the Council anymore… It is extremely alarming.
2 - *The five Aeromedical Centres of Expertise of Aircrew*, at present with 2 civil centres and 3 military centres, which remain the backbone of the aeromedical organization… an essential problem we tried to develop.
3 - *The thousand qualified aeromedical examiners for class 2 pilots*, whose place in the service of general aviation is compromised by the appearance of the leisure licence.

The attribution of the leisure licence allows the holder to fly on practically all the aircrafts existing in flying clubs. Qualified examiners for class 2 pilots are almost excluded because the medical certificate can be issued by a general practitioner. Besides, the final objective of the extended periodicity is to eliminate the medical examination, and yet this examination remains annually required to practise almost any other sport.

This licence practically based on an exclusive questionnaire is not adapted to our country.
Standards of fitness, for instance aortic aneurism between 55 and 65 millimetres, are too much permissive and call into question the flight safety.

IN CONCLUSION :

Doctors, particularly in the AMC, unquestionably take part in the flight safety. Thus, a relaxation of the lawful medical requirements, which clearly appears in the new proposals of the EASA, defeats the initial safety purpose in aeronautics.

	In addition, the will of standardization within the European Community, with a typical Anglo-Saxon organization, shall disorganize the present aeromedical structures, particularly in France. All the changes which are suggested are likely to call into question the flight safety, then it is justified to revalaute them. It is strongly desirable that the national authorities decide on the implementation of these proposals, because they are in the best position to appreciate the opportunity and the details.
response	*Noted*
	Thank you for this elaborated comment. The paragraphs in this response are numbered following the headers of the comment which are in bold format. 1. The medical IRs and AMCs in this NPA are based on JAR-FCL 3 which has long been implemented in Europe. Changes in the requirements for class 1 have only been accepted after consultation of medical assessors in the licensing authorities around Europe and professionals from Organisations and Associations involved. Class 2 requirements have been aligned with ICAO Annex 1 principles and also only after consulting the aeromedical professionals mentioned above. The LAPL medical certificate has a lower standard than ICAO class 2 and is more flexible than the requirements for class 1 and class 2. This has been done following the will of the legislator (Council) and the European Parliament and is therefore legitimate. After review of the comments to this NPA, the IRs and AMCs for the LAPL medical certificate were redrafted but still with the aim to keep a standard that is considered appropriate for the type of activity and therefore below ICAO class 2 provisions. 2. Individual AMEs who perform examinations and assessments for commercial pilots (class 1) and issue their medical certificates is very common in the whole of Europe, the corresponding rules were already established in JAR-FCL 3. The co-existance of AeMCs and AMEs exists in all of Europe, not only in the United Kingdom. Full implementation of the European rules in Part-FCL and Part-Medical will be realised after a transition period that may be used to qualify AMEs Class 1 in France without disturbing the system. The Authority Requirements (NPA 2008-22) provide the competent/licensing authority with tools to conduct oversight to ensure that all AMEs work according to the rules and assess pilots in a way that does not endanger flight safety. For the LAPL medical certificate please see the paragraph above. 3. The provisions of JAR-FCL 3 have been implemented under national law which resulted in different interpretation and systems. The European Member States transferred their power to regulate aviation to the European institutions and the aim is to have one system in all Europe in the future. This system shall be of high quality and tailored to the risk of the activity of pilots. Therefore, a lower standard for recreational activities has been proposed while the standard for commercial pilots has been maintained. The prerequisites for AeMCs are high and it is not

expected that the number of AeMCs will go up significantly. Any competition between AeMCs and AMEs class 1 will be limited by the different structure which requires the AeMC to follow the rules for Organisations whereas the AME can work in his practice. Quality of examinations and assessments done by AeMCs and AMEs will be ensured by oversight of the licensing/competent authority.

4. Regulation 216/2008 (Basic Regulation)
Prior to implementation, Regulation 216/2008 was agreed by the Council (Member States) and the Parliament. As in all European legislation Member States have to adapt to and implement the new rules. In some countries the changes are minimal, in others significant but in the end there is a level playing field that gives the citizens not only the right, but also the possibility, to move and work in all member states. Which leads to the fact that an AME class 1 who has been issued with a certificate by one member state can also exercise his privileges in another member state, if he/she complies with the laws to set-up practice in that MS.

The IRs in this NPA were drafted based on a) the Basic Regulation, b) ICAO Annex 1 and c) JAR-FCL 3. It was the task of the Agency to draft IRs that further determine the Basic Regulation and the Essential Requirements. The Basic Regulation does not exclude any AME from issuing medical certificates. Therefore, in the IRs, it is determined that an AME class 1 can issue a class 1 medical certificate for revalidation or renewal, but only an AeMC can issue an initial class 1 medical certificate.

5. The AeMC and AME do not have exactly the same privileges. The AeMC can issue initial class 1 medical certificates whereas the AME cannot do so.

6. The requirements for AeMCs are higher than for AMEs because the AeMC is an Organisation with more privileges than an AME can achieve. It is considered that the initial medical certificate class 1 is very important and the AeMC must have the necessary structure and quality to take the correct decision.

7. It is clear that the quality provided in French AeMCs is extremely high, however, under European law and once Part-FCL and Part-Medical are implemented, a French professional pilot will be in a position to get his/her class 1 medical certificate form any AeMC or AME (with the privilege to issue class 1 medical certificates) in Europe.

The period of validity of a AME or AeMC certificate has been limited to 3 years following comments in this NPA. The requirements to get this certificate are the same as in JAR-FCL 3 which worked well in Europe.

8. The quality of an AME class 1 will be supervised by the licensing authority. If the reports that an AME send are insufficient or if his/her decisions regarding fitness to fly are dubious, the licensing authority can suspend the certificate and require further training.

9. It was the aim of the European legislator to create one system for all fields in aviation. All EU Member States agreed to this by agreeing to adopt Regulation 216/2008. Therefore, in the case of aviation medicine, physicians and AeMCs have a right to be issued with a certificate when they fulfil the requirements, number cannot be restricted due to European non-discrimination law and due to

	the right of access to professions. The content of training courses will be added to the AMCs of Part-Medical and the course should be approved by the competent authority. Control of examinations will not be mentioned at this stage because it is not regulated in JAR-FCL 3. Provisions regarding these examinations may be added in the upcoming rulemaking task MED.001. 10. Conclusion noted.

comment	*1653*	comment by: *Elmar KUEMMEL*
	Die Einführung der Bestimmungen 2003 haben zu einer Vielzahl zurückgegebener Lizenzen geführt. Desweiteren sind allein in meinem Verein etwa 20 % junge begeisterte Menschen wegen nicht nachvollziehbarer Kriterien von dem Sport ausgeschlossen worden. Einen Teil davon (z.B. Farbsehschwäche) hat man in Nachbesserungen zu spät korrigiert. Die Kriterien des Class 2 Medical mögen von einer Seite aus gerechtfertigt erscheinen, die ein hohes Maß an Investitionssicherheit bedingen. Zum Beispiel in der paramilitärischen Ausbildung, wo man von Anfang an nur Leute haben möchte, die nachher auch die gesamte Ausbildung durchlaufen können. Das ist aber im Freizeitsport keinesfalls gegeben. Diese Kriterien haben quasi jegliche Daseinsberechtigung verloren und gehören, auch ICAO weit, entsprechend abgeändert und anerkannt. Ein möglicher kommender Segelflugpilot sollte über eine normale sportmedizinische Kontrolle, den Nachweis der normalen Funktionsfähigkeit der Sinnesorgane (samt Korrekturhilfen) und des Herzkreislaufsystems verfügen, um diesen Sport ausführen zu können, mehr nicht. Der Rest ist in seiner Einschränkungsphobie schlicht nicht nötig und sollte ersatzlos gestrichen werden. Auch ist nicht ersichtlich, warum dazu ein spezieller Arzt samt exorbitant hoher Rechnung (die von keiner Krankenkasse unterstützt wird) nötig ist. Die gesundheitlichen Anforderungen an einen Freizeitfußballer, einen Auto/Motorrad-fahrer, einen Bootfahrer sind nicht geringer. Der sportfliegerische Nachwuchs aber wird damit drangsaliert und bestraft. Da mir beim Durcharbeiten der Verordnung aufgefallen ist, dass sich im Prinzip daran gegenüber 2003 fast nichts Wesentliches geändert hat, man im Falle eines Falles immer noch die unnötigen Gänge durch die Instanzen samt Justiz in Anspruch nehmen muss, halte ich es für nicht erforderlich, jeden einzelnen Punkt zu kommentieren. Der exorbitante Kostenapparat, begleitet mit Frust und Ärger ist wahrscheinlich einmalig in der EU. Offensichtlich hat man aus den letzten 5 Jahren keinerlei Erkenntnisse ziehen können. Ich möchte hier ausdrücklich nicht als Nörgler erscheinen und eine Tauglichkeitsuntersuchung für den militärischen Bereich, die kommerzielle	

	Luftfahrt, die von den Piloten 100%-ige Einsatzbereitschaft verlangt, steht ausser Frage. Diese Bedingungen jedoch, wenn auch in abgeschwächter Form, auf den Flugsport und den Freizeitbereich auszudehnen, widerspricht jeglicher Akzeptanz und Sinnhaftigkeit. Es ist ein Relikt aus den Zeiten des paramilitärischen Segelflugs. Absolut unverständlich, dass so etwas heute in der EU ernsthaft betrieben wird. Ein Flugschüler hat mittlerweile in Deutschland mit medzinischen Untersuchungskosten in Höhe von etwa 200 - 300 Euro zu rechnen, bevor er richtig mit dem Sport anfangen kann. Und das auch nur, wenn KEINERLEI Komplikationen mit Nachuntersuchungen auftreten, sonst wird es 4-stellig und der Zeitraum bis zur Tauglichkeit ist sehr schnell länger als die gesamte Ausbildung gedauert hätte. Dieser Schüler hat mit Sicherheit nie wieder etwas mit der Luftfahrt zu tun. Ich glaube das ist der Sportwelt einmalig (traurig). Ich würde gerne, wie viele andere Sportler auch, diese Feststellungen an unsere Europaabgeordneten weiterreichen, wenn ich auch nur den Hauch eines Sinnes darin sehen würde. Aus diesem Grund appeliere ich an sie, als Fachleute, diesem grausamen Treiben ein Ende zu setzen, wenn sie daran interessiert sieht, dass es in ein paar Jahren auch noch eine nennenswerte Freizeitfliegerei geben soll. Ausdrücklich mit Unterschrift Mit freundlichen Grüßen Elmar Kümmel
response	*Noted*
	The class 2 medical provisions for private pilots holding an ICAO compliant licence are based on ICAO Annex 1 and JAR-FCL 3. However, private pilots flying aircraft with a maximum certificated take-off mass of 2000 kg or less could also obtain a LAPL where the medical requirements are lower than class 2.

comment	*2102*	comment by: *Lubbock Edward*
	In the United Kingdom, as is normal practice for all UK residents, I am registered with a medically qualified General Practitioner (GP). That GP holds all my medical records, test results and comments on my general state of health since I was born. He has extensive knowledge of my complete medical history. To require me to obtain an AeMC is in my opinion not necessary for me to fly my privately owned balloon which I use just for leisure flying a maximum of 25 time per year. At present my medical fitness satifies the standards required for a professional driver and that can be adequately assessed by my GP. To require me to obtain an AeMC would make my hobby extortionately expensive to the extent that I will probably have to give up flying.	
response	*Noted*	
	In the case of an LPL (B) licence a LAPL medical certificate is required. This	

	medical certificate, if without limitation other than spectacles, can be issued by a General Medical Practitioner.

comment	*2147*	comment by: *ECA- European Cockpit Association*
	ADD SECONDARY REVIEW PROCESS OR COMMON EUROPEAN MEDICAL BOARD Justification: Old JAR-FCL 3.125, regarding a secondary review process is missing from new regulation, and would be good to have in the regulation. Maybe a common European "medical board", that would take a stand in cases where a local Authority and a pilot disagree would be a good solution.	
response	*Noted*	
	The principle of flexibility of JAR-FCL 3.125 is now in MED.A.045. The secondary review process itself (the procedure) was not regulated in JAR-FCL 3 but carried out at a national level and was therefore different in the member states. A European Medical Board is presently not within the EASA remit. Such a Board could be discussed at MS level but as it touches the subsidiarity principle any change may be difficult.	

comment	*2191*	comment by: *Oxford Gliding Club*
	The use of a GP medical has worked well in the UK and we are pleased to see it appearing in these proposals.	
response	*Noted*	
	Thank you for your positive feedback.	

comment	*2200*	comment by: *Royal Netherlands Aeronautical Association*
	In general: Medical standards for LPL The KNVvL fully agrees with the intention to come to a European standard to describe medical fitness for pilots. With respect to the lot of work we would give some suggestions for a better implementation. The document that describes the assessments is in the new regulation an extended paper with scattered information on several pages. It increases the risk for making mistakes or missing relevant information on the assessments. We suggest making a clear parallel description of the several classes 1, 2 and LPL. KNVvL PROPOSAL: A parallel description of classes 1,2 and LPL	
response	*Partially accepted*	
	Following the principle of the proportionality of rules, the LAPL medical	

	requirements could not be written in the same way as Class 1 and 2 requirements. Only basic elements are proposed in Implementing Rules (Subpart B Section 3) and specific provisions are in the AMC providing the highest possible flexibility. However, the IRs/AMCs have been redrafted following comments to this NPA and the form that is criticised in this comment has been withdrawn.

comment	*2332*	comment by: *Graham Bishop*
	The BGA is in support of the GMP medical. GPs in the UK have endorsed the self declaration of thousands of pilots in the UK	
response	*Noted*	
	Thank you for your feedback.	

comment	*2369*	comment by: *Europe Air Sports, VP*
	Please refer to the comments delivered by The European Gliding Union on behalf of Europe Air Sports.	
response	*Noted*	
	Thank you for this information.	

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comment	*221*	comment by: *Hans-Dieter Weigel*
	Meine Meinung zum Medical JAR-FCL 3 deutsch: Bessere und sichere Entscheidungen als der Fliegerarzt kann der Hausarzt fällen. Meine Meinung betrifft nur Segelflug- und ähnliche Piloten. Ab Echo-Klasse-Piloten, sowie in der kommerziellen Fliegerei, sollen schärfere Bestimmungen gelten. Begründung: 1. In einigen mir bekannten Fällen hatten Fliegerärzte entschieden, langjährig untaugliche Piloten, mit einem Alter von mehr als 80 Jahren, wieder als flugtauglich zu erklären. Unabhängig von medizinisch messbaren Werten, ist z.B. das Reaktionsvermögen und die Beweglichkeit der Gliedmaßen eine wichtige Grundlage für diese Entscheidung. Dieses wird aber von Fliegerärzten nicht beurteilt. 2. Der Hausarzt ist über alle medizinischen Faktoren besser informiert als ein Fliegerarzt. Er bekommt von allen medizinischen Einrichtungen Berichte über die Therapieerfolge seines Patienten. Der ständige Kontakt mit seinen Patienten ermöglicht es ihm auch über das allgemeine Befinden zu urteilen. 3. Ein Hobby-Segelflieger wird sich bei Krankheitsproblemen mit großer Sicherheit nicht in ein Flugzeug setzen, um mit großen Anstrengungen einen Flug ausführen. "Hobby" bedeutet eine Tätigkeit, die man mit Spaß und Lust ausübt.	

	4. In meinem Bekanntenkreis kann auch ein Pilot ohne Medical weiterhin sein Auto führen. Bei Reaktionsproblemen könnte es zu schwersten Unfällen mit vielen Toten kommen. Kein Arzt fragt nach diesen nicht messbaren Werten. 5. Die Bildung von Harnstein (JAR-FCL 3.305"c") trifft heute bei sehr vielen Menschen zu. Eine Gefährdung bei einer Kolik tritt nicht schlagartig auf. Man kann deshalb ohne Eile Entscheidungen treffen. Vor ca. 15 Jahren erlebte ich einen derartigen Zustand. Ich bin nach ca. 1 Stunde, nach Beginn der Kolik, mit meinem Auto in ein Krankenhaus der Kreisstadt gefahren. Wenn sich bei einem Segelflugpiloten Schmerzen ankündigen wird er versuchen, schnellst möglich ein Landefeld oder seinen Heimatflugplatz zu erreichen. Für diese Aktion hat er demnach mehr als eine Stunde Zeit. Er wird sich nicht in eine Stadt stürzen - warum auch? 6. Eine Krebsdiagnose führt nicht zur Hilflosigkeit oder Selbstmordgefährdung (s. JAR-FCL 3.370). Da ich selbst betroffen bin, kann ich auch dieses gut beurteilen. Bei der heutigen frühzeitigen Erkennung sind, bei entsprechender Therapie, gute Heilungschancen gegeben. In diesem Stadium gibt es keine großen Schmerzen und Selbstmorgefährdung. In einem sehr fortgeschrittenem Stadium mit erheblichen Schmerzen, wird sich kein Pilot zur Freude in ein Segelflugzeug setzen - er hat andere Probleme zu meistern. Bitte überlassen Sie die Entscheidung, ob ein Segelflugpilot aus medizinischen u.a. Gründen ein Segelflugzeug führen darf, den Hausärzten. Bringen Sie dieses bitte in die Europäische Gesetze ein.
response	*Noted*
	We acknowledge this contribution and confirm that, if permitted under national law, a GMP can issue the medical certificate for glider pilots who hold an LPL (S) licence.

comment	*487*	comment by: *Jürgen Böttcher*
	MED.A.020 (h) If this means that it would be illegal to hold an EASA medical and an FAA medical at the same time, this is absolutely unacceptable since EASA and FAA do not currently accept the other authority's medical.	
response	*Accepted*	
	The paragraph will be amended to clarify that a pilot shall only hold one medical certificate for a European FCL license.	

comment	*1173*	comment by: *FAI*
	Commission Internationale Medico-Physiologique (CIMP) Page 3 of 66. A problem is the excess paper; the NPA together with the Basic Law totals well over 800 pages of which the medical component is in over 90 pages. In comparison the entire FAA proposal (8) for the Sport Pilot Licence was 115 pages of which only a few contain medical references. The ICAO (6) Annex 1 Chapter 6 (Medical) has only 16 pages. In this NPA there is much duplication and complexity	

	resulting in some internal contradictions. The problem of pilot medical fitness can be considered with three simple headings. What level of fitness is necessary, how can that fitness to be validated, and who is to do the validation. **CIMP CONCLUSION** **-The reasoning and philosophy as to how regulations are mandated to the AME and the Essential Requirements is too complex.** **-SUGGESTION: State only basic principles in regulations. Leave the judgement of medical problems to senior AMEs, medical advisors and AMCs. Reduce paper.** **-USE three simple headings.** **1. What level of fitness is necessary,** **2. How can that fitness to be validated,** **3. Who is to do the validation?** **CIMP OVERALL CONCLUSIONS** **-The aim of the Essential Requirements has not been met.** **-This NPA suffers from the contagion of European bureaucracy.** **-Too long, too complex, internally contradictory and unlikely to be acceptable to either pilots or doctors.** **Suggestions:** **-What are needed are simple documents that implement the Essential Requirements for Class 2 and the LPL.** **-For this the existing French Class 2 and the New Zealand gliding medical form are commended.** References: 8. Department of Transportation Federal Aviation Administration, Certification of Aircraft and Airmen for the operation of light sport aircraft. RIN 2120-AH19 Dated 05/02/02. 6. ICAO Annex 1 Chapter 1 (Definitions and General Rules concerning licences) and Chapter 6 (Medical provisions for licensing).
response	*Noted*
	We acknowledge the contribution to this NPA which has been drafted based on JAR-FCL 3 requirements for class 1, JAR-FCL 3 requirements aligned with ICAO Annex 1 standards and recommendations for class 2, and less stringent and more flexible Implementing Rules (IR) and Acceptable Means of Compliance (AMC) for the LAPL medical certificate. Of course, we did not mean to introduce contradicting IRs and/or AMCs in this Draft NPA and will correct any contradiction that is pointed out in the comments or that we find while drafting the Draft Opinion and Decision. A medical group consisting of NAAs, Organisations and Unions will be included in the final review before publication of the Draft Opinion and Decision. The IRs and AMCs must outline the standards and recommendations to determine fitness of a pilot to ensure one single standard of implementation in all EU/EASA associated States. The details given in the IRs and AMCs can therefore not be deleted.

comment	*1792*	comment by: *DAeC*
	<u>In General: The following concepts are endorsed.</u> 1.**Primarily unnecessary regulation should be avoided.** 2.Future regulation should **not increase the bureaucratic burden or costs** to pilots and clubs. 3.The **LAPL / GP questionnaire is to long** and time consuming, and irrevelant. - No support from DAeC! 4.The **JAR FCL Medical Self Declaration** is sufficient for all examinations by AME / GP. 5.There is **low level of risk (particularly to third parties) due to medical incapacitation** of sport / recreational pilots. Major reasons for **mishaps are related** to human factors, not medical conditions. 6.**Medical standards**, especially in terms of disqualifying conditions, **should** therefore **be** less **rigorous in regard to the Sport Pilot Licensees,** so not preclude those people otherwise capable from flying. 7.**Reduced medical standards for Sport Pilot Licensees**, already exist in the US, and the FAA has regulated this for three years now without any increase in medical incapacitations. 8.**Frequent periodic examinations of recreational pilots only** by AMEs is expensive. There is additional specialist fees and a additional travel cost, as their offices are often further away. For healthy pilots it does not provide any greater assurance of fitness than a Medical Examination by any other physician. Therefore **the GP solution is supported**. 9.**GP Guidance** could be provided by any competent organization, also from the national aero-club. 10.In case of disqualifying conditions it is wise to consult an **AME / AMC** for **the issuance of a waiver.** 11.EASA should follow JAR-FCL 3 in setting (accepted/known) **statistical limits for acceptable risk**? 12.It is important to have a **unified appealing process** for disqualifying conditions. This should be on a European Community level to reduce bias and ambiguity in the process.	
response	*Noted*	
	1. Noted — but not applicable to this regulation which is needed to determine the standards of fitness to fly for all pilots. 2. Noted — the IRs/AMCs are based on JAR-FCL and the administrative rules did not change.	

	3. Accepted. Following comments the LAPL questionnaire has been removed, the application and examination forms of JAR-FCL 3 (with less items to check for the LAPL medical) has been introduced. 4. Noted. We are unaware of a JAR-FCL Medical Self Declaration, all medical certificates under the presently valid JAR-FCL 3requirements are issued after aeromedical examination and assessment. 5. Accepted. This is why the medical requirement for LAPL medical certificates are low and flexible. 6. Accepted. This was the aim for the Leisure Pilot Licence and the proposed rules are less stringent than for the ICAO compliant PPL. 7. Noted. The FAA Sports License does not allow pilots to fly motor-powered aircraft up to 2000 kg max t/o weight. 8. Noted. The GMP can issue the medical certificate if permitted under national law. 9. Noted. The Guidance material (GM) should be the same in all member states. Proposals for GM from any relevant source are welcome and could be taken up in a future EASA rulemaking task. 10. Noted. Please see MED.A.045. 11. Accepted. The JAR-FCL 3 GM dealing with risk assessment will be reviewed and checked by a specialist in medical statistics and re-introduced in rulemaking task MED.001. 12. Noted. A European Appeal Board is presently not within the EASA remit.

comment	*1887*	comment by: *Susana Nogueira*
	In our opinión shall be convenient to adequate the Authority concept. In this Part are the following concepts: Competent Authority Licensing Authority and not Medical Authority (AMS) as in JAR-FCL. We propose to delete all references to the Authority and refer exclusively to Authority Aeromedical Section. Is more clear and directly related with the object of this part.	
response	*Not accepted*	
	The expression 'licensing authority' originated from ICAO Annex 1 and was used to clarify that medical certificates are under the responsibility of the licensing authority.	

comment	*2363*	comment by: *Swedish Association of Flight Instructors*
	Attachment #2	
	see attached file	
response	*Noted*	

comment	2379	comment by: *European Sailplane Manufacturers*
	The European sailplane manufacturers have principal comments regarding the medicals and the proposed regulation: A) Within the gliding community this topic has already created a lot of frustration as gliding is a simple and easy to learn and an affordable way of flying which must not be made too difficult by application of medical rules wich clearly come from the world of commercial air transport (read: ICAO). If someone can drive a car / ride a bicycle / walk more than 1 kilometre he/she can operate a sailplane safely. B) It is understood that the concept now is to allow a sailplane licence for "lower medical standards" under the name LPL(S) and a licence for "higher standards" under the name SPL. Such a division makes perhaps sense nevertheless it must be guaranteed that holders of both licences can interchange their licence by simply getting the according medical. This concept would easier be accomplished by having ONE licence and only the two different medicals. C) The concept of MDM.032 (simple regulation for light aviation) somehow has been totally forgotten in the proposed regulation.... D) Still nobody has been found who has proven that • medical reasons result into a statistically important number of accidents in gliding • possible medical problems which might be dangerous could be detected with reasonable success and effort • pilots who decide against flying because they feel not fit are not the best cure against any medical problems in aviation (this decision is a luxury the sport / recreational pilots have) Therefore: Without going into detail of NPA 2008-17c the manufacturers feel that this proposed regulation is simply asking too much for glider pilots. The result will be wasted time and money and in the end loss of motivation and thereby a even more dwindling number of pilots. If Europe really wants to see more aviation it should make this as easy and as affordable at the entry level which gliding represents. WE HAVE NO MEDICAL PROBLEMS IN GLIDING !!!!!	
response	*Noted*	
	A) See ICAO Annex 1, paragraph 2.9 Glider Pilot Licence, subparagraph '2.9.1.5 Medical fitness: The applicant shall hold a current Class 2 Medical Assessment'. In spite of the fact that we reduced the provisions for a JAR-FCL 3 Class 2 medical to ICAO level for class 2 assessments it has been decided to introduce lower standards for the LAPL. It should also be noted that flying, as opposed to any activity on the ground, has a third dimension which influences the risk involved.	

B) Noted. The assumption is correct, an LPL(S) holder needs a LAPL medical certificate, an SPL holder needs a class 2 medical certificate.
C) Noted. The proposal for the LAPL medical was added to this NPA without changes. However, the corresponding IRs and AMCs have been redrafted for this CRD following comments.

D) Noted.

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comment *116* comment by: *Reinhold Haser*

Durch ein Medical können keine Unfälle verhütet werden, weil sich der Körper laufend d.h. täglich verändert. Ein Pilot, der sich nicht wohl fühlt, fliegt nicht bzw. benützt sein Flugzeug nicht.
Eine Studie in den USA belegt, dass ca. in 0,3% der Flugunfälle medizinische Probleme des Piloten zum Unfall geführt haben.
http://www.aopa.at/news/archiv/aug02.htm
Nur einzelne Fliegerärzte haben Befürchtungen, dass es ohne fliegeräztliche Untersuchung zu erheblichen Unfällen im Segelflug kommen wird.
Weder die Studie BEKLAS
http://www.daec.de/flusi/downfiles/Beklas/BEKLAS_Abschlussbericht.pdf
noch der NALL – Report und auch keine anderen einschlägigen Untersuchungen wie z.B. der französische Rapport Sénateur Belot:
http://www.aviation-civile.gouv.fr/html/avia_leg/pdf/Rapport_senateur_belot.pdf noch die Untersuchungen der Engländer aus den 60iger Jahren und die Berichte der Schweizer bestätigen diese lauten Befürchtungen gewisser Fliegerärzte, die ganz offensichtlich nur eine lukrative Einnahmequelle versiegen sehen.
Das Gegenteil ist der Fall, und diesbezügliche Details liefere ich Ihnen gerne nach und sie müssten Ihnen eigentlich auch bereits bekannt sein!
Nach dem Gesagten dagegen gerät ein Radfahrer oder gar ein Schwertransporter bei medizinisch bedingten plötzlichen Ausfällen zu 50% in den Gegenverkehr und kann dort so einiges anrichten. Die Medien sind voll davon. Wer aber fordert von einem Radfahrer ein Medical?
Wo bleibt der Rechtsgrundsatz der Gleichbehandlung? Zumal eine besondere Gefahr weder von einem Segelflieger-, Motorsegler-, oder Kleinmotorflugzeugpilot nachweislich ausgeht. Diese Gefahr können nur reine Theoretiker behaupten, die von der praktischen Fliegerei keine Kenntnisse besitzen.

In Europa (England, Schweiz) und den USA gibt es meines Wissens keine laufenden ärztlichen Wiederholungsuntersuchungen, weil in diesen Staaten erkannt wurde, dass ein Medical nichts zur Unfallvermeidung beiträgt. Die Studie aus den USA zeigt, dass die Unfallzahlen gleicht hoch sind mit oder ohne Medical. Also was soll dann dieser bürokratische und kostspielige Aufwand?
Andere Verkehrsteilnehmer (LKW-, PKW-, Radfahrer usw.) benötigen auch kein Medical. Die Unfallgefahr mit Verletzung anderer Verkehrsteilnehmer oder Passanten ist weit größer als beim Segelflug, Motorsegler oder

	Kleinmotorflugzeuge. Es ist m.E. sinnvoll, dass der Hausarzt bei Beginn der Ausbildung eine Bescheinigung ausstellt, ob der Flugschüler gesund ist und wenn er ein Fahrzeug bedienen darf, dann darf er auch ein Kleinflugzeug bedienen und zwar so lange, bis seine Fahrerlaubnis widerrufen wird. Die Gefahr, dass ein Flugzeug einen Passanten ect. durch Absturz verletzt, ist gleich Null. Das hat die Vergangenheit gezeigt. Ich habe den Eindruck, dass es nicht um Sicherheitsaspekte in dieser Sache geht, sondern, dass die Administration Betätigungsfelder sucht, um ihre Daseinsberechtigung zu zeigen und, dass Interessenten abgehalten werden, den Flugschein zu erwerben. Die Anzahl der Piloten gehen laufend zurück. Nur nicht bei UL-Piloten und weshalb? Weil der Flugschein zu erwerben wesentlich einfacher ist. Auch ist zu bedenken, dass sehr viele Airline-Piloten aus dem Segelflugbereich kommen. Wenn die Pilotenanzahl weiter sinkt, sterben viele Vereine. Die Vereine übernehmen eine große soziale Aufgabe. Die Jugendlichen lernen Verantwortung und mit Aufgaben umzugehen. Nicht jeder will Fußball spielen oder Tennis usw. Die Chancengleichheit muss gewahrt sein. Die EU kann mit der Abschaffung des Medical einen großen Beitrag zum Bürokratieabbau beitragen, was ja ihr großes Ansinnen ist. Diese Vorgehensweise hilft sicherlich, den Flugschein einfacher und billiger zu erwerben. Deshalb halte ich das Medical in der vorliegenden Form nicht sinnvoll.
response	*Not accepted*
	We understand that this comment proposes to abolish the medical certificate for private pilots. Please refer to response to comment 37 in segment 'General Comments'.

comment	*1307*	comment by: *Rolf Maier*
	NPA 17c Genereller Kommentar zu C u.a. Eigene europäische Medicals mit unterschiedlichen Merkmalen sind nach den derzeitigen Erfahrungen nicht einzuführen. Da hier immer internationales Recht vor europäischem und nationalem Recht geht. Die nach internationalen Richtlinien ausgestellten Medicals immer Vorrang vor anderen nach eigenen Richtlinien wie sie Europa vor hat nicht hin-nembar sind. Es kann keine verschiedene Medicals geben. Hier hat der Gleichheitsgrundsatz seine Gültigkeit. Es kann nicht angehen, daß eine Aussage getroffen wird halb tauglich oder halb flugfähig. Europa sollte schon internationales Recht beibehalten. Also vereinfacht ausge- so belassen wie es ist bzw. erst eingeführt wurde. Wir brauchen keine Beschneidung durch irgendwelche Politiker die sich profilieren möchten . Dort wo Politik regeln will wird nichts einfacher sondern immer komplizierter und teurer.	
response	*Noted*	
	The aim of the rules/AMCs for LAPL licenses is to have proportional rules with regard to the type of activity in order to ensure access to private flying to as many applicants as possible without increasing the risk. The rules are different for different types of operation. This does not result in	

	discrimination but in helping to get access to general aviation. There is no 'half fit' assessment as proposed in this comment. But there is the requirement to medically assess an individual applicant who does not fully comply with the rules to evaluate whether he/she could still continue flying with a limitation without jeopardising flight safety. This is also the ICAO approach.

comment	*1315*	comment by: *Martin Day*
	I support the use of the pilot's General Practitioner doctor for issuing medicals because: 1 - The BGA's comments regarding using the pilot's GP seem to make good sense. It would be simpler for a pilot with a medical problem to hide it from a doctor not known to him or her. 2 - It is quicker and cheaper than the alternatives.	
response	*Noted*	
	Thank you for your support.	

comment	*1768*	comment by: *AECA(SPAIN)*
	When, in this Part, on make reference to the Authority we think is best to refer **AMS (Aeromedical Section)** not 'licensing authority' Is a concretion to the Authority important in this case.	
response	*Noted*	
	Please refer to comment 1887 in segment Draft Opinion Part-Med.	

comment	*2125*	comment by: *AMS Denmark*
	The danish AMS agree to base a lighter medical assessment on the ICAO Class 2 medical standards and recommended practices	
response	*Noted*	
	Thank you for your positive feedback.	

comment	*2441*	comment by: *SANMA Swedish Aeronautical Associatation*
	De föreslagna kraven underskrider nuvarande ICAO standard Klass 2 vilket ej kan accepteras då LPL och klass 2 pilot skall göra samma typer av flygning.	
response	*Noted*	
	The Agency acknowledges your opinion. However, the proposed requirements reflect the provisions for a LAPL certificate decided by the legislator in the Basic Regulation (Article 7), thus with a view to facilitate access to private flying to as many applicants as possible without	

increasing the risk. Furthermore, Member States are free to decide in their territory whether GMPs may, or may not, act as AMEs for LAPL medical certificate.

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comment	*1898*	comment by: *Belgian Gliding Federation*
	General comment: Absence of a board of Appeal *Although the basic law in 216/2008 introduces mechanisms for appeal in other areas of certification, this does not apply to medical decisions. To establish an EASA medical appeal board would reduce the possibility of discontented individuals going to law and the probability of diverse judgments setting unwelcome precedents.* **<u>Proposal:</u>** **That EASA establish an independent medical appeal board and that this be available initially through national escalation process.**	
response	*Not accepted*	
	The existing EASA Appeal Board deals with complaints against decisions taken by the Agency within its remit, e.g. certification of aircraft. However, the individual aeromedical assessment of pilots as well as the issuance of pilots' licences are not in the remit of the Agency but under the responsibility of the Member States (subsidiarity principle). Any appeal against these decisions will be dealt with by the Member State where the licence or medical certificate was issued. We are aware of the problems that may arise from eventually different medical assessments in different member states and will follow up on the issue in due time.	

C. Draft Opinion Part-MED — Subpart A: General Requirements — Section 1: General — MED.A.001: Competent authority p. 3

comment	*30*	comment by: *Horst Metzig*
	Ich bin nicht mit dem sinnlichen Inhalt des Text MED.A.001 " competent authority " einverstanden. Dieser Text lässt die Interpretation zu, das der Segelflugpilot zukünftig gezwungen ist, in dem Land seines Hauptwohnsitz die fliegerärztliche Untersuchung machen zu lassen. Ich möchte in allen EASA Mitgliedstaaten zukünftig meine fliegerärztliche Untersuchung machen lassen, ganz gleich, ob ich zu ein AeMC, AME oder general medical practitioner - GMP - gehe.	

	Ich begründe das mit der Tatsache, das wir in ein grenzenlosen Europa leben, und leben wollen. Wenn jemand abweichend seines Hauptwohnsitz den Flugsport in ein anderen EASA Mitgliedstaat durchführt, also beispielsweise ein in Deutschland wohnhafter Pilot ausnamslos nur in Spanien Segelflug betreibt, so erkenne ich das " principal place of flying business " nicht in Deutschland, sondern in Spanien. Ich bitte daher die EASA, diesen englischen Text abändernd so zu gestalten, das durch eine Übersetzung in keinster Art und Weise eine inhaltliche Textinterpretation vorgenommen werden kann, das der übersetzte Text MED.A.001 so zu verstehen ist, das eine fliegerärztliche Untersuchung auf dem Territorium des Hauptwohnsitzes des Bewerbers zu erfolgen hat, egal ob bei ein AeMC, AME oder GMP. Horst Metzig
response	*Noted*
	Free movement of people and workplace is one of the principles of the European Union. The licensing authority is the authority where the pilot holds his/her licence (which is not necessarily the member state where the pilot lives). The competent authority is the authority to which the AME or AeMC applies for the issuance of their certificate or to which the GMP declares his/her activity. This may, or may not, be also the licensing authority of the pilot. The pilot can undergo his/her medical examination with an AME or AeMC in any Member State; however, their medical files will always be kept by their licensing authority. For LAPL, the licensing authority will accept examinations by a GMP only if permitted under national law of that licensing authority.

comment	*34*	comment by: *Uwe Hagenauer*
	Der Inhalt des Kapitel MED.A.001 "competent authority" widerspricht der Idee eines gemeinsamen europäischen Regelwerks, in dem dem Antragsteller verwehrt wird, sein Medical in irgendeinem EASA Mitgliedsstaat durchführen zu lassen. Desweiteren verwehrt mir diese Regelung, meinen bisherigen AME in Deutschland zu konsultieren, da ich als deutscher Staatsbürger mit einer deutschen Lizenz und schweizer Hauptwohnsitz mein Medical nicht mehr in Deutschland beantragen kann. Somit muss ich einen neuen AME mit meiner Untersuchung beauftragen, der meine Krankheitsgeschichte / Lebensgewohnheiten nicht kennt. Dies ist einer tiefgehenden medizinischen Untersuchung nicht zuträglich. <u>Wenn die Kriterien zu Flugtauglichkeit in allen Mitgliedsländern gleich sind, dann gibt es nicht geringsten Grund, eine Regelung wie diese einzuführen.</u> Ich beantrage daher, den Artikel MED.A.001 in einer Form zu verfassen, die dem Antragsteller die Wahlfreiheit lässt, jeden AME/AMC oder GMP in jedem EASA Mitgliedsstaat zu konsultieren.	

response	*Noted*
	See response to comment number 30 in this segment.

comment	*39*	comment by: *Ernst Siebrecht*
	Ich mache den Vorschlag, das Medical für Segel- und Motorflugpiloten im nichtgewerblichen und nichtkommerziellen Betrieb komplett zu streichen. Begründung: Nach 25 Jahren als PIC (PPA-A) sind mir Fälle bekannt, in denen Piloten mit frischem Medical nach oder vor dem Flug verstorben sind. Ein Medical ist nur eine Momentaufnahme und kann keinenfalls eine Prognose für die nächsten 60 bzw. 24 Monate treffen. Besser wäre, wenn von Nöten, eine Bescheinigung vom Hausarzt, der den Patienten in der Regel seit Jahren kennt (inklusive Umfeld). Ernst Siebrecht	
response	*Not accepted*	
	Please refer to comment No 37 in segment 'General Comments'.	

comment	*58*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Comment: Acceptable	
response	*Noted*	
	Thank you for the positive comment.	

comment	*510*	comment by: *British Microlight Aircraft Association*
	Accepted	
response	*Noted*	
	Thank you for the support.	

comment	*965*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: **Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008** **Section: 1 General MED. A . 001 - Competent Authority** **Page: 3**	

	Relevant Text: - For the purpose of this Part, the competent authority shall be the authority designated by the Member State where the Aeromedical centre (AeMC), the Aeromedical examiner (AME) or the general medical practitioner (GMP) to whom a person applies for the issue of a medical certificate has their principal place of business. **Comment**: From the Explanatory notes to the proposed regulation it follows that for the time being the regulation for competent authority is not yet elaborated. So the absence of clear definition what personnel in competent authority deals with medical issues as well as the requirements to the level of training and competence of these personnel provides different understandings of the proposed requirements in some parts of it, does not give consistency to the rules especially to the issue of medical confidentiality **Proposal**: - For the purpose of this Part, the competent authority shall be the authority designated by the Member State where the Aeromedical centre (AeMC), the Aeromedical examiner (AME) or the general medical practitioner (GMP) to whom a person applies for the issue of a medical certificate has their principal place of business. Competent Authority shall use the service of medical doctors for all issues related to the medical certifications. These medical doctors shall be qualified and experienced in medicine and in aviation medicine and shall receive refresher training at regular intervals. Medical examiners shall have practical knowledge and experience of the conditions in which the holders of licenses and ratings carry out their duties.
response	*Not accepted*
	The AME/AeMC apply to the *competent* authority for their certificate. The definition of 'competent authority' has been amended to cover also AMEs/AeMCs outside the territory of Member States. However, the Medical Assessor in the *licensing authority* will deal with the medical files of pilots. For further clarification please refer to NPA 2009-22 which gives details on the qualification of the medical assessor. The difference between competent authority and licensing authority has been made to ensure that the medical files of pilots are kept by only one authority, no matter where they undergo their medical, and separated from other files in the authority.

comment	*1065*	comment by: *BMVBS (German Ministry of Transport)*
	MED A.001 "Competent Authority" appears to be a definition. For ease of reference and proximity to the definition of licensing authority, the text should be moved to MED.A010. This is a question of general structure/layout and would apply to all other parts accordingly. The advantage to start in every part with a definition of competent authority is not seen. It would be more reasonable to begin every part with the "scope", and include a definition of competent authority under "definitions".	
response	*Not accepted*	
	What is meant in this paragraph on the 'competent authority' goes beyond a	

	definition.

comment	*1092*	comment by: *Moldavian Society of Aviation Medicine*
	Comment: For the time being the regulation for competent authority is not yet adopted. So the absence of clear definition what personnel in competent authority deals with medical issues as well as the requirements to the level of training and competence of these personnel provides different understandings of the proposed requirements in some parts of it, does not give consistency to the rules especially to the issue of medical confidentiality Proposal: - For the purpose of this Part, the competent authority shall be the authority designated by the Member State where the aeromedical centre (AeMC), the aeromedical examiner (AME) or the general medical practitioner (GMP) to whom a person applies for the issue of a medical certificate has their principal place of business. Competent Authority shall use the service of medical doctors for all issues related to the medical certifications. These medical doctors shall be qualified and experienced in medicine and in aviation medicine and shall receive refresher training at regular intervals. Medical examiners shall have practical knowledge and experience of the conditions in which the holders of licences and ratings carry out their duties.	
response	*Noted*	
	See response to comment No 965 in this segment.	

comment	*1137*	comment by: *Keith WHITE*
	Should this not just be ".. **where they have their place of business**.", or perhaps "... **designated by the member state shall be that in which a/the person applies for a certificate**."? Otherwise it might be interpreted that, for an international company running AeMCs, although one might apply to a unit in one country, the competent authority might be considered to be in another country, where the principal/largest establisment is, or where the registered office is.	
response	*Noted*	
	There should be no restrictions in Europe as to where satellite businesses can be set up. Cooperative oversight shall be in place in order to ensure compliance with the rules. Your interpretation of the rule is the one that was intended.	

comment	*1302*	comment by: *Oxytrans*
	Comment: For the explanatory notes to the proposed regulation it follows that for the time being the regulation for competent authority is not elaborated. The absence of definition what personal in competent authority deals with medical issues as wll as the requirements to the level of training and competance of these personal provides different understandings of the proposed requirements, does not give consistency to the rules especially to the issue of medical confidentiality.	

	Proposal: For the purpose of this Part, the competent authority shall be the authority designated by the Member State where the aeromedical center, the aeromedical examiner or the general practitioner to whom a person applies for the issue of a medical certificate has their principal place of business. The Competent Authority shall use the service of medical doctors for all issues related to the medical certifications. Medical doctors must be qualified and experienced in medicine and in aviation medicine and shall receive refresher training at regular intervals.They shall have practical knowledge of the conditions in which the holders of licenses and ratings carry out their duties.
response	*Noted*
	See response to comment No 965 in this segment.

comment	*1323*	comment by: *Markus Hitter / JAR-Contra*
	Deutsch: (english below) Diese Regel hat bei JAR-Contra zu einer hitzigen Debatte darüber geführt, wessen "principal place of business" hier gemeint ist, der des Lizenzinhabers oder der des AeMCs/AMEs/GMPs. Es sollte klarer formuliert werden, dass hier der "principal place of business" des AeMCs/AMEs/GMPs gemeint ist und ein Lizenzinhaber frei in der Wahl ist, in welchem Mitgliedsstaat er sich für ein Medical bewirbt. - - - **English:** This rule has led to heated debates at JAR-Contra about whom's "principal place of business" is meant here. That of the licence holder or that of the AeMC/AME/GMP. It should be worded more clearly here is meant the "principal place of business" of the AeMC/AME/GMP and there's no restriction in which member state an applicant or licence holder applies for a medical.	
response	*Noted*	
	Pilots are not mentioned in paragraph MED.A.001. A rule cannot apply to a person or a group of persons that are not mentioned.	

comment	*1436*	comment by: *Terry Maycock*
	Strongly recomend that medicals for the LPL are carried out by a general practitioner and are based on the heavy goods licence requirments.	
response	*Noted*	
	Thank you for your comment.	

comment	*1477*	comment by: *David Bowden*
	Most glider pilots have had medical certificates issued by GP's. The GP is in the best position to assess the fitness of any pilot. The present system has proven	

	itself over the years to be effective, affordable and accessible.
response	*Noted*
	Thank you for your positive input.

comment	*1493*	comment by: *Cord Wilhems (Thoelk)*
	Wenn man die Tauglichkeitsuntersuchungen praktisch abschaffen möchte und dieses nur noch den Hausärzten überlassen will, führt das dazu dass noch mehr untaugliche Piloten umherfliegen und das Leben von Passagieren und Personen am Boden gefärden. Meiner Meinung nach sollte man auch im Straßenverkehr regelmäßige Tauglichkeitsuntersuchungen einführen und zwar von unabhängigen Stellen und nicht von erpressbaren Hausärzten. Piloten neigen aufgrund ihrer Psyche ohnehin dazu sich zu überschätzen und sich für die größten zu halten sonst würden sie sich nicht ständig unnötig in Gefahr bringen. Genauso wenig sind sie bereit ihre eigene gesundheit richtig einzuschätzen. Wieviele kommen mit massivem Übergewicht zur Tauglichkeitsuntersuchung und mit unzureichenden Brillen. das massive Übergewicht führt häufig zu Schlafapnoe also Kurzzeitschlafen und die falsche Brille zu schweren Sehstörungen besonders in schlechten Sichtverhältnissen. Teilweise gibt es auch Alkoholiker unter den Piloten und Leute die kurz vor dem Schlaganfall stehen, wie die sehr häuig vorkommenden Piloten, welche Bluthochdruck haben. Nach meiner 5 jährigen Fliegerarzttätigkeit kann ich nur schwer davor warnen praktisch Jeden fliegen zu lassen, was bei einer Untersuchung durch den Hausarzt, welcher dann üblicherweise Gefälligkeitsatteste ausstellt, noch mehr passieren würde als jetzt auch schon. Meiner Meinung nach führt dass mit Sicherheit zu einer Zunahme der Luftunfalle, deren Ursache jetzt auch schon im Dunkeln bleibt, da Obduktionen ja üblicherweise nach einem Unfall nicht durchgeführt werden. Die menschlichen Fehler sind immernoch die häufigsten bei Flugunfällen aber auch im Straßenverkehr. Meiner Meinung nach sollte man sogar staatlich völlig unabhängige Fliegerärzte beauftragen, wie beim Auto TÜV, die diese Untersuchung durchzuführen haben.	
response	*Noted*	
	The GMP can only issue medical certificates if permitted under national law. The possibility for the Member State to accept GMPs to issue medical certificates is in the Basic Regulation.	

comment	*1564*	comment by: *Steve BARBER*
	Inclusion of a General Medical Practitioner is an excellent idea. For Leisure Pilots, a medical standard similar to that for a car driver is generally appropriate, and a GMP is well qualified to certify to that level. From past experience, the GMP's certifiction has proved adequate, and so an examination by an Aeromedical Examiner is unlikely to improve flight safety. [Even when an examination by an Aeromedical Examiner is a reasonable requirement - eg for commercial licences , or for aircraft with more than a few (four perhaps) seats - pilot's GMP should be required to confirm the applicant's	

	medical history.]
response	*Noted*
	Thank you for your feedback.

comment	*1607*	comment by: *Dr Lilla Ungváry*
	I don't agree that GMP is allowed to do the examinations for pilots. Every insured Hungarian person should have a GP, however there is a free of choice and unlimited changes situation. In the case visiting a specialist on his own, there are no obligatory reporting system to the GP. Upon this the actual GP does not necessarily have all the medical data from the certain person.	
response	*Noted*	
	The GMP must have sufficient knowledge of the pilot's medical history in order to act as an AME. If there is no obligatory reporting system, the GMP can still ask the pilot to provide the full medical history just as happens when the pilot sees an AME or AeMC. However, the GMP will only be allowed to issue medical certificates if permitted under national law.	

comment	*1697*	comment by: *Norwegian Association of Aviation Medicine*
	MED.A.001: We do not recommend any requirements below ICAO standard! The ICAO standard is looked upon as a minimum, and Europe will be a bad example to the rest of the world if we adopt lower standards. This could become a great hazard to aviation safety in the whole world. The ICAO have specific requirements for an extensive education of the medical examiners and it have standards for approval of pilots. It is important to keep this as minimum standard. Harmonisation of medical standards between the different continents are also an important issue, and an other reason not to go under ICAO standards. NFF's opinion on the GMP matter will be fully commented in the subpart D. We will therefore refer to that comment. But we recomend that all referals to GMP is removed.	
response	*Noted*	
	The Basic Regulation (Article 7) provides the possibility of a GMP to assess the medical fitness for a LAPL applicant/holder if permitted under national law. The proposed Implementing Rules in this NPA and in NPA 2008-22 provide the criteria under which the GMP can issue medical certificates.	

comment	*1726*	comment by: *Civil Aviation Authority Finland*
	General comment It should be included the acceptable level of incapacitation risk per year for each class of medical certificate.	

	Safety risk levels should be stated. The "requirements" for the medical cerification of the LPL holders and the really long validity times of such Medical Cerificates do not garantee an acceptable level of safety compared to the SARPs of ICAO Annex 1. Also the training and experience requirements and "the acceptance" and the inspecting procedures of the general medical practioners (GMPs) are too generic. Arranging the real Authority supervision and quality auditing of the acting GMPs is very difficult. So, the level of examinatios may vary much between different GMPs. In several States (also in Finland) the medical legislation and the data protection act are so restrictive that the AMEs or GMPs do not have access to all the medical history of the Medical Certificate applicant. Standardisation. Add **MED.A.040 (c): the level of incapacitation risk is acceptable for the class of medical certificate issued, taking into account any mitigating factors and limitations applied.** Add **AMC to MED.A.040 (c): (a) For Class 1 medical certificates the maximum acceptable annual risk of incapacitation is 1% for multi pilot operations and 0.5% for single pilot operations.** **(b) For Class 2 medical certificates the maximum acceptable annual risk of incapacitation is 2%.**
response	*Partially accepted*
	The risk assessment was included in the Guidance Material (Manual of Aviation Medicine) of JAR-FCL 3. The text needs to be reviewed and the calculations need to be assessed by a specialist in medical statistics. This will be done and the revised/updated risk assessment will be included in the future rulemaking task MED.001.

comment	*1754*	comment by: *Aeromedical Shipping and Maritime Center, Budapest*
	I do not recommend medical requirements below ICAO standard! The ICAO standard is a minimum, and my opinion is, in Europe we can not adopt lower standards. This could become a great hazard to aviation safety in our continent. In Hungary the GMP-s are under hight worklood and cannot bee familier with aviation medical issues.	
response	*Noted*	
	Thank you for your input.	

comment	*1769*	comment by: *AECA(SPAIN)*
	Need to be checked in accordance with AR MED 020 and 025.	
response	*Noted*	

comment	*1790*	comment by: *Lars Tjensvoll*
	<![endif]--> The GMP is far below the ICAO standard and should not be accepted! This will be an extremely bad model to all those countries in the world that are struggling to improve their standards! What skills do a GMP have in Zimbabwe, Burundi, Cambodia, Vietnam, Malaysia, Uruguay, etc. Europe should behave as a good example to all this countries and keep a high standard and have in mind the work on harmonising the medical requirements to the pilots and the education of the AME's all over the world. That is why I will recommend to remove the GMP from the whole document/requirement.	
response	*Not accepted*	
	The GMP cannot be removed from the document as this privilege is in the Basic Regulation. However, this is the only provision where Member States are free to accept or reject the rule in their territory.	

comment	*1876*	comment by: *Phil King*
	I strongly support the principle of GMPs being able to issue medical certificates. I have been involved with British gliding for 45 years during which time medical certificates have been issued by GMPs. This experience has shown me that GMPs are at least as effective as AMEs in preventing accidents from medical causes. Access to the pilot's clinical medical records ensures that in many cases GMPs are more aware than AMEs of the presence of medical problems in their patients that are relevant for General Aviation.	
response	*Noted*	
	Thank you for your input.	

comment	*1902*	comment by: *Michael Hinz*
	Ich bin der Meinung, dass man die Untersuchung, sofern überhaupt nötig, in jedem Staat durchführen lassen können soll. Das gebietet das Recht auf freizügigkeit und die freie Berufswahl.	
response	*Noted*	
	The pilot can have his/her medical examination by an AME or AeMC in any Member State; however, their medical files will always be kept by their licensing authority. For LAPL, the licensing authority will accept examinations by a GMP only if permitted under the national law of that licensing authority.	

comment	*1912*	comment by: *Klaus Melchinger*
	Whom's "principal place of business" is meant here?? That of the licence holder or that of the AeMC/AME/GMP.	

	It should be worded more clearly here is meant the "principal place of business" of the AeMC/AME/GMP and there's no restriction in which member state an applicant or licence holder applies for a medical.
response	*Noted*
	Principle place of business of all persons/parties mentioned in this context in this paragraph. These are: Aeromedical centre, aeromedical examiner, general medical practitioner. 'A person' is only mentioned in the context of applying to an AME, AeMC or GMP for a medical certificate.

comment	*1961*	comment by: *Civil Aviation Authority of Norway*
	Throughout the text we can find the phrase "Licensing Authority" which is defined as meaning the Competent Authority. Why not instead use Competent Authority, which is done in the other parts of NPA 17 an NPA 22? The use of the phrase Competent Authority instead of Licensing Authority would contribute to standardise the rules.	
response	*Noted*	
	Licensing authority is not necessarily the competent authority. The AMEs, AeMCs apply to the competent authority for a certificate. The GMPs declare their activity to the competent authority. The pilots apply to the licensing authority for their medical certificates. The licensing authority is the authority where they hold their licence. In most cases, licensing and competent authority will be under the same roof but the medical files of the pilot will be kept in the licensing authority with the Medical Assessor. In the case of a pilot from country A going to an aeromedical examination in country B, the AME will have applied for his/her certificate to the competent authority in country B, but he/she will send the medical files of the examination to the Medical Assessor in the licensing authority of country A.	

comment	*2001*	comment by: *Max Heinz Katzschke*
	Diese Regel ist unklar formuliert, da nicht ersichtlich ist wessen "principal place of business" gemeint ist. Es sollte formuliert werden, dass damit der "pricipal place of business" des AeMCs, des AMEs und des GMPs gemeint ist und der Lizenzinhaber die Wahl hat in welchem Mitgliedstaat der EU er sich um ein Medical bewirbt. Eine Einschränkung der Auswahl, in welchem Mitgliedstaat sich der Bewerber für ein Medical bewerben darf, verstösst gegen die Grundregeln der Freizügigkeit innerhalb der Mitgliedstaaten der EU.	
response	*Noted*	

Principle place of business of all persons/parties mentioned in this context in this paragraph. These are: Aeromedical centre, aeromedical examiner, general medical practitioner. 'A person' is only mentioned in the context of applying to an AME, AeMC or GMP for a medical certificate.

comment	*2077*	comment by: *Dr. Christoph Larisch*
	Es sollte klargestellt werden, daß jeder europäische Bürger AeMCs, AMEs und GMPs in jeden europäischen Land nutzen kann. Die von den Bürgern heute geforderte berufliche Flexibilität (längere Auslandsaufenthalte) würde sonst zu erheblichen Problemen und Belastungen führen. Außerdem stellt sich in diesem Zusammenhang dann auch ganz schnell die Frage nach der Gleichbehandlung aller Bürger.	
response	*Noted*	
	The pilot can have his/her medical examination by an AME or AeMC in any Member State; however, their medical files will always be kept by their licensing authority. For LAPL, the licensing authority will accept examinations by a GMP only if permitted under national law of the licensing authority.	

comment	*2171*	comment by: *Dr.Piek Armin*
	pilots have only to deal with AeMC and AME because of the specialty of an aeromedical examination, which a GMP is not able to do	
response	*Noted*	
	Thank you for you input.	

comment	*2236*	comment by: *Douglas Gardner*
	I strongly endorse the concept of the "competent authority" for medical certification of leisure pilots being the pilot's GMP	
response	*Noted*	
	Thank you for your support.	

comment	*2239*	comment by: *AMS CAA - Hungary*
	We do not recommend any requirements below ICAO standards! The ICAO standard is la common minimum.If Europe adopt lower standardswill be kind of dysharmonisation. This could become a great hazard to aviation safety in the whole world. The ICAO have specific requirements for an extensive education of the medical examiners and it have standards for approval of pilots. It is important to keep this	

	as minimum standard. Harmonisation of medical standards between the different continents are also an important issue, and an other reason not to go under ICAO standards.
response	*Noted*
	See response to comment No 1697 in this segment.

comment	*2243*	comment by: *Andrew Sampson*
	I agree a GMP should be qualified to issue the medical certificate.	
response	*Noted*	
	Thank you for your positive input.	

comment	*2370*	comment by: *Paul Mc G*
	This new tool belongs in a bin by the way - it is an example of appalling systems design and inappropriate implementation. Why are the advantages of using general practitioners as a medical reference being ignored? is this for safety or financial reasons? The GP - assuming interity - has detailed knowledge of a patient which an AME may miss or unfortunately be duped into misreading or ignoring. The GP (GMP) provides an efficient low cost check. Sometimes GPs will not issue and require an AME opinion.	
response	*Noted*	
	Para 1: Thank you for giving us your opinion. Para 2: We do not fully understand the comment. The GMP can issue medical certificates without limitations (other than a limitation for spectacles) for LAPL, if permitted under national law.	

comment	*2563*	comment by: *Heinz Fricke-Bohl and Kirsten Bohl*
	MED.A.001: Ein GMP ist abzulehnen. GMP stellen Gefälligkeitsbescheinigungen aus um ihren Patienten wohlgesonnen zu sein. Dieses ist z.Bsp. bei den Untersuchungen für Taxi und LKW-Fahrern eher die Regel als die Ausnahme. In England hat jeder Patient eine Lebenslaufakte (wie ein Flugzeug) wo alle Daten registriert sind. Dieses ist in Deutschland schon aus Datenschutzgründen nicht der Fall. So werden des öfteren Krankheiten verschwiegen oder besondere Umstände z.Bsp. Alkoholmissbrauch nicht offen dargelegt.	
response	*Noted*	
	The provision allowing GMPs to issue medical certificates for LAPL applicants is laid down in the Basic Regulation. It requires GMPs to have sufficient detailed knowledge of the applicant’s medical background.	

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comment	*511*	comment by: *British Microlight Aircraft Association*
	Accepted	
response	*Noted*	
	The Agency acknowledges your feedback.	

comment	*1053*	comment by: *British Gliding Association*
	The British Gliding Association strongly supports the concept of a GMP medical. Under a similar GP endorsed self declaration system within UK national regulation, thousands of pilots are able to fly with no greater first or third party risk from medical incapacitation than others who hold JAR medical certificates. There are however a number of details within the NPA proposals that the BGA believes should be considered. These are listed below.	
response	*Noted*	
	The Agency acknowledges your positive comment.	

comment	*1062*	comment by: *BMVBS (German Ministry of Transport)*
	the scope of this part also covers the suspension, limitation and revocation. For consistancy with NPA-2008-22b subpara. (a) should amended accordingly.	
response	*Noted*	
	Your contribution is appreciated but since this Part is directed to pilots, AMEs and GMPs, whereas Part-AR is directed to Authorities, the wording used in the respective Parts for the same issue may therefore be different for clarity purposes.	

comment	*1187*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Comment: Acceptable	
response	*Noted*	
	The Agency acknowledges your positive feedback.	

comment	*1316*	comment by: *Vincent EARL*
	I strongly support the view that General Medical Practitioners should be	

	recognised as a competent authority for the issuance, validity, revalidation and renewal of medical certificates for all types of leisure pilot.
response	*Noted*
	The Agency acknowledges your positive feedback.

comment	*1468*	comment by: *Trevor Wilcock*
	I very strongly support he issuance of an LPL medical certificate by a GMP.	
response	*Noted*	
	The Agency acknowledges your positive feedback.	

comment	*1601*	comment by: *Jeremy BRYSON*
	Medical certificates should be issued by a GMP. Expensive Class 2 medicals in most cases are unnecessary.	
response	*Noted*	
	The Agency acknowledges your opinion but reminds that class 2 medical certificate is required in accordance with ICAO. Nonetheless, if flying non-commercial and only in Europe, there is the possibility to apply for the LAPL medical certificate that may be issued by a GMP on the basis of medical history.	

comment	*1602*	comment by: *James MILLS*
	Gliding is an expensive sport already, as a student and a member of Queens University Belfast Gliding club i am well aware of the fact . Our Gliding club has already found it difficult to obtain funding for this sport. As a small university club we lack some of the equipment larger clubs have. We fly from the Ulster Gliding club were our glider is based however we lack our own aircraft for aero tow and as a result each member has to personally pay to make use of the Ulster gliding clubs aircraft, on top of the fees for flying lessons. As students this restricts the amount of gliding we can do. The proposal to include a £180 medical before solo status therefore concerns me personally and in my opinion will put many younger pilots and students off taking their solo exams and therefore will be both damaging to the individuals progress in Gliding ,our clubs and Gliding as a whole . I support the BGA's opinion that a GP endorsed medical should be sufficient, im sure a GP is qualified enough to give a suitable medical as they has been in the past.	
response	*Noted*	
	The Agency acknowledges the information provided, but does not understand the reference to the '£180 medical before solo'. The proposal is that the medical certificate for a LAPL (S) is based on medical history and a simple examination, and may be issued by a GMP, if permitted under national law.	

comment	1603	comment by: Barry SULLIVAN
	The first proposal which I feel would most affect my continuing to learn is the necessity to obtain a prohibitively expensive medical certificate in order to fly solo. I feel that a GP endorsed medical should be sufficient and would ensure a responsible level of health is maintained by solo pilots.	
response	*Noted*	
	The Agency acknowledges your opinion but conversely to what is stated in your comment, medical certificates for LAPL may be issued by GMP if permitted under national law.	

comment	1605	comment by: Matthew CASSIDY
	I am writing to express my concern with the new laws being brought in by EASA affecting gliding. It has been pointed out that in order for me to continue my training to fly solo I will need to undertake a medical at a cost of £180. This is of most concern to me as I am a student and a member of the Queen's University Gliding Club, and with such a large added expense, I will have to seriously consider dropping gliding until after university. I think this will be the general consensus and there will be a large decrease in young members participating in the sport.	
response	*Noted*	
	Your comment, similar to many others, seems to indicate some misunderstanding of the NPA proposals and unjustified concerns. If flying sailplane non-commercial and in Europe, there is the possibility of the LAPL medical certificate based on medical history and a simple examination and that may also be issued by a GMP, if permitted under national law.	

comment	1606	comment by: Prof W. Brian WHALLEY
	I wish to make some personal comments on NPA 2008-17. I support the general and specific responses of the BGA but wish to make additional comments, specifically as it affects me as a learner glider pilot in the Queens University Gliding Club. I am an academic on the staff of the University and feel able to make some reasoned comments regarding gliding in the North of Ireland. The QUB Club has only recently been restarted and one of the proposals in particular would be greatly detrimental to the future of the Club - especially as the novice pilots are young. I refer here to the possible requirement that a specific medical certificate would be mandatory for solo flying. The cost of this is likely to be very detrimental to student members and indeed to me too. There are many sports where a medical certificate is required and is a sensible request. However, this can surely be supplied by a general practitioner, as is the case for other sports, at low cost or free. I trust that a reasonable response to the original proposal would be for a certificate from a general practitioner or local medial practice.	
response	*Noted*	

	The Agency acknowledges your opinion but your concerns are not justified. Please refer to response to comment No 1605.

comment	*1615*	comment by: *David Lisk*
	I feel that EASA should support the GP endorsed medical as otherwise the cost of obtaining a medical would discourage many participants from flying solo. I could however understand that instructors would require higher medical standards as they would have a student pilot as P2 on board.	
response	*Noted*	
	The Agency confirms that the NPA proposal includes the possibility for a LAPL medical certificate based on medical history and a simple examination and that it may be issued by a GMP, if permitted under national law. See also response to comment No 1605.	

comment	*1665*	comment by: *Steven Chapman*
	I strongly agree with the concept of a GMP Medical. In the UK, a similar GP Endorsed self decleration system, enable thousands of pilot to fly with no greater first or third party risk from medical incapacitation than others who hold a JAR medical certificate.	
response	*Noted*	
	The Agency acknowledges your positive comment.	

comment	*1675*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.A.005(c) Scope **Page** 3 **Comment** **Justification** There is a Europe wide requirement for accrediting physicians in cardiology and it is appropriate that pilots should be examined by such a cardiologist. **Proposed Text** "Cardiologist means a physician accredited in cardiology by EAC CME (uems.net)	
response	*Not accepted*	
	Definition of cardiologist will not be provided in the NPA.	

comment	*1747*	comment by: *Claire MULVENNA*
	As a member of the Queens University Gliding Club I would like to express my opinions on the new EASA proposals. As a learner pilot within the club the new proposals will directly affect my gliding lessons and my interest towards learning	

	to fly as a solo pilot for many reasons. One of these is cost, the expense of a medical of £180 is unreasonable to expect a student to pay. A medical from my GP should be sufficient. The additional financial expense would be too much of a personal burden. Also, due to Northern Ireland's typical weather conditions, heavy cloud load is to be expected and therefore very unreasonable if clouds were to be avoided during lessons as well as the extra expenditure for more lessons. Personally I feel if the gliding regulations were tightened, it would inevitably result in additional expenditure and hassle, for example having to go to GP for an expensive medical would take time out of studies as well as student finance. Therefore discouraging people from taking up such a unique and exciting sport and in particular for students who want to take gliding lessons with the aim of flying solo. [Same response copied to NPA 2008-17a]
response	*Noted*
	The Agency acknowledges your opinion and the information provided. As for your comment No 370 copied in NPA 2008-17a, in relation to your first point, in accordance with article 7(2) of the Basic Regulation, GMPs may if permitted under national law issue for the LPL medical certificates based on medical history. For other licences, medical certificates need to be issued by aeromedical centres or aeromedical examiners in accordance with ICAO. As regards your second point, the issue of cloud flying and flight under IMC conditions is currently being discussed within the scope of rulemaking task FCL.008. This task will result in an NPA, which will be submitted to public consultation. We suggest you provide your comments on that NPA.

comment	*1983*	comment by: *EFLEVA*
	EFLEVA endorses the ability of GMPs to certify the medical status of pilots.	
response	*Noted*	
	The Agency acknowledges your positive feedback.	

comment	*2078*	comment by: *Royal Swedish Aeroclub*
	Royal Swedish Aeroclub (KSAK) strongly support the proposal that a general medical practitioners (GMP) may carry out the medical examination for the renewal of the license	
response	*Noted*	
	The Agency acknowledges your positive comment.	

comment	*2108*	comment by: *Light Aircraft Association UK*
	The LAA strongly supports the ability of GMPs to certify the medical status of pilots, based on experience in the UK with a similar system. There are some details that we do not agree with and these are contained in the comments below.	
response	*Noted*	
	The Agency acknowledges your positive comment.	

comment	*2122*	comment by: *Croft Brown*
	Croft Brown strongly supports the concept of a GMP medical. Under a similar GP endorsed self declaration system within UK national regulation, thousands of pilots are able to fly with no greater first or third party risk from medical incapacitation than others who hold JAR medical certificates. There are however a number of details within the NPA proposals that the BGA believes should be considered. These are listed below.	
response	*Noted*	
	The Agency acknowledges your positive feedback and further contribution.	

comment	*2175*	comment by: *neil mcaulay*
	I believe that the proposed change to General Medical Practitioners certifying fitness to fly is a very good and practical move in the correct direction. This works very well in the UK at present.	
response	*Noted*	
	The Agency acknowledges your positive comment.	

comment	*2299*	comment by: *David Miller*
	I strongly support the idea of medical certificates issued by general medical practitioners.	
response	*Noted*	
	The Agency acknowledges your positive comment.	

comment	*2362*	comment by: *Andy Balkwill*
	I support the principle of a GMP medical for glider pilots. this system has worked well in the UK for many years with no greater risk identified than for pilots holding JAA medicals. Although as an instructor I recognise and accept the need for a more rigorous medical certification process, I believe that the existing GMP endorsed self declaration process which applies for the majority of glider pilots is appropriate,	

	pragmatic and economic. It ensures that gliding is available to the widest range of participants at affordable costs.
response	*Noted*
	The Agency acknowledges your support to the NPA proposal.

comment	*2424*	comment by: *Frank birlison*
	I strongly support the Leisure Pilot Licence (LPL) for gliding and in particular the medical standards which are appropriate for the level of risk.	
response	*Noted*	
	The Agency acknowledges your support to the NPA proposal in this matter.	

comment	*2439*	comment by: *SANMA Swedish Aeronautical Associatation*
	Skall GP göra undersökningarna går det ej att kvalitetsäkra dessa pga för låg undersökningsvolym för varje enskild läkare.	
response	*Not accepted*	
	The Agency acknowledges your opinion but cannot agree with your statement. The Basic Regulation (Article 7) provides the possibility of a GMP to assess the medical fitness for an LPL applicant/holder if permitted under national law and the proposed Implementing Rules in this NPA and in NPA 2008-22 provide the criteria under which the GMP can issue medical certificates. The GMP must have sufficient knowledge of the pilot's medical history in order to act as an AME, and in case of any doubt the GMP shall send the medical report to an AME or AeMC for further evaluation (see AMC to MED.A.040).	

comment	*2455*	comment by: *Queen's University Gliding Club*
	[This comment has also been copied to NPAs 2008-17a and 2008-17b] Dear Sir/Madam, I am the writing on behalf of the Queen's University Gliding Club, Northern Ireland as Treasurer in relation to the EASA proposals for licensing, medical requirements and privileges detailed in NPA 2008-17. Our University Gliding Club has currently around 65 members, the vast majority of which are students. I would like to bring to your attention several of the proposals in NPA 2008-17 which very likely to affect the viability of continuing operation of our club. I chose to respond by letter as the comment response tool did not offer the flexibility required to fully express our situation and viewpoint. From reading the proposed document, it was very unclear as to how the medical requirements might be fulfilled. We feel it is necessary that the GP medical is	

	recognised, as a requirement to visit an AME would prohibit many of our members going solo due to expense. Secondly, the removal of cloud flying privileges will affect the sport in many ways. Reduction of the height band within which we can operate will adversely affect safety, as this more constricted airspace will now be shared with GA traffic. In addition, cloud base is generally much lower in the UK including Northern Ireland than mainland Europe. As a result, much of the glider pilot's time will be in selecting fields as opposed soaring. **These two issues alone will discourage many from participating which will have a serious impact on our club and could lead to its demise.** Our club fully supports the BGA's viewpoint on all of the remaining issues they have raised, including the minima for aerotowing and aerobatics which seem excessive; the removal of the Basic Instructor rating which will affect hundreds of volunteer instructors across the UK with no clear statement of how this will integrate into the new licence categories, and the existence of two licences with identical instructional requirements yet different instructor privileges: LPL (S) and SPL. We are very disappointed that the above matters concerning glider pilots have not been given more thought by EASA, as in addition to the problems stated, the transition process alone has caused a considerable amount of hassle and incurred significant costs for the club through the submission of a great deal of paperwork. I would like to see a resolution to the above issues with the goal of promoting the sport of gliding within the UK, such that it continues to attract participants as it has done for many years. Yours faithfully, David Lisk (Treasurer) Aby Rushton (Chairperson)
response	*Noted*
	The Agency acknowledges your opinion and the information provided. As regards your first point on medical, the Agency confirms that the NPA proposal includes, in accordance with article 7(2) of the Basic Regulation, the possibility, for the LAPL, of a medical certificate based on medical history and a simple examination and that it may be issued by a GMP, if permitted under national law. For those who wish to have commercial activities and/or to fly outside Europe, they would need to apply for a sailplane licence (SPL) with such privileges in accordance with ICAO, thus requiring a Class 2 medical certificate to be issued by an AME or AeMC. As regards your second point, the issue of cloud flying and IMC conditions is currently being discussed within the scope of rulemaking task FCL.008. This task will result in an NPA, which will be submitted to public consultation. We suggest you provide your comments on that NPA. As regards the other points raised, please refer to the response to your comment

	with number 8259 to NPA 2008-17b, Subparts I 'Additional Ratings' and J 'Instructors'.

comment	*2456*	comment by: *Paul Mc G*
	The ability of GPs to certify the medical status of pilots, based on experience in the UK with a similar system must be maintained. Under a GP endorsed self declaration system within UK national regulation, pilots are able to fly with no greater first or third party risk from medical incapacitation than others who hold JAR medical certificates.	
response	*Noted*	
	The Agency acknowledges your opinion and the information provided.	

C. Draft Opinion Part-MED — Subpart A: General Requirements — Section 1: General — MED.A.010: Definitions p. 3

comment	*121*	comment by: *Civil Aviation Authority - The Netherlands*
	MED.A.010. (Blz. 3 van 66) De definitie van "colour safe" is volgens de CAA-The Netherlands te ruim en daarmee onvolledig. Colours "used in air navigation" en "aviation coloured lights" zijn rood, wit en groen. Het is van belang dat de kleuren, gebruikt op een kleuren display, glass cockpits en navigatiekaarten onderscheiden kunnen worden. Gelet op bovenstaande verzoekt de CAA-The Netherlands om aanpassing van de definitie "colour safe".	
response	*Not accepted*	
	'A pilot shall be required to demonstrate the ability to perceive readily those colours the perception of which is necessary for the safe performance of duties' (ICAO Annex 1, 6.2.4.2). A pilot who cannot demonstrate this ability '... shall be assessed as unfit unless able to readily distinguish the colours used in air navigation and correctly identify aviation coloured lights.' (ICAO Annex 1, 6.2.4.4). Colour safe in Part MED means that an applicant cannot demonstrate colour vision as required in ICAO 6.2.4.2 (MED.B.070 (a)) but does meet the standard in 6.2.4.4.	

comment	*235*	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany Head of Lufthansa Medical Services Head of German Academy of Aviation and Travel Medicine Section: 1	

General
MED. A . 010 - Definitions

Page: 3
Relevant Text: -Refractive Error- means the deviation for emmetropia measured in dioptres in the most ametropic meridian, measured by standard methods.

Comment: Most of the ophthalmologists in universities calculate astigmatism only half of the dioptres of the cylinder in the most ametropic meridian.

Proposal: -Refractive Error- means the deviation for emmetropia measured in dioptres in the most ametropic meridian, measured by standard methods. Cylindercorrection for astigmatism shall be added only half of the dioptres of the cylinder.

response *Not accepted*

The basis of this NPA is JAR-FCL 3 and the rules have only been amended for compelling reasons. The definition from JAR-FCL 3.220 (b) (Class 1) and JAR-FCL 3.340 (b) (Class 2) has been carried over to Part Medical.

Eventual changes could be introduced via the rulemaking task MED.001.

comment *249* comment by: *Lufthansa German Airlines*

Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany

Section: MED.A.010

Page: 3
Relevant Text: "Eye specialist" means an ophthalmologist or a vision care specialist qualified in optometry (...)

Comment: vision care specialists are not qualified or authorised by law to diagnose pathological conditions of the eyes or commit treatment in patients. The term "Eye specialist" should be limited to ophthalmologists as medical doctors.

Proposal: "Eye specialist" means an ophthalmologist trained or experienced in optometry and aviation medicine.

response *Not accepted*

The definition of 'eye specialist' has to be maintained because of the different medical systems in Europe. In some European countries access to ophthalmologists is limited and the routine examinations that are necessary for a medical certificate are not performed by ophthalmologists.

'Eye specialists' under this definition have to be trained to recognise pathological ophthalmological conditions and they have a corresponding diploma. Nevertheless, they have to refer pilots with an eye pathology to an ophthalmologist. This will be added in AMC to MED.B.065. Examinations/assessments will be done by ophthalmologists in countries where this kind of diploma does not exist.

comment	288	comment by: *Lufthansa German Airlines*

Author: Dr. Esther Stahl-Buhl AMC Frankfurt
Section: 1
Subpart A
MED.A.010 - General Requirements
Page: 3
Relevant Text:
'Eye specialist' means an ophthalmologist or a vision care specialist qualified in optometry and trained to recognise pathological conditions.

Comment:
Except for the UK, nowhere in Europe have we sufficiently trained optometrists, only opticians. An optician is in no way trained to evaluate the condition of an eye or able to recognise pathological conditions.

Proposal:
Eye specialist means an ophthalmologist!

Later on during the entire text the words: ophthalmic evaluation should be replaced by: ophthalmic evaluation by an ophthalmologist.

Visual field: It should be specified, that a visual field should be the following test: Goldmann Perimetry with marks III-4, I -4, and I-3, or automatic perimetrys corresponding in their quality to a Goldmann perimetry. 100 points should always be offered, they should be offered at least till 70 degrees superior, 40 degrees temporal and 40 degrees inferior.

There are no specific statements concerning eye medication:
My comment: If a pilot class 1 , class 2 or LPL needs oral or iv. medication for his eyes or affecting his eyes or if any of these pilots needs eye drops, he shall report this to his AME. The AME shall decide, whether that pilot needs a comprehensive eye examination in order to assess medical fitness or a routine eye examination.

response *Noted*

Eye specialist: See response to comment No 249.
The second comment does not refer to this paragraph.

comment	369	comment by: *UK CAA*

MED.A.010 Definitions

Comment:
Definition requires amendment.

Justification:
Definition of colour safe is not appropriate for all types of certification and is different from that in MED.B.070.

Proposed Text:

	'Colour safe' means the ability of the applicant to perceive readily the colours that are necessary for the safe performance of duties.
response	*Noted*
	The definition proposed in this comment is a copy of the text in ICAO Annex 1, 6.2.4.2 and is contained in MED.B.070 (a). This standard is considered to be met if the applicant is tested for the ability to correctly identify a series of pseudoisochromatic plates in daylight or artificial light ... (ICAO 6.2.4.3) ... ... and obtains a satisfactory result. An applicant who does not obtain a satisfactory result in such a test 'shall be assessed as unfit unless able to readily distinguish the colours used in air navigation and correctly identify aviation coloured lights' (ICAO 6.2.4.4). The latter is the definition for 'colour safe' in this NPA.

comment	*512*	comment by: *British Microlight Aircraft Association*
	Accepted	
response	*Noted*	
	The Agency acknowledges your positive feedback.	

comment	*685*	comment by: *BMVBS (German Ministry of Transport)*
	Definition of "Licensing authority": A "pilot" who has not yet applied for a license is legally speaking not a pilot yet. It should be considered to replace the term "the pilot" by the word " a person". T	
response	*Partially accepted*	
	The word 'pilot' in the text will be replaced by 'applicant' and/or 'licence holder'.	

comment	*926*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM) - Group Ophthalmology - Section: 1 Subpart A MED.A.010 - General Requirements **Page**: 3 **Relevant Text:** 'Eye specialist' means an ophthalmologist or a vision care specialist qualified in optometry and trained to recognise pathological conditions. **Comment**: Nowhere in Europe, except in the UK and Malta, we do have sufficiently trained optometrists, only opticians. An optician is in no way trained to evaluate the	

	condition of an eye nor able to recognise pathological conditions. **Proposal**: The wording: Eye specialist has to always be replaced by an ophthalmologist! Later on during the entire text the words: ophthalmic evaluation shall be replaced by: ophthalmic evaluation by an ophthalmologist. In countries, where ophthalmologists deny doing the examination, optometrists are allowed to perform an examination at the discretion of the national competent authority.
response	*Noted*
	See response to comment No 249.

comment	*1188*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Comment: Acceptable	
response	*Noted*	
	The Agency acknowledges your positive feedback.	

comment	*1331*	comment by: *Jürgen Blome*
	Ich unterstütze die Einführung eins Tauglichkeitsstandards unterhalb ICAO Klasse 2 und die Möglichkeit der Untersuchung durch den Hausarzt. *Die Sicherheit wird nicht gemindert, die Kosten für den Erwerb und Unterhalt der Lizenz werden gesenkt, die Zugänglichkeit zum Luftsport wird erleichtert.*	
response	*Noted*	
	The Agency acknowledges your feedback.	

comment	*1336*	comment by: *ophtalmologie aerospace medecin*
	The wording: Eye specialist has to always be replaced by an ophthalmologist! Later on during the entire text the words: ophthalmic evaluation shall be replaced by: ophthalmic evaluation by an ophthalmologist. In countries, where ophthalmologists deny doing the examination, optometrists are allowed to perform an examination at the discretion of the national competent authority.	
response	*Noted*	
	See response to comment No 249.	

comment	1499	comment by: *Austrian Medical Chamber*

The **principle of subsidiarity** as defined in the EC Treaty strictly confines European legislators in the field of health care. **Art 152 par. 5 of the EC Treaty** sets forth:

(5) Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care…"

This implies that the **Member States are responsible for defining for each health profession which kind of health services they are allowed to provide.** European legislation fully respects this competence inherent to Member States (cp. for instance Article 21 par. 1 of Directive 2005/36/EC on the recognition of professional qualifications, according to which professional recognition of health professionals engaged in medical activities in another Member State is subject to the legislation of the host Member State, and not to the one of the country of origin). Art 15 par. 2 (d) of Directive 2006/123/EC on services in the internal market gives Member States the right to reserve access to service activities in question to particular providers by virtue of the specific nature of the activity.

The proposed **definition of „eye specialist"** would lead to the fact that the professionals covered by this definition would be **authorized to perform the comprehensive eye examination and the routine eye examinations prescribed for pilots in all Member States**. This regulation is contrary to the system outlined earlier and **massively interferes in the competence of the Member States**.

The Austrian Medical Chamber holds the opinion that due to the principle of subsidiarity and the national legislative competence in health care **it is inadmissible to transform such regulation into a European standard**.

Furthermore, we have severe medical concerns against this definition: If the draft was implemented in its present form, this would lead to the fact that opticians, regardless of any additional training, would be authorized to perform the required medical eye examinations and to assess pathological ophthalmological anomalies. This means that they would carry out a differentiated diagnosis and give medical expertise. An **optometrist**, who is able to perform examinations in a technically correct manner, **does not have the comprehensive medical background knowledge of a medical doctor**, required in order to judge and assess the data with regard to other physical parameters. The **examination of eye functions, including vision, is only one of the elements** of a serious ophthalmological expertise. The examination with regard to ocular pathologies (such as diabetes, hypertension, ceratoconus, reduced colour vision, cataract, glaucoma, post-operative conditions etc.) is as important as **the general assessment of the patient**.

In Austria, ophthalmic optics is a trade according to Art 94 par. 2 of the Austrian Trade Regulations. According to Art 98 of the Austrian Trade Regulations, **the professional portfolio of optometrists** covers the **adjustment and dispensing of corrective glasses** including the determination of eye glasses, as

	well as retail trade of contact lenses. No further competences and no further training curricula are foreseen for the profession of optometrists. For this reason, **the diagnosing of pathological conditions by optometrists** would mean a **violation of the Trade Regulations in Austria.** In the medical certification required for pilots, the examination and detection of possible pathological conditions clearly outweighs the assessment of purely "optometric" data, such as visual fitness. The **examination of patients for exploring possible physical and mental diseases or disorders,** disabilities or abnormalities and malformations, of pathological nature, constitutes a **medical activity** according to the Austrian law (Art 2 par. 2 line 1, Austrian Medical Act), which is reserved to medical doctors for reasons of patient safety according to Art 3 par. 2, Austrian Medical Act. This means that the **performance of such activities by optometrists** would **conflict with the Austrian Medical Act**. Obviously, the EASA, too, is aware of the fact that comprehensive specialist training is required for **assessing abnormal and doubtful cases**. It is with good cause that it is **stipulated explicitly** in AMC A - MED.B.065, VISUAL SYSTEM class 1 medical certificates, that all abnormal and doubtful cases **should be referred to an ophthalmologist, i.e. a medical specialist**. This makes it even less comprehensive how the EASA would medically justify the regulation of the optometrists' right to perform ophthalmological certificates in the entire EU. The Austrian Medical Chamber is convinced that **minimum solutions are out of place, when it comes to aviation safety**, where a great number of human lives are at stake. In times where airplanes transport up to 900 passengers in increasingly crowded flight traffic, it is of greatest importance that pilots have unobjectionable sight. Therefore, from the medical point of view, we consider it as absolutely imperative that the **ophthalmological and optometric fitness of pilots is assessed by fully qualified specialists.** These considerations lead us to urge the introduction of **high standards at EU level for the medical certification of pilots.** If harmonization cannot be achieved at a high quality level, **there should be at least the possibility for individual Member States** to foresee **higher quality standards in their national legislation**. **For this reason, we urgently request deletion of the definition of "eye specialist".** Cancelling of this both inadmissible and redundant European definition would lead to the fact that the Member States would continue to be competent for defining the providers authorized to perform eye examinations, without downgrading the quality of European standards.
response	*Noted*
	See response to comment No 249. The aeromedical assessment of pilots is not considered to be 'public health care' but is regulated to ensure as far as possible that pilots are medically fit to fly and do not suffer an incapacitation during flight. The Basic Regulation (216/2008), Article 7, empowers the European Commission to set up implementing rules regarding medical fitness.

comment	*1540*	comment by: *British Airways*
	The three definitions 'Colour safe', 'Eye specialist', 'Refractive error', relate specifically to ophthalmology. There is no more reason to include these here than the terminology specific to any other clinical specialty. **Proposal**: These definitions should be included in the relevant sections of Subparts B-D (if required at all)	
response	*Not accepted*	
	Following the structure of this and other NPAs, all definitions of the document are placed in paragraphs XXX.010.	

comment	*1608*	comment by: *Dr Lilla Ungváry*
	"comment to "eye specialist": We have optometrists but they are only trained to examine the orthoptic status of the patient. They are not familier with colour vision, slit lamp or fundus examination. It is not allowed them to measure the eye pressure. I propose:Eye specialist has to always be replaced by an ophthalmologist.	
response	*Noted*	
	See comment No 249.	

comment	*1671*	comment by: *Aeromedical Shipping and Maritime Center, Budapest*
	my opinion is....	
response	*Noted*	
	Comment is missing.	

comment	*1721*	comment by: *Österr. Ophthalmologische Gesellschaft*
	Attachment #3	
	cancellation of the definition of "eye specialist"	
response	*Noted*	
	See response to comment No 249.	

comment	*1741*	comment by: *DCA Malta*
	MED.A010 Definition of 'Eye specialist' Malta agrees with the definition of 'Eye specialist' as it is. In Malta our optometrists have the highest qualification obtainable in the UK. The Aeromedical Section and AeMC make use of the services of such qualified	

	individuals.
response	*Noted*
	Thank you for the positive comment. See comment No 249.

comment	*1765*	comment by: *Civil Aviation Authority Finland*
	The proposed definition "Eye specialist" says that an ophthalmologist and a vision care specialist qualified in optometry would be equivalent to make desisions, if a pilot can continue flying after getting the first coorecting lenses (ref. MED.A.060 (c)). Because in many States (as in Finland) the visual function tests or the examination of the heathy state of eyes does not belong in the training of the eye care specialists (opticians or optometrists) and the training does not correspond the standard EC is possible thinking, the definition should be deleted and the term "ophthalmologist taken instead. (Ref. the letter U.E.M.S. of 8 February 2009). **Delete from the definition "Eye care specialist" and incert only the term "ophtalmologist".**	
response	*Noted*	
	See response to comment No 249.	

comment	*1770*	comment by: *AECA(SPAIN)*
	To include a definition of **medical confidentiality.** Justification: To avoid missinterpretations or different levels of compromisse	
response	*Not accepted*	
	Medical confidentiality in Europe is applied according to the European Directive on Data Protection and will not be repeated in Part Medical. Any definition on data protection may be unintentionally in conflict with the European Directive.	

comment	*1771*	comment by: *AECA(SPAIN)*
	'Colour safe' Delete last sentence 'and correctly identity aviation coloured lights'. Justification: Reiterative	
response	*Noted*	
	See response to comment No 369.	

comment	*1772*	comment by: *AECA(SPAIN)*
	'Licensing Authority' Revisión to harmonize with AR MED 020 and 025	
response	*Accepted*	
	Consistency with Part Authority Requirements will be checked and amended accordingly.	

comment	*1786*	comment by: *AECA(SPAIN)*
	To include a definition of 'acredited medical opinion' Is a new concept.	
response	*Partially accepted*	
	A definition of 'Accredited medical conclusion' based on the ICAO definition will be included.	

comment	*1798*	comment by: *CAA Belgium*
	Relevant Text: "Eye specialist" means an ophthalmologist or a vision care specialist qualified in optometry (…) Comment: vision care specialists are not qualified or authorised by law to diagnose pathological conditions of the eyes or commit treatment in patients. The term "Eye specialist" should be limited to ophthalmologists as medical doctors. Proposal: "Eye specialist" means an ophthalmologist trained or experienced in optometry and aviation medicine.	
response	*Noted*	
	See response to comment No 249.	

comment	*1888*	comment by: *Susana Nogueira*
	Include following definitions: Medical Confidentiality Acredited Medical Opinion	
response	*Noted*	
	See responses to comments No 1770 and 1786.	

comment	*1977*	comment by: *MOT Austria*
	Comment: Austria opposes, that 'optometrists' should be involved in eye examination of flying personnel. Comprehensive eye examinations shall be performed by ophthalmologists only.	

Justification:

Optometrists in Austria are no 'eye specialists' because they have no clinical training and are unable to recognize pathological eye conditions.

By Austrian law (Gewerbeordnung 1994) 'optometrists' are just opticians, who are just allowed to sell and to adapt eyeglasses and contact lenses.

Proposed Text:

Delete the definition of 'eye specialist'.

response

Noted

See response to comment No 249.

comment

2290 comment by: *DLR*

The training of optometrists varies a lot through Europe and range from a few week course to a college program. Therefore ophthalmologists and optometrists are not comparable at all. 80% of the surrounding is perceived by the eyes. The assessment of the visual system should therefore be uniform and on a high standard level. The assessment of the visual system should be a unique medical investigation. The Definition of the Medical Act by the European Union of Medical Specialists read:
The medical act encompasses all the professional actions e.g. scientific, teaching, training, and educational, clinical and medico technical steps, performed to promote health and functioning, prevent diseases, provide diagnosis, or therapeutic and rehabilitative care to patients, individuals, groups or communities in the framework of the respect of ethical and deontological value. It is the responsibility of, and must always be performed by a registered medical doctor/physician or under his or her direct supervision and/or prescription.
Proposal:
The wording: Eye specialist has to always be replaced by an ophthalmologist!

Later on during the entire text the words: ophthalmic evaluation shall be replaced by: ophthalmic evaluation by an ophthalmologist.

In countries, where ophthalmologists deny doing the examination, optometrists are allowed to perform an examination at the discretion of the national competent authority.

response

Noted

See response to comment No 249.

comment

2359 comment by: *Federal Ministry of Transport, Austria (BMVIT)*

1. In the definition for "eye specialist" the reference to the **vision care specialist** should either be **deleted** or the text should read "...ophtalmologist or - **if permitted by national law of the Member State** - a vision care specialist..."

Justification: In Austria as well in a lot of other Member States national law allows **only ophtalmologists** to diagnose pathological conditions in the eye. For good reason: Such activities should only be conducted by fully trained physicians.

2. A further definition should be added:

"aviation psychologist": A person permitted to conduct psychological evaluations by national law and who is appropriately trained in aviation psychology; only aviation psychologists may perform psychological evaluations according to this Part.

Justification: Only adequately trained psychologists should perform psychological evaluations of pilots.

response

Not accepted

1. See responses to comments No 249 and 926.

2. Medical speciality 'Aviation psychologist' does not exist in the majority of the Member States. The introduction of your proposed definition in Implementing Rules would be too restrictive for them. It is outside the scope of this document.

comment

2429 comment by: *UEMS section of ophthalmology*

Definitinion of "eye specialist"

The Ophthalmic Specialty Section of the UEMS (Union Européenne des Médecins Spécialistes) represents the 40,000 opthalmologists practising across the EU and I write to you on their behalf, since flight crew licensing appears to be in your remit. Copies have also been sent to the other directors of EASA as there seems to be some overlap in your respective responsibilities.

According to the EASA website, its mission is to establish and promote the highest and uniform standards of safety in civil aviation to best protect EU citizens. We both welcome and support this but find it at odds with you proposed definition of "eye specialists" on page 3 of your Draft NPA No 2008-17c. In MED.A.010 Definitions, it proposes ophthalmologists and optometrists as equivalent when this is not the case: the former are medically qualified, whereas the latter are not. Even in member states, such as the UK, where optometric education and accreditation is seen by the European Council of Optometry and Optics (ECOO) as the gold standard, they are neither equivalent nor comparable.

Although optometry exists in several member states, there is no consistency (unlike in medicine) in either length or standards of training across the EU: some are 3 year college programmes, whereas others are only a few weekend courses, yet at the end of both the trainee can call him/herself an optometrist. The ECOO is well aware of these severe disparities and knows it will take considerable time to harmonise training programmes and raise the standards of those that are not up to the required level. It is to be congratulated for its launch later this year of a European Academy of Optometry and Optics, which will begin to address this educational problem.

However, while such disparities still exist, optometrists are not comparable across the EU and in any event cannot be seen as equivalent to ophthalmologists for the reasons given above.

Some EU states do not legally recognise optometry and are clear they do not require it. In these states, the comprehensive visual function tests for pilots will continue to be done by ophthalmologists, ie medically qualified doctors who have specialised in ophthalmology. In several EU states, some of the vision tests have been satisfactorily done by optometrists for years under the aegis of the medical doctor ultimately issuing the medical fitness certificate, together with any review and more comprehensive assessment being carried out by an ophthalmologist should this be required. This should continue and is very much in line with the UEMS (1,6 million specialised doctors) accepted definition of the "medical act", which is enclosed.

If the EASA mission statement is to be honoured, standards of assessment of the visual system must not only be uniform but of the highest calibre. This assumes that EASA has robust verification mechanisms in place to ensure that the promised highest standard is indeed established and maintained. In line with this, as ophthalmologists, we will continue to provide our well established expertise in assessing visual function. The Section of Ophthalmology of the UEMS asks that EASA recognise in their documents the difference between ophthalmologists and optometrists and indeed any other licensed paramedics or technicians, eg orthoptists and nurses, who work under the responsibility of an ophthalmologist, and to understand the contribution to public safety and the value of the overseeing role of ophthalmologists if persons of variable qualification are recruited to provide eye tests for pilots.

response *Noted*

See response to comment No 249.

C. Draft Opinion Part-MED — Subpart A: General Requirements — Section 1: General — MED.A.015: Medical confidentiality p. 4

comment *70* comment by: *Dr.Beiderwellen, Secretary of GAAME*

Author: Dr.Beiderwellen,AME member of the AB of ESAM
Section:
AMC to Med A015 Section 1
Page: 4

Relevant Text: Medical confidentiality
Comment: Medical confidentiality is not guarantied, involded personnel has to be defined as medical personal/doctors.

Proposal: to be added at the end of chapter: "...according to the informational acts of the member states."

response *Not accepted*

	Medical confidentiality in Europe is applied according to the European Directive on Data Protection and will not be repeated in Part Medical.

comment	*117*	comment by: *Civil Aviation Authority - The Netherlands*
response	*Noted*	
	There is no comment in 117.	

comment	*236*	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany Head of Lufthansa Medical Services Head of German Academy of Aviation and Travel Medicine Section: 1 General MED. A . 015 - Medical confidentiality - MED. A. 050 - Obligations of AeMC, AME and GMP 4c- d - e **Page**: 4; 6; 7 Relevant Text: All persons involved in medical examinations, assessment and certification shall ensure that medical confidentiality is respected at all times. **Comment**: The competent authority or the licensing authority in the EASA member states normally are not medical doctors. Due to national personal data protection laws and EU Directive 95/46/EC on the protection of personal data, it is not allowed for AME´s and GP´s in most of the EASA member states to submit personal medical data (e.g. medical application form with family history and medical data not only from the pilot but also from his/her relatives) to an organisation where non medical personal has access to these data. **Proposal**: All persons involved in medical examinations, assessment and certification shall ensure that medical confidentiality is respected at all times. All personal medical data shall be stored by AeMC´s , AME´s and GP`s for 10 years. Only the fit or unfit result of the medical investigation shall be transmitted to the licensing authority . Upon request by the competent authority AeMCs, AMEs and GMPs shall submit medical files, reports and any other medical data as required in an anonymous form to the medical doctor of the competent authority for oversight.	
response	*Not accepted*	
	1. Regarding medical confidentiality see comment No 70. 2. Requirements for storing medical data are included in MED.A.050 and OR.AeMC.220. 3. The statements in the comment seem to be incorrect: All NAAs employ one or	

more physicians with specific knowledge in aviation medicine (see JAR-FCL 3.080).

AMEs and AMCs in all EU Member States and EASA associated States, except Germany, send the following documentation to the Aeromedical Section ('licensing authority' in Part Medical) of the NAA as required in JAR-FCL 3: The application form with the medical history of the applicant, the examination form detailing the results of the examination, results of other medical tests if carried out for an aeromedical examination for the issue of a medical certificate and the result of the examination and assessment (fit/unfit). These requirements from JAR-FCL 3 (which are based on ICAO Annex 1 standards) have been carried over to Part MED.

German AMEs who are approved aeromedical examiners for a Civil Aviation Administration outside Europe (e.g. FAA, TCAA, CASA) send without legal problems all medical details of an applicant, obtained during the aeromedical examination and assessment for a medical certificate, to the medical assessor of the Aviation Authority for which they issue the medical certificate.

The licensing authority has to follow data protection laws and medical data of pilots shall not be made available to unauthorised staff (EU Directive on Data Protection).

comment	*513*	comment by: *British Microlight Aircraft Association*
	Strongly agree	
response	*Noted*	
	The Agency acknowledges your support to the NPA proposal in this matter.	

comment	*966*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: 1
General
MED. A . 015 - Medical confidentiality -
MED. A. 050 - Obligations of AeMC, AME and GMP 4c- d - e

Page: 4; 6; 7

Comment:
The competent authority or the licensing authority in the EASA member states normally are not medical doctors. Due to national personal data protection laws and EU Directive 95/46/EC on the protection of personal data, it is not allowed for AME´s and GP´s in most of the EASA member states to submit personal medical data (e.g. medical application form with family history and medical data not only from the pilot but also from his/her relatives) to an organisation where non

	medical personal has access to these data. Medical confidentiality should be better defined here as it is done in the AMC to Med.A.015. For compliance with ICAO requirements of Annex 1 1.2.4.6 Having completed the medical examination of the applicant in accordance with Chapter 6, the medical examiner shall coordinate the results of the examination and submit a signed report, or equivalent, to the Licensing Authority, in accordance with its requirements, detailing the results of the examination and evaluating the findings with regard to medical fitness. this paragraph should contain information to whom medical information should be available. In most countries this procedure is respected. In the countries like Germany, where the transmission of medical data is forbidden the information could be limited to the statement of fitness or unfitness of the pilot that is also the result of examination. **Proposal**: All persons involved in medical examinations, assessment and certification shall ensure that medical confidentiality is respected at all times. All medical records in hard copies or electronically stored should be securely held with accessibility restricted to authorised medical personnel. The results of medical examinations shall be submitted to the medical service of the competent authority. In EASA member states where medical confidentiality cannot be guaranteed on all administration levels all personal medical data of pilots shall be stored by AeMC´s , AME´s and GP`s and only the fit or unfit result of the medical investigation shall be transmitted to the licensing authority. Upon request by the competent authority AeMCs, AMEs and GMPs shall submit medical files, reports and any other medical data as required in an anonymous form to the authorized medical doctor of the competent authority for oversight.
response	*Noted*
	See comment No 236. Please note that the ICAO definition for 'Medical Assessor' will be added to Part AR to ease the understanding that a medical doctor is in the licensing authority.

comment	*1094*	comment by: *Moldavian Society of Aviation Medicine*
	Comment: Medical confidentiality should be better defined here as it is done in the AMC to Med.A.015. For compliance with ICAO requirements of Annex 1 1.2.4.6 Having completed the medical examination of the applicant in accordance with Chapter 6, the medical examiner shall coordinate the results of the examination and submit a signed report, or equivalent, to the Licensing Authority, in accordance with its requirements, detailing the results of the examination and evaluating the findings with regard to medical fitness. this paragraph should contain information to whom medical information should be available. In most countries this procedure is respected.	

	In the countries like Germany, where the transmission of medical data is forbidden the information could be limited to the statement of fitness or unfitness of the pilot that is also the result of examination. Proposal: All persons involved in medical examinations, assessment and certification shall ensure that medical confidentiality is respected at all times. All medical records in hard copies or electronically stored should be securely held with accessibility restricted to authorised medical personnel. The results of medical examinations shall be submitted to the medical service of the competent authority.
response	*Noted*
	See comment No 236.

comment	*1128*	comment by: *Keith WHITE*
	add "**except where, in pursuance of an investigation, medical records are requested by the appropriate national authority."**	
response	*Noted*	
	See comment No 236.	

comment	*1189*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Comment: Acceptable	
response	*Noted*	
	The Agency acknowledges your positive feedback.	

comment	*1303*	comment by: *Oxytrans*
	Comment: In EASA member states the competent authority or the licensing authority normally are no medical doctors. Due to national data protection laws and EU Directive 95/46/EC on protection of personal data, it is not allowed for medical doctors to submit personal data to an organisation where non medical personal has access to these data. Proposal: All persons involved in medical examinations and cerftification shall ensure that medical confitentiality is respected at all times. Medical records of any kind must be securely held with accessibility restricted to authorised medical personal.	
response	*Noted*	

	The second sentence of your proposal is included in AMC to MED.A.015.

comment	*1421*	comment by: *Julia WILKINSON*
	I think that GPs (in the UK) should carry out an LPL Medical. There are GPs available and easily accessible to everyone and the system is already in place. The LPL should also be based on the HGV and car driving standards.	
response	*Noted*	
	Thank you for the positive comment. The provision allowing GMPs to issue medical certificates for LAPL applicants is laid down in the Basic Regulation. It requires GMPs to have sufficient detailed knowledge of the applicant's medical background. A comparison with road traffic is not valid because in road traffic the 3rd dimension is missing and altitude can be a limiting factor in some medical conditions. The LAPL medical requirements will therefore not be based on the HGV and car driving standards.	

comment	*2194*	comment by: *David Johnstone*
	Requirement for LPL medical certificates - should be able to be carried out using the pilot's GMP	
response	*Noted*	
	Thank you for the positive comment. The provision allowing GMPs to issue medical certificates for LAPL applicants is laid down in the Basic Regulation. It requires GMPs to have sufficient detailed knowledge of the applicant's medical background.	

comment	*2254*	comment by: *Rudi Fecker*
	Im Hinblick auf die ärtzliche Flugtauglichkiet ist ganz offensichtlich die Fehlentwicklung der letzten Jahre erkannt worden. Es ist daher zu begrüßen, dass die sportmedizinischen Anforderungen an die Lizenzinhaber den tatsächlichen Erfordernissen angepasst werden sollen. Jeder Lizeninhaber ist sich der Verantwortung bewusst, die er beim Führen eines Luftfahrzeuges übernimmt; es wird also niemand ein Luftfahrzeug führen wollen, der Bedenken zu seinem Gesundheitszustand hat. Diese Feststellung untermauern Ergebnisse aus Flugunfalluntersuchungen in den europäischen Ländern, in denen ein Gesundheitsnachweis nur bei der Ersterlangung einer Lizenz gefordert wird.	
response	*Noted*	
	Safety in aviation is ensured by many different measures, one of them being a medical certificate for private and commercial pilots. The legal basis for the medical certificate is the ICAO SARPs and the EU Basic Regulation. The latter	

provides the possibility to draft licensing rules tailored to the complexity of the aircraft and the kind of operation which has specifically been done in the medical field for the private pilot community by creating the leisure pilot licence.

comment | 2373 | comment by: *ESAM and GAAME*

Subpart A

AMC to Med.A015

Datenschutz ist hier stark gefährdet, da hier nichtärztliche Personen Einblick in medizinische Akten erhalten, um Lizenz zu erteilen oder nicht zu bewilligen. Nach deutschem Recht ist das nicht möglich und wird von uns Fliegerärzten strikt abgelehnt. Die Entscheidung, ob aus flugmedizinischer Sicht geflogen werden darf und unter welchen Auflagen oder nicht, muß bei den AME/AMC verbleiben.

AMC to Med.A025

Hier kommt es zur Zuständigkeit von 3 damit befassten Stellen, die zu der medizinischen Tauglichkeit entscheiden, dem primär aufgesuchten GP, dann dem AME/AMC und der lizenzerteilenden Stelle. Die Entscheidung muß im zweifelsfall bei dem AME/AMC bleiben, da nur er flugmedizinischen sachverstand besitzt und dementsprechend die Risiken für die Allgemeinheit einschätzen kann. DEr GP hat nicht ausreichende Erfahrung, von der lizenzerteilenden Stelle darf man den nötigen Sachverstand nicht erwarten, der kann im Ausnahmsfall gegeben sein.

AMC to Med.A040

Diese Regelung ist mit deutschem Datenschutz, den alle Piloten und Fliegerärzte sehr hoch angesiedelt wissen möchten, unvereinbar.

AMC to Med.A045

Das flugmedizinische Zertifikat darf keine medizinischen daten enthalten, nur die nötigen Auflagen und Einschränkungen sowie die nächstfälligen und letzte Untersuchung.

AMC to Med.A050 3 i

Der EASA-Entwurf widerspricht der derzeitig gültigen Stichtagsregelung in Deutschland, diese sollte übernommen werden.

AMC to Med.A.050 4

Die LAPL-Laufzeiten gehen davon aus, dass man auf die gesamte medizinische Vorgeschichte wie in UK zurückgreifen kann, das ist in fast keinem europäischen Land der Fall und wird nach meinem Dafürhalten nicht anders werden, weil der Datenschutz immer höherrangig angesiedelt werden wird. Dementsprechend langfristig angesetzt die die Kontrolluntersuchungsfristen. Dabei dürften wesentliche Erkrankungen vor Lebebensjahr 45 wie MSD, Myocarditis und Diab.mell.I und früher Typ 2, HIV etc. erst mit 45 Jahren aufgedeckt werden und

der Pilot als großes Risiko für die Allgemeinheit herumfliegen. Vor 45 sollten alle 5 jahre, ab 45 J alle 2 Jahre und ab 60 J alle 6 bzw. 12 Monate Untersuchungen stattfinden.

AMC to Med.A.55 c

Die Beurteilung der Tauglichkeit von LAPL-Piloten durch medizinische Hilfseinrichtungen wäre hier möglich ohne entsprechenden Sachverstand zu den tatsächlichen Risiken.

Subpart B

AMC to Med.B.005

Bei jeder fliegerärztlichen Verlängerungsuntersuchung muß ein 12-Kanal-EKG als Mindeststandard geschrieben werden, sowohl bei Kl.1, als auch bei Kl.2.

Die "erweiterte kardiologische Untersuchung" sollte definiert werden mit Minimalstandards.

Der Lipidstatus ist als risiko sowohl bei Kkl.1 als auch bei Kl. 2 anzusehen und nicht erst ab 40Lj.

AMC to Med. B.010

Klasse 2-Piloten, da sie oft alleine fliegen, stellen ein wesentlich größeres Risiko für die Allgemeinheit dar, wenn sie plötzlich einen Asthmaanfall oder aufgrund respiratorischer oder obstruktiver Lungenerkrankung hypoxisch werden. **Eine komplette Lungenfunktion gehört zu jeder Verlängerungsuntersuchung!** Probanden können bei fehlender Klinik und Anamnese ent-
sprechend einschränkende Befunde vorweisen.

AMC to Med.B.020

Nicht jeder insulinpflichtige Diabetiker ist aufgrund heutiger Erkenntnisse der Diabetologie fluguntauglich.

AMC to Med.B.065

Zu den augenärztlichen Einschränkungen,Untersuchungsnotwendigkeiten etc. ist die Stellungnahme der augenärztlichen Fachgruppe, die Stellung bezogen hat, vollständig zu berücksichtigen**.**

Zusammenfassend wird hier nicht sinnvollerweise die Entscheidungskompetenz wieder von medizinischem Sachverstand auf lizenzerteilende Stellen, die sachinkompetent sind, verwiesen. Den erreichten Status, der sich zur Zufriedenheit aller Beteiligten eingestellt hat, sollte auch die EASA erhalten! dazu verweise ich auf den neu geregelten §24 c LuftVZO.

Subpart C

AMC to Med.C.010

Es graut mir vor der Zukunft, wenn Piloten von GP´s ihr Medical erhalten, die mangels Erfahrung und Kenntnissen über Luftfahrtmedizin und die speziellen Anforderungen ihr Medical ausstellen. Es reicht, wenn der Proband sich bückt, adaequat antwortet und die Schrift auf dem Monitor des Untersuchers erkennt, um ihm die Tauglichkeit zu attestieren.
Minimal sollte dazu ein AME berechtigt sein. Ausreichende eigene Flugerfahrung als Inhaber einer Lizenz, die man zumindest gehabt haben sollte, ist erforderlich.

AMC to MedC.020

Grundkurse und Refresherkurse für Flugmediziner, die von einer Authority anerkannt werden, sind von den anderen europäischen Authorities ebenfalls anzuerkennen. 20 Stunden innerhalb von drei Kalenderjahren sollten Grundlage zur Anerkennung sein.
1 Zeitstunde soltte international als Zeitstunde anerkannt werden.

Basiskurse sollten minimal 120 Stunden dauern und einen international einheitlichen Standard als Grundlage haben.

Subpart D

Ganz abgesehen davon, dass der GP für diese Aufgaben völlig ungeeignet ist, sollte die Minimalqualifikation des GP, falls er AME werden möchte, präziser definiert werden. Die von ihm getroffene Entscheidung, jemanden fliegen zu lassen und das evtl. aus Freundschaft oder Gefälligkeit als Hausarzt, beeinträchtigt das gesellschaftliche Risiko durch ein erhöhtes Flugunfallrisiko mangels gesundheitlicher Fittness.

Für mich ist es undenkbar, dass ein GP die berechtigung erhält, Piloten aus medizinischen Gründen das Fliegen zu ermöglichen. Sollte diese regelung umgesetzt werden, wird eine Klagewelle folgen, an der ich mich sicher beteiligen werde.

response *Noted*

AMC to Med.A015
Proposed rules require from all persons involved in aeromedical certification to strictly follow medical confidentiality principle. The text will be amended to clarify that the medical assessor will decide which persons may have access to medical data.
In addition, proposed rules give more responsibility to AMEs and AeMCs retaining the possibility for the licensing authority to review borderline cases.

C. Draft Opinion Part-MED — Subpart A: General Requirements — Section 1: General — MED.A.020: Medical certification p. 4

comment	36	comment by: *Johannes Niesslbeck*

I doubt that a medical certificate is useful for private pilots flying solo or with other pilots. Flying statistics prove, that there is no significant difference in the number of accidents or incidents, known in countries requiring a medical and countries, not requiring any medical.

AOPA published a study, saying just 0,33% of all aviation accidents had a medical reason. In the USA there is no medical required for private pilots - glider and recreational pilots, the number of accidents caused by medical reasons there, is even less than 0,33%.

So statistics say: The risk for an aviation accident or incident is slightly higher in countries, requiring a medical than in countries, not requiring any medical.

So please think it over, I request You to cancel the requirement of a medical for glider pilots and private pilots flying single engine piston planes with less than 2000kg.

Sehr geehrte Damen und Herren,
seit 1973 also mittlerweile 35 Jahre lang bin ich begeisterter Segelflieger und seit 30 Jahren Segelfluglehrer. 38 Jahre lang war ich Fluglotse und musste im Rhythmus von 2 Jahren ein fliegerärztliches Tauglichkeitszeugnis Klasse II vorlegen.
Im Gegensatz zu meiner beruflichen Tätigkeit, bei der ich eine medizinische Tauglichkeitsuntersuchung durchaus befürworte, ist mir der Sinn eines Medicals für Segelflieger, ja für Privatflugzeugführer nie so richtig klar gewesen. Segelfliegen ist mit Sicherheit für die Allgemeinheit bei weitem weniger gefährlich als z. B. die Teilnahme am Straßenverkehr mit einem Auto oder einem Fahrrad, ja selbst Fußgänger gefährden andere Verkehrsteilnehmer deutlich öfter als Segelflieger.
Warum also wird von diesen Verkehrsteilnehmern kein Medical, von Privatflugzeugführern aber sehr wohl?
In Deutschland führt dies gegenwärtig zu der absurden Situation, dass ein ansonsten gesunder Mensch der durch einen Eingriff mittels Laser seine Sehschärfe wiederherstellen lässt kein Segelflugzeug führen darf, in den USA aber mit dem gleichen Befund sogar für einen Einsatz als Astronaut tauglich ist.
Geschaffen wurde das Medical für Piloten ja anfänglich nur, um sicherzustellen, dass Anwärter auf eine Militärpilotenlaufbahn nicht in die teuere Ausbildung gelangen, die sich später vielleicht den Anforderungen aus gesundheitlichen Gründen nicht gewachsen zeigen. Das Verkehrsflugzeugführer einer gesundheitlichen Kontrolle unterliegen ist für mich durchaus ebenso nachzuvollziehen, bei Privatpiloten fehlt mir dafür jedes Verständnis. Solange man es nicht für erforderlich hält, allen Verkehrsteilnehmern ein Medical abzuverlangen, ist auch ein solches für Privatpiloten nicht erforderlich. Der einzige nachvollziehbare Grund für ein solches Medical ist meines Erachtens das wirtschaftliche Interesse der Fliegerärzte. In Deutschland geht es dabei immerhin um etwa 35.000 Privatpiloten, die im Schnitt alle 2 Jahre ca. 100 Euro hinlegen müssen, um sich bestätigen zu lassen, dass sie relativ gesund sind, macht also etwa 1.750.000 Euro jährlich aus. Diese Geldquelle würde mit der Abschaffung des Medicals für Privatflugzeugführer versiegen und das alleine ist der Grund für den Widerstand der Flugmediziner.

	Was hofft man mit der Vergabe eines Medicals nun wirklich zu verhindern? Mögliche Gründe: Absturz eines Leichtflugzeuges, verursacht durch den Ausfall des Piloten aus medizinischen Gründen. Solche Flugunfälle (nicht nur Abstürze) passieren nach einer Studie der AOPA nur in 0,36% aller bekannten Flugunfälle. · Gleichzeitig stellt die FAA für die USA fest: Im Zeitraum von 1990 - 2000 passierten in den USA 609 Flugunfälle von Segelflugzeugen und Ballonen. Für diese Lizenzen braucht man in den USA KEIN Medical. Lediglich in 2 Fällen, also bei 0,33% aller Unfälle war die Ursache ein Ausfall des Piloten aus medizinischen Gründen (meistens Herzanfälle). Dritte wurden dabei in keinem Fall geschädigt. Das Risiko ist also, wenn überhaupt vorhanden, beschränkt auf die Piloten selbst, Dritte müssen keinerlei Befürchtungen haben, durch einen solchen Unfall in Mitleidenschaft gezogen zu werden. Das Risiko von einem Autofahrer überfahren zu werden, der am Steuer seines Autos einen Herzinfarkt erleidet, ist um ein zigtausendfaches größer! Im übrigen möchte ich noch auf das Ihnen sicher bekannte Schreiben von Herrn Dr. Claus Zink hinweisen, in dem sehr ausführlich begründet wird, warum ein Medical für Privatpiloten keinerlei praktischen Nutzen hat und daher ersatzlos gestrichen werden sollte. Mit freundlichen Grüßen Johannes Nießlbeck
response	*Noted*
	Safety in aviation is ensured by many different measures, one of them being a medical certificate for private and commercial pilots. The legal basis for the medical certificate is the ICAO SARPs and the EU Basic Regulation. The latter provides the possibility to draft licensing rules tailored to the complexity of the aircraft and the kind of operation which has specifically been done in the medical field for the private pilot community by creating the leisure pilot licence. It is not possible, for safety and legal reasons, to abolish the medical certificate for private pilots. For glider pilots please refer to ICAO Annex 1, Section 2.9. Glider pilot licence, paragraph '2.9.1.5: An applicant shall hold a current Class 2 Medical Assessment'.

comment	*42*	comment by: *Helmut Dantz*
	"Medical" für LPL (leisure pilot license) also für Segelflieger (Gliderpilots, sailingplane pilots) sollte komplett gestrichen werden. Ein Führerscheininhaber ,Fahrradfahrer oder Gabelstaplerfahrer benötigt auch kein "Medical", hat aber ein vielfach höheres Risiko, seine Mitmenschen erheblich zu verletzen. Ein Segelflieger, der sich nicht fit fühlt, würde kaum starten ... der Flug würde ihm keinen Spaß machen. Mir ist kein einziger Fall bekannt, wo ein Segelflieger infolge gesundheitlicher Probleme andere Menschen gefährdet hat. Für Segelflieger müßte reichen, daß jeder Allgemeinmediziner ein einmaliges Attest ausstellen kann, welches einen normalen Gesundheitszustand bescheinigt. Das Medical für Segelflieger ist ein Relikt aus der Hitlerzeit, wo Segelflieger allzu oft zu Kampfpiloten umfunktioniert wurden. Diese üble Zeit haben wir gottlob	

	hinter uns.
response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*46*	comment by: *Bernhard Blasen*
	for Microlight plane, Glider plane and single engine plane licences a medical should not be necessary at all. There are many reasons for that: 1. There is no study, investigation or something else proving that a medical can prevent accidents. A AOPA study showed, that accident rates are not higher in countries not requiring a medical than in those where a medical is mandatory. 2. Accidents where a medical reason could be considdered as reason are so rare, that there is no need to make a medical mandatory. According to BFU accident report 2005 there is no(!) accident with medical reasons listed in private aviation activities whereas in commercial aviation several incidents took place, where one of the crew had severe medical problems during flight. Obviously there are cases in commercial aviation where pilots fly without being totally sane whereas in private aviation such cases play no role at all. The motivation for flying a plane is different if you do it for leisure or for business! So for private aviation a self declaration together with the confirmation of a normal medical practioneer is sufficient at all. 3. The risk for damage caused by accidents with Microlight planes, glider planes, single engine planes is not higher than the risk caused by cars in daily traffic situations (and much less than that caused by trucks, vans or even heavy SUVs). There is no example where a person outside a plain was hurt or even threatened by an accident caused by such kind of aircraft. Looking at the accident on August, 17th, 2008 in South Germany where a Single engine plane crashed in the wires of a power line one can see, that damages caused by light aircraft are not fatal for most of the environment.	
response	*Noted*	
	Please refer to response to comment 36 in this segment.	

comment	*55*	comment by: *MartinFeeg*
	It came to my attention that medicals similar to JAR-FCL are to be put into place under EASA. Whilst these medicals make sense for aircrew they don't hold value to protect aircrew or public in case of recreational aviation. I am sure you are aware of the American study which proves more accidents take place on the way to and from the airfield than while committing aviation. Great Britain and Australia only require a statement of the pilot and, again no significant accidents related to medical conditions are reported. (Currently I am living in Australia, prior I have been living in the UK and will soon return to Germany.) Sanctioning those medicals are an unnecessary burden for authority and aviators	

	like wise (time, financial and recruitment of new pilots) with no gain for the public. Hence I urge EASA to follow the British regime. If you should need copies of the study or rules I am referring to please don't hesitate contacting me.
response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*60*	comment by: *Rudolf Goebel*
	Das Medical für Segelflugpiloten muss ersatzlos gestrichen werden. Es dient lediglich einer Fliegerarzt-Lobby, aber nicht der Sicherheit. Begründung: Was soll das Medical verhindern ? Wen soll es schützen ? Welches Risiko soll es abwenden ? Der Anteil der Segelflugunfälle, die auf medizinischen Ursachen basieren, beträgt weniger als ein halbes Prozent. Der Segelflugpilot würde bei einem Start trotz medizinischer Nichttauglichkeit lediglich sich selbst in Gefahr bringen. Der Selbsterhaltungstrieb würde einen Start unter diesen Umständen jedoch extrem unwahrscheinlich machen. Die Wahrscheinlichkeit der Gefährdung eines Fremden durch den Absturz eines Segelflugzeugs mit einem medizinisch nicht tauglichen Piloten (Herzinfarkt -der meist vorher gar nicht erkannt wird-, Bewusstseinstrübung oder ähnliches) ist noch einmal verschwindend gering. Ernst zu nehmende Statistiker haben ermittelt, dass ein solcher Vorfall **einmal in 3000 (dreitausend) Jahren** geschehen könnte. Die Gefährdung anderer Menschen z.B. durch nicht fahrtaugliche Kraftfahrer ist extrem ungleich höher, aber hier werden medizinische Tauglichkeitsuntersuchungen nicht einmal angedacht, geschweige denn geplant oder praktiziert. Wohlgemerkt, ich spreche nicht von Berufspiloten oder Bus- und Taxifahrern mit Personentransport, sondern von Segelflugpiloten, die allein oder allenfalls zu zweit unterwegs sind (was die Sicherheit wieder drastisch erhöhen würde). Sollte ein Segelflieger einmal Zweifel an seiner Flugtauglichkeit haben, reicht es aus, wenn er sich bei seinem Hausarzt rückversichert, der seinen Gesundheitszustand wegen der bekannten "Krankheits"-geschichte in der Regel besser beurteilen kann als eine fliegertaugliche Untersuchungsstelle, die in irgendwelchen regelmässigen Abständen eine Untersuchung für die Zukunft vornimmt. Und dies wird ein verantwortungsbewusster Pilot mit seinem gesunden und natürlichen Selbsterhaltungstrieb (und dazu zähle ich alle Segelflugpiloten) tun. Letzlich ist das Leben lebensgefährlich. Die Risiken für sich selbst und für Mitmenschen sind im Alltag, im Straßenverkehr, im Haushalt, im Job oder im Urlaub deutlich höher als beim Segelfliegen ohne Medical. Ebenso unsinnig ist die ZÜP nach §7 LuftSiG, mit der man keinen einzigen Terrorakt und auch sonst gar nichts verhindern kann, was andere gefährden könnte. Man tut so, als könne man einen Bankraub verhindern, wenn man ein Halteverbot vor der Bank einrichten würde. Aber das ist ein anderes Thema.	

Dipl.-Ing. Rudolf Goebel
Inhaber JAR-FCL PPL A und C, FI für A und C sowie zahlreiche (fast alle) Berechtigungen für Privatpiloten, Ges.Flugzeit > 7100 h als PPL-Inhaber

response

Noted

Please refer to response to comment No 36 in this segment.

comment

129 comment by: *Markus Gayda*

In my humble opinion the requirement for a medical for glider pilots is heavyly "over the top".
Until now **no accidents** with harm to other people were caused by a medical incident by glider pilots.

The requirements for medicals for glider pilots are unneccessary.
Especially if you consider the dangers in automobile usage which is NOT reglemented by any medicals. THERE the danger is exponentially higher to cause unwanted damage to third persons if you are medically unfit.
But action is not taken.
So why take action against a **proven undangerous** group (the pilots)?

Sincerely
Markus Gayda

response

Noted

Please refer to response to comment No 36 in this segment.

comment

160 comment by: *Schwarz, Wolfgang*

Ich spreche mich gegen die MED.A.020 b aus. Ich lehne ein generelles Medical für Segelflieger ab, weil hierdurch die Sicherheit für Piloten und Unbeteiligte in keiner Weise erhöht wird. Unfälle mit Segelfliegern aufgrund medizinischer Probleme treten sowohl bei uns (D) als auch in Ländern ohne Medical nicht bzw. überhaupt nicht auf. Mir ist kein Fall bekannt. Hierzu führt vermutlich die Tatsache, dass Segelfliegen ein Freizeitsport ist und sich Piloten, die sich nicht gesund fühlen auch nicht ins Cockpit setzen. Man sollte daher der Eigenverantwortung auch eine Ihrer hervorragenden Funktion entsprechenden Gewichtung und Bedeutung zukommen lassen.

Ich schließe mich ausdrücklich der von C-D Zink geäußerten Wahrscheinlichkeitsrechnung für die Verletzung von Unbeteiligten bedingt durch gesundheitliche Ausfälle an. Diesbezüglich möchte ich aus einem aktuellen Fall ergänzen, dass ein kerngesunder 25-jähriger aus formalen Gründen noch nach der Erstuntersuchung zum Augenarzt und zum HNO-Arzt geschickt wurde. Hierbei ist die statistische Wahrscheinlichkeit vermutlich höher, dass er auf dem Weg zu den ganzen Ärzten sich oder jemand anderen im Straßenverkehr verletzt, als einen Flugunfall aufgrund von Gesundheitsproblemen verursacht. (egal ob mit oder ohne Medical)

	Darüberhinaus schadet der Aufwand, die Kosten und die hiermit verbundene Bürokratie massiv dem Segelflugsport und natürlich auch der EASA.
response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*161*	comment by: *Hans Peukert*
	Glider Pilots / Leisure Pilots shall not have more medical requirements than car drivers / bus drivers. There is more danger from car drivers in the public than from Leisure Pilots.	
response	*Noted*	
	Please refer to response to comment No 36 in this segment.	

comment	*162*	comment by: *Eberhard Lulay*
	There is no need for a medical certificate for a LPL and PPL. Researches and studies (AOPA-USA, the Beklas-studies and others) prove this factum. First evidence was given in Great Britain in the last Fifties published by Ph. Wills, a famous British glider pilot. The history of medical certifacates goes back to the need of medical examinations esspecially for fighter and airline piliots. I agree to this. The training (education) of professional-, leisure- and private- pilots should concentrate on Human Factors. A passenger of an airliner is confident into the knowledge and the social competence of the cockpit-crew. Sometimes we cannot rely on this basics. Professional pilots are often urged to to do their job ,when they feel unwell or indisposed. A leisure pilot and a private pilote is not forced to fly, when he doesn't feel well. He has the liberty of decision to say "no". Nearly all fatal accidents are based on less training, less self-responsibility, unsufficient social criteria and technical reasons. Best regards Eberhard Lulay Nachtrag: Wie kürzlich errechnet, liegt die Unfallwahrscheinlichkeit im Bereich des Segelflugs bei 1:1000, die Wahrscheinlichkeit, dass Dritte zu Schaden kommen, gesc hätz bei 1.1 000 000. Flugunfälle passieren laut AOPA Studie der USA zu 0,3 %. D er Jahrebericht 2007 der BFU weist bei Unfällen und schweren Störungen beim Betrieb ziviler Luftfahrzeuge (Seite 4) für Segelflugzeuge 92 Unfälle auf. Als Unfallursache werden weder technische Gründe beim Segelflugzeug noch medizinische Ursachen aufgeführt. Das Kreissektorendiagramm der Seite 3 unterstreicht, dass die Unfallursachen ausschließlich im Bereich der Human	

	Factors zu suchen sind. Auch aus diesen Gründen halte ich ein Medical für obsolet.
response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*173*	comment by: *Thorsten Böttjer*
	Hiermit spreche ich mich gegen MED.A.020 b aus. Ich denke der Segelflugsport benötigt, wie in anderen Ländern (USA, England) kein MEDICAL. Es ist meiner Meinung nach problemlos, Piloten die diesen Sport ausüben möchten nach einer Eingangsuntersuchung auf rot grün blindheit etc. ohne weitere Kontrolle fliegen zu lassen (wie es auch im UL und Paragliderspor bisher der Fall ist). Weiterhin ist natürlich zu beachten das die jetzigen Fliegerärzte entlastet würden um die wirklich zu prüfenden Piloten aus der gewerblichen Fliegerei und dem Militär zu untersuchen. Damit möchte ich sagen das ich es jedem Allgemein Mediziner zutraue die Eingangsuntersuchung, abgesehen von den Augenärztlichenuntersuchung, vozunehmen. Die völlig überhöhten Preise der Fliegerärzte sind um ein Hobby zu betreiben einfach zu hoch und unnötig, die dort durchgeführte Untersuchung ebenso. Untersucht zu werden wie jemand der täglich mehrere hundert Leuten rund um die Welt befördert steht in keinem Verhältnis zum HOBBY Segelfliegen.	
response	*Noted*	
	Please refer to response to comment No 36 in this segment.	

comment	*178*	comment by: *Jürgen Vad*
	Die medizinische Tauglichkeitsuntersuchung ist immer nur eine Momentaufnahme, die nur Krankheiten aufdecken kann die jedem Piloten selbst sicher längst bekannt sind. Das Gefährdungspotenzial durch kurzfristig auftretende akute Erkrankungen kann damit niemals erkannt werden, ist jedoch nach meiner Einschätzung wesentlich größer. Es liegt nach wie vor in der Eigenverantwortung jedes Piloten ob er mit einer akuten Erkältung oder Grippe ein Flugzeug besteigt. Das hat auch in der Vergangenheit bereits bestens funktioniert. Jeder Pilot muß in regelmäßigen Abständen seine Fähigkeit ein Flugzeug zu führen gegenüber einem Examiner oder Fluglehrer nachweisen. Dies sollte Gelegenheit genug sein "Gefahren für die Allgemeinheit" nicht nur aus medizinischen Gründen aus dem Verkehr zu ziehen. Ein Medical stellt in meinen Augen nur ein Feigenblatt dar, das unnötige Kosten verursacht und in der Sache sehr wenig bringt.	
response	*Noted*	
	Please refer to response to comment No 36 in this segment.	

comment	*199*	comment by: *Uwe Lorenz*
	Segelflieger und Piloten von Leichtflugzeugen (max. 2 Mann Besatzung) sollten	

	auch ohne Medical fliegen können. Lt. AOPA Studie sind in Ländern die kein Medical haben (USA, Schweiz) die Unfallzahlen auch nicht höher, im Gegenteil manchmal sogar geringer. Im nichtkommerziellen Bereich wird nur geflogen weil es Spaß macht. Und wer krank ist dem macht fliegen keinen Spaß. Vor dem 2. Weltkrieg wurde auch ohne Medical geflogen. Dies wurde nur eingeführt, um die Piloten in Jagdflieger, Bomberpiloten usw. einzuordnen. Dieses Relekt aus dem 3.Reich gehört für Sportpiloten die noch nicht mal Kunstflug machen wollen ersatzlos gestrichen, eine allgemeine Gesundheitsuntersuchung beim Hausarzt zu Beginn der Ausbildung sollte reichen.
response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*200*	comment by: *Hans Jürgen Schmidt*

Kommentar zur medizinischen Tauglichkeitsprüfung:

Sehr geehrte Damen und Herren,

zunächst möchte ich Sie mit folgenden Fakten konfrontieren:

Europa hat eine Fläche von 10.180.000 km². Mit 680.000.000 Einwohnern kommt man auf 65 Einwohner pro Quadratkilometer. Die Wahrscheinlichkeit, bei einem Absturz einen Menschen zu verletzen ist also erheblich geringer, als würde der potenzielle Unfalverursacher - erfolgreich druch einen Fliegerarzt um seine Lizenz gebracht, seine medizinische Beeinträchtigung im Straßenverkehr erleiden. Dieses Risiko ist durch die Eindimensionalität der Straße gegen über der Zweidimensionalität bei einem Absturz oder der Dreidimensionalität bei einem Luftzusammenstoß Milliarden mal größer. Aber selbst die auf der Straße passierenden Unfälle werden nach allgemeiner Darstellung der Medien von weiten Teilen der Bevölkerung getragen.

Aber *nur zu ca. 0,3 % (durch die AOPA-Studie und Nall-Report bewiesen) aus medizinischer Ursache; AOPA, dort der 9. Artikel.*

der Flugunfälle passieren aus medizinischen Gründen. Wenn sich hieraus Fragen bezüglich der weltweiten Flugunfälle ergeben, wären hierzu weitere Untersuchungen notwendig.

Bei 100 jährlichen Segelflugunfällen ist meines Wissens kein einziger tödlicher Unfall aus medizinischen Gründen erfolgt.

Folgende Studien untermauern die oben geführte Risikoabschätzung statistisch:
http://www.daec.de/flusi/downfiles/Beklas/BEKLAS_Abschlussbericht.pdf

http://www.aviation-civile.gouv.fr/html/avia_leg/pdf/Rapport_senateur_belot.pdf

Historisch scheint mir die Förderung des Segelfluges einen Teil seiner Wurzeln in der Rekrutierung von Militärpiloten begründet. Damit ist auch klar, dass man versucht, die Förderung in geeignete und damit gesunde, junge Menschen zu

	investieren, woraus sich die Gründe für die Einführung eines Medicals ableiten lassen. Meines Erachtens ist diese Beründung für Medicals nicht mehr gegeben. Selbst die Vereinigten Staaten, ein denen häufig Sicherheitsaspekte bis ins kleinste umgesetzt werden, haben bisher keine Notwendigkeit eines Segelfliegermedicals gesehen. Andere Länder (England, Schweiz)haben aus ihren positiven Erfahrungen heraus meines Wissens auch kein Medical eingeführt. Zum ausfüllen einer Self-Declaration nach Dr. Hunter sehe ich mich aufgrund fehlender Medizinischer Kenntnisse außer Stande. Ich fürchte, dass sich Ärzte nur schwer bereiterklären, ein solches dokument auszufüllen, was dazu führt, dass die Fliegerärtez uns wieder zur Kasse bitten. Da sich die meisten Krankheiten wohl ankündigen, scheint mir eine Erklärung des Hausarztes ausreichend, dass ein plötzlicher Ausfall aufgrund des Gesundheitszustandes nicht zu erwarten ist. Ich hoffe auf eine Streichung des Medicals für Segelflieger und Danke Ihnen für Ihre Aufmerksamkeit. Mit freundlichen Grüßen, Dr. rer. nat. Hans-Jürgen Schmidt
response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*201*	comment by: *Christian Schebitz*
	Ich lehne ein "Medical" für Segelflieger grundsätzlich ab. Gründe: 1. Weder Autofahrer, noch Motorradfahrer, geschweige denn Berufskraftfahrer benötigen ein Medical, obwohl die Wahrscheinlichkeit eines Unfalls mit tödlichen Folgen für andere Verkehrsteilnehmer ungleich höher ist als bei einem Segelflieger, welcher allein in der Luft fliegt und zu Start und Landung eine riesige, freie Piste zur verfügung hat. 2. Der Grundsatz der Gelichbehandlung verbietet - auch unter o.g. Gesichtspunkten ein Medical. 3. Ein Gesundheitscheck bei einem Sportmediziner ist eher angemessen und ausreichend. Um dem nachvollziehbaren Bedürfnis der Öffentlichkeit nachzukommen und den bereits beschlossenen Grundprinzipien der EASA zu genügen, würde für Segelflieger auch eine einfachste Untersuchung von einem Allgemeinarzt genügen, in der Arzt und Pilot bestätigen, dass keine zu plötzlicher Handlungsunfähigkeit führenden Krankheiten bekannt sind. 4. Kein Segelflieger geht in die Luft, wenn es ihm schlecht geht, denn in erster Linie will er Spaß haben. Oder er landet, wenn es ihm plötzlich schlecht geht. 5. Ein gültiges Medical würde ohnhin nicht verhindern können, dass ein mitterweile kranker Pilot fliegt, wenn er es wollte. Es verhindert ja auch nicht dass ein betrunkener Verkehrsflugzeugführer fliegt, wie es aus meiner eigenen Erfahrung täglich hunderte Male vorkommt.	

response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*202*	comment by: *Bernd Schwehm*
	Betreff MED.A.020.b: Ich halte die Forderung nach einem Medical für alleinfliegende Segelflieger für völlig überzogen. Die angelsächsischen Staaten wie auch die Schweiz haben da eine realisitischere Einschätzung der Gefährdungslage. Denn nichts anderes kann die Forderung einer Begutachtung durch einen Fliegerarzt jeglicher Couleur sein, eine Risikominderung der durch die Fliegerei für die Allgemeinheit drohenden Gefahr. Auch in Deutschland hat es meines Wissens noch keinen Fall gegeben, dass ein aus medizinischen Gründen handlungseingeschränkter- oder unfähiger Pilot mit seinem Segelflugzeug eine Dritte Person verletzt/geschädigt hat. Dies bei der hohen Bevölkerungsdichte in Europa und der höchsten Segelflugzeug-Dichte der Welt! Auch der Vorschlag einer gemeinsamen Erklärung von Hausarzt und Pilot zum Gesundheitszustand zielt leider fehl, da sich kein Mediziner ohne eingehende Untersuchung diesen Schuh (diese Verantwortung) anziehen wird. Wenn, dann kann sich eine Einfache Erklärung nur auf den Ausschluss von zur plötzlichen Handlungsunfähigkeit führenden Krankheiten beziehen. Wir bilden unseren Segelflieger-Nachwuchs in einem komplexen Umfeld zu verantwortungsbewussten Luftfahrzeugführern aus. Man sollte ihnen auch zutrauen die Gefährdung für sich und die Umwelt durch Krankheiten richtig einzuschätzen und einen Allgemeinmediziner aufzusuchen.	
response	*Noted*	
	Please refer to response to comment No 36 in this segment.	

comment	*204*	comment by: *Wilfried Müller*
	Ladies and Gentlemen, I would like you to reconsider the demand for a „Medical" for glider pilots SPL. Decades of experience in the USA and Switzerland have not given any evidence that medical malfunction of a glider pilot has caused casualties to bystanders or general public. A glider pilot will not enter his or her sailplane, if he or she fells indisposed. This is also my personal experience with young and elderly glider pilots I have trained over many decades as honorary flight instructor gliding. Personally I do believe that a glider pilot should be physically and mentally fit when flying a sailplane, similar to any driver or cyclist on the road. This can be easily monitored by using the UK – based medical for glider pilots. A General Practitioner and the pilot sign a declaration stating the pilot's medical	

fitness: **No medical deficiencies are known that could lead to a sudden inability.** This declaration should every five years be renewed.
Finally, I would like your organisation EASA to take a fresh look to the future of gliding and shed the ballast of old fashioned regulations.

Thank you for your cooperation

Wilfried Müller

Königswinter, 08-28-2008

Further, I would like you to take a similar approach to the LPL Medical using the above mentioned proposal as the one made for SPL.
Thank you

Wilfried Müller 11-22-2008

response *Noted*

Please refer to response to comment No 36 in this segment.

comment *211* comment by: *Bernd Schober*

Sehr geehrte Damen und Herren,
vorneweg möchte ich bemerken, dass ich alle Argumente meines Segelfliegerkameraden Claus-Dieter Zink in vollem Umfang unterschreiben kann. Deshalb ist es müßig, sie hier zu wiederholen.
Nach mittlerweile mehr als 20 Jahren und ca. 1300 Stunden Flugerfahrung mit Segelflugzeugen und Motorseglern kann ich zum Thema Medical zweierlei feststellen und erlaube mir im Nachtrag, dies zu verallgemeinern:
Das zweijährige Intervall der fliegerärztlichen Untersuchung bot mir in den ersten Jahren als relativ junger Mensch die Chance auf eine umfassende medizinische Untersuchung. Überrascht hat mich das jeweilige Ergebnis in keinem einzigen Fall. Wenn ich mich gesund fühlte entsprach dies auch dem Untersuchungsergebnis, eine Erkältung oder vergleichbar geringe Erkrankungen schlugen sich ebenso im Protokoll wieder. Für die Flugtauglichkeit hat es bei mir immer gereicht, und wird es bei Menschen, die sich gesund fühlen ebenfalls tun. Wer schon ein gesundheitliches Leiden hat, muss nicht erst durch den Fliegerarzt darauf hingewiesen werden.
Zweitens: Die fliegerärztlichen Untersuchungen (bei mir immer im Herbst) waren immer eine Momentaufnahme und hatten keine Aussagekraft auf den physischen Zustand während der Flugsaison. Also bin ich immer nur dann ins Cockpit gestiegen, wenn ich mich fit genug gefühlt habe und ich dazu Lust hatte. Mit dieser Strategie bin ich viele Jahre gut geflogen und werde auch weiter so verfahren. Segelfliegen ist schließlich eine Freizeitbeschäftigung und keine erzwungene Fortbewegungsart. Beim Auto sieht es zugegebener Maßen manchmal etwas anders aus, aber da kann man im Zweifelsfall kurz rechts ranfahren und benötigt außerdem kein Medical!
Als fairen Kompromiss kann ich mir vorstellen, dass jeder Segelflieger innerhalb eines bestimmten Intervalls einen Arzt seines Vertrauens aufsucht und sich nach einem definierten Kriterienkatalog untersuchen lässt. Jedem Segelflieger darf so viel Kompetenz zugemutet werden, an Hand des Untersuchungsergebnisses und

	nach einem Gepräch mit dem Arzt selbst zu entscheiden, ob er noch flugfähig ist oder nicht. Die Statistik, die Herr Zink diesbezüglich erläutert hat und die Erfahrungen anderer Länder sprechen eindeutig dafür. Die direkte Folge ist eine erhebliche Entbürokratisierung. Bürokratische Hürden, die erst gar nicht aufgebaut werden, müssen auch nicht unter Jammern und Zähneklappern der damit Betrauten eingerissen werden. In der Hoffnung, Ihnen bei der Entscheidungsfindung für die neue EASA-Segelfluglizenz geholfen zu haben verbleibe ich mit freundlichen Grüßen Bernd Schober.
response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*214*	comment by: *Christoph Kossira*
	Der Pilot eines Segelflugzeuges braucht meiner Meinung nach keine flugmedizinische Tauglichkeitsuntersuchung, da mir aus Ländern ohne diese Vorschrift (z.B. USA) keine Unfälle aufgrund von medizinischer Untauglichkeit des Piloten bekannt sind. Viel mehr muß man die Eigenverantwortung des Piloten stärken, da auch bei Besitz einer flugärztlichen Tauglichkeitsbescheinigung temporäre gesundheitliche Einschränkungen bestehen können, z.B. eine starke Erkältung o.ä. ,mit denen niemand fliegen sollte. Im Übrigen nehme ich Bezug auf die diesbezügliche Meinung von Dr. Claus-Dieter Zink.	
response	*Noted*	
	Please refer to comment No 36 in this segment.	

comment	*215*	comment by: *Diether Memmert*
	Betreff: MED.A.020 (b) und (c), sowie MED.A.055 (a) lit.3, 4 und 5 Sehr geehrte Damen und Herren von der EASA, wir reden hier doch ausschließlich von Sicherheitserfordernissen gegen Dritte, die jedoch dem Grundsatz der Verhältnismäßigkeit entsprechen müssen. Es gibt eben keinerlei Statistiken, Untersuchungen oder fundierte Erkenntnisse, die es erforderlich machen, daß auch Segelflieger zur Vermeidung von Gefahren gegenüber unbeteiligten Dritten ein Pflicht-'medical' brauchen. Segelflieger sind in dieser Hinsicht mit gewerblichen Motorfliegern oder gar Verkehrspiloten auf Grund ihrer speziellen Betriebserfordernisse überhaupt nicht zu vergleichen. Sie wissen sicher mindestens so gut wie ich, daß sämtliche Unfalluntersuchungen von AOPA/FAA, BEKLAS, Rapport-Sénateur-Belot, Schweiz und UK zeigen, daß generell medizinische Ursachen bei Flugunfällen wesentlich unter 1% und demgemäß Gefährdungen unbeteiligter Dritter noch mehrere Zehnerpotenzen darunterliegen. Dabei liegen die Unfallraten mit medizinischem Hintergrund bei Piloten mit 'medical' aber noch über denen der Piloten, die kein 'medical' absolvieren mußten. Diese 'medicals' Segelflug sind ein Relikt aus der unseligen Zeit, wo zu	

militärischen Zwecken auch "die Deutschen ein Volk von Fliegern werden sollten". Der andere Grund sind möglicherweise die Fliegerärzte, die natürlich nicht mehr auf die gewohnten Einkünfte verzichten wollen, ohne aber eine 100%ige Garantie bieten zu können, daß bis zur nachfolgenden Untersuchung keine gesundheitlichen Beeinträchtigungen auftreten werden. D.h. diese Untersuchungen sind ausschließlich Geldschneiderei, bieten aber keinerlei Sicherheitsgewinn.
Es reicht ganz sicher nach Einmaluntersuchung zu Beginn der Ausbildung, wenn Pilot und Hausarzt periodisch bestätigen, daß keine zu plötzlicher Handlungsunfähigkeit führenden Krankheiten bekannt sind!
Außerdem, wie war das eigentlich mit der Eigenverantwortung des mündigen Piloten? (s. MED.A.025 (a)!)

Falls Sie aber trotzdem auf Nachuntersuchungen nicht glauben verzichten zu können, so könnte allenfalls eine an den Erfordernissen für gewöhnliche Autofahrer orientierte Vorgehensweise infrage kommen.

Im Neuanfang des vereinten Europa sollten Sie endlich die Konsequenzen ziehen und auf diese nutzlosen, teuren und überholten Zöpfe verzichten, die keinerlei Sicherheitszuwachs bringen. Das Geld sollte man lieber in mehr Flugpraxis stecken.

Mit freundlichen Grüßen
Dipl.-Ing. TU Diether Memmert, Segelflugpilot seit 1953 mit > 8500 Segelflugstunden.

NUR ZUR ERINNERUNG: AOPA News August 2002
MEDICAL CERTIFICATION: DOES IT PREVENT ACCIDENTS?
A just-completed AOPA Air Safety Foundation analysis of U. S. accidents caused by medical problems shows no meaningful correlation between FAA medical certificate requirements and GA accident rates.

ASF researchers analyzed 37,946 general aviation accidents that occurred from 1983 - 2000, involving fixed wing aircraft under 12,500 pounds gross weight and operated under FAR Part 91 general flight and operating rules. All such aircraft require a valid FAA medical certificate for the pilot in command. Of that total, they found 137 accidents caused by medical incapacitation, for a rate of just 0.36%, slightly over one-third of one percent (heart attacks were the most common accident cause.)

A similar study conducted by the FAA of accidents in gliders and balloons (whose pilots are *not* required to have a valid medical certificate), found only two medically-induced accidents in the ten-year period from 1990 - 2000. With a total of 609 glider and balloon accidents shown in the ASF database for that period, the no-medical-certificate required rate works out to 0.33%, slightly *lower* than that for pilots requiring an FAA medical certificate.

ÄNDERUNGEN
Neufassung von (b):
Applicants for and holders of a leisure pilot licence(LPL) shall hold a valid LPL medical certificate.

Inhaber einer LPL(S) und/oder TMG benötigen lediglich in fünfjährigem Turnus eine auch vom Inhaber unterschriebene Bescheinigung des Hausarztes, daß keine zu plötzlicher Handlungsunfähigkeit führenden Krankheiten bekannt sind.

Neufassung von (c):
Applicants for and holders of a private pilot licence(PPL) shall hold a valid class 2 medical certificate.

Inhaber einer SPL und/oder TMG benötigen lediglich in fünfjährigem Turnus eine auch vom Inhaber unterschriebene Bescheinigung des Hausarztes, daß keine zu plötzlicher Handlungsunfähigkeit führenden Krankheiten bekannt sind.

*Ebenso sind **MED.A.055 (a) lit.3, 4 und 5** entsprechend zu ändern.*

response

Noted

Please refer to response to comment 36 in this segment.

comment

218	comment by: *Kurt Sautter*

Seit über 40 Jahren betreibe ich den Segelflugsport. Nachdem nachweislich wegen medizinischer Mängel noch kein Dritter zu Schaden gekommen ist, halte ich die fliegerärztliche Untersuchung für Segelflieger für überflüssig. Dies belegen ja auch Statitiken aus den USA wo keine Untersuchung erforderlich ist.
In einem vereinten Europa müssen die gleichen Regeln für alle gelten,
Radfahren, Autofahren o.ä. ist für Dritte sicherlich gefährlicher als der Segelflugsport. Dies soll und muß bei weiteren Überlegungen doch seine Berücksichtigung finden.

Kurt Sautter

response

Noted

Please refer to response to comment No 36 in this segment.

comment

219	comment by: *Edgar Uekoetter*

Sehr geehrte Damen und Herren,

das medical für Segelflieger entbehrt jeglicher Grundlage. Es ist nicht nachvollziehbar, warum gerade Segelflieger eine regelmäßige, amtliche Gesundheitsprüfung über sich ergehen lassen müssen, obwohl durch (kranke) Segelflieger keine Gefahr ausgeht. Es setzt sich kein Segelflieger, der sich gesundheitlich nicht fit fühlt in ein Flugzeug. Das kann ich als Fluglehrer und seit 35 Jahren Segelflieger gut beurteilen.
Im Straßenverkehr ist es z.B. üblich, dass wenn man sich nicht wohl fühlt, mit dem Auto zu Arzt fährt, um sich dort untersuchen zu lassen. Dieses ist um ein Vielfaches gefährlicher, da hier die Gefahr viel größer ist einen anderen Verkehrsteilnehmer zu gefährden als in der Privatfliegerei.
Die Wahrscheinlickeit, wenn sich dennoch ein Segelflieger in das Flugzeug setzt,

	eine Gefahr für unbeteiligte Dritte zu sein, ist dagegen verschwindend gering. Die einseitig enge Überwachung durch den Staat ist hier total fehl am Platze. Der Segelflugsport wird im Wesentlichen in Vereinen betrieben, die nachweislich sehr verantwortungsbewußt mit dem Fluggerät und dem Wohlergehen der Vereinsmitglieder umgehen. Auch die Förderung der Jugendlichen beweist das verantwortungsvolle Verhalten der Vereine. Diese Selbstverantwortung in den Verbänden und Vereinen ist in der Wirkung wesentlich effektiver als jegliche staatliche Überwachung. Daher lehne ich die flugmedizinische Überwachung ab.
response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*220*	comment by: *Christof Büttner*
	Sehr geehrte Damen und Herren, ich bin seit mehr als 20 Jahren begeisterter Segelflieger und als solcher bis jetzt auch regelmäßig fliegerärztlich untersucht worden. Allerdings sehe ich inzwischen keinen Sinn und Nutzen mehr in einer regelmäßigen fliegerärztlichen Untersuchung, insbesondere für alleinfliegende Segelflieger, und lehne ein "Pflicht-Medical" in der jetzt von der EASA vorgeschlagenen Form ab. **Begründung:** 1. Die Wahrscheinlichkeit eines Segelflugunfalls aufgrund gesundheitlicher Probleme ist lt. Statistik äußerst gering. Noch geringer ist die Wahrscheinlichkeit, dass ein Segelflieger in einem solchen Fall einen nennenswerten oder (noch schlimmer: tödlichen) Drittschaden verursacht. Sofern man diesem Argument nicht folgt, müßte analog viel eher für den Straßenverkehr ein "Medical" eingeführt werden, da hier die Wahrscheinlichkeit eines Unfalls mit (insbesondere tödlichem) Drittschaden wesentlich höher liegt (aber dieses ließe sich politisch wahrscheinlich nicht durchsetzen). 2. Andere Länder, wie z.B. die besonders auf Sicherheit bedachten USA, zeigen, dass Segelfliegen ohne Medical möglich ist, ohne die öffentliche Sicherheit zu gefährden. 3. Jeder Segelflieger wird bei vorübergehenden oder dauerhaften, gesundheitlichen Problemen schon im Eigeninteresse nicht in ein Segelflugzeug steigen, sondern im Zweifel eher auf einen Start verzichten, es sei denn, er ist lebensmüde (aber dann hilft auch kein Medical). Eine plötzliche gesundheitliche Verschlechterung läßt sich aus meiner Sicht aber auch durch kein Medical vermeiden. Aber die Wahrscheinlichkeit, dass ein Dritter ernsthaft zu Schaden kommt ist in diesem Fall, wie oben geschildert, äußerst gering. 4. Segelflieger halten sich üblicherweise fern von der Verkehrsfliegerei, bei der, z.B. im Falle einer Kollision, mit wesentlich größeren Schäden zu rechnen ist. Daher halte ich ein Medical für Flieger, die mit der Verkehrsfliegerei in Kontakt kommen (z.B. in der Nähe von Verkehrsflughäfen) auch für erforderlich. Aber nicht für Segelflieger!	

	5. Der einzige Vorteil eines Pflichtmedicals für Segelflieger besteht darin, dass eine Lobby von Fliegerärzten zunehmend an einer weiteren Verschärfung der Regularien verdient. Fazit: Ich lehne ein "Pflicht-Medical" für Segelflieger in der jetzt angedachten Form vehement ab, würde es aber akzeptieren, wenn für Segelflieger eine abgespeckte Untersuchung in Form eines einfachen "Check-ups" bei einem Hausarzt in angemessenen Zeitabständen von z.B. 4 Jahren eingeführt wird. Aber auch hier muß sichgestellt sein, dass bei einem positiven Befund die Verhältnismäßigkeit bzgl. Flugunfähigkeit in Anbetracht der o.g. wesentlich geringeren Gefahr für Dritte, gewahrt bleibt. Ich hoffe und wünsche der EASA, dass sie unter dem o.g. Gesichtspunkt eine pragmatische und praktikable Regelung findet, ohne Fehler der Vergangenheit zu wiederholen oder fortzusetzen. Mit freundlichem Gruß Christof Büttner 26446 Friedeburg Deutschland
response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*223*	comment by: *Uwe Kabitzke*
	Besitzer einer LPL brauchen kein Medical, eine allgemeine Untersuchung des Gesundheitszustandes, wie sie von jedem Hausarzt durchgeführt wird, reicht völlig. Jeder LPL-Pilot hat genug Eigenverantwortlichkeit, um an Tagen,an denen er sich nicht fit fühlt, als verantwortlicher Pilot ein (Segel-) Flugzeug zu steuern. Ich bin seit 1979 Segelflieger und mir ist kein Fall bekannt, bei dem ein Pilot aus gesundheitlichen Gründen abgestürzt ist oder gar Dritte verletzt hat.	
response	*Noted*	
	Please refer to response to comment No 36 in this segment.	

comment	*225*	comment by: *Dr. Uwe Kaiser*
	Eine Abstufung in Klasse 1 und 2 spiegelt in keiner Weise die große Bandbreite an unterschiedlichen Anforderungen im Luftverkehr wieder. Für reine Segelflieger müsste aufgrund des sehr geringen Gefährdungspotentials eine eigne, mit wesentlich geringeren Anforderungen versehenen, Klasse geben. In vielen Ländern gibt es für Segelflieger kein Medical oder nur eine einfache Bescheinigung vom Hausarzt. In Studien konnte nachgewiesen werden, dass es in diesen Ländern keine Zunahme von krankheitsbedingten Flugunfällen gibt im Vergleich zu Ländern mit einem Medical. Insbesondere die in den letzten Jahrenhinzu gekommenen Anforderungen stehen hier in keinem Verhältnis zu den tatsächlichen Anforderungen im Luftverkehr. Hier könnte in deutlich größerem	

	Umfang in die Eigenverantwortung des Piloten vertraut werden. Segelflüge sind reine "Lustflüge". Bei Unwohlsein wird ein Pilot nicht starten, da er einen Flug so nicht geniesen kann. Notfalls kann ein Segelflug auch innerhalb einer sehr kurzen Zeitspanne abgebrochen werden. Eine Außenlandung, die für einen Segelflieger eine norme Prozedur darstellt, kann fast überall vorgenommen werden.
response	*Noted*
	Please refer to response to comment No 36 in this Segment.

comment	*233*	comment by: *Pekka Oksanen*
	Comment: A minimum age requirement for a medical certificate application is missing. Justification: A maximum 6 months prior to attaining the required pilot licence age is reasonable to provide the initial medical examination to be passed before beginning training. Proposal: Add a subparagraph (b) and renumber others: **(b) The initial medical certificate shall not be issued prior to six months before the applicant is eligible to a pilot licence of the desired type.**	
response	*Not accepted*	
	There is no minimum age for medical certificates in JAR FCL 3 which is the basis of Part FCL Medical. The longest period of validity for any type of medical certificate will be 5 years.	

comment	*250*	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.A.020 **Page**: 4 Relevant Text: (h) A pilot shall not hold more than one medical certificate at any time **Comment**: Pilots may execute their rights in different classes, so if the paragraph prohibits to hold more than one medical certificate, it's necessary to define, that a "higher class" includes a "lower class" of medical certificate. Though defined in AMC to MED.A.020, the text should be cited at this site. **Proposal**: (h) A pilot shall not hold more than one medical certificate at any time. A higher class of medical certificate includes the lower one whith its specified duration in the following sequence: class 1 includes class 2, class 2 includes LPL.	
response	*Not accepted*	
	The Implementing Rule defines a safety objective and the Acceptable Means of Compliance define a way to achieve the safety objective. In this case, the	

	requirement to hold only one valid medical certificate is a safety objective. An explanation that 'higher class' includes privileges of 'lower class' and the holder of 'higher class' medical certificate does not need to hold additional 'lower class' medical certificate(s) helps to achieve this safety objective. For clarity purposes the text of AMC to MED.A.020 will be further developed.

comment	*286*	comment by: *Rainer Steinmüller*
	Sehr geehrte Damen und Herren von der EASA! Statistisch gesehen ist bekannt, daß noch niemals ein Segelflieger aus medizinischer Ursache einen unbeteiligten Dritten ernsthaft geschädigt hat und dies wohl auch nie tun wird, weil er seinen Sport aus Spaß an der Sache ausübt und auch nur, wenn er sich wohlfühlt und sicher ist. Wie groß ist die Gefahr, daß z.B. ein Radfahrer oder Autofahrer durch medizinisch bedingte Ursachen einen Unfall verursacht? Und bei einem LKW-Fahrer, wie groß wäre die Gefahr durch unmittelbare Folgeunfälle? Weder für Autofahrer noch für Fahrradfahrer gibt es ein solches Medical. Das Pflichtmedical ist für Alleinsegelflieger demnach völlig unverhältnismäßig. Wo bleibt der Rechtsgrundsatz der Gleichbehandlung? Warum brauchen andere Staaten wie z.B. USA, England, Schweiz kein solches Medical und sind trotzdem genauso sicher wie wir hier in Deutschland? Das Medical ist deshalb einfach nur überflüssig, nützt keinem wirklich (außer der Fliegerarzt-Lobby natürlich, denn die sind die einzigen Nutznießer und verdienen sicher sehr gut daran, uns Segelflieger regelmäßig "melken" zu dürfen) und sollte schlicht abgeschafft werden. Entsprechend den Grundprinzipien der EASA würde ein einfachstes Medical von einem Allgemeinarzt genügen, das eine Bestätigung enthält, daß keine medizinischen Tatsachen bekannt sind, die zu einer Handlungsunfähigkeit führen könnten. Im Übrigen schließe ich mich der diesbezüglichen Meinung von Dr. Claus-Dieter Zink an. Mit freundlichen Grüßen Rainer Steinmüller	
response	*Noted*	
	Please refer to response to comment No 36 in this segment.	

comment	*287*	comment by: *Knut Kaiser*
	The following comment in EU-language "German": Ich bin mit der MED.A.020 nicht einverstanden. Dieser Text fordert auch von Freizeitpiloten (LPL) ein medizinisches Gutachten,	

	also auch für Segelflugpiloten. Diese Forderung ist unverhältnismäßig: das Risiko dass durch gesundheitliche Beeinträchtigungen zu Flugunfällen kommt, ist äußerst gering wenn man es z.B. mit dem Risiko durch Fahrzeuglenkern im Strassenverkehr vergleicht. Eine ähnliche Forderung an z.B. Fahrer von Fahhrädern (!), PKW oder LKW gibt es jedoch nicht, und wäre in dem dargestellten Umfang auch nicht durchsetzbar. Ich lehne das im Text geforderte "medical certificate" daher ab.
response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*311*	comment by: *Thomas Wendl*
	Wieviele tödliche Segelflugunfälle sind auf medizinische Ursachen zurückzuführen? Solange es keine statischen Erhebungen darüber gibt, muss das Medical für Segelflieger ersatzlos gestrichen werden. Ich besitze einen US Segelflugschein und laut ICAO und dtsch. Recht darf ich damit ausserhalb der USA mit einem ICAO Medical (!!!) segelfliegen. Innerhalb der USA fliege ich Segelflugzeuge und Reisemotorsegler gänzlich OHNE Medical. Ein JAR-FCL Medical der Klasse II für einen Sportpiloten zu verlangen ist in keiner Weise verhältnismäßig und dient nicht dem Zweck der Erhöhung der Flugsicherheit. Ein ICAO Medical class III (z.B. US Medical) sollte auf alle Fälle auch in Europa zum Ausüben des Sports ausreichend sein. Thoms Wendl Euckenstr. 18 81369 München twendl@arcor.de	
response	*Noted*	
	Please refer to response to comment No 36 in this segment.	

comment	*312*	comment by: *Michael Joachim*
	Sehr geehrte Damen und Herrn Eine europäische Vereinheitlichung der Gesetze sollte den Bürgern Freiheiten verschaffen, nicht neue Zwänge zu den bestehenden nationalen hinzufügen. Der Entwurf kann so ausgelegt werden, dass auch alleinfliegende Segelflieger ein Tauglichkeitszeugnis vorweisen müssen. In der zunehmenden Bürokratisierung der Lizensierung von Sportpiloten sehe ich	

	die Auswirkungen von kommerziellen Interessengruppen, hier der Mediziner, die hier die Chance sehen, nicht nur an Kranken Geld verdienen zu können. Sie schüren eine Hysterie auf unsachlichen Emotionen, ausgelöst durch den 11. September. Ich bin seit 1973 Segelflieger und habe noch nie von einem Segelflug-Unfall mit nennenswertem Fremdschaden gehört, der sich auf die mangelhafte Gesundheit des Piloten zurückführen ließ. Hier wird ein sehr geringes Risiko mit sehr hohem Aufwand bekämpft, das entspricht nicht der Verhältnismässigkeit der Mittel und dient einseitigen Interessensgruppen. Meines Wissens waren Tauglichkeitszeugnisse in vielen Ländern für Segelflieger nicht notwendig oder nur in sehr einfacher Form. Dort sind die gesundheitsbedingten Unfallraten nicht signifikant höher als in Deutschland, wo diese Überprüfungen regelässig notwendig waren. In England war bis vor Kurzem kein Tauglichkeitszeugnis notwendig, in den USA soll es jetzt abgeschafft werden, in Österreich und der Tschechei sind die Konditionen sehr viel vernünftiger und realistischer als in Deutschland. Mir ist keine wissenschaftlich fundierte Studie bekannt, die handfeste Gründe für ein Medical Class 2 für alleinfliegende Segelflieger oder auch Ultralight-Piloten rechtfertigt. Zudem muss es aus Gründen der Freizügigkeit innerhalb der EU auch möglich sein, die Fluglizenz aus anderen Staaten der EU ohne Umstände in Deutschland und umgekehrt zu nutzen, ebenso eventuelle Tauglichkeitsprüfungen und ähnliche Zertifikate. Ich bitte darum, Segelflieger, insbesondere alleinfliegende Segelflieger und Ulralight-Piloten, die nicht kommerzielle Rundflüge machen, von der Medical-Pflicht auszunehmen, bzw. diese auf ein vernünftiges Maß zu begrenzen. Ein normaler Hausarzt sollte diesen Anforderungen genügen. Segelflieger mit dem gleichen Maß wie militärische Kampfpiloten und Piloten von Passagierjets zu behandeln ist nicht realistisch. Dann müssten Radfahrer auch wie Busfahrer behandelt werden. Angesichts dieser Entwicklung wäre es besser, Segelflugzeuge zur Klasse der Sportgeräte zuzuschlagen und wie Ultralight-Flugzeuge zu behandeln und die UL-Klasse entsprechend an die Abfluggewichte der Segelflugzeuge anzupassen. In der Hoffnung auf eine praktikable und realistische Entscheidung Michael Joachim
response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*314*	comment by: *Aero-Club of Switzerland*

MED.A.020 (b)

The Aero-Club of Switzerland sees a fundamental difference between minimum medical standards applicable for glider pilots and for pilots of powered aircraft. The latter can operate aeroplanes of up to 2 tons MTOM and carry up to 3 passengers. A glider pilot can carry only one passenger. For this reason we want to create a split and we propose therefore

"Applicants for and holders of a Basic LPL and of a LPL(S) shall hold a valid LPL medical certificate.

Applicants for and holders of a LPL(A) licence, LPL(H) licence and LPL(B) licence shall hold a valid class 2 medical certificate."

Justification: In accepting such a split the nature of the aircraft flown is better dealed with.

response *Not accepted*

The leisure pilot licence (LAPL) as defined in the BR is for gliders, balloons, aeroplanes and helicopters up to MTOW of 2000 kg. The licensing requirements are slightly below ICAO Annex I standards and the medical requirements are lower than ICAO class 2 standards. For the time being, it is the aim of the Agency to have one medical certificate for all LAPLs.

comment *320* comment by: *Thomas Winter*

Eine fliegerärztliche Untersuchung ist eine Diskriminierung von Freizeitpiloten (hier: Segelflieger) im Vergleich zur übrigen Bevölkerung.
Begründung:

1. Es gibt bisher keinen Unfall, bei dem Dritte durch einen gesundheitlich beeinträchtigen Freizeitpiloten geschädigt wurden.

2. Für vergleichbare Sportarten sind keine wiederholte ärztliche Untersuchungen notwendig. (Segler, Taucher, Bergsteiger, Motorradfahrer)

3. Alle Unfälle, die in den letzten zwanzig Jahren in der Umgebung meines Heimatflugplatzes geschehen sind, hatten als Ursache Pilotenfehler oder mangelnde Übung, in keinem einzigen Fall war eine gesundheitliche Beeinträchtigung nachweisbar.

4. Die Unfallrate bei Segelfliegern in Grossbritannien (hier wird nur eine hausärztliche Bescheinigung verlangt) ist nicht höher als in Deutschland.

Aus oben angeführten Gründen ergibt sich, dass durch eine überzogene fliegerärztliche Untersuchung keinerlei Verbesserung erreicht wird.

response *Noted*

Please refer to response to comment No 36 in this segment.

comment	322	comment by: *Franz Dittmar*

Sehr geehrte Damen und Herren von der EASA,
Trotz Empfehlung, dieses Schreiben kurz zu halten, muss ich zeitweise doch etwas weiter ausholen und Studien, Artikel etc. zitieren. Soweit ich das nicht mache, nehme ich darauf Bezug und bitte, in diesen Quellen nachzulesen.
Trotzdem ich schon 56 Jahre alt bin, übe ich seit kurzem begeistert das Segelfliegen aus und bin mir der Gefährlichkeit dieser Sportart (für mich) bewusst. Wobei ich die Gefährlichkeit ausschließlich dann gelten lasse, wenn Verantwortliche (Vereinsmitglieder, -vorstände und Fluglehrer) ihrer Verantwortung nicht nachkommen. Und das ist mir in meiner, wenn auch noch kurzen, Segelfliegerkarriere **nie untergekommen.** Warum gibt es bei dieser so gefährlichen Sportart – oder sagen wir: Fortbewegungsart – nicht eine ähnlich hohe Altersbebefreiung wie für das Führen von Kfz, Motorrädern, LKW's ?
Deswegen beschäftige ich mich seither intensiv mit dieser Sache und werde Ihnen heute Tatsachen vortragen, die Sie nachdenklich machen sollten. Fliegerärzte verdienen sehr gut an Segelfliegern und nur deshalb behaupten sie, sie könnten die Menschheit durch ihre verantwortliche Tätigkeit vor gar schrecklichen Katastrophen bewahren. Bei einem Berufspiloten mit Hunderten von Passagieren an Bord kann ich die geltenden Vorschriften auch nachvollziehen.
Gilt dies aber auch für einen einsamen Alleinsegelflieger?
Gestatten Sie mir bitte, da einmal genauer hinzusehen. Folgende Überschrift – vorzugsweise – in der Bild-Zeitung gilt es doch durch das Medical für Alleinsegelflieger zu verhindern:
"Abstürzender toter Segelflieger erschlägt Passanten."
Ich werde Ihnen im Folgenden durch eine einfache Rechnung beweisen, wie oft ein solcher von allen befürchteter Unfall wahrscheinlich jetzt und in Zukunft tatsächlich und wirklich vorkommen wird:
Die echte Gefahrenzone eines solchen "Horrorszenarios" aus obiger Schlagzeile mit ernsthaften Folgen für Dritte nehme ich mit 15 Quadratmetern an. Bei 65 Einwohnern pro Quadratkilometer (1.000.000 m²) in Europa ist die Wahrscheinlichkeit eines solchen Geschehens – schon von der riesig möglichen Absturzfläche her – also nur ca. 1:1.000 pro Absturz. Flugunfälle (nicht nur Abstürze!) passieren nun aber bewiesener Maßen nur zu ca. 0,3 % aus medizinischer Ursache (siehe AOPA-Studie und Nall-Report); AOPA, dort der 9. Artikel.
Niemand kann einfach behaupten, dass diese klare Statistik nicht für die gesamte Welt gelten soll.
Und ob diese medizinische Ursache auch vorsorglich voraussehbar ist, und ob der Pilot dann sofort völlig handlungsunfähig und damit ungesteuert aufschlägt – dies reduziert die Wahrscheinlichkeit, dass der unschuldige Passant zu ernsthaftem Schaden kommt, weiter auf weit unter 0,1 %. Jeder gesundheitlich gestörte Pilot wird gar nicht erst starten und wenn plötzliche Gesundheitsprobleme auftreten immer noch eine Notlandung auf freiem Feld einleiten können – jedenfalls nicht über bewohntem Gebiet weiter fliegen. Obiger Unfall hat also eine rechnerische Wahrscheinlichkeit von sicher unter 0,000001 % pro Unfall.
Die BFU registriert aktuell ca. 100 Segelflugunfälle pro Jahr in Deutschland (übrigens einschließlich Doppelsitzer). Nach meiner Auskunft von dort ist eine sichere medizinische Ursache mit einem tödlichen Drittschaden noch nie sicher bekannt geworden. Bei dreifacher Bevölkerungsdichte in Deutschland komme ich auf eine Wahrscheinlichkeit eines einzigen solchen schlimmen Unfalls in

Deutschland mit tödlicher Beteiligung jenes unschuldigen Passanten auf ein einziges Mal in 3000 Jahren.
Darüber reden wir! Über was bitte sonst?
Die Geschichte des Segelfliegens wird also einen solchen Maximalunfall eines unschuldig Mitbeteiligten aus medizinischen Gründen tatsächlich nie erleben! Und dies ist also die einzig sachlich logisch nachvollziehbare – also äußerst fragliche – Begründung für das regelmäßige Pflicht-Medical für Segelflieger.
Weder die Studie Beklas noch der NALL–Report und auch keine anderen einschlägigen Untersuchungen wie z. B. der französische Rapport Sénateur Belot, die englischen Untersuchungen in den 60iger Jahren oder die Berichte der Schweizer bestätigen die Befürchtungen gewisser Fliegerärzte, die ganz offensichtlich nur eine lukrative Einnahmequelle versiegen sehen. Das Gegenteil ist der Fall, und diesbezügliche Details liefere ich Ihnen gerne nach und sie müssten eigentlich auch bekannt sein! Nach dem Vorgenannten gerät ein Radfahrer oder gar ein Schwertransporter dagegen durch medizinisch bedingte plötzliche Ausfälle in 50 Prozent der Fälle in den Gegenverkehr. Die Folgen können Sie sich ausmalen, die Medien sind voll davon. Wer aber fordert von einem Radfahrer ein Medical ?
Der Rechtsgrundsatz der Gleichbehandlung bleibt hier auf der Strecke!?
Und nun zur Historie und zum weiteren Verständnis, warum es dieses Pflichtmedical auch für uns Segelflieger überhaupt gibt und welche weit verbreiteten Vorurteile dahinter stecken:
In den vergangenen Kriegszeiten haben viele große Staaten das Segelfliegen ihrer Jugend ganz massiv finanziell und ideell gefördert. Künftige Kampfpiloten zu finden, war das klare Ziel. Denn ein kranker Kampfpilot in seinem teuren Flugzeug wäre ja auch ein finanzieller "Totalausfall"; das musste verständlicherweise mit bewiesener totaler Gesundheit verhindert werden. Ohne wirkliche Logik wurden diese Regeln für uns Freizeitsegelflieger einfach gedankenlos übernommen. **Segelfliegen aber hat aber überhaupt keinen vergleichbaren Zweck !**
Will die EASA aus dem Jahre 2010 diese Wirbelschleppe aus uralten Zeiten tatsächlich weiter mit in die Zukunft übernehmen? Oder ist die EASA auch zu echten, die Wirklichkeit verändernden Zukunftsvisionen fähig?
Länder ohne Medical für Segelflieger – wie die USA – haben sich dabei doch sicher auch etwas gedacht. Ich denke da nicht nur an die grundsätzlich andere Herangehensweise gegenüber der Bevölkerung. Die Briten, die Schweizer etc. sind mit aus medizinischen Ursachen abstürzenden Segelfliegern keineswegs ungewöhnlich häufig „heimgesucht"? Mir ist davon nichts bekannt. Ganz im Gegenteil. Britische Untersuchungen aus den 60iger Jahren und ebensolche aus der Schweiz sprechen eine eindeutige und völlig andere Sprache.
Klare und beweisbare medizinische Ursachen sind für Drittschäden schlicht bedeutungslos!
Warum werden diese Tatsachen nicht ernst genommen und die einzig richtigen Konsequenzen daraus gezogen?
Werden wir Segelflieger den emotionalen Befürchtungen der weit verbreiteten Angst vor dem Fliegen und den Fliegern auch weiterhin geopfert?
Oder beabsichtigt die EASA, klare – inzwischen erkennbare Fakten – zu akzeptieren; oder sollen die irrationalen und rein pekuniären Ängste von der Lobby bestimmter Fliegerärzte weiterhin bedient werden ?
Des Weiteren wird offenbar nicht bedacht, dass sicherlich jeder Freizeitpilot immer verantwortlich handeln und sein Flugzeug aus Gefahren- oder

Gefährdungsbereichen herausfliegen würde. Wir Segelflieger – und die Menschheit – sind doch auf ganz klare Weise von Natur aus und instinktiv sehr gut geschützt. Der Mensch an sich – selbst ein Psychotiker – ist doch kein Selbstmörder.
Segelfliegen findet anfangs überwiegend in Vereinen statt, denen auch die Flugzeuge gehören. Die natürliche Kontrolle durch die Vereinsmitglieder und die dortigen Fluglehrer scheint übersehen zu werden. Der geistig verwirrte Irrflieger von Frankfurt wurde von zwei Vereinen als Schüler einfach abgelehnt. Warum erkennt und bedenkt die EASA nicht solche natürlichen Grundprinzipien der menschlichen Natur und handelt genau danach?! Von Staats wegen die Vereine im Sinne eines amerikanischen Airport Watch Programms zu sensibilisieren ohne die Rechte des Einzelnen zu beschneiden, wäre viel sinnvoller.
Auch scheint von den Fliegerärzten bewusst nicht eingerechnet und beachtet zu werden, dass 99,9 % aller Krankheiten – und dies sagt Ihnen jeder Arzt – sich vorher durch Unpässlichkeiten ankündigen. Das hat die Natur nun einmal so eingerichtet. Die Allgemeinheit ist daher auf einfachste Weise vor dem Einstieg eines Kranken oder Sterbenden in ein Segelflugzeug durch hervorragende, Millionen Jahre alte, Instinkte perfekt geschützt.
Vom Wesen des Segelfliegens her herrschen leider in der allgemeinen und unwissenden Bevölkerung völlig falsche und von Angst beherschte Vorstellungen, wie mir Unterhaltungen mit Nichtfliegern immer wieder bestätigen. Wir Segelflieger und unser Sport sind aber allenfalls vergleichbar mit Bootsfahrten im Wildwasser, allerdings in den Strudeln und Wellenbildungen der strömenden Luft. Segelfliegen ist also ein harter Kampfsport in hilfloser Einsamkeit. Wir gefährden dort oben (wie ein Kanufahrer im Wildbach) niemanden, außer uns selbst und weil wir dies wissen, gehen wir mit unserem Leben und dieser Gefahr sehr respektvoll und verantwortlich um.
Der Freizeitsport des Segelfliegens hat also mit den üblichen Vorstellungen der Fliegerei kaum etwas zu tun. Es ist einfach unverständlich, dass daran verdienender Lobbyismus, Nichtsegelflieger mit laienhaften Vorstellungen, Entscheidendes und Endgültiges zu sagen bekommen. Das kann nicht richtig sein! In Fragen des Tiefseetauchens würde ein Segelflieger ja auch nicht mitreden wollen, der davon keinerlei Ahnung hat!
Die aktuell (Medicalvorschlag von Dr. Hunter) favorisierte Self-Declaration wird – und das ist zu befürchten – keinerlei Erleichterung für die Sportler-Basis bringen. Solche umfangreichen Formulare gewissenhaft auszufüllen bedarf mindestens der Hilfe eines fachkundigen Arztes und der wird sich auch künftig seine Zeit bezahlen lassen (müssen). Und da es keinen perfekt gesunden Menschen gibt, wird jede medizinische Andersartigkeit – wie in der Vergangenheit – zu weiteren teuren Untersuchungen führen. Kein Arzt wird die Verantwortung dafür übernehmen, vielleicht dann doch etwas übersehen zu haben und damit Gefahr laufen zu müssen, dafür letztlich vor einem Gericht verantwortlich zu sein, was meines Wissens noch nie geschehen ist.
Ich hoffe, Ihnen hiermit nachprüfbare Fakten geliefert zu haben um nach entsprechender Faktenabwägung im Sinne von uns Segelfliegern unvoreingenommen entscheiden zu können.
Demokratische Prinzipien gehen doch nicht von einem entmündigten Bürger aus! Hat Selbstverantwortung nicht auch etwas mit der Würde des Menschen zu tun!? Diese Freiheit sollte nur bei Gefahr für Unbeteiligte eingeschränkt werden dürfen. Segelfliegen ist keine solche mit Logik zu begründende und deshalb durch ein teures Pflichtmedical zu regelnde riesige Gefahr. Ein Kind auf einer öffentlichen Straße ist für die Allgemeinheit wesentlich gefährlicher! Diese „Gefährlichkeit" aber ist allgemein kalkulierbar. Warum klärt man die Bevölkerung nicht über

	unsere Ungefährlichkeit auf, statt die schon oben beschriebene allgemein übliche Angst vor dem Fliegen weiter zu schüren? Um dem nachvollziehbaren Bedürfnis der Öffentlichkeit nachzukommen und den bereits beschlossenen Grundprinzipien der EASA zu genügen, wäre für Segelflieger auch ein einfachstes Medical – von einem Allgemeinarzt ausgestellt – genügend, wo beispielsweise Arzt und Pilot in einem Satz die Gesundheit regelmäßig aktuell bestätigen und augenscheinlich keine zu plötzlicher Handlungsunfähigkeit führenden Beschwerden vorliegen. Auch das derzeitige Medical ist nur eine Momentaufnahme; daher würde im übrigen eine Art medizinisches Airport Watch Programm besser als Präventivemaßnahme taugen. In einem solchen wären dann auch bspw. die durch Alkohol bedingten Human-Faktors-Unfälle auch zu verhindern, die kein Fliegerarzt voraussagen kann. Aus eigener Erfahrung ist zum Thema Alkohol hier allerdings zu sagen, dass damit und insbesondere auch den Folgewirkungen von den Segelfliegern sehr verantwortlich umgegangen wird ! Es wird schon eher mit etwas Alkohol gefahren denn geflogen ! Letztlich wünsche ich mir eine zukunftsorientierte EASA, die sich den genannten, ich denke, nunmehr besser nachvollziehbaren Fehlern verschließt und ihre Entscheidungen nach einfachsten Statistiken und Überlegungen trifft. Im Übrigen beziehe ich mich auf die Ausführungen von Dr. med. Claus-Dieter Zink in seiner Stellungnahme an die EASA. Mit freundlichen Grüßen Franz Dittmar Wildbirnenweg 1 D-14469 Potsdam
response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*325*	comment by: *FOCA Switzerland*
	MED.A.020 (g) Pilots with Instrument Rating should be colour safe. Justification: modern cockpits are equipped with complex displays with different colours. Different colours help to clarify the information presented also in diffenent illumination and light conditions. Proposed text: **Add: "and must be colour safe": (g) If an instrument rating .....medical certificate holders and must be colour safe**	
response	*Noted*	
	This is covered by MED.A.020(e): 'If a night rating is added to a PPL or LAPL, the pilot shall be colour safe'. A night rating is a prerequisite for an instrument rating.	

comment	*326*	comment by: *FOCA Switzerland*
	MED.A.020 b) and c) are not sufficiently clear and must be more detailed	

	Proposed wording: • **(b): Applicants and holders of a leisure pilot license LPL (A)(H) (S) (B)) shall hold....** • **(c): Applicants of a private pilot license PPL (A)(H)(B)(S) shall hold**
response	*Partially accepted*
	All LAPL holders have to hold a LAPL medical certificate. It is therefore not necessary to mention the types of LAPL licenses. However, as PPL does not cover SPL or BPL these licences need to be mentioned separately. The text will be amended accordingly.

comment	*348*	comment by: *Otto Karlig*
	It is absurd to arrogate a pure tone audiometry from PPL/IR holders as claimed for the Class 1 medical. VFR allow the use of all the airspaces (expect airspace A) that IFR flights also use. So a private flight under IFR does not need a better hearing pilot than under VFR.	
response	*Not accepted*	
	Please refer to ICAO Annex 1, 2.7.1.3: Applicants who hold a private pilot licence shall have established their hearing acuity on the basis of compliance with the hearing requirements for the issue of a Class 1 Medical Assessment. Also refer to PPL requirements FAA Title 14, § 67.305: Provide acceptable results of pure tone audiometric testing of unaided hearing acuity according to ... The following table shows the values also given for Class 1.	

comment	*361*	comment by: *Karl Höck*
	Mit Absatz b bin ich nicht einverstanden: alleinfliegende Piloten, die schon mal bei einer Erstuntersuchung ihre Tauglichkeit nachgewiesen haben, sollten nicht mehr einer Nachuntersuchungspflicht unterliegen. Begründung: 1.Gleichstellung mit Verkehrsteilnehmern auf der Straße, mit einem wesentlich höheren Gefährdungspotential wegen Verkehrsdichte und Raum, die brauchen auch kein medical. 2:Das Gefährdungsrisiko beim Luftverkehr ist hier verschwindend gering.	
response	*Noted*	
	The medical disposition of a person changes over life. A comparison with road traffic is not valid because in road traffic the 3rd dimension is missing and altitude can be a limiting factor in some medical conditions. Even if a comparison is made	

	with driving licences — after a certain age visual testing is obligatory to revalidate a driving licence.

comment	*363*	comment by: *Gregor Schon*
	Ich lehne ein "Medical certificate" ab. Die Prüfung erfüllt nicht die Voraussetzung der Verhältnismäßigkeit: Der riesigen Aufwand versucht ein minimales Risiko zu bekämpfen: Das minimale Risiko, dass ein Segelflieger aus gesundheitlichen Gründen vom Himmel stürzt und dann auch noch zufällig Sachwerte oder gar einen anderen Menschen trifft - das wurde noch nicht beobachtet - und diese Nicht-Gefahr wird mit riesigen Aufwand bekämpft. Unverhältnismäßigkeit ist deshalb eine Sünde, weil sie Ressourcen bindet, die an anderer Stelle mehr Sicherheit bringen können - bei Piloten ist das zum Beispiel zusätzliches Training: Zusätzliche Flugstunden erhöhen die Sicherheit nachgewiesenermaßen Die Prüfung erfüllt nicht den Gleichheitsgrundsatz: Jeden Tag bewegen sich Millonen Kraftfahrzeuge mit mehrere Tonnen Gewicht über Straßen und durch Städte und an Bürgersteigen vorbei. ein dabei vorhandenes Risiko durch gesundheitliche Störungen der Fahrer wird akzeptiert. Vermutlich aus folgenden Grund: Man ist froh wenn die Fahrer nicht betrunken sind, Gegenüber diesem Risiko eines betrunkenen Fahrers ist die gesundheitliche Einschränkung als Risiko wahrscheinlich selbst im Straßenverkehr mit seine großen Nähe vieler Verkehrsteilnehmer marginal. Die Prüfung ist nicht wirksam: Mein Arzt hat mir gesagt, dass die Vorhersagekraft eines Medicals bezüglich des plötzlichen Ausfalls eines Piloten gering ist: Wollte man diese Vorhersage verbessern, müsste man sehr belastende Untersuchungen durchführen, die Mediziner nur wirklich kranken Personen zumuten. Ich habe versucht als Bürger meine Meinung sachlich zu beschreiben und lasse Spekulationen, wer welche Interessen an den Medical Certificates und eine immer restriktiven Gestaltung solcher bürokratischer Verfahren hat, außen vor. Die äußere ich bei den Wahlen.	
response	*Noted*	
	Please refer to response to comment No 36 in this segment.	

comment	*364*	comment by: *Manfred Dankert*
	Wenn doch alle so gleich behandelt werden sollen, dann müßte man ja in der logischen Konsequenz auch alle Teilnehmer im und am Straßenverkehr auf deren Gesundheitszustand hin überprüfen. Da dem nicht so ist, lehne ich Aufgrund des Rechtsgrundsatzes der Gleichbehandlung das Medical ab und befürworte die Eigenverantwortung und der Kontrolle durch Vereine. Länder ohne Medical haben nachweislich keine höheren Unfallraten als wir, also was sollen wir noch mit den alten Zöpfen der Bürokratie? Gerettet wird dadurch	

	bestimmt niemand, und selbst wenn mal etwas passieren sollte, könnte dieses auch nach einer Ärzlichen Untersuchung im Rahmen des Medical geschehen... Um es mit einem Zitat von Dr. C.D. Zink zu sagen: *Die BFU registriert aktuell ca. 100 Segelflugunfälle pro Jahr in Deutschland (übrigens einschließlich Doppelsitzer). Nach meiner Auskunft von dort ist eine sichere medizinische Ursache mit einem tödlichen Drittschaden noch nie sicher bekannt geworden. Bei dreifacher Bevölkerungsdichte in Deutschland komme ich auf eine Wahrscheinlichkeit eines einzigen solchen schlimmen Unfalls in Deutschland mit tödlicher Beteiligung jenes unschuldigen Passanten auf ein einziges Mal in 3000 Jahren.* Mit freundlichen Grüßen Manfred Dankert PS: Denken sie bitteauch mal darüber nach, wie man der breiten Masse den Zugang zu (Online-) Petitionen erleichtern kann. Mir kommt es manchmal wie ein Versteckspiel vor...
response	*Noted*
	Please refer to response to comment No 36 in this segment.

comment	*367*	comment by: *Peer Ketterle*
	Please see my comment in the Explanatory Notes about this issue. Please remove the requirement of a medical for an LPL-holder altogether and do explicitly NOT reqiure ANY kind of medicla certificate for LPL holders. This does not do a service to GA or Europe. Also, please include a possibillity for a PPL-holder to not need any medical-certificate. Maybe you can include certain requirements for this case, like the plane has to have 4 seats or less and has to have a MOTM of 2 tons or less and with a VNe of 250 kts or less. This way the theoretical possibillity of a PPL flying big and fast airplanes without a medical is removed. The lack of a need for this is explained in my comments in the Explanatory Notes.	
response	*Noted*	
	Please refer to response to comment No 36 in this segment.	

comment	*370*	comment by: *UK CAA*
	MED.A.020 (c) and (d) Comment: (c) and (d) need to be amalgamated to cover PPL, BPL and SPL. As BPL will require a Class 2 certificate, irrespective of whether commercial ballooning is involved, para (d) becomes obsolete. Justification:	

	Medical requirements for SPL and BPL need to be specified. Proposed Text: Amend (c) to: ...private pilot licence (PPL)**, balloon pilot licence (BPL) or sailplane pilot licence (SPL)** shall hold a valid class 2 medical certificate.' Delete (d).
response	*Partially accepted*
	As PPL does not cover SPL or BPL these licences need to be mentioned separately. The text in (c) will be amended accordingly. Paragraph (d) is a specific case because the holder of the balloon pilot licence can be involved in the commercial ballooning while holding a Class 2 medical certificate. This is a special case that has to be mentioned separately because following the definition of the commercial activities in aviation any pilot involved in commercial flying needs a Class 1 medical certificate.

comment	*371*	comment by: *UK CAA*
	MED.A.020 Additional requirement Comment: A minimum age for certificate issue is required to ensure standardisation. Justification: It is inappropriate to undertake medical assessments too far in advance of the first solo in the case of SPL, BPL or LPL (A/H) and 6 months is a reasonable time period for the medical to be obtained. It is appropriate to link the earliest application date for a class 1 certificate to the earliest date of application for a CPL. Proposed Text: Add: **'(i) An applicant for a medical certificate shall be at least:** **(1) 17 ½ years of age for Class 1** **(2) 15 ½ years of age for Class 2** **(3) 13 ½ years of age for LPL.'**	
response	*Noted*	
	See response to comment No 233 in this segment.	

comment	*374*	comment by: *European CMO Forum*
	Add New Paragraph Comment: A minimum age is needed for the issue of a medical certificate. Justification:	

	It is inappropriate to examine children and also inappropriate to examine too far in advance of the first solo flight. Proposed Text: Add a new rule to specify a minimum age 6 months in advance of the first solo for Class 2 and LPL and 17 and a half years of age for Class 1.
response	*Noted*
	See response to comment No 233 in this segment.

comment	*509*	comment by: *Hartmut Beil*
	It is advised to consider a 3 class medical license system. A IFR addition to a PPL should not require a class1 medical testing. The ruling should consider the lowest common requirement for the privilege to fly instead of the highest possible ones. That is class 3 for general purpose flying. Class 2 for flying for hire and class 3 for flying of airliners. Simple does it. The system of ATC can easily drop a non- understanding pilot out of the IFR and send him back to VFR in most cases. The yearly test can not assure the full function of a pilot, the ATC system has to accomodate for that anyway.	
response	*Not accepted*	
	Please refer to ICAO Annex 1, 2.7.1.3: Applicants who hold a private pilot licence shall have established their hearing acuity on the basis of compliance with the hearing requirements for the issue of a Class 1 Medical Assessment. Also refer to PPL requirements FAA Title 14, § 67.305: Provide acceptable results of pure tone audiometric testing of unaided hearing acuity according to ... The following table shows the values also given for Class 1.	

comment	*514*	comment by: *British Microlight Aircraft Association*
	1. This Section should state that higher level medical certificates include privileges of given by lower level certificates. 2. The subsections (b), (c), (d) should state that the medical requirement for each Licence is a minimum level. 3. (h) Why not?	
response	*Noted*	
	See response to comment No 250. 1. Provisions for the inclusion of lower level privileges into a higher level are proposed in AMC to MED.A.020. 2. Implementing Rules are binding in their entirety; they are not minimum standards, but the rule which ensures uniform interpretation and equal conditions in all Member States.	

3. Requirement to hold only one valid medical certificate at any time is a transposition of the requirement from JAR FCL 3.065(e).

comment	635	comment by: *Frank Bender*
	Für Segelflieger und Motorsegelflieger sollte es meiner Meinung nach nicht erforderlich sein, ein Medical class 2 zu benötigen. Ich begründe dies damit, dass mir keine Fälle bekannt sind, wo dies in der Vergangenheit half, Unfälle zu vermeiden. Segelflieger haben noch nie aus medizinischen Gründen einen unbeteiligten Dritten ernsthaft geschädigt. Ein Medical ist für Segelflieger also völlig unverhältnismäßig und könnte deshalb abgeschafft werden.	
response	*Noted*	
	Please refer to response to comment No 36 in this segment.	

comment	668	comment by: *Jan-Hendrik Vehling*
	Ich bin mit dem Absatz 2/2.1 im NOTICE OF PROPOSED AMENDMENT nicht einverstanden. Ein Fliegerarzt der einem Diabetiker das Medical verweigert, kann niemals beurteilen ob die Person gut auf seine Krankheit eingestellt ist. Die Person sollte sich ganz einfach durch den behandelnden Diabetologen bestätigen lassen, dass sie gut eingestellt ist und zum fliegen geeignet ist. Schließlich braucht ein Diabetiker auch keinen Medicalbericht wenn er einen 40 Tonnen Lkw auf der Autobahn fährt. Im Laufe der Jahre hat die Forschung viele neue Erkenntnisse in Sachen Diabetes gebracht. Messungen des Blutzuckers sind simpel auszuführen und gar schon mit Geräten stetig messbar. Weiterhin leben wir in der heutigen Zeit in einem gemeinsamen Europa und somit kann es nicht sein das es Diabetiker in z.b. England erlaubt sein kann Segelflug zu betreiben und in Deutschland nicht. Das Problem liegt da drin dass, die Menschen nicht richtig aufgeklärt sind und somit Begriffe auftreten wie "*schwerer Diabetes*" den es so nicht gibt.	
response	*Noted*	
	Thank you for your comment. The aeromedical assessment of a diabetic pilot shall be performed by an AME or an AeMC. In this assessment the AME may use information obtained from the treating diabetologist.	

comment	761	comment by: *Tjeerd Mulder*
	MED.A.20: (h) A pilot shall not hold more than one valid medical certificate at any time. Comment: It is unclear wether this includes medical certificates issued by non member states. Proposal: In case (h) includes medical certificates issued by non member states (h) should be deleted otherwise (h) should be rewritten so that is clear hat only medical	

	certificates issued by member states are ment.
response	*Accepted*
	Provisions laid down in Part Medical are applicable to Community medical certificates only. MED.A.020 (h) will be amended to refer only to a Part MED medical certificate.

comment	*927*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM) - Group Ophthalmology - **Section:** 1 MED.A.020 Medical Certification (g) **Page**: 4 **Relevant Text:** (g) If an instrument rating is added to a PPL, the pilot shall under take pure tone audiometry examinations according to the periodicity and the standard required for class 1 medical certificate holders. **Comment**: In modern cockpits many complex displays are presented in different colours. Seeing different illumination, lightning and glare conditions, it is possible that displays are not correctly identified and understood. This happens especially in protanomalous pilots, who see red displays much darker compared to how they are seen in an objective presentation. If the colour of the information cannot be identified correctly, the information can be misinterpreted. This can lead to very dangerous situations. **Proposal**: (g) If an instrument rating is added to a PPL, the pilot shall under take pure tone audiometry examinations according to the periodicity and the standard required for class 1 medical certificate holders. The pilot must be colour safe.	
response	*Noted*	
	To add an instrument rating to a license a night rating (see FCL.610 (a)(1) is required. To obtain a night rating a pilot must be colour safe (see MED.A.020 (e). The addition 'the pilot must be colour safe' is not needed in this paragraph.	

comment	*968*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: : **Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008** **Section:** MED.A.020	

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Relevant Text:
Relevant Text: (a) A student pilot shall no fly solo unless that student pilot holds a valid medical certificate, as required for the relevant licence.

Comment:
It's desirable that a student pilot should be able to begin his training before obtaining a medical, but the period should be limited for e.g. 3 months. If not, psychopathic, criminal or otherwise unqualified individuals (alcohol dependant, epileptic patients) could remain in the state of a student pilot for years and jeopardise flight safety or prepare terrorist attacks.

Proposal:
(a) A student pilot shall no fly solo unless that student pilot holds a valid medical certificate, as required for the relevant licence. A medical certificate has to be obtained not later than 3 months after starting the flight-training.

response *Noted*

Our proposal does not prevent to start training before obtaining a medical certificate which is required for the first solo flight.

See also response to comment No 233.

comment *969* comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

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Relevant Text:
(h) A pilot shall not hold more than one medical certificate at any time

Comment:
Pilots may execute their rights in different classes, so if the paragraph prohibits to hold more than one medical certificate, it's necessary to define, that a "higher class" includes a "lower class" of medical certificate. Though defined in AMC to MED.A.020, the text should be cited at this site.

Proposal:
(h) A pilot shall not hold more than one medical certificate at any time. A higher class of medical certificate includes the lower one with its specified duration in the following sequence: class 1 includes class 2, class 2 includes LPL.

response *Not accepted*

See response to comment No 250.

comment	*1063*	comment by: *BMVBS (German Ministry of Transport)*
	(c) applicants for and holders of a LPL shall in our view hold a valid class 2 medical (see our comment 688).	
response	*Not accepted*	
	Medical requirements as regards LAPL were developed following the principle that all measures must be proportionate and tailored to the risk involved. Class 2 medical requirements for all LAPL applicants would be too restrictive. See also response to comment No 314.	

comment	*1083*	comment by: *Regierung von Oberbayern-Luftamt Südbayern*
	Nach dieser Vorschrift genügt für jede LPL-Lizenz ein LPL-Medical Certificate, das nach Aussage der EASA hinter den Anforderungen des ICAO class 2 medical zurückbleibt. Im Regulatory Impact Assessment NPA 2008-22f , Nr. 2.12 (insb. 2.12.1 und 2.12.8 auf S. 128 ff.) wird als "Rechtfertigung" für diesen niedrigeren akzeptierten Sicherheitsstandard u. A. angegeben, dass für das spezielle LPL medical certificate auch besondere "limited privileges (flight only within aerodrome zone)" gelten würden. Nach MED.A.020 gilt das LPL medical certificate jedoch für jede LPL-Lizenz, also auch z. B. für den LPL (A) und den LPL (S), für die es keine 50-km-Entfernungsgrenze gibt wie für den Basic LPL (FCL.105.BA/H). Die Begründung für die Einführung des speziellen LPL-Medicals wurde somit bei Erstellung der FCL-Vorschriften nicht umgesetzt. Sinn würden die Hinweise im RIA nur dann machen, wenn man die Gültigkeit des LPL-Medicals auch auf den Basic-LPL beschränkt. Bezieht man die Gültigkeit des LPL-Medicals auf sämtliche LPL-Lizenzen, mag nicht recht einleuchten, wodurch sich die deutlich verringerten gesundheitlichen Anforderungen rechtfertigen lassen, da die Rechte, die ein LPL (A) vermittelt, kaum hinter den Rechten eines PPL (A)-Piloten zurückbleiben. Es wird daher vorgeschlagen, die Gültigkeit des LPL-Medicals auf die Ausübung der Rechte aus dem Basic LPL zu beschränken.	
response	*Noted*	
	See response to comment No 314.	

comment	*1095*	comment by: *Moldavian Society of Aviation Medicine*
	Comment: Humans should have been taking into consideration as the most possible factor involved in incidents and accidents in aviation and the higher rate of accidents among light aircrafts in special. We consider the requirements for Class 2 are enough flexible and should be used for LPL pilots as well. It would be also compliant to ICAO regulation. The flexibility of the requirements should be ensured by the good control that could be made only by experienced professionals, having enough knowledge in aviation.	

	Only AME(s) - doctors who have enough knowledge in aviation medicine, pilot's environment could make assessment of the medical fitness of pilots nevertheless of the weight of aircraft and the purpose of flying - private, leisure or commercial. Very important is the advise that doctors experienced in aviation medicine could give to pilots concerning their health and risks related with different kind of sickness, medication and others. Experience of using precisely written JAR-FCL 3 also for Class 2 throughout the most European countries gives good example of more or less harmonized system of medical certification and could be used for LPL. Introduction of new regulation in transition period will not support the flight safety in contrary will divide and bring a lot of misunderstandings. Proposal: MED. A . 020 (b) Applicants for and holders of a leisure pilot licence (LPL) shall hold a valid Class 2 medical certificate.
response	*Noted*
	See response to comment No 1063.

comment	*1109*	comment by: *George Knight*
	Rule appears to exclude a pilot with a Class 1 medical from exercising LPL, PPL or BPL privileges. Ditto a class 2 holder from LPL. **Propose change** (b) Applicants for and holders of a leisure pilot licence (LPL) shall hold a valid LPL medical certificate **OR HIGHER**. (c) Applicants for and holders of a private pilot licence (PPL) shall hold a valid class 2 medical certificate **OR HIGHER**. (d) Applicants for and holders of a balloon pilot licence (BPL) involved in commercial ballooning shall hold a valid class 2 medical certificate **OR HIGHER.**	
response	*Noted*	
	See response to comment No 250.	

comment	*1110*	comment by: *George Knight*
	(h) A pilot shall not hold more than one valid medical certificate at any time. This rule would seem to create difficulties in several situations and needs to be redrafted or removed. E.g.: • Upgrading from LPL medical to Class 2 or Class 1 whilst the LPL medical is still valid. • Downgrading from Class 2 to LPL if the LPL examination is undertaken before the Class 2 has expired. If medicals are not permitted to overlap when upgrading or downgrading pilots may either be breaking the law or will be forced to suspend flying for a time to ensure a break between the end of validity of one medical and the start of the next.	

	if a medical is renewed in the 45 days preceding its expiry does not that put the pilot in breach as well?
response	*Noted*
	In the cases described under the bullet points one new medical certificate will be issued, with correct dates of expiry for the different privileges. The 45-day period is allowed in ICAO Annex 1 to give some flexibility to the examination dates. A new medical certificate will be issued once the fit assessment is made.

comment	*1127*	comment by: *Stefan Zingg*
	MED.A.020 **(b) and (c)** For glider pilots, no medical certificate should be required. If some kind of fitness declaration should be felt to be necessairy, then glider pilots should be allowed to declare their own medical fitness with a self declaration form. For commercial glider operations (which are extremely rare in Europe) and for flight instructors, a medical certificate may be appropriate. For a new applicant, an medical entry test may be appropriate. Reason: Flying gliders is a purely recreational leisure activity, comparable to boating, diving, mountain climbing etc. The potential danger for persons on the ground is negligible, a glider pilot doesn't endanger anybody but himself. The vast majority of glider flights are solo flights. Double seaters are usually occupied by two qualified glider pilots who have chosen to fly together. But even if a "true" passenger is carried, this passenger is virtually always a close friend or a relative to the pilot. So there is nobody to be protected from a glider pilot. Consequently, judging his fitness should be strictly the glider pilot's own responsibility. For the very least, the requirement should be reduced to the LPL medical certificate.	
response	*Not accepted*	
	The Agency acknowledges your opinion, but cannot agree with your proposal. Paragraph 4.a.1 of the Essential Requirements of the Basic Regulation determines that: *'All pilots must periodically demonstrate medical fitness (...). Compliance must be shown by appropriate assessment (...)'.* The requirement for appropriate assessment cannot be satisfied only with a self-declaration. There is a need for a GMP or AME to perform a medical assessment. Also, the implementing rules for medical certification have to comply with the principles and essential requirements in the Basic Regulation. Therefore, it is not possible not to require a medical certificate for pilots. What is proposed is therefore a system where the medical requirements applicable to each category of pilot are proportionate to the activity developed and the risks involved.	

comment	1127	comment by: Stefan Zingg
	MED.A.020 **(b) and (c)** For glider pilots, no medical certificate should be required. If some kind of fitness declaration should be felt to be necessairy, then glider pilots should be allowed to declare their own medical fitness with a self declaration form. For commercial glider operations (which are extremely rare in Europe) and for flight instructors, a medical certificate may be appropriate. For a new applicant, an medical entry test may be appropriate. Reason: Flying gliders is a purely recreational leisure activity, comparable to boating, diving, mountain climbing etc. The potential danger for persons on the ground is negligible, a glider pilot doesn't endanger anybody but himself. The vast majority of glider flights are solo flights. Double seaters are usually occupied by two qualified glider pilots who have chosen to fly together. But even if a "true" passenger is carried, this passenger is virtually always a close friend or a relative to the pilot. So there is nobody to be protected from a glider pilot. Consequently, judging his fitness should be strictly the glider pilot's own responsibility. For the very least, the requirement should be reduced to the LPL medical certificate.	
response	*Noted*	
	See response to comment No 1127 above.	

comment	1132	comment by: jim white
	MED.A.020 makes no reference to medical requirements for SPL. Applicants for SPL should hold a valid LPL medical certificate. There is no need for the excessive requirements or expense of ICAO class 2 medical for SPL pilots especially an electrocardiagram which history shows has little predictive utility for future incapicitation.	
response	*Not accepted*	
	As PPL does not cover SPL or BPL these licences need to be mentioned separately. The text in MED.A.020 (c) will be amended accordingly. SPL is a licence for private flying and requires holding a Class 2 medical certificate. This is also an ICAO standard: please refer to ICAO Annex 1, Section 2.9. Glider pilot licence, paragraph '2.9.1.5: An applicant shall hold a current Class 2 Medical Assessment'. For a LAPL(S) a LAPL medical certificate will be sufficient.	

comment	1138	comment by: Keith WHITE

	Attachment #4
	LPL(S) and SPL are not mentioned in this section. (h) It is surely possible that the holder of any licence could also hold e.g. an SPL licence. Is there a heirachy of licencing that I have not yet read? Would it not also be reasonable that there will be different medical requirements for solo flying of gliders and dual/instructor flying? See attached BGA Laws and Rules para 16.2. It seems to me that there is, so far, inadequate separate provision for glider pilots.
response	*Noted*
	See response to comment No 1132.

comment	*1143*	comment by: *Stephan Johannes*
	Sehr geehrte Damen und Herren, ich bin seit 23 Jahren Segelflieger und Segelfluglehrer. Seit 1985 habe ich mich regelmäßig der fliegerärztlichen Untersuchung gestellt. Nun wird erneut über dieses "Medical" diskutiert und damit sollte man die Frage erlauben, ob ein Medical für Segelflieger einen "Sicherheitsgewinn" für den Segelflug bedeutet. Oder sind das nur Formalismen, die ausschließlich die Kosten in die Höhe treiben. Was macht eine Fliegertauglichkeit aus, wenn der Fliegerarzt dem 85 jährigen nicht nahelegt mit Sicherheitspiloten zu fliegen oder zumindest das Gästefliegen zu unterbinden. Sicher ist die Untersuchung von Blut, Urin, der Reflexe, Augen und Ohren wichtig, aber muss diese Untersuchung ein Fliegerarzt durchführen? Kann nicht der Hausarzt aufgrund einer Checkliste diese Tauglichkeit bestätigen? Es gibt Studien, die besagen, dass der medizinische Faktor bei Unfällen im Segelflug zu vernachlässigen ist. Segelflugpiloten, die sich nicht wohl fühlen, steigen nicht in das Flugzeug. Man macht das nicht beruflich, wo man vielleicht gezwungen ist, einen Flug durchzuführen, obwohl es vielleicht grenzwertig mit der Gesundheit ist. Ich halte ein Modell, wie es in England gelebt wird, für den Segelflug als Ideal. Die Kosten würden sinken, die Ausbildung von neuen Piloten erleichtert. Mit freundlichem Gruß Stephan Johannes
response	*Noted*	
	See response to comment No 36.	

comment	*1190*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.020 (a) **Comment:** For a student pilot, there should be certain time frames between	

	recieving a medical certificate and the first solo flight. The first reason is to prevent students with incapacitating disorders from starting practical flying training, where also the instructor might be at risk. E.g. if the student suffers a seizure when at the controls, it might be impossible for the instructor to control the aircraft. The second reason is to prevent student pilots from recieving a medical certificate several years in advance in order to hide medical problems that might appear later in life. For a class 2 medical certificate this period might be 5 years and for a LPL medical certificate more than 30 years. During this period a number of mental or physical problems may develop, but the medical certificate would still be valid unless the disorder is properly reported, which experience has shown is very rare for private pilots. **Proposal:** Amend MED.A.020 (a): "... The medical certificate shall be issued no earlier than one year before and no later than 3 months after the practical flying training has started."
response	*Noted*
	See response to comment No 233 in this section.

comment	*1191*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.020 (b) **Comment**: No separate requirements for LPL should be issued (see general comment on LPL) unless restricted to ELA 1-aircraft less than 600 kg MTOM as proposed by the MDM.032 working group and with operational limitations similar to the US Sport pilot licence. **Proposal:** Delete (b) and renumber thereafter, amend (c) to include LPL.	
response	*Noted*	
	See response to comment No 314.	

comment	*1192*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.020 (g) **Comment**: The pilot does not only need to undertake the audiometry examinations, he/she also needs to have the examination results assessed as acceptable. This is not clear in the proposed text. **Proposal**: Amend MED.A.020 (g): "... according to the periodicity and **meet** the standard required for ..."	

response	*Partially accepted*
	The Agency acknowledges your comment. For clarity purposes, 'according to' will be replaced by 'in accordance with' that has the meaning of 'in conformity with'.

comment	*1291*	comment by: *HAEGELE, Gert*
	Dear Ladies and Gentlemen of EASA, being a glider pilot for quite some years, I would like to make to the following proposal to this section of the NPA: 1 Statistics as well as personal experience shows that the health status of glider pilots are no threat at all, neither for any human (or other) being nor any object on the ground. Throughout my whole pilots' career, I am not aware of any incident where persons were injured or killed due to a sick glider pilot. 2 Therefore, the requirement for a Medical Certificate of Class 2 for any PPL licences seems to me far beyond reason, especially for glider pilots who are typically on their own in their gliders cockpit. 3 My proposal is to skip all medical requirements for glider pilots. Medicals for other PPL licences shall be in a reasonable ratio towards possble/probable damage a PPL pilot may cause (ie. amount of passenger seats etc). Best regards from Ludwigsburg (Germany), Gert Hägele	
response	*Noted*	
	See responses to comments No 36 and 1132.	

comment	*1293*	comment by: *David Chapman*
	I am told that for Gliding/Sailplanes there will be both a "LPL(Sailplanes)" and an "SPL" (Sailplane Pilots Licence). This section makes no mention to either licence, so the section is not clear in its scope or intention.	
response	*Noted*	
	See response to comment No 1132.	

comment	*1308*	comment by: *RP Kassel*
	Example: Pilot is the owner of an ATPL and a SPL. As a pilot shall not hold more than one medical certificate, it should be regulated, that class 1 medical certificate (needed for ATPL) includes class 2 (needed for SPL). Such a Regulation is not apparent.	
response	*Noted*	

	See response to comment No 250.

comment	1312	comment by: *Joachim Grohme*
	Die Forderung nach einem Pflichtmedical auch für den privaten Luftverkehr widerspricht zahlreichen Studien, die die Häufigkeit von Unfällen aufgrund medizinischer Insuffizienz und deren Auswirkung auf die Umgebung zum Thema hatten. Den Studien zufolge sind medizinische Unfallursachen äusserst selten, nicht vorhersagbar und haben keinerlei Auswirkung auf die Sicherheit der Umgebung. Nähere Erläuterungen gibt hier der Brief von Dr. Claus-Dieter Zink an die EASA anlässlich dieser NPA. Sollte diese Forderung mit dem Annex III der Basic Regulation begründet werden, ergibt sich hier eine im Kreis geführte Begründung, da die Basic Regulation wiederum auf dem bisherigen Vorgehen der JAA und EASA basiert. Dieser Argumentationskreis sollte durchbrochen werden.	
response	*Noted*	
	See response to comment No 36.	

comment	1322	comment by: *Markus Hitter / JAR-Contra*
	Deutsch: (english below) Eine Betrachtung der Statistiken der Erfolge der bisherigen Tradition, für eine Fluglizenz grundsätzlich eine eingehende ärztliche Untersuchung zu fordern, ergibt klar, dass medizinische Insuffizienzen als nicht sinnvoll vorhersagbar gelten müssen. Dass die Basic Regulation keineswegs umfangreiche medizinische Untersuchungen fordert, wurde bereits in Kommentar Nr. 157 zur NPA 2008-17a beschrieben. Uns ist keine einzige Studie bekannt, die die Beibehaltung des Medicals in der Privatfliegerei befürworten oder nahe legen würde. Dagegen gibt es eine Reihe von Studien, die die geringe Wirkung flugmedizinischer Vorschriften nahe legen oder nachweisen. Darunter sind: 1) Die amerikanische AOPA hat eine Befreiung vom Medical für eine Probefrist durchgesetzt und gegen Ende der Probezeit festgestellt, dass diese Befreiung keinerlei negative Auswirkungen hatte: http://www.aopa.org/whatsnew/newsitems/2003/030116petition.html Folgerichtig sind heute weite Teile der US-amerikanischen privaten Luftfahrt von der Medicalpflicht befreit. 2) Die deutsche Studie BEKLAS hat medizinische Unfallursachen als vernachlässigbar festgestellt. Weder die Sehschärfe sei von entscheidender Bedeutung (Kapitel 5.3.3. Satz 3.) noch kämen medizinische Ursachen überhaupt bei den Unfallursachen von Kollisionen in der Luft vor (Kapitel 5.4). http://www.daec.de/flusi/downfiles/Beklas/BEKLAS_Abschlussbericht.pdf	

3) Der französische Rapport Senateur Belot stellt fest, dass Luftfahrzeuge, die ohne Medical zu betrieben sind, deutlich geringere Unfallzahlen erfahren als solche, die mit einer medicalpflichtigen Lizenz zu betreiben sind. Siehe Seite 19 unten:

http://www.aviation-civile.gouv.fr/html/avia_leg/pdf/Rapport_senateur_belot.pdf

4) Der deutsche Arzt Claus-Dieter Zink rechnet ohne Mühe vor, dass statistisch gesehen nur alle 3000 Jahre ein einziger Unbeteiligter durch medizinische Insuffizienzen eines Piloten zu Schaden kommt. Es ist also nicht verwunderlich, dass dies in den bislang 100 Jahren der Zivilluftfahrt noch kein einziges Mal vorgekommen ist:

http://jarcontra.csa-gmbh.com/joomla/index.php?option=com_content&task=view&id=424&Itemid=1

Da die LPL-Lizenzen als nicht ICAO-konform geplant sind **schlagen wir vor**, die medizinische Untersuchung durch eine im Einverständnis mit seinem Hausarzt erbrachte Selbsterklärung des Piloten zu ersetzen. Dies ist für die Sicherheit mehr als ausreichend und genügt den Anforderungen der Basic Regulation.

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English:

Looking at statistics regarding the achievements of the present tradition of requiring detailed medical examinations for any type of flight license the outcome is clearly, medical insufficiencies can't be predicted in a reasonable way. In comment no. 157 to NPA 2008-17a we already laid out why the basic regulation does not require detailed medical examinations.

We're not aware of any scientific study which would suggest keeping medical certificates in private aviation. However, there's a whole bunch of studies which show up the minuscule significance of aeronautical medical examinations. Among those are:

1) US-american AOPA has accomplished relief from a medical certificate for some probation period and at the end of this period it was determined freeing private pilots from a medical has zero negative consequences:

http://www.aopa.org/whatsnew/newsitems/2003/030116petition.html

Accordingly, wide parts of US-american private aviation are freed from enforced medical certificates today.

2) The german study BEKLAS has recognized accidents due to medical reasons are negligible. Neither sharpness of eyesight would be of significance (chapter 5.3.3., sentence 3) nor any mid-air collision can be justified by medical reasons (chapter 5.4).

http://www.daec.de/flusi/downfiles/Beklas/BEKLAS_Abschlussbericht.pdf

	3) The french Rapport Senateur Belot determines aircrafts which are allowed to be operated without medical certification experience much less accidents than aircrafts which require an enforced medical. See page 19: http://www.aviation-civile.gouv.fr/html/avia_leg/pdf/Rapport_senateur_belot.pdf 4) German physician Claus-Dieter Zink demonstrates without trouble a calculation which proves, statistically once in 3000 years a casual bystander is harmed due to an aircraft coming down due to medical incapacitation of it's pilot. Seeing this, it's not surprising this hasn't happenend during the past hundred years of human aviation yet: http://jarcontra.csa-gmbh.com/joomla/index.php?option=com_content&task=view&id=424&Itemid=1 As LPL licences are planned to be not conforming to ICAO requirements, **we propose** to require a self-declaration of the pilot in accordance with his general medical pracitcioner instead of detailed medical examinations. This is more than sufficient for safety and conforms to requirements of the basic regulation.
response	*Not accepted*
	Your proposal to accept LPL self-declaration and issue the medical certificate without the need for an assessment when the GMP has the medical history of the pilot cannot be accepted. In fact, having knowledge of the medical background of the applicant is a prerequisite for a GMP to be allowed to issue medical certificates, in accordance with article 7(2) of the Basic Regulation. But the same article further determines that a medical certificate shall only be issued when the applicant demonstrates compliance with the Essential Requirements in Annex III to the Basic Regulation. Furthermore, paragraph 4.a.1 of the Essential Requirements determines the following: *'All pilots must periodically demonstrate medical fitness (...). Compliance must be shown by appropriate assessment (...)'.* The Agency's view is that this requirement for appropriate assessment cannot be satisfied with the mere analysis of medical records. There is a need for the GMP to perform a medical assessment. Existing medical records may be taken into account when performing the assessment, but cannot be the only element used. The same reason was behind the decision not to allow the system of self-declaration of medical fitness that is used in some Member States. In the Agency's view, a self-declaration cannot fulfil the requirement for a appropriate aeromedical assessment in the Basic Regulation

comment	*1327*	comment by: *Thomas Geiger*
	Sehr geehrte Damen und Herren, Vor nunmehr 25 Jahren bin ich durch einen Unfall teilweise querschnittsgelähmt. Bereits ein Jahr danach habe ich durch Nachweis meiner Flugfähigkeit meine	

	Flugscheine wieder erhalten. Ein halbes Jahr später war ich einer der Ersten, der beim LBA in Braunschweig die IFR Prüfung per PC ablegte! Verlangt wurde von mir der unbürokratische Nachweis, dass ich in der Lage war ein Flugzeug zu steuern. Seither flog ich unfallfrei ein und zweimotorige Flugzeuge! Die IFR Lizenz gab ich vor fünf Jahren zurück, weil unser Innenminister in mir, und allen anderen deutschen Piloten, einen potentiellen Terroristen sieht. Vor zwei Jahren stellte man bei einer Routineuntersuchung fest, dass eine Herzklappe bei besagtem Unfall vor 25 Jahren einen Schaden erlitten hat. Die daraufhin konsultierten Herzspezialisten sahen für mein weiteres Leben keine Gefahr, da die nun jährliche Kontrolle keine Veränderung aufweist. Ein weiteres Fliegen mit deutschem Flugschein ist aber in der BRD ausgeschlossen, oder bestenfalls nur durch Einsatz von viel Geld möglich. Ich fliege also weiter - mit einer ausländischen Lizenz - unfallfrei! Wieviel diese "Medicals" wert sind, kann man an den Vorfällen, die trotz der teuren Untersuchungen passiert sind, feststellen. Ich möchte nur an den CO-Piloten einer Lufthansamaschine erinnnern, der auf einem ganz normalen Linienflug eine Herzattacke erlitt. Noch spektakulärer war der Tod des Herausgebers von Pilot & Flugzeug, Heiko Teegen, der trotz Medical 1, an Herzversagen starb. Ein Fliegerarzt wurde deshalb noch nie zur Verantwortung gezogen, trotz hoher Rechnungen. Ein teures Medical erhöht nachweisbar die Flugsicherheit nicht! Deshalb wurde dies in einigen Ländern auch abgeschafft. Eine Hausarztbestätigung reicht völlig aus. Die EASA ist angetreten die ausufernde Bürokratie einzudämmen. Man darf gespannt sein, was daraus wird. Ich bitte Sie, streichen Sie das Medical 2 aus den Vorschriften. Mit freundlichen Grüssen Thomas Geiger
response	*Noted*
	See response to comment No 36.

comment	*1337*	comment by: *ophtalmologie aerospace medecin*
	Comment: In modern cockpits many complex displays are presented in different colours. Seeing different illumination, lightning and glare conditions, it is possible that displays are not correctly identified and understood. This happens especially in protanomalous pilots, who see red displays much darker compared to how they are seen in an objective presentation. If the colour of the information cannot be identified correctly, the information can be misinterpreted. This can lead to very dangerous situations. **Proposal**: (g) If an instrument rating is added to a PPL, the pilot shall under take pure tone audiometry examinations according to the periodicity and the standard required for class 1 medical certificate holders. The pilot must be colour safe.	
response	*Noted*	
	See the response to comments No 325 and 927.	

comment	*1396*	comment by: *Prutech Innovation Services Ltd.*
	MED.A.020(b): Applicants for and holders of a leisure pilot licence (LPL), or a private pilot licence (PPL) for an aircraft of 600kg or less, shall hold a valid LPL medical certificate. **Comment:** *As has been shown by EASA in previous documents, national requirements in operation up to now in several States allow GMP certification and without noticeable deterioration in safety. These new Community rules should not be more excessive than the minimum required for safety in **any** Member State, in line also with the rules for other safety situations in the Community (such as those governing the approval and certification of electrical equipment).* *This could also be a major factor in persuading those persons who are currently determined to resist the extraction of such lighter aircraft from the current exemptions of Annex II that European-level regulation can be a non-burdensome direction.* *Finally, the (current) elimination of the GMP as a potential medical certifier for Class 2 medicals (MED.A.030) makes this adjustment for lighter aircraft all the more necessary.*	
response	*Not accepted*	
	Private pilot licence holders shall hold a valid Class 2 medical certificate regardless of the MTOM of the aircraft flown. GMPs have never been considered as potential medical examiners for Class 2 medical certificates. The provision allowing GMPs to issue medical certificates for LAPL applicants, if permitted under national law, is laid down in the Basic Regulation. It requires GMPs to have sufficient detailed knowledge of the applicant's medical background. See also response to comment No 314.	

comment	*1416*	comment by: *Bob Berben*
	see (d) what medical is required for a basic (BPL without commercial qualification) ? Not mentioned as such.	
response	*Noted*	
	As PPL does not cover SPL or BPL, these licences need to be mentioned separately. The text in (c) will be amended accordingly.	

comment	*1427*	comment by: *David Usill*
	It would be preferable for GPs to be able to conduct medical examinations, based on the standard for that of HGV and car licences, for all but passsenger flying qualifications.	
response	*Noted*	
	See response to comment No 361.	

comment	1431	comment by: Dr Klaus Wagner
	MED.A.020 (b) Das "Medical" für LPL (leisure pilot license) also für Segelflieger (Gliderpilots, sailingplane pilots) sollte komplett gestrichen werden. Begründung: Im täglichen Leben -als normaler Bürger- sind wir vielfältigen Gefahren ausgesetzt und stellen selbst ein Risiko dar, Mitmenschen erheblich zu veletzen; z.B. als Führerscheininhaber, als Fahrer eines Gefahrgut-Lkws oder schon als Fahrradfahrer. In diesen Fällen wird kein Medical gefordert, obwohl die Stistiken beweisen, dass Unfälle, auch aus medizinischen Gründen, häufig passieren (Unwohlsein bei hohen Geschwindigkeiten auf der Autobahn, kranke, übermüdete oder alkoholisierte Lkw-Fahrer). Trotz dieser Risiken benötigen diese Personen keinerlei medizinische Überprüfung. Die Forderung nach einem Medical für LPL-Piloten ist daher völlig unangemessen und durch keinerlei Unfallstatistik gerechtfertigt, siehe Unfalluntersuchungen der AOPA. Wie schon die Lizenzbezeichnung aussagt (leisure pilot license), fliegt ein Segelflieger zum Vergnügen - ohne Druck und ohne den Zwang, an ein bestimmtes Ziel zu kommen. Ein Segelflieger, der sich nicht fit fühlt, würde kaum starten ... der Flug würde ihm keinen Spaß machen. Mir ist kein einziger Fall bekannt, wo ein Segelflieger infolge gesundheitlicher Probleme andere Menschen gefährdet hat. Die Gefahr, dass er anderen Menschen "auf den Kopf fällt", ist so minimal und beträgt etwa 1 mal in 3000 Jahren (für Europa). Falls der Segelflieger weitere Lizenzen anstrebt, sind schon Medicals festgelegt, aber in der Mehrheit bleibt er Segelflieger und muss nicht vorher schon einen exzellenten Gesundheitszustand nachweisen. Für Segelflieger muss es reichen, dass jeder Allgemeinmediziner ein einmaliges Attest ausstellen kann, welches einen normalen Gesundheitszustand bescheinigt.	
response	*Noted*	
	See response to comment No 36.	

comment	1433	comment by: Rolf Ross
	Gentlemen, at first I must protest against a hearing tool in a language, which differs from that of 50% of the glider pilots in this world ! Then I wish to remark, that the effect will be a huge under-representation of this group of pilots, who are by far the biggest national group in the EU. What we feel about the actual medical testing for glider- and TMG-pilots is, that there is big artillery-fire on small birds. Has any glider pilot ever in history damaged someone as thousends of car-drivers, motorbikers, truck-drivers do every day in each country, who may never have seen any doctor after their	

	licencing? The actual procedure in Germany is over-sophisticated by far, as if we all would sit in combat-fighters, which weigh tons instead of gliders of some hundred kilos. It would be sufficient, to ask a general practician about the condition of his patient, as we all know, that even extreme research methods would hardly bring more than a 50% result in prognosis. Everybody knows the story about the US-airline-captain, who died a sudden death in the medical ward after a positive testing. If you compare procedure, risk and result of the actual medical testing, you may quietly follow the knowledge of a family-doctor about his patient's condition. With kind regards Rolf Ross, FI, PPL A, B, C 6000h of flight
response	*Noted*
	See response to comment No 36.

comment	*1464*	comment by: *Dieter Walz*
	There are no data available which give any indication that a medical especially for glider pilots can avoid accidents. Several studies have shown that well defined medical reasons don´t play any role in crashes that involve innocent bystanders ! Why does nobody take these facts serious and why does nobody draw the only correct consequences from these findings ? Countries without obligatory medical examinations, like the US, have foregone these exams with good reasoning. The English, the Swiss and others have no more accidents with gliders than the rest of the world. I don´t know anything about higher accident- or fatality rates. To the contrary, English investigations from the 60ies and Swiss reports speak an unmistakable and quite different language. Nevertheless there is a statistical risk close to zero (which is proven by reality) that somebody on the ground will be hit or killed by a tumbling sailplaine.	
response	*Noted*	
	See response to comment No 36.	

comment	*1478*	comment by: *Dr Ronald H Bishop*
	I am an occasional trainee glider pilot aged 63 in Northern Ireland who wishes to participate in the sport much more extensively when I retire in two years time. EASA’s proposal NPA 2008 17a/b/c contains a number of sensible suggestions to improve the safety of leisure flying and gliding and the agency must be commended for these. However, there are some which I feel will seriously reduce my ability to partake in and enjoy this sport without any obvious improved safety	

	benefit, and I would ask that the Agency look at these again carefully and consider their impact on glider pilots. In particular, I am concerned that; 1. The proposed medical requirements for the Leisure Pilots License are reasonable but the unnecessarily complex form (in NPA-17c) to be completed by the certifying GMP will considerably increase the cost of obtaining the annual medical clearance to an estimated 200 euros. On my retirement income this will be a significant barrier to participation. The current UK NPPL procedure seems adequate for the reduction of incapacitation risk and I support the proposal by the British Gliding Association of adoption of a form similar to that used in New Zealand 2. I cannot see that ICAO VFR conditions are either practicable or necessary for the safe operation of gliders in the appropriate category of airspace. It is seldom possible to fly sufficiently clear of the cloudbase and take advantage of the gliding performance of one's aircraft, particularly in my part of the world. The LPL-S and SPL licences really do need to have a cloud-flying qualification and decades of experience shows that glider pilots will not abuse the removal of this restriction. I appreciate that a working group is to be established to consider this further but I am concerned that it will report too late to fit into the main FCL implementation timescale. [This comment has also been added to NPA 2008-17a]
response	*Noted*
	1. See response to comment of BGA. 2. Thank you for providing your opinion containing a proposal for a future Cloud Flying Rating. It was indicated in NPA 2008-17a that this issue is currently being discussed in a separate Rulemaking task: FCL.008. The comments received on A-NPA 14-2006 and on this NPA dealing with the issue of the Cloud Flying Rating will be taken into account by this working group. The task FCL.008 will result in an NPA which will be submitted to public consultation, and on which you will be able to make your comments.

comment	*1508*	comment by: *Max Heinz Katzschke*
	Die Statistik zu Flugunfällen mit Leichtflugzeugen, insbesondere Segelflugzeugen, in der USA zeigen, daß von Piloten ohne Medical (also nur mit einer Anfangsuntersuchung wie zum Erwerb einer Fahrerlaubnis) keine höhere Gefahr ausgeht (sie war statistisch <0,03 %) als von Piloten mit Medical. **Die wirklichen Indikationen zu flugbeinträchtigenden körperlichen Ereignissen sind nur vom Piloten selbst in unmittelbar vor dem Start und während des Fluges zu geschehender Selbsteinschätzung möglich.** Die periodische Untersuchung durch einen Fliegerarzt ist damit unnötig. Eine Konsultation eines Allgemeinmediziners oder Fachmediziners bei körperlicher Beeinträchtigung zeitlich unmittelbar zu einem derartigen Ereignis ist sinnvoller. Deshalb sollte für Segelflug, Ultraleicht- und einmotorige Flugzeuge (insbesondere unter 1000 kg MOTOW) ein periodisch zu erneuerndes Medical nicht erforderlich sein.	

Siehe hierzu mein Komentar zu NPA 2008-17a Page 4-7 Cmt# 294
a) In den Studien der amerikanischen AOPA ist, nach einer Probezeit ohne Zwang zur fliegerärztlichen Untersuchung als Voraussetzung zum Führen von Luftfahrzeugen, keine negative Auswirkung auf die Flugsicherheit festgestellt worden.
Siehe: http://www.aopa.org/whatsnew/newsitems/2003/03116petition.html
Auch die deutsche Studie BEKLAS hat medizinische Ursachen als vernachlässigbar für Unfälle festgestellt.Siehe:
http://www.daec.de/flusi/douwnfiles/Beklas/BEKLAS_Abschlussbericht.pdf
Der französische Rapport Senateur Belot stellt sogar fest, dass von Luftfahrzeugen die ohne Medical betrieben werden dürfen geringere Unfallzahlen verursacht wurden als von nur mit Medical zu betreibenden. Siehe:
http://www.aviation-civile.gruv.fr/html/avia_leg/pdf/Rapport_senateur_belot.pdf

Aus meiner ~50 Jahre dauernden Tätigkeit als Segelfluglehrer sehe ich es als ausreichend an, dass zu Beginn einer fliegerischen Tätigkeit zum LPL und SPL die grundsätzliche Eignung des Flugschülers vom dem mit der Ausbildung beginnenden Fluglehrer festgestellt wird; dies muss er verantwortungsbewusst tun, indem er im Laufe der Ausbildung den Schüler nach und nach auch mit außergewöhnlichen Aufgaben konfrontiert, die Reaktion bewertet und auch mit dem Schüler gemeinsam auswertet. Mit einem derartigen Vertrauensverhältnis sind auch schwierige Entscheidungen, wie sie die Ablehnung einer weiteren Ausbildung durch den Fluglehrer darstellt, lösbar.
Die Konsultation eines Allgemeinmediziners, möglichst des Hausarztes, mit einer formlosen schriftlichen Feststellung der Eignung zum Fliegen (oder der Bedenken dagegen) auf der Basis der Voruntersuchung zum Kraftfahrzeug-Führerschein zeitnah zu Beginn der Ausbildung empfehle ich als notwendige Ergänzung. Diese schriftliche Feststellung sollte vor dem ersten Alleinflug dem Flugleher vorzulegen sein, der damit verantwortungsbewusst handeln kann und bei Erfordernis die Untersuchung bei einem Facharzt oder Fliegerarzt (AME oder AMC) verlangen darf.

b) Die unter a) angeführten Studien und Rapporte belegen auch, dass für die Erlaubnisse LPL und insbesondere für die Erlaubnisse LPL(S) sowie SPL die periodisch zu erneuernden Medicals keine Verbesserung der Flugsicherheit erbringen.

Eine einfache, periodisch zu wiederholende Selbsterklärung (bei akuten medizinischen Ereignissen eine zeitnahe Selbsterklärung) unter der Aufsicht eines Arztes als Zeugen (im Fall einer speziellen Diagnose: ...eines Facharztes...) halte ich für sicherheitsrelevanter als die zeitferne Diagnose eines Flugmediziners bei einer periodisch vorgeschriebenen Untersuchung.

response *Noted*

See response to comment No 36.

comment *1513* comment by: *Dr Ian Perry*

In MED.A.20(a) should the lower age limit of 17 be included in this section

response	*Not accepted*
	Age limits are proposed in NPA 2008-17b Implementing Rules for Pilot Licensing — Part FCL.

comment	*1571*	comment by: *FAA*
	MED.A.020: Differences with paragraphs (d), (f), and (g) are filed with ICAO.	
response	*Noted*	
	Thank you for the information.	

comment	*1620*	comment by: *Bayerisches Staatsministerium für Wirtschaft, Infrastruktur, Verkehr und Technologie*
	Nach dieser Vorschrift genügt für jede LPL-Lizenz ein LPL-Medical Certificate, das hinter den Anforderungen des ICAO class 2 medical zurückbleibt. Im Regulatory Impact Assessment NPA 2008-22f, Nr. 2.12 (insb. 2.12.1 und 2.12.8 auf S. 128 ff.) wird als Grund für diesen niedrigeren akzeptierten Sicherheitsstandard u.a. angegeben, dass für das spezielle LPL-medical certificate auch besondere "limited privileges (flight only within aerodrome zone)" gelten würden. Nach MED.A.020 gilt das LPL-medical certificate jedoch für jede LPL-Lizenz, also auch z.B. für den LPL (A) und den LPL (S), für die es keine 50-km-Entfernungsgrenze gibt wie für den Basic LPL (FCL.105.BA/H). Die Begründung für die Einführung des speziellen LPL-Medicals wurde somit bei Erstellung der FCL-Vorschriften nicht umgesetzt. Sinnvoll wären die Hinweise im RIA nur dann, wenn man die Gültigkeit des LPL-Medicals auch auf den Basic-LPL beschränkt. Bezieht man die Gültigkeit des LPL-Medicals auf sämtliche LPL-Lizenzen, erscheint es nicht nachvollziehbar, wodurch sich die deutlich verringerten gesundheitlichen Anforderungen rechtfertigen lassen, da die Rechte, die ein LPL (A) vermittelt, kaum hinter den Rechten eines PPL (A)-Piloten zurückbleiben. Es wird daher vorgeschlagen, die Gültigkeit des LPL-Medicals auf die Ausübung der Rechte aus dem Basic LPL zu beschränken.	
response	*Noted*	
	See response to comment No 314.	

comment	*1631*	comment by: *Akaflieg Tübingen*
	de	
response	*Noted*	
	There is no comment in 1631.	

comment	*1632*	comment by: *Akaflieg Tübingen*

	Sehr geehrte Damen und Herren von der EASA! Das geplante teure Pflichtmedical für Segelflieger widerspricht allen Rechtsstaatsprinzipien. Es hat keine schützende Wirkung gegen eine Bedrohung aus der Luft, die von einem Segelflieger ausgehen soll. Ein Pflichtmedical ist nur von Sinn in der Berufsfliegerei und für das Miltär; nur hiervon gehen echte Gefahren aus. Im Bereich der privaten Motor und Segelfliegerei bringt das Zwangsmedical keinerlei Sicherheitsgewinn. Denn Segelfliegen und und die unteren Gewichtsklassen stellen keine Gefahr für die Allgemeinheit dar. Nachweislich ist Segelfliegen für die Allgemeinheit nicht gefährlicher als ein Bergwanderer oder ein Segelboot auf dem Wasser und es gehen von Piloten eines Segelflugzeugs oder Kleinflugzeugs weit geringere Gefährdungen aus als z B von einem Teilnehmer am Strassenverkehr. Die Vereinigten Staaten und einige europäische Länder haben dies schon vor Jahren erkannt und konsequent umgesetzt, indem sie auf eine Medicalpflicht verzichten im Bereich der SegelfliegereiIn. Die uralte Medicalpflicht wurde dort wegen erwiesener Unwirksamkeit aus vernünftiger Sicht abgeschafft. Es gibt zeitgemäße Alternativen um einen kranken fluguntauglichen Piloten zu erkennen, dazu ist jeder Hausarzt in der Lage. Ausserdem hat auch noch niemals ein Segelflieger aus medizinischer Ursache einen Unbeteiligten Dritten ernsthaft geschädigt Das Medical ist für Segelflieger also völlig unverhältnismäßig und blanke Willkür. Es macht daher keinen wirklichen Sinn. Es könnte deshalb, wie in den USA aus erwiesener Unwirksamkeit schon längst abgeschafft sein. Von einem radfahrenden Menschen geht eine grössere Gefährdung der Allgemeinheit aus als von einem Segelflugzeugführer über den Bergen. Ein Pkw-Fahrer stellt ein viel grösseres Gefahrenpotential dar, und müsste folglich ein zu einem extrem strengen Medical in regelmässigen Abständen gezwungen werden. Segelflieger sind mit diesen nicht zu vergleichen.
response	*Noted*
	See response to comment No 36.

comment	*1633*	comment by: *Akaflieg Tübingen*
	Die USA haben nach umfangreichen statistische Untersuchungen, das Pflichtmedical für Segelflieger schon wegen seiner Unwirksamkeit allein abgeschafft. Deutschland und Europa sollte in USA gewonnenen Erkenntnisse nicht igorieren und seine Bürger nicht noch mehr entmündigen und gängeln durch immer kompliziertere Regularien. Damit wird der Flugsport in Vereinen noch mehr an Attraktivität verlieren, wo junge und aktive Mitbürger mit technischen und handwerklichen Interessen mit viel Engagment und oft geringen finanziellen Möglichkeiten ihr Hobby ausüben können, und viel zu Innovationen für die allgemeine Luftfahrt und zum technischen Fortschritt beitragen. Für Segelflieger würde ein einfaches Zeugnis von einem Allgemeinarzt genügen, wo Arzt und Pilot in einem Satz bestätigen, dass keine zu plötzlicher Handlungsunfähigkeit führenden Krankheiten bekannt sind. Mit freundlichen Grüssen Dr V G	
response	*Noted*	

	See response to comment No 36.

comment	*1638*	comment by: *Tomasz Gorzenski*
	Self-certification should be sufficient for LPL-holders as well as for glider pilots and balloon pilots. Even though the basic regulation mentions medical certification, a self-certification is a form a cerftification, as good as any other. Overwhelming evidence from USA (and UK) clearly indicates that self-certification is sufficient for pilots of gliders and balloons (as well as for skydivers). The same is very likely to be true in case of small sport airplanes. The widely known fact from these statistics is, that the percentage of accidents with medical cause or factor is lower in the self-certification group, than it is in the case of FAA medical certificate class 3 (equivalent of ICAO, JAA and EASA Class 2) holders (required for private pilot flying activities), which clearly demonstrates medical certification for that group of pilots, other than self-certification, doesn't make sense. The current proposal will cause an unneccessary burden, while having no potential to increase safety at all.	
response	*Noted*	
	See responses to comments No 36 and 1322.	

comment	*1655*	comment by: *Nils Wedi*
	Rule a) Given current practice for glider experience flights (as student pilot flights) it would seriously undermine non-profit gliding club efforts to recruit new members, if prospective members are required to have a medical certificate. There is no evidence that the current level of self-certification before flight is inadequate for glider experience flights and I strongly suggest to maintain these as an exception (e.g. add to this rule with the exception of air experience glider flights).	
response	*Noted*	
	See response to comments No 36 and 1127.	

comment	*1657*	comment by: *Nils Wedi*
	Rule b,c,h) It is not clear here that a holder of a class 2 medical certificate can also excerise with this medical the privileges of a LPL licence that the pilot may hold.	
response	*Noted*	
	The clarification is given in AMC to MED.A.020.	

comment	*1702*	comment by: *Norwegian Association of Aviation Medicine*
	MED.A.020: We suggest that there are only 2 medical classes: Medical class 1 for the ATPL and CPL and a Medical class 2 for the PPL, LPL and the BPL. The 3 categories in	

	class 2 shall be using the same airspace and it is important to assure the same medical fitness to all the licenced pilots. The Norwegian Aeromedical Association notes that the largest difference between suggested class 2 and LPL medicalsis not the requirements themselves, but how well and how often compliance with the requirements should be controlled. This is obviously done in order to save costs for leisure pilots, but increases the chance of non-compliance with the requirements immensely. The quality control effectiveness of Flight function-related health issues controlled by a non-knowledgable person regarding stresses of flight, with long intervals, is at best severely lacking. We therefor recomend that all referals to a LPL medical is removed.
response	*Not accepted*
	The provisions for a LAPL medical certificate were developed in accordance with Article 7 of the Basic Regulation following the principle that all measures must be proportionate and tailored to the risk involved. It is a Rulemaking task and may not be deleted. However, in the light of the comments to this NPA the proposed requirements for a LAPL medical certificate have been redrafted.

comment	*1703*	comment by: *Klaus Schneider-Zapp*
	Several studies (AOPA-USA, Beklas-studies, Rapport Senateur Belot, and others) show that the enforcement of a medical certification does not increase safety. We do not know about a single study or statistical evaluation which suggests the need of a medical certificate. It is not possible to reliably diagnose potential medical dangers reliably in advance. The chance that third parties are harmed due to a medical cause is way too low to justify the costs and bureaucracy which is caused by the medical requirement.	
response	*Noted*	
	See response to comment No 36.	

comment	*1728*	comment by: *Civil Aviation Authority Finland*
	The minimum age requirements for the persons applying the Medical Certificate are missing. A maximum 6 months prior to attaining the required pilot licence age is reasonable to provide the initial medical examination to be passed before beginning training. Add a subparagraph (b) and renumber others: **(b) The initial Medical Certificate shall not be issued prior to six months before the applicant is eligible for a pilot licence of the desired type.**	
response	*Noted*	

	See response to comment No 233 in this section.

comment	*1751*	comment by: *Albert Brüning*
	Betreff Med.A.020 Absatz b: Es besteht kein hinreichend logischer Grund, einem alleinfliegenden Segelflieger, der am gesunden Nachhausekommen am Abend ebenso interessiert ist wie jeder Autofahrer, eine zusätzliche medizinische Untersuchung abzuverlangen. Dies ist lediglich ein zusätzlicher Kostenfaktor und ein unnötiger bürokratischer Aufwand. In Zeiten, in denen alle Verwaltungen von "verschlanken" sprechen, ist dies eindeutig der falsche Weg. Ebenso gibt es keine Zahlen, die belegen, dass ein Staat, in denen kein Medical für alleinfliegende Segelflieger verlangt wird, eine höhere Unfallquote , hervorgerufen durch kranke Piloten, aufweist.	
response	*Noted*	
	See response to comment No 36.	

comment	*1773*	comment by: *AECA(SPAIN)*
	(b) Applicants for and holders of a leisure pilot licence (LPL) shall hold **al least** a valid LPL medical certificate. Justification: A medical certificate of class 2 or class 1 is valid for this licence. Take in account paragraph (h)	
response	*Noted*	
	See response to comment No 250.	

comment	*1774*	comment by: *AECA(SPAIN)*
	(c) Applicants for or holders of a private pilot licence (PPL) shall hold **at least** a valid class 2 ... Justification: A class 1 medical certificate is valid for this liocence. See paragraph (h)	
response	*Noted*	
	See response to comment No 250.	

comment	*1778*	comment by: *AECA(SPAIN)*
	(d) Applicants for or holfer of a balloon pilot licence (BPL) involved in commercial balloning shall hold **al least** a valid class 2 ... Validity of class 1 medical certificates for this pourposes.	

response	*Noted*
	See response to comment No 250.

comment	*1791*	comment by: *Lars Tjensvoll*
	<![endif]--> In my opinion there should be only two medical classes: Class 1 and class 2. Class 1 for the commercial pilots (ATPL and CPL). Class 2 for all the private categories including LPL. There is in principle no difference in the strain, physically and mentaly,on the pilots in the different categories. They are using the same airfields and should feel safe and sure to know that all the pilots around them are approved by the same, high medical standard. To make it cheeper and easier for the LPL pilots is a high risk to take and will hassard the aviation safety! It is not difficult to gues that a pilot who fails the class 2 medical, can easily go to he any GP and pass the proposed LPL licence! There will be no way to controll this!	
response	*Noted*	
	See response to comments No 1063 and 1702.	

comment	*1799*	comment by: *CAA Belgium*
	Relevant Text: (h) A pilot shall not hold more than one medical certificate at any time Comment: Pilots may execute their rights in different classes, so if the paragraph prohibits to hold more than one medical certificate, it's necessary to define, that a "higher class" includes a "lower class" of medical certificate. Though defined in AMC to MED.A.020, the text should be cited at this site. Proposal: (h) A pilot shall not hold more than one medical certificate at any time. A higher class of medical certificate includes the lower one whith its specified duration in the following sequence: class 1 includes class 2	
response	*Noted*	
	See response to comment No 250.	

comment	*1855*	comment by: *Aerovision*
	MED.A.020 (d) - A Class 2 medical is adequate for all balloon flying. If EASA introduce the strongly recommended CPL for balloons, a Class 2 medical is still OK. There is no safety justification in stating that a CPL (Balloons) needs a Class 1 medical!	
response	*Noted*	
	Thank you for the supporting comment.	

comment	*1872*	comment by: *ECA- European Cockpit Association*

	Comment on paragraph (g): ECA recommends to consider as well ICAO Recommendation in Annex 1, paragraph 2.7.1.3.2.: 2.7.1.3.2 **Recommendation.—** Contracting States should consider requiring the holder of a private pilot licence to comply with the physical and mental, and visual requirements for the issue of a Class 1 Medical Assessment.
response	*Not accepted*
	ICAO standard in 2.7.1.3.1 for PPL wishing to obtain an instrument rating requires complying with Class 1 hearing requirements. Acceptance of the recommendation (to add physical and mental and visual requirements) as an Implementing Rule would practically mean that PPL have to comply with Class 1 medical requirements. This would be overly restrictive.

comment	*1889*	comment by: *Susana Nogueira*
	(b) (c) (d) ... shall hold **at least** a valid class... medical certificate.' A class 1 or class 2 nmedical certificate are valid to covert requirements of lower class.	
response	*Noted*	
	See response to comment No 250.	

comment	*1890*	comment by: *Susana Nogueira*
	(a) Delete the second 'that student pilot'	
response	*Not accepted*	
	The deletion of this part of the text adds no additional clarity.	

comment	*1903*	comment by: *Michael Hinz*
	Ich bin der Meinung, dass für Privatpiloten eine gleiche Überprüfung wie für das Autofahren reicht. Autofahren ist gefährlicher für andere Verkehrsteilnehmer. Durch die fliegerärztliche Untersuchung ist noch kein Unfall verhindert worden, wie alle relevanten Statistiken zeigen. Insbesondere für Segelflieger ist eine ärztliche Überprüfung unsinnig. Wenn aber eine ärztliche Untersuchung nicht vermieden werden kann, dann muss der Arzt die uneingeschränkte Kompetenz besitzen, die Tauglichkeit zu bescheinigen oder eben nicht. Es dürfen keine gesetzlichen oder andere Vorgaben gemacht werden, die die Kompetenz des Arztes einschränken. Da jeder Mensch medizinisch und sozial unterschiedlich ist, kann immer nur der Einzelfall beurteilt werden. Pauschale Vorgaben führen im Einzelfall immer zu unverhältnismäßigen	

	Einschränkungen. Diese müssen im Einzelfall korrigierbar bleiben. Es kann auch nicht sein, dass in vielen intensiv fliegenden Staaten Tauglichkeitszeugnisse für Berufpiloten erteilt werden, die zum Beispiel in Deutschland noch nicht mal ein Segelflugzeug fliegen dürften. In Deutschland wird das Tauglichkeitszeugnis missbraucht, um unnötige Einschränkungen und Hindernisse unter dem Deckmantel der Sicherheit aufzubauen.
response	*Noted*
	See response to comment No 36.

comment	*1906*	comment by: *Klaus Staender*
	Mit besten Wissen und Gewissen möchte ich dazu Stellung nehmen. In weitgehend bekannten, wissenschaftliche Untersuchungen wurde festgestellt, dass für Segelflieger kein aufwendiges Attest (medical) notwenig ist. Eine Untersuchung des Hausarztes ist völlig ausreichend! Bitte wenden sie die in der USA zugelassene Med. Untersuchung für Segelflieger auch in Deutschland an! Viele Grüße Klaus Ständer Fischerstr. 35 72124 Pliezhausen	
response	*Noted*	
	See response to comment No 36.	

comment	*1913*	comment by: *Klaus Melchinger*
	Looking at statistics regarding the achievements of the present tradition of requiring detailed medical examinations for any type of flight license the outcome is clearly, medical insufficiencies can't be predicted in a reasonable way. In my equivalent comment to NPA 2008-17a I already laid out why the basic regulation does not require detailed medical examinations. I'm not aware of any scientific study which would suggest keeping medical certificates in private aviation. However, there's a whole bunch of studies which show up the minuscule significance of aeronautical medical examinations. Among those are: 1) US-american AOPA has accomplished relief from a medical certificate for some probation period and at the end of this period it was determined freeing private pilots from a medical has zero negative consequences: http://www.aopa.org/whatsnew/newsitems/2003/030116petition.html Accordingly, wide parts of US-american private aviation are freed from enforced medical certificates today.	

	2) The german study BEKLAS has recognized accidents due to medical reasons are negligible. Neither sharpness of eyesight would be of significance (chapter 5.3.3., sentence 3) nor any mid-air collision can be justified by medical reasons (chapter 5.4). http://www.daec.de/flusi/downfiles/Beklas/BEKLAS_Abschlussbericht.pdf 3) The french Rapport Senateur Belot determines aircrafts which are allowed to be operated without medical certification experience much less accidents than aircrafts which require an enforced medical. See page 19: http://www.aviation-civile.gouv.fr/html/avia_leg/pdf/Rapport_senateur_belot.pdf 4) German physician Claus-Dieter Zink demonstrates without trouble a calculation which proves, statistically once in 3000 years a casual bystander is harmed due to an aircraft coming down due to medical incapacitation of it's pilot. Seeing this, it's not surprising this hasn't happenend during the past hundred years of human aviation yet: http://jarcontra.csa-gmbh.com/joomla/index.php?option=com_content&ask=view&id=424&Itemid=1 As LPL licences are planned to be not conforming to ICAO requirements, it's proposed to require a self-declaration of the pilot in accordance with his general medical practicioner instead of detailed medical examinations. This is more than sufficient for safety and conforms to requirements of the basic regulation.
response	*Noted*
	See response to comment No 1322.

comment	*1922*	comment by: *Esko RUOHTULA*
	1) According to MED.A.005 the requirements concerning what level of a medical certificate a pilot licence holder shall have when utilizing the privileges of his licence and ratings are not within the scope of the Part MED. **Therefore I propose that the requirements in MED.A.020 are transferred to Part FCL**. 2) The requirements for applicants of pilot licences as proposed are correct, but regardless whether the requirements in draft MED.A.020 remain in Part MED or are transferred to Part FCL **I propose following changes**: **The requirement "..holders of a xxx pilot licence shall hold a valid medical certificate" should be removed from subparagraphs (b), (c), (d) and (f)** This requirement, if left in, means that a pilot may never let his medical certificate lapse. If he lets it happen, for instance due to flu just when he should	

go to an AME, he is not complying with the requirements of Part-Med, and according to draft FCL.070 his licence shall be suspended or revoked by the competent authority. After a week or so he recovers from the flu, gets a medical certificate and apparently has to reapply for the pilot licence. I fail to understand the logic behind.

3)
The requirement, what level of valid medical certificate a pilot licence holder shall have when flying, should be based on the type of operation, not on the type of the licence. The licence is actually a diploma of a certain level of education, training, passed examinations and experience. The licence alone does not give any privileges, e.g. class-, type- or instrument ratings and a medical certificate are required in order to be able to fly. If a pilot lets any of his ratings lapse, it should have no effect on his licence. A pilot's education, training and experience do not dissapear when a rating lapses. E.g. if a holder of an ATPL only has a single engine piston rating valid, he still has his ATPL licence but his privileges are according to SEP rating.
Similarily, if a holder of a CPL or ATPL is not flying commercialy for any reason, he has no need for class 1 medical certificate. Because keeping a class 2 medical certificate is cheaper, a holder of CPL or ATPL may want to let his class 1 medical certificate lapse and take a class 2 medical certificate instead. This shoud be allowed and have no effect on his licence or ratings, only his privileges are effected.

In order avoid differing interpretations by national authorities, Part-MED or Part-FCL should include unambiguous requirements or statements what level of medical certificate is required for different operations. The wording for PPL, CPL and ATPL could be something as follows:

In order to utilize privileges of his/her licence, a holder of a PPL, CPL or ATPL shall have a valid medical certificate as follows:

Operation
Medical Certificate

Private operations, including flying as a flight instructor or an flight examiner: Class 2

Skill test or proficiency check as an examiner, including proficiency checks and skill tests when the examiner receives remuneration: Class 2

Commercial operations: Class 1

Reason for allowing skill- and proficiency checks to be carried out by an examiner with a level 2 medical certificate is, that as the examiner is acting for an authority, a skill test or proficiency check is not commercial operation.
An other reason is, that the medical requirements should reflect the required safety of operation. No paying passengers or freight is carried on a skill test or a proficiency check, and the pilot(s) checked should be fully competent. Consequently an examiner with class 2 medical certificate does not mean

	unacceptable increase of risk.
response	*Noted*
	1. Not accepted. The scope of Part Medical covers all medical certificates as well as the certification of AMEs and the qualification of GMPs. This includes requirements on what kind of medical certificate for which type of licence is needed. 2. Noted. A pilot licence is only valid with valid type or class rating and valid medical certificate. If a pilot lets his/her medical certificate elapse, his/her licence is automatically invalid. It will be valid again after a new medical certificate has been issued and the type or class rating is valid as well. 3. Not accepted. According to ICAO Annex I the type of medical certificate is linked to the type of licence.

comment	*1923*	comment by: *CAA Belgium*
	A minimum age is needed for the issue of a medical certificate. It is inappropriate to examine children and also inappropriate to examine too far in advance of the first solo flight. Add a new rule to specify a minimum age 6 months in advance of the first solo for Class 2 and 17 and a half years of age for Class 1.	
response	*Noted*	
	See response to comment No 233 in this section.	

comment	*1955*	comment by: *Claus-Dieter Zink*
	Sehr geehrte Damen und Herren von der EASA! (Anfangsbemerkung: Jedermann hat mir bisher empfohlen, dieses Schreiben kürzer zu halten. Das aber nur aus der Geschichte verständliche fest geprägte Vorurteil über die Notwendigkeit eines Pflichtmedicals für Freizeitsegelflieger - diese Verkrustung - kann nicht durch wenige Sätze aufgeweicht werden. Dazu ist mir die Freiheit und die tatsächliche Realität zu wichtig. Und darüber müsste ich eigentlich sogar ein Buch schreiben.) Zusammenfassung: In Folgender Analyse wird von mir nachweisen, dass ein teures Pflichtmedical für Segelflieger zentralen Rechtsstaatsprinzipien widerspricht. Es hat keinerlei wirklich schützende Wirkung für Dritte. Das Pflichtmedical ist nur historisch aus der Berufs- Transport- und Militärfliegerei erklärbar und entspringt einem nur traditionell und nur herkömmlich gefühltem Sicherheitsgewinn. Dieser ist nicht beweisbar, sondern im Gegenteil nachweisbar irreal. Segelfliegen ist für die Allgemeinheit nicht gefährlicher als ein einsamer Bergwanderer im Fels oder ein winziges Segelboot auf dem Ozean! In den USA wurde diese uralte Medicalpflicht auch deshalb wegen erwiesener Unwirksamkeit	

bereits erfolgreich und fortschrittlich abgeschafft. Es werden von mir am Schluss viel wirksamere und zeitgemäßere Alternativen aufgezeigt, um den einzelnen Piloten und Allgemeinwerte zu schützen und verhinderbare Unfälle zentraler und viel sicherer zu vermeiden.

****

Seit nunmehr über 50 Jahren bin ich begeisterter Segelflieger und der Herausgeber des bekannten www.fotokalender-segelfliegen.de

Im Jahre 2004 gelang es der deutschen Bürokratie, mich wegen einer medizinischen Bagatelle während der zentralen Flugmonate des Sommers zu grounden und mir das Medical zu verweigern. Erst eine über 500 Euro teure Fliegerarztuntersuchung brachte mich schließlich wieder in den Himmel, obwohl der kollegial sofort hinzu gezogenen Kardiologe (ich bin selber Facharzt für Allgemeinmedizin!) mir meine Vermutung bestätigte, dass meine "EKG-Störung" klinisch völlig unbedeutend sei.
Der Fliegerarztkollege kam natürlich zu demselben Ergebnis, brauchte aber über 3 Monate und kassierte eigentlich nur ab!

Auf Grund dieser Erfahrung beschäftige ich mich seither eingehend mit diesem Thema und werde Ihnen heute Tatsachen vorlegen, die Sie nachdenklich machen könnten.

Die Fliegerärzte verdienen sehr gut an uns Segelfliegern und im Grund behaupten sie nur, sie könnten die Menschheit durch ihr Schaffen vor gar schrecklichen Katastrophen bewahren.
Bei einem Airline-Kapitän mit Hunderten von Passagieren an Bord kann ich dies sogar nachvollziehen. Gilt dies aber auch für einen einsamen Alleinsegelflieger?

Gestatten Sie mir bitte, da einmal genauer hinzusehen.

Folgende Zeitungsschlagzeile gilt es doch durch das Medical für Alleinsegelflieger zu verhindern:

"Abstürzender toter Segelflieger erschlägt unschuldigen Passanten."

Ich werde Ihnen im Folgenden durch eine einfache Rechnung beweisen,
wie oft ein solcher, von allen befürchteter Unfall wahrscheinlich jetzt und in Zukunft tatsächlich und wirklich vorkommen wird:

Die echte Gefahrenzone eines solchen "Horrorszenariums" aus meiner Schlagzeile mit ernsthaften Folgen für einen Dritten nehme ich mit 15 Quadratmetern an.

Bei 65 Einwohnern pro Quadratkilometer (1 000 000 Quadratmeter) in Europa ist die Wahrscheinlichkeit eines solchen Geschehens - schon von der riesigen möglichen Absturzfläche her - also nur ca. 1 zu 1 000 pro Absturz.

Flugunfälle (nicht nur Abstürze!) passieren nun aber nur zu ca. 0,3 % (durch die AOPA-Studie und Nall-Report bewiesen) aus medizinischer Ursache.

http://www.aopa.at/news/archiv/aug02.htm Dort der 9. Artikel

Niemand kann einfach behaupten, dass diese klare Statistik nicht für die gesamte Welt gelten soll.
Und ob diese medizinische Ursache auch vorsorglich voraussehbar ist, und ob der Pilot dann sofort völlig handlungsunfähig und damit ungesteuert direkt aufschlägt - dies reduziert die Wahrscheinlichkeit, dass der unschuldige Passant zu ernsthaftem Schaden kommt, weiter auf sicher unter 0,1 %. Jeder gesundheitlich gestörte Pilot wird nämlich vorher eine Notlandung auf einem freien Feld probieren.
Obiger Unfall hat also eine rechnerische Wahrscheinlichkeit von sicher unter 0,000 001 % pro Unfall.
Die BFU registriert aktuell ca. 100 Segelflugunfälle pro Jahr in Deutschland (übrigens einschließlich Doppelsitzer). Nach meiner Auskunft von dort ist eine sichere medizinische Ursache mit einem tödlichen Drittschaden noch nie sicher bekannt geworden. Europaweit ist es sicher nicht anders.
Bei dreifacher Bevölkerungsdichte in Deutschland komme ich auf eine Wahrscheinlichkeit eines einzigen solchen schlimmen Unfalls in Deutschland mit tödlicher Beteiligung jenes unschuldigen Passanten auf ein einziges Mal in 3000 Jahren.
Davon reden wir.
Von was bitte sonst?
Die Geschichte des Segelfliegens wird also einen solchen Maximalunfall eines unschuldig Mitbeteiligten aus medizinischen Gründen tatsächlich nie erleben!
Und dies ist also die einzig sachlich logisch nachvollziehbare, mehr als fragliche Begründung für das regelmäßige Pflicht-Medical für uns Segelflieger.
Weder die Studie BEKLAS
http://www.daec.de/flusi/downfiles/Beklas/BEKLAS_Abschlussbericht.pdf
noch der NALL – Report und auch keine anderen einschlägigen Untersuchungen wie z.B. der französische Rapport Sénateur Belot:
http://www.aviation-civile.gouv.fr/html/avia_leg/pdf/Rapport_senateur_belot.pdf
noch die Untersuchungen der Engländer aus den 60iger Jahren und die Berichte der Schweizer bestätigen diese lauten Befürchtungen gewisser Fliegerärzte, die ganz offensichtlich nur eine lukrative Einnahmequelle versiegen sehen.
Das Gegenteil ist der Fall, und diesbezügliche Details liefere ich Ihnen gerne nach und sie müssten Ihnen eigentlich auch bereits bekannt sein!
Nach dem Gesagten dagegen gerät ein Radfahrer oder gar ein Schwertransporter bei medizinisch bedingten plötzlichen Ausfällen zu 50% in den Gegenverkehr und kann dort so einiges anrichten. Die Medien sind voll davon. Wer aber fordert von einem Radfahrer ein Medical?
Wo bleibt der Rechtsgrundsatz der Gleichbehandlung?

Und nun zur Historie und zum weiteren Verständnis, warum es dieses Pflichtmedical auch für uns Segelflieger überhaupt gibt und welche weit verbreitete Vorurteile dahinter stecken:
In den vergangenen Kriegszeiten haben viele große Staaten das Segelfliegen ihrer Jugend ganz massiv finanziell und ideell gefördert. Künftige Kampfpiloten zu finden, das war ein klares Ziel. Ein kranker Kampfpilot mit seinem teuren Flugzeug aber war auch ein finanzieller "Totalausfall" und das musste verständlicherweise mit bewiesener totaler Gesundheit verhindert werden. Die Investition musste abgesichert sein.
Ohne wirklich wirksame Logik wurden diese Regeln dann einfach für uns

Freizeitsegelflieger gedankenlos übernommen.
Segelfliegen aber hat keinen vergleichbaren Zweck.
Will die EASA aus dem Jahre 2010 diese Wirbelschleppe aus uralten Zeiten tatsächlich weiter mit in die Zukunft übernehmen?
Oder ist die EASA auch zu echten, die Wirklichkeit ändernden Zukunftsvisionen fähig?
Länder ohne Medical für Segelflieger - wie die USA – haben sich dabei doch auch etwas gedacht (siehe detaillierter weiter unten). Die Briten, die Schweizer etc. sind mit aus medizinischen Ursachen abstürzenden Segelfliegern keineswegs ungewöhnlich häufig „heimgesucht"? Mir ist davon nichts bekannt. Ganz im Gegenteil. Britische Untersuchungen aus den 60iger Jahren und ebensolche aus der Schweiz sprechen eine eindeutige und völlig andere Sprache.
Klare und beweisbare medizinische Ursachen sind für Drittschäden beim Segelfliegen schlicht bedeutungslos!
Warum werden diese Tatsachen nicht ernst genommen und daraus die einzig richtigen Konsequenzen gezogen?
Werden wir Segelflieger den emotionalen Befürchtungen der weit verbreiteten Angst vor dem Fliegen auch weiterhin geopfert?
Oder beabsichtigt die EASA, klare - inzwischen erkennbare Fakten - zu akzeptieren oder werden weiterhin die irrationalen und rein pekuniären Ängste der Lobby bestimmter Fliegerärzte unter den erkennbaren Fakten weiter gepflegt?
Des Weiteren wird folgendes offenbar nicht bedacht:
Am 22.6.08 durfte ich höchstpersönlich sehr Interessantes erleben und es würde sicherlich jeder Freizeitpilot aus spontanen Sicherheitsgründen ebenso handeln:
Ich war in meinem Segelflugzeug in Südfrankreich nach etwa 2 Stunden Flugzeit ca. 50 Kilometer vom Heimatflughafen unterwegs, als ich mich plötzlich nicht mehr so ganz wohl fühlte.
Ich hatte wohl einfach die letzten Tage bereits zu viel geflogen und das Es in mir hatte offenbar keine rechte Lust mehr. Ich flog nach kurzem Zögern einfach aus meiner großen Höhe kerzengerade wieder nach Haus und bin eine halbe Stunde später einfach wieder gelandet.
Ich legte mich ins Bett, habe ausgeschlafen und war am Tage darauf wieder völlig fit und wieder fast sieben Stunden in der Luft.
Die sehr wohl auch bei mir funktionierende Selbstverantwortung hat dies wie selbstverständlich ermöglicht.
Ich habe mich also sofort selbst als fluguntauglich deklariert, einfach weil es keinen Spaß mehr machte.
Hätte ich dagegen als Linienpilot mit Passagieren an Bord ein weit entferntes Ziel angeflogen, ob sich das alles dann auch so elegant gelöst hätte?
Wir Segelflieger sind doch – ohne Medicalpflicht - auf ganz klare Weise von Natur aus und rein instinktiv sehr gut geschützt. Diese natürliche Wirksamkeit kann ein Pflichtmedical gar nicht erreichen.
Der Mensch an sich – selbst ein Psychotiker - ist doch keine Selbstmörder.
Auch ältere Piloten hören doch in aller Regel irgendwann ganz von alleine auf, wohl weil wir alle auf natürlichste Weise sehr genau unsere Grenzen kennen.
Auch dieser wirklich wirksame Sofortschutz scheint überhaupt nicht allgemein anerkannt zu sein und keine Verordnung kann diesen Fakt ersetzen.

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Segelfliegen findet überwiegend in Vereinen statt, denen auch die Flugzeuge gehören. Die natürliche Kontrolle durch die Vereinsmitglieder und die dortigen Fluglehrer scheint übersehen zu werden. Der geistig verwirrte Irrflieger von

Frankfurt wurde von zwei Vereinen als Schüler einfach abgelehnt.
Warum erkennt und bedenkt die EASA nicht solche natürlichen Grundprinzipien der menschlichen Natur und handelt genau danach?
Das wäre beispielhaft und fortschrittlich im sinne einer Wahrheit, die ängstlich oder finanziell gefärbte Menschen nicht erkennen können.
Was wäre dagegen sinnvoller?
Es wäre viel sinnvoller und sicher wirksamer, wenn die Behörden die Öffentlichkeit und besonders die Vereine im Sinne eines amerikanischen Airport Watch Programms – hier in medizinischem Sinne – sensibilisieren würde. Damit wären die Rechte des Einzelnen nicht beschnitten. (siehe weiter unten)
Auch scheint von den Unwissenden nicht eingerechnet und wirklich beachtet zu sein, dass 99,9 % aller Krankheiten – und dies sage ich als Arzt - sich vorher durch Unpässlichkeiten ankündigen. Die Natur ist nun einmal so gestrickt und ein Kranker oder Sterbender ist auf einfachste Weise - wie oben - vom Einsteigen in ein Segelflugzeug durch hervorragende, Millionen Jahre alte Instinkte perfekt geschützt. Dass jemand urplötzlich stirbt, das ist extrem unwahrscheinlich. Leider es ist ebenso extrem dekorativ und damit verführerisch um damit die eigenen Urängste zu begründen und zu beruhigen.
Vom Wesen des Segelfliegens herrschen leider in der allgemeinen und unwissenden Bevölkerung allein deshalb völlig falsche und angstbesetzte Vorstellungen. (Das weiß ich nicht nur von Vorträgen im Rahmen der Volkshochschule.) Wir Segelflieger und unser Sport sind aber allenfalls vergleichbar mit einem kleinen Boot im Wildwasser, allerdings in den Strudeln und Wellenbildungen der strömenden Luft. Segelfliegen ist also ein harter und durchaus auch gefährlicher Kampfsport in hilfloser Einsamkeit. Wir gefährden dort oben (wie ein Kanufahrer im Wildbach) aber niemanden, außer uns selbst und weil wir dies wissen, gehen wir mit unserem Leben und dieser Gefahr sehr respektvoll um.
Der Freizeitsport des Segelfliegens hat also mit der üblichen Vorstellungen der Fliegerei kaum etwas zu tun. Es ist einfach unverständlich, warum daran verdienender Lobbyismus, laienhafte Angstvorstellungen und Nichtsegelflieger Entscheidendes und Endgültiges zu Sagen bekommen. Es kann nur falsch sein! In Fragen des Tiefseetauchens werde ich als Segelflieger ja auch nicht mitreden wollen, weil ich davon keinerlei Ahnung habe!
Die aktuell (Medicalvorschlag von Dr. Hunter) favorisierte Self-Declaration wird – und das ist zu befürchten – keinerlei Erleichterung für die Basis bringen. Solche umfangreichen Formulare gewissenhaft auszufüllen bedarf eines fachkundigen Arztes und der wird sich auch künftig seine Zeit bezahlen lassen. Und da es von Natur aus keinen perfekt gesunden Menschen gibt, wird jede medizinische Andersartigkeit – wie in der Vergangenheit - zu weiteren teuren Untersuchungen führen. Kein Arzt wird die Verantwortung dafür übernehmen, vielleicht dann doch etwas im Detail übersehen zu haben und damit Gefahr laufen zu müssen, dafür letztlich vor einem Gericht verantwortlich zu sein, was meines Wissens noch nie geschehen ist.
Ich hoffe, dass ich ihnen hiermit nachprüfbare Fakten geliefert habe. Mit den irrationalen Befürchtungen unserer damit nur Geld verdienenden Gegnern und mit den unwissenden Ängsten von Laien hat dies nichts zu tun.
Hinzu gilt es auch Folgendes zu bedenken:

In demokratischen Staaten westlicher Prägung gilt das Rechtsprinzip der Verhältnismäßigkeit, das aus den Grundrechten zum Schutze des Bürgers vor dem Staat abgeleitet ist.

http://de.wikipedia.org/wiki/Verh%C3%A4ltnism%C3%A4%C3%9Figkeitsprinzip

Danach muss – um rechtens zu sein - eine staatliche Verordnung zum Erreichen eines bestimmten Zwecks immer dafür **geeignet**, **erforderlich** und **angemessen** sein. Sonst ist ein solches Gesetz nichtig. Allein mit diesem Rechtsprinzip, das sicherlich auch in den Grundrechten der EU festgehalten ist, dürfte das Pflichtmedical für Segelflieger zum juristischen Einsturz zu bringen sein.

Nach dem Gesagten ist also ein strenges Medical für Segelflieger
weder geeignet, noch erforderlich und auch nicht angemessen,
um die Bevölkerung vor plötzlich schwer krank werdenden Segelflugpiloten zu schützen, welche für andere Bürger wirklich ernsthafte Gefahren verursachen könnten.

Ein solches Medical bewirkt kausal rein gar nichts.

Der bürokratische Aufwand steht in keinem verstehbaren oder angemessenen Verhältnis zu einem nicht sichtbaren Vorteil.

Ein überaus strenges Pflichtmedical wäre für Teilnehmer am Straßenverkehr (einschließlich Kinder!) wesentlich sinnvoller.
…….

Auch auf diesem Hintergrund haben die USA nach umfangreichen statistische Untersuchungen, die meine Argumente beweisend ergänzen, das Pflichtmedical für Segelflieger - schon wegen seiner medizinischen Unwirksamkeit allein - abgeschafft. Dort genügt ein Führerschein als Nachweis, dass jemand quasi nicht blind, taub oder gelähmt ist.

Details finden sich hier:

http://jarcontra.csa-gmbh.com/joomla/index.php?option=com_content&task=view&id=425&Itemid=1

Mit den Argumenten des bereits Gesagten plane ich eine Petition an das Europäische Parlament zu richten und letztlich auch gerichtlich dagegen vorzugehen, wenn dieses Segelfliegermedical kommen sollte.

+ + + +

Demokratische Prinzipien, die gehen doch nicht von einem entmündigten Bürger aus! Hat Selbstverantwortung nicht auch etwas mit der Würde des Menschen zu tun? Diese Freiheit sollte nur bei Gefahr für Unbeteiligte eingeschränkt werden dürfen. Segelfliegen ist keine solche mit Logik zu begründende und deshalb durch ein teures Pflichtmedical zu regelnde riesige Gefahr. Ein Kind auf einer öffentlichen Straße ist für die Allgemeinheit wesentlich gefährlicher. Warum klärt man die Bevölkerung nicht über unsere Ungefährlichkeit auf, statt uns unüberlegt der allgemein üblichen Urangst vor dem Abstürzen an sich zu opfern?
Um dem nachvollziehbaren Bedürfnis dieser Öffentlichkeit nachzukommen und den bereits beschlossenen Grundprinzipien
http://www.egu-info.org/dwnl/EC_216_2008_en.pdf

	der EASA zu genügen, die ja ein Medical für alle Piloten fordert und nur schwierig geändert werden kann, würde für uns Segelflieger auch ein einfachstes Medical von einem beliebigen Allgemeinarzt genügen, wo Arzt und Pilot in einem einzigen Satz per Unterschrift bestätigen, dass keine zu plötzlicher Handlungsunfähigkeit führenden Krankheiten bekannt sind. Alles andere ist ausufernde Bürokratie. ********** Im Übrigen würde ich, wie bereits erwähnt, eher für eine Art medizinisches Airport-Watch-Programm der EU plädieren, das auf menschenwürdiger Selbstverantwortung beruht. Z.B.: Auf staatlichen Plakaten wird - auch - vor der Möglichkeit von krankhafter Handlungsunfähigkeit (Im Wesentlichen nur Schlaganfall, Epilepsie, Herzstillstand, Blutzuckerentgleisungen …) gewarnt. In ein solches Programm - mit der Forderung eines angemessenen und öffentlich antrainierten Verhaltens - wären dann auch z.B. die so eher vermeidbaren überaus vielen realen Unfälle mit einbegriffen, die durch den wirklich sehr unfallgewichtigen „Human Faktor" (z.B. Alkohol, Übermüdung, Nachlässigkeiten ….) bedingt sind. Diese Unfälle kann kein Fliegerarzt voraussehen. Die Nachbarpiloten aber oder die Vereinskameraden könnten es sehr wohl! Hier könnte die EASA etwas wirklich Wesentliches – quasi eine neue Kultur - zur Sicherheit bewirken. Meines Wissens tut sie aber nichts! Letztlich würde ich mir eine zukunftsorientierte EASA wünschen, die sich unschuldig hält von solchen inzwischen nicht mehr nachvollziehbaren Fehlern, die sich mit einfachsten und uralten Statistiken und Überlegungen als klare aber aufwändige Irrtümer öffentlich und logisch nachweisen lassen. Mit nachdenklichen und freundlichen Grüßen Dr. med. Claus-Dieter Zink
response	*Noted*
	See response to comment No 36.

comment	*2033*	comment by: *Steffen Losch*
	Ich bin mit dem Abschnitt "MED.A.020" nicht einverstanden. Dieser besagt, dass Segelflugpiloten und -schüler gezwungen sein werden, ein Medical zu bestehen. Es ist aber längst in Studien aus den USA bewiesen, dass keine Korrelation zwischen Medical und niedrigeren Unfallzahlen herzustellen ist. Darüber hinaus kann nachgewiesen werden, dass gesundheitliche Probleme, die zu Unfällen führen, so gut wie nicht vorkommen. Das alles führt mich zu dem Schluss, dass es sich bei dieser Regelung nur um Augenwischerei für die Öffentlichkeit handelt, die jedoch keinen praktischen Nutzen hat. Im Gegenteil, es werden ausschließlich Steuergelder in bürokratische Vorgängeverschwendet, die keinerlei positive Effekte erzeugen. Die Pflicht, sich als Privatpilot fliegerärztlich untersuchen zu lassen, sollte daher komplett entfallen.	
response	*Noted*	
	See response to comment No 36.	

comment	2039	comment by: *Holger WILD*

Hello,

I fly as private pilot holding current license JAR-FLC + JAR-FCL/TMG + GPL for more than 20 years with over 2000 hours and 5000 flights and I'am flight instructor since 1995.

I cannot agree with the proposed continued request for special "Medical certifications" for usual private pilots without IFR and airrcrafts below 2000 kg MTOW.
This is only a old legacy request without really adding safety for airmen or third party.
It is absolute nonsens for glider pilots, since the "danger" for themselves is the same as for any car driver, but the danger for third party is nearly not measureable.
There are calculations and statistics about the risk of kill a third party person when crashing a glider when pilot is unable to fly for healthy reasons: I think it was 1 time in 3000 years...
Please note USA and Swiss statistics which do not bludgeon glider pilots to continue a medical at all: 0.04% of accidents (same or less compared with medical-holding pilots), but 80%
of accidents are less pilots skills there (and here for sure too, we are only humans). The count of accidents at all lowers more or less in the last years. Reason is NOT medical approvments, it is better informing the pilots where the pitfalls are.

Why seems then a medical at all important? It comes from hard military requests, so not 200% "perfect" human should not fly a 20 millons of Euro aircraft nor flying a commercial aircraft with hundreds of persons and they should not fly to the moon and back. HERE only it is accepted and necessary. This pilots HAVE to fly every day, with ugly whether, partly disabled or shoot aircraft, regardless they are in good or less good daily shape. It is their job and when they retire to often, they will loose it. The third-party risk for such big and/or fast aircraft is very huge, usually the make approches to very busy, urban locations with lot of people, industries, power plants.
And this kind of aircraft is able to make big damages, the small aircraft NEVER.
Therefore medical request seems a must to aviod danger for this kind of pilots.

I will examine and explain my thoughts and facts about some items regarding that.

a) Government, representatives and officials usually don't be pilots and don't know this. There is a big medical lobby that use this past and commerical correct request and still want include all pilots into medicals with crazy scenarios like "crashing glider kills Airbus A380 and then 1000 people...". Nowadays government - especially german unfortunatly without any real reason - like pre-emptive strikes without knowing, what is it really for and what are the results for private flying and industrial parts who live from private flying! And having all pilots under the same rules ease the laws and rules, but this is not correct at all !!

b) Third party risk should for governments the one and ONLY reason for such a

request, nothing else and absolutly not the "AME" for collecting continous money and act as a judge for "you cannot fly" or "you can fly". The "pilot" losing his medical could just enter a Bus as driver and drive next day with 60 children over the alps - no problem at all. But flying is forbidden. This simple fact you have seen 2003 in Germany, who officials translate "likely" to "fact" and change the medical rules. After that hundreds of pilots were and stay (mostly) simply pedestrians after flying 25 years without accidents with the same handicap. Is that flight safety? Will you repeat and continue that? I agree with it only, if every car driver have to pass similar medical check every year, that the risk for third party with cars is very much higher - look into newspapers. Small Aircraft crash mostly outside without third party involved, isn't it? So same risk, same procedure. For car driver this is real not necessary, but for pilots it is not necessary to get a medical TOO.

c) Since gliders have usually no fuel (or with small engine only small fuel amount) and a weight of about 250 kg, fly slow and cannot climb or continue flying for long time without pilot actions it is not dangerous for the environment nor third party. Usually gliders don't fly about cities, under low Charlie oder Delta airspaces, oceans or close to big airports - it is forbidden or with given height impossible. For this special conditions there is really no risk at all for third parties. According to the calculations and statistics I have checked any request of a medical should be stopped forever. There is only one exception: The should see something in the vicinity since Air-to-Air collision is a real danger. This could be very simply and cheap covered: Before getting license and after 45 years at latest the license is only valid together with a simple eye test that car-drivers need, repeated every 2 years (simple, no doctor!). If they don't pass, they have to wear eye classes when flying, like today but without doctor - he takes TODAY not place in the aircraft when pilot fly without classes with a stamp in medical "only with eye-glasses, isn't it? So please where is the difference? That is all and it would work. For Car-Drivers is it only ONE TIME at beginning, never later until they die with 85 years. Would you please think about and tell us WHERE/what is the difference too?? A little child in a city or traffic sign is smaller than a airport and car looks smaller than any aircraft in sight, but glider and other pilots must have eye check every medical check.

d) Private, non commercial pilots fly for fun. They don't climb in a aircraft for take-off when they are not in a good shape for THIS day and/or flight. If something in the air goes wrong, the simply cut the flight or make a safety landing on a field - no problem, Glider-pilots "standard". Where - again - is any special risk? And this item not only for gliders, it is a fact for every small aircraft, isn't it?

e) You never can aviod "black sheeps", drunks and other unreliable human between the medical checks nor covering or aviod a deadly heard attack one day after positive medical examination (few years ago it became a fact in Mainz). Again compare third party risk from a car driver with a glider or privat pilot like described and only this should be the reason for rules. It is common accepted, that car drivers have deadly heard attacks with 80 years and kill a few people, that is called "live risk" - but it is not accepted when glider pilots WITHOUT medical would do it one time in 1000 years. Would you please think about too?

f) I speak for glider pilots, but the items are more or less correct for the whole

	recreational, private flying including small motor-aircraft less then 2 tons for VFR flights. Suggestions: - skip medical at once complete at least for all "only" glider pilots. What is the problem or risk for you? Not risk at all, if it does not work (against good experience in USA, Swiss...) it could easy requested from you few years later again, so simply try it !! - add simply repeatable eye-test certificate like for car-driver license as a add-on request for a valid license like medical is today a must (by the way this should a rule for all car-drivers too !!) - add a first medical check before license - but not more than a Truck driver would need ! Reason is, that pilot should know his possible risks. Again: If able to drive a car, he is able to fly a small aircraft for sure - add more details to "medical human behavior" in the studend pilot training like we do today with oxygen responsibilty for pilots. So every pilot should know about medical risks. Since he want to fly a second time, he will aviod it and for motor-pilots additionally, because of the slightly higher third party risks - maybe pilots have to tell every doctor, that they are private pilots ALWAYS. If they don't do so, the license could be void from the government. A simple document, signed from both parties as a protocol should tell a medical risk to pilots and his acknowledge to deal with it. So pilots still has full self-responsibility, but it is documented and they cannot say "I'am not informed about". Today with "medical" you don't try to ask anything since you don't want loose your medical & license, isn't it? So today doctor is a judge and enemy, with other way it becomes a friend and advisor. Again: Compare with car drivers or Truck drivers then you understand. I hope the text was not too much and PLEASE THINK ABOUT. Greetings Holger Wild
response	*Noted*
	See responses to comments No 36 and 1127.

comment	*2068*	comment by: *Dr. Christoph Larisch*
	Für LPL und PPL sollte ganz auf ein Medical verzichtet werden. Es gibt keine Studien oder Untersuchungen die belegen, daß dadurch Unfälle vermieden werden können. Die Erfahrungen in der Schweiz, Großbritannien und den USA zeigen, daß der vollständige oder teilweise Verzicht auf medizinische Voraussetzungen keinen Einfluß auf die Sicherheit haben. Da die Gefährdung unbeteiligter Dritter durch LPL oder PPL Piloten mit der Gefährdung durch PKW Fahrer vergleichbar ist, sollten auch analoge Regeln gelten, d.h. mehr als eine Untersuchung durch den Hausarzt sollte keinesfalls erforderlich sein.	
response	*Noted*	
	See response to comment No 36.	

comment	*2149*	comment by: *Tietze*
	A medical certificate for LPL should not bei necesarry. Work and cost are high in comparison with the benefit. Several studies show, that there is even no difference between countries with and without medical. Further more an accident with a small plane like an glider only strikes the pilot himself.	
response	*Noted*	
	See response to comment No 36.	

comment	*2150*	comment by: *Colin Troise*
	There is no indication of the type of medical certificate required for the SPL. In the UK, a sailplane pilot who does not instruct requires a simple medical certificate signed by his General Medical Practitioner. This is equivalent to the qualification required for the driving of an ordinary passenger car on the public highway. It has the advantage of being a non-expensive certificate compared to JAR medical certificates. I see no reason why this should change.	
response	*Noted*	
	See responses to comments No 36 and 1132.	

comment	*2169*	comment by: *CAA CZ*
	A reference to SPL is missing.	
response	*Noted*	
	Please refer to response to comment No 326 in this segment.	

comment	*2235*	comment by: *Prof. Dr. Alexander Bubenik*
	MED.A.020 (b) ... You should seriously consider if medical certificates for LPLs are necessary at all. Pilot incapacitation is an extreme rare circumstance! Refer to comment #2234.	
response	*Noted*	
	See responses to the comments No 36 and 1702.	

comment	*2238*	comment by: *Adrien Volkmann*
	Sehr geehrtes Personal von der EASA. Ich möchte hiermit eindringlich dafür plädieren, daß ein Medical für Segelflieger	

nicht nur nicht notwendig ist, sondern auch eine unnötige Beschneidung der Freiheit der Bürger der EU-Mitgliedsstaaten darstellt.
Zu Beginn möchte ich auch noch erwähnen, daß ich selber davon betroffen bin.
Ich leide an einer Einschränkung der Stereosicht, die ich von Geburt an besitze. Ich kannte nie etwas anderes, und ich komme damit ausgezeichnet im Alltag zurecht, auch im Straßenverkehr, in welchem wesentlich mehr visuelle Eindrücke aufgenommen und verarbeitet werden müssen, finde ich mich bestens zurecht. Ich wusste bis zu jenem Tag beim Augenarzt gar nichts davon! Mein großer Traum war (und ist, trotz alledem) die Segelfliegerei, als ich das Medical ablegen wollte, wurde es mir wegen eben jener Krankheit verweigert. Ich wäre nun gezwungen, zum Fliegen in die Schweiz auszuweichen, wo es mir ohne weiteres erlaubt wäre, es ist mir finanziell jedoch nicht möglich, diesen Schritt zu tun. Dies ganze wirft doch nun die Frage auf, und damit kommen wir zum eigentlichen Thema, weshalb eine derartige Ungleichbehandlung herrscht.
Das Fliegen spielt sich in einem wesentlich größeren "Aktionsraum" als der Straßenverkehr ab, da begrenzende Objekte wie Häuser etc wegfallen und auch noch der Höhenunterschied dazukommt, und die Luftfahrzeuge kommen sich (von luftakrobatischen Einlagen einmal abgesehen) kaum näher als ein paar hundert Meter.
Die einzig kritischen Situationen, das Landen und Starten, beinhalten immer noch eine "freie" Startbahn. Von derart freien Straßen kann der heutige Autofahrer nur träumen.
Und doch genügt, um den Autoführerschein abzulegen, eine normale Untersuchung beim Allgemeinmediziner und ein Sehschärfetest. Bei der Fliegerei jedoch wird jede noch so kleine gesundheitliche Anomalie rausgesiebt und mit Verweigerung des Medical geahndet. Bei gewerblichen Piloten, die zahlende Passagiere transportieren, oder gar Militärpiloten ist das ja gut und billig, da das Leben dritter unmittelbar in Gefahr wäre, und jede potentielle Gefahr ausgeschlossen werden muss. Dass nun für Privatpiloten, die unmotorisierte Segelflugzeuge allein und auf eigene Verantwortung steuern, die selben Maßstäbe angelegt werden, wirft nun doch die Frage nach der Verhältnismäßigkeit auf. Ist diese hier wirklich noch gegeben? Ich finde nicht, genauso wenig wie sich ein LKW oder Formel 1 Fahrer mit einem Radfahrer vergleichen lässt oder die Anforderungen zum Ausüben der jeweiligen Tätigkeit, läßt sich ein Hobbysegelflieger mit einem Berufspiloten vergleichen.
Diese Gleichstellung des Ungleichen erfolgt nicht aus rationaler Basis, sondern rein gefühlsbetont, da Otto Normalmensch das Fliegen automatisch mit Gefahr assoziiert, und sich dann auch gleich Horrorszenarien an die Wand pinseln lassen. Diese Paranoia, geschürt von Fliegerärzten, die an den Medicals ein gutes Geld verdienen, hat es leider auch bis in ihre Behörde geschafft. Die USA haben das Segelflugmedical vor einiger Zeit bereits abgeschafft, und die Statistiken weisen keineswegs einen rapider Anstieg von Unfällen auf, im Gegenteil.
Die Kalkulationen über die Wahrscheinlichkeit, daß ein Segelflieger Dritte in Gefahr bringt, hat Hr.Dr.Claus-Dieter Zink in seinem Kommentar ja bereits eingehend geschildert, und darauf will ich jetzt auch nicht näher eingehen.
Daraus kann man jedoch folgende Schlussfolgerung ableiten: Segelfliegen ist ein SPORT wie jeder andere auch, er birgt seine gewissen Gefahren, doch sind diese nicht höher als beispielsweise bem maritimen Segeln, beim Surfen, Tauchen oder auch Wildwasser-Kayaking. Wer diese Sportarten ausüben will, wird kaum ein derartiges Procedere durchgehen müssen wie der Segelflieger, nein, er hat die Freiheit, es einfach zu tun.
Es mag nun die Frage im Raum stehen, daß ja immer noch des Fliegers Leben

	gefährdet sei. Fakt ist, daß, wie bei jeder anderen Sportart auch, der Einzelne sehr wohl in der Lage ist, zu beurteilen, ob er z.Zt. in der Verfassung ist, seine Sportart gefahrlos auszuüben oder nicht. Da nur die Wenigsten suizidäre Gedanken hegen, sondern an ihrem Leben hängen, werden sie, sollten sie an sich Beeinträchtigungen bemerken, auf den Take-off verzichten. Natürlich kann man das nicht mit Sicherheit von jedem sagen. Aber da sind wir dann an einem Punkt angelangt, wo entschieden werden muss, inwieweit der Bürger mündig ist oder ob er gegängelt wird wie ein kleines Kind. Um noch einmal auf das Auto zurückzukommen. Warum wird, selbst wenn es dort entschiedenermaßen angebrachter wäre, kein vergleichbar strenges Medical gefordert? Die Antwort ist einfach: Der Aufschrei und der Protest wäre ungleich größer, da Millionen von einem wichtigen Aspekt ihres Lebens ausgeschlossen würden. Die Gemeinde der Segelflieger ist recht klein, und die Proteststimmen verhallen oft ungehört von der Öffentlichkeit. Doch ist das Unrecht das man uns antut, wenn man uns einen wichtigen Aspekt unseres Lebens wegnimmt, aus fadenscheinigen und logisch nicht nachvollziehbaren Gründen, deshalb weniger schwerwiegend? Ich bitte sie deshalb noch einmal, das Medical für Segelflieger aus den Bestimmungen zu streichen. Sie erweisen damit nicht nur der Freiheit einen Dienst, sondern auch allen Menschen in der EU, deren Herz für das Fliegen schlägt und gebrochen wurde durch diese kafkaeske und veraltete Regelung. Im Namen aller Fliegerkameraden vertraue ich in ihre Urteilskraft und ihren Gerechtigkeitssinn und appeliere an sie: Gehen sie mit der Zeit, setzen sie Zeichen, und schaffen sie das Segelfugmedical ab! Hochachtungsvoll, Adrien Volkmann
response	*Noted*
	See response to comment No 36.

comment	*2240*	comment by: *AMS CAA - Hungary*
	We support only 2 medical classes: Medical class 1 for the ATPL and CPL ans a Medical class 2 for the PPL, LPL and the BPL. The 3 categories in class 2 shall be using the same airspace and it is important to assure the same medical fitness to all the licenced pilots. CAA Hungary do not support separate Medical certification for LPL, because there are no significant differences beetween the 2 classes from medical ponint of view.	
response	*Noted*	
	Thank you for your opinion. See responses to comments No 36 and 1702.	

comment	*2265*	comment by: *Ingo Wiebelitz*
	Segelflieger sollen ausschließlich ein sportärztliches Attest nachweisen können. Damit ist der staatlichen Sorgfaltspflicht genüge getan.	

	Die heute in Deutschland übliche Praxis, das Medical betreffend, ist übertrieben und dient in der Hauptsache finanziellen Interessen bestimmter Gruppen. Durch ein undurchschaubares und hohes Kostengebilde ist keine Erhöhung der Flugsicherheit zu erwarten. Flugsportbegeisterte Menschen werden von einem schönen Hobby dadurch leicht ausgegrenzt. Daher soll die Medical-Praxis so einfach wie möglich gehalten und die Eigenverantwortung der Piloten höher als bislang üblich bewertet werden.
response	*Noted*
	See response to comment No 36.

comment	*2291*	comment by: *DLR*
	In modern cockpits many complex displays are presented in different colours. Seeing different illumination, lightning and glare conditions, it is possible that displays are not correctly identified and understood. This happens especially in protanomalous pilots, who see red displays much darker compared to how they are seen in an objective presentation. If the colour of the information cannot be identified correctly, the information can be misinterpreted. This can lead to very dangerous situations. **Proposal**: (g) If an instrument rating is added to a PPL, the pilot shall under take pure tone audiometry examinations according to the periodicity and the standard required for class 1 medical certificate holders. The pilot must be colour safe.	
response	*Noted*	
	See response to comment No 325.	

comment	*2322*	comment by: *Tim FREEGARDE*
	MEDA020(g) If a glider pilot instrument rating is included, it should not require the audiometry examination, for which there is no requirement.	
response	*Noted*	
	There will be no instrument rating for SPL. In case your comment relates to the issue of the cloud rating, please refer to the response to comment No 1478.	

comment	*2382*	comment by: *Irish Aviation Authority*
	New paragraph For the issue of a medical certificate, a minimum age shall be given.	
response	*Noted*	
	See response to comment No 233 in this section.	

comment	*2423*	comment by: *Philippe HAMAIN*

	On the medical question : it's not reasonable to assimilate the activity of a balloon pilot and the activity of a commercial plane (between Paris and New York) A balloon pilot flies one hour to do between 10 and 30 km. Concerning security, we must have the same medical conditions(class2) as for the leisure activities. (an accident involving 3 persons in a leisure activity is as serios as a commercial activity involving 10 or 12 persons).
response	*Noted*
	See response to comment No 36. I addition we would like to draw your attention to the fact that we proposed for hot air balloon pilots to hold Class 2 medical certificates — even for those who are involved in commercial operations. The provisions for an LPL medical certificate were developed in accordance with Article 7 of the Basic Regulation following the principle that all measures must be proportionate and tailored to the risk involved.

comment	*2426*	comment by: *Frank birlison*
	Since the LPL(S) and SPL, the two gliding licences, are identical in terms of training and knowledge, it is essential to maintain the only difference between them which is medical standards	
response	*Accepted*	
	We agree with your opinion. LPL(S) shall meet LAPL medical standards and SPL shall meet Class 2 medical standards.	

comment	*2442*	comment by: *SANMA Swedish Aeronautical Associatation*
	Samma risker att flyga PPL och LPL varför kraven skall vara lika.	
response	*Noted*	
	See response to comment No 1702.	

comment	*2446*	comment by: *SANMA Swedish Aeronautical Associatation*
	Det föreslagna systemet gör att piloter som ej blir godkända som PPL Klass 2 kan bli godkända som LPL och göra samma flygning. DVS kan manipulera systemet. Oacceptabelt.	
response	*Not accepted*	
	See response to comment No 1702.	

comment	*2449*	comment by: *SANMA Swedish Aeronautical Associatation*
	Nuvarande förslag innebär att många Klass 2 piloter går över till LPL-systemet. Detta medför problem att skola Klass 1 samt Klass 2 flygläkare framöver. Få Klass 2 undersökning kommer att genomföras varför läkare ej kommer att ha	

	kvalifikationer att gå vidare till Klass 1.
response	*Noted*
	It is the right of the applicant to choose the type of the medical certificate to apply for.

comment	*2450*	comment by: *SANMA Swedish Aeronautical Associatation*
	Förslag: Inom Civila flyget skall JAR FCL Klass 1(CPL) Klass2(PPL) samt Klass 3(Flygtrafikledare finnas.) Detta ger ett enhetligt system och undersökningarna samt de som utför dessa är kvalitetssäkrade och medicinska rekommendationer vilar på medicinsk kunskap samt erfarenhet.	
response	*Noted*	
	We agree with you opinion. Medical requirements for Air Traffic Controllers will be developed and proposed later as a separate Rulemaking task. The provisions for a LAPL medical certificate were developed in accordance with Article 7 of the Basic Regulation following the principle that all measures must be proportionate and tailored to the risk involved	

comment	*2468*	comment by: *AOPA Sweden*
	For CPL and ATPL holders who only wishes to have priviliges for private flights. The holder of a CPL/ATPL should be able to fly those non-commercial flights on a Class II medical, while still retaining the CPL/ATPL licence. Compare with the FAA system where the Medical will also determine wich priviliges the pilot can exercise.	
response	*Noted*	
	See response to comment No 250.	

C. Draft Opinion Part-MED — Subpart A: General Requirements — Section 1: General — MED.A.025: Decrease in medical fitness p. 4

comment	*71*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **AMC to Med A025 Section 1** **Page**: 4 Relevant Text: **Comment**: No compulsory reporting to AMC or AME required **Proposal**: ad in d) in all cases concerning with a) - c) the pilot has to contact	

	AMC or AME imediately
response	*Partially accepted*
	This issue is covered in MED.A.060 for holders of class 1 and class 2 medical certificates. Reporting for holders of LAPL medical certificates will be revised and details to be developed in an AMC to MED.A.060.

comment	*251*	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.A.025 **Page**: 4 Relevant Text: Pilots shall not exercise the privileges of their licence and related ratings or certificates at any time when they are aware of any decrease in their medical fitness which might render them unable to safely exercise those privileges. **Comment**: Daily experience of the Aeromedical Centers demonstrates, that many pilots a very "unsensitive" concerning their decrease in medical fitness or tend to deny it, even if there is great evidence of their incapacitation (e.g. alcoholism, following myocardium infarction, following stroke, need of strong acting medication etc.). Lay opinion is not sufficient to give adequate judgement. So the pilot should be encouraged to seek the opinion of his Aeromedical Examiner. Though defined in AMC to MED.A.025, the text should be cited at this site to clarify the legal situation. **Proposal**: Pilots shall not exercise the privileges of their licence and related ratings or certificates at any time when they are aware of any decrease in their medical fitness which might render them unable to safely exercise those privileges. When in doubt, at presence of symptoms of illness or when under medication consultants of an AME is necessary prior to performance of flight duties.	
response	*Noted*	
	See response to comment No 71.	

comment	*252*	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.A.025 **Page**: 4 Relevant Text: Pilots shall not take or use any medication prescribed or non-prescribed which is likely to interfere with the safe exercise of the privileges of the applicable licence. **Comment**: Pilots or general practitioners are not qualified to judge, if a medication is likely to interfere with the safe exercise of flight duties with respect to time-zone-shift, hypoxia, impairment of relevant sensoric functions (visual	

	system, colour vision, vestibulocochlear system). The decision should be limited to experienced AMEs who are specially trained for these questions. **Proposal**: Pilots shall not take or use any medication prescribed or non-prescribed which is likely to interfere with the safe exercise of the privileges of the applicable licence. At commencement of any medical treatment the pilot shall consult with his AME.
response	*Noted*
	See response to comment No 71.

comment	*344*	comment by: *Medical Officer BBAC*
	MED.B.005 (a) (4) There will need to be some guidance as to what level the serum lipids will require action or refusal of a licence.	
response	*Noted*	
	The guidance with regard to the estimation of serum lipids together with other cardiovascular risk factors is proposed in AMC to MED.B.005(b)(1).	

comment	*515*	comment by: *British Microlight Aircraft Association*
	Strongly agree	
response	*Noted*	
	Thank you for the positive comment.	

comment	*572*	comment by: *Florian Söhn*
	to b and c: Due to lack of medical education a pilot can not decide which medication or treatment is likly to interfere with fight safty . Therefore he should contact his AME before taking any kind of medication or before flying during a ongoing treatment.	
response	*Noted*	
	See comment No 71.	

comment	*686*	comment by: *BMVBS (German Ministry of Transport)*
	under (b) the words "or substances" should be included after "...use any medication". As a consequence the word "is" later in the sentence should read "are". Reason: Not only medication can interfere with the safe exercise of privileges of the applicable licence. There are numerous "problematic substances" which have the potential to do so too, such as alcohol, drugs etc.	

response	*Not accepted*
	Implementing Rules related to the use/abuse of alcohol and other substances are proposed in Subpart B Section 2 MED.B.050 Psychiatry. 'Substances' are not included in MED.A.025 because this paragraph deals with medication used for medical conditions.

comment	*784*	comment by: *Swiss Association of Aviation Medecine*

The Swiss Society of Aviation Medicine supports the following comments of our colleagues in Germany.

Comment:
The experience of 35 000 Class 1 medicals in the AMC Frankfurt over the last 5 years under JAA requirements shows, that no pilot is aware of his responsibility in decrease of medical fitness. Nobody was informed about his responsibilities. Pilots did not read the internet sites of the national competent authorities where those rules were published. The result was, that many pilots did not realize that to fly with an invalid medical certificate after going back to the cockpit after surgery or medical treatment is illegal.

(a) Daily experience of the Aeromedical Centers demonstrates, that many pilots are very "unsensitive" concerning their decrease in medical fitness or tend to deny it, even if there is great evidence of their incapacitation (e.g. alcoholism, following myocardium infarction, following stroke, need of strong acting medication etc.). Lay opinion is not sufficient to give adequate judgement. So the pilot should be encouraged to seek the opinion of his Aeromedical Examiner. Though defined in AMC to MED.A.025, the text should be cited at this site to clarify the legal situation.

(b) Pilots or general practitioners are not qualified to judge, if a medication is likely to interfere with the safe exercise of flight duties with respect to time-zone-shift, hypoxia, impairment of relevant sensoric functions (visual system, colour vision, vestibulocochlear system). The decision should be limited to experienced AMEs .

Proposal:
Print the paragraphs of decrease of medical fitness on the medical certificate in that way, that the pilot has signed his understanding of this paragraph. This certificate will handed out to each pilot personally. This guarantees, that each pilot is informed about his responsibilities and makes him liable for correct reports.

(a) Pilots shall not exercise the privileges of their licence and related ratings or certificates at any time when they are aware of any decrease in their medical fitness which might render them unable to safely exercise those privileges. When in doubt, at presence of symptoms of illness or when under medication consultants of an AME is necessary prior to performance of flight duties.
Pilots shall not take or use any medication prescribed or non-prescribed which is likely to interfere with the safe exercise of the privileges of the applicable licence. At commencement of any medical treatment the pilot shall consult with his AME.

response	*Noted*
	See response to comment No 71.

comment	*970*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: 2
MED. A. 025 - Decrease of medical fitness - (a); (b); (c)

Page: 4

Relevant text:
(a) Pilots shall not exercise the privileges of their license..... when they are aware of any decrease in their medical fitness.....
(b) Pilots shall not take or use any medication.....
(c) Pilots shall not exercise.... Whilst receiving any medical, surgical or other treatment

Comment:
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- (a) Pilots shall not exercise the privileges of their licence and related ratings or certificates at any time when they are aware of any decrease in their medical fitness which might render them unable to safely exercise those privileges. When in doubt, at presence of symptoms of illness or when under medication consultants of an AME is necessary prior to performance of flight duties.
- (b) Pilots shall not take or use any medication prescribed or non-prescribed which is likely to interfere with the safe exercise of the privileges of the applicable licence. At commencement of any medical treatment the pilot shall consult with his AME.

response *Noted*

Regarding information of decrease in medical fitness, see response to comment No 71.

Regarding the format of the medical certificate, see response to comment No 1541.

comment *1139* comment by: *CMO, Aeromedical Center Stockholm*

a) Medical fitness kan vara både objektivt och subjektivt påverkad. För att säkerställa att även "objektiv" Medical fitness råder, behövs undersökningsintervall som är rimliga. Dvs det är inte rimligt att ex kunna ha ett giltigt LPL Medical i upp till mer än 25 år utan revalidation eller renewal av Medical.

response *Noted*

Aeromedical examination intervals are proposed in MED.A.055 'Validity, revalidation and renewal of medical certificates'. LAPL examination intervals will be reconsidered.

comment *1193* comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*

Comment: acceptable

response *Noted*

Thank you for the support.

comment *1306* comment by: *Oxytrans*

Comment:

a) The daily experience of aeromedical exploration over the last fife years under JAA in HOF showed it very clearly, no pilot is aware of his responsibility in decrease in medical fitness. Pilots did not take cognisance of the published rules or deliberately ignored these rules. The result was, that many pilots did not realize that to fly with an invalid medical certificate is illegal (e.g. after surgery or

	medical treatment) Pilots are often very insensitive concerning their decrease in medical fitness or tend to deny it. (E.g. need of strong acting medication, handicap following stroke, alcoholism, diabetes) Pilots should be encouraged to seek the opinion and advice of an AME. b) Pilots as well as a GMP are not qualified to judge if a medication is likely to interfere with the safe exercise of flight duties with respect to hypoxia and impairment of relevant sensory functions as visual system or vestibular and cochlear system. Decisions should be limited to an experienced AME. Proposal: a) Pilots shall not exercise the privileges of their licence and related ratings or certificates at any time when they are aware of any decrease in their medical fitness which might render them unable to safely exercise those privileges. When in doubt, at presence of symptoms of illness or when under medication consultation with an AME is necessary prior to performance of flight duties. b) Pilots shall not take or use any medication prescribed or non-prescribed which is likely to interfere with the safe exercise of the privileges of the applicable licence. At commencement of any medical treatment the pilot shall consult with his AME.
response	*Noted*
	See response to comment No 71.

comment	*1314*	comment by: *Joachim Grohme*
	Diese Regeln allein genügen, auch ohne flugmedizinisches Zertifikat (Medical), die Sicherheit der Umgebung im maximal möglichen Umfang zu gewährleisten.	
response	*Noted*	
	See response to comment No 1324.	

comment	*1324*	comment by: *Markus Hitter / JAR-Contra*
	Deutsch: (english below) Wie bereits in anderen Kommentaren beschrieben würden diese Regeln allein genügen, auch ohne flugmedizinisches Zertifikat (Medical), die Sicherheit der Umgebung im maximal möglichen Umfang zu gewährleisten. - - - **English:** As pointed out in other comments already, these rules would be fully sufficient to warrant a maximum possible amount of safety for the environment, even without an aeromedical certification (medical).	

response	*Noted*
	Safety in aviation is ensured by many different measures, one of them being a medical certificate for private and commercial pilots. The legal basis for the medical certificate is the ICAO SARPs and the EU Basic Regulation. The latter provides the possibility to draft licensing rules tailored to the complexity of the aircraft and the kind of operation which has specifically been done in the medical field for the private pilot community by creating the leisure pilot licence. It is not possible, for safety and legal reasons, to abolish the medical certificate for private pilots. For glider pilots please refer to ICAO Annex 1, Section 2.9. Glider pilot licence, paragraph '2.9.1.5: An applicant shall hold a current Class 2 Medical Assessment'.

comment	*1541*	comment by: *British Airways*
	There is evidence to indicate that many pilots are not aware of the existing JAA requirements on exercising the privileges of their licence while taking medication or receiving medical / surgical treatment. **Proposal**: To increase pilot awareness, these paragraphs should be printed on the medical certificate.	
response	*Noted*	
	Thank you for the proposal. The format of the medical certificate will be considered in NPA 2008-22b Authority Requirements.	

comment	*1676*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.A.025(b) Decrease of medical fitness **Page** 4 **Comment** "Pilots shall not take or use any medication.." This is vague. There is wide variation in Europe with regard to prescription and non-prescription medication. Some might regard products that can be brought without prescription as not being 'medication' **Justification** **Proposed Text** "….or use any medication, whether prescribed or not which is …..	
response	*Partially accepted*	
	The text has been amended for clarity purposes	

comment	*1755*	comment by: *Civil Aviation Authority Finland*
	The drugs (abuse of substsnces) should also be mentioned in IR-FCL. (Ref. JAR-FCL 3.040(b)) The broblem abuse of substances is growing and some ceses are met also in aviation Add: ... use any medications **or drugs** prescribed or ...	
response	*Noted*	
	See response to comment No 686.	

comment	*1780*	comment by: *AECA(SPAIN)*
	In headlines ad '... and use of medication' This requirement refers to two subjects.	
response	*Not accepted*	
	The use of medication is regulated only in one subparagraph (b) in MED.A.025. The heading 'decrease in medical fitness' links (a), (b) and (c) together and was therefore chosen as a headline.	

comment	*1800*	comment by: *CAA Belgium*
	Relevant Text: Pilots shall not exercise the privileges of their licence and related ratings or certificates at any time when they are aware of any decrease in their medical fitness which might render them unable to safely exercise those privileges. Comment: many pilots a very "unsensitive" concerning their decrease in medical fitness or tend to deny it, even if there is great evidence of their incapacitation (e.g. alcoholism, following myocardium infarction, following stroke, need of strong acting medication etc.). The pilot should be encouraged to seek the opinion of his Aeromedical Examiner. Though defined in AMC to MED.A.025, the text should be cited at this site to clarify the legal situation. Proposal: Pilots shall not exercise the privileges of their licence and related ratings or certificates at any time when they are aware of any decrease in their medical fitness which might render them unable to safely exercise those privileges. When in doubt, at presence of symptoms of illness or when under medication ,consultation of an AME is necessary prior to exercising the privileges of the flying licence..	
response	*Noted*	
	See response to comment No 71.	

comment	*1801*	comment by: *CAA Belgium*

	Relevant Text: Pilots shall not take or use any medication prescribed or non-prescribed which is likely to interfere with the safe exercise of the privileges of the applicable licence. Comment: Pilots or general practitioners are not qualified to judge, if a medication is likely to interfere with the safe exercise of flight duties with respect to time-zone-shift, hypoxia, etc . The decision should be limited to experienced AMEs who are specially trained for these questions. Proposal: Pilots shall not take or use any medication prescribed or non-prescribed which is likely to interfere with the safe exercise of the privileges of the applicable licence;
response	*Noted*
	Your proposal is identical with the text proposed in MED.A.025(b). See also response to comment No 71.

comment	*1914*	comment by: *Klaus Melchinger*
	As pointed out in other comments already, these rules would be fully sufficient to warrant a maximum possible amount of safety for the environment, even without an aeromedical certification (medical).	
response	*Noted*	
	See response to comment No 1324.	

comment	*1919*	comment by: *Dr. Kureck*
	As Internist with mor than 15 years experience and Flight surgeon I strongly doubt that most pilots are aware of their responsibility in decrease of medical fitness. Nobody is informed about his responsibilities. Pilots did not read the internet sites of the national competent authorities where those rules were published. Most pilots do not realize that they fly with an invalid medical certificate after going back to the cockpit after surgery or medical treatment is illegal. (a) My daily experience demonstrates, that most pilots deny their decrease in medical fitness, even if there is great evidence of their incapacitation (e.g. alcoholism, following myocardium infarction, following stroke, need of strong acting medication etc.). Pilots should be encouraged to seek the opinion of his Aeromedical Examiner. T (b) Pilots or general practitioners are not qualified to judge, if a medication is likely to interfere with the safe exercise of flight duties with respect to time-zone-shift, hypoxia, impairment of relevant sensoric functions (visual system, colour vision, vestibulocochlear system). The decision should be limited to no less than experienced AMEs .	
response	*Noted*	
	See response to comment No 71.	

comment	*1945*	comment by: *Civil Aviation Authority of Norway*
	It is not defined to whom the licence holder shall report decrease in medical fitness. Reporting procedures should be established.	
response	*Noted*	
	See response to comment No 71.	

comment	*1962*	comment by: *AEA*
	Comment There is evidence to indicate that many pilots are not aware of the existing JAA requirements on exercising the privileges of their licence while taking medication or receiving medical / surgical treatment. **Proposal**: To increase pilot awareness, these paragraphs should be printed on the medical certificate.	
response	*Noted*	
	See response to comment No 1541.	

comment	*2070*	comment by: *CAA Belgium*
	Relevant Text: Pilots shall not exercise the privileges of their licence and related ratings or certificates at any time when they are aware of any decrease in their medical fitness which might render them unable to safely exercise those privileges. Comment: Daily experience of the Aeromedical Centers demonstrates, that many pilots a very "unsensitive" concerning their decrease in medical fitness or tend to deny it, even if there is great evidence of their incapacitation (e.g. alcoholism, following myocardium infarction, following stroke, need of strong acting medication etc.). The pilot should be encouraged to seek the opinion of his Aeromedical Examiner. Though defined in AMC to MED.A.025, the text should be cited at this site to clarify the legal situation. Proposal: Pilots shall not exercise the privileges of their licence and related ratings or certificates at any time when they are aware of any decrease in their medical fitness which might render them unable to safely exercise those privileges. When in doubt, at presence of symptoms of illness or when under medication ,consultation of an AME is necessary prior to exercising the privileges of the flying licence..	
response	*Noted*	
	See response to comment No 71.	

comment	*2071*	comment by: *CAA Belgium*
	Relevant Text:	

	Pilots shall not take or use any medication prescribed or non-prescribed which is likely to interfere with the safe exercise of the privileges of the applicable licence. Comment: Pilots or general practitioners are not qualified to judge, if a medication is likely to interfere with the safe exercise of flight duties with respect to time-zone-shift, hypoxia, impairment of relevant sensoric functions (visual system, colour vision, vestibulocochlear system). The decision should be limited to experienced AMEs who are specially trained for these questions. Proposal: Pilots shall not take or use any medication prescribed or non-prescribed which is likely to interfere with the safe exercise of the privileges of the applicable licence. At commencement of any medical
response	*Noted*
	See response to comment No 71.

comment	*2131*	comment by: *AMS Denmark*
	Pilots shall not exercise the privileges .....unable to safely exercise those privileges, - and when in doubt they shall contact there AME.	
response	*Noted*	
	See response to comment No 71.	

comment	*2267*	comment by: *Ingo Wiebelitz*
	MED.A.025 Piloten soll eine persönliche höhere Verantwortung für das eigene Tun auferlegt werden. Dann kann im Gegenzug die Kontrolle durch Fliegerärzte verringert werden. Im Falle eines Flugunfalls ist es vermutlich in den meisten Fällen nur schwer nachweisbar, dass ein Fliegerarzt diesen hätte vermeiden können. Ein Pilot ist in der Regel selbst an guter Gesundheit interessiert. Insbesondere für Segelflieger und Sportpiloten (GPL/ TMG/ SEP) soll dies Berücksichtigung finden.	
response	*Noted*	
	See response to comment No 1324.	

C. Draft Opinion Part-MED — Subpart A: General Requirements — Section 2: Issuance, revalidation and renewal of medical certificates p. 4

comment	*40*	comment by: *Horst Metzig*
	Ich möchte vorschlagen, das jeder Pilot, ob Class 1, Class 2 oder LPL, im Falle einer Untauglichkeit, zu dem AeMC, AME seines Vertrauens gehen darf, auch	

wenn dieses AeMC oder AME in einen anderen nationalen Staat liegt.

Ich begründe mein Vorschlag mit der Tatsache, das in der Vergangenheit zu unterschiedlich medizinische Befunde für eine Flugtauglichkeit bewertet wurden. Als Beweis und nach Rücksprache mit Herrn Flugkapitän a. D. Herrn Rainer Stammberger veröffentliche ich hier bei der EASA vier Dokumente, die unterschiedlicher gegenüber der deutschen flugmedizinischen Entscheidung gar nicht sein können:

Diese Dokumente sind auf meiner Homepage einsehbar
http://freenet-homepage.de/HorstMetzig/Sta4.jpg

Ich möchte erreichen, das solche unterschiedliche Auslegungen von Flugtauglichkeiten in den EASA Mitgliedstaaten nicht mehr vorkommen.
Ich möchte erreichen, das jeder Pilot im Falle einer Fluguntauglichkeitsschreibung zu dem AeMC, AME seiner Wahl gehen kann, auch wenn diese AeMC oder AME in ein anderen Mitgliedstaat liegt. So hätte Herr Rainer Stammberger in Deutschland seine Untauglichkeit auf Lebenszeit erhalten, in England, Frankreich hätte Herr Stammberger bei einer Rekursuntersuchung eine Flugtauglichkeit erhalten. Dieser Fall von Herrn Stammberger dokumentiert deutlich, das die englischen Behörden von der deutschen Fluguntauglichkeitsschreibung Kenntnis hatten, und in England besonders genau untersucht und geurteilt wurde.
Solche grosse Unterschiede bei der flugmedizinischen Entscheidungsfällung soll es meiner Ansicht nicht mehr geben.

Nachweislich haben hier die deutschen Behörden grosse Fehler gemacht.

Aus diesen Grund will ich der EASA vorschlagen, in Härtefällen einen gemeinsamen Ausschuss aller Mitgliedsstaaten zu gründen, welcher Uneinigkeiten der flugmedizinischen Entscheidung gemeinsam erörtert, und dann eine Entscheidung trifft, die mit einer 50 % Mehrheit für alle wirksam sein muss.

Horst Metzig

response *Noted*

The pilot can have his/her medical examination by an AME or AeMC in any Member State; however, their medical files will always be kept by their licensing authority.

For LAPL, the licensing authority will accept examinations by a GMP only if permitted under national law of the licensing authority.

A supra-national review board is presently not within the remit of EASA because the issue of medical certificates and pilot licenses is under the responsibility of the Member States.

comment *45* comment by: *Bernhard Blasen*

A european citizen should be allowed to use anyAeMC, AME or GMP approved by any european nation even if not in his native country.
Reason for that is that many professions make it necessary to go to foreign

	country for business or for the job for a long time. It could be too burdensome to make a long travel to go to a AeMC, AME, GMP in the home country.
response	*Noted*
	Please see response to comment No 40.

comment	*583*	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany Head of Lufthansa Medical Services Head of German Academy of Aviation and Travel Medicine Section**: 2** **MED. A. 025 - Decrease of medical fitness - (a); (b); (c)** **Page**: 4 Relevant text: (a) Pilots shall not exercise the privileges of their license..... when they are aware of any decrease in their medical fitness..... (b) Pilots shall not take or use any medication..... (c) Pilots shall not exercise.... Whilst receiving any medical, surgical or other treatment **Comment**: The experience of 35 000 Class 1 medicals in our AMC Frankfurt over the last 5 years under JAA requirements shows us, that no pilot is aware of his responsibility in decrease of medical fitness. Nobody was informed about his responsibilities. Pilots did not read the internet sites of the national competent authorities where those rules were published. The result was, that many pilots did not realize that to fly with an invalid medical certificate after going back to the cockpit after surgery or medical treatment is illegal. **Proposal**: Print the paragraphs of decrease of medical fitness **on the medical certificate**. This certificate will handed out to each pilot personally. This guarantees, that each pilot is informed about his responsibilities and makes him liable for correct reports.	
response	*Noted*	
	See response to comment No 71 in the segment of comments to MED.A.025. The format of the medical certificate will be considered in NPA 2008-22b Authority Requirements.	

comment	*1418*	comment by: *Derry MOORE*
	My GP is better informed of my state of health and his signature on the UK National Certificate (akin to the HGV standard) should be accepted.	
response	*Noted*	

	There will be no national medical certificates. You may continue to apply for a medical certification to your GMP for a LAPL medical certificate. Class 2 or Class 1 medical certificates have to be issued by an AME or AeMC.

comment	*1423*	comment by: *Trevor HILLS*
	Extract: "LPL medical certificates shall be issued by an AeMC, an AME or, if permitted under national law, by a general medical practitioner (GMP)." Comment: I thoroughly approve of the move to permit GMP to issue medical certificates.	
response	*Noted*	
	Thank you for the supportive comment.	

comment	*1562*	comment by: *Swiss Association of Aviation Medecine*
	General remarks: EASA decided to create new regulations concerning medical fitness for flight crews. We do not understand why EASA does not use the already existing JAR or ICAO rules. Creating new rules is a time consuming work. The proposed rules (Class I, Class II, LPL) are not convincing at all. It make sense to have a simple questionaire that can be answered by pilots (via Internet), a standardized form to fill in by the examiner and requirements (like JAR-FCL 3). The questionaire should be the same for all pilots. The requirements should be based on a predefined risk of sudden incapacitation (i.e. 1% for Class 1, 2% for Class 2 and 3-5% for Class 3 (LPL) A 3-5% risk should be reserved for Leisure Pilots with light aircrafts (i.e. sailplanes). The proposal recommends LPL even for engine-aircrafts up to 2 tons. Even if third party damages are rare it is not acceptable to double the risk for an airplane crash.	
response	*Noted*	
	The European Union Member States, the European Parliament and the Council agreed to Regulation (EC) No 216/2008 which extended the remit of EASA to FLight Crew Licensing and Flight Operations. The task to draft European rules has been given to EASA in that same Regulation. The basis for Part Medical is ICAO Annex 1 and JAR-FCL 3 for ICAO compliant licenses. The provisions for a LAPL medical certificate have been redrafted following the comments to this NPA. The form in AMC to MED.A.040 was withdrawn and the	

	former JAA application and examination forms have been added. However, not all boxes in these forms will be applicable for the LAPL medical certificate. The text on risk assessment that was in the JAA Guidance Material will be reviewed and amended with the advice of a specialist in medical statistics and re-introduced in the rulemaking task MED.001.

comment	*1753*	comment by: *Max Heinz Katzschke*
	Hierzu habe ich in NPA2008-17b Cmt#4048 geschrieben: "Diese Einschränkung entspricht nicht den Lebensumständen, da vielfältige Anforderungen und Qulifizierungen besonders im Beruf immer öfter zu einem Wechsel des Wohnsitzes oder Lebensmittelpunktes führen. Deshalb muss es ermöglicht werden Erweiterungen oder periodisch verlangte Nachweise der theoretischen und praktischen Fähigkeiten in einem beliebigen Land der Europäischen Union ablegen zu können. Nur so ist die in der Wirtschaft notwendige Beweglichkeit der Menschen zu gewährleisten." Deshalb sollte ein europäischer Bürger auch jeden beliebigen europäischen AeMC, AME, GMP und jeden Allgemeinarzt auswählen können, auch wenn der nicht aus seinem Land/seinem ständigen Wohnsitz entsprechend, praktiziert und/oder stammt. Alle anderen Regeln sind nicht zumutbar.	
response	*Noted*	
	For the examination and issue of a medical certificate see response to comment No 40 in this segment. For training and testing please see Part FCL.	

comment	*1782*	comment by: *AECA(SPAIN)*
	(d) Delete all paragraph. Not in JAR-FCL and this rule will be the end of harmonization.	
response	*Not accepted*	
	The licensing authority is the equivalent of the AMS in JAR-FCL 3. Medical Certificates are presently issued by the AMS for the initial issue Class 1 and after review.	

comment	*1796*	comment by: *Karl Mürkens*
	Ich bin mit einem Medical für Segelflug- und Sportpiloten absolut nicht einverstanden, da es aus Schicherheitsgründen nachgewiesen, keinen Sinn macht. Entfernen Sie bitte diesen Unsinn aus grauen Vorkriegstagen aus unserem demokratischen Europa. Nichts verhindert unsere Europäische Freiheit mehr als das Geschäft mit der Angst, also überprüfen Sie nochmals ersthaft Ihren Standpunkt und die Notwendigkeit. Dieses Medical ist Besten Falls, durch den verlorenen Erfahrungsverlust der fadenscheinig entzogenen Lizenzen in der Lage den Flugsport zu gefährden, als	

	ihm zu nutzen.
response	*Not accepted*
	Thank you for your comment. It was not the intention of the legislator to abolish medical certificates for pilot licences.

comment	*1957*	comment by: *UK Department for Transport*
	A.030 The UK Department for Transport strongly supports the proposal that the medical certificate for the Leisure Pilot Licence can be issued by a General Medical Practitioner if permitted under national law.The UK DfT would support the medical provisions for the LPL going forward as drafted.	
response	*Noted*	
	Thank you for the support.	

comment	*1978*	comment by: *MOT Austria*
	Comment: Austro Control GmbH as the aviation Authority, competent for pilots' licences, does not agree with the plan to create the special LPL. Anyway, we cannot accept, that general medical practitioners examine the medical fitness of leisure pilots. There is a sufficient number of AMEs available in Austria, highly trained in aviation medicine, to perform high qualitative examinations of all pilots. **Justification:** In Austria there exists the right to choose one's own doctor at anytime, there is no assignment to the practice of a certain medical practitioner. The individuals are allowed to change the GMP as often as they want. Therefore a certain GMP has no complete set of medical data of an individual person, which could be the base for an extended clinical assessment of fitness to fly, based on personal knowledge about the applicant's medical history. To keep up high standard of aviation safety, it should not depend on national regulators of the Member States to declare a GMP qualified and licensed to perform medical examinations of leisure pilots. **Proposed Text:** Delete: ", or, if permitted under national law, by a general medical practitioner (GMP). "	
response	*Noted*	
	The provisions for a LAPL medical certificate have been redrafted following the comments received; however, they are still less stringent and more flexible than ICAO Annex 1 Standards for class 2 medical certificates which was the intention	

	of the legislator. The GMP will only be allowed to issue medical certificates for the LAPL if permitted under national law. This is laid down in the Basic regulation and cannot be reversed by Implementing Rules.

comment	*2065*	comment by: *DSvU*
	In general: The Danish Soaring Association strongly supports this NPA 2008-17c and the medical requirements for LPL-licenses. It is really a huge step forward towards the idea of easy access to flying, whatever it is soaring, ballooning or anything else regulated by authorities. We really do want to express our satisfaction.	
response	*Noted*	
	Thank you for the support.	

comment	*2302*	comment by: *David Miller*
	I strongly support the idea of GMP issued medical certificates but these must not be too onerous for the GMPs to issue otherwise they are likely to refer pilots to AMEs, or charge considerably more than the present £15 for validation using existing records. Note, the current UK medical is based on existing standards for professional and non-professional drivers, is well understood by GMPs, and hence does not require a complex check-list. Where the GMP knows the pilot and has records of several years medical history there seems little value in performing a physical examination.	
response	*Noted*	
	LAPL pilots may continue to address their GMPs and obtain medical certificates, if permitted under national law. The provisions for a LAPL medical certificate have been redrafted following comments to this NPA with the aim to make it easier for the GMP or AME and to include an aeromedical assessment. Driving standards were not considered adequate for a medical certificate for a pilot because the third dimension and the cockpit environment are not included in the aeromedical assessment of a pilot.	

C. Draft Opinion Part-MED — Subpart A: General Requirements — Section 2: Issuance, revalidation and renewal of medical certificates — MED.A.030: Competence for the issue, revalidation and renewal of medical certificates p. 4-5

comment	*28*	comment by: *GEMA*
	¿Qué puede volar un LPL?	

response	*Noted*
	LAPL licence holders will have privileges to fly hot air balloons, sailplanes, helicopters and airplanes with MTOM less than 2000 kg.

comment	*47*	comment by: *Bernhard Blasen*
	A european citizen should be allowed to use anyAeMC, AME or GMP approved by any european nation even if not in his native country. Reason for that is that in future job or bisiness requirements wil cause longer stay in foreign countries.	
response	*Noted*	
	The reason for these European regulations is to ensure free movement of people and workplace in Europe. The medical certificate will be accepted in all Member States no matter in which Member State it was issued. However, for LAPL medical certificates issued by a GMP, according to national law, see response to comment No 349.	

comment	*59*	comment by: *phil mathews*
	Ensure that National Authorities enact National Law to allow LPL medicals to be issued and renewed by General Medical Practitioners	
response	*Noted*	
	Article 7(2) of the Basic Regulation states that GMPs can issue medical certificates for the LAPL if permitted under national law.	

comment	*72*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **AMC to Med A030 b) and c) Section 2** **Page**: 4 Relevant Text: LPL **Comment**: without any valid examination of the pilot, no AMC,AME or GP shall take the risk to hand out a medical. If the government wants to have a low-level LAPL-medical, the risk and responsibility shall be transferred to the government **Proposal**: remove parts b) and c) and add instead b) LPL medical certificates shall be issued by the government after having received a self declaration of the LAPL-Pilot. c) ...shall be revalidated or renewed by the government.....	
response	*Not accepted*	
	As stated in the Basic Regulation, the medical certificates for LAPL licence holders shall be issued by an AME, AeMC or a GMP, if permitted under national law.	

	As a result of the comments received, the provisions for a GMP to issue LAPL medical certificates as well as the medical requirements for LAPL have been amended.

comment	*169*	comment by: *Paul SPELLWARD*
	I strongly support the issue of LPL(B) certifcates by GMPs. This enables a doctor who knows the pilot well and has full understanding of his medical history to perform the examination and assessment. There would be no additional medical benefits gained by requiring LPL(B) holders to use AMEs.	
response	*Noted*	
	Thank you for the supportive comment.	

comment	*226*	comment by: *Dr. Uwe Kaiser*
	Die Untersuchung durch einen Allgemeinarzt / den Hausarzt sollte für Segelflieger generell erlaubt sein.	
response	*Not accepted*	
	SPL is a licence for private flying and requires holding a Class 2 medical certificate. This is also an ICAO standard: please refer to ICAO Annex 1, Section 2.9. Glider pilot licence, paragraph '2.9.1.5: An applicant shall hold a current Class 2 Medical Assessment'. For a LAPL(S), a LAPL medical certificate will be sufficient.	

comment	*239*	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany Head of Lufthansa Medical Services Head of German Academy of Aviation and Travel Medicine Section**: 2** **MED.A. 030** **Issuance, revalidation and renewal of medical certificates (b) Initial issue** **Page**: 4 Relevant Text: (1) Class 1 medical certificates shall be issued by an AeMC **Comment**: Under subpart C MED.0.01 --- MED.0.30 you can not find any definition of the privileges of an AeMC. Due to the very good German experience after implementing JAR FCL-3 amendment 5 one year ago, one should know more about the future role of AeMCs under EASA requirements. In Germany the competent authority delegated the competence of waiver decision for class 1 medical applicants to the AeMCs because they are the competent specialists in	

cardiology, internal medicine, psychiatry and other special faculties working close together with big hospitals or universities. These specialists are much more experienced and competent than doctors in competent authorities who never investigate pilots themselves and who are decision makers only by paperwork. In AeMCs an interdisciplinary risk assessment with different specialists is normal and medical confidentiality is respected at all times as is standard in hospitals. In Germany this works much better now than before implementing amendment 5-JAR FCL 3. Today a waiver decision in our AMC Frankfurt takes on average 4 days. The years before amendment 5 the AeMCs had to send the special opinion to the competent authority. The doctor in the competent authority read the special opinion and charged only for the authority stamp on the medical certificate 940 € . This process took on average at minimum 12 days in 2007 up to 36 days in the first year 2003 after implementing JAR FCL 3. This cost and time consuming process was the reason to delegate the competence of waiver decision to the AeMCs in Germany. The experience of this delegation of competence by the competent authority is absolutely positive.

Proposal:
The EASA should provide in their requirements the possibility of delegation of competence from the competent authority / licensing authority to AeMCs and AMEs, provided that the same safety standard is guaranteed by oversight procedures of the competent authority.

response *Partially accepted*

The possibility for AeMCs to issue initial Class 1 medical certificates is already included in our proposal MED.A.030(b). This is a transposition of a Long Term Exemption No 112 in JAR-FCL 3.100.
Safety standards will be guaranteed by the oversight of the competent authority as it is proposed in NPA 2008-22b Authority Requirements Subpart AeMC - Specific requirements related to aeromedical centres and in NPA 2008-22c Organisation Requirements Subpart AeMC - Aeromedical centres.

For those borderline cases listed in Subpart B, the decision shall be referred to the licensing authority for class 1; for class 2 the AME or the AeMC may take the decision in consultation with the licensing authority.

comment *327* comment by: *FOCA Switzerland*

MED.A.030 (b) (1)-(3), c and d): In many situations (not restricted to referrals as mentioned in (d) , also the comptent licensing authority issues medical certificates (for instance in review situations or when initial certificates are not issued according to the requirements by the AeMC or the AME or in case of change of state of license issue and more.

Proposed text for:
b 1): Class 1 medical certificates shall be issued by the AeMC or the competent licensing authority.
b 2): Class 2 .....shall be issued by an AeMC, an AME or the competent licensing authority.
c 2) LPL.... by an AeMC, the AME or the licensing authority.
Alternatively delete the word referral in (d):

	New text: **d) Notwithstanding (b) and (c), the licensing authority may**.....
response	*Partially accepted*
	Our proposal results from the text of the Basic Regulation which gives the competence to issue medical certificates for Class 1 and Class 2 only to the AeMC and AME. For clarity reasons in the text of (d) the possibility will be added for the licensing authority to issue medical certificates in cases when they were issued incorrectly.

comment	*349*	comment by: *Teh Danish Organiation of Flight Surgeons (DAFLO)*
	Objection: Disagree **Reasons**: As a consequence any Danish holder of a pilot's license may acquire LAPL abroad and thereby manage to extend intervals between renewals of a medical certificate unreasonably. For fligth safety reasons we find this irresponsible and unacceptable. **Suggestions:** generally DAFLO (the Danish Assiciation of Fligth Surgeons) does not favour LAPL introduced. If however, inevitable LAPL is recommended it must be as a National approval applicable in limited sections outside controlled airspace and implying at least minimum ICAO standards concerning health requirements.	
response	*Noted*	
	The LAPL has been established by the BR as one of several licence types. Licences shall be accepted all over Europe — which was the intention of the regulator.	

comment	*362*	comment by: *Karl Höck*
	Absatz (2) Das class2 medical sollte ebenfalls durch den Hausarzt des Aspiranten ausgestellt werden dürfen. Begründung: 1. Der Hausarzt kennt Aspiranten am besten und sollte deshalb genauso, bzw. besser beurteilen können, ob man sich für die Ausübung des Flugsportes eignet bzw. irgendwelche Krankheiten dagegen sprechen. 2. Die speziellen medizinischen Anforderungen durch den Sport (z.B. Höhentauglichkeit, Schwindelfreiheit, Reaktionsvermögen U.S.W.) werden im Rahmen der Ausbildung durch den Fluglehrer in der Praxis am besten getestet. Hier muss der Fuglehrer (habe selbst 35 Jahre ausgebildet) die Verantwortung übernehmen und ungeeignete Aspiranten aussieben. 3. Die bisherige Praxis mit den viel zu strengen medical-Anforderungen haben m. E. in keiner Weise zu mehr Sicherheit im privaten Flugverkehr beigetragen bzw.	

	auch nur einen Unfall verhindert. Sie haben aber viele Hobbyflieger vom Himmel geholt und somit wirtschaftlichen und ideellen Schaden angerichtet. Ganz zu Schweigen von der Bevormundung und Gängelung vieler eigentlich gesunden Piloten. Hier wurde oft mit Kanonen auf Spatzen geschossen, vollkommen unberechtigt und zum Teil auch unfundiert. 4. Auch im Sinne mit der Gleichbehandlung im Straßenverkehr können hier keine höheren medizinischen Anforderungen erhoben werden, zumal das Gefährdungspotential wesentlich geringer ist.
response	*Not accepted*
	To be ICAO compliant the class 2 medical certificates have to be issued by an AME or an AeMC.

comment	*368*	comment by: *Peer Ketterle*
	I am a JAR-FCL PPL (A) Holder, 34 years of age. I have no problems obtaining a Class-2-Medical. Please see also my comment in the Explanantory Notes. If there has to be an LPL-certificate, please do not allow the restriction of a GMP by national law. If it is reasonable to ease the burden of obtaining a LPL-Medical for people in some member-states, why should it be not be reasonable for other member-states? This should be harmonized in Europe for the best of the population of Europe, and I wish for a strong EASA that does not give in to unrational fears or lobbyism.	
response	*Noted*	
	See response to comment No 59.	

comment	*375*	comment by: *European CMO Forum*
	MED.A.030 ((b) (3) Comment: The majority of PPL holders are flying aircraft less than 2 tonnes with up to 3 passengers and may fly in all classes of airspace. The privileges for a full LPL are the same, but the medical requirements are considerably less. This is not equitable. If there is a dual system of LPL and Class 2 certification there is a risk that AMEs will not find it viable to continue and there will be insufficient aeromedical expertise available. In many countries the applicant's GP cannot act as an AME due to conflict of interest. Any other doctor will not have access to the medical history and this is a flight safety concern. It must be clear that the LPL requirements can only apply in a few countries.	

	The experience of the US Sports Pilot's Licence is that many applicants would have been refused a FAA Class 3 certificate. This US licence is restricted in terms of airspace, route, no passengers carried, maximum speed and maximum take off weight and distance from airfield. It may be appropriate to restrict LPL medical certification to light sports aircraft under 600kg as discussed by the MDM.032 group according to the EASA web site presentation. Justification: In most Member States there is a highly qualified AME network that can provide an expert service for aeromedical assessment. Any LPL applicant with a medical problem will, in any case, have to seek further advice from an AME. It is impossible to have oversight of, or have control over the work of, a GP if there is no approval mechanism. Comment: Add: '...under national law **of the state of the licensing authority**, by a ...' In Part FCL the requirement for medical certification for LPL should be restricted to pilots flying light sports aircraft.
response	*Partially accepted*
	Regarding mutual acceptance of LAPL medical certificates issued by GMPs in a Member State not permitting GMPs to issue the certificate, the text has been amended accordingly. Regarding limited privileges for a LAPL medical certificate, see response to comment No 314 on MED.A.020 (b).

comment	*376*	comment by: *European CMO Forum*
	MED.A.030 (b) (1) (2) and (3) Comment: 'Shall' is inappropriate. Justification: The Basic Regulation states that a medical certificate 'may' be issued by an AeMC or AME. The IRs must comply with the Basic Regulation. Proposed Text: Change 'shall' to '**may**' in (1) (2) and (3).	

response	*Not accepted*
	'May' in the Basic Regulation says who can issue medical certificates. The detailed implementing rules state who 'shall' issue a medical certificate for which class of medical certificates.

comment	*379*	comment by: *European CMO Forum*
	MED.A.030 (d) Comment: An authority must have the option to issue a medical certificate. Justification: There may be other circumstances when an authority needs to issue a medical certificate. eg when a medical certificate has been lost or an AME has issued a certificate with a missing limitation. Proposed Text: Delete 'in the cases of referral'.	
response	*Noted*	
	See response to comment No 327.	

comment	*516*	comment by: *British Microlight Aircraft Association*
	Accepted	
response	*Noted*	
	Thank you for the positive comment.	

comment	*550*	comment by: *Union Française de l'Hélicoptère*
	La possibilité de mettre à jour sa situation médicale auprès du médecin traitant est particulièrement appréciée. Cependant, l'égalité de traitement entre les ressortissants de l'Union devrait s'opposer à ce que des dispositions libérales européennes puissent s'appliquer ou pas en fonction des dispositions nationales. Si dans le cas général, l'intervention du médecin généraliste est limitée à la production d'un certificat de conformité, il devrait en outre être possible d'étendre cette faculté, au moins au PPL.	
response	*Noted*	
	The GMP will be required to have experience in the aviation environment. However, this does not necessarily have to be a license.	

comment	*573*	comment by: *Florian Söhn*
	The licencing authority should be allowed to delegate the decision to issue a renewed or revalidated medical to either AMC or AME class 1. Reasening is that	

	medical decisions regarding flgiht safty should be decided by comtent medical examiners with all medical specialties available. The licensing authory (in Germany) will not be able to provide that with adequate speed and sufficient mecial personal. The way its done atm with AMc deciding about the medical questions and the Atuhories issuing the licence in accodance to the AMC decision seems to be working very well and should not be changed.
response	*Noted*
	See response to comment No 239 in this segment.

comment	*584*	comment by: *Lufthansa German Airlines*

Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany
Head of Lufthansa Medical Services
Head of German Academy of Aviation and Travel Medicine
Section: **2**
MED.A. 030
Issuance, revalidation and renewal of medical certificates
Page: 4

Relevant Text: (3) LPL medical certificates shall be issued by an AeMC, an AME or, if permitted under national law, by a general practitioner

Comment: The JAA System of AMEs and AeMCs is the only medical system which has been harmonized. All medical doctors in this system had medical basic and advanced courses which followed the prescribed JAA syllabus. Every AME in this system had to attend refresher courses with a minimum of 20 CME points to renew his AME license every three years. These AMEs have to know the requirements of JAA or in future of EASA and then be able to make decisions on basis of these requirements.

In Germany 150 000 GPs are working in their own office. On the basic level of the requirements for general practitioners **(see MED.D.001 Subpart D Page 21)** this number will increase to 175 000. If all 70 000 PPL license holders in Germany will decide to give up their PPL and fly only with an LPL license, there is only a small chance for a GP to perform **1.25 LPL medical /10 years**. Between the age of 16 up to the age of 80 years a LPL pilot has to perform 20 medicals. 70 000 license holders X 20 medicals = 1 400 000 Medicals in Germany in 64 years, which are 21 875 LPL Medicals /year. Statistically there is a chance of 1.25 LPL Medical in 10 years for one GP in Germany. This is not enough for getting experience to make safety relevant medical decisions for LPL.

Proposal:
(3) LPL medical certificates shall be issued by an AeMC, an AME class 1 or AME class 2

response	*Not accepted*
	Medical requirements as regards LAPL were developed following the principle that all measures must be proportionate and tailored to the risk involved. The Basic Regulation (Article 7(2)) allows GMP to issue a medical certificate for a LAPL licence if permitted under national law. Implementing Rules shall reflect this

	provision.

comment	*636*	comment by: *Robert Cronk*
	The issue / renewal of LPL medicals by a GMP is fully supported.	
response	*Noted*	
	Thank you for the support.	

comment	*642*	comment by: *Royal Danish Aeroclub*
	MED.A.030(b)(3): The text says: "if permitted under national law" - this mean that the "local" authorities just can say "no" for no professional reason. The same goes for revalidation and renewal. We suggest to change the text to the following: "LPL medical certificates shall be issued by an AeMC, an AME or by a general medical practitioner (GMP).	
response	*Noted*	
	See response to comment No 59.	

comment	*664*	comment by: *Pekka Oksanen*
	Issue by AeMC, AME should not be obligatory. Reason: The Authoritys must be able to issue medical certificates. Propose: (1) Initial issue.... (a) .. **may** be issued by **the Authority** or an AeMC. (b) .. **may** be issued by **the Authority**, an AeMC or an AME. (d) Add the Authority	
response	*Noted*	
	See response to comment No 327.	

comment	*687*	comment by: *BMVBS (German Ministry of Transport)*
	General remark regarding A.030 (b)(3): The final decision to permit GMPs to issue LPL medical certificates is still pending in Germany. It is most likely, however, that Germany will not permit such system. Reason: In Germany patients can freely choose their doctor. As a consequence there are usually no complete medical files, unless a person stays with the same doctor throughout his entire life which is an exception rather than the rule. Hence, it is unlikely that the GMP option will be acceptable for Germany. The option will, nevertheless, be looked at with an open mind, although at this point we do see risks but no advantages.	

response	*Noted*
	Thank you for the information. See response to comment No 59.

comment	*774*	comment by: *Thomas Cook Airlines UK*
	Commentator: The UK Association of Aviation Medical Examiners **Paragraph**: Med.A.030 **Page Numbers:** 4, 5 **Comment:** GMPs should have some experience and training in Aviation Medicine before being permitted to issue LPL medical certificates. GMPs should have access to a copy of the regulations and guidelines before issuing medical certificates. GMPs should have a list of AeMCs and AMEs to whom they can refer applicants who have limitations. **Justification:** It is difficult for a busy GMP with no knowledge of aviation medicine to be able to make an accurate assessment of an individual's fitness to hold a private pilot licence. Access to the guidelines is imperative and easy access to a local AME or AeMC is essential. **Proposed text:** Med A.030 (b) (3) LPL medical certificates shall be issued by an AeMC, or an AME or, if permitted under national law, by a general medical practitioner (GMP) who has experience of or basic training in Aviation Medicine	
response	*Partially accepted*	
	A GMP with a Basic Training course certificate would become an AME. The Basic Regulation does not require GMPs to have fulfilled a Basic Training Course in aviation medicine for AMEs. However, the requirements for a GMP acting as an AME in MED.D.001 will include a requirement for knowledge in aviation medicine.	

comment	*786*	comment by: *Swiss Association of Aviation Medecine*
	The Swiss Society of Aviation Medicine supports the following comments of our colleagues in Germany. **1. Comment**: The introduction of the LPL medical certification appears to be contradictory to the basic principle of EASA, being the maintenance of Safety. **Paragraph (3) of the introductory text of the Basic Regulation reads: "Community essential requirements and rules adopted for their inplementation should ensure that Member States fulfil the obligations created by the Chicago Convention." Paragraph (4) of the introductory text of the Basic Regulation reads: "The Community should lay down, in line with standards and recommended practices set by the Chicago**	

	<u>Convention</u>, essential requirements applicable to ... The Commission should be empowered to develop the necessary implementing rules." 2. ICAO is the lowest acceptable standard for medical requirements in 198 countries. The introduction of a standard that fails to meet ICAO is not acceptable. We should not practice below ICAO standard. 3. There shall be no separate medical criteria for LPL. If such criteria must exist, they shall be moved to the implementing rules to make them binding and guarantee harmonised application. 4. The specific requirements for LPL medical certification introduce new standards that appear to be in conflict with scientifically proven medical data 5. LPL medical certification is not consistent with Class 2 ICAO standards. It shows no medical relationship to existing Class 2 rules. e.g. Hearing requirements. Sometimes the criteria are higher and sometimes lower than ICAO Class 2. There are questions regarding the evidence and the validity by which such standards are proposed. There exists only an acceptable means of compliance for LPL medical certification, but this is not included in the implementing rules. As a result, the acceptable means of compliance are not binding. These *will not be known by the GMP or the LPL applicant*. 6. The validity of the LPL medical certificate ignores the peak of many pathologies, in the time between the first and the subsequent medical examination at the age of 45 years, particularly in the psychiatric and psychological areas including mania and schizophrenia, allowing a pilot to continue flying without medical supervision. This presents an important risk to flight safety. 7. The use of the word "should" and "may" as applied to the medical status fails to apply any restriction, but merely advises rather than directs. This reduces the clarity, transparency and the standard of the medical assessment offered. 8. The introduction of a system with many standards such as LPL and Class 2, you introduce the risk of reducing the validity, transparency and quality of the assessment offered. 9. The LPL and Class 2 pilot share the same environment, airspace and aircraft. so the risks and the consequences are similar. There is a risk to shift problematic cases from Class 2 to LPL, in the absence of medical supervision. 10. The existing NPP and Sports Pilots Licences appear to be used by some pilots who cannot comply with Class 2 standards. In countries where the sports licence exists, experience shows that it attracts pilots who have medical or health issues. **Proposal**: Delete the specific requirements for medical certification and replace them with the medical criteria of ICAO or Class 2.
response	*Not accepted*
	Safety in aviation is ensured by many different measures, one of them being a medical certificate for private and commercial pilots. The legal basis for the medical certificate is the ICAO SARPs and the EU Basic Regulation. The latter provides the possibility to draft licensing rules tailored to the complexity of the aircraft and the kind of operation which has specifically been done in the medical field for the private pilot community by creating the leisure pilot licence. Medical requirements as regards LAPL were developed following the principle that all measures must be proportionate and tailored to the risk involved. The Basic Regulation (Article 7(2)) allows GMP to issue a medical certificate for a LAPL licence if permitted under national law. Implementing Rules shall reflect this

	provision. However, the requirements for the LAPL medical certificate have been redrafted.

comment	*971*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: **Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008** **Section**: **2** MED.A.030 (a), (b), and (c) **Issuance, revalidation and renewal of medical certificates (b) Initial issue** **Page**: 4 **Relevant Text**: (1) Class 1 medical certificates shall be issued by an AeMC ..... **Proposal**: The EASA should provide in their requirements the possibility of delegation of competence from the competent authority / licensing authority to AeMCs and AMEs, provided that the same safety standard is guaranteed by oversight procedures of the competent authority. (a) leave it as it is (b) initial issue (1) Class 1 medical certificates shall be issued by the licensing authority or by an AeMC. (2) Class 2 medical certificates shall be issued by the licensing authority or by an AeMC or an AME (3) LPL medical certificates shall be issued by the licensing authority or by an AeMC or an AME or,if permitted under national law, by a general practitioner (GMP) n MED.A.030 (b) and (c) "shall" should be replaced by "may". If "shall" has to be used in the IRs, then the text of each subparagraph should be amended: *"... medical certificates shall be issued by the authority or by ...."* . If so, then a new AMC MED.A.030 has to be developed*: "The privileges for an AeMC, an AME or a GMP to issue medical certificates should be defined in their respective authorisation or certificate."* MED.A.030 (b)(3) and (c)(2) must be amended: *"... if permitted under national law* ***of the licensing authority,*** *by a GMP."*	
response	*Noted*	
	See responses to comments No 349 and 327.	

comment	*972*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: 2
MED.A.030 (a), (b), and (c)

Issuance, revalidation and renewal of medical certificates (b) (3)Initial issue (c) (2) revalidation and renewal
And all following paragraphs where LPL is mentioned

Page: all pages where LPL is mentioned

Relevant Text: Implementation of LPL - General Statement on this issue

•1. Comment:
The introduction of the LPL medical certification appears to be contradictory to the basic principle of EASA, being the maintenance of Safety.
Paragraph (3) of the introductory text of the Basic Regulation reads: "Community essential requirements and rules adopted for their inplementation should ensure that Member States fulfil the obligations created by the Chicago Convention." Paragraph (4) of the introductory text of the Basic Regulation reads: "The Community should lay down, in line with standards and recommended practices set by the Chicago Convention, essential requirements applicable to ... The Commission should be empowered to develop the necessary implementing rules."

- 2. ICAO is the lowest acceptable standard for medical requirements in 198 countries. The introduction of a standard that fails to meet ICAO is not acceptable. We should not practice below ICAO standard.
- 3. There shall be no separate medical criteria for LPL. If such criteria must exist, they shall be moved to the implementing rules to make them binding and guarantee harmonised application.
- 4. The specific requirements for LPL medical certification introduce new standards that appear to be in conflict with scientifically proven medical data
- 5. LPL medical certification is not consistent with Class 2 ICAO standards. It shows no medical relationship to existing Class 2 rules. e.g. Hearing requirements. Sometimes the criteria are higher and sometimes lower than ICAO Class 2. There are questions regarding the evidence and the validity by which such standards are proposed. There exists only an acceptable means of compliance for LPL medical certification, but this is not included in the implementing rules. As a result, the acceptable means of compliance are not binding. These *will not be known by the GMP or the LPL applicant*.
- 6. The validity of the LPL medical certificate ignores the peak of many pathologies, in the time between the first and the subsequent medical examination at the age of 45 years, particularly in the psychiatric and psychological areas including mania and schizophrenia, allowing a pilot to continue flying without medical supervision. This presents an important risk to flight safety.
- 7. The use of the word "should" and "may" as applied to the medical status fails to apply any restriction, but merely advises rather than directs. This

reduces the clarity, transparency and the standard of the medical assessment offered.
- 8. The introduction of a system with many standards such as LPL and Class 2, you introduce the risk of reducing the validity, transparency and quality of the assessment offered.
- 9. The LPL and Class 2 pilot share the same environment, airspace and aircraft. so the risks and the consequences are similar. There is a risk to shift problematic cases from Class 2 to LPL, in the absence of medical supervision.
- 10. The existing NPP and Sports Pilots Licences appear to be used by some pilots who cannot comply with Class 2 standards. In countries where the sports licence exists, experience shows that it attracts pilots who have medical or health issues.

Proposal:
Delete the specific requirements for medical certification and replace them with the medical criteria of ICAO or Class 2.

response *Noted*

See response to comment No 786.

comment *1048* comment by: *Ilse Janicke Heart Center Duisburg*

I. General:
For EASA Class 2 License the ICAO requirements are adequate and the higher JAR-FCL 3 section need not be applied. But the medical requirements for **LAPL will be below the ICAO Standard Class 2 (SARPS).**
Leisure, recreational or light aircraft pilot license shall include all aircrafts ≤ 2 t. And IFR??

For balloon and glider pilots I think the low medical standard is acceptable.
For the very large mass of recreational pilots who are often flying as high and very high age group (PPL-A) these requirements are much too low. These pilots are flying in the same controlled airspace, airspace C and D together with commercial pilots and airlines, and they are landing on the same controlled airports like commercials! And they are single pilot in command and so a potential danger for the commercials in case of very low medical standard.

ICAO requires (Doc 8984-AN/895 von 2008): medical certification outside the requirements in Chapter 6 is reliant upon so-called „flexibility standard and is allowable subject to accredited medical conclusion, provided that this „ **is not likely to jeopardize flight safety".**
Likely means "a probability of occurence that is unacceptable to the Medical Assessor".
(Manual of Civil Aviation Medicine preliminary Edition 2008, ICAO).

My comments try to interprete the word "likely" for common cardiovascular problems in the general aviator.

Was sagt das Versicherungs-System in Europa? Keiner weiß

Comment: In a single-crew environment major events especially due to heart

	attacks have high probability of a catastrophic outcome for the pilot and accompanying persons. 1)Some datas from the Australian ATSB Transport Safety Report 2007 (Newman DG: *Pilot Incapacitation. Analysis of Medical Conditions Affecting Pilots Involved in Accidents and Incidents 1975-2006)* This research project investigated the prevalence, type, nature and significance of in-flight medical conditions and incapacitation events occuring in civil aviation. All together in 30 years 98 occurences (16 accidents and 81 incidents, 0,6 % due to medical) due to the effects of medical conditions are rare, 22,4 % belonged to private flying. 10 occurences (10,2 %) were a fatal accident. All fatal accidents occured in single-pilot operations, where **heart attack** in the pilot was the most common cause of the subsequent accident.. In-flight heart attacks resulted in a fatal accidents in 63 per cent of cases. 2) *Booze CF: Sudden inflight incapacitation in general aviation. Aviat Space Environ Med 1989; 60:332-5.* 3 Unfälle von 1000 total are a direct result of incapacitation of the pilot. Ist sehr wenig. The medical certification system appears to beworking well. Due to cardiovascular disease with incapacitation no fatal accident is described in a two-pilot commercial passenger-carrying operations above 5,7 t anywhere in the world. **Cardiovascular disease** still ranks as the single biggest cause for medical disqualification in all pilot groups and continues to receive much research attention.. In-flight cardiac events leading to fatal accidents may well be some underreported, since there is often no postmortem obduction and due to difficulties in post mortem circumstances. Another situation exist in the large mass of often elderly recreational pilots with growing prevalence of coronary heart disease. **Proposal:** additional sheet for private pilots over the age of 70 years to highlight the problem of the older recreational pilot. **The so called "1% rule"** is based on the risk of a cardiovascular event, and represents the annual medical incapacitation risk limit in multi-crew commercial air trasnport operations. The same 1 % risk for Class 2 pilots did not need popular acceptance and is not nessecary to fullfil the ICAO "likely" s.o. The UK driving license authority uses a 2 % risk level for professional drivers and this approximates to an ICAO Class 2. For private drivers a greater risk is acceptable. In some circumstances the 2 % rule will be more practible and is practised in the waivers, according to the Study of *Froom P et al.: Air accidents, pilot experience, and disease-related inflight sudden incapacitation. Aviat Space Environ Med 1978;49:517-8.* **Proposal**: The special cardiological comments should be based on a **2 % rule** and not lower. A car accident due to heart attack would be often not so fatal with died persons like moving in an aircraft in the 3rd dimension.
response	*Noted*
	The text of the risk assement which is presently published in the JAA Guidance

	Material will be reviewed by a specialist in medical statistics, amended and re-introduced in Part MED as guidance material during the rulamking task MED.001

comment	*1052*	comment by: *Julia DEAN*
	Very much approve of the recommendation that local General Medical Practitioner can sign the medical certificate/document as they know the individual and it is the same system used successfully for other medical requirements in the UK - eg heavy goods vehicle driving, motor racing medicals, scuba diving.	
response	*Noted*	
	The Agency acknowledges your support.	

comment	*1084*	comment by: *Regierung von Oberbayern-Luftamt Südbayern*
	In Absatz (d) der Vorschrift MED.A.030 wird der lizenzierenden Behörde die grundsätzliche Möglichkeit eröffnet, selbst das Tauglichkeitszeugnis auszustellen. Dies korrespondiert mit den Vorschriften MED.A.045, wonach die Behörde eigene Limitations für das Medical verhängen kann sowie mit AR-MED.315, wonach die Behörde die Untersuchungsberichte erhält und das Medical selbst zu widerrufen hat, wenn sie der Auffassung ist, dass es falsch ausgestellt wurde. Dieses System der Einbindung der lizenzierenden Behörde in den medizinischen Teil der Beurteilung der Tauglichkeit der Luftfahrer halten wir für übermäßig kompliziert sowohl für die Luftfahrer als auch für die Behörden. Nach dem in Deutschland geltenden System ist der flugmedizinische Sachverständige allein für die medizinische Begutachtung des Luftfahrers verantwortlich. Um als Flugmediziner anerkannt zu werden, muss er Spezialkenntnisse der Flugmedizin nachweisen. Die örtlich zuständige Luftfahrtbehörde erkennt einen Medziner auf dessen Antrag als flugmedizinischen Sachverständigen an, wenn er die medizinischen und verwaltungsmäßigen Voraussetzungen seiner Praxis nachweist. Für die Untersuchungsinhalte und die Entscheidung über die Tauglichkeit ist ihm die Verantwortung (und damit auch die Haftung) übertragen. Ist ein Pilot mit dem Ergebnis seiner Untersuchung nicht einverstanden, kann er bei der nächsthöheren flugmedizinischen Stelle (Flugmediziner Klasse 1, flugmedizinisches Zentrum) eine Überprüfung beantragen. Erhält die lizenzierende Behörde die Mitteilung, dass ein Pilot für untauglich befunden wurde, hat sie die Möglichkeit, das Ruhen der Lizenz anzuordnen. Die Überprüfung medizinischer Befunde durch die Behörde erfolgt allenfalls in anonymisierter Form. Dieses System gewährleistet eine saubere Trennung von Fragen der Lizenzierung und der fachlichen medizinischen Begutachtung (unter Berücksichtigung der ärztliche Schweigeverpflichtung). Es wird nicht für erforderlich und darüber hinaus datenschutzrechtlich für bedenklich gehalten, wenn die Behörde künftig sämtliche Untersuchungsergebnisse der Bewerber um ein Tauglichkeitszeugnis erhalten soll. Die Vorhaltung eines flugmedizinischen Sachverständigen bei der Behörde wird	

	erhebliche Kosten verursachen, die möglicherweise durch die behördliche Begutachtung der übersandten Tauglichkeitszeugnisse wiederum auf die Piloten umgewälzt werden müssten. Schließlich ergibt sich für die Behörde auch eine haftungsrechtliche Problematik bei unrichtig durchgeführter Untersuchung durch den Flugmediziner. Es erscheint überbürokratisch (und wird auch für den Piloten in medizinischen Zweifelsfällen mit zusätzlichem Zeitaufwand und Kosten verbunden sein), die Behörde zusätzlich zu den qualifizierten Sachverständigen auf fachmedizinischer Ebene in das Verwaltungsverfahren einzubinden. Gerade dem Vergleich mit dem neuen EASA-System der Prüfer-Anerkennung für den Erwerb von Lizenzen ("Wegzonung" der Auswahl geeigneter Prüfer von der Behörde; grundsätzlich hat jeder einen Anspruch, als Prüfer anerkannt zu werden, wenn er bestimmte Voraussetzungen erfüllt), hält diese zusätzliche fachliche Einbindung der lizenzierenden Behörde bei den Tauglichkeitszeugnissen nicht stand. Möglicherweise wird hier auch ein weiterer (Verwaltungs-)Rechtsweg eröffnet: Klage gegen den Widerruf eines Medicals (neben der möglichen Klage gegen die Ruhensanordnung einer Lizenz). Auch dies sollte vermieden werden.
response	*Not accepted*
	We appreciate your detailed comment outlining a system that is different from JAR-FCL 3. However, the basis of this NPA is JAR-FCL 3 which is presently implemented in all European Union Member States. JAR FCL 3 and Part FCL are in line with ICAO Annex I in this respect. We agree that the German system have its merits; however, the aeromedical system worldwide is organised differently.

comment	*1097*	comment by: *Moldavian Society of Aviation Medicine*
	Comment: 1) See my comments to MED.A.020 and 2) the argument that GMP could be used for medical certification of LPL pilots because they "have sufficient detailed knowledge of the applicant's medical background" is incorrect. Pilots could not be treated by the only one doctor - GMP. In all European countries the Medical Health Care system is different and in majority, people could not obligatory address to the one and the same physician. Better access, simplicity and cheaper availability of GMP are also controversial in comparison with AME who also could be the same doctor for the whole "flight life" of a LPL pilot. 3) in general we think that such phrase like "...if permitted under national law" should have been avoided because by this principal the harmonization of requirements is putted into a doubt and will not allow the mutual recognition to take place within states with different approach to the same issues. Also we should not give any cause for "medical tourism" as in such a cases the flight safety would be under a big threat. (3) Medical certificates for the LPL shall be issued by an AeMC or AME .	
response	*Noted*	

	1) See the response to your comment No 1095 in MED.A.020. 2) and 3) See the response to comment No 786 in this segment.

comment	*1129*	comment by: *Keith WHITE*
	030 initial issue (3) and revalidation (2), add "**LPL(S) and SPL**"	
response	*Not accepted*	
	These paragraphs are related to the issuance of all LPL medical certificates, therefore, LPL(S) are already included. SPL is a licence for private flying and requires holding Class 2 medical certificate. This is also an ICAO standard: please refer to ICAO Annex 1, Section 2.9. Glider pilot licence, paragraph '2.9.1.5: An applicant shall hold a current Class 2 Medical Assessment'.	

comment	*1162*	comment by: *Aero-Club of Switzerland*
	MED.A.030 (b) (3) Where permitted by national law, GMP may issue medical certificates for holders or for candidates of the LPL Licence. This is good for the Aero-Club of Switzerland. Justification: Switzerland did not accept this system so far. It may be acceptable to other countries, so we do not oppose.	
response	*Noted*	
	Thank you for the opinion.	

comment	*1194*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.030 (b) and (c) **Comment**: The Basic Regulation states that medical certificates **may** be issued by an AeMC or an AME, or a GMP. In the EASA NPA this has been changed to shall, which is an unacceptable deviation from the Basic Regulation. Since the member states have different medical legislation and health systems as well as different organisations, administrative systems and empowerment of the Civil Aviation Authorities, the word may should be kept also in the Implementing Rules. Due to national legislation on medical confidentiality and procedures, only the authority, and not the AeMC or an AME, may have the right to collect the full medical information needed for the aeromedical assessment. This is essential, especially for the initial issue of a medical certificate. Depending on the qualifications of an AeMC and an AME, their individual privileges should be decided by the competent authority and be defined in their respective authorisation/certificate. The detailed requirements then should be defined in MED.C, in the Part Authority Requirements, and in Part Management Systems	

with the corresponding AMCs and GMs.

However, the lowest levels of competence for initial issue and revalidation/renewal as proposed in MED.A.030 are acceptable.

Issuing, revalidation and renewal of LPL medical certificates by a GMP must be permitted by national law. However, the Basic Regulation does not define which state the national law refers to, not even whether the proposed permission for GMPs is restricted to GMPs within the EU. In this context, it must be the national law of the state of the licensing authority having the sole responsibility for the license and medical certificate. This has to be clarified in MED.A.030 (b) and (c).

Proposal:
Option 1: In MED.A.030 (b) and (c) "shall" should be replaced by "may".

Option 2: If "shall" has to be used in the IRs, then the text of each subparagraph should be amended:
"... medical certificates shall be issued by the authority or by ...."
If so, then a new AMC to MED.A.030 should be developed:
"The privileges for an AeMC, an AME or a GMP to issue medical certificates should be defined in their respective authorisation or certificate."

MED.A.030 (b)(3) and (c)(2) must be amended: "... if permitted under national law **of** the state of the licensing authority, by a GMP."

response

Noted

See the responses to comments No 376 and 349.

comment

1195 comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*

Attachments #5 #6 #7 #8

MED.A.030 (d)
Comment:
The licensing authority has the full responsibility for its licence holders and must have the sovereign power to issue a correct medical certificate whenever an incorrect certificate has been issued by an AeMC, an AME or a GMP. Unfortunately this is a common situation, including bad assessments as well as pure typing errors of wrong date of birth, expiry date and limitations. At the ICASM in Madrid 2003[lj1] , FAA presented the high proportion of erronous medical certificates issued by FAA AMEs (32.000/month) , which corresponds well with the proportions experienced in Sweden.These errors will result in an invalid medical certificate which the pilot usually is unaware of, but the invalid certificate will be detected during a ramp check or after an accident with possible legal implications for the pilot. If a change of MED.A.030 (b) and (c) is made according to our proposal, the subparagraph (d) can be deleted.

Proposal:
Option 1: Together with the proposed changes of MED.A.030 (b) and (c), MED.A.030 (d) can be deleted.

	Option 2: If the proposed changes of MED.A.030 (b) and (c) are not made, MED.A.030 (d) should be amended as follows: "Notwithstanding (b) and (c), the licensing authority may always issue (a corrected) medical certificate". _____ [lj1] Länka till FAA presentationen !
response	*Noted*
	See response to comment No 327.

comment	*1294*	comment by: *David Chapman*
	It makes good sense for a GMP to be able to issue a LPL medical licence in all countries. The GMP can be advised that the standard of fitness expected is the same as that required for a motor vehicle licence, therefore avoiding a huge expense in having a GMP having to understand exactly what fitness standard is expected?	
response	*Noted*	
	Thank you for the comment. Revised LAPL medical requirements will be found in MED.B.090 and the corresponding AMC to MED.B.090. A reference to road traffic standards is not possible because in road traffic the 3rd dimension is missing and altitude can be a limiting factor in some medical conditions. Please note that the GMP can only issue medical certificates for the LAPL if permitted under national law.	

comment	*1328*	comment by: *Jochen KOENIG*
	Ich unterstütze die Einführung eins Tauglichkeitsstandards unterhalb ICAO Klasse 2 und die Möglichkeit der Untersuchung durch den Hausarzt. Die Sicherheit wird nicht gemindert, die Kosten für den Erwerb und Unterhalt der Lizenz werden gesenkt, die Zugänglichkeit zum Luftsport wird erleichtert.	
response	*Noted*	
	Thank you for your support.	

comment	*1332*	comment by: *Thomas Lukaschewski*
	Ich unterstütze die Einführung eins Tauglichkeitsstandards unterhalb ICAO Klasse 2 und die Möglichkeit der Untersuchung durch den Hausarzt. Die Sicherheit wird nicht gemindert, die Kosten für den Erwerb und Unterhalt der Lizenz werden gesenkt, die Zugänglichkeit zum Luftsport wird erleichtert.	
response	*Noted*	
	Thank you for the positive comment.	

comment	1341	comment by: *Luftamt Nordbayern*

Ausstellung von Tauglichkeitszeugnissen durch Hausärzte:

Das Luftamt Nordbayern setzt sich dafür ein, flugmedizinischen Tauglichkeitszeugnisse nach wie vor von flugmedizinisch anerkanntem Fachpersonal erstellen zu lassen. Die Ausstellung von Tauglichkeitszeugnissen durch Allgemeinmediziner lehnen wir ab. Aus Sicherheitsgründen und im Hinblick auf das komplexe flugmedizinischen Anforderungsprofil, welches in der Regel nicht dem Allgemeinarzt- oder Hausarztfachwissen unterliegt, sollte auf diese "Erleichterung" für die Piloten verzichtet werden. Um die Auswirkung der spezifischen Faktoren im Luftverkehr einschätzen zu können, bedarf es einer fundierten Spezialausbildung. Die auf den Piloten einwirkenden Kräfte und die körperlichen Leistungsanforderungen unterschieden sich beim LPL nicht vom PPL. Auch die durch LPL und PPL verliehenen Rechte unterscheiden sich nicht wesentlich. Flugunfälle aufgrund von unentdeckten medizinischen Problemen haben, unabhängig davon ob der Pilot LPL oder PPL Inhaber ist, die gleichen Folgen.

Die Ausstellung von Tauglichkeitszeugnissen im LPL-Bereich durch Allgemeinmedizininer (GMP) dürfte auch für die Piloten keine Vorteile bringen. Wird die Untersuchung genau so sorgfältig durchgeführt wie beim Flugmediziner dürfte sie sich auch kostenmäßig auf ähnlichem Niveau bewegen. Erfolgt die Untersuchung beim Allgemeinmediziner aus Kostengründen weniger tiefgehend, so ergeben sich hierdurch unüberblickbare Gefahren für die Luftsicherheit durch unentdeckte Gebrechen. Um entsprechend der Verordnung (EG) Nr. 216/2008 jederzeit ein einheitliches und hohes Schutzniveau zu gewährleisten, muss auch für den LPL die Ausstellung von Tauglichkeitszeugnissen und die Untersuchung der Probanten unbedingt den AeMCs und AMEs vorbehalten bleiben.

Allenfalls könnte ausschließlich für den Basic LPL ein "Hausarztmodell" eingeführt werden, nach dem sich der Hausarzt einer erfolgreichen anerkannten Fortbildung im Fachgebiet Flugmedizin zu unterziehen hat, und dann berechtigt ist, einen "Weiterbildungstitel Flugmedizin" zu führen. Zusätzlich müssten ggfs. auch hinsichtlich der Praxisausstattung Mindestanforderungen gestellt werden. Beschränkt für den Basic LPL Bereich wäre dies als Ausnahme denkbar. Aufgrund der Begrenzung des Aktionsradius auf einen Umkreis von 50 km um den Startplatz könnte evtl. der Flugplatz bei unerwarteten und, aufgrund der i.d.R. weniger umfangreichen Diagnosemöglichkeiten, beim Allgemeinmediziner übersehenen medizinischen Problemen gerade noch rechtzeitig erreicht werden.

Letztentscheidung der Behörde über medizinische Fachfragen:

In Absatz (d) der Vorschrift MED.A.030 wird der lizenzierenden Behörde die grundsätzliche Möglichkeit eröffnet, selbst das Tauglichkeitszeugnis auszustellen. Dies korrespondiert mit den Vorschriften MED.A.045, wonach die Behörde eigene Limitations für das Medical verhängen kann sowie mit AR-MED.315, wonach die Behörde die Untersuchungsberichte erhält und das Medical selbst zu widerrufen hat, wenn sie der Auffassung ist, dass es falsch ausgestellt wurde.

Dieses System der Einbindung der lizenzierenden Behörde in den medizinischen

Teil der Beurteilung der Tauglichkeit der Luftfahrer halten wir für nicht wünschenswert, weder für die Luftfahrer noch für die Behörden.

Es erscheint aufgrund der Erfahrungen in der Vergangenheit unnötig bürokratisch, die Behörde zusätzlich zu den qualifizierten Sachverständigen auf fachmedizinischer Ebene in das Verwaltungsverfahren einzubinden. Im Übrigen dürfte die Entscheidung i.d.R. komplexer medizinischer Fragen ohne unmittelbare Kenntnis des Patienten, allein anhand einer Akte, sehr anfällig für Fehlentscheidungen sein. Abgesehen davon ist es aus Gründen des Datenschutzes bedenklich, wenn die Behörde künftig Einsicht in sämtliche Untersuchungsergebnisse der Bewerber nimmt.

Nach dem in Deutschland bisher geltenden System ist der flugmedizinische Sachverständige allein für die medizinische Begutachtung des Luftfahrers verantwortlich. Er trifft seine Entscheidung nach unmittelbarer Untersuchung des Probanten und kann auftretende Rückfragen unmittelbar mit diesem klären. Um als Flugmediziner anerkannt zu werden, muss er Spezialkenntnisse der Flugmedizin nachweisen. Die örtlich zuständige Luftfahrtbehörde erkennt einen Mediziner auf dessen Antrag als flugmedizinischen Sachverständigen an, wenn er die medizinischen und verwaltungsmäßigen Voraussetzungen seiner Praxis nachweist. Für die Untersuchungsinhalte und die Entscheidung über die Tauglichkeit ist ihm die Verantwortung (und damit auch die Haftung) übertragen. Das ist auch angemessen, da er die Untersuchungsbefunde erhebt. Jede medizinische Entscheidung steht und fällt mit der Sorgfalt der durchgeführten körperlichen Untersuchung. Für die Behörde ergibt sich daher auch eine haftungsrechtliche Problematik bei unrichtig durchgeführter Untersuchung durch den Flugmediziner. Eine Tauglichkeitsentscheidung und Verantwortung des unmittelbar untersuchenden Flugmediziners ist einer nur aufgrund einer Aktenauswertung bei der Behörde zu treffenden medizinischen Beurteilung daher unbedingt vorzuziehen. Ist ein Pilot mit dem Ergebnis seiner Untersuchung nicht einverstanden, kann er bisher bei der nächsthöheren flugmedizinischen Stelle (Flugmediziner Klasse 1, flugmedizinisches Zentrum) eine Überprüfung beantragen. Diese Überprüfung erfolgt jedoch abermals nicht ohne persönliche Kenntnis und Untersuchung des Patienten. Erhält die lizenzierende Behörde die Mitteilung, dass ein Pilot für untauglich befunden wurde, hat sie die Möglichkeit das Ruhen der Lizenz anzuordnen.

Dieses System gewährleistet eine saubere Trennung von Fragen der Lizenzierung und der fachlichen medizinischen Begutachtung (unter Berücksichtigung der ärztliche Schweigeverpflichtung). Die angedachte Letztentscheidungbefugnis der Behörde über medizinische Fragen würde ohne Not die Kompetenz der Flugmediziner in Frage stellen.

Die Vorhaltung eines flugmedizinischen Sachverständigen bei der Behörde wird auch erhebliche Kosten verursachen, die letztlich wiederum auf die Piloten umgewälzt werden müssten, ohne die Qualität der medizinischen Tauglichkeitsentscheidungen steigern zu können.

Es dürfte im Übrigen aus den genannten Gründen im gesamten medizinischen Bereich unüblich sein, dass ein Arzt weitreichende medizinische Entscheidungen trifft, ohne den Patienten jemals selbst gesehen bzw. untersucht zu haben.

response	*Noted*
	GMP: The BR states that the GMP may act as AME if permitted under national law. Any Member State may refuse to allow GMPs to issue medical certificates for LAPL in their national territory. See also response to comment No 1084.

comment	*1345*	comment by: *Ken Moules*
	I strongly support the involvement of the pilot's GMP proposed for the LPL. The best person to judge fitness is an honest appraisal by the pilot, supported by close relations. From a medical profession perspective, I believe that an individual's GMP is best placed to judge the fitness of a pilot against a set of criteria. Where an issue arises then referral or advice from specialist is normal practice and I see no reason why aviation specialist input needs to be different. I hold a Class 2 medical and have stayed over the years with the same AME, who knows me well. My AME and GP work as team to address issues. This position would be weaker if I opted to go to any AME annually. It must be very difficult for any medical professional to get a full picture based on a bit of form filling and a relatively brief examination. My point is that as the GMP has a more detailed and ongoing 'picture' of an individual, the GMP is far more likely to spot an issue that may be a flight safety risk. I would therfore argue that a GMP based LPL medical would be better at spotting issues and therefore potentially safer than the higher levels of medical.	
response	*Noted*	
	The Agency acknowledges your positive opinion.	

comment	*1346*	comment by: *Dieter Lenzkes*
	Allgemeiner Kommentar zu NPA 2008, 17c. Ich unterstütze den Vorschlag für den LPL ein Medical eines Allgemeinmediziners einzuführen, und zwar genau so, wie dieser in Artikel 7 Absatz 2 der Verordnung (EG) Nr. 216/2008 beschrieben ist: *…a general medical practitioner who has sufficient detailed knowledge of the applicant's medical background*…. Dies ist das, was in Deutschland auch "Hausarzt" genannt wird. Dieser kennt in der Regel seine Patienten über viele Jahre, häufig schon vom Kindesalter an und ist bestens über den allgemeinen Gesundheitszustand informiert. Sein Urteil ist bezüglich aller sportlichen und Freizeitaktivitäten sicher verlässlicher, als das eines speziellen Fliegerarztes der nur im Abstand mehrerer Jahre aufgesucht wird. Ich halte deshalb die „Hausarzt-Lösung" für Freizeitpiloten sogar für die bessere Lösung, weil der Hausarzt, wenn er die Freizeitaktivitäten seines Patienten kennt,	

	auch bei kurzzeitig und temporär auftretenden Krankheiten und Medikationen entsprechende Verhaltenshinweise geben kann. **Ergänzender Vorschlag zu MED.A.030; (b) (3) und (c) (2):** Streiche in beiden Fällen den Satzteil: „if permitted under national law". **Begründung:** Es sollte nicht im Ermessen eines einzelnen Mitgliedstaates liegen ob die Hausarztlösung zulässig ist oder nicht. Dies widerspricht dem Grundprinzip der Europäischen Harmonisierung. Es würde darüberhinaus sofort die Diskussion provozieren, ob eine LPL die in einem Mitgliedsstaat auf Basis eines GMP-Medicals ausgestellt wurde, in einem anderen Mitgliedsstaat der diese Praxis nicht erlaubt, Gültigkeit hat. Falls diese Frage per Verordnung positiv geregelt wird, würde dieser Zustand zu einem Lizenz-Tourismus führen, wie in der Vergangenheit bereits geschehen. Abgesehen davon, dass dies unnötige Kosten verursacht, würde dies aber genau die oben geschilderten Vorteile der Hausarzt-Lösung für Freizeitpiloten zunichte machen. Es ist das Grundprinzip der Europäischen Harmonisierung, dass solche essentiellen Anforderungen einheitlich geregelt werden müssen, auch wenn einige interessierte Kreise sich dann umstellen müssen. Wenn nationale Gesetze einer allgemein als gut anerkannten harmonisierten Problemlösung entgegenstehen, dann muss daraufhin gearbeitet werden, dass diese nationalen Gesetze geändert werden. Ansonsten wird jede Europäische Harmonisierung ad absurdum geführt.
response	*Noted*
	See response to comment No 59.

comment	*1352*	comment by: *Pat Pruchnickyj*
	It would be much more practical and accessible for pilots to have their own General Practitioner (GP) conduct and issue the LPL Medical.	
response	*Noted*	
	Our proposed rules do not prevent LAPL applicants to obtain medical certificates from their GMPs, if permitted under national law.	

comment	*1353*	comment by: *Andrew Kaye*
	I would support the issue of Medical Certificates by GMP for National Licences as there are good availability of GMPs in relation to to AeMC and AME's and thd standard is already set in the U.K. for HGV and Driving Car standards.	
response	*Noted*	
	Thank you for the support. There will be national licences only for aircraft mentioned in Annex II of the Basic Regulation (e.g. Microlights). In this case, the NAA may decide that a national medical certificate is needed and is free to set the standards. All other licences	

	will be European ones.

comment	*1392*	comment by: *Eleanor Fearon*
	It is a good idea that a GMP would be allowed to issue a initial certificate for LPL.	
response	*Noted*	
	Thank you for the support.	

comment	*1393*	comment by: *John Fenton*
	I think that the pilots GP should be able to conduct the LPL Medical and it should be based on car driving standards.	
response	*Noted*	
	Thank you for the feedback. LAPL medical certificates may be issued by a GMP, if permitted under national law. The LAPL medical requirements may not be based solely on car driving standards because in road traffic the 3rd dimension is missing and altitude can be a limiting factor in some medical conditions.	

comment	*1394*	comment by: *len vaughan*
	please allow gmp to conduct lpl medicals as now	
response	*Noted*	
	This provision of the Basic Regulation is already in our proposed Implementing Rules.	

comment	*1395*	comment by: *Tim DUDMAN*
	Unil now, balloon PPL medicals have been issued by a GP. I would like to see this continue for pilots not involved in commercial ballooning. There will be considerable additional expence involved in AeMC issue.	
response	*Noted*	
	Hot air balloon pilots shall hold Class 2 medical certificate. MED.A.030(b)(2) gives a possibility to obtain Class 2 medical certificates either from AeMC or AME. For a LAPL(B), a LAPL medical certificate may be issued by a GMP, if permitted under national law.	

comment	*1397*	comment by: *Prutech Innovation Services Ltd.*
	MED.A.030 (2): Class 2 medical certificates shall be issued by an AeMC or an AME or - in reduced format in accordance with "X" - by a GMP, in the case of aircraft of mass not greater than 600kg. **Comment:** It should be possible for a GMP to medically certify pilots for aircraft	

	not exceeding 600kg. If a class 2 type medical is deemed essential, then the current requirements for class 2 should be examined and a list of requirement exemptions should be specified, leading to format Class 2-format "X", for such lighter aircraft.
response	*Noted*
	According to the Basic Regulation the GMP can act as an AME for LAPL, if permitted under national law. A LAPL can be issued to fly aircraft of MTOW of 2000 kg or less. Regarding limited privileges for a LAPL medical certificate, see response to comment No 314 on MED.A.020 (b).

comment	*1398*	comment by: *Prutech Innovation Services Ltd.*
	MED.A.030 (3): LPL medical certificates shall be issued by an AeMC, an AME or, if ~~permitted~~ not prohibited under national law, by a general medical practitioner (GMP). **Comment:** *It should be a basic axiom that what applies in one Member State shall apply in all, except where there are very exceptional reasons for varying from this. The current wording is almost inviting national bodies to opt out of approving the use of GMPs for LPL medicals - which is inappropriate. The overwhelming support of the user community for GMP licencing must be recognised and not overridden by some national administrations, used to excessive stringency.*	
response	*Not accepted*	
	The Implementing Rules cannot deviate from the Basic Regulation. Our proposed text exactly reflects the text of Article 7(2).	

comment	*1399*	comment by: *Prutech Innovation Services Ltd.*
	MED.A.030(c)(1): Same comment as for MED.A.030(b)(1)	
response	*Noted*	

comment	*1400*	comment by: *Prutech Innovation Services Ltd.*
	MED.A.030(c)(2): **MED.A.030 (3):** LPL medical certificates shall be revalidated or renewed by an AeMC, an AME or, if ~~permitted~~ not prohibited under national law, by a general medical practitioner (GMP). **Comment:** *It should be a basic axiom that what applies in one Member State shall apply in all, except where there are very exceptional reasons for varying from this. The current wording is almost inviting national bodies to opt out of approving the use of GMPs for LPL revalidating/renewing medicals - which is inappropriate. The overwhelming support of the user community for GMP licencing must be recognised and not overridden by some national administrations, used to*	

	excessive stringency.
response	*Noted*
	See response to comment No 1398.

comment	*1401*	comment by: *Prutech Innovation Services Ltd.*
	MED.A.030(d): **Comment:** *In addition (or instead), EASA should reserve to itself the right to issue certificates, as not all national authorities can be relied on to act in accordance with prevailing practices.*	
response	*Not accepted*	
	Implementation of rules and issuance of certificates is a task of National Aviation Authoriities. The Agency may not take this task.	

comment	*1409*	comment by: *Martin Axon*
	MED A 030 Page 4 Medicals for the LPL are currently signed off by a general practitioner (doctor). in the UK. This should continue. A change is unnecessary and would mean a significant cost penalty.	
response	*Noted*	
	Thank you for the supporting opinion.	

comment	*1420*	comment by: *barry birch*
	I feel that it is imperative in the LPL category of license that examination by a General Medical Practitioner is sufficient for issuing the license. The category 'Light? as applied to this license implies that visiting an AME should not be necessary and a declaration of health should be OK. Also there are more GP's readily available to carry out examinations. Barry Birch (member of BBAC)	
response	*Noted*	
	Thank you for your support of the possibility of GMPs to issue medical certificates for the LPL.	

comment	*1422*	comment by: *Michael Gibbons*
	I am pleased to see that LPL medical certificates can still be issued by GMP's as they always have been for balloon pilots in the UK.	
response	*Noted*	
	Thank you for the positive feedback.	

comment	1426	comment by: Robert WORSMAN
	If a medical cert is required to fly a balloon (I suggest one certainly is not below the age of 65) then I very strongly support the proposal that a GP (GMP) can carry out the medical. My GP is much more knowledgable about my health. An seperate medical examiner would have no knowledge of my health and could easily fail to recognise a dangerous condition. I live in a rural community well away from specialist examiners. A visit to a specialist examiner would be prohibitively expensive for me - I would have to stop the sport of ballooning. Ballooning is a very safe sport - I consider it safer than driving a car. I do not need a medical cert. to drive a car - why should I require a medical cert to fly a balloon? This is very overly bureauratic and unnecessary. If EASA wants me (a private flyer) to have a medical certificate then it should pay my GP the cost of performing this unnecessary action and EASA should pay my expenses for the visit. I do not object to a GP issuing a medical certificate for commercial balloon flyers. Commercial balloon flyers should pay for their cert. and not EASA. EASA must carry the cost for any medical cert. required for private flying. I make these points both for the initial issue and for revalidation and renewal. I see no reason to have a AeMC. I regard this just as a fancy name for someone detached from everyday medical care and purely specialised in generating income for a bureaucratic process. An AeMC is much more likely to become detached from medical conditions, will have less experience than a GP and will not form balanced views or opinions. He'll end up costing more for a very inferior service.	
response	*Noted*	
	A General Medical Practitioner may issue medical certificates only for applicants for hot air balloon LAPL, if permitted under national law. BPL holders and BPL holders involved in commercial operations shall have class 2 medical certificate (as specified in MED.A.020(d)) which may be issued by an AME, AeMC or, in the case of referral, by the licensing authority.	

comment	1428	comment by: David BAKER
	I fully support the idea that a GMP can conduct the LPL medical. I believe the medical should be based on the HGV and car driving standards.	
response	*Noted*	
	Thank you for the support. See response to comment No 1393.	

comment	1429	comment by: Brian Trowbridge
	I am very much in support of the general medical practitioner being able to issue medical certificates for the LPL. He has first hand knowledge of a pilot's medical	

	history. This prevents the possibility of false statements of history from the pilot. In the UK our GMPs are well experienced in issuing medical certificates for heavy goods vehicle drivers which have the same requirements and restrictions as the ballooning medicals. They should be allowed to continue to issue and renew certificates without any need for further training or validation.
response	*Noted*
	Thank you for your positive comment.

comment	*1430*	comment by: *Patrick Goss*
	It would be preferable if the LPL Medical Certificate could be issued by a GMP (general medical practitioner)	
response	*Noted*	
	Thank you for the support, this is in line with our proposal.	

comment	*1435*	comment by: *Kenneth Scott*
	I am a PPL and would like to continue using a General Practicioner to issue and revsalidate my medical. The need to use a AeMC is both restructive and expensive.	
response	*Noted*	
	A PPL holder shall hold a Class 2 medical certificate which may be issued by AeMC or AME.	

comment	*1437*	comment by: *ray LESLIE*
	the restrictions applying to the lpl are such that the pilots gp should be more than capable of certifing a pilots general fitness.requireng a class 2 medical defeats much of the ETHOS AND BENIFITS OF THE LPL LICENCSE.	
response	*Noted*	
	Thank you for the supporting comment. There is no requirement for LPL to hold a Class 2 medical certificate in our proposals.	

comment	*1438*	comment by: *Huw PARKER*
	LPL medical certificates must be available from a GMP. The current CAA rules for medical certification of private balloonists are well established and do a great deal to keep the sport affordable. Any move to AeMC or AME will create significant obstacles to many leisure pilots.	
response	*Noted*	
	A General Medical Practitioner may issue medical certificates only for applicants for hot air balloon LAPL, if permitted under national law. BPL holders, and BPL	

	holders involved in commercial operations shall have class 2 medical certificate (as specified in MED.A.020(d)) which may be issued by an AME, AeMC or, in the case of referral, by the licensing authority.

comment	*1439*	comment by: *David COURT*
	Allowing a General Medical Practitioner to administer the LPL Medical is a good idea from EASA. It will mean there are more practitioners available to administer the LPL medical. Visiting your own General Medical Practitioner makes entry to the sport feel more accessible to those who wish to take up aviation for the first time rather than a visit to an Aeromedical Centre or AME. A GMP will know more about the mental stability of an applicant as he knows all his medical history. This is an important factor in determining if someone new to aviation is fit to fly. Mental stability is an important safety factor particularly for new entrants to aviation who are most likely to start with LPL and the associated LPL medical.	
response	*Noted*	
	Thank you for the supportive opinion.	

comment	*1442*	comment by: *Jamie Campbell*
	the current UK system of GP's being able to complete the LPL medical using the same process as that use for UK HGV's works very well and makes it easily accessable at a sensible cost. It is great that this is to continue.	
response	*Noted*	
	See response to comment No 1393.	

comment	*1444*	comment by: *BBAC*
	I support the idea that a General Practitioner can conduct the medical examination for a Balloon LPL.	
response	*Noted*	
	Thank you for the supportive opinion.	

comment	*1445*	comment by: *Richard Plume*
	It is very important that GMPs (or GPs as they are known in UK) can conduct the LPL medical. This is currently allowed under the UK scheme, and there is no evidence whatsoever of any problems arising from this, so there is clearly no	

	need to change it. To increase the requirement to make LPL medicals done by an AeMC or AME would incresae the level of work for these people, and would increase the cost and inconvenience for LPL holders. No doubt there are vested interests amongst AeMCs and AMEs who would like the extra paid work for themselves but there is clearly no valid requirement for this to be done.
response	*Noted*
	Thank you for your comment.

comment	*1446*	comment by: *Peter Gunning-Stevenson*
	Medical certificates should be issued by GP's. These people are qualified and should be aware of their patients medical history. They are in an ideal position to sign off for an LPL medical. GP's are plentiful and there should not be a need to travel excessively for a medical examination.	
response	*Noted*	
	Thank you for the supportive opinion.	

comment	*1465*	comment by: *Richard Allan*
	I support the idea that GMP should be allowed to issue medicals for the LAPL as there are not enough AME and it is difficult to book appointments due to other work that they do.	
response	*Noted*	
	Thank you for the supportive opinion.	

comment	*1466*	comment by: *richard benham*
	In my opinion, my local GP must be able to conduct and issue the LPL medical (that which applies to me as a non-commercial pilot), based on car driving / heavy goods vehicle minimum standard. The high number of local GP's will make it a lot easier to gain access to a large pool of medical practitioners without excessive travel and incurred costs. As a private pilot flying approx 6-10 times per year, having anything but a GP issue this, will incurr excessive costs and inconvenience to me	
response	*Noted*	
	See response to comment No 1393.	

comment	*1467*	comment by: *R I M Kerr*
	The best person to confirm a pilot's fitness to P1 is the pilot's GMP. They know the pilot best, and it shares the total workload over a vastly greater number of doctors.	
response	*Noted*	

	Thank you for the supportive opinion.

comment	*1475*	comment by: *RG Carrell*
	GMPs are sufficiently qualified to assess the suitability of LPL pilots, in particular if they have the patients medical history to hand. AME examinations are a pointless complication for LBL balloon pilots, (and possibly worse as there are commercial interests) It will be much simpler to use standards such as HGV licencing standards which are widely understood within the medical profession.	
response	*Noted*	
	Thank you for the opinion. See response to comment No 1393.	

comment	*1476*	comment by: *tobydavis*
	I support the idea that a pilots GP should be able to carry out the medical for the LPL. In most cases these doctors already know past medical history and are well practiced at carrying out driving medicals upon which i believe the pilot medicals should be based. Also using a pilots GP would make sense as they are usually local to the pilot and readily available, there would be sufficient numbers of GP available so no time is wasted.	
response	*Noted*	
	Thank you for the positive comment. See response to comment No 1393.	

comment	*1479*	comment by: *John THOMPSON*
	I am in favour of retaining GMP's for pilot medical assessments as long as they have access to a sufficient history of the applicants medical records. In the event they are not available then a more detailed examination, again by the GMP, being required makes perfect sense. Any changes to the assessment process that will have a significant impact on cost must be challenged for validity.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1481*	comment by: *Sue Rorstad*
	For LPL medicals a GP conducting the medical is the only practical way.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1487*	comment by: *Graham CANNON*
	It is important that a GMP can provide the medical for a LPL	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1488*	comment by: *lotus Balloons*
	I can support the suggestion that a GP can approve medical status for an LPL. I believe it could be carried out in accordance with driving licence standards.	
response	*Noted*	
	Thank you for the positive comment. See response to comment No 1393.	

comment	*1489*	comment by: *Richard ALLEN*
	LPL medicals issued and revalidated by a GMP - This is currently done by GMPs in the UK and functions well. The medical requirements for balloon medical certification are set ast the same as professional HGV drivers, so a GMP knows what they are assessing. If GMPs are able to issue and revalidate the LPL medical it will save a need for these leisure licence holders to find an AeMC or AME. This will also mean that AeMCs and AMEs are not burdened with so much work that they cannot certificate all that wish to be certificated.	
response	*Noted*	
	Thank you for the positive comment. See response to comment No 1393.	

comment	*1491*	comment by: *Peter Kenington*
	The ability for a general medical practitioner to issue and renew an LPL medical certificate is good practical solution and should remain. The use of an AeMC is unnecessary and adds to the incremental costs and difficulties (due to AeMC scarcity) of obtaining and retaining an LPL.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1492*	comment by: *Lindsay Sadler*
	The LPL Medical Certificates should continue to be issued by your own General Medical Practitioner, they will know your medical history and current status and should be able to issue the certificate quickly and efficiently. Stopping this would be a hinderance to some sporting/pleasure pilots and would discourage people from joining or continuing their sporting/pleasure avaiation.	

response	*Noted*
	Thank you for the positive comment.

comment	*1495*	comment by: *Dr. med. H.-J. Böhm*
	Die Einführung eines LPL mit dem geplanten Procedere (Selbsterklärungsbogen vor einem GP, Untersuchungsumfang, Untersuchungsintervalle, u.a.) sind fachlich und medizinisch falsch und bergen die Gefahr, daß Piloten mit relevanten Gesundheitsstörungen so in den Besitz einer formalen medizinischen Tauglichkeitsbescheinigung kommen, und dies über einen unverhältnismäßigen langen Zeitraum! Damit wird die Gefahr auf Zunahme von Flugunfällen durch "menschliches Versagen" meines Erachtens deutlich erhöht. Es ist bewiesen, daß in etwa 70 -80 % aller Flugunfälle der Faktor Mensch durch Fehlleistungen als Ursache steht; technische Ursachen treten heutzutage immer mehr in den Hintergrund. Literatur: Der Privatflugzeugführer Band 8 - Menschliches Leistungsvermögen von Jan Kupzog (ISBN 3-935220-36-7) Oft sind diese Fehlleistungen in Verbindung mit physischen oder psychischen Auffälligkeiten zu sehen bzw haben einen Krankheitshintergrund, wobei eine "strengere Medical-Vergabe " (als in den geplanten LPL-Vorschriften vorgesehen) diese zum Teil aufdecken kann!	
response	*Noted*	
	Thank you for the comment. Following the comments received, the requirements for a LAPL medical certificate have been redrafted.	

comment	*1496*	comment by: *Rory Worsman*
	I strongly support medical certificates being issued by a GMP, GP, - general medical practitioner, for both LPL and BPL if indeed they are actually required. My GMP has full knowledge of my health whereas any AeMC does not. A move to issue by AeMC is neither safe nor sensible. I live in a rural environment -many miles from any AeMC. The cost of seeing an AeMC would prevent me from continuing with the sport. There is no requirement for a medical cert. to drive a car, ride a bike or to be a pedestrian - all more dangerous than flying by balloon. To impose one lacks common sense, is overly bureaucratic and simply just not required. It suggests that this rule has been drawn up by those not familiar with hot-air balloon flight. What is the justification for requiring a medical cert? How will it make ballooning any safer? If you examine the risks and took a very worst case - a medically unfit pilot - if you removed flying time from the pilot and his car driving time increased as a result then I would suggest you are making the EU a more dangerous place to live	

	in. An accident due to ill health at the wheel of the car is significantly more dangerous than an accident due to ill health flying a balloon.
response	*Noted*
	Thank you for the positive comment. See responses to comments No 362 and 1438.

comment	*1497*	comment by: *Rory Worsman*
	I do not support the requirement for a medical certificate for Balloon LPL and BPL licenses for pilots below the age of 65. The idea is bureaucratic, unnecessary and very expensive. It's sole function is to prop up and generate income for AeMC doctors not capable or willing enough to enter full time into the medical profession. Their exposure to mainstream medical care is limited, their experience is very reduced in comparison to a GMP.	
response	*Not accepted*	
	BPL is a licence for private flying and requires holding Class 2 medical certificate. This is also an ICAO standard: please refer to ICAO Annex 1, Section 2.10. Free balloon pilot licence, paragraph '2.10.1.5: An applicant shall hold a current Class 2 Medical Assessment'.	

comment	*1505*	comment by: *Derek Maltby*
	I am in support of this proposal. Since the introduction of medicals issued by GP's, the transistion has been much smoother with no detriment to air safety.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1512*	comment by: *Peter MEECHAM*
	LPL medical certificates should be issuerd by the pilots' own GMP who is more accessable and has a good knowledge of his patient's record.	
response	*Noted*	
	The Basic Regulation provides the possibility for GMP who has sufficient detailed knowledge of the applicant's medical background to issue LPL medical certificate, if permitted under national law.	

comment	*1525*	comment by: *Nina Bates*
	I fully support the inclusion of General Medical Practitioner as issuers of LPL Medical Certificates. Their inclusion prevents any accusation of profiteering on the part of Aero Medical Centres and ensures that all LPL holders have adequate access to a suitably qualified person.	

response	*Noted*
	Thank you for the positive comment.

comment	*1532*	comment by: *Erwin J. Keijsers*
	Ich unterstütze die Einführung eins Tauglichkeitsstandards unterhalb ICAO Klasse 2 und die Möglichkeit der Untersuchung durch den Hausarzt. Die Sicherheit wird nicht gemindert, die Kosten für den Erwerb und Unterhalt der Lizenz werden gesenkt, die Zugänglichkeit zum Luftsport wird erleichtert.	
response	*Noted*	
	See response to comment No 1332.	

comment	*1567*	comment by: *Francesca WORSMAN*
	I believe that medical certification for private (non-commercial) balloon flightsshould follow current practise for private cars in the UK I only support allowing a Gp (GMP) to carry out medicals (if they are actually required)for LPL and BPL balloon license. I do NOT support AeMCs being allowed to carry out medicals for ballooning. My GMP knows by health better than anyone. AeMCs are a completely unnecessary bureaucratic overhead to the sport of balloon. Ballooning is a safe sport, safer than driving a car, cycling or being a pedestrian, neither require regular medicals. If EASA require AeMC medicals for ballooning then they must cover the entire cost of the process including all medical costs. No cost should be borne by the pilot for such an irrelevent process.	
response	*Noted*	
	See responses to comments No 1497 and 1438.	

comment	*1568*	comment by: *Sarah Bettin*
	I agree with the proposal that General Medical Practitioners should be able to conduct the LPL medical.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1619*	comment by: *Bayerisches Staatsministerium für Wirtschaft, Infrastruktur, Verkehr und Technologie*

	Flugmedizinische Tauglichkeitszeugnisse sollten auch weiterhin von flugmedizinisch anerkanntem Fachpersonal und nicht - wie in den Vorschriften vorgesehen - durch Hausärzte erstellt werden. Begründung: Aus Sicherheitsgründen und im Hinblick auf das komplexe flugmedizinischen Anforderungsprofil, welches in der Regel nicht dem Allgemeinarzt oder Hausarztfachwissen unterliegt, sollte auf diese "Erleichterung" für die Piloten verzichtet werden. Um die Auswirkung der spezifischen Faktoren im Luftverkehr einschätzen zu können, bedarf es einer fundierten Spezialausbildung. Die auf den Piloten einwirkenden Kräfte und die körperlichen Leistungsanforderungen unterschieden sich beim LPL nicht vom PPL. Auch die durch LPL und PPL verliehenen Rechte unterscheiden sich nicht wesentlich. Flugunfälle aufgrund von unentdeckten medizinischen Problemen haben, unabhängig davon ob der Pilot LPL- oder PPL-Inhaber ist, die gleichen Folgen. Die Ausstellung von Tauglichkeitszeugnissen im LPL-Bereich durch Allgemeinmedizininer (GMP) dürfte auch für die Piloten keine Vorteile bringen. Wird die Untersuchung genau so sorgfältig durchgeführt wie beim Flugmediziner, dürfte sie sich auch kostenmäßig auf ähnlichem Niveau bewegen. Erfolgt die Untersuchung beim Allgemeinmediziner aus Kostengründen aber weniger tiefgehend, so ergeben sich hierdurch unüberblickbare Gefahren für die Luftsicherheit durch unentdeckte Gebrechen. Um entsprechend der Verordnung (EG) Nr. 216/2008 jederzeit ein einheitliches und hohes Schutz- und Sicherheitsniveau zu gewährleisten, muss auch für den LPL die Ausstellung von Tauglichkeitszeugnissen und die Untersuchung der Probanten unbedingt den AeMCs und AMEs vorbehalten bleiben. Allenfalls könnte ausschließlich für den Basic LPL ein "Hausarztmodell" eingeführt werden, nach dem sich der Hausarzt einer erfolgreichen anerkannten Fortbildung im Fachgebiet Flugmedizin zu unterziehen hat, und dann berechtigt ist, einen "Weiterbildungstitel Flugmedizin" zu führen. Zusätzlich müssten ggfs. auch hinsichtlich der Praxisausstattung Mindestanforderungen gestellt werden. Beschränkt für den Basic LPL-Bereich wäre dies als Ausnahme denkbar.
response	*Noted*
	See response to comment No 1341.

comment	*1635*	comment by: *Peter Hecker*
	Ich unterstütze die Einführung eins Tauglichkeitsstandards unterhalb ICAO Klasse 2 und die Möglichkeit der Untersuchung durch den Hausarzt. Die Sicherheit wird nicht gemindert, die Kosten für den Erwerb und Unterhalt der Lizenz werden gesenkt, die Zugänglichkeit zum Luftsport wird erleichtert.	
response	*Noted*	
	See response to comment No 1332.	

comment	*1651*	comment by: *Claudia Buengen*

	(b) (3) provision for GPs to be entitled to issue medical certificate. This will certainly be an improvement on the current ruling in several of the EASA countries. The GP knows the pilot's medical background much better than a doctor who only sees him every five years to issue a specific aviation medical. A very pragmatic and safe solution.
response	*Noted*
	Thank you for the positive comment.

comment	*1682*	comment by: *David Weekes*
	I strongly support the concept of medical certificates for glider pilots being issued by the pilot's General Medical Practitioner (GMP) on the basis of the pilot's known medical history. This concept has worked well in recent years in countries such as the UK and New Zealand. Where a long-term medical history is available there should not be a need for specific medical examinations.	
response	*Noted*	
	GMP may issue medical certificates only for LPL glider pilots. Glider pilots — see response to comment No 1129.	

comment	*1715*	comment by: *Yvonne Heeser*
	Ich unterstütze die Einführung eines Tauglichkeitsstandards unterhalb ICAO Klasse 2 und die Möglichkeit der Untersuchung durch den Hausarzt. Die Sicherheit wird nicht gemindert, die Kosten für den Erwerb und Unterhalt der Lizenz werden gesenkt, die Zugänglichkeit zum Luftsport wird erleichtert.	
response	*Noted*	
	See response to comment No 1332.	

comment	*1723*	comment by: *Rita Marshall*
	I request that UK LPL pilots be able to continue to have Medicals there GP's, a. They hold the individuals full medical history & records. b. They are based locally c. There is no shortage of them in the UK: therefore cost of time, travel and booking will be kept to a minimum.	
response	*Noted*	
	We proposed the possibility for LAPL pilots in all Member States to obtain medical certificates from GMP, if permitted under national law.	

comment	*1724*	comment by: *Tony Gould*
	Balloon flying is a physically demanding sport for a leisure pilot with a small crew	

	of only 3 or 4 people. At times the level of mental concentration during flight can be quite high. It would be exceedingly rare for an unfit pilot. either physically or mentally to attempt a flight unless he personally felt fit. There is thus a very strong case for a local General Medical Practitioner to issue the certificate. The axiom is true that it is generally the pilot that decides to voluntarily give up flying and not seek recertification rather than the GMP 'failing' an applicant.
response	*Noted*
	See response to comment No 1395.

comment	*1727*	comment by: *Civil Aviation Authority Finland*

MED.A.030 ((b) (3)
The majority of PPL holders are flying aircraft less than 2 tonnes with up to 3 passengers and may fly in all classes of airspace. The privileges for a full LPL are the same as for PPL, but the training and medical requirements are considerably less. This is not acceptable, bacause they can have serious health/medical problems or lack of operational knowledge of the airspace.

If there is a dual system of LPL and Class 2 medical certification, there is a real risk that many AMEs are not willing to continue as innspecting AMEs and there will be lack of AMEs in different areas of the State.

In many States the applicant's GMP cannot act as an AME due to conflict of interests. Any other AME will not have access to the medical history the applicant and this is a real flight safety concern (ref. the data protection act).

It must be clear that the LPL requirements can only apply in few States.

The experience of the US Sports Pilot's Licence is, that many applicants would have been refused a FAA Class 3 certificate. This US licence is restricted in terms of airspace, route, no passengers carried, maximum speed and maximum take off weight and distance from airfield. It may be appropriate to restrict LPL medical certification to light sports aircraft under 600kg as discussed by the MDM.032 group according to the EASA web site presentation.

In most Member States, as in Finland spead thorough the State, there is a highly qualified AME network, that can provide an expert service for aeromedical assessment.

Any LPL applicant with a medical problem will, in any case, have to seek further advice from an AME or AeMC.

It is impossible to have Authority oversight of, or have control over the work of, GPs if there is no approval mechanism of GMPs.

response	*Noted*
	The aim of the Implementing Rules/AMCs for LAPL is to have proportional rules with regard to the type of operation in order to ensure access to private flying to as many applicants as possible without increasing the risk. The Basic Regulation in article 7(7) clearly states that LAPL pilots will have the

	possibility to exercise non-commercial activities involving aircraft up to 2000 kg MTOM. The GMP declaration of the activity as an AME is a legally sufficient basis for the Authority oversight. Regarding limited privileges for a LAPL medical certificate, see response to comment No 314 on MED.A.020 (b).

comment	*1732*	comment by: *DCA Malta*
	MED.A.030(b)(3) and (c)(2) Delete 'or, if permitted under national law, by a general medical practitioner (GMP)' GMPs are not considered to be qualified in aviation medicine.	
response	*Not accepted*	
	Medical requirements as regards LAPL were developed following the principle that all measures must be proportionate and tailored to the risk involved. The Basic Regulation (Article 7(2)) allows GMP to issue a medical certificate for a LAPL if permitted under national law. This has to be taken into account in the implementing rules.	

comment	*1749*	comment by: *Graham PHILPOT*
	I believe that for leisure/sport flying a pilot's own doctor (GP) is the most suitable clinician to sign them as fit. Where a member state has a valid medical standard (eg UK DVLC driving standard for HGV lorries and cars) this should be accepted as suitable and should not disadvantage the individual by insisting on AME with exorbitant fees – if necessary these schemes could be registered centrally. <u>In other areas of EU legislation the lowest common denominator is supposed to apply, the proposals could be an Infringement of Human Rights</u>	
response	*Noted*	
	See response to comment No 1393.	

comment	*1750*	comment by: *Hugh STEWART*
	I think that a GMP should be able to conduct the LPL medical on initial issue and on renewal. There are sufficient numbers of GMPs who carry out standard medical health checks for driving, sub-aqua and other sports so there is not reason at all why they should not also conduct LPL examinations.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1752*	comment by: *Max Heinz Katzschke*
	Hierzu habe ich in NPA2008-17b Cmt#4048 geschrieben: "Diese Einschränkung entspricht nicht den Lebensumständen, da vielfältige Anforderungen und Qulifizierungen besonders im Beruf immer öfter zu einem Wechsel des Wohnsitzes oder Lebensmittelpunktes führen. Deshalb muss es ermöglicht werden Erweiterungen oder periodisch verlangte Nachweise der theoretischen und praktischen Fähigkeiten in einem beliebigen Land der Europäischen Union ablegen zu können. Nur so ist die in der Wirtschaft notwendige Beweglichkeit der Menschen zu gewährleisten." Deshanb sollte ein europäischer Bürger auch jeden beliebigen europäischen AeMC, AME, GMP und jeden Allgemeinarzt auswählen können, auch wenn der nicht aus seinem Land/seinem ständigen Wohnsitz entsprechend, praktiziert und/oder stammt. Alle anderen Regeln sind nicht zumutbar.	
response	*Noted*	
	See response to comment No 47.	

comment	*1756*	comment by: *Civil Aviation Authority Finland*
	MED.A.030 (b) (1), (2) and (3) 'Shall' is inappropriate. The Basic Regulation states that a medical certificate **may** be issued by an AeMC or AME. The IRs must comply with the Basic Regulation. The Basic Regulation states that a medical certificate **may** be issued by an AeMC or AME. The IRs must comply with the Basic Regulation.	
response	*Noted*	
	See response to comment No 376.	

comment	*1866*	comment by: *R Gyselynck*
	A general practitioner should be able to issue the LPL medical as in the UK at presnt. The system has been successfully used for many years now and is a sensible balance of risk vs medical judgement.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1870*	comment by: *ECA- European Cockpit Association*
	Comment on paragraph (b): ECA questions the need for different initial and revalidation criteria. However, the initial place of issue for class 1 certificate should be AeMC in order to guarantee the experience and expertise of the medical check up.	
response	*Noted*	

	The only difference between initial issue and revelidation/renewal is the initial issue of Class 1 medical certificate. Possibility for AeMCs to issue initial Class 1 medical certificates is a transposition of a Long Term Exemption No 112 in JAR-FCL 3.100.

comment	*1891*	comment by: *Susana Nogueira*
	(d) Delete all paragraph. Not in JAR-FCL. Is the end of harmonization	
response	*Not accepted*	
	This principle was applied in accordance with JAR-FCL 3 and helped to implement this document in the most harmonised way.	

comment	*1895*	comment by: *David Trouse*
	I strongly support the proposal to enable general medical practitioner (GMP) to issue and revalidate or renew LPL medical certificates.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1904*	comment by: *Michael Hinz*
	Klasse 2 Medicals und insbesondere LPL Medicals sollten auch immer von Allgemeinmedizinern (GMP) ausgestellt werden können. Die Hausärzte kennen den Piloten am besten. Sie können insgesamt am besten beurteilen, ob wirkliche medizinische Probleme vorliegen, die das Fliegen oder das Autofahren verhindern. Es ist mit dem gleichen recht für alle nicht vereinbar, wenn es dem nationalen recht überlassen bleibt, ob ein GMP ein Medical ausstellen darf. Er muss es immer und in jedem Staat dürfen. Auch muss es möglich sein, sich ein Medical bei einem GMP im Ausland ausstellen zu lassen. Solche Medicals müssen in jedem Staat anerkannt werden. Positive Medicals müssen von der Luftfahrtbehörde in jedem Fall anerkannt werden. Es darf nicht sein, dass Nicht-Mediziner sich über das Urteil eines GMP oder gar eines AME hinweg setzen.	
response	*Noted*	
	See responses to comments No 59, 349, and 362.	

comment	*1918*	comment by: *Dr. Kureck*
	As a General Internist and flight surgeon I consider the fact that a "regular GP" can issue a medical certificate dangerous: I have a few (3) patients with chronical illnesses and a pilot licencense, all of them with marginal fitness. However all of them neglect their medical problems, like a nucleus pulposus prolaps or a	

	polyneuropathy. Last year I saw a 70 y/o patient with heart failure applying for a license. He didnt get it from me, but he did not understand that i considered him unfit for flying.
response	*Noted*
	See response to comment No 72.

comment	*1920*	comment by: *Robert Harris 7699*
	I strongly believe that medical certificates for LPL should be issued by a GMP. This has been the case for very many years in the UK and assessments for HGV and car driving should be perfectly adequate for LPL standards. GMP's are perfectly qualified for this level of examination and are readily available. AeMC and AME are scarce and relatively expensive and requiring LPL to utilise these certificators will add yet further barriers and expense in the way of the private pilot and his recreation leading to a further reduction in the private aviation sector	
response	*Noted*	
	See response to comment No 1393.	

comment	*1921*	comment by: *Dr. Kureck*
	1. In our local -as well as in the European airspace, the LPL and Class 2 , even Class 1 pilot share the same environment, airspace and aircraft. so the risks and the consequences are similar.I do see a risk when (mentally)slightly impaired senior pilots enter a busy airspace. The proposed rules tend to shift problematic cases from Class 2 to LPL, in the absence of medical supervision. The rare intervals for LPL-applicants show a risk for developing chronic disorders. **Most** of my PPL-applicants are not aware of the fact that they should seek my advice after hospital treatment or after getting new drugs by their GP's. Plus, most GP's have no idea with what diseases and drugs a pilot may or may not be able to safely perform his or her privileges	
response	*Noted*	
	The requirements for the LAPL medical certificate will be redrafted. See also response to comment No 72.	

comment	*1924*	comment by: *CAA Belgium*
	(d) An authority must have the option to issue a medical certificate. There may be other circumstances when an authority needs to issue a medical certificate. eg when a medical certificate has been lost or an AME has issued a certificate with a missing limitation.	

	Delete 'in the cases of referral'.
response	*Noted*
	See response to comment No 327.

comment	*1946*	comment by: *Civil Aviation Authority of Norway*
	Comment to (b) and (c): According to the basic regulation, who says "the medical certificate **may** be issued by an AeMC or AME". The text "**shall**" be issued by an AeMC or AME is therefore wrong.	
response	*Noted*	
	See response to comment No 376.	

comment	*1947*	comment by: *Jeff Roberts*
	I agree that it is acceptable that a general medical practioner can issue a medical certificate for the LPL.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1950*	comment by: *Jeff Roberts*
	I agree that it is acceptabale that a general medical practioner can issue a medical certificate for the LPL.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*2004*	comment by: *AA Brown BBAC # 3448*
	MED.A.030 Competence for the issue, revalidation and renewal of medical certificates. BPL medical certificates ie. JAA Class 2 certificates should be issued by an AeMC or an AME. However, LPL medical certificates should also be able to be issued by properly qualified GMP's as in the UK.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*2010*	comment by: *Broadland Balloon Flights*
	I strongly support the suggestion that LPL medicals can be issued by GMPs. Presumably the standard will tally with some existing recognised standard (driving licence?).	

response	*Noted*
	Thank you for the positive comment. See response to comment No 1393.

comment	*2050*	comment by: *Barry Bower*
	There are sufficient GMPs in the UK to support this issue.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*2066*	comment by: *Dr Ron Pearson*
	MED.A.030(d) is badly worded, "in the cases of referral" should read "when cases are referred" MED.B.005(a)(2) indicates that a resting ECG is not required for initial issue of a class 2 certificate under age 40. This means that a pilot can complete his training, spend a great deal of money on further ratings and perhaps own an aircraft, then find that at age 40 he has a conduction abnormality, which requires catheterisation and ablation (ventricular pre-excitation). Since it is now proposed that commercial cabin staff have a resting ECG on initial examination under age 40, it seems inconsistent that PPL's do not require similar treatment. MED.B.005(c) blood pressure "normality" is not defined, either here or in the AMC MED.B.005(d)requires "cardiological evaluation" and the AMC outlines and adequate means of completing this evaluation, however, without referral to the numerical assessment of risk, there is no means of comparing alternate means of compliance. Subpart C AME's Appointment and training are not specified other than the completion of a training course in aviation medicine approved by the competent authority and being medically qualified. The difference between Class I and 2 qualified examiners is minimal and the degree of additional Aeromedical training required is unspecified. The figures presented in the consultation paper discussion show that France has no AMEs qualified to carry out Class 1 medical examinations - they require professional pilots to attend regional centres. Within the last two years the UK has almost doubled it's Class 1 AME's (ignoring the JAR requirements regarding pilot population and geographic distribution on the process). This has led to a r significant reduction in examinations per AME and so a loss of effectiveness. How can standardisation of quality be assured and will freedom of employment allow UK AME's to relocate to France?	
response	*Partially accepted*	
	MED.A.030(d) The text will be amended accordingly for clarity reasons. MED.B.005(a)(2) Following the principle to put Class 2 requirements in line with ICAO standards, private pilots will not be required to undergo ECG until the first aeromedical	

	examination after the age of 40. The proposed rule does not prevent the applicant to request ECG. In addition, AME may request the ECG in the case of clinical indication. MED.B.005(c) Medical requirement for pilots may only indicate blood pressure limits acceptable for flight safety. Blood pressure 'normality' is defined in special medical literature. MED.B.005(d) The risk assessment will be included in the Guidance Material. Subpart C Rules with regard to the authorisation and oversight of AMEs are proposed with Authority requirements in NPA 2008-22b.

comment	*2072*	comment by: *CAA Belgium*
	Relevant Text: LPL medical certificates shall be issued by an AeMC, an AME or, if permitted under national law, by a general medical practitioner (GM). Comment: GMPs are not experienced and trained in Aviation medicine, and even after a course of training the necessary involvement in the special knowledge of the topic is in doubt. Lacking own airman experience the meaning of certain pathologies for flight safety is impossible to judge for a GMP. Following basic jurisdiction principles , it's not acceptable and forbidden by law, that the same physician, who treats the patient, should be the one who issues any license or gives specialist opinion to the licensing authority. The treating physician is under commercial pressure to do his patient "a favour" and at risk to give an untrue, "positive" testimony. If so for a simple driving license,as well as for flying passengers in an aircraft the basic principle of jurisdiction should be applied: Treatment by the GMP, certification by an independent AME. Proposal: LPL medical certificates shall be issued by an AeMC, or an AME ~~or, if permitted under national law, by a general medical practitioner (GM).~~ The same applied to MED.A.030 (c, 2)	
response	*Noted*	
	See responses to comments No 59 and 72.	

comment	*2092*	comment by: *Peter Mossman*
	Up till now medicals for a PPL (LPL) were carried out by our own GPs to a set standard which has proved very successful. To create a situation where only specified Medical Officers can do this work will result in a huge volume for a few Doctors totally unnecessarily and be unworkable.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*2095*	comment by: *Kevin Ison*
	I would only support an LPL medical conducted by my local GP. There are insufficient numbers of A&MC in this area.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*2116*	comment by: *Direction de l'Aviation Civile Luxembourg*
	Luxembourg does not consider to introduce a general medical practitioner for the issue of medical certificates for pilots, even if we consider that MED.D.001 requirements are well chosen, especially the credit given to medical examiners having experience as a pilot. **New proposal**: LPL medical certificates shall be issued by an AeMC, or AME.	
response	*Noted*	
	See responses to the comments No 59 and 72.	

comment	*2139*	comment by: *AMS Denmark*
	MED.A.030 (b) (3) delete and "by a general medical practitioner (GMP)" Reason: Not safe and not cost effective GMP have no education in Licensing and authorities will have much more work with attestations made by GMPs, which will increase the cost for the applicant. Beside the fact that the GMP does not know the health requirement and can therefore not advice the applicant, but will take the same price as an educated doctor..	
response	*Noted*	
	See responses to commentsNo 59 and 72.	

comment	*2155*	comment by: *Roger B. Coote*
	We strongly support the BGA medical system, based on DVLA Group 1&2 standards and certification, carried out by the pilot's GP and as used for the NPPL. It is claimed that the SPL ICAO 2 is set at a lower level than the CAA Class 2 medical but what are the comparative standards?	
response	*Noted*	
	See response to comment No 1393. Comparative standards are in the Explanatory memorandum to Part Medical (NPA 2008-17a).	

comment	*2174*	comment by: *Dr.Piek Armin*
	competent medical examination for pilots can only be practised by AeMC or AME and not by GMP independant of the pilot's class	
response	*Noted*	
	See response to comment No 72.	

comment	*2184*	comment by: *Finnish Aeronautical Association - Kai Mönkkönen*
	The Finnish Aeronautical Association supports the possibility of a General Medical Practioner in case of LPL to issue medical certificate. Justification: There is well working system with good experience seen in the UK today and for example for glider pilots in Finland, General Medical Practioners were allowed to carry out medical checks for glider pilots until 1990´s after which heavy burdensome JAR-system overtook that, without any safety related justification.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*2185*	comment by: *Finnish Aeronautical Association - Kai Mönkkönen*
	(b)(3) A general medical practioner GMP is allowed to issue medical certificate for a new LPL (or also for its renewal). However, the additional text "if permitted under national law" may lead to the unwanted situation where the "local" authorities just can say "no" – to protect the current system of their AME's – even not for professional but commercial reasons of those. GMP should be allowed to issue medical certificate for a new LPL in general. And at least if having also history records of the applicant available, for example from at least last 3 years backwards. Justification: Professionally GMP shall be considered capable for doing the work. In the view of medical depth for the check, such can be set by requiring also medical history of an applicant, for example from the last 3 years available. So, we do not see what is the real purpose of words: "if permitted under national law". Proposed text: Change text on item MED.A.030 (b)(3) to read: "*LPL medical certificates shall be issued by an AeMC, an AME or by a general medical practitioner (GMP)"*.	
response	*Noted*	
	See response to comment No 59.	

comment	*2186*	comment by: *Finnish Aeronautical Association - Kai Mönkkönen*
	(c)(2) A general medical practioner GMP is allowed to renew medical certificate for a new LPL (or also for a new one). However, the additional text "if permitted under national law" may lead to the unwanted situation where the "local" authorities just can say "no" – to protect the current system of their AME's – even not for professional but commercial reasons of those. GMP should be allowed to renew medical certificate for a LPL in general. And at least if having also history records of the applicant available, for example from at least last 3 years backwards. Justification: Professionally GMP shall be considered capable for doing the work. In the view of medical depth for the check, such can be set by requiring also medical history of an applicant, for example from the last 3 years available. So, we do not see what is the real purpose of words: "if permitted under national law". Proposed text: Change text on item MED.A.030 (c)(2) to read: "*LPL medical certificates shall be revalidated or renewed by an AeMC, an AME or by a general medical practitioner (GMP)"*.	
response	*Noted*	
	See response to comment No 59.	

comment	*2188*	comment by: *Proffessionele Ballonvaarders Nederland*
	MED.A.020 (b) ; medical class 2 for all ballonists and not just for BPL. fofr these same reasons as mentioned below in part 030 c. **MED.A.030 (c) (2) revalidation and renewal** Reaction on this part, in relation to LPL for balloons ; In essence this part is alright in my view, and may be upgraded in one particular item ; LPL medicals should also be revalidated by an AeMC or AME, and **not by** a GMP, because these institutes have more expertise on the human performances and limitations that aviation has. LPL holders share the same airspace as others and need to be fit to be in between there, in all respects. Combined with the fact that people over 60 years old should be granted to keep there licence as long as they comply to these standards, the contents of a medical examination should be covering a suitable standard, that in my experience is not covered by a regular GMP.	
response	*Noted*	
	See response to comment No 72.	

comment	*2193*	comment by: *JOSEP LLADO-COSTA*
	LPL medical certificates should be allowed by the same doctors than issue the medical certificate for car driving licenses. It is not required a superior skill for LPL pilot and it should facilitate the cost of renew a license that now is quite expensive because they act as a lobby.	
response	*Noted*	
	See response to comment No 1393.	

comment	*2225*	comment by: *Jaime Stewart*
	In the UK it is essential that General Medical Practitioners continue to be able to conduct medicals and issue certificates for the LPL. Our HGV and car driving standards are also perfectly appropriate for the health standards required for flying balloon on an LPL.	
response	*Noted*	
	See response to comment No 1393.	

comment	*2226*	comment by: *Don Brown*
	In the UK an established procedure exists for GMPs to perform and issue medical certificates for Private Balloon Pilots based on the clear medical fitness criteria contained in National Driving Standards for Heavy Goods Vehicles. This system has proven to be Safe, Legally acceptable and Reasonably inexpensive in administration & cost to the pilot. It has the major benefit that the GMP is the person who best knows the Pilot/Patients medical history & fitness A change to this practice would make no improvement to flight safety but would prove overburdonsome for private pilots who would have incur higher costs for AME examination and inconvenience in having to travel some distance to be examined by someone who knows nothing about them.	
response	*Noted*	
	See responses to comments No 1393 and 1497.	

comment	*2227*	comment by: *Dave Turner*
	For UK balloon pilots it is important that GPs will be permitted to continue to revalidate and renew medical certificates	
response	*Noted*	
	GMPs may issue medical certificates for LPL balloon pilots. For balloon pilots see response to comment No 1497.	

comment	*2228*	comment by: *Nevill Arms BC*
	It is important that GMPs are allowed to conduct the LPL medical. This is the	

	current situation in the UK and there are no reasons to suggest that this should be changed
response	*Noted*
	Thank you for the positive comment.

comment	*2241*	comment by: *AMS CAA - Hungary*
	According to our comment No 2240 we suggest to delete: MED.A.030 (b) (3) and (c) (2) Regarding para (b) and (c) medical certificate issuence: The licensing Authority must have right to issue Medical Certification, becuse there are some cases when the licensing Authority has to issue medical certificate eg. when a medical certificate has been lost or an AME has issued a certificate with a missing limitation etc. Proposal add to para's (b) (1), (2) and (c) (1): … medical certification shall be issued by an ……. **and Aeromedical Section of Licensing Authority**	
response	*Noted*	
	See responses to comments No 72 and 327. In NPA 2008-17c the JAA term 'Aeromedical Section' (AMS) is replaced by 'licensing authority'. The Basic Regulation gives the competence to issue medical certificates for class 1 and class 2 to the AME and AeMC. Implementing rules cannot deviate from the Basic regulation. However, (d) will be amended to permit the licensing authority to re-issue a medical certificate which has been issued incorrectly.	

comment	*2247*	comment by: *A.Garside*
	The suggestion that GMPs should open thier records to the competant authority appears to breach both the data protection act and the human rights act. It could divulge information that has no bearing on medical issues for flying but of a sensitive nature to the individual.	
response	*Noted*	
	GMPs who declare their activities as an AMEs shall be supervised by the licensing authority. For this purpose the authority shall use the services of a medical assessor who shall be a medical professional. In this way, neither data protection nor medical confidentiality requirements would be violated.	

comment	*2248*	comment by: *nigel carr*
	i think its important that a GMP is allowed to issue LPL medical certificates owing two limited availability of AME doctors	

response	*Noted*	
	Thank you for the positive comment.	

comment	*2253*	comment by: *David Maine*
	The present arrangement of General Medical Practitioner works well and means that everyone can access a local medical examiner. All UK GMP's are familiar with the standard required as laid down by national law.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*2261*	comment by: *LSG Erbsloeh*
	Seit Einführung des Faches Human Factors unterrichte ich als pensionierter Arzt und leidenschaftlicher Segelflieger Flugschüler und Fluglehrer ehrenamtlich im Verein. Aus meinen Erfahrungen resultiert, dass ein Medical unterhalb der Klasse 2 ausreicht. Wiederholungsinterwalle der ärztlichen Untersuchungen können auch bei Älteren in größeren Zeitanständen (z. B. in 5 Jahresabständen) ohne weiters erfolgen. Zu befürworten ist die Vereinfachung im Rahmen der hausärztlichen Kontrolle, wo alle Unterlagen zu Verfügung stehen. Dies erleichtert den Einstieg in den Luftsport, verhindert hohe Kosten und aufwendige Administrationen	
response	*Noted*	
	See response to comment No 226.	

comment	*2264*	comment by: *BBAC 6824*
	A GP will be quite capable of issuing a LPL Medical certificate and these should be based on the standards for HGV and car drivers. Safety will not be compromised. This will also mean there are sufficient numbers of issuers in the country for the LPLs.	
response	*Noted*	
	Thank you for the positive comment. See response to comment No 1393.	

comment	*2268*	comment by: *Ingo Wiebelitz*
	MED.A.030 zu b) Class 2 medical certificates shall be issued by an AME only! zu c) LPL medical certificates shall be issued by a general medical practitioner only Grundsätzlich: "Höherwertige" Medicals schließen die " geringer wertigen" ein!	

	LPL medical certificates shall be revalidated or renewed by a GMP only!
response	*Not accepted*
	The Basic Regulation gives the competence to the AME and AeMC to issue medical certificates for class 2. Implementing rules cannot deviate from the Basic Regulation and limit the right to issue medical medical certificates only for the AME or the GMP. Moreover, in the case of referral or incorrect issue, a medical certificate may be issued by the licensing authority. A GMP may issue a LAPL medical certificate if it is permitted by national law. In case of doubt the applicant shall be referred to AME or AeMC. The AMC to MED.A.020 explains that a Class 1 medical certificate includes the privileges of Class 2 and LAPL medical certificates. A Class 2 medical certificate includes the privileges of a LAPL medical certificate.

comment	*2271*	comment by: *Chris Smart*
	I believe that the best medical authority for assessing an LPL(B) holder for continued flying is the pilot's General Medical Practioner. He is the only person who understands the full medical history of the pilot and has knowledge of any drug threapy that the pilot may be receiving that could affect the pilot's suitability for safe flight. An Aero Medical Examiner can only assess based upon what he sees. Underlying medical conditions that are being masked by drugs could be invisible and avoid assessment.	
response	*Noted*	
	Thank you for the positive comment. GMP may issue LPL medical certificate if it is permitted by national law. In case of doubt the applicant shall be referred to AME or AeMC.	

comment	*2279*	comment by: *Richard Sargeant*
	MED A 030 Page 4 I strongly support the proposal that a GMC be able to issue or revalidate a medical certificate for the LPL as this currently mirrors practise in the UK. The normal GP (GMC) of any LPL is likely to appreciate the general medical condition of an applicant far better than any other doctor. Ballooning in particular doesn't make physical demands that would indicate that medical checks need be carried out by specialists and is less demanding than driving a car. Currently (at least in the UK) medical tests for driving including HGV driving are done by GMC. The UK moved away from requiring specialists carrying out such tests many years ago and I see no evidence that safety standards were compromised by that move or that they would be improved by a return to specialists.	
response	*Noted*	
	Thank you for the positive comment. See response to comment No 1393.	

comment	*2357*	comment by: *Dragon Balloon Co.*
	It is important that a GMP should be able to certify LPL pilots due to the cost of AME certification in the UK	
response	*Noted*	
	Thank you for the positive comment.	

comment	*2358*	comment by: *Rupert STANLEY*
	It is an unreasonably restrictive practice to limit certificate issuance to AeMC or AME, the GMP option must be retained.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*2365*	comment by: *George Ibbotson*
	I support the GMP being able to issue medical certificates. For simplicity the medical requirements should be identical to those for drivers of motor vehicles (cars)	
response	*Noted*	
	Thank you for the positive comment. See response to comment No 1393.	

comment	*2383*	comment by: *Irish Aviation Authority*
	((b)(3) Most PPL holders are flying aircraft less than 2 tonnes with up to 3 passengers and may fly in all classes of airspace. The privileges for a full LPL are the same, but the medical requirements are far less. This should be equitable. If there is not only one system for LPL and Class 2 certification there is a risk that AMEs will not continue and there will be inot enough aeromedical expertise available. In many countries the applicant's GP cannot act as an AME because of conflict of interest. Any other doctor will not have access to the medical history and this is a flight safety concern. It is clear that the LPL requirements can only apply in a few countries. The experience of the US Sports Pilot's Licence is that many applicants would have been refused a FAA Class 3 certificate. This US licence is restricted in terms of airspace, route, no passengers carried, maximum speed and maximum take off weight and distance from airfield. It would be appropriate to restrict LPL medical certification to light sports aircraft under 600kg as discussed by the MDM.032 group according to the EASA web site presentation.	

Justification:
JAA States have a good highly qualified AME network that provides and should continue to provide excellent/ expert service for aeromedical assessments.
The AME will have to be contacted anyhow by any LPL applicant with a medical problem will.
It is not possible to have oversight /control over the work of, a GP unless there is an approval mechanism.

Proposed text:
Add: '…under national law **of the applicable state**, by a …'
In Part FCL the requirement for medical certification for LPL should only possible for pilots flying light sports aircraft.

response *Noted*

Regarding mutual acceptance of LAPL medical certificates issued by GMPs in a Member State not permitting GMPs to issue the certificate, please see response to comment No 349 in this segment.
Regarding limited privileges for a LAPL medical certificate, please see response to comment No 314 on MED.A.020 (b).

comment *2384* comment by: *Irish Aviation Authority*

(b)(1)(2) and (3)
'Shall' is not appropriate.

Justification:
The Basic Regulation states that a medical certificate 'may' be issued by an AeMC or AME.
The IRs shall be in compliance with the Basic Regulation.
Proposed text:
Cha '**may**' instead of 'shall' in (1) (2) and (3).

response *Noted*

See response to comment No 376.

comment *2385* comment by: *Irish Aviation Authority*

(d)
An authority must be able to issue a medical certificate.

Justification:
There may be other circumstances where the authority needs to issue a medical certificate. For example in the case of loss of a medical certificate or when an AME has issued a certificate with a missing limitation, or a certificate which is otherwise not completely correct.

Proposed text:
'~~in the cases of referral~~'.

response	*Noted*
	See response to comment No 327.

comment	*2427*	comment by: *Andrew DELANEY*
	I would be unhappy to be forced to undertake an expensive medical with a doctor that has no knowledge of my previous medical history. I am aware of the medical requirements for powered flying and to my mind the requirement of specific aero medical training is hard to see a justification for. My medical was conducted by my General Medical Practitioner who is qualified to ascertain whether or not I have a medical condition which excludes me from flying. In the UK these standards are based on the DVLA2 (professional driver) standard. The driver of a 40 tonne truck does not require a specially trained heavy haulage doctor. I cannot see an argument for requiring this of glider pilots and there is potentially a serious disadvantage if the doctor does not have access to previous medical history.	
response	*Noted*	
	See responses to comments No 1129 and 1393.	

comment	*2431*	comment by: *John McWilliam*
	"Medical certificates are issued by aeromedical centres or aeromedical examiners and, additionally, for the leisure pilot licence, a general medical practitioner, if so permitted by national law." I am delighted with this proposed Rule, in particular the final sentence applicable to the leisure pilot. I used to have medicals for my JAR PPL done by a CAA-recognised examiner but found that they were expensive and the test was superficially, since the doctor had no knowledge of my medical history. They never heard of me till I walked in their door. When I moved to England I took out an NPPL solely because it allowed my doctor to do my flying medical. It is much more realistically since my own doctor has my total medical history and I feel much more confident in his judgement of me as fit to fly - I glad to see EASA holds the same view.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*2434*	comment by: *AOPA Sweden*
	For PPL and LPL holder GMP (general medical practionioners should be able to make the medical examinations. All GMP should be able to do the examination, without further knowledge on aeromedical details. The CAA or approved organisation will then issue the medical class II. The reason for this proposal is that in sweden, the distance and therefore the cost for travelling to the doctor will be very high. Therefore it is of vital importance that GMP can continue to to medical examinations of pilots also in the future. Before JAR-FCL, the above	

	system was used in Sweden with no problems regarding flight safety. However the initial examination should be performed by a Aeromedical doctor. The cost for the transport to a medical doctor might be higher than the examination itself when the time for transport is included.
response	*Noted*
	Safety in aviation is ensured by many different measures, one of them being a medical certificate for private and commercial pilots. The legal basis for the medical certificate is the ICAO SARPs and the EU Basic Regulation. The latter provides the possibility to draft licensing rules tailored to the complexity of the aircraft and the kind of operation which has specifically been done in the medical field for the private pilot community by creating the leisure pilot licence. The ICAO SARPs require that medical fitness of private pilots is assessed by an AME. However, the Basic Regulation provides the possibility of a GMP to assess the medical fitness for an LPL applicant/holder, if permitted under national law.

comment	*2436*	comment by: *AOPA Sweden*
	For LPL we encourage that GMP shall be able to perform the medical assessments.' In sweden, this system has worked also on PPL level wihtout problem. AOPA Sweden is positive that this system is also implemented on PPL-level in the EASA system.	
response	*Not accepted*	
	The Basic Regulation provides the possibility of a GMP to assess the medical fitness only for a LAPL applicant/holder, if permitted under national law. See also response to comment No 362.	

comment	*2437*	comment by: *Jackie MAGNANI*
	These new proposals would have a serious effect on someone like myself who is involved in this sport purely for pleasure as a hobby, not for financial gain or business purposes. about medicals will be expensive, why can't my own GP who knows me well do my medical?	
response	*Noted*	
	See response to comment No 2436.	

C. Draft Opinion Part-MED — Subpart A: General Requirements — Section 2: Issuance, revalidation and renewal of medical certificates — MED.A.035: Application for a medical certificate p. 5

comment	*240*	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany	

Head of Lufthansa Medical Services
Head of German Academy of Aviation and Travel Medicine
Section: . **2**
MED.A. 035
Application for a medical certificate
Page: 5

Relevant Text:
(a) Applications for a medical certificate shall be made in a format established by the competent authority.

Comment: Does this mean that EASA will not require a unique application format for all member states? If yes, it will result a lot of difficulties in the daily work. The different national computer systems will not understand the different application formats. Statistical comparisons of medical data between the different EASA member states cannot be done due to different formats. Evidence based aviation medicine seems to be impossible if the formats of application forms and all the other medical forms are not harmonized .

Proposal:
(a) Applications for a medical certificate shall be made in a format established by **EASA**.

response *Partially accepted*

The application form that was in Section 2 of JAR-FCL 3 will be added in an AMC to this paragraph. However, as it is an AMC, the text 'in a format as established by the competent authority' will not be changed. With the working you propose, the Agency would turn an AMC into a rule — which is not possible.

comment *328* comment by: *FOCA Switzerland*

MED.A.035 b) already now and even more in future, documents will no longer be written, but also electronically transmitted. Therefore the possibility of electronic transmittel must be included

Proposed text:
(**b) 2) and 3): a written or electronically transmitted declaration of...**

response *Partially accepted*

The wording 'written' will be replaced by 'signed' and guidance material with regard to electronically transmitted data will be developed during the rulemaking task MED.001.

comment *377* comment by: *UK CAA*

MED.A.035 (b) (2) and (3)
Comment:
Declarations need not always be written.

Justification:

	Some countries use electronic systems and the declaration from the pilot may be in a format other than written Proposed Text: Delete 'written' in both sentences.
response	*Noted*
	See response to comment No 328.

comment	*378*	comment by: *UK CAA*
	MED.A.035 (c) Comment: AMC material needed. Justification: Mechanism needed to enable to revalidate or renew a med cert if have lost current or previous certificate. Proposed Text: AMC to MED.A.035 (c) **In the case of applicants who do not have their current or previous medical certificate at the time of examination, the AeMC, AME or GMP should verify the certification history with the Licensing Authority.**	
response	*Partially accepted*	
	Thank you for the proposal. A revised text with the addition of the wording 'prior to the relevant examinations' will be included in AMC to MED.A.035.	

comment	*380*	comment by: *European CMO Forum*
	MED.A.035 (b) (2) and (3) Comment: The IRs need to be open to new methods of working such as electronic working. Justification: Method of declaration could be electronic. Verification of the individual is essential but can be achieved by password identification or a written or electronic signature. Proposed Text: Delete 'written' in (2) and (3).	
response	*Noted*	
	See response to comment No 328.	

comment	*517*	comment by: *British Microlight Aircraft Association*
	Accepted. Declarations should be made on a form approved by the competent authority.	
response	*Noted*	

	See response to comment No 240.

comment	*665*	comment by: *Pekka Oksanen*
	Comment: Application must be made available through internet, delete word *written* in (b)(2) ja (b3). Proposal: (b) Applicants.... (2) a ~~written~~ declaration of... (3) a ~~written~~ declaration as ...	
response	*Noted*	
	See response to comment No 328.	

comment	*775*	comment by: *Thomas Cook Airlines UK*
response	*Noted*	
	There is no comment.	

comment	*787*	comment by: *Swiss Association of Aviation Medecine*
	Comment: Does this mean that EASA will not require a unique application format and content for all member states? If yes, it will result a lot of difficulties in the daily work. The different national computer systems will not understand the different application formats. Statistical comparisons of medical data between the different EASA member states cannot be done due to different formats. Evidence based aviation medicine seems to be impossible if the formats of application forms and all the other medical forms are not harmonized. Due to the different national languages in Europe we need the content in all forms bilingual in national and English language to understand each other. **Proposal:** (a) All documents needed for a medical certification process shall be developed by **EASA** in a binding format with harmonized content for all member states and always provided in national and English language. The application form should be equal for all pilots (Class I, II, LPL, etc.) The pilot and AME's should be able to download the application form from the EASA Homepage.	
response	*Noted*	
	See response to comment 240. An application form that is in a rule may be too difficult for the implementation because computer systems are different throughout the Member States. EASA	

	cannot upload these forms on its home page for language reasons and because the national logo will still be there.

comment	*976*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: **Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008** **Section: 2** **MED.A. 035** **Application for a medical certificate** **Page**: 5 **Relevant Text:** (a) Applications for a medical certificate shall be made in a format established by the competent authority. **Comment**: Does this mean that EASA will not require a unique application format and content for all member states? If yes, it will result a lot of difficulties in the daily work. The different national computer systems will not understand the different application formats. Statistical comparisons of medical data between the different EASA member states cannot be done due to different formats. Evidence based aviation medicine seems to be impossible if the formats of application forms and all the other medical forms are not harmonized. Due to the different national languages in Europe we need the content in all forms bilingual in national and English language to understand each other. **Proposal:** (a) All documents needed for a medical certification process shall be developed by **EASA** in a binding format with harmonized content for all member states and always provided in national and English language.	
response	*Noted*	
	See response to comment No 240.	

comment	*1112*	comment by: *George Knight*
	(3) a written declaration as to whether they have previously undergone an examination for a medical certificate and, if so, by whom and with what result. **This should have a time limit on it of say 5 years. I had an 18 year break in flying after having children and resumed in my 50s. I cannot remember details of who conducted medicals when I was in my early 20's.**	
response	*Not accepted*	
	Some medical conditions which may have impact on flight safety can last more	

	than 5 years. Therefore, an individual approach is needed in each case. The pilot is requested to declare the fact of previous aeromedical examination(s) and if he/she doesn't remember, the AeMC/AME/GMP should verify the previous aeromedical history from the licensing authority.

comment	*1113*	comment by: *George Knight*
	(4) a declaration as to whether they have ever been assessed as unfit or had a medical certificate suspended or revoked. **This should only go back 5 years. If someone had a transient medical issue 20 or 30 years previously they may well have forgotten all about it.**	
response	*Noted*	
	See response to comment No 1112.	

comment	*1130*	comment by: *Keith WHITE*
	035. If applying to a GP, the GP will already have detailed knowledge of the applicant's medical history [if necessary, state that only a GP with this knowledge may issue a certificate]. This written submission therefore becomes irrelevant for a glider pilot applying to a GMP. For gliding in the UK, the current medical requirements set by the BGA are as for a private driving licence if flying alone, and as for a commercial driving licence if instructing or flying dual. I think that this should be adequate for an SPL medical certificate. Whilst there need to be stringent regulations for commercial pilots, it could be considered,surely, that the solo glider pilot is taking risk only with himself.	
response	*Noted*	
	SPL is a licence for private flying and requires holding Class 2 medical certificate. This is also an ICAO standard: please refer to ICAO Annex 1, Section 2.9. Glider pilot licence, paragraph '2.9.1.5: An applicant shall hold a current Class 2 Medical Assessment'. Only LAPL sailplane pilots may obtain their medical certificates from GMPs, if permitted under national law. Medical requirements may not be fully based on car driving standards because of a different nature of physiological stresses.	

comment	*1196*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.035 (a) **Comment**: Due to the increasing international working market for pilots, the application for a medical certificate must be made in the same standardised format in all member states, preferably established by EASA and not by each separate member state. If each member state will produce its own application form, the present harmonisation achieved by JAA will disappear. This will result in increasing difficulties to adapt to computerised licensing systems and to collect and compare	

	statistical data as requested by both ICAO and the aviation industry. As a result, a licensing authority might no longer be able to accept applications and examinations made in other member states. This is against the basic principles of free movement within the EU. **Proposal**: An AMC or GM to MED.A.035 (a) should be developed by EASA in order to create harmonisation of format and content of the application forms to be established by competent authorities.
response	*Noted*
	See response to comment No 240.

comment	*1197*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.035 (b) **Comment**: The declarations provided to the examiner may be given either in a written form or in a digital form with a digital signature, making the word "written" inappropriate. More important is that the reports must be signed by the applicant as required in ICAO Annex 1, which is not included in the proposed text. **Proposal**: Amend MED.A.035 (b)(2), (3), and (4) to read: "a signed declaration ... "	
response	*Noted*	
	See response to comment No 328.	

comment	*1198*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.035 (c) **Comment**: The word "present" can be interpreted in different ways and should be clarified: does it mean that the pilot shall just show his/her previous medical certificate, or shall he/she return it to the examining doctor? There is also a need for an AMC to MED.A.035 describing what measures should be taken if the applicant does not present his previous medical certificate, resulting in the examiner having no information of expiry dates or possible limitations. The proposed requirement that the medical certificate shall be presented prior to the examination is appreciated. **Proposal**: Develop an AMC to MED.A.035 describing what measures should be taken if the	

	applicant does not present his/her previous medical certificate.
response	*Noted*
	See response to comment No 378.

comment	*1402*	comment by: *Prutech Innovation Services Ltd.*
	MED.A.035(b)(4): ... ever been assessed as unfit for flying ... **Comment:** *general unfitness (e.g. for basketball or swimming competitions or ...) should not be deemed relevant in this context.*	
response	*Not accepted*	
	All requirements proposed in Part Medical are related to the fitness for flying as it is specified in MED.A.005(a). There is no need to repeat the wording.	

comment	*1514*	comment by: *Dr Ian Perry*
	Med.A.035 (b) (1) should also include proof of age	
response	*Not accepted*	
	The proof of identity includes the proof of age.	

comment	*1542*	comment by: *British Airways*
	Does sub-para (a) mean that EASA will not require a single certificate format for all member states? If so, this will create a number of difficulties. The different national computer systems will not recognise the different application formats. Statistical comparisons of medical data between the different EASA member states will be hampered by the different formats. Development of evidence based aviation medicine will be more difficult if the formats of application forms and all the other medical forms are not harmonised. Proposal: Medical certificates shall be in a standardised format established by EASA.	
response	*Noted*	
	See response to comment No 240 for the application form. The medical certificate will be in a rule in Part Authority Requirements	

comment	*1925*	comment by: *CAA Belgium*
	(b) (2) and (3) The IRs need to be open to new methods of working such as electronic working. Method of declaration could be electronic. Verification of the individual is essential but can be achieved by password identification or a written or electronic signature.	

	Delete 'written' in (2) and (3).
response	*Noted*
	See response to comment No 328.

comment	*1964*	comment by: *AEA*
	Comment Does sub-para (a) mean that EASA will not require a single certificate format for all member states? If so, this will create a number of difficulties. The different national computer systems will not recognise the different application formats. Statistical comparisons of medical data between the different EASA member states will be hampered by the different formats. Development of evidence based aviation medicine will be more difficult if the formats of application forms and all the other medical forms are not harmonised. **Proposal**: Medical certificates shall be in a standardised format established by EASA.	
response	*Noted*	
	See response to comments No 240 and 1542.	

comment	*2168*	comment by: *Dr.Piek Armin*
	pilots should only provide the AeMC and AME and not GMP's	
response	*Not accepted*	
	LAPL applicants shall provide all facts of their medical history to GMP if these facts are relevant to the issuance of the LAPL medical certificate.	

comment	*2386*	comment by: *Irish Aviation Authority*
	(b)(2) and (3) The IRs need to be open to new working methods of working like electronic working. Justification: The method of declaration could be electronic. Verification of the individual is essential but can be achieved a written or electronic signature or by password identification. Proposed text: '~~written~~' in (2) and (3).	
response	*Noted*	
	See response to comment No 328.	

comment	*2433*	comment by: *AOPA Sweden*
	The detailed medical requirements for any licence (LPL/PPL/CPL/ATPL) should be	

	put as AMC as discussed in the explanatory note. The reason is that the proposed system will be not flexible enough in order to take advante of new medecines or treatments within the medical science. With the proposed system, the result will be that pilots be grounded without reason, even though there is a suitable and safe treatment available.
response	*Noted*
	See response to comment No 1554. Same response applies.

C. Draft Opinion Part-MED — Subpart A: General Requirements — Section 2: Issuance, revalidation and renewal of medical certificates — MED.A.040: Requirements for the issue, revalidation and renewal of medical certificates p. 5

comment	*73*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **AMC to Med A040 a) section 2** **Page**: 5 Relevant Text: ... complete medical history... **Comment**: Beside in the UK in no other memberstate a "complete medical history" is available **Proposal**: • a) AME or AMC has asked for and received a complete medical Anamnesis of the pilot concerning with all deseases/disabilities effecting flight safety	
response	*Not accepted*	
	In the majority of the Member States it is possible for the applicant to provide an AeMC, AME or GMP with a complete medical history. Where medical/legal systems of the Member State do not provide this opportunity, the inclusion of the applicant's authorisation for the examining physician to receive medical facts necessary for the aeromedical examination will be included in the standard application form. The proposed requirement aims to prevent the concealment of aeromedically important facts and stress the responsibility of the applicant.	

comment	*266*	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. Jürgen Kriebel Section: 2 Subpart A General Requirements AMC to MED A.040 4 - Psychiatric illness	

	Page: 4 Relevant Text: : Does the pilot have history of: 4.1 significant psychiatric disorder within the past 6 months 4.2 psychotic illness within the past 3 years, including psychotic depression? **Comment**: **Proposal**: 4.1 does or did the pilot take any psychotropic medication? Substitute the original 4.2 with: 4.2 significant psychiatric disorder which needed medical treatment?
response	*Noted*
	The requirements for a LAPL medical certificate have been redrafted and appear in MED.B.090 and the related AMC to MED.B.090. The standard application and medical examination form for class 1 and class 2 will be used also for LAPL, with non-mandatory areas for LAPL being shaded.

comment	*267*	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. Jürgen Kriebel Section: 2 Subpart A General Requirements AMC to MED A.040 6 - Nervous System **Page**: 4 Relevant Text:: Does the pilot have a history of: 6.1 an epileptic fit after the age of 5 years 6.2 blackout or impaired consciousness within the last 5 years other than simple faint and cough syncope with low risk of recurrence **Comment**: 6.1 no change recommended 6.2 cough syncope: this type of Valsalva syncope is more often found in short, stocky male smokers with a tendency to chronic obstructive pulmonary disease which needs further evaluation **Proposal**: 6.2 take out cough syncope	
response	*Noted*	
	See response to comment No 266 of this segment.	

comment	*306*	comment by: *Lufthansa German Airlines*

Author: Dr. Esther Stahl-Buhl, AMC Frankfurt
Section: 2
AMC to MED A.040
5
Page: 24

Relevant Text:
The questionnaire asks:
Vision: Does the pilot:
5.1 experience diplopia?
5.2 have any other significant ophthalmic condition?

Comment:
We are talking about a questionnaire, not a medical or ophthalmic exam!!!!

No applicant for a LPL should be granted a LPL without a proper comprehensive ophthalmic exam! A questionnaire is in no way sufficient to evaluate the ophthalmic aspect of a pilot. If we accept a questionnaire, checked by a GP, pilots will be in the air, seeing less than any person driving a car on a street in Europe.
The text should say: An applicant for a LPL should undergo a comprehensive eye exam by an ophthalmologist. The criteria to be assessed as fit should be the same as for a class 2 medical!

response *Noted*

See response to comment No 266 of this segment.

comment *329* comment by: *FOCA Switzerland*

MED.A.040: Consistent to the EC 216/2008 the text concerning GMP must be modified and the text of EC 216/2008 "if permitted under national law" must be added

Proposal:
The AeMC, the AME or GMP, if permitted under national law, shall only issue, ...

response *Not accepted*

The wording 'if permitted under national law' is already used in MED.A.030 (b) and (c) where the GMP competence for the issue, revalidation and renewal of LPL medical certificates is described. There is no need in further repetitions.

comment *518* comment by: *British Microlight Aircraft Association*

Accepted

response *Noted*

Thank you for the positive comment.

comment *1199* comment by: *Swedish Transport Agency, Civil Aviation Department*

	(Transportstyrelsen, Luftfartsavdelningen)
	MED.A.040 (a) **Comment**: It might be difficult for the examining doctor to know what information might be available at other medical facilities (or at the licensing authority) if the applicant does not give the information. The authority might, as with the present legal situation is in Sweden, be the only body with legal right to request medical information without a written consent of the applicant. This might be solved if the applicant, when signing the application form, also authorises the examining physician to request any medical information that may be needed for the aeromedical assessment. **Proposal**: An AMC to MED.A.035 (a) should include an obligation for an applicant to sign the application form declaring that he/she authorises the examining physician to request any medical information that may be needed for the aeromedical assessment.
response	*Accepted*
	See response to comment No 73.

comment	*1200*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
		Comment: The acceptable safety risk level for each type of air operation and the corresponding acceptable risk for incapacitation for each class of medical certificate should be stated by EASA and be included in the requirements. In AMC to MED.B.090, a 2% per year risk for epileptic seizure is proposed as an acceptable risk level for LPL. **Proposal**: Amend MED.A.040 with a new MED.A.040 (c): "the level of incapacitation risk is assessed to be acceptable for the class of medical certificate concerned, taking into account any mitigating factors and limitations applied." Add an AMC to MED.A.040 (c): "(a) For a holder of a class 1 medical certificate the maximum acceptable annual risk of incapacitation should not exceed 1% for multi pilot operations and 0.5% for single pilot operations. (b) For a holder of a class 2 medical certificate the maximum acceptable annual risk of incapacitation should not exceed 2%."
response		*Partially accepted*
		The risk assessment will be included in the next rulemaking task MED.001 and the revised and peer reviewed text of JAR-FCL 3 Guidance Material will be added to Guidance Material to Part MED.

comment	*1424*	comment by: *Trevor HILLS*
	Extract: "The AeMC, AME or GMP shall only issue, revalidate or renew a medical certificate when: (a) the pilot has provided them with a complete medical history..." Comment: An individual in the UK does not have access to his/her medical records and so cannot furnish a complete medical history.	
response	*Noted*	
	See response to comment No 73.	

comment	*1905*	comment by: *Michael Hinz*
	Das Medical soll auch ausgestellt werden können, wenn die Sollvorgaben für das Medical in bestimmten Fällen zwar nicht erfüllt sind, es jedoch Gründe für eine Ausnahme gibt, weil die sollvorgabe bei diesem speziellen Menschen nicht zutrifft oder deren Überschreitung zu keiner Gefährdung beim Fliegen führt. Die individuelle Beurteilung des Arztes muss oberste Priorität haben. Dies muss vergleichbar sein mit Gutachtern, die psychisch und sexuell gestörten Straftätern gegebenfalls wieder ein Leben in Freiheit ermöglichen.	
response	*Noted*	
	See MED.A.045 where exactly this possibility is in the rule.	

comment	*1984*	comment by: *EFLEVA*
	The proposed system is significantly more burdensome than the equivalent systems in the UK and USA. EFLEVA recommends that a system more closely matching that of the UK be adopted. In some member states there is also VAT on the charge for the medical examination for the medical certificate further increasing the cost burden of this requirement.	
response	*Noted*	
	Thank you for the comment. The proposed system for medical certification and the rules for medical fitness are based on JAR-FCL 3 that has been implemented for many years all over Europe, including the UK. We agree that the system in the US is different.	

comment	*2085*	comment by: *Royal Swedish Aeroclub*
	KSAK suggests that the requirements be more in line with what is proposed from the UK and the USA. Partly to reduce costs but also to make renewal easier. The medical procedure for the renewal of a PPL(A) is medically NOT elaborate or difficult. The medical requirements are not demanding. For LDL(A) possibly even a bit less. The whole procedure could be kept simple and cheap. Considering the	

	general increase in costs for flying, every bit of reduction in costs is helpful in halting the trend of diminishing number of licenses. New and renewed.
response	*Noted*
	See response to comment No 1984.

comment	*2109*	comment by: *Light Aircraft Association UK*
	The text states that "the AeMC, AME or GMP shall … have conducted all the relevant medical examinations and assessments…" With regards the LPL, the experience in the UK is that a physical examination is not generally required when the medical certificate is being issued by a GMP for a NPPL. The GMP, having knowledge of the applicant's medical history, is in a position to adequately determine whether a medical certificate may be issued (in the UK, based on the concept that if a person is sufficiently healthy to permit him to drive a heavy goods vehicle, then they are fit to fly an aircraft). The difference in cost is that a GMP will often charge €0-€17 to review a medical history, whereas if an examination is required a GMP might charge €190 (guidelines from the British Medical Association). This adds yet another significant hurdle and cost to the student pilot: note that the aims of the MDM032 working group were to halt the "decrease in the activity of classical leisure aviation". The proposed system is significantly more burdensome than the equivalent systems in the UK and USA. The LAA recommends that a system more closely matching that of the UK be adopted: this system has a very good operational safety level.	
response	*Not accepted*	
	Your proposal to have the GMP issue the LAPL medical certificate without the need for a physical examination when the GMP has the medical history of the pilot cannot be accepted for all Europe. However, having knowledge of the medical background of the applicant is a prerequisite for a GMP to issue medical certificates in accordance with article 7(2) of the Basic Regulation. But the same article further determines that a medical certificate shall only be issued when the applicant demonstrates compliance with the Essential Requirements in Annex III to the Basic Regulation. Furthermore, paragraph 4.a.1 of the Essential Requirements determines the following: *'All pilots must periodically <u>demonstrate</u> medical fitness (...). Compliance must be shown by appropriate assessment (...)'.* The Agency's view is that this requirement for appropriate assessment cannot be satisfied with the analysis of medical records only. There is a need for the GMP to perform a medical examination. Existing medical records may be taken into account when performing the assessment, but cannot be the only element used. The same reason was behind the decision not to allow the system of self-declaration of medical fitness that is presently being used in some Member States. In the Agency's view, a self-declaration cannot fulfil the requirement for a appropriate aeromedical assessment in the Basic Regulation.	

comment	*2117*	comment by: *Direction de l'Aviation Civile Luxembourg*
	New proposal: Delete the GMP's in the different sections.	
response	*Not accepted*	
	The Basic Regulation (Article 7) allows a GMP to issue a medical certificate for a LPL licence (if permitted under national law). This has to be taken into account in the implementing rules.	

comment	*2166*	comment by: *Dr.Piek Armin*
	Reqirements for issue and revalidations only by AeMC and AME	
response	*Noted*	
	See response to comment No 2117.	

comment	*2269*	comment by: *Ingo Wiebelitz*
	MED.A.040 Der Pilot muß dem AeMC/ AME/ GMP unterschreiben, dass aus seiner Sicht keine gesundheitlichen Bedenken gegen die Ausübung einer fliegerischen Tätigkeit sprechen. Alles andere ist zu komlex und kostenintensiv und eröffnet dem Untersuchenden Tür und Tor, Mißbrauch mit den Unterlagen zu betreiben. Ich möchte hiermit an den "Fall" **Rainer Stammberger** erinnern, der trotz vorliegender positiver Gutachten vom AeMC seiner Berufslaufbahn entzogen wurde, obwohl dies NACHWEISLICH nicht erforderlich war! Möglichkeiten eines solchen Mißbrauchs von Daten darf ein AeMC/AME/ GMP niemals mehr bekommen!	
response	*Noted*	
	See response to comment No 73 and 266 of this segment.	

comment	*2371*	comment by: *Wolfgang Lamminger*
	The provision of the MD with the applicants medical history shall be limited to a short form with simple YES/NO answers	
response	*Noted*	
	See response to comment No 2109.	

comment	*2457*	comment by: *Paul Mc G*
	The text states that "the AeMC, AME or GMP shall … have conducted all the	

	relevant medical examinations and assessments…" With regards to the LPL, the experience in the UK is that a physical examination is not generally required when the medical certificate is being issued by a GMP for a NPPL. The GMP, having knowledge of the applicant's medical history, is in a position to adequately determine whether a medical certificate may be issued quickly and efficiently and at low cost. It has been shown in the UK, that if a person is sufficiently healthy to drive a heavy goods vehicle, then they are fit to fly an aircraft. The difference in cost is that a GMP will often charge £16 ish to review a medical history, whereas if an examination is required a GMP might charge £160 ish (The British Medical Association issues guidelines). This adds more cost to the student pilot, which is odd since the aims of the MDM032 working group were to halt the "decrease in the activity of classical leisure aviation". The proposed system is significantly more burdensome than the equivalent systems in the UK and USA.
response	*Noted*
	See responses to comments No 1984 and 2109.

comment	*2573*	comment by: *Heinz Fricke-Bohl and Kirsten Bohl*
	MED.A.40: Dieser Punkt kann komplett entfallen, da die Standarts nach Class 2 gelten sollten.	
response	*Not accepted*	
	Medical requirements as regards LAPL were developed following the principle that all measures must be proportionate and tailored to the risk involved. See also response to comment No 266 of this segment.	

C. Draft Opinion Part-MED — Subpart A: General Requirements — Section 2: Issuance, revalidation and renewal of medical certificates — MED.A.045: Limitations to medical certificates p. 5-6

comment	*61*	comment by: *Dr Graham Cresswell, chief medical officer, bmi*
	MED.A.045 (a) (1) (i) This means that every pilot who has an OML limitation will not be able to receive his certificate from his AME. In countries where the OML arrangements have been little used, this may be insignificant but, in countries such as the UK, where OML has been extensively used to maintain the experience base of our professional pilots, this will be problematic for the airlines and place an unnecessary burden on the Authority and on the aircrew. Suggest... MED.A.045 (a) (1) (i) in the case of applicants for a class 1 medical certificate *for whom any limitation is being applied for the first time*, refer the decision on fitness of the applicant to the licensing authority as indicated in Subpart B, except those requiring a	

	limitation related only to the use of corrective lenses;
response	*Partially accepted*
	We agree with your proposal. The text of the NPA will be amended: 'notwithstanding (i) and (ii), the AeMC or AME may reissue a medical certificate with the same limitation without referring the applicant to the licensing authority'.

comment	*62*	comment by: *Dr Graham Cresswell, chief medical officer, bmi*
	MED.A.045 (c) (1) (i) The prohibition of two OMLs flying together presents serious rostering difficulties, particularly for smaller airlines. Roster disruption introduces much more risk than does two OMLs flying together. This regulation is unjustified. The "1% rule" (which, I note, does not feature in these proposals) was derived from the starting point of two pilots who both just meet the standard for OML. The risk of dual incapacitation can be shown mathematically to be infinitessimally low and lower that that accepted for double engine failure in ETOPS. It is illogical to demand higher reliability from the pilots than from the engines. Furthermore, aircrew who discover that they are less employable if they have an OML will conceal medical information from their AMEs in order to avoid the limitation. The industry will then be exposed to risk that it does not know about and therefore cannot manage. This is a clear case where the unintended consequences of regulation based on intuition rather than evidence will impair flight safety rather than enhance it. Suggest remove... *, is not subject to an OML* from the last line of this subpara.	
response	*Not accepted*	
	The draft rules are based on JAR-FCL 3 where 2 pilots with OML limitation are not permitted to fly together. The issue had been discussed by JAA Licensing Sub-Sectorial Team (Medical) re-discussed in a general medical meeting in the Agency in January 2010 but could not be accepted. The draft rules contain significant changes as compared to JAR-FCL 3 only if either generally accepted or if they result in an improved safety standard. Other changes requested by stakeholders will be added to the next rulemaking task MED.001. This will be the case to 2 OMLs flying together.	

comment	*120*	comment by: *Civil Aviation Authority - The Netherlands*
	MED.A.045, onder 1, eerste lid, sub ii (blz. 5 van 66) De CAA-The Netherlands is het er niet mee eens dat de AeMC of de AME zelf beoordeelt of het klasse 2 medische certificaat afgegeven kan worden. Wanneer de kandidaat niet 100% voldoet aan de medische eisen zou altijd doorverwezen	

	moeten worden naar de desbetreffende autoriteit. Volgens de CAA-The Netherlands kan juist in complexe gevallen de desbetreffende AME de afweging niet alleen maken. Voor die afweging zou de autoriteit moeten worden geraadpleegd. **MED.A.045, onder (b) (Blz. 5 van 66)** Ingevolge MED.A.045, onder b, zal de GMPS de desbetreffende persoon doorverwijzen naar de AeMC of AME, wanneer geen sprake is van 100% medische geschiktheid. De CAA-The Netherlands is het hier niet mee eens. De CAA-The Netherlands is van mening dat de GMPS, het AeMC en de AME bij twijfel aan medische geschiktheid, dienen allen door te verwijzen naar de Inspectie VenW. De ervaring leert dat de complexe medische gevallen in de "klasse 2" categorie vallen. Nu de medische eisen voor LPL lager dan klasse 2 is komen te liggen, zullen in die categorie evenveel of meer complexe gevallen voorkomen. Het doorverwijzen van de ene huisarts (GMPS) naar de andere huisarts (AME) heeft geen zin. Bovendien zou het medische keurings- en afgifteproces zich op die manier volledig aan het gezichtsveld van de Inspectie VenW onttrekken. Daarmee wordt de invloed van de Inspectie VenW bij complexe medische gevallen ernstig ingeperkt met als gevolg een gebrek aan sturing aan het begin van het proces. De Inspectie VenW heeft dan uitsluitend de bevoegdheden die in MED.A.065 staan; schorsen en intrekken. Door uitsluitend achteraf te kunnen ingrijpen kan voor aanvragers van met name klasse 2 en medische LPL certificaten enige mate van rechtsonzekerheid ontstaan. Immers de Inspectie VenW kan achteraf een besluit van de AeMC of de AME terugdraaien. Het op eenduidige wijze interpreteren van de medische eisen in de NPA kan uitsluitend worden gewaarborgd wanneer de Inspectie VenW zicht heeft op het keurings- en afgifteproces van medische certificaten. Volgens de CAA-The Netherlands moet MED.A.045, onder (b) op zo'n manier worden aangepast dat in geval van medische twijfelgevallen, de applicant wordt doorverwezen naar de competent authority.
response	*Partially accepted*
	Thank you for your contribution. An AeMC or AME has to assess class 2 applicants in consultation with the licensing authority in borderline cases and/or when applying a new limitation, except for limitations related to the use of corrective lenses or a time limitation to the medical certificate. Initial application of the OSL limitation shall only be made in consultation with the licensing authority. For LAPL the application of a new limitation may be done by an AeMC or an AME, except for limitations related to the use of corrective lenses or a time limitation to the medical certificate which may be applied by a GMP. The possibility for AeMCs and AMEs to refer the decision to the authority in borderline cases is provided in AMC to MED.A.045(a). The OML and OSL limitations shall only be removed by the licensing authority. Other limitations shall only be removed by the licensing authority for class 1

medical certificates, for class 2 medical certificates, by an AeMC or AME in consultation with the licensing authority, and for LAPL medical certificate by the AME or AeMC.

MED.A.045 will be amended accordingly.

MED.A.030 (d) will be amended to enable the licensing authority to re-issue a medical certificate when it has identified any administrative incorrection.

comment 241 comment by: *Lufthansa German Airlines*

Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany
Head of Lufthansa Medical Services
Head of German Academy of Aviation and Travel Medicine
Section:**2**
MED.A.045 Limitations to medical certificates (a) (1) and Subpart B
Page: 5 ; 9 and following

Relevant Text: When, in accordance with the Aeromedical examinations and assessments, the applicant does not fully comply with the requirements for the relevant class of medical certificate but is considered to be not likely to jeopardise flight safety the AeMC or AME shall:
(i) in the case of applicants for class 1 medical certificate refer the decision on fitness of the applicant to the licensing authority as indicated in Subpart B, except those requiring a limitation related only to the use of corrective lenses.

Comment:
Why shall in cases of MED. B. 005 Cardiovascular System
b (3) i -- ix
d (1) i - ii
d (5) last sentence
e (1) i - vi
e (4) i-ii
MED . B. 020 Metabolic and Endocrine System
c (2) last sentence
MED . B. 025 Haematology
c (1) -- (5)
MED . B. 050 Psychiatry
(b) - (d) - (e)
MED . B . 060 Neurology
(c) 1 - 7
MED . B . 085 Oncology
(b)
for class 1medical applicants always to be referred to the licensing authority, but not in cases of
Respiratory System
Digestive System
Genitourinary System
Infectious Disease
Obstetrics and Gynaecology
Musculoskeletal System

	Psychology Visual System Otorhino- larygology Dermatology The risk assessment for class 1 medical certificates is inconsequent. Why is a licensing authority able to do a risk assessment for class 1medicals in MED. B.005 - B.085 as shown in the upper part and why do they think that AeMCs and AMEs can do it in the lower Paragraphs - Respiratory ....Dermatology.? Why does a licensing or competent authority has no problem to delegate the risk assessment for all MED . B. paragraphs to the AMEs class 2, who are on a lower training level than Class 1 AMEs or AeMCs? Does the licensing authority employs medical specialists who are able to be competent for all specialities in MED . B. and to make a sufficient riskmanagement? The experience of the past 5 years under JAA requirements showed that competent authorities very often only hire consultans or medical doctors on low salary and inexperienced in aviation medicine. In Germany we had medical doctors in the authority without any basic or advanced course in aviation medicine who made the risk assessment for class 1 pilots. This may happen also under EASA requirements if the qualification of these medical doctors is not defined and binding for the member states. **Proposal**: All assessments for class 1medicals shall be done by AeMCs. Class 2 and LPL medical assessment shall be done by AeMCs ;AMEs. The EASA should provide in their requirements the possibility of delegation of competence for class 1medical assessment from the competent authority / licensing authority to AeMCs and for class 2 and LPL medical assessment to AMEs, provided that the safety standard is guaranteed by oversight procedures of the competent authority. The competence level of an medical doctor in the competence authority/ licensing authority shall be required by EASA on a higher level as it is required for the heads of AeMCs or AMEs class 1. Otherwise the tail wags the dog, because competence of medical specialists and well trained AMEs in an AeMC can be overruled by a beginner doctor in the authority. **Alternative proposal:** EASA centralises medical decision making in an EASA medical department with a European air surgeon, analogue to the FAA system. Then 15 safety relevant illnesses have to be referred to this department for decision, all other illnesses can be decided by AMEs. Provided EASA implements a central computer system and a central medical data bank into which all EASA - AMEs will send their medical reports and medical certificates, this will be the better alternative. Medical confidentiality, standardisation, correct oversight and evidence based aviation medicine will be guaranteed in this System.
response	*Not accepted*
	We would like to draw your attention to MED.A.030 where competences for the issue of medical certificates are explained. The NPA proposes that only initial Class 1 medical certificates shall be issued by an AeMC. Revalidation and renewal medical examination may be carried out by an AeMC or AME with advanced training in aviation medicine. Medical requirements proposed in NPA 2008-17c are based on JAR-FCL 3 for Class 1 whereas Class 2 medical requirements were aligned with ICAO Class 2. The latter had also been agreed with the LSST(M).

	In borderline cases referral to the licensing authority is indicated in Subpart B for class 1. For class 2 the AME or the AeMC may take the decision in consultation with the licensing authority. Rules related to the competence of the medical assessor employed by the Authority and oversight of AMEs are proposed in NPA 2008-22b.

comment	*242*	comment by: *Lufthansa German Airlines*
	Author: : Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany Head of Lufthansa Medical Services Head of German Academy of Aviation and Travel Medicine Section: **2** **MED.A.045 (a) Limitations to medical certificates** **Page**: 5 Relevant Text: (2) (i) whether **accredited** medical opinion..... **Comment**: What is meant by accredited medical opinion? Does this mean, that only specialists accredited by the competent authority can be used for a special opinion when assessing whether a limitation is necessary. **Proposal**: delete the word **accredited** and put in **special**	
response	*Not accepted*	
	For clarity reasons, the wording 'Accredited medical opinion' will be changed to 'Accredited medical conclusion' to be consistent with ICAO Annex I. The EASA adapted explanation of 'accredited medical opinion' is to be found in MED.A.010, Definitions.	

comment	*330*	comment by: *FOCA Switzerland*
	MED.A.045 c) (2) OSL Limitation. This limitation shall be imposed and removed only by the licensing authority. Justification: The AMEs have not sufficient knowledge to explain and to expose to the pilots the legal consequenses of an OSL Limitation regarding the conditions that a safety pilot must comply with. Proposal: **Add text**: **The holder of a medical certificate with an OSL limit.....at the controls. The OSL for class 2 and LPL shall only be imposed and removed by the licensing authority.**	
response	*Partially accepted*	
	See response to comment No 120 of this segment.	

comment	*331*	comment by: *FOCA Switzerland*

	MED.A.045 c) (3) Other Limitations: (OCL, APL, AHL,OPL,SIC,SSL,OAL) shall only be imposed and removed by the licensing authority, whereas medical restrictions (TML, VNL, VML, VDL, VCL, CCL, RXO) may be imposed and removed by the AME or the AeMC. Justification: There are legal consequences and conditions that are linked with the operational restrictions and the AMEs or AeMC are not sufficiently familiar with these restrictions Proposal: **Add new text** **(5): The following restrictions shall only be imposed and removed by the licensing authority: OCL, APL, AHL, OPL, SIC, SSL, OAL, OML, OSL**
response	*Partially accepted*
	Limitations other than OML and OSL will be moved to an AMC to MED.A.045. With the exception of TML and limitations for visual correction all other limitations should be imposed and removed: • by the licensing authority for class 1 medical certificates, • by an AeMC or AME in consultation with the licensing authority for class 2 medical certificates, and • by an AME or AeMC for LAPL medical certificates. The explanations of the other limitation codes will be amended to be in line with those in JAR-FCL 3.

comment	*381*	comment by: *UK CAA*
	MED.A.045 (a) Comment: Proposal supported Justification: Essential for ICAO compliance.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*382*	comment by: *European CMO Forum*
	MED.A.045 (a) (1) (i) Comment: Pilots with medical conditions that have not changed do not need to be referred to the authority. Justification: The authority only needs to be involved with certificate issue in these circumstances if the condition has changed. Proposed Text: Add to MED.A.045 (a) (1) (i) :The AeMC or AME may reissue a medical certificate with the same limitation without referring the applicant to the authority.	
response	*Accepted*	

	Thank you for the proposal. The text of the Implementing Rule will be amended accordingly.

comment	*383*	comment by: *European CMO Forum*
response	*Noted*	
	There is no comment.	

comment	*384*	comment by: *UK CAA*
	MED.A.045 Comment: Proposal supported. Justification: The mechanism for imposition of limitations that is proposed is good.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*385*	comment by: *European CMO Forum*
	MED.A.045 (a) (2) (i) Comment: Accredited medical opinion is not defined and is inappropriate to use instead of the accepted ICAO phrase. Justification: Accredited medical opinion is not an ICAO term. Proposed Text: Change 'Accredited medical opinion' to 'Accredited medical **conclusion**'.	
response	*Accepted*	
	Thank you for the proposal. For clarity reasons, the wording 'Accredited medical opinion' will be changed to 'Accredited medical conclusion'. The EASA adapted explanation of 'accredited medical opinion' is to be found in MED.A.010, Definitions.	

comment	*386*	comment by: *UK CAA*

MED.A.045 (a) (1) (i)
Comment:
This means that AMEs would need to refer any Class 1 applicant with a limitation (other than for correcting lenses) to the Licensing Authority at all revalidation/renewal exams.

Justification:
AMEs should be able to issue a revalidation/renewal medical certificate with a limitation if the underlying condition for which the limitation was applied is unchanged.

Proposed Text:
Add to MED.A.045 (a) (1) (i) **In the case of conditions that have not deteriorated the AeMC or AME shall revalidate or renew a medical certificate with a limitation previously imposed by a Licensing Authority.**

response *Noted*

See response to comment No 382.

comment *387* comment by: *European CMO Forum*

MED.A.045 (a) (2) (i)
Comment:

Accredited medical conclusion requires the involvement of one or more medical experts.

Justification:
The current text is not ICAO compliant. The AME cannot undertake an accredited medical conclusion and limitations (other than corrective lenses) should be imposed and removed by the authority. This will assist with standardisation across the Member States, in accordance with the principle of equity.

Proposed Text:

MED.A.045 (a): add (a) (3) **'The AeMC or AME shall refer all cases that may require a limitation to be imposed for the first time or removed, other than for corrective lenses, to the authority.'**

response *Noted*

See responses to comments No 120 and 241 of this segment.

comment *388* comment by: *UK CAA*

MED.A.045 (a) (1)
Comment:
AMEs will often need to refer Class 2 applicants with borderline fitness to the Licensing Authority and there needs to be a mechanism to enable this.

Justification:

	AMEs vary in their experience of aeromedical assessment and especially of assessment of borderline cases. Proposed Text: Add to MED.A.045 (a) (1) **(iii) Notwithstanding (i) and (ii) the AeMC or AME shall refer the decision on fitness of an applicant to the Licensing Authority in borderline cases or when there is doubt about fitness.**
response	*Noted*
	See response to comment No 120 of this segment.

comment	*389*	comment by: *European CMO Forum*
	MED.A.045 (c) (3) and (4) Comment: The SSL limitation is different to the current JAR. The SIC limitation is different to the current JAR. A code is needed for (c) 4. Justification: There will be considerable confusion and potential flight safety implications if the limitation codes are changed from those which all JAA states are currently using with JAR FCL 3. Codes are necessary for standardisation. Proposed Text: (c) (3) (iv): delete 'of operation (SSL)'. (c) (3) (vii): Change the sentence to describe SIC to **'special instructions apply - contact the licensing authority'**. (4) - Use the code after the sentence '**(SSL)**'.	
response	*Noted*	
	See response to comment No 331 of this segment.	

comment	*390*	comment by: *UK CAA*
	MED.A.045 (b) Comment: Text ambiguous Justification: Clarity required.	

	Proposed Text: Change 'shall comply with the requirements...' to 'shall comply with the **process established in (a)**'
response	*Partially accepted*
	The text of MED.A.045 (b) will be amended.

comment	*392*	comment by: *UK CAA*
	MED.A.045 (b) Comment: Deferred LPL cases are likely to be medically complex and will require an advanced level of aeromedical decision making. Justification: AMEs vary in their experience of aeromedical assessment and especially of assessment of borderline cases. Proposed Text: Insert into MED.A.045 (b) '**shall refer the applicant to the Licensing Authority, or an AeMC or AME designated by the Licensing authority, which shall...'**	
response	*Noted*	
	See response to comment No 120 of this segment.	

comment	*394*	comment by: *UK CAA*
	MED.A.045 (c) (1) (i) Comment: There is no safety reason to prevent a pilot with an OML on his certificate flying with another 'OML' limited pilot. Justification: The risk of both pilots in a two pilot operation becoming incapacitated simultaneously is negligible. There is no reason to prevent two pilots, both with OMLs, flying together. Proposed Text: Delete: 'is not subject to an OML'.	
response	*Noted*	
	See response to comment No 62.	

comment	*396*	comment by: *UK CAA*
	MED.A.045 (c) (1) (i)	

	Comment: Current wording is not entirely accurate. Justification: The OML limitation applies to pilots operating aircraft certificated for multi crew operations. Proposed Text: Change 'The holder of a medical certificate with an OML limitation shall only operate an aircraft in multi pilot operations,...' to '**The holder of a medical certificate with an OML limitation shall only operate an aircraft certificated for multi crew operations**....'
response	*Not accepted*
	The wording 'multi pilot operations' is transposed from JAR FCL 3.035(d)(1). Member States are currently using this wording and the proposed change may cause confusion in a currently harmonised application of the limitation. The limitation 'OML' is meant to be imposed in cases where single pilot operation cannot be considered irrespective of aircraft certification or type of operation. A re-evaluation of the expression could be considered in the next rulemaking task MED.001.

comment	*407*	comment by: *UK CAA*
	MED.A.045 (c) (1) (ii) Comment: This sentence is ambiguous. Justification: This sentence could be interpreted to allow single pilot commercial air transport to be undertaken by a pilot with an OML by implying that the limitation only applies when flying with another pilot. Proposed Text: Amend sentence to*: '*When the holder of a CPL or ATPL has been referred to the licensing authority, it shall assess whether the medical certificate may be issued with **an OML limitation to be used only when flying as or with a co-pilot in commercial air transport operations.'** And add***: ' The holder of a medical certificate with an OML limitation shall not undertake single pilot commercial air transport operations'**.	
response	*Partially accepted*	
	Thank you for the comment. For clarity reasons the text will be amended. However, the OML limitation applies to any commercial operation, not only to commercial air transport. Additional sentence is superfluous as it is covered in (c)(1)(i).	

comment	*411*	comment by: *UK CAA*
	MED.A.045 (c) (3) (iv) **Comment:** Duplication and this is not the current use of the Code SSL in JAR FCL3 so makes administrative changeover to EASA Part Medical difficult. **Justification:** SSL is already covered by MED.A.045 (4) **Proposed Text:** Delete 'of operation (SSL)'.	
response	*Noted*	
	See response to comment No 331.	

comment	*412*	comment by: *UK CAA*
	MED.A.045 (c) (3) (vii) **Comment:** This is not the current use of the Code SIC in JAR FCL 3 so makes administrative changeover to EASA Part Medical difficult. **Justification:** SIC is already covered by MED.A.045 (4) **Proposed Text:** Delete (vii)	
response	*Noted*	
	See response to comment No 331.	

comment	*413*	comment by: *UK CAA*
	MED.A.045 (c) (4) **Comment:** This is the SSL limitation in JAR FCL 3. **Justification:** Continued use of this code will facilitate understanding. **Proposed Text:** Add '**SSL - specific restrictions as specified'**.	
response	*Noted*	
	See response to comment No 331.	

comment	414	comment by: UK CAA
	MED.A.045 **Comment:** Only the Authority should be able to remove a limitation on a Class 1 medical certificate. **Justification:** Removal of a limitation is rare. This is an area of great importance for flight safety and should be the responsibility of the authority. **Proposed Text:** Add: '(e) In the case of class one medical certificates limitations, other than those for corrective lenses, shall only be removed by the authority.'	
response	*Noted*	
	See response to comment No 120.	

comment	519	comment by: British Microlight Aircraft Association
	Accepted. Except that the Operational Safety Pilot Limitation (OSL). Should only be used where the OPL is not appropriate as the first alternative.	
response	*Noted*	
	Thank you for the comment.	

comment	585	comment by: Lufthansa German Airlines
	Author: : Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany Head of Lufthansa Medical Services Head of German Academy of Aviation and Travel Medicine Section: : **2** **MED.A.045 Limitations to medical certificates** (b) Limitations to LPL medical certificates **Page**: 5 Relevant Text: When the applicant does not fully meet the requirements for medical fitness, the GMP shall refer the applicant to an AeMC or AME which shall comply with the requirements established in (a) for class 2 medical certificates. **Comment**: Statistically a GMP in Germany will perform 1.25 LPL medicals in 10 years. (see comment No. 7) This will lead to time consuming processes for the pilots because GMPs will not have training and experience to make decisions and assessment under LPL requirements. Therefore every question of a GMP will be referred to AMEs. I do not see any whether economical nor time benefit for this process. Pilots will have to pay twice and they will wait until a decision is made.	

	Proposal: Delete GMPs in the requirements and AMC for all EASA member states.
response	*Not accepted*
	The Basic Regulation (Article 7) allows a GMP to issue a medical certificate for an LPL licence if permitted under national law. This provision has to be taken into acount in the implementing rules.

comment	*586*	comment by: *Lufthansa German Airlines*
	Author: : Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany Head of Lufthansa Medical Services Head of German Academy of Aviation and Travel Medicine Section: : **2** **MED.A.045 Limitations to medical certificates** **(c)** Limitation codes (1) (iii) **Page**: 6 Relevant Text: The OML for class 1 medical certificates shall only be imposed and removed by the licensing authority. **Comment**: Why can OML only be imposed or removed by the licensing authority for class 1, and on the other hand, it is sufficient for the competent authority, if an AME can impose or remove OSL for class 2 . How is the process for the pilot or his AeMC or AME to appeal to remove an OML restriction? Will there be an appeal board for this. Is there a review process with new special medical opinions? There is nothing like this in the requirements. **Proposal**: Delegation of responsibility to impose or remove OML and other limitations for class 1 to an AeMC shall be possible for EASA member states which needs so . Implement a process **of first and second review** or **a board of medical experts** for decisions and assessment which pilots can use if they are outside the requirements or if they feel unfair treatment by the competent authority/ licensing authority.	
response	*Not accepted*	
	Class 1 medical requirements with regard to the OML limitation are transposed from JAR FCL 3.035(d). This practice is standardised in all Member Sates and so far they did not request to provide with a possibility to delegate the right to impose and remove OML limitation to AeMCs. See also response to comment No 120 of this segment. Review procedures are proposed in Authority Requirements Subpart MED Section 3.	

comment	656	comment by: ERA
	MED.A.045 limitations to medical certificates ERA suggest rewording (a) Limitations to class 1 and class 2 medical certificates (1) (i) to read: 'in the case of applicants for a class 1 medical certificate ***for whom any limitation is being applied for the first time***, refer the decision on fitness of the applicant to the licensing authority as indicated in Subpart B, except those requiring a limitation related only to the use of corrective lenses;	
response	*Noted*	
	See response to comment No 61.	

comment	666	comment by: Pekka Oksanen
	Comment (a): To pilots with stable medical condition AeMC or AME can issue a certificate with previous limitations if no change in condition. Only inform the Authority. The wording in (a)(2)1). Proposal: Add a new subparagraph to (a)(1): **(iii) The AeMC or AME may reissue a medical certificate with same limitations without referring the applicant to the Authority.** Comment (a)(2)(1) incorrect wording. Proposal: Change (a)(2)(1) ~~opinion~~ **conclusion**	
response	*Noted*	
	(a)(1) See response to comment No 382. (a)(2)(i) See response to comment No 385.	

comment	667	comment by: Pekka Oksanen
	In a medical conclusion at least two experts are needed. The AME or AeMC cannot make a decision for limitations other then visual. Therefore the limitation for the first time must be imposed by the Authority. Proposal: Add a new paragraph **(a)(3) the AeMC or AME shall refer all cases that may require a limitation to be imposed for the first time or removed, other than for corrective lenses, to the Authority.**	
response	*Noted*	
	See responses to comments No 61 and120.	

comment	669	comment by: Pekka Oksanen

	Subpara (4) add **SLL**
response	*Noted*
	See response to comment No 331.

comment	*776*	comment by: *Thomas Cook Airlines UK*
	Commentator: The UK Association of Aviation Medical Examiners **Paragraph**: Med.A.045 (b) **Page Number:** 5 **Comment:** Can a GMP issue a medical certificate with visual correction limitations? The wording of this suggests that a GMP has to refer any applicant with any limitation to an AeMC or an AME. Can a GMP only issue a certificate with NO limitations whatsoever including VNL, VDL etc? **Justification:** The present wording is ambiguous. **Proposed text: Med A.045 (b)** When the applicant does not fully meet the requirements for medical fitness, the GMP shall refer the applicant to an AeMC or AME which shall comply with the requirements established in (a) for class 2 medical certificates. This requirement shall not apply to standard visual limitations such as VDL or VNL.	
response	*Noted*	
	See response to comment No 120 of this segment.	

comment	*777*	comment by: *Thomas Cook Airlines UK*
	Commentator: The UK Association of Aviation Medical Examiners **Paragraph**: Med.A.045 (c) **Page Numbers:** 4, 5 **Comment:** There is no evidence that flight safety has ever been compromised when two OML pilots have flown together. This rule is very restricting for airlines. **Justification:** Regulations should be based on sound evidence based medicine. This restriction is not based on any evidence. **Proposed text:** (c) (1) Operational multi-pilot limitation (OML) (i) The holder of a medical certificate with an OML limitation shall only operate an aircraft in multi-pilot operations and when the other pilot is fully qualified on the relevant type of aircraft. Two pilots with OML limitations may fly in a multi-crew capacity provided that at least one of the pilots is not more than 60 years of age.	

response	*Noted*
	See response to comment No 62.

comment	*790*	comment by: *Swiss Association of Aviation Medecine*

Comment:
1 (i) The licensing authority may delegate the competence to issue the medical certificate with limitations as necessary to an AeMC, provided that medical specialists acceptable to the authority are working in this AeMC and oversight by the authority guarantees the required safety standard.
(ii)
In case of class 2 medical certificates the AME class 2 shall submit doubtful cases to an AeMC where an evaluation by medical experts can be done and limitations as necessary can be assessed. This makes sure that a medical assessment in pilots who do not meet the requirements, always is done by medical experts experienced in aviation medicine.
(b)
Statistically a GMP in Germany will perform 1.25 LPL medicals in 10 years .This will lead to time consuming processes for the pilots because GMPs will not have training and experience to make decisions and assessment under LPL requirements. Therefore every question of a GMP will be referred to AMEs. We do not see any whether economical nor time benefit for this process. Pilots will have to pay twice and they will wait until a decision is made. If there is not one national health system in Europe, not even the British one, where it is guaranteed that the GPs have access to the complete medical file of a pilot and pilots cannot hide important medical information by consulting private doctors, why do EASA implement such requirements which no member state can fulfil.

Proposal:
1 (i) The licensing authority may delegate the competence to issue the medical certificate with limitations as necessary to an AeMC, provided that medical specialists acceptable to the authority are working in this AeMC and oversight by the authority guarantees the required safety standard.
(ii)
In case of class 2 medical certificates the AME class 2 shall submit doubtful cases to an AeMC where an evaluation by medical experts can be done and limitations as necessary can be assessed.
(b)
Delete GMPs in the requirements and AMC for all EASA member states.

response	*Noted*
	See responses to comments No 61 and 120. (b) Not accepted. The Basic Regulation (Article 7) allows a GMP to issue a medical certificate for a LAPL licence (if permitted under national law). This has to be taken into account in the implementing rules.

comment	*825*	comment by: *Thomas Cook Airlines UK*

Commentator: The UK Association of Aviation Medical Examiners

Paragraph: Med.A.045

Page Numbers: 5 (a) (1) (i)

Comment: This means that every pilot with a limitation other than for visual correction has to be referred to AeMC. This would mean that every pilot already with an OML would have to be referred. The wording should be changed to permit an AME to issue a certificate to a pilot with any limitation provided this limitation is already in place and the circumstances have not changed.

Justification: Pilots with any limitation other than for visual correction would not be able to be issued with a renewal or revalidation certificate at the time of their medical examination with an AME. This would mean many pilots, who are otherwise fit would be denied a medical certificate until issued by the AeMC. This would cause unacceptable delays and prevent pilots with an OML from flying until re-assessed by the AeMC.

Proposed text: Med A.045 (a) Limitations to class 1 and class 2 medical certificates

(1) (i) In the case of applicants for a class 1 medical certificate, for whom any limitation is being applied for the first time, an AME shall refer the decision on fitness to the AeMC. Pilots with a limitation already imposed by the AeMC on their medical certificate may be issued with a medical certificate by the AME provided that the reasons for that limitation have not significantly changed since the limitation was applied.

response

Noted

See responses to comments No 61 and 120.

comment

977 comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: 2
MED.A.045 Limitations to medical certificates (a) (1) and Subpart B

Page: : 5 ; 9 and following

Relevant Text:
When, in accordance with the Aeromedical examinations and assessments, the applicant does not fully comply with the requirements for the relevant class of medical certificate but is considered to be not likely to jeopardise flight safety the AeMC or AME shall:
(i) in the case of applicants for class 1 medical certificate refer the decision on fitness of the applicant to the licensing authority as indicated in Subpart B, except those requiring a limitation related only to the use of corrective lenses.

Comment:
Why shall in cases of MED. B. 005 Cardiovascular System
b (3) i -- ix
d (1) i - ii
d (5) last sentence
e (1) i - vi
e (4) i-ii
MED . B. 020 Metabolic and Endocrine System
c (2) last sentence
MED . B. 025 Haematology
c (1) -- (5)
MED . B. 050 Psychiatry
(b) - (d) - (e)
MED . B . 060 Neurology
(c) 1 - 7
MED . B . 085 Oncology
(b)
for class 1medical applicants always to be referred to the licensing authority, but not in cases of
Respiratory System
Digestive System
Genitourinary System
Infectious Disease
Obstetrics and Gynaecology
Musculoskeletal System
Psychology
Visual System
Otorhino- larygology
Dermatology
The risk assessment for class 1 medical certificates is inconsequent. Why is a licensing authority able to do a risk assessment for class 1medicals in MED. B.005 - B.085 as shown in the upper part and why do they think that AeMCs and AMEs can do it in the lower Paragraphs - Respiratory ....Dermatology.? Why does a licensing or competent authority has no problem to delegate the risk assessment for all MED . B. paragraphs to the AMEs class 2, who are on a lower training level than Class 1 AMEs or AeMCs? Does the licensing authority employs medical specialists who are able to be competent for all specialities in MED . B. and to make a sufficient riskmanagement? The experience of the past 5 years under JAA requirements showed that competent authorities very often only hire consultans or medical doctors on low salary and inexperienced in aviation medicine. In Germany we had medical doctors in the authority without any basic or advanced course in aviation medicine who made the risk assessment for class 1 pilots. This may happen also under EASA requirements if the qualification of these medical doctors is not defined and binding for the member states.

1st Aspect: The limit of "not likely to jeopardise flight safety" is not defined and thus up to a widespread scope of individual opinions. The implementation of the "1-percent-rule", as a basis of the JAA and international flight-safety philosophy, is necessary at that point.

2 nd Aspect: In many countries the "licensing authority" is not privileged to have

	their own medical staff in house, thus completely lacking medical knowledge. For example in Germany, more than 26 regional authorities do not dispose of any physician. In these cases the authority is unable to come to an adequate judgement, moreover it's not authorised to keep personal medical data in their files or obtain them (protection by privacy laws). This means that medical data and decision making must be separated from the authority. For that purpose Aeromedical Centers, controlled and structurally certified by the authorities, have been implemented by the different states as Centers of Aeromedical competence and Centers of special trust. Consequently, the decision making concerning medical licensing class 1 and class 2 should be delegated to the Aeromedical Centers, that should work under conditions controlled by the AMS. **Proposal:** All assessments for class 1 medicals shall be done by AeMCs. Class 2 and LPL medical assessment shall be done by AeMCs ;AMEs. An adequate definition should be given under MED.A.010 (Definitions): "A sufficient level of medical flight safety" is achieved, when the probability of a sudden incapacitation, inherent to a identified disease or abnormality, does not exceed 1 % per year for class 1and 2 % - 5% per year for class 2 and LPL). The EASA should provide in their requirements the possibility of delegation of competence for class 1medical assessment from the competent authority / licensing authority to AeMCs and for clas s 2 and LPL medical assessment to AMEs, provided that the safety standard is guaranteed by oversight procedures of the competent authority. The competence level of an medical doctor in the competence authority/ licensing authority shall be required by EASA on a higher level as it is required for the heads of AeMCs or AMEs class 1. Otherwise the tail wags the dog, because competence of medical specialists and well trained AMEs in an AeMC can be overruled by a beginner doctor in the authority. **Alternative proposal:** EASA centralises medical decision making in an EASA medical department with a European air surgeon, analogue to the FAA system. Then 15 safety relevant illnesses have to be referred to this department for decision, all other illnesses can be decided by AMEs. Provided EASA implements a central computer system and a central medical data bank into which all EASA - AMEs will send their medical reports and medical certificates, this will be the better alternative. Medical confidentiality, standardisation, correct oversight and evidence based aviation medicine will be guaranteed in this System. The best would be to use the same computer system in EASA which already works perfect in the FAA system. This provides the chance to have a world wide database for scientific and evidence based medical assessment. Officials from FAA are in favour with this idea and offered the software already for free if EASA wants to use it. (statement at the 1st European Conference on Aviation Medicine and the 3rd FAA refresher seminar August 21st - 24th 2008 in Wiesbaden/Germany)
response	*Noted*
	See response to comment No 241.

comment	978	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: 2
MED.A.045 (a) Limitations to medical certificates

Page: 5

Relevant Text:
(2) (i) whether **accredited** medical opinion.....

Comment:
What is meant by accredited medical opinion? Does this mean, that only specialists accredited by the competent authority can be used for a special opinion when assessing whether a limitation is necessary.

Proposal: Use the term -**accredited medical conclusion** - as it is defined in ICAO Annex 1 Chapter 1 (1.1) Definitions." Accredited medical conclusions - The conclusion reached by one or more medical experts acceptable to the Licensing Authority for the purposes of the case concerned, in consultation with flight operations or other experts as necessary."

response	*Noted*
	See response to comment No 242.

comment	979	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: 2
MED.A.045 Limitations to medical certificates
(a) (1) and (2)(i) and (ii)
(b) Limitations to LPL medical certificates

Page: 5

Relevant Text:
1(i)
in the case of applicants for a class medical certificate refer the decision on fitness of the applicant to the licensing authority.....,except those requiring a limitation related only to the use of corrective lenses.
(ii)
in case of class 2 medical certificate.....and issue the medical with limitations as necessary.
(b)
When the applicant does not fully meet the requirements for medical fitness, the

GMP shall refer the applicant to an AeMC or AME which shall comply with the requirements established in (a) for class 2 medical certificates.

Comment:
1 (i) The licensing authority may delegate the competence to issue the medical certificate with limitations as necessary to an AeMC, provided that medical specialists acceptable to the authority are working in this AeMC and oversight by the authority guarantees the required safety standard.
(ii)
In case of class 2 medical certificates the AME class 2 shall submit doubtful cases to an AeMC where an evaluation by medical experts can be done and limitations as necessary can be assessed. This makes sure that a medical assessment in pilots who do not meet the requirements, always is done by medical experts experienced in aviation medicine.
(b)
Statistically a GMP in Germany will perform 1.25 LPL medicals in 10 years .This will lead to time consuming processes for the pilots because GMPs will not have training and experience to make decisions and assessment under LPL requirements. Therefore every question of a GMP will be referred to AMEs. We do not see any whether economical nor time benefit for this process. Pilots will have to pay twice and they will wait until a decision is made. If there is not one national health system in Europe, not even the British one, where it is guaranteed that the GPs have access to the complete medical file of a pilot and pilots cannot hide important medical information by consulting private doctors, why do EASA implement such requirements which no member state can fulfil.

Proposal:
1 (i) The licensing authority may delegate the competence to issue the medical certificate with limitations as necessary to an AeMC, provided that medical specialists acceptable to the authority are working in this AeMC and oversight by the authority guarantees the required safety standard.
(ii)
In case of class 2 medical certificates the AME class 2 shall submit doubtful cases to an AeMC where an evaluation by medical experts can be done and limitations as necessary can be assessed.
(b)
Delete GMPs in the requirements and AMC for all EASA member states.

response *Noted*

See response to comment No 790.

comment *980* comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: 2
MED.A.045 Limitations to medical certificates
(c) Limitation codes
(1) (iii)

Page: 6

Relevant Text:
The OML for class 1 medical certificates shall only be imposed and removed by the licensing authority.

Comment:
Why can OML only be imposed or removed by the licensing authority for class 1, and on the other hand, it is sufficient for the competent authority, if an AME can impose or remove OSL for class 2. How is the process for the pilot or his AeMC or AME to appeal to remove an OML restriction? Will there be an appeal board for this. Is there a review process with new special medical opinions? There is nothing like this in the requirements.

Proposal:
Delegation of responsibility to impose or remove OML and other limitations for class 1 to an AeMC shall be possible for EASA member states which needs so .
Implement a process **of first and second review** or **a board of medical experts** for decisions and assessment which pilots can use if they are outside the requirements or if they feel unfair treatment by the competent authority/ licensing authority.

response *Noted*

See response to comment No 586 of this segment.

comment *1066* comment by: *BMVBS (German Ministry of Transport)*

MED.A.045(a)(1)(i) should read as follows:

in the case of applicants for a class 1 medical certificate refer the decision on fitness of the applicant to *an independent AeMC* .....

Reason: The involvement of the authority should be strictly confined to its oversight role. The authority should not take medical decisions. Not all Aeromedical sections will have the medical/technical capabilities to study and evaluate critical cases in detail to reach a competent and justified decision. The final decision, in particular in critical cases, should be taken where the expertise rests and that is with the AeMCs. To refer the applicant to an independent AeMC would address the aspect of objectivitiy and mitigate the risk of false decisions sufficiently. The term "independent AeMC" might need to be defined as ...independent from the AeMC or AME which concluded that the applicant does not fully comply with the requirements, or replaced by a better term.

response *Not accepted*

Decision of the aeromedical fitness of Class 1 applicants when they do not fully comply with the requirements shall be made by the licensing authority. For this reason the licensing authority shall have one or more medical assessors to undertake this and other related tasks. Qualification of the medical assessor shall be sufficient for these tasks and is proposed in NPA 2008-22b 'Authority Requirements'.

comment	1068	comment by: Dr. Ludger Beyerle

Text:
MED.A.045 Limitations to medical certificates (a) (1) and Subpart B

Page: : 5 ; 9 and following

Relevant Text:
When, in accordance with the Aeromedical examinations and assessments, the applicant does not fully comply with the requirements for the relevant class of medical certificate but is considered to be not likely to jeopardise flight safety the AeMC or AME shall:
(i) in the case of applicants for class 1 medical certificate refer the decision on fitness of the applicant to the licensing authority as indicated in Subpart B, except those requiring a limitation related only to the use of corrective lenses.

Comment:
The risk assessment for class 1 medical certificates is inconsequent.

1.: The limit of "not likely to jeopardise flight safety" is not defined and thus up to a widespread scope of individual opinions. The implementation of the "1-percent-rule", as a basis of the JAA and international flight-safety philosophy, is necessary at that point.

2.: Aspect: In many countries the "licensing authority" is not privileged to have their own medical staff in house, thus completely lacking medical knowledge. For example in Germany, more than 26 regional authorities do not dispose of any physician. In these cases the authority is unable to come to an adequate judgement, moreover it's not authorised to keep personal medical data in their files or obtain them (protection by privacy laws). This means that medical data and decision making must be separated from the authority. For that purpose Aeromedical Centers, controlled and structurally certified by the authorities, have been implemented by the different states as centers of aeromedical competence and centers of special trust. Consequently, the decision making concerning medical licensing class 1 and class 2 should be delegated to the Aeromedical Centers, that should work under conditions controlled by the AMS.

Proposal:
All assessments for class 1medicals shall be done by AeMCs.
Class 2 and LPL medical assessment shall be done by AeMCs ;AMEs.

An adequate definition should be given under MED.A.010 (Definitions): "A sufficient level of medical flight safety" is achieved, when the probability of a sudden incapacitation, inherent to a identified disease or abnormality, does not exceed 1 % per year for class 1and 2 % - 5% per year for class 2 and LPL).

The EASA should provide in their requirements the possibility of delegation of competence for class 1medical assessment from the competent authority / licensing authority to AeMCs and for clas s 2 and LPL medical assessment to AMEs, provided that the safety standard is guaranteed by oversight procedures of the competent authority.

	The competence level of an medical doctor in the competence authority/ licensing authority shall be required by EASA on a higher level as it is required for the heads of AeMCs or AMEs class 1.
response	*Noted*
	In each Member State there shall be only one licensing authority responsible for the aeromedical issues. The Basic Regulation gives the competence to issue medical certificates for Class 1 and 2 applicants to the AeMC and AME. Revalidation and renewal examinations for Class 1 applicants may be carried out by both AeMCs and AMEs with the advanced training in aviation medicine. The risk assessment will be included in the Guidance Material during the next rulemaking task MED.001. The Basic Regulation (Article 7) allows a GMP to issue a medical certificate for a LAPL licence (if permitted under national law). This has to be taken into account in the implementing rules. Qualification of the medical assessor of the licensing authority is proposed in NPA 2008-22b 'Authority Requirements'. See also response to comment No 241 of this segment.

comment	*1069*	comment by: *Dr. Ludger Beyerle*
	MED.A.045 Limitations to medical certificates **(a) (1) and (2)(i) and (ii)** **(b) Limitations to LPL medical certificates** **Page: 5** **Relevant Text:** 1(i) in the case of applicants for a class medical certificate refer the decision on fitness of the applicant to the licensing authority.....,except those requiring a limitation related only to the use of corrective lenses. (ii) in case of class 2 medical certificate.....and issue the medical with limitations as necessary. (b) When the applicant does not fully meet the requirements for medical fitness, the GMP shall refer the applicant to an AeMC or AME which shall comply with the requirements established in (a) for class 2 medical certificates. **Comment:** **1 (i)** The licensing authority may delegate the competence to issue the medical certificate with limitations as necessary to an AeMC, provided that medical specialists acceptable to the authority are working in this AeMC and oversight by the authority guarantees the required safety standard. **(ii)** In case of class 2 medical certificates the AME class 2 shall submit doubtful cases to an AeMC where an evaluation by medical experts can be done and limitations	

as necessary can be assessed. This makes sure that a medical assessment in pilots who do not meet the requirements, always is done by medical experts experienced in aviation medicine.
(b)
Statistically a GMP in Germany will perform 1.25 LPL medicals in 10 years .This will lead to time consuming processes for the pilots because GMPs will not have training and experience to make decisions and assessment under LPL requirements. Therefore every question of a GMP will be referred to AMEs. We do not see any whether economical nor time benefit for this process. Pilots will have to pay twice and they will wait until a decision is made. If there is not one national health system in Europe, not even the British one, where it is guaranteed that the GPs have access to the complete medical file of a pilot and pilots cannot hide important medical information by consulting private doctors, why do EASA implement such requirements which no member state can fulfil.

Proposal:
1 (i) The licensing authority may delegate the competence to issue the medical certificate with limitations as necessary to an AeMC, provided that medical specialists acceptable to the authority are working in this AeMC and oversight by the authority guarantees the required safety standard.
(ii)
In case of class 2 medical certificates the AME class 2 shall submit doubtful cases to an AeMC where an evaluation by medical experts can be done and limitations as necessary can be assessed.
(b)
Delete GMPs in the requirements and AMC for all EASA member states.

response *Noted*

See response to comment No 790.

comment *1116* comment by: *BALPA*

MED.A.045
Limitations to medical certificates
(a) Limitations to class 1 and class 2 medical certificates

1) When, in accordance with the aeromedical examinations and assessments, the applicant does not fully comply with the requirements for the relevant class of medical certificate but is considered to be not likely to jeopardise flight safety the AeMC or AME shall:

(i) in the case of applicants for a class 1 medical certificate refer the decision on fitness of the applicant to the licensing authority as indicated in Subpart B, except those requiring a limitation related only to the use of corrective lenses;

This appears to suggest that only the AeMC can renew or revalidate Class 1 medicals with an OML restriction. Currently an AME may renew or revalidate a Class 1 with an OML restriction and this position should be maintained

Suggested replacement text
(i) in the case of applicants for a class 1 medical certificate refer the decision on

	fitness of the applicant to the licensing authority as indicated in Subpart B, except those requiring a renewal based on a stable existing OML restriction or a limitation related only to the use of corrective lenses;
response	*Noted*
	See response to comment No 61.

comment	*1131*	comment by: *Keith WHITE*
	Limitations to LPL ... Add "**SPL and LPL(S)**" Further, it would appear that, if the applicant needs corrective spectacles, he would have to be referred to an AeMC or an AME. I think this is unnecessary for glider pilots, and would involve them in considerable expense such that many needing spectacles would not continue flying gliders. **Develop suitable medical requirements for the various categories of glider pilot [solo, instructor, etc.], which are appropriate for a leisure sport, with the appropriate national gliding authorities.**	
response	*Noted*	
	See response to comment No 61. SPL is a licence for private flying and requires holding Class 2 medical certificate. This is also an ICAO standard: please refer to ICAO Annex 1, Section 2.9. Glider pilot licence, paragraph '2.9.1.5: An applicant shall hold a current Class 2 Medical Assessment'.	

comment	*1175*	comment by: *FAI*
	(CIMP) Page 5 of 66 The Essential Requirements provide for mitigating measures and these take the form of limitations placed on the licence. Although limitations may be applied to any medical certificate, the majority of limited pilots are likely to be those holding the LPL, effectively itself a limitation to EU airspace. The limitations listed are sufficient but the procedures are too complex and greater guidance is required. Any certifying doctor should be able to apply any limitation, temporary or permanent. Both AMEs and GMPs may wish to consult more experienced colleagues on borderline cases but this can be informal. The closer the medical decision maker is to the pilot applicant, the more likely is the decision to be correct and the wisdom of the decision accepted by the pilot. However an appeal by the pilot against denial or a limitation to independent expertise must be possible and this has not been specified. For the air sports where the necessary expertise does not exist in national authorities, suitably experienced doctors can be appointed to act as advisers on behalf of the authority. **CIMP CONCLUSION** **-Licence Limitations will permit less fit pilots to fly. Any certifying doctor should be able to apply any limitation. Appeals must be possible.** **-Suitably experienced and air sport qualified doctors should be nominated by national Aero-clubs to act as advisers on behalf of the**	

	authority.
response	*Noted*
	See response to comment No 120 of this segment. Review procedures are proposed in NPA 2008-22b 'Authority Requirements' Subpart MED Section 3. AMEs are already qualified and experienced to perform aeromedical examinations.

comment	*1201*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*

MED.A.045 (a)(1)
Comment:
As with the class 1 medical certificates, the assessment of class 2 and LPL applicants not fully complying with the requirements will require thorough knowledge and experience from the relevant flight operations, which very few GMPs and AMEs do have, especially if they only perform a few examinations on private pilots. The full assessment in these cases can usually only be made by the licensing authority.

In MED.A.045 (a)(1)(i) a reference is made to Subpart B, to those conditions when the decision for a limitation shall be deferred to the licensing authority. For those conditions where a deferral is not specified in Subpart B, the individual AeMC or AME will be permitted to take the decision. We are of the opinion that the same procedure for limitations should apply to all medical conditions.

According to Swedish administrative law, a negative decision (including imposing a limitation on a medical certificate) must be made by the authority adhering to very specified procedures, and the applicant must have the possibility to appeal to an administrative court. It is not possible to appeal to an administrative court against a decision made by an independent AeMC, AME or GMP; in these cases the individual has to open a civil case in a civil court on his own expense.

To ensure the principle of equity and the legal rights of an applicant, decisions concerning operational limitations should therefore as a rule be deferred to the licensing authority, except for those related only to the use of corrective lenses.
However, an AMC to MED.A.045 should be developed to give the possibility for a licensing authority to delegate certain of those decisions to individual AeMCs or AMEs, but still under the responsibility of the authority.

Similarly, if the authority already has made an assessment and decided on a limitation and possible requirements for future follow-up, the AeMC or AME should not be required to refer the case at every renewal examination unless the condition has changed. This is not reflected in the proposed text.

If the present text of MED.A.045 will not be changed, the mentioning of corrective lenses in MED.A.045 (a)(1)(i) is a duplicate information which should be deleted.

Proposal:

	MED.A.045 (a) should be amended to include both class 2 and LPL medical certificates, and that all operational limitations shall be decided by the licensing authority. Renewals of limitations do not need to be referred to the authority unless the condition has changed. MED.A.045 (a)(1)(ii) should be deleted.
response	*Noted*
	See responses to comments No 61 and 120 of this segment. Requirements with regard to the appeals are proposed in NPA 2008-22b 'Authority Requirements'.

comment	*1202*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.045 (a)(2) **Comment**: To avoid confusion and future legal discussions, the expression "accredited medical opinion" should be changed to "accredited medical conclusion" which is used by ICAO and defined in ICAO Annex 1: "the conclusion reached by one or more medical experts acceptable to the Licensing Authority for the purposes of the case concerned, in consultation with flight operations or other experts as necessary." As with the class 1 medical certificates, the assessment of class 2 and LPL applicants not fully complying with the requirements will require involvement of experts with thorough knowledge and experience from the relevant flight operations, which very few GMPs and AMEs do have, especially if they only perform a few examinations on private pilots. The full assessment in these cases can usually only be made by the licensing authority. **Proposal**: "accredited medical opinion" should be changed to "accredited medical conclusion"	
response	*Noted*	
	See response to comment No 242.	

comment	*1203*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.045 (b) **Comment**: The proposed medical requirements for LPL, if they will be implemented, are set at such a low level that anybody who does not fully comply with the requirements for a LPL medical certificate should receive a denial and should not be considered for any approval, not even with a limitation. Furthermore, the proposed text implies that the LPL holder in case of a referral	

	shall be assessed according to the procedures for the higher class 2 requirements. **Proposal**: MED.A.045 (b) should be deleted.
response	*Noted*
	See response to comment No 585 of this segment.

comment	*1204*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.045 (c)(1)(i) **Comment**: The age limit of 60 years should be more clearly defined: "not more than 60 years of age" might be interpreted as valid until the age 60 years and 364 days, while the intention of the rule seems to be to have the limit at the 60th birthday. A comparison should be made with definition of age limits in other paragraphs and Parts to gain consistency throughout the EASA regulations. **Proposal**: MED.A.045 (c)(1)(i) should be amended: "... and has not reached the age of 60."	
response	*Accepted*	
	The wording will be amended: '... and has not attained the age of 60 years'.	

comment	*1205*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.045 (c)(1)(iii) **Comment**: If our proposals to change MED.A.045 (a) and (b) will be effective, this paragraph can be deleted. **Proposal**: The text should be deleted in case of acceptance of our proposed changes to MED.A.045 (a) and (b).	
response	*Noted*	
	See responses to comments No 1201 and 1203.	

comment	*1206*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.045 (c)(2) **Comment**: If our proposals to change MED.A.045 (a) and (b) are not accepted, there is a need to add an additional text restricting the imposing and removing of the OSL limitation to the licensing authority.	

Proposal:
If no changes are made to MED.A.045 (a) and (b) the text should be amended:
MED.A.045 (2)(ii) "OSL for class 2 and LPL medical certificates shall only be imposed and removed by the licensing authority."

response *Accepted*

See also comment to response No 120 of this section.

comment *1207* comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*

MED.A.045 (c)(3) and (4)
Comment:
The addition of a new limitation "CCL" is appreciated.

The explanations of the SSL and SIC limitations are different from the current explanations in JAR-FCL 3. There will be considerable confusion and potential flight safety implications if the same limitation codes are used for different purposes than those which all JAA states are currently using with JAR-FCL 3. SIC may include any specific medical examinations for the next renewal, not only regular examinations.

Codes are necessary for standardisation and for simplifying ramp checks. Therefore, a new code is needed for "specified type of operation".

A code is needed for (c) 4, which is the explanation for "SSL" in JAR-FCL 3.

Proposal:
Amend MED.A.045 (c)(3) and (4):
(c)(3)(iv): create a new code for "specified type of operation" and delete "(SSL)".
(c)(3)(vii): "a requirement to undergo specific additional medical examination(s), contact the licensing authority"
(c)(4): enter the code (SSL) after the sentence

response *Noted*

See response to comment No 331.

comment *1403* comment by: *Prutech Innovation Services Ltd.*

MED.A.045(b): When the applicant does not fully meet the requirements for medical fitness, the GMP shall ~~refer the applicant to an AeMC or AME~~ comply with the requirements corresponding to those established in (a) for class 2 medical certificates, or - in cases of doubt - refer the decision on fitness of the applicant to an AeMC or AME.
Comment: *It is important to respect the capabilities of GMPs, who take life-critical decisions daily and who are quite capable of judging where their competence ends - as again they do on a daily basis. The use of GMPs in this process is VERY widely supported (except in some cases by those who are less affected) and should not be diminished for 'political' reasons.*

	[Note: the term "corresponding to those" is needed in any case in section (b) as it is not the exact class 2 requirements that should apply for LPL.]
response	*Not accepted*
	In cases where the applicant does not fully meet the requirements for medical fitness, the GMP must always refer applicants to AME or AeMC. See also comment to response No 120 of this section.

comment	*1404*	comment by: *Prutech Innovation Services Ltd.*
	MED.A.045(4): The word "essential" must be used instead of "required", as this is a drastic authorisation to the medical certifier i.e. one of unlimited powers.	
response	*Not accepted*	
	The Implementing Rules are requirements. If applicants feel their privileges were overly restricted they may apply for a review of their cases. Review procedures are proposed in NPA 2008-22 'Authority Requirements'.	

comment	*1455*	comment by: *Virgin Atlantic Airways Ltd*
	Relevant Text: (i) in the case of applicants for a class 1 medical certificate refer the decision on fitness of the applicant to the licensing authority as indicated in Subpart B, except those requiring a limitation related only to the use of corrective lenses; **Comment** A pilot with a limitation (such as OML) would have to be referred back to the licensing authority each time, rather than just when the limitation is first applied **Proposal**: Add a comment that once applied, the limitation can be continued by the AME without reference to the licensing authority	
response	*Noted*	
	See response to comment No 61.	

comment	*1456*	comment by: *Virgin Atlantic Airways Ltd*
	Relevant Text: **Para C 1 i** The holder of a medical certificate with an OML limitation shall only operate an aircraft in multipilot operations, when the other pilot is fully qualified on the relevant type of aircraft, is not subject to an OML and is not more than 60 years of age. **Comment**: This will reduce flexibility, especially for small airlines. Pilots with an OML are not unsafe and still have to comply with the 1% rule. It should also be considered that if you substitute a young inexperienced pilot for an older more experienced one with an OML, there may be other unforeseen impacts on flight safety. **Proposal**: Remove "is not subject to an OML"	

response	*Noted*
	See response to comment No 62.

comment	*1527*	comment by: *Andrew CAMPBELL*
	MED.A.045(c)(3) makes no mention of limitations in respect of hearing loss. Hearing loss takes various forms and, as with vision requirements there can be safe operation of aircraft by those with hearing disabilities where the use of hearing aids or similar devices rectify hearing deficiencies to a level where there is no impact on safe operation of aircraft. This may be the case even though the aid or device, as with visual defects, does not rectify the deficiency back to perfect levels. Reference should be made in this provision: "; or (x) a requirement to use corrective hearing aids or devices or regular cockpit hearing tests."	
response	*Partially accepted*	
	A specific limitation for the use of the hearing aids has been added in AMC to MED.A.045.	

comment	*1546*	comment by: *British Airways*
	Comment: Para (a) (1) (i) also implies that anyone with a limitation (such as OML) would have to be referred to the authority each time their certificate is revalidated / renewed. **Proposal**: Add a comment that once applied, the limitation can be continued by the AME without reference to the licensing authority unless there has been a change in the medical condition for which the limitation has been applied.	
response	*Noted*	
	See response to comment No 61.	

comment	*1547*	comment by: *British Airways*
	Comment: Para (a) (2) (i) refers to "whether accredited medical opinion indicates that in special circumstances…….". What is meant by 'accredited medical opinion' or 'special circumstances'? The essential consideration is whether the failure to meet the requirement is likely to jeopardise flight safety. **Proposal**: delete the phrase 'whether accredited medical opinion indicates that in special circumstances'.	
response	*Noted*	
	See response to comment No 242.	

comment	1548	comment by: British Airways
	Comment: Para (c) (1) (i) states that: "The holder of a medical certificate with an OML limitation shall only operate an aircraft in multipilot operations, when the other pilot is fully qualified on the relevant type of aircraft, is not subject to an OML and is not more than 60 years of age." This will reduce flexibility, especially for small airlines. Pilots with an OML are not unsafe and still have to comply with the 1% rule. Substituting a young inexperienced new pilot for an older more experienced one with an OML may have an adverse impact on safety in itself. The risk of sudden incapacitation of 2 pilots, even if both have an OML limitation, is substantially less than the risk of sudden incapacitation of a single pilot in single pilot commercial operations and substantially less than the regulatory standards for risk for failure of other critical aircraft systems. There is therefore no basis in risk to flight safety for this restriction. **Proposal**: Remove "is not subject to an OML"	
response	*Noted*	
	See response to comment No 62.	

comment	1595	comment by: DGAC FRANCE
	MED.A 045 COMMENT: To give privilege to class 2 AMEs to issue all medical certificates even those with one or more limitations will jeopardize the objective of harmonisation of decisions throughout EU and associated countries and against **equity principles.** This should remain the duty of Licensing Authority. Decisions will not be homogeneous and standardisation of the decisions between states will be never obtained. As it is indicated in MED.065, the authority shall suspend or revoke a medical certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. It is better to take ,in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid contentious cases with AME's which takes a lot of time to treat. Modification : MED.A.045 Limitations to medical certificates a)Limitations to class 1 and class 2 medical certificates	

	ii) In the case of applicants for a class 2 medical certificate, ~~evaluate whether the applicant is able to perform their duties safely ……..as necessary~~ **refer the decision on fitness of the applicant to the licensing authority as indicated in subpart B for class 1, except those requiring a limitation related only to the use of corrective lenses.**
response	*Noted*
	See comment to response No 120 of this section. The responsibility of the licensing authorities is to develop an oversight programme to monitor the conduct and performance of AeMCs and AMEs. The authority shall also ensure that the aeromedical examinations performed by less experienced AMEs will meet harmonised flight safety standards.

comment	*1716*	comment by: *Norwegian Association of Aviation Medicine*
	According to our earlier arguments: part b (Limitataion to LPL Medical certificate) should be removed. In pars a,1,ii, we suggest the following addition: If the AeMC or AME, is not able to issue the medical, or is in doubt if the applicant do meet the requirements, he should not deny, but refer the decision to the licencing authority.	
response	*Noted*	
	See comment to response No 120 of this section. The text of MED.A.045 (b) will also be amended. Applicants may be referred to the licensing authority as it is provided in AMC to MED.A.045 (a).	

comment	*1729*	comment by: *Civil Aviation Authority Finland*
	MED.A.045 (a) (2) (i) "Accredited medical opinion" is not defined and is inappropriate to use instead of the accepted ICAO phraseology. Accredited medical opinion is not an ICAO term. **Change "Accredited medical opinion" to Accredited medical conclusion.**	
response	*Noted*	
	See response to comment No 242.	

comment	*1730*	comment by: *Civil Aviation Authority Finland*
	MED.A.045 (c) (3) and (4) The SSL limitation is different to the current JAR-FCL 3. The SIC limitation is different to the current JAR-FCL 3. A code is needed for (c) 4.	

	There will be considerable confusion and potential flight safety implications, if the limitation codes are changed from those, which all JAA states are currently using with JAR-FCL 3. Codes are necessary for standardisation. (c) (3) (iv): delete of operation (SSL). (c) (3) (vii): Change the sentence to describe SIC to **"special instructions apply – contact the licensing Authority"**. (4) – Use the code after the sentence **(SSL)**.
response	*Noted*
	See response to comment No 331.

comment	*1757*	comment by: *Max Heinz Katzschke*
	Zu c): Aus datenschutzrechtlichen Bedürfnissen der Piloten dürfen Berichte, medizinische Befunde und anderes (z.B. Bilder ö. ä.) nicht an die die Lizenz erteilende oder verlängernde Behörde (aktenführende Behörde) übergeben werden. Solche Details, auch spezielle Erkenntnisse des untersuchenden Arztes, müssen entsprechend der ärzlichen Schweigepflicht behandelt werden. Zu e): Berichte, medizinische Befunde und anderes (z.B. Bilder ö. ä.) dürfen auch nicht an irgendeine Behörde übergeben werden, wenn der Pilot dieser Übertragung nicht ausdrücklich zugestimmt hat. Ausnahme ist nur die Übergabe derartiger Dokumente an den Allgemeinarzt (Hausarzt), AME oder AMC.	
response	*Not accepted*	
	According to ICAO Annex I, a detailed report of the medical assessment is sent to the licensing authority. Other ICAO contracting states comply with this standard which is also included in JAR FCL 3 and in this NPA Part Medical.	

comment	*1783*	comment by: *AECA(SPAIN)*
	(a)(1)(i) refer the decision on fitness of the applicant **to the AMS.** According MED 025 the reference will be to the **'competent authority'.** In any case we prefer this other expresion. This is valid for many other paragraphs.	
response	*Not accepted*	
	It was considered necessary to ensure a general uderstanding of some terms and for this reason the term 'Licensing authority' will replace the JAA term 'Aeromedical Section'.	

comment	*1865*	comment by: *Dr Stephen Gibson*
	re Med A.045 Limitations to LPL medical certificates	

	As written it would appear to oblige AME or AeMC to place a limitation on any LPL referred by GMP. I suggest AME or AeMC should be left the freedom to decide an LPL applicant is fit enough not to be limited. proposal: Add to the end of MedA.045 (b) the words "or issue the medical certificate without limitation."
response	*Partially accepted*
	Thank you for your contribution. The text will be amended to reflect your proposal.

comment	*1871*	comment by: *ECA- European Cockpit Association*
	Add Text: (a) Limitations to class 1 and class 2 medical certificates (1) When, in accordance with the aeromedical examinations and assessments, the applicant does not fully comply with the requirements for the relevant class of medical certificate but is considered to be not likely to jeopardise flight safety the AeMC or AME shall: (i) in the case of applicants for a class 1 medical certificate refer the decision on fitness of the applicant to the licensing authority as indicated in Subpart B, except those requiring a limitation related only to the use of corrective lenses; **This decision shall be prepared and motivated by a qualifyed of aeromedical doctor.** Justification: In the EASA regulations, AMS (aeromedical section) has been deleted and substituted by "the competent authority". This means in practice that a person different from an aeromedical doctor can be the head of the competent authority and makes the final decisions on medical fitness. The rule must state that Licensing decision in borderline cases to be solely a medical one, it must not be subject to any other non expert person's interpretation of these IRs, AMCs or GMs. The wording in ICAO is "accredited medical opinion" and in Part Medical it appears in the following: *(ii) in all other cases, evaluate whether the applicant is able to perform their duties safely when complying with one or more limitations endorsed on the medical certificate.* *(2) When performing this evaluation, the AeMC or AME shall give particular consideration to:* *(i) whether accredited medical opinion indicates that in special circumstances the applicant's failure to meet any requirement, whether numerical or otherwise, is such that exercise of the privileges of the licence applied for is not likely to jeopardise flight safety;* *(ii) the relevant ability, skill and experience of the applicant.*	
response	*Noted*	
	See response to comment No 1066. Please note that the terms used in JAR-FCL were changed, but no actual change	

	occurred: AMS is now the licensing authority and the Head of the AMS is now the medical assessor. Any medical decision on the fitness of a pilot will be taken by the medical assessor of the licensing authority.

comment	*1873*	comment by: *ECA- European Cockpit Association*
	Comment on paragraph (c)(1)(i): The statistical risk of two OMLs flying together still remains acceptable and therefore two OMLs flying together should be accepted.	
response	*Noted*	
	See response to comment No 62.	

comment	*1879*	comment by: *AECA(SPAIN)*
	(a)(2)(ii) .... The AeMC or AME when assesing whether a limitation is necessary, particular consideration shal be given to: the applicant's ability, skill and experience relevant to the operation to be performed. -------- This is impossible for an AeMC or AME. Sugestion: **(ii) operational reports about the applicant's ability, skill and experience.**	
response	*Not accepted*	
	There is no need to limit the evaluation only to the operational reports. Our proposed text includes all other possible means, e.g., medical flight test.	

comment	*1880*	comment by: *AECA(SPAIN)*
	(c)(3)(ix) a requirement for specialistophtalmological examinations (RXO). This is **not a limitation** of the pilot's licence. This is a condition for future medical examinations. Is a condition for validity of medical certificates.	
response	*Noted*	
	See response to comment No 331.	

comment	*1892*	comment by: *Susana Nogueira*
	New redaction: (a)(2)(ii) operational report(s) related to applicants ability, skill and experience. As in draft is impossible for AeMC or AME.	
response	*Noted*	
	See response to comment No 1879.	

comment	*1893*	comment by: *Susana Nogueira*
	(c)(3)(ix) The content of this paragraph is not a limitation, is a condition for future medical assesments.	
response	*Noted*	
	See response to comment No 331.	

comment	*1926*	comment by: *CAA Belgium*
	(a) (1) (i) Pilots with medical conditions that have not changed do not need to be referred to the authority. The authority only needs to be involved with certificate issue in these circumstances if the condition has changed. Add to MED.A.045 (a) (1) (i) :The AeMC or AME may reissue a medical certificate with the same limitation without referring the applicant to the authority.	
response	*Noted*	
	See response to comment No 61.	

comment	*1927*	comment by: *CAA Belgium*
	(a) (2) (i) Accredited medical opinion is not defined and is inappropriate to use instead of the accepted ICAO phrase. Accredited medical opinion is not an ICAO term. Change 'Accredited medical opinion' to 'Accredited medical conclusion'.	
response	*Noted*	
	See response to comment No 242.	

comment	*1928*	comment by: *CAA Belgium*
	(a)(2)(i) Accredited medical conclusion requires the involvement of one or more medical experts. The current text is not ICAO compliant. The AME cannot undertake an accredited medical conclusion and limitations (other than corrective lenses) should be imposed and removed by the authority. This will assist with standardisation across the Member States, in accordance with the principle of equity.	

	MED.A.045 (a): add (a) (3) 'The AeMC or AME shall refer all cases that may require a limitation to be imposed for the first time or removed, other than for corrective lenses, to the authority.'
response	*Noted*
	See response to comment No 120.

comment	*1929*	comment by: *CAA Belgium*
	(c) (3) and (4) The SSL limitation is different to the current JAR. The SIC limitation is different to the current JAR. A code is needed for (c) 4. There will be considerable confusion and potential flight safety implications if the limitation codes are changed from those which all JAA states are currently using with JAR FCL 3. Codes are necessary for standardisation. (c) (3) (iv): delete 'of operation (SSL)'. (c) (3) (vii): Change the sentence to describe SIC to 'special instructions apply – contact the licensing authority'. (4) – Use the code after the sentence '(SSL)'.	
response	*Noted*	
	See response to comment No 331.	

comment	*1939*	comment by: *International Air Transport Association (IATA)*
	Page 6 Med. A.045 (c) (1) (i) Unless there is a specific reason that we are not aware of, this should reflect the change in age requirement in ICAO and 60 should be changed to 65. It can also be argued that the likelihood of two pilots with OML limitations becoming incapacitated at the same time is extremely remote and the risk is certainly much lower than the 2% risk accepted by some states with absolutely no deterioration of flight safety. Furthermore, this does not take into account crew with more than two pilots. To keep this limitation on all other pilots in such circumstances would create major rostering problems without enhancing safety. Ideally "is not subject to an OML" should be removed. A compromise could be "The holder of a medical certificate with an OML limitation shall only operate an aircraft in multi-pilot operations, when the other pilot of a two crew operation is fully qualified on the relevant type of aircraft, is not subject to an OML and is not more than 65 years of age. However, when there are more than two pilots, more than one pilot can have an OML limitation."	
response	*Not accepted*	

	The age limit of 60 years is a transposition from JAR-FCL. Medical requirements proposed in NPA 2008-17c were to be prepared on the basis of the JAR FCL 3 and NPAs that were agreed but not published under the JAA system. Any further changes that are not generally agreed or improve safety will require to be introduced under a new rulemaking task. See also response to comment No 62.

comment	*1965*	comment by: *AEA*
	Comment: Para (a) (2) (i) refers to "whether accredited medical opinion indicates that in special circumstances……..". What is meant by 'accredited medical opinion' or 'special circumstances'? The essential consideration is whether the failure to meet the requirement is likely to jeopardise flight safety. **Proposal**: delete the phrase 'whether accredited medical opinion indicates that in special circumstances'.	
response	*Noted*	
	See response to comment No 242.	

comment	*1966*	comment by: *AEA*
	Comment: Para (a) (1) (i) also implies that anyone with a limitation (such as OML) would have to be referred to the authority each time their certificate is revalidated / renewed. **Proposal**: Add a comment that once applied, the limitation can be continued by the AME without reference to the licensing authority unless there has been a change in the medical condition for which the limitation has been applied.	
response	*Noted*	
	See response to comment No 61.	

comment	*2007*	comment by: *Lars Tjensvoll*
	There should be a system where the AME's and AeMC's should be obliged to refer difficult cases and decisions to a higher level! This is to assure that all pilots are treated equally and that the right decision is taken! The final word should be on the authority level, or may be even higher on a regional (European region) level! I will suggest that the whole part b is removed	
response	*Not accepted*	
	See comment to response No 120 of this section. The text of MED.A.045 (b) will also be amended. The possibility for AeMC and AME to refer borderline cases to the licensing authority is provided in AMC to MED.A.045.	

comment	*2035*	comment by: *Tomasz Gorzenski*
	The EASA should consider creating a waiver program, similar to that developed by the FAA. By the way of special medical certificate issuance, allowing applicants, who meet all but one requirement (provided additional medical examination is performed as neccessary to assure adequate level of safety), to exercise privileges of class 1 or class 2 medical certificate holders, without operational multi-pilot or safety pilot limitation, EASA may create in future better medical standards, based more on medical facts, than some old, unneccessary standards. This is the only way to get rid of some unneccessary and unjustly discriminating regulations This is exactly what happened in the USA and later in world with uncorrected vision standard. Thanks to the FAA waiver program, by allowing thousands of pilots and ATC controller to excercises their privileges despite being unable to meet the standard, the FAA was able to observe, that they had performed their duties safely and proficiently. Consequently the FAA removed the uncorrected vision standard from FAR Part 67 and later the ICAO and other aviation authorities followed the FAA.	
response	*Noted*	
	Safety in aviation is ensured by many different measures, one of them being a medical certificate for private and commercial pilots. The legal basis for the medical certificate is the ICAO SARPs, JAR FCL 3 and the EU Basic Regulation. The latter provides the possibility to draft licensing rules tailored to the complexity of the aircraft and the kind of operation which has specifically been done in the medical field for the private pilot community by creating the leisure pilot licence. The list of limitations proposed in MED.A.045 is sufficient to provide necessary flexibility in decisions on aeromedical fitness and ensures that our proposed rules are in line with ICAO standard laid down in Annex I paragraph 1.2.4.8 and MED.A.045(a)(1). Any further changes that are not generally agreed or improve safety will require to be introduced under a new rulemaking task.	

comment	*2058*	comment by: *Dr Ron Pearson*
	This section, specifically MED.A.045(a)(2) is a return to the ICAO generic regulation that was specifically addressed by the development of JAR-FCL Pt 3, because each country had developed their own interpretation of "accredited medical conclusion(opinion). It would appear that after more than ten years of comparatively stable interpretation of the JAR, a return to national standards is proposed. This will lead to "medical tourism" of marginal cases as the AMC's can still only be advisory. I see no method of assessing alternate means of compliance or reference to the level of acceptable risk. There is also no means of appeal proposed - a formal medical review is always preferable to decisions made through the courts.	
response	*Noted*	
	We believe that ICAO term "accredited medical conclusion", which is used by all ICAO Member States, provides at least the same harmonisation possibilities as JAA term "at the discretion of AMS".	

	The risk assessment will be included in the Guidance Material of Part MED after review and amendments to the JAR-FCL text. This wil be included in the rulemaking task MED.001. Requirements with regards to the appeals are proposed in NPA 2008-22b "Authority Requirements".

comment	*2086*	comment by: *Royal Swedish Aeroclub*
	KSAK support the longer periods between renewals of a medical license for LPL	
response	*Noted*	
	Thank you for the positive comment.	

comment	*2110*	comment by: *Light Aircraft Association UK*
	AMC should be created to describe the limitation codes in greater detail and include the codes given in JAR-FCL 3. In addition, any AME/GMP may impose a limitation and also remove a limitation when a condition has passed.	
response	*Noted*	
	See responses to the comments No 120 and 331.	

comment	*2140*	comment by: *AMS Denmark*
	(a) The AeMC or AME shall refer all cases that requires a limitation (except for RXO, VDL, VML, VNL, TML) to the authority. (b) delete	
response	*Noted*	
	See comment to the response No 120 of this section. The text of MED.A.045 (b) will also be amended.	

comment	*2176*	comment by: *Dr.Piek Armin*
	Because the GMP cannot judge the medical fitness of a pilot - he has no special training - so it is necessary that all pilots only have to contact AeMC's or AME's	
response	*Not accepted*	
	The ICAO SARPs require that medical fitness of pilots is assessed by an AME. However, the Basic Regulation provides the possibility of a GMP to assess the medical fitness for a LAPL applicant /holder if permitted under national law.	

comment	*2199*	comment by: *Royal Netherlands Aeronautical Association*
	MED.A.045 Limiitations to medical certificates	

	Appeal An appeal by the pilot against denial or a limitation to independent expertise must be possible and this has **not** been specified. For the air sports where the necessary expertise does not exist in national authorities, suitably experienced doctors can be appointed to act as advisers on behalf of the authority. KNVvL PROPOSAL: -Appeals must be possible. -Suitably experienced doctors, AMEs and air sport qualified doctors should be nominated by National Aero Clubs to act as advisers on behalf of the authority.
response	*Noted*
	In MED.A.050 (b)(3) there is an obligation of AeMC, AME and GMP if the applicant has been assessed as unfit, inform them of their right of appeal to the licensing authority. Requirements with regards to the appeals are proposed in NPA 2008-22b "Authority Requirements". It is not clear the meaning of "suitably experienced and air sport qualified doctors". AMEs are already qualified and experienced to perform aeromedical examinations and additional aeromedical qualification will be confusing. For decision of the aeromedical fitness in case of referral to the licensing authority the licensing authority shall have one or more medical assessors. Qualification of the medical assessor shall be sufficient for these tasks and is proposed in NPA 2008-22b "Authority Requirements".

comment	*2242*	comment by: *Aki Kylamaa*
	MED.A.045 Current JAA regulations do not allow to work as flight instructor in commercial flight school with class 2 medical certificate. Nowadays there is not enought flight instructor available. Many retired commercial pilots would like to work as flight instructor in commercial flight schools. If these persons can't renew their class 1 medical certificate, they can't work anymore in commercial flight schools. Some of these pilots could get class 2 medical certificate. Many ICAO contracting states allow flight instructors to work in commercial flight schools with class 2 or class 3 medical certificate. In USA flight instructors can work with FAA class 3 medical certificate. There should be requirement which allow pilots with flight instructor rating to work as flight instructor in commercial flight schools with class 2 medical certificate.	
response	*Not accepted*	
	A flight instructor needs to hold at least the licence for which he is giving instruction. He also needs to hold the corresponding medical certificate. The type of training organisation has no implication on the privileges of the instructor.	

	Synthetic flight instructors do not need a medical certificate. Otherwise a Class 1 medical certificate is required for instruction towards a commercial licence. Also see Part FCL 915

comment	*2260*	comment by: *LSG Erbsloeh*
	Seit Einführung des Faches Human Factors unterrichte ich als pensionierter Arzt und leidenschaftlicher Segelflieger Flugschüler und Fluglehrer ehrenamtlich im Verein. Aus meinen Erfahrungen resultiert, dass ein Medical unterhalb der Klasse 2 ausreicht. Wiederholungsinterwalle der ärztlichen Untersuchungen können auch bei Älteren in größeren Zeitanständen (z. B. in 5 Jahresabständen) ohne weiters erfolgen. Zu befürworten ist die Vereinfachung im Rahmen der hausärztlichen Kontrolle, wo alle Unterlagen zu Verfügung stehen. Dies erleichtert den Einstieg in den Luftsport, verhindert hohe Kosten und aufwendige Administrationen.	
response	*Noted*	
	The proposed LAPL medical requirements seem to be in line with your proposal.	

comment	*2270*	comment by: *Ingo Wiebelitz*
	MED.A.045 (b) AeMC und AME sollen für die Flugtauglichkeit des LPL medical certificate NICHT zuständig sein. Der GMP soll zusammen mit dem Piloten eine Lösung finden!	
response	*Noted*	
	See response to comment No 120 of this segment.	

comment	*2303*	comment by: *AMS CAA - Hungary*
	If the AeMC or AME, is not able to issue the medical, or is in doubt, they should not deny, but deferto the licencing authority final decision.	
response	*Noted*	
	AeMC or AME can refer borderline cases to the licensing authority as it is proposed in AMC to MED.A.045.	

comment	*2315*	comment by: *AMS CAA - Hungary*
	Add a new e) point as: Limitation's except related only to the use of corrective lenses should be removed by the Aeromedical Section of the licensing authority	
response	*Noted*	

	See response to comment No 120 of this segment.

comment	*2372*	comment by: *Paul Mc G*
	General pracitiioners have often seen patients (pilots) over many years and often have detailed knowledge of patients which may not be ascertained through a reading of medical notes and short examination with an AME. Surely the local GP is at least a first port of call and the AME will only be needed if there is a possible problem needing referal. This reduces costs for gliders and motor gliders within the local National systems - where international circumstances arise then the need for a europe wide and eventually world wide medical and licencing systems will be needed and in this it is possible to see where EASA is going but in this you could destroy the EU gliding systems and the EU glider industry as so few people would. Obviously the sitaution for power pilots differs and this is understood but the effects on low cost flying such as gliding and class D will be rather worrying.	
response	*Noted*	
	SPL is a licence for private flying and requires to hold Class 2 medical certificate. This is also an ICAO standard: refer, please, to ICAO Annex 1, Section 2.9. Glider pilot licence, paragraph "2.9.1.5: An applicant shall hold a current Class 2 Medical Assessment." The Basic Regulation provides the possibility of a GMP to assess the medical fitness for a LPL applicant /holder if permitted under national law.	

comment	*2387*	comment by: *Irish Aviation Authority*
	(a)(1)(i) Pilots with medical conditions that have not changed need not to be referred to the authority. Justification: The authority needs to be involved only with certificate issue in these circumstances if the condition has changed. Proposed text: Add to MED.A.045 (a) (1) (i) :The medical certificate with the same limitation may be re-issued by an AeMC or AME without referring the applicant to the authority.	
response	*Noted*	
	See response to comment No 61.	

comment	*2388*	comment by: *Irish Aviation Authority*
	(a)(2)(i) Accredited medical opinion is not defined and is not appropriate to use instead of the accepted ICAO phrase.	

	Justification: Accredited medical opinion is no ICAO term. Proposed text: Do change 'Accredited medical opinion' to 'Accredited medical **conclusion**'.
response	*Noted*
	See response to comment No 242.

comment	*2389*	comment by: *Irish Aviation Authority*
	(a)(2)(i) For an accredited medical conclusion the involvement of one or more medical experts is required. Justification: The current text is not ICAO compliant. The AME cannot undertake an accredited medical conclusion and limitations (other than corrective lenses) should be imposed and removed by the authority. This will improve standardisation across the Member States, in accordance with the principle of equity. Proposed text: MED.A.045 (a): add (a) (3) **'The AeMC or AME shall refer all cases that may require to have a limitation imposed for the first time or to have a limitation removed, other than for corrective lenses, to the authority.'**	
response	*Noted*	
	See response to comment No 120 of this segment.	

comment	*2390*	comment by: *Irish Aviation Authority*
	(c)(3) and (4) The SSL limitation is not the same as the current JAR. The SIC limitation is not the same as current JAR. A code would be needed for (c) 4. Justification: There will be quite some confusion and potential flight safety implications when the limitation codes would be changed from those which all JAA states are now using under JAR FCL 3. Codes are needed for standardisation. Proposed text: (c) (3) (iv): '~~of operation~~ (SSL)'. (c) (3) (vii): Change the description of SIC to **'special instructions apply – contact the licensing authority'**. (4) – Use code after the sentence '**(SSL)**'.	
response	*Noted*	

	See response to comment No 331.

comment	*2458*	comment by: *Paul Mc G*
	Any AME/GMP may impose a limitation and also remove a limitation when a condition has passed, which covers most eventualities	
response	*Not accepted*	
	See response to comment No 120 of this segment.	

comment	*2469*	comment by: *Civil Aviation Authority Finland*
	MED.A.045 (a) (2) (i) "Accredited medical conclusion" requires the involvement of one or more medical experts. The current text is not ICAO compliant. The AME cannot undertake an accredited medical conclusion and limitations (other than corrective lenses) should be imposed and removed by the Authority. This will assist with standardisation across the Member States, in accordance with the principle of equity. MED.A.045 (a): add (a) (3) **The AeMC or AME shall refer all cases, that may require a limitation to be imposed for the first time or removed, other than for corrective lenses, to the Authority.**	
response	*Noted*	
	See response to comment No 120 of this segment.	

comment	*2579*	comment by: *UK General Aviation Alliance*
	A pilot’s age should not be used as a reason to curtail licence privileges if they are able to hold the required medical certification.	
response	*Noted*	
	This is medical and statistical fact that human performance declines with the age. There are only limitations for commercial pilots which are directly related to the age of the applicant - multi-pilot limitation when they reach the age of 60 and no commercail air transport operations after the age of 65. This is based on statistically proven facts that the possibility of a sudden incapacitating cardiovascular event after the age of 60 exceeds 1 percent per year and is still higher after the age of 65. There are no other statistically proven limitations related to the pilot's age.	

C. Draft Opinion Part-MED — Subpart A: General Requirements — Section 2: Issuance, revalidation and renewal of medical certificates — MED.A.050: Obligations of AeMC, AME and GMP p. 6-7

comment	74	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **AMC to Med A050 c) section 2** **Page**: 2 Relevant Text: ... shall transfer relevant medical documentation to the licensing authority.. **Comment**: Medical confidentiality is not insured **Proposal**: ...shall transfer..... to an AME class I or AMC, named by the licensing authority	
response	*Not accepted*	
	Medical confidentiality shall be respected at all times and by all persons involved in medical examination. This requirement is proposed in MED.A 015. Licensing authorities shall meet this requirement and for this reason shall use services of the medical assessors. Medical assessors shall be licensed and qualified in medicine and have aeromedical advanced training and experience as proposed in NPA 2008-22b Authority Requirements Subpart MED Section 1 AR.MED.020. Requirements related to the medical record keeping and availability are proposed in the paragraph AR.MED.120 of same section. Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data provides with the possibility to tranfer and process medical data in following articles: Article 1 Object of the Directive 1. In accordance with this Directive, Member States shall protect the fundamental rights and freedoms of natural persons, and in particular their right to privacy with respect to the processing of personal data. 2. Member States shall neither restrict nor prohibit the free flow of personal data between Member States for reasons connected with the protection afforded under paragraph 1. Article 8 The processing of special categories of data 1. Member States shall prohibit the processing of personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, trade-union membership, and the processing of data concerning health or sex life. 2. Paragraph 1 shall not apply where: (a) the data subject has given his explicit consent to the processing of those data, except where the laws of the Member State provide that the prohibition referred to in paragraph 1 may not be lifted by the data subject's giving his consent; or... 3. Paragraph 1 shall not apply where processing of the data is required for the purposes of preventive medicine, medical diagnosis, the provision of care or treatment or the management of health-care services, and where those data are processed by a health professional subject under national law or rules established by national competent bodies to the obligation of professional secrecy or by	

another person also subject to an equivalent obligation of secrecy.

For this reason the Agency will propose in AMC an application form based on corresponding JAR application form already harmonised and used by all mutually recognised Member States. Applicant's consent to relase medical information will be transposed together with the authorisation for the examining physician to request medical information for the aeromedical assessment.

comment | *95* | comment by: *British Gliding Association*

Page 7 of 66
MED.A.050 Obligations of AeMC, AME and GMP
(e) Upon request by the competent authority, AeMC, AMEs and GMP shall submit to the competent authority all aeromedical records and reports, and any other information, as required for oversight activities.
Comment: This provision appears contrary to the European Directive on data protection and to normal medical ethics. While AMEs are recognised as agents of the Authority, GMP's are unlikely to open their medical records collected for clinical purposes to the authority. It removes any possibility of co-operation by GMPs and is also unnecessary.
BGA Proposal: That MED.A.050 (e) be deleted.
Reference: Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995.

response | *Partially accepted*

MED.A.050 (e) will be amended to clarify that medical information should be requested only when needed for the purpose of oversight of GMPs, AMEs and AeMCs, and that the medical information needed in those cases shall be sent to the medical assessor of the competent authority in order to observe medical confidentiality.

See also response to comment No 74.

comment | *122* | comment by: *Civil Aviation Authority - The Netherlands*

MED.A. 050, onder e. (Blz. 7 van 66)

Volgens MED.A.050 moeten op verzoek van de CAA-The Netherlands, ten behoeve van toezicht de GMPS, AeMC en de AME medische dossiers overleggen.
Echter, in Nederland bestaat het medisch beroepsgeheim, hetgeen betekent dat de desbetreffende arts in beginsel een medisch dossier aan niemand zal verstrekken, zelfs niet aan een andere arts.
Hierdoor kan onder de huidige Nederlandse wet- en regelgeving de toepassing van MED.A.050, onder e, geen doorgang vinden. De CAA-The Netherlands is niet voornemens haar wet- en regelgeving op dit punt aan te passen. EASA stelt de aanwezigheid van een arts bij de autoriteiten niet verplicht. De vraag kan gesteld worden of het overleggen van medische dossiers door een arts aan medewerker van de desbetreffende luchtvaartautoriteit (geen arts) überhaupt mogelijk is. Wie, anders dan een arts, zou bij de autoriteit de vertrouwelijke behandeling van het medisch dossier moeten garanderen?

response	*Noted*
	See responses to the comments No 74 and 95 of this segment.

comment	*184*	comment by: *Bernhard Blasen*
	sentence (c): Medical documentation must not be transferred to the licensing authority. Only the result of the examination may be reported due to data protection reasons. Detailled medical issues are to be kept secret between the examiner and the pilot. sentence (e): It is clearly illegal if aeromedical records and reports are forwarded to any authority without explicit permission by the pilot. There is no need to give these information to anybody eccept the GMP, AME or AMC. There is a clear hirarchy in AMC,AME and GMP. No civil authority knows more about the pilot than theese ficilities do! Personal data protection is a very high value. Examples all over Europe prove that abuse of data takes place very often. Therefore the personal data records must be kept within the examiner's files. No outstanding person has the right to inspect those records without explicit permit of the pilot. There is no need for a mandatory transfer or a transfer "on request".	
response	*Noted*	
	See responses to the comments No 74 and 95 of this segment.	

comment	*332*	comment by: *FOCA Switzerland*
	MED.A.050 Make sure, that also electronic transmittal is possible Proposed text: **(4) submit without delay a signed or electronically authentified report to include**...	
response	*Partially accepted*	
	Thank you for the proposal. The text will be amended in an AMC to reflect that "signed" also will include signatures made electronically. See also response to comment No 328 on MED.A.035.	

comment	*350*	comment by: *Teh Danish Organiation of Flight Surgeons (DAFLO)*
	Objection: Disagree **Reasons:** Not every GMP can be expected to posses sufficiently amount of aeromedical knowledge to deliver proper instruction concerning limitations to a medical certificate. **Suggestions:** GMP is deleted from text.	

response	*Not accepted*
	The Basic Regulation (Article 7) allows a GMP to issue a medical certificate for a LPL licence (if permitted under national law). This has to be taken into account in the implementing rules.

comment	*415*	comment by: *UK CAA*
	MED.A.050 (b) (1) **Comment:** GMPs may not necessarily refer to the Licensing Authority **Justification:** GMPs may refer to an AME or AeMC as per MED.A.045 (b) **Proposed Text:** Delete 'to the licensing authority'.	
response	*Partially accepted*	
	The text will be amended to include referral also to AME and AeMC, but a referral directly to the licensing authority will also be possible.	

comment	*416*	comment by: *UK CAA*
	MED.A.050 (b) (4) **Comment:** Not compatible with electronic submission of reports. **Justification:** Administrative facilitation and cost efficiency. With electronic submission of reports and data directly to the authority it is sufficient to require verification of the examiner and applicant using passwords and/or security tokens. If the authority has an electronic system it can ascertain what data has been input by the examiner and the information that has been printed on the medical certificate. Submission of hard copy reports and certificates is superfluous and inefficient. **Proposed Text:** Delete 'signed'.	
response	*Noted*	
	See response to comment No 332.	

comment	*520*	comment by: *British Microlight Aircraft Association*
	Accepted	
response	*Noted*	

	Thank you for the positive comment.

comment	*574*	comment by: *Florian Söhn*
	to c: Medical date should not be transmitted to the lincencing authory, as the "Schweigepflicht" is not ensured. Transmission of medical data to othter medical personal is ok. PRtectiojn of medical data should have absolute priority.	
response	*Noted*	
	See responses to the comments No 74 and 95 of this segment. The medical data will be tranferred to the medical assessor of the competent authority. Please see ICAO definition of Medical Assessor: A physician, appoined by the Licensing Authority, qualified and experienced in the practive of aviation medicine and competent in evaluating and assessing medical conditions of flight safety significance. Note 1. -Medical assessors evaluate medical reports submitted to the Licensing Authority by medical examiners.	

comment	*587*	comment by: *Lufthansa German Airlines*
	Author: : Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany Head of Lufthansa Medical Services Head of German Academy of Aviation and Travel Medicine Section: **2** **MED .A. 050 Obligations of AeMC, AME and GMP** (a) (2) **Page**: 6 Relevant Text: When conducting medical examinations and assessments, AeMC, AME and GMP shall: (2) make the applicant **aware of the consequences** of providing incomplete, inaccurate or false statements on their medical history **Comment**: In Germany the prevailing case law of the highest court does pilots allow to give inaccurate or false statements because nobody needs or can be forced to accuse himself. What are the consequences if pilots follow their right in Germany. Will EASA implement an overruling European law that makes punishment possible. See FAA, which can punish pilots with thousands of dollar, if they make false declarations. We need this too in Europe. Otherwise it is senseless to make pilots aware of consequences, if there are none. **Proposal**: Implement equal consequences in all EASA member states and overrule national law. If this is not possible, create better medical standards, which those EASA member states have to follow, where false statements by pilots are allowed. In these cases the AME has to find out by more intensive medical investigation, what might be hidden by the pilot.	

response	*Noted*
	Our proposal contains Community law which is superior to the national law. The issue is is covered in NPA 2008-22b Subpart MED Section 2 para AR.MED.250 (a)(4) and (5).

comment	*588*	comment by: *Lufthansa German Airlines*
	Author: : Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany Head of Lufthansa Medical Services Head of German Academy of Aviation and Travel Medicine Section: **2** **MED .A. 050 Obligations of AeMC, AME and GMP** (b) (3) **Page**: 7 Relevant Text: if the applicant has been assessed as unfit, inform them of their right of appeal to the licensing authority **Comment**: In class 1 medical assessment, many medical problems have to be referred to the licensing authority, where the assessment will be done.(see comment No. 9) If the licensing authority comes to an unfit decision , the pilot has to appeal at the same institution which made the unfit decision! That cannot be the right way to come to an objective independent decision. Pilots who are in this situation will be forced to go directly to court. **Proposal**: Implement a process **of first and second review** or **a board of medical experts** which pilots can use if they feel an unfair treatment or assessment of their medical problem by the competent authority/ licensing authority.	
response	*Noted*	
	MED.A.050 deals with the obligation for an AeMC, AME or GMP to inform applicants which they have assessed as unfit of their right to appeal to a higher level, i.e. the licensing authority. The right to appeal decisions made by the licensing authority is covered in NPA 2008-22b Subpart MED Section 3.	

comment	*639*	comment by: *Alexander Ciliox*
	med a50 e: (Freie) Sammlung der Untersuchungsdaten bei der competent authority ist unzulässig im Sinne der Europäischen Datenschutzbestimmungen. Im Zeiter immer schneller Vernetzung ist die Sammlund sensibler DAten kritisch. Zumal hierdurch kein Sicherheitsgewinn erreicht wird. Falls soch Daten übermittelt werden,müssen diese genaustes spezifiziert sein. Eine Mittelung über den Befund der Untersuchungsstelle ist absolut ausreichend.	

response	*Noted*
	See response to comment No 95 of this segment.

comment	*643*	comment by: *Royal Danish Aeroclub*
	MED.A.050(b)(3): the text say: "if the applicant has been assessed as unfit, inform them of their right of appeal to the licensing authority;" To whom could one appeal if assessed as unfit. The licensing authority is hardly independent. We suggest to change the text to the following: "if the applicant has been assessed as unfit, inform them of their right of appeal to an independent authority".	
response	*Noted*	
	See response to comment No 588 of this segment.	

comment	*657*	comment by: *ERA*
	MED.A.045 Limitations to medical certificates ERA members feel that sub-paragraph (i) to (c) Limitaion codes paragraph (1) Operational multi-pilot limitation [OML], should clarify the statement '*....*, *when the other pilot is fully qualified....*' that "fully qualified" means PIC -pilot in command and that the last line '.... ,*is not subject to an OML...'* for the same medical reason.	
response	*Not accepted*	
	The purpose of the operational multi-pilot limitation is to ensure that the second pilot will take over the control of the aircraft in the case of the sudden incapacitation of another pilot. Therefore, there is enough to mention in Part Medical that the other pilot is qualified to take over the control.	

comment	*682*	comment by: *Tjeerd Mulder*
	MED.A.050: (e) Upon request by the competent authorithy etc ... Comment: The wording of (e) does not require the competent authority to supply any reason for its request. I think this is not acceptable. Reference: EU Directive 95/46/EC. Furthermore recent events where people representing authorities have lost or forgotten USB sticks and notebooks holding unencrypted sensitive personal data in taxis and trains have clearly shown that the authorities can not always be trusted to treat sensitive data with the apropriate care. Proposal: MED.A.050 (e) be deleted.	

response	*Noted*
	See response to comment No 95.

comment	*691*	comment by: *Robert Cronk*
	MED.A.050 (e). GMPs are not likely to be able to release clinical details, and as such, this provision would prevent their involvement. I suggest the inclusion of GMPs in this is deleted.	
response	*Noted*	
	The Basic Regulation allows a GMP to "...act as an aeromedical examiner..." which includes the obligation to submit to the authority all aeromedical records. When GMPs declare their activity as an AME for LAPL applicants to the competent authority, as it is specified in MED.D.001, this is a legal basis for the authority to include them in the oversight program. See also responses to the comments No 74 and 95 of this segment.	

comment	*697*	comment by: *Pekka Oksanen*
	Comment: How does the Authority supervise the GMPS? Proposal: ~~Upon request by the competent authority,~~ **AeMC, AMEs and GMP shall submit ...**	
response	*Noted*	
	When GMPs declare their activity as an AME for LPL applicants to the competent authority, as it is specified in MED.D.001, this is a legal basis for the authority to include them in the oversight program. See also responses to comments No 74 and 95 of this segment.	

comment	*792*	comment by: *Swiss Association of Aviation Medecine*
	Comment: In class 1 medical assessment, many medical problems have to be referred to the licensing authority, where the assessment will be done. If the licensing authority comes to an unfit decision , the pilot has **to appeal at the same institution which made the unfit decision!** That cannot be the right way to come to an objective independent decision. Pilots who are in this situation will be forced to go directly to court. **Proposal:** Implement a process **of first and second review** or **a board of medical experts** which pilots can use if they feel an unfair treatment or assessment of their medical problem by the competent authority/ licensing authority.	
response	*Noted*	
	See response to comment No 588 of this segment.	

comment	967	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: 1
General
MED. A . 015 - Medical confidentiality -
MED. A. 050 - Obligations of AeMC, AME and GMP 4c- d - e

Page: 4; 6; 7

Comment:
The competent authority or the licensing authority in the EASA member states normally are not medical doctors. Due to national personal data protection laws and EU Directive 95/46/EC on the protection of personal data, it is not allowed for AME´s and GP´s in most of the EASA member states to submit personal medical data (e.g. medical application form with family history and medical data not only from the pilot but also from his/her relatives) to an organisation where non medical personal has access to these data.
Medical confidentiality should be better defined here as it is done in the AMC to Med.A.015.
For compliance with ICAO requirements of Annex 1

1.2.4.6 Having completed the medical examination of the applicant in accordance with Chapter 6, the medical examiner shall coordinate the results of the examination and submit a signed report, or equivalent, to the Licensing Authority, in accordance with its requirements, detailing the results of the examination and evaluating the findings with regard to medical fitness.

this paragraph should contain information to whom medical information should be available. In most countries this procedure is respected.
In the countries like Germany, where the transmission of medical data is forbidden the information could be limited to the statement of fitness or unfitness of the pilot that is also the result of examination.

Proposal:
All persons involved in medical examinations, assessment and certification shall ensure that medical confidentiality is respected at all times.
All medical records in hard copies or electronically stored should be securely held with accessibility restricted to authorised medical personnel.

The results of medical examinations shall be submitted to the medical service of the competent authority.
In EASA member states where medical confidentiality cannot be guaranteed on all administration levels all personal medical data of pilots shall be stored by AeMC´s , AME´s and GP`s and only the fit or unfit result of the medical investigation shall be transmitted to the licensing authority. Upon request by the competent authority AeMCs, AMEs and GMPs shall submit medical files, reports and any other medical data as required in an anonymous form to the authorized

	medical doctor of the competent authority for oversight.
response	*Noted*
	See responses to the comments No 74 and 95 of this segment. Your proposal is covered in MED.A.015 and in the paragraph AR.MED.120 of Part Authority Requirments as well as in MED.A 050(b), (d) and (e).

comment	*981*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: 2
MED .A. 050 Obligations of AeMC, AME and GMP
(b) (3)

Page: 6

Relevant Text:
if the applicant has been assessed as unfit, inform them of their right of appeal to the licensing authority

Comment:
In class 1 medical assessment, many medical problems have to be referred to the licensing authority, where the assessment will be done.
If the licensing authority comes to an unfit decission , the pilot has **to appeal at the same institution which made the unfit decision!**
That cannot be the right way to come to an objective independent decision. Pilots who are in this situation will be forced to go directly to court.

Proposal:
Implement a process **of first and second review** or **a board of medical experts** which pilots can use if they feel an unfair treatment or assessment of their medical problem by the competent authority/ licensing authority.

response	*Noted*
	See response to comment No 588 of this segment.

comment	*1090*	comment by: *Regierung von Oberbayern-Luftamt Südbayern*

Hier wird Bezug genommen auf unsere Anmerkungen zu MED.A.030.

Eine Einbindung der lizenzierenden Behörde in die medizinischen Fachfragen wird für verfehlt gehalten. Diese sollte abschließend den AeMC, AME bzw. GMP überlassen werden.

response	*Noted*

	See responses to the comments No 74 and 95 of this segment.

comment	*1105*	comment by: *George Knight*
	(e) Upon request by the competent authority, AeMC, AMEs and GMP shall submit to the competent authority all aeromedical records and reports, and any other information, as required for oversight activities. Comment This seems to be excessive and probably illegal under hunman rights and data protection laws.	
response	*Noted*	
	See response to comment No 95.	

comment	*1117*	comment by: *BALPA*
	MED.A.045 Limitations to medical certificates (c) Limitation codes (1) Operational multipilot limitation (OML) (i) The holder of a medical certificate with an OML limitation shall only operate an aircraft in multipilot operations, when the other pilot is fully qualified on the relevant type of aircraft, is not subject to an OML and is not more than 60 years of age. (ii) When the holder of a CPL or an ATPL has been referred to the licensing authority, it shall assess whether the medical certificate may be issued with a limitation to be used only in the context of a multipilot environment. (iii) The OML for class 1 medical certificates shall only be imposed and removed by the licensing authority. *There should be no additional restriction on 2 OML-restricted pilots operating together. This has been position in the UK for many years without any resulting adverse impact on flight safety.* *Furthermore, the statistical risk of dual pilot incapacitation is less than the accepted risk of dual engine failure in ETOPS operations. We should not require higher reliability for pilots when compared to any other accepted risk in flight safety.* *Suggested replacement text:* (i) The holder of a medical certificate with an OML limitation shall only operate an aircraft in multipilot operations, when the other pilot is fully qualified on the relevant type of aircraft and is not more than 60 years of age.	
response	*Not accepted*	
	The issue of the two OMLs flying together was discussed by JAA Licensing Sub-Sectorial Team (Medical) and was rejected. The assessment of this problem could	

	not be purely mathematical. Individual circumstances should be taken into account. Medical requirements of proposed in NPA 2008-17c were prepared by a rulemaking drafting group consisting of the representatives of National Aviation Authorities, industry and general aviation. Following proposals of the group, Class 1 medical requirements are in line with JAR FCL 3 where the possibility of two OMLs flying together was not accepted.

comment	*1146*	comment by: *Keith WHITE*
	045 (b). Some 50% of the population will have to be referred because of non-compliance with eyesight requirements, which are routinely corrected by the use of spectacles. It should not be necessary for the GMP to refer the applicant for an LPL(S) or an SPL in cases where the requirements for a non-commercial driving licence are met for an applicant not wishing to undertake instruction or passenger flying. See UK BGA rules. **Develop suitable rules for LPL(S) ans SPL applicants with the national gliding authorities.**	
response	*Noted*	
	SPL is a licence for private flying and requires holding class 2 medical certificate. This is also an ICAO standard: refer, please, to ICAO Annex 1, Section 2.9. Glider pilot licence, paragraph "2.9.1.5: An applicant shall hold a current Class 2 Medical Assessment." The medical requirements for the LAPL, including LAPL(S) provide pilots with the option of a less stringent medical certificate.	

comment	*1147*	comment by: *Keith WHITE*
	050 (d). In order to be not too burdensome, for an SPL or LPL(S) where the examination is done by a GMP, the **record should be part of the applicant's medical record only.** (e) The requirement to submit "any other information" must be limited to be at the widest **'relevant'** information. It is far too wide ranging a power to allow "any information" to be collected, especially from a GMP who might have private information which is of no relevance to an investigation. Also, **AeMC and GMP need to be in plural**.	
response	*Partially accepted*	
	The scope of the requirements proposed in Part Medical is limited to the aeromedical issues as it is stated in MED.A.005. As a consequence, the requirement to submit information is limited to the medical information which is important for aeromedical decisionmaking. There is no need in repeating this principle in each paragraph. See also responses to the comments No 74 and 95 of this segment. Your comment to use the plural forms will be considered.	

comment	1174	comment by: FAI
	(CIMP) Page 6 of 66 A special difficulty is likely to arise with medical confidentiality. NPA 17c MED.A.050(e) (3) requires that 'on request by the competent authority, AeMC, AMEs and GMP shall submit to the competent authority all aeromedical records and reports and any other information as required for oversight activities'. This open access is contrary to both the EU Directive (15) on data protection and conventional medial ethics. Few GMPs will be prepared to cooperate with the issue of LPL medical certificates if this remains a condition. It is also unnecessary, because where evidence of fraudulent activity exists; that can be supplied to the police who have powers of investigation under criminal law. **CIMP CONCLUSION** **-Medical records are confidential and should not be open to routine inspection, whether held by AME or GMP.** References: 3. EASA NPA 2008-17c Part-Medical 15. Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data	
response	*Noted*	
	See response to comment No 95.	

comment	1208	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Comment: The instructions given in MED.A.050 (a) are appreciated.	
response	*Noted*	
	Thank you for the positive comment.	

comment	1209	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.050 (b)(4) [and consequently AMC to MED.A.050, para 1] **Comment**: It is not sufficient that the signed report only includes the assessment result, the results of the examination and the evaluation of the findings. According to ICAO Annex 1, the medical history of the applicant shall be signed (see also MED.A.035) by the applicant. This medical history with the signature of the applicant must also be included for legal purposes. It is impossible to take any legal action against false declarations compromising flight safety unless the applicant has submitted a signed report of his/her medical history.	

	Proposal: The text of MED.A.050 (b)(4) [or AMC to MED.A.050, para 1] should be amended: "... a signed report to include the medical history signed by the applicant and the assessment result ..."
response	*Partially accepted*
	Legal action in the case of the false declaration of medical history facts is ensured by MED.A.035 (b), MED.A.040 (a) and MED.A.065 (a). To ensure better consistency with those paragraphs MED.A.050 is proposed to be amended to read "a signed full report".

comment	*1210*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Comment: This paragraph (b) is only related to the obligations of AeMC, AME and GMP when performing a routine aeromedical examination. Any other situation between the aeromedical examinations, e.g. when AeMC, AME or GMP will be addressed by a holder of a medical certificate as required in MED.A.025 and MED.A.060, is not covered by the regulation. As proposed for a LPL medical certificate, there might be 30 years between the initial and the next examination, without any obligation for the addressed physician how to act. This should be corrected. **Proposal**: Amend the obligations in MED.A.050 (b) to also include assessments between the routine aeromedical examinations.	
response	*Partially accepted*	
	Your described situation is the decrease in medical fitness during medical certificate validity period. Requirements with regards to this situation are proposed in AMC to MED.A.025 and MED.A.060. For the purpose of clarity amendments will be made to MED.A.060 and AMC to MED.A.025.	

comment	*1295*	comment by: *David Chapman*
	For the LPL, the GMP should be expected to understand and apply the fitness criteria for the medical assessment correctly, and provide a final signed/authorised report to the applicant, probably at the end of a face-to-face assessment appointment. The GMP should be expected to maintain a record for thier file. The GMP should not be expected to send a copy to the Licencing Authority if the applicant will do that task. For part (e) the GMP should not be expected to maintain some "All Pilots Licencing" file system. Any cross check coming from the Licencing authority should reference the Patient(s) and the Medical Document(s) previously submitted, with request for additonal information as appropriate.	
response	*Noted*	

	Thank you for your positive comment on the GMP examination for LAPL. See also responses to comments No 74 and 95 of this segment.

comment	*1304*	comment by: *Oxytrans*
	MED A.050 4c - d - e Comment: The transfer of medical data to an organisation where non medical personal has access to these data ist in some countries like Germany forbidden by law. Proposal: The result of medical examinations shall be submitted to the medical service of the competent authority. In EASA member states where medical confidentiality cannot be guaranteed on all administration levels all personal medical data of pilots and applicants shall be stored by AeMC's AME's and Gp's. Only the fit or unfit result of the medical investigation shall be transmittedto to the licensing authority. On request by the competent authority AeMCs, AMEs and GMPs shall submit medical files, reports and any other medical data as required in an anonymous form to the authorized medical doctor of the competent authority for oversight.	
response	*Noted*	
	See responses to the comments No 74, 95, and 967.	

comment	*1309*	comment by: *RP Kassel*
	In case of unfit the applicant has a right to apply to the licensing authority. It's not defined, on what terms the authority has to decide. JAR-FCL 3 (German) currently regulates that the applicant in case of unfit can turn to an AME Class 1 (unfit Class 2) or an AeMC (unfit Class 1). This scheme is useful, because it helps to avoid many administrative procedures.	
response	*Noted*	
	The issue is covered in NPA 2008-22b Subpart MED Section 3.	

comment	*1317*	comment by: *Vincent EARL*
	Part (e) General Practitioners are unlikely to release details of a patient's medical history to the Authority without the consent of the patient (Pilot). In order to ensure that GMPs are not excluded by stealth from providing the service that the Authority seeks, I propose that section (e) of this requirement be deleted.	
response	*Noted*	
	See response to comment No 95.	

comment	1325	comment by: Markus Hitter / JAR-Contra
	Deutsch: (english below) Dies ist geradezu ein Aufruf an die Competent Authorities, freizügig vertrauliche Daten der Lizenzinhaber zu sammeln und damit entgegen den europäischen Datenschutzbestimmungen zu handeln. Die Art der zu übertragenden Daten und deren Verwendungszweck sollten genau spezifiziert sein und dem datenschutzrechtlichen Schutzbedürfnis der Piloten Rechnung tragen. Eine Übertragung von Daten zu statistischen Zwecken sollte untersagt bleiben. - - - **English:** This is almost an invocation to competent authorities to generously collect confidential data about licence holders and thus acting against european data privacy rules. The type and destination of data to be transferred should be described exactly to accomodate with pilots data safety exigences. Transferral of data for the purpose of statistics should be forbidden.	
response	*Noted*	
	See responses to the comments No 74 and 95 of this segment.	

comment	1415	comment by: Dr. med. Michael Glaesner
	Commentary on proposed changes in Light Aircraft Pilot's Licences Medical issuance Judging from my 20-years experience as an AME practitioneer, it is evident that lowering the qualification requirements for LPL medicals in the sense that every general practitioner can issue them will result in a significantly increased number of (deadly) flight accidents. A mayor contributing factor in that development lies in the aging of a big share of active lisence holders. Unfortunately, only few general practitioners are able to distinguish between the nessesary physical and psychological abilities required for driving a car in city trafic versus navigating a 250 km/h fast Cessna with three passengers in the proximity of Frankfurt International Airport. Drawing from my own experience, in 2008 I had to refuse a Medical for a moronic motor pilot and for a flight instructor. The flight instructor had a heart attack with reanimation and sufferd from an anoxic brain damage and has lost all his knowledge on radio message communication. I am sure that both pilots would have obtained their Medical from their entrusted general practioner. I strongly recommend to hold on to the established Medical system and its experince over decades to maintain the safety of future airtraffic. Dr. med. Michael Glaesner, AME I+II, internist, diabetologist, expert for traffic medicine	
response	*Noted*	
	The Basic Regulation (Article 7) allows a GMP to issue a medical certificate for a LAPL licence (if permitted under national law). This has to be taken into account	

	in the implementing rules. As a result of comments received, the provisions for a GMP to issue LAPL medical certificates as well as the medical requirements for LAPL will be amended.

comment	*1470*	comment by: *Trevor Wilcock*
	MED.A.050 p7: while the need to transfer information from GMPs under the circumstances of sub-para c) are understood, the proposal under sub-para e) would appear to breach normal medical ethics and data confidentiality.	
response	*Noted*	
	See response to comment No 95.	

comment	*1545*	comment by: *British Airways*
	Comment: Para (b) (3) Is this an appeal to the national authority or to EASA and is the appeals process determined at national level or by EASA? **Proposal:** Clarification is required	
response	*Noted*	
	See response to comment No 588 of this segment.	

comment	*1611*	comment by: *Helmut PRANG*
	With reference to par. (d) it appears not be justified to keep records for an unlimited period of time. Protection and Security of personal medical data have to be balanced against the interest in the medical history of the applicant. I suggest to limit filing records with details of medical examinations to no longer than 10 years from the date of the relevant examination. Only the results of the medical examination (fail or pass) shall be kept for over and beyond that period. AeMC, AME and GMP shall be obliged to delete any details of medical examinations beyond the filing period. Such regulation shall apply to all classes of medical examination.	
response	*Noted*	
	The issue is covered in NPA 22 Subpart MED Section 1 para AR.MED.120 and is also subject to the national law.	

comment	*1621*	comment by: *Bayerisches Staatsministerium für Wirtschaft, Infrastruktur, Verkehr und Technologie*

	Hier wird Bezug genommen auf die Anmerkungen zu MED.A.030. Eine Einbindung der lizenzierenden Behörde in die medizinischen Fachfragen wird für verfehlt gehalten. Diese sollte abschließend den AeMC, AME bzw. GMP überlassen werden.
response	*Noted*
	See responses to the comments No 74 and 95 of this segment.

comment	*1637*	comment by: *Max Heinz Katzschke*
	Der freizügige Umgang mit vertraulichen Daten des Lizenzinhabers durch die "Competent Athorities" sollte eingeschränkt werden, denn er verstösst gegen die europäischen Datenschutzbestimmungen. Die Art der zu übertragenen Daten und deren Verwendung sollte auf ein Minimum beschränkt und exakt spezifiziert werden um dem datenschutzrechtlichen Schutzbedürfnis des Lizenzinhabers/Bewerbers eines Medicals gerecht zu werden. Eine Übertragung von Daten zu statistischen Zwecken sollte nur ohne Rückgriffsmöglichkeiten auf die Person und nur zu ausgewählten eingeschränkten Zwecken erlaubt sein.	
response	*Noted*	
	See responses to the comments No 74 and 95 of this segment.	

comment	*1644*	comment by: *Medical Officer BBAC*
	MED.A.050 e) conflicts with MED.A.015 confidentiality. The form must state that the pilot (on signature) gives authority to the AeMC, AME or GMP to release records and reports to competent authorities.	
response	*Noted*	
	See responses to the comments No 74 and 95 of this segment.	

comment	*1659*	comment by: *Deutscher Aero Club (DAeC)*
	Comment: This provision appears contrary to the European Directive on data protection and to normal medical ethics. While AMEs are recognised as agents of the Authority, GMPs are unlikely to open their medical records collected for clinical purposes to the authority. It removes any possibility of co-operation by GMPs and is also unnecessary. DAeC does not see any influence of such a rule on the risk hazard for pilots requesting for the LPL medical standard. DAeC Proposal: That MED.A.050 (e) be deleted. Reference: Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995.	
response	*Noted*	
	See responses to the comments No 74 and 95 of this segment.	

comment	*1704*	comment by: *Klaus Schneider-Zapp*
	Transfer of personal data should be limited according to data privacy rules. The type and destination of data to be transfered should be stated exactly. The collection of confidental data by authorities should be explicitly forbidden.	
response	*Noted*	
	See responses to comments No 74 and 95 of this segment.	

comment	*1707*	comment by: *Deutscher Aero Club*
	MED.A.050 Obligations of AeMC, AME and GMP (e) Upon request by the competent authority, AeMC, AMEs and GMP shall submit to the competent authority all aeromedical records and reports, and any other information, as required for oversight activities. Comment: This provision appears contrary to the European Directive on data protection and to normal medical ethics. While AMEs are recognised as agents of the Authority, GMPs are unlikely to open their medical records collected for clinical purposes to the authority. It removes any possibility of co-operation by GMPs and is also unnecessary. EGU Proposal: That MED.A.050 (e) be deleted. Reference: Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995.	
response	*Noted*	
	See responses to the comments No 74 and 95 of this segment.	

comment	*1857*	comment by: *Dr Stephen Gibson*
	re page7 Med A.050 (e) "shall submit all aeromedical records and any other information" A medical practitioner cannot do this without contravening data protection, medical ethics and Med A.015, unless the pilot gives permission. The form Med A 040 or the declaration Med A .035 (2) therefore needs a clause inserted to be signed by the applicant authorising the giving of this information.	
response	*Noted*	
	See responses to the comments No 74 and 95 of this segment.	

comment	*1901*	comment by: *Chris Fox*
	The requirement in MED.A.050 (e) for submission of medical data to the authority is in contravention of Data Protection law and normal medical ethics and practice. It should be deleted.	
response	*Noted*	

	See responses to the comments No 74 and 95 of this segment.

comment	*1907*	comment by: *Tom GARDNER*
	My GMP will, on principle, refuse to forward medical records without a court order! Reason: his professional requirement to maintain patient confidentiality! GMPs have access to historical medical records, thus preventing risks associated with a failure to disclose relevant history to an AME that does not know the pilot. Hence I strongly support allowing a GMP to issue an LPL medical certificate.	
response	*Noted*	
	Thank you for the support. See response to comment No 74.	

comment	*1916*	comment by: *Klaus Melchinger*
	This is almost an invocation to competent authorities to generously collect confidential data about licence holders and thus acting against european data privacy rules! The type and destination of data to be transferred should be described exactly to accomodate with pilots data safety exigences. Transferral of data for the purpose of statistics should be forbidden!	
response	*Noted*	
	See response to comment No 74.	

comment	*1967*	comment by: *AEA*
	Comment: Para (a) (2). In Germany the prevailing case law of the highest court does allow pilots to give inaccurate or false statements because nobody needs or can be forced to accuse himself. **Proposal:** Add: 'which may include risk to flight safety, the pilot's health or other possible legal, employment or administrative actions.'	
response	*Noted*	
	See response to comment No 587 of this segment.	

comment	*1968*	comment by: *AEA*
	Comment: Para (b) (3) Is this an appeal to the national authority or to EASA and is the appeals process determined at national level or by EASA?	

	Proposal: Clarification is required
response	*Noted*
	See response to comment No 588 of this segment.

comment	*1969*	comment by: *AEA*
	Comment Paras (c) and (e) require transfer of medical information to the licensing authority. The competent authority or the licensing authority in the EASA member states may not be medical doctors. The requirements of MED.A.50 may therefore in some instances contravene medical confidentiality requirements. **Proposal**: MED.A.50 be re-drafted to take account of the requirements of medical confidentiality in states where submission of medical documentation to the competent authority or licensing authority would not be to a medical doctor.	
response	*Noted*	
	See responses to the comments No 74 and 95 of this segment.	

comment	*2031*	comment by: *Tomasz Gorzenski*
	The EASA should consider creating a waiver program, similar to that developed by the FAA. By the way of special medical certificate issuance, allowing applicants, who meet all but one requirement (provided additional medical examination is performed as neccessary to assure adequate level of safety), to exercise privileges of class 1 or class 2 medical certificate holders, without operational multi-pilot or safety pilot limitation, EASA may create in future better medical standards, based more on medical facts, than some old, unneccessary standards. This is the only way to get rid of some unneccessary and unjustly discriminating regulations This is exactly what happened in the USA and later in world with uncorrected vision standard. Thanks to the FAA waiver program, by allowing thousands of pilots and ATC controller to excercises their privileges despite being unable to meet the standard, the FAA was able to observe, that they had performed their duties safely and proficiently. Consequently the FAA removed the uncorrected vision standard from FAR Part 67 and later the ICAO and other aviation authorities followed the FAA.	
response	*Noted*	
	See response to comment No 2035 in the section MED.A.045.	

comment	*2063*	comment by: *Norwegian Association of Aviation Medicine*
	Part b,4: we would suggest the following change: (4) submit without delay a signed report to include the complete assessment result and a copy of the medical certificate to the licensing authority, preferably as an electronically transmission into the central database.	

	in part c, the GMP should be removed, of course but our particular comment to this part is a suggestion for a change in the text: .....shall transfer **all** medical documentation to the licensing authority.
response	*Noted*
	(b)(4) See response to comment No 332. (c) The Basic Regulation (Article 7) allows a GMP to issue a medical certificate for a LAPL licence (if permitted under national law). This has to be taken into account in the implementing rules. Licensing authority shall receive only information related to the aeromedical examination.

comment	*2098*	comment by: *Dr. Christoph Larisch*
	Medizinische Daten benötigt die Behörde nicht, es reicht das Ergebnis der Untersuchung. Die Sicherheit des Luftverkehrs wird sicher nicht durch die Weitergabe sensibler persönlicher Daten erhöht. Der persönliche Datenschutz hat hier auf jeden Fall Vorrang vor einer nutzlosen und mit Blick auf die Bürgerrechte höchst problematischen Datensammlung durch die Behörden.	
response	*Noted*	
	See responses to the comments No 74 and 95 of this segment.	

comment	*2103*	comment by: *Luftfahrtbehörde Schleswig-Holstein Landesbetrieb Straßenbau und Verkehr*
	Die Einbindung der lizenzierenden Behörde in fachmedizinische Fragen ist nicht notwendig. Eine abschließende medizinische Beurteilung sollte den AeMC, AME bzw. GMP vorbehalten sein.	
response	*Noted*	
	See responses to the comments No 74 and 95 of this segment.	

comment	*2105*	comment by: *BMVBS (German Ministry of Transport)*
	In terms of data protection transfer of medical data/documentation is a highly sensitive subject. The proposed concept would unnecessarily require an extensive exchange of such data between aeromedical examiners and the authority (AMS), but also amongst the various AMSs throughout Europe. The concept should be changed in such a way that medical data are generally transfered for oversight purposes only, or in cases where it must be suspected that a person holds a valid medical certificate although there are indications he or she is aeromedically unfit. Data submitted to the authority for oversight purposes should be anonymized to an extent that the authority is still able to perform its	

	oversight role. The information that may be submitted must be clearly specified in the IRs in order to be in line with European data protetction law.
response	*Noted*
	See responses to the comments No 74 and 95 of this segment.

comment	*2114*	comment by: *peter Gray*
	Para (e) Submission to the competent authority of medical information to resolve a referral for further assessment is one thing. "...any other information as required for oversight activities" smacks of breach of confidentiality. Confidentiality matters are specifically addressed at MED.A 015	
response	*Noted*	
	See response to comment No 95.	

comment	*2123*	comment by: *Croft Brown*
	Page 7 of 66 MED.A.050 Obligations of AeMC, AME and GMP (e) Upon request by the competent authority, AeMC, AMEs and GMP shall submit to the competent authority all aeromedical records and reports, and any other information, as required for oversight activities. Comment: This provision appears contrary to the European Directive on data protection and to normal medical ethics. While AMEs are recognised as agents of the Authority, GMP's are unlikely to open their medical records collected for clinical purposes to the authority. It removes any possibility of co-operation by GMPs and is also unnecessary. Croft Brown edorses the BGA Proposal: That MED.A.050 (e) be deleted. Reference: Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995.	
response	*Noted*	
	See response to comment No 95.	

comment	*2177*	comment by: *Dr.Piek Armin*
	Because GMP's don't have any experience in aeromedical medicine they can' t overtake any aeromedical obligations	
response	*Noted*	
	See response to comment No 1415 of this segment.	

comment	*2198*	comment by: *Royal Netherlands Aeronautical Association*
	MED.A.050 Obligations of AeMC, AME and GMP	

Confidentiality:
A special difficulty is likely to arise with medical confidentiality. NPA 17c MED.A.050(e) requires that 'on request by the competent authority, AeMC, AMEs and GMP shall submit to the competent authority all aero medical records and reports and any other information as required for oversight activities'. This open access is contrary to both the EU Directive on data protection and conventional medical ethics. It is also unnecessary, because where evidence of fraudulent activity exists, this can be supplied to the police who have powers of investigation under criminal law.
KNVvL PROPOSAL
-Medical records are confidential and should not be open to routine inspection, whether held by AME, GMP, medical officer or sportdoctor.

References:

Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data

response *Noted*

See responses to the comments No 74 and 95 of this segment.

comment *2223* comment by: *Swiss Association of Aviation Medecine*

Examiners
We do not agree that GP's without formation are authorized to judge pilots. This is against the actual trend of improving quality of medicine. Nowadays doctors have to ensure that their volume in a special field is high enough to assure acceptable quality of medecine. In most of the speciality physicians need an accreditation. With the proposed solution the volume and with this the skill of AME will decrease, wheras the GP who examines 1 or 2 pilots every year will not reach an acceptable efficacy and quality.

response *Noted*

See response to comment No 1415 of this segment.

comment *2244* comment by: *Andrew Sampson*

Part (e) I do not agree that the "competent authority" should have a right to oblige my GMP to give access to my private medical records, except perhaps as part of an air accident investigation.

response *Noted*

See response to comment No 95.

comment *2266* comment by: *Mike Armstrong*

Page 6 of 66 MED.A.050

	In the UK, aeromedical examinations and assessments are not required by a GMP for issue/renewal of NPPL medical - only an assessment based on examination of medical records of the individual with further examination or assessment if any fitness doubts emerge. To my knowledge, this system has not led to any safety issues. I therefore propose: "(b) After completion of the aeromedical assessment of records and subsequent examination if required, AeMC, ..." The cost of medicals in leisure/sport aviation is a significant factor and this would reduce costs for most cases without detriment to safety.
response	*Not accepted*
	Your proposal to have the GMP issue the medical certificate without the need for an examination of the pilot cannot be accepted. Paragraph 4.a.1 of the Essential Requirements determines the following: *'All pilots must periodically demonstrate medical fitness (...). Compliance must be shown by appropriate assessment (...)'.* The Agency's view is that this requirement for appropriate assessment cannot be satisfied with the mere analysis of medical records. There is a need for the GMP to perform a medical assessment. Existing medical records may be taken into account when performing the assessment, but cannot be the only element used. The same reason behind the decision not to allow the system of self-declaration of medical fitness was that is used in some Member States. In the Agency's view, a self-declaration cannot fulfil the requirement for an appropriate aero-medical assessment in the Basic Regulation.

comment	*2275*	comment by: *Mike Armstrong*
	Page 7 MED.A.050 (e) appears to be against all data protection rules and rules on medical ethics where patient confidentiality is sacrosanct. It also appears to contradict MED.C.010 (c)(2). Perhaps it could be amended to state "but only with the patient's permission"	
response	*Noted*	
	See response to comment No 95.	

comment	*2324*	comment by: *Tim FREEGARDE*
	MEDA050(e) The requirement of a GP to submit patients' records to the competent authority is contrary to data protection and patient confidentiality principles, and in any case unnecessary.	
response	*Noted*	
	See response to comment No 95.	

comment	*2334*	comment by: *Graham Bishop*
	The requirement to disclose medical records seems to be contrary to the European rules on data protection. GPs are unlikely to agree this would remove any chance for cooperation with the AMEs	
response	*Noted*	
	See responses to the comments No 74 and 95.	

comment	*2364*	comment by: *Federal Ministry of Transport, Austria (BMVIT)*
	Two observations concerning (b) (4): It is not clear what the term "assessment result" means. If no medical certificate is issued by the AME we think that this should be reported to the authority. The text as it is seems to preclude this.	
response	*Noted*	
	Assessment result is a decision on fitness. Subparagraph (4) requires to inform licensing authority about all assessment results.	

comment	*2459*	comment by: *Paul Mc G*
	(e) Upon request by the competent authority, AeMC, AMEs and GMP shall submit to the competent authority all aeromedical records and reports, and any other information, as required for oversight activities. This provision is contrary to the European Directive on data protection and breaches Human Rights rules and is unenforceable! It is also contrary to normal medical ethics. AMEs are agents of the Authority, but GMP's are unlikely to open their medical records collected for clinical purposes to the authority. Just lose this. It will be destroyed by a HR challenge.	
response	*Noted*	
	See response to comment No 95.	

comment	*2564*	comment by: *Heinz Fricke-Bohl and Kirsten Bohl*
	MED.A.050: Damit ist der Punkt Med. A 05(b) hinfällig. (3) Eine 24- monatige Gültigkeit wäre besser im Alter von 40-60 Jahre.	
response	*Noted*	
	Please, see responses to the comment No 48 to MED.A.055.	

C. Draft Opinion Part-MED - Subpart A: General Requirements - Section 2: Issuance, revalidation and renewal of medical certificates - MED.A.055: p. 7-8

Validity, revalidation and renewal of medical certificates

comment	*48*	comment by: *Bernhard Blasen*
	The vaildity of the medicals should be the same as in ICAO rules. There is no reason to make different rules than anywhere in the world.	
response	*Noted*	
	Our proposed validity periods for class 1 and class 2 medical certificates are based on the already harmonised and implemented JAR FCL 3 Amendment 5 standards which are in line with the ICAO Standard and Recommended Practice. Amendments of the existing validity periods might be proposed in a future rulemaking task. For LAPL medical certificates the validity periods will be amended to reduce the validity period to 60 months until age 50 and then to 24 months until age 70. After age 70 the validity period will be 12 months.	

comment	*49*	comment by: *Bernhard Blasen*
	There suould not be any differences between initial medical examinations and consequent examinations. According to that the rules for an expired medical are obsolete. Reason for that: a medical examination always shows condition that is valid at the moment. There are cases where severe medical diseases took place very short after medical examinations. So if medical examinations shall be senseful, they must be the same every time they take place.	
response	*Noted*	
	Our proposed differences in medical examination are based on the time span after the expiration of validity of the medical certificate. The longer the time span, the higher the probability of the health disorder. Then the medical examination must be more exhaustive. In addition, as you rightfully noticed, diseases may appear very shortly after medical examinations. We would like to draw your attention to the fact that in these cases the pilot must without delay seek the advice of an AeMC or AME.	

comment	*63*	comment by: *Dr Graham Cresswell, chief medical officer, bmi*
	MED.A.055 (a) (5) and This was an opportunity to return to end-of-month expiries, which was much easier and secured more reliable compliance. The 45-day grace period is useful for the same reasons and should be retained. Suggest... MED.A.055 (a) throughout after "months" add *and the remainder of the month of expiry*	

response	*Not accepted*
	The calculation of the validity period of medical certificates is in line with already harmonised and implemented JAR FCL 3 Amendment 5 standards. The 45 day grace period is retained in MED.A.55 (b).

comment	*75*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **AMC to Med A055 4) section 2** **Page**: 7 Relevant Text: **Comment**: The validity of LAPL medical is to long. Many severe deseases can occure in that long period of time, sometimes not even to see or recognise by the pilot. Flight safety will decrease therefore. **Proposal**: validity of LAPL- medical certificates shall refer to the validity of class 2 medicals	
response	*Partially accepted*	
	See response to comment No 48 of this segment.	

comment	*108*	comment by: *Matthias Saure*
	The 24 month period for class 2 medical should be extended to pilots up to an age of 60.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*111*	comment by: *Aero-Club of Switzerland*
	Looking at MED.A.055 (a) (3) the Aero-Club of Switzerland proposes: "(ii) 24 months between the age of 40 and 60. A medical certificate issued prior to reaching the age of 60 shall cease to be valid after the pilot reaches the age of 61, and (iii) 12 months after the age of 60". Justification: The risk of sudden incapacitation raises especially after the age of 60. An interval of 24 months between the age of 50 and 60 is sufficient and justified.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	123	comment by: *Civil Aviation Authority - The Netherlands*
	MED.A.055, vierde lid. (Blz. 7 van 66) De CAA-The Netherlands kan zich niet vinden in de duur van de intervallen aangaande de geldigheid van het LPL. In het bijzonder is de interval tot 45 jaar te lang. (MED.A.055, onder i). Het verbinden van geldigheid aan een medisch certificaat zonder tussenliggende medische keuringen is in de ogen van de CAA-The Netherlands niet verantwoord. De geldigheid van het LPL zou volgens de CAA-The Netherlands minstens gelijk moeten zijn aan die van het klasse 2 medische certificaat.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	185	comment by: *Bernhard Blasen*
	A AME or AMC is competent enough to decide about the prerequisites for issuing a medical certificate. There is no need for Rule (c) (i).	
response	*Not accepted*	
	AMEs and AeMCs shall be qualified to take aeromedical decisions. But their decisions shall have a legal basis. The latter is provided by our proposed rules.	

comment	227	comment by: *Dr. Uwe Kaiser*
	Die lange Periode für unter 40 ist ine adäquate Regelung. Die Verkürzung der Perioden ab 50 erfolgt jedoch zu schnell und trägt der heutigen Netwicklung der Lebenserwartung und körperliche Verfassung nicht Rechnung. Die Intervalle sollten frühestens ab 65 auf 12 Monate verkürtzt werden.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	243	comment by: *Lufthansa German Airlines*
	Author: : Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany Head of Lufthansa Medical Services Head of German Academy of Aviation and Travel Medicine Section: **2** **MED .A. 055 Validity, revalidation and renewal of medical certificates** (a) Validity **Page**: 7 Relevant Text: (3) Class 2 medical certificates shall be valid for a period of : (ii) 24 months between the age of 40 and 50.	

(iii) 12 months after the age of 50.

Comment:
These validity dates are too stringent for class 2 and shorter as in JAR FCL 3.
What is the medical evidence for this.?
The coronary heart risk of the average male population in Europe passes the 1% / year risk at the age of 65. (See special medical opinion of Prof. Dr. Bachmann, former head of the cardiology department University of Erlangen 2003 for the German court, where continuing flying for class 1 pilots over 60 was retried.
If the accepted risk for a sudden incapacitation for class 2 pilots by heart attack is 2% / year ,there is no need for annual medicals prior the age of 65 or older .

Proposal:
(3) Class 2 medical certificates shall be valid for a period of :
(ii) 24 months between the age of 40 and **65.** .....

(iii) 12 months after the age of **65**.

response *Noted*

See response to comment No 48 of this segment.

comment *244* comment by: *Lufthansa German Airlines*

Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany
Head of Lufthansa Medical Services
Head of German Academy of Aviation and Travel Medicine
Section: : **2**
MED .A. 055 Validity, revalidation and renewal of medical certificates
(a) Validity
Page: 7

Relevant Text: (4) LPL medical shall be valid :
(i) until the age of 45
(ii) between the age of 45 and 60, for a period of 60 months.....
(iii) after the age of 60, for a period of 24 months.

Comment:
The risk of sudden incapacitation does not change if flying a Cessna with 3 passengers under class 2 or LPL requirements. The gap between the age of 16 and 45 without any medical examination or medical self - declaration, opens the door for all pilots, who are unable for a medical self assessment, due to illnesses like psychosis, mania, depression ,alcohol or drug dependency and others, which occur most frequently just in this gap between 16 and 45. The normal standard of alcohol dependent patients in the working population is 5 to 7% ,1 to 3 % are suffering from depression or psychosis. If only 5 % of these patients are flying in that time gap between16 and 45 while possessing a valid medical issued at the age of 16, between 1000 up to 3500 pilots with aircrafts up to 2000kg with maximum 3 passengers on board, will take part in the normal daily air traffic only in Germany.

	Arguments that this happens also with thousands of car drivers each day are not solid, because normally cannot violate airspace where Boeings 747 are flying. In case of collision of an commercial aircraft and a Cessna 172, it is normally a fatal accident for both aircrafts, which means that such a flying patient can kill hundreds of passengers. **Proposal**: Take the same validity dates for LPL as for class 2
response	*Noted*
	See response to comment No 48 of this segment.

comment	*268*	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. Jürgen Kriebel Section: 2 Subpart A General Requirements MED.A.055 (a) - Validity **Page**: 5 Relevant Text:: (4) Medical certificate for the LAPL shall be valid: • (i) until the age 45; • (ii) between the age of 45 and 60 for a period of 60 months; • (iii) after the age of 60, for a period of 12 months **Comment**: Neurological and psychiatric disorders/diseases including the risk of sudden incapacitation like seizures, subarachnoid hemorrhages or psychoses are likely to occur in adolescence and the following years. MS or abuse/dependency problems may start in young adults etc. **Proposal**: • (i) for a period of 60 months until the pilot reaches the age of 60; • (ii) after the age of 60 for a period of 12 months delete part (iii) completely	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*276*	comment by: *Lufthansa German Airlines*
	Section: 2 MED.A.055 Subpart A	

a (2)(i) - Validity, Revalidation and Renewal of Medical Certificates
Page: 7

Relevant Text:
The period of validity shall be reduced to 6 months for pilots who are engaged in single pilot commercial air transport operations carrying passengers and have passed their 40th birthday.

Comment:
The medical requirements are identical for passenger and cargo operations.

Proposal:
The period of validity shall be reduced to 6 months for pilots who are engaged in single pilot commercial air transport operations and have passed their 40th birthday.

response *Not accepted*

Our proposed rules for class 1 medical certification are based JAR FCL 3 Amendment 5 provisions. Your proposal is not in line with ICAO standard laid down in Annex I pargraph 1.2.5.2.2 and JAR FCL 3.105(a)(1).

comment *277* comment by: *Lufthansa German Airlines*

Author: Dr. Ulrike Springer AMC Frankfurt
Section: 2
MED.A.055
a (4)(i) - Validity, Revalidation and Renewal of Medical Certificates
Page: 7

Relevant Text:
Medical certificates for the LAPL shall be valid until the age of 45.

Comment:
Even prior to the 45th birthday, changes in health are possible.

Proposal:
Following additions are recommended:

- if no change in health exists
- if the applicant passes regular physical examinations, including ENT values, by a private physician (GMP) every 60 months

response *Noted*

See response to comment No 48 of this segment.

We also would like to draw your attention to the fact that in case of decrease in medical fitness the pilot must without delay seek the advice of an AeMC, AME or a GMP.

comment	303	comment by: *Lufthansa German Airlines*
	Author: Dr. Esther Stahl-Buhl, AMC Frankfurt **Section**: 1 Subpart A MED A.055 (i) 4 **Page**: 7 **Relevant Text:** LPL medical certificates shall be valid (i) until the age of 45 **Comment**: **Proposal**: I would comment the same as for class 2: If a pilot needs correcting glasses or lenses or has any kind of ophthalmic problem, his medical should be valid for 24 months.	
response	*Not accepted*	
	The need to carry corrective lenses cannot alone be considered as a requirement for more frequent general examinations or additional specialist ophthalmological examinations. Whenever needed, an AME may request additional ophthalmological examinations and impose the necessary limitation RXO. See also response to comment No 48 of this segment.	

comment	304	comment by: *Lufthansa German Airlines*
	Author: Dr. Esther Stahl-Buhl, AMC Frankfurt **Section**: 1 Subpart A MED A.055 (a) 3 **Page**: 7 **Relevant Text:** Class 2 medical certificates shall be valid for a period of: (i) 60 months until the pilot reaches the age of 40. A medical certificate issued prior to reaching the age of 40 shall cease to be valid after the pilot reaches the age of 42. **Comment**: **Proposal**: I would write: If a pilot needs correcting glasses or lenses or has any kind of ophthalmic problem, his medical should be valid for 24 months.	
response	*Noted*	
	See response to comment No 303 of this segment.	

comment	305	comment by: *Lufthansa German Airlines*
	Author: Dr. Esther Stahl-Buhl, AMC Frankfurt **Section:** 1 Subpart A MED A.055 (ii) 4 **Page**: 7 **Relevant Text:** LPL medical certificates shall be valid: (ii) between the age of 45 and 60, for a period of 60 months **Comment**: **Proposal**: I would comment the same as for class 2: If a pilot needs correcting glasses or lenses or has any kind of ophthalmic problem, his medical should be valid for 24 months. Every 24 months an ophthalmic exam is indicated. Up to the age of 45, if the pilot does not need glasses or lenses and has no ophthalmic problems, he should be should have an ophthalmic exam every 60 months in order to be assessed as fit .	
response	*Noted*	
	See response to comment No 303 of this segment.	

comment	352	comment by: *Teh Danish Organiation of Flight Surgeons (DAFLO)*
	Item: dot 4 **Objection:** Disagree **Reasons:** 30 years of validity of a medical certificate is meaningless as this will increase the risk of diseases undetected and prevent report of pontetial limitations with considerable reduction in flight safety as a consequence. **Suggestions:** LAPL, if introduced, and calss 2 should have equal periods of validity if privileges of the applicable license(s) are equal.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	391	comment by: *European CMO Forum*
	MED.A.055 (a) (1) (2) and (3) Comment: The validities as proposed in the NPA are supported.	

response	*Noted*
	Thank you for the positive comment.

comment	*393*	comment by: *European CMO Forum*
	MED.A.055 (a) (4) (i) Comment: The validity periods for LPL are too long, especially in the youngest age group. Justification: Certain medical conditions commonly present under the age of 45, in particular, psychiatric problems and alcohol and substance abuse. These are the commonest medical cause of general aviation accidents and will not be reported spontaneously; medical assessment is required more than once during the period from first examination until the age of 45. Proposed Text: Same periodicity as class 2.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*417*	comment by: *UK CAA*
	MED.A.055 (a) (3) (ii) and (iii) **Comment:** The NPA proposal includes the ICAO Recommendation 1.2.5.2.5 of annual medical examinations for Class 2 certification over the age of 50. This is above the ICAO Standard 1.2.5.2.4 which specifies a medical examination every 24 months over the age of 40. **Justification:** ICAO class 2 medical certification is the appropriate standard on which to base the EASA requirements for private flying. **Proposed Text:** Amend as follows: (ii) 24 months after the age of 40 Delete (iii)	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	418	comment by: UK CAA

MED.A.055 (a) (3) (ii) (iii)

Comment:
Consideration needs to be given to the effect of the NPA proposal to allow flight instruction using a Class 2 medical certificate, rather than a Class 1 as in the JARs. This is repercussive for the medical requirements as flying instructors will be able to instruct on a lower medical standard.

Increased cardiovascular assessment may be appropriate for flying instructors over the age of 60.

Justification:
There is an increased risk of incapacitation, in particular from cardiovascular cause, over the age of 60.

Proposed Text:
Add: **'In the case of flying instructors, class 2 medical certificates shall be valid for a period of:**

a) 24 months between the age of 40 and 60. A medical certificate issued prior to reaching the age of 60 shall cease to be valid after the flying instructor reaches the age of 61; and
b) 12 months after the age of 60.'

response	*Not accepted*

The medical certificate relates to the licence held and not to the activity. An Instructor shall hold at least the licence he/she is instructing for. In the case of an Instructor holding a PPL a class 2 medical certificate is needed, for a LAFI a LAPL medical certificate.

There were no provisions for instructors in JAR-FCL that would require a class 1 medical certificate for instructors who hold and instruct for a PPL.

comment	419	comment by: UK CAA

MED.A.055 (a) (5) and (c) (1)

Comment:
The term 'renewal' is applied both to the holder of a medical certificate who has let it expire and to a pilot who attends whilst his certificate is still valid but in advance of 45 days before the expiry date.

This is not compatible with the definitions of 'revalidation' and 'renewal' on page 170 of NPA 17b GM to FCL.010 B. This can be corrected by the use of the phrase 'early revalidation'.

Justification:
A pilot may be seconded for several months to an area where a medical examiner is not available and need to attend early for his next medical examination.

If a pilot has to attend for a renewal examination more than 45 days in advance of the date his medical certificate is due to expire, it is only fair that he should still be entitled to the additional 45 day validity period that he would have been entitled to if he had attended on the 45th day prior to expiry.

Proposed Text:
Add to MED.A.055 (a) (5): **'*Early revalidation*: In the case of a pilot attending for examination in advance of 45 days prior to expiry, the period of validity shall be calculated from 45 days after the date of examination.'**

response *Not accepted*

An "early revalidation" would lead to the situation where validity periods of medical certificates considerably exceed the validity periods proposed in this NPA as well as the validity periods given in ICAO.

The introduction of provisions based on ICAO 1.2.5.2.6 could be discussed in a future rulemaking task.

comment *420* comment by: *UK CAA*

MED.A.055 (c) (2) (ii)

Comment:
It is unnecessary for pilots who have let their certificate expire for more than 5 years to attend an AeMC.
It is also unfair to assess pilots who have not flown for a few years to initial medical requirements.

Justification:
An AME is capable of undertaking the renewal assessment.
There is no justification in having a different assessment standard for pilots who have let their certificate expire.

Proposed Text:
Delete MED.A.055 (c) (2) (ii)

response *Noted*

Our proposal is a transposition of the JAR FCL 3 Amendment 5 provisions.

See response to comment No 795 of this segment.

comment *488* comment by: *Jürgen Böttcher*

MED.A.055 Validity of Class 2 medicals should be 24 months even beyond age 50. There is absolutely no data indicating higher occurrence of medical incapacitation in flight in pilots beyond age 50. In fact, these pilots are even more likely to cancel a flight when not feeling perfectly well. FAA does not require annual medicals for older pilots, either. This only causes higher cost and effort for pilots

	and may lead to early retirement of older pilots no longer willing to bear these costs and efforts, thus weakening GA in general by removing experienced pilots.
response	*Noted*
	See response to comment No 48 of this segment.

comment	*521*	comment by: *British Microlight Aircraft Association*
	Accepted. Except (c) Renewal (1). Examinations carried out more than 45 days before the expiry date should be treated as a revalidation, rather than as a renewal, although with the new certificate starting from the date of examination rather than the date of expiry of the certificate being replaced. There may be a circumstance when the pilot does not have access to the examiner within the 45 day period whose medical certificate would otherwise expire before he could arrange to undergo an examination after that date.	
response	*Noted*	
	See response to comment No 419.	

comment	*575*	comment by: *Florian Söhn*
	To a 3: Valitdity for calss 2 medical should 24 mounth for age 40 to 60 as it is now under JAR. shortenig of this to 12 months makes no medical sence to me. To a 4: From the mecial point of view a first renewel of medical fitness at age 45 seems totally out of line. Just taking psychiatirc disease intpo account: Maniac depressive disorder or Schizophrenic disorder usually manifest themselves during the age 20 to 40. Due to the nature of these diseases the pilot himself cannot percieve that he is unable to steer any aircraft. Shoreting this examination interval as it is in class 2 would enable a compentent physical to recognize early symptoms, so that that the scenorio of "maniac voice-hearing LPL-Pilots playing kamikaze for years" does not happen. More examples would be an early onset diabetes or testicle carcinoma. The possibily of a pilot not being seen by a doctor for possibley over 20 years seems not to be compatible with air safty in any way. Easiest solution in my opinion to fuse number 3 and 4 into one paragraph using the times used for class2 in the current JAR regulations.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*582*	comment by: *Aerovision*
	Validity of LPL Medicals: LPL medical is valid until age 45. Age 45 to 60 valid for 5 years. Age 60 plus valid for 2 years	

	Agree.
response	*Noted*
	Thank you for the positive comment.

comment	*589*	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany Head of Lufthansa Medical Services Head of German Academy of Aviation and Travel Medicine Section: **2** **MED .A. 055 Validity, revalidation and renewal of medical certificates** (c) Renewal (ii) **Page**: 8 Relevant Text: (ii) if the medical has expired for more than 5 years, the requirements for initial issue shall apply. **Comment**: If a pilot is experienced with some hundred flying hours and his medical has expired for more than 5 years and this pilot got older, it might happen that he/she does not meets the criteria of an first examination. E.g. Astigmatism is allowed for first examination class 1 only up to two dioptres, at revalidation exceeding 2 dioptres is allowed. Why should it be a safety risk, if this pilot is assessed fit exceeding 2 dioptres. **Proposal**: The (ii) text should clarify, that the requirements of the medical investigation for a first medical examination shall be performed if the medical certificate has expired for more than 5 years. For the fit/ unfit medical assessment the values/ restrictions of a revalidation can be used by the responsible AME.	
response	*Noted*	
	See response to comment No 795.	

comment	*658*	comment by: *ERA*
	MED.A.055 Validity, revalidation and renewal of medical certificates ERA members suggest that the phrase '....*and the remainder of the month of expiry'* be added after the word 'months' throughout the items in Paragraph (a) Validity.	
response	*Partially accepted*	
	See response to comment No 63.	

comment	670	comment by: *Pekka Oksanen*
	(a)(4): Validity periods are too long. Changes in medical condition occure relatively often, the major causes are changes in vision requiring corrective lenses in age group 20-30 yrs, mental problems, overweight with developing type 2 diabetes between age 30-45. Proposal: **Apply Class 2 periodicity**.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	688	comment by: *BMVBS (German Ministry of Transport)*
	A.055 (3) (ii): The clarification that a medical certificate shall cease to be valid after the pilot reaches the age of 42 is welcome and supported. The respective terminology in ICAO Annex 1 must be understood in a way, that a medical certificate issued shortly before a person turns 40 years of age would be valid until shortly before his 45th birthday (see ICAO Annex 1, Note after para. 1.2.5.2.5: The periods of validity....are based on the age of the applicant at the time of undergoing the medical examination). ICAO should be invited to amend its provisons. Until then, the deviation would need to be notified to ICAO. A.055(3) (iii): This mandatory provision is a reflection of the respective ICAO recommended practice. It is believed, however, that for class 2 certificates a medical check every two years would be sufficient until the age of 60, thereafter the interval should be reduced to 12 month. This would bring the sequences (40 and 60) in line with the ones for class 1. As stated in the explanatory notes (2008-17a) it is time consuming to change implementing rules once they are published. If ICAO were to reconsider its recommended practice on this (which is not unlikely), Europe would need to go through this cumbersome amendmend process. Therefore, it is suggested to come up with a reasonable rule right from the start, and subsequently convince ICAO to do the same. A.055(4): We generally agree that the requirements should be tailored to the risks involved with private flying, but we disagree with the balance found. Considering the type of aircraft that can be operated with an LPL, and also the risks involved, there is no justification for merely a "one-off check" before the age of 45. This is considered insufficient. Likewise the interval of 60 month between age 45 and 60 appears to be too long, when compared to classes 1 and 2. Twenty-four month should apply here, as for class 2. After 60 years of age 12 month should apply. In short: The validity of a LPL medical certificate should be identical to class 2. Furthermore, there should generally only be two classes, namely class 1 and class 2 medicals. Pilots holding a LPL should be required to hold a class 2 medical certificate. Class 2 should correspond to ICAO class 2. Anything else would unnecessarily undermine well established international safety levels. In a densely	

	populated territory like Europe it can hardly be justified to the general public, why requirements for medical fitness of pilots should be lower than ICAO level.
response	*Noted*
	A.055 (3) (ii) Thank you for the support. A.055(3) (iii) See response to comment No 48 of this segment. A.055(4) See response to comment No 48 of this segment.

comment	*755*	comment by: *Swiss Association of Aviation Medecine*
	Comment: To save costs without reducing flight safety in Class II pilots the validity could be prolonged **Proposal:** **Class II** (ii) 24 months between the age of 40 and 60 (iii) 12 months after the age of 60 **Comment**: Even prior to the 45 th birthday changes in health are frequent **Proposal**: LPL medical certificates shall be valid: in according to class 2 requirements	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*781*	comment by: *Swiss Association of Aviation Medecine*
	Comment: The competent authority or the licensing authority in the EASA member states normally are not medical doctors. Due to national personal data protection laws and EU Directive 95/46/EC on the protection of personal data, it is not allowed for AME´s and GP´s in most of the EASA member states to submit personal medical data (e.g. medical application form with family history and medical data not only from the pilot but also from his/her relatives) to an organisation where non medical personal has access to these data. Medical confidentiality should be better defined here as it is done in the AMC to Med.A.015. For compliance with ICAO requirements of Annex 1 1.2.4.6 Having completed the medical examination of the applicant in accordance	

with Chapter 6, the medical examiner shall coordinate the results of the examination and submit a signed report, or equivalent, to the Licensing Authority, in accordance with its requirements, detailing the results of the examination and evaluating the findings with regard to medical fitness.

this paragraph should contain information to whom medical information should be available. In most countries this procedure is respected.
In the countries like Germany, where the transmission of medical data is forbidden the information could be limited to the statement of fitness or unfitness of the pilot that is also the result of examination.

Proposal:
All persons involved in medical examinations, assessment and certification shall ensure that medical confidentiality is respected at all times.
All medical records in hard copies or electronically stored should be securely held with accessibility restricted to authorised medical personnel.

The results of medical examinations shall be submitted to the medical service of the competent authority.
In EASA member states where medical confidentiality cannot be guaranteed on all administration levels all personal medical data of pilots shall be stored by AeMC´s , AME´s and GP`s and only the fit or unfit result of the medical investigation shall be transmitted to the licensing authority. Upon request by the competent authority AeMCs, AMEs and GMPs shall submit medical files, reports and any other medical data as required in an anonymous form to the authorized medical doctor of the competent authority for oversight.

response

Noted

See response to comment No 74 in MED.A.050 segment.

comment *794* comment by: *Swiss Association of Aviation Medecine*

Comment:
There is no reason to introduce validity periods for LPL, below ICAO standards, different from those for class 2. Both types of licenses will give privileges to fly the same classes of aircraft, including carrying passengers.
Paragraph (3) of the introductory text of the Basic Regulation reads: "Community essential requirements and rules adopted for their inplementation should ensure that Member States fulfil the obligations created by the Chicago Convention."
Paragraph (4) of the introductory text of the Basic Regulation reads: "The Community should lay down, in line with standards and recommended practices set by the Chicago Convention, essential requirements applicable to ... The Commission should be empowered to develop the necessary implementing rules."
Therefore any proposal below ICAO Standard is unacceptable.

The risk of sudden incapacitation does not change if flying a Cessna with 3 passengers under class 2 or LPL requirements. The gap between the age of 16 and 45 without any medical examination or medical self - declaration, opens the door for all pilots, who are unable for a medical self assessment, due to illnesses like psychosis, mania, depression ,alcohol or drug dependency and others, which occur most frequently just in this gap between 16 and 45.

	The normal standard of alcohol dependent patients in the working population is 5 to 7% , 1 to 3 % are suffering from depression or psychosis. If only 5 % of these patients are flying in that time gap between16 and 45 while possessing a valid medical issued at the age of 16, between 1000 up to 3500 pilots with aircrafts up to 2000kg with maximum 3 passengers on board, will take part in the normal daily air traffic only in Germany. Arguments that this happens also with thousands of car drivers each day are not solid, because normally cannot violate airspace where Boeings 747 are flying. In case of collision of an commercial aircraft and a Cessna 172, it is normally a fatal accident for both aircrafts, which means that such a flying patient can kill hundreds of passengers. From a medical point of view the validity periods of the LPL are not acceptable. (1): Even when applying for marathon competition or diving, medical certificates, not older than 2 - 3 years, are required in young applicants for the experience of sudden cardiac death or otherwise incapacitation have to be expected in sporting events. Besides, control of vision, that may worsen considerably between age 30 - 45, is a major goal of medical examination in young leisure pilots. So should a sportsman, who only may put at risk himself, be subdued to more rigid examinations than a leisure pilot, who may put at risk 3 more passengers or far more people when crashing into a crowded site? (2) In case of a damage, jurisdiction and insurance companies might be in the situation, that the pilot's last "medical" is as old as 30 years (student pilot at age 15, no further examination until age 45), so in fact there is no medical certificate that could give information, if the affected pilot was medically qualified or not at all to perform flight-duties. (3) Passengers boarding for sightseeing flights on LPL aircraft should have a minimum safety level, that "their" pilot is medically qualified to take them for a ride without jeopardising their lives. As they are not able to recognize the pilot's sternotomy-scar following bypass-grafting or similar sequelae, they must rely on the presumption, that only medically qualified personnel may hold a flying licence. Class 2 regulations form a minimum of safety standard in respect of the privilege to carry passengers. **Proposal:** Take the same validity dates for LPL as for class 2
response	*Noted*
	See response to comment No 48 of this segment.

comment	*795*	comment by: *Swiss Association of Aviation Medecine*
	Comment: If a pilot is experienced with some hundred flying hours and his medical has expired for more than 5 years and this pilot got older, it might happen that he/she does not meets the criteria of an first examination. E.g. Astigmatism is allowed for first examination class 1 only up to two dioptres, at revalidation exceeding 2 dioptres is allowed. Why should it be a safety risk, if this pilot is assessed fit exceeding 2 dioptres. **Proposal**: The (ii) text should clarify, that the requirements of the medical	

	investigation for a first medical examination shall be performed if the medical certificate has expired for more than 5 years. For the fit/ unfit medical assessment the values / restrictions of a revalidation shall be used by the AeMC / AME.
response	*Partially accepted*
	MED.A.055 (c)(2)(ii) will be amended to clarify that if the medical certificate has expired for more than 5 years, the examination requirements for initial issue shall apply and the assessment shall be based on the revalidation requirements.

comment	*796*	comment by: *George Rowden*
	MED.A.050 Obligations of AeMC, AME and GMP Comment. The requirement to have AeMC, AMEs and GMPs submit the medical records of pilots to the competent authority for oversight activities is unlikely to be permitted in respect of data protection and medical ethics. In particular GMP's are very unlikely to provide their patient's medical records to the authourity and if they were excluded from taking part in the pilot's application for a medical certificate because of this, this would remove their unique position as the person with the most knowledge of the applicant's health. I propose that MED.A.050 (e) be deleted as it seems unnecessary.	
response	*Noted*	
	See responses to the comments No 74 and 95 in MED.A.050 segment.	

comment	*826*	comment by: *Thomas Cook Airlines UK*
	Commentator: The UK Association of Aviation Medical Examiners **Paragraph**: Med.A.055 **Page Numbers:** 7 **Comment:** For LPL certificates a period of 60 months validity for pilots between ages of 45 - 60 is too long bearing in mind the increasing incidence of potentially serious diseases such as ischaemic heart disease, cancer etc. developing in the 50 - 60 decades. The validity should be 2 years up to 50 then annual after 50 years of age. **Justification:** Flight safety will be compromised because many common diseases developing in the 40 - 60 age decades will not be detected if LPL pilots are permitted to hold a medical certificate up to the age of 60 without any medical assessment in those 20 years. **Proposed text:** Med A 055 (a) (4) (ii) between the ages of 45 - 60 for a period of 24 months. A LPL medical certificate issued prior to reaching the age of 60 shall cease to be valid after the pilot reaches the age of 62; and (iii) after the age of 60, for a period of 12 months.	

response	*Noted*
	See response to comment No 48 of this segment.

comment	*832*	comment by: *Thomas Cook Airlines UK*
	Commentator: The UK Association of Aviation Medical Examiners **Paragraph**: Med. A.055 (b) Revalidation **Page Number: 7** **Comment:** An end of month validity period ensures better compliance than the 45 day rule and is simpler to operate. Consideration should be given to incorporate an end of month validity date with the medical being performed at any time during that month. **Justification:** The 45 day rule causes confusion and difficulty in calculating the end date of the validity period. There is a real risk of pilots continuing to fly with out-of-date medical certificates. **Proposed text:** Med A. 055 (a) (5) The period of validity shall include the remainder of the month in which the medical certificate was issued. (b) Revalidation Delete this paragraph.	
response	*Noted*	
	See response to comment No 419.	

comment	*841*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM) - Group ENT - **Section:** 2 **Med.A. 055** A(4)(i) - (iii) Validity Revalidation and Renewal of Medical Certificates **Page**: 7 **Relevant Text**: Medical certificates of the LAPL shall be valid until the age of 45 **Comment**: Even prior to the 45 the birthday changes in health are frequent **Proposal**: LPL medical certificates shall be valid: in according to class 2 requirements	

response	*Noted*
	See response to comment No 48 of this segment.

comment	*871*	comment by: *Swiss Association of Aviation Medecine*

Comment:
LPL pilots and class 2 pilots use the same airspace and can fly nearly the same type of aircrafts (in class 2 only heavier and with a higher cruising range) and they have the same privileges. Therefore it does not make sense to have, from a safety perspective, different requirements for these two kinds of licenses. LPL pilots may even have glass cockpits with a lot of colour information. Safety issues should not be decided upon by politicians, but by specialist. It looks like the LPL is introduced only as a result of enormous pressure of the leisure pilot associations. The requirements are lower than the ones for sailing a boat on a lake. If a plane with the weight of two tons crashes in a public building it can cause fatal accidents and death to people in this area.

Proposal:
LPL requirements should be the same as class 2 including a comprehensive ophthalmological eye examination by an ophthalmologist at initial examination or if indicated.

response	*Noted*
	See response to comment No 48 of this segment.

comment	*928*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author: European Society of Space and Aviation Medicine (ESAM)- Group Ophthalmology -

Section: 1
Subpart A
MED A.055
(a) 3

Page: 7

Relevant Text:
Class 2 medical certificates shall be valid for a period of:
(i) 60 months until the pilot reaches the age of 40. A medical certificate issued prior to reaching the age of 40 shall cease to be valid after the pilot reaches the age of 42.

Comment:
If a pilot needs glasses, changes in refraction occur. Myopia in young ages, astigmatism in middle ages and presbyopia later on. We need to prevent problems like anisometropia resulting in monocularity , or undercorrection ,of refractive errors , which may result in squinting and therefore headaches all day long. Therefore it is necessary to follow up on the refraction and its correction. Also overcorrection, which often occurs in middle ages, can cause problems like

	headaches. These incorrect optic corrections and resulting headaches can distract the concentration and attention during flight. The routine ophthalmological examination has been dropped by the medical subcommittee of the JAA. This was done as not to burden those pilots, who have no optic correction and therefore see well, do not suffer from any eye- disease or complications. But the idea was to send pilots to an ophthalmologist if problems occur! **Proposal**: If an applicant needs correcting glasses or lenses or has any kind of ophthalmic problem, an ophthalmic evaluation by an ophthalmologist has to be performed every 24 months.
response	*Noted*
	See response to comment No 303 of this segment.

comment	*929*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author: European Society of Space and Aviation Medicine (ESAM) - Group Ophthalmology -

Section: 1
Subpart A
MED A.055
(a) 4 an AMC to MED B. 090

Page: 7 and 60

Relevant Text:
LPL medical certificates shall be valid:

- (i) until the age of 45

Specific requirements for LPL medical certificates

Comment:
LPL pilots and class 2 pilots use the same airspace and can fly nearly the same type of aircrafts (in class 2 only heavier and with a higher cruising range) and they have the same privileges. Therefore it does not make sense to have, from a safety perspective, different requirements for these two kinds of licenses. LPL pilots may even have glass cockpits with a lot of colour information. Safety issues should not be decided upon by politicians, but by specialist. It looks like the LPL is introduced only as a result of enormous pressure of the leisure pilot associations. The requirements are lower than the ones for sailing a boat on a lake. If a plane with the weight of two tons crashes in a public building it can cause fatal accidents and death to people in this area.

Proposal:
LPL requirements should be the same as class 2 including a comprehensive ophthalmological eye examination by an ophthalmologist at initial examination or if indicated.

response	*Noted*
	See response to comment No 48 of this segment.

comment	*982*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008
Section: 2
MED .A. 055 Validity, revalidation and renewal of medical certificates
(a) Validity
Page: 7
Relevant Text:
(3) Class 2 medical certificates shall be valid for a period of :
(ii) 24 months between the age of 40 and 50. .....
(iii) 12 months after the age of 50.
Comment:
These validity dates are too stringent for class 2 and shorter as in JAR FCL 3.
What is the medical evidence for this.?
The coronary heart risk of the average male population in Europe passes the 1% / year risk at the age of 65. (See special medical opinion of Prof. Dr. Bachmann, former head of the cardiology department University of Erlangen 2003 for the German court, where continuing flying for class 1 pilots over 60 was retried.)
If the accepted risk for a sudden incapacitation for class 2 pilots by heart attack is 2% / year ,there is no evidence for annual medicals prior the age of 65 or older .
Proposal:
Implement the ICAO standard
(3) Class 2 medical certificates shall be valid for a period of :
(ii) 24 months between the age of 40 and **60**. .....
(iii) 12 months after the age of **60**.

response	*Noted*
	See response to comment No 48 of this segment.

comment	*983*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: 2
MED .A. 055 Validity, revalidation and renewal of medical certificates
(a) Validity

Page: 7

Relevant Text:
(4) LPL medical shall be valid :
(i) until the age of 45
(ii) between the age of 45 and 60, for a period of 60 months.....

(iii) after the age of 60, for a period of 24 months.

Comment:
There is no reason to introduce validity periods for LPL, below ICAO standards, different from those for class 2. Both types of licenses will give privileges to fly the same classes of aircraft, including carrying passengers.
Paragraph (3) of the introductory text of the Basic Regulation reads: "Community essential requirements and rules adopted for their inplementation should ensure that Member States fulfil the obligations created by the Chicago Convention."
Paragraph (4) of the introductory text of the Basic Regulation reads: "The Community should lay down, in line with standards and recommended practices set by the Chicago Convention, essential requirements applicable to ... The Commission should be empowered to develop the necessary implementing rules."
Therefore any proposal below ICAO Standard is unacceptable.

The risk of sudden incapacitation does not change if flying a Cessna with 3 passengers under class 2 or LPL requirements. The gap between the age of 16 and 45 without any medical examination or medical self - declaration, opens the door for all pilots, who are unable for a medical self assessment, due to illnesses like psychosis, mania, depression ,alcohol or drug dependency and others, which occur most frequently just in this gap between 16 and 45.
The normal standard of alcohol dependent patients in the working population is 5 to 7% ,
1 to 3 % are suffering from depression or psychosis. If only 5 % of these patients are flying in that time gap between16 and 45 while possessing a valid medical issued at the age of 16, between 1000 up to 3500 pilots with aircrafts up to 2000kg with maximum 3 passengers on board, will take part in the normal daily air traffic only in Germany.
Arguments that this happens also with thousands of car drivers each day are not solid, because normally cannot violate airspace where Boeings 747 are flying. In case of collision of an commercial aircraft and a Cessna 172, it is normally a fatal accident for both aircrafts, which means that such a flying patient can kill hundreds of passengers.
. From a medical point of view the validity periods of the LPL are not acceptable.
(1): Even when applying for marathon competition or diving, medical certificates, not older than 2 - 3 years, are required in young applicants for the experience of sudden cardiac death or otherwise incapacitation have to be expected in sporting events. Besides, control of vision, that may worsen considerably between age 30 - 45, is a major goal of medical examination in young leisure pilots.
So should a sportsman, who only may put at risk himself, be subdued to more rigid examinations than a leisure pilot, who may put at risk 3 more passengers or far more people when crashing into a crowded site?
(2) In case of a damage, jurisdiction and insurance companies might be in the situation, that the pilot's last "medical" is as old as 30 years (student pilot at age 15, no further examination until age 45), so in fact there is no medical certificate that could give information, if the affected pilot was medically qualified or not at all to perform flight-duties.
(3) Passengers boarding for sightseeing flights on LPL aircraft should have a minimum safety level, that "their" pilot is medically qualified to take them for a ride without jeopardising their lives. As they are not able to recognize the pilot's sternotomy-scar following bypass-grafting or similar sequelae, they must rely on the presumption, that only medically qualified personnel may hold a flying licence.

	Class 2 regulations form a minimum of safety standard in respect of the privilege to carry passengers. **Proposal:** Take the same validity dates for LPL as for class 2
response	*Noted*
	See response to comment No 48 of this segment.

comment	*984*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: **2**
MED .A. 055 Validity, revalidation and renewal of medical certificates
(c) Renewal
(ii)

Page: 8

Relevant Text:
(ii) if the medical has expired for more than 5 years, the requirements for initial issue shall apply.

Comment:
If a pilot is experienced with some hundred flying hours and his medical has expired for more than 5 years and this pilot got older, it might happen that he/she does not meets the criteria of an first examination. E.g. Astigmatism is allowed for first examination class 1 only up to two dioptres, at revalidation exceeding 2 dioptres is allowed. Why should it be a safety risk, if this pilot is assessed fit exceeding 2 dioptres.

Proposal: The (ii) text should clarify, that the requirements of the medical investigation for a first medical examination shall be performed if the medical certificate has expired for more than 5 years. For the fit/ unfit medical assessment the values / restrictions of a revalidation shall be used by the AeMC / AME.

response	*Noted*
	See response to comment No 795.

comment	*1024*	comment by: *ASSOCIATION EMAM*

A propos de la « Notice of Proposed Amendment » (NPA) N° 2008-17c.

Projet de modifications dans la réglementation de l'aptitude médicale aéronautique : point de vue d'un groupe de huit médecins agréés de Haute Savoie en France : A. ALBORINI, A. BONIDAL, P. CIBOULET, G.

DEBRAY, D. HEILIGENSTEIN, D. MACHEDA, J.M. MANIGLIER, J. RIEGEL. Association Entretiens de Médecine Aérospatiale de Mégève (EMAM).

C'est avec intérêt que nous avons pris connaissance du dernier projet de l'European Aviation Safety Agency (EASA), en particulier la partie C, c'est-à-dire la partie médicale.
Nous aimerions apporter des commentaires simplement sur les modalités de surveillance médicale de la Leisure Pilot Licence (LPL).
Nous avons compris que cette LPL pouvait concerner l'ensemble ou presque de la population navigante des aéroclubs, héliclubs, clubs de vol à voile et de ballon.
Nous avons compris que le privilège de cette licence permettrait de partager tous les espace aériens à l'exclusion simplement de celui de classe A.
Nous avons compris que cette licence autoriserait ses détenteurs à pratiquer toutes sortes de vols, dont certains exigeant sur le plan médico-physiologique : voltige, vol d'onde à très haute altitude, vol en montagne...
Nous avons compris que la surveillance médicale aéronautique de cette licence serait très simplifiée.
Nous pensons que cette simplification du suivi médical de ces pilotes n'est pas justifiée pour différentes raisons :

- - les statistiques françaises d'accidents aériens telles que nous les connaissons n'apportent rien d'objectif permettant de justifier une libéralisation de la surveillance médicale.
- - L'incidence des accidents pour raison médicale est sans aucun doute sous évaluée car la recherche de la cause médicale d'accidents est difficile et empêchée par l'absence d'autopsie après un accident mortel.
- - Il n'est pas certain que la population des pilotes français comprenne rapidement la portée de leur engagement à solliciter eux-mêmes le médecin pour vérifier une aptitude à voler après un évènement médical.
- - Le suivi médical nous paraît être un point important à conserver dans le cadre de l'expertise médico-aéronautique, afin d'éviter les situations où le pilote continuerait à voler en ayant perdu les critères d'aptitude.

Par ailleurs, sur un plan historique, tout le monde sait bien que l'introduction de la sélection médicale des pilotes s'est imposée il ya très longtemps à cause d'une accidentologie fortement corrélée au facteur physiologique. Elle s'est développée par la suite fait au fil des années parallèlement aux avancées scientifiques. Ce serait dommage de risquer de revenir en arrière et d'attendre l'apparition d'accidents nouveaux pour revenir à des règles plus restrictives.

Enfin, nous remarquons qu'en France, la règlementation pour l'accès aux sports de compétition, plongée, parachutisme, sports automobiles est conditionnée à une visite médicale annuelle. Envisager la quasi disparition d'un suivi médical jusqu'à 45 ans pour des pilotes d'avion paraît dans ce contexte fortement paradoxal.

Ainsi notre proposition est d'appliquer aux futurs pilotes détenteurs d'une LPL les mêmes règles de surveillance médicale que les pilotes de classe 2.

response *Noted*

	See response to comment No 48 of this segment.

comment	*1067*	comment by: *Gerhard Hehl*
	Class 2 medical: Die Gültigkeitsdauer zwischen 50 und 60 ist mit 12 Monaten zu kurz. Es sollten zwischen 40 und 60 Jahren 24 Monate und über 60 Jahren 12 Monate sein. Es werden überzogene Kosten produziert.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*1070*	comment by: *Dr. Ludger Beyerle*
	MED .A. 055 Validity, revalidation and renewal of medical certificates (a) Validity **Page**: 7 **Relevant Text:** (4) LPL medical shall be valid : (i) until the age of 45 (ii) between the age of 45 and 60, for a period of 60 months..... (iii) after the age of 60, for a period of 24 months. **Comment**: There is no reason to introduce validity periods for LPL, below ICAO standards, different from those for class 2. Both types of licenses will give privileges to fly the same classes of aircraft, including carrying passengers. Paragraph (3) of the introductory text of the Basic Regulation reads: "Community essential requirements and rules adopted for their inplementation should ensure that Member States fulfil the obligations created by the Chicago Convention." Paragraph (4) of the introductory text of the Basic Regulation reads: "The Community should lay down, in line with standards and recommended practices set by the Chicago Convention, essential requirements applicable to ... The Commission should be empowered to develop the necessary implementing rules." Therefore any proposal below ICAO Standard is unacceptable. The risk of sudden incapacitation does not change if flying a Cessna with 3 passengers under class 2 or LPL requirements. The gap between the age of 16 and 45 without any medical examination or medical self - declaration, opens the door for all pilots, who are unable for a medical self assessment, due to illnesses like psychosis, mania, depression ,alcohol or drug dependency and others, which occur most frequently just in this gap between 16 and 45. The normal standard of alcohol dependent patients in the working population is 5 to 7% , 1 to 3 % are suffering from depression or psychosis. If only 5 % of these patients are flying in that time gap between16 and 45 while possessing a valid medical issued at the age of 16, between 1000 up to 3500 pilots with aircrafts up to 2000kg with maximum 3 passengers on board, will take part in the normal daily air traffic only in Germany.	

Arguments that this happens also with thousands of car drivers each day are not solid, because normally cannot violate airspace where Boeings 747 are flying. In case of collision of an commercial aircraft and a Cessna 172, it is normally a fatal accident for both aircrafts, which means that such a flying patient can kill hundreds of passengers.
. From a medical point of view the validity periods of the LPL are not acceptable.
(1): Even when applying for marathon competition or diving, medical certificates, not older than 2 - 3 years, are required in young applicants for the experience of sudden cardiac death or otherwise incapacitation have to be expected in sporting events. Besides, control of vision, that may worsen considerably between age 30 - 45, is a major goal of medical examination in young leisure pilots.
So should a sportsman, who only may put at risk himself, be subdued to more rigid examinations than a leisure pilot, who may put at risk 3 more passengers or far more people when crashing into a crowded site?
(2) In case of a damage, jurisdiction and insurance companies might be in the situation, that the pilot's last "medical" is as old as 30 years (student pilot at age 15, no further examination until age 45), so in fact there is no medical certificate that could give information, if the affected pilot was medically qualified or not at all to perform flight-duties.
(3) Passengers boarding for sightseeing flights on LPL aircraft should have a minimum safety level, that "their" pilot is medically qualified to take them for a ride without jeopardising their lives. As they are not able to recognize the pilot's sternotomy-scar following bypass-grafting or similar sequelae, they must rely on the presumption, that only medically qualified personnel may hold a flying licence. Class 2 regulations form a minimum of safety standard in respect of the privilege to carry passengers.

Proposal:
Take the same validity dates for LPL as for class 2

response

Noted

See response to comment No 48 of this segment.

comment

1093 comment by: *Regierung von Oberbayern-Luftamt Südbayern*

Nach (a) Nr. 4 gilt das (einmalig) einzuholende LPL-Medical bis zum 45. Lebensjahr.

Dies führt dazu, dass z. T. über einen Zeitraum von mehr als 30 Jahren bei LPL-Inhabern keine flugmedizinische Untersuchung durchgeführt werden muss (beispielsweise könnte so ein 13-jähriger Schüler, der mit der Segelflugausbildung beginnt, ein Medical einholen, das bis zu seinem 45. Lebensjahr Gültigkeit besitzt).

Diese Zeitspanne halten wir für deutlich zu lang. Jeder Privatpilot sollte wenigstens einmal alle 5 Jahre (hilfsweise: alle 6 bis 8 Jahre) eine flugmedizinische Untersuchung durchführen lassen. Auch kostenmäßig dürfte dies - angesichts der Gesamtkosten die das Hobby des Fliegens mit sich bringt - keine übermäßige und erkennbar ins Gewicht fallende Belastung für den Privatpiloten darstellen. Einen erkennbaren Sicherheitsgewinn würde dies jedoch mit sich bringen.

Die Unterscheidung der Gültigkeitsdauer von Class-1-Medicals und Class-2-Medicals ist einleuchtend. Ein Berufspilot wird im gewerblichen Verkehr tätig. Die Passagiere, die in der Regel keine Wahl haben, wer ihr Pilot auf dem jeweiligen Flug ist, sind in höchstem Maße darauf angewiesen, dass der Pilot in gesundheitlicher Hinsicht uneingeschränkt flugtauglich ist und dies in regelmäßigen und kurzen Abständen überprüfen lässt. Nicht nachvollzogen kann hingegen, warum bei den Privatpiloten eine ganz erhebliche Unterscheidung zwischen LPL-Piloten und PPL-Piloten gemacht wird. Unterschiedliche Sicherheitsrisiken, die unterschiedliche gesundheitliche Anforderungen rechtfertigen würden, können bei diesen Arten der fliegerischen Betätigung nicht erkannt werden. Insbesondere kann der Inhaber eines LPL Luftfahrzeuge bis 2 Tonnen fliegen.

response *Noted*

See response to comment No 48 of this segment.

comment *1098* comment by: *Moldavian Society of Aviation Medicine*

See my comments to MED.A.020(b) and MED.A.030(b)(3).

Proposal: to delete MED. A. 055 (4), all other paragraphs and Sections concerning the LPL medical certificates and GMPs as we proposed in Comment to MED.A.020(b) to refer medical certification of LPL licence to Class 2 and renumber the items throughout the text.

response *Not accepted*

The Basic Regulation (Article 7) allows a GMP to issue a medical certificate for an LPL licence (if permitted under national law). This has to be taken into account in the Implementing Rules.

Also see response to comment No 48 of this segment.

comment *1118* comment by: *BALPA*

MED.A.055
Validity, revalidation and renewal of medical certificates
(c) Renewal

(ii) If the medical certificate has expired for more than 5 years, the requirements for initial issue shall apply.

*At present, if a licence holder allows his Medical Certificate to expire by more than five years, renewal shall require an initial or **extended** aeromedical examination at AMS discretion, performed at an AMC which has obtained his relevant medical records. This current position should be maintained, rather than a blanket imposition of initial standards.*

Suggested replacement text:

	(ii) If the medical certificate has expired for more than 5 years renewal shall require an initial or extended aeromedical examination at AMS discretion performed at an AMC which has obtained his relevant medical records.
response	*Noted*
	See response to comment No 795. The wording "at AMS discretion" is not used in the NPA. In order to avoid ambiguous wording in the Implementing Rules, we proposed to apply initial requirements for cases when the validity of the medical certificate has expired more than 5 years.

comment	*1148*	comment by: *Keith WHITE*
	055 (4) (iii). The UK BGA medical requirements [Laws and Rules para 16.3] require revalidation of a glider pilot's licence every year from the age of 65. Suggest that **from age 65 the medical renewal requirement be 1 year**	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*1172*	comment by: *Felix.Reichl*
	To be in line with class1 medical I suggest to change class 2 medical to the 24month interval until you reach the age of 60 and afterwards 12 month validity.	
response	*Noted*	
	See response to comment No 108.	

comment	*1211*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.055 (a)(4) **Comment**: There is no reason to introduce validity periods for LPL, below ICAO standards, different from those for class 2. Both types of licenses will give privileges to fly in the same classes of airspace, with the same classes of aircraft, including carrying passengers and thus should be subject to the same medical criteria, including the validity periods. Different validity periods for the same privileges do not follow the principle of equity. For a LPL medical certificate there might be 30 years between the initial and next examination, during which time a lot of medical conditions may develop, especially in the field of psychiatry and alcohol or substance abuse. This proposed extended validity period will most probably have a negative impact on flight safety. Thus, this Implementing Rule does not ensure that the level of safety is maintained, which is required in Article 7 of the Basic Regulation. Also, paragraph (3) of the recital to the Basic Regulation reads: "Community essential requirements and rules adopted for their implementation should ensure that Member States fulfil the obligations created by the Chicago Convention."	

	Also, paragraph (4) of the recital to the Basic Regulation reads: "The Community should lay down, in line with standards and recommended practices set by the Chicago Convention, essential requirements applicable to ... The Commission should be empowered to develop the necessary implementing rules." The proposal in MED.A.055 (a)(4) would enforce a regulation on all EU member states, making it impossible to fulfil the obligations crated by the Chicago Convention which is not acceptable. **Proposal**: The paragraph MED.A.055 (a)(4) should be deleted.
response	*Noted*
	The Basic Regulation (Article 7) allows a GMP to issue a medical certificate for an LPL licence (if permitted under national law). This has to be taken into account in the Implementing Rules. See also response to comment No 48 of this segment.

comment	*1212*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.055 (c)(2)(ii) **Comment**: The current requirements in JAR-FCL states that the requirements for initial examination shall apply; however the assessment shall be according to the requirements for revalidation/renewal. This procedure is more appropriate and is recommended to be kept in the EASA IRs. **Proposal**: The paragraph MED.A.055 (c)(2)(ii) should be amended: " ... the requirements for initial examination shall apply. Assessment shall be performed according to the requirements for revalidation/renewal."	
response	*Noted*	
	See response to comment No 795.	

comment	*1313*	comment by: *Joachim Grohme*
	Allein um den Bestimmungen der Basic Regulation zu genügen sollte das Intervall auf 20 Jahre bis zum Alter von 60 Jahren und auf 10 Jahre für die Zeit danach festgelegt werden. Wie bereits bei MED.A.020 aufgezeigt, ist eine regelmässige medizinische Untersuchung der Flugsicherheit in der privaten Luftfahrt bzw. Freizeitfliegerei nicht dienlich.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	1334	comment by: Diether Memmert

Betreff: MED.A.020 (b) und (c), sowie MED.A.055 (a) lit.3, 4 und 5

Sehr geehrte Damen und Herren von der EASA,

wir reden hier doch ausschließlich von Sicherheitserfordernissen gegen Dritte, die jedoch dem Grundsatz der Verhältnismäßigkeit entsprechen müssen.
Es gibt eben keinerlei Statistiken, Untersuchungen oder fundierte Erkenntnisse, die es erforderlich machen, daß auch Segelflieger zur Vermeidung von Gefahren gegenüber unbeteiligten Dritten ein Pflicht-'medical' brauchen.
Segelflieger sind in dieser Hinsicht mit gewerblichen Motorfliegern oder gar Verkehrspiloten auf Grund ihrer speziellen Betriebserfordernisse überhaupt nicht zu vergleichen.
Sie wissen sicher mindestens so gut wie ich, daß sämtliche Unfalluntersuchungen von AOPA/FAA, BEKLAS, Rapport-Sénateur-Belot, Schweiz und UK zeigen, daß generell medizinische Ursachen bei Flugunfällen wesentlich unter 1% und demgemäß Gefährdungen unbeteiligter Dritter noch mehrere Zehnerpotenzen darunterliegen. Dabei liegen die Unfallraten mit medizinischem Hintergrund bei Piloten mit 'medical' aber noch über denen der Piloten, die kein 'medical' absolvieren mußten.
Diese 'medicals' Segelflug sind ein Relikt aus der unseligen Zeit, wo zu militärischen Zwecken auch "die Deutschen ein Volk von Fliegern werden sollten".
Der andere Grund sind möglicherweise die Fliegerärzte, die natürlich nicht mehr auf die gewohnten Einkünfte verzichten wollen, ohne aber eine 100%ige Garantie bieten zu können, daß bis zur nachfolgenden Untersuchung keine gesundheitlichen Beeinträchtigungen auftreten werden. D.h. diese Untersuchungen sind ausschließlich Geldschneiderei, bieten aber keinerlei Sicherheitsgewinn.
Es reicht ganz sicher nach Einmaluntersuchung zu Beginn der Ausbildung, wenn Pilot und Hausarzt periodisch bestätigen, daß keine zu plötzlicher Handlungsunfähigkeit führenden Krankheiten bekannt sind!
Außerdem, wie war das eigentlich mit der Eigenverantwortung des mündigen Piloten? (s. MED.A.025 (a)!)

Falls Sie aber trotzdem auf Nachuntersuchungen nicht glauben verzichten zu können, so könnte allenfalls eine an den Erfordernissen für gewöhnliche Autofahrer orientierte Vorgehensweise infrage kommen.

Im Neuanfang des vereinten Europa sollten Sie endlich die Konsequenzen ziehen und auf diese nutzlosen, teuren und überholten Zöpfe verzichten, die keinerlei Sicherheitszuwachs bringen. Das Geld sollte man lieber in mehr Flugpraxis stecken.

Mit freundlichen Grüßen
Dipl.-Ing. TU Diether Memmert, Segelflugpilot seit 1953 mit > 8500 Segelflugstunden.

ÄNDERUNGEN

Neufassung von (a)/(3) wobei (I),(II),(III) bleibt:
dazu (IV)

	Inhaber einer SPL und/oder TMG 60 Monate Neufassung von (a)/(4) wobei (I),(II),(III) bleibt: **dazu (IV)** *Inhaber einer LPL(S) und/oder TMG 60 Monate* *Ebenso sind **MED.A.020 (b) und (c)** entsprechend zu ändern.*
response	*Not accepted*
	SPL is a licence for private flying and requires holding a class 2 medical certificate with the validity periods established for class 2, which is also an ICAO standard. LAPL(S) pilots shall hold a LAPL medical certificate with the validity periods established for the LAPL medical certificate. See also response to comment No 48 of this segment.

comment	*1338*	comment by: *ophtalmologie aerospace medecin*
	Comment: If a pilot needs glasses, changes in refraction occur. Myopia in young ages, astigmatism in middle ages and presbyopia later on. We need to prevent problems like anisometropia resulting in monocularity , or undercorrection ,of refractive errors , which may result in squinting and therefore headaches all day long. Therefore it is necessary to follow up on the refraction and its correction. Also overcorrection, which often occurs in middle ages, can cause problems like headaches. These incorrect optic corrections and resulting headaches can distract the concentration and attention during flight. The routine ophthalmological examination has been dropped by the medical subcommittee of the JAA. This was done as not to burden those pilots, who have no optic correction and therefore see well, do not suffer from any eye- disease or complications. But the idea was to send pilots to an ophthalmologist if problems occur! **Proposal**: If an applicant needs correcting glasses or lenses or has any kind of ophthalmic problem, an ophthalmic evaluation by an ophthalmologist has to be performed every 24 months.	
response	*Noted*	
	See response to comment No 303 of this segment.	

comment	*1405*	comment by: *Prutech Innovation Services Ltd.*
	MED.A.055(4): *LPL validity periods are not very wrong but need to recognise more the type of flying carried out by leisure pilots (mainly open country avoiding busy and/or controlled areas). Also that those pilots are duty-bound in any case to report medical conditions that arise for them. The vast majority would do so honestly anyway and the dishonest ones will in any case avoid being grounded by medicals, regardless of age rules.* *Accordingly, we think the more appropriate LPL periodicities should be:*	

	(i) until 60 *(ii) between 60 and 75, for a period of 24 months* *(iii) over 75, every 12 months*
response	*Noted*
	See response to comment No 48 of this segment.

comment	*1432*	comment by: *Claudia Steinbach*
	Dear Sir or Madam, are there data which can prove that for older people the intervals between renewals of the medical must be shorter than 2 years? I believe relying on empirical data would not even justify this interval! There are a lot of young people who have heart attacks or serious infections in between the interval which cannot be controlled. Shorter Intervals are typical for paternalism, which weakens self-responsibility, and low self-reliance is an attitude which is least wanted in the aviation. And what is the Equality Act for? Why is an LPL-Pilot over 60 of better health than PPL-Pilot over 50 years. Probably this is a joke, but sorry, this field of licences should be taken more serious! Proposal: All pilots in accordance to your suggestion should have a medical recheck every 24 months! (cp. MED.A.055(a)(4)(iii))	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*1434*	comment by: *Joachim Werner*
	Dear Sir or Madam, I wonder why the age for a medical retest for older people is again reduced from 2 years (JAR-FCL) to every year (cp. MED.A.55(a)(3)(III)? Are there empirical statistics which show that after the age of 50 there are sudden and unexpected diseases which are critical for a flying pilot? What is the General Equal Treatment Act for? For a car driver age is no factor, why for a pilot? The damage a crashing small airplane can cause is in no way higher than the often appearing chain-reaction collisions on our Autobahnen. **Please correct a print error in MED.A.055(a)(4)(iii): Pilots with LPL over 60 are not healthier than pilots with PPL over 50!!** Suggestion: Medical check for very young people every 5 years and for all others at most(!) 2 years. There is no empirical evidence for crashes because of age! Considering the **real risk** a **5-years-term would suffice**. All shorter intervals are pure capriciousness. I am missing data, otherwise arguments are arbitrary. I know the department of Safety and Research has recorded various accident categories, but did not draw the obvious conclusions. Evidently (?) the data are absolute and not relative numbers, so that comparison of EASA and US is not given. Social sciences offer plenty of opportunities for valid empirical investigations and have enumerated a lot of mistakes which can happen. Statistics are a sensitive field and have to be handled by experts, otherwise one can prove everything.	

response	*Noted*
	See response to comment No 48 of this segment. There is no difference between validity periods of medical certificates between JAR-FCL and PAat MED as proposed in NPA 2008-17 (c): "JAR-FCL 3.105 (a) A medical certificate shall be valid .... for (2) Class 2 medical certificates, 60 months until age 40, then 24 months until age 50 and 12 months thereafter."

comment	*1441*	comment by: *David COURT*
	The Regulatory Impact Assessment (NPA 22f page 160 of 165) uses a validity period of 24 months for the Class 2 medical after age 50. The validity period for Class 2 age above 50 should be increased to 24 months to match the RIA.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*1551*	comment by: *British Airways*
	Para (c) (2) (ii) states "if the medical has expired for more than 5 years, the requirements for initial issue shall apply." It is not clear whether this refers to the administrative requirements, i.e. that the certificate must be issued by the licensing authority, or whether it also means that the initial medical standards should apply, where these are more stringent than those for renewal. There is no rationale to support a requirement to meet medical standards more stringent than those required for renewal. **Proposal:** Clarify which requirements apply.	
response	*Noted*	
	See response to comment No 795.	

comment	*1570*	comment by: *FAA*
	MED.A.055 (a) (2) (i): U.S. commercial pilots engaged in single-crew, commercial air transport operations carrying passengers have a 12-month validity on their medical certificates regardless of age. A 12-month validity for individuals exercising commercial pilot privileges has provided a consistently high level of safety for many years. Therefore no cause exists to modify this standard to require a 6-month validity for single-crew operations. Difference is filed with ICAO. MED.A.055 (a)(3)(i) (ii): The U.S. does not truncate medical certificate validity periods to this extent. The U.S. validity standard is set forth in terms of pilots under age 40 and pilots over age 40 only.	

	MED.A.055 (a)(3) (iii): A 24-month period of validity for private pilots after age 50 has been long-standing in the United States with no adverse impact on safety. MED.A.055: (a)(4): The United States does not have an equivalent to EASA LPL standards. MED.A. 055 (a)(5), (b), and (c): The U.S. has initial issue medical examinations but does not have codified in its regulations an equivalent to EASA renewal and revalidation examinations
response	*Noted*
	Thank you for the information.

comment	*1586*	comment by: *Axel Mitzscherlich*
	(a)(4) LPL medical certificates: all these three periods should give enough safety in this segment and should be kept.	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1587*	comment by: *Axel Mitzscherlich*
	(a)(3) Class 2 medical certificates (i),(ii) these period are okay and should be kept (iii) the validity of 12 months should be shifted to the age after 60 as it is the common experience that this timeframe is sufficient to support flight safety.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*1609*	comment by: *Dr Lilla Ungváry*
	Relevant Text: Class 2 medical certificates shall be valid for a period of: (i) 60 months until the pilot reaches the age of 40. A medical certificate issued prior to reaching the age of 40 shall cease to be valid after the pilot reaches the age of 42. **Comment**: If a pilot needs glasses, changes in refraction occur. Myopia in young ages, astigmatism in middle ages and presbyopia later on. We need to prevent problems like anisometropia resulting in monocularity, or undercorrection ,of refractive errors , which may result in squinting and therefore headaches all day long. Therefore it is necessary to follow up on the refraction and its correction. Also overcorrection, which often occurs in middle ages, can cause problems like	

	headaches. These incorrect optic corrections and resulting headaches can distract the concentration and attention during flight. The routine ophthalmological examination has been dropped by the medical subcommittee of the JAA. This was done as not to burden those pilots, who have no optic correction and therefore see well, do not suffer from any eye- disease or complications. But the idea was to send pilots to an ophthalmologist if problems occur! **Proposal**: If an applicant needs correcting glasses or lenses or has any kind of ophthalmic problem, an ophthalmic evaluation by an ophthalmologist has to be performed every 24 months.
response	*Noted*
	See response to comment No 303 of this segment.

comment	*1610*	comment by: *Dr Lilla Ungváry*
	Relevant Text: LPL medical certificates shall be valid: i. until the age of 45 Specific requirements for LPL medical certificates **Comment**: LPL pilots and class 2 pilots use the same airspace and can fly nearly the same type of aircrafts (in class 2 only heavier and with a higher cruising range) and they have the same privileges. Therefore it does not make sense to have, from a safety perspective, different requirements for these two kinds of licenses. LPL pilots may even have glass cockpits with a lot of colour information. Safety issues should not be decided upon by politicians, but by specialist. It looks like the LPL is introduced only as a result of enormous pressure of the leisure pilot associations. The requirements are lower than the ones for sailing a boat on a lake. If a plane with the weight of two tons crashes in a public building it can cause fatal accidents and death to people in this area. **Proposal**: LPL requirements should be the same as class 2 including a comprehensive ophthalmological eye examination by an ophthalmologist at initial examination or if indicated.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*1616*	comment by: *Helmut PRANG*
	The proposed validity of Class 2 medical certificates (3) does not reflect the increasing fitness of our aging demography and instead appears to be based on historic data and experience carried forward. Reference to mortality tables underlines physical and mental fitness of	

	traditionally older generations over and beyond the age classes referenced in the proposal. I propose to update the age in (3) (i) from 40 to 50 years, in (ii) to raise the age span to between 50 and 60 and in (iii) to beyond 60 years.
response	*Noted*
	See response to comment No 48 of this segment.

comment	*1622*	comment by: *Bayerisches Staatsministerium für Wirtschaft, Infrastruktur, Verkehr und Technologie*
	Nach (a) Nr. 4 gilt das (einmalig) einzuholende LPL-Medical bis zum 45. Lebensjahr. Dies führt dazu, dass z.T. über einen Zeitraum von mehr als 30 Jahren bei LPL-Inhabern keine flugmedizinische Untersuchung durchgeführt werden muss (beispielsweise könnte so ein 13-jähriger Schüler, der mit der Segelflug ausbildung beginnt, ein Medical einholen, das bis zu seinem 45. Lebensjahr Gültigkeit besitzt). Diese Zeitspanne wird für deutlich zu lang gehalten. Jeder Privatpilot sollte wenigstens einmal alle 5 Jahre (hilfsweise: alle 6 bis 8 Jahre) eine flugmedizinische Untersuchung durchführen lassen. Auch kostenmäßig dürfte dies - angesichts der Gesamtkosten die das Hobby des Fliegens mit sich bringt - keine übermäßige und erkennbar ins Gewicht fallende Belastung für den Privatpiloten darstellen. Zudem würde dies einen erkennbaren Sicherheitsgewinn mit sich bringen. Die Unterscheidung der Gültigkeitsdauer von Class-1-Medicals und Class-2-Medicals ist plausibel. Ein Berufspilot wird im gewerblichen Verkehr tätig. Die Passagiere, die in der Regel keine Wahl haben, wer ihr Pilot auf dem jeweiligen Flug ist, sind in höchstem Maße darauf angewiesen, dass der Pilot in gesundheitlicher Hinsicht uneingeschränkt flugtauglich ist und dies in regelmäßigen und kurzen Abständen überprüfen lässt. Nicht plausibel ist hingegen, warum bei den Privatpiloten eine ganz erhebliche Unterscheidung zwischen LPL-Piloten und PPL-Piloten gemacht wird. Unterschiedliche Sicherheitsrisiken, die unterschiedliche gesundheitliche Anforderungen rechtfertigen würden, können bei diesen Arten der fliegerischen Betätigung nicht erkannt werden. Insbesondere kann der Inhaber eines LPL Luftfahrzeuge bis 2 Tonnen fliegen.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*1717*	comment by: *Norwegian Association of Aviation Medicine*
	If there should be a separate LPL medical, this limit should be 40 years as in the other medical classes.	

response	*Noted*
	The LAPL medical certificate, although redrafted, is below ICAO standards and the validity periods of medical certificates are therefore different.

comment	*1731*	comment by: *Civil Aviation Authority Finland*
	MED.A.055 (a) (4) (i) The validity periods for Medical Certificates of LPL are extremely too long, especially in the youngest age group. The experience has shown, that certain medical conditions are commonly present under the age of 45, in particular, psychiatric problems and alcohol and substance abuse. These are the commonest medical cause of general aviation accidents and will not be reported by the pilots spontaneously. Medical assessment is required more often than once during the period from first examination until the age of 45. The same periodicity as for Class 2 should be kept.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*1734*	comment by: *DCA Malta*
	MED.A.055 (4) Should be the same as a(3) The validity of the LPL medical certificate should be the same as for the Class 2.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*1759*	comment by: *Max Heinz Katzschke*
	a) Warum werden hier von der ICAO-Regelung abweichende Fristen eingeführt ? Dies ist unnötiger bürokratischer Aufwand. Die Dauer der Gültigkeit von Medicals und relevanten Selbsterklärungen sollte mit den gleichen Fristen wie von der ICAO vorgegeben geregelt werden. b) AMEs, AMCs und GMP sind ausreichend kompetent zu entscheiden, ob ein Medical gegeben werden kann; Allgemeinarzt oder Facharzt ebenfalls (zur Feststellung der Eignung zum Fliegen oder Bedenken dagegen). Festlegungen (c)(1) sind deshalb nicht erforderlich.	
response	*Noted*	
	See responses to the comments No 48 and 419 of this segment.	

comment	*1881*	comment by: *AECA(SPAIN)*
	(a)(4) The periods of validity for LPL medical certificates are not acceptable. We think that the same periods as for class 2 medical certificate are right. Justification: Between 16 and 45 years of age the changes in health of persons are significative: e.gr. from adolescence to maturity...	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*1894*	comment by: *Susana Nogueira*
	(a)(4) Delete all paragraph. (a)(3) Class 2 **and LPL** medical certificates... The periodicity is to large for every age stage according to the way of life.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*1948*	comment by: *Civil Aviation Authority of Norway*
	Comment to (a) (4): According to the proposal a medical certificate issued at the age of 16 is valid until the age of 45, a period of 29 years. That seems far too long. The frequency of ICAO class 2 seems to be more appropriate.	
response	*Noted*	
	See response to comment No 75.	

comment	*2008*	comment by: *Lars Tjensvoll*
	remove part 4.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*2022*	comment by: *Dick*
	I understand that when i have reached the age of 60, I can't longer fluy a balloon for my profession. Is it not possible that between 60 and 65 the certificate is valid for a period of 6 months? Nowedays the condition of pepeople is better en let a doctor check that condition en when its oké, then give a medical certificate for 6 months.	

response	*Noted*
	Commercial operations above age 60 are only possible in a multi-pilot environment. This includes commercial ballooning. Please, refer to the responses to the comments to FCL.065 of NPA 2008-17b.

comment	*2061*	comment by: *French Fédération Française Aéronautique groups the 580 French powered flying aer-clubs and their 43 000 private pilots*
	Med.A.055 - Validity, revalidation and renewal of medical certificates. (a) (3) *Class 2 medical certificates.* FFA supports class 2 medical certificates validity, however, in order to be more ICAO compliant, FFA supports and asks for a 24 month validity after the age of 50.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*2062*	comment by: *French Fédération Française Aéronautique groups the 580 French powered flying aer-clubs and their 43 000 private pilots*
	Med.A.O55 (a)(4) - LPL medical certificates. The FFA agrees and supports the proposed validity for LPL medical certificates.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*2073*	comment by: *CAA Belgium*
	Relevant Text: (4): LPL medical certificates shall be valid: (…) Comment: From a medical point of view the validity periods of the LPL are not acceptable. (1): Even when applying for marathon competition or diving, medical certificates, not older than 2 – 3 years, are required in young applicants for the experience of sudden cardiac death or otherwise incapacitation have to be expected in sporting events. Besides, control of vision, that may worsen considerably between age 30 – 45, is a major goal of medical examination in young leisure pilots. So should a sportsman, who only may put at risk himself, be subdued to more rigid examinations than a leisure pilot, who may put at risk 3 more passengers or far more people when crashing (2) In case of a damage, jurisdiction and insurance companies might be in the situation, that the pilot's last "medical" is as old as 30 years (student pilot at age 15, no further examination until age 45), so in fact there is no medical certificate that could give information, if the affected pilot was medically qualified or not at all to perform flight-duties. (3) Passengers boarding for sightseeing flights on LPL aircraft should have a minimum safety level, that "their" pilot is medically qualified to take them for a ride without jeopardising their lives. As they are not able to recognize the pilot's	

	sternotomy-scar following bypass-grafting or similar sequelae, they must rely on the presumption, that only medically qualified personnel may hold a flying licence. Class 2 regulations form a minimum of safety standard in respect of the privilege to carry passengers. Proposal: LPL examinations should be performed at the same intervals as class 2 examinations, because execution of the rights of the two licenses inheres the same risk to passengers and the public. At least the safety level of public sporting events should be guaranteed.
response	*Noted*
	See response to comment No 48 of this segment.

comment	*2099*	comment by: *Dr. Christoph Larisch*
	Die Gültigkeitszeiten der Medicals sollten mit den ICAO Regeln übereinstimmen. Es gibt keinen Grund, es anders als der Rest der Welt zu machen.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*2118*	comment by: *Direction de l'Aviation Civile Luxembourg*
	The validity of the class 2 medical certificate should be the same as for LPL medical certificate **New proposal**: Reconsider the validity of class 2 and LPL medical certificates.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*2135*	comment by: *peter Gray*
	I have argued in my response to NPA2008-17a that the distinction between the LPL(S) and the SPL is anomalous in that the training requirements are the same. Indeed it has been stated that, overall, the proposed criteria for the LPL(S) are higher than the ICAO requirements for SPL. It is also anomalous to have a lower criterion of medical fitness for the higher standard licence than for the lesser one. The logic would be to accept the less onerous medical standards for the SPL particularly since evidence, from the UK at least, indicates that the lower frequency of examinations and the lack of intervention by AeMCs have no deleterious effect on flight safety. Indeed they have a beneficial effect on the pilots pocket and the Agency should be mindful of the fact that it is not in the business of gratuitously increasing the cost burden to the populace. It may be argued that you can't have an ICAO compliant licence without an ICAO compliant medical but I submit that there is no reason why not if the pilot is flying in the EU and the EU accepts the position.	

	From the standpoint of a UK citizen the periods of renewal by full examination for class 2 and LPL medicals are excessively frequent. Symptomatic deterioration in a pilot's health will be a stimulus to seek advice and this is enshrined as a duty in this document. Conditions that may asymptomatic such as diabetes or hypertension which could carry a risk of unexpected incapitation may be detected by low cost screening as may be available at a GMP's surgery without submission to the full rigours and expense of an examination by an AeMC. Not only should a GMP be entitled to sign off a healthy pilot for both class 2 and LPL but he/she should be able to certify continuing good health indefinitely. I would propose a system for class 2 licences whereby initial and thereafter, infrequent, examinations are conducted by an AeMC and the intervening assessments are by the pilot's normal doctor (GMP) based on the GMP's knowledge of the pilot's continuing medical history, an interview to detect any new and disregarded symptoms and a simple, proscribed screen for asymptomatic patho-physiology. (e.g. urinalysis, ECG, blood-pressure, visual acuity and a routine physical examination)
response	*Not accepted*
	SPL is a licence for private flying and requires holding class 2 medical certificate. This is also an ICAO standard: refer, please, to ICAO Annex 1, Section 2.9. Glider pilot licence, paragraph "2.9.1.5: An applicant shall hold a current Class 2 Medical Assessment." When drafting the rules and AMCs, one of the objectives is to support Member States to fulfill their obligations against ICAO. However, in some clearly defined cases (e.g. LAPL) the ICAO standard is not kept. These licences are only valid in Europe but the ICAO compliant licenses are in place for all private pilots who want to fly also outside Europe. The ICAO SARPs require that medical fitness of class 2 pilots is assessed by an AME. However, the Basic Regulation provides the possibility of a GMP to assess the medical fitness for a LAPL applicant /holder if permitted under national law. See also response to comment No 48 of this segment.

comment	*2141*	comment by: *AMS Denmark*
	MED.A. 055 (a) (4) (i) LPL should follow ICAO class 2 and have the same validity period. Reason: Psychiatric problems and abuse that are very common in youger pilots will not be identified if the periodicity is up to app. 15 years....	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*2142*	comment by: *Michael Heiß*

	Due to the low amount of accidents caused by medical reasons, it is not necessary to check each glider pilot over 50 years every 12 month. This causes high costs for each pilot and if it would be necessary, it would be also necessary for all car drivers. The probability to hurt other persons through o car accident is much higher than to hurt others trough an accident with a plane under 2 tons. The decision for the time between two checkups should be left at the doctors and the pilot should have the right to improve that decision by another doctor. A general period of 12 months is to short.
response	*Noted*
	See response to comment No 48 of this segment.

comment	*2178*	comment by: *Dr.Piek Armin*
	for LPL-pilots should be valid the same obligations as for class-2-pilots	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*2208*	comment by: *Royal Netherlands Aeronautical Association*
	LPL validity: Only one medical assessment before the age of 45 years is unacceptable because in this long period there is a real risk for incapacitating diseases, e.g. cardiovascular or visual. A period of validity of 5 years until the age of 45 is recommended. It is for the applicant an strong regular reminder to take care of the importance of his physical condition in order to keep flying in a safe manner. KNVvL PROPOSAL: -Until the age of 45 years a validity of 5 years is recommended, to minimize the risk of sudden incapacitation and as a reminder for all pilots of the importance of medical fitness.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*2229*	comment by: *Ulrich Ablassmeier*
	The validity of medicals class 1 and class 2 is the same for the age from 50 to 60. It is 12 months. Due to greater resposibility of pilots needing class 1 the validity of class 2 is too short. I suggest it should be the same as in the United States. A FAA-medical for private pilots is valid 24 months for all pilots who are over 40 years old. This is also in accordance with the standards of ICAO. ICAO says a validity of 24 months is sufficient for Private Pilots. EASA should not exceed that. Investigations of FAA and AOPA-US showed that savety is not detracted. For the pilots this would mean lower cost and less bureaucracy.	

response	*Noted*
	See response to comment No 48 of this segment.

comment	*2233*	comment by: *Prof. Dr. Alexander Bubenik*
	MED.A.055 (a) (3) (ii) 24 months between the age of 40 and 60. A medical certificate issued prior reaching th age of 60 shall cease to be valid after the pilot reaches the age of 61; and (iii) 12 months after the age of 60. This places no undue threat to anybody, but reduces cumbersomenesses. Pilot incapacitation is an extremely rare matter in aviation accidents. If you wouldn't agree in principle, you would not have worded MED.A.055 (a) (4) (ii) + (iii) the way you did ...	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*2234*	comment by: *Prof. Dr. Alexander Bubenik*
	You should seriously consider if medical certificates for LPLs are necessary at all. Pilot incapacitation is an extreme rare circumstance! I'm convinced no undue threat on public safety will be the result of such a citizen (pilot)-friendly measure.	
response	*Noted*	
	To hold a medical certificate is a pre-requisite for any pilot, in accordance with Article 7 (2) of the Basic Regulation. The Implementing Rules proposed by the Agency shall not deviate from the requirements in the Basic Regulation. Furthermore, paragraph 4.a.1 of the Essential Requirements determines the following: *'All pilots must periodically demonstrate medical fitness (...). Compliance must be shown by appropriate assessment (...)'.* The Agency's view is that this requirement for appropriate assessment cannot be satisfied with the mere analysis of medical records or a self-declaration of medical fitness that is used in some Member States.	

comment	*2272*	comment by: *Ingo Wiebelitz*
response	*Noted*	
	There is no comment.	

comment	*2292*	comment by: *DLR*
	If a pilot needs glasses, changes in refraction occur. Myopia in young ages, astigmatism in middle ages and presbyopia later on. Problems like anisometropia	

	resulting in monocularity, or undercorrection ,of refractive errors , which may result in squinting and therefore headaches all day long can occur. Therefore it is necessary to follow up on the refraction and its correction. Also overcorrection, which often occurs in middle ages, can cause problems like headaches. These incorrect optic corrections and resulting headaches can distract the concentration and attention during flight. The routine ophthalmological examination has been dropped by the medical subcommittee of the JAA. This was done as not to burden those pilots, who have a good visual acuity without correction But the idea was to send pilots to an ophthalmologist if this situation changes or they have deviations from the normal right from the beginning. Proposal: If an applicant needs correcting glasses or lenses or has any kind of ophthalmic problem, an ophthalmic evaluation by an ophthalmologist has to be performed every 24 months.
response	*Noted*
	See response to comment No 303 of this segment.

comment	*2293*	comment by: *DLR*
	LPL pilots and class 2 pilots use the same airspace and can fly nearly the same type of aircrafts (in class 2 only heavier and with a higher cruising range) and they have the same privileges. Therefore it does not make sense to have, from a safety perspective, different requirements for these two kinds of licenses. LPL pilots may even have glass cockpits with a lot of colour information. Safety issues should not be decided upon by politicians, but by specialist. It looks like the LPL is introduced only as a result of enormous pressure of the leisure pilot associations. The requirements are lower than the ones for sailing a boat on a lake. If a plane with the weight of two tons crashes in a public building it can cause fatal accidents and death to people in this area. Proposal: LPL requirements should be the same as class 2 including a comprehensive ophthalmological eye examination by an ophthalmologist at initial examination or if indicated.	
response	*Not accepted*	
	The Basic Regulation (Article 7) allows a GMP to issue a medical certificate for a LAPL licence (if permitted under national law). This has to be taken into account in the Implementing Rules. Safety in aviation is ensured by many different measures, one of them being a medical certificate for private and commercial pilots. The legal basis for the medical certificate is the ICAO SARPs and the EU Basic Regulation. The latter provides the possibility to draft licensing rules tailored to the complexity of the aircraft and the kind of operation which has specifically been done in the medical field for the private pilot community by creating the leisure pilot licence. Medical requirements as regards LAPL have been developed following the principle that all measures must be proportionate and tailored to the risk involved. A comprehensive ophthalmological examination by an ophtalmoligist for LAPL applicants would be too restrictive.	

comment	2317	comment by: *AMS CAA - Hungary*
	If there will be a separate LPL medical, the expire date's should be the same as to the Class 2 medical certificate.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	2352	comment by: *RSA*
	MED A O55 paragraph (a) (3) The requirements for the validity of a Class 2 certificate are not in line with ICAO requirements The medical certificate should be valid for 24 months for pilot over the age of 40 with no additional limitation at 12 Months from the age of 51 RSA propose to amend the text to read as follows (3) Class 2 medical certificates shall be valid for a period of (i) 60 months.... (ii) ***24 months from the age of 40 years***	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	2391	comment by: *Irish Aviation Authority*
	(a)(1)(2) and (3) The validity as proposed in the NPA is supported.	
response	*Noted*	
	Thank you for the positive comment.	

comment	2392	comment by: *Irish Aviation Authority*
	(a)(4)(i) The validity periods for LPL are too long, especially for the youngest age group. Justification: Some medical conditions usually present under the age of 45, especiallyr, psychiatric problems and alcohol and substance abuse. These are the most frequent medical cause of general aviation accidents and are not reported spontaneously; more frequent medical assessment is required during the period from first examination until the age of 45.	

	Proposed text: periodicity shall be as Class 2.
response	*Noted*
	See response to comment No 48 of this segment.

comment	*2443*	comment by: *SANMA Swedish Aeronautical Associatation*
	Undersöknings intervallet för LPL är för stort.(16 år- 45 år) Mycket kan hända under detta tidsintervall och det är ansvarslöst att ej ha någon kontroll på piloten under denna tid.	
response	*Noted*	
	See response to comment No 48 of this segment.	

comment	*2565*	comment by: *Heinz Fricke-Bohl and Kirsten Bohl*
	MED.A.055: (4) LPL-Piloten sind die Klasse von Piloten, die in Deutschland mit 70 Todesfällen bei Flugunfällen/Jahr im Gegensatz zu den PPLA-Piloten 8-10 Todesfälle/Jahr die höchste Unfallquote hat. Schon aus diesem Grund müssen die Kriterien beibehalten bleiben wie bei Class 2 und somit muss dieser Punkt komplett entfallen.	
response	*Noted*	
	See response to comment No 48 of this segment.	

C. Draft Opinion Part-MED - Subpart A: General Requirements - Section 3: Suspension and revocation p. 8

comment	*986*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: **Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008** **Section**: **3** **MED.A.065 Suspension and revocation of medical certificates** **Page**: 8 **Relevant Text**: Whole paragraph a 1 ...3 b **Comment**: How shall this work? Requirements which cannot be controlled that pilots are following them are senseless. False declaration is allowed in Germany and will not be punished. How shall the violation of the provisions of paragraph MED.A.060 be	

	controlled, if there is no provision for documentation. What is a **justified concern** (see b) Does the competent authority has to go to court to get their concern justified before they can suspend a medical certificate? How will the competent authority justify something of (a) 1 - 7 without documentation. **Proposal**: MED.A.065 (b) should be amended: *"The licensing authority shall consider the need to suspend the certificate pending ..."* Make a new set up of this MED.A.065 with documentation procedures and control mechanism or skip it totally and give it to the responsibility of the pilots.
response	*Noted*
	Regarding "justified concern", see response to comment No 245 to MED.A.065. Regarding the proposed amendment to MED.A.065 (b), see response to the comment 1216 to MED.A.065.

C. Draft Opinion Part-MED - Subpart A: General Requirements - Section 3: Suspension and revocation - MED.A.060: Suspension of exercise of privileges p. 8

comment	*50*	comment by: *Bernhard Blasen*
	Strict rules for the mentioned suspension reasons should not be fixed. The GMP or AME that did the medical treatment of the pilot best can give advice wheather it's save to fly or not.	
response	*Not accepted*	
	Implementing Rules shall provide licensing authorities, AeMCs, AMEs and GMPs with the legal possibility for their aeromedical decisions. In the cases when flexibility is needed, provisions may be proposed as an Acceptable Means of Compliance.	

comment	*51*	comment by: *Bernhard Blasen*
	Pregnancy should not be a cause for suspension Reason: Pregnancy is not a disease. This rules discriminates women i an unacceptable way.	
response	*Noted*	
	Pregnancy is not a disease, but it may lead to the sudden incapacitation during flight. Therefore, special rules in line with ICAO standards and JAR FCL 3 are proposed. See MED.B.040.	

comment	*76*	comment by: *Dr.Beiderwellen, Secretary of GAAME*

	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **AMC to Med A060 c) section 3** **Page**: 8 Relevant Text: ..shall inform their doctor or vision carespecialist... **Comment**: Not qualified to decide **Proposal**: ..have to inform the AME or AMC
response	*Noted*
	See response to comment No 238 of this segment.

comment	*203*	comment by: *Ilse Janicke Heart Center Duisburg*
response	*Noted*	
	There is no comment.	

comment	*234*	comment by: *G.C. Valdonio, AOPA Italia*
	The requirements of this paragraph are ludicrously restrictive and dangerously undefined, so that they could give rise to unwarranted litigation with insurance companies and other entities on the real impairment of medical ability to fly. In particular, the following are listed as causes of loss of the medical ability: (1) "a surgical operation or invasive procedure", without stating a given level of seriousness of the intervention. So even the removal of an ingrowing nail or an endoscopy might be construed to be a cause for grounding. (2)"admitted to a hospital or medical clinic": again, even for a check-up? (3) "having commenced the regular use of any medication": are vitamines allowed? (4) first require corrective lenses - OK (5) personal injury involving incapacity - OK (6) "any illness involving incapacity ... for a period of 21 days": does a cast arm or leg cause grounding? (7) pregnancy: from day one? Please provide suitable descriptive limits, in order to avoid instrumental use of a shoddily written rule Giulio Valdonio AOPA Italia
response	*Noted*	

(1) to (3)
As defined in (b) and (c) pilots shall in these cases seek the advice of an AeMC, AME or, in case of LAPL the GMP who signed the medical certificate, before continuing to exercise the privileges of their licence. These situations usually have an underlying cause which may not be properly evaluated by the pilot himself.

(4) and (5)
Thank you for the support.

(6)
The text will be amended to be aligned with latest amendment of ICAO Annex 1 inserting "significant" instead of the time limit of 21 days.
An AMC to MED.A.060 (a) may need to be developed in a future rulemaking task to clarify the interpretation of "significant" in this context.
Medical conditions which may render a pilot unfit are detailed in Subpart B and AMCs to Subpart B.

(7)
Pregnancy - see MED.B.040(c).

comment	*237*	comment by: *Lufthansa German Airlines*

Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany
Head of Lufthansa Medical Services
Head of German Academy of Aviation and Travel Medicine
Section: **3**
MED. A. 060 - Suspension of exercise of privileges- (b)
Page: 8

Relevant Text:
(b) In these cases, holders of a medical certificate shall without undue delay seek the advice of an AeMC or AME. The AeMC or AME shall assess the medical fitness of the pilot and decide whether they are fit to resume the exercise of their privileges

Comment:
If there were an illness you could find under MED.A. 060 (a) 1 - 7 and the pilot did not seek the advice of his AME and a fit assessment was not done, then the pilot is flying with an invalid medical certificate. In case of an incident or accident, this might have a big impact on the insurance conditions for the company and for the pilot.

Proposal:
First: Print the § (a) 1 - -7 on the medical certificate to inform the pilots.
Second: A documentation of the medical advice and the fit assessment is essential because it is a revalidation of the medical certificate after serious illness. A special form should be created, which can be submitted to the pilot by e-mail or fax to give him safety that he is legal.

response *Noted*

First:
See response to the commentg No 1541 to MED.A.025.

Second:
See response to comment No 398 of this segment.

comment 238 comment by: *Lufthansa German Airlines*

Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany
Head of Lufthansa Medical Services
Head of German Academy of Aviation and Travel Medicine
Section: **3**
MED. A. 060 - Suspension of exercise of privileges- (c)
Page: 8

Relevant Text:
Holders of a LPL medical certificate shall inform their doctor or vision care specialist that they are licence holders before they are examined. If pilots are told that the conditions from which they are suffering may make it unsafe to perform their duties, they shall not exercise the privileges of their license until advised to do so by a GMP or an AME

Comment:
This text shows, that the author does not know anything about the real world of GMPs and vision care specialists. Only in Germany are there about 175 000 GMPs working in their own office, treating each day 50 to 100 sick patients. These doctors do not know anything about the privileges of a LPL or PPL license. How shall these doctors make a decision if a medical treatment or suffering by a chronic illness affects the privilege of a license. If all German license holders are seriously ill once in a year and they seek advice from their treating doctor, statistically every doctor will be asked once every two years. Does the author of this text really think that these doctors are really interested to read and learn the EASA requirements of the LPL continually, if he/she needs this only for one case every two years? Not really fit in decision making, a doubtful GMP will need time to find out what to do and where to ask. This will be counterproductive for LPL pilots, waiting for their medical o.k.

Proposal:
Use the well trained and EASA harmonized system of European AMEs.
Implement the same process and the same requirements in cases of decrease of medical fitness for LPL license holders as for Class 2 license holders. This will be time and cost effective and will provide a harmonized European safety standard in the European air space.

response *Partially accepted*

The Basic Regulation (Article 7) allows a GMP to issue a medical certificate for a LAPL licence (if permitted under national law). This has to be taken into account in the Implementing Rules.

MED.A.060 will be amended for holders of LAPL medical certificates to be in line

	with the obligations for holders of class 1 and class 2 medical certificates. In addition,the holder of a LAPL medical certificate may also seek the advice from the GMP who signed his LAPL medical certificate.

comment	*253*	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.A.060 **Page**: 8 Relevant Text: (a) Holders of class 1 and class 2 medical certificates shall not exercise the privileges granted by their licences when they (...) **Comment**: see also Comment No. 9: LPL should be subdued to the same rule as class 2, because they impose the same risks to passengers and the public. Especially if ill, following surgery or onset of regular medication, specialist advice is necessary to judge the impact of the present circumstances to the performance of flight-duties. A GMP is generally not qualified to give adequate judgement, even worse a "vision care specialist". In the rendered cases, the advice of an AME or AeMC should be seeked. **Proposal**: Drop paragraph (c.) as exception for LPL, and treat LPL equivalent to class 2.	
response	*Noted*	
	See response to comment No 238 of this segment.	

comment	*333*	comment by: *FOCA Switzerland*
	MED.A.060 Reporting of unfitness by GMP: GMPs have no aeromedical competence, therefore a different mechanisms has to be created for unfit LPL certificate holders. GMPs must be removed from this paragraph Proposed text: **delete para (c). Add LPL to the title of para (a) . New text of title of para (a) : (a): Class 1 and Class 2 and LPL medical certificates:**	
response	*Noted*	
	See response to comment No 238 of this segment.	

comment	*353*	comment by: *Teh Danish Organiation of Flight Surgeons (DAFLO)*
	Item: dot c **Objection:** Disagress **Reasons:** The extended periode of validity may reduce probability for reproting of health problems and consequently potential negative impact on flight safety.	

	Suggestions: In case of introduction of LAPL is should be mandatory for pilots experiencing health problems to consult an AME as in the case of Class 2.
response	*Noted*
	See response to comment No 238 of this segment.

comment	*395*	comment by: *European CMO Forum*
	Comment: This section should be AMC. Justification: This section describes the actions to be taken in the event of a decrease in medical fitness. The ICAO State Letter 08/33 has proposed removing the 21day requirement for illness reporting as many serious illnesses should be reported before this period has elapsed. Proposed Text: Transfer MED.A.060 to new AMC to MED.A.025.	
response	*Not accepted*	
	MED.A.060 provides with the the legal basis for the suspension of exercise of privileges and the possibility for the individual investigation of the case. This very important part of the rule is transposed from JAR FCL 3 Section 1 and therefore was proposed as an Implementing Rule. MED.A.060 (a)(6) will be amended to be aligned with latest amendment of ICAO Annex 1 inserting "significant" instead of the time limit of 21 days. An AMC to MED.A.060 (a) may need to be developed in a future rulemaking task to clarify the interpretation of "significant" in this context.	

comment	*397*	comment by: *European CMO Forum*
	MED.A.060(b) Comment: The authority must be included. Justification: The Authority may also be approached for advice. Proposed Text: Change to: `...seek the advice of an **AME, AeMC or medical assessor**. The	

	AME, AeMC or medical assessor shall assess....'.
response	*Not accepted*
	The first aeromedical advice to be sought by the pilot is AME od AeMC. They may refer the case to the licensing authority as it is proposed in AMC to MED.A.045(a).

comment	*398*	comment by: *European CMO Forum*
	MED.A.060(b) Comment: Advice must be documented. Justification: For legal reasons and authority oversight it is essential for the advice to be documented. Proposed Text: Add new AMC to MED.A.060(b**): 'The AME, AeMC or medical assessor should document the advice given to holders of medical certificates.'**	
response	*Not accepted*	
	Physicians have the professional obligation to document any advice they give. There is no need to mention that in Part Med.	

comment	*399*	comment by: *European CMO Forum*
	MED.A.060(c) Comment: This paragraph is inappropriate for GMPs. A reporting mechanism of unfitness needs to be established for the LPL. Justification: GMPs do not have aeromedical expertise. The GMP must be removed from this paragraph. Pilots who have become unfit need to seek the advice of an AME, AeMC or the authority. Proposed Text: Delete para (c) and amend title of (a) to: '**Class 1, Class 2 and LPL medical certificates**.'	
response	*Noted*	

	See response to comment No 238 of this segment.

comment	*421*	comment by: *UK CAA*
	MED.A.060 (a) (5) and (6) **Comment:** This is not compatible with the ICAO proposals in State Letter reference 1.2.6.1.1. **Justification:** The 21 day period is arbitrary and obsolete. **Proposed Text:** Delete (6) and amend (5) to '**have suffered any significant personal injury or illness involving incapacity to function as a member of the flight crew;**'	
response	*Partially accepted*	
	Thank you for the proposal. The text will be amended to be aligned with latest amendment of ICAO Annex 1 inserting "significant" instead of the time limit of 21 days. An AMC to MED.A.060 (a) may need to be developed in a future rulemaking task to clarify the interpretation of "significant" in this context.	

comment	*422*	comment by: *UK CAA*
	MED.A.060 (b) **Comments:** Advice may need to be sought from the Authority. **Justification:** Advice may need to be sought when the Authority has dealt with a referral. **Proposed Text:** Amend to '...**without undue delay seek the advice of an AeMC, AME or licensing authority. The AeMC, AME or licensing authority shall assess**...'	
response	*Noted*	
	See response to the proposal No 397 of this segment.	

comment	*423*	comment by: *UK CAA*
	MED.A.060 (a) and (c) **Comment:** Para (a) applies to all certificates including the LPL. **Justification:** The causes of unfitness stated in (a) are relevant for all certificate holders, including LPL. The GMP will not have had aviation medical training that enables a	

	fitness judgement to be made in these circumstances. **Proposed Text:** Delete (c) and change title of (a) to '***Class 1, Class 2 and LPL medical*** certificates'***.***
response	*Noted*
	See response to comment No 238 of this segment.

comment	*522*	comment by: *British Microlight Aircraft Association*
	Accepted	
response	*Noted*	
	Thank you for the positive comment.	

comment	*671*	comment by: *Pekka Oksanen*
	Subpara (b): The Authority with its medical expertize is omitted. In difficult cases AME or AeMC must seek advise from Authority. Proposal: ..., holders of a medical certificate shall without undue delay seek the advice of an **AME, AeMC or medical assessor. The AME, AeMC or medical assessor** shall assess ...	
response	*Noted*	
	See response to comment No 397 of this segment.	

comment	*672*	comment by: *Pekka Oksanen*
	Subpara(b): Advise given by a specialist must be documented. Proposal: Add a new paragraph: **The AME, AeMC or medical assessor must document the advice given to holders of medical certificates**.	
response	*Noted*	
	See response to comment No 398.	

comment	*673*	comment by: *Pekka Oksanen*
	Subpara (c): The GMP does not have enough aeromedical expertise and therefore must be deleted from the paragraph. Unfit pilots must see advise from AME, AeMC or medical assessor. Proposal: Delete para (c) and change title (a) to **Class 1, Class 2 and LPL medical certificates.**	

response	*Noted*
	See response to comment No 238 of this segment.

comment	*683*	comment by: *Tjeerd Mulder*
	MED.A.060 (a)(1) have undergone a surgical operation or invasive procedure; Comment: The term "invasive procedure" has already caused problems in Germany previously. Please think for example about blood donors. Cases where the certificate holder is unfit to exercise the right of his license after an "invasive procedure" that is not a surgical operation are already covered in MED.A.025. Proposal: The last three words of (a)(1) be deleted.	
response	*Not accepted*	
	Blood donation always was and still is not advised for flying personnel because of sudden decrease of blood oxygen carrying capacity. Regeneration of the capacity is individual. During this period holders of medical certificates are temporary unfit. In addition, invasive procedures usually require anaesthesia which makes medical certificate holders temporary unfit. Individual requirements for medical certificate holders are proposed in MED.A.025 while MED.A.060 describes circumstances when AeMC, AME and, in the case of the referrral, the licensing authority shall decide on the pilot's fitness to resume the exercise of privileges granted by the licence.	

comment	*801*	comment by: *Swiss Association of Aviation Medecine*
	The Swiss Society of Aviation Medicine supports the following comments of our german colleagues. In Switzerland the network of AME's is big enough to ensure a quick decision making about flight ability for every pilot. (Class I, II, LPL etc.) (c) can be deleted The proposed MED.A.060 (c), however, is below ICAO Standard and can not be accepted This text shows that the author never worked with patients in a normal health care system. More than 95 % of normal doctors or vision care specialists in such a system cannot tell pilots that a suffering condition has an impact to the ability to fly an aeroplane. They are not educated in aviation medicine and they do not know anything about medical requirements. Therefore this paragraph is absolute senseless, because more than 95% of those LPL license holders will be referred to an AME by his treating doctor. On the other hand we do know by our daily experience in the AMC Frankfurt that GPs and medical specialists normally think that flying an aeroplane is a big challenge for human beings and absolute dangerous. Due to this they write pilots much longer unfit to work as they do in same cases with normal working people.	

	This is not in the interest of a LPL pilot. In Germany alone there are about potential 175 000 GMPs working in their own offices, treating each day 50 to 100 sick patients. These doctors do not know anything about the privileges of a LPL or PPL license. How shall these doctors make a decision if a medical treatment or suffering by a chronic illness affects the privilege of a license. If all German license holders are seriously ill once in a year and they seek advice from their treating doctor, statistically every doctor will be asked once every two years. Does the author of this text really think that these doctors are really interested to read and learn the EASA requirements of the LPL continually, if he/she needs this only for one case every two years? If not really fit in decision making, a doubtful GMP will need time to find out what to do and where to ask. This will be counterproductive for LPL pilots, waiting for their medical o.k.
response	*Noted*
	See response to comment No 238.

comment	*985*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: **3**
MED.A.060 Suspension of exercise of privileges (a) and (b) (c) LPL medical certificates

Page: 8

Relevant Text:
(a) and (b) holders of class 1 and class 2 medical certificates shall not exercise.....

(c) Holders of a LPL medical certificate shall inform their doctor or vision care specialist that they are licence holders before they are examined. If pilots are told that the condition from which they are suffering may make it unsafe to perform their duties, they shall not exercise the privileges of their license until advised to do so by a GMP or an AME.

Comment:
The text of MED.A.060 (a) and (b) is relevant.

The evaluation of the applicant is always with the licensing authority. Therefore the expression "competent authority" in this paragraph should be changed to "licensing authority" in consequence with MED.A.065 (a). It is also imperative to avoid confusion, because when "competent authority" is used in Part MED it is in MED.A.001 defined as the authority where the AeMC, AME or GMP have their principal place of business and not the authority responsible for the licence and medical certificate.
In MED.A.065 (b) "may" is used in an implementing rule. This should be changed

	to "shall", or the paragraph would need to be moved to AMC MED.A.065. If there were an illness you could find under MED.A. 060 (a) 1 - 7 and the pilot did not seek the advice of his AME and a fit assessment was not done, then the pilot is flying with an invalid medical certificate. In case of an incident or accident, this might have a big impact on the insurance conditions for the company and for the pilot. The proposed MED.A.060 (c), however, is below ICAO Standard and can not be accepted This text shows that the author never worked with patients in a normal health care system. More than 95 % of normal doctors or vision care specialists in such a system cannot tell pilots that a suffering condition has an impact to the ability to fly an aeroplane. They are not educated in aviation medicine and they do not know anything about medical requirements. Therefore this paragraph is absolute senseless, because more than 95% of those LPL license holders will be referred to an AME by his treating doctor. On the other hand we do know by our daily experience in the AMC Frankfurt that GPs and medical specialists normally think that flying an aeroplane is a big challenge for human beings and absolute dangerous. Due to this they write pilots much longer unfit to work as they do in same cases with normal working people. This is not in the interest of a LPL pilot. In Germany alone there are about potential 175 000 GMPs working in their own offices, treating each day 50 to 100 sick patients. These doctors do not know anything about the privileges of a LPL or PPL license. How shall these doctors make a decision if a medical treatment or suffering by a chronic illness affects the privilege of a license. If all German license holders are seriously ill once in a year and they seek advice from their treating doctor, statistically every doctor will be asked once every two years. Does the author of this text really think that these doctors are really interested to read and learn the EASA requirements of the LPL continually, if he/she needs this only for one case every two years? If not really fit in decision making, a doubtful GMP will need time to find out what to do and where to ask. This will be counterproductive for LPL pilots, waiting for their medical o.k. **Proposal**: First: Print the § (a) 1 - -7 on the medical certificate to inform the pilots. Second: A documentation of the medical advice and the fit assessment is essential because it is a revalidation of the medical certificate after serious illness. A special form should be created, which can be submitted to the pilot by e-mail or fax to give him safety that he is legal. Third: **in (c)** implement the same requirements for LPL pilots as for class 1 and 2 in (a) and (b).
response	*Noted*
	First: See response to comment No 237. Second:

See response to comment No 398.

Third:
See response to comment No 238.

comment 1071 comment by: *Dr. Ludger Beyerle*

MED.A.060 Suspension of exercise of privileges (a) and (b) (c) LPL medical certificates

Page: 8

Relevant Text:
(a) and (b) holders of class 1 and class 2 medical certificates shall not exercise.....

(c) Holders of a LPL medical certificate shall inform their doctor or vision care specialist that they are licence holders before they are examined. If pilots are told that the condition from which they are suffering may make it unsafe to perform their duties, they shall not exercise the privileges of their license until advised to do so by a GMP or an AME.

Comment:
The text of MED.A.060 (a) and (b) is relevant.

The evaluation of the applicant is always with the licensing authority. Therefore the expression "competent authority" in this paragraph should be changed to "licensing authority" in consequence with MED.A.065 (a). It is also imperative to avoid confusion, because when "competent authority" is used in Part MED it is in MED.A.001 defined as the authority where the AeMC, AME or GMP have their principal place of business and not the authority responsible for the licence and medical certificate.
In MED.A.065 (b) "may" is used in an implementing rule. This should be changed to "shall", or the paragraph would need to be moved to AMC MED.A.065.

If there were an illness you could find under MED.A. 060 (a) 1 - 7 and the pilot did not seek the advice of his AME and a fit assessment was not done, then the pilot is flying with an invalid medical certificate. In case of an incident or accident, this might have a big impact on the insurance conditions for the company and for the pilot.

The proposed MED.A.060 (c), however, is below ICAO Standard and can not be accepted

In Germany alone there are about potential 65 000 GMPs working in their own offices, treating each day 50 to 100 patients.
These doctors do not know anything about the privileges of a LPL or PPL license. How shall these doctors make a decision if a medical treatment or suffering by a chronic illness affects the privilege of a license.

Proposal:

	1. Print the § (a) 1 - -7 on the medical certificate to inform the pilots. 2. A documentation of the medical advice and the fit assessment is essential because it is a revalidation of the medical certificate after serious illness. A special form should be created, which can be submitted to the pilot by e-mail or fax to give him safety that he is legal. 3. **in (c)** implement the same requirements for LPL pilots as for class 1 and 2 in (a) and (b).
response	*Noted*
	First: See response to comment No 237. Second: See response to comment No 398. Third: See response to comment No 238.

comment	*1096*	comment by: *Regierung von Oberbayern-Luftamt Südbayern*
	Die unterschiedliche rechtliche Behandlung von Inhabern von Klasse- 1/2-Medicals auf der einen Seite und LPL-Medicals auf der anderen Seite kann nicht nachvollzogen werden. Die potenziellen Gefahren, die von einem gesundheitlich beeinträchtigten Privatpiloten für den Luftverkehr ausgehen, sind im Wesentlichen dieselben, gleich, ob es sich um einen LPL-Piloten handelt oder um einen PPL-Piloten. Auch für LPL-Piloten sollten klare gesetzliche Vorgaben gelten, ab welchem Zeitpunkt es dem Piloten nicht mehr gestattet ist, bis zu einer ärztlichen Untersuchung von seiner Lizenz Gebrauch zu machen. Der Absatz (c) sollte daher aufgehoben werden, Absätze (a) und (b) sollten auch für LPL-Inhaber gelten.	
response	*Noted*	
	See response to comment No 238.	

comment	*1114*	comment by: *George Knight*
	(b) In these cases, holders of a medical certificate **shall without undue delay** seek the advice of an AeMC or AME. The AeMC or AME shall assess the medical fitness of the pilot and decide whether they are fit to resume the exercise of their privileges. Why should the pilot seek advice without undue delay? They would be sensible to wait until they think that they have recovered sufficiently to resume flying. Surely the rule should state	

	(b) In these cases, holders of a medical certificate shall ~~without undue delay~~ seek the advice of an AeMC or AME **before resuming**. **the exercising of privileges.** The AeMC or AME shall assess the medical fitness of the pilot and decide whether they are fit to resume the exercise of their privileges.
response	*Not accepted*
	Pilots cannot continue flying after the recovery without informing aeromedical specialists and shall seek the advice without undue delay, because the index event happens during the period of validity of their medical certificate.

comment	*1115*	comment by: *George Knight*
	(a) *Class 1 and class 2 medical certificates* **Holders of class 1 and class 2 medical certificates shall not exercise the privileges granted by their licences when they: ...** *I think that particularly for private pilots or leisure pilots with a Class 2 medical that this rule is too onerous and more flexibility as suggested below is appropriate.* 1. Pilots are responsible for their own fitness to fly and this is to be mentally self certified prior to every flight. 2. Pilots may ground or limit themselves for a period of up to 21 days at their own discretion. After 21 days an AME or the certifying GMP must be informed. 3. Pilots are responsible to ensure that any Over the Counter (OTC) medicine does not adversely affect flight. 4. Pilots receiving treatment or medication from any doctor are to enquire of possible adverse effects on flight. 5. AMEs or certifying GMPs may informally suspend or limit a medical certificate for up to 90 days. This would include the recovery period from most surgical operations. 6. After full recovery within 90 days, an AME or certifying GMP can lift any suspension or limitation. If there is a permanent change in health status a revalidation becomes necessary and this may impose a limitation. If the pilot remains unfit for any flight, the Authority must be informed whether or not a revalidation medical examination took place. Reference: Regulation (EC) No 216/2008 of the European Parliament and of the Council on common rules in the field of civil aviation...Annex 111, 1.b.1 (v).	
response	*Not accepted*	
	The paragraph 1.b.1.(v) of the Annex III you refer to in the comment requires that pilots have theoretical knowledge in the field of human performance and limitations. We agree with the proposal that there shall be personal responsibility with regards to the fitness, but it shall not extend to the field of the aeromedical decision making and shall not replace aeromedical certification system already harmonised and used in all Member States.	

comment	*1213*	comment by: *Swedish Transport Agency, Civil Aviation Department*

	(Transportstyrelsen, Luftfartsavdelningen)
MED.A.060 (a) **Comment**: The text of MED.A.060 (a) and (b) is relevant, but should include also LPL. As proposed in the ICAO State Letter 2008/33, the member states should ensure that all licence holders are aware of when they shall not exercise the privileges of their licences. This could to some extent be achieved by printing the requirements in MED.A.060 (a) and (b) on the medical certificate. Also, the applicant should be requested to sign his/her medical certificate, with the implication that he/she has read, understood and will follow the obligations in MED.A.025 and MED.A.060 (a) and (b). **Proposal**: The text of MED.A.060 (a) and (b) should be amended to include also LPL medical certificates. The text of MED.A.060 (a) and (b) should be included in the layout of the medical certificate. The signature of the applicant on the medical certificate should confirm his/her awareness of the obligations in MED.A.060 (a) and (b).	
response	*Noted*
Requirements for holders of a LAPL medical certificate: See response to comment No 238. Information on the medical certificate: See response to comment No 237.	

comment		
	1214	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
MED.A.060 (b) **Comment**: Depending on different national provisions and availability of AeMCs and AMEs, the advice to be sought should not only be limited to AeMC and AME, but it should also be possible to address the licensing authority. For legal reasons, the EASA requirements should include an obligation for the AeMC, AME or authority to document the advice given. **Proposal**: The text of MED.A.060 (b) should be amended to include also the licensing authority. An obligation to document the advice should be given here or in an AMC to MED.A.060.		
response	*Noted*	
For inclusion of the licensing authority: See response to comment No 397. For requirement of documentation of advice:		

See response to comment No 398.

comment

1215	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*

MED.A.060 (c)
Comment:
This text may be interpreted in different ways regarding when it is applicable. In MED.A.060 (c), the holders of a LPL are only required to inform their doctor before they are examined (by any physician treating a medical condition, or at the next aeromedical examination, which might not occur until 30 years later), not to seek the advice.

For safety reasons there is an obligation in MED.A.060 (a) and (b) for class 1 and class 2 holders not to exercise the privileges of a licence in a number of defined situations until being declared fit by an AME or AeMC. For LPL the opposite approach is proposed, which means that a LPL licence holder may continue to fly even with very dangerous conditions, as long as nobody has told him/her that the condition will make it unsafe for him/her to perform his duties. This is not acceptable, especially as the requirement only focuses on the pilot, not on the possible three passengers carried.

'Their doctor' is not defined, it might be any physician/specialist treating the pilot and not the AME, GP or the GMP responsible for the medical certificate. This treating physician will most probably not have any knowledge concerning the LPL medical requirements and will thus neither be able to to tell the licence holder whether a condition will make it unsafe for him to perform his duties, nor being aware of the requirement to do so. When a similar question arises during the examination for a LPL medical certificate, a GMP is obliged to refer the applicant to an AME or AeMC for evaluation.

The proposed MED.A.060 (c) is not in conformity with MED.A.025 and is also a deviation from the ICAO Standard. This Implementing Rule will not ensure that the level of safety is maintained, which is required in Article 7 of the Basic Regulation.

Proposal:
MED.A.060 (c) should be deleted and LPL should be included in MED.A.060 (a) and (b).

response

Noted
See response to comment No 238.

comment

1296	comment by: *David Chapman*

Holders of a LPL medical certificate shall inform their doctor or vision care specialist that they are
licence holders before they are examined. If pilots are told that the condition from which they are
suffering may make it unsafe to perform their duties, they shall not exercise the

	privileges of their licence until advised to do so by a GMP or an AME. Is the intention of this paragraph better stated as, ... Holders of a LPL medical certificate shall inform their doctor or vision care specialist that they are licence holders before **any routine or exceptional examination**. If pilots are told that the condition from which they are suffering may make it unsafe to perform their duties, they shall not exercise the privileges of their licence until advised to do so by a GMP or an AME.
response	*Noted*
	See response to comment No 238.

comment	*1552*	comment by: *British Airways*
	Sub-para (b) requires holders of a medical certificate to without undue delay seek the advice of an AeMC or AME in the circumstances described in sub-para (a). The AeMC or AME shall assess the medical fitness of the pilot and decide whether they are fit to resume the exercise of their privileges. Documentation of the medical advice and the fitness assessment by the AeMC or AME is essential in order to protect the pilot. **Proposal**: First: Print (a) 1 - 7 on the medical certificate to inform the pilots. Second: Add: The AeMC or AME must record the assessment in the holder's medical documentation and, if the holder is found to be temporarily unfit to exercise the privileges of their licence, advise the licensing authority. If found to be temporarily unfit, holders of a medical certificate shall seek the advice of an AeMC or AME before resuming the exercise of their privileges.	
response	*Noted*	
	First: See response to comment No 237. Second: See response to comment No 398.	

comment	*1572*	comment by: *FAA*
	MED. A.060: paragraphs (a)(4) and (a)(7) do not necessarily merit suspension of exercise of privilege. A broad-based, decrease in medical fitness standard has worked well in the U.S. to provide for change(s) in a medical certificate holder's medical status. See 14 CFR § 61.53	

	http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=3135b29aa4f449dedf20f7e684534003&rgn=div8&view=text&node=14:2.0.1.1.2.1.1.32&idno=14 Also, the United States provides for change in medical condition under 14 CFR § § 67.113, .213, and .313: See, for example, § 67.113: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=cfcb03761578d591dd11e611aaef8ef0&rgn=div8&view=text&node=14:2.0.1.1.5.2.1.7&idno=14 The United States notes that ICAO, per the attached state letter, is revising its decrease in medical fitness standard: See pg.2 Item 5 b) of the attached ICAO State letter 33 dated 5 May 2008: http://www.icao.int/cgi/SLEDfile.pl?y=2008&f=033e.pdf&w=awfrwc&a=US
response	*Noted*
	Thank you for the information.

comment	*1617*	comment by: *Helmut PRANG*
	In (a) there should be a clear distinction between Class 1 and 2 medical certificates reflecting their scope of application. Reasons for Class 2 certificates to be suspended should be much more restricted than those for Class 1. I suggest the following wording for Class 2 certificates: 1. have undergone major surgical operation ... 2. have been admitted to hospital or medical clinic for more than five consecutive days or for reasons other than routine check-ups 3. have commenced the continous use of any prescribed medication In (b) it appears unreasonable having to consult an AeMC or AME in all of the instances listed in (a). As long as the restrictions listed no longer persist, there are few reasons for medical consultation before resuming exercising the priviliges of the licence. For example, it is difficult to comprehend the necessity to consult an AeMC in order to confirm that pregnancy is over or that a flu has passed. Such regulation would create unnecessary cost and administrative expense.	
response	*Not accepted*	
	Medical conditions listed in MED.A.060(a) are a seriuos flight safety threat for both class 1 and class 2 flight operations. This is currently accepted practice to require all pilots who undergone surgical operation or started medication to seek an aeromedical advice and this principle should be maintained. Your proposal to lower the number of days of the hospitalisation makes this requirement more	

	restrictive for class 2 medical certificate holders in comparison to class 1 medical certificate holders. We believe that all pilots planning to resume their flight duties after a medical index event must not take aeromedical decisions by themselves and shall seek the professional aeromedical advice.

comment	*1623*	comment by: *Bayerisches Staatsministerium für Wirtschaft, Infrastruktur, Verkehr und Technologie*
	Die unterschiedliche rechtliche Behandlung von Inhabern von Klasse- 1/2-Medicals auf der einen Seite und LPL-Medicals auf der anderen Seite kann nicht nachvollzogen werden. Die potenziellen Gefahren, die von einem gesundheitlich beeinträchtigten Privatpiloten für den Luftverkehr ausgehen, sind im Wesentlichen dieselben, gleich, ob es sich um einen LPL-Piloten handelt oder um einen PPL-Piloten. Auch für LPL-Piloten sollten klare rechtliche Vorgaben gelten, ab welchem Zeitpunkt es dem Piloten nicht mehr gestattet ist, bis zu einer ärztlichen Untersuchung von seiner Lizenz Gebrauch zu machen. Vorschlag: Der Absatz (c) sollte daher aufgehoben werden, Absätze (a) und (b) sollten auch für LPL-Inhaber gelten.	
response	*Noted*	
	See response to comment No 238.	

comment	*1660*	comment by: *Deutscher Aero Club (DAeC)*
	(c) LPL medical certificates Holders of a LPL medical certificate shall inform their doctor or vision care specialist that they are licence holders before they are examined. If pilots are told that the condition from which they are suffering may make it unsafe to perform their duties, they shall not exercise the privileges of their licence until advised to do so by a GMP or an AME. Comment: This rule is not necessary as a practitioner is obliged to inform the patient about any possible disabilities induced by the observed diagnosis or treatments anyway. This represents good clinical practice. Therefore this rule represents a unnecessary double regulation. DAeC Proposal: That MED.A.060 (c) be deleted.	
response	*Not accepted*	
	MED.A.060 (c) may not be deleted, because it is not about a good clinical practice. Medical practitioners shall give the advice with regards to the aeromedical fitness. See also response to comment No 238.	

comment	*1718*	comment by: *Norwegian Association of Aviation Medicine*
	According to our view: part c) should be removed.	
response	*Noted*	
	See response to comment No 238.	

comment	*1733*	comment by: *Civil Aviation Authority Finland*
	MED.A.060(b) The Authority must be included in the chain and get the knowledge of the decrease the medical fitness and possible restrictions of pilots. This because some pilots have continued flying despite the advise of the AME. The pilot may also approach directly the Authority for advice. (Ref. JAR-FCL 3.040) Change to: …seek the advice of an **AME, AeMC or medical assessor of the Authority**. The **AME, AeMC or medical assessor** shall assess…. Add: **The AME or AeMC shall inform the Authority of the case and possible limitations.**	
response	*Noted*	
	See response to comment No 397.	

comment	*1761*	comment by: *Max Heinz Katzschke*
	a) Regeln für die Verweigerung des Medicals sollten nicht festgelegt werden. Der Flieger- und/oder Allgemeinarzt kann selbst entscheiden oder einen Facharzt hinzuziehen und mit diesem entscheiden, ob und wie eine gesundheitliche Gefahr beim Fliegen zu erwarten ist. b) Schwangerschaft ist keine Erkrankung. In vielfältigen Urteilen von Gerichten ist dazu Stellung genommen worden und allermeist eine Restriktion aus Gründen einer Schwangerschaft als diskriminierend festgestellt worden.	
response	*Noted*	
	We believe that all pilots planning to resume their flight duties after a medical index event must not take aeromedical decisions by themselves and shall seek the professional aeromedical advice. Pregnancy is not a disease, but it may lead to the sudden incapacitation during flight. Therefore, a special rule in line with ICAO standards and JAR FCL 3 is proposed. See MED.B.040.	

comment	*1930*	comment by: *CAA Belgium*
	This section should be AMC.	

	This section describes the actions to be taken in the event of a decrease in medical fitness. The ICAO State Letter 08/33 has proposed removing the 21day requirement for illness reporting as many serious illnesses should be reported before this period has elapsed. Transfer MED.A.060 to new AMC to MED.A.025.
response	*Noted*
	See response to comment No 395.

comment	*1931*	comment by: *CAA Belgium*
	(b) The authority must be included. The Authority may also be approached for advice. Change to: '…seek the advice of an AME, AeMC or medical assessor. The AME, AeMC or medical assessor shall assess….'	
response	*Noted*	
	See response to comment No 397.	

comment	*1932*	comment by: *CAA Belgium*
	(b) Advice must be documented. For legal reasons and authority oversight it is essential for the advice to be documented. Add new AMC to MED.A.060(b): 'The AME, AeMC or medical assessor should document the advice given to holders of medical certificates.'	
response	*Noted*	
	See response to comment No 398.	

comment	*1933*	comment by: *CAA Belgium*
	(c) This paragraph is inappropriate for GMPs. A reporting mechanism of unfitness needs to be established for the LPL. GMPs do not have aeromedical expertise. The GMP must be removed from this paragraph. Pilots who have become unfit need to seek the advice of an AME, AeMC or the authority.	

	Delete para (c) and amend title of (a) to: 'Class 1, Class 2 and LPL medical certificates.'
response	*Noted*
	See response to comment No 238.

comment	*1941*	comment by: *International Air Transport Association (IATA)*
	Page 8 Med.A.060 (a) (6) This sentence does not makes sense. "…….for a period of at least 21 days" should be removed. Otherwise, holders of class 1 and class 2 medical certificates could exercise the privileges granted by their licences when they have been suffering from any illness involving incapacity to function as a member of the flight crew if the period of illness has been lest than 21 days.	
response	*Noted*	
	See response to comment No 421.	

comment	*1949*	comment by: *Civil Aviation Authority of Norway*
	Comment to (c): A GP or vision care specialist do not know the regulations, thus he/she cannot give a qualified advice. Reporting procedures should therefore be established.	
response	*Noted*	
	See response to comment No 238.	

comment	*1970*	comment by: *AEA*
	Comment_1 Sub-para (b) requires holders of a medical certificate to without undue delay seek the advice of an AeMC or AME in the circumstances described in sub-para (a). The AeMC or AME shall assess the medical fitness of the pilot and decide whether they are fit to resume the exercise of their privileges. **Comment_2** Documentation of the medical advice and the fitness assessment by the AeMC or AME is essential in order to protect the pilot. **Proposal**: *First*: Print (a) 1 - -7 on the medical certificate to inform the pilots. *Second:* Add: The AeMC or AME must record the assessment in the holder's medical documentation and, if the holder is found to be temporarily unfit to exercise the privileges of their licence, advise the licensing authority. If found to be temporarily unfit, holders of a medical certificate shall seek the advice of an AeMC or AME before resuming the exercise of their privileges.	
response	*Noted*	

Comment 1 See response to comment No 237. Comment 2 See response to comment No 398.

comment	*2009*	comment by: *Lars Tjensvoll*
	remove part c.	
response	*Noted*	
	See response to comment No 238.	

comment	*2051*	comment by: *Michael Hinz*
	Ein automatisches Flugverbot selbst bei Bagatelleingriffen oder bei einer Schwangerschaft ist unverhältnismäßig und persönlichkeitsverletzend.	
response	*Noted*	
	See response to comment No 1761.	

comment	*2064*	comment by: *French Fédération Française Aéronautique groups the 580 French powered flying aer-clubs and their 43 000 private pilots*
	MED.A.060 - Suspension of exercise of privileges. (a)(2) and (3) The FFA considers those two requirements to much demanding for Class 2 medical certificates. For this class 2 certificate, an admission to a hospital or medical clinic for a few days (lets say 3 days) would not necessarily stop exercise the privileges by the licence holder. Likewise regular use of any medication shall not stop the licence holder to exercise the privileges of a Class 2 medical certificate. To demanding requirements for non commercial pilots medical certificate (Class 2) can lead to an adverse effect as pilots can be encouraged to hide their medical problems. The FFA propose to lighten this requirements for class 2 certificate, adding a minimum of 3 days (at least) to apply the (a)(2) requirement, and deleting the (a)(3) requirement, as it is completely unrealistic in private flying, especially in sports and recreational aviation.	
response	*Noted*	
	See response to comment No 1617.	

comment	*2074*	comment by: *CAA Belgium*
	Relevant Text: (a) Holders of class 1 and class 2 medical certificates shall not exercise the privileges granted by their licences when they (…)	

	Comment: LPL should be subdued to the same rule as class 2, because they impose the same risks to passengers and the public. Especially if ill, following surgery or onset of regular medication, specialist advice is necessary to judge the impact of the present circumstances to the performance of flight-duties. A GMP is generally not qualified to give adequate judgement, even worse a "vision care specialist". In the rendered cases, the advice of an AME or AeMC should be seeked. Proposal: Drop paragraph (c.) as exception for LPL, and treat LPL equivalent to class 2.
response	*Noted*
	See response to comment No 238.

comment	*2100*	comment by: *Dr. Christoph Larisch*
	Schwangerschaft ist keine Krankheit ! Diese Regel diskriminiert Frauen in unzumutbarer Weise. Wie würde die Öffentlichkeit wohl reagieren, wenn schwangere Frauen kein Auto mehr fahren dürften ?	
response	*Noted*	
	See response to comment No 51.	

comment	*2328*	comment by: *AMS CAA - Hungary*
	Comment: Pilots may seek advice from the Authority as well. Add to the textí. '…seek the advice of an **AME, AeMC or licensing authority**. The **AME, AeMC or licensing authority** shall assess….'	
response	*Noted*	
	See response to comment No 397.	

comment	*2393*	comment by: *Irish Aviation Authority*
	This should be AMC. Justification: This describes the actions to be taken in the event of a decrease in medical fitness. The ICAO State Letter 08/33 has proposed removing the 21day requirement for illness reporting as many serious illnesses should be reported before this period has elapsed. Proposed text: Transfer MED.A.060 to anew AMC for MED.A.025.	
response	*Noted*	

	See response to comment No 395.

comment	*2394*	comment by: *Irish Aviation Authority*
	(b) The authority has to be included. Justification: One may also approach the Authority for advice. Proposed text: To be changed to: '…seek the advice of an **AME, AeMC or medical assessor**. The **AME, AeMC or medical assessor** shall assess….'	
response	*Noted*	
	See response to comment No 397.	

comment	*2395*	comment by: *Irish Aviation Authority*
	(b) Advice must always be documented. Justification: For legal reasons and authority oversight it the advice has to be documented. Proposed text: Add new AMC to MED.A.060(b**): 'The AME, AeMC or medical assessor should document all advice given to of medical certificate holders.'**	
response	*Noted*	
	See response to comment No 398.	

comment	*2396*	comment by: *Irish Aviation Authority*
	(c) This paragraph is not appropriate for GMPs. A clear reporting mechanism of unfitness needs to be established for the LPL. Justification: GMPs have no aeromedical expertise. The GMP must be removed from this paragraph. Pilots who have become unfit need to look for advice from an AME, AeMC or the authority. Proposed text: ~~para (c)~~ and amend title of (a) to: '**Class 1, Class 2 and LPL medical certificates**.'	
response	*Noted*	

	See response to comment No 238.

comment	*2470*	comment by: *Civil Aviation Authority Finland*
	MED.A.060(b) The advice shall be documented. For legal reasons and authority oversight it is essential for the advice given to be documented. Add a new AMC to MED.A.060(b**): The AME, AeMC or medical assessor of the Authority should document the advice given to holders of medical certificates.**	
response	*Noted*	
	See response to comment No 398.	

comment	*2471*	comment by: *Civil Aviation Authority Finland*
	MED.A.060(c) This paragraph is inappropriate for GMPs. A reporting mechanism of unfitness needs to be established for the LPL. GMPs do not have aeromedical expertise. The GMP must be removed from this paragraph. Pilots, who have become unfit, need to seek the advice of an AME, AeMC or the Authority. Delete para (c) and amend title of (a) to: **Class 1, Class 2 and LPL medical certificates**.	
response	*Noted*	
	See response to comment No 238.	

comment	*2566*	comment by: *Heinz Fricke-Bohl and Kirsten Bohl*
	MED.A.060(c): Es fallen immer wieder bei den jetzigen Untersuchungen von Segelfliegern Nabel- und Leistenhernien auf, Diab. mell. Typ I, Hypertonie (Neuerkrankung) sowie Hodentumore auf. Bei der Modalität LPL wird so etwas kaum entdeckt.	
response	*Noted*	
	See response to comment No 238.	

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certificates

comment	245	comment by: *Lufthansa German Airlines*

Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany
Head of Lufthansa Medical Services
Head of German Academy of Aviation and Travel Medicine
Section: **3**
MED.A.065 Suspension and revocation of medical certificates
Page: 8

Relevant Text: Whole paragraph a 1 ...3
b
Comment:
How shall this work? Requirements which cannot be controlled that pilots are following them are senseless. False declaration is allowed in Germany and will not be punished. (See comment No. 13) How shall the violation of the provisions of paragraph MED.A.060 be controlled if there is no provision for documentation. What is a **justified concern** (see b) Does the competent authority has to go to court to get their concern justified before they can suspend a medical certificate? How will the competent authority justify something of (a) 1 - 7 without documentation.

Proposal:
Make a new set up of this MED.A.065 with documentation procedures and control mechanism or skip it totally and give it to the responsibility of the pilots.

response	*Not accepted*

We would like to highlight the fact that it is a primary task of the National Aviation Authority to ensure that requirements are followed. At the same time, it is not clear how and why false declarations may be tolerated. We believe that the proposed rules will provide National Aviation Authorities with the tool to ensure flight safety.
Our understanding of "justified concern" is that in order to express doubts about the medical fitness of a certificate holder the licensing authority has to have received reports or other medical evidence.

comment	354	comment by: *Teh Danish Organiation of Flight Surgeons (DAFLO)*

Item: dot c

Objection: Disagree

Reasons: A licensing authority can not suspend a medical certificate if health problems has not been reported because of violation of the provisions of paragraph MED.A. 060 (too long period of validity makes the pilot likely to forget reporting health problems)

Suggestions: In case of introduction of LAPL we strongly recommend close

	intervals of medical examinations equal to the case of Class 2.
response	*Noted*
	To improve the safety level for LAPL, the validity periods for LAPL medical certificates will be amended. Also for LAPL the provision to seek advice in case of decrease in medical fitness will be amended. See responses to the comments No 48 to MED.A.055 and No 238 to MED.A.060.

comment	*523*	comment by: *British Microlight Aircraft Association*
	Strongly agree	
response	*Noted*	
	Thank you for the positive comment.	

comment	*576*	comment by: *Florian Söhn*
	to d: the licencing authority should be allowed to delegate the medical investigation to an AME or AMC as its currently done in germany. Medical decisions should in my opinion always stay in the hand of medical doctors qualified for aviation medcine and not in the hands of an administrative authority. The administration is not qualified to know when to specific clinical dedical testing is indicatedI. ssuing the licence should allways be based on and AME/AMC decision.	
response	*Noted*	
	There is no subparagraph (d) in MED.A.065, but we agree with your opinion that the issuance of class 1 and class 2 medical certificates shall be based on the medical examinations performed by AMEs or AeMCs. The Medical Assessor in the licensing authority is required to have the necessary qualification. See NPA 2008-22B, paragraph AR.MED.020.	

comment	*698*	comment by: *Pekka Oksanen*
	Comment: Identifying a safety risk is not the same as not fulfilling the requirements. Proposal: Change text ... The licencing authority shall suspend or revoke a medical certificate when it has identified ~~a safety~~ **an aeromedical** risk or it has clear evidence that ...	
response	*Not accepted*	
	Required safety level is determined by the requirements. We agree with your statement, but detection of the violation of the requirement may be done by any medical professional even without aeromedical training. Identification of a safety risk due to the violation of the requirement needs a special training and this is one of main tasks of the licensing authority in the case of the referral.	

comment	1100	comment by: Regierung von Oberbayern-Luftamt Südbayern
	In Ergänzung zu unserer Anmerkung zu MED.A.030 weisen wir darauf hin, dass wir es für systemwidrig halten, wenn das Medical, das von einem Flugmediziner ausgestellt wurde, von einer anderen Stelle - nämlich der Lizenzierungsbehörde - zu widerrufen ist, bzw. das Ruhen anzuordnen ist. Vielmehr sollte die Behörde hier darauf beschränkt bleiben, etwaige lizenzrechtliche Maßnahmen zu treffen (z. B. Ruhensanordnung der Lizenz, bis bis durch ein AeMC die Tauglichkeit des Piloten nachgewiesen ist). Eine entsprechende Ergänzung fehlt auch in der Vorschrift AR.FCL.250. Es kann nicht sein, dass ein Pilot, der sein Tauglichkeitszeugnis fälscht, die Lizenz als Rechtsschein weiterhin in Händen hält. Ein solcher Pilot sollte auch lizenzrechtlich (vorübergehend) aus dem Verkehr gezogen werden.	
response	*Noted*	
	All competences that are not specifically attributed by the BR to other parties are to be exercised by the competent authorities of MS. In the case of medical certificates, the BR establishes the possibility for AMEs and AeMC to issue them, and only that. Therefore, in accordance with the general principle indicated above, the competence for their suspension or revocation remains with the competent authorities of the MS. The suspension and revokaiton of medical certificates are also related to the oversight function: the suspension and revocation of a medical certificate are a consequence of a non-compliance with applicable rules, which cannot be evaluated by an AME or AeMC. In cases where a medical certificate has been revoked, the licence shall be revoked as well (FCL.070).	

comment	1136	comment by: Regierung von Oberbayern-Luftamt Südbayern
	Es fehlt eine Regelung, welche Rechtsfolge der Widerruf bzw. die Ruhensanordnung hinsichtlich eines Medicals hat. Zu welchem Zeitpunkt ist es dem Piloten möglich, ein neues Medical zu beantragen ? Wie lange kann die Behörde das Ruhen des Medicals (z. B. in dem Fall, dass der Pilot bei seiner Untersuchung unrichtige Angaben gemacht hat) anordnen oder festlegen, ab wann nach Widerruf der Pilot ein neues Medical beantragen kann ? Die Vorschrift müsste daher durch eine Ruhensfrist (bei suspension)bzw. eine Sperrfrist (bei revocation) für die frühestmögliche Neubeantragung eines Medicals ergänzt werden. Beispielsweise könnte hier geregelt werden, dass bei den genannten Fallgruppen die Mindestsperrfrist bzw. Mindestruhensfrist ein Jahr ab Anordnung der Sperre/des Ruhens beträgt.	
response	*Noted*	
	The suspension of a medical certificate will be until such time that the pilot meets	

	the medical requirements (again). In cases of a false declaration, a medical assessment is needed to determine whether the pilot meets the requirements when all facts are considered, including the ones on which the false declaration has been made. Time limit where a pilot cannot re-apply for his medical has not been determined but could be considered in a new rulemaking task.

comment	*1216*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.065 (a) **Comment**: The proposed text of MED.A.065 (a) is acceptable. However, if this paragraph shall be effective, reliable procedures to identify safety risks and violations to MED.A.025 and MED.A.060 must be in place. To apply the provisions in MED.A.065 (a) (2) and (3), the licensing authority will be obliged to prove that the pilot has been aware that a condition might have rendered him/her unable to safely exercise the privileges of the licence, especially for LPL. **Proposal**: Reliable procedures to identify safety risks and violations to MED.A.025 and MED.A.060 should be developed and included in Part Authority Requirements.	
response	*Noted*	
	MED.A.065 has been included to ensure that the licensing authority has the competence to revoke or suspend a medical certificate. Procedures to do so have not yet been developed but could be envisaged at a later stage.	

comment	*1217*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.A.065 (b) **Comment**: The evaluation of the applicant always rests with the licensing authority. Therefore, the expression "competent authority" in this paragraph should be changed to "licensing authority" in consequence with MED.A.065 (a). "Competent authority", when being used in Part MED, is defined in MED.A.001 as the authority where the AeMC, AME or GMP have their principal place of business and not the authority responsible for the licence and medical certificate. Also, to avoid confusion, "licensing authority" should be used here. In MED.A.065 (b) "may" is used in an implementing rule. This should be changed to "shall", with a flexibility comment, or the paragraph would need to be moved to AMC MED.A.065. Reference of the use of "may" has also been made in our comments to MED.A.030 (b) and (c).	

	Proposal: MED.A.065 (b) should be amended: "The licensing authority shall consider the need to suspend the certificate pending ..."
response	*Accepted*

comment	*1310*	comment by: *RP Kassel*
	In cases of safety risks and other the licencing authority can revoke a medical certificate. This does not correspond to German law, because a public authority can only revoke its own (public) decisions. The certificate issued by the AME is no public decision, because the AME itself is not an authority. The medical certificate is only an Admission to prepare a public-law decision granting the license or to keep it guilty. In my opinion no rule on this point is needed. The licencing authority is informed by the AME (MED.A.050 (b)(4)), that the applicant is unfit. The flight-licence can by revoked. When the medical certificate remains by the pilot, there is no safety risk, while the licence is revoked. Proposal: No scheme by EASA, Regulations by the different Members of EU seems to be the best way.	
response	*Not accepted*	
	Our proposed rules are in line with internationally accepted JAR FCL 3 system currently implemented and followed by all EASA Member States. In this system licensing authority has sole responsibility to oversight aviation medicine issues in their country and take final decisions including decisions on aeromedical fitness. See also response to the Comment 1100 of this segment.	

comment	*1624*	comment by: *Bayerisches Staatsministerium für Wirtschaft, Infrastruktur, Verkehr und Technologie*
	In Ergänzung der Anmerkung zu MED.A.030 wird darauf hingewiesen, dass es systemwidrig wäre, wenn das Medical, das von einem Flugmediziner ausgestellt wurde, von einer anderen Stelle - nämlich der Lizenzierungsbehörde - zu widerrufen ist, bzw. das Ruhen anzuordnen ist. Vielmehr sollte die Behörde hier darauf beschränkt bleiben, etwaige lizenzrechtliche Maßnahmen zu treffen (z. B. Ruhensanordnung der Lizenz, bis bis durch ein AeMC die Tauglichkeit des Piloten nachgewiesen ist). Eine entsprechende Ergänzung fehlt auch in der Vorschrift AR.FCL.250. Es darf nicht angehen, dass ein Pilot, der sein Tauglichkeitszeugnis fälscht, die Lizenz als Rechtsschein weiterhin in Händen hält. Ein solcher Pilot sollte auch lizenzrechtlich (vorübergehend) aus dem Verkehr gezogen werden können.	
response	*Noted*	
	See response to comment No 1100 of this segment.	

comment	*1625*	comment by: *Bayerisches Staatsministerium für Wirtschaft, Infrastruktur, Verkehr und Technologie*
	Eine Regelung, welche Rechtsfolge der Widerruf bzw. die Ruhensanordnung hinsichtlich eines Medicals hat, ist nicht vorhanden und sollte eingefügt werden. Zudem werden Regelungen zum möglichen Zeitpunkt der Beantragung ein neues Medicals durch den Piloten und zur möglichen Dauer des Ruhens des Medicals (z.B. für den Fall, dass der Pilot bei seiner Untersuchung unrichtige Angaben gemacht hat) durch die zuständige Behörde sowie zur Festlegung des möglichen Zeitpunkts der Beantragung eines neuen Medicals durch den Piloten nach dem Widerruf für erforderlich gehalten. Vorschlag: Die Vorschrift müsste daher durch eine Ruhensfrist (bei suspension) bzw. eine Sperrfrist (bei revocation) für die frühestmögliche Neubeantragung eines Medicals ergänzt werden. Beispielsweise könnte hier geregelt werden, dass bei den genannten Fallgruppen die Mindestsperrfrist bzw. Mindestruhensfrist ein Jahr ab Anordnung der Sperre/des Ruhens beträgt.	
response	*Noted*	
	See response to comment No 1136 of this segment.	

comment	*1677*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.A.065(a)(1) Suspension and revocation of medical certificates **Page** 8 **Comment** Misrepresentation of the clinical facts by the AME in collusion with the pilot does occur. It is desirable that the AME should be penalised in this case. **Justification** **Proposed Text** "….a false declaration, or by misrepresentation of the clinical documentary evidence by the AME;"	
response	*Not accepted*	
	Actions of the licensing authority in the case of AME misconduct are proposed in NPA 2008-22b "Authority Requirements" Subpart MED Section 2 "Aeromedical Examiners" paragraph AR.MED.250.	

comment	*2052*	comment by: *Michael Hinz*
	Hier wird ein geringes medizinisches Problem zum Anlass genommen, die Fluglizenz zu entziehen. Auch sind Schwangerschaften in den ersten Tagen bzw. Wochen nicht feststellbar. Hier werden die Piloten kriminalisiert. Es würde reichen, wenn Lizenzentzug angedroht wird, wenn massive medizinische Einschränkungen ignoriert werden.	

response	*Noted*
	The suspension of a medical certificate (e.g. pregnancy) will be lifted once the situation has been assessed, the pilot can then resume the priviledges of his licence.

comment	*2127*	comment by: *BMVBS (German Ministry of Transport)*
	The medical certificate is issued by an AeMC or AME. MED.A.065 (a) however requires the authority to suspend or revoke the medical certificate. This appears inconsistent. The cases desribed in MED.A.065 should rather trigger an action on the part of the licensing authority to suspend or revoke the licence until such time when medical fitness can demonstrated again. It is rather inconceivable that a pilot who falsified his medical certificate may be allowed to keep his pilot licence.	
response	*Noted*	
	See response to comment No 1100 of this segment. It is a personal responsibility of the medical certificate holder to seek an aeromedical advice in cases described in MED.A.025. For the actions of the licensing authority - see response to comment No 1310.	

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comment	*321*	comment by: *Uso WALTER*
	Please consider my comment in the further discussions and decisions: A medical certificate for glider pilots does not make any sense in today's circumstances! I fully support the letter of Dr. C-D Zink with respect to this issue. I urge you to accept his arguments and to follow his reasoning. Any avoidable bureaucracy and unnecessary cost should soonest be eliminated from the respective European regulations. The current development of joint European rules is a unique chance to clean this area from outdated national regulations and to follow the favourable experience of UK and Switzerland (and USA) in waiving any medical certificate for glider pilots. Of course, a statement from the family doctor would make sense, rather to make the individual glider pilot aware of any health aspects than to fill the files of any office or authority. Any health problems of a student pilot are always clearly identified during flight training and the ensuing theoretical and practical examinations. As a really progressive action, EASA should immediately issue a recommendation to all member states to wave medicals for glider pilots flying solo or together with another certified glider pilot. This would simplify things, save money and not at all increase the risk of damage to outsiders.	
response	*Not accepted*	
	Safety in aviation is ensured by many different measures, one of them being a medical certificate for commercial and private pilots, including glider pilots. The	

	legal basis for the medical certificate is the ICAO SARPs and the EU Basic Regulation. The latter provides the possibility to draft licensing rules tailored to the complexity of the aircraft and the kind of operation which has specifically been done in the medical field for the private pilot community by adapting the JAR-FCL 3 requirements to ICAO Class 2 SARPs and propose even lighter provisions for the LAPL. It is not possible, for safety and legal reasons, to abolish the medical certificate for private pilots.

comment	*2308*	comment by: *David Miller*
	I strongly support the medical requirements proposed in the NPA but note that there is no justification for setting higher standards than the current ICAO class 2 level.	
response	*Noted*	
	The medical criteria for class 2 have been adapted to ICAO class 2. The rules for class 1 are set at a higher standard also following ICAO SARPs.	

comment	*2445*	comment by: *SANMA Swedish Aeronautical Associatation*
	De medicinska kraven är alltför låga och det är helt oklart på vilka grunder de är tagna. Var finns den medicinska bevisningen för att dessa krav är tillräckliga? Nuvarande krav kommer att leda till olyckor pga. Medicinska orsaker och kan ej accpeteras.	
response	*Noted*	
	The proposed medical requirements are based on JAR FCL 3(Medical) and ICAO standards. JAR and ICAO standards were applicable for a long time and proved to be safe. It is not clear on which data the statement in the comment is based.	

comment	*2578*	comment by: *UK General Aviation Alliance*
	ICAO medical requirements for Commercial Air Transport are adequate and EASA should not seek to increase requirements on the basis of JAR without proving that certification standards in excess of ICAO standards improve flight safety.	
response	*Noted*	
	The medical criteria for class 2 have been adapted to ICAO class 2. In MED.A.020(d) it is proposed that balloon pilot licence holders involved in commercial ballooning shall hold a class 2 medical certificate. Class 1 medical requirements were not increased, but transposed from JAR FCL 3 requirements already implemented and harmonised in all Member States.	

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comment	52	comment by: *Bernhard Blasen*
	the detailed description of diseases that disallow a pilot to fly should be avoided. The AeMC, AME or GMP doing the medical examination should be taken as competent enough to decide about the ability to fly. Reason: This rule causes bureaucracy and creates situations in which the decision about awareness or not can be doubtful. A person infected by HIV can be without incapabilities at all or total incapable. It must be a physician who take those decisions.	
response	*Noted*	
	All EU and EASA Member States are contracting states to ICAO. The ICAO SARPs in Annex 1 are reflected in this NPA in order to provide AMEs with clear rules to follow, pilots with legal certainty against which criteria they will be examined and also to help member states to fulfill their obligations regarding ICAO.	

comment	68	comment by: *Dr Graham Cresswell, chief medical officer, bmi*
	MED.B.001 I can find no reference in the document to any guidance on risk assessment. For many years, aeromedical certification has been guided by the 1% rule, which, while it is imperfect and almost certainly unnecessarily conservative, forces aeromedical decision-making to be made against the evidence base. In the absence of any such guidance it is likely that decisions will be intuition-based rather than evidence-based. This may result in unnecessary loss of experienced pilots from the industry and the settling of aeromedical decisions in court. Suggest... AMC to MED.B.001 As a general rule, pilots who do not fully meet these requirements but who are assessed by accredited medical conclusion to have a risk of sudden or subtle incapacitation of 1% per annum or less during the period of validity of the certificate may be assessed as fit for Class 1 OML or for unrestricted Class 2.	
response	*Partially accepted*	
	We agree that the guidance material on risk assessment needs to be reviewed and amended. Also, an expert in medical statistics should be involved in the drafting. This is why the risk assessment is excluded in this NPA and will be included in the rulemaking task MED.001 which follows immediately after this NPA is finalised as Opinion. The risk assessment will then be included as guidance material after a new NPA.	

comment	69	comment by: *Dr Graham Cresswell, chief medical officer, bmi*
	MED.B.001 I can find no reference in the document to any process by which EASA can respond to advances in medicine or medical technology that might demand a change in these regulations. If all specific prohibitions were removed from the implementing procedures to the AMCs the situation might be more flexible but it	

	is essential that there is a formal procedure allowing the assessment of developments and, if appropriate, the introduction of changes merited by those developments. See also ICAO letter AN 5/22-08/33 of 5 May 2008. Suggest... MED.B.002 Any EASA state that wishes to assess an advance in medicine or medical technology that might justify changes to these regulations and that can secure the support of one other state, shall submit to EASA a protocol for a trial. The protocol must cover • the background of the development or change in evidence base that merits the assessment • the trial procedure • proposals for mitigating any identifiable flight safety risk during the trial
response	*Partially accepted*
	IRs: The EASA rulemaking process allows anybody to propose a rulemaking task. This is, of course, also applicable to necessary changes to the provisions in this NPA. AMCs: Alternative AMCs can be approved by the Member States which provides a possiblity to include new medical developments in an AMC. A risk assessment is to be provided to the competent authority which will decide whether or not the same level of safety can be reached with an alternative AMC. Alternative AMCs will be sent to the Agency to be included in the rulemaking process. Please see corresponding paragraphs in Authority Requirements (AR).

comment	*77*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **Med B 001 d) section 1** **Page**: 9 Relevant Text: Licensing authority may require.... **Comment**: Licensing authority is not qualified to make this decision. It has to be done by the AMC or AME **Proposal**: Remove text from "or" to "authority" in the first line	
response	*Not accepted*	
	The Medical Assessor in the licensing authority is required to have the necessary qualification. See NPA 2008-22B, paragraph AR.MED.020.	

comment	524	comment by: *British Microlight Aircraft Association*
	Accepted	
response	*Noted*	
	Thank you for the positive comment.	

comment	594	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.B.001 **Page**: 9 Relevant Text: (a) Applicants for a medical certificate shall be free from any (...) that would entail a degree of functional incapacity which is likely to interfere with the safe exercise of the privileges of the applicable licence(s) or could render the applicant likely to become suddenly unable to exercise the privileges of the licence(s) safely. **Comment**: The acceptable range of "likelihood" of sudden incapacitation is not sufficiently defined. According to international (JAA/FAA) commitment and safety-philosophy a maximum probability of 1 % per year for sudden incapacitation shall not be exceeded. This standard should be prescribed mandatory for all European countries to guarantee the same level of flight safety. **Proposal**: (a) Applicants for a medical certificate shall be free from any (...) that would entail a degree of functional incapacity which is likely to interfere with the safe exercise of the privileges of the applicable licence(s) or could render the applicant likely to become suddenly unable to exercise the privileges of the licence(s) safely. No medical certification may be issued, when the risk for sudden incapacitation inherent to an applicant's disease, disability or abnormality is regarded to exceed 1 % per year (class 1; 2 % per year class 2 and LPL) to the conviction of the licensing authority, following examination and expert opinion by an AeMC in conjunction with a specialist of the involved medical field.	
response	*Noted*	
	Please see response to comment No 69.	

comment	663	comment by: *ERA*
	MED.B.001 General ERA would recommend the addition of an AMC to MED.B.001. The reason is that as a general rule, pilots who do not fully meet these requirements but who are assessed by accredited medical conclusion to have a risk of sudden or subtle incapacitation of 1% per annum or less during the period of validity of the certificate may be assessed as fit for Class 1 OML or for unrestricted Class 2. ERA would also like to add an MED.B.002. The reason is that any EASA state that wishes to assess an advance in medicine or medical technology that might justify	

	changes to these regulations and that can secure the support of one other state, shall submit to EASA a protocol for a trial. The protocol must cover • the background of the development or change in evidence base that merits the assessment • the trial procedure • proposals for mitigating any identifiable flight safety risk during the trial
response	*Noted*
	Please see answer to comment 69 in this Section. The proposed additional paragraph cannot be added becasue it would lead to very different standards in different Member States.

comment	*831*	comment by: *Thomas Cook Airlines UK*
	Commentator: The UK Association of Aviation Medical Examiners **Paragraph**: Med.B.001 General **Page Number 9** **Comment:** There is no mention in the document of the 1% rule. Aero-medical decisions should be made on evidence - based medicine. There needs to be flexibility in the regulations to permit changes with the advancement of medical knowledge. EASA needs to keep abreast of advances in medical science and amend the regulations accordingly. Individual states should be able to submit evidence based arguments for changes to the regulations if necessary on a trial basis initially. **Justification:** The 1% rule has stood the test of time as a practical and pragmatic method of calculating risk. **Proposed text:** Med B.001 add in new paragraph (e) Pilots who do not fully meet these requirements but who are assessed by an AeMC to have a risk of sudden incapacitation of 1% per annum or less during the period of validity may be assessed as fit for class 1 OML or for unrestricted class 2.	
response	*Partially accepted*	
	Please see response to comment No 68	

comment	*1149*	comment by: *Keith WHITE*
	001 (a). Elsewhere I have read that only one licence may be held at any time. The plurals in (4) are therefore confusing. (d). **Add GMP**.	
response	*Noted*	
	(a)	

	Requirement to hold only one valid medical certificate is proposed in MED.A.020(h). It is unclear to which paragraph (4) the comment is referring to. The singular/plural issue will be taken into account when reviewing the text for publication. (d) GMPs were not included because they cannot take decisions in these cases and shall refer LAPL applicants to AME or AeMC in cases where additional examinations are required.

comment	*1347*	comment by: *European Disabled Aviators*
	Attachment #9	
	On first reading, this article may lead to conclude that any disability will prevent being granted a medical certificate. In fact, if one takes into account listed restrictions and/or the possibility to compensate functional incapacities by using specific approved devices, the disability is no longer a disqualifying factor for it does not interfere with the safe exercise of flying the machine. However, in order to lift any ambiguity, we suggest adding the underlined sentence at the end of paragraph (a): [...] suddenly unable to exercise the privileges of the licence(s) safely. In case further assessment is required to ascertain the above requirement, the applicant shall pass a functional ability flight test or a simulator flight test with a competent flight examiner, using alternate procedures and/or an approved adaptation, if necessary.	
response	*Partially accepted*	
	A flight test, if needed in a case of disability or otherwise, is included in AMC to MED.A.045 (b) "...should evaluate the medical condition of the applicant in consultation with flight operations and other experts if necessary." Also MED.B.045 "Musculoskeletal System" has been amended for clarification.	

comment	*1440*	comment by: *David COURT*
	As a general comment. The EASA Class 2 medical should be set at the same level as ICAO Class 2. If the EASA Class 2 is set at a higher level (as the JAR Class 2 was) this will discriminate against European pilots as they must pass a higher medical than their non European competitors.	
response	*Noted*	
	The medical criteria for class 2 have been adapted to ICAO class 2. SARPs.	

comment	*1553*	comment by: *British Airways*
	In para (a), the acceptable range of "likelihood" of sudden incapacitation is not	

	sufficiently defined. According to international (JAA/FAA) commitment and safety-philosophy a maximum probability of 1 % per year for sudden incapacitation shall not be exceeded for Class One OML medical certification. **Proposal**: Add: A Class One medical certification may not be issued, where the licensing authority believes the risk for sudden incapacitation inherent to an applicant's disease, disability or abnormality is greater than 1 % per year. The authority should seek advice from aeromedical experts and relevant specialists in making the assessment.
response	*Noted*
	Please see response to comment No 68.

comment	*1554*	comment by: *British Airways*
	In NPA 2008-17(a), page 35 paras 14-15, the agency notes that nearly all of the requirements of Sub-Part B (Class 1) were transferred to the implementing rules, that this limits the application of the flexibility provisions given in Med.A.045, and that the agency would have preferred to transfer these requirements to the AMC. This was not done because of "objections from its experts". There is no safety benefit in reducing the flexibility to amend or update the requirements in the light of changes in medical management or understanding, and probably an adverse impact in the unnecessary removal of experienced pilots from the cockpit. The AEA, and its panel of medical experts, strongly endorses the agencies' view that these requirements should be moved to the AMC. **Proposal**: All of the requirements of JAR FCL 3 Subpart B should be placed in the AMC.	
response	*Not accepted*	
	The rules/AMCs in this NPA are based on JAR-FCL 3 and a right balance between hard law and soft law had to be found. The AMC Material in Part Medical was in the Appendices to Subparts B and C of JAR-FCL 3, which defined them as rules. Moving the rules from JAR-FCL 3 Appendices to AMCs under Part Medical results in even more flexibility as previously possible under JAR-FCL 3, if implemented correctly. IRs are also needed to maintain a common standard of assessment in Europe. MED.A.045 (b) is applicable to Implementing Rules. Flexibility concerning AMCs is by alternative AMCs as approved by the NAA and sent to the Agency for rulemaking purposes. Implementing Rules are to clearly state limits of fitness, necessary limitations to be applied and in which cases the licensing authority has to be involved. AMCs are to describe how to assess an applicant.	

comment	*1555*	comment by: *British Airways*
	Some commentators have suggested amendments to apply more stringent	

	requirements than those included in the latest amendment of JAR FCL 3 Medical Subpart B. The AEA believes that the application of more stringent requirements should only be considered where there is clear evidence that such requirements would mitigate a significant safety risk. **Proposal**: The requirements of JAR FCL 3 Subpart B should be placed in the AMC without amendment, except where there is clear evidence that such amendments would mitigate a significant safety risk, or where new evidence indicates that a less stringent requirement can safely be implemented.
response	*Not accepted*
	See response to comment No 1554.

comment	*1758*	comment by: *Civil Aviation Authority Finland*
response	*Noted*	
	Thank you for your efforts, but there is no comment.	

comment	*1760*	comment by: *Civil Aviation Authority Finland*
	MED.B.001 (a)(4) The drugs (abuse of substsnces) should also be mentioned in IR-FCL. The broblem abuse of substances is growing and some ceses are met also in aviation. Add: ... or preventive medication taken **or drugs (abuse of substances);**	
response	*Noted*	
	Requirements with regards to abuse of substances are mentioned in IR-FCL in MED.B.050 (Psychiatry) together with the abuse of alcohol. The requirement is written in a way which gives a possibility to return to flying duties for those applicants who demonstrate recovery and freedom from substance.	

comment	*1762*	comment by: *Max Heinz Katzschke*
	Aufzählungen und Listen von Krankheiten und Symptome, die zu Fluguntauglichkeit führen, sollten nicht festgelegt werden. Ärzte sind kompetend genug um über die Tauglichkeit für das Fliegen zu entscheiden. Erfahrungsgemäß werden mit solchen Listen medizinisch nicht kompetende Personen und Bürokratieen tätig, was zu Komplikationen führt.	
response	*Not accepted*	
	Our rules follow the ICAO SARPs obliging Contracting States to have medical	

	requirements in place.

comment	*1971*	comment by: *AEA*
	Comment In NPA 2008-17(a), page 35 paras 14-15, the agency notes that nearly all of the requirements of Sub-Part B (Class 1) were transferred to the implementing rules, that this limits the application of the flexibility provisions given in Med.A.045, and that the agency would have preferred to transfer these requirements to the AMC. This was not done because of "objections from its experts". There is no safety benefit in reducing the flexibility to amend or update the requirements in the light of changes in medical management or understanding, and probably an adverse impact in the unnecessary removal of experienced pilots from the cockpit. The AEA, and its panel of medical experts, strongly endorses the agencies' view that these requirements should be moved to the AMC. **Proposal**: All of the requirements of JAR FCL 3 Subpart B should be placed in the AMC.	
response	*Not accepted*	
	See response to comment No 1554.	

comment	*1972*	comment by: *AEA*
	Comment Some commentators have suggested amendments to apply more stringent requirements than those included in the latest amendment of JAR FCL 3 Medical Subpart B. The AEA believes that the application of more stringent requirements should only be considered where there is clear evidence that such requirements would mitigate a significant safety risk. **Proposal**: The requirements of JAR FCL 3 Subpart B should be placed in the AMC without amendment, except where there is clear evidence that such amendments would mitigate a significant safety risk, or where new evidence indicates that a less stringent requirement can safely be implemented.	
response	*Not accepted*	
	See response to comment No 1554.	

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comment	*1458*	comment by: *Virgin Atlantic Airways Ltd*
	All sections. **Comment:** To incorporate these blanket rules in the "Requirements" is too inflexible and allows for no individual risk assessment. Furthermore, as medical	

	science and techniques advance, the process of proposing and implementing amendments will be hugely bureaucratic. **Proposal:** In order to make changes easier to achieve in the future as medical knowledge improves and allow a greater degree of flexibility, this section should be relocated to the AMC.
response	*Noted*
	Please see response to comment 1554 in Segment MED.B.001.

comment	*2201*	comment by: *Royal Netherlands Aeronautical Association*
	Pilot fitness Aeromedical risk concerns diseases that can cause sudden incapacity or sudden changes of function. These are a small but significant cause of accidents but can only be predicted using medical expertise. The common causes of sudden incapacity are epileptic fits, cardiovascular disease comprising heart attacks or strokes, and abnormal low blood sugar caused by the treatment of diabetes. All pilots have to decide on every occasion that they are fit to fly, short term infections, fatigue, alcohol, medication (I AM SAFE) can all be reasons for temporary unfitness and so a "self declaration" by the pilot is routine. This self management is best supported by human factors training, instructional supervision and responsible peer pressure. KNVvL CONCLUSION -Primary concern of medical certification must be “sudden incapacitation”, mainly: -Epileptic fits -Cardiovascular Disease (heart attacks, strokes) -Diabetes and abnormal blood sugar -Function should not be a major concern for doctors in the examination of sport pilots. Any deficiency of function will be observed by flying instructors who have assessed and certify pilot performance. Education in human factors is an important contribution to medical fitness. -Numerical prediction of risk in sport or other pilots has not been included in the new regulation. Defined statistical risk levels are necessary to obtain common standards and permit later validation from accident and incident data. KNVvL PROPOSAL: -The proposed statistical risk levels for known illnesses accord with current practice and meet the Essential Requirement for mitigating measures. They have to be included in the new regulation -Self management by the pilot should be supported by human factors training	
response	*Noted*	
	The guidance material on risk assessment of JAR-FCL will be reviewed and amended, also by professionals in medical statistics, and included in the rulemaking task MED.001. Provisions for self management are provided in MED.A.025 and AMC to MED.A.025 "Decrease in medical fitness".	

comment	*2354*	comment by: *Tomasz Gorzenski*
	This is to congratulate EASA on selecting ICAO Annex 1 medical certificate class 2 standards (for private pilots) as a basis for EASA requirements. After years of misery, courtesy of JAA, when EU was dragging behind the ICAO and the FAA, this is very good sign that EASA admits that the ICAO minimum standard can be enough for high level of safety, while avoiding typical EU bureaucratic burden. Unfortunately, the EASA stopped in the middle of the road and did not proceed with the same philosophy regarding EASA medical certificate class 1 standards, not to even mention pilot's training (FCL). But this class 2 medical certificate standard case gives us at least hope for the future.	
response	*Noted*	
	Thank you for your support regarding class 2 medical certificates.	

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comment	*1*	comment by: *GEMA*
	(a) (4). Medicina preventiva, no tiene ningún papel en el examen aeromédico	
response	*Noted*	
	We agree with your opinion. In addition we would like to draw your attention to the fact that our proposed medical requirements are based on JAR FCL 3(Medical) and ICAO medical requirements. These requirements were established to determine aeromedical fitnes of the applicant for certain period of time. Increase of serum lipids, including cholesterol, is statistically significant risk factor (together with other risk factors: hypertension, diabetes, smoking, etc.) of the development of coronary artery disease. Having in mind the fact that coronary artery disease is one of main causes of denial of medical certificates, this test was retained in the NPA.	

comment	*64*	comment by: *Dr Graham Cresswell, chief medical officer, bmi*
	MED.B.005 (b) (2) (ii) and (iii) At bmi we have one pilot, a very experienced and competent training captain, who has had a Ross procedure. He remains extremely well and is regularly re-assessed by CAA cardiologists. He is not a threat to flight safety. We have also started to allow pilots to fly commercial airliners when stabilised on oral anticoagulants and under strictly controlled conditions. This philosophy allows us to retain experience in the flight deck. If these regulations are enacted, these pilots will become unemployed and will take their cases to the European Court of Human Rights.	

	I strongly suggest that all blanket prohibitions like these are removed from the implementing rules because they make it impossible to respond to advances in medicine. Such restrictions must be demoted at least to AMC so that the European industry can quickly adapt to changes in the evidence base for aeromedically significant illness. Suggest... Everything after MED.B.005 (b) (1) should be demoted at least to AMC. This should apply to all specific prohibitions in all systems.
response	*Partially accepted*
	Proposal to move all IRs to AMCs: The rules/AMCs in this NPA are based on JAR-FCL 3 and a right balance between hard law and soft law had to be found. The AMC Material in Part Medical was in the Appendices to Subparts B and C of JAR-FCL 3, which defined them as rules. Moving the rules from JAR-FCL 3 Appendices to AMCs under Part Medical results in even more flexibility as previously possible under JAR-FCL 3, if implemented correctly. IRs are also needed to maintain a common standard of assessment in Europe. Anticoagulant therapy: (b)(2)(iii) has been moved to (b)(3) which provides the licensing authority to accept this therapy under certain conditions.

comment	*78*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: Med B 005 a) 1 section 2 **Page**: 9 Relevant Text: Standard ECG **Comment**: Has to be done more often **Proposal**: .. has to be completed in all examinations	
response	*Not accepted*	
	JAR FCL 3 class 2 requirements were considered as being too stringent for private flying and it had been agreed to adapt these requirements to ICAO class 2 level. Frequency of standard ECG proposed in MED.B.005(a)(1)(ii) is in line with ICAO standard laid down in the paragraph 6.4.2.6.	

comment	*79*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM	

	Section: Med B 005 a) 4) section 2 **Page**: 9 Relevant Text: **Comment**: Class 2 pilots shall undergo also a risk evaluation concerning with lipids **Proposal**: ...for class 1 and class 2 medical certificate .....
response	*Not accepted*
	JAR FCL 3 class 2 requirements were considered as being too stringent for private flying and it had been agreed to adapt these requirements to ICAO class 2 level. ICAO class 2 standards do not contain the requirement to test serum lipids.

comment	*80*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **Med to B 005** **Page**: 9ff Relevant Text: Referring to licensing authority **Comment**: Not possible due to lack of qualified medical personal and medical confidentiality **Proposal**: According to national law referred pilots shall be examined by AME class I or AMC	
response	*Not accepted*	
	The Medical Assessor in the licensing authority is required to have the necessary qualification. See NPA 2008-22B, paragraph AR.MED.020. Medical confidentiality - see response to comment No 75 in the section MED.A.050. The principle of the primacy of European law over national law ensures that the IRs will apply independently of what is said in national law.	

comment	*87*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **Med to B 005** **Page**: 9ff	

	Relevant Text: Referring to licensing authority **Comment**: Not possible due to lack of qualified medical personal and medical confidentiality **Proposal**: According to national law referred pilots shall be examined by AME class I or AMC
response	*Not accepted*
	See response to comment No 80.

comment	*124*	comment by: *Civil Aviation Authority - The Netherlands*
	MED.B.005, onder a, derde lid. (Blz. 9 van 66) De CAA-The Netherlands is van mening dat het voorschrift op een dusdanige wijze moet worden aangevuld dat duidelijk blijkt dat het in het derde lid bedoelde onderzoek uitsluitend door een cardioloog verricht mag worden.	
response	*Not accepted*	
	For the explanation of the extended cardiovascular assessment see, please, the AMC to MED.B.005 2.2.	

comment	*125*	comment by: *Civil Aviation Authority - The Netherlands*
	MED.B.005, onder d, (2). (Blz. 10 van 66) Ook kandidaten die een medisch klasse 2 certificaat hebben aangevraagd en vallen onder MED.B.005, onder d, tweede lid, moeten volgens de CAA-The Netherlands worden doorgestuurd naar de bevoegde autoriteit.	
response	*Not accepted*	
	Any applicant for a class 1 or call 2 medical certificate may be referred to the authority, see AMC to MED.A.045). However, applicants for a class 2 medical certificate with a condition as defined in (d) may be assessed by an AME or AeMC after cardiological evaluation.	

comment	*401*	comment by: *European CMO Forum*
	MED.B.005 (e) (1) Comment: Additional item of Brugada to be added as a reason for authority referral. Justification: Brugada is an important cause of sudden cardiac death.	

	Proposed Text: Add **(vii) Brugada pattern on electrocardiography**
response	*Accepted*
	Accepted for class 1 medical certificate.

comment	*424*	comment by: *UK CAA*
	MED.B.005 (b) (2) (ii) **Page: 10** **Comment:** Not explicit. **Justification:** Only functional abnormalities would entail unfitness. **Proposed Text:** Insert ' ....significant **functional** abnormality of any of the heart valves.'	
response	*Accepted*	
	Thank you for your input.	

comment	*425*	comment by: *UK CAA*
	MED.B.005 (b) (2) **Page: 10** **Comment:** Inappropriate for IR. Agree with Agency's note in NPA 17a para 15. **Justification:** Not future-proof: Any change of the IRs may be lengthy and a pilot may be prevented from being assessed as fit even though new measures to mitigate the medical risk may be available. **Proposed Text:** Delete Para (2). Add (2) (i) (ii) and (iii) to para (3) and also insert para (2) (i) (ii) and (iii) to AMC and change 'shall' to 'should'.	
response	*Noted*	
	To move IRs to AMCs on a general basis: Please see response to comment No 64. Paragraph (b)(2) (iii) on anticoagulant therapy will be moved to (b)(3) and can be accepted under certain conditions (see response to comment No 64).	

comment	*426*	comment by: *UK CAA*

MED.B.005 (b) (2) (iii)
Page: 10

Comment:
Inappropriate for IR.

The LSST/M agreed to permit anticoagulation under certain circumstances. See WP 19/07 and Final WP 19-1/07 (Annex 9 of the minutes of LSSTM Meeting No 18). This change should be progressed as it was due to be adopted under the JAA system and was only halted due to the dissolution of the JAA NPA process.

Justification:
Newer anticoagulants are currently being introduced which are likely to have acceptable side effect profile for use by pilots.

Proposed Text:
Delete (iii).

response *Noted*

Anticoagulant therapy may be accepted on the certain conditions, for class 1 this decision may be taken by the authority. Please see response to comment No 64.

comment *427* comment by: *UK CAA*

MED.B.005 (b) (4)
Page: 10

Comment:
The most significant/complex conditions should be referred to the Licensing Authority.

Justification:
Not all will need review by a cardiologist.

Proposed Text:
Delete 'evaluated by a cardiologist' and replace with '**referred to the Licensing Authority'**.

response *Partially accepted*

Class 2 applicants will be assessed in consultation with the Licensing Authority.

comment *428* comment by: *UK CAA*

MED.B.005 (c) (3)
Page: 10

Comment:
Inappropriate for IR. Agree with Agency's note in NPA 17a para 15.

Justification:

	Not future-proof: Any change of the IRs may be lengthy and a pilot may be prevented from being assessed as fit even though new measures to mitigate the medical risk may be available. **Proposed Text:** Move to AMC and change 'shall' to 'should'.
response	*Noted*
	Please see response to the comment No 64

comment	*429*	comment by: *UK CAA*
	MED.B.005 (d) (1) (i) and throughout document. **Page: 10** **Comment:** Incorrect term. **Justification:** More appropriate text. **Proposed Text:** Change 'cardiac ischaemia' to '**myocardial ischaemia**'. NB This change should be applied throughout the text.	
response	*Accepted*	
	Thank you for your comment.	

comment	*430*	comment by: *UK CAA*
	MED.B.005 (d) (1) (ii) **Page: 10** **Comment:** Pilots with minor coronary artery disease will be on treatment. It is only anti-anginal treatment that would preclude certification. **Justification:** Pilots likely to be on aspirin and lipid lowering treatment. **Proposed Text:** Insert additional word: 'requiring no **anti-anginal** treatment'.	
response	*Accepted*	
	Thank you for the comment. The text will be changed accordingly.	

comment	*431*	comment by: *UK CAA*
	MED.B.005 (d) (3) **Page: 11** **Comment:**	

	a) Simplification of text makes the intention clearer. b) Inappropriate for IR. Agree with Agency's note in NPA 17a para 15. **Justification:** a) Clarity. b) Not future-proof: Any change of the IRs may be lengthy and a pilot may be prevented from being assessed as fit even though new measures to mitigate the medical risk may be available. **Proposed Text:** Change text to: 'Applicants with: **(i) silent or symptomatic myocardial ischaemia** (ii) **symptomatic** coronary artery disease controlled by medication **should** be assessed as unfit. And move to AMC.
response	*Not accepted*
	a) The conditions mentioned (myocardial ischaemia, symptomatic coronary arthery disease, symptoms of coronary artery disease controlled by medication) need treatment and are clearly not compatible with fitness to fly. b) Pleae see response to comment No 64.

comment	*432*	comment by: *UK CAA*
	MED.B.005 (d) (4) **Page: 11** **Comment:** No justification for a difference between initial and revalidation/renewal standards. **Justification:** General principle is that initial and revalidation/renewal requirements should be the same for individuals with the same risk of incapacitation. **Proposed Text:** Delete 'initial' and amend 'assessed as unfit' to '**referred to the Licensing Authority'**.	
response	*Not accepted*	
	Some differences between initial and revalidation examinations have been abolished when transferring JAR-FCL 3 requirements into Implementing Rules. However, the requirement MED.005 (d)(4) has been transferred from JAR FCL 3.140(c) because of the seriousness of the conditions (myocardial ischaemia, myocardial infarction and revascularisation for coronary artery disease).	

comment	*433*	comment by: *UK CAA*

MED.B.005 (d) (5)
Page: 11
Comment:
See comment on MED.B.005 (d) (4).

Justification:
See comment on MED.B.005 (d) (4).

Proposed Text:
Delete last sentence.

response *Noted*

Please see response to the comment No 432.

comment *434* comment by: *UK CAA*

MED.B.005 (e) (1), (2), (4) and (5)
Page: 11

Comment:
The whole 'Rhythm/Conduction Disturbances' section should be moved to AMC.

Justification:
Not future-proof: Any change of the IRs may be lengthy and a pilot may be prevented from being assessed as fit even though new measures to mitigate the medical risk may be available.

Proposed Text:
Move to AMC and change 'shall' to 'should' in all 4 paragraphs.

response *Noted*

Please see response to comment No 64.

comment *436* comment by: *UK CAA*

MED.B.005 (e) (1)
Page: 12

Comment:
Add Brugada to the list of conditions that should be referred to the Licensing Authority.

Justification:
Brugada is increasingly recognised as a risk factor for sudden death.

Proposed Text:
Add **(vii) Brugada pattern on electrocardiography.**

response *Noted*

	Please see response to comment No 401

comment	*525*	comment by: *British Microlight Aircraft Association*
	(a) (b) (1) Strongly agree other parts no knowledge	
response	*Noted*	
	Thank you for your input.	

comment	*571*	comment by: *Lufthansa German Airlines*
	Comment: An ecg should be written on the intial exam as well. Preexitation, RBBB and rhythm disorders do exist in younger pilots as well. CAD incidence increases with age, therefore ecgs should be checked in two years intervals above age 40 already! **Proposal**: (ii) For a Class 2 medical certificate, at the first examination, and then every 2 years after the age 40.	
response	*Noted*	
	Please see response to comment No 78.	

comment	*620*	comment by: *Lufthansa German Airlines*
	Author: Dr. Christine Huber, Cardiologist, AMC Frankfurt Section: Subpart B Requirements for medical certificate - Section 2 - Specific requirements for class 1 and class 2 medical certificates MED.B.005 Cardiovascular System (a) Examination (1) (ii) Draft Version 3.0 **Page**: 31 Relevant Text: (1) A standard 12-lesd resting ecg and report shall be completed on clinical indication and: (ii) For a Class 2 medical certificate, at the first examination after age 40 and then every 2 years after the age 50. **Comment**: An ecg should be written on the intial exam as well. Preexitation, RBBB and rhythm disorders do exist in younger pilots as well. CAD incidence increases with age, therefore ecgs should be checked in two years intervals above age 40 already! **Proposal**: (ii) For a Class 2 medical certificate, at the first examination, and then every 2 years after the age 40.	
response	*Noted*	
	See response to comment No 78.	

comment	644	comment by: *Royal Danish Aeroclub*
	MED.B.005(b)(4): The text say: "Applicants for a class 2 medical certificate with an established diagnosis of one of the conditions specified in (2) shall be evaluated by a cardiologist before a fit assessment can be considered." Considered by whom? The same issue in (d)(2) and (e)(2) and (3). We suggest the text to say: "Applicants for a class 2 medical certificate with an established diagnosis of one of the conditions specified in (2) shall be evaluated by a cardiologist before a fit assessment can be considered by the AeMC, the AME or the GMP."	
response	*Noted*	
	Class 2 applicants will be assessed by the AME or AeMC in consultation with the licensing authority. The GMP cannot assess class 2 pilots and also not LAPL holders who do not meet the requirements	

comment	659	comment by: *ERA*
	MED.B.005 Cardiovascular System ERA recommends that everything after subpara (b) (1) should be demoted at least to an AMC. This principle should apply to all specific prohibitions in all systems.	
response	*Noted*	
	Please see response to comment No 64.	

comment	674	comment by: *Pekka Oksanen*
	Subpara (b)(2)(iii) Modern anticoagulant therapy is used for conditions that per se are not disqualifying. Older warfarin type medications are reason for a denial. New low-dose heparin derivaties do not increase the risk of sudden bleeding leading to incapacitation. Their use must be evaluated by the Authority. Proposal: Add a new subparagraph (b)(3)(x): **(x) use of low molecular weight heparin derivatives**	
response	*Noted*	
	See response to comment No 64.	

comment	675	comment by: *Pekka Oksanen*
	Brugada pattern in ECG is an important cause of sudden death. Add a new text: **(vii) Brugada pattern on electrocardiography.**	
response	*Noted*	
	Please see response to comment No 401.	

comment	730	comment by: *Swiss Association of Aviation Medecine*
	Comment: ecg is necessary at initial to asses conduction defects for instance and after the age of 40, because coronary arteriosclerosis increases after this age. **Proposal**: (a) Examination (1) A standard 12lead resting electrocardiogram (ECG) and report shall be completed on clinical indication, and: (ii) For a class 2 medical certificate, at initial, at age 40 and then every 2 years after age 40.	
response	*Noted*	
	Please see response to comment No 78.	

comment	731	comment by: *Swiss Association of Aviation Medecine*
	Comment: overlapping passages, a more precise list is necessary. **Proposal**: (2) Applicants for a class 1 and 2 medical certificate with any of the following conditions: (i) aneurysm of the thoracic or suprarenal abdominal aorta, before or after surgery; (ii) abnormality of any of the heart valves and after valvular surgery; (iii) a cardiovascular condition requiring systemic anticoagulant therapy; (iv) heart or heart/lung transplantation (v) peripheral arterial disease before or and after any kind of revascularization; (vi) aneurysm of the infrarenal abdominal aorta, before or after surgery; (vii) abnormality of the pericardium, myocardium or endocardium, (viii) congenital abnormality of the heart, before or after corrective surgery; (ix) any kind of syncope, (x) arterial or venous thrombosis, (xi) pulmonary embolism shall be assessed as unfit. A fit assessment may be considered by the AMS after cardiological evaluation.	
response	*Not accepted*	
	Subpart B Section 2 details the requirements for class 1 and class 2 medical	

	certificates. Requirements that are applicable to both classes of medical certificates do not mention either class in the text. Those applicable for only class 1 or only class 2 specify in the text the class of medical certificate concerned.

comment	*732*	comment by: *Swiss Association of Aviation Medecine*
	Comment: The wording is unprecise and the definition of minor coronary artery disease is lacking. The cardiological evaluation is necessary in any case of suspected or proven CAD and this applies for class 1, as well as for class 2. **Proposal**: (1) Applicants for a class 1 and 2 medical certificate with suspected or proven coronary artery disease/ischemic heart disease shall be subjected to a detailed cardiological evaluation, before a fit assessment can be considered by the licensing authority.	
response	*Not accepted*	
	The difference between class 1 and class 2 is that class 1 applicants shall be referred to the licensing authority whereas class 2 applicants shall be assessed in consultation with the licensing authority. This includes the possibility for the authority to refer the decision back to the AME or to an AeMC.	

comment	*733*	comment by: *Swiss Association of Aviation Medecine*
	Comment: the rhythm disorders have to be listed according to their relevance and in a clear order. Irrelevant passages should be removed. Unfitness has to be assessed in the most relevant issues. In some cases other cardiac abnormalities have to be ruled out and then fitness is assessed. Mainly the original part (3) contains a lot of unimportant descriptions. Part (4) mentions previous passages once more and most of it can be removed. **Proposal**: (e) Rhythm/Conduction Disturbances (1) Applicants for a class 1 and 2 medical certificate shall be assessed as unfit, when they have any significant disturbance of cardiac conduction or rhythm, including any of the following: (i) disturbance of supraventricular rhythm, including intermittent or established sinoatrial dysfunction, atrial fibrillation and/or flutter (ii) complete left bundle branch block; (iii) Mobitz type 2 atrioventricular block and complete AV block; (iv) broad and/or narrow complex tachycardia; (v) ventricular preexcitation; (vi) QT prolongation. A fit assessment may be considered by the AMS after detailed cardiological evaluation. (2) Applicants with any of the following: (i) complete right bundle branch block; (ii) sinus tachycardia; (iii) isolated uniform supraventricular or ventricular ectopic complexes;	

(iv) first degree atrioventricular block;
(v) Mobitz type 1 (Wenckebach) atrioventricular block,
may be assessed as fit in the absence of any other abnormality and subject to satisfactory
cardiological evaluation.

(3) Applicants with a history of:
(i) ablation therapy; or
(ii) pacemaker implantation;
shall undergo satisfactory cardiovascular evaluation before a fit assessment can be made.

(4) Applicants with an automatic implantable defibrillating system shall be assessed as unfit.

response *Noted*

Brugada pattern on electrocardiography has been added to rhythm/conduction disturbances (see comment No 401). The assessment for class 2 applicants will be done in consultation with the licensing authority (the term AMS will not exist any more). Please see resulting text.

comment *994* comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author: **European Society of Space and Aviation Medicine (ESAM) - Cardiology Group -**

Subpart B Requirements for medical certificates
Section: 2 Specific requirements for class 1 and class 2 medical certificates
MED.B.005 Cardiovascular System

Page: 9

Relevant Text:
(a) Examination

- (1) Astandard 12lead resting electrocardiogram(ECG)and reportshall becompleted on clinical indication, and:

(ii) For a class 2 medical certificate, at the first examination after age 40 and then every 2 years after age 50.

Comment: ecg is necessary at initial to asses conduction defects for instance and after the age of 40, because coronary arteriosclerosis increases after this age.

Proposal:
(a) Examination
(1) A standard 12lead resting electrocardiogram (ECG) and report shall be completed on clinical indication, and:
(ii) For a class 2 medical certificate, at initial, at age 40 and then every 2 years after age 40.

response	*Noted*
	Please see response to comment No 78.

comment	*995*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author: **European Society of Space and Aviation Medicine (ESAM) - Cardiology Group -**

Subpart B Requirements for medical certificates
Section: 2 Specific requirements for class 1 and class 2 medical certificates
MED.B.005 Cardiovascular System

Page: 9-10

Relevant Text:
(b) Cardiovascular System - General
(1) Applicants shall not possess any cardiovascular disorder which is likely to interfere with the safe exercise of the privileges of the applicable licence(s).

(2) Applicants for a class 1 medical certificate with any of the following conditions:
(i) aneurysm of the thoracic or suprarenal abdominal aorta, before or after surgery;
(ii) significant abnormality of any of the heart valves;
(iii) a cardiovascular condition requiring systemic anticoagulant therapy;
(iv) heart or heart/lung transplantation
shall be assessed as unfit.

(3) Applicants for a class 1 medical certificate with an established history or diagnosis of any of the following conditions shall be referred to the licensing authority:
(i) peripheral arterial disease before or after surgery;
(ii) aneurysm of the infrarenal abdominal aorta, before or after surgery;
(iii) minor cardiac valvular abnormalities,
(iv) after cardiac valve surgery,
(v) abnormality of the pericardium, myocardium or endocardium,
(vi) congenital abnormality of the heart, before or after corrective surgery;
(vii) recurrent vasovagal syncope,
(viii) arterial or venous thrombosis,
(ix) pulmonary embolism.

(4) Applicants for a class 2 medical certificate with an established diagnosis of one of the conditions specified in (2) shall be evaluated by a cardiologist before a fit assessment can be considered.

Comment: overlapping passages, a more precise list is necessary.
Proposal:
(2) Applicants for a class 1 and 2 medical certificate with any of the following conditions:
(i) aneurysm of the thoracic or suprarenal abdominal aorta, before or after

surgery;
(ii) abnormality of any of the heart valves and after valvular surgery;
(iii) a cardiovascular condition requiring systemic anticoagulant therapy;
(iv) heart or heart/lung transplantation
(v) peripheral arterial disease before or and after any kind of revascularization;
(vi) aneurysm of the infrarenal abdominal aorta, before or after surgery;
(vii) abnormality of the pericardium, myocardium or endocardium,
(viii) congenital abnormality of the heart, before or after corrective surgery;
(ix) any kind of syncope,
(x) arterial or venous thrombosis,
(xi) pulmonary embolism
shall be assessed as unfit. A fit assessment may be considered by the AMS after cardiological evaluation.

response *Not accepted*

We do not see overlaps; the content in these paragraphs has been taken over from JAR-FCL 3.

comment *996* comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author: **European Society of Space and Aviation Medicine (ESAM) - Cardiology Group -**

Subpart B Requirements for medical certificates
Section: 2 Specific requirements for class 1 and class 2 medical certificates
MED.B.005 Cardiovascular System

Page: 10-11

Relevant Text: (d) Coronary Artery Disease
(1) Applicants for a class 1 medical certificate with:
(i) suspected cardiac ischaemia; or
(ii) asymptomatic minor coronary artery disease requiring no treatment;
shall be referred to the licensing authority and undergo cardiological evaluation to exclude cardiac ischaemia before a fit assessment can be considered.

(2) Applicants for a class 2 medical certificate with any of the conditions detailed in (1) shall undergo cardiological evaluation before a fit assessment can be considered.
(3) Applicants with:
(i) cardiac ischaemia;
(ii) symptomatic coronary artery disease, or
(iii) symptoms of coronary artery disease controlled by medication;
shall be assessed as unfit.

(4) Applicants for the initial issue of a class 1 medical certificate with a history or diagnosis of:
(i) cardiac ischaemia;
(ii) myocardial infarction; or
(ii) revascularisation for coronary artery disease;

shall be assessed as unfit.

(5) Applicants for a class 2 medical certificate who are asymptomatic after myocardial infarction or surgery for coronary artery disease shall undergo satisfactory cardiological evaluation before a fit assessment can be considered. Applicants for the revalidation of a class 1 medical certificate shall be referred to the licensing authority.

Comment: The wording is unprecise and the definition of minor coronary artery disease is lacking. The cardiological evaluation is necessary in any case of suspected or proven CAD and this applies for class 1, as well as for class 2.

Proposal:
(1) Applicants for a class 1 and 2 medical certificate with suspected or proven coronary artery disease /ischemic heart disease shall be subjected to a detailed cardiological evaluation, before a fit assessment can be considered by the licensing authority.

response *Not accepted*

The content of this paragraph has been taken over from JAR-FCL 3. We do not consider the text as imprecise.

comment *997* comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author: **European Society of Space and Aviation Medicine - Cardiology Group -**

Subpart B Requirements for medical certificates
Section: 2 Specific requirements for class 1 and class 2 medical certificates
MED.B.005 Cardiovascular System

Page:11 - 12

Relevant Text:
(e) Rhythm/Conduction Disturbances
(1) Applicants for a class 1 medical certificate shall be referred to the licensing authority when they have any significant disturbance of cardiac conduction or rhythm, including any of the following:
(i) disturbance of supraventricular rhythm, including intermittent or established sinoatrial dysfunction, atrial fibrillation and/or flutter and asymptomatic sinus pauses;
(ii) complete left bundle branch block;
(iii) Mobitz type 2 atrioventricular block;
(iv) broad and/or narrow complex tachycardia;
(v) ventricular preexcitation; or
(vi) asymptomatic QT prolongation.

(2) Applicants for a class 2 medical certificate with any of the conditions detailed in (1) shall be evaluated by a cardiologist before a fit assessment can be considered.

(3) Applicants with any of the following:
(i) incomplete bundle branch block;
(ii) complete right bundle branch block;
(iii) stable left axis deviation;
(iv) asymptomatic sinus bradycardia;
(v) asymptomatic sinus tachycardia;
(vi) asymptomatic isolated uniform supraventricular or ventricular ectopic complexes;
(vii) first degree atrioventricular block; or
(viii) Mobitz type 1 atrioventricular block,
may be assessed as fit in the absence of any other abnormality and subject to satisfactory cardiological evaluation.

(4) Applicants with a history of:
(i) ablation therapy; or
(ii) pacemaker implantation;
shall undergo satisfactory cardiovascular evaluation before a fit assessment can be made.
Applicants for a class 1 medical certificate shall be referred to the licensing authority.

(5) Applicants with:
(i) symptomatic sinoatrial disease;
(ii) complete atrioventricular block;
(iii) symptomatic QT prolongation;
(iv) an automatic implantable defibrillating system; or
(v) an antitachycardia pacemaker;
shall be assessed as unfit.

Comment: the rhythm disorders have to be listed according to their relevance and in a clear order. Irrelevant passages should be removed. Unfitness has to be assessed in the most relevant issues. In some cases other cardiac abnormalities have to be ruled out and then fitness is assessed. Mainly the original part (3) contains a lot of unimportant descriptions. Part (4) mentions previous passages once more and most of it can be removed.

Proposal:
(e) Rhythm/Conduction Disturbances
(1) Applicants for a class 1 and 2 medical certificate shall be assessed as unfit, when they have any significant disturbance of cardiac conduction or rhythm, including any of the following:
(i) disturbance of supraventricular rhythm, including intermittent or established sinoatrial dysfunction, atrial fibrillation and/or flutter
(ii) complete left bundle branch block;
(iii) Mobitz type 2 atrioventricular block and complete AV block;
(iv) broad and/or narrow complex tachycardia;
(v) ventricular preexcitation;
(vi) QT prolongation.
A fit assessment may be considered by the AMS after detailed cardiological evaluation.

	(2) Applicants with any of the following: (i) complete right bundle branch block; (ii) sinus tachycardia; (iii) isolated uniform supraventricular or ventricular ectopic complexes; (iv) first degree atrioventricular block; (v) Mobitz type 1 (Wenckebach) atrioventricular block, may be assessed as fit in the absence of any other abnormality and subject to satisfactory cardiological evaluation. (3) Applicants with a history of: (i) ablation therapy; or (ii) pacemaker implantation; shall undergo satisfactory cardiovascular evaluation before a fit assessment can be made. (4) Applicants with an automatic implantable defibrillating system shall be assessed as unfit.
response	*Not accepted*
	The content of this paragraph has been transposed from JAR-FCL 3. Nothing was added and we do not see irrelevant passages.

comment	*1025*	comment by: *Ilse Janicke Heart Center Duisburg*
	Author: Janicke Ilse, Senior MD, AME I and II, Cardiologist and Angiologist at Heart Center Duisburg Section: **Subpart B, Requirements for Medical Certificates** Section 2:Specific requirements for Class 1 and Class 2 medical certificates **MED.B.005 Cardiovascular System** **Page**: 9 (NPA 2008-17c) Relevant Text: a) **Examination** (1) A standard 12-lead resting electrocardiogramm (ECG) shall be completed....and (II) For class 2 medical certificate, at the first examination after age 40 and then every 2 years after age 50 **Comment**: Also for class 2 medical a resting ECG at first examination is mandatory for certain fitness, ie a complete RBBB or LBBB or WPW/preexcitation, or signs of hypertrophie which normally will be seen in younger people too, cannot be found. Cardiovascular diseases and pathological ECG changes increase with age, therefore ECG is necessary every two years after the age of 40. **Proposal**: (ii) For a class 2 medical certificate, at the first examination, and then every 2 years after the age 40.	
response	*Noted*	
	Please see response to the comment No 78.	

comment	1101	comment by: *Moldavian Society of Aviation Medicine*
	Comment: ECG is the easiest tool to discover any abnormality of rhythm disturbance and indirectly of other heart abnormalities at earlier stage so it is necessary at initial and after the age of 40, when coronary pathology could appear. Proposal: (a) Examination (1) A standard 12lead resting electrocardiogram (ECG) and report shall be completed on clinical indication, and: (i) For a class 1 medical certificate, at the examination for first issue of a medical certificate, then every 5 years until age 30, every 2 years until age 40, annually until age 50, and at all revalidation or renewal examinations thereafter; (ii) For a class 2 medical certificate, at initial, at age 40 and then every 2 years after age 40.	
response	*Noted*	
	Please see response to comment No 78.	

comment	1104	comment by: *Moldavian Society of Aviation Medicine*
	MED.B.005 Cardiovascular System (d) Coronary Artery Disease Comment: The definition of minor coronary artery disease is lacking. The cardiological evaluation is necessary in any case of suspected or proven CAD and this applies for class 1, as well as for class 2. Proposal: (1) Applicants for a class 1 and 2 medical certificate with suspected or proven coronary artery disease / ischemic heart disease shall be subjected to a detailed cardiological evaluation, before a fit assessment can be considered by the licensing authority.	
response	*Noted*	
	One addition has been made to clarify the text: "asymptomatc minor cornary artery disease requiring no **anti-anginal** treatment". Please see response to comment No 430.	

comment	1119	comment by: *BALPA*
	MED.B.005 ***Cardiovascular System*** *(b) Cardiovascular System - General* *(2) Applicants for a class 1 medical certificate with any of the following conditions:*	

(iii) a cardiovascular condition requiring systemic anticoagulant therapy; shall be assessed as unfit.

Prohibition of the use of systemic anticoagulants should be written in the Acceptable Means of Compliance rather than specified within the Implementing Rules. This would allow the future possible use of anticoagulants in selected pilots in whom good, stable anticoagulant control has been demonstrated.
Suggested replacement text:
Delete (iii)

MED.B.005 Cardiovascular System
(c) Blood Pressure

(3) Applicants for a class 1 medical certificate:

(ii) whose blood pressure at examination consistently exceeds 160 mmHg systolic and/or95 mmHg diastolic, with or without treatment...
shall be assessed as unfit

At present up to 170mmHg systolic is permissible provided that further clinical investigations are arranged. This current position should be maintained.

Suggested replacement text:
(ii) whose blood pressure at examination up to 170mmHg systolic is permissible provided that further clinical investigations are arranged.

response *Noted*

Systemic anticoagulant therapy - see response to comment No 64.

170 mmHg systolic blood pressure - not accepted. The internationally agreed limit of normal blood pressure, which was also in JAR FCL 3, will be retained.

comment *1176* comment by: *FAI*

(CIMP)
Page 9 of 66

All humans suffer the same diseases and disabilities. It is an Essential Requirement (5) that pilots are fit for their role and those conditions that may adversely affect fitness are set out in ICAO Annex 6 (6). Pilot fitness can be divided into function and risk. Function is a predictor of success in flight training and measurement of function is the major item of military selection. In countries with developed health care systems, vision and hearing will have been tested. For private pilots, the cost of training failure is not a matter for public concern. As function is always judged by a flying instructor, less attention need to be given to this for LPL holders; although some cases of limb defects may require specialist medical advice and even aircraft modifications with associated limitations on the medical certificate. Aeromedical risk concerns diseases that can cause sudden incapacity or sudden changes of function. These are a small but significant cause of accidents but can only be predicted using medical expertise. The common

causes of sudden incapacity are epileptic fits; cardiovascular disease comprising heart attacks or strokes, and abnormal low blood sugar caused by the treatment of diabetes. All pilots have to decide on every occasion that they are fit to fly, short term infections, fatigue, alcohol, dental procedures, blood donation and medication can all be reasons for temporary unfitness and so a self declaration by the pilot is routine. This self management is best supported by human factors training, instructional supervision and responsible peer pressure.

CIMP CONCLUSION
-USE Follow ICAO Annex 6 concerning "Pilot Fitness"
-Primary concern of medical certification must be "sudden incapacitation".
-Epileptic fits
-Cardiovascular Disease (heart attacks, Strokes)
-Diabetes and abnormal blood sugar
-Function should not be a major concern for doctors in the examination of sport pilots. Any deficiency of function will be observed by flying instructors who have assess and certify pilot performance. There may be a failure to train but few, if any, accidents arise from deficiencies of function. Education in human factors is an important contribution to medical fitness.

The first two cannot ever be entirely excluded although statistical predictions are possible. ICAO (6) uses the term "likely to interfere". The problem is: how likely is likely? The JAR-FCL 3 (7) addressed this problem in the Manual of Civil Aviation Medicine under 'The Concept of Aeromedical Risk Assessment (Manual-General 5) and concluded that for Class 1 pilots the risk of sudden incapacity should not exceed 1% in the following year. The difficulty was that the JAA applied the same risk level to private Class 2 pilots but this never met with general acceptance. A numerical prediction of risk also permits, after a period of time, the validation of policy by accident analysis and accords with the World Health Organisation paper (9) that all medical screening must contain an internal mechanism by which effectiveness can ultimately be measured. Surprisingly this statistical concept of aeromedical risk has been omitted from NPA 17a (1), although it re-appears in the detailed consideration of some specific diseases (NPA 17 c p64) (3). It is suggested by the FAI that there is a hierarchy of acceptable risk, ranging from a Class 1 professional pilot down to a limited leisure pilot. Inevitably, individual pilots with increasing age and decreasing fitness must pass down through these levels during the course of a flying career. Suggested statistical risk levels that would accord with current practice and meet the Essential Requirement for mitigating measures are:

Class 1 professional pilot 1%
Class 2 private pilot 2%
Leisure pilot 2%
Leisure pilot limited to no passengers 20%

Based on these figures predictions (10) have been published as to the accidents and casualties that would be expected from the various policy options.

CIMP CONCLUSION
-Numerical prediction of risk in sport or other pilots has not been

	included in the new regulation. Defined statistical risk levels are necessary to obtain common standards and permit later validation from accident and incident data. **Suggestion: The proposed statistical risk levels for known illnesses accord with current practice and meet the Essential Requirement for mitigating measures. They have to be included in the new regulation.** References: 6. ICAO Annex 1 Chapter 1 (Definitions and General Rules concerning licences) and Chapter 6 (Medical provisions for licensing). 7. JAR-FCL 3 Flight Crew Licensing (Medical). 9. Wilson J, & Jungner G (1968) Principles and practice of screening for disease. World Health Organisation Public Health Paper 34. WHO Geneva.
response	*Noted*
	The guidance material on risk assessment from JAR-FCL 3 needs to be reviewed and amended. Also, an expert in medical statistics should be involved in the drafting. This is why the risk assessment is excluded in this NPA but will be included in the rulemaking task MED.001 which follows immediately after this NPA is finalised as Opinion. The risk assessment will then be included as guidance material after a new NPA.

comment	*1218*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.B.005 (a)(1)(ii) **Comment**: ECG is required at all initial examinations, both as a reference for later examinations, and for detection and assessment of possible conduction defects which also occur at young ages. The incidence of coronary artery disease increases already from age 40, and therefore regular ECG checks should be required from age 40 and not from age 50. **Proposal**: For a class 2 medical certificate, at the examination for first issue of a medical certificate, at the first examination after age 40, and every 2 years thereafter.	
response	*Noted*	
	Please see response to comment No 78.	

comment	*1219*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.B.005 (b) **Comment**: The conditions described in (b)(2) disqualifying for class 1 should also apply to class 2. The conditions described in (b)(3) requiring referral to the licensing authority should also apply to class 2. These conditions will require an assessment	

	according to the ICAO defined expression accredited medical conclusion: "The conclusion by one or more medical experts acceptable to the licensing authority, in consultation with flight operations or other experts as necessary". Only in very exceptional cases an AME will have the possibility to perform this task, which will be even more difficult for AMEs only examining class 2 pilots. **Proposal**: Amend MED.B.005 (b)(2) and (3) to include also class 2. Delete MED.B.005 (b)(4).
response	*Noted*
	Class 2 pilots will be assessed in consultation with the licensing authority which will provide the licensing authority with some flexibility as to who will do the assessment (AME, AeMC or licensing authority).

comment	*1220*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.B.005 (b)(2)(iii) **Comment**: The development of modern anticoagulant therapy may permit fit assessment in selected cases. Therefore, these conditions should not automatically make the applicant assessed as unfit, but be referred to the authority. **Proposal**: Delete MED.B.005 (b)(2)(iii) and insert the same text as a new MED.B.005 (b)(3)(x).	
response	*Noted*	
	Please see response to comment No 64.	

comment	*1221*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.B.005 (d) **Comment**: The conditions described in (d)(1) requiring referral to the licensing authority should also apply to class 2. A cardiological evaluation is required in any case of suspected or proven CAD, both for class 1 as well as for class 2. These conditions will require an assessment according to the ICAO defined expression accredited medical conclusion: "The conclusion by one or more medical experts acceptable to the licensing authority, in consultation with flight operations or other experts as necessary". Only in very exceptional cases an AME will have the possibility to perform this task, which will be even more difficult for AMEs only examining class 2 pilots. MED.B.005 (d)(3) and (4) are acceptable. The conditions described in (d)(5) should require referral to the licensing authority also for class 2 for the same reasons as above.	

	Proposal: Amend MED.B.005 (d)(1) to include also class 2. Delete MED.B.005 (d)(2). Amend MED.B.005 (d)(5) to read: "Applicants for a class 2 medical certificate, and applicants for a revalidation of a class 1 medical certificate, who are asymptomatic after myocardial infarction or surgery for coronary artery disease shall be referred to the licensing authority and undergo cardiological evaluation before a fit assessment can be considered."
response	*Noted*
	Please see response to comment No 1219.

comment	*1222*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.B.005 (e) **Comment**: The conditions described in (e)(1) requiring referral to the licensing authority should also apply to class 2. A cardiological evaluation is required in any case of these conduction disturbances, both for class 1 as well as for class 2. These conditions will require an assessment according to the ICAO defined expression accredited medical conclusion: "The conclusion by one or more medical experts acceptable to the licensing authority, in consultation with flight operations or other experts as necessary". Only in very exceptional cases, an AME will have the possibility to perform this task, which will be even more difficult for AMEs only examining class 2 pilots. MED.B.005 (e)(3) and (e)(5) are acceptable. The conditions described in (e)(4) should require referral to the licensing authority also for class 2 for the same reasons as above. **Proposal**: Amend MED.B.005 (e)(1) and (e)(4) to include also class 2. Delete MED.B.005 (e)(2). Amend MED.B.005 (e)(4) to read: "... shall be referred to the licensing authority and undergo satisfactory cardiovascular evaluation before a fit assessment can be made."	
response	*Noted*	
	Please see response to comment No 1219.	

comment	*1406*	comment by: *Prutech Innovation Services Ltd.*
	MED.B.005(a)(1)(ii): For a class 2 cert, at 40 and then every 4 years, would be	

	more reasonable.
response	*Noted*
	Please see response to comment No 78.

comment	*1457*	comment by: *Virgin Atlantic Airways Ltd*
	MED.B.005 Cardiovascular System Para b.2 (ii) **Relevant Text:** significant abnormality of any of the heart valves; **Comment:** There is no indication of the meaning of "significant abnormality" **Proposal:** add "which might lead to incapacitation"	
response	*Noted*	
	The wording "significant abnormality" will be changed to "fsignificant functional abnormality". Please see response to comment No 424.	

comment	*1459*	comment by: *Virgin Atlantic Airways Ltd*
	Amendment to the PROPOSAL in previous comment 1457: **MED.B.005 Cardiovascular System Para b.2 (ii)** **Relevant Text:** significant abnormality of any of the heart valves; **Comment:** There is no indication of the meaning of "significant abnormality" **Proposal:** Instead of an "unfit assessment" change to "should be referred to the licensing authority"	
response	*Not accepted*	
	Requirement form JAR-FCL 3.150 (c) significant abnormality of any of the heart valves. Following comments "significant" will be replaced by "functional". Nevertheless the unfit assessment to be transposed from JAR-FCL 3.	

comment	*1460*	comment by: *Virgin Atlantic Airways Ltd*
	MED.B.005 Cardiovascular System b.2.iii **Relevant Text**: a cardiovascular condition requiring systemic anticoagulant therapy **Comment**: Currently traditional anticoagulant therapy with warfarin has (arguably) too many problems to allow its use, but medical and therapeutic advances mean that this may change in the near future. To incorporate this is the "Requirements" is too inflexible	

	Proposal: This text should be removed and placed in the AMC to allow less bureaucratic processes once scientific justification exists to chanmge the position
response	*Noted*
	Please see response to comment No 64.

comment	*1461*	comment by: *Virgin Atlantic Airways Ltd*
	Section: **MED.B.005 Cardiovascular System b 2,3,4; and sections c, d and e** **Relevant Text:** all text in relevant sections **Comment**: Including such conditions in the **requirements** is too inflexible and does not allow for easy transition when medical science changes **Proposal**: These conditions should be in the AMC	
response	*Noted*	
	Please see response to comment No 64.	

comment	*1533*	comment by: *DGAC FRANCE*
	MED B 005 cardiovascular system COMMENT : **It's better to keep the decision to be taken by the authority like in JAR FCL 3.** Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained. As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid contentious cases with AME's or AMC's which takes a lot of time to treat. It is also important for authorities to have an homogeneous feed back of these kind of decisions to improve the rules in the future. Give privileges to class 2 AME's to issue all medical certificates even those with one or more limitations instead of the licensing authority is dangerous for harmonisation of decisions throughout EU and associated countries and against equity principles**.** This should remain the duty of the licensing authority Justification: Decisions will not be homogeneous and standardisation of the	

decisions between states will be never obtained.

As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

MODIFICATION :

b)*Cardiovascular system* - General

(2) Applicants for a class 1 **and 2** medical certificate with…….conditions.

(i). etc

(3) Applicants for a class 1 **and 2** medical certificate with an established history or diagnostics of any of the following conditions shall be referred to the licensing authority :
(i).....etc

~~(4) Applicants for a class 2 medical certificate with……..in (2) ……considered~~

(d) *Coronary Artery Disease*

(1) Applicants for a class 1 **and 2** medical certificate with :

(i).etc

shall be referred to the licensing authority ~~and undergo cardiological evaluation to exclude cardiac ischaemia before a fit assessment can be considered.~~

~~(2) Applicants for a class 2…….considered.~~

(5) Applicants for a class 2 medical certificate who are asymptomatic after myocardial infraction or surgery for coronary artery disease **shall be referred to the licensing authority.** Applicants for the revalidation of a class 1 medical certificate shall be referred to the licensing authority.

(e) *Rhythm/Conduction Disturbances*

(1) Applicants for a class 1 **and 2** medical certificates shall be referred to the licensing authority when they have any significant disturbance of cardiac conduction or rhythm, including any of the following :

(i).....
.etc….

~~(2)Applications for a class 2 medical certificate with any of the conditions detailed in (1) shall be evaluated by a cardiologist before a fit assessment can be considered.~~

(3) Applicants **for a class 1 and 2 medical certificate** with ~~any of the following~~ a history of :

(i).....etc

shall be referred to the licensing authority.

(4) Applicants with a history of :

(i) Ablation therapy
(ii) .....Etc…

~~shall undergo satisfactory cardiovascular evaluation before a fit assessment can be made. Applicants for a class 1 medical certificate shall be referred to the licensing authority~~**.**
shall be referred to the licensing authority.

response *Partially accepted*

Class 2 applicants will be assessed in consultation with the licensing authority where indicated in Subpart B.

comment *1573* comment by: *FAA*

MED.B.005:

MED.B.005 (a) (i) and (ii) : Electrocardiography is initially required for U.S. airline transport pilots after age 35 but not specifically required for commercial or private pilots unless clinically indicated.

Note: U.S. aviation and medical communities were not supportive of 1994 rulemaking action (Notice No. 91-31, 59 FR 53226; October 21, 1994) to require routine resting electrocardiograms for applicants for second-class airman medical certification (commercial pilots and non-FAA air traffic controllers). Basically, commenters objected to the cost of implementing such a proposal given limited prognostic capabilities of the resting electrocardiogram.

MED.B.005 (a) (3): The United States does not modify physical examinations based on age unless clinically indicated.

MED.B.005 (a)(4): U.S. pilots do not undertake serum lipid or cholesterol testing unless clinically indicated.

ED.B. 005 (b):
Some U.S. pilots may be/may have been found eligible for special-issuance "waiver" for some of these conditions. [Is it correct to interpret the intent of MED.045 (a) to mean that "accredited medical opinion" may allow the same in EASA member countries?]

MED.B.005(d)

	The hyperlink provided below refers to protocols the United States follows when making an assessment regarding coronary artery disease: http://www.faa.gov/about/office_org/headquarters_offices/ avs/offices/aam/ame/guide/dec_cons/disease_prot/coronary/ MED.B.005 (d)(5): The United States refers all applicants, including private pilots, to the licensing authority following myocardial infarction. MED.B.005(d) The hyperlink provided below refers to protocols the United States follows when making an assessment regarding coronary artery disease: http://www.faa.gov/about/office_org/headquarters_offices/ avs/offices/aam/ame/guide/dec_cons/disease_prot/coronary/ MED.B.005 (d)(5): The United States refers all applicants, including private pilots, to the licensing authority following myocardial infarction. MED.B.005(e) The hyperlinks provided below refer to protocols the United States follows when making an assessment regarding rhythm/conduction disturbances: http://www.faa.gov/about/office_org/headquarters_offices/ avs/offices/aam/ame/guide/dec_cons/disease_prot/pacemaker/ http://www.faa.gov/about/office_org/headquarters_offices/ avs/offices/aam/ame/guide/app_process/exam_tech/item36/amd/arrhythmias
response	*Noted*
	Thank you for this information.

comment	*1678*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.B.005(a)(4) Cardiovascular System – General **Page** 9 **Comment** "estimation of serum lipids" is a vague statement. **Justification** **Proposed Text** "…..estimation of serum lipids including cholesterol fractions, shall be required…"	
response	*Not accepted*	
	The NPA text is transposed from JAR FCL 3. Requirements of the JAR FCL 3 are	

	implemented and applied uniformly in all Member States.

comment	*1679*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.B.005(b)(1) Cardiovascular System – General **Page** 10 **Comment** It is suggested that this general statement should be qualified and that all specific statements with regard to conditions moved into the AMC paragraphs. **Justification** The general statement paragraphs need careful qualification. Repair of a bicuspid aortic valve with a Dacron cuff, for example, in the ascending aorta to replace localised aortic disease, may be consistent with OML status. **Proposed Text** (1)" ….for interpretation see also Chapter 8: AMC for Class 1 medical certificates. Paras *****". This statement should be included wherever qualification is required.	
response	*Noted*	
	Please see response to comment No 64.	

comment	*1680*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.B.005(d)(3) **Page** 11 **Comment** Suggest running (i), (ii), (iii) into one paragraph. **Justification** **Proposed Text** "Myocardial ischaemia whether silent or symptomatic, in the receipt of treatment or not, shall be assessed as unfit".	
response	*Not accepted*	
	The differentiation stems from JAR-FCL 3 and may be revised at a later stage.	

comment	*1802*	comment by: *CAA Belgium*
	Relevant Text: MED.B.005 (a) (1) (ii) For a class 2 medical certificate, at the first examination after 40… Comment: How to make the diagnosis of rhythm or conduction disturbances, WPW, hypertrophy …without an ECG ? Proposal: For a class 2 medical certificate, at the examination for the first issue, at the first examination after 40…	

response	*Not accepted*
	See response to comment No 78.

comment	*1803*	comment by: *CAA Belgium*
	Relevant Text: MED.B.005 (b) (4) Applicants of class 2 medical certificate with an established diagnosis of one of the conditions specified in (2) shall be evaluated… Comment: the conditions specified in (3) are also at risk for the security and should be investigated in class 2 pilots. Proposal: Applicants of class 2 medical certificate with an established diagnosis of one of the conditions specified in (2) and (3) shall be evaluated	
response	*Noted*	
	The conditions specified under (3) result in an unfit assessment for class 1 and class 2.	

comment	*1804*	comment by: *CAA Belgium*
	Relevant Text: MED.B.005 (e) (1) Applicants for a class 1 medical certificate shall be referred to the licensing authority when they have any significant disturbance of cardiac conduction or rhythm, including any of the following: (i) Disturbance of supraventricular rhythm… Comment: other diseases which are at high risk of symptomatic rhythm or conduction disturbances, should be added to this list :Bifascicular block, short QT, Brugada syndrome, short PR Proposal: Applicants for a class 1 medical certificate shall be referred to the licensing authority when they have any significant disturbance of cardiac conduction or rhythm, including any of the following: (i) Disturbance of supraventricular rhythm… (ii) Complete left bundle branch block (iii) Bifascicular block (iv) Mobitz type 2 atrioventricular block (v) Broad and/or… (vi) Ventricular pre-excitation : WPW, short PR (vii) Asymptomatic QT prolongation, short QT (viii) ECG abnormality suggesting Brugada syndrome	
response	*Partially accepted*	
	See response to comment No 401.	

comment	*1836*	comment by: *European CMO Forum*
	Paragraph: MED. B. 005 **Page No: 10** **Comment:** Authorities in many non-JAA member states (e.g. US-FAA, New Zealand,	

	Australia, Transport Canada) allow anticoagulation therapy under special conditions. The European requirements should accept anticoagulation with special conditions according to the medical circumstances if the underlying disease demanding anticoagulation is acceptable and stable anticoagulation is demonstrated within the last 6 months (at least 5 INR values, of which 4 are within the INR target range). **Justification:** Self monitoring of INR is now available which enables individuals to maintain stable anticoagulant levels. Studies which showed an increase risk of major bleeding in the past have been superceded by studies that demonstrate this risk is much reduced in the pilot population age group and with maintenance of INR levels in the target range. **Proposed Text:** **(if applicable)** delete (b) (2) (iii), Add new **MED. B. 005 (b) (3) (x) a condition requiring systemic anticoagulation**
response	*Noted*
	See response to comment No 425.

comment	*1942*	comment by: *International Air Transport Association (IATA)*
	Page 9 Med.B.005 (a) (1) (i) Is there any specific reason why this standard does not reflect ICAO recommendation 6.3.2.6.2? If not, it should state "For class 1 medical certificate, at the examination for first issue of a medical certificate, then every two year between the age of 30 and 50, and yearly thereafter". Page 9 Med.B.005 (a) (4) I believe "estimation" should be replaced by "measurements". Page 10 Med.B.005 (b) (1) Shouldn't the word « possess » be replaced by « suffer from » everywhere in the text? Page 10 Med.B.005 (b) (2) (iii) This seems very stringent. A number of countries accept systemic anticoagulant therapy for certain medical conditions because the risk has been shown to be acceptable. There should at least be place for flexibility.	
response	*Partially accepted*	
	The basis for class 1 rules is JAR-FCL 3. The periodicity of ECGs therefore follows JAR-FCL 3.	

(a) (4): Wording from JAR-FCL 3 was transposed. We agree that "estimation" is open for interpretation, but it does not seem a problem under JAR-FCL 3.

(b)(1): accepted for this paragraph

(b)(2)(iii) - see response to comment No 64.

comment	*2054*	comment by: *Michael Hinz*
	Eine Entscheidung über Tauglichkeit / Untauglichkeit sollte letztenendes immer ein Arzt im Einzelfall beurteilen können, niemals jedoch eine allgemeine Gesetzesaussage, die im Einzelfall immer auch unzutreffend und den Piloten diskreminierend sein kann.	
response	*Noted*	

comment	*2144*	comment by: *ECA- European Cockpit Association*
	Change number: (c) Blood Pressure (3) Applicants for a class 1 medical certificate: (ii) whose blood pressure at examination consistently exceeds ~~160~~**170** mmHg systolic and/or 95 mmHg diastolic, with or without treatment; Justification: At the present in UK systolic pressure up to 170 is allowed providing that investigations are arranged.	
response	*Noted*	
	Please see response to comment No 1119.	

comment	*2152*	comment by: *DGAC FRANCE*
	MED.B.005 Cardiovascular System, **paragraph (b)** comment : Authorities in many non-JAA member states (e.g. US-FAA, New Zealand, Australia, Transport Canada) allow anticoagulation therapy under special conditions. The European requirements should accept anticoagulation with special conditions according to the medical circumstances if the underlying disease demanding anticoagulation is acceptable and stable anticoagulation is demonstrated within the last 6 months (at least 5 INR values, of which 4 are within the INR target range). Self monitoring of INR is now available which enables individuals to maintain stable anticoagulant levels. Studies which showed an increase risk of major bleeding in the past have been superceded by studies that demonstrate this risk	

	is much reduced in the pilot population age group and with maintenance of INR levels in the target range. Modification : First, delete the paragraph (iii) in (b) (2) (b) (2) ~~(iii) a cardiovascular condition requiring systemic anticoagulant therapy ;~~ Second, add a new paragraph (x) in (b) (3) as followed : (b) (3) **(x) a condition requiring systemic anticoagulation**
response	*Noted*
	See response to comment No 425.

comment	*2281*	comment by: *Dr Ron Pearson*
	MED.B.005(a)(2) indicates that a resting ECG is not required for initial issue of a class 2 certificate under age 40. This means that a pilot can complete his training, spend a great deal of money on further ratings and perhaps own an aircraft, then find that at age 40 he has a conduction abnormality, which requires catheterisation and ablation (ventricular pre-excitation). Since it is now proposed that commercial cabin staff have a resting ECG on initial examination under age 40, it seems inconsistent that PPL's do not require similar treatment.	
response	*Not accepted*	
	See response to comment No 78.	

comment	*2282*	comment by: *Dr Ron Pearson*
	MED.B.005(c) blood pressure "normality" is not defined, either here or in the AMC MED.B.005(d)requires "cardiological evaluation" and the AMC outlines and adequate means of completing this evaluation, however, without referral to the numerical assessment of risk, there is no means of comparing alternate means of compliance.	
response	*Noted*	
	"Normality" of blood pressure is defined in special medical literature and this is outside the scope of our proposed document. Our proposal defines blood pressure limits which are acceptable for aeromedical certification. The risk assessment will be included in the Guidance Material.	

comment	*2397*	comment by: *Irish Aviation Authority*
	Authorities in many non-JAA member states (like the US-FAA, New Zealand, Australia, Transport Canada) allow anticoagulation therapy under special	

	conditions. The European requirements should also accept anticoagulation with special.clear conditions according to the medical circumstances if the underlying disease demanding anticoagulation is acceptable and stable anticoagulation is demonstrated within the last 6 months (at least 5 INR values, of which 4 are within the INR target range). Justification: Self monitoring of INR is available and enables individuals to maintain stable anticoagulant levels. Studies which showed an increase risk of major bleeding in the past have been superseded by studies that demonstrate that this risk is reduced in the pilot population age group and with maintenance of INR levels in the target range. Proposed text: ~~(b) (2) (iii),~~ Add new **MED. B. 005 (b) (3) (x) a condition requiring systemic anticoagulation**
response	*Noted*
	See response to comment No 425.

comment	*2398*	comment by: *Irish Aviation Authority*
	(e)(1) Brugada needs to be added as a reason for authority referral. Justification: Brugada is an important cause for sudden cardiac death. Proposed text: Add **(vii) Brugada pattern on electrocardiography**.	
response	*Accepted*	
	Accepted for class 1 medical certificate	

comment	*2447*	comment by: *SANMA Swedish Aeronautical Associatation*
	(c) Läkarundersökningen kräver endast att blodtryck tas men ej undersöka hjärta och lungor eller göra Neurologisk undersökning Oacceptabelt för flygning.	
response	*Noted*	
	MED.B.005 describes cardiovascular system requirements. Its subparagraph (c) specifically explains requirements related to blod pressure. The rest of cardiovascular requirements are proposed in other subparagraphs. Requirements related to respiratory and nervous systems are in MED.B.010 and MED.B. 060 respectively.	

comment	*2473*	comment by: *UK CAA MEDICAL ADVISORY PANEL*

Paragraph MED.B.005(b)(2)(ii) Cardiovascular System – General
Page 10

Comment
Likewise the word 'significant' needs close qualification if it is associated with an enduring refusal with regard to fitness. The very least structure reference must be made to definitions if Chapter A: AMC for Class 1 medical certificates and relate to both structure and function.

Justification

Proposed Text

response *Noted*

See response to comment No 1457.

comment *2474* comment by: *UK CAA MEDICAL ADVISORY PANEL*

Paragraph MED.B.005(b)(2)(iii) Cardiovascular System – General
Page 10

Comment
Likewise the cardiovascular condition requiring systemic anticoagulant therapy should not be included here as with the advent of the new DTIs (Direct Thrombin Inhibitors) anticoagulation will be significantly safer and these products are likely to be acceptable for certification in certain cases.

Justification

Proposed Text

response *Noted*

Please see response to comment No 64.

comment *2475* comment by: *UK CAA MEDICAL ADVISORY PANEL*

Paragraph MED.B.005(b)(2)(iv) Cardiovascular System – General
Page 10

Comment
This leaves heart/lung transplantation which is so rare that it would be appropriate to lift it into the AMC.

Justification

Proposed Text

response *Noted*

A incidence of a condition does not say anything about its effect on safety.

	Otherwise please see response to comment No 64.

comment	*2476*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.B.005(b)(3)(iii) **Page** 10 **Comment** 'Minor', unqualified, lacks a definition. **Justification** **Proposed Text** Suggest statement "for interpretation" as above is inserted.	
response	*Partially accepted*	
	The wording "minor" will be changed to "functionally insignificant".	

comment	*2477*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.B.005(b)(3)(vii) **Page** 10 **Comment** Suggest deletion of 'recurrent'. **Justification** Vasovagal syncope almost always recurs and it needs review even on first presentation to establish the diagnosis. **Proposed Text** Delete "recurrent".	
response	*Not accepted*	
	The wording "recurrent vasovagal syncope" is transposed from JAR FCL 3.150(h) and will be retained in the text. However, we will keep the comment in mind when reviewing the medical provisions in rulemaking task MED.001.	

comment	*2478*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.B.005(c)(1) Blood pressure **Page** 10 **Comment** There is no statement as to how the blood pressure should be recorded. **Justification** Automated systems may be unreliable.	

	Proposed Text Insert "….using the technique of Riva-Rocce".
response	*Not accepted*
	It seemed obvious that blood pressure is measured using a reliable technique. The comment will be taken into account for the GUidance Material that is to be developed.

comment	*2479*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.B.005(c)(3)(i) Blood pressure **Page** 10 **Comment** The blood pressure cannot be both high and low. **Justification** **Proposed Text** Insert …"with symptomatic hypotension, or,…"	
response	*Accepted*	
	Thank you for your input.	

comment	*2480*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.B.005(c)(4) and (d)(1)(i) **Page** 10 **Comment** Throughout the term 'myocardial ischaemia' not 'cardiac ischaemia' is appropriate. **Justification** This is proper nomenclature. **Proposed Text** "Suspected myocardial ischaemia, however presenting".	
response	*Noted*	
	Please see response to comment No 429.	

comment	*2481*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.B.005(d)(1)(ii) Coronary artery disease **Page** 10 **Comment** Asymptomatic minor coronary artery disease always needs treatment, i.e. with	

	Aspirin and a statin. **Justification** **Proposed Text** Delete "requiring no treatment".
response	*Partially accepted*
	The wording will be: requiring no anti-anginal treatment.

comment	*2482*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.B.005(d)(4)(i) **Page** 11 **Comment** **Justification** **Proposed Text** Insert "…silent or symptomatic myocardial ischaemia".	
response	*Noted*	
	Myocardial ischaemia covers both, silent and symptomatic disease.	

comment	*2483*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.B.005(d)(5) **Page** 11 **Comment** **Justification** Better syntax. **Proposed Text** Suggest the word "after" is deleted and "following" is inserted.	
response	*Accepted*	
	Thank you for your input.	

comment	*2484*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.B.005(e)(1)(iii) Rhythm/conduction disturbance **Page** 11 **Comment** Atrioventricular block requires insertion as it has been left out and has a similar outcome to Mobitz Type 2 AV block.	

Justification

Proposed Text
"….atrioventricular block; 2:1 atrioventricular block;"

response | *Not accepted*

Complete a-v block should be covered under B.005(e)(1), (vii) (viii) and (e)(5)(ii)

comment | *2485* | comment by: *UK CAA MEDICAL ADVISORY PANEL*

Paragraph MED.B.005(e)(3)(vii)
Page 11

Comment
The Brugada electrocardiographic pattern is uncommon but of importance.

Justification

Proposed Text
Insert "(vii) The Brugada pattern on the electrocardiogram".

response | *Noted*

Please see response to comment No 401.

comment | *2567* | comment by: *Heinz Fricke-Bohl and Kirsten Bohl*

MED.B.005: Nur durch ein Belastungs-EKG ist eine sinnvolle Aussage zum Herzen möglich. Ein normales EKG ist nicht aussagefähig z.Bsp. bei KHK, zu mal wenn die KHK noch gar nicht bekannt ist und erst beim Fliegerarzt entdeckt wird. Eine genauere Untersuchung wäre noch eine Echokardiographie des Herzens.

response | *Noted*

C. Draft Opinion Part-MED - Subpart B: Requirements for Medical Certificates - Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.010: Respiratory System p. 12

comment | *81* | comment by: *Dr.Beiderwellen, Secretary of GAAME*

Author: : Dr.Beiderwellen,AME member of the AB of ESAM
Section:
Med B 010 b) and c) section 2
Page: 12

Relevant Text:

Comment:

	Pulmonary function shall be tested at any examination **Proposal**: remove b) and c) Add: b) class 1 and class 2 applicants shall undergo a pulmonary functional test at any examination, including FEV 1, VC, PEF, FEV1/VC
response	*Not accepted*
	Class 1 and class 2 requirements with regard to pulmonary function tests are transposed from JAR FCL 3. These requirements were uniformly applied in all Member States and proved to meet required safety standards. There is no statistical justification for the increased requirements.

comment	*254*	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.B.010 **Page**: 12 Relevant Text: (a) Applicants with significant impairment of pulmonary function shall be assessed as unfit. A fit assessment may be considered once pulmonary function has recovered and is satisfactory. **Comment**: "Significant" impairment must be defined, if not - there is no limit at all. Because Chronic obstructive lung disease (COPD) bears the risk of hypoxic incapacitation (impaired colour vision at low altitudes - esp. in smokers) the affected patients should be excluded from performance of flight duties. The measurement of SO2 is a cheap and readily available method to demonstrate sufficient capacity of oxygenation. **Proposal**: (a) Applicants with significant impairment of pulmonary function shall be assessed as unfit. A fit assessment may be considered once pulmonary function has recovered and is satisfactory. Minimum values for FEV1/FVC of 70 % and FVC of 80 % must be demonstrated. In the presence of chronic obstructive lung disease a satisfactory level of blood oxygenation (SO2 > 95 % at room air on the ground) has to be demonstrated.	
response	*Noted*	
	Thank you for your comment. Your input will be considered for the Guidance Material to be drafted in rulemaking task MED.001 that will start after delivery of this Opinion.	

comment	*255*	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.B.010 **Page**: 12 Relevant Text: (c.) For a class 2 medical certificate, applicants are required to undertake pulmonary function tests on clinical indication.	

	Comment: Physical laws and the danger of altitude related hypoxia apply to class 2 and LAPL pilots as well as to class 1 pilots. In practice, the risk to suffer incapacitation from hypoxia is even higher in class 2 and LAPL, because the used aircrafts do not dispose of a pressure cabin and leisure pilots tend to fly in high altitude even without oxygen supply. So evaluation of pulmonary function at least at initial and then on clinical indication is a minimum to achieve the desired safety-level. Pulmonary function test is a cheap method, readily applicable at any practice. **Proposal**: (c.) For a class 2 medical certificate, applicants are required to undertake pulmonary function tests at the initial examination and on clinical indication.
response	*Not accepted*
	The medical provisions for class 2 have been adapted to ICAO Annex 1

comment	*435*	comment by: *UK CAA*
	MED.B.010 (e) **Comment:** Inappropriate for IR. Agree with Agency's note in NPA 17a para 15. **Justification:** Not future-proof: Any change of the IRs may be lengthy and a pilot may be prevented from being assessed as fit even though new measures to mitigate the medical risk may be available. **Proposed Text:** Move to AMC and change 'shall' to 'should'.	
response	*Not accepted*	
	The rules and AMCs in this NPA are based on JAR-FCL 3 and a right balance between hard law and soft law had to be found: The requirements from JAR-FCL 3 that were in the Appendices to Subpart B and C are now AMC material in Part Medical. The requirements from Sections B and C in JAR-FCL 3 are now Implementing Rules. This provides more flexibility than under JAR-FCL 3 while ensuring a common standard of medical assessments in Europe. The Guidance Material from JAR-FCL 3 will be revised and added in the rulemaing task MED.001.	

comment	*526*	comment by: *British Microlight Aircraft Association*
	Strongly agree other parts no knowledge	
response	*Noted*	
	Thank you for your input.	

comment	762	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author: European Society of Space and Aviation Medicine (ESAM) - Internal Medicine Group -

Section:1
MED.B.010 - Respiratory System

Page: 12

Relevant Text:
(a) Applicants with significant impairment of pulmonary function shall be assessed as unfit. A fit assessment may be considered once pulmonary function has recovered and is satisfactory.

(b) For a class 1 medical certificate, applicants are required to undertake pulmonary function tests at the initial examination and on clinical indication.

(c) For a class 2 medical certificate, applicants are required to undertake pulmonary function tests on clinical indication.

(d) Applicants with a history or established diagnosis of:

(1) asthma;
(2) active inflammatory disease of the respiratory system;
(3) active sarcoidosis;
(4) pneumothorax;
(5) sleep apnoea syndrome;
(6) major thoracic surgery;
shall undergo respiratory evaluation with a satisfactory result before a fit assessment can be
considered.

(e) Applicants for a class 1 medical certificate who have undergone a total pneumonectomy shall be
assessed as unfit.

Comment:

Proposal:
(a) Applicants with significant impairment of pulmonary function shall be assessed as unfit. A fit assessment may be considered once pulmonary function has recovered and is satisfactory.

(b) For a class 1 and class 2 medical certificate, applicants are required to undertake pulmonary function tests at the initial examination and on clinical indication.

(c) Applicants with a history or established diagnosis of:

(1) asthma;
(2) active inflammatory disease of the respiratory system;

	(3) active sarcoidosis; (4) pneumothorax; (5) sleep apnoea syndrome; (6) major thoracic surgery; shall undergo respiratory evaluation with a satisfactory result before a fit assessment can be considered. (d) Applicants for a class 1 medical certificate who have undergone a pneumonectomy shall be assessed as unfit.
response	*Not accepted*
	Neither ICAO nor JAR FCL 3 Amendment 5 require pulmonary function tests for the initial class 2 applicants. Introduction of this requirement would be too restrictive. We proposed unfit decision only for those class 1 applicants who have undergone total pneumonectomy. We believe that class 1 applicants after minor excision of the lung should have the possibility to return to flying.

comment	*1462*	comment by: *Virgin Atlantic Airways Ltd*
	Para (a). **Comment:** The wording in Para (a) is both vague and inflexible. There is no definition os "significant impairment" **Proposal**: Adopt the wording used elsewhere e.g.in B.015: "Applicants shall not possess any respiratory impairment likely to interfere with the safe exercise....etc".	
response	*Not accepted*	
	The proposed wording could only be added, (a) would remain. We do not think that the addition is necessary.	

comment	*1574*	comment by: *FAA*
	MED.B.010 (b): U.S. applicants undertake pulmonary function tests and other appropriate pulmonary tests upon clinical indication.	
response	*Noted*	
	Thank you for your interest and the information provided.	

comment	*1681*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.B.010(d)(3) Respiratory system **Page** 12 **Comment**	

	Active sarcoidosis, if it involves the heart, is a cause of sudden cardiac death. **Justification** **Proposed Text** The concluding statement to read: "shall undergo respiratory and cardiological evaluation..".
response	*Accepted*

comment	*2055*	comment by: *Michael Hinz*
	Eine Entscheidung über Tauglichkeit / Untauglichkeit sollte letztenendes immer ein Arzt im Einzelfall beurteilen können, niemals jedoch eine allgemeine Gesetzesaussage, die im Einzelfall immer auch unzutreffend und den Piloten diskreminierend sein kann.	
response	*Noted*	
	Same comment as number 2054 Section Cardiology	

comment	*2075*	comment by: *CAA Belgium*
	Relevant Text: (c.) For a class 2 medical certificate, applicants are required to undertake pulmonary function tests on clinical indication. Comment: Physical laws and the danger of altitude related hypoxia apply to class 2 and LAPL pilots as well as to class 1 pilots. In practice, the risk to suffer incapacitation from hypoxia is even higher in class 2 and LAPL, because the used aircrafts do not dispose of a pressure cabin and leisure pilots tend to fly in high altitude even without oxygen supply. So evaluation of pulmonary function at least at initial and then on clinical indication is a minimum to achieve the desired safety-level. Pulmonary function test is a cheap method, readily applicable at any practice. Proposal: (c.) For a class 2 medical certificate, applicants are required to undertake pulmonary function tests at the initial examination and on clinical indication.	
response	*Noted*	
	Please see response to comment No 255.	

comment	*2076*	comment by: *CAA Belgium*
	Relevant Text: (e) Applicants for a class 1 medical certificate who have undergone a total pneumonectomy shall be assessed as unfit. Comment: Physical laws and the danger of altitude related hypoxia apply to class 2 and LAPL pilots as well as to class 1 pilots. In practice, the risk to suffer incapacitation from hypoxia is even higher in class 2 and LAPL, because the used aircrafts do not dispose of a pressure cabin and leisure pilots tend to fly in high altitude even	

	without oxygen supply. Total pneumonectomy leads to a degree of pulmonary function loss not acceptable for any class of medical certificate. Proposal: (e) Applicants for any class of medical certificate who have undergone a total pneumonectomy shall be assessed as unfit.
response	*Not accepted*
	Requirements with regards to the assessment of class 2 applicants who have undergone major thoracic surgery are proposed in AMC to MED.B.010 (7). This would ensure the flexibility in the aeromedical assessment of private pilots.

C. Draft Opinion Part-MED - Subpart B: Requirements for Medical Certificates - Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.015: Digestive System p. 12-13

comment	*256*	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.B.020 **Page**: 66 Relevant Text: (d) (...) shall be assessed as unfit. A fit assessment may be considered after successful treatment or full recovery after surgery and subject to satisfactory gastroenterological evaluation. **Comment**: After abdominal surgery, especially after removal of organs or part of organs, a minimum time of 6 weeks should elapse before returning to flight-duties, to prevent sequelae from wound pain and adhesions. If no minimum interval is prescribed, the most lenient doctor gains the patients for commercial reasons against those working with responsibility. **Proposal**: (d) (...) shall be assessed as unfit. A fit assessment may be considered after successful treatment or full recovery after surgery and subject to satisfactory gastroenterological evaluation, <u>not earlier than 6 weeks following the operation</u>.	
response	*Not accepted*	
	Fixed minimal period of unfitness after abdominal surgery was moved to the AMC to MED.B.015 (6). Leaving this requirement in the implementing rule would not allow flexibility in the case if earlier full recovery and satisfactory gastroenterological evaluation.	

comment	*437*	comment by: *UK CAA*
	MED.B.015 (d) **Comment:** Text change to clarify.	

	Justification: Clarity. **Proposed Text:** Amend 'shall be assessed as unfit. A fit assessment may be considered after successful....' to '**may be assessed as fit following successful**...'
response	*Not accepted*
	The wording "A fit assessment may be considered ...." is consistent with the wording in JAR-FCL 3 and appears in other paragraphs in this NPA. There is also a subtle difference in the meaning when comared to "may be assessed as fit after...." but the NPA wording does not have a negative impact on how to assess a pilot and the outcome fit/unfit. The proposed wording will be contained.

comment	*438*	comment by: *UK CAA*
	MED.B.020 (c) **Comment:** Inappropriate for IR. Agree with Agency's note in NPA 17a para 15. **Justification:** Not future-proof: Any change of the IRs may be lengthy and a pilot may be prevented from being assessed as fit even though new measures to mitigate the medical risk may be available. This is compliant with ICAO State Letter 08-33 proposals. **Proposed Text:** Move (c) to AMC.	
response	*Noted*	
	See identical comment No 429 in Segment B.005, 435 in Segment B.010 and others, all by the same commenter. Please see reponse to comment No 435 in Segment B.010.	

comment	*528*	comment by: *British Microlight Aircraft Association*
	(a) Strongly agree other parts no knowledge	
response	*Noted*	
	Thank you for the positive comment.	

comment	*645*	comment by: *Royal Danish Aeroclub*
	MED.B.015 Digestive System (d)(1) The text say: "Applicants with disorders of the gastro-intestinal system including: (1) recurrent dyspeptic disorder requiring medication;" is considered as unfit.	

	Why? We don't think so because modern effective medicine usually cures this disorder. It is considered a minor medical problem nowadays. We suggest to delete the (d)(1).
response	*Not accepted*
	Requirements with regards to recurrent dyspeptic disorders requiring medication were transposed to the Implementing Rules from JAR FCL 3.170(a) and JAR FCL 3.290(a). We believe, the last sentence of the MED.B.015(d) paragraph is flexible enough and gives the possibility for a fit assessment.

comment	*1534*	comment by: *DGAC FRANCE*

MED B 015 Digestive System

COMMENT :

It's better to keep the decision to be taken by the authority like in JAR FCL 3

Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained.

As it is indicated in MED.065, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid contentious cases with AME's or AMC's which takes a lot of time to treat.

It is also important for authorities to have an homogeneous feed back of these kind of decisions to improve the rules in the future.

Give privileges to class 2 AME's to issue all medical certificates even those with one or more limitations instead of the licensing authority is dangerous for harmonisation of decisions throughout EU and associated countries and against equity principles. This should remain the duty of the licensing authority

Justification : Decisions will not be homogeneous and standardisation of the decisions between states will be never obtained.

As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

MODIFICATION :

	MED B 015 Digestive System (d) Applicants for a class 1 **and 2** medical certificate with disorders of the gastro-intestinal system including : (1) ~~recurrent dyspeptic disorder~~ (2) pancreatitis (3) ..... (4) ..... (5) .....… **shall be referred to the licensing authority.** Add a paragraph (e) : **(e) Recurrent dyspeptic disorder requiring medication may be considered fit after successful treatment and subject to satisfactory gastroenterological evaluation.**
response	*Partially accepted*
	Referral of the class 2 applicants to the authority The Agency believes that holders of AeMC or AME certificates with appropriate training and experience should be in a position to assess the medical fitness of class 2 pilots without involving the licensing authority. However, all Implementing Rules in Subpart B will be amended because all applicants for a class 2 medical certificate who did not fully meet the requirements were referred to the Aeromedical Section of the Authority under JAR-FCL 3 requirements and this is the basis of this NPA. The amendment consists in requiring the AeMC or AME to assess these pilots "in consultation with the licensing authority". This gives the licensing authority a certain degree of flexibility of who takes the final decision on fitness and who issues medical certificates with limitations for private pilots. The Authority Requirements will be amended to provide clarity. Recurrent dyspeptic disorders requiring medication See response to comment No 645.

comment	*2056*	comment by: *Michael Hinz*
	Eine Entscheidung über Tauglichkeit / Untauglichkeit sollte letztenendes immer ein Arzt im Einzelfall beurteilen können, niemals jedoch eine allgemeine Gesetzesaussage, die im Einzelfall immer auch unzutreffend und den Piloten diskreminierend sein kann.	
response	*Noted*	
	This comment has been answered elsewhere in the CRT.	

comment	*2079*	comment by: *CAA Belgium*

	Relevant Text: (d) (…) shall be assessed as unfit. A fit assessment may be considered after successful treatment or full recovery after surgery and subject to satisfactory gastroenterological evaluation. Comment: After abdominal surgery, especially after removal of organs or part of organs, a minimum time of 6 weeks should elapse before returning to flight-duties, to prevent sequelae from wound pain and adhesions. If no minimum interval is prescribed, the most lenient doctor gains the patients for commercial reasons against those working with responsibility. Proposal: (d) (…) shall be assessed as unfit. A fit assessment may be considered after successful treatment or full recovery after surgery and subject to satisfactory gastroenterological evaluation, not earlier than 6 weeks following the operation.
response	*Noted*
	Please see response to comment No 256.

C. Draft Opinion Part-MED - Subpart B: Requirements for Medical Certificates - Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.020: Metabolic and Endocrine Systems p. 13

comment	*65*	comment by: *Dr Graham Cresswell, chief medical officer, bmi*
	MED.B.020 (c) (1) It is likely that technological advances in glycaemia control will permit insulin-dependent diabetics to meet the incapacitation risk criterion for Class 1 OML. This regulation would prevent the European industry from adapting to that advance. This is a specific prohibition which should not be in the implementing rules. It should be demoted at least to AMC and this should apply to all specific prohibitions in all systems. See also ICAO letter AN 5/22-08/33 of 5 May 2008. Suggest... Delete MED.B.020 (c) in its entirety or move it to AMC.	
response	*Not accepted*	
	The standard "6.3.2.16 Applicants with insulin treated diabetes mellitus shall be assessed as unfit" has not been changed in ICAO Annex 1, although following the ICAO State letter a Note has been added, saying "Guidance on assessment of Type 2 insulin treated diabetic applicants under the provisions of 1.2.4.8 is contained in the Manual of Civil Aviation Medicine (Doc 8984). Implementing Rules will be updated on a regular basis. There is no need to move a rule to AMC for the mere reason to change it at a certain stage.	

comment	82	comment by: *Dr.Beiderwellen, Secretary of GAAME*

Author: : Dr.Beiderwellen,AME member of the AB of ESAM
Section:
Med to B 005
Page: 9ff

Relevant Text:
Referring to licensing authority

Comment:
Not possible due to lack of qualified medical personal and medical confidentiality

Proposal:
According to national law referred pilots shall be examined by AME class I or AMC

response *Not accepted*

National law on pilot licensing and medical certificates will be superceded by European law once the Implementing Rules are adopted and impelmented.

The JAR Standardisation reports on JAR-FCL 3 inspections clearly show that all European NAAs have qualified physicians on staff in their authorities.

comment	257	comment by: *Lufthansa German Airlines*

Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany
Section: MED.B.020
Page: 13

Relevant Text: (c.) Diabetes mellitus
(1) Applicants with diabetes requiring insulin shall be assessed as unfit.
(2) Applicants with diabetes mellitus not requiring insulin shall be assessed as unfit unless it can be demonstrated that blood sugar control has been achieved. Applicants for a class 1 medical certificate shall be referred to the licensing authority.

Comment: Besides insulin several different drugs can induce severe hypoglycaemia with loss of consciousness, as demonstrated in numerous lethal traffic accidents on the roads. So the use of antidiabetics should be limited to those which are not at risk to cause hypoglycaemic situations.
The rules should not be limited to class 1 but be applicable to all classes, because they even apply as minimum criteria for driving licences on the roads.

Proposal:
(c.) Diabetes mellitus
(1) Applicants with diabetes requiring insulin or antidiabetics which might induce hypoglycaemia shall be assessed as unfit.
(2) Applicants with diabetes mellitus not requiring insulin shall be assessed as unfit unless it can be demonstrated that blood sugar control has been achieved with absence of hypoglycaemic events or excess blood levels of more than 180 mg/dl. Applicants for any class of medical certificate shall be referred to the

	licensing authority.
response	*Noted*
	(1) partially accepted, please resulting text. (2) not accepted: If blood sugar control has been achieved, it implies that neither hypoglycaemic events nor blood sugar levels of more than 180 mg/dl occur. The risk resulting from incapaciation as seen as lower in private pilots than in commercial pilots. The assessment of medical fitness is therefore different. Insulin dependant diabetes mellitus is accepted for private driving. Applicants for any class of medical certificate may be referred to the licensing authority as it is specified AMC to MED.A.045. However, this NPA carries comments of the same commenter saying that no pilot should be referred to the licensing authority and that any assessment of borderline cases could be done by an AeMC. The Agency appreciates the fact that keeping the JAR-FCL 3 system is not totally rejected by the commenter.

comment	*527*	comment by: *British Microlight Aircraft Association*
	(a) Strongly agree other parts no knowledge	
response	*Noted*	
	Thank you for your input.	

comment	*646*	comment by: *Royal Danish Aeroclub*
	MED.B.020 Metabolic and Endocrine Systems It's important to emphasize that there is a rapid evolution of new treatments and medicine, not only for diabetic patients, that one has to take into consideration in these matters. There are less side effects and a much safer profile in diabetic medicine in a very near future. Suggestion: The details should be mentioned in AMC because it is more dynamic and has a much shorter implementation time.	
response	*Noted*	
	Comments to move hard law to soft law have been answered several times in previous sections. For reference please see e.g. answers to comment No 1554 in Segment B.001 and comment 64 in Segment B.005.	

comment	*660*	comment by: *ERA*
	MED.B.020 Metabolic and Endocrine Systems (c) Diabetes mellitus	

(1) ERA consider that it is likely that technological advances in glycaemia control will permit insulin-dependent diabetics to meet the incapacitation risk criterion for Class 1 OML. This regulation would prevent the European industry from adapting to that advance.

This is a specific prohibition which should not be in the implementing rules. It should be demoted at least to AMC and this should apply to all specific prohibitions in all systems.

response *Noted*

Comments to move hard law to soft law have been answered several times in previous sections. For reference please see e.g. responses to comment No 1554 in Segment B.001, comment No 64 in Segment B.005 and comment No 646 above.

comment *763* comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author: European Society of Space and Aviation Medicine (ESAM) - Internal Medicine Group -

Section: 1
MED.B.020 Metabolic and Endocrine Systems

Page: 13

Relevant Text:

(a) Applicants shall not possess any functional or structural metabolic, nutritional or endocrine disorder which is likely to interfere with the safe exercise of the privileges of the applicable licence(s).

(b) Applicants with metabolic, nutritional or endocrine dysfunction may be assessed as fit subject to demonstrated stability of the condition and satisfactory aeromedical evaluation.

(c) Diabetes mellitus
(1) Applicants with diabetes requiring insulin shall be assessed as unfit.

(2) Applicants with diabetes mellitus not requiring insulin shall be assessed as unfit unless it can be demonstrated that blood sugar control has been achieved. Applicants for a class 1 medical
certificate shall be referred to the licensing authority.

Comment:

Proposal:
(a) Applicants shall not possess any functional or structural metabolic, nutritional or endocrine disorder which is likely to interfere with the safe exercise of the privileges of the applicable licence(s).

	(b) Applicants with metabolic, nutritional or endocrine dysfunction may be assessed as fit subject to demonstrated stability of the condition and satisfactory aeromedical evaluation. (c) Diabetes mellitus (1) Applicants with diabetes requiring insulin shall be assessed as unfit. (2) Applicants with diabetes mellitus not requiring insulin shall be assessed as unfit unless it can be demonstrated that blood sugar control has been achieved
response	*Not accepted*
	Following JAR-FCL 3, which was the basis for this NPA, the licensing authority will continue to assess the fitness of commercial pilots (class 1 medical certificates) who do not fully meet the rules.

comment	*811*	comment by: *Swiss Association of Aviation Medecine*
	Proposal: (a) Applicants shall not possess any functional or structural metabolic, nutritional or endocrine disorder which is likely to interfere with the safe exercise of the privileges of the applicable licence(s). (b) Applicants with metabolic, nutritional or endocrine dysfunction may be assessed as fit subject to demonstrated stability of the condition and satisfactory aeromedical evaluation. (c) Diabetes mellitus (1) Applicants with diabetes requiring insulin shall be assessed as unfit. (2) Applicants with diabetes mellitus not requiring insulin shall be assessed as unfit unless it can be demonstrated that blood sugar control has been achieved	
response	*Not accepted*	
	See response to comment No 763.	

comment	*827*	comment by: *Thomas Cook Airlines UK*
	Commentator: The UK Association of Aviation Medical Examiners **Paragraph:** Med.B.001 General **Page Number** 9 **Comment:** There is no mention in the document of the 1% rule. Aero-medical decisions should be made on evidence - based medicine. There needs to be flexibility in the regulations to permit changes with the advancement of medical knowledge. EASA needs to keep abreast of advances in medical science and amend the regulations accordingly. Individual states should be able to submit evidence based arguments for changes to the regulations if necessary on a trial basis initially.	

Justification: The 1% rule has stood the test of time as a practical and pragmatic method of calculating risk.

Proposed text: Med B.001 add in new paragraph (e) Pilots who do not fully meet these requirements but who are assessed by an AeMC to have a risk of sudden incapacitation of 1% per annum or less during the period of validity may be assessed as fit for class 1 OML or for unrestricted class 2.

Commentator: The UK Association of Aviation Medical Examiners

Paragraph: MED.B.005 Cardiovascular system (a) (4)

Page Numbers: 9

Comment: There is no logic in performing lipid analysis at the age of 40 and never repeating this investigation. It is suggested that when lipids are found to be abnormal or in pilots with other cardiovascular risk factors then lipid analysis should be repeated at annual intervals.

Justification: Attention to reducing Cholesterol levels has been shown conclusively to lower the risk of a cardiovascular event.

Proposed text: MED.B.005 (a) (4) For a class 1 medical certificate, estimation of fasting serum lipids, including cholesterol, shall be required at the examination for first issue of a medical certificate, and at the first examination after having reached the age of 40. This estimation shall be repeated annually in those pilots who have other cardiovascular risk factors.

Commentator: The UK Association of Aviation Medical Examiners

Paragraph: MED.B.020 Metabolic and Endocrine Systems

Page Number: 13

Comment: Advances in diabetes treatment in the future could lead to a diabetic pilot under good control, even on Insulin being perfectly fit to fly in a multi-crew capacity with an OML. Consideration should be given to amending this ruling to allow for future developments in treatment of all types of diabetes.

Justification: Modern diabetic treatment is leading to better control and a very small risk of hypoglycaemia.

Proposed text: MED.B.020 (c) (3) Consideration will be given in the light of new developments in the future in the control of diabetes for some class 1 pilots on Insulin treatment to be assessed as fit subject to proof of strict control and OML.

Commentator: The UK Association of Aviation Medical Examiners

Paragraph: MED.B.020 Metabolic and Endocrine Systems

Page Numbers: 13

Comment: There should be more definite rules concerning the obese pilot. A BMI greater than 30 should require more extensive investigation of other risk factors and more stringent and repeated investigation of cardio-vascular and other disease risks. Consideration should be given to requiring an obese pilot over 40 years of age to be medically examined more frequently than every 12 months and to undergo appropriate investigations to assess risk.

Justification: There is clear proof that obesity is common and that it leads to premature onset of a variety of diseases including cardiovascular disease, hypertension, Type 2 diabetes, cancer and arthritis.

Proposed text: add in new paragraph (3) Pilots with a BMI greater than 30 shall undergo further cardiovascular risk assessment and may be required to attend more frequently than 12 month intervals for medical certification examination.

response *Partially accepted*

Med.B.001 General: Noted. Please see response to comment No 64 in that Segment.

MED.B.005 Cardiovascular system (a) (4): Noted. Please see responses to similar comments in Section B.005.

MED.B.020 Metabolic and Endocrine Systems, diabetes: Not accepted. The propsoed change to the text would lead to having no common rule in Europe on the assessment of pilots who suffer from diabetes mellitus.

MED.B.020, obesity: Noted. Please see AMC to MD.A.020 (2).

comment *1120* comment by: *BALPA*

MED.B.020 Metabolic and Endocrine Systems
(c) Diabetes mellitus

(1) Applicants with diabetes requiring insulin shall be assessed as unfit.

Prohibition of the use of insulin should be written in the Acceptable Means of Compliance rather than specified within the Implementing Rules. This would allow the future possible use of insulin in selected pilots in whom good control - without hypoglycaemia - has been demonstrated.

Suggested replacement text:

Delete (i)

response *Not accepted*

The Implementing Rules Part Medical provide for a common standard medical assessment of pilots in Europe and it is not possible to move a rule to AMC for the sole reason to change it and to bypass the European rulemaking process. Implementing Rules will be amended as is necessary, the next rulemaking task MED.001 will start after finalisation of this Opinion.

For balance of hard law and soft law also see e.g. responses to comment No 1554 in Segment B.001, comment No 64 in Segment B.005 and comments No 646 and 660 in this Segment.

comment

1463	comment by: *Virgin Atlantic Airways Ltd*

Section: MED.B.020 (c) (1) **Metabolic and Endocrine Systems**

Relevant Text: (c) *Diabetes mellitus*
(1) Applicants with diabetes requiring insulin shall be assessed as unfit.

Comment: As with other conditions, it is likely that technological advances in glycaemia control may in the future permit insulin-dependent diabetics to meet the incapacitation risk criterion for Class 1 OML. Indeed some regulators already allow this. Including this in a rule is too inflexible and it should be relegated to the AMC.

response

Noted

Comments to move hard law to soft law have been answered several times in previous sections. For reference please see e.g. responses to comment No 1554 in Segment B.001, comment No 64 in Segment B.005 and comments No 646, 660 and 1120 in this Segment.

comment

1535	comment by: *DGAC FRANCE*

MED B 020 Metabolic and Endocrine Systems

COMMENT :
It's better to keep the decision to be taken by the authority like in JAR FCL 3

Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained.

As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid contentious cases with AME's or AMC's which takes a lot of time to treat.

It is also important for authorities to have an homogeneous feed back of these kind of decisions to improve the rules in the future.

Give privileges to class 2 AME's to issue all medical certificates even those with one or more limitations instead of the licensing authority is dangerous for harmonisation of decisions throughout EU and associated countries and against

	equity principles. This should remain the duty of the licensing authority Justification : Decisions will not be homogeneous and standardisation of the decisions between states will be never obtained. As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. MODIFICATION : MED B 020 Metabolic and Endocrine Systems *c) (c) Diabetes mellitus* (2) Applicants…..… achieved. Applicants for a class 1 **and 2** medical certificate shall be referred to the licensing authority.
response	*Noted*
	Please see response to your comment No 1534 in Segment B.015.

comment	*2053*	comment by: *Michael Hinz*
	Diabetiker, die Insulin nehmen, sind genau so fit wie Nicht-Diabetiker. Die sorgfältige Einstellung mit Insulin gleicht das defizit vollständig aus. Es ist vergleichbar mit der Korrektur der Sehschärfe durch eine Brille. In den USA ist es Insulin nehmenden Diabetikern durchaus erlaubt, Airline Piloten zu sein. Auch bei Privatpiloten sind keine Unfälle wegen der Insulinpflicht bekannt. Solche Airline Piloten fliegen auch zu uns nach Europa. Noch nie hat es dabei ein Problem gegeben. Ich fordere daher, das insulinpflichtige Diabetiker nicht per Gesetzt als unfit eingestuft werden, sondern dass der Arzt das beurteilen soll. Hier dringend der Ermessensspielraum des Fliegerarztes nötig, denn jeder Fall eines Diabetikers muss einzeln betrachtet werden. Viele insulinpflichtige Diabetiker fliegen bereits auf der Welt und verursachen keine Probleme. Hier darf keiner Gruppe ohne zwingende Notwendigkeit die Fluglizenz vorenthalten werden.	
response	*Not accepted*	
	JAR-FCL 3 and ICAO Annex 1 are the basis for this NPA. Changes to JAR-FCL 3, requirements for class 1 assessments, were made in cases where safety was significantly enhanced. Provisions for class 2 were adapted to ICAO SARPs which are lower than JAR-FCL 3. Both, JAR-FCL 3 and ICAO Annex 1, state that pilots with diabetes mellitus requiring insulin shall be assessed as unfit. However, the assessment of insulin dependant diabetes mellitus will be re-discussed in the first revision of PArt MED (task MED.001).	

Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.025: Haematology

comment	*2*	comment by: *GEMA*
	(c) (3) ¿Qué es eso de "agrandamiento linfático significativo? Es un término muy antiguo, procederá probablemente de OACI, ahora no se utiliza en ninguna lengua	
response	*Noted*	
	The wording "significant lymphatic enlargement" is the wording also used in JAR FCL 3 which was the basis for this NPA.	

comment	*5*	comment by: *GEMA*
	(c) Una vulgar anemia ferropénica tiene que ser evaluada por la Autoridad?	
response	*Noted*	
	This should depend on the severity of the anaemia.	

comment	*84*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **Med B 025 b) section 2** **Page**: 13 Relevant Text: **Comment**: HB shall be taken also in class 2 applicants **Proposal**: New: For class 1 and class 2 medical certificate, haemoglobin.....	
response	*Not accepted*	
	Haemoglobin testing for class 2 applicants is required on clinical indication. Class 2 requirements are based on ICAO Annex 1 SARPs and routine testing of applicants is not required.	

comment	*258*	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.B.025 **Page**: 13 Relevant Text: (b) For a class 1 medical certificate, haemoglobin shall be tested at each examination for the issue of a medical certificate.	

	Comment: Nowadays in many countries it is not even possible to solely determine haemoglobin levels. The haemoglobin value is "side-product" of a cell-count, which is cheaper and easier to perform. The outdated analysis of haemoglobin by extinction measurement is not even available in modern countries. So the text should be orientated at modern circumstances. A sufficient level of oxygen-bearing red cells is essential for a safe function of the brain and the remaining organs in all airmen, not only class 1. Class 2 and LPL pilots are even more at risk to hypoxia due to lack of pressure cabin or supplementary oxygen in the leisure aircraft. So estimation of red blood cells should be mandatory for all class of medical certificate. **Proposal**: (b) For any class of medical certificate, blood count shall be tested at each examination for the issue of a medical certificate.
response	*Not accepted*
	Class 1 medical requirements are in line with JAR FCL 3 while Class 2 medical requirements were aligned with ICAO Class 2. For class 1 applicants requirement to test haemoglobin at every medical examination was transposed from JAR FCL 3.180(b). ICAO Annex I does not require to test heamoglobin for class 2 applicants on a regular basis.

comment	*529*	comment by: *British Microlight Aircraft Association*
	(a) Strongly agree other parts no knowledge	
response	*Noted*	
	Thank you for the positive comment.	

comment	*764*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM) - Internal Medicine Group - **Section: 1** **MED.B.025 Haematology** **Page**: 13 **Relevant Text:** (a) Applicants shall not possess any haematological disease which is likely to interfere with the safe exercise of the privileges of the applicable licence(s). (b) For a class 1 medical certificate, haemoglobin shall be tested at each examination for the issue of a medical certificate. (c) Applicants with a haematological condition, such as: (1) abnormal haemoglobin, including, but not limited to anaemia, polycythaemia or haemoglobinopathy;	

	(2) coagulation, haemorragic or thrombotic disorder; (3) significant lymphatic enlargement (4) acute or chronic leukaemia; (5) enlargement of the spleen; may be assessed as fit subject to satisfactory aeromedical evaluation. Applicants for a class 1 medical certificate shall be referred to the licensing authority. **Comment**: **Proposal**: (a) Applicants shall not possess any haematological disease which is likely to interfere with the safe exercise of the privileges of the applicable licence(s). (b) For a class 1 medical certificate, haemoglobin shall be tested at each examination for the issue of a medical certificate. (c) Applicants with a haematological condition, such as: (1) abnormal haemoglobin, including, but not limited to anaemia, polycythaemia or haemoglobinopathy; (2) coagulation, haemorragic or thrombotic disorder; (3) significant lymphatic enlargement (4) acute or chronic leukaemia; (5) enlargement of the spleen; shall be assessed as unfit until to satisfactory aeromedical evaluation.
response	*Not accepted*
	The principle to refer class 1 applicants with haematological conditions listed in MED.B.025(c) to the licensing authority was transposed from JAR FCL 3.

comment	*812*	comment by: *Swiss Association of Aviation Medecine*
	Proposal: (a) Applicants shall not possess any haematological disease which is likely to interfere with the safe exercise of the privileges of the applicable licence(s). (b) For a class 1 medical certificate, haemoglobin shall be tested at each examination for the issue of a medical certificate. (c) Applicants with a haematological condition, such as: (1) abnormal haemoglobin, including, but not limited to anaemia, polycythaemia or haemoglobinopathy; (2) coagulation, haemorragic or thrombotic disorder; (3) significant lymphatic enlargement (4) acute or chronic leukaemia; (5) enlargement of the spleen; shall be assessed as unfit until to satisfactory aeromedical evaluation.	
response	*Noted*	

	See response to comment No 764.

comment	*837*	comment by: *Thomas Cook Airlines UK*

Commentator: The UK Association of Aviation Medical Examiners

Paragraph: MED.B.025 Haematology

Page Number: 13, 39

Comment: there is no evidence based justification whatsoever for performing a routine haemoglobin on all Class 1 pilots at every medical examination.

Justification: Flight safety is not enhanced in anyway by this unnecessary investigation which is disliked by pilots and who frequently ask why the test is being performed.

Proposed text: Delete paragraph MED.B.025 section (b)

Commentator: The UK Association of Aviation Medical Examiners

Paragraph: AMC A to MED.B.025 Haematology - class 1 medical certificates

Page Number: 40

Comment: Consideration should be given to permit pilots on long-term anticoagulation to be able to have an OML endorsement. Some of the modern anti-coagulant drugs are more effective and risks of bleeding are minimal under expert control.

Justification: There is no evidence that pilots on long-term anticoagulation who are well controlled compromise flight safety.

Proposed text: AMC A to MED B 025 paragraph 5. add in a new sub-paragraph: Applicants on long-term anticoagulation for conditions not considered to present a sudden incapacitation risk and who are well stabilised may be assessed as fit by the AeMC subject to OML

response	*Not accepted*

MED.B.025 Haematology
The requirement to test haemoglobin in class 1 applicants at every medical examination was transposed from JAR FCL 3.180(b). The reason this test is required is that a sufficient level of oxygen-bearing red cells is essential for a safe function of the brain and the remaining organs in pilots, specifically commercial air transport where most aircraft used have pressurised cabin.

AMC A to MED.B.025 Anticoagulation: Please responses to similar comments in that Segment.

comment	*1536*	comment by: *DGAC FRANCE*

MED B 025 Haematology

COMMENT :
It's better to keep the decision to be taken by the authority like in JAR FCL 3

Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained.

As it is indicated in MED.065, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid contentious cases with AME's or AMC's which takes a lot of time to treat.

It is also important for authorities to have an homogeneous feed back of these kind of decisions to improve the rules in the future.

Give privileges to class 2 AME's to issue all medical certificates even those with one or more limitations instead of the licensing authority is dangerous for harmonisation of decisions throughout EU and associated countries and against equity principles. This should remain the duty of the licensing authority

Justification: Decisions will not be homogeneous and standardisation of the decisions between states will be never obtained.

As it is indicated in MED .065, the authority shall suspend or revoke a medical certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

MODIFICATION :

MED B 025 Haematology

c) Applicants **<u>for a class 1 and 2 medical certificate</u>** with a haematological condition, such as :

(1) .....

(5)…….

~~may be assessed as fit subject to satisfactory aeromedical evaluation . Applicants for class 1 medical certificate~~ shall be referred to the licensing authority.

response *Noted*

Please see response to your comment No 1534 in Segment B.015

comment	*1575*	comment by: *FAA*
	MED.B.025(b): U.S. applicants undertake appropriate hematological testing upon clinical indication.	
response	*Noted*	
	Thank you for the information.	

comment	*2057*	comment by: *Michael Hinz*
	Eine Entscheidung über Tauglichkeit / Untauglichkeit sollte letztenendes immer ein Arzt im Einzelfall beurteilen können, niemals jedoch eine allgemeine Gesetzesaussage, die im Einzelfall immer auch unzutreffend und den Piloten diskreminierend sein kann.	
response	*Noted*	

comment	*2568*	comment by: *Heinz Fricke-Bohl and Kirsten Bohl*
	MED.B.025: (4) Akute Leukämie: dann sind die Patienten todkrank. Es muss also nicht gesondert aufgeführt werden. Chronische Leukämie: Flugtauglichkeit nach Begutachtung durch den Fliegerarzt.	
response	*Noted*	
	The rules are established to determine aeromedical fitness. Class 1 and 2 applicants with acute leukaemia may be asessed as fit if the disease is in remission stage and aeromedical risk acceptable. Class 1 applicants with acute or chronic leukaemia must be referred to the licensing authority. Class 2 applicants will be assessed in consultation with the licensing authority.	

C. Draft Opinion Part-MED - Subpart B: Requirements for Medical Certificates - Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.030: Genitourinary System p. 13-14

comment	*3*	comment by: *GEMA*
	(b) Análisis de orina rutinario, entiendo que una tira de orina, cualitativo, inútil	
response	*Noted*	
	No, rutine urine analysis does not mean a dipstisk test which may be a part of the analysis. Our proposed medical requirements do not deviate from JAR FCL 3. Urine analysis shall follow questions laid down in the Medical Examination Form.	

comment	*4*	comment by: *GEMA*
	¿Por qué 3 meses? Quitar periodos fijos tras intervenciones, no tiene ningún sentido	

response	*Partially accepted*
	The period of 3 months has been moved to the AMC of this paragraph.

comment	*83*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **Med to B 005** **Page**: 9ff Relevant Text: Referring to licensing authority **Comment**: Not possible due to lack of qualified medical personal and medical confidentiality **Proposal**: According to national law referred pilots shall be examined by AME class I or AMC	
response	*Noted*	
	This comment by this commenter has been answered several times in other segments.	

comment	*439*	comment by: *UK CAA*
	MED.B.030 (e) **Comment:** Text change to clarify. **Justification:** Clarity. **Proposed Text:** Replace 'be assessed as unfit and be re-assessed' with **'undergo satisfactory evaluation'**.	
response	*Not accepted*	
	JAR FCL 3 text requires minimal unfitness period after major surgical operation. Replacing 'be assessed as unfit and be re-assessed' with 'undergo satisfactory evaluation' would significantly change the requirement. This propsoal coule be taken up in rulemaking task MED.001.	

comment	*530*	comment by: *British Microlight Aircraft Association*
	(a) Strongly agree other parts no knowledge	
response	*Noted*	
	Thank you for the input.	

comment	1537	comment by: DGAC FRANCE

MED B 030 Genitourinary System

COMMENT :
It's better to keep the decision to be taken by the authority like in JAR FCL 3

Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained.

As it is indicated in MED.065, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid contentious cases with AME's or AMC's which takes a lot of time to treat.

It is also important for authorities to have an homogeneous feed back of these kind of decisions to improve the rules in the future.

Give privileges to class 2 AME's to issue all medical certificates even those with one or more limitations instead of the licensing authority is dangerous for harmonisation of decisions throughout EU and associated countries and against equity principles**.** This should remain the duty of the licensing authority.

Justification : Decisions will not be homogeneous and standardisation of the decisions between states will be never obtained.

As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

MODIFICATION:

MED B 030 Genitourinary System

(d) Applicants **for a class 1 and 2 medical certificate** with a genitourinary disorder, such as :

(1) .....etc

~~may be assessed as fit subject to satisfactory renal/urological evaluation.~~**shall be referred to the licensing authority.**

(e) Applicants **for a class 1 and 2 medical certificate** who have undergone a major surgical operation in the urinary apparatus involving a total or partial

	excision or a diversion of its organs shall be ~~assessed as unfit and be re-assessed after full recovery before a fit assessment can be made.~~ **referred to the licensing authority a minimum of three months after the operation.** ~~In the case of applicants for a class 1 medical certificate the re-assessment shall be made by the licensing authority a minimum of three monts after the operation.~~
response	*Noted*
	This comment by this commenter has been answered several times in other Segments.

comment	*1576*	comment by: *FAA*
	MED.B.030 (b): Urine testing (for protein and sugar), not urinalysis, is part of every U.S. examination. U.S. applicants undertake urinalysis and other appropriate genitor-urinary testing upon clinical indication.	
response	*Noted*	
	Thank you for the information.	

comment	*2059*	comment by: *Michael Hinz*
	Eine Entscheidung über Tauglichkeit / Untauglichkeit sollte letztenendes immer ein Arzt im Einzelfall beurteilen können, niemals jedoch eine allgemeine Gesetzesaussage, die im Einzelfall immer auch unzutreffend und den Piloten diskreminierend sein kann.	
response	*Noted*	
	This comment by the same commenter has been answered several times in other segments.	

C. Draft Opinion Part-MED - Subpart B: Requirements for Medical Certificates - Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.035: Infectious Disease p. 14

comment	*259*	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.B.035 **Page**: 14 Relevant Text: (b) Applicants who are HIV-positive may be assessed as fit subject to satisfactory aeromedical evaluation. **Comment**: Patients with manifest immunodeficiency (AIDS) should be excluded from flight-duties due to the high risk of unforeseeable events: seizures due to cerebral infection (fungus, Pneumocystis carinii), cerebral Karposi-Sarkoma,	

	AIDS-related dementia and psychopathy, etc. **Proposal**: (b) Applicants who are HIV-positive may be assessed as fit subject to satisfactory aeromedical evaluation, when no evidence of manifest immunodeficiency (AIDS) is present and CD4-count is higher than 200 c/yl.
response	*Partially accepted*
	We agree that applicants with manifest immunodeficiency (AIDS) shall be excluded from flight duties. However, the rule only sais that HIV positivity does not necessarily by itself lead to an unfit assessment which is different from JAR-FCL 3. The AMC A to MED.035 will be amended to better explain the "satisfactory aeromedical evaluation".

comment	*531*	comment by: *British Microlight Aircraft Association*
	(a) Strongly agree other parts no knowledge	
response	*Noted*	
	Thank you for the comment.	

comment	*1538*	comment by: *DGAC FRANCE*
	MED B 035 Infectious Disease COMMENT : **It's better to keep the decision to be taken by the authority like in JAR FCL 3** Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained. As it is indicated in MED.065, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid contentious cases with AME's or AMC's which takes a lot of time to treat. It is also important for authorities to have an homogeneous feed back of these kind of decisions to improve the rules in the future. Give privileges to class 2 AME's to issue all medical certificates even those with one or more limitations instead of the licensing authority is dangerous for harmonisation of decisions throughout EU and associated countries and against equity principles. This should remain the duty of the licensing authority. Justification : Decisions will not be homogeneous and standardisation of the	

	decisions between states will be never obtained. As it is indicated in MED.065, the authority shall suspend or revoke a medical certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. MODIFICATION : MED B 035 Infectious Disease (b) Applicants **for a class 1 and 2 medical certificate** who are HIV positive may be assessed as fit ~~subject to satisfactory aeromedical evaluation~~ **by the licensing authority.**
response	*Noted*
	This comment by the same commenter has been answered several times in other Segments.

C. Draft Opinion Part-MED - Subpart B: Requirements for Medical Certificates - Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.040: Obstetrics and Gynaecology p. 14

comment	*532*	comment by: *British Microlight Aircraft Association*
	(a) Strongly agree other parts no knowledge	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1539*	comment by: *DGAC FRANCE*
	MED B 040 Obstetrics and Gynaecology COMMENT : **It's better to keep the decision to be taken by the authority like in JAR FCL 3** Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained. As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid	

	contentious cases with AME's or AMC's which takes a lot of time to treat. It is also important for authorities to have an homogeneous feed back of these kind of decisions to improve the rules in the future. Give privileges to class 2 AME's to issue all medical certificates even those with one or more limitations instead of the licensing authority is dangerous for harmonisation of decisions throughout EU and associated countries and against equity principles**.** This should remain the duty of the licensing authority Justification: Decisions will not be homogeneous and standardisation of the decisions between states will be never obtained. As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. MODIFICATION : MED B 040 Obstetrics and Gynaecology (b) Applicants **for a class 1 and 2 medical certificate** who have undergone a major gynaecological operation shall be assessed as unfit for a period of three months or until full recovery. **They may be assessed as fit by the licensing authority.**
response	*Noted*
	This comment by the same commenter has been answered several times in other segments.

comment	*1577*	comment by: *FAA*
	MED.B.040 MED.B.040 (a) and (b): The U.S. provides for organic, functional, or structural disease, defect, or limitation under one comprehensive standard. See, for example, § 67.113: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=cfcb03761578d591dd11e611aaef8ef0&rgn=div8&view=text&node=14:2.0.1.1.5.2.1.7&idno=14 MED.B.040 (a) and (b): The United States notes that ICAO, per the attached state letter has revised its standard on gynecological issues from the more specific to the more general. See pg.2 Item 5 g) of the attached ICAO State letter 33 dated 5 May 2008 : **http://www.icao.int/cgi/SLEDfile.pl?y=2008&f=033e.pdf&w=awfrwc&a=US** MED.B.040 (c): The United States notes that ICAO, per the attached state letter has revised its standard on pregnancy: See pg. 2 Item 5 b) of the attached ICAO State letter 33 dated 5 May 2008: **http://www.icao.int/cgi/SLEDfile.pl?y=2008&f=033e.pdf&w=awfrwc&a=US**	

response	*Noted*
	Thank you for the information.

C. Draft Opinion Part-MED - Subpart B: Requirements for Medical Certificates - Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.045: Musculoskeletal System p. 14

comment	*440*	comment by: *UK CAA*
	MED.B.045 (b) **Comment:** Inappropriate for IR. **Justification:** Applicants with disabilities may not satisfy this requirement but there may be measures available to enable them to mitigate the medical risk. **Proposed Text:** Move to AMC and change 'shall' to 'should.	
response	*Not accepted*	
	This comment by the same commenter has been answered in previous segments.	

comment	*533*	comment by: *British Microlight Aircraft Association*
	(a) strongly agree (b) strongly agree (c) agree	
response	*Noted*	
	Thank you for the positive comments.	

comment	*1348*	comment by: *European Disabled Aviators*
	Attachment #10	
	Paragraph (c) of this article, if left unchanged may lead to assess as unfit any person having a musculoskeletal system condition, regardless of the situation in which the license is exercised. A more detailed wording is therefore proposed: (c) An applicant shall have satisfactory functional use of the musculoskeletal system for the safe exercise of the privileges of the applicable licence(s).	
response	*Partially accepted*	
	Amended text will be: An applicant shall have satisfactory functional use of the musculoskeletal system to enable the safe exercise of the privileges of the applicable licence(s). Fitness of the applicants shall be determined in consultation with the licensing authority.	

C. Draft Opinion Part-MED - Subpart B: Requirements for Medical Certificates - Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.050: Psychiatry p. 14-15

comment	*85*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **Med to B 005** **Page**: 9ff Relevant Text: Referring to licensing authority **Comment**: Not possible due to lack of qualified medical personal and medical confidentiality **Proposal**: According to national law referred pilots shall be examined by AME class I or AMC	
response	*Noted*	
	This comment by the same commenter has been answered in previous segments.	

comment	*269*	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. Jürgen Kriebel Section: 2 Subpart B Requirements for medical certificates Specific requirements for class 1 and class 2 MED.B.050 - Psychiatry **Page**: Relevant Text:: (b) Applicants with a mental or behavioural disorder due to alcohol or other substance use shall be assessed as unfit pending recovery and freedom from substance use and subject to satisfactory psychiatric evaluation. Applicants for a class 1 medical certificate shall be referred to the licensing authority. **Comment**: Freedom from substance use needs follow up after successful treatment. **Proposal**: (b) Applicants with a mental or behavioural disorder due to alcohol or other substance use shall be assessed as unfit pending recovery and freedom from substance use and after successful treatment as well as subject to satisfactory psychiatric evaluation. Applicants for a class 1 medical certificate shall be referred to the licensing authority.	
response	*Partially accepted*	
	The text will be changed to: "... and subject to satisfactory psychiatic evaluation	

	after successful treatment.”

comment	*441*	comment by: *UK CAA*
	MED.B.050 (e) **Comment:** Text deletion to clarify. **Justification:** Clarity. **Proposed Text:** Delete ‘be assessed as unfit. Applicants shall'	
response	*Noted*	
	Corresponding JAR-FCL-3 text requires unfitness after acts of deliberate self-harm. Your proposed text replacement would significantly change the requirement. The same comment by this commenter has also been answered in Segment B.030.	

comment	*534*	comment by: *British Microlight Aircraft Association*
	(a) strongly agree (b) accepted (c) (d) accepted (e) accepted	
response	*Noted*	
	Thank you for the input.	

comment	*830*	comment by: *Thomas Cook Airlines UK*
	Commentator: The UK Association of Aviation Medical Examiners **Paragraph**: MED.B.050 Psychiatry and AMC A to MED.B.050 **Page Numbers:** 14,15 and 43 **Comment:** Pilots on SSRIs should be able to hold a Class 1 or 2 medical certificate provided that they have fully recovered from their depressive illness and are on purely maintenance doses and have no side effects from the medication. It is well known that there are depressed pilots flying who should be on treatment and pilots on SSRIs who choose not to declare their medication to their AME because they do not wish to lose their medical certificate. Other countries such as Canada and Australia permit selected pilots on SSRIs to continue to fly as OML under strict conditions. EASA should move with the times	

	and take a more pragmatic view on this subject. Such pilots would need an OML. **Justification:** Other countries have already demonstrated that some pilots on SSRI maintenance treatment can operate entirely safely with no evidence of performance deterioration. **Proposed text:** AMC A to MED.B.050 paragraph 5. Mood disorder. An established mood disorder is disqualifying. A fit assessment may be considered after full consideration of an individual case, depending on the mood disorder characteristics and gravity. In certain circumstances, the continued use of appropriate maintenance medication will be considered for a fit assessment with OML. Regular supervision by the AeMC will be required.
response	*Noted*
	See responses in Segment AMC A to MED.B.050.

comment	*865*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM) - Group Neurology Psychiatry- **Section: 2** **Subpart B** **Requirements for class 1 and class 2 medical certificates** **MED.B.050 Psychiatry** **No comment!** **Page**: 14 -15 **Relevant Text:** **Comment**: **Proposal**:	
response	*Noted*	

comment	*1443*	comment by: *Eugene Beirne*
	Under JAA rules the use of SSRI was approved in 2008, specifically allowing pilots to operate with class 1/2 medicals. The wording of this section should mention this exception for specific types of medical conditions as acceptable subject to the agreed protocol as described in the JAA proprosal. The current wording would suggest that medical conditions that require medication are not acceptable if considered long term and therefore I believe this section should be amended to reflect the JAA recommendations on this subject.	
response	*Noted*	

JAR-FCL-3 was the basis for Part MED. However, we cannot see any requirement that would allow the use of SSRIs in JAR-FCL-3.

comment *1589* comment by: *DGAC FRANCE*

MED B 050 Psychiatry

COMMENT :
It's better to keep the decision to be taken by the authority like in JAR FCL 3

Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained.

As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid contentious cases with AME's or AMC's which takes a lot of time to treat.

It is also important for authorities to have an homogeneous feed back of these kind of decisions to improve the rules in the future.

Give privileges to class 2 AME's to issue all medical certificates even those with one or more limitations instead of the licensing authority is dangerous for harmonisation of decisions throughout EU and associated countries and against equity principles. This should remain the duty of the licensing authority.

Justification : Decisions will not be homogeneous and standardisation of the decisions between states will be never obtained.

As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

MODIFICATION :

MED B 050 Psychiatry

(b) Applicants with a mental or behavioural disorder due to alcohol or other substance use shall be assessed as unfit pending recovery and freedom from substance use and subject to satisfactory psychiatric evaluation. Applicants for a class 1 **and 2** medical certificate shall be referred to the licensing authority.

(d)Applicants with a psychiatric conditions such as :
(1) etc…….

shall undergo satisfactory psychiatric evaluatio before a fit assessment can be

	made. Applicants for a class 1 **and 2** medical certificate shall be referred to the licensing authority.
response	*Noted*
	This comment by the same commenter has been answered previously.

comment	*1764*	comment by: *Civil Aviation Authority Finland*
	MED.B.050 (b) Alcohol, alcoholism and drugs (abuse of substsnces) should also be mentioned in MED.B.050. (Ref. JAR-FCL 3.205 and 3.325) The broblematic use or abuse of alcohol, psychotropic substances or drugs and alcoholism is a growing broblem inaviation, also amongst the private pilots. Not only the mental or behavioural disorder due these, but it can be also a desease. Therefore these all should be included in MED.B.050 and not restricted only to class 1 medical certificates. Add: ... or other substance use **or having diagnosis of alcoholism** shall be assessed unfit ... Strice out: Applicants for a ~~**class 1**~~ medical certificate ...	
response	*Partially accepted*	
	Diagnosis of alcoholism is included in the wording "mental or behavioural disorder due to alcohol". Class 2 applicants will be referred to the licensing authority.	

comment	*1829*	comment by: *CAA Belgium*
	Relevant Text:: (b) Applicants with a mental or behavioural disorder due to alcohol or other substance use shall be assessed as unfit pending recovery and freedom from substance use and subject to satisfactory psychiatric evaluation. Applicants for a class 1 medical certificate shall be referred to the licensing authority. Comment: Freedom from substance use needs follow up after successful treatment. Proposal: (b) Applicants with a mental or behavioural disorder due to alcohol or other substance use shall be assessed as unfit pending recovery and freedom from substance use and after successful treatment as well as subject to satisfactory psychiatric evaluation. Applicants for a class 1 medical certificate shall be referred to the licensing authority.	
response	*Not accepted*	
	See response to comment No 269.	

Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.055: Psychology

comment	*179*	comment by: *Oliver Dzvonik*
	Comment: From the clinical praxis and preventive care are very well known the cases, that just psychological changes are often present as one of the first indicators of not only mental disorders but also many other somatic illness process. Psychological changes and defficiencies can be early indicators the factors which can reduce pilot`s operational capacity and safety. Therefore this formulation should be inverted or reformulated in the following way: **Proposal**: **(b) Psychological evaluation shall be required as independent special examination and may indicate further medical examinations. When appropriate, psychological examination may be also required as part of, or complementary to, a specialist psychiatric or neurological examination.**	
response	*Not accepted*	
	The issue should be covered in AMC A to MED.B.055 and AMC B to MED.B.055. Psychological examination is part of an aeromedical examination and assessment. The final assessment regarding fitness is done by the AME, AeMC or, in some cases, the licensing authority. The results of all specific examinations (e.g. psychology but also cardiology, ophthalmology etc) are taken into account. This is also laid down in ICAO Annex 1, 1.2.4.6, 1.2.4.6.2 and 1.2.4.7.	

comment	*182*	comment by: *Oliver Dzvonik*
	a) Applicants or holder of Class 1 medical certificate shall have no established psychological deficiencies, which are likely to interfere with the safe operation of the privileges of the applicable licence(s). Authority receives verifiable information from an identifiable source which evokes doubts concerning the mental fitness or personality of a particular individual. Sources for this information can be accidents or incidents, problems in training or proficiency checks, delinquency or knowledge relevant to the safe exercise of the privileges of the applicable licences. b) A psychological evaluation shall be required as independent special examination and may indicate further medical examimations (e.g. neurological or psychiatric or other). c) When appropriate, a psychological examination may be also required as part of, or complementary to, a specialist psychiatric or neurological examination, or other medical examination) d) The psychological evaluation may include a collection of biographical data, the	

	administration of aptitude as well as personality tests and psychological interview.
response	*Not accepted*
	The requirements proposed in this NPA are transposed from JAR-FCL-3. It was not the aim to amend JAR-FCL-3. Accidents, incidents etc will be taken care of by the licensing authority as appropriate. Please see the relvant paragraphs in Authority Requirements. Also see response to your comment No 179.

comment	*270*	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. Jürgen Kriebel Section: 2 MED.B.055 - Psychology **Page**: 12 Relevant Text:: (a) applicants shall have no established psychological deficiencies, which are likely to interfere with a safe exercise of the privileges of the applicable license(s). **Comment**: It is necessary to clarify the competence and responsibility. Some AMEs are not experienced to differentiate between psychology (selection), clinical psychology, neuropsychology and psychiatry. This differentiation is important for practical reasons especially for expert opinions concerning medical fitness. **Proposal**: Include the following sentence: Medical examinations should rule out that the suspicious behaviour is not of somatic or psychiatric origin.	
response	*Noted*	
	In case of doubt the AME should require a psychiatric or psycological examination as appropriate. A note has been made to re-consider this comment in the drafting phase of Guidance Material in the rulemaking task MED.001.	

comment	*535*	comment by: *British Microlight Aircraft Association*
	(a) strongly agree (b) accepted	
response	*Noted*	
	Thank you for the positive comment.	

comment	*857*	comment by: *Swiss Association of Aviation Medecine*
	Proposal: Applicants with a psychological deficiency, likely to interfere with aviation safety	

	should be referred for psychological or psychiatric or neurological opinion and advice. Disorders may need to be referred for psychological or neuropsychiatric opinion and advice. (delete sentence)
response	*Noted*
	Referal of a pilot for psychological assessment is in the AMC to MED.B.055

comment	*866*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM) - Group Neurology Psychiatry- **Section: 2** **Subpart B** **Requirements for class 1 and class 2 medical certificates** **MED.B.055 Psychology** **No comment!** **Page**: 14 -15 **Relevant Text:** **Comment**: **Proposal**:	
response	*Noted*	

comment	*1140*	comment by: *Austrian Professional Association of Psychologists (BÖP)*
	Attachment #11	
	For legal and safety reasons (see attachement), we recommend the following IR on "Psychology": (a) Applicants shall have no established psychological deficiencies or mental disability, particularly in operational aptitudes or any relevant personality factor, which are likely to interfere with the safe exercise of the privileges of the applicable licence(s). (b) When the authority receives verifiable information from an identifiable source which evokes doubts concerning the mental fitness or personality of a particular individual a psychological evaluation may be required. Sources for this information can be accidents or incidents, problems in training or proficiency checks, delinquency or knowledge relevant to the safe exercise of the privileges of the applicable licences. (c) When a psychological evaluation is indicated, it has to be done by a	

	psychologist who is entitled to do such evaluation through applicable European law or, in the absence of European law, the national law of such state where the authority requiring the evaluation is located. Such psychologist must have demonstrated sufficient knowledge in Aviation Psychology to the relevant authority and be certificated by the authority as an Aero Psychological Examiner. The relevant authority has to run a list of such psychologists and to publish it in an adequate way. (d) The psychologist shall submit to the relevant authority a written report detailing his opinion and recommendation.
response	*Noted*
	The basis of this NPA was JAR-FCL-3 and ICAO Annex 1, the aim was not to amend JAR-FCL-3. (a) is covered under Annex III of the Basic Regulation and MED.B.001 (b) is covered in the Authority Requirements. In cases of doubt the licensing authority and/or an AeMC or AME will decide which examinations/assessments have to be undertaken to confirm fitness to fly. With reference to this comment this may be a psychological, a neurological or a psychiatric assessment. (c) European law with regard to flight crew licensing/medical fitness of pilots will be this Part MED which, as such will prevail on any existing national law. (d) The submission of a report will be included in AMC A and B to MED.055.

comment	*1745*	comment by: *EFPA*
	Attachment #12	
	Comments on behalf of the EFPA – European Federation of Psychologists' Associations Notices of Proposed Amendment (NPA) No. 2008-17c - Psychology Dear Mr. Kneepkens, Dear Sir, EFPA, the European Federation of Psychologists' Associations, is the leading Federation of National Psychology Associations in Europe. There are 34 member associations of EFPA representing about 200,000 psychologists. In many of the EFPA member state countries Aviation Psychologists are active on the basis of national aviation law. One major source of national aviation regulation are the JAA-Requirements, which had to be implemented into national aviation law for execution. Part of these JAA-Regulations are JAR-FCL. 3.240 and JAR-FCL 3.360 "Psychological Requirements" for pilot license applicants or license holders. According to these regulations, "… a psychological evaluation should be considered … when the Authority receives verifiable information from an identifiable source which evokes doubts concerning the mental fitness or personality of a particular individual (see Appendix 17 to Subparts B and C to JAR-FCL. 3.240 and JAR-FCL 3.360)."	

Because of the clear regulation that only Psychologists acceptable to the authority are allowed to provide a psychological evaluation, a high qualification standard for licence applicants or holders is guaranteed. In some of the European countries, like in Austria, it is further required that working on psychological issues can only be carried out by psychologists according to the law (for psychologists) and who are knowledgeable in Aviation Psychology. These Psychologists have to fulfil certain criteria to the national aviation authority in order to be accepted as an Aviation Psychologist.

The high level of qualification as well as quality in methods and execution of psychological evaluations in general seems to be especially important in regard to the well known fact, that up to 80% of all accidents involve human factors. The increasing technological complexity and further increasing demographical change of the flight crew will require even more assistance from aviation psychologists in the future.

Unfortunately, the current EASA-FCL-NPA medical draft will reduce this high standard of quality. Psychological evaluations will be required without determining the demands to qualify as a psychological examiner as done in the JAR-FCL 3.240 / JAR-FCL 3.3.60. Who will guarantee the education and qualification of the person that works with the applicant? This open situation will give space to a lot of less qualified professionals and lead to problems for the applicants as well as for the authority. If someone not allowed by the applicable law will carry out psychological evaluations legal discussions in addition to safety ones can be predicted.

In order to provide a clear regulation regarding psychological evaluations that consider both national legislations as well as certain standards and qualifications of the protagonists, EFPA, in accordance also with the European Association of Aviation Psychologists (EAAP), recommends a revision of the current NPA in the sense of at least the current JAR-FCL 3 level for "Psychological Requirements" and offers it's support with the assistance of Aviation Psychologists represented by the EAAP.

Sincerely,

Roal Ulrichsen

President

response *Noted*

Thank you for the comment. We believe the standards of JAR-FCL-3 have been transposed into the new requirements as far as possible under European law.
Subparagraph (c) of JAR-FCL-3 will be added in the AMC.

comment *1841* comment by: *CAA Belgium*

Relevant Text::
(a) applicants shall have no established psychological deficiencies, which are likely to interfere with a safe exercise of the privileges of the applicable license(s).
Comment:

	It is necessary to clarify the competence and responsibility. Some AMEs are not experienced to differentiate between psychology (selection), clinical psychology, neuropsychology and psychiatry. This differentiation is important for practical reasons especially for expert opinions concerning medical fitness. Proposal: Include the following sentence: Medical examinations should rule out that the suspicious behaviour is not of somatic or psychiatric origin.
response	*Not accepted*
	See response to comment No 270.

comment	*1936*	comment by: *Deutsches Zentrum für Luft- und Raumfahrt, Abteilung Luft- und Raumfahrtpsychologie, Hamburg*

It is not specified or recommended who should perform the psychological evaluation, nor any specification of the required certification. This is in conflict with the high level safety objectives of the commission with FCL that a.o. includes: *"to require organizations, flight synthetic training devices and persons involved in the training, testing, checking and medical assessments to be certified on the basis of common rules.*

- Oversight over the psychological evaluation should remain with the best available professional in that discipline, which is a psychologist with a university degree in psychology and specialized by work experience in aviation or equivalent professional training.

DLR supports the proposal of the European Association for Aviation Psychology (EAAP) with respect to a revision of <![endif]-->the Subpart B.055 Psychology of Part Medical (Class 1 and 2, and Leisure Pilot License). The recommended new phrasing based on JAR is as follows:

MED.B.055 Psychology (for class 1 and 2, and for the Leisure Pilot License (LPL))

(a) Applicants shall have no established psychological deficiencies or mental disability, particularly in operational aptitudes or any relevant personality factor, which are likely to interfere with the safe exercise of the privileges of the applicable licence(s).

(b) When the authority receives verifiable information from an identifiable source which evokes doubts concerning the mental fitness or personality of a particular individual a psychological evaluation may be required. Sources for this information can be accidents or incidents, results in training or proficiency checks, delinquency or knowledge relevant to the safe exercise of the privileges of the applicable licences.

(c) When a psychological evaluation is indicated, it has to be done by a psychologist who is entitled to do such evaluation through applicable European law or, in the absence of European law, the national law of such state where the authority (AMC or AME) requiring the evaluation is located. Such psychologist must have demonstrated sufficient knowledge in Aviation Psychology to the relevant authority which defines such knowledge and publishes it in an adequate way. Such psychologist will be certified by the authority as Aero Psychological Examiner (APE).

.(d) The psychologist shall submit to the relevant authority a written report

	detailing (results and) his/her opinion and recommendation.
response	*Noted*
	See response to comment No 182.

comment	*1951*	comment by: *Civil Aviation Authority of Norway*
	Comment to (b): A psychological assessment or a neuropsychological testing is a very valuable assessment and may be required as part of, or complementary to, a specialist psychiatric or neurological examination. A psychological or neuropsychological evaluation may therefore be required.	
response	*Noted*	
	Thank you for the opinion.	

comment	*2451*	comment by: *AEPA, Asociación Española de Psicología de la Aviación Civil*
	Attached herewith you can find the comments on "Psychology" sections of the proposed EASA FCL by AEPA, Asociación Española de Psicología de la Aviación Civil (Spanish Association for Aviation Psychology). With all due respect and with only the desire to contribute to flight safety we would like to state that in our view the current EASA draft in regard to "Psychology" represents a rather big step backwards regarding the last JAR-FCL which may contribute to reduce the risks management in aviation that, either crew personnel or the system like a whole have to cope in the next future. The draft requires a Psychological Evaluation, without considering Psychology as the profession which is by law exclusively allowed to do a psychological evaluation backed by elaborate studies and long experience since decades again. As we all know few pilots in this population have a psychological pathology but it is necessary evaluate and predict their performance through cognitive, emotional, motivational, attitudinal aspects. The evaluation of these aspects must be done by a qualified aviation psychologist accepted by the authority.	
response	*Not accepted*	
	The assessment of medical fitness is done by an AME, AeMC or, in some cases, the licensing authority. A psychological examination is not done routinely to assess the fitness to fly. If the AME concludes during the aeromedical examination that a specialist psychological assessment needs to be done before fitness can be determined (or not) the AME is entitled to include a psychologist. This is in line with ICAO Annex 1. The speciality "aviation psychologist" does not exist in the whole of Europe. We do not see a difference between JAR-FCL-3 and this Draft Part MED except that the wording "accceptable to the AMS" has been deleted. Please note that "acceptable to the Authority" was taken out of all rules (OPS, FCL) because it	

leads to different rules around Europe as the authorities (have to) draft their own rules of what they accept.

comment

2452	comment by: *AEPA, Asociación Española de Psicología de la Aviación Civil*

Comments in regard to the Psychological Part of the 2008-17 c NPA (MED.B.055 Psychology (including AMC A to MED.B.055 PSYCHOLOGY (AMC class 1 medical certificates), AMC B to MED.B.055 (AMC for Class 2 medical certificates and Psychological and the "Specific requirements for LPL medical certificates – Psychology) draft

- The psychology sections are underdeveloped, lack detail and are therefore open to misinterpretation and misuse.

- The wording used is inconsistent, the terminology psychological "disorders" and/or "deficiencies" are both used but lack any definition or specification.

- The psychological evaluation is only indicated "as part of" a medical examination. There can be many other safety related indications for a psychological evaluation or treatment such as training and proficiency problems, insufficient coping with stresses of work, changes in operational risk taking behaviour, recurring incidents, operational performance deviations and not at least findings in accident investigations etc. (See JAR-FCL 3 Appendix 17 to JAR-FCL 3.240 and 3.360)

- A clinical evaluation as part of the medical evaluation differs in many aspects from a psychological performance evaluation of a pilot or pilot candidate. While a clinical evaluation leads to a diagnose of "pathology" or "not pathology", the psychological performance evaluation is based on the assessment of the person's cognitive functions, mental abilities, motivational factors and other personal factors in relation to the operational job requirements of a pilot.

- It is not specified or recommended who should perform the psychological evaluation, nor any specification of the required certification. This is in conflict with the high level safety objectives of the commission with FCL that a.o. includes: *"to require organizations, flight synthetic training devices and persons involved in the training, testing, checking and medical assessments to be certified on the basis of common rules.*

- With all respect for the medical science and the good collaboration in the clinical fields, psychology was and is an independent science focusing on the abilities and mental capacity in a specified operational, technical, organizational and cultural context. To understand the complexity and professionally assess such as psychological performance factors is of outmost relevance for safety in aviation. Not at least do the incident and accident rates provide the evidence.

- Oversight over a psychological evaluation is not within the competence of an AME who is untrained in Aviation psychology.

- It is therefore recommended that any psychological evaluation should only be

	performed by psychologists specialized and trained in "Aviation Psychology". Their training will allow the timely detection and mediation of potential deviations in performance capabilities and protects the pilot community against unrealistic assessments that do not address the specific aviation working context. - Psychological evaluation is today not always under the head of Aviation Medicine. This position has been and is supported by national authorities (example Austria) who already maintain a list of certified aviation psychologists for psychological evaluations next to a list of AeroMedical Examiners (AME). In order to assure a "level playing field", the Commission is proposing that examiners are no longer acting on a delegation from the authority, but exercising the privileges that are given to them by the certificate they hold. Also, for approval "instructors providing flight training and flight simulation training, as well as examiners and aeromedical examiners, shall hold a certificate attesting their compliance with the essential requirements and relating implementing rules". - Consistent rulemaking would benefit from developing a certificate for an "Aero Psychological Examiner" or accept and approve the authorization in Spain set by AEPA, the Spanish professional organization in the field. - An "Aero Psychological Examiner" or Aviation Psychologist certificate is recommended as an alternative to delegation by national authorities only and/or detailing many specific psychological requirements in the rule text and/or AMC. A certification as an Aero Psychological Examiner or as Aviation Psychologist would assure at least a standardization of criteria and methods. - Our association, AEPA, could assist either in providing adequate training for an "Aero Psychological Examiner" or in advising the Authorities in these issues.
response	*Noted*
	A psychological examination is not required to be done on a routine basis to determine fitness to fly. The larger percentage of pilots will never undergo any psychological assessment except for an operator who requires a psychological assessment as part of entry procedure for pilots or re-assessments for career reasons. A pschological assessment as part of an aeromedical assessment is done e.g. in cases of suspected alcohol/drug/substance dependency and as such part of a medical examination.

comment	*2453*	comment by: *AEPA, Asociación Española de Psicología de la Aviación Civil*
	Proposal for solution **MED.B.055 Psychology (for class 1 and 2, and for the Leisure Pilot License (LPL)** (a) Applicants shall have no established psychological deficiencies (operational aptitudes, memory, attention, etc) or mental disability, particularly in operational aptitudes or any relevant personality factor, which are likely to	

	interfere with the safe exercise of the privileges of the applicable licence(s). (b) When the authority receives verifiable information from an identifiable source which evokes doubts concerning the mental fitness, behaviour or personality of a particular individual a psychological evaluation may be required. Sources for this information can be accidents or incidents, problems in training or proficiency checks, delinquency or knowledge relevant to the safe exercise of the privileges of the applicable licences (c) Psychological evaluation must be mandatory and it has to be done by a psychologist who is entitled to do such evaluation through applicable European law or, in the absence of European law, the national law of such state where the authority (represented by the AMS, the AMC or the AME) requiring the evaluation is located. Such psychologist must have demonstrated sufficient knowledge and publishes it in an adequate way. The relevant authority has to run a list of such psychologists and to publish it in an adequate way. The psychologist shall submit to the relevant authority a written report detailing assessment results and recommendations.
response	*Not accepted*
	The basis of this NPA is JAR-FCL 3 and ICAO Annex 1. Neither of these requires mandatory psychological assessments, this is why they are not introduced in Part MED. Also see responses to comments No 1140, 2451 and 2452.

C. Draft Opinion Part-MED - Subpart B: Requirements for Medical Certificates - Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.060: Neurology p. 15

comment	*86*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **Med to B 005** **Page**: 9ff Relevant Text: Referring to licensing authority **Comment**: Not possible due to lack of qualified medical personal and medical confidentiality **Proposal**: According to national law referred pilots shall be examined by AME class I or AMC	
response	*Noted*	
	Duplication of comment.	

comment	*442*	comment by: *UK CAA*
	MED.B.060 (c) (1) **Comment:** Text change to clarify. **Justification:** Clarity. **Proposed Text:** Replace `and without ` with `**or without recurrence off all'.**	
response	*Not accepted*	
	Change wording "...without treatment..." to "...without recurrence of all treatment..." does not provide additional clarity.	

comment	*536*	comment by: *British Microlight Aircraft Association*
	(a) strongly agree (b) accepted (c) accepted	
response	*Noted*	
	Thank you for the positive comment.	

comment	*602*	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. Jürgen Kriebel Section: 2 AMC A to MED.B.060 NEUROLOGY - class 1 medical certificates 3.2 **Page**: Relevant Text:: 3.2. Clinical EEG abnormalities: Epileptiform paroxymal EEG abnormalities and focal slow waves should be disqualifying. **Comment**: Sometimes focal slow waves are not clinically relevant residuals e.g after head injuries or successfully treated ischemic or infectious disorders. **Proposal**: Epileptiform paroxymal EEG abnormalities should be disqualifying. Focal slow waves, especially if not over temporal leads need further specialist evaluation.	

response	*Not accepted*
	The NPA text is:"Applicants with ... epileptiform EEG abnormalities and focal slow waves ... shall undergo further evaluation before a fit assessment can be considered." This evaluation should discover clinically irrelevant residuals.

comment	*853*	comment by: *Swiss Association of Aviation Medecine*
	Comment: Focal slow waves e.g. after head trauma or successfully treated diseases are in some cases waiverable **Proposal**: Epileptiform paroxysmal EEG abnormalities and focal slow waves (delete) should be disqualifying. Focal slow waves should undergo neurological evaluation.	
response	*Not accepted*	
	See response to comment No 602.	

comment	*868*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM) - Group Neurology Psychiatry- **Section: 2** **Subpart B** **Requirements for class 1 and class 2 medical certificates** **MED.B.060 Neurology:** **No comment!** **Page**: 14 -15 **Relevant Text:** **Comment**: **Proposal**:	
response	*Noted*	
	There is no comment.	

comment	*1590*	comment by: *DGAC FRANCE*
	MED B 060 Neurology COMMENT : **It's better to keep the decision to be taken by the authority like in JAR**	

FCL 3

Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained.

As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid contentious cases with AME's or AMC's which takes a lot of time to treat.

It is also important for authorities to have an homogeneous feed back of these kind of decisions to improve the rules in the future.

Give privileges to class 2 AME's to issue all medical certificates even those with one or more limitations instead of the licensing authority is dangerous for harmonisation of decisions throughout EU and associated countries and against equity principles**.** This should remain the duty of the licensing authority

Justification : Decisions will not be homogeneous and standardisation of the decisions between states will be never obtained.

As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

MODIFICATION :

MED B 060 Neurology

c) Applicants with an established history or clinical diagnosis of :

(1) .....etc

shall undergo further evaluation before a fit assessment can be considered. Applicants for **a class 1 and 2** medical certificate shall be referred to the licensing authority.

response *Noted*

Duplication of comment.

comment *2179* comment by: *Dr.Piek Armin*

With regard to medical pilots examination we should go back to the rootes and

	examine as we have learned it; we didn't do so bad a job before JAAR
response	*Noted*

C. Draft Opinion Part-MED - Subpart B: Requirements for Medical Certificates - Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.065: Visual System p. 15-16

comment	*6*	comment by: *GEMA*
	(j)(5) Algo tendrá que usar si quiere ver!	
response	*Noted*	

comment	*54*	comment by: *David Storch*
	Attachments #13 #14	
	My name is David Storch from Germany and I am a licenced private pilot under U.S. / FAA regulations with a valid and current class III medical. Due to my monocular view (-> no vision in left eye) I never had a chance to receive a medical certificate in Germany or under JAR-FCL rules in general. This is the reason why I finally gained my licence under US law, where such a physical condition requires a special assessment including a special flight test and leading to a waiver, called Statement of Demonstrated Abilities (SODA). Such a SODA doesn't expire for the class of medical issued. Therefore, I am very happy to read that in the current draft of the EASA regarding medical certicates, a person with substandard vision in one eye might be considered for the issuance of a class II medical. You may find it interesting to hear that in the U.S., there are 209 airline pilots with a class I and 476 commercial pilots with a class II medical flying with vision in one eye only (see attached file). I would appreciate if EASA took me as a positive example and consider people with monocular vision for medical certification, any class. If you have any more questions regarding my case, you are highly welcome to contact me. Thanks for reading. David Storch Frankfurt am Main / Germany June 2008	
response	*Noted*	
	Thank you for the information.	

comment	66	comment by: *Dr Graham Cresswell, chief medical officer, bmi*
	MED.B.065 (c) (3) and (e) This prohibits monocular pilots from holding a Class 1 certificate. There is plenty of experience worldwide of monocular or amblyopic pilots operating safely and without difficulty. If anything, acquired monocularity is more problematic than monocularity established in infancy. All MED.B.065 paragraphs from (e) onwards are specific prohibitions that should be in AMC so that it is possible to respond to medical advances that may mitigate risk. This philosophy should apply to the whole document.	
response	*Not accepted*	
	JAR-FCL-3 formed the basis for this NPA. Further changes may be considered in the rulemaking task MED.001. Already, some requirements of JAR-FCL-3 have been moved to AMC material but a proper balance between IRs and AMC must be kept. The Agency believes that this has been achieved in the field of ophthalmologyby by removing firm unfitness critera from the rules. The conditions (not only) from (e) onwards in IR are mentioned to garantuee the specific assessment and to provide a hook for further provisions in the AMC.	

comment	106	comment by: *Daniel Noll*
	This point is well regulated. A commercial pilot should have a visual acuity 6/6 because he is responsible for many lives. A private pilot should have a visual acuity 0.7 (70%), like a car driver. I hope this point will be adopted into the final regulation like he is in this draft, because there is no reason for setting higher limits then for a car driver in visual acuity for private pilots.	
response	*Noted*	
	Thank you for your comment.	

comment	126	comment by: *Civil Aviation Authority - The Netherlands*
response	*Noted*	
	No comment visible under this number	

comment	127	comment by: *Civil Aviation Authority - The Netherlands*
	MED.B.065, onder b, tweede lid, onder i. (Blz. 15 van 66) De CAA-The Netherlands acht een routine oogonderzoek voor een initiële afgifte van een medisch klasse 2 certificaat onvoldoende. Een uitgebreid onderzoek zou	

moeten zijn vereist.

MED.B.065, onder c, tweede lid. (Blz. 15 van 66)
De CAA-The Netherlands acht de eis van "6/9 of beter" te licht. Om veiligheidsredenen kan volgens de CAA-The Netherlands niet minder worden geëist dan een "visual acquity" van 6/6 (1.0) met twee ogen. De CAA-The Netherlands verzoekt om het voorschrift conform Nederlandse opvatting aan te passen.

MED.B.065, onder j, vijfde lid. (Blz. 15 van 66)

Uit het voorschrift blijkt niet wat met "large" wordt bedoeld. Dit blijkt ook niet uit de AMC. De CAA-The Netherlands is van mening dat dergelijke vage begrippen zo veel als mogelijk gemeden moeten worden. De CAA-The Netherlands verzoekt dan ook om het woord "large" met cijfers te omschrijven.

response *Partially accepted*

The class 2 requirements have been adapted to ICAO Annex 1 SARPs. Even the wording in the NPA Part MED could be read as going above ICAO 6.4.3 where no regular eye examinations are required.

MED.B.065, onder c, tweede lid - The class 2 requirements were adapted to ICAO Annex 1 SARPs where under 6.4.3.2 the binocular visual acuity is required to be 6/9 or better.

MED.B.065, onder j, vijfde lid - Partially accepted. A clarification will be added in the AMC.

comment *171* comment by: *Joanne Debono*

My question is regarding refractive eye surgery. I have had Lasik done over 5 years ago and my eye sight then exceeded the -6 limit. Today, I have stable vision with no complications and can pass Class 1 Medical unless there is a restriciton. The only factor stopping me from getting a JAR class 1 is that the requirements state that pre- surgery the eye sight cannot exceed +5 to -6 diopters. Currently and as I understood even the proposal state in Clause 9 Page 45 of NPA No 200817C that:

9. *Eye surgery*
9.1. After refractive surgery, a fit assessment may be considered provided that:
(i) preoperative refraction was no greater than +5 or -6 dioptres;

which means there are no changes unless I understood differently as in Page 15 MED.B.065, it states nothing about limits but only:

(f) Applicants who have undergone refractive surgery may be assessed as fit subject to satisfactory ophthalmic evaluation.

Considering the above may I ask:

1. Why is the intial medical test requirement for Class 1 limited to -6 prior to

	refractive surgery? 2. If my eye sight is good and I have no complications post surgery, why should I be neglected from studying for an airline pilot? 3 If during renewal, pilots who exceed the -6 diopters are considered anyhow, why should I be discriminated through the initial test? **I hope that visual limit requirements for an initial Class 1 will be increased or left to the discression of the opthalmist after professionally checking current vision, especially if refractive surgery took place and vision is stable and within limits.** I thank you in advance for your reply.
response	*Noted*
	Refractive surgery does not change the anatomy of the eye. High myopia (> -6dpt) can lead to complications especially retinal and intraocular pressure problems. Myopia tends to increase until around age 30. So the amount of finally stabalized myopia can be judged.

comment	*289*	comment by: *Lufthansa German Airlines*
	Author: Dr. Esther Stahl-Buhl AMC Frankfurt **Section**: 2 **Class 1** 1) Subpart B - Requirements for medical certificates MED.B.065 c (2) 2) AMC A to MED.B.065 6.1 **Page**: 16 and 46 **Relevant Text:** 1) An applicant with substandard vision in one eye may be assessed as fit subject to satisfactory ophthalmic assessment 2) Applicants with reduced central vision in one eye may be assessed as fit if the binocular visual field is normal and the underlying pathology is acceptable according to ophthalmic assessment. II: The better eye achieves distant visual acuity of 6/6 (1.0) corrected or uncorrected III: in the case of acute loss of vision in one eye, a period of adaptation time has passed from the known point of visual loss, during which the pilot is assessed as unfit.	
response	*Noted*	
	Unfortunately the comment is missing.	

comment	*290*	comment by: *Lufthansa German Airlines*

Author: Dr. Esther Stahl-Buhl, AMC Frankfurt
Section: 1
Subpart B

- 1) MED.B.065

g (3)

- 2) AMC to MED.B.065

7
Page: 16 and 46

Relevant Text:

- 1) Applicants for class 1 medical certificate with a clinical diagnosis of keratoconus may be assessed as fit subject to a satisfactory examination by an ophthalmologist.

- 2) *Keratoconus:*

Applicants with keratoconus may be considered for a fit assessment, if the visual requirements are met with the use of corrective lenses and periodic review is undertaken by an ophthalmologist.

Comment:
If applicants for class 1 can be assessed as fit with the clinical diagnosis of keratoconus, we will "produce" a considerable amount of pilots, who will for sure later on have to be assessed as unfit, as even with contact lenses their visual requirements will not be sufficient any longer. Should we discuss this?

response *Noted*

The present view is that fitness is determined for the validity period of the medical certificate. The AME should inform the pilot that his/her fitness may not continue depending on the development of a known condition (e.g. keratoconus).

comment *299* comment by: *Lufthansa German Airlines*

Author: Dr. Esther Stahl-Buhl, AMC Frankfurt
Section: 1
Subpart B
Class 2
MED.B.065
2
Page: 16

Relevant Text:
A routine eye examination shall form part of the initial and all revalidation and renewal examinations.

Comment:

Proposal:
The initial examination should be a comprehensive eye examination performed by an ophthalmologist. Reason: A lot of problems we usually run into later on can be

	prevented by checking properly at the first exam. E.g. strabism, glaucoma, monocularity...
response	*Not accepted*
	The medical requirements for Class 2 have been adapted to ICAO 6.4.3 which does not require the applicant to undergo specific ophthalmological examinations.

comment	*334*	comment by: *FOCA Switzerland*
	MED.B.065 (g) In case of Keratoconus it may be difficult to support rigid contact lenses in dry environment of a cockpit. These pilot depend on correct correcton of their condition. They should be assessed only as fit if they fulfill the requirements also with glasses when they remove the lenses. Proposed text: **Add: "as long as .....removing the lenses": Applicants for class 1 medical certificate with clinical diagnosis of keratoconus may be assessed as fit subject to a satisfactory examination by an ophthalmologist as long as they fulfill all visual requirements as well with glasses after removing the lenses**.	
response	*Noted*	
	The rule does not require a pilot with keratoconus to wear rigid contact lenses. In the AMC it is stated that an applicant with keratoconus must meet the requirements "with the use of corrective lenses". Corrective lenses could be spectacles. This was the wording in Appendix 13 of JAR-FCL 3 and will remain unchanged for the time being.	

comment	*335*	comment by: *FOCA Switzerland*
	MED.B.065 (h) Applicants with minor astigmatism or anisometropia should not need in every case an opthalmologic evaluation. An ophtalmologic evaluation should only be mandatory if the applicant is outside the limits, if he has symptoms or if the visual function has deteriorated since the last exam, but not if he is stable, symptomless and best corrected. Proposed Text: **(h) Applicants with astigmatism or anisometropia within limits mentioned in AMC A to MED .B.065 4.1 may be assessed as fit by the AeMC or the AME. A fitness assessment by an ophthalmolgist is necessary at initial and in case of deterioration since the previous exam or in case of asthenopic problems**.	
response	*Partially accepted*	
	The comment is not well understood because the wording under MED.B.065 (h) is: "Applicants with (1) astigmatism; or (2) anisometropia may be assessed as fit subject to satisfactory ophthalmic evaluation." This requirement does not say that additional eye examinations have to be performed at each aero-medical examination.	

AMC A to MED.B.060 will be amended under 4.3 to clarify the issue

comment	443	comment by: UK CAA
	MED.B.065 (e) **Comment:** Need to retain equivalent wording to that agreed in JAR FCL 3.220 (6) (c). **Justification:** Normal visual fields and normal binocular function are not clearly defined and are frequently contentious and open to challenge. The JAR FCL 3 text more accurately describes the type of visual field or binocular function defect that should not be permitted. **Proposed Text:** Amend wording to '**Applicants for a class 1 medical certificate shall not have a significant defect of visual fields or binocular function'**.	
response	*Not accepted*	
	JAR-FCL 3.220 (c) has no further subparagraphs. The text is: "An applicant with significant defects of binocular vision shall be assessed as unfit." JAR-FCL 3.220 (f) states: "An applicant with abnormal visual fields shall be assessed as unfit." In order to retain equivalent JAR-FCL 3 wording MED.B.065 (e) would have to be be amended to: "An applicant with significant defects of binocular vision or abnormal visual fields shall be assessed as unfit". This does not seem appropriate. Another reference to visual field_ is in Appendix 13 of JAR-FCL 3 under paragraph (6)(b) in a slightly different context than in MED.B.065(e) : "Applicants with central vision in one eye below the limits .... may be assessed as fit at revalidation or renewal for Class 1 if the binocular visual field is normal and the underlying pathology is acceptable..." However, this does not seem to meet the intention of MED.B.065 (e).	

comment	537	comment by: British Microlight Aircraft Association
	(a) strongly agree (b) (1) accepted (2) accepted (c) (d) (e) (f) accepted (g) (h)	

	(i) (j) accepted
response	*Noted*
	Thank you for your comment.

comment	604	comment by: *Lufthansa German Airlines*

Author: Dr. Esther Stahl-Buhl, AMC Frankfurt
Section: 1 + 2

- 1) Requirements for Medical Certificates

Subpart B
MED.B.065 - visual system - h 1-2 section 2
2) AMC A to MED.B.065 - 4.2 section 1
Page: 16 and 45

Relevant Text:
(h) Applicants with astigmatism or anisometropia may be assessed as fit subject to satisfactory ophthalmic evaluation.

At revalidation an applicant may be assessed as fit with:
(iii) Astigmatism exceeding 2.0 dioptres
(iv) Anisometropia exceeding 2.0 dioptres (contact lenses should be worn if the anisometropia exceeds 3.0 dioptres), provided that optimal correction has been considered and no significant pathology is demonstrated.

Comment:
Should we ask for a limit of astigmatism? Ask for an obligatory test of binocularity? Ask for an obligatory test of glare sensitivity and mesopic contrast sensitivity in these cases?

Should we really oblige pilots with anisometropia exceeding 3 dioptres to wear contact lenses, should it not be dealt according to what kind of correction is better tolerated by the pilot?
Should we not introduce the test of glare sensitivity and mesopic contrast sensitivity as integral part of the opthalmoglical examination when optic corrections with high values of astigmatism or aniseikonia are required?

(optic corrections with high values often impair glare sensitivity.) Also I think in cases of high values of astigmatism or aniseikonia it is very important to prove, that the pilot has binocularity, as this is often impaired.

Proposal:

response	*Noted*

comment	605	comment by: *Lufthansa German Airlines*

Author: Dr. Esther Stahl-Buhl, AMC Frankfurt
Section: 1

MED.B.065
c (2)
Page: 16

Relevant Text:
In the case of class 2 medical certificates 6/12 or better in each eye separately and visual acuity with both eyes shall be 6/9 or better. An applicant with substandard vision in one eye may be assessed as fit subject to satisfactory ophthalmic assessment.

Comment:

Proposal:
Visual acuity with both eyes should be 6/6!!

response *Not accepted*

The Class 2 requirements were adapted to ICAO Annex 1 SARPs where under 6.4.3.2 the binocular visual acuity shall be 6/9 or better.

comment *661* comment by: *ERA*

MED.B.065 Visual Systems

All MED.B.065 paragraphs from (c) (3) (e) onwards are specific prohibitions that should be in AMC so that it is possible to respond to medical advances that may mitigate risk. This philosophy should apply to the whole document

response *Not accepted*

See identical comment 66. Same response applies.

comment *829* comment by: *Thomas Cook Airlines UK*

Commentator: The UK Association of Aviation Medical Examiners

Paragraph: MED.B.065 Visual System

Page Numbers: 15,16

Comment: Consideration should be given to permit certain monocular pilots to hold a Class 1 medical certificate subject to detailed ophthalmic examination.

Justification: Flight safety has not been compromised in monocular pilots. Experienced aerobatic pilots with monocular vision are known and have shown extraordinary flying skills.

Proposed text: MED.B.065 Visual System Paragraph (c) (3) Applicants for an initial class 1 medical certificate with long standing and stable substandard vision in one eye may be assessed as fit subject to satisfactory ophthalmic assessment.

	(e) Applicants for a class 1 medical certificate shall be required to have normal fields of vision and normal binocular function except for those pilots with stable and long established monocular vision who shall be subject to detailed ophthalmic assessment.
response	*Not accepted*

comment	*833*	comment by: *Thomas Cook Airlines UK*
	Clarification of the extended ophthalmic examination is required in this section.	
response	*Noted*	
	The comprehensive eye examination is described in AMC A to MED.B.065 (2).	

comment	*931*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author: European Society of Space and Aviation Medicine (ESAM)- Group Ophthalmology -

Section: 2
Class 1
1) Subpart B - Requirements for medical certificates
MED.B.065
c (2)
2) AMC A to MED.B.065
6.1

Page: 16 and 46

Relevant Text:
1) An applicant with substandard vision in one eye may be assessed as fit subject to satisfactory ophthalmic assessment

2) Applicants with reduced central vision in one eye may be assessed as fit if the binocular visual field is normal and the underlying pathology is acceptable according to ophthalmic assessment.

II: The better eye achieves distant visual acuity of 6/6 (1.0) corrected or uncorrected
III: in the case of acute loss of vision in one eye, a period of adaptation time has passed from the known point of visual loss, during which the pilot is assessed as unfit.

Comment:
Substandard Vision in one eye can mean monocularity, or functional monocularity or severe amblyopia.
The reduced vision has a major impact on visual functions as the binocular vision is a summation of visual functions of both eyes.
Nearly all thresholds of monocular visual function are with normal binocular vision better than monocular.
The absolute threshold for light is 1,5-1,8 times better

	The contrast recognition is 1,5-1,7 times better The resolution is 1,1 times better The recognition of moving stimulus is 1,9 times better. The visual field is reduced. The blind spot can mostly not be compensated. Dille and Booze published in 1979 (1974-1976) the "Accident experience of civilian pilots with static physical defects", FAA Office of Aviation Medicine Report No. AM-79-19, 77-20, 76-7. They showed that pilots with blindness or absence of one eye had significantly higher accident observed-to-expected ratios and higher rates per 100.000 hours. Airmen with deficient distant vision had significantly higher observed-to-expected ratios and higher rates per 100.000 hours (0,001). In 1984 Dille and Booze published "The 1980 and 1981 Accident Experience of Civil Airmen with Selected Visual Pathology", Aviat. Space Environ. Med. 1984: 55:966-9 In the years 1980 and 1981 monocular and amblyopic airmen had higher accident rates than the total airmen population. Mayer and Lane published in 1973 "Monocular Pilots - a Follow-up Study", Aerosp. Med. 44: 1070-1074. The number of monocular pilots who applied for a student pilot license after having obtained a waiver was proportionately less (84%) than the number of controls who applied (91%). More monocular pilots than control pilots became endorsed on more than one aircraft. There is a suspicion, that monocular pilots were involved in somewhat more hazardous events than control pilots. The decision of the monocularity working group of the JAA was that monocularity in a class 1 applicant or the pilot is not acceptable. Therefor it is essential to implement the sentence" Monocularity is not acceptable for a class 1 applicant" into the "Implementing Rules". **Proposal**: Monocularity is not acceptable for a class 1 applicant. Initial applicants for class 1 medical certificate with reduced central vision should be assessed as unfit. At revalidation applicants for a class 1 medical certificate with a substandard vision of 0.5 (6/12) or better in one eye can be assessed as fit. In this case the visual acuity of the better eye should be at least 1.0 uncorrected or corrected. However a comprehensive eye examination and evaluation have to be performed for a fit assessment.
response	*Noted*
	Monocularity In our proposed rule only initial class 1 applicants are not acceptable. The requirement is transposed from JAR-FCL-3. Reduced central vision Issue is covered by MED.B.065(a). Substandard vision

Issue is covered by AMC A to MED.B.065 (6).

comment	933	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author: European Society of Space and Aviation Medicine (ESAM)- Group Ophthalmology -

Section: 2
Class 2
1) Subpart B - Requirements for medical certificates
MED.B.065
c (2)
2) AMC A to MED.B.065
6.1

Page: 16 and 57

Relevant Text:
(c) (2) In the case of class 2 medical certificates, 6/12 or better in each eye separately and visual acuity with both eyes shall be 6/9 or better. An applicant with substandard vision in one eye may be assessed as fit subject to a satisfactory ophthalmic assessment.

4. Substandard Vision
4.1 Reduced stereopsis, abnormal convergence not interfering with near vision and ocular misalignment where the fusional reserves are sufficient to prevent asthenopia and diplopia may be acceptable.

Comment:
Substandard Vision in one eye can mean monocularity, or functional monocularity, or severe amblyopia.
The reduced vision is a major impact on visual functions as the binocular vision is a summation of visual functions of both eyes.
Nearly all thresholds of monocular visual function are with normal binocular vision better than monocular
The absolute threshold for light is 1,5-1,8 times better
The contrast recognition is 1,5-1,7 times better
The resolution is 1,1 times better
The recognition of moving stimulus is 1,9 times better.

The visual field is reduced.
The blind spot can mostly not be compensated.

Dille and Booze published in 1979 (1974-1976) the "Accident experience of civilian pilots with static physical defects", FAA Office of Aviation Medicine Report No. AM-79-19, 77-20, 76-7. They showed that pilots with blindness or absence of one eye had significantly higher accident observed-to-expected ratios and higher rates per 100.000 hours. Airmen with deficient distant vision had significantly higher observed-to-expected ratios and higher rates per 100.000 hours (0,001).

In 1984 Dille and Booze published "The 1980 and 1981 Accident Experience of

Civil Airmen with Selected Visual Pathology", Aviat. Space Environ. Med. 1984: 55:966-9
In the years 1980 and 1981 monocular and amblyopic airmen had higher accident rates than did the total airmen population.

Mayer and Lane published in 1973 "Monocular Pilots - a Follow-up Study", Aerosp. Med. 44: 1070-1074. The number of monocular pilots who applied for a student pilot license after having obtained a waiver was proportionately less (84%) than the number of controls who applied (91%). More monocular pilots than control pilots became endorsed on more than one aircraft. There is a suspicion, that monocular pilots were involved in somewhat more hazardous events than control pilots.

The proposal is slightly above the requirements for car drivers who move in just two dimensions with additional clues that are usually not available in the air. A visual acuity of 0.3 is substandard vision or amblyopia.

Proposal:
Monocularity is not acceptable for an initial class 2 applicant certification.
In the case of a substandard vision in a class 2 applicant, one eye should have a visual acuity of at least 0.5 (6/12) with or without correction and the better other eye at least 0.5 (6/12) uncorrected or corrected. Visual acuity with both eyes shall be 1.0 (6/6)!! or better uncorrected or corrected. Ocular misalignment where the fusional reserves are sufficient to prevent asthenopia and diplopia may be acceptable. Binocular vision shall be normal.

response *Noted*

Same comment as comment No 931, here for class 2.

comment *935* comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author: **European Society of Space and Aviation Medicine (ESAM**) **-Group Ophthalmology-**

Section: 1
AMC B to MED 0.65 (j)

Page: 16

Relevant Text:
(j) Spectacles and contact lenses
If satisfactory visual function is achieved only with the use of correction:
(1)... (7)

Comment:
There exist cockpit windshields in aviation which are polarized. If someone wears sunglasses which are also polarized, but in a 90° direction to the polarization of the windshield this person sees only black through the sunglasses which means the person sees nothing. To avoid that and because there is very often the need for sunglasses in flying sunglasses shall not have polarized glasses.

	Proposal: (j) Spectacles and contact lenses If satisfactory visual function is achieved only with the use of correction: (8) There shall be NO! use of polarized sunglasses, photochromatic sunglasses and NO use of prismatic glasses.
response	*Partially accepted*
	This comment will be taken into account in the AMCs.

comment	*937*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM)- Group Ophthalmology - **Section:** 1 Subpart B **Class 2** MED.B.065 2 **Page**: 16 **Relevant Text:** A routine eye examination shall form part of the initial and all revalidation and renewal examinations. **Comment**: The initial examination should be a comprehensive eye examination performed by an ophthalmologist. Reason: A lot of problems we usually run into later during two examinations can be prevented by checking properly at the first exam. E.g. strabism, decompensated heterophoria, diplopia, glaucoma, monocularity... Besides in the U.K. no general practitioners are trained to do an eye examination. Especially at the initial examination diseases or risk factors that could cause in-flight problems could be seen and additional restrictions or examinations can become necessary. **Proposal**: A comprehensive eye examination shall be performed by an ophthalmologist and shall be part of the initial examination.	
response	*Noted*	
	Please see response to comment No 299.	

comment	*938*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM)- Group Ophthalmology - **Section: 1** **Subpart B**	

	•**1) MED.B.065 g (3)** •**2) AMC to MED.B.065 7** **Page: 16,** and 46 and page 57 **Relevant Text:** •**1**) Applicants for class 1 medical certificate with a clinical diagnosis of keratoconus may be assessed as fit subject to a satisfactory examination by an ophthalmologist. •2) *Keratoconus:* Applicants with keratoconus may be considered for a fit assessment, if the visual requirements are met with the use of corrective lenses and periodic review is undertaken by an ophthalmologist. 3) No text concerning keratoconus in class 2 was found on page 57. Comment: If applicants for class 1 and 2 can be assessed as fit with the clinical diagnosis of keratoconus, we will "produce" a considerable amount of pilots, who will for sure later on have to be assessed as unfit, as even with contact lenses their visual requirements will not be sufficient any longer. Many eyes with keratoconus in young patients will end in keratoplasty which also makes unfit. Proposal: Applicants class 1 and class 2! with the diagnosis of keratoconus are assessed as unfit. At revalidation examination applicants for a class 1 and class 2 medical certificate with a clinical diagnosis of keratoconus may be assessed as fit subject to a satisfactory examination by an ophthalmologist. •1) *Keratoconus:* At renewal examinations applicants with keratoconus may be considered for a fit assessment, if the visual requirements are met with the use of corrective lenses and at least a yearly examination is undertaken by an ophthalmologist.
response	*Noted*
	Please see response to comment No 290.

comment	*941*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM) - Group Ophthalmology- **Section:** 1 Subpart B • 1) MED.B.065 g (3) • 2) AMC to MED.B.065 7	

Page: **16** and 46

Relevant Text:

- 1) Applicants for class 1 medical certificate with a clinical diagnosis of keratoconus may be assessed as fit subject to a satisfactory examination by an ophthalmologist.
- 2) *Keratoconus:*

Applicants with keratoconus may be considered for a fit assessment, if the visual requirements are met with the use of corrective lenses and periodic review is undertaken by an ophthalmologist.

Comment:
If applicants for class 1 can be assessed as fit with the clinical diagnosis of keratoconus, we will "produce" a considerable amount of pilots, who will for sure later on have to be assessed as unfit, as even with contact lenses their visual requirements will not be sufficient any longer. Should we discuss this?
Most eyes with keratoconus in young patients will end in keratoplasty which also makes unfit.

Proposal:

- 1) Applicants class 1 and class 2! with the diagnosis of keratoconus are assessed as unfit. At revalidation examination applicants for a class 1 and class 2 medical certificate with a clinical diagnosis of keratoconus may be assessed as fit subject to a satisfactory examination by an ophthalmologist.
- 2) *Keratoconus:*

Applicants with keratoconus may be considered for a fit assessment, if the visual requirements are met with the use of corrective lenses and at least a yearly examination is undertaken by an ophthalmologist.

response | *Noted*

See response to comment No 290.

comment | *943* | comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author: European Society of Space and Aviation Medicine (ESAM)- Group Ophthalmology -

Section: 1
MED.B.065
(d)

Page: 15

Relevant Text:
(b) (i) a comprehensive eye examination shall form part of the initial examination

	and be undertaken periodically depending on the refraction and the functional performance of the eye; **Comment**: A comprehensive eye examination should be performed at least every 5 years. 'Otherwise there is little chance to detect pathological conditions, which cause in-flight problems, early enough . Any intraocular changes can only be detected by ophthalmologists. Intraocular changes or pathological findings may be present, although vision acuity still meets requirements. **Proposal**: A comprehensive eye examination shall form part of the initial examination and shall be undertaken every 60 months. If the condition of the eye requires more frequent eye examinations by an ophthalmologist a comprehensive eye examination shall be performed at a more frequent interval decided by an AME and or ophthalmologist.
response	*Noted*
	The issue is covered in AMC A to MED.B.065 2, 4.3 and 4.4.

comment	*944*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM)- Group Ophthalmology - **Section:** 1 MED.B.065 **Page**: 16 **Relevant Text:** (2) For a class 2 medical certificate (i) a routine eye examination shall form part of the initial and all revalidation and renewal examinations **Comment**: A lot of problems we run into later on, could be prevented, if the initial examination was a comprehensive one. General practitioners are in no way trained to perform a thorough eye exam. They cannot detect diseases or risk factors that could cause in-flight problems later. They also cannot see, which ophthalmological condition needs additional restrictions or additional eye examinations. **Proposal**: For a class 2 medical certificate a comprehensive eye examination shall form part of the initial examination and if required.	
response	*Noted*	
	Please see response to comment No 299.	

comment	1021	comment by: Jan Speidel
	MED.B.065 (c) (3): General: Private Pilots with valid class 2 medical and significant flying experience should not be treated as an "applicant for an initial class 1 medical" but as an "applicant for revalidation" Explanation: It is common sense that flying experience can compensate for many medical deficiencies, for example substandard vision in one eye. For that reason there exists AMC A to MED.B065 paragraph 6 (substandard vision, class 1) and AMC B to MED.B.065 paragraph 4 (substandard vision, class 2). But what about a private pilot (holding a valid class 2 medical) with substandard vision who has significant flying experience and now wants to turn his hobby into a profession (i.e. becoming a commercial pilot)? Hundreds of hours in his log book do not help him to get a class 1 medical, whereas professional pilots who develop substandard vision after initial class 1 medical issuance have a real chance to keep their class 1 medical, even though they do not have more flight experience or better eye vision than the aforementioned private pilot. Therefore I suggest to change MED.B.065 (c) (3) to: "Applicants for an initial class 1 medical certificate with substandard vision in one eye may be assesed as fit if the applicant holds a valid class 2 medical certificate and possesses significant flying experience and if the applicant's substandard vision is unlikely to interfere with safe exercise of the license held. At revalidation, applicants with acquired substandard vision in one eye may be assessed as fit if it is unlikely to interfere with safe exercise of the license held." Kind regards, Jan Speidel	
response	*Not accepted*	
	The NPA Part Medical (class 1) contains the requirements transposed from JAR-FCL 3. There is no reference in JAR-FCL 3 that aeromedical assessments for class 1 can be based on medical certificates for class 2.	

comment	1121	comment by: BALPA
	MED.B.065 Visual System (j) *Spectacles and contact lenses.* If satisfactory visual function is achieved only with the use of correction: (1) spectacles or contact lenses shall be worn whilst exercising the privileges of the applicable licence(s);	

(2) a spare set of similarly correcting spectacles shall be readily available for immediate use whilst exercising the privileges of the applicable licence(s)

At present, a near vision restriction (VNL) only requires that the pilot have one pair of correcting lenses available and these are worn only when required rather than 'shall be worn'. The current position should be maintained.

Suggested replacement text:
(1) spectacles or contact lenses shall be worn whilst exercising the privileges of the applicable licence(s) except in the case of near vision restriction (VNL) only, the pilot shall have correcting lenses available.

response *Partially accepted*

Clarification on glasses "to correct"/ "to be available" for near vision only will be added to the AMC

comment *1339* comment by: *ophtalmologie aerospace medecin*

Comment:
If applicants for class 1 and 2 can be assessed as fit with the clinical diagnosis of keratoconus, we will "produce" a considerable amount of pilots, who will for sure later on have to be assessed as unfit, as even with contact lenses their visual requirements will not be sufficient any longer. Many eyes with keratoconus in young patients will end in keratoplasty which also makes unfit.

Proposal:
Applicants class 1 and class 2! with the diagnosis of keratoconus are assessed as unfit. At revalidation examination applicants for a class 1 and class 2 medical certificate with a clinical diagnosis of keratoconus may be assessed as fit subject to a satisfactory examination by an ophthalmologist.

1) *Keratoconus:*
At renewal examinations applicants with keratoconus may be considered for a fit assessment, if the visual requirements are met with the use of corrective lenses and at least a yearly examination is undertaken by an ophthalmologist.

response *Noted*

See response to comment No 290.

comment *1344* comment by: *Dr. Raphael Diepgen*

In (e) there is a requirement of "normal" binocular function. "Normality" is a statistical category, not a legal category. "Normal" means only that most of the people have it. But for the purpose of legal medical requirements for pilots it doesn´t matter if a function is "normal" or not. The only question is: Is a function necessary for the job of a pilot - or not? Obviously there are several "normal" binocular functions - binocularity, binocular summary, binocular fusion, static stereoscopic vision, dynamic stereoscopic vision, the absense (of diplopia, convergence, ... - but only a few of these "normal" binocular functions are

	necessary for the visual tasks of an airplane pilot. For example: Static stereoscopic vision is not necessary for the spatial visual orientation of a pilot, because it works only for short distances of some metres. In fact these spatial visual orientation of a pilot relies only on monocular cues. There is some evidence that pilots congenital without stereoscopic vision have a better spatial vision than "normal" pilots due to a better sensibility for monocular cues. For details see: Diepgen, R.: Brauchen Piloten Stereosehen? *Klinische Monatsblätter für Augenheilkunde 201*, 1993, 94-101; Diepgen, R.: Räumliches Sehen bei Piloten von Flächenflugzeugen - Ein Literaturüberblick. *Zeitschrift für Flugwissenschaften und Weltraumforschung 17*, 1993, 331-342. So it is not justified to require "normal" binocular vision without a specification of the really necessary binocular (sub)functions - if there are any. Beside this: In (i) there is the special requirement of the absence of diplopia - this would be redundant because obviously it is part of "normal" binocular function. The same argument works with respect to the limits for heterophoria in AMC A to MED.B.065 No. 8. And due to AMC A to MED.B.065 No. 6.2. fitness can be assessed in the case of functional monocularity and uniocularity: This would be a contradiction to the required "normal" binocular function in (e).
response	*Noted*
	Thank you for your comment.

comment	*1360*	comment by: *ophtalmologie aerospace medecin*
	Comment: A comprehensive eye examination should be performed at least every 5 years. ‘Otherwise there is little chance to detect pathological conditions, which cause in-flight problems, early enough . Any intraocular changes can only be detected by ophthalmologists. Intraocular changes or pathological findings may be present, although vision acuity still meets requirements. **Proposal**: A comprehensive eye examination shall form part of the initial examination and shall be undertaken every 60 months. If the condition of the eye requires more frequent eye examinations by an ophthalmologist a comprehensive eye examination shall be performed at a more frequent interval decided by an AME and or ophthalmologist.	
response	*Noted*	
	See response to comment No 943.	

comment	*1361*	comment by: *ophtalmologie aerospace medecin*
	Comment: A lot of problems we run into later on, could be prevented, if the initial examination was a comprehensive one. General practitioners are in no way trained to perform a thorough eye exam. They cannot detect diseases or risk factors that could cause in-flight problems later. They also cannot see, which ophthalmolical condition needs additional restrictions or additional eye	

	examinations. **Proposal**: For a class 2 medical certificate a comprehensive eye examination shall form part of the initial examination and if required.
response	*Noted*
	See response to comment No 937.

comment	*1578*	comment by: *FAA*
	MED.B.065: U.S. does not distinguish between "comprehensive", "routine", and "extended" eye examinations. U.S. eye examination does not include refraction. Differences with paragraphs (j) (2) and (j) (6) are on file with ICAO.	
response	*Noted*	
	Thank you for the information.	

comment	*1591*	comment by: *DGAC FRANCE*
	MED B 065 Visual System COMMENT : **It's better to keep the decision to be taken by the authority like in JAR FCL 3** Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained. As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid contentious cases with AME's or AMC's which takes a lot of time to treat. It is also important for authorities to have an homogeneous feed back of these kind of decisions to improve the rules in the future. Give privileges to class 2 AME's to issue all medical certificates even those with one or more limitations instead of the licensing authority is dangerous for harmonisation of decisions throughout EU and associated countries and against	

equity principles**.** This should remain the duty of the licensing authority

Justification : Decisions will not be homogeneous and standardisation of the decisions between states will be never obtained.

As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

MODIFICATION :

MED B 065 Visual System

c) Distant visual acuity, with or without correction, shall be :

(1).....etc
(2).....
(3) Applicants ~~for an initial class 1 medical certificate~~ with substandard vision in one eye ~~shall be assessed as unfit. At revalidation, applicants with acquired substandard vision in one eye~~ may be assessed as fit **by the licensing authority for class 1 and 2** if it is unlikely to interfere with safe exercise of the licence held**.**

g) (g) Applicants for a class 1 medical certificate with a clinical diagnosis of keratoconus may be assessed as fit ~~subject to a satisfactory examination by an ophthalmologist~~ ***by the licensing authority*****.**

response *Noted*

This comment by the same commenter has been answered in previous Sections.

comment *1612* comment by: *Dr Lilla Ungváry*

Relevant Text:
(b) (i) a comprehensive eye examination shall form part of the initial examination and be undertaken periodically depending on the refraction and the functional performance of the eye;

Comment:
A comprehensive eye examination should be performed at least every 5 years. 'Otherwise there is little chance to detect pathological conditions, which cause in-flight problems, early enough . Any intraocular changes can only be detected by ophthalmologists. Intraocular changes or pathological findings may be present, although vision acuity still meets requirements.

Proposal:
A comprehensive eye examination shall form part of the initial examination and shall be undertaken every 60 months. If the condition of the eye requires more

	frequent eye examinations by an ophthalmologist a comprehensive eye examination shall be performed at a more frequent interval decided by an AME and or ophthalmologist.
response	*Noted*
	See response to comment No 943.

comment	*1613*	comment by: *Dr Lilla Ungváry*
	Relevant Text: (2) For a class 2 medical certificate (i) a routine eye examination shall form part of the initial and all revalidation and renewal examinations **Comment**: A lot of problems we run into later on, could be prevented, if the initial examination was a comprehensive one. General practitioners are in no way trained to perform a thorough eye exam. They cannot detect diseases or risk factors that could cause in-flight problems later. They also cannot see, which ophthalmolical condition needs additional restrictions or additional eye examinations. **Proposal**: For a class 2 medical certificate a comprehensive eye examination shall form part of the initial examination and if required.	
response	*Noted*	
	See response to comment No 937.	

comment	*1877*	comment by: *ECA- European Cockpit Association*
	At the EASA workshop "From JARs to IRs", EASA requested feedback on the proposed differentiation between IR and AMC in the area of visual system. The proposed division in this area is acceptable.	
response	*Noted*	
	Thank you for your supporting comment.	

comment	*1943*	comment by: *International Air Transport Association (IATA)*
	Page 15 Med.B.065 (b) (1) (i) Comprehensive eye examination should probably be in the definitions or at least refer to page 44 where it is defined in details.	
response	*Noted*	

comment	*1952*	comment by: *Civil Aviation Authority of Norway*

	Comment to (c) (2):Class 2 pilots fly usually single pilot operations. There is no reason to accept reduced visual acuity of 6/9 or better with both eyes. The requirement for visual acuity with both eyes should therefore be 6/6 or better.
response	*Noted*
	Please see response to comment No 605.

comment	*2013*	comment by: *Dr. med. Hans Brandl*
	The second sentence in section (c) (3) should be deleted and replaced by the following wording: **"At revalidation, applicants with substandard vision in one eye may be assessed as fit with acquired visual acuity (sc/cc) better or equivalent to 6/12 (0,5) in the eye of substandard vision."** **The complete text in section (c) (3) should read as:** **(3) Applicants for an initial class 1 medical certificate with substandard vision in one eye shall be assessed as unfit. At revalidation, applicants with substandard vision in one eye may be assessed as fit with acquired visual acuity (sc/cc) better or equivalent to 6/12 (0,5) in the eye of substandard vision.**	
response	*Noted*	
	Issue is covered by AMC A to MED.B.065 (6).	

comment	*2019*	comment by: *Dr. med. Hans Brandl*
	The sentence in section (j) (5) **(5) applicants with a large refractive error shall use contact lenses or highindex spectacle lenses** **should be completely deleted.** **Rational:** **The sentence listed under (j) (3) (see below) is already a sufficient description of the allowed low vision aids.** **(3) the correction shall provide optimal visual function, be welltolerated and suitable for aviation purposes;**	
response	*Noted*	
	Please see response to comment No 127.	

comment	*2145*	comment by: *ECA- European Cockpit Association*
	Delete and replace word: (j) Spectacles and contact lenses. If satisfactory visual function is achieved only with the use of correction: (1) spectacles or contact lenses shall be ~~worn~~**available** whilst exercising the	

	privileges of the applicable licence(s); Justification: At the present only "have available" if required only for near vision. Would be advisable also for the new regulation
response	*Noted*
	Please see response to comment No 1121.

comment	*2311*	comment by: *DLR*
	A comprehensive eye examination should be performed at least every 5 years. 'Otherwise there is little chance to detect pathological conditions, which cause in-flight problems, early enough . Any intraocular changes can only be detected by ophthalmologists. Intraocular changes or pathological findings may be present, although vision acuity still meets requirements. Proposal: A comprehensive eye examination shall form part of the initial examination and shall be undertaken every 60 months. If the condition of the eye requires more frequent eye examinations by an ophthalmologist a comprehensive eye examination shall be performed at a more frequent interval decided by an AME and or ophthalmologist.	
response	*Noted*	
	See response to comment No 943.	

comment	*2320*	comment by: *David Miller*
	The current UK medical standards only require corrected vision to be tested with no requirement for each eye (with or without correction) to be tested seperately. The NPA states that "an applicant with substandard vision in one eye may be assessed as fit subject to satisfactory ophthalmic assessment" but the NPA does not state the criteria for this assessment.	
response	*Noted*	
	The criteria for visual acuity are in AMC A (class 1) and AMC B (class 2) to MED.065.	

comment	*2338*	comment by: *AMS CAA - Hungary*
	In Hungary we have favourable experiences we monocular pilots in CLass 1 and Class 2. For the national certification process we followed the FAA policy and pratices as You see below. We suggest to folow this kind of certification requirements by EASA as well. **Monocularity** The following is FAA policy regarding Monocular Vision:	

“Although it has been repeatedly demonstrated that binocular vision is not a prerequisite for flying, some aspects of depth perception, either by stereopsis or by monocular cues, are necessary. It take time for the monocular airman to develop the techniques to interpret the monocular cues that substitute for stereopsis; such as, the interposition of objects, convergence, geometrical perspective, distribution of light and shade, size of known objects, aerial perspective, and motion parallax.”

“In addition, it takes time for the monocular airman to compensate for his or her decrease in effective visual field. A monocular airman’s effective visual field is reduced by as much as 30%. This is especially important because of speed smear; i.e., the effect of speed diminishes the effective visual field such that normal visual field is decreased from 180 degrees to as narrow as 42 degrees or less as speed increases. A monocular airman’s already reduced effective visual field could be reduced to even less than 42 degrees by speed smear.”

“For the above reasons, a waiting period of six months is recommended to permit an adequate adjustment period for learning techniques to interpret monocular cues and accommodation to the reduction in the effective visual field.”

“An individual with one eye, effective visual acuity equivalent to monocular (i.e., best corrected distant visual acuity in the poorer eye is no better than 20/200), may be considered by the regional flight surgeons or the AMCD for any class medical certification through the special issuance provisions of FAR Part 67 if:

A six month period has elapsed to allow for adaptation to monocularity.
A complete evaluation by an eye specialist as reported of FAA ForM 8500-7, Report of Eye Evaluation, reveals no pathology of either eye which could affect the stability of the findings.
Uncorrected distant visual acuity in the better eye is 20/200 or better and is corrected to 20/20 or better by lenses of no greater power than plus or minus 3.5 diopters spherical equivalent.
Any applicant eligible for a medical certificate through special issuance under these guidelines shall pass a medical flight test…”

AMEs may issue a certificate to monocular pilots with the limitation of “Valid for student pilot purposes only,” provided the applicant meets the standards in the better eye.

response | *Noted*

Thank for this information.

comment | *2435* | comment by: *AOPA Sweden*

For special examinations of eyes and ears, it should be a possibility to go to a Eye or Ear doctor who is already experts on the ears and eyes(no special Aeromedical Eye or Ear doctor). Thereafter the protocol should be sent to the AME or the CAA

	(or approved organisation) to see if the applicant is approved for flight. In sweden, many pilots have to travel 250 or 500 km to do a aeromedical examination or ears or eyes.
response	*Noted*
	The Agency fully agrees with the view of the commenter. The Ophthalmologist or ENT specialist (or any other specialist physician or psychologist) are to assess the applicant in their field of competence and provide the AME or AeMC with the outcome of the examination. The AME will evaluate whether a fit assessment can be made, taking into account the result of specialist examinations. Part Medical does not oblige a pilot to go to a physician or psychologist who has an additional (national) aero-medical qualification, that does not even exist in many countries.

C. Draft Opinion Part-MED - Subpart B: Requirements for Medical Certificates - Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.070: Colour vision p. 16-17

comment	*444*	comment by: *UK CAA*
	MED.B.065 (j) (3) (4) (5) (6) and (7) **Comment:** Inappropriate for IR. Agree with Agency's note in NPA 17a para 15. **Justification:** Not future-proof: Any change of the IRs may be lengthy and a pilot may be prevented from being assessed as fit even though new types of visual correction may become available which would mitigate the medical risk. **Proposed Text:** Move to AMC and change 'shall' to 'should' throughout.	
response	*Noted*	
	This comment has been answered previously.	

comment	*445*	comment by: *UK CAA*
	MED.B.070 (c) **Comment:** Colour vision may not be critical to certain types of operation eg daytime aerial work. **Justification:** In some circumstances an applicant may be assessed as fit with restriction to specified operational duties. **Proposed Text:** Replace 'shall be assessed as unfit' with '**may be assessed as fit with restriction to specified type of operation'**.	
response	*Not accepted*	

	Please refer to ICAO Annex 1, para 6.2.4.4: The minimum for class 1 is to be able to readily distinguish the colours used in air navigation and to correctly identify aviation coloured lights. Applicants who fail to meet thee criteria shall be assessed as unfit except for class 2.

comment	*538*	comment by: *British Microlight Aircraft Association*
	(a) agree (b) accepted (c) accepted (d) accepted	
response	*Noted*	
	Thank you for the positive comment.	

comment	*647*	comment by: *Royal Danish Aeroclub*
	MED.B.070 In our opinion the implementation of colour vision restrictions is old fashioned and influenced by old tradition before safe radio communication and by unawareness of the rule makers of the perception of colours by the so called "colour blind". By far the most colour deficient people can readily se the colours (red/green) but they need to be a little closer to the object. A colour deficient person can recognize a difference e.g. see the different lights in a VASI/PAPI and comply with this information. Sugestion: We suggest that there should be no colour restrictions for class 2 and LPL at all. As a compromise we could suggest that a satisfactory medical flight test could be used to assess an applicant as fit.	
response	*Not accepted*	
	Applicants for a class 2 medical certificate who cannot readily distiguish the colours used in air navigation and cannot correctly identify aviation coloured lights may be assessed as fit with the limitation "valid daytime only". This is an ICAO standard.	

comment	*957*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM) - Group Ophthalmology- **Section:** Chapter B MED.B.070 **Page**: 16 **Relevant Text:**	

(d) In the case of class 2 medical certificates, when the applicant does not have satisfactory perception of colours, their flying privileges shall be limited to daytime only.

Comment:
Colour coded information occur in different areas of aviation. Scientific publications show that a normal trichromatic observer notices information faster and more effectively if it is based on colour differences. This reduces the rate of errors and of reaction time. Colour displays all imply that they are focused by a biologically "normal" eye with the possibility of discrimination of the entire colour spectrum. The correct perception and reading of a display is necessary, even more if difficult environmental conditions like glare, high light intensity in the cockpit and on the displays occur.
Electronic flight information displays present several colours at the same time in order to code information thus being identified and resolved faster. Humans with colour vision deficiencies are only able to identify two to three colours if another comparable colour is missing. People with colour vision deficiencies make even more errors at display work if only white signals with different illumination are presented. Already in 1965 Gramberg-Danielsen showed, that protanomals or protanopes have a higher number of rear-end collisions while driving. In 1975 Christ showed that colour coding on displays shows a 200% advantage over size and form coding. The perception time and the error rate can be reduced (Cole, MacDonald). The probability of a person with a colour vision deficiency to perform as good as a colour normal in the identification of colour information decrease by the increase of the degree of severity of the colour vision deficiency and is about 0 in the protanopes. In 1980 Robert Dille published that pilots with a waiver for colour vision deficiency are significant more often involved in aviation accidents than it is expectable by the statistics. In 2000 Ivan declared that people with colour vision deficiencies are usually not aware of the whole limited performance but think that they can identify colours and work satisfactorily in their operative environment. But the colour discrimination of these persons is not based on biological colour discrimination but on different aids as differences in illumination or learning by trial and error.
Only normal trichromates should be considered to be colour safe. 4% of the Deuteranomals pass the Ishihara plates anyhow. Applicants could otherwise be protanomal, trichromatic and have a matching range of 4 scale units. But they are no normal trichromatic and do see red lights much darker or even as grey or yellow, compared to normal trichromatic. This can be very dangerous.

Proposal:
(d) In the case of class 2 medical certificates, when the applicant does not have satisfactory perception of colours, their flying privileges shall be limited to daytime and VFR only.

response *Not accepted*

A pilot who is not colour safe cannot obtain a night rating because his privileges are restricted to daytime only.

A night rating is a pre-requisite to obtain an instrument rating. A pilot who does not hold an instrument rating can only fly VFR.

A restriction to daytime only therefore autmatically excludes IR privileges.

ICAO 6.2.4.4: Restriction: valid daytime only.

comment

1223	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*

MED.B.070 (c)
Comment:
The text has been changed from JAR-FCL, where an applicant should be assessed as 'colour safe' if he/she once was able to pass one of the available further colour tests but failed the rest. With the proposed text 'colour safe' means that the applicant may not fail any further colour test. This will eliminate the previous ambiguous legal situation, which is highly appreciated.

response

Noted

comment

1383	comment by: *ophtalmologie aerospace medecin*

Comment:
Colour coded information occur in different areas of aviation. Scientific publications show that a normal trichromatic observer notices information faster and more effectively if it is based on colour differences. This reduces the rate of errors and of reaction time. Colour displays all imply that they are focused by a biologically "normal" eye with the possibility of discrimination of the entire colour spectrum. The correct perception and reading of a display is necessary, even more if difficult environmental conditions like glare, high light intensity in the cockpit and on the displays occur.
Electronic flight information displays present several colours at the same time in order to code information thus being identified and resolved faster. Humans with colour vision deficiencies are only able to identify two to three colours if another comparable colour is missing. People with colour vision deficiencies make even more errors at display work if only white signals with different illumination are presented. Already in 1965 Gramberg-Danielsen showed, that protanomals or protanopes have a higher number of rear-end collisions while driving. In 1975 Christ showed that colour coding on displays shows a 200% advantage over size and form coding. The perception time and the error rate can be reduced (Cole, MacDonald). The probability of a person with a colour vision deficiency to perform as good as a colour normal in the identification of colour information decrease by the increase of the degree of severity of the colour vision deficiency and is about 0 in the protanopes. In 1980 Robert Dille published that pilots with a waiver for colour vision deficiency are significant more often involved in aviation accidents than it is expectable by the statistics. In 2000 Ivan declared that people with colour vision deficiencies are usually not aware of the whole limited performance but think that they can identify colours and work satisfactorily in their operative environment. But the colour discrimination of these persons is not based on biological colour discrimination but on different aids as differences in illumination or learning by trial and error.
Only normal trichromates should be considered to be colour safe. 4% of the Deuteranomals pass the Ishihara plates anyhow. Applicants could otherwise be protanomal, trichromatic and have a matching range of 4 scale units. But they are no normal trichromatic and do see red lights much darker or even as grey or

	yellow, compared to normal trichromatic. This can be very dangerous. **Proposal**: (d) In the case of class 2 medical certificates, when the applicant does not have satisfactory perception of colours, their flying privileges shall be limited to daytime and VFR only.
response	*Not accepted*
	See response to comment Nr 957.

comment	*1417*	comment by: *Philippe Hendriks*
	Dear Sir, Dear Madame, This is a personall comment about the current regulation for colordifficiency for a class 1 medical when people are tested negative on the anomalscoop. I personally have been tested negative on the anomaloscoop and have been waiting for a couple of years hoping there will be made some changes that will make the current regulation less hard. The doctor who performed the anomaloscoop test is very well know in the AMC in Amsterdam. We discussed the result and he mentioned that the difficiency i have is very minor but the current regulation for class 1 medical is so hard therfore he must adviced negative. Even this doctor mentioned that he find the current regulation very very hard and that in my partical case there is absolutely no danger in misinterpretar colors which could lead to a possible dangerous situations. Therefore you may understand that, by hearing this from a well known doctor, it is for me very hard to accept that this current regulation will remain. Especially because it is my dream to become an airline pilot. Besides from a peronal point of view i find it very questionable in relation to the current color difficiency regulation that for example the regulation for visual capacity the last years dramatically changed. I believe that Initial for visual is currently +5 -5 which means that if a pilot for example losses his/here glasses they won't be able to see anything. furthermore given the technical improvents that are currently used in flightdecks and basically will be further improved the current regulation shouldn't be so hard as it was for 20 years ago. Therefore i would like to comment that the heavy current regulation for colordifficiency for class 1 medical should be reconsiderd. As it was the last years for the visual capacity. could you please provide the thoughts on EASA on this? Kind Regards,	
response	*Noted*	
	The proposed NPA text is based on JAR FCL 3 and, for class 1, basically did not change. New colour vision tests that are presently under investigation but proof is	

	still needed to determine whether the ability to distinguish colours correctly can be assessed with these tests. The ability to distinguish colours correctly is considered to be important for commercial operations because of colour coded information on cockpit screens.

comment	*1579*	comment by: *FAA*
	MED.B.070: U.S. color vision determinations are made according to the following guidance: http://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide/app_process/exam_tech/item52/et/	
response	*Noted*	
	Thank you for the information.	

comment	*1592*	comment by: *DGAC FRANCE*
	MED B 070 Colour Vision COMMENT : **It's better to keep the decision to be taken by the authority like in JAR FCL 3** Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained. As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid contentious cases with AME's or AMC's which takes a lot of time to treat. It is also important for authorities to have an homogeneous feed back of these kind of decisions to improve the rules in the future. Give privileges to class 2 AME's to issue all medical certificates even those with one or more limitations instead of the licensing authority is dangerous for harmonisation of decisions throughout EU and associated countries and against equity principles**.** This should remain the duty of the licensing authority Justification : Decisions will not be homogeneous and standardisation of the decisions between states will be never obtained. As it is indicated in MED .O65, the authority shall suspend or revoke a medical	

	certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. MODIFICATION : MED B 070 Colour Vision (c)In the case of class 1 medical certificates, applicants shall have normal perception of colours or be colour safe. Applicants who fail further colour perception testing shall be assessed as unfit. **The decision of fitness must be taken by the licensing authority.**
response	*Noted*
	This comment has been answered in previous Segments.

comment	*1639*	comment by: *Tomasz Gorzenski*
	There are quite a few commercial pilot activities (particularly in helicopters and small airplanes) which can be safely and proficiently performed in daylight conditions by commercial pilots who are not color normal and even not color safe. Actually, some of those activities can be performed only during daylight and in VMC, as VFR/day-only operations. Assessing those pilots as unfit is an unneccessary discrimination - their flying priviliges could have been limited to daytime only, as in case of proposed EASA class 2 medical certificate. This is how it works in the USA, and how it should have worked in the EU, too.	
response	*Not accepted*	
	Please see response to comment No 445.	

comment	*1766*	comment by: *Civil Aviation Authority Finland*
	MED.B.070 (d) In the aircraft of today modern "glass cockpit instruments" with many different colour symbols are used. Therefore the pilot shall be colour safe and have normal perception of colours. Also PPL (class 2 medical certificate holders) flying IFR day shall be colour safe. Add in MED.B.070 (d): ... shall be limited to **VFR** daytime only.	
response	*Noted*	
	Please see response to comment No 957.	

comment	*1953*	comment by: *Civil Aviation Authority of Norway*
	Comment to (b) (2): The phraseing "Further colour perception testing" does not define the test method and is unprecise. Applicants who fail to obtain a	

	satisfactory result in the Ishihara test should undergo further colour perception testing by anomaloscopy (Nagel or equivalent) or lantern testing (Holmes-Wright, Beynes or Spectrolux).
response	*Noted*
	The issue is covered in AMC A to MED.B070 (3) and new methods of colour testing are under development.

comment	*2296*	comment by: *DLR*
	Substandard Vision in one eye can mean monocularity, or functional monocularity or severe amblyopia. The reduced vision has a major impact on visual functions as the binocular vision is a summation of visual functions of both eyes. Nearly all thresholds of monocular visual function are with normal binocular vision better than monocular. The absolute threshold for light is 1,5-1,8 times better The contrast recognition is 1,5-1,7 times better The resolution is 1,1 times better The recognition of moving stimulus is 1,9 times better. The visual field is reduced. The blind spot can mostly not be compensated. Dille and Booze published in 1979 (1974-1976) the "Accident experience of civilian pilots with static physical defects", FAA Office of Aviation Medicine Report No. AM-79-19, 77-20, 76-7. They showed that pilots with blindness or absence of one eye had significantly higher accident observed-to-expected ratios and higher rates per 100.000 hours. Airmen with deficient distant vision had significantly higher observed-to-expected ratios and higher rates per 100.000 hours (0,001). In 1984 Dille and Booze published "The 1980 and 1981 Accident Experience of Civil Airmen with Selected Visual Pathology", Aviat. Space Environ. Med. 1984: 55:966-9 In the years 1980 and 1981 monocular and amblyopic airmen had higher accident rates than the total airmen population. Mayer and Lane published in 1973 "Monocular Pilots – a Follow-up Study", Aerosp. Med. 44: 1070-1074. The number of monocular pilots who applied for a student pilot license after having obtained a waiver was proportionately less (84%) than the number of controls who applied (91%). More monocular pilots than control pilots became endorsed on more than one aircraft. There is a suspicion, that monocular pilots were involved in somewhat more hazardous events than control pilots. The decision of the monocularity working group of the JAA was that monocularity in a class 1 applicant or the pilot is not acceptable. Therefore it is essential to implement the sentence" Monocularity is not acceptable for a class 1 applicant" into the "Implementing Rules". Proposal: Monocularity is not acceptable for a class 1 applicant.	

	Initial applicants for class 1 medical certificate with reduced central vision should be assessed as unfit. At revalidation applicants for a class 1 medical certificate with a substandard vision of 0.5 (6/12) or better in one eye can be assessed as fit. In this case the visual acuity of the better eye should be at least 1.0 uncorrected or corrected. However a comprehensive eye examination and evaluation have to be performed for a fit assessment.
response	*Noted*
	Please see responses to identical comments 931 and 933 (ESAM, Segment Visual Reqirements).

comment	*2298*	comment by: *DLR*
	There exist cockpit windshields in aviation which are polarized. If someone wears sunglasses which are also polarized, but in a 90° direction to the polarization of the windshield this person sees only black through the sunglasses which means the person sees nothing. To avoid that and because there is very often the need for sunglasses in flying sunglasses shall not have polarized glasses. Proposal: (j) Spectacles and contact lenses If satisfactory visual function is achieved only with the use of correction: (8) There shall be NO! use of polarized sunglasses, photochromatic sunglasses and NO use of prismatic glasses.	
response	*Noted*	
	Copy of comment 939 in Segment Visual Requirements. Response in that Segment.	

comment	*2301*	comment by: *DLR*
	The initial examination should be a comprehensive eye examination performed by an ophthalmologist. Reason: A lot of problems we usually run into later during two examinations can be prevented by checking properly at the first exam. E.g. strabism, decompensated heterophoria, diplopia, glaucoma, monocularity… Besides in the U.K. no general practitioners are trained to do an eye examination. Especially at the initial examination diseases or risk factors that could cause in-flight problems could be seen and additional restrictions or examinations can become necessary. It is impossible for a normal flight surgeon to perform an eye examination and judge whether the requirements are fulfilled e.g. normal visual field, binocular vision,no chronic or acute diseases that could interfere with the safe performance in an aircraft. Proposal: A comprehensive eye examination shall be performed by an ophthalmologist and shall be part of the initial examination. the initial applicant The requirements that a class 2 applicant has to fulfil are	
response	*Noted*	

	Please se responses to identical comments No 290 and 937 (LH and ESAM, Segment Visial Requirements).

comment	*2304*	comment by: *DLR*
	If applicants for class 1 and 2 can be assessed as fit with the clinical diagnosis of keratoconus, we will "produce" a considerable amount of pilots, who will for sure later on have to be assessed as unfit, as even with contact lenses their visual requirements will not be sufficient any longer. Many eyes with keratoconus in young patients will end in keratoplasty which also makes unfit. **Proposal:** Applicants class 1 and class 2! with the diagnosis of keratoconus are assessed as unfit. At revalidation examination applicants for a class 1 and class 2 medical certificate with a clinical diagnosis of keratoconus may be assessed as fit subject to a satisfactory examination by an ophthalmologist. 1) *Keratoconus:* **At renewal examinations applicants with keratoconus may be considered for a fit assessment, if the visual requirements are met with the use of corrective lenses and at least a yearly examination is undertaken by an ophthalmologist.**	
response	*Noted*	
	Please see responses to identical comment No 938 in Segment Visual Requirements.	

comment	*2310*	comment by: *DLR*
	If applicants for class 1 can be assessed as fit with the clinical diagnosis of keratoconus, we will "produce" a considerable amount of pilots, who will for sure later on have to be assessed as unfit, as even with contact lenses their visual requirements will not be sufficient any longer. Should we discuss this? Most eyes with keratoconus in young patients will end in keratoplasty which also makes unfit. **Proposal**: 1) Applicants class 1 and class 2! with the diagnosis of keratoconus are assessed as unfit. At revalidation examination applicants for a class 1 and class 2 medical certificate with a clinical diagnosis of keratoconus may be assessed as fit subject to a satisfactory examination by an ophthalmologist. 2) *Keratoconus:* Applicants with keratoconus may be considered for a fit assessment, if the visual requirements are met with the use of corrective lenses and at least a yearly examination is undertaken by an ophthalmologist.	
response	*Noted*	
	Please see response to identical comment No 938 in Segment Visual Requirements.	

comment	*2312*	comment by: *DLR*
	A lot of problems we run into later on, could be prevented, if the initial examination was a comprehensive one. General practitioners are in no way trained to perform a thorough eye exam. They cannot detect diseases or risk factors that could cause in-flight problems later. They also cannot see, which ophthalmological condition needs additional restrictions or additional eye examinations. Proposal: For a class 2 medical certificate a comprehensive eye examination shall form part of the initial examination and if required.	
response	*Noted*	
	Please see identical and similar comments in Segement Visual Requirements, e.g. comments No 299 (LH), 944 (ESAM) and others.	

comment	*2339*	comment by: *DLR*
	Colour coded information occur in different areas of aviation. Scientific publications show that a normal trichromatic observer notices information faster and more effectively if it is based on colour differences. This reduces the rate of errors and of reaction time. Colour displays all imply that they are focused by a biologically "normal" eye with the possibility of discrimination of the entire colour spectrum. The correct perception and reading of a display is necessary, even more if difficult environmental conditions like glare, high light intensity in the cockpit and on the displays occur. Electronic flight information displays present several colours at the same time in order to code information thus being identified and resolved faster. Humans with colour vision deficiencies are only able to identify two to three colours if another comparable colour is missing. People with colour vision deficiencies make even more errors at display work if only white signals with different illumination are presented. Already in 1965 Gramberg-Danielsen showed, that protanomals or protanopes have a higher number of rear-end collisions while driving. In 1975 Christ showed that colour coding on displays shows a 200% advantage over size and form coding. The perception time and the error rate can be reduced (Cole, MacDonald). The probability of a person with a colour vision deficiency to perform as good as a colour normal in the identification of colour information decrease by the increase of the degree of severity of the colour vision deficiency and is about 0 in the protanopes. In 1980 Robert Dille published that pilots with a waiver for colour vision deficiency are significant more often involved in aviation accidents than it is expectable by the statistics. In 2000 Ivan declared that people with colour vision deficiencies are usually not aware of the whole limited performance but think that they can identify colours and work satisfactorily in their operative environment. But the colour discrimination of these persons is not based on biological colour discrimination but on different aids as differences in illumination or learning by trial and error. Only normal trichromates should be considered to be colour safe. 4% of the Deuteranomals pass the Ishihara plates anyhow. Applicants could otherwise be protanomal, trichromatic and have a matching range of 4 scale units. But they are no normal trichromatic and do see red lights much darker or even as grey or yellow, compared to normal trichromatic. This can be very dangerous.	

	Proposal: (d) In the case of class 2 medical certificates, when the applicant does not have satisfactory perception of colours, their flying privileges shall be limited to daytime and VFR only.
response	*Noted*
	Please see responses to identical comments No 957 and 1383 in this Segment.

C. Draft Opinion Part-MED - Subpart B: Requirements for Medical Certificates - Section 2: Specific requirements for class 1 and class 2 medical certificates - MED.B.075: Otorhino-laryngology p. 17

comment	*7*	comment by: *GEMA*
	Audiometrías en periódicos es medicina preventiva	
response	*Noted*	
	The IRs are based on JAR-FCL 3 requirement and ICAO SARPs.	

comment	*281*	comment by: *Lufthansa German Airlines*
	Author: Dr. Ulrike Springer AMC Frankfurt **Section:** 2 Subpart B MED.B.075 b - Specific Requirements for Class 1 and Class 2 Medical Certificates **Page**: 17 **Relevant Text:** Hearing **Comment**: Vestibular function added. **Proposal**: Hearing and **vestibular function** should be satisfactory for the safe exercise of the privileges of the applicable licence(s).	
response	*Not accepted*	
	The issue is covered in MED.B.075(a).	

comment	*282*	comment by: *Lufthansa German Airlines*
	Author: Dr. Ulrike Springer AMC Frankfurt **Section:** 2 Subpart B MED.B.075 c (1) (iii)	

	Page: 17 **Relevant Text:** Applicants with hypoacusis shall demonstrate satisfactory functional hearing. **Comment**: This is a precise and reproducible method. **Proposal**: Speech audiometry is required. In case of an unilateral hearing loss, a brainstern evoked response audiometry has to be performed.
response	*Not accepted*
	Additional tests may be requiren in accordance with MED.B.001(d).

comment	*283*	comment by: *Lufthansa German Airlines*
	Author: Dr. Ulrike Springer AMC Frankfurt **Section:** 2 Subpart B MED.B.075 c (2) **Page**: 17 **Relevant Text:** A comprehensive ENT-examination shall be undertaken for the initial issue of a class 1 medical certificate. Periodically thereafter when clinically indicated. **Comment**: Diseases of ear, nose and throat are often seen in pilots due to the cockpit environment. Preventive medical examination is required. **Proposal**: Comprehensive ENT-examination shall be undertaken every 60 months up to the age of 40. Thereafter every 24 months.	
response	*Not accepted*	
	The proposed NPA text is a transposition of the corresponding requirement from JAR FCL 3.	

comment	*539*	comment by: *British Microlight Aircraft Association*
	(a) strongly agree (b) strongly agree (c) (d) strongly agree	
response	*Noted*	

	Thank you for the positive comment.

comment	*842*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author: **European Society of Space and Aviation Medicine (ESAM) - Group ENT -**

Section:
Subpart B MED.B.075 c Examination

Page: 17

Relevant Text:

- (1) Hearing shall be tested at all examinations
- (2) A comprehensive ear, nose and throat examination shall be undertaken for the initial issue of a class 1 medical certificate and periodically thereafter when clinically indicated

Comment:
Diseases of ear, nose and throat are often seen in pilots due to cockpit environments. Preventive medical examination is required. At each examination, a clinical ear, nose and throat examination has to be performed. Attacks of vertigo can be extremely dangerous should they occur in flight. Even mild episodes of vertigo occurring in critical phases of flight could be disastrous. An AME normally may not be competent enough to perform the ENT examination.

Proposal:
(c) Examination

- (1) a thorough examination of the equilibrium is to undertaken for all classes
- (2) Hearing shall be tested at all examinations

(i) *same text*
(ii) *same text*
(iii) *same text*

- (3) A comprehensive ear, nose and throat examination under supervision of an ENT specialist accepted by the authorities shall be undertaken for the initial issue of a class 1 medical certificate and periodically thereafter when clinically indicated.

response	*Noted*
	The proposed NPA text is a transposition of the corresponding requirement from JAR-FCL 3. Requirement with regard to the examination of the vestibular function is proposed in AMC to MED.B.075 2(iv).

comment	*1054*	comment by: *Dr Michel Kossowski AeMC Clamart*

	(c) (1) (ii) Audiometry must be done for all frequencies : 250, 500, 1000, 2000, 3000, 4000, 6000, 8000 Hz. I think it's véry important for the diagnosis demarch, indepedantly of the auditory thresholds. For example a hypoacusis on 4000, 6000, 8000 can be due to an acoustic neuroma which has a consequence on the firness, even if the thresholds are good on the othyer frequencies. (c) (1)(ii) the thresholds are too high for an initial visit. I think it's better to distinguish the initial observation with thresholds at 20 dB at 500, 1000, 2000 and 35 dB at 3000 Hz and conserve 35 db at 500, 1000, 2000 and 50 dBat 3000 for renewal. 'c)'1)(11) : we must define what is a satisfactory functionnal hearing ability : what kind of test (speech audiometry in silent, in noise, at what intensity, how? ear by ear, binaural?, what values (max of intelligibility at what intensity, dynamic of the curve...) (d) : a tympanometry must be done for the first examination to eliminate eutachian dysfunction. Dysfunction of eustachian tube must be specified in the text
response	*Not accepted*
	The proposed NPA text is a transposition of the corresponding requirement from JAR-FCL 3.

comment	*1311*	comment by: *Matthias Runte*
	According to MED.B.075 (c) (1) (i) it shall be required to provide a hearing test with pure tone audiometry, when an instrument rating is to be added to the license held. According to MED.B.075 (c) (1) (ii), the hearing loss must not be more than 35dB IN EITHER EAR SEPARATELY. I would like to comment to following. The requirement, that a hearing loss must not be present IN EITHER EAR is too strict. The rule is inappropriate. The rule excludes pilots with full or sufficient hearing capabilities IN ONE EAR, and insufficient hearing (or complete loss of hearing) IN THE OTHER EAR, without a rational, comprehensible reason. The advantage for a human being of being capable to hear on two ears is to locate the origin of a sound around him. In a powered aircraft flying in instrument conditions this is irrelevant. A pilot with two fully functioning ears has no advantage over a pilot with just one functioning ear. In correspondence to hearing capability it can be stated: 1. When flying an aircraft, it does not matter where a sound (engine, outer/middle marker, radio, warning signals) is coming from. The LOCATION OF THE ORIGIN OF THE SOUND is irrelevant to the save operation of the aircraft or can be determined easily even when the pilot is hearing with just one ear. 2. Pilots with hearing incapability are always wearing a HEADSET. The speakers in the ear-phones are wired together. The headset is providing MONO SOUND. For a person with hearing loss on one ear it does not matter whether you hear the	

	sound in one ear or in both. The INFORMATION is identical, because the ORIGIN OF THE SOUND is wiped out even for pilots with two good ears. Secondly it is incomprehensible why pilots that already hold an instrument rating (see MED.B.075 (c) (1) (ii) sentence two), may have a greater hearing loss than pilots who apply for the license for the first time. In summary it can be stated that pilots with hearing loss on one ear do not have any limitations to fly an aircraft under instrument conditions. If they provide normal hearing capability, this should also be sufficient for an instrument rating. I therefore propose to implement the following changes: 1. MED.B.075 (c) (1) (i): DELETE "and class 2 medical certificates when an instrument rating is to be added to the licence held" 2. MED.B.075 (c) (1) (ii): CHANGE "in either ear separately" TO "in at least one ear". Thank you very much.
response	*Not accepted*
	The proposed NPA text is a transposition of the corresponding requirement from JAR-FCL 3.

comment	*1340*	comment by: *Van Dessel Frans*
	Med B 075. 1) Class 1 a)Hearing requirements: " ... a hearing loss of 35 db at the frequenties 500, 1000 and 2000 Hz..." In my opinion this loss is too much for an applicant. b) For speech audiometry, the manual of amendment 5 says: "... nevertheles a " standardised flight noise environnement " cannot be "defined" In my opinion a pilote has to understand a coversation when he is in very difficult situations ! 2)Class 2 : "The applcant shall be able to understand correctly ordinary conversation.." The Manual of amendement 5 says: "In the clinical tests (the whispered and spoken voice tests) intensity standardisation is crude and examiner dependent."	
response	*Not accepted*	
	The proposed NPA text is a transposition of the corresponding requirement from JAR-FCL 3 Amendment 5.	

comment	*1407*	comment by: *Prutech Innovation Services Ltd.*

	MED.B.075(c)(1)(2): *The proposed figures are unnecessarily severe for the purpose - we propose adding an extra 5 db at the lower frequencies and an extra 10db at 3000 Hz.*
response	*Not accepted*
	The proposed NPA text is a transposition of the corresponding requirement from JAR FCL 3 Amendment 5.

comment	*1447*	comment by: *Michel KOSSOWSKI*
	MED.B.075 (c)(1)(ii): the thresholds are too high for an initial visit. I think it's better to distinguish the initial examination with thresholds at 20 db at 500, 1000, 2000 Hz and 35 at 3000 Htz and conserve 35 db at 500, 1000,2000 and 50 db at 3000 for renewal.	
response	*Not accepted*	
	The proposed NPA text is a transposition of the corresponding requirement from JAR-FCL 3 Amendment 5.	

comment	*1448*	comment by: *Michel KOSSOWSKI*
	MED.B.075 (c)(1)(ii): we must define what is a satisfactory functional hearing ablity : what kind of test (speech audiométry in sislence, in noise, at what intensity, how? ear by ear?, both ears?, what values (max of intelligibility at what intensity, dynamic of the curve?...)	
response	*Noted*	
	The proposed NPA text is a transposition of the corresponding requirement from JAR-FCL 3 Amendment 5.	

comment	*1449*	comment by: *Michel KOSSOWSKI*
	MED.B.075 (d): a tympanometry must be done for the first examination to eliminate eustachian dysfunction. Dysfunction of eutachian tube must be specified.	
response	*Noted*	
	The issue is covered in AMC to MED.B.075 2(iv).	

comment	*1501*	comment by: *PPL/IR Europe*
	Our comment in this section refers to the Hearing Test for Class 2 Medical holders who wish to exercise the privileges of an Instrument rating (typically, PPL/IRs). We are aware of the ICAO recommendation that PPL/IRs should meet Class 1 hearing standards. However, we believe the Audiometry test is in excess of ICAO Class 1 standards, and we note that applicants for revalidation or renewal who do not pass the Audiometry test may, alternatively, qualify on the basis of a satisfactory functional hearing test.	

	The audiometry requirement for initial award of Class 1 hearing certification for Class 2 medical holders we believe is unnecessary, and unfairly restricts pilots with some hearing loss, who are nevertheless able to function safely, from exercising Instrument privileges. We are aware of many cases where pilots have had very inconsistent standards applied by AMEs in this respect, causing difficulty and distress quite needlessly. Our proposal is that para (c) (ii) should be reworded such that the last sentence reads *"Applicants for revalidation or renewal,and applicants for the initial award of Class 1 hearing standards on a Class 2 Medical, with greater hearing loss shall demonstrate satisfactory functional hearing ability"* Alternatively, para (c) (ii) could simply extend the functional hearing test AMC to all applicants with the wording *"Applicants with greater hearing loss shall demonstrate satisfactory functional hearing ability"*
response	*Noted*
	open.

comment	*1506*	comment by: *Derek Maltby*
	A proficiency check with an examiner is not essential to guarantee air safety and good airmanship. If any such check is required, the standard imposed by a consistent use of 'instructors' is sufficient.	
response	*Noted*	
	Proficiency check is not subject to the rules proposed in Part Medical.	

comment	*1528*	comment by: *Andrew CAMPBELL*
	1. MED.B.075 takes no account whatsoever in respect of hearing defects which are stable and which are able to be corrected, or their effect lessened, so as to permit safe operation of aircraft, but which on testing do not satisfy the rigid criteria in MED.B.075(c)(1)(ii). This is the case with visual rectification aids so why not hearing aids? 2. No mention is made in relation to use of hearing aids or similar devices which assist hearing acquity. (a) This leaves medical examiners unable to know whether to test with or without taking into account the effect of such aids or devices. (b) It leaves applicants with correctible hearing defects unable to know the legal position before applying for a medical certificate; and unable to know what the impact of such aids or devices will be on the grant of a certificate or how it will be consistently approached by AME or AeMC. Explicit mention should be made in the legislation as to how hearing aids and such devices will be dealt with and the approach to be taken.	

3. Separately, in my view, as with visual defects, the appropriate test for satisfactory hearing should be that: with the assistance of hearing aids and/ or active noise reduction headsets the applicant is able to operate effectively and safely in the cockpit environment.

Compare with the visual standards, which are not for example stated by reference to simple dioptre limits but complex considerations and assessment processes. This is presumably because more pilots may be likely to have visual defects than hearing defects but why should those with a hearing defect be discriminated against? An aircraft can be safely flown to the ground without a radio or if the pilot becomes suddenly deaf but it cannot ordinarily be flown to the ground by a suddenly blind pilot. Discrimination of this nature is not permitted under the EU Treaty and the additional effort involved to remedy this situation should be undertaken when drafting the EASA medical requirements to ensure proportionality of legislative approach.

If a pilot with a hearing defect wishes to be a CPL and that defect can be corrected adequately by the use of hearing aids and/ or similar devices including ANR headsets then, provided there is a deviation in the Class 1 medical certificate mandating their use, and the rating examiner confirms in a practical cockpit environment that there is no impact on safety, then why should this not be permitted? What is the regulatory imperative for the heavier burden on the applicant?

4. Separately, MED.B.075(c)(1)(i) refers to the requirement to satisfy the frequency requirements when an applicant with a Class 2 certificate wishes to add an instrument rating to a licence. This was not the case under the JAR requirements which were widely accepted to impose an undue regulatory burden on the industry. Instead JAR legislation permitted those with a Class 2 medical certificate to add an instrument rating provided they satisfied a practical cockpit audio test undertaken by the rating examiner. The practical cockpit audio test should replace the requirement in (c)(1)(i) in these circumstances rather than imposing the heavy burden of compliance currently set out in (c)(1)(ii). In what instances under the JAR or prior regulatory regimes has imposing the lesser burden impacted on safety? A lesser burden should be imposed where there is no evidence to support a heavier one - such burdens are present not to ensure consistency for the ease of administration of rules by a state regulator but are to guarantee safe cockpit operation; consistency of rules is therefore not a defensible argument. The rules may stem from ICAO requirements but ICAO requirements will have predated modern advances in hearing medicine and the now very limited use of morse code communications in the cockpit. It is only right that these advances and change in circumstances are reflected in the new legislation.

I declare an interest in that I failed my JAR Class 1 medical examination due to being 5dB below one of the frequency limits yet it was accepted by the AME that a combination of my hearing aids plus an active noise reduction headset would render my hearing defect irrelevant to safe aircraft operation. I continue to fly fixed wing and rotary under a Class 2 medical but am barred from obtaining a Class 1 certificate even with deviations which would ensure no detriment to cockpit safety. This means I cannot obtain a CPL to do even limited commercial work. Further, the terms of this provision would ensure that I could not even

	obtain an instrument rating for private use. In my country, Scotland, the weather is so variable and poor that possessing an instrument rating is a positive safety advantage but this option would be denied me under the new rules even if I flew without a Class 1 certificate.
response	*Noted*
	Open.

comment	*1582*	comment by: *FAA*
	MED.B.075: Differences with paragraph (c) (1) (i) are on file with ICAO. MED.B.075 (c) (2): A comprehensive ear, nose, and throat examination is not required of U.S. applicants unless clinically indicated.	
response	*Noted*	
	Thank you for the information.	

comment	*1593*	comment by: *DGAC FRANCE*
	MED B 075 Otorhino-laryngology COMMENT : **It's better to keep the decision to be taken by the authority like in JAR FCL 3** Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained. As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid contentious cases with AME's or AMC's which takes a lot of time to treat. It is also important for authorities to have an homogeneous feed back of these kind of decisions to improve the rules in the future. Give privileges to class 2 AME's to issue all medical certificates even those with one or more limitations instead of the licensing authority is dangerous for harmonisation of decisions throughout EU and associated countries and against equity principles. This should remain the duty of the licensing authority Justification : Decisions will not be homogeneous and standardisation of the	

decisions between states will be never obtained.

As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level.

MODIFICATION :

MED B 075 Otorhino-laryngology

c) examination

(1) .....etc

(ii) When tested on a pure-tone audiometer, initial applicants shall not have a hearing loss of more than 35 Db at any of the frequencies 500, 1 000 or 2 000 Hz, or more than 50 Db at 3 000 Hz, in either ear separately. Applicants for revalidation or renewal, with greater hearing loss shall demonstrate satisfactory functional hearing ability. **In the two cases the decision must be taken by the licensing authority.**

d) Applicants for a class 1 **and 2** medical certificate with :

(1) .....etc

shall be assessment by licensing authority ~~shall undergo further medical examination and assessment to establish that the condition does not interfere with the safe exercise of the privileges of he licence held.~~

response

Partially accepted

Text changes with the clarification of the referral of class 2 applicants to the licensing authority will be introduced. At the same time, we would like to draw your attention to the fact that it is a responsibility of the National Aviation Authority of the mutually recognised Member State to ensure that the procedures and decisions in the field of aviation medicine will be homogeneous and standardised.

comment

1986 comment by: *CAA Belgium*

(b)

Relevant Text:
Hearing…

Comment:
Vestibular function has to be added, this function is essential for flying.

Proposal:
Hearing and vestibular function should be satisfactory for the safe exercise of the privileges of the applicable licence(s).

response	*Not accepted*
	See response to comment No 281.

comment	*1987*	comment by: *CAA Belgium*
	(c)(1)(ii) Relevant Text: Applicants for revalidation or renewal with greater hearing loss shall demonstrate satisfactory functional hearing ability. Comment: No details in the text. Reference must be added. What kind of test? There are a lot of speech discrimination tests used in clinic. Proposal: Applicants for revalidation or renewal with greater hearing loss shall demonstrate satisfactory functional hearing ability. A fit assessment can be made if a functional flight deck hearing test in a noise field corresponding to normal flight deck working conditions demonstrates satisfactory hearing ability.	
response	*Noted*	
	The issue is covered in AMC to MED.B.075 (1).	

comment	*1988*	comment by: *CAA Belgium*
	(c)(1)(i)(ii)(iii) Relevant Text: (i) In the case of class 1… (ii) (ii) When tested on a pure-tone audiometer, ….. (iii) Applicants with hypoacusis ….. Comment: (i) : agree (ii) : All the world of ENT, audiologists and also a lot of pilots do not agree the hearing loss level for INITIAL examination and do not understand why this initial level is so below. If a pilot starts his training with this type of hearing loss level, he will have a lot of problems to integrate all radio messages in flight conditions and also theoretical and practical training . The cockpit rate noise level is from 70 > 80 dB for airliners and till 95 db for single engine piston and helicopters. Bad speech discrimination, thus ATC misunderstanding can be a major cause of accidents. The requirements for ATC is MAXIMUM a hearing loss of 20 dB for 500, 1000, 2000 Hz and 35dB for 3000 Hz and they work in SILENT conditions, thus for pilot ????? We need high frequencies for understanding in noise. A patient with the initial hearing loss as describe NEEDS a Hearing Device !!!!!!!! and he is considered as handicapped in his social live. For revalidation, it is possible with there levels because the brain auditory area has integrated a dictionary-memory of aviation auditory data. (iii) Yes but which kind of test? The best is speech discrimination test in cockpit	

	noise. Proposal: (i) idem (ii) When tested on a pure-tone audiometer, initial applicants shall not have a hearing loss of more than 20 dB at any of the frequencies 500, 1 000 or 2 000 Hz, or more than 35 dB at 3 000 Hz, in either ear separately. For renewal and revalidation, applicants shall not have a hearing loss of more than 35 dB at any of the frequencies 500, 1 000 or 2 000 Hz, or more than 50 dB at 3 000 Hz, in either ear separately. (iii) For renewal and revalidation, applicants with hypoacusis shall demonstrate satisfactory functional hearing ability. A fit assessment can be made if a functional flight deck hearing test in a noise field corresponding to normal flight deck working conditions demonstrates satisfactory hearing ability. A hearing device can be eventually worn .
response	*Not accepted*
	Threshold transferred from JAR-FCL 3 and in line with ICAO Annex 1.

comment	*1989*	comment by: *CAA Belgium*
	(c)(2) Relevant Text: (2) A comprehensive ear, nose and throat examination shall be undertaken for the initial issue of a class 1 medical certificate and periodically thereafter when clinically indicated. Comment: At each examination, a clinical ear, nose and throat examination has to be performed. This must be specified for the AME. Proposal: Add a (3): A routine ear, nose and throat examination shall form part of all revalidation and renewal examinations.	
response	*Not accepted*	
	The proposed NPA text is a transposition of the corresponding requirement from JAR FCL 3 Amendment 5.	

comment	*2230*	comment by: *Ulrich Ablassmeier*
	In the United States Private Pilots with Instrument Rating do not need a test with a pure-tone audimeter for their medical. I think in Europe it is also not necessary.	
response	*Not accepted*	

	The requirement to test private pilots with a pure-tone audimeter is in ICAO standards.

comment	*2420*	comment by: *CMO/AMC and President of Danish Aviation & Marine Medical Association*
	The requirements (both class 1 and class 2) on the ENT area are in some extent obsolete. Rulemakers should focus on what real matters concerning aviation and ENT: The risk of barotrauma in middle and inner ear and sinus, as well as risk of dizziness. Paragraph in other medical areas describe in details how to examine the condition properly, whereas it is stated that applicants shall undergo further medical examination without any specification in case of a potential hazardous condition as "disturbance of vestibular function". The paragraph need specified up-to-date vestibular examination program (see http://www.icao.int/icaonet/dcs/8984/8984_Part_3_en.pdf). This reference can also be recommended on the ENT barotrauma considerations. Some aviation medical surveys do not mention barotrauma whereas other scientific papers take the risk of barotrauma into account (see Rosenkvist, L., Klokker, M. and Katholm, M. Upper respiratory nfections and barotraumas in commercial pilots, a retrospective study. 2008. Aviat. Space Environ. Med. 79: 960-3.) Why not consider (objective) examination of the pilot's ability to do Valsalva using tympanometry as a request? One must take into account that the Accident Investigation Board never investigates dizziness or barotrauma as a reason to air crash whereas cardiac and other medical reasons are considered during forensic pathology (- it is very hard to do a proper post-mortem examination of inner ear and not routine on middle ear). Therefore, accidents due to ENT diseases are underestimated but still an important area to examine to prevent sudden incapacitation in the pilot.	
response	*Noted*	
	Thank you for the comment. Medical requirements of proposed in NPA 2008-17c were prepared by a rulemaking drafting group consisting of the representatives of National Aviation Authorities, industry and general aviation. Following proposals of the group, Class 1 medical requirements are in line with JAR FCL 3 while Class 2 medical requirements were aligned with ICAO Class 2. Implementing Rules contain only standards which were agreed by all Member States and provide a basis for a harmonisation.	

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comment	*540*	comment by: *British Microlight Aircraft Association*
	Strongly agree	
response	*Noted*	

Thank you for the positive comment.

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comment	*8*	comment by: *GEMA*
	¿Un neurinoma del acustico es intracerebral?. Pero extradural, sin riesgo de epilepsia postraumática	
response	*Noted*	
	For the aeromedical evaluation of the applicants with acustic neurinoma MED.A.060 and MED.A.085 applies.	

comment	*260*	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.B.085 **Page**: 18 Relevant Text: (a) Applicants shall have no established primary or secondary malignant disease likely to interfere with the safe exercise of the privileges of the applicable licence(s). (b) After treatment for malignant disease, applicants shall undergo satisfactory oncological evaluation before a fit assessment can be made. Class 1 applicants shall be referred to the licensing authority. **Comment**: The Likelihood to interfere with the safe exercise of the privileges must be defined to achieve uniform safety-levels. The "one-percent-rule" should be applicable as well in malignant disease, esp. for incapacitating events like unforeseen seizures from brain metastasis, severe haemorrhage, pathologic bone ore vertebra fracture etc. The essential safety level should be applicable for all kind of medical classes. A minimum recovery time of three months after diagnosis or treatment of cancer deems essential to overcome the debilitating effects of the disease itself or chemotherapy or radiation as well as the secondary psychic affections (secondary depression etc.). Following chemotherapy or radiation patients are at risk to develop progressive cardiomyopathy even years after treatment. Regular cardiologic follow-up should be guaranteed. Though additional specifications are given in AMC A to MED.B.085, the precise defintion should be given at this site. **Proposal**: (a) Applicants shall have no established primary or secondary malignant disease likely to interfere with the safe exercise of the privileges of the applicable licence(s). (b) After diagnosis or treatment for malignant disease, applicants shall undergo	

	satisfactory oncologic evaluation before a fit assessment can be made. The malignant disease must be considered eliminated or in full remission. The inherent risk of sudden incapacitation due to silent brain metastasis, haemorrhage or bone metastasis must not exceed 1 percent per year. A fit assessment can not be made earlier than 3 months after termination of treatment. Regular oncologic follow-up examinations are obligatory at intervals of 6 months for the first three years, at intervals of 12 months hereafter until the fifth year after successful treatment is completed. Class 1 applicants shall be referred to the licensing authority. (c) Following systemic chemotherapy or radiotherapy involving the thorax an annual cardiologic examination including ECG and Echocardiography is necessary.
response	*Partially accepted*
	The JAR-FCL 3 text on risk assessment will be reviewed and amended during the rulemaking task MED.001. AMC A to MED.B.085 will be amended to include cardiological assessment after chemotherapy or radiotherapy involving the thorax.

comment	*541*	comment by: *British Microlight Aircraft Association*
	(a) strongly agree (b) accepted	
response	*Noted*	
	Thank you for the positive comment.	

comment	*765*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM) - Internal Medicine Group - **Section: 1** **MED.B.085 Oncology** **Page**: 18 **Relevant Text:** (a) Applicants shall have no established primary or secondary malignant disease likely to interfere with the safe exercise of the privileges of the applicable licence(s). (b) After treatment for malignant disease, applicants shall undergo satisfactory oncological evaluation before a fit assessment can be made. Class 1 applicants shall be referred to the licensing authority. (c) Applicants with an established history or clinical diagnosis of intracerebral malignant tumour shall be assessed as unfit. **Comment**:	

	Proposal: (a) Applicants shall have no established primary or secondary malignant disease likely to interfere with the safe exercise of the privileges of the applicable licence(s). (b) After treatment for malignant disease, applicants shall undergo satisfactory oncological evaluation. and regulare followup examination before a fit assessment can be made. Class 1 applicants shall be referred to the licensing authority. (c) Applicants with an established history or clinical diagnosis of intracerebral malignant tumour shall be assessed as unfit.
response	*Not accepted*
	Follow-up examinations are covered in AMC to MED.B.085 1(v) and 2.

comment	*813*	comment by: *Swiss Association of Aviation Medecine*
	Proposal: (a) Applicants shall have no established primary or secondary malignant disease likely to interfere with the safe exercise of the privileges of the applicable licence(s). (b) After treatment for malignant disease, applicants shall undergo satisfactory oncological evaluation. and regulare followup examination before a fit assessment can be made. Class 1 applicants shall be referred to the licensing authority. (c) Applicants with an established history or clinical diagnosis of intracerebral malignant tumour shall be assessed as unfit.	
response	*Noted*	
	Please see response to comment No 765.	

comment	*1594*	comment by: *DGAC FRANCE*
	MED B 085 Oncology COMMENT : **It's better to keep the decision to be taken by the authority like in JAR FCL 3** Decisions will not be homogeneous and standardisation of the decisions between states will never be obtained. As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk. All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. It is better to take in difficult cases, the decision at the level of licensing authority because the decision will be more homogeneous. With that we also avoid	

	contentious cases with AME's or AMC's which takes a lot of time to treat. It is also important for authorities to have an homogeneous feed back of these kind of decisions to improve the rules in the future. Give privileges to class 2 AME's to issue all medical certificates even those with one or more limitations instead of the licensing authority is dangerous for harmonisation of decisions throughout EU and associated countries and against equity principles**.** This should remain the duty of the licensing authority Justification : Decisions will not be homogeneous and standardisation of the decisions between states will be never obtained. As it is indicated in MED .O65, the authority shall suspend or revoke a medical certificate when it has identified a safety risk.All authorities have not the same level of control of the examination and in certain cases bad decision taken by an AME will not be discovered and will reduce safety level. MODIFICATION : MED B 085 Oncology b) After treatment for malignant disease, applicants shall undergo satisfactory oncological evaluation before a fit assessment can be made. Class 1 **and class 2** applicants shall be referred to the licensing authority.
response	*Noted*
	This comment has been answered in previous segments.

comment	*2419*	comment by: *CMO/AMC and President of Danish Aviation & Marine Medical Association*
	The paragraph on oncology is too week and inadequate for a requirement. When can a newly treated pilot be considered to be safe? It is well known that several adverse effects are seen much later than at during the time of treatment.	
response	*Noted*	
	Requirements with regard to the fitness after treatment for malignant disease are proposed in AMC A to MED.B.085 and AMC B to MED.B.085.	

C. Draft Opinion Part-MED - Subpart B: Requirements for Medical Certificates - Section 3: Specific requirements LPL medical certificates p. 18

comment	*285*	comment by: *Pekka Oksanen*
	Comment: LPL requirements are not acceptable.The standards are far below ICAO and JAA standards and would lead into severe difficulties. Justification: ICAO standards are universally accepted for private and leisure	

	pilots. NPA 2008-17c Class 2 to be applied to both groups. **Proposal: Delete LPL proposal as such and apply Class 2 standards throughout the NPA.**
response	*Not accepted*
	The Basic Regulation requires a medical certificate for LAPL. Following the principle of the proportionality, this medical certificate will be sub-ICAO Class 2.

comment	*366*	comment by: *Peer Ketterle*
	Please see my comment in the Explanatory Notes about this issue. Please remove this section altogether and do explicitly NOT reqiure ANY kind of medicla certificate for LPL holders. This does not do a service to GA or Europe.	
response	*Noted*	
	Please see response to comment No 285 and many similar comments in this NPA.	

comment	*577*	comment by: *Florian Söhn*
	The examnation standard shown in this this paragraph is below ICAO-Standards which should be the lowest acceptable standard world-wide in my opinion. A medical issused should at least fulfill ICOA standard. Even Truck drivers have harder medical conditions attached to their driving licence then the proposed LPL-licence requirements - in my opinon this not fulfil the spirit of air safty at all. Best solution would be to simply scrap the LDL -medical and merge it with class2 medical requirements.	
response	*Noted*	
	The medical provisions for the LAPL have been revised to reflect the concerns of aero-medical specialists, national aviation authorities and professional pilots. The new proposal is still below ICAO class 2 standards but is no longer based on a driving licence but takes aviation medicine principles into into account.	

comment	*1133*	comment by: *jim white*
	This should also be the rquirement for SPL	
response	*Not accepted*	
	Sailplane pilots shall have a Class 2 medical certificate.	

comment	*1289*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Attachment #15	
	Comment:	

1. Safety risk assessment

The acceptable safety risk level for each type of air operation, and the corresponding acceptable risk for incapacitation for each class of medical certificate, should be stated by EASA and be included in the requirements. For CPL/ATPL and PPL there is a general consensus concerning the 1%-rule, but no risk assessment has been presented for LPL. Some medical conditions with as high as 40% risk for sudden death within 12 months have been suggested to be acceptable for LPL.

2. Comparison with FAA medical requirements

The LPL is very similar to the FAA Recreational pilot licence. However, the privileges of the FAA Recreational pilot licence are considerably more restricted regarding, for example, number of passengers allowed, aircraft performance, and airspace. A holder of a FAA Recreational pilot licence is required to hold a FAA class 3 medical certificate, corresponding to the ICAO class 2 medical certificate.

The proposed new aircraft category ELA-1, as discussed by the MDM.032 group, is very similar to the FAA Light sport aircraft, with a MTOM of 600 kg. However, also the privileges for the FAA Light sport aircraft have a number of additional operational and aircraft performance restrictions. For this category of aircraft only, FAA accepts a lower level of medical requirements, corresponding to those required to hold a driving licence.

Generally, the medical requirements for LPL, if they will be implemented, are set at a very low level, for some conditions even below the requirements to hold a driving licence according to the EU Directive 2006/103/EC. If any medical requirements, at a level so far below ICAO class 2 will be implemented, they should only be applicable for ELA-1 with very restricted privileges similar to those applied to FAA Light sport aircraft.

For LPL, the worldwide accepted level of ICAO class 2 medical requirements should be kept in the same way as for the FAA Recreational pilot licence.

3. Comparison between LPL and PPL privileges

The vast majority of PPL holders fly singe-engine piston aircraft with a MTOW of less than 2000 kg and a maximum of 4 seats. Only a very small number fly larger or complex aircraft, or have IR or ME-ratings. A full LPL will give the same privileges to fly in the same classes of airspace, with the same class of aircraft, including carrying 4 passengers.

The proposed medical requirements for LPL will introduce a new set of rules for the same category of operations and with the same privileges as an ordinary PPL, but considerably below ICAO standards. To introduce a second set of rules for the same privileges does not follow the principle of equity, and from a safety perspective there seems to be no justified reason for the proposal. Both types of licenses should be subject to the same medical criteria, including the validity periods.

Introducing several levels of requirements will also create confusion, both among

pilots and among medical examiners.

If a holder of a PPL and class 2 medical certificate no longer fulfils the class 2 requirements, he/she might fulfil the lower requirements for LPL and might therefore decide to request a LPL, which will give him/her the same privileges as the previous PPL (except for possible multi-engine or instrument rating). This happened with the US Sport Pilot Licence, which mainly attracted PPL holders who no longer fulfilled the medical requirements. According to the FAA website, the FAA, in the interest of public safety, had to add a provision stating that an applicant for a Sport Pilot Licence shall previously not have been deemed medically ineligible for a PPL.

For LPL, a corresponding provision must be included in the regulation.

4. References to the Basic regulation

Paragraph (3) of the recital to the Basic Regulation reads: "Community essential requirements and rules adopted for their implementation should ensure that Member States fulfil the obligations created by the Chicago Convention."

Paragraph (4) of the recital to the Basic Regulation reads: "The Community should lay down, in line with standards and recommended practices set by the Chicago Convention, essential requirements applicable to [...]. The Commission should be empowered to develop the necessary implementing rules."

Some of the proposals in Subpart A, the whole proposal for LPL medical requirements in Subpart B, section 3, and Subpart D are far below the Standards and Recommended practices in Annex 1 to the Chicago convention. This will have the implication that a regulation will be enforced on all EU member states preventing them from fulfilling the obligations created by the Chicago Convention. This is not according to the intentions of the Basic regulation and can not be accepted.

Article 7 of the Basic Regulation requires that the implementing rules concerning LPL shall ensure that the level of safety is maintained.

Several proposals in Subpart A concerning LPL, the whole proposal for LPL medical requirements in Subpart B, section 3, and the GMP proposal in Subpart D will make quality control and corrective actions concerning LPL extremely difficult. The requirements are far below the presently used JAR-FCL 3 requirements and the ICAO Standards and Recommended practices in Annex 1 to the Chicago convention. The proposed requirements will lead to a lack of control to such an extent that the level of safety can not be maintained, which is not in line with the requirements in Article 7 of the Basic regulation.

Annex III to the Basic regulation, para 4.a.1 states that compliance with the requirements "must be shown by appropriate assessment based on aero-medical best practice".

Several proposals in Subpart A concerning LPL, the whole proposal for LPL medical requirements in Subpart B, section 3, and the GMP proposal in Subpart D do not require any assessment based on aero-medical best practice. A GMP has

neither sufficient aeromedical nor operational knowledge to make an aeromedical assessment or to tell a licence holder whether a condition may make it unsafe for him/her to perform his duties. The Essential Requirements laid down in Annex III to the Basic regulation are thus not fulfilled for LPL.

5. Level of medical requirements for LPL.

The binding requirements in MED.B.090 of the Implementing Rules do not include any physical examination of the applicant, except for the musculoskeletal system. It would not be possible, or not even permitted, for a physician to issue a certificate of medical fitness without a full physical examination. For flight safety issues, the most important parts to be covered by the physical examination are the cardiovascular, neurological, and mental status of the applicant. These areas are not covered at all by the Implementing Rules for LPL, which is not acceptable.

For LPL, the detailed descriptions of medical status required and possibly disqualifying conditions are only found in the AMC to MED.B.090.
. In an AMC, the use of the binding "shall" is not permitted. The word "should" is only a recommendation, which any physician unaware of EC legislation might deviate from. This will result in a totally uncontrollable situation for LPL where, in reality, no regulation is effective at all. This is against the principle of equity and will not fulfil Article 7 of the Basic Regulation, requiring the IR to ensure that the level of safety is maintained. This is unacceptable from both a medical and a legal standpoint.

If there should be any separate medical requirements at all for LPL, they must be binding and included in the IR and not only in the AMC.

The ICAO Standards and Recommended Practices outlined in Annex 1 to the Chicago convention represent the aero-medical best practice world-wide and are based on long, world-wide experience. The proposed medical requirements for LPL in the AMC to MED.B.090 are presented without any scientific medical support, raising questions on the validity and evidence for the proposals. Some of the proposed standards appear to be in conflict with scientifically proven medical data, even with deviations from validated standard examination methods. The AMC to MED.B.090 is mainly focused on description of previous disease instead of the required assessment of present physical and mental status and fitness to fly. In several instances, the levels set are in contradiction to widespread aeromedical and traffic medicine experience.

The LPL medical report form outlined in AMC to MED.A.040 does not cover many potentially dangerous medical conditions, e.g. no assessment of previous or present vestibular function or present mental status is included. Also, several questions are not relevant for an aeromedical assessment.

In the requirements for LPL in AMC to MED.B.090, there are a number of inconsistencies resulting in a number of potentially dangerous medical conditions not being covered, or described only at a superficial and inappropriate level for flight safety. At the same time, other conditions are described extremely detailed, far more than required for class 1 and class 2 assessments. Some of the detailed requirements seem to reflect the area of interest of the author, and not flight safety related issues. For class 1 and class 2 assessments, performed by an AME,

AeMC or the licensing authority, more flexibility is included in the requirements than for LPL, which in many areas results in disproportionate requirements for LPL. AMC to MED.B.090 also has a number of inconsistencies both with the IR in MED.B.090 and the examination form in AMC to MED.A.040. as well as a number of ambiguities, which is unacceptable in a regulatory text.

Annex III to the Basic regulation, para 4.a.1 states that compliance with the requirements "must be shown by appropriate assessment based on aero-medical best practice". MED.B.090, the AMC to MED.B.090 and the AMC to MED.A.040 do neither require an appropriate assessment, nor are they based on aero-medical best practice. Therefore, they can not be accepted.

6. Requirements for LPL holders

Unlike holders of class 1 and class 2 medical certificates, the holders of a LPL medical certificate are only required to inform their doctor when being examined for medical conditions, not to seek the advice. The proposed MED.A.060 (c) is not in conformity with MED.A.025. It is also a deviation from the ICAO Standard. A LPL holder may also continue to fly with a dangerous condition until advised not to do so, while class 1 and class 2 holders are obliged not to exercise their privileges until being declared fit. This Implementing Rule will neither ensure that the level of safety is maintained, which is required in Article 7 of the Basic Regulation, nor fulfil the requirement for an appropriate assessment based on aero-medical best practice as laid down in Annex III to the Basic regulation.

Proposal:

The present proposed medical requirements for LPL can not be accepted.

The ICAO class 2 standards and recommended practices are based on world-wide experience and should be used also for LPL. The medical requirements for LPL will then also be in conformity with the medical requirements for the FAA Recreational pilot licence, which would facilitate future EASA-FAA harmonisation.

If any separate requirements should be used for LPL, they should be revised after an independent safety assessment has been made, and be included in the IRs. They should then be limited to ELA 1-aircraft of less than 600 kg MTOM as proposed by the MDM.032 working group, and with operational limitations similar to the FAA Light sport aircraft pilot licence. Such an approach would facilitate future EASA-FAA harmonisation also for this category of aviation.

response *Noted*

Thank you very much for this elaborated and detailed comment. The medical provisions for the LAPL have been redrafted to better reflect medical principles for aviation.

comment *1558* comment by: *Swiss Association of Aviation Medecine*

Comment:
LPL pilots and class 2 pilots use the same airspace and can fly nearly the same type of aircrafts (in class 2 only heavier and with a higher cruising range) and

	they have the same privileges. Therefore it does not make sense to have, from a safety perspective, different requirements for these two kinds of licenses. It looks like the LPL is introduced only as a result of enormous pressure of the leisure pilot associations. The requirements are lower than the ones for sailing a boat on a lake. If a plane with the weight of two tons crashes in a public building it can cause fatal accidents and death to people in this area. **Proposal:** Delete the LPL Section (see also below)
response	*Noted*
	The Basic Regulation (EC) No 216/2008 requires to introduce a leisure pilot license. There is no possibility to delete this section. Also see response to comment No 285.

comment	*1643*	comment by: *Des Russell*
	I believe that any pilot deemed fit by his GP should be allowed to fly and has the right to do so being a Europeon citizen. I therefore support the LPL and the medical standards laid down for this. The authorisation of the LPL should be left to the individual member state. Private pilots are just that,not commercial pilots, and the danger to them and others due to a medical problem is far less flying a light aircraft than driving a vehicle on a motorway.	
response	*Noted*	
	There is no 'right to fly' but a priviledge of a licence that can be exercised if all training has been done, all tests are passed and aeromedical fitness has been confirmed. The risk of flying light aircraft is seen as lower as other flying activities and therefore the medical standard is lower than e.g. for commercial aviation. However, a minimum standard will be kept because the airspace is used by all. The Member States actively transferred their powers to regulate pilot licences and medical certificates to the European Union and their intention is not to reverse that decision.	

C. Draft Opinion Part-MED — Subpart B: Requirements for Medical Certificates — Section 3: Specific requirements LPL medical certificates — MED.B.090: Medical examination of applicants for LPL medical certificates p. 18

comment	*88*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **Med B 090 section 3** **Page**: 18 Relevant Text: all	

Comment:
Examination not defined

Proposal:
Version 1 :From ...shall remove text and insert: shall be executed according to the class II examination

Version 2 . delete complete chapter and let the applicants give a self declaration

response *Noted*

The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.

comment *128* comment by: *Civil Aviation Authority - The Netherlands*

MED.B.090, onder 1. (Blz. 18 van 66)
De eis van EASA de medische geschiedenis van de kandidaat te beoordelen is uitsluitend mogelijk op basis van hetgeen mondeling is medegedeeld door de kandidaat. In Nederland geldt het medisch beroepsgeheim. Een arts is niet verplicht een medisch dossier op aanvraag te verstrekken aan een andere arts. Nationale wet- en regelgeving zal op dit punt niet worden aangepast.

MED.B.090. (Blz. 18 van 66)
De CAA-The Netherlands acht de eisen van onderzoek te summier. Volgens de CAA-The Netherlands ontbreken in ieder geval hart en long onderzoek.

response *Noted*

The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.

comment *261* comment by: *Lufthansa German Airlines*

Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany
Section: MED.B.090
Page: 18

Relevant Text:
Aeromedical examination and assessment of applicants for a LPL medical certificate shall consist at least of the following :
(1) evaluation of their medical history;
(2) examination of vision;
(3) urine test;
(4) blood pressure test;
(5) whispered voice test;
(6) examination of musculoskeletal system.

Comment: According to medical good-practice no medical certification for any purpose can be issued without a general examination of the patient. When focussing the general examination on the musculoskeletal system alone, the

	physician is ex expected to issue a positive certificate even in the presence of otherwise evident disease (heart failure, permanent defects after stroke, personality disorder etc.). How should a physician diagnose a severe valvular heart failure, if cardiac auscultation (a normal procedure in any medical examination) is abolished? The registration of an ECG is a cheap and helpful examination, that is obligatory even in medical certificates for sporting events (marathon) or for diving purposes. Examination of red blood count is essential to protect the patient from hypoxia due to anaemia or haemoglobinopathy, regardless of the desired class of certificate. Should a pilot, bearing the responsibility for 3 more passengers, be examined more lenient than a sportsman bearing the responsibility for himself only? **Proposal**: Aeromedical examination and assessment of applicants for a LPL medical certificate shall consist at least of the following : (1) evaluation of their medical history; (2) examination of vision; (3) urine test and cell count; (4) blood pressure test; (5) whispered voice test; (6) sound general examination. (7) ECG at rest and at stress, if medically indicated.
response	*Noted*
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.

comment	*336*	comment by: *FOCA Switzerland*
	MED.B.090 Privileges for LPL Pilots will be in many aspects similar to PPL privileges. The proposed LPL medical standards are below ICAO and even below driving license standards. The EASA Class 2 proposals are significantly lower than previous JAR Class 2 standards, therefore they are also appropriate for LPL privileges. A single system for Class 2 and LPL is easier to adapt to new medical knowledge than two different systems. Proposal: **Delete Section 3 (including only para MED.B.090) . Include LPL requirements in the Class 2 requirements in the entire section 2.**	
response	*Noted*	
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.	

comment	*355*	comment by: *Teh Danish Organiation of Flight Surgeons (DAFLO)*
	Objection: Disagree **Reasons:** Pilots holding LAPL's may fly aircrafts weighing up til 2000 kg in the	

	same airspaces as polits holding conventional PPL. Issues concerning fligth safety ar consequently equal and therefore health related conditions should be alike af well. **Suggestions:** In case of introduction of LAPL it is strongly recommended athe health requirement at least follow the ICAO standards
response	*Noted*
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.

comment	*402*	comment by: *European CMO Forum*
	Comment: These LPL proposals are lower, in many instances, than in the European driving standard directive. The NPA Class 2 proposals, based on ICAO, are an appropriate standard for private and leisure pilots. Justification: The ICAO standards are internationally accepted as the suitable level for private flying. Flexibility for individual medical circumstances is being included in the Class 2 proposals. A two tier medical system for pilots is less bureaucratic than the proposed 3 tier system and more appropriate for medical regulation. Proposed Text: Delete Section 3 MED.B.090 and the LPL proposals.	
response	*Noted*	
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.	

comment	*542*	comment by: *British Microlight Aircraft Association*
	Accepted	
response	*Noted*	
	Thank you for the positive comment.	

comment	*824*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM) - Internal Medicine Group - **Section: Draft Decision AMC and GM for Part Medical and AMC to MED B.090**	

Page: 18, 60 ff.

Relevant Text:
All of it

Comment:
If our comments are not accepted, the responsibility for issuing the LPL licence and for aeromedical consequences must be taken by the licensing authorities. The Internal Medicine working group would strongly recommend to any medical doctor not to issue a LPL-medical certification as a legal document under the existing conditions.

Proposal:
Set Class 2 standards and certification procedures as a reasonable, minimum, safe and acceptable standard for any Aeromedical certification.

response *Not accepted*

The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.

comment *1049* comment by: *Ilse Janicke Heart Center Duisburg*

II. Medical Report
"if any of the answers are in a shaded box the medical report should be referred to the licensing authority".
That needs a long time for the pilot to get the license. The licensing authority often have little experience of the air sports and little experience in medical decisions or none medical doctor in the lokal Authorities.
Proposal: The licensing authority in conjunction with air sports federations could appoint medical advisors to assist AMEs and GMPs in assessing applicants. A large enough and experienced group could become professionaly responsible to the authority.

response *Noted*

Licensing authorities always have doctors with at least privileges to issue Class 1 medical certificates and advanced experience in aviation medicine. Aeromedical examiners are specially trained and experienced in the aeromedical evaluation of applicants and introduction of additional medical advisors will only lead to a longer LPL medical examination.

comment *1055* comment by: *Dr Michel Kossowski AeMC Clamart*

Precise the type of whispered test : ear by ear? binaural? Give any value : for example if the whispered voice is not understood at 30 cm of the ear, the mean deficience is about 30 db

response *Accepted*

The whispered test is more strict than the test of the conversational voice for PPL.

	It will be changed into a conversational speech test.

comment	*1102*	comment by: *Regierung von Oberbayern-Luftamt Südbayern*
	Im Gegensatz zu den detailierten Anforderungen an ein Medical der Klassen 1 bzw. 2 (vgl. MED.B.005 ff.) sind die Anforderungen an ein LPL-Medical äußerst spärlich. Der größte Teil ist "nur" in AMC`s geregelt. Es scheint uns bedenklich, die gesundheitlichen Anforderungen an die gesundheitliche Tauglichkeit, ein Luiftfahrzeug zu führen, in sogenannten "non-binding" AMC`s zu regeln. Dies könnte letztlich dazu führen, dass einzelne EASA-Mitgliedsstaaten im Laufe der Zeit auf Antrag alternative AMC`s zulassen und damit in verschiedenen Staaten unterschiedliche Anforderungen an die gesundheitlichen Voraussetzungen gestellt werden, die ein Privatpilot aufweisen muss. Dies würde nicht nur zu Verwirrung und Verunsicherung bei den beteligten Flugmedizinern und Piloten führen, sondern auch zu einer Rechtsunsicherheit, ob die aktuell jeweils angewendeten AMC`s einer Prüfung durch die EASA letztlich standhalten. Hinsichtlich der gesundheitlichen Anforderungen und deren Bedeutung für die Sicherheit des Luftverkehrs erscheint uns eine derartige Flexibilität nicht als angebracht. Im Übrigen geht die Umsetzung des "reduzierten" LPL-Medicals nicht mit dessen Begründung im RIA in NPA 2008-22f (dort 2.12.1) konform. Auf unseren dortige Anmerkung nehmen wir Bezug.	
response	*Noted*	
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.	

comment	*1150*	comment by: *Keith WHITE*
	Attachments #16 #17	
	Are these also to be the requirements for the LPL(S) and SPL licences? A urine test would considerably complicate the examination, making it no longer something that a GMP could do in surgery. This would add considerably to the cost of issuing the medical certificate. This is not a requirement of the UK BGA medical certificate. Please find attached the UK BGA requirements referred to in the Laws and Rules para 16.4 [no longer available at the site stated in L&R]. I do not believe there is any evidence to show that adherence to these rules results in danger to glider pilots or to the public. The UK BGA web site contains 179 accident reports going back to 2002. There is only one incident of fatality to a member of the public, and this incident was not caused by a medical condition of the pilot. Whilst there are numerous pilot deaths reported, none is attributed to medical causes.	
response	*Noted*	
	Requirements of MED.B.090 are for LPL(S) licence holders. SPL license holders	

	have to meet Class 2 medical requirements. Urine testing is considered a part of any aeromedical examination to discover cases of diabetes.

comment	*1224*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Comment: The requirements in MED.B.090 do not include any physical examination of the applicant, except for the musculoskeletal system, which is not even included in the LPL requirements in AMC to MED.B.090 ! According to Swedish national law, it is not permitted for a physician to issue a certificate of medical fitness without a full physical examination. For flight safety issues, the most important parts to be covered by the physical examination are the cardiovascular, neurological, and mental status of the applicant. These areas are not covered at all by the regulation, which is not acceptable. The more detailed descriptions of medical status required and possibly disqualifying conditions for LPL are only found in the AMC to MED.B.090, which means that the text contains no binding "shall" but only recommended "should", which any physician can deviate from. This will result in a totally uncontrollable situation for LPL where, in reality, no regulation is effective at all. This is against the principle of equity and will not fulfil Article 7 of the Basic Regulation, requiring the IR to ensure that the level of safety is maintained. This is unacceptable from both a medical and a legal standpoint. If there should be any separate medical requirements at all for LPL, they must be included in the IR and not only in the AMC. **Proposal**: Delete Section 3, MED.B.090 and the corresponding AMC to MED.B.090.	
response	*Noted*	
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.	

comment	*1297*	comment by: *David Chapman*
	While most sub parts here are obvious, it is not clear what is needed from the MED.B.090 (3) Urine test -> test for colour? test for incapacitating drugs? every known test "just in case"? Degree of fitness or incapitation? The GMP may not be aware of what is needed for an LPL -> the assessment should be considered as it it were fitness for a motor vehicle licence?	
response	*Noted*	
	The medical provisions for the LAPL were redrafted to address concerns of low standards expressed in many comments. The medical standards for driving are lacking consideration of the third dimention involved when flying an aircraft.	

comment	*1322* ❖	comment by: *Markus Hitter / JAR-Contra*

Deutsch: (english below)

Eine Betrachtung der Statistiken der Erfolge der bisherigen Tradition, für eine Fluglizenz grundsätzlich eine eingehende ärztliche Untersuchung zu fordern, ergibt klar, dass medizinische Insuffizienzen als nicht sinnvoll vorhersagbar gelten müssen. Dass die Basic Regulation keineswegs umfangreiche medizinische Untersuchungen fordert, wurde bereits in Kommentar Nr. 157 zur NPA 2008-17a beschrieben.

Uns ist keine einzige Studie bekannt, die die Beibehaltung des Medicals in der Privatfliegerei befürworten oder nahe legen würde. Dagegen gibt es eine Reihe von Studien, die die geringe Wirkung flugmedizinischer Vorschriften nahe legen oder nachweisen. Darunter sind:

1) Die amerikanische AOPA hat eine Befreiung vom Medical für eine Probefrist durchgesetzt und gegen Ende der Probezeit festgestellt, dass diese Befreiung keinerlei negative Auswirkungen hatte:

http://www.aopa.org/whatsnew/newsitems/2003/030116petition.html

Folgerichtig sind heute weite Teile der US-amerikanischen privaten Luftfahrt von der Medicalpflicht befreit.

2) Die deutsche Studie BEKLAS hat medizinische Unfallursachen als vernachlässigbar festgestellt. Weder die Sehschärfe sei von entscheidender Bedeutung (Kapitel 5.3.3. Satz 3.) noch kämen medizinische Ursachen überhaupt bei den Unfallursachen von Kollisionen in der Luft vor (Kapitel 5.4).

http://www.daec.de/flusi/downfiles/Beklas/BEKLAS_Abschlussbericht.pdf

3) Der französische Rapport Senateur Belot stellt fest, dass Luftfahrzeuge, die ohne Medical zu betrieben sind, deutlich geringere Unfallzahlen erfahren als solche, die mit einer medicalpflichtigen Lizenz zu betreiben sind. Siehe Seite 19 unten:

http://www.aviation-civile.gouv.fr/html/avia_leg/pdf/Rapport_senateur_belot.pdf

4) Der deutsche Arzt Claus-Dieter Zink rechnet ohne Mühe vor, dass statistisch gesehen nur alle 3000 Jahre ein einziger Unbeteiligter durch medizinische Insuffizienzen eines Piloten zu Schaden kommt. Es ist also nicht verwunderlich, dass dies in den bislang 100 Jahren der Zivilluftfahrt noch kein einziges Mal vorgekommen ist:

http://jarcontra.csa-gmbh.com/joomla/index.php?option=com_content&task=view&id=424&Itemid=1

Da die LPL-Lizenzen als nicht ICAO-konform geplant sind **schlagen wir vor**, die medizinische Untersuchung durch eine im Einverständnis mit seinem Hausarzt erbrachte Selbsterklärung des Piloten zu ersetzen. Dies ist für die Sicherheit mehr als ausreichend und genügt den Anforderungen der Basic Regulation.

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English:

Looking at statistics regarding the achievements of the present tradition of requiring detailed medical examinations for any type of flight license the outcome is clearly, medical insufficiencies can't be predicted in a reasonable way. In comment no. 157 to NPA 2008-17a we already laid out why the basic regulation does not require detailed medical examinations.

We're not aware of any scientific study which would suggest keeping medical certificates in private aviation. However, there's a whole bunch of studies which show up the minuscule significance of aeronautical medical examinations. Among those are:

1) US-american AOPA has accomplished relief from a medical certificate for some probation period and at the end of this period it was determined freeing private pilots from a medical has zero negative consequences:

http://www.aopa.org/whatsnew/newsitems/2003/030116petition.html

Accordingly, wide parts of US-american private aviation are freed from enforced medical certificates today.

2) The german study BEKLAS has recognized accidents due to medical reasons are negligible. Neither sharpness of eyesight would be of significance (chapter 5.3.3., sentence 3) nor any mid-air collision can be justified by medical reasons (chapter 5.4).

http://www.daec.de/flusi/downfiles/Beklas/BEKLAS_Abschlussbericht.pdf

3) The french Rapport Senateur Belot determines aircrafts which are allowed to be operated without medical certification experience much less accidents than aircrafts which require an enforced medical. See page 19:

http://www.aviation-civile.gouv.fr/html/avia_leg/pdf/Rapport_senateur_belot.pdf

4) German physician Claus-Dieter Zink demonstrates without trouble a calculation which proves, statistically once in 3000 years a casual bystander is harmed due to an aircraft coming down due to medical incapacitation of it's pilot. Seeing this, it's not surprising this hasn't happenend during the past hundred years of human aviation yet:

http://jarcontra.csa-gmbh.com/joomla/index.php?option=com_content&task=view&id=424&Itemid=1

As LPL licences are planned to be not conforming to ICAO requirements, **we propose** to require a self-declaration of the pilot in accordance with his general medical pracitcioner instead of detailed medical examinations. This is more than sufficient for safety and conforms to requirements of the basic regulation.

response *Noted*

The medical provisions for the LAPL were redrafted to address concerns of unacceptably low medical standards for the LAPL expressed in many comments.

	However, the requirements remain below ICAO class 2 standards. A self-declaration is not possible becasue the Basic Regulation requires all pilots to hold a medical certificate.

comment	*1450*	comment by: *Michel KOSSOWSKI*
	MED.B.090 (5): precise the type of whipered test : ear by ear, both ear. Give any value : for example if the whispered voice is not understood at 30 cm of the ear, the mean deficience is about 30 db...	
response	*Noted*	
	Please see response to comment No 1055.	

comment	*1597*	comment by: *DGAC FRANCE*
	MED B .090 Medical examination of applicants for LPL medical certificates Comment : New class 2 European rules have been settled to ICAO rules. That was accepted by a major part of the countries as a compromise. Whatever the physician designated by the authority, the medical rules about LPL licence don't seem adapted. ICAO rules accepted by all states are a better compromise. The study of medical LPL rules compared to the actual science data (consensus conference) are not in conformity with some pathologies (coronary artery disease, aorta aneurism). MODIFICATION : MED B .090 Aeromedical examination and assessment of applicants for LPL medical certificates shall consist ~~at least of the following~~ **in a class 2 medical examination.** ~~(1) evaluation of their medical history~~ ~~(2)examination of the vision ;~~ ~~(3)urine test ;~~ ~~(4)blood pressure test ;~~ ~~(5)whispered voice testt ;~~ ~~(6)examination of musculoskeletal system.~~	
response	*Noted*	
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.	

comment	*1626*	comment by: *Bayerisches Staatsministerium für Wirtschaft, Infrastruktur, Verkehr und Technologie*

	Im Gegensatz zu den detailierten Anforderungen an ein Medical der Klassen 1 bzw. 2 (vgl. MED.B.005 ff.) sind die Anforderungen an ein LPL-Medical äußerst gering. Der größte Teil ist lediglich in AMC`s geregelt.  Es erscheint nicht angemessen, die gesundheitlichen Anforderungen an die gesundheitliche Tauglichkeit, ein Luftfahrzeug zu führen, in sogenannten "non-binding" AMC`s zu regeln. Dies könnte letztlich dazu führen, dass einzelne EASA-Mitgliedsstaaten im Laufe der Zeit auf Antrag alternative AMC`s zulassen und damit in verschiedenen Staaten unterschiedliche Anforderungen an die gesundheitlichen Voraussetzungen gestellt werden, die ein Privatpilot aufweisen muss. Dies würde nicht nur zu Verwirrung und Verunsicherung bei den beteligten Flugmedizinern und Piloten führen, sondern auch zu einer Rechtsunsicherheit, ob die aktuell jeweils angewendeten AMC`s einer Prüfung durch die EASA letztlich standhalten. Hinsichtlich der gesundheitlichen Anforderungen und deren Bedeutung für die Sicherheit des Luftverkehrs erscheint eine derartige Flexibilität nicht als angebracht. Statt Im Übrigen geht die Umsetzung des "reduzierten" LPL-Medicals nicht mit dessen Begründung im RIA in NPA 2008-22f (dort 2.12.1) konform.
response	*Noted*
	Please see response to comment No 1102.

comment	*1640*	comment by: *Tomasz Gorzenski*
	Self-certification should be sufficient. Applicant should certify that he/she has not known medical problems or conditions which may adversely affect his/her ability to fly safely. Generally an applicant able to drive a car safely should considered himself/herself fit to fly - it should be sufficient to testify that the applicant has adequate distant vision acuity - 6/9 both eyes and 6/12 each eye separately (one eye with 6/9 should also be sufficient), no heart and high blood pressure problems, no evidence of epilepsy. This has worked for so many years and for so many thousands of people, flying safely balloons, gliders and ultralights, and skydiving, that cannot be ignored.	
response	*Noted*	
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.	

comment	*1767*	comment by: *Civil Aviation Authority Finland*
	MED.B.090 These LPL proposals are lower, in many instances, than in the European driving standard directive. The NPA Class 2 proposals, based on ICAO, are an appropriate and better standard for PPL and LPL pilots. The ICAO standards are internationally accepted as the suitable level for private flying. Flexibility for individual medical circumstances is being included in the	

	Class 2 proposals. A two tier medical system for pilots is less bureaucratic than the proposed 3 tier system and more appropriate for medical regulation. **Delete Section 3 MED.B.090 and the LPL proposals totally.**
response	*Noted*
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.

comment	*1867*	comment by: *Dr Stephen Gibson*
	re Med B.090 Medical examination for LPL I suggest add to the end " Except where a GMP has an adequately longterm and complete medical record of an LPL applicant in which case the GMP holding the record should be allowed to issue a valid EASA LPL medical certificate without further examination if the GMP is willing to do so, other than examination of the self declaration of the applicant and the medical records . The examination in Part A of the Medical certificate can be completed by giving the last recorded date of such measurements unless this date is more than 5 years previous or such lesser period as specified in Med A.055 (a)(4) Reason: I have not found in 216/2008 a requirement for physical examination. If the medical records hold sufficient information already then it seems an uneccessary burden to demand examination for LPL purposes.	
response	*Noted*	
	Medical examination of LPL is based on Basic Regulation Article 7(2) fourth subparagraph: '... a general medical practitioner ... may ... act as an aeromedical examiner ...' It is compulsory for aeromedical examiners to perform physical examinations of the applicants for any kind of medical certificate.	

comment	*1956*	comment by: *Civil Aviation Authority of Norway*
	A complete medical examination is basicly necessary to make an assessment of fitness to fly. A questionnaire cannot replace that.	
response	*Noted*	
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments. The questionnaire has been withdrawn.	

comment	*2153*	comment by: *BMVBS (German Ministry of Transport)*
	The medical requirements for LPL are insufficient. MED.B.090 does not constitute a performance requirement, as it does not specify sufficiently clear enough, what the safety objective is. It appears inappropriate to place the actual medical requirements in AMC material. Consequently, every member state would be free	

	to set the actual minimum requirements via alternate AMC material as it prefers. A regulatory race to the bottom would be the result. Apart from that Germany holds the view that LPL holders should comply with class 2 requirements!
response	*Noted*
	See response to comment No 1626 in this section.

comment	*2211*	comment by: *Royal Netherlands Aeronautical Association*
	Medical examination The parts 1-6 of the medical examination does not reflect the content of the AMC on Specific medical requirements. KNVvL PROPOSAL: Aeromedical examination and assessment of applicants for a LPL medical certificate shall consist at least of the following: (1) evaluation of their medical history; (2) physical examination, including: 1. the cardiovascular system 2. the pulmonal system 3. the neurological system 4. the visual system 5. vestibular and otorhino-laryngologic system 6. the musculoskeletal system	
response	*Not accepted*	
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.	

comment	*2399*	comment by: *Irish Aviation Authority*
	These LPL proposals are in many cases lower than the European driving standard directive. The NPA Class 2 proposals, based on ICAO, are a good standard for private and leisure pilots. Justification: The ICAO standards are internationally accepted as the suitable level for private flying. Flexibility for individual medical circumstances is included in the Class 2 proposals. A two tier medical system for pilots is less bureaucratic than the proposed 3 tier system and much more appropriate for medical regulation. Proposed text: ~~Section 3 MED.B.090 and the LPL proposals~~.	
response	*Noted*	
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.	

comment	*2421*	comment by: *CMO/AMC and President of Danish Aviation & Marine Medical Association*
	The consideration of LPL and GMP is a joke! – Why have Rulemakers required applicants to be able to hear whispered voice and not to have a normal vestibular function (and examine the vestibular system)? As the requirements have been stated, LPL pilots can have all kind of dizziness (beside Meniere's disease, which erroneously in the requirements is stated as a neurological disease)! Furthermore, no blood pressure limitations are mentioned etc. No proper education for the GMP is stated. It is believed that the GMP will refer any LPL applicant in case of inadequate fulfilment of requirements and problem with safe aviation. However, how does the poorly aviation medicine-educated GMP know this? What is the scientific evidence to introduce GMP and LPL? This system has only been tried for very few years in UK and has not been scientific evaluated in peer-reviewed journals.	
response	*Noted*	
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.	

comment	*2569*	comment by: *Heinz Fricke-Bohl and Kirsten Bohl*
	MED.B.090: LPL muss den gleichen Standard enthalten wie bei Klasse 2. Piloten haben kein Sonderstatus, sonst gäbe es nur Gefälligkeitsgutachten, wie schon oben erwähnt. Dieser Punkt sollte entfallen.	
response	*Noted*	
	The medical provisions for the LAPL were redrafted to address concerns expressed in many comments.	

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comment	*1177*	comment by: *FAI*
	Attachment #18	
	(CIMP) Pages 19 - 21 of 66 Whatever levels of fitness are decided, a mechanism has to be in place to ensure that individual pilots meet these requirements. EU nations have well developed health care systems covering the whole population. Eyesight of children is checked and refractive variations corrected. Disease is investigated, treated and recorded. The outcome is that pilot applicants are aware of their health status and the residual quantity of undiagnosed but serious disease prevalent in the population is small.	

The result is that almost all the information required to assess the fitness of a pilot is both known to the applicant and documented somewhere. While most pilots are honest and make a full declaration, sadly there is evidence that a few may be economical with the truth (11). Some serious adverse medical conditions are undetectable on routine clinical examination and this is a particular problem with neurological (epilepsy) and psychiatric disease. Falsification by applicants has been the subject of a Congressional Report (11) in the USA. Unreported and disqualifying treatment has been exposed during the investigation of accidents (12).

Following an accident in the UK when an epileptic gliding instructor, holding a pilot medical certificate, killed himself and a pupil; a system was introduced by which a sport pilot medical fitness could be validated against clinical records rather than by examination. Over more than forty years this has provided as good, if not better safety record than by clinical examination and is also economical of medical time. The UK was then unique in having a national system of transferable personal medical records, but these are becoming more usual in Europe. They have been introduced in France and four nations are proposing a summary record to be encoded on the European Health Card.

The Essential Requirements (5, Article 7) permit a General Medical Practitioner with 'sufficient detailed knowledge' to validate fitness. It is essential for Acceptable Means of Compliance to define this level of knowledge and it is suggested that at least three years of clinical records compiled for clinical purposes is a minimum. Then the availability of good records should obviate the need to spend expensive medical time screening for disease that would already be documented if present. This can be alternative for the LPL and is similar in principle to that laid down for the maintenance of aircraft where there can either be a continuing relationship with a maintenance organisation or a full independent survey. It is proposed that the validation of pilot declaration could either be by reference to records or by clinical examination. Such a system is in use by the New Zealand Gliding Association and the form is available on their web site (13).

CIMP CONCLUSION
-Self declaration is an integral part of all medical examinations and other licensing procedures. Falsification by applicants is a hazard for flight safety and undeclared disease has caused sudden incapacitations of pilots. Medical examinations cannot expose all incapacity causes and are expensive in medical time, generating high costs for the LPL.
-Suggestion: In nations with developed health care systems, serious but undiagnosed disease is uncommon. Measures to confirm the validity of pilot self declarations are as great a contribution to safety as examinations. This alternative should be accepted by all EASA states.

References:

11. United States House of Representatives; Committee on Transportation and Infrastructure. FAA Oversight of falsifications on airman medical certificate applications. Released March 27, 2007.
5. Regulation (EC) No 216/2008 of the European Parliament and of the Council of 20 February 2008 on common rules in the field of civil aviation.....
13. Gliding New Zealand

	www.gliding.co.nz/Operations/MOAP/Ops/Forms/OPS01%20Medical%20Declaration.pdf
response	*Noted*
	We agree that a self-declaration is an integral part of an aeromedical assessment. However, it is not the only one. The medical requirements for the LAPL have been redrafted to match the needs of aviation as opposed to the medical needed for a driving license. The standards are still lower than ICAO Annex 1 in order to attract as many young individuals into flying as possible and not to prevent the elderly from continuing their flying activities. On the other hand we think that the standards are adequate to maintain flight safety taking into account that this medical can be used for flying non-complex motor-powered aircraft up to a maw t/o weight of 2000 kg.

comment	*1354*	comment by: *PR Jean Pierre GOURBAT*

LE DIRECTEUR
General J.P GOURBAT
Professor at the Val de Grâce
Member of the Medical Council of Civil Aviation
President of the French Society of Aerospace Medicine

I am expressing myself here in the name of the 20 specialist physicians of aerospace medicine who have been working in the French centres of aeronautical expertise for years.

The objective that we all share is to maintain the flight safety.
Nevertheless, the decreasing incidence of the aircraft crashes related to a proven medical cause implies a will of relaxation of the lawful medical requirements, the periodicity of the visits and the qualification level necessary for the doctors in charge of the monitoring of the flight crew of civil aviation.
This will clearly appears in the proposals of the EASA.
The methods of organization of aeronautical medicine which are considered, do not take into account national specificities and existing structures. Their possible implementation will disorganize in a country as France the aeromedical organization without improving the flight safety, quite the reverse.
If a liberalization of requirements is legitimate, a full safety means it must be applied by experienced doctors in solid and adapted structures in every country, i.e. corresponding to the history, the culture and the uses.

The new text suggested by the EASA takes as a starting point various principles :

- Standardization of the practices in the European Union, with adjustment on the Anglo-Saxon practices;
- Will of simplification of procedures with a levelling down;
- Drastic reduction of medical requirements;
- Application of fitness standards by doctors who are little or not qualified in aeronautical medicine.

Two subjects appear essential and deserve to be detailed because they risk to

strike a blow at the aeronautical medicine in France if they are applied:
- The possibility that isolated aeromedical examiners to practise the periodical visits of class 1 pilots;
- The appearance of the leisure licence.

The coexistence of AMC (AeroMedical Centres) and AME (AeroMedical Examiners) has existed in the United Kingdom for a long time, but the fact is that this situation is adapted to their culture and their legal system.

In France, the monitoring of professional pilots is carried out in AMC exclusively. Sometimes pilots have to move a lot to get to these centres, their operation can be considered difficult at times, but qualitatively this centralized system presents only advantages.
Unfortunately, nowadays quality is out of place, simplification and economies are more important. To do that, the EASA introduces a possible competition between the AMC and the AME which appears in a recent history that it is useful to remind.

The medical expertise of the flight crew is governed in France by a decree of January 27th, 2005 relative to the physical and mental fitness of the technical flight crew of professional civil aviation, which was published in the Official Journal of the French Republic on March 13rd, 2005.
This text is the translation in the French law of the JAR FCL 3, which was the result of more than ten years of discussions between the various members of the JAA. The idea was a consensus which allowed every country to adopt a common attitude towards medical expertise problems.
This consensus respected both the organization of the aeronautical expertise medicine and the national specificities. In particular, it was expected that the examination of a professional pilot could be carried out by an AME ('may' and not 'shall' in the English text), letting the national authorities to choose their organization.

The text in the EEC 216 /2008 regulations introduces changes in this approach. It has not been the subject of a preliminary consultation, and there is an ambiguity.
It is written that the medical certificate can be delivered by an aeromedical examiner **or** an aeromedical centre. We will consider the interpretations that we can give to this "or".

The NPA 2008 17 C looks like the application decree of the ECC 216/2008 regulations, and it brings an interpretation to this "or"; thus "may" is turned into "shall", de facto imposing the coexistence of aeromedical centres and aeromedical examiners for the class 1 pilot certification in all countries.
This evolution appears extremely serious to us, it definitely does not take into account of the present situations, the cultural identities and the national methods of organization. Consequently, it imposes to every country, whatever its previous organization, the Anglo-Saxon organization which is not always adapted and shall disorganize the present structures without improving the flight safety.

A legal approach is needed:
The EEC 216/2008 regulations (OJEU 03.19.2008 p L79/1) concerning the medical certificates for pilots, in the article 7, paragraph 2, subparagraph 3, specify that a person is issued with a medical certificate only if this one satisfies the established rules to guarantee conformity with the essential requirements

relative to the medical fitness fixed in appendix 3.
This medical certificate can be issued by an examiner **or** a centre.

Are the examiner and the centre equal for the issue of the medical certificate ?
In order that the medical certificate should be issued in a completely equivalent way by the examiner or the centre, it is necessary to be sure that the required guarantees and safety rules are filled exactly the same on both sides.
The necessary conditions that the aeromedical examiner has to meet are very limited: to be allowed with the legal practice of medicine, to have received an initial and permanent training in aeronautical medicine, and to have knowledge and experience of the working conditions of pilots.

The conditions which are planned for the aeromedical centre are much more restrictive, seeing that it has to own means and staff necessary to assume the whole responsibilities related to its privileges, as well as installations, material equipments, technical tools, documentation, data access and filing system.
Moreover, the centre has to implement a management system relative to the safety and quality of the aeromedical assessments and also to a constant improvement of these systems.
It is also expected that the approval is granted to the aeromedical centre only when this one satisfies the established rules.
No equivalent approval system is discussed concerning the competence of the aeromedical examiner.

It appears that the pilots who will be assessed in an AMC or by an AME will not be treated in the same way. Moreover, the quality, equity and safety-first principles, required to achieve the objective of safety as specified in the Chicago convention, the ICAO and the European regulations, are not respected.

The whole French aircrew has always been selected and followed in the AMC. This system is qualitatively and quantitatively well adapted to our country. Thanks to it, the mission can be carried out with a relatively reduced number of highly specialized physicians in 5 fully equipped centres.
In the Principal Aeromedical Centre of Expertise of Aircrew in Paris, from 80 to 100 initial or renewal examinations for civilian and military crew members are carried out every day. Such a quantity of aeromedical assessments as well normal as abnormal confers a solid experience on medical experts who are used to broaching the limits of normality and the acceptable limits for fitness decisions in a legitimate way.

In such centres, the aeromedical expertise is plural, what offers a guarantee of quality and equity which is not met for isolated examiners.
If one compares the examination in an aeromedical centre and by a simple aeromedical examiner, it appears clearly that the qualitative level is not equivalent.
These questions have been studied in the Kourilsky and Viney report relative to the safety-first principle and in the Lepage commission's work within the framework of the Borloo mission about Grenelle of the environment, which have shown that **plural expertise is greatly higher than individual expertise.**
The problem of training and competence of the physicians in charge of

aeromedical examinations is also essential. In France, the physicians working in the military centres have profited from a 5-year special training to rise to a specialist qualification after passing final theoretical and practical exams.
The 10 aeromedical assessments which are daily performed on average by each physician, this specific training and a team work, allow examiners of these centres to answer the safety requirements which are asked by the French authorities and also by the European commission concerning the medical monitoring of class 1 pilots.

In France, the setting up authorization of isolated aeromedical examiners for class 1 pilots (AME), who will coexist with aeromedical centres (AMC), will call into question the present situation without a benefit for the flight safety, because it shall involve an economic competition. The AME shall profit from an asset of proximity and an attractive price (an isolated expertise is obviously less expensive than a plural expertise in a centre) to the detriment of quality, in particular when one examines the approval conditions for an AME.
In order to obtain this approval, actually you only have to be a present qualified examiner for class 2 pilots, to have carried out 30 aeromedical assessments (clearly a very limited experience), and to have followed an additional training anywhere in a European country. Then you only have to carry out 10 yearly assessments to keep this approval for unlimited period.
In this context, the conditions of practice and attribution of approvals are not equitable between the AMC and the AME, and the quality level suggested to the flight crew is not comparable.
Moreover, we shall witness a decrease of abilities. Indeed, the quality of aeronautical expertise is closely related to the number of examinations carried out, then the decreasing number of examinations in the AMC will affect their quality level, if they purely and simply do not disappear…

The best solution is to let the initiative to the national authorities with regard to the place of the AME in the management of class 1 pilots:

- opportunity of authorizing them,
- adaptation of the number to the needs,
- training and control exams at the national level only.

In France, our aviation medicine is a mature, old and structured medicine with very clear reference marks which are called into question by the EASA proposals.
1 - *The Medical Council of Civil aviation*, with its recognized medical experts who are used to examining the aircrew files in a full neutrality to discuss fitness with a waiver and limitations: in the NPA 2008 17 C, it is proposed that the files concerning class 2 pilots and LPL pilots will not be submitted to the Council anymore… It is extremely alarming.
2 - *The five Aeromedical Centres of Expertise of Aircrew*, at present with 2 civil centres and 3 military centres, which remain the backbone of the aeromedical organization… an essential problem we tried to develop.
3 - *The thousand qualified aeromedical examiners for class 2 pilots*, whose place in the service of general aviation is compromised by the appearance of the leisure licence.

The attribution of the leisure licence allows the holder to fly on practically all the

	aircrafts existing in flying clubs. Qualified examiners for class 2 pilots are almost excluded because the medical certificate can be issued by a general practitioner. Besides, the final objective of the extended periodicity is to eliminate the medical examination, and yet this examination remains annually required to practise almost any other sport. This licence practically based on an exclusive questionnaire is not adapted to our country. Standards of fitness, for instance aortic aneurism between 55 and 65 millimetres, are too much permissive and call into question the flight safety. **IN CONCLUSION :** Doctors, particularly in the AMC, unquestionably take part in the flight safety. Thus, a relaxation of the lawful medical requirements, which clearly appears in the new proposals of the EASA, defeats the initial safety purpose in aeronautics. In addition, the will of standardization within the European Community, with a typical Anglo-Saxon organization, shall disorganize the present aeromedical structures, particularly in France. All the changes which are suggested are likely to call into question the flight safety, then it is justified to revaluate them. It is strongly desirable that the national authorities decide on the implementation of these proposals, because they are in the best position to appreciate the opportunity and the details.
response	*Noted*
	Thank you for your detailed and elaborated comment. The Medical rules in NPA 2008-17c for class 1 and class 2 medical certificates are based on JAR-FCL 3 and ICAO Annex 1. For class 1 hardly any medical technical changes occurred and class 2 requirements were slightly lowered to strictly comply with ICAO class 2 standards. The system of independent AMEs class 1 and class 2 and AeMCs is a long established system that exists in JAR-FCL 3 and has been implemented in most countries in Europe without problems. Oversight by the licensing authority should ensure homogeneous decisions by AMEs and AeMCs and all AMEs should be trained to fulfil their obligations correctly. The European Member States transferred the legal powers to regulate aviation to the European Community and European law prevails over national law. It is therefore not possible not to authorise AMEs to carry out class 1 assessments (if they fulfil the requirements) or to limit the numbers of AMEs or AeMCs. The Light Aircraft Pilot Licence laid down in the Basic Regulation is agreed upon by all Member States. However, whether a GMP can act as AME or not is the decision of the individual Member State.

comment	*2202*	comment by: *Royal Netherlands Aeronautical Association*

	In geneneral regarding subpart C+D Self declaration and questionnaire Whatever levels of fitness are decided, a mechanism has to be in place to ensure that individual pilots meet these requirements. Pilot applicants are aware of their health status and the residual quantity of undiagnosed but serious disease prevalent in the population is small. The result is that almost all the information required to assess the fitness of a pilot is both known to the applicant and documented somewhere. Some serious adverse medical conditions are undetectable on routine clinical examination and this is a particular problem with neurological (epilepsy) and psychiatric disease). KNVvL PROPOSAL: -Self declaration and a questionnaire is an integral part of all medical examinations and other licensing procedures. -For all classes the same questionnaire has to be used -In all nations a self declaration in combination with a medical examination is necessary -The known questionnaires of JAR or ICAO are proven to be sufficient and relevant References: United States House of Representatives; Committee on Transportation and Infrastructure. FAA Oversight of falsifications on airman medical certificate applications. Released March 27, 2007. Regulation (EC) No 216/2008 of the European Parliament and of the Council of 20 February 2008 on common rules in the field of civil aviation.....
response	*Noted*
	Self-declaration — see response to comment No 1177. ICAO does not provide with the standard questionnaire form. JAR FCL 3 application form together with the applicants' authorisation for the examining physician to request medical information for the aeromedical assessment will be included in AMC.

comment	*2360*	comment by: *Federal Ministry of Transport, Austria (BMVIT)*
	We think that the content in subpart C should be placed into the IR concerning "authority requirements". The AME either acts on behalf of the authority or as authority in his/her own right (by issuing medical certificates). The legal status of Aero Medical Centres which are not contained in this IR but in the "authority requirements" is the same as that of an AME.	
response	*Noted*	
	Subpart C of Part MED addresses individual AMEs, whereas AeMCs are considered to be an Organisation and therefore regulated in Organisation Requirements. AMEs and AeMCs do not act as an authority and also not on behalf of the authority. They always need to be issued with an AME certificates or Oragnsiation approval (AeMC) and are under the oversight of the licensing authority.	

C. Draft Opinion Part-MED — Subpart C: Aero Medical Examiners (AMES) — MED.C.001: Privileges p. 19

comment	*9*	comment by: *GEMA*
	¿Qué es BII?	
response	*Noted*	
	There is no missing text in the MED.C.001 (b) (ii). The typing error will be corrected.	

comment	*57*	comment by: *CAA CZ*
	(b)(ii) - text missing	
response	*Noted*	
	See response to comment No 9.	

comment	*130*	comment by: *Civil Aviation Authority - The Netherlands*
	MED.C.001, onder b, onder ii. (Blz. 19 van 66) De CAA-The Netherlands merkt op dat er een drukfout staat in MED.C.001, onder b, onder ii. Het voorschrift is op dat onderdeel leeg.	
response	*Noted*	
	See response to comment No 9.	

comment	*543*	comment by: *British Microlight Aircraft Association*
	(a) accepted (b) (ii) missing (c) accepted	
response	*Noted*	
	(a) and (c) Thank you for the positive comments. (b)(ii) See response to comment No 9.	

comment	*689*	comment by: *BMVBS (German Ministry of Transport)*
	(b) (ii) missing	
response	*Noted*	

	See response to comment No 9.

comment	*797*	comment by: *George Rowden*
	Comment: The requirements for AMEs are set out in the basic regulation, 216/2008 which notes that they "have acquired practical knowledge and experience of the conditions in which pilots carry out their duties." This important proviso has been omitted from the NPA and needs addressing. Historically, where pilots have complained about a denial of certification, these denials have often been due to of a lack of knowledge AME's of the piloting task. I therefore propose that an implementing rule be drafted defining how the basic regulation in 216/2008 is to be enabled	
response	*Noted*	
	The Basic Regulation applies and is not repeated in the implementing rules. The training course will provide the AME with the necessary knowledge.	

comment	*987*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: **Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008** **Section: MED.C.001 (b) Privileges** **Page**: 19 Relevant Text: Holders of an AME certificate may apply for an extension of their privileges..... **Comment**: The text of MED.C.001 (b) should be in line with MED.C.001 (a), including not only the medical examinations but also the privileges to revalidate and renew class 1 medical certificates. For MED.C.001 (b)(ii) the text is missing ! **Proposal**: MED.C.001 (b) should be amended: *"Holders of an AME certificate may apply for an extension of their privileges to include* *(i) revalidation and renewal of class 1 medical certificates, and conduct the relevant medical examinations and assessments, when thy comply with the requirements in paragraph MED.C.015; and* *(ii) (missing text to be inserted) "*	
response	*Noted*	
	See response to comment No 9.	

comment	*1225*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.C.001 (b) **Comment**: The text of MED.C.001 (b) should be in line with MED.C.001 (a), including not only the medical examinations but also the privileges to revalidate and renew class 1 medical certificates. For MED.C.001 (b)(ii), the text is missing! This paragraph might include a provision for the competent authority to have flexibility when deciding the privileges of each individual AME and delegation of certain authority decisions. See also our comment to MED.A.030. **Proposal**: MED.C.001 (b) should be amended: "Holders of an AME certificate may apply for an extension of their privileges to include (i) revalidation and renewal of class 1 medical certificates, and conduct the relevant medical examinations and assessments, when they comply with the requirements in paragraph MED.C.015; and (ii) (missing text to be inserted) "	
response	*Noted*	
	See response to comment No 9.	

comment	*1882*	comment by: *AECA(SPAIN)*
	(b)(ii) This paragraph is blank	
response	*Noted*	
	See response to comment No 9.	

comment	*2195*	comment by: *DGAC FRANCE*
	FCL MED C .001 Comment : Each EASA country must designate its own AMEs within its national boundaries and control them. Modification : Add a paragraph (d) in MED C.001 Privileges as followed : **(d) The authority designate and authorize AMEs within its national boundaries. Physicians resident in non EU AELE and Switzerland wishing to become an AME may apply to EASA.**	

response	*Not accepted*
	The NPA follows the principle of free movement of people and workplace in Europe. This means that an AME who is authorised in one country can also have a practice in another EU Member State. However, the AME has to ensure that he/she complies with the national legislation of that other MS when doing so.

C. Draft Opinion Part-MED — Subpart C: Aero Medical Examiners (AMES) — MED.C.005: Application p. 19

comment	*10*	comment by: *GEMA*
	(b)(3) A qué se refiere?	
response	*Noted*	
	(b)(3) requires AMEs to issue medical certificates in accordance with the Agency's adopted IRs and AMCs and, under certain conditions, enables them to use alternative AMCs if alternative AMCs are adopted by the Agency. For the procedure please see Authority Requirements	

comment	*544*	comment by: *British Microlight Aircraft Association*
	Accepted	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1226*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Comment: The text is acceptable. To ensure harmonised application procedures throughout the EU, guidance material on the form and manner to make the application should be developed by EASA, possibly linked to the Part Authority Requirements. **Proposal**: AMC or guidance material should be developed by EASA.	
response	*Partially accepted*	
	Thank you for the support. An application form for the AME certificate will be developed.	

C. Draft Opinion Part-MED — Subpart C: Aero Medical Examiners (AMES) — MED.C.010: Requirements for the issue of an AME certificate p. 19

comment	*96*	comment by: *British Gliding Association*

Page 19 of 66
MED.C.010 Requirements for the issue of an AME certificate
Applicants for an AME certificate shall:
(a) be fully qualified and licensed for the practice of medicine and hold a qualification in general practice or other medical speciality relevant to aeromedical practice;
(b) have undertaken a training course in aviation medicine;
(c) demonstrate to the competent authority that they:
(1) have adequate facilities and functioning equipment suitable for aeromedical examinations;
and
(2) have in place the necessary procedures and conditions to ensure medical confidentiality according to the applicable national legislation.

Comment: The requirements for AMEs are set out in the basic regulation, 216/2008. In addition to aeromedical training, it is a requirement that they "have acquired practical knowledge and experience of the conditions in which pilots carry out their duties." This has been omitted from the NPA and no implementing rule exists except as an option for GMPs. This omission needs addressing. Many complaints have been made in the past by pilots against denial of certification and these often arose because of a lack of knowledge by doctors of the piloting task.
BGA Proposal: That an Implementing Rule be drafted defining how this basic law is to be enabled eg: the past or current possession of a pilot licence as in MED.D.001. It is accepted that many current AMEs do not comply with the basic law and 'grandfather rights' would have to be permitted.
Reference: Regulation (EC) No 216/2008 of the European Parliament and of the Council on common rules in the field of civil aviation... Annex 111, 4.b.1.(iii).

response

Noted

The Basic Regulation applies and is not repeated in the implementing rules. The training course will provide the AME with the necessary knowledge.

comment

131 comment by: *Civil Aviation Authority - The Netherlands*

MED.C.010, onder b. (Blz. 19 van 66)

De CAA-The Netherlands is van mening dat in de voorschriften eisen dienen te worden opgenomen waaraan de in voorschrift MED.C.010, onder b, bedoelde training dient te voldoen. In de JAR-FCL staan de eisen voor een dergelijke training, hetgeen de uniforme kwaliteit garandeert van de AME's. De CAA-The Netherlands acht dit niet overeenstemmend met de "level playing field" gedachte.

Voorts wordt opgemerkt dat de CAA-The Netherlands zich afvraagt of EASA voldoende heeft gerealiseerd dat het voor nationale autoriteiten niet mogelijk is om te verifiëren of het keuringsrapport van een buitenlandse keuringsinstelling, dat een kandidaat overlegt met het verzoek om afgifte van een medisch certificaat, ook daadwerkelijk is opgesteld door een arts.

De CAA-The Netherlands stelt EASA de vraag hoe een autoriteit toetst of het voor

	hem liggende buitenlandse keuringsrapport is opgemaakt door een arts?
response	*Noted*
	Syllabi for the basic, advanced and refresher training will be transposed from JAR FCL 3 to AMC and this will guarantee uniformity. The report received from the NAA is usually prepared by an AME. Training of AMEs is standardised in Member States and includes the training in the completion of medical reports. So far, we do not know cases when medical assessor of the NAA was not able to check the report written by his/her certified AME. Rules with regard to the transfer of the medical data from AME/AeMC or GMP to the licensing authority are proposed in MED.A.050 and AMC to MED.A.050.

comment	*446*	comment by: *UK CAA*
	MED.C.010 (a) **Comment:** The level of qualification and experience required to be a class 2 AME is far too low. The proposed standard could be met by a doctor who has not undertaken any significant postgraduate training. A doctor with such a low level of qualification and experience could not safely work in an unsupervised clinical environment. Completion of higher training is an essential pre-requisite for an AME. **Justification:** The aviation industry may reasonably expect that regulatory aviation medicine doctors should have qualification and experience similar to clinical care doctors. AMC material should clarify type of qualification required prior to approval and will ensure the quality of AMEs and standardisation of approvals. The proposed text should have the effect of maintaining AME numbers at a level that is satisfactory for maintaining safety oversight. **Proposed Text:** Replace MED.C.010 (a) and (b) with **MED.C.010 (a) 'have completed higher medical training, a basic course in aviation medicine and shall have qualification and experience in general and aviation medicine.'** Add AMC to **MED.C.010 (a)**: **'AME applicants should have qualification and experience totalling 4 points or more as follows:** ***General medicine*** **Completion of a higher training in any single area of medical practice, e.g. occupational physician, general practitioner, physician, surgeon, radiologist, anaesthetist etc 3 points** **Aviation medicine** **6 months or more full-time or part-time equivalent course in Aviation Medicine or equivalent (confers exemption from the requirement to have undertaken the basic and/or advanced course). 2 points**	

	OR **One year of full time, or part time equivalent, aviation medicine practice e.g. airline medical staff, air ambulance work, regulator, air force, air traffic control etc 1 point** **OR** **Two years or more of full time, or part-time equivalent, aviation medicine practice e.g. airline medical staff, air ambulance work, regulator, air force, air traffic control etc 2 points** **<u>Flying experience</u> (licences and ratings can be expired)** **ICAO PPL, EASA LPL or equivalent 1 point** **or** **ICAO CPL 2 points** **or** **ICAO Instrument Rating 2 points'**
response	*Noted*
	The text of the proposed rule will be amended in order to align it with the corresponding JAR FCL 3 requirements. Amendments to AME training could be considered in the rumaking task MED.001.

comment	*545*	comment by: *British Microlight Aircraft Association*
	Accepted	
response	*Noted*	
	Thank you for the positive comment.	

comment	*591*	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany Head of Lufthansa Medical Services Head of German Academy of Aviation and Travel Medicine Section: **Subpart C** **Aeromedical Examiners (AMEs)** **MED.C.010 Requirements for the issue of an AME certificate** **MED.C.015 Requirements for the extension of privileges** **Page**: 19 Relevant Text: MED.C.010 (b): have undertaken a training course in aviation medicine MED.C.015 (b) undertaken an additional training course in aviation medicine **Comment**: It should be a differentiation between training courses for class 2 AMEs and LPL-GMPs and the training course for class 1 AMEs. **Proposal**:	

	MED.C.010 (b): have undertaken a **basic** training course in aviation medicine MED.C.015 (b) undertaken an **advanced** training course in aviation medicine
response	*Accepted*
	Thank you for the proposal. The text in the IR will be amended accordingly. In addition, syllabi for both basic and advanced courses will be proposed in AMC.

comment	*676*	comment by: *Pekka Oksanen*
	Subpara (a): Medical training differs in member states. Therefore the authority must decide on the requirements. Propose a new insertion text: **Compentent authority defines the qualifications and experience of an AME in accordance with national medical regulation.**	
response	*Not accepted*	
	National medical regulation relates to the qualifications and experience of the medical professionals; however, the proposed rules regulate qualifications and experience of the aeromedical examiners. The EU Member States conferred the legislative powers for aviation to the Community and therefore these requirements are subject to community regulation.	

comment	*804*	comment by: *Swiss Association of Aviation Medecine*
	Comment: It should be a differentiation between training courses for class 2 AMEs and LPL-GMPs and the training course for class 1 AMEs. **Proposal**: MED.C.010 (b): have undertaken a **basic** training course in aviation medicine MED.C.015 (b) undertaken an **advanced** training course in aviation medicine	
response	*Noted*	
	See response to comment No 591.	

comment	*988*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: **Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008** **Section**: **Subpart C** **Aeromedical Examiners (AMEs)** **MED.C.010 Requirements for the issue of an AME certificate** **MED.C.015 Requirements for the extension of privileges** **Page**: 19	

	Relevant Text: MED.C.010 (b): have undertaken a training course in aviation medicine MED.C.015 (b) undertaken an additional training course in aviation medicine **Comment**: It should be a differentiation between training courses for class 2 AMEs and LPL-GMPs and the training course for class 1 AMEs. **Proposal**: MED.C.010 (b): have undertaken a **basic** training course in aviation medicine MED.C.015 (b) undertaken an **advanced** training course in aviation medicine
response	*Noted*
	See response to comment No 591.

comment	*1072*	comment by: *Dr. Ludger Beyerle*
	Section: **Subpart C** **Aeromedical Examiners (AMEs)** **MED.C.010 Requirements for the issue of an AME certificate** **MED.C.015 Requirements for the extension of privileges** **Page**: 19 **Relevant Text**: MED.C.010 (b): have undertaken a training course in aviation medicine MED.C.015 (b) undertaken an additional training course in aviation medicine **Comment**: It should be a differentiation between training courses for class 2 AMEs and LPL-GMPs and the training course for class 1 AMEs. **Proposal**: MED.C.010 (b): have undertaken a basic training course in aviation medicine MED.C.015 (b) undertaken an advanced training course in aviation medicine	
response	*Noted*	
	See response to comment No 591.	

comment	*1163*	comment by: *European CMO Forum*
	MED.C.010(a) Comment Each State must be able to define the basic qualifications of AMEs they approve. Justification Healthcare systems are not the same in all Member States. The basic medical training varies between States. Defining medical qualifications for all member states is not possible due to the different systems of medical regulation and	

different post-graduate qualifications.

Proposed Text
Insert new **AMC to MED.C.010 (a)**
'The qualifications and experience of an AME should be defined by the competent authority in accordance with national medical regulation.'

response *Noted*

See response to comment No 676.

comment *1178* comment by: *FAI*

(CIMP)
Page 19 of 66

A question is; who can be authorised to validate pilot medical fitness. Essential Requirements (5) lay down in Article 7 and Annex 111 qualifications of Aeromedical Examiners. These should be amplified by Implementing Rules and AMCs. An omission is that the level of 'practical knowledge and experience of the conditions in which pilots carry out their duties' has not been defined. It is often thought by pilots that many AMEs do not fully understand their needs because their personal experience of aviation is too limited. This gap must be remedied in order to meet the essential requirements and establish the necessary trust. Most AMEs are also GMPs and in countries where there are a large number of AMEs, the roles are often combined. Some of the pressure for GMPs to act as AMEs comes from countries where there are too few AMEs. As a potential remedy, in the Netherlands the air sports associations nominate sports doctors to act as AMEs for the medical certification of pilots within that air sport. This practice has proved safe and should be adopted by EASA. A hierarchy of AMES already exists because not all are approved to conduct Class 1 examinations. It is a simple extension to authorise further AMEs who can conduct LPL medical certification.

CIMP CONCLUSION
-The AME level of 'practical knowledge and experience of the conditions in which pilots carry out their duties' must be defined, especially for the air sports which differ greatly from commercial operations.
-Suggestion: Hold or have previously held a pilot licence.

Reference:
5. Regulation (EC) No 216/2008 of the European Parliament and of the Council of 20 February 2008 on common rules in the field of civil aviation.....

response *Noted*

See response to comment No 96.

comment *1227* comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*

MED.C.010 (a)
Comment:

	Medical speciality relevant to aeromedical practice needs to be defined. Relevant AMC or guidance material need to be developed. The medical regulations, healthcare systems, basic medical training, and postgraduate qualifications vary between States. Definitions of medical qualifications for AMEs should be determined by the competent authority. **Proposal**: Insert a new AMC to MED.C.010 (a) (or in Part Authority Requirements): "The qualifications and experience required of an AME should be defined by the competent authority in accordance with national medical regulation."
response	*Noted*
	See response to comment No 676.

comment	*1228*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.C.010(c)(1) **Comment**: It is noticeable that no such requirements exist for GMP in Subpart D! There is also a need to require adequate procedures and documentation. **Proposal**: MED.C.010 (c)(1) should be amended: " ... facilities, procedures, documentation and functioning equipment ..."	
response	*Accepted*	

comment	*1330*	comment by: *Regierung von Oberbayern-Luftamt Südbayern*
	Hier fehlen zu (c) (1) genaue Festlegungen (ggfalls. in einem AMC) hinsichtlich der medizintechnischen, personellen und organisatorischen Voraussetzungen, die die Untersuchungsstelle zu erfüllen hat (vgl. z. B. Anlage 6 zu § 4 Abs. 2 der 1. DVLuftVZO). Zum einen ist dies erforderlich, um einen gleichen Ausstattungsstandard in allen EASA-Mitgliedsstaaten zu gewährleisten und um Ungleichbehandlungen zu vermeiden. Zum anderen ist es der nationalen Luftfahrtbehörde nur mit einer genauen Vorgabe hinsichtlich der notwendigen Ausstattung der Arztpraxis möglich, ihre aufsichtlichen Aufgaben ("Monitoring") gemäß AR.MED.245 wahrzunehmen.	
response	*Noted*	
	The proposal to provide requirements/ AMCs to determine the equipment, staff and organisation of an AME practice is noted and will be taken up in the rulemaking task MED.001..	

comment	*1419*	comment by: *Ruediger Brendes*

	Any pilot license will be useful to determin the requirements to fly an aircraft safely. Medical knowledge alone will not be sufficient if the AME does not know what a pilot has to do
response	*Noted*
	See response to comment No 96.

comment	*1661*	comment by: *Deutscher Aero Club (DAeC)*
	Comment: The requirements for AMEs are set out in the basic regulation, 216/2008. In addition to aeromedical training, it is a requirement that they "have acquired practical knowledge and experience of the conditions in which pilots carry out their duties." This has been omitted from the NPA and no implementing rule exists except as an option for GMPs. This omission needs addressing. It is interesting that Many complaints have been made in the past by pilots against denial of certification and these often arose because of a lack of knowledge by doctors of the piloting task. DAeC Proposal: That an Implementing Rule be drafted defining how this basic law is to be enabled eg: the past or current possession of a pilot licence as in MED.D.001. It is accepted that many current AMEs do not comply with the basic law and 'grandfather rights' would have to be permitted. Reference: Regulation (EC) No 216/2008 of the European Parliament and of the Council on common rules in the field of civil aviation... Annex 111, 4.b.1.(iii).	
response	*Noted*	
	See response to comment No 96. The compliance of AMEs with the qualification requirements is ensured by the oversight of the licensing authority and standardisation inspections.	

comment	*1708*	comment by: *Deutscher Aero Club*
	MED.C.010 Requirements for the issue of an AME certificate Applicants for an AME certificate shall: (a) be fully qualified and licensed for the practice of medicine and hold a qualification in general practice or other medical specialty relevant to aeromedical practice; (b) have undertaken a training course in aviation medicine; (c) demonstrate to the competent authority that they: (1) have adequate facilities and functioning equipment suitable for aeromedical examinations; And (2) have in place the necessary procedures and conditions to ensure medical confidentiality according to the applicable national legislation. Comment: The requirements for AMEs are set out in the basic regulation, 216/2008. In	

	addition to aeromedical training, it is a requirement that they "have acquired practical knowledge and experience of the conditions in which pilots carry out their duties." This has been omitted from the NPA and no implementing rule exists except as an option for GMPs. This omission needs addressing. It is interesting that many complaints have been made in the past by pilots against denial of certification and these often arose because of a lack of knowledge by doctors of the piloting task. EGU Proposal: That an Implementing Rule be drafted defining how this basic law is to be enabled eg: the past or current possession of a pilot licence as in MED.D.001. It is accepted that many current AMEs do not comply with the basic law and 'grandfather rights' would have to be permitted. Reference: Regulation (EC) No 216/2008 of the European Parliament and of the Council on common rules in the field of civil aviation... Annex 111, 4.b.1.(iii).
response	*Noted*
	Please see response to your comment No 1661.

comment	*1738*	comment by: *Civil Aviation Authority Finland*
	MED.C.010 (a) Each State must be able to define the basic qualifications of AMEs they approve. Healthcare systems are not the same in all Member States. The basic medical training varies between States. Defining medical qualifications for all member states is not possible due to the different systems of medical legislation and different post-graduate qualifications. Insert new **AMC to MED.C.010 (a)** **The qualifications and experience of an AME should be defined by the competent authority in accordance with the national medical legislation.** **NOTE: This sentence may need to go into the Authority Requirements.**	
response	*Noted*	
	See response to comment No 676.	

comment	*1884*	comment by: *AECA(SPAIN)*
	(a)'... or other medical speciality relevant to aeromedical practice'. Wich one are this specialities? If the answer is as in AMC MED.D.001 'competence to perform medical assesments in any of the systems descibed in Subparte B', to be included this descripction in this rule.	
response	*Noted*	
	The text of the paragraph will be changed taking into account the text of the	

Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications.

comment	*1899*	comment by: *Belgian Gliding Federation*
	MED.C.010 Requirements for the issue of an AME certificate *Applicants for an AME certificate shall:* *(a) be fully qualified and licensed for the practice of medicine and hold a qualification in general practice or other medical specialty relevant to aeromedical practice;* *(b) have undertaken a training course in aviation medicine;* *(c) demonstrate to the competent authority that they:* *(1) have adequate facilities and functioning equipment suitable for aeromedical examinations;* *and* *(2) have in place the necessary procedures and conditions to ensure medical confidentiality according to the applicable national legislation.* Comment: The requirements for AMEs are set out in the basic regulation, 216/2008. In addition to aeromedical training, it is a requirement that they "have acquired practical knowledge and experience of the conditions in which pilots carry out their duties." This has been omitted from the NPA and no implementing rule exists except as an option for GMPs. This omission needs addressing. It is interesting that many complaints have been made in the past by pilots against denial of certification and these often arose because of a lack of knowledge by doctors of the piloting task. **<u>Proposal:</u>** **That an Implementing Rule be drafted defining how this basic law is to be enabled eg: the past or current possession of a pilot licence as in MED.D.001. It is accepted that many current AMEs do not comply with the basic law and 'grandfather rights' would have to be permitted.** **Reference: Regulation (EC) No 216/2008 of the European Parliament and of the Council on common rules in the field of civil aviation... Annex 111, 4.b.1.(iii).**	
response	*Noted*	
	See response to comment No 1661.	

comment	*1958*	comment by: *Civil Aviation Authority of Norway*
	There is no limitation regarding the number and location of AMEs. Precautions seems to be necessary in order to guarantee a minimum aeromedical acticity in aereas with only a few licenceholders.The licensing authority should be allowed to determine the number and location of AMEs it requires, taking in account the number and geographic distribution of its licenceholdes population.	
response	*Not accepted*	

A number of AMEs may be not regulated because of the non-discrimination law. Law on free movement of people and workplace prevents the possibility to regulate the geographical distribution of the AMEs. If an AME cannot achieve the minimum number of aeromedical examinations/assessments his/her certificate will not be renewed.

comment	*1973*	comment by: *AEA*
	Comment There should be a clear differentiation between training courses for class 2 AMEs and LPL- GMPs and the training course for class 1 AMEs. **Proposal**: MED.C.010 (b): have undertaken a **basic** training course in aviation medicine	
response	*Partially accepted*	
	See response to comment No 591. There may be not an aeromedical special course for GMPs as it is considered by the Basic Regulation that GMP qualification is sufficient to issue LAPL medical certificates.	

comment	*2124*	comment by: *Croft Brown*
	Page 19 of 66 MED.C.010 Requirements for the issue of an AME certificate Applicants for an AME certificate shall: (a) be fully qualified and licensed for the practice of medicine and hold a qualification in general practice or other medical speciality relevant to aeromedical practice; (b) have undertaken a training course in aviation medicine; (c) demonstrate to the competent authority that they: (1) have adequate facilities and functioning equipment suitable for aeromedical examinations; And (2) have in place the necessary procedures and conditions to ensure medical confidentiality according to the applicable national legislation. Comment: The requirements for AMEs are set out in the basic regulation, 216/2008. In addition to aeromedical training, it is a requirement that they "have acquired practical knowledge and experience of the conditions in which pilots carry out their duties." This has been omitted from the NPA and no implementing rule exists except as an option for GMPs. This omission needs addressing. Many complaints have been made in the past by pilots against denial of certification and these often arose because of a lack of knowledge by doctors of the piloting task. BGA Proposal: That an Implementing Rule be drafted defining how this basic law is to be enabled eg: the past or current possession of a pilot licence as in MED.D.001. It is accepted that many current AMEs do not comply with the basic law and 'grandfather rights' would have to be permitted. Reference: Regulation (EC) No 216/2008 of the European Parliament and of the Council on common rules in the field of civil aviation... Annex 111, 4.b.1.(iii).	

response	*Noted*
	See response to comment No 1661.

comment	*2203*	comment by: *Royal Netherlands Aeronautical Association*
	MED.C.010 Requirements for the issue of an AME certificate (KNVvL) Essential Requirements (5) lay down in Article 7 and Annex 111 qualifications of Aeromedical Examiners. These should be amplified by Implementing Rules and AMCs. An omission is that the level of 'practical knowledge and experience of the conditions in which pilots carry out their duties' has not been defined KNVvL PROPOSAL: -The AME level of 'practical knowledge and experience of the conditions in which pilots carry out their duties' must be defined, especially for the air sports which differ greatly from commercial operations. Reference: Regulation (EC) No 216/2008 of the European Parliament and of the Council of 20 February 2008 on common rules in the field of civil aviation.....	
response	*Noted*	
	See response to comment No 96.	

comment	*2276*	comment by: *Mike Armstrong*
	Page 19 of 66 MED.C.010 There appears to be no definition of the content of "a training course in aviation medicine" in part (b). This is important and should include information on the physical and mental tasks involved in exercising the privileges of the particular licence for which the medical certificate is being requested.	
response	*Noted*	
	See response to comment No 591.	

comment	*2284*	comment by: *Dr Ron Pearson*
	As previously mentioned in NPA 2008-17a, the training courses for AMEs are unspecified and yet all other FCL examiners qualifications are specified in Annexes - where is the comparative safety risk analysis, particularly with increasing AME numbers?	
response	*Noted*	
	See response to comment No 591.	

comment	*2336*	comment by: *Graham Bishop*
	The NPA no longer requires that AMEs to have acquired practical knowledge and	

	experience of the conditions in which pilots carry out their duties. This ommission needs addressing
response	*Noted*
	See response to comment No 96.

comment	*2400*	comment by: *Irish Aviation Authority*
	(a) Each State must be able to define the basic qualifications of AMEs they will approve. Justification: Healthcare systems are different in Member States. The medical training varies between States. Defining medical qualifications for all member states is not possible due to the different systems of medical regulation and different post-graduate qualifications. Proposed text: Insert new **AMC to MED.C.010 (a)** **'The qualifications and experience of an AME will be defined by the competent authority in accordance with national medical regulation.'**	
response	*Noted*	
	See response to comment No 676.	

comment	*2460*	comment by: *Paul Mc G*
	Applicants for an AME certificate shall: (a) be fully qualified and licensed for the practice of medicine and hold a qualification in general practice or other medical speciality relevant to aeromedical practice; (b) have undertaken a training course in aviation medicine; (c) demonstrate to the competent authority that they: (1) have adequate facilities and functioning equipment suitable for aeromedical examinations; and (2) have in place the necessary procedures and conditions to ensure medical confidentiality according to the applicable national legislation. The requirements for AMEs are set out in the basic regulation, 216/2008. In addition to aeromedical training, it is a requirement that they "have acquired practical knowledge and experience of the conditions in which pilots carry out their duties." This has been omitted from the NPA and no implementing rule exists except as an option for GMPs. This omission needs addressing. Many complaints have been made in the past by pilots against denial of certification and these often arose because of a lack of knowledge by doctors. The BGA Proposal is interesting in that to comply with the declaration of HR there are few options other than accepting this position.: That an Implementing Rule be drafted defining how this basic law is to be enabled eg: the past or current	

	possession of a pilot licence as in MED.D.001. It is accepted that many current AMEs do not comply with the basic law and 'grandfather rights' would have to be permitted.
response	*Noted*
	See response to comment No 1661.

comment	*2570*	comment by: *Heinz Fricke-Bohl and Kirsten Bohl*
	MED.C.010: Facharztqualifikation Allgemeinmedizin/Innere Medizin sollte Voraussetzung sein. Weder ein Pathologe, ein Gynäkologe sowie ein Kinderarzt, um nur ein einige zu erwähnen, sind meines Erachtens nicht in der Lage ein EKG sachgerecht auszuwerten.	
response	*Not accepted*	
	The possibility to be certified as an AME should not be limited only to the specialists in internal medicine. Majority of Member States issue AME certificates for the specialists in ophthalmology, otorhinolaryngology and other fields of medicine. This practice proved to be safe and efficient and should be retained in future rules.	

C. Draft Opinion Part-MED — Subpart C: Aero Medical Examiners (AMES) — MED.C.015: Requirements for the extension of privileges p. 19-20

comment	*403*	comment by: *European CMO Forum*
	Comment: The proposed level of additional training for AMEs to be able to apply for an extension of their privileges from Class 2 to Class 1 is insufficient. The European Aviation Authorities' Chief Medical Officer's Forum has concerns that lowering the bar to entry as an AME could have adverse safety implications. Justification: Aeromedical assessment of Class 1 applicants has to be of high quality because of the increased public safety risk. Proposed Text: Add new AMC to MED.C.015**: 'AMEs applying for an extension of their privileges from Class 2 to Class 1 examinations should undertake advanced practical training supervised by a medical assessor.'**	
response	*Partially accepted*	
	All Member States are currently harmonising training of AMEs in line with JAR FCL 3 provisions. This system will be transposed to our proposed rules.	

IR requiring practical training in AeMC together with corresponding AMC will be introduced.

comment 447 comment by: *UK CAA*

MED.C.015 (a)

Comment:
The level of qualification and experience to be a class 1 AME is far too low.

Justification:
The aviation industry may reasonably expect that regulatory aviation medicine doctors should have qualification and experience similar to clinical care doctors. The proposal is similar to UK policy (adopted in August 2006) which has had the effect of maintaining UK AME numbers at a reasonable level.

Proposed Text:
Replace MED.C.015 (a) with:
'qualifications and experience totalling 5 points or more as detailed in AMC to MED.C.010 (a)' or
'Applicants for the extension of their privileges to medical examinations for the revalidation and renewal of Class 1 medical certificates shall have **undertaken an additional training course in aviation medicine and:**
(a) conducted at least **50** examinations for the issue, revalidation or renewal of Class 2 medical certificates or;
(b) have equivalent experience as a civilian or military AME.'

response *Not accepted*

The text of NPA will be changed in order to align AME qualification and training requirements with JAR FCL 3 provisions.

comment 546 comment by: *British Microlight Aircraft Association*

Accepted

response *Noted*

Thank you for the positive comment.

comment 590 comment by: *Lufthansa German Airlines*

Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany
Head of Lufthansa Medical Services
Head of German Academy of Aviation and Travel Medicine
Section: **Subpart C**
Aeromedical Examiners (AMEs)
MED.C.010 Requirements for the issue of an AME certificate
MED.C.015 Requirements for the extension of privileges
Page: 19

Relevant Text:
MED.C.010 (b): have undertaken a training course in aviation medicine
MED.C.015 (b) undertaken an additional training course in aviation medicine

Comment:
It should be a differentiation between training courses for class 2 AMEs and LPL-GMPs and the training course for class 1 AMEs.

Proposal:
MED.C.010 (b): have undertaken a **basic** training course in aviation medicine
MED.C.015 (b) undertaken an **advanced** training course in aviation medicine

response *Accepted*

The text will be changed accordingly.

comment *677* comment by: *Pekka Oksanen*

The need for high quality aeromedical education for class 1 AMEs must be emphasised. They are responsible for the risk assessment in commercial flight operations.
Proposal: add a new subpara: **AMEs applying for an extension of their privileges from Class 2 to Class 1 examinations shall undertake advanced practical training supervised by the medical assessor.**

response *Noted*

See response to comment No 403.

comment *805* comment by: *Swiss Association of Aviation Medecine*

Comment:
It should be a differentiation between training courses for class 2 AMEs and LPL-GMPs and the training course for class 1 AMEs.

Proposal:
MED.C.010 (b): have undertaken a **basic** training course in aviation medicine
MED.C.015 (b) undertaken an **advanced** training course in aviation medicine

response *Accepted*

The text will be changed accordingly.

comment *989* comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: **Subpart C**
Aeromedical Examiners (AMEs)

MED.C.010 Requirements for the issue of an AME certificate
MED.C.015 Requirements for the extension of privileges

Page: 19

Relevant Text:
MED.C.010 (b): have undertaken a training course in aviation medicine
MED.C.015 (b) undertaken an additional training course in aviation medicine

Comment:
It should be a differentiation between training courses for class 2 AMEs and LPL-GMPs and the training course for class 1 AMEs.

Proposal:
MED.C.010 (b): have undertaken a **basic** training course in aviation medicine
MED.C.015 (b) undertaken an **advanced** training course in aviation medicine

response *Accepted*

The text will be changed accordingly.

comment *1229* comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*

MED.C.015 (a)
Comment:
No time limit for conducting the 30 examinations is mentioned, which means that the examinations might have been performed e.g. 20 years ago. A specified time limit of e.g within the last 5 years should be introduced. It should also be clearly stated that no credit should be given for examinations for LPL medical certificates.
Proposal:
A specified time limit of e.g within the last 5 years should be introduced.

response *Noted*

JAR FCL 3 provision limiting validity of the AME certificate to three years will be transposed into IR. In addition, AME shall perform at least 10 medical examinations per year as it is required in MED.C.030(c) in order to maintain his/her AME certificate valid. Both requirements will lead to the situation where AMEs will be required to perform at least 30 medical examinations during a single period of validity of their certificates.

The text of MED.C.015(a) clearly states that there shall be class 2 medical examinations.

comment *1230* comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*

MED.C.015 (b)
Comment:
An additional theoretical training course might not be sufficient for having the privileges extended to examination and assessment of commercial pilots. There

	should also be a requirement for practical training under supervision, at an AeMC and/or by a medical assessor at the competent authority. This should be included in an AMC to MED.C.015 and also in a training syllabus in an AMC to MED.C.020. **Proposal**: Add an AMC to MED.C.015: "AMEs applying for an extension of their privileges to examinations for class 1 medical certificates should have undertaken additional training in aviation medicine, including practical training under supervision at an AeMC or by a medical assessor at the competent authority".
response	*Noted*
	See response to comment No 403.

comment	*1596*	comment by: *DGAC FRANCE*
	MED C 015 : Requirements for extension of privileges. Comment : Becoming a class 1 medical examiner must be well controlled by the Authority if the Authority wants to apply without difficulties MED.065. Too many AMEs and not well trained will have a real impact on aviation safety because their control by the authority will be impossible. Modification : MED.C.015 Requirements for the extension of privileges Applicants for the extension of their privileges to medical examinations for the revalidation and renewal of class 1 medical certificates shall have : a) conducted at least ~~30~~ **50** for the issue, revalidation or renewal class 2 medical certificates **during a period of one year** ***;*** and b) Undertaken an additional training course in aviation medicine **including at least 30 days training in an aeromedical centre. During this OJT, they must do class 1 examinations under supervision of a qualified physician of the centre.** **Possession of a certificate of advanced training course in aviation medicine does not constitute a legal right to be authorized as an AME for class 1 or class 2 examinations.**	
response	*Noted*	
	a) See response to comment No 1229. b) See response to comment No 447.	

comment	1735	comment by: DCA Malta
	MED.C.015(a) Delete This is not considered necessary if the AME has completed the required additional training in aviation medicine. In a small country this requirement would be difficult to meet, and since the requirement in MED.C.015(b) is considered sufficient, paragraph (a) should be deleted.	
response	*Not accepted*	
	AME shall perform at least 10 medical examinations per year as it is required in MED.C.030(c) in order to maintain his/her AME certificate valid. This requirement is transposed from JAR FCL 3 Amendment 5. Paragraph (a) is a requirement for the experience and paragraph (b) is a requirement for training and therefore must not be deleted.	

comment	1740	comment by: Civil Aviation Authority Finland
	MED.C.015 The proposed level of additional training for AMEs to be able to apply for an extension of their privileges from Class 2 to Class 1 is insufficient. This additional training has been better defined in the existing JAR-FCL 3. Lowering the bar to entry as an AME 1 could have adverse safety implications. Aeromedical assessment of Class 1 applicants has to be of high quality because of the increased public and passenger safety risk. Add new AMC to MED.C.015**: AMEs applying for an extension of their privileges from Class 2 to Class 1 examinations should undertake advanced practical training supervised by a medical assessor of the Authority.**	
response	*Noted*	
	See response to comment No 403.	

comment	1974	comment by: AEA
	Comment There should be a clear differentiation between training courses for class 2 AMEs and LPL- GMPs and the training course for class 1 AMEs. **Proposal**: MED.C.015 (b) undertaken an **advanced** training course in aviation medicine	
response	*Accepted*	
	The text will be changed accordingly.	

comment	2401	comment by: *Irish Aviation Authority*
	The proposed level of additional training for AMEs to be able to apply for an extension of their privileges from Class 2 to Class 1 is not sufficient. There are concerns that lowering the bar to entry as an AME would have negative safety implications. Justification: Aeromedical assessment of Class 1 applicants must be of high quality because of the increased public safety risk. Proposed text: Add new AMC to MED.C.015**: 'AMEs applying for an extension of their privileges from Class 2 to Class 1 examinations will undertake advanced practical training supervised by the medical assessor.'**	
response	*Noted*	
	See response to comment No 403.	

C. Draft Opinion Part-MED - Subpart C: Aero Medical Examiners (AMES) - MED.C.020: Training courses in aviation medicine p. 20

comment	246	comment by: *Lufthansa German Airlines*
	Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany Head of Lufthansa Medical Services Head of German Academy of Aviation and Travel Medicine Section: **Subpart C** **Aeromedical Examiners (AMEs)** **MED.C.020 Training courses in aviation medicine** **Page**: 20 Relevant Text: Training courses in aviation medicine shall be approved by the competent authority of the Member State where the organisation providing it has its principal place of business. The organisation providing the course shall demonstrate that the course syllabus is adequate and that the persons in charge of providing the training have adequate knowledge and experience. **Comment**: Due to the implementation of the LPL medical and the GMPs, there is a huge decrease of interest to become an AME. This means that even big member states cannot organize basic and advanced courses with only 5 - 8 attendees at acceptable costs. If the competent authority will organize these courses and it is free of charge for the interested doctors nobody will protest against. If an non profit organisation organises a 60 hrs basic course it will cost about 1500 € provided that 25 doctors will attend the course and will pay. This is our experience in 18 years unsalaried work in the German Academy of Aviation Medicine. Before the rumours of the EASA action to implement LPL and GPs went through the community of German medical doctors we had a waiting list of 2 -3 years for interested doctors. Only few medical doctors are interested anymore in	

	Germany. Therefore we founded the European School of Aviation Medicine and we teach in all courses in English language to be open for all interested doctors of all EASA Member States. If this will be the future, it is essential that such courses are certified by EASA and not by competent authorities of different member states. Such an EASA certification must be binding for all EASA member states to accept the AME training courses in their country. The experience of the last 6 months was, that EASA did not certified our courses because of lack of legal power. The German competent authority certified our courses on national and JAA legislation but was not willing to give us an certificate instead of German in English language which other competent authorities could understand. So we have to ask every national competent authority separately if they certify our course for an attendee of their country. This is the reality of a harmonized Europe under JAA and EASA and makes a lot of problems ,work and costs. **Proposal**: 1) We need a definition of hours and content of basic, advanced, and LPL medical training courses. 2) We need a central registration and certification of these courses by EASA 3) If EASA has not the legal power for a central registration and certification and national competent authorities shall do this, an EASA requirement must be implemented, stating that competent authorities have to certify in English language understandable for all other EASA member states and that a certificate of one EASA member state has to be accepted by all other EASA member states.
response	*Noted*
	1. Syllabi of the basic and advanced courses in aviation medicine will be included in AMC as they were included in JAR-FCL 3, but without stating the hours per subject. The reason is that the curriculum has not been updated for many years and although the subjects are still valid this may not be the case regarding the hours spent to teach the content. The full curriculum will then be revised in rulemaking task MED.001 and hours per subject will be re-introduced after discussion. 2. Central registration and certification of the courses in aviation medicine by EASA is difficult at this moment due to the absence of legal basis. However, as not all Member States will offer training courses, a solution for acceptance of certificates has to be found. This will be taken up in rulemaking task MED.001. 3. Member States are free in their choice of language. EASA does not have regulatory power in this issue also because organisations providing training for AMEs are not regulated and there are no rules for these organisations in Organisation and Authority Requirements.

comment	*547*	comment by: *British Microlight Aircraft Association*
	Accepted	
response	*Noted*	
	Thank you for the positive comment.	

comment	595	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.C.020 **Page**: 20 Relevant Text: (a) Training courses in aviation medicine shall be approved by the competent authority of the Member State where the organisation providing it has its principal place of busines. The organisation providing the course shall demonstrate that the course syllabus is adequate and that the persons in charge of providing the training have adequate knowledge and experience. **Comment**: A uniform syllabus for all EASA-member-states should be defined, so that uniform formation of AMEs is guaranteed at the one hand, at the other hand that no organisation willing to offer courses is rejected by the regional authority due to arbitrary and self-made "rules" of the locals. A course is to be certified by the local authority, when the syllabus is covered. **Proposal**: Define a uniform syllabus for all EASA member states.	
response	*Accepted*	
	The syllabus for the basic and advanced courses will be transposed from JAR FCL 3 to AMC . Syllabus of the refresher course will be transposed to GM.	

comment	806	comment by: *Swiss Association of Aviation Medecine*
	The Swiss Society of Aviation Medicine supports the following comments of the german colleagues. **Comment**: A uniform syllabus for all EASA-member-states should be defined, so that uniform formation of AMEs is guaranteed at the one hand, at the other hand that no organisation willing to offer courses is rejected by the regional authority due to arbitrary and self-made "rules" of the locals. A course is to be certified by the local authority, when the syllabus is covered. Due to the implementation of the LPL medical and the GMPs, there is a huge decrease of interest to become an AME. This means that even big member states cannot organize basic and advanced courses with only 5 - 8 attendees at acceptable costs. If the competent authority will organize these courses and it is free of charge for the interested doctors, nobody will argue against. If an non profit organisation organises a 60 hrs basic course it will cost about 1500 € provided that 25 doctors will attend the course and will pay. This is our experience in 18 years unsalaried work in the German Academy of Aviation Medicine. In future it is essential that such courses are certified by EASA and not by competent authorities of different member states. Such an EASA certification must be binding for all EASA member states to accept the AME training courses in their country.	

The experience of the last 6 months was, that EASA did not certified our courses because of lack of legal power. The German competent authority certified our courses on national and JAA legislation, but was not willing to give us an certificate instead of German in English language which other competent authorities could understand.
So we have to ask every national competent authority separately, if they certify our course for an attendee of their country. This is the reality of a harmonized Europe under JAA and EASA and makes a lot of problems ,work and costs.

Proposal:
Define a uniform syllabus for all EASA member states.

1) We need a definition of hours and content of basic, advanced, and LPL medical training courses.
2) We need a central registration and certification of these courses by EASA
3) If EASA has not the legal power for a central registration and certification and national competent authorities shall do this, an EASA requirement must be implemented, stating that competent authorities have to certify in English language understandable for all other EASA member states and that a certificate of one EASA member state has to be accepted by all other EASA member states.

response *Noted*

See response to comment No 246.

comment *990* comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author:
Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008

Section: **Subpart C**
Aeromedical Examiners (AMEs)
MED.C.020 Training courses in aviation medicine

Page: 20

Relevant Text:
Training courses in aviation medicine shall be approved by the competent authority of the Member State where the organisation providing it has its principal place of business. The organisation providing the course shall demonstrate that the course syllabus is adequate and that the persons in charge of providing the training have adequate knowledge and experience.

Comment:
A uniform syllabus for all EASA-member-states should be defined, so that uniform formation of AMEs is guaranteed at the one hand, at the other hand that no organisation willing to offer courses is rejected by the regional authority due to arbitrary and self-made "rules" of the locals. A course is to be certified by the local authority, when the syllabus is covered.

Due to the implementation of the LPL medical and the GMPs, there is a huge

decrease of interest to become an AME. This means that even big member states cannot organize basic and advanced courses with only 5 - 8 attendees at acceptable costs.
If the competent authority will organize these courses and it is free of charge for the interested doctors, nobody will argue against.
If an non profit organisation organises a 60 hrs basic course it will cost about 1500 € provided that 25 doctors will attend the course and will pay. This is our experience in 18 years unsalaried work in the German Academy of Aviation Medicine.
In future it is essential that such courses are certified by EASA and not by competent authorities of different member states. Such an EASA certification must be binding for all EASA member states to accept the AME training courses in their country.
The experience of the last 6 months was, that EASA did not certified our courses because of lack of legal power. The German competent authority certified our courses on national and JAA legislation, but was not willing to give us an certificate instead of German in English language which other competent authorities could understand.
So we have to ask every national competent authority separately, if they certify our course for an attendee of their country. This is the reality of a harmonized Europe under JAA and EASA and makes a lot of problems ,work and costs.

Proposal:
Define a uniform syllabus for all EASA member states.

1) We need a definition of hours and content of basic, advanced, and LPL medical training courses.
2) We need a central registration and certification of these courses by EASA
3) If EASA has not the legal power for a central registration and certification and national competent authorities shall do this, an EASA requirement must be implemented, stating that competent authorities have to certify in English language understandable for all other EASA member states and that a certificate of one EASA member state has to be accepted by all other EASA member states.

response *Noted*

See response to comment No 246.

comment *1122* comment by: *Moldavian Society of Aviation Medicine*

MED.C.020 Training courses in aviation medicine
(a)

Comment:
AME population in Europe in comparison with doctors of other specialties is not big (appr. 3000) so the number of new irregular coming AMEs that will need initial training is small, even for big countries. It is impossible to have appropriately organized course in aviation medicine for each country on a regular basis for them. For the present time there are 11 states in Europe who provide regularly or none regularly the basic course in aviation medicine and only 9 countries who conduct the advanced training. The competent Authority should have a possibility to approve the training also in the other member state.

	The adequacy of the training course syllabus shall be defined. The content to be more or less similar throughout Europe as knowledge that is given in aviation medicine and experience in aviation have to be the same. Proposal: (a) Training courses in aviation medicine shall be approved by the competent authority of the Member State. The organization providing the course shall demonstrate that the course syllabus is adequate and that the persons in charge of providing the training have adequate knowledge and experience. Course syllabus shall correspond to the recommended by EASA and worked out on the basis of JAR-FCL 3.090 (AMC FCL 3.090).
response	*Noted*
	AME training, course syllabus: Please see response to comment No 595. We agree that it would be adventageous to get an approval of the NAA. This has not been included in this NPA because the basis of the NPA was JAR-FCL 3 where no approval requirements have been set for AME courses. AME training will be reviewed in rulemaking task MED.001.

comment	*1231*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Comment: To ensure a uniform level of training, there is a need for a common syllabus and learning objectives throughout EU. This will also make it possible to recieve training in other member states if no training courses are available in the state of the competent authority. If the separate LPL requirements and the GMP system will be introduced, there might be a considerably reduced interest to become an AME which will reduce or even preclude the possibilities to arrange future training courses in aviation medicine. The consequences need to be described in a RIA. **Proposal**: An AMC to MED.C.020 should be developed to define training syllabus and learning objectives. A RIA has to be developed to describe the possibilities for future training in aviation medicine.	
response	*Noted*	
	See response to comment No 595.	

comment	*1329*	comment by: *Regierung von Oberbayern-Luftamt Südbayern*
	Es fehlt eine verbindliche Festlegung bzw. einAMC, in dem ein Ausbildungsplan für den "Training course in aviation medicine" enthalten ist (vgl. etwa §§ 6 und 7der 1. DV LuftVZO). Darin sollte die Mindeststundenzahl enthalten sein sowie die	

	abzudeckenden Themenbereiche. Dies erscheint zwingend erforderlich, um in allen Mitgliedsstaaten ein einheitliches Ausbildungsniveau und auch einheitliche Maßstäbe bei den durchzuführenden Untersuchungen zu gewährleisten. Gleiches gilt natürlich für den "Refresher training course" in MED C.030 (b).
response	*Partially accepted*
	The minimum course duration for all courses including refresher training as well as the course content will be in an AMC and GM to this paragraph.

comment	*1683*	comment by: *UK CAA MEDICAL ADVISORY PANEL*
	Paragraph MED.C.020 Training courses in aviation medicine **Page** 20 **Comment** There have been instances of withholding of information, or its misrepresentation by AMEs. **Justification** **Proposed Text** Insertion of 2(f) Deliberate withholding or misrepresentation of relevant clinical or documentary material will lead to review of the AME's privileges".	
response	*Noted*	
	The issue is covered in Authority Requirements. See paragraph AR.MED.250.	

comment	*1999*	comment by: *AMS CAA - Hungary*
	Attachment #19	
	<![endif]--> <![endif]--> <![endif]--> **Comment:** Many states can not organize acceptable training in aviation medicine for the limited number of AME(s) needed so the courses of the other European states should have been accepted. Mutual recognition of the training courses would be most possible if they would correspond to one and the same curriculum that ensures the adequate training for AME(s). **Proposal**: ESAM proposes: 1. to write **MED.C.020** (a): (a) Training courses in aviation medicine shall be approved by the competent authority of the Member State where the organisation providing it has its principal place of business and be mutually recognized by the other states. The organisation providing the course shall demonstrate that the course syllabus is adequate and that the persons in charge of providing the training have adequate	

	knowledge and experience. The training shall at least correspond to the standard curriculum (see AMC to MED.C.020) 2. to place AMC to MED.C.020 with the standards for Curriculum for the Training in Aviation Medicine Subpart C Aeromedical Examiners (AMEs) Curriculum for training in Aviation Medicine In aggreement with ESAM I attach the Curriculum for AME training completed by the ESAM!
response	*Noted*
	See response to comment No 595.

comment	*2005*	comment by: *Lars Tjensvoll*
	there should be one common course used by all the EASA states. EASA should decide on a syllabus that all the member states has to follow - no more or no less. It is important to assure the minimum, but also prevent states to make their own, advanced rules when they want to educate AME's	
response	*Noted*	
	See response to comment No 595.	

comment	*2060*	comment by: *Norwegian Association of Aviation Medicine*
	We are of the opinion that there should be a common training course used by all the EASA states. EASA should decide on a syllabus that all the member states has to follow - no more or no less. It is important to assure the minimum, but also prevent states to make their own, advanced requirements.	
response	*Noted*	
	See response to comment No 595.	

comment	*2094*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: **Group General Requirements** **European Society of Space and Aviation Medicine (ESAM)** Section: **MED.C.020 Training courses in aviation medicine** **Page**: **20** **Relevant Text:** (a) Training courses in aviation medicine shall be approved by the competent authority of the Member State where the organisation providing it has its principal	

	place of business. The organisation providing the course shall demonstrate that the course syllabus is adequate and that the persons in charge of providing the training have adequate knowledge and experience. **Comment**: Many states can not organize acceptable training in aviation medicine for the limited number of AME(s) needed so the courses of the other European states should have been accepted. Mutual recognition of the training courses would be most possible if they would correspond to one and the same curriculum that ensures the adequate training for AME(s). **Proposal**: ESAM proposes: 1. to write **MED.C.020** (a): (a) Training courses in aviation medicine shall be approved by the competent authority of the Member State where the organisation providing it has its principal place of business and be mutually recognized by the other states. The organisation providing the course shall demonstrate that the course syllabus is adequate and that the persons in charge of providing the training have adequate knowledge and experience. The training shall at least correspond to the standard curriculum (see AMC to MED.C.020) 2. to place AMC to MED.C.020 with the standards for Curriculum for the Training in Aviation Medicine in a new Subpart C to **AMC / GM to PART MEDICAL**
response	*Noted*
	See response to comment No 595.

comment	*2097*	comment by: *European Society of Space and Aviation Medicine (ESAM)*

Author : Group General Requirements
European Society of Space and Aviation Medicine (ESAM)

Section: MED.C.020 Training courses in aviation medicine

Page: 20

Proposal:
Curriculum for training in aviation medicine

A	**BASIC TRAINING IN AVIATION MEDICINE**	**60 HOURS**
1.	**Introduction to Aviation Medicine**	2 hour
	History of aviation medicine	
	Specific aspects of civil aviation medicine	
	Different types of recreational flying	
	AME and pilots relationship	
	Responsibility of aeromedical examiner in aviation safety	

2.	**Basic aeronautical knowledge** Flight mechanisms Man-machine interface, informational processing Propulsion Conventional instruments, 'glass cockpit' Recreational flying Simulator/aircraft experience	2 hours
3	**Aviation Physiology** ATMOSPHERE Functional limits for humans in flight Divisions of the atmosphere Gas laws -physiological significance Physiological effects of decompression RESPIRATION Blood gas exchange Oxygen saturation HYPOXIA signs and symptoms Average time of useful consciousness (TUC) Hyperventilation signs and symptoms Barotrauma Decompression sickness ACCELERATION G-Vector orientation Effects and limits of G-Ioad Methods to increase gz-tolerance Positive/negative acceleration Acceleration and the vestibular system VISUAL DISORIENTATION Sloping cloud deck Ground lights and stars confusion Visual autokinesis VESTIBULAR DISORIENTATION Anatomy of the inner ear Function of the semicircular canals Function of the otolith organs The oculogyral and coriolis illusion 'Leans' SIMULATOR ILLUSION Forward acceleration illusion of 'nose up' Deceleration illusion of 'nose down' Motion sickness -causes and management NOISE AND VIBRATION Preventive measures	10 hours

4 Ophthalmology 4 hours
including demonstration and practical

Anatomy of the eye
Relation to aviation duties
Examination techniques;
visual acuity assessment;
visual aids;
visual fields – acceptable limits for certification;
ocular muscle balance;
assessment of pathological eye conditions;
glaucoma
Monocularity and medical flight tests
Colour vision
Methods of testing: pseudoisochromatic plates, lantern tests, anomaloscopy

Importance of standardization of tests and of test protocols
Assessment after eye surgery

5 Otorhinolaryngology 3 hours
including demonstration and practical skills

Anatomy of the systems
Clinical examination in ORL
Functional hearing tests
Vestibular system; vertigo, examination techniques
Assessment after ENT surgery
Barotrauma ears and sinuses
Aeronautical ENT pathology
ENT requirements

6 Cardiovascular system including demonstration and practical skills 3 hours

Relation to aviation; risk of incapacitation
Examination procedures; ECG, laboratory testing and other special examinations
Cardiovascular diseases:
Hypertension, treatment and assessment
Ischaemic heart disease
ECG findings
Assessment of satisfactory recovery from myocardial infarction, interventional procedures and surgery
Cardiomyopathies; pericarditis; rheumatic heart disease, valvular diseases

Rhythm and conduction disturbances, treatment and assessment
Congenital heart disease; surgical treatment, assessment
Cardiovascular syncope – single and repeated episodes

7. General Medicine including demonstration and practical skills 9 hours

Respiratory system

Relation to aviation, risk of incapacitation
Examination procedures: spirometry, peak flow, x-ray, other examinations

Pulmonary diseases: asthma, chronic obstructive pulmonary diseases

Infections, tuberculosis
Bullae, pneumothorax;
Treatment and assessment

Digestive system

Relation to aviation, risk of incapacitation
Examination of the system
Gastro-intestinal disorders: gastritis, ulcer disease
Biliary tract disorders
Hepatitis and pancreatitis
Inflammatory bowel disease, Irritable colon
Hernias
Treatment and assessment including post abdominal surgery

Endocrine diseases

Relation to aviation, risk of incapacitation
Endocrine disorders:
Diabetes mellitus type I & II
Diagnostic criteria
Glucose tolerance tests
Anti-diabetic therapy
Operational aspects in aviation
Satisfactory control criteria for aviation
Hyper/hypothyroidism
Pituitary and adrenal glands disorders
Treatment and assessment

Haematology

Relation to aviation, risk of incapacitation
Blood donation aspects
Polycythaemia; anaemias; leukaemias; lymphomas
Platelet disorders
Haemoglobinopathies; geographical distribution; classification; sickling conditions.
Treatment and assessment

Urinary system

Relation to aviation, risk of incapacitation
Action to be taken after discovery of abnormalities in routine dipstick urinalysis e.g haematuria; albuminuria
Urinary system disorders:
Nephritis; pyelonephritis; obstructive uropathies
Tuberculosis
Lithiasis: single episode; recurrence
Nephrectomy, transplantation, other treatment and assessment

Gynaecology-obstetrics

Relation to aviation, risk of incapacitation
Pregnancy and aviation
Disorders, treatment and assessment

Orthopaedic disorders

Musculoskeletal disorders, including:

Vertebral column diseases
Arthropathies and arthroprosthesis
Disabled pilots
Treatment of musculoskeletal system, assessment for flying.

Malignant Disease
Relation to aviation, risk of metastasis and incapacitation
Risk management and waiver decisions
Different methods of treatment and assessment

8 Neurology 3 hours

Relation to aviation, risk of incapacitation
Examination procedures
Neurological disorders:
seizures – assessment of single episode;
epilepsy;
multiple sclerosis;
head trauma;
post-traumatic states;
vascular diseases;
tumours;
disturbance of consciousness – assessment of single and repeated episodes

Degenerative diseases
Treatment and assessment

9 Psychiatry in Aviation 3 hours
Relation to aviation, risk of incapacitation
Psychiatric examination
Psychiatric disorders: neurosis; personality disorders; psychosis; organic mental illness;
Drugs, alcohol and substance abuse
Treatment, rehabilitation and assessment

10 Psychology 3 hours

Introduction to psychology in aviation as a supplement to neuropsychiatric assessment
Methods of psychological examination
Behaviour and personality
Workload management and situational awareness
Flight motivation and suitability
Group social factors
Psychological stress, stress coping, fatigue
Psychomotor functions and age
Mental fitness and training

11 Incidents and accidents, Escape and Survival 2 hours

Accident statistics
Injuries
Aviation pathology, postmortem examination, identification

Escape from aircraft in flight
aircraft on fire
aircraft in water
by parachute

12 Medication and Flying 2 hours

Hazards of medications
Common side effects; prescription medications; over-the-counter medications; herbal medications;'alternative' therapies
Medication for sleep disturbance

13 Legislation, Rules and Regulations 4 hours

ICAO Standards and Recommended Practices JAA provisions (Requirements, Appendices, AMCs and IEMs)
Incapacitation: acceptable aeromedical risk of incapacitation; types of incapacitation; 'two communication' rule; operational aspects
Basic principles in assessment of fitness for aviation
Operational and environmental conditions
Use of medical literature in assessing medical fitness; differences between scientific study populations and licensed populations
Flexibility
ICAO Annex 1, paragraph 1.2.4.8,
Accredited Medical Conclusion; consideration of knowledge, skill and experience
Trained versus untrained crews; incapacitation training
Medical flight tests.

14 Practical demonstrations of basic aeronautical knowledge 8 hours

15 Concluding items 2 hours

Final examination
De-briefing and critique

B ADVANCED TRAINING IN AVIATION MEDICINE 60 hours

1 Pilot working environment 6 hours

Commercial aircraft cockpit

Business jet, commuter flights
Military aviation:
low level high speed flying
high dynamic flight
night vision devices (NVD)
forward looking infrared (FLIR)

Professional airline operations
Fixed wing and helicopter, aerial work
Air traffic control
Single-pilot/multi-crew

2 Aerospace physiology 3 hours

Brief review of basics in physiology
(hypoxia, rapid/slow decompression, hyperventilation, acceleration, ejection seat, spatial disorientation)

3 Ophthalmology including demonstration and practical skills 4 hours

Brief review of basics
(visual acuity, refraction, colour vision, visual fields, night vision, stereopsis, monocularity...)
Class 1 visual requirements
Implications of refractive and other eye surgery
Case review

4 Otorhinolaryngology including demonstration and practical skills 4 hours

Brief review of basics
(barotrauma -ears and sinuses, functional hearing tests..)
Noise and its prevention
Vibration, kinetosis
Class 1 hearing requirements
Case review

5 Dentistry 2 hours
Oral examination including dental formula
Oral cavity, dental disorders and treatment, including implants, fillings, prosthesis etc.
Barodontalgia
Class 1 requirements
Case review

6 Cardiology including demonstration and practical skills 3 hours

Cardiological examination and review of basics

Class 1 requirements
Diagnostic steps in cardiology
Clinical cases

7 General Medicine including demonstration and practical skills 5 hours

Complete physical examination
Review of basics with relationship to commercial flight operations
Class 1 requirements
Clinical cases

8 Neurology / Psychiatry including demonstration and practical skills 4 hours

Brief review of basics
(neurological and psychiatric examination)
Drugs and alcohol
Class 1 requirements
Case review

9 Human Factors in aviation including 8 hours demonstration and practical experience 19 hours

a. Long haul flight operations
flight time limitations
sleep disturbance
extended/expanded crew
jet lag/time zones

b. Human information processing and system design
FMS, PFD, datalink. fly by wire
adaptation to the glass cockpit
CCC, CRM, LOFT etc.
practical simulator training
ergonomics

c. Crew commonality:
flying under the same type rating
e.g. B737-300, -400, -500

d. Human factors in aircraft incidents and accidents
e. Flight safety strategies in commercial aviation
f. Fear and refusal of flying
g. Psychological selection criteria
h. Operational requirements (flight time limitation, exposure to radiation etc.)

10 Incidents and accidents, Escape and Survival 2 hours

Accident statistics
Types of injuries
Aviation pathology, postmortem examination specific related to aircraft accidents, identification

Rescue and emergency evacuation

11 Hygiene 2 hours

Aircraft and transmission of diseases
Hygiene aboard aircraft:
water supply, oxygen supply, disposal of waste, cleaning, disinfection and disinsection
Catering
Crew nutrition

12 Tropical medicine 2 hours

Endemicity of tropical disease
Infections diseases (communicable diseases, sexual transmitted diseases, HIV etc.)
Vaccination of flight crew and passengers
Diseases transmitted by vectors
Food and water-borne diseases
Parasitic diseases.
International health regulations
Personal hygiene of aviation personnel

13 Cabin crew working conditions 2 hours

Cabin environment, workload, duty and rest time
General health conditions

14 Space medicine 1 hour

Microgravity and metabolism, life sciences

15 Concluding items 2 hours

Final examination
De-briefing and critique

C REFRESHER TRAINING IN AVIATION MEDICINE 20 hours

Refresher course supervised by the NAA (minimum 6 hours)

Including updates in clinical aviation medicine, regulation etc.

Agreed accreditation times for training:

Attendance at International Academy of Aviation and Space Medicine Annual Congresses Hours of the scientific presentations

Attendance at Aerospace Medical Association Annual Scientific Meetings
Hours of the scientific presentations

Other scientific meetings, as organised or approved by AMS of Member State.* Hours of the scientific presentations

Flight deck experience (a maximum of 5 hours credit per 3 years)
i. jump seat (5 sectors -1 hour credit)

ii. simulator (4 hours -1 hour credit)

iii. aircraft piloting (4 hours -1 hour credit)

All credited time must be agreed with the AMS.

* A minimum of 6 hours must be under the direct supervision of the AMS.

Abbreviations
CCC Crew Co-ordination Concept
CRM Crew Resource Management
FMS Flight Management System
LOFT Line Oriented Flight Training
PFD Primary Flight Display

response *Noted*

Thank you for your valuable input. The proposed curriculum could be considered in the rulemaking task MED.001 during which the AME training will be revised. Also see response to comment No 595.

comment *2170* comment by: *Moldavian Society of Aviation Medicine*

Comment: Many states can not organize acceptable training in aviation medicine for the limited number of AME(s) needed so the courses of the other European states should have been accepted. Mutual recognition of the training courses would be most possible if they would correspond to one and the same curriculum that ensures the adequate training for AME(s).
Proposal:
ESAM proposes:
1. to write **MED.C.020** (a):
Training courses in aviation medicine shall be approved by the competent authority of the Member State where the organisation providing it has its principal place of business and be mutually recognized by the other states. The organisation providing the course shall demonstrate that the course syllabus is adequate and that the persons in charge of providing the training have adequate knowledge and experience. The training shall at least correspond to the standard curriculum (see AMC to MED.C.020)

2. to place AMC to MED.C.020 with the standards for Curriculum for the Training in Aviation Medicine in a new Subpart C to **AMC / GM to PART MEDICAL**

Subpart C
Aeromedical Examiners (AMEs)
Curriculum for training in Aviation Medicine
Curriculum for training in aviation medicine

A	BASIC TRAINING IN AVIATION MEDICINE	60 HOURS
1.	Introduction to Aviation Medicine	2 hour
	History of aviation medicine	
	Specific aspects of civil aviation medicine	
	Different types of recreational flying	
	AME and pilots relationship	
	Responsibility of aeromedical examiner in aviation safety	
2.	Basic aeronautical knowledge	2 hours
	Flight mechanisms	
	Man-machine interface, informational processing	
	Propulsion	
	Conventional instruments, 'glass cockpit'	
	Recreational flying	
	Simulator/aircraft experience	
3	Aviation Physiology	10 hours
	ATMOSPHERE	
	Functional limits for humans in flight	
	Divisions of the atmosphere	
	Gas laws -physiological significance	
	Physiological effects of decompression	
	RESPIRATION	
	Blood gas exchange	
	Oxygen saturation	
	HYPOXIA signs and symptoms	
	Average time of useful consciousness (TUC)	
	Hyperventilation signs and symptoms	
	Barotrauma	
	Decompression sickness	
	ACCELERATION	
	G-Vector orientation	
	Effects and limits of G-Ioad	
	Methods to increase gz-tolerance	
	Positive/negative acceleration	
	Acceleration and the vestibular system	
	VISUAL DISORIENTATION	
	Sloping cloud deck	
	Ground lights and stars confusion	

Visual autokinesis

VESTIBULAR DISORIENTATION
Anatomy of the inner ear
Function of the semicircular canals
Function of the otolith organs
The oculogyral and coriolis illusion
'Leans'

SIMULATOR ILLUSION
Forward acceleration illusion of 'nose up'
Deceleration illusion of 'nose down'
Motion sickness -causes and management

NOISE AND VIBRATION
Preventive measures

4 Ophthalmology 4 hours
including demonstration and practical
Anatomy of the eye
Relation to aviation duties
Examination techniques;
visual acuity assessment;
visual aids;
visual fields – acceptable limits for certification;
ocular muscle balance;
assessment of pathological eye conditions;
glaucoma
Monocularity and medical flight tests
Colour vision
Methods of testing: pseudoisochromatic plates, lantern tests, anomaloscopy

Importance of standardization of tests and of test protocols
Assessment after eye surgery

5 Otorhinolaryngology 3 hours
including demonstration and practical skills

Anatomy of the systems
Clinical examination in ORL
Functional hearing tests
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Aeronautical ENT pathology
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Relation to aviation; risk of incapacitation
Examination procedures; ECG, laboratory testing and other special examinations
Cardiovascular diseases:

Hypertension, treatment and assessment
Ischaemic heart disease
ECG findings
Assessment of satisfactory recovery from myocardial infarction, interventional procedures and surgery
Cardiomyopathies; pericarditis; rheumatic heart disease, valvular diseases

Rhythm and conduction disturbances, treatment and assessment
Congenital heart disease; surgical treatment, assessment
Cardiovascular syncope – single and repeated episodes

7. General Medicine including demonstration and practical skills 9 hours
Respiratory system
Relation to aviation, risk of incapacitation
Examination procedures: spirometry, peak flow, x-ray, other examinations

Pulmonary diseases: asthma, chronic obstructive pulmonary diseases
Infections, tuberculosis
Bullae, pneumothorax;
Treatment and assessment
Digestive system
Relation to aviation, risk of incapacitation
Examination of the system
Gastro-intestinal disorders: gastritis, ulcer disease
Biliary tract disorders
Hepatitis and pancreatitis
Inflammatory bowel disease, Irritable colon
Hernias
Treatment and assessment including post abdominal surgery
Endocrine diseases
Relation to aviation, risk of incapacitation
Endocrine disorders:
Diabetes mellitus type I & II
Diagnostic criteria
Glucose tolerance tests
Anti-diabetic therapy
Operational aspects in aviation
Satisfactory control criteria for aviation
Hyper/hypothyroidism
Pituitary and adrenal glands disorders
Treatment and assessment
Haematology
Relation to aviation, risk of incapacitation
Blood donation aspects
Polycythaemia; anaemias; leukaemias; lymphomas
Platelet disorders
Haemoglobinopathies; geographical distribution; classification; sickling conditions.
Treatment and assessment
Urinary system
Relation to aviation, risk of incapacitation
Action to be taken after discovery of abnormalities in routine dipstick

urinalysis e.g haematuria; albuminuria
Urinary system disorders:
Nephritis; pyelonephritis; obstructive uropathies
Tuberculosis
Lithiasis: single episode; recurrence
Nephrectomy, transplantation, other treatment and assessment
Gynaecology-obstetrics
Relation to aviation, risk of incapacitation
Pregnancy and aviation
Disorders, treatment and assessment
Orthopaedic disorders
Muscularskeletal disorders, including:
Vertebral column diseases
Arthropathies and arthroprosthesis
Disabled pilots
Treatment of musculoskeletal system, assessment for flying.

Malignant Disease
Relation to aviation, risk of metastasis and incapacitation
Risk management and waiver decisions
Different methods of treatment and assessment

8 Neurology 3 hours

Relation to aviation, risk of incapacitation
Examination procedures
Neurological disorders:
seizures – assessment of single episode;
epilepsy;
multiple sclerosis;
head trauma;
post-traumatic states;
vascular diseases;
tumours;
disturbance of consciousness – assessment of single and repeated episodes

Degenerative diseases
Treatment and assessment

9 Psychiatry in Aviation 3 hours
Relation to aviation, risk of incapacitation
Psychiatric examination
Psychiatric disorders: neurosis; personality disorders; psychosis; organic mental illness;
Drugs, alcohol and substance abuse
Treatment, rehabilitation and assessment

10 Psychology 3 hours

Introduction to psychology in aviation as a supplement to neuropsychiatric assessment
Methods of psychological examination

Behaviour and personality
Workload management and situational awareness
Flight motivation and suitability
Group social factors
Psychological stress, stress coping, fatigue
Psychomotor functions and age
Mental fitness and training

11 Incidents and accidents, Escape and Survival 2 hours

Accident statistics
Injuries
Aviation pathology, postmortem examination, identification

Escape from aircraft in flight
aircraft on fire
aircraft in water
by parachute

12 Medication and Flying 2 hours
Hazards of medications
Common side effects; prescription medications; over-the-counter medications; herbal medications;'alternative' therapies
Medication for sleep disturbance

13 Legislation, Rules and Regulations 4 hours

ICAO Standards and Recommended Practices JAA provisions (Requirements, Appendices, AMCs and IEMs)
Incapacitation: acceptable aeromedical risk of incapacitation; types of incapacitation; 'two communication' rule; operational aspects
Basic principles in assessment of fitness for aviation
Operational and environmental conditions
Use of medical literature in assessing medical fitness; differences between scientific study populations and licensed populations
Flexibility
ICAO Annex 1, paragraph 1.2.4.8,
Accredited Medical Conclusion; consideration of knowledge, skill and experience
Trained versus untrained crews; incapacitation training
Medical flight tests.

14 Practical demonstrations of basic aeronautical knowledge 8 hours

15 Concluding items 2 hours

Final examination
De-briefing and critique

B ADVANCED TRAINING IN AVIATION MEDICINE 60 hours

1 Pilot working environment 6 hours

Commercial aircraft cockpit
Business jet, commuter flights
Military aviation:
low level high speed flying
high dynamic flight
night vision devices (NVD)
forward looking infrared (FLIR)

Professional airline operations
Fixed wing and helicopter, aerial work
Air traffic control
Single-pilot/multi-crew

2 Aerospace physiology 3 hours

Brief review of basics in physiology
(hypoxia, rapid/slow decompression, hyperventilation, acceleration, ejection seat, spatial disorientation)

3 Ophthalmology including demonstration and practical skills 4 hours

Brief review of basics
(visual acuity, refraction, colour vision, visual fields, night vision, stereopsis, monocularity...)
Class 1 visual requirements
Implications of refractive and other eye surgery
Case review

4 Otorhinolaryngology including demonstration and practical skills 4 hours

Brief review of basics
(barotrauma -ears and sinuses, functional hearing tests..)
Noise and its prevention
Vibration, kinetosis
Class 1 hearing requirements
Case review

5 Dentistry 2 hours
Oral examination including dental formula
Oral cavity, dental disorders and treatment, including implants, fillings, prosthesis etc.
Barodontalgia
Class 1 requirements
Case review

6 Cardiology including demonstration and practical skills 3 hours
Cardiological examination and review of basics

Class 1 requirements
Diagnostic steps in cardiology
Clinical cases

7 General Medicine including demonstration and practical skills 5 hours

Complete physical examination
Review of basics with relationship to commercial flight operations
Class 1 requirements
Clinical cases

8 Neurology/Psychiatry including demonstration and practical skills 4 hours

Brief review of basics
(neurological and psychiatric examination)
Drugs and alcohol
Class 1 requirements
Case review

9 Human Factors in aviation including 8 hours demonstration and practical experience 19 hours

a. Long haul flight operations
flight time limitations
sleep disturbance
extended/expanded crew
jet lag/time zones

b. Human information processing and system design
FMS, PFD, datalink. fly by wire
adaptation to the glass cockpit
CCC, CRM, LOFT etc.
practical simulator training
ergonomics

c. Crew commonality:
flying under the same type rating
e.g. B737-300, -400, -500

d. Human factors in aircraft incidents and accidents

e. Flight safety strategies in commercial aviation

f. Fear and refusal of flying

g. Psychological selection criteria

h. Operational requirements (flight time limitation, exposure to radiation etc.)

10 Incidents and accidents, Escape and Survival 2 hours

Accident statistics
Types of injuries
Aviation pathology, postmortem examination specific related to aircraft accidents, identification

Rescue and emergency evacuation

11 Hygiene 2 hours

Aircraft and transmission of diseases
Hygiene aboard aircraft:
water supply, oxygen supply, disposal of waste, cleaning, disinfection and disinsection
Catering
Crew nutrition

12 Tropical medicine 2 hours

Endemicity of tropical disease
Infections diseases (communicable diseases, sexual transmitted diseases, HIV etc.)
Vaccination of flight crew and passengers
Diseases transmitted by vectors
Food and water-borne diseases
Parasitic diseases.
International health regulations
Personal hygiene of aviation personnel

13 Cabin crew working conditions 2 hours
Cabin environment, workload, duty and rest time
General health conditions

14 Space medicine 1 hour

Microgravity and metabolism, life sciences

15 Concluding items 2 hours

Final examination
De-briefing and critique

C REFRESHER TRAINING IN AVIATION MEDICINE 20 hours

Refresher course supervised by the NAA (minimum 6 hours)
Including updates in clinical aviation medicine, regulation etc.

Agreed accreditation times for training:
Attendance at International Academy of Aviation and Space Medicine Annual Congresses Hours of the scientific presentations

Attendance at Aerospace Medical Association Annual Scientific Meetings
Hours of the scientific presentations

Other scientific meetings, as organised or approved by AMS of Member State.* Hours of the scientific presentations

Flight deck experience (a maximum of 5 hours credit per 3 years)
i. jump seat (5 sectors -1 hour credit)
ii. simulator (4 hours -1 hour credit)
iii. aircraft piloting (4 hours -1 hour credit)

All credited time must be agreed with the AMS.

* A minimum of 6 hours must be under the direct supervision of the AMS.

Abbreviations
CCC Crew Co-ordination Concept
CRM Crew Resource Management
FMS Flight Management System
LOFT Line Oriented Flight Training
PFD Primary Flight Display

response *Noted*

Please see responses to comments No 595 and 2097.

comment *2173* comment by: *Moldavian Society of Aviation Medicine*

comment: The interpretation of the number of hours or points for the refresher training aries between member nations. The aim should be to have a common regulation in Europe. If one Authority (former AMS) accepts for a course or congress a certain amount of training hours the other Authorities should accept that without own assessments.
Proposal: Med. C 030 B :
the number of hours accredited by, or on behalf of, the national Authority (AMS) in which country the refresher training takes place, shall be accepted by all other national Authorities (AMS)

response *Noted*

Acceptance of training is not necessary because the AME certificate will be accepted without further assessment.

Acceptance of training only (basic/advanced/refresher) may need some checking before it can be accepted because it also contains national specifics, e.g. documentation. Nevertheless, more IR/AMC/Guidance with regard to AME training will be included in Part MED requirements

comment *2285* comment by: *Dr Ron Pearson*

As indicated in NPA 2008-17a, it is essential that the level of training required be specified as per other certificated examiners and the qualification of those giving instruction (at least European aeromedical specialist)

response *Noted*

See response to comment No 595.

C. Draft Opinion Part-MED - Subpart C: Aero Medical Examiners (AMES) - p. 20

MED.C.025: Changes to the AME certificate

comment	*548*	comment by: *British Microlight Aircraft Association*
	Accepted	
response	*Noted*	
	Thank you for the positive comment.	

comment	*596*	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.C.025 **Page**: 20 Relevant Text: (b) Failure to inform the competent authority shall result in the suspension or revocation of the privileges of the authorisation. **Comment**: Suspension of the privileges is an inadequate action after a AME has failed to inform the authority about moving the practice. **Proposal**: (b) Failure to inform the competent authority shall lead to admonishment of the AME and may result in the suspension or revocation of the privileges of the authorisation in severe or repeated cases, when no alternate legal action is appropriate to ensure sufficient supervision by the authority.	
response	*Noted*	
	Actions of the competent authority shall always be appropriate when non-compliance of an AME is found. Any suspension of the AME certificate until a change of location is clarified (that has not been reported) is a possibility the competent authority must have, especially in cases where the AME works at several locations. Conditions for the limitation, suspension and revocation of AMEs certificate are also in Authority Requirements (NPA 2008-22b Subpart MED Section 2 AR.MED.250).	

comment	*991*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: **Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008** **Section: MED.C.025** **Page**: 20	

	Relevant Text: (b) Failure to inform the competent authority shall result in the suspension or revocation of the privileges of the authorisation. **Comment**: Suspension of the privileges is an inadequate action after a AME has failed to inform the authority about moving the practice. **Proposal**: (b) Failure to inform the competent authority shall lead to admonishment of the AME and may result in the suspension or revocation of the privileges of the authorisation in severe or repeated cases, when no alternate legal action is appropriate to ensure sufficient supervision by the authority.
response	*Noted*
	See response to comment No 596.

comment	*1232*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Comment: To ensure harmonised assessment procedures throughout the EU, corresponding AMC and Guidance Material should be developed by EASA, possibly linked to Part Authority Requirements. The AMC and GM should include an option for the competent authority to issue AME certificates with different durations and levels of privileges to each individual AME, depending on their competence, experience, and performance. To ensure a high and common level of quality, Sweden currently has a practice to issue initial certificates for one year only, followed by an early audit before an extension is granted. **Proposal**: AMC and Guidance Material to MED.C.025 should be developed by EASA.	
response	*Noted*	
	All Member States implemented and harmonised a system of AME training and certification in accordance with JAR FCL 3 provisions. These provisions will be transposed into AMC. The validity period of an AME certificate will be 3 years as it was in JAR FCL 3 (see MED.C.030). High and common level of quality will be ensured by the transposition of the basic and advanced training syllabi from JAR FCL 3. The competent authority will be required to supervise AMEs and take necessary actions as it is proposed in Authority Requirements (NPA 2008-22b Subpart MED Section 2 Aero-medical Examiners). AMC/GM to MED.C.025 will be developed as necessary.	

comment	*1233*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	MED.C.025 (b) **Comment**: The consequences described in MED.C.025 (b) when an AME fails to inform the	

	competent authority are regarded as appropriate by the Swedish National Board of Health, which is the authority responsible for the oversight of medical practitioners.
response	*Noted*
	Thank you for the positive comment.

C. Draft Opinion Part-MED - Subpart C: Aero Medical Examiners (AMES) - MED.C.030: Validity of AME certificates p. 20

comment	*132*	comment by: *Civil Aviation Authority - The Netherlands*
	MED.C.030, onder b. (Blz. 20 van 66) De CAA-The Netherlands vraagt zich af wat wordt bedoeld met "refresher course". Gelet op het doel van standaardisatie en een "level playing field", acht de CAA-The Netherlands het wenselijk dat uit de voorschriften blijkt aan welke eisen een dergelijke "refresher course" dient te voldoen.	
response	*Noted*	
	Syllabus for the refresher course will be included in AMC.	

comment	*356*	comment by: *Teh Danish Organiation of Flight Surgeons (DAFLO)*
	Item: dot c **Objection:** Disagree **Reasons:** A number of ten medical examinations pr. year is considered insufficient for an AME to maintain proper experience. **Suggestions:** A minimum of 25 medical examinations pr. year is considered necessary to keep AME certificate. National authorities should decide eht number of active AMEs needed.	
response	*Not accepted*	
	The basis for this NPA was JAR-FCL 3 where a minimum number of 10 examinations per year is required. This number is relatively low but it has to be taken into account that AMEs in small countries may have problems to reach even that number. On the other hand it should be ensured that in thinly populated countries (e.g. Nordic countries), the pilot does not have to travel extensively to reach an AME which may be the case if the experience requirements are too high. The rules for AME training will be reviewed in the rulemaking task MED.001 and the concerns of commentators on this paragraph will be included in the discussions. The number of AMEs cannot be restricted for legal reasons.	

comment	*404*	comment by: *European CMO Forum*
	Comment: The validity of an AME certificate must be limited. Justification: Certificates of 3 years duration are required to ensure consistency of IRs in Part FCL and Part Medical. The same 3 year period of certificate validity applies to Flight Instructors (Part FCL.940), Flight Examiners (Part FCL.1025), TRIs and TREs. Proposed Text: Delete: 'An AME certificate shall be issued for an unlimited duration. It shall remain valid subject to the holder:' Replace with: **'An AME certificate shall be valid for a period of 3 years subject to the holder:'** Add new '**MED.C.035 Revalidation and Renewal of AME certificates** **An AME certificate shall only be revalidated or renewed when the AME demonstrates continued compliance with the requirements in Subpart C.'**	
response	*Partially accepted*	
	Requirements with regard to AME certificate period of validity of 3 years and revalidation conditions will be transposed from JAR FCL 3. A requirement to comply with Subpart C is in MED.C.030 (e) because 'this Part' covers all Part MED. Depending on the privileges of the AME this means all Subparts (A-C) and AMCs.	

comment	*405*	comment by: *European CMO Forum*
	MED.C.030 (b) Comment: A course is not the only way to undertake refresher training. Justification: Training can be attending a conference, scientific meeting, e-learning etc. Proposed Text: Delete 'a' and 'course'	
response	*Accepted*	
	The text will be changed accordingly.	

comment	448	comment by: UK CAA
	MED.C.030 (b) **Comment:** Course not necessarily required. **Justification:** Refresher training may consist of means other than a course. **Proposed Text:** Amend to: **(b) 'undertaking refresher training in aviation medicine within the last 3 years'**	
response	*Noted*	
	Please see response to comment No 405.	

comment	449	comment by: UK CAA
	MED.C.030 (c) **Comment:** 10 examinations per year is too low. **Justification:** 10 examinations are insufficient to maintain sufficient experience in aviation medicine practice. **Proposed Text:** Amend '10' to **'25'**.	
response	*Noted*	
	See response to comment No 356.	

comment	549	comment by: British Microlight Aircraft Association
	Accepted	
response	*Noted*	
	Thank you for the positive comment.	

comment	678	comment by: Pekka Oksanen
	The validity period of an AME certificate must be limited. In cases of delinquency the process of terminating an unlimited certificate will be complicated, time consuming and may lead to legal action. Other type of examiners' authorisation is limited.	

	Propose: Delete first sentence ~~An AME certificate shall be issued ...~~ and replace it with: **An AME certificate shall be valid for a period of 3 years subject to the holder.** Add a new text: **MED.C.035 Revalidation and renewal of AME certificates.** **(1) An AME certificate shall only be revalidated or renewed when the AME demonstrates continued compliance with the requirements in Subpart C.** Accepted training will be decided by Authority, leave subpara open for other types of training. In subpara (b)change to...undertaking**~~a~~ refresher training... ~~course~~**
response	*Noted*
	See responses to comments No 404 and 405.

comment	*690*	comment by: *BMVBS (German Ministry of Transport)*
	There are no provisions to address what happens, when the holder of an AME certificate does not continue to comply with the prerequisites. Would the certificate simply be not valid anymore, or would the authority need to withdraw it formally? How could the AME re-activate his certificate? Since the requirements for issue (MED.C.010) are relatively moderate, the person could simply re-apply?!	
response	*Noted*	
	Conditions for the limitation, suspension and revocation of AME certificate are proposed in Authority Requirements (NPA 2008-22b Subpart MED Section 2 AR.MED.250).	

comment	*1064*	comment by: *BMVBS (German Ministry of Transport)*
	Privileges of an AME to issue class 1 medicals should expire, when the holder of the AME certificate reaches his 68th birthday.	
response	*Not accepted*	
	The age of an AME is not a limiting factor for the validity of the AME certificate. The age limit was discussed for the last JAA NPA to JAR-FCL 3 and was withdrawn as not being compliant with the Non-Discrimination Directive. FCL 3 Amendment 5, which was the basis for this NPA, no longer included the age limit.	

comment	*1234*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Comment: The proposed unlimited time duration of an AME certificate has a number of draw-backs compared to the present system with a time-limited AME certificate. The AME certificate will continue to be valid even if the AME does no longer fulfil the criteria, until the competent authority makes an audit or the AME notifies the authority.	

It is also easier for the authority to deny an application for a renewal of an AME certificate than to suspend or revoke a valid certificate, which usually results in a court case which can be extended for years. During the lengthy court process, the certificate might still be valid, unless this has been taken care of in the Basic Regulation or Implementing Rules.

The corresponding certificates for flight instructors (Part FCL.940), flight examiners (Part FCL.1025), TRIs and TREs will still be valid only for a limited period of time. There should be consistency between Part FCL and Part Medical, hence also the AME certificates should have their period of validity limited to three years.

The proposed requirement in MED.C.030 (c) of at least 10 examinations every year might result in a suspended or revoked certificate, if the AME makes less than 10 examinations one year (due to e.g. pregnancy, overseas work or temporary illness/injury), even if the AME has performed 200 examinations the previous year and is expected to perform the same amount the next year again. Flexibility is needed, which might be regulated in MED.C.030, in an AMC to MED.C.030 or in Part Authority Requirements with corresponding AMCs.

For an AME with extended privileges, the minimum examinations per year might be set higher than 10 in order to guarantee the higher level of experience required when assessing commercial pilots. This could be regulated in MED.C.030 or left to the competent authority as proposed in our comment to MED.C.025.

Regulation of the limitation, suspension, and revocation of an AME certificate when an AME no longer fulfils the requirements in MED.C.030 is not included. This is expected to be included in Part Authority Requirements, but a general reference to Part AR might be necessary in MED.C.030.

Additional regulations and/or AMCs need to be developed by EASA.

Proposal:
Delete: "An AME certificate shall be issued for an unlimited duration. It shall remain valid subject to the holder:
Replace with: "An AME certificate shall be valid for a period of maximum 3 years subject to the holder: "

Add a new 'MED.C.035 Revalidation and Renewal of AME certificates:
"An AME certificate shall only be revalidated or renewed when the AME demonstrates continued compliance with the requirements in Subpart C."

response

Noted

See response to comment No 404.

comment

1235	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*

MED.C.030 (b)
Comment:

	Refresher training can be achieved in a number of different ways, including a training course, attending conferences, scientific meetings, e-learning, supervised training at an AeMC or authority etc. The requirement for a specific training course thus is inappropriate. In order to ensure a common level of competence, an AMC to MED.C.030 should detail how refresher training might be conducted. **Proposal**: Amend MED.C.030 (b) to read: " undertaking refresher training in aviation medicine within the first 3 years " Develop an AMC to MED.C.030 to detail refresher training requirements.
response	*Noted*
	See response to comment No 404.

comment	*1507*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: **Group General Requirements European Society of Space and Aviation Medicine (ESAM)** Section NPA 2008 - 17c subpart C Aeromedical examiners (AME's) Med.C.030 validity of AME Certificates **Page**: 20 **Relevant Text:** (b), undertaking a refresher training course in Aviation Medicine in the last 3 years **Comment**: JAR-FCL 3.090 defines a requirement for 20 hours of refresher training for AME's within 3 years. The interpretation of the number of hours or points varies between member nations. The aim should be to have a common regulation in Europe. If one Authority (former AMS) accepts for a course or congress a certain amount of training hours the other Authorities should accept that without own assessments. **Proposal**: Med. C 030 B : the number of hours accredited by, or on behalf of, the national Authority (AMS) in which country the refresher training takes place, shall be accepted by all other national Authorities (AMS)	
response	*Noted*	
	AME training will be in MED.C.025. This paragraph only mentions the fact that the	

	AME will have to do the refresher training in order to have his/her certificate revalidated. The AME certificate is automatically accepted in all Member States. For this reason AME training is accepted without further checking. However, there may be specific national issues (e.g. documentation, data protection) that may deem additional training necessary.

comment	*1742*	comment by: *Civil Aviation Authority Finland*
	MED.C.030 The validity of an AME certificate must be limited. Certificates of 3 years duration are required to ensure consistency of IRs in Part FCL and Part Medical. The same 3 year period of certificate validity applies to Flight Instructors (Part FCL.940), Flight Examiners (Part FCL.1025), TRIs and TREs Delete: An AME certificate shall be issued for an unlimited duration. It shall remain valid subject to the holder: Replace with: **An AME certificate shall be valid for a period of 3 years subject to the holder:** Add new **MED.C.035 Revalidation and Renewal of AME certificates** **An AME certificate shall only be revalidated or renewed, when the AME demonstrates continued compliance with the requirements in Subpart C.**	
response	*Noted*	
	See response to comment No 404.	

comment	*1959*	comment by: *Civil Aviation Authority of Norway*
	It is much easier not to renew a designation as an AME than to withdraw it. An AME certificate should therefore instead be issued for a limited duration of three years. Ref. FCL. 1025 a) where a (flight) examiner certificate shall be valid for three years.	
response	*Noted*	
	See response to comment No 404.	

comment	*2119*	comment by: *Direction de l'Aviation Civile Luxembourg*
	We do not approve that the validity of an AME certificate shall be issued for an unlimited period of time because: The draft text does not mention that the authority can limit the number of AME to the strict necessary so that the aero medical system will work properly. For a small country as Luxemburg, it is very important to limit the number of AME's so that they can do a great number of medical certificates per year and maintain and improve their knowledge in aviation medicine. It will be very difficult to end an agreement for an AME when they are authorised	

	in doing medical certificates for an unlimited duration and in the same time doing bad quality examinations of pilots. **New proposal**: Experience shows that it is difficult to suspend or revoke a medical examiner authorisation; therefore we want the authorisation to be limited in time
response	*Noted*
	See response to comment No 404.

comment	*2154*	comment by: *AMS Denmark*
	It will be a huge task for the authority to work with to many low experienced AMEs - and it will decrease safety too. Ten examinations pr. Year should be increased.	
response	*Noted*	
	See response to comment No 356.	

comment	*2172*	comment by: *Moldavian Society of Aviation Medicine*
	comment : The interpretation of the number of hours or points for the refresher training aries between member nations. The aim should be to have a common regulation in Europe. If one Authority (former AMS) accepts for a course or congress a certain amount of training hours the other Authorities should accept that without own assessments. **Proposal** : Med. C 030 B : the number of hours accredited by, or on behalf of, the national Authority (AMS) in which country the refresher training takes place, shall be accepted by all other national Authorities (AMS)	
response	*Accepted*	
	Please see responses to comments No 404 and 1507. Requirements with regard to AME training will become an implementing rule and AMC and, therefore, will be compulsory for all Member States.	

comment	*2181*	comment by: *Dr.Piek Armin*
	If the AME proves his aeromedical experience for instance by undertaking aeromedical refresher training courses the validity of AME certificates should be issued for an unlimited period and not according to his age	
response	*Noted*	
	There is no age limit for AMEs in Part Medical	

comment	*2196*	comment by: *DGAC FRANCE*

	FCL MED 030 comment : FE certificates (FCL1000) are limited to three years. To give a certificate with limited duration permits a better follow up and contact with AMEs. Requirements for European class 3 medical certification of air traffic controllers p 4 para 2.4 stipulate that" medical certificates for the performance of air traffic control duties shall be given to physicians for a specific period of time" . Modification : MED C030: Validity of AME certificates An AME certificate shall be issued ~~for an unlimited duration~~ **for a period not exceeding three years.** It ~~shall~~ **can be** ~~remain valid~~ **renewed** subject to the holder ***:*** ...
response	*Noted*
	See response to comment No 404.

comment	*2402*	comment by: *Irish Aviation Authority*
	The validity of an AME certificate has to be limited. Justification: Certificates of 3 years duration are required to ensure consistency of IRs in Part FCL and Part Medical. The same 3 year period of certificate validity applies to Flight Instructors (Part FCL.940), Flight Examiners (Part FCL.1025), TRIs and TREs. Proposed text: : '~~An AME certificate shall be issued for an unlimited duration. It shall remain valid subject to the holder:'~~ Replace by: **'The AME certificate shall be valid for a period of 3 years subject to the holder:'** Add new '**MED.C.035 Revalidation and Renewal of AME certificates** **The AME certificate shall be revalidated or renewed only if the AME demonstrates continued compliance with the requirements in Subpart C.'**	
response	*Noted*	
	See response to comment No 404.	

comment	*2403*	comment by: *Irish Aviation Authority*

(b)
A course is not the only way to undertake refresher training.

Justification:
Training can also be attending conferences, scientific meetings, e-learning etc.

Proposed text:
'~~a~~' and '~~course~~'.

response *Noted*

See response to comment No 405.

comment *2472* comment by: *Civil Aviation Authority Finland*

MED.C.030 (b)
A course is not the only way to undertake refresher training.

Training can be attending a conference, scientific meeting, e-learning etc.
Delete 'a course'.

response *Noted*

See response to comment No 405.

comment *2571* comment by: *Heinz Fricke-Bohl and Kirsten Bohl*

MED.C.030: Flugerfahrung ggf. eine Fluglizenz sind unabdingbar.

response *Noted*

Experience in form of a pilot licence or other flight experience gives added value to an AME certificate. However, neither ICAO Annex 1 nor JAR-FCL 3 provide further rules to this effect. The AMC/GM for AME training will be more specific — but the conditions that you propose for an AME certificate are too specific for a rule. And this is because there are several ways to gain flight experience other than piloting an aircraft.

C. Draft Opinion Part-MED - Subpart D: General Medical Practitioners (GMPS) p. 21

comment *119* comment by: *Civil Aviation Authority - The Netherlands*

MED.D.001, onder (b)(Blz. 21 van 66)

- De eisen voor de GMPS zijn strenger dan die voor de AME. Ingevolge MED.D.001, onder b (blz. 21 van 66) moet de GMPS om LPL certificaten af te kunnen geven 1 jaar medische ervaring in de luchtvaart hebben of een bewijs van bevoegdheid hebben.
  In MED.C.010 (blz. 19 van 66), waarin de eisen voor de AME staan, ontbreekt deze eis. De AME mag zowel klasse 2 als LPL certificaten afgeven. Volgens de CAA- The Netherlands dient deze ongelijkheid te worden

	opgeheven. • Ingevolge MED.D.001, onder b moet de GMPS een training in luchtvaartgeneeskunde hebben afgerond. In Nederland is de enige door de CAA-The Netherlands goedgekeurde opleiding in luchtvaartgeneeskunde de opleiding die momenteel voor AME's geldt. Wanneer de opleiding succesvol is afgerond is de desbetreffende huisarts dus geschikt om als AME medische onderzoeken te doen en certificaten af te geven. In zijn momenteel 4 huisartsen AME. In dat licht is de introductie van de GMPS niet van toegevoegde waarde in Nederland. Nederlandse wet- en regelgeving zal ingevolge de NPA, voor wat betreft de introductie van de huisarts in MED.D.001, niet worden aangepast.
response	*Noted*
	The requirements for GMPs are less strict than for AMEs, because there is no requirement for them to complete the special AME training of 60 hours. In addition, they are required only to declare this activity to a competent authority.

comment	*679*	comment by: *Pekka Oksanen*
	In Finland there is no family doctor system whereby all medical information of an applicant would be available to GMPs. Long-time experience (40 years) has shown that ordinary GPs have no sufficient knowledge to examine and assess complicated aeromedical cases. It could lead into issuing a certificate without secondary assessment. Also revoking a certificate would have difficulties. Proposal: See comment #285 (**delete GMPS)**	
response	*Not accepted*	
	The Basic Regulation in its Article 7(2) fourth subparagraph states: '... in the case of a leisure pilot licence a general medical practitioner ... may, if so permitted under national law, act as aeromedical examiner, ...'. This is a decision of a legislator and EASA may not change it. If a GMP is permitted to issue LAPL medical certificates under national law, they shall refer applicants who do not fully meet requirements to an AME or AeMC. This should solve the issue of the secondary assessment. The medical report form has to be sent to the licensing authority that could revoke the medical certificate if it was issued incorrectly.	

comment	*1134*	comment by: *jim white*
	In my opinion it is sufficient for the GP to know the patient, have access to the patients medical history, and access to guidance notes about specific requirements for safe flight as P1. The present reference to driving licence standards is well understood by all GPs	

	and is a practical requirement for recreational pilots. It is not necessary for a GP to have specific aviation medicine training or a pilots licence to know whether a pilot can meet the driving licence standard.
response	*Noted*
	LAPL medical requirements are not fully based on car driving standards because of a different nature of physiological stress. Physicians who see pilots to assess their fitness to fly should be aware of the aviation environment. The GMPs can acquire this knowledge by either following training in aviation medicine or undergo practical training with an AME. Holding a pilot licence is also considered to provide that knowledge.

comment	*1290*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*

Comment:
1. GMP versus GP

The concept "General Medical Practitioner, GMP" is described in the Directive 2005/36 EC, which gives a high level of flexibility for the member states. There is a basic requirement for a GMP to have a licence to practice as a physician and a requirement to have additional post-graduate training. However, the post-graduate training is not defined, neither regarding the time required, nor regarding the content of the training. This will be defined by the national ministry of health or the national competent medical authority, and the definitions are different throughout Europe. As a result, a GMP may have a few years experience from only one single field of medicine, e.g. gynaecology, pediatrics, dermatology, plastic surgery etc, and no training in holistic medicine. Hence, there is no uniform level of competence for a GMP in Europe, and an authorisation as GMP in one state is not accepted without formalities by other states.

There is another expression frequently used in some countries, which is "General Practitioner, GP". This is not the same as a GMP, but in most states a GP is defined as a physician with a specialist diploma in General Practice. This diploma usually requires 4-5 years of postgraduate training, including specified theoretical and practical courses and exams in specified medical specialties. Thus, a GP is generally more qualified with a broader spectrum covering most aspects of family medicine and general practice than a GMP.

From discussions on NPA 2008-17 and GMP in different fora it is quite obvoius that the difference between these two entities is not known to most of the persons taking part in the discussions. Frequent references are made to the UK National Health System, NHS, where each UK citizen shall be registered with his personal GP. One must remember that this is a GP, not a GMP as defined in the EC Directive and used in the Regulation 216:2008 EC and NPA 2008-17.

This confusion is also reflected in the official EC translation of the Regulation (EC) No 216/2008 to Swedish, where "GMP" has been translated into a Swedish word with the meaning "GP", or "specialist in general practice". This results in a different interpretation of Article 7 of the Basic regulation in Sweden compared to

other member states.

2. GMP qualifications

Depending on the national health systems and national qualifications of GMPs, their privileges should be decided by the competent authority and be defined in national regulations and not in the IRs.

For GMPs, when permitted under national law to perform aeromedical examinations and issue medical certificates, very strict requirements are needed.

The explanatory notes to Subpart D specifically describes that a GMP who wants to examine and assess pilots for LPL will need *"theoretical and practical aeromedical training and to hold or have held a pilot licence when practical training has not been obtained."* This seems to be an acceptable level of basic aeromedical competency. However, this is not reflected in the requirements in Subpart D.

The basic requirements in MED.D.001 (a) and (b) first line seem to be appropriate, provided that "or" is changed to "and".

The alternative requirements in MED.D.001 (b)(1), and (b)(2) can not be alternates because they are not exchangeable as the first refers to medical experience and the second to aviation experience. They seem to be irrelevant for the ability of a GMP to perform the aeromedical examination and assessment tasks.

Most GMPs will only perform very sporadic aeromedical examinations. An oversight of more than 100 GMP examinations for glider and ultralight pilots in Sweden 2008 showed that almost all of the GMPs concerned have performed only one single examination each, with the exception for 4 GMPs who have performed 5 or more examinations each. With such a small number of examinations, the GMPs will probably never obtain the experience to make a proper aeromedical assessment. The small number of examinations will not even make any proper quality audit possible.

Annex III to the Basic regulation, para 4.a.1 states that compliance with the requirements "must be shown by appropriate assessment based on aero-medical best practice". The use of GMPs without proper aeromedical training and experience will not fulfil this requirement.

3. GMP authorisation, oversight and enforcement

The requirement in MED.D.001 (c) is not clear - a declaration to the competent authority is of no value as long as this authority has no power whatsoever concerning the GMPs. After consultation with the Swedish National Board of Health, it is clear that the Civil Aviation Authority has no legal right to have any oversight over, or place any enforcement against, GMPs unless they are certified as AMEs acting on behalf of the authority. If a GMP has received aeromedical training, as described in the explanatory notes, he/she should be authorised as an AME in order to ensure a continuing common level of performance and permitting oversights.

MED.C.005 and MED.C.010 contain very detailed requirements with respect to a number of features required from an AME. For GMPs there are no requirements at all to be fulfilled.

Article 7 of the Basic Regulation accepts, if permitted under national law, that GMPs may act as aeromedical examiners. According to ICAO Annex 1, an aeromedical examiner shall conduct medical examinations of fitness for applicants and, as proposed in ICAO State letter 2008:33, also perform assessment and aeromedical risk analysis. Aeromedical examiners shall, according to ICAO Annex 1, have received training in aviation medicine, shall receive refresher training, and have practical knowledge and experience from the aviation environment. Nothing of this is required for a GMP.

ICAO Annex 1 also requires that aeromedical examiners shall be regularly audited by the authority, and the same requirement is expected in the Part Authority Requirements. However, when the competent aviation authorities have no rights to make oversights/audits of GMPs unless they have an AME certificate, the required audits can not be performed.

An AME certificate shall be limited, suspended or revoked if the aeromedical examiner does not fulfil the requirements. For GMPs, acting as aeromedical examiners according to the Basic Regulation, the competent aviation authorities have no enforcement power to prevent the GMPs from continuing to perform aeromedical examinations and issuing medical certificates even if they are not following the regulations. This is a matter for the Ministry of Health or National Board of Health and civil courts, where these types of cases seldom result in any action, unless there has been an extreme malpractice resulting in withdrawal of the licence to practice.

The GMPs are not even required to inform the licensing authority, an AME or an AeMC when they have identified a medical condition that makes a pilot unsafe to perform his/her duties, as described in MED.A.060 (c).

4. GMPs Sufficient detailed knowledge

Article 7 of the Basic Regulation accepts, if permitted under national law, that a GMP with sufficient detailed knowledge of the applicant's medical background may act as an aeromedical examiner. No definition or explanation of this requirement can be found, neither in the Basic regulation, nor in the IR or AMC. Neither is there a common definition within the Swedish health system. If no definition exists, it will be left to the individual GMP to decide what he/she thinks is sufficient. This is against the principles of equity and will not ensure a common level of safety to be maintained, which is required in Article 7 of the Basic regulation.

5. GMP privileges.

A possibility in national legislation to permit GMPs to perform only renewal examinations on glider pilots, balloon pilots and pilots of ultralight aircraft according to the ICAO class 2 standards, but without permission to make the aeromedical assessment or to issue the medical certificate has been practised in Sweden. This Swedish system has allowed for an assessment according to best aeromedical practice, even when the examination has been performed by a GMP

not trained in aviation medicine, and thus would have maintained an acceptable level of safety.

With the privileges given to GMPs as proposed in NPA 2008-17 there would be no option to continue with this system, unless the requirements are revised. Since the level of safety will not be maintained, Sweden would no longer be able to permit GMPs without aeromedical training to perform examinations for aviation purposes if the GMPs also must be allowed to issue medical certificates.

According to Article 7 of the Basic Regulation, the implementing rules concerning GMPs shall ensure that the level of safety is maintained. As described above, the requirements for GMPs as they have been proposed in MED.A.030 and MED.D.001 might be a threat to aviation safety, unless the assessment and issuing of the medical certificate is restricted to the licensing authority.

Proposal:

The proposed requirements and privileges for GMPs can not be accepted in the present form.

EASA should revise the requirements and privileges for GMPs after an independent safety assessment has been made.

response *Noted*

The Basic Regulation permits GMPs to act as AME for the LAPL applicants. The proposed implementing rules define the privileges of a GMP to issue medical certificates for LAPL applicants only if they fully comply with the medical requirements. If LAPL applicants do not fully comply with the requirements, GMPs must refer them to AME or AeMC's. This ensures a required level of safety.

comment *1355* comment by: *PR Jean Pierre GOURBAT*

LE DIRECTEUR
General J.P GOURBAT
Professor at the Val de Grâce
Member of the Medical Council of Civil Aviation
President of the French Society of Aerospace Medicine

I am expressing myself here in the name of the 20 specialist physicians of aerospace medicine who have been working in the French centres of aeronautical expertise for years.

The objective that we all share is to maintain the flight safety.
Nevertheless, the decreasing incidence of the aircraft crashes related to a proven medical cause implies a will of relaxation of the lawful medical requirements, the periodicity of the visits and the qualification level necessary for the doctors in charge of the monitoring of the flight crew of civil aviation.
This will clearly appears in the proposals of the EASA.
The methods of organization of aeronautical medicine which are considered, do not take into account national specificities and existing structures. Their possible implementation will disorganize in a country as France the aeromedical

organization without improving the flight safety, quite the reverse.
If a liberalization of requirements is legitimate, a full safety means it must be applied by experienced doctors in solid and adapted structures in every country, i.e. corresponding to the history, the culture and the uses.

The new text suggested by the EASA takes as a starting point various principles :

- Standardization of the practices in the European Union, with adjustment on the Anglo-Saxon practices;
- Will of simplification of procedures with a levelling down;
- Drastic reduction of medical requirements;
- Application of fitness standards by doctors who are little or not qualified in aeronautical medicine.

Two subjects appear essential and deserve to be detailed because they risk to strike a blow at the aeronautical medicine in France if they are applied:
- The possibility that isolated aeromedical examiners to practise the periodical visits of class 1 pilots;
- The appearance of the leisure licence.

The coexistence of AMC (AeroMedical Centres) and AME (AeroMedical Examiners) has existed in the United Kingdom for a long time, but the fact is that this situation is adapted to their culture and their legal system.

In France, the monitoring of professional pilots is carried out in AMC exclusively. Sometimes pilots have to move a lot to get to these centres, their operation can be considered difficult at times, but qualitatively this centralized system presents only advantages.
Unfortunately, nowadays quality is out of place, simplification and economies are more important. To do that, the EASA introduces a possible competition between the AMC and the AME which appears in a recent history that it is useful to remind.

The medical expertise of the flight crew is governed in France by a decree of January 27th, 2005 relative to the physical and mental fitness of the technical flight crew of professional civil aviation, which was published in the Official Journal of the French Republic on March 13rd, 2005.
This text is the translation in the French law of the JAR FCL 3, which was the result of more than ten years of discussions between the various members of the JAA. The idea was a consensus which allowed every country to adopt a common attitude towards medical expertise problems.
This consensus respected both the organization of the aeronautical expertise medicine and the national specificities. In particular, it was expected that the examination of a professional pilot could be carried out by an AME ('may' and not 'shall' in the English text), letting the national authorities to choose their organization.

The text in the EEC 216 /2008 regulations introduces changes in this approach. It has not been the subject of a preliminary consultation, and there is an ambiguity.
It is written that the medical certificate can be delivered by an aeromedical examiner **or** an aeromedical centre. We will consider the interpretations that we can give to this "or".

The NPA 2008 17 C looks like the application decree of the ECC 216/2008 regulations, and it brings an interpretation to this "or"; thus "may" is turned into "shall", de facto imposing the coexistence of aeromedical centres and aeromedical examiners for the class 1 pilot certification in all countries.
This evolution appears extremely serious to us, it definitely does not take into account of the present situations, the cultural identities and the national methods of organization. Consequently, it imposes to every country, whatever its previous organization, the Anglo-Saxon organization which is not always adapted and shall disorganize the present structures without improving the flight safety.

A legal approach is needed:
The EEC 216/2008 regulations (OJEU 03.19.2008 p L79/1) concerning the medical certificates for pilots, in the article 7, paragraph 2, subparagraph 3, specify that a person is issued with a medical certificate only if this one satisfies the established rules to guarantee conformity with the essential requirements relative to the medical fitness fixed in appendix 3.
This medical certificate can be issued by an examiner **or** a centre.

Are the examiner and the centre equal for the issue of the medical certificate ?
In order that the medical certificate should be issued in a completely equivalent way by the examiner or the centre, it is necessary to be sure that the required guarantees and safety rules are filled exactly the same on both sides.
The necessary conditions that the aeromedical examiner has to meet are very limited: to be allowed with the legal practice of medicine, to have received an initial and permanent training in aeronautical medicine, and to have knowledge and experience of the working conditions of pilots.

The conditions which are planned for the aeromedical centre are much more restrictive, seeing that it has to own means and staff necessary to assume the whole responsibilities related to its privileges, as well as installations, material equipments, technical tools, documentation, data access and filing system.
Moreover, the centre has to implement a management system relative to the safety and quality of the aeromedical assessments and also to a constant improvement of these systems.
It is also expected that the approval is granted to the aeromedical centre only when this one satisfies the established rules.
No equivalent approval system is discussed concerning the competence of the aeromedical examiner.

It appears that the pilots who will be assessed in an AMC or by an AME will not be treated in the same way. Moreover, the quality, equity and safety-first principles, required to achieve the objective of safety as specified in the Chicago convention, the ICAO and the European regulations, are not respected.

The whole French aircrew has always been selected and followed in the AMC. This system is qualitatively and quantitatively well adapted to our country. Thanks to it, the mission can be carried out with a relatively reduced number of highly specialized physicians in 5 fully equipped centres.
In the Principal Aeromedical Centre of Expertise of Aircrew in Paris, from 80 to

100 initial or renewal examinations for civilian and military crew members are carried out every day. Such a quantity of aeromedical assessments as well normal as abnormal confers a solid experience on medical experts who are used to broaching the limits of normality and the acceptable limits for fitness decisions in a legitimate way.

In such centres, the aeromedical expertise is plural, what offers a guarantee of quality and equity which is not met for isolated examiners.
If one compares the examination in an aeromedical centre and by a simple aeromedical examiner, it appears clearly that the qualitative level is not equivalent.
These questions have been studied in the Kourilsky and Viney report relative to the safety-first principle and in the Lepage commission's work within the framework of the Borloo mission about Grenelle of the environment, which have shown that **plural expertise is greatly higher than individual expertise.**
The problem of training and competence of the physicians in charge of aeromedical examinations is also essential. In France, the physicians working in the military centres have profited from a 5-year special training to rise to a specialist qualification after passing final theoretical and practical exams.
The 10 aeromedical assessments which are daily performed on average by each physician, this specific training and a team work, allow examiners of these centres to answer the safety requirements which are asked by the French authorities and also by the European commission concerning the medical monitoring of class 1 pilots.

In France, the setting up authorization of isolated aeromedical examiners for class 1 pilots (AME), who will coexist with aeromedical centres (AMC), will call into question the present situation without a benefit for the flight safety, because it shall involve an economic competition. The AME shall profit from an asset of proximity and an attractive price (an isolated expertise is obviously less expensive than a plural expertise in a centre) to the detriment of quality, in particular when one examines the approval conditions for an AME.
In order to obtain this approval, actually you only have to be a present qualified examiner for class 2 pilots, to have carried out 30 aeromedical assessments (clearly a very limited experience), and to have followed an additional training anywhere in a European country. Then you only have to carry out 10 yearly assessments to keep this approval for unlimited period.
In this context, the conditions of practice and attribution of approvals are not equitable between the AMC and the AME, and the quality level suggested to the flight crew is not comparable.
Moreover, we shall witness a decrease of abilities. Indeed, the quality of aeronautical expertise is closely related to the number of examinations carried out, then the decreasing number of examinations in the AMC will affect their quality level, if they purely and simply do not disappear…

The best solution is to let the initiative to the national authorities with regard to the place of the AME in the management of class 1 pilots:

- opportunity of authorizing them,
- adaptation of the number to the needs,
- training and control exams at the national level only.

In France, our aviation medicine is a mature, old and structured medicine with very clear reference marks which are called into question by the EASA proposals.
1 - *The Medical Council of Civil aviation*, with its recognized medical experts who are used to examining the aircrew files in a full neutrality to discuss fitness with a waiver and limitations: in the NPA 2008 17 C, it is proposed that the files concerning class 2 pilots and LPL pilots will not be submitted to the Council anymore… It is extremely alarming.
2 - *The five Aeromedical Centres of Expertise of Aircrew*, at present with 2 civil centres and 3 military centres, which remain the backbone of the aeromedical organization… an essential problem we tried to develop.
3 - *The thousand qualified aeromedical examiners for class 2 pilots*, whose place in the service of general aviation is compromised by the appearance of the leisure licence.

The attribution of the leisure licence allows the holder to fly on practically all the aircrafts existing in flying clubs. Qualified examiners for class 2 pilots are almost excluded because the medical certificate can be issued by a general practitioner. Besides, the final objective of the extended periodicity is to eliminate the medical examination, and yet this examination remains annually required to practise almost any other sport.

This licence practically based on an exclusive questionnaire is not adapted to our country.
Standards of fitness, for instance aortic aneurism between 55 and 65 millimetres, are too much permissive and call into question the flight safety.

IN CONCLUSION :

Doctors, particularly in the AMC, unquestionably take part in the flight safety. Thus, a relaxation of the lawful medical requirements, which clearly appears in the new proposals of the EASA, defeats the initial safety purpose in aeronautics.

In addition, the will of standardization within the European Community, with a typical Anglo-Saxon organization, shall disorganize the present aeromedical structures, particularly in France. All the changes which are suggested are likely to call into question the flight safety, then it is justified to revaluate them.

It is strongly desirable that the national authorities decide on the implementation of these proposals, because they are in the best position to appreciate the opportunity and the details.

response *Noted*

Thank you for the comment. Medical requirements for LAPL applicants are tailored to the risks involved in this type of flying. The implementation of these proposals related to the GMPs will depend on whether they will be permitted to act as AMEs for LAPL applicants under national law. It means that national authorities will decide on the acceptance of the GMPs.

comment *1561* comment by: *Swiss Association of Aviation Medecine*

We do not agree that GP's without formation are authorized to judge pilots. This

	is against the actual trend of improving quality of medecine. Nowadays doctors have to ensure that their volume in a special field is high enough to assure acceptable quality of medecine. In most of the speciality physicians need an accreditation. With the proposed solution the volume and with this the skill of AME will decrease, wheras the GP who examines 1 or 2 pilots every year will not reach an acceptable efficacy and quality.
response	*Noted*
	See response to comment No 679.

comment	*1565*	comment by: *Steve BARBER*
	The current medical standard required to fly sailplanes is based on the standards required for drivers' licences. This has proved to be satisfactory, and there is no need to raise the standards. In order to issue a medical certificate to these standards, a GMP does not need any aviation medical training or speciality. The particular advantage of using an applicant's own GMP is not recognised in the current draft - namely that the applicant's own GMP will have ready access to the applicant's records, and even personal knowledge of the applicant's medical status. (Hence my suggestion above that the GMP should have input to a medical, assessment even if the applicant is independently examined by an Aeromedical specialist).	
response	*Noted*	
	The amended medical standards for the LAPL are now based on aeromedical criteria that are more flexible and easier to comply with than ICAO class 2 standards. The amended MED.D.001(b) does not contain a requirement for GMPs to receive training in aviation medicine for the issuance of LAPL medical certificates (see response to comment No 119). The proposed rule does not prevent the applicant’s own GMP to issue a LAPL medical certificate.	

comment	*2120*	comment by: *Direction de l'Aviation Civile Luxembourg*
	Delete this chapter for the same reason as mentioned before.	
response	*Noted*	
	See response to comment No 679.	

comment	*2182*	comment by: *Dr.Piek Armin*
	Because GMPS don't have aeromedical experience there should not exist reqirements	
response	*Noted*	

See response to comment No 679.

C. Draft Opinion Part-MED - Subpart D: General Medical Practitioners (GMPS) - MED.D.001: Requirements for general medical practitioners p. 21

comment	*53*	comment by: *Bernhard Blasen*
	It makes no sense to define prerequisits for a GMP, as those make them low level AMEs. Every physician allowed to work as a Medical practioneer should be able to act as GMP. Especially the training course in aviation medicine makes no sense as there are no differences to the everyday work of those persons. They know how to deal with diseases.	
response	*Noted*	
	The requirement to complete a training course in aviation medicine has been replaced by 'have acquired knowledge in aviation medicine'. This is not specified any further in the rule. There is absolutely no doubt that GPs/GMPs know how to deal with diseases. However, in the case of issuing medical certificates for pilots, the GMPs are not asked to deal with a disease, but to assess whether any disease a pilot may have has an impact on the safe conduct of a flight. Therefore, in addition to the medical qualification, some knowledge of the aviation environment is considered necessary.	

comment	*89*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **Med D 001 section 3** **Page**: 21 Relevant Text: all **Comment**: GMP are not qualified for any aeromedical examination. If You want aeromedical examinations, leave it to the AME or AMC. otherwise leave it completely to aself declaration of the applicant **Proposal**: Delete complete chapter	
response	*Not accepted*	
	The Basic Regulation in its Article 7(2) fourth subparagraph: '... in the case of a leisure pilot licence a general medical practitioner ... may, if so permitted under national law, act as aeromedical examiner, ...'. The Basic Regulation has been adopted by the Member States and the European Parliament. The decision whether a GMP can issue medical certificates for the	

LAPL or not will be up to the Member States.

If a GMP is permitted to issue LAPL medical certificates under national law, they shall refer applicants who do not fully meet requirements to an AME or AeMC.

A pure self-declaration is not possible because the Basic Regulation also states that a medical certificate is needed to exercise the privileges of the licence, and that a pilot must demonstrate medical fitness to be issued with a medical certificate.

comment 97 comment by: *British Gliding Association*

Page 21 of 66
MED.D.001 Requirements for general medical practitioners
In order to issue LPL medical certificates, general medical practitioners (GMP) shall be fully qualified and licensed for the practice of medicine in accordance with applicable national rules, and
(a) have completed postgraduate training in general medical practice or any speciality relevant to aeromedical practice ; or
(b) have completed a training course in aviation medicine and have either:
(1) 1 year fulltime, or parttime equivalent, experience in practicing a medical speciality relevant to aeromedical practice; or
(2) hold, or have held a pilot's licence for any kind of light aircraft.
(c) declare their activity to the competent authority.

Comment: In Article 7 of 216/2008 it states "in the case of a leisure pilot licence a general medical practitioner who has sufficient detailed knowledge of the applicant's medical background may . . . ". The requirements listed above are different and miss the essential point that the advantage of a GMP is that they actually know the medical history of the applicant and falsification is not possible. The instruction for the LPL medical report actually authorises a GMP to complete the form without such knowledge and in breach of the basic law. The depth and length of the medical history available to the GMP need to be defined.
BGA Proposal: That a GMP completing a report on an applicant for an LPL must have access to at least three years of medical records that have been accumulated for clinical purposes.
Reference: Regulation (EC) No 216/2008 of the European Parliament and of the Council on common rules in the field of civil aviation...
Article 7, para 2.

response *Partially accepted*

We agree with your opinion that knowledge of the applicant's medical history is a basis for the issuance of LAPL medical certificates by GMPs. The paragraph has been amended and requires the GMP to have access to the full medical history of the applicant.

The originally proposed examination report form for the LAPL has been deleted. A medical report form, based on the JAR-FCL 3 form but tailored to the LAPL activities, has been introduced.

comment	*112*	comment by: *Aero-Club of Switzerland*
	Please delete the "S" in the title line, as GMP is sufficient as acronym for the General medical practitioner.	
response	*Not accepted*	
	Acronyms will be used in line with the text of the JAR FCL 3 (AMEs, etc.).	

comment	*133*	comment by: *Civil Aviation Authority - The Netherlands*
	MED.D.001, onder b. (Blz. 21 van 66) De CAA-The Netherlands vraagt zich af wat wordt bedoeld met "training course". Gelet op het doel van standaardisatie en een "level playing field", acht de CAA-The Netherlands het wenselijk dat uit de voorschriften blijkt aan welke eisen een dergelijke "training course" dient te voldoen.	
response	*Accepted*	
	Syllabi of the training courses in aviation medicine will be transposed from JAR FCL 3 to AMC.	

comment	*180*	comment by: *Oliver Dzvonik*
	Comment: There is no definition of specialist in aviation psychology - aviation psychologist. EAAP (European Association for Aviation Psychology) recognises and certifies the aviation psychologists who are able and full qualified to work in aviation environment. It is suggested to be included into the next Subpart E the definition of specialist in aviation psychology. **AVIATION PSYCHOLOGIST (AP)** The requirements to be certified as an Aviation Psychologist are: • Official university degree (Masters) in psychology to be able to work independently as psychologist • Membership of EAAP • Three years (minimum 3000 working hours) experience in applying aviation psychology in one or more of the specialist areas in the civil or military environment. • To be knowledgeable in the aviation technical field, documented by either: • o Being a technical professional (e.g. flight crew, cabin crew, ATC, engineer), or • o Having succeeded in a theoretical course examination (e.g. PPL), or • o Demonstrating to the Board a specific expertise in the technical aviation field by means of proof like: position(s) occupied / documented achievements and / or publications / official recommendations. • o A continuous professional occupation in the field must be documented. • o Having successfully completed two EAAP training courses on differing topics of aviation psychology. **Note:** EAAP can accept courses at other institutions as equivalents for EAAP training courses, where approved by the EAAP board. After a period of five years the certified Aviation Psychologist will have to re-qualify. The requirements for re-qualification are:	

- A continuous professional occupation in the field must be documented
- One EAAP training course must be attended within 5 years (The Board may accept expert accomplishments instead of credits given by specific EAAP courses or conferences)
- EAAP can accept courses at other institutions as equivalents for EAAP training courses, if approved by the EAAP board.

response *Not accepted*

Thank you for your comment providing valuable information.

The definition of a professional speciality is outside the scope of EASA. No definitions for specialised professionals are included in Part Medical after careful consideration of the Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications. It also seems that there is no State recognition Aviation Psychology, although well developed criteria obviously exist.

Medial fitness is determined by an AME/AeMC and they will include psychologist advice when needed. ICAO Annex 1 does not regulate input from specialists as the AME.

comment *247* comment by: *Lufthansa German Airlines*

Author: Prof. Dr. U. Stüben Head of AMC Frankfurt - Germany
Head of Lufthansa Medical Services
Head of German Academy of Aviation and Travel Medicine
Section:
Subpart D General Medical practitioners (GMPs)
MED.D.001 Requirements for general medical practitioners a - c
Page: 21

Relevant Text:
the whole text.

Comment: This text opens the possibility as worst case that
1) a medical doctor who completed postgraduate training in general medical practice or any speciality relevant to aeromedical practice (ophthalmologist? ENT specialist?) can issue a LPL medical certificate **without any training course in aviation medicine**.
2) a medical doctor **without postgraduate training** but with a training course in aviation medicine and an old invalid licence for any kind of light aircraft can also issue a LPL medical certificate. In my opinion both doctors don't have sufficient training or medical experience for this job.

Proposal: Delete the whole paragraph. Delete GMPs in the EASA requirements and use the AME and AeMC system, which is the only harmonized system of medical specialists in Europe where it can be expected that doctors in this system know the different requirements and have a sufficient training record by the prescribed refresher courses and a minimum of 10 medical examinations in one year. The GMPs are neither cheaper nor better in medical assessment. EASAs target to bring as much people as possible in an aircrafts cockpit by lowest

	standards and nearly no salary for the GPs or AMEs cannot be successful by these means.
response	*Noted*
	See response to comment No 89.

comment	*337*	comment by: *FOCA Switzerland*
	MED.D.001 General medical practitioners will only be accepted if permitted under national law. Switzerland will not permit them. Nevertheless Switzerland will have to accept certificates from other EASA member states. Therefore we support, that those GMPs in other countries, that are accepted to perfom medical exams for pilots, have a minimum of aviation medicine knowledge. Proposed text: **replace in para (a) the second word "or" with "and" as follows: (a) have completed postgraduate training in general medical practice or any speciality relevant to aeromedical practice AND..... (b)...**	
response	*Accepted*	
	The text will be changed and the requirement to acquire knowledge in aviation medicine or to hold a pilot licence will be introduced. Acceptance of medical certificates: Medical certificates issued by a GMP for a LAPL holder are valid everywhere in the EU and associated States if the state of licence issue permits the GMP to act as AME. However, pilots from a Member State where GMPs are not permitted to issue medical certificates cannot expect that his/her medical certificate issued by a GMP of another Member State is valid in the state of licence issue.	

comment	*357*	comment by: *Teh Danish Organiation of Flight Surgeons (DAFLO)*
	Objection: Disagree **Reasons:** Flight safety must be considered the overriding issue. An aeromedical examiner (AME) has been trained to include factors with a potential impact on health in airspace. This expert knowledge must be included when an individual is assessed for eligibility as a pilot. A GMP has treatment as a primery focus whereas the perspective of an AME primerily is detecting potential helath problems that may impact the individual when moving in airpace. Expert knowledge in this field is a prerequisite which the GMP does not possess. **Suggestions:** In case of introduction of LAPL itis strongly recommended the health requirements as a minimum are equal to ICAO standard and is managed by aeromedical examiners (AME).	
response	*Noted*	
	See response to comment No 89.	

comment	365	comment by: *Féderation Française de Planeurs Ultralégers motorisés*
	Concerning subpart D (b) The imposition of a training course to GMPS is a way of prohibiting them from delivering LPL medical certificates. By this way the aeronautical medical lobby try to protect themselves from the intrusion of strangers in there business. EASA in its preambules determine that it is necessary to simplify the procedure to become a leisure pilot and introduce the possibility that a general practitioner could deliver certificate. By putting this supplementary requirement they kill this possibilty. A general pratitioner will not spent time in a course that will be by essence short, otherwise it will be a aeronautical medicine specialty that will give him the AME title. The medical expert of the french ultralight federation is of the opinion that a general practionner who read the limitations contained is this draft is perfectly competent for issuing an LPL certificate. If EASA want to be sure that the GMP know concretely the aeronautical fact, alinea (2) will be sufficient	
response	*Noted*	
	See response to comment No 53.	

comment	450	comment by: *UK CAA*
	MED.D.001 [and Explanatory Note NPA-17(a) page 37 para 22] **Comment:** MED.D.001 is correct. The LPL report form is designed so that the GMP does not need aviation medicine training nor needs to hold, or have held, a pilots licence. **Please note that the Explanatory Note NPA-17(a) page 37 para 22 is incorrect.** **Justification:** The LPL report form is designed so that the GMP does not need aviation medicine training nor needs to hold, or have held, a pilots licence. **Proposed Text:** MED.D.001 is correct and must not be changed. Explanatory Note NPA-17(a) page 37 para 22 is incorrect.	
response	*Not accepted*	
	Thank you for the input. However, the Explanatory Note is a document that hasn't been changed since it was published. In the meantime it has been agreed that the report form will be replaced by JAA report form which has been adapted to the LAPL provisions. MED.D.001 (b) will be changed to ask either knowledge in aviation medicine or require the GMP to hold or have held a pilot licence. This change has been made following comments to this NPA and taking into account the range of aircraft that can be flown with a LAPL.	

comment	451	comment by: *UK CAA*
	MED.D.001 (b) (2) **Comment:** No need to restrict to light aircraft. **Justification:** There is no definition of 'light aircraft' and holders of other types of pilot licence would be appropriate for inclusion. **Proposed Text:** Delete 'light.	
response	*Accepted*	
	The text will be changed accordingly.	

comment	551	comment by: *British Microlight Aircraft Association*
	(a) should specify minimum requirements for postgraduate training (b) specify the requirements for the Course Provider (c) accepted General comment: Many GMPs will not wish to undertake this activity because (1) they may not have capacity for non-essential medical work, (2) may wish to avoid any connection with aviation certification to distance themselves from potential litigation. Applicants for he LPL Medical Certificate should have access to AMEs and AeMCs if their own doctor will not carry out the examinations and the cost of the examination for the LPL Medical Certificate should be proportionate to the level of examination required and not fixed at a level appropriate for higher medical classes.	
response	*Noted*	
	(a) Requirements for medical postgraduate training are determined by the Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications. (b) The GMP is no longer required to follow a course in aviation medicine and could acquire the knowledge by other means. Applicants for LAPL medical certificates will have access to GMPs, AMEs and AMCs as stated in MED.A.030(b)(3) and (c)(2).	

comment	592	comment by: *dr roland vermeiren eurocontrol*
	Comments on NPA No 2008-17c Part-Medical About the aeromedical assessment by GMP's **Author:** Dr Roland Vermeiren , head medical service Eurocontrol	

Section : Draft Opinion, annex II, subpart A, page 3
subpart D, page 21
Draft Decision, AMC/GM, subpart D, page 66

Comment:

- 1) GMP's without specific training do not have knowledge or experience of typical aero-medical problems. This is clearly below ICAO standards which require training and aviation medicine , refresher training at regular intervals and competency in aviation medicine (Annex 1, art 1.2.4.4.1) and contradictory to the paragraph (3) of the introductory text of the Basic Regulation about application of ICAO standards by EASA.

The risks for a LPL pilot are similar to that of class 2 pilot (for example spatial disorientation), and safety aspects concerning airplane , passenger(s) and environment are similar so the medical examiner should be aware of them.

- 2) The independence of a treating GMP is an important issue :
- - "goodwill" attestations are a real problem in the deontological area : during my 6 years of experience as a member of the Belgian "ordre des médecins" around 20 to 25% of the disciplinary cases were in this area of incorrect or unverified medical attestations and certifications ! and there is no reason to believe that this situation would be different in other countries...(But the consequences of a goodwill attestation have in aviation safety risks for the applicant and general population which are less or not at all existing in other individual sport and leisure activities, and harder to oversee by a not trained GMP.)
- - This is very logical since in most of the EU countries the role of the treating doctor is to support and help his patient in every situation. Also in most of the EU countries the patient is directly paying the treating doctor and is thus , often together with the whole of his family , the decisive factor for the income of the treating doctors which are thus under pressure to deliver the necessary documents.
- - Therefore in many countries the treating doctor is not allowed to act as an expert and write attestations/certificates because of the obvious risk for conflicting roles and the influence of this on the therapeutic relationship. Patients may even dissimulate certain medical problems in order to get a certificate which is dangerous for their own health.
- - So for clear deontological reasons it is wrong for treating doctors to act as an aero-medical assessor, which includes a ban of direct access to the private medical files of the applicant, which is an important factor in the whole concept of the assessment by a GMP .

- 3) the payment of the examination by GMP's is also an issue :
- - some practical tests by colleagues in Germany show that a professional compilation of the medical data according to the report proposed may take up to 30 minutes or more. Apart from the question if GMP's will have the time to do this in between their other work, the question is how much will be the cost of such a longer time-slot and if this would be indeed cheaper for the applicant than a basic AME visit.
- - The costs for such an assessment examination are to be paid entirely by the applicant. In case of a visit to the own treating doctor the risk is great

that the costs will be paid via the national social sickness insurance systems, which is easy for the examiner and cheap for the applicant , but a violation of most of the national legislations in this aspect. The sickness insurance systems should be made aware of this risk and take appropriate measures. In the case of national health systems without direct paying of treating doctors the situation may even become more confuse.

- 4) quality control will become impossible with the introduction of GMP's :
- - quality control is an important factor in an assessment with safety implications for the general population ; in a typical GMP situation there are only 2 actors : the patient and his doctor (and so is his doctor also trained) but in this assessment the general population is the 3th (but not visible and not attending) interested party !
- - quality control implicates the possibility of corrective actions towards not well performing experts : this will not be possible for the assessment by GMP's because they are not linked to a supervising Aero-medical Authority but to the sickness insurance systems.
- - No information about changes and new (or extinguished) risks in aviation will be transmitted , aviation medicine and risk assessment is not a part of the normal refresher courses for GMP's.
- - Each specialty, and thus also aviation medicine, should have his own system of communicating problems and solutions such as peer-groups, which is only possible within the aviation medicine community.
- - The risk of an implosion of training in aviation medicine and thus a loss of awareness of professional risks linked with medical conditions is existing when no special training and designation is needed anymore and this will have an impact on aero-medical safety aspects in the future. Basic practice in aviation medicine is the basis for a good response to more complex situations later and could be lost.
- - All of this may have consequences for liability and insurance of faults in a non supervised assessment procedure.

- 5) GMP's should have a training and recent experience in holistic medicine and cannot be a subspecialist in a certain medical area to assess general fitness, including organs he/she does not deal with on a regular basis. This includes family medicine, general intern medicine or surgery (becoming both more rare) , occupational medicine,...

- 6) the whole system of European harmonisation, which was build up progressively during so many JAA years via the controlled system of AME's would disappear , apart for class 1 and probably rare class 2 pilots. Even if it was still imperfect, examinations by GMP's will show much less European harmonisation because of different medical cultures (not by lack of inherent general medical competencies !)

conclusion :

GMP's can only make aero-medical assessments under specific conditions :

Proposal :

To change Draft Decision, AMC/GM, subpart D, page 66

	AMC to MED.D.001 Requirements for general medical practitioners 1) they must have followed a basic course in aviation medicine 2) they must be appointed/designated by the Authority 3) they cannot assess own patients 4) they must be trained in, and have recent experience in holistic medicine Brussels, 04/09/08
response	*Not accepted*
	A GMP who completed a (basic) training course in aviation medicine could apply for a certificate as an AME class 2. GMPs must declare their activity to the National Aviation Authority. GMPs may assess their own patients, because in this case they will know the medical history of the applicant and the pilot cannot conceal medical facts. In cases where a consultation of a specialist in a specific medical area is needed, the GMP is required to refer the applicant to an AME.

comment	*597*	comment by: *Lufthansa German Airlines*
	Author: Gabel A MD, AME/Cardiologist Aeromedical Center Frankfurt/M, Germany Section: MED.D.001 **Page**: 21 Relevant Text: (b) have completed a training course in aviation medicine and have either: (1) 1 year full-time, or part-time equivalent, experience in practicing a medical speciality relevant to aeromedical practice; or (2) hold, or have held a pilots's licence for any kind of light aircraft. **Comment**: To achieve an uniform level of knowledge and safety its necessary for the GMP as well as for the AME to attend a full 60-hours course of Aviation medicine. There is no medical speciality "relevant to aeromedical practice" that could replace experience in Aviation medicine itself. Working 1 year as an ophthalmologist e.g. (relevant to aeromedical practice) does not qualify to judge, if a pilot is safe to fly after suffering a myocardial infarction. To achieve the necessary knowledge about the circumstances of flight, one year practice in aviation medicine itself or at least an own pilot licence should be required. **Proposal**: (b) have completed a full 60-hours training course in aviation medicine and have either: (1) 1 year full-time, or part-time equivalent, experience in practicing aviation medicine; or (2) hold, or have held a pilots's licence for any kind of light aircraft.	

response	*Noted*
	See response to comment No 592.

comment	*637*	comment by: *Robert Cronk*
	Most GPs will not undertake a training course in aviation medicine, or have any kind of pilots licence. This means that the patients normal General Practitioner will generally NOT be able to certify a medical for LPL, which is missing the whole point. The pilot's normal doctor is best placed to certify their health. The current UK system for the NPPL medical (and for glider pilots medicals) is for the pilot's normal GP to examine their medical record, and certify their fitness on the same criteria as a commercial HGV driver. The system works well, in the context for which it is designed, and is highly recommended. I suggest that air sport associations may nominate doctors to their Authority who have complied with the requirements for AMEs in regard to having practical knowledge and experience of the relevant air sport; these doctors may then advise GMPs and AMEs on cases relating to that air sport as necessary.	
response	*Noted*	
	Thank you for the opinion. The GMP will have to refer a pilot to an AME if the applicant does not fully meet the standards. The AME can get advice from the licensing authority. The system you describe could be put in place by the licensing authority as long as it does not interfere with the rules.	

comment	*648*	comment by: *Royal Danish Aeroclub*
	MED.D.001 Requiments for general medical practitioners It is difficult to understand with the "and" and "or's" - especially if you are not familiar wiht the educational system for GP's. Suggestion: Rewrite the paragraph.	
response	*Accepted*	
	Thank you for the opinion, the text will be re-written to provide more clarity.	

comment	*692*	comment by: *Robert Cronk*
response	*Noted*	

comment	*696*	comment by: *Pekka Oksanen*

	Comments: (a) no definition of term "relevant to aeromedical practice (b) the contents of the course, approved by whom? (b)(1) and (2) they are not equivalent (c) approval from the Authority is required The whole requirement does not fulfill critical requirements Proposal: see comment #285 **Delete Subpart D**
response	*Not accepted*
	(a) The text will be changed and aligned with the Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications. (b) GMPs will be required to acquire the knowledge in aviation medicine, but not to complete an AME course. (b) (1) and (2) The text will be changed for clarification. (c) GMP shall only declare their activity to NAA. See response to comment No 89.

comment	*798*	comment by: *George Rowden*
	Comment: In Article 7 of 216/2008 it states "in the case of a leisure pilot licence a general medical practitioner who has sufficient detailed knowledge of the applicant's medical background may . . . ". The above recognises the important advantage of a GMP over any other medical examiner ie they actually know the medical history of the applicant and falsification by the applicant is not possible. The requirements in this NPA actually allow the GMP to complete the form without such knowledge, which cannot be correct. I therefore propose that the GMP validating a medical certificate for a LPL must be in possession of a minimum of 3 years of the applicants medical records.	
response	*Noted*	
	See response to comment No 97.	

comment	*808*	comment by: *Swiss Association of Aviation Medecine*
	Comment: This text opens the possibility as worst case that: 1) a medical doctor who completed postgraduate training in general medical practice or any speciality relevant to aeromedical practice (ophthalmologist? ENT specialist?) can issue a LPL medical certificate **without any training course in aviation medicine**. 2) a medical doctor **without postgraduate training** but with a training course in aviation medicine and an old invalid licence for any kind of light aircraft can also issue a LPL medical certificate. In my opinion both doctors don't have	

	sufficient training or medical experience for this job. To achieve a uniform level of knowledge and safety its necessary for the GMP as well as for the AME to attend a full 60-hour basic course of aviation medicine. There is no medical speciality 'relevant to aeromedical practice' that could replace experience in aviation medicine itself. Working 1 year as an ophthalmologist e.g. (relevant to aeromedical practice) does not qualify to judge, if a pilot is safe to fly after suffering a myocardial infarction. To achieve the necessary knowledge about the circumstances of flight, one year practice in aviation medicine itself or at least an own pilot license should be required. For GMPs, when permitted under national law to perform aeromedical examinations and issue medical certificates, very strict requirements are needed. The basic requirements in MED.D.001 (a), (b) first line, and (b)(2) seem to be appropriate. The sentence in MED.D.001 (b)(1), however, is totally irrelevant for their ability to perform these tasks and should be deleted. The requirement in MED.D.001 (c) is not understood - a declaration to the competent authority is of no value as long as this authority has no power whatsoever concerning the GMPs. Article 7 of the Basic Regulation accepts, if permitted under national law, that GMPs may act as Aeromedical examiners. According to ICAO Annex 1, the aeromedical examiners shall be regularly audited by the authority, and the same requirement is expected in Part Authority Requirements. However, the competent aviation authorities have no rights to make oversights/audits of GMPs unless they have an AME certificate. An AME certificate shall be limitied, suspended, or revoked if the aeromedical examiner does not fulfil the requirements. For GMPs, acting as Aeromedical examiners according to the Basic Regulation, the competent aviation authorities have no legal power to prevent the GMPs from continue to perform aeromedical examinations and issue medical certificates even if they are not following the regulations. This is a matter for the Ministry of Health or National Board of Health and civil courts, where this type of cases seldom will result in any action unless there has been an extreme malpractice resulting in withdrawal of the licence to practice. According to Article 7 of the Basic Regulation the implementing rules concerning GMPs shall ensure that the level of safety is maintained As described above, the requirements for GMPs as they have been proposed in MED.A.030 and MED.D.001 might be a real threat to aviation safety, unless the assessment and issuing of the medical certificate is restricted to the licensing authority. The present proposed requirements and privileges for GMPs therefore can not be accepted. **Proposal**: EASA should revise the requirements and privileges for GMPs after an independent Safety Assessment has been made. Delete the whole paragraph. Delete GMPs in the EASA requirements and use the AME and AeMC system, which is the only harmonized system of medical specialists in Europe where it can be expected that doctors in this system know the different requirements and have a sufficient training record by the prescribed refresher courses and a minimum of 10 medical examinations in one year. The GMPs are neither cheaper nor better in medical assessment. EASAs target to bring as much people as possible in an aircrafts cockpit by lowest standards and nearly no salary for the GPs or AMEs cannot be successful by these means.
response	*Noted*

See response to comment No 89.

comment	834	comment by: *Thomas Cook Airlines UK*
	Commentator: The UK Association of Aviation Medical Examiners **Paragraph**: MED.D.001 and AMC to MED.D.001 Requirements for general medical practitioners **Page Numbers:** 21, 66 **Comment:** GMPs performing LPL examinations should be able to demonstrate some knowledge of basic aviation medicine or have attended a suitable basic aviation medicine training course. **Justification:** GMPs will perform very few medical examinations for LPL certificates during their career and those that choose to perform these assessments should demonstrate knowledge of basic aviation medicine. **Proposed text:** AMC to MED.D.001 Requirements for general medical practitioners In order to issue LPL medical certificates, general medical practitioners (GMP) shall be fully qualified and licensed for the practice of medicine in accordance with applicable national rules, and have completed postgraduate training in general medical practice and have completed a basic training course in aviation medicine.	
response	*Noted*	
	The GMP can act as an AME for the issue of LAPL medical certificates if permitted under national law. The experience is good in one Member State where the GMP without additional training is allowed to issue medical certificates according to the standards of a driving licence and relying on the medical history of the pilot. However, the Agency is of the opinion that the GMP should comply with some additional requirements that will ensure that he/she is aware of the most important aspects of medical assessments of pilots in the aviation environment. However, the full basic training course will only be needed for physicians who want to become an AME. Also see response to comment No 592.	

comment	992	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: **Group General Requirements - European Society of Space and Aviation Medicine (ESAM) - Wiesbaden August 23rd- 24th 2008** **Section**: 3 Subpart D General Medical practitioners (GMPs)	

Requirements for general medical practitioners
MED.D.001

Page: 21

Relevant Text:
The whole text.

Comment:
This text opens the possibility as worst case that:
1) a medical doctor who completed postgraduate training in general medical practice or any speciality relevant to Aeromedical practice (ophthalmologist? ENT specialist?) can issue a LPL medical certificate **without any training course in aviation medicine**.
2) a medical doctor **without postgraduate training** but with a training course in aviation medicine and an old invalid licence for any kind of light aircraft can also issue a LPL medical certificate. In my opinion both doctors don't have sufficient training or medical experience for this job.

To achieve a uniform level of knowledge and safety its necessary for the GMP as well as for the AME to attend a full 60-hour basic course of aviation medicine. There is no medical speciality `relevant to Aeromedical practice' that could replace experience in aviation medicine itself. Working 1 year as an ophthalmologist e.g. (relevant to Aeromedical practice) does not qualify to judge, if a pilot is safe to fly after suffering a myocardial infarction. To achieve the necessary knowledge about the circumstances of flight, one year practice in aviation medicine itself or at least an own pilot license should be required.
For GMPs, when permitted under national law to perform Aeromedical examinations and issue medical certificates, very strict requirements are needed. The basic requirements in MED.D.001 (a), (b) first line, and (b)(2) seem to be appropriate. The sentence in MED.D.001 (b)(1), however, is totally irrelevant for their ability to perform these tasks and should be deleted.
The requirement in MED.D.001 (c) is not understood - a declaration to the competent authority is of no value as long as this authority has no power whatsoever concerning the GMPs.
Article 7 of the Basic Regulation accepts, if permitted under national law, that GMPs may act as Aeromedical examiners. According to ICAO Annex 1, the Aeromedical examiners shall be regularly audited by the authority, and the same requirement is expected in Part Authority Requirements. However, the competent aviation authorities have no rights to make oversights/audits of GMPs unless they have an AME certificate. An AME certificate shall be limitied, suspended, or revoked if the Aeromedical examiner does not fulfil the requirements. For GMPs, acting as Aeromedical examiners according to the Basic Regulation, the competent aviation authorities have no legal power to prevent the GMPs from continue to perform Aeromedical examinations and issue medical certificates even if they are not following the regulations. This is a matter for the Ministry of Health or National Board of Health and civil courts, where this type of cases seldom will result in any action unless there has been an extreme malpractice resulting in withdrawal of the licence to practice.
According to Article 7 of the Basic Regulation the implementing rules concerning GMPs shall ensure that the level of safety is maintained As described above, the requirements for GMPs as they have been proposed in MED.A.030 and MED.D.001

	might be a real threat to aviation safety, unless the assessment and issuing of the medical certificate is restricted to the licensing authority. The present proposed requirements and privileges for GMPs therefore can not be accepted. **Proposal**: EASA should revise the requirements and privileges for GMPs after an independent Safety Assessment has been made. Delete the whole paragraph. Delete GMPs in the EASA requirements and use the AME and AeMC system, which is the only harmonized system of medical specialists in Europe where it can be expected that doctors in this system know the different requirements and have a sufficient training record by the prescribed refresher courses and a minimum of 10 medical examinations in one year. The GMPs are neither cheaper nor better in medical assessment. EASAs target to bring as much people as possible in an aircrafts cockpit by lowest standards and nearly no salary for the GPs or AMEs cannot be successful by these means.
response	*Noted*
	Please see response to comment No 89.

comment	*1051*	comment by: *Julia DEAN*
	Very much approve of the recommendation that local General Medical Practitioners can sign the medical certificate/document as they know the individual and it is the same system used successfully for other medical requirements in the UK - eg heavy goods vehicle driving, motor racing medicals, scuba diving. However it seems surprising, and at odds with what appears to be the intention to make LPL medicals less bureaucratic, that the general medical practioner is required to have completed a training course in medical aviation when the requirements for the medical as listed in Section 3 Med.B.090 page 18 seem so straightforward and with minimal explnation. Could the trainign course requirement be reconsidered.	
response	*Noted*	
	Thank you for the support of the proposed rule. The rule to undergo a training course in aviation medicine has been reworded to say 'has acquired knowledge in aviation medicine' without further specification. Also see response to comment No 53.	

comment	*1073*	comment by: *Dr. Ludger Beyerle*
	Subpart D General Medical practitioners (GMPs) Requirements for general medical practitioners **MED.D.001** **Page**: 21	

Relevant Text:
The whole text.

Comment:
This text opens the possibility that:
1) a medical doctor who completed postgraduate training in general medical practice or any speciality relevant to aeromedical practice can issue a LPL medical certificate without any training course in aviation medicine.
2) a medical doctor without postgraduate training but with a training course in aviation medicine and an old invalid licence for any kind of light aircraft can also issue a LPL medical certificate. In my opinion both doctors don't have sufficient training or medical experience for this job.

To achieve a uniform level of knowledge and safety its necessary for the GMP as well as for the AME to attend a full 60-hour basic course of aviation medicine. There is no medical speciality 'relevant to aeromedical practice' that could replace experience in aviation medicine itself.

The requirement in MED.D.001 (c) is not understood - a declaration to the competent authority is of no value as long as this authority has no power whatsoever concerning the GMPs.
Article 7 of the Basic Regulation accepts, if permitted under national law, that GMPs may act as Aeromedical examiners. According to ICAO Annex 1, the aeromedical examiners shall be regularly audited by the authority, and the same requirement is expected in Part Authority Requirements. However, the competent aviation authorities have no rights to make oversights/audits of GMPs unless they have an AME certificate. An AME certificate shall be limitied, suspended, or revoked if the aeromedical examiner does not fulfil the requirements. For GMPs, acting as Aeromedical examiners according to the Basic Regulation, the competent aviation authorities have no legal power to prevent the GMPs from continue to perform aeromedical examinations and issue medical certificates even if they are not following the regulations.

According to Article 7 of the Basic Regulation the implementing rules concerning GMPs shall ensure that the level of safety is maintained As described above, the requirements for GMPs as they have been proposed in MED.A.030 and MED.D.001 might be a real threat to aviation safety, unless the assessment and issuing of the medical certificate is restricted to the licensing authority. The present proposed requirements and privileges for GMPs therefore can not be accepted.

Proposal:
EASA should revise the requirements and privileges for GMPs after an independent Safety Assessment has been made.

EASAs target to bring as much people as possible in an aircrafts cockpit is neglecting basic safety standards of the air traffic

response *Noted*

The reason to introduce the LAPL medical rules that are less restrictive than ICAO Annex 1 and to give GMPs the possibility to issue medical certificates for this licence was to give wider access to general aviation. It is assumed that the risk of incidents and accidents due to medical problems is low for these licence holders

	and that a GMP who knows the medical history of the applicant can issue a medical certificate without the full knowledge of aviation medicine that an AME has to have. It is correct that the national aviation authority cannot regulate GMPs. However, the GMP who issues a medical certificate has to send the full documentation to the licensing authority (application form, examination form) and the licensing authority can suspend or revoke a medical certificate that has not been issued according to the rules. The privilege for the GMP to issue medical certificates cannot be taken away on a general basis because all European Member States agreed to it when adopting the Basic Regulation. However, it is up to the individual Member State to implement this possibility or not. Also see response to comment No 89.

comment	*1151*	comment by: *Keith WHITE*
	Add LPL(S) and SPL to list of licences. **(GMP)** becomes **(GMPs).**	
response	*Not accepted*	
	SPL is an ICAO compliant private pilot licence and the pilot must therefore hold Class 2 medical certificate. The standard is in ICAO Annex 1, Section 2.9. Glider pilot licence, paragraph '2.9.1.5: An applicant shall hold a current Class 2 Medical Assessment'. LPL(S) is covered under 'LAPL medical certificates' in MED.B.090.	

comment	*1167*	comment by: *D.Hahn, class I AME*
	(a) it is felt, that training in general medical practice does not necissarily include: 1. knowledge in ophthalmology as nescessary for decisions in aeromedical fitness. 2. knowledge of importence of audiological limitätions in aeronautical communication 3 decisionmaking in sensible limitations e.g. of COPD, sleepapnea, not apparent coronary desease. 4 enough general knowledge in technical testing in internal medicine for aeromedical decisionmaking (e.g.ECG,rythmology) (b) nothing is said about the necessary minimal technical equipment of the GP. After his training course he shold prove to be equiped with the minimal technical AME-equipment for investigation of eye-,ear-,lung- and hearttesting	
response	*Noted*	
	The medical provisions for the LAPL are below ICAO Annex 1 standard and drafted for light aircraft activities. The experience in one Member State shows that lower medical standards and evaluation of fitness by a GMP do not lead to a higher incident or accident rate, and that the GMP is perfectly capable to assess these pilots. Medical tests have been reduced to a minimum.	

A GMP has to refer pilots who do not fully comply with the medical provisions to an AME.

No Member State is obliged to accept that their GMPs issue medical certificates. In this case this task will be given to the AMEs and AeMCs.

comment	*1179*	comment by: *FAI*

(CIMP)
Page 21 of 66

The right of General Medical Practitioners to certify LPL pilots is highly controversial. The proposals in NPA 17c MED.D.001 (3) do not meet the Essential Requirements (5) nor do they follow any existing practices in Europe or elsewhere. The qualifications laid down are complex but do not necessitate any prior medical relationship with the applicant. The unique value of GMPs is that they know their patients and this more than compensates for an absence of aeromedical expertise. GMPs are not inferior AMEs, they follow a different decision path using past knowledge. They will know of new and serious illness. The proposals in the NPA 17 (1-3) not only ignores existing experience but would offer an opportunity for the less scrupulous doctors to provide certification to less honest pilots without proper control.

CIMP CONCLUSION
-GMPs should be permitted to certify pilots, only when they have had regional and professional relationships to the applicant pilots. A close relationship with aero-clubs facilitates medical supervision.

References:
3. EASA NPA 2008-17c Part-Medical
5. Regulation (EC) No 216/2008 of the European Parliament and of the Council of 20 February 2008 on common rules in the field of civil aviation.....

response *Noted*

The medical system differs widely between Member States . In some countries there is 'the GMP' who takes care of his/her patients for many years, sometimes for a life, and who has complete knowledge of their medical history.

In other countries there is 'a GMP' who sees a patient sometimes only once because patients are free to change their GMP if they wish so. This GMP may not be aware of the patient's past knowledge and in any case only as far as the patient volunteers information.

Rules for the qualification of the GMPs have been included in Part Medical to bridge that gap.

The wording of MED.D.001 has been amended and now states that only those GMPs can act as AMEs who exercise their professional activities in a country where the GMP has appropriate access to the full medical records of a pilot.

	Supervision of the GMP will be done by the licensing authority.

comment	*1182*	comment by: *Ray Partridge*
	It is more important to know the general health of the pilot than to understand aviation in the case of a sport pilot. Self certification must be the safest route, as explained above. If regulation is necessary then adopt the BGA proposal.	
response	*Noted*	
	Having knowledge of the medical background of the applicant is a prerequisite for a GMP to issue medical certificates for the LAPL. In addition, the applicant has to '*demonstrate medical fitness*' (Annex III to the Basic Regulation). A self-declaration for medical fitness would not be in compliance with the Basic Regulation and its Annex III.	

comment	*1236*	comment by: *Swedish Transport Agency, Civil Aviation Department (Transportstyrelsen, Luftfartsavdelningen)*
	Comment: For GMPs, when permitted under national law to perform aeromedical examinations and issue medical certificates, very strict requirements are needed. The explanatory notes to Subpart D specifically describes that a GMP who wants to examine and assess pilots for LPL will need "theoretical and practical aeromedical training and to hold or have held a pilot licence when practical training has not been obtained." However, this is not reflected in the requirements in Subpart D. The basic requirements in MED.D.001 (a) and (b) first line seem to be appropriate, provided that "or" is changed to "and". The alternative requirements in MED.D.001 (b)(1), and (b)(2) can not be alternates because they are not exchangeable as the first refers to medical experience and the second to aviation experience. They seem to be irrelevant for the ability of a GMP to perform the aeromedical examination and assessment tasks. The requirement in MED.D.001 (c) is not understood - a declaration to the competent authority is of no value as long as this authority has no power whatsoever concerning the GMPs. After consultation with the Swedish National Board of Health it is quite clear that the Civil Aviation Authority has no legal right to have any oversight over, or take any action against, GMPs unless they are certified as AMEs acting on behalf of the authority. Article 7 of the Basic Regulation accepts, if permitted under national law, that GMPs may act as aeromedical examiners. According to ICAO Annex 1, the aeromedical examiners shall be regularly audited by the authority, and the same requirement is expected in the Part Authority Requirements. However, when the competent aviation authorities have no rights to make oversights/audits of GMPs	

	unless they have an AME certificate, the required audits can not be performed. An AME certificate shall be limitied, suspended, or revoked if the aeromedical examiner does not fulfil the requirements. For GMPs, acting as aeromedical examiners according to the Basic Regulation, the competent aviation authorities have no legal power to prevent the GMPs from continue to perform aeromedical examinations and issue medical certificates even if they are not following the regulations. This is a matter for the Ministry of Health or National Board of Health and civil courts, where this type of cases seldom will result in any action unless there has been an extreme malpractice resulting in withdrawal of the licence to practice. The GMPs are not even required to inform the licensing authority, nor an AME or an AeMC when they have identified a medical condition making a pilot unsafe to perform his/her duties, as described in MED.A.060 (c). According to Article 7 of the Basic Regulation, the implementing rules concerning GMPs shall ensure that the level of safety is maintained. As described above, the requirements for GMPs as they have been proposed in MED.A.030 and MED.D.001 might be a real threat to aviation safety, unless the assessment and the issuing of the medical certificate is restricted to the licensing authority. The present proposed requirements and privileges for GMPs can therefore not be accepted. A possibility in national legislation to permit GMPs to perform only renewal examinations on LPL holders according to the ICAO class 2 standards, but without permission to make the aeromedical assessment or to issue the medical certificate has been practised in Sweden. This Swedish system has allowed for a professional aeromedical assessment even when the examination has been performed by a GMP not trained in aviation medicine, and thus would have maintained an acceptable level of safety. With the privileges given to GMPs as proposed in NPA 2008-17 there is no option to continue with this system, and because the level of safety can no longer be maintained, the GMPs will no longer be permitted to perform examinations for aviation purposes. **Proposal**: EASA should revise the requirements and privileges for GMPs after an independent safety assessment has been made.
response	*Noted*
	Subparagraph (b) on the qualification of a GMP has been redrafted to say that the GMP has to have acquired knowledge in aviation medicine or has to hold or have held a pilot licence. The Agency takes note of the comment that an NAA may not have the possibility to properly supervise a GMP and may not be in a position to take action against a GMP as long as he/she is not certified by the NAA. This will be clarified before finalising the Opinion. Audits of GMPs will be dealt with in the Authority requirements.

MED.A.060 (c): In a case where a holder of a LAPL medical certificate presents with a condition mentioned in MED.A.060(a) he/she has to inform the GMP who issued the medical certificate (amended during the review phase). The GMP has to refer a pilot who does not fulfil the requirements to an AME or AeMC (see MED.A.045 (b)(1)), but this may not be necessary in all cases under MED.A.060 and is therefore not mentioned.

Maintain the level of safety: The experience of one Member State where GMPs may issue medical certificates for holder of national licences showed that the incident or accident rate did not change. These GMPs issue medical certificates without any involvement in aviation medicine. A safety assessment has been carried out and no safety concerns have been voiced.

The paragraph on GMPs has been amended also to say that a GMP can only issue medical certificates if they work in a country where appropriate access to the full medical history of the pilot is possible.

comment *1298* comment by: *David Chapman*

The whole section is not fully clear, If the GMP has completed post graduate training in GMP, then there is no requirement fo the GMP to have any "avaiation specific" training or experiance? If this is the meaning, I fully agree, ...

It is unreasonable to apply these "knowledge/experiance in aviation medicine" requirements before a GMP can issue an LPL medical licence. Many/most GMP will not have this knowledge. This requirement could in fact have adverse, severe, and unintended consequences.....

This section should start with the requirement that is GMP is the "normal or primary GMP" of the pilot being examined. Is it better to have a GMP with a full and through knowledge of the pilot, than to find a GMP with an expert knowledge of aviation, but not knowing well the pilot, and (if we are lucky) sifting through the pilots medical history/notes.

The GMP should assess the pilot against easily recognised standards, such as fitness to drive a motor car - there is not a huge difference (except there is often no need to have a Drivers Medical Licence - think about that for a moment!). If the GMP has knowledge of specifc illness or incapacitatons that would making driving a car unsafe (e.g. epilepsey) then the GMP should refuse the application or pass the assessment process to an AME.

Suggestion - reword Med.D.001

MED.D.001 Requirements for general medical practitioners

In order to issue LPL medical certificates, general medical practitioners (GMP) shall be fully qualified and
licensed for the practice of medicine in accordance with applicable national rules, and
(a) have completed postgraduate training in general medical practice; or
(b) have completed post graduate training in a speciality relevant to aeromedical

	practice ; or (c) have completed a training course in aviation medicine and have either: (1) 1 year fulltime, or parttime equivalent, experience in practicing a medical speciality relevant to aeromedical practice; or (2) hold, or have held, a pilot's licence for any kind of light aircraft. It is not clear what intention is being sought with the final part **"declare their activity to the competent authority."** Is this linked only to the avaition medicine specialist making declaration to the general medical competant authority? or what?
response	*Not accepted*
	The medical systems of the European Member States are very different and a 'normal and primary GMP' does not exist everywhere. Driving licence standards are not appropriate for aviation, the third dimension is missing and the skills needed for flying are different from those for driving. 'Declare their activity' means to inform the licensing authority that medical certificates for LAPL will be issued.

comment	*1318*	comment by: *Vincent EARL*
	This requirement does not include a reference to the most important aspect of GMP certification, that they have access to the applicant's prior medical history and so falsification or denial by the applicant cannot go undetected. **Proposal:** **Any GMP that supplies a report for an LPL(S) or SPL applicant must have access to at least 3 years medical history of the applicant.**	
response	*Noted*	
	A new paragraph (a) has been added to say that a GMP can issue medical certificates for LAPL holders only in those countries where the GMP has appropriate access to the full medical records of a pilot. SPL holders have an ICAO compliant licence and need a class 2 medical certificate.	

comment	*1410*	comment by: *Prutech Innovation Services Ltd.*
	MED.D.001(a): Add a new sub-part (aa), as follows: "(aa) have experience of not less than 5 years practice as a GMP in a publicly available general medical practice; or" **Comment:** *Practical experience as a functional GMP over a reasonable period is at least as valuable as postgraduate training in detecting human failings.*	
response	*Not accepted*	
	A GMP who has undergone postgraduate training is supposed to have the	

	knowledge required to treat patients. In this case he/she should also be in a position to evaluate whether an applicant for a medical certificate complies with the rules or not. If so, the medical certificate can be issued. If not, the decision will be referred to an AME or AeMC. For this reason we think that additional medical/technical requirements are not needed.

comment	*1411*	comment by: *Prutech Innovation Services Ltd.*
	MED.D.001(c): This is vague; declare which activity?	
response	*Noted*	
	The declaration of the activity to the competent authority is required from those GMPs who wish to act as AMEs for the issuance of LAPL medical certificates.	

comment	*1425*	comment by: *Trevor HILLS*
	What is relevance of GMP holding a pilots' licence?	
response	*Noted*	
	If GMP holds a pilot licence, he/she is familiar with the aviation environment. Together with the medical knowledge and skills, it provides the basis to issue LAPL medical certificates.	

comment	*1515*	comment by: *Dr Ian Perry*
	MED.D.001 (a) the word "or" at the end of the paragraph should be deleted. The word "and" should be inserted. Reason; The requirements read as though there are two different levels of skill for a GMP. There must be no difference in GMP skill levels.	
response	*Noted*	
	See response to comment No 53.	

comment	*1641*	comment by: *simon reeve*
	Any GP is capable of carrying out the requirements for providing a LPL Medical certificate. By requiring further training as shown in MED.D.001 then it is almost certain to restrict the availability of suitably qualified GPs. In addition any GP who does undergo the training is almost certain to make a charge (currently this is not always the case in the UK). As a result, unnecessary barriers to compliance are being put in place that out weigh the benefits in my view. The statistics of aviation accidents do not bear out the need for this extra layer of bureaucracy. For compliance to be good as possible a regulation needs to be both simple and inexpensive to those who have to comply.	
response	*Noted*	

	See response to comment No 53.

comment	*1645*	comment by: *Medical Officer BBAC*
	For the GMP to be truly effective he/she should have access to the pilot's general medical history through their practice-based records.	
response	*Noted*	
	See response to comment No 97.	

comment	*1649*	comment by: *Medical Officer BBAC*
	We fully support the inclusion of GMPS as competent medical practitioners in issuing medical certificates for LPLs. This system has operated in the UK for ballooning since the first modern balloon licence was issued in the late 1960s. Since then there have been no recorded accidents or incidences as a result of pilot incapacitation. This represents an estimated 350,000 hours in balloons.	
response	*Noted*	
	Thank you for the supportive comment.	

comment	*1736*	comment by: *DCA Malta*
	Delete The minimum qualifications to issue a medical certificate should be those for an AME	
response	*Noted*	
	The possibility for a GMP to issue medical certificates for LAPL holders is provided in the Basic Regulation. However, this Regulation also states that this is only possible if permitted under national law.	

comment	*1744*	comment by: *Civil Aviation Authority Finland*
	MED.D.001 See the earlier comments against **MED.B.090** The level of medical cCertification of LPL and the system of GMPs does not fulfill the ICAO Annex 1 and the safety requirements. Delete Subpart D.	
response	*Noted*	
	See response to comment No 89.	

comment	1763	comment by: Max Heinz Katzschke

Voraussetzungen zu definieren, welcher Allgemeinarzt Fliegertauglichkeit bescheinigen kann, ist eine versteckte Form von "Zulassung als Fliegerarzt".
Jeder Arzt, der als Allgemeinmediziner arbeiten darf, sollte als Berechtigter (GMP) betrachtet werden.

Hierzu meinen Komentar zu NPA 2008-17c Page 4 Cmt#1508 beachten:
"Die Statistik zu Flugunfällen mit Leichtflugzeugen, insbesondere Segelflugzeugen, in der USA zeigen, daß von Piloten ohne Medical (also nur mit einer Anfangsuntersuchung wie zum Erwerb einer Fahrerlaubnis) keine höhere Gefahr ausgeht (sie war statistisch <0,03 %) als von Piloten mit Medical.
Die wirklichen Indikationen zu flugbeinträchtigenden körperlichen Ereignissen sind nur vom Piloten selbst in unmittelbar vor dem Start und während des Fluges zu geschehender Selbsteinschätzung möglich.
Die periodische Untersuchung durch einen Fliegerarzt ist damit unnötig. Eine Konsultation eines Allgemeinmediziners oder Fachmediziners bei körperlicher Beeinträchtigung zeitlich unmittelbar zu einem derartigen Ereignis ist sinnvoller.
Deshalb sollte für Segelflug, Ultraleicht- und einmotorige Flugzeuge (insbesondere unter 1000 kg MOTOW) ein periodisch zu erneuerndes Medical nicht erforderlich sein."

Zu diesem Komentar siehe auch mein Komentar zu NPA 2008-17a, Page 4-7, Cmt# 294:
a) In den Studien der amerikanischen AOPA ist, nach einer Probezeit ohne Zwang zur fliegerärztlichen Untersuchung als Voraussetzung zum Führen von Luftfahrzeugen, keine negative Auswirkung auf die Flugsicherheit festgestellt worden.
Siehe: http://www.aopa.org/whatsnew/newsitems/2003/03116petition.html
Auch die deutsche Studie BEKLAS hat medizinische Ursachen als vernachlässigbar für Unfälle festgestellt.Siehe:
http://www.daec.de/flusi/douwnfiles/Beklas/BEKLAS_Abschlussbericht.pdf
Der französische Rapport Senateur Belot stellt sogar fest, dass von Luftfahrzeugen die ohne Medical betrieben werden dürfen geringere Unfallzahlen verursacht wurden als von nur mit Medical zu betreibenden. Siehe:
http://www.aviation-civile.gruv.fr/html/avia_leg/pdf/Rapport_senateur_belot.pdf

Aus meiner ~50 Jahre dauernden Tätigkeit als Segelfluglehrer sehe ich es als ausreichend an, dass zu Beginn einer fliegerischen Tätigkeit zum LPL und SPL die grundsätzliche Eignung des Flugschülers vom dem mit der Ausbildung beginnenden Fluglehrer festgestellt wird; dies muss er verantwortungsbewusst tun, indem er im Laufe der Ausbildung den Schüler nach und nach auch mit außergewöhnlichen Aufgaben konfrontiert, die Reaktion bewertet und auch mit dem Schüler gemeinsam auswertet. Mit einem derartigen Vertrauensverhältnis sind auch schwierige Entscheidungen, wie sie die Ablehnung einer weiteren Ausbildung durch den Fluglehrer darstellt, lösbar.
Die Konsultation eines Allgemeinmediziners, möglichst des Hausarztes, mit einer formlosen schriftlichen Feststellung der Eignung zum Fliegen (oder der Bedenken dagegen) auf der Basis der Voruntersuchung zum Kraftfahrzeug-Führerschein zeitnah zu Beginn der Ausbildung empfehle ich als notwendige Ergänzung. Diese schriftliche Feststellung sollte vor dem ersten Alleinflug dem Flugleher vorzulegen sein, der damit verantwortungsbewusst handeln kann und bei Erfordernis die

	Untersuchung bei einem Facharzt oder Fliegerarzt (AME oder AMC) verlangen darf. *b) Die unter a) angeführten Studien und Rapporte belegen auch, dass für die Erlaubnisse LPL und insbesondere für die Erlaubnisse LPL(S) sowie SPL die periodisch zu erneuernden Medicals keine Verbesserung der Flugsicherheit erbringen.* *Eine einfache, periodisch zu wiederholende Selbsterklärung (bei akuten medizinischen Ereignissen eine zeitnahe Selbsterklärung) unter der Aufsicht eines Arztes als Zeugen (im Fall einer speziellen Diagnose: ...eines Facharztes...) halte ich für sicherheitsrelevanter als die zeitferne Diagnose eines Flugmediziners bei einer periodisch vorgeschriebenen Untersuchung.*
response	*Noted*
	Please note that a SPL holder has an ICAO compliant licence and needs a class 2 medical certificate.

comment	*1784*	comment by: *Norwegian Association of Aviation Medicine*
	The Norwegian Association will propose to remove the suggestion to let GMP's do the examination of any pilots for different reasons: There is no way to ensure that the applicant goes to his GMP for the medical. In most countries there are also private GMP's that are more accessible on short notice. It is easy for the applicant to go to another GP than his/he usual one to get a medical certificate. Many It is important to aviation safety to assure that the aviation medical examiners have a high medical standard and that they do know the regulation very well, especially the limitations and the medical conditions that make a pilot unfit. The requirements need a lot of experience to understand. One example is the Med 0,65 and 0,70 on vision. This is a case where even experienced AME's can easily do wrong. In Norway, there are a similar problem on the role of the GMP's in the issuing of offshore medical certificates. This certificates is not very extensive or complicated, but even so there are problems due to lack of knowledge among the GMP's and the government wants to remove the right to issue the offshore medical from the GMP's! I am allowed to reprint a statement from the Alf Magne Horneland, MD, and Director of the Norwegian Centre for Maritime Medicine (NCMM). See comment 1785	
response	*Noted*	
	See response to comment No 89.	

comment	*1785*	comment by: *Norwegian Association of Aviation Medicine*
	Dear Dr Tjensvoll, Referring to our brief discussion on the telephone today, I would like to summarize very briefly our point of view on the topic of pre-employment and periodic medical examinations. The Norwegian legislation on this field today consists of four different regulations:	

The regulation of medical examination of employers on board ships. The regulations of health requirements for maritime pilots
The regulations of visual requirements for maritime pilots
The regulation of health requirements for persons in offshore petroleum industry

The approved doctors for the examination of seafarers also examine the maritime pilots. The requirements for getting such approval are a declaration of own competence and willingness to oblige with the regulations, a willingness to keep the knowledge up to date, an assumption that at least 50 seafarers will be examined each year, the declaration of having access to the necessary medical equipment to carry out the examination, and a medical certificate of normal colour vision, together with the certificate of authorization as a medical doctor according to Norwegian legislation. There is no requirement of specific knowledge of the maritime industry, the maritime environment, the special demands and risks for employers in these occupations.
Approved doctors for the examinations of seafarers have a special position as compared to other doctors. They make "Individual Decisions" according to the Norwegian "Civil Cervices Act", and by doing so, are acting on behalf of the national authorities, not only giving expert advice about the person's health.

For the persons in offshore petroleum industry, any medical doctor holding a valid Norwegian authorization, can issue health certificates. They do not need a special approval.
During our discussions with the Norwegian Maritime Directorate, the Norwegian Directorate for Health, the Norwegian Board of Health Supervision, the Norwegian Coastal Agency, the Medical Services of the Norwegian Navy and Coast guard, the Norwegian Petroleum Directorate, the Norwegian Oil Industry Association and the Norwegian Society of Maritime Medicine, we have noticed the common understanding that quality improvement of the issuing of health certificates is urgently needed.
The Norwegian Centre for Maritime Medicine has proposed that doctors should be approved for issuing certificates for all the above mentioned groups of personnel. Approval for the first time would require a basic course in maritime medicine. Approval should be given for a period of five years, and expire automatically if not renewed. Renewal will depend on a minimum of CME (Continuing Medical Education) points in the 5-year period, a minimum of persons examined, and one of the following: 1) practice from research in maritime medicine, 2) practice from maritime health service, 3) experience as a ship medical doctor or 4) other service after individual assessment.
This proposal was welcomed by all the above mentioned parties in the process that was meant to lead to one single, common regulation for all of these groups.
In August 2008, the parties agreed to develop further along these lines, but making three new regulations (Offshore, Seafarers, Pilots), due to the difficulties involving different Ministries and different Directorates in the legal process, and the difficulties connected to maintaining these regulations in the future, if several different ministries and directorates all the time should have to agree on every detail.
However, the principles of the process still is the basis for the developments of new regulations
Best regards
Alf Magne Horneland, MD,
Director

	Norwegian Centre for Maritime Medicine (NCMM) E-mail: amho@helse-bergen.no Tel: +47 5597 3862 Fax: +47 5597 5137 Mobile phone: +47 90990461
response	*Noted*
	Thank you for the information.

comment	*1793*	comment by: *Paul Morrison*
	In Article 7 of 216/2008 it states "*in the case of a leisure pilot licence a general medical practitioner who has sufficient detailed knowledge of the applicant'smedical background may . . .* ". The requirements listed above are different and miss the essential point that the advantage of a GMP is that they actually know the medical history of the applicant and falsification is not possible. The instruction for the LPL medical report actually authorises a GMP to complete the form without such knowledge and in breach of the basic law. The depth and length of the medical history available to the GMP needs to be defined. I therefore support the BGA proposal that a GMP completing a report on an applicant for an LPL must have access to at least three years of medical records that have been accumulated for clinical purposes.	
response	*Noted*	
	See response to comment No 97.	

comment	*1862*	comment by: *Sally Woolrich*
	At present my GP signs me as fit to drive according to the regulations of the DVLA, and that is the basis of my fitness to fly. He/she doesn't have to do any examinations, and of course they have full access to all my medical notes which in my view puts them in an ideal position to sign me off - or not. So far as I am aware there is no evidence that this basis is unsuitable for recreational glider and NPPL pilots, and changing it is likely to substantially increase both the cost and complexity of getting my medical revalidated when necessary, and is also likely to instroduce additional delays to the system. As I pointed out to my GP last time she signed my medical, I could be unfit to fly on any day due for reasons including illness (cold for example), medication (antihistaines making me sleepy), stress (cannot concentrate on the task of flying), alcohol, fatigue etc. and it is my duty as a pilot (and as a driver) to make that assessment of my fitness each and every time I fly (or drive). IMHO given that I am in general good health, that step of self-assessment is actually the most powerful way of ensuring that when I fly I am fit to do so.	
response	*Noted*	
	The knowledge of the medical background of the applicant is a prerequisite for a	

	GMP to issue a medical certificate. However, a physical examination and some very basic tests are also part of an examination for fitness to fly.

comment	*1875*	comment by: *ECA- European Cockpit Association*
	Comment: change text as follows: In order to issue LPL medical certificates, general medical practitioners (GMP) shall be fully qualified and licensed for the practice of medicine in accordance with applicable national rules, declare their activity to the competent authority, and (a) have completed postgraduate training in general medical practice or any speciality relevant to aeromedical practice ; or (b) have completed a training course in aviation medicine and have either: (1) 1 year fulltime, or parttime equivalent, experience in practicing a medical speciality relevant to aeromedical practice; or (2) hold, or have held a pilot's licence for any kind of light aircraft. ~~(c) declare their activity to the competent authority.~~ Justification: For clarification, order of paragraphs (point (c) should be changed. Clarification is also needed on what any speciality is relevant to aeromedical practice.	
response	*Not accepted*	
	This paragraph has been redrafted but the subparagraph concerning the declaration of the activity to the competent authority remains at the end. The reason is that the GMP can declare his/her activity only after complying with all the requirements in the subparagraphs above.	

comment	*1878*	comment by: *Phil King*
	It would appear that these requirements omit an essential point -- the advantage of having GMPs issue medical certificates is that they have access to the pilot's medical records. Having access to medical records helps prevent the pilot from hiding potentially dangerous conditions. I support the BGA proposal: *That a GMP completing a report on an applicant for an LPL must have access to at least three years of medical records that have been accumulated for clinical purposes.*	
response	*Noted*	
	See response to comment No 97.	

comment	*1885*	comment by: *AECA(SPAIN)*
	Between (a) and (b). Change 'or' by **'and**'. Training is neccesary though be to explain the requirements for LPL medical certificate.	
response	*Noted*	

	The GMP will issue medical certificates mainly on the basis of the medical history and only if the pilot complies with the rules. In case a pilot does not fully comply with the rules, he/she will be referred to an AME or AeMC who has the necessary training and qualification and will assess borderline cases. A training course in aviation medicine for GMPs will therefore not be required.

comment	*1900*	comment by: *Chris Fox*
	The requirements for a GMP issuing LPL medical certificates to have specific aeromedical experience and/or training is in contradition to Article 7 of 216/2008, and misses the point that it is the knowledge of the patient's medical history that permits a GMP to issue certificates. It may be appropriate to instead define a minimum length of medical history to be available to the GMP before issuing an LPL certificate.	
response	*Noted*	
	See response to comments No 53 and 97.	

comment	*1960*	comment by: *Civil Aviation Authority of Norway*
	If general medical practitioners issue LPL medicals it will be difficult to keep the oversight for the Authority. The number of pilots in Norway is limited and the network of trained AMEs will be able to assess LPL pilots.	
response	*Noted*	
	The Member States are free to decide whether they want to allow GMPs to issue medical certificates — or not.	

comment	*2006*	comment by: *AA Brown BBAC # 3448*
	MED.D.001 Requirements for general medical practitioners I support the proposal that in addition to AeMC and AME, GMP's suitably qualified and where permitted under national law should also be able to issue LPL medical certificates.	
response	*Noted*	
	Thank you for your positive comment.	

comment	*2011*	comment by: *Lars Tjensvoll*
	This Subpart should be cancelled! It is below ICAO standards, it is against the goal to keep a high standard on both the pilots and the examiners, and it is contradictory to all knowledge on what is important to keep a high professional standard to a very specialised field within medicine!	
response	*Noted*	

	See response to comment No 89.

comment	*2023*	comment by: *BSANSM*
	Dear colleagues, The system for health insurance and medical servicing of the population using general practicing in Bulgaria is relatively new and therefore subject of development and corrections. The informational system with medical profiles of the patients is not yet complete and effective, wherefore we think that at this stage the medical certifying of LPL is better to be done by aviomedical examiners. In future the certification could be done by GP medical staff if they pass suitable preparation courses and licensing and this activity is included in GP duties by contract with the National Health Insurance Fund. Best regards: Associate Professor, L. Alexiev, MD, PhD, Chairman of BSANSM Senior assistant professor, M. Spahieva, MD, PhD, Secretary of BSANSM	
response	*Noted*	
	Rules proposed in the NPA must not be implemented immediately. The latest date of the implementation is 08 April 2012. The legislator provided Member States with sufficient time to adapt the national legal system and to involve GMPs in Medical certification of LAPL applicants if they wish so. The rules do not require GMPs to complete courses for AMEs. Certificates for AMEs will be issued by the competent authority. Also see response to comment No 89.	

comment	*2069*	comment by: *CAA Belgium*
	Proposal: "In order to issue medical certificates, general medical practitioners (GMP) shall be fully qualified and licensed for the practice of medicine in accordance with applicable national rules and a have completed a training course in aviation medicine or hold, or have held a pilot's licence for any kind of light aircraft b be accepted by the national licency authority"	
response	*Not accepted*	
	The proposed changes go beyond of what is required for an AME certificate (see MED.C.010) and would render the idea of GMPs to issue medical certificates invalid. However, the Basic Regulation also provides the possibility that Member States do not permit GMPs to do so.	

comment	*2088*	comment by: *Royal Swedish Aeroclub*
	The limitations to accept only GMPs with certain qualifications should be	

	abolished. Every GMP is able to do the renewal examination. Every GMP is licensed by a National Medical Board and performes his/her duties as a physician under the auspices of that Board. This should be sufficient. The AMC contain what pertinent information is needed. The costs for medical examinations now constitutes a large part of a private pilots budget and in some cases equivalent to several flying hours each year. In less densely populated areas of Sweden, representing a big part of this country, a pilot may have spend a whole day to get an examination if the number of GMPs is limited by special requirements as proposed in this document. There is no reason to question if a GMP is skilled enough to judge if a private pilot is well enough to continue as a pilot. The requirements should rather be in level with the requirements for a driving license allthough with some adjustments. The requirements on a GMP may should not include special training, own pilot's license, or flying experience. The important thing is that the GMP is aware of what the examination is about (indicated by the examination form and AMC). KSAK can not see any need for the authority (NAA) to authorize, supervise or train GMPs perfoming medical axeamination for the renewal of LDL(A) flying licenses.
response	*Noted*
	GMPs may issue medical certificates for LAPL holders. We are not sure what a LDL(A) is but if it is to be the future LAPL the GMP can issue the medical certificate if permitted under national law. The paragraph has been redrafted to say that the GMP has to have acquired knowledge in aviation medicine and this is not necessarily a training course. If the GMP holds a pilot licence he/she has sufficient knowledge in the aviation environment. The national authority is responsible for all licences issued in the corresponding Member State and therefore has to exercise its oversight functions, including the GMPs who issue medical certificates.

comment	*2111*	comment by: *French Fédération Française Aéronautique groups the 580 French powered flying aer-clubs and their 43 000 private pilots*
	MED.D.001 - Requirements for general medical practitioners. Although it is not confirmed that the use of General Practitioner for LPL medical certificate will be possible in France, the FFA supports this innovative option proposed in this NPA. However, FFA believes that the terms "post-graduate training in general medical practice", used in the first option offered in § (a), needs clarification.	
response	*Accepted*	
	Thank you for the positive comment. The 'post-graduate training in general medical practice' is aligned with Articles 21(2), 24, 28 and 29 of the Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications. The document provides requirements for the 'Basic medical training' and the 'Specific training in general medical practice'.	

comment	2126	comment by: Croft Brown
	Page 21 of 66 MED.D.001 Requirements for general medical practitioners In order to issue LPL medical certificates, general medical practitioners (GMP) shall be fully qualified and licensed for the practice of medicine in accordance with applicable national rules, and (a) have completed postgraduate training in general medical practice or any speciality relevant to aeromedical practice ; or (b) have completed a training course in aviation medicine and have either: (1) 1 year fulltime, or parttime equivalent, experience in practicing a medical speciality relevant to aeromedical practice; or (2) hold, or have held a pilot's licence for any kind of light aircraft. (c) declare their activity to the competent authority. Comment: In Article 7 of 216/2008 it states "in the case of a leisure pilot licence a general medical practitioner who has sufficient detailed knowledge of the applicant's medical background may . . . ". The requirements listed above are different and miss the essential point that the advantage of a GMP is that they actually know the medical history of the applicant and falsification is not possible. The instruction for the LPL medical report actually authorises a GMP to complete the form without such knowledge and in breach of the basic law. The depth and length of the medical history available to the GMP need to be defined. Croft Brown endorses the BGA Proposal: That a GMP completing a report on an applicant for an LPL must have access to at least three years of medical records that have been accumulated for clinical purposes. Reference: Regulation (EC) No 216/2008 of the European Parliament and of the Council on common rules in the field of civil aviation... Article 7, para 2.	
response	*Noted*	
	See response to comment No 97.	

comment	2187	comment by: Finnish Aeronautical Association - Kai Mönkkönen
	General Medical Practioner (GMP) should be allowed to issue a new or revalidated or renewed medical certificate for LPL as a general rule based on his/her basic professionality and medical information of an applicant. Instead or additional wording "if permitted under national law" on items MED.A.030 (b)(3) and (c)(2) suitable medical history depth could be set here, for example by requiring at least previous 3 years medical history of an applicant available. Justification: Professionally GMP shall be considered capable for doing the work. In the view of medical depth for the check, such can be set by requiring also medical history of an applicant, for example from the last 3 years available. Proposed text: See comment of the European Gliding Union (EGU) on MED.D.001.	
response	*Noted*	

	See response to comment No 97.

comment	*2204*	comment by: *Royal Netherlands Aeronautical Association*
	MED.D.001 Requirement for general medical practitioners (KNVvL) Besides GMP's there are other medical doctors with the same working field, training and experience as GMP's. These are qualified sport doctors, health officers or other medical practitioners who fulfill the requirements of MED.D.001. We strongly advise that these medical doctors should be permitted to perform LPL medical assessments, next to GMP's. KNVvL PROPOSAL: The question of competency to perform aero medical assessments can be read as: MED.D.001: Any medical doctor, qualified and licensed for the practice of medicine in accordance with applicable national rules, and (a) that have completed postgraduate training in general medical practice or any speciality relevant to aero medical practice, or (b) (1) and (2)... … agreed (c) ……..….agreed -LPL medical certificates can be issued by GMPs, sport qualified doctors, medical officers as far as they meet the above mentioned qualifications -The existing Netherlands medical system for unpowered aviation has proven to be a safe and simple system for medical fitness for the LPL. -GMP's, sport medical doctors and medical officers who can not hold a pilot license should have theoretical and practical training in aviation References: Regulation (EC) No 216/2008 of the European Parliament and of the Council of 20 February 2008 on common rules in the field of civil aviation.....	
response	*Noted*	
	See comment No 2088. Sport medical doctors and medical officers may issue LPL medical certificates if they comply with MED.D.001 provisions.	

comment	*2245*	comment by: *Andrew Sampson*
	Surely it should be a condition that the GMP /AME actually knows the pilot's medical history?	
response	*Noted*	
	The answer is yes.	

comment	*2251*	comment by: *Féderation Française de Planeurs Ultralégers motorisés*

	It almost kill the possibility to use a GMP to deliver a medical certificate since it impose a training course that most of them had no time or desire to follow and which is of no use if they are really GMP and have read the particular requirement for delivering a certificate !
response	*Noted*
	Please see response to comment No 53. Please note that Ultralights remain under national jurisdiction and Part MED will not necessarily apply.

comment	*2255*	comment by: *Martyn Johnson*
	In Article 7 of 216/2008 it states "in the case of a leisure pilot licence a general medical practitioner who has sufficient detailed knowledge of the applicant's medical background may . . . ". The requirements listed above are different and miss the essential point that the advantage of a GMP is that they actually know the medical history of the applicant and falsification is not possible. The instruction for the LPL medical report actually authorises a GMP to complete the form without such knowledge and in breach of the basic law. The depth and length of the medical history available to the GMP need to be defined. It is sensible that GMP completing a report on an applicant for an LPL must have access to at least three years of medical records that have been accumulated for clinical purposes.	
response	*Noted*	
	See response to comment No 97.	

comment	*2278*	comment by: *Mike Armstrong*
	Page 21 of 66 MED.D.001 It is not clear whether (c) is an alternative to (a) or (b) or whether it is in addition to (a) or (b). The meaning of (c) is not clear from the draft wording. A confirmation by the GMP of reading an appropriately prepared set of concise general briefing notes for GMP's covering the medical issues that would affect a patient's suitability to fly would seem to be another suitable alternative qualification.	
response	*Noted*	
	GMPs may issue a LAPL medical certificate if they have a full access to the applicant’s medical history and if the applicant has no health problems. When health problems are diagnosed, the applicant shall be referred to AME or AeMC. LAPL medical requirements are proposed in AMC to MED.B.090.	

comment	2287	comment by: Dick Dixon
	I believ that some of the proposals for requirements for medical examiners are far too demanding in so far as they refer to medical examinations for glider pilots. I have been flying and instructing in gliders for nearly 40 years and am now in my 71st year, having given up instructing on my 70th birthday. In my view the current medical examination requirements for **solo flight** for a pilot of my age are sufficient and have proved to be as effective as the much more rigorous standards which are rightly applied to commercial airline pilots. All that is required is an annual self declaration with an endorsement by the pilot's own General Practitioner who normally has access to the pilot's medical records over some years. If the GP does not have such records available, then a simple medical examination can be carried out. All that is necessary is for the solo glider pilot to meet the medical standards of the Driving Licence authority.	
response	*Noted*	
	See responses to comments No 97 and 1182.	

comment	2344	comment by: Graham Bishop
	In article 7 of 216/2008 it refers to leisure pilots requiring a GMP who has sufficient detailed knowledge to provide the medical endorsement. The requirements have been changed. The fact that the GMP has detailed knowledge of the medical history was the point of this provision.	
response	*Noted*	
	The Basic Regulation (EC) No 216/2008 is adopted and in place and what is said in this Regulation applies and cannot be changed by implementing rules.	

comment	2374	comment by: Gareth Davies
	A pilot’s own General Medical Practitioner (GP) should be able to issue a Medical Certificate for the LPL licence. It has for long been accepted practice in the UK that the medical requirements for a Private Pilot’s Licence are based on the UK’s driving standards, and this can be adequately assessed by a GP. The pilot’s own GP has the best knowledge of their medical history and is best able to judge the level of fitness and capabilities of the applicant. The medical should continue to be based on the current standard in the UK, for levels of fitness required for driving.	
response	*Noted*	
	Part Medical will be implemented in all Member States and, after a transition period, will replace the present national rules. A pilot can go to his/her own GMP for a medical certificate if that GMP complies with MED.D.001. However, this paragraph has been redrafted and no training course will be required for the GMP, although he/she needs knowledge in aviation medicine.	

comment	2404	comment by: Irish Aviation Authority

	See comments against **MED.B.090**
response	*Noted*
	See responses to comments against MED.B.090.

comment	*2428*	comment by: *Gareth Jones*
	Recreational flying medical requirements a) The existing UK NPPL declaration, countersigned by the pilot's GP, should be adopted. b) There is no reason that GMPs shoud have to "declare their activity to the competent authority". This is simply a bureaucratic hurdle for no benefit.	
response	*Noted*	
	a) See response to comment No 2374. b) GMP will be allowed to issue medical certificates for pilots; therefore, they must declare this activity to the authority which has sole responsibility for the flight safety in the Member State.	

comment	*2461*	comment by: *Paul Mc G*
	In order to issue LPL medical certificates, general medical practitioners (GMP) shall be fully qualified and licensed for the practice of medicine in accordance with applicable national rules, and (a) have completed postgraduate training in general medical practice or any speciality relevant to aeromedical practice ; or (b) have completed a training course in aviation medicine and have either: (1) 1 year fulltime, or part time equivalent, experience in practicing a medical speciality relevant to aeromedical practice; or (2) hold, or have held a pilot's licence for any kind of light aircraft. (c) declare their activity to the competent authority. In Article 7 of 216/2008 it states "in the case of a leisure pilot licence a general medical practitioner who has sufficient detailed knowledge of the applicant's medical background may . . . ". The requirements listed above are different and miss the essential point that the advantage of a GMP is that they actually know the medical history of the applicant and falsification is not possible. The instruction for the LPL medical report actually authorises a GMP to complete the form without such knowledge and in breach of the basic law. The depth and length of the medical history available to the GMP need to be defined. BGA Proposal: That a GMP completing a report on an applicant for an LPL must have access to at least three years of medical records that have been accumulated for clinical purposes.	
response	*Noted*	
	Level of legislation: 1. Basic Regulation, BR,(216/2008) and Essential Requirements, ER (Annexes to	

	the Basic Regulation) are the highest level of legislation. 2. Implementing rules are in place to amend the Basic Regulation and the Annexes, in no case do they replace anything that is said in the BR and its ERs. Repetitions from BR and ER are avoided as much as possible. 3. AMCs further explain the implementing rules. See also response to comment No 97.

comment	*2572*	comment by: *Heinz Fricke-Bohl and Kirsten Bohl*
	MED.D.001: Dieser Punkt sollte entfallen, da Innere Medizin/Allgemeinmedizin und Zusatzbezeichung Flugmedizin Voraussetzung sein sollten und eine Lizenz haben oder gehabt haben sollen.	
response	*Noted*	
	MED.D.001 cannot be deleted because the possibility for the GMP to issue medical certificates is already in the Basic Regulation.	

C. Draft Decision Part-MED - Subpart A: General Requirements p. 22

comment	*882*	comment by: *European Society of Space and Aviation Medicine (ESAM)*
	Author: European Society of Space and Aviation Medicine (ESAM) - Group Neurology Psychiatry- **Section: 1** **II Draft decision AMC and GM for Part-Medical** **AMC/GM to Part-Medical** **Subpart A** **General Requirements** **Page**: 22 **Relevant Text:** **(all Text)** **Comment**: Univocal comment from the international group representing neurology, psychiatry and psychology: From a medical point of view, especially the branch related LPL is inacceptable. The requirements are below ICAO standard. Many of neurological and psychiatric aeromedical diseases emerge in the time span between the first examination and age of 45 e.g. MS, seizures, subarachnoid hemorrhages (SAH), schizophrenic and manic psychosis, psychotic depression with suicidality etc. Some of these diseases present with low self criticism and lack of insight. This risk for aviation safety cannot be covered with requirements below ICAO standards and such large time intervals. Further more a general practitioner without experience in neurology and psychiatry and without aeromedical education is not able to fulfill reliable	

	examinations/evaluations. In the worst case, if LPL were to be implemented, the question rises why do we need the explanations in section 2 specific requirements LPL medical certificates if a grey box in the questionnaire is ticked. The medical report should be referred to an AME or AeMC for further assessment. AME or AeMC have the knowledge and experience and don't need the information AMC to MED.B.090 etc. **Proposal**: Instead of LPL requirements class 2.
response	*Partially accepted*
	The Basic Regulation (Article 7) allows a GMP to issue a medical certificate for a LAPL licence (if permitted under national law). This has to be taken into account in the implementing rules. Medical requirements as regards LAPL were developed following the principle that all measures must be proportionate and tailored to the risk involved. As a result of the comments received, the provisions for a GMP to issue LAPL medical certificates as well as the medical requirements for LAPL will be amended.

C. Draft Decision Part-MED - Subpart A: General Requirements - Section 1: General p. 22

comment	*1917*	comment by: *Andrew BARDGETT*
	I support the concept of a GMP medical for pilots. The UK's GMP endorsed self declaration system produces no greater risk than the JAR medical system.	
response	*Noted*	
	Thank you for your support of the possibility of GMPs to issue medical certificates for the LPL.	

C. Draft Decision Part-MED - Subpart A: General Requirements - Section 1: General - AMC to MED.A.015: Medical confidentiality p. 22

comment	*90*	comment by: *Dr.Beiderwellen, Secretary of GAAME*
	Author: : Dr.Beiderwellen,AME member of the AB of ESAM Section: **AMC to Med A015** **Page**: 22 Relevant Text: Authorised personal **Comment**: No definition of "authorised personal" is given **Proposal**:	

	Define "authorised personal" as medical personal / doctors
response	*Noted*
	Definition of the authorised personnel is wider and doesn't relate only to the medical personnel/doctors. There may be additional staff employed to support the physicians of the licensing authority: IT specialists in the case when the reports are submitted in electronic format and administrative staff to process documents. In all cases requirements proposed in MED.A.015 and AMC to MED.A.015 apply. For the purpose of clarity, the text will be amended to 'personnel authorised by the medical assessor'.

comment	*552*	comment by: *British Microlight Aircraft Association*
	Strongly agree	
response	*Noted*	
	Thank you for the positive comment.	

comment	*1152*	comment by: *Keith WHITE*
	Add: **No record may be released which is not strictly relevant to aeromedical certification.**	
response	*Not accepted*	
	Medical confidentiality includes the duty not to release any documents containing medical information other than for the purposes mentioned in Part MED.	

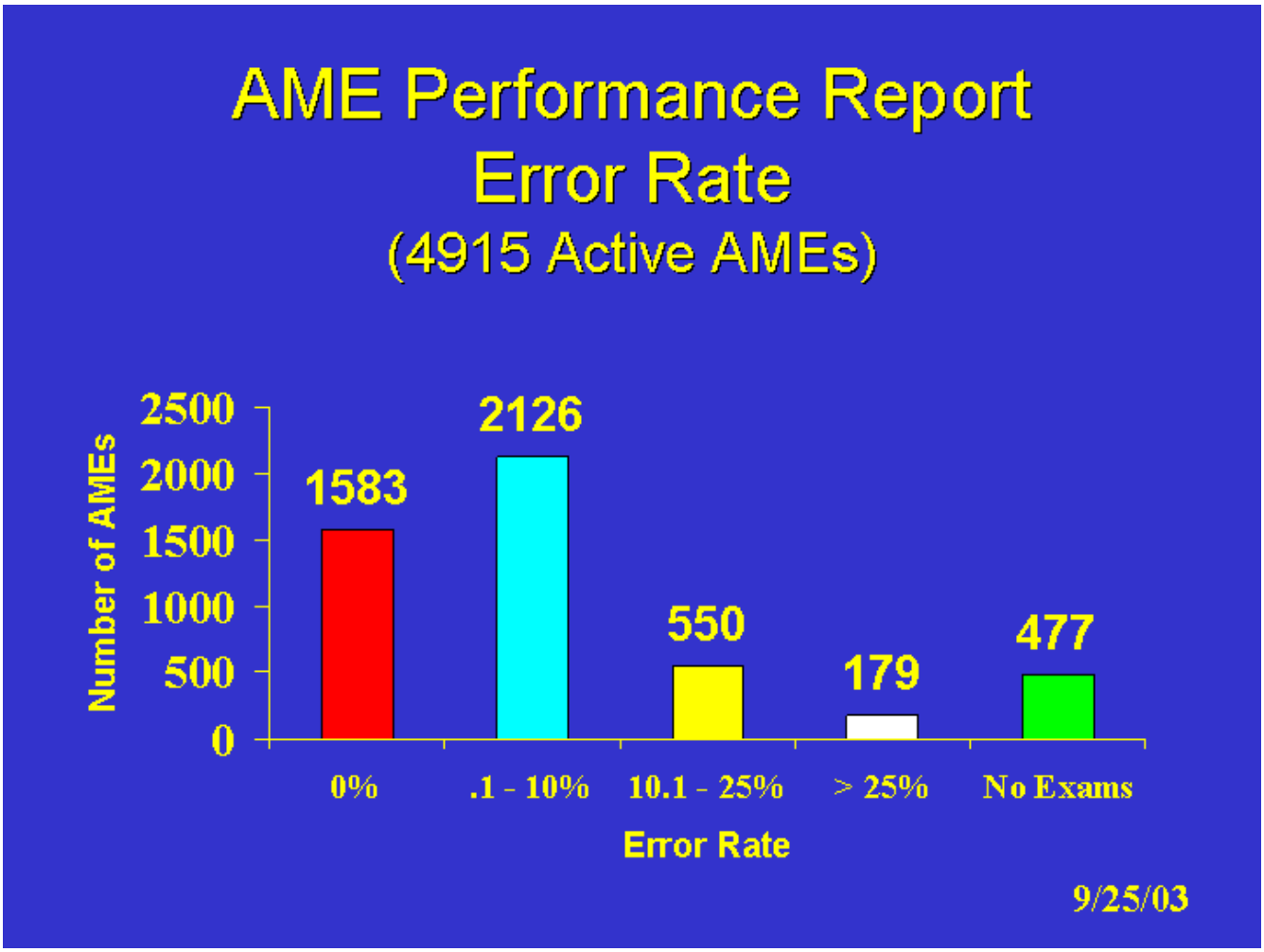
Appendix A - Attachments

EASA NPL Part Medical Comments Dr Brock .pdf
Attachment #1 to comment #343

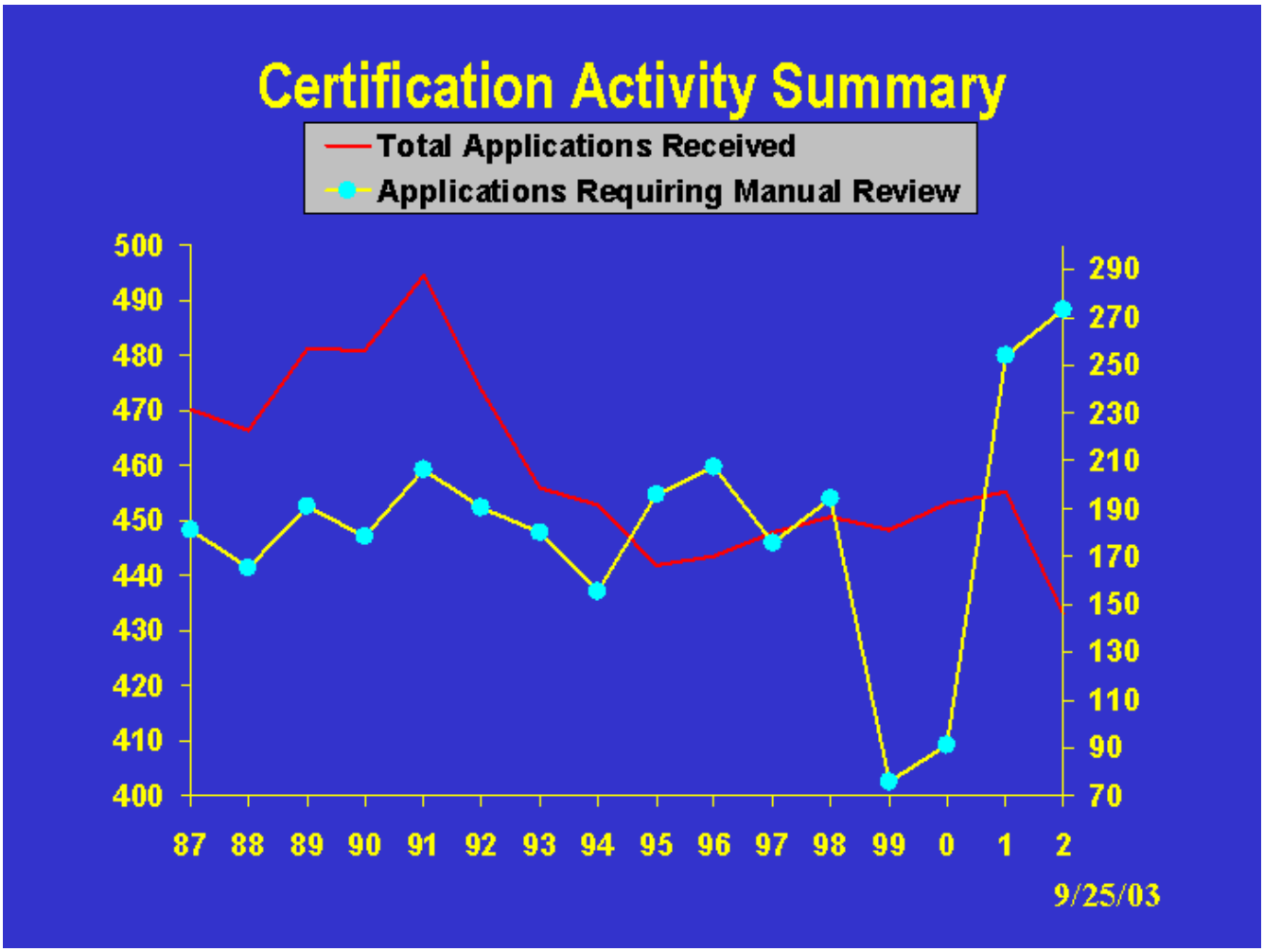
SFUF_NPA17_MED.pdf
Attachment #2 to comment #2363

ÖÄK comments_A_EASA draft pilot licensing_Feb09_en.pdf
Attachment #3 to comment #1721

lawsandrules.pdf
Attachment #4 to comment #1138



Attachment #5 to comment #1195



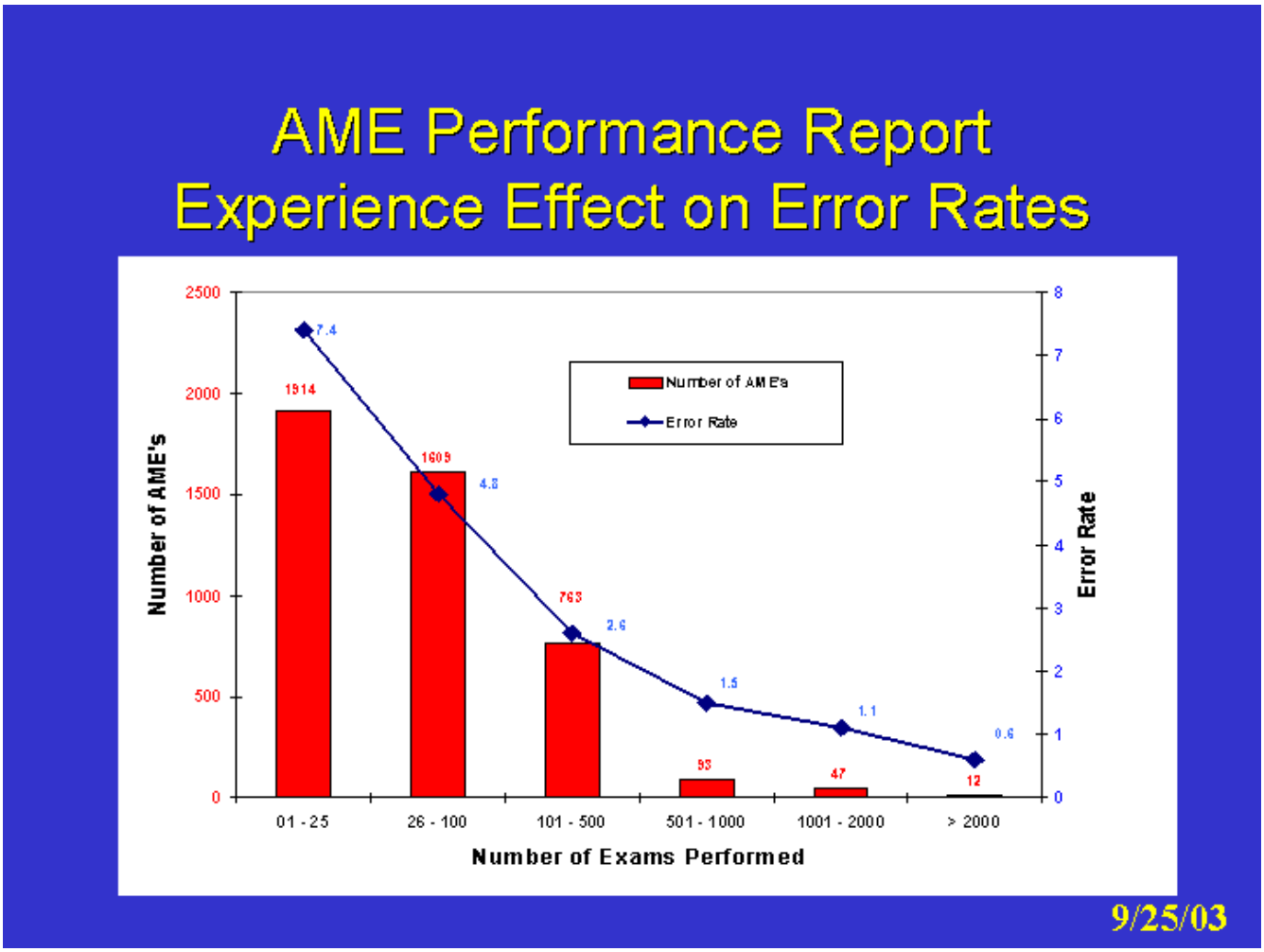
Attachment #6 to comment #1195

AME Performance Report
Adjusted Error Rates

Error Description	Errors October 2002
STU/MED AGE LESS THAN 16	59
MEDICATION BLANK ON INPUT	315
URINALYSIS SUGAR IS BLANK - ABNORMAL ASSUMED	0
02 RESTRICTION ASSIGNED - CC REQUIRED	8518
DV CORRECTED VALUE EXCEEDS STANDARDS OR BLANK	9434
NV VALUE BLANK	3151
NV CORRECTED VALUE EXCEEDS STANDARDS OR BLANK	5896
01 RESTRICTION ASSIGNED - CC REQUIRED	2820
FIELD OF VISION ABNORMAL	298
COLOR VISION FIELD BLANK	11
BP DIASTOLIC OVER 95	1369
BP SYSTOLIC OVER 155	679
ALL OR PART OF MEDICAL HISTORY BLANK	0
HEARING BLANK	0
ABNORMALITY BLANK ON INPUT	0
AME NOT AUTHORIZED FOR FIRST CLASS	419
03 RESTRICTION ASSIGNED - CC REQUIRED	1717
IV CORRECTED VALUE EXCEEDS STANDARDS OR BLANK	1074
Total	**35760**

9/25/03

Attachment #7 to comment #1195



Attachment #8 to comment #1195

Comments_attachement.pdf
Attachment #9 to comment #1347

Comments_attachement.pdf
Attachment #10 to comment #1348

BÖP_brief20081201.pdf
Attachment #11 to comment #1140

EFPA Letter to EASA Kneepens Feb 2009 final version.pdf
Attachment #12 to comment #1745

pilot_vision.pdf
Attachment #13 to comment #54

StarBulletin.com _ News _ _ ...pdf
Attachment #14 to comment #54

vvfs_2008-158-166.pdf
Attachment #15 to comment #1289

SRG1204UKCAAMed.pdf
Attachment #16 to comment #1150

aagv1DVLAMed.pdf
Attachment #17 to comment #1150

OPS 1.pdf
Attachment #18 to comment #1177

Curriculum from ESAM.pdf
Attachment #1 to comment #1999