Conversation Piece – the Aeromedical Doctor

DR P.D. WELSBY: Could I ask what is the structure of Civil Aviation Authority medical services and what are your duties?

DR R.A. PEARSON (Senior Medical Officer in Aeromedical Certification for the Civil Aviation Authority, Safety Regulation Group, Gatwick Airport, West Sussex): The Civil Aviation Authority has one Chief Medical Officer, four Senior Medical Officers, and two Medical Officers. The duties are divided according to responsibilities – one Senior Medical Officer is responsible for National Air Traffic Services and the Occupation Health of the Authority, a second is responsible for running our clinic in which we carry out all initial medical examinations for professional aircrew and in which we review professional aircrew with medical problems. A third is responsible for research in conjunction with our Chief Scientist's Office and Institute of Aviation Medicine in Farnborough. My responsibility is the supervision of approximately 600 examiners in this country and overseas who perform approximately 35,000 examinations annually. I also act as consultant adviser to the examiners should they have difficulty in completing an assessment.

PDW: Do these medical officers provide general practice services to members of the public passing through major airports and, if not who does?

RAP: The airports are the responsibility of British Airports Authority and individual corporations who run the major airports; some have medical services but most do not. Some employ a local general practitioner on a retainer to handle emergencies but generally speaking there is not a great demand.

PWD: What training is required? Do most of your recruits come from the Air Force?

RAP: We attempt to recruit individuals who have demonstrated an interest in aviation either by being private pilots or having service experience with aircrew. At the time of writing both current trainees have no service experience. We have two posts registered with the Faculty of Occupational Medicine to qualify as occupational medicine physicians and they are also sponsored through the Diploma in Aviation Medicine (a six month full-time course) if they do not have this already.

PDW: What are the career prospects?

RAP: Career prospects are few. Apart from ourselves, British Airways has 13 doctors, Dan-Air has two, and Britannia one part-time medical officer.

PDW: Is there much opportunity for travel? If so at what discount?

RAP: We do travel as part of our job but the Authority cannot accept any discount from operators as this would cause a conflict of interests; our assessments have to be impartial.

PDW: What are the major medical problems that the public present to airlines? Is there any official list of medical disorders that should be notified to an airline before a member of the public can travel? It has always amazed me

that there is little monitoring of the illnesses of passengers. When I worked at the Hospital for Tropical Diseases in London we used to get all sorts of desperately ill patients collapsing themselves into hospital after intercontinental flights in search of expert medical services.

RAP: There is no official list of disorders. All airlines have medical guidelines which are distributed to their ticketing agencies. Conditions such as recent myocardial infarction or women in the last four weeks of pregnancy should (but often do not) notify the carrier.

PDW: What medical tests are applied to air traffic controllers and pilots? What are the common problems?

RAP: All professional aircrew have periodic medicals on, at least, an annual basis until they are aged 40, when the reviews occur every 6 months. Air traffic controllers have annual examinations. The most common cause of disqualification is coronary artery disease with neuropsychiatric problems being the second most frequent cause.

PDW: What medical conditions immediately exclude a prospective pilot, or an operating pilot from duty?

RAP: Epilepsy, diabetes, multiple sclerosis, and other conditions in which acute incapacitation is a possibility. Visual problems are the major cause for refusal among initial applicants for professional aircrew certificates.

PDW: The nature of work and responsibilities of house officers are often compared to those of airline pilots. Do you think this a fair comparison and, if not, why not?

RAP: I am afraid that I do not think one can compare the position of house officers and airline pilots. Having performed both jobs I feel the only shared feature is that they are responsible positions. House officers often work long hours but usually the level of responsibility and ability required is very much less than that of a registrar or consultant. In contrast, a first officer is flying alternate legs of flights with his captain from day one. House officers work long hours whereas the airline pilots have strictly controlled duty hours because the pilots operate strictly to schedule rather than responding to need. The case for reducing the duty hours of house officers so that errors caused by fatigue can be minimized is obvious, but this would imply an increase in the years spent in junior positions to ensure that an adequate level of experience is gained before career progression.

PDW: I understand you were initially a general practitioner. How do the two careers compare?

RAP: I spent 15 years in general practice, including 10 years working in the ideal medical environment of Canada. Civil aviation medicine provides challenges and variety that never fail to interest. One never knows what the next phone call will bring – perhaps a pilot with suspected hypomania or a lady pilot recovering from breast cancer for example. In both one must confirm the diagnosis, consider the risk and implications of a recurrence, and then decide whether that risk is acceptable – a little different from the mixture of coughs, colds, and 'flu' on a winter morning's surgery.