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PILOT MEDICAL FITNESS

Experience of the British Gliding Association

by
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[Telling my story]

BRITISH GLIDING STATISTICS [2002]

Clubs	104
Pilot Members[15% Inst. Cat.]	9757
Temporary Members	416987
Aircraft [All Types]	2456
Annual flying hours	170023
Average Pilot membership since 1967	10000

[1/3 million pilot years, 4.5 m flying hours]

HISTORY OF THE BGA
[Medical aspects]

1931 Power to control gliding delegated to the BGA [For the British Empire!]

1948 ICAO Convention required licences for glider pilots. The UK neither enforced this nor filed a difference.

1950s Introduction of two seat gliders for training.

1967 A bad accident to a two seat glider killed the epileptic instructor and a young pupil.

THE ACCIDENT IN 1967

This accident occurred when a two seater T21 glider dived suddenly into the ground when flying a training circuit with an early pupil.

The pilot was known to his own family doctor as an epileptic under treatment. The doctor with the investigating team counted the tablets in his room and showed that he had not taken those prescribed.

The report found the cause of the accident to be an epileptic fit. The pilot held a PPL with a valid medical certificate, but had lied on the declaration to the AME.

ACTION BY THE BGA

It was clear that the previous policy of not requiring any medical check could not be continued.

An ICAO compliant medical examination had not prevented this accident.

I was then a glider pilot and practising aviation medicine as an Air Force medical officer. I was asked to provide a solution by a RAF General officer who then represented military sporting gliding on the BGA Executive Council.

The requirement was to develop a safe system at low cost .

MY PROPOSALS

[Developed one afternoon in my apartment in Cyprus]

1. Pilots to be personally responsible for declaring fitness to fly. This to cover short term illness as well as long term.

2. Pilots authorised to be responsible for others in the air had to have their declaration endorsed by a doctor with access to their clinical record.

3. Known disease which would disqualify from holding a PPL should also disqualify from being responsible for pupils or passengers in the air. For solo flying, driving licence standards were acceptable to meet third party ground risk.

ACTION BY THE BGA

My proposals were accepted and enacted into the BGA rules. They remained unchanged until the NPPL was introduced last year.

I became the Medical Adviser and undertook on a voluntary basis to provide advice in individual cases. General advice to pilots on aviation medical subjects was another task.

The principles established have stood the test of time and were adopted for the UK National PPL.

INSULIN DEPENDENT DIABETICS

This disease is mentioned because it gave me serious early concern. Soon after the BGA policy was accepted, the Driving Licence Authority relaxed requirements for insulin for private road drivers. This meant that unless the policy was changed, these patients would also be flying gliders.

Despite some professional criticism, I decided to make no change and these pilots were permitted to fly, albeit only solo. There were no accidents and recently I did a survey which has been published. [Saundby, RP. 1998 Av, Space & Env Med. 69:995-8]

More recently the FAA in the USA have followed suite.

MEDICAL QUERIES

Over the years there has been a steady rise in the number of medical queries. From less than ten a year prior to 1985, to a recent average of thirty per year. Enquiries from doctors, both family practitioners or specialists are constant. The increase is among pilots. About half relate to cardio vascular disease and a fifth to neurological disease. The outcome in most cases is a restriction to solo flying.

The most difficult cases are psychiatric in diagnosis. Often the query comes from club officials. A successful outcome depends upon cooperation between the pilot and club supervisors. This requires the pilot to agree to a breach of confidentiality.

ACCIDENT EXPERIENCE

There have been accidents and incidents from medical causes. Since the original accident in 1967, all have been cardio vascular in cause. One pilot died after a normal landing, another a crash landing, others in the air. One died on take off while towing a glider. He held a valid JAA Class 2 medical certificate.

Recently the UK Air Accident Investigation Branch made a statistical comparison between gliding, microlight and balloon flying, private and commercial pilots, and the military. No significant differences appeared in the incapacity rates.