Ian Andrews case - implications for medical certification standards and appeal rights

In this issue of *The Legal Lounge* I update you on the final outcome of the medical appeal taken by Ian Andrews against the CAA (refer to my previous article on this case in September 2011). I also provide some thoughts on the wider implications of this case on the medical certification standards and appeal rights, and possible areas for procedural improvement or legislative reform.

Ian Douglas Andrews v The Director of Civil Aviation [2009-2012]

The Facts - refresher

In 1991 Mr Andrews suffered what was considered to have been a minor stroke. He did not fly again until 1994. Between then and 2006 Mr Andrews was issued with unrestricted medical certificates at various times, more recently limited to a Class 2 certificate, permitting him to exercise the privileges of his NZ PPL. This was on the basis that he was assessed by his ME as having a five-year risk of 6% (or an annualised risk of approximately 1.2%), of suffering from a further cardiovascular event or incapacitating event in flight.

The relevant General Direction issued by the Director under Part 2A of the Civil Aviation Act 1990 dictates that a five-year risk of less than ten per *cent "may be interpreted as not being of aeromedical significance"* in relation to private pilot licence privileges. This equates to an annualised risk rate of less than 2% per annum, and was the basis on which the ME issued an unrestricted medical certificate.

In 2007 Mr Andrews' medical file was reviewed as part of a routine random audit by the CAA central medical unit. The 1991 stroke was noted and Mr Andrews was required to undergo medical tests including a stress echocardiogram. Pending the outcome of those tests, a notice of conditions and restrictions was issued under s27I(1) of the Act, preventing him from carrying passengers, towing gliders and flying over built-up areas. This notice was to last for ten days in accordance with s27I(6). Before the results of the tests were known, the CAA then issued a further notice under s27I(7) imposing the conditions and restrictions for the balance of the validity of Mr Andrews' medical certificate. This was purportedly on the basis that Mr Andrews was assessed by the CAA medical unit as having an annualised risk rate of between 3 – 8%, although it does not appear that any clear explanation or documented evidence was provided to Mr Andrews at that time (or for that matter during the appeal hearing) as to how this assessment was made.

In the interim, Mr Andrews underwent the stress echocardiogram which produced a result "normal with no evidence of ischemia", although mild left ventricular hypertrophy was noted, consistent with treated hypertension. After the CAA obtained the test results the medical file was referred to a neurologist, Dr Wallis. Based on his opinion, the CAA determined that Mr Andrew's annualised risk rate, while lower than initially thought, was considered to be between 2 to 4% per annum. This assessment also appears not to have been recorded by the CAA at the time. Mr Andrews appealed against that determination, and the imposition of the conditions, to the District Court.

The outcome of the appeal

The case initially went to the Court of Appeal on a point of law, as to whether the Director could use the s27(1) power to suspend or impose conditions on a medical certificate, when the ME had already issued an unrestricted medical certificate on the same information. The Court of Appeal ruled that the Director could do so, provided the statutory test to exercise the relevant power was met.

The relevant test under section 27I(1), requires that the Director has *"reasonable grounds to believe"* that a licence holder *"may be unable"* to safely exercise the privileges of the licence. The Court of Appeal noted that there must be a proper medical basis for this belief. If so, the director may temporarily suspend the medical certificate or impose conditions on it. However, this statutory power can only be used for ten days, and extended once for a further ten days.

Beyond that, the Director must then rely on his powers under s27I(7) to impose conditions for a longer period, or to revoke or disqualify a person from holding a medical certificate. Interestingly however, there is no statutory criterion in Part 2A of the Act that stipulates on what basis the Director can use his powers to take more permanent action against a certificate. The case appears to have proceeded on the unchallenged assumption that the same threshold as applies to the use of the temporary powers under s27I(1) applies to the power under s27I(7) to impose permanent conditions or take permanent action against a medical certificate.

The Judge stated that, beyond what was stated in section 27I(1), there was no further guidance in the statute as to what degree of possible incapacitation there must be before it could be considered that there is *reasonable grounds to believe that a person may not be able to safely fly an aircraft*. He noted that the wording of the statutory threshold is so inherently subjective, that it could not be consistently applied or meaningfully challenged on appeal, unless it is given some more concrete articulation. The Judge went on to say however that Mr Andrews did not challenge the CAA's annualised percentage based mechanism, or the threshold of less than 2% per annum, as the appropriate basis to determine this. This analysis is somewhat flawed, as it overlooks that this mechanism and the 2% threshold is stipulated in the General Direction Notice, which is a statutory instrument and thus legally binding.

The Judge accordingly proceeded on the basis that, if there is reasonable grounds for believing that Mr Andrews' percentage risk is 2% or higher per annum, then there is reasonable grounds for believing that he may be unable safely to exercise the privileges to which the certificate relates.

After examining the extensive medical evidence of both parties, the Judge came to the conclusion that he was unable to discount the opinion of any of the experts for the CAA, who assessed Mr Andrews' percentage risk at 2% per annum or greater.

Notwithstanding some valid medical opinions to the contrary on behalf of Mr Andrews, and despite acknowledging the evidence of one of his experts as well-reasoned and impressive, the Judge determined that he was not able to conclude that the experts for the CAA were wrong in their assessment. On that basis, the Judge concluded that the Director had reasonable grounds to believe that Mr Andrews may have been unable to safely exercise the privileges of his licence. Accordingly, the Judge held that the statutory threshold was met and the imposition of the conditions was lawful.

Comment on some wider implications of the case

As I have indicated, this case proceeded on the unchallenged assumption that the imposition of final conditions on a medical certificate under s27I(7) was dependent on meeting the same test that applies to the imposition of temporary conditions or suspension under s27I(1). Part 2A is silent on this point, but it does not appear to me that the same test should necessarily apply. There may need to be a debate as to whether the threshold to take permanent adverse action against a medical certificate should be higher, or at the very least subject to a requirement to obtain and take into account any necessary medical test results and opinions. This might require a trade-off to extend the time period during which the temporary powers in s27(1) – (3) can be used.

This case also highlights some serious issues concerning the transparency of the process through which determinations under these statutory powers are made and documented by the CAA medical unit, and communicated to an affected participant. The Judge noted that no documentary evidence or clear explanation of the basis of the CAA's initial assessment of an annualised risk rate of 3-8% was provided at the hearing, and that neither this nor the subsequent assessment of a 2-4% risk rate appears to have been recorded by the CAA at the time of those determinations. This gives the unfortunate appearance that the CAA may be making arbitrary determinations, and then obtaining expert evidence to support the initially unsubstantiated determination, only when challenged.

I have also noticed a lack of detail in a number of Accredited Medical Conclusions made by the CAA medical unit, which often simply state that a specified medical standard is not met by an applicant. This creates natural justice issues, as the affected licence holder does not know the basis on which a medical determination has been made by the CAA. This can make it difficult to seek an independent medical opinion, or to seek a legal opinion as to the merits of an appeal, if it is not clear on what basis the CAA medical unit reached the conclusion it did in the first instance. It may also be forcing participants to unnecessarily go through a medical convener review, simply to obtain a better understanding as to why the CAA medical unit reached the assessment it did.

These are matters that require addressing through internal procedures, and/or through further legislative reform, to ensure sufficient information is provided to participants at an early stage.

The Judge also highlighted some concerns about the applicability and use of some of the medical studies relied on by the CAA and its witnesses in making the assessment of Mr Andrews' risk percentage. His comments suggest that the CAA medical unit should perhaps revisit the General Direction, and/or any published guidelines, and consider revising or updating their processes to take account of these concerns.

There is also the broader policy issue of whether the District Court is the appropriate forum to hear such complex appeals. The Judge in this case (correctly in my view) noted that the Court was not required to make its own assessment as to the percentage per annum future risk rate of Mr Andrews, but only to assess whether the CAA had reasonable grounds to form the view that it did. This differs somewhat from the approach adopted by the Administrative Appeals Tribunal in Australia. That may be partly due to a different legal test, but also appears to be due to the fact that medical appeals are heard by a panel that includes medical experts, who are therefore more ready and qualified, and able, to reach their own view on the medical assessments under challenge (refer to my article in the August 2011 edition of *The Legal Lounge* for an example).

The speed with which medical appeals can be heard by the District Court is also problematic, particularly as medical certificates expire periodically. This exposes appellants to the risk that the CAA may apply to have a pending appeal dismissed without determination, on the basis that the medical certificate has since expired and there is no “live issue” to consider. Indeed, the CAA tried as much in this case. While that application was dismissed, there is no guarantee that the CAA would not be successful in making such an application in a future appeal, thus rendering the appeal right worthless.

For these reasons, the appropriate forum to hear medical appeals may need to be revisited, possibly as part of a wider legislative policy review.

Angela Beazer is a lawyer and Director of AMC Legal Services Ltd, a law firm specialising in civil aviation and public law matters. Earlier articles published in June and July 2011 provide a basic outline of the New Zealand civil aviation medical system and the review and appeal options available. These and other articles from *The Legal Lounge* series may be viewed at www.amclegal.co.nz Disclaimer: The information and views expressed in this column are necessarily general and do not address any specific individual or entity’s circumstances. This column may not be relied on or construed by any person as the provision of advice within a lawyer and client relationship. Legal or other professional advice should be sought in particular matters.