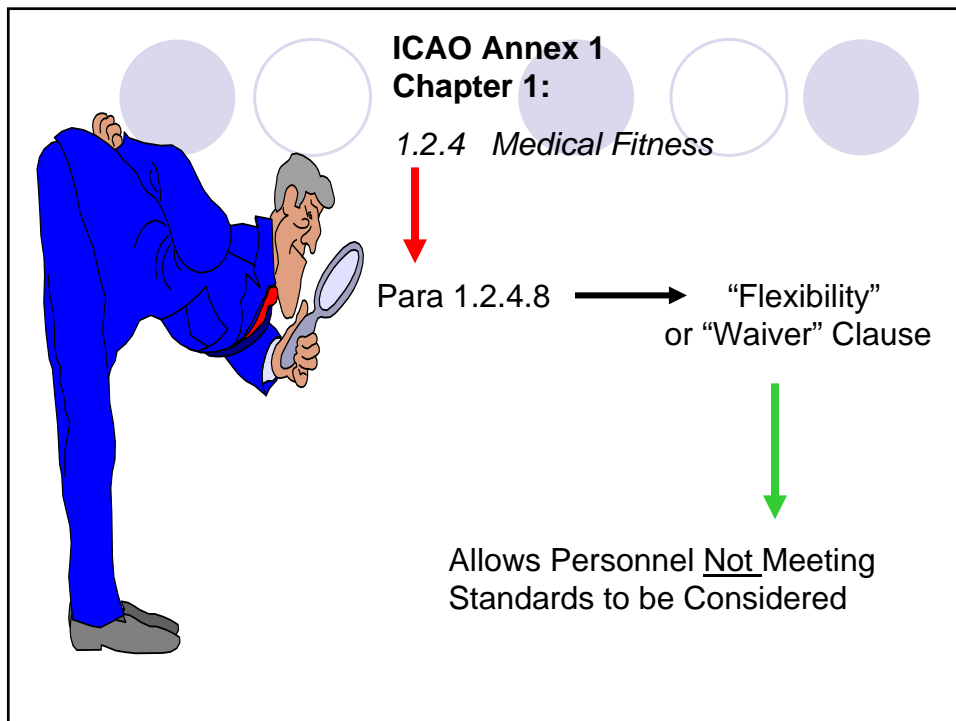


Case Studies for Licencing

MEDICAL CASES-LIMA MARCH 2009



Para 1.2.4.8

If the Medical Standards prescribed in *Chapter 6* for a particular licence are not met, the appropriate Medical Assessment shall not be issued or renewed unless the following conditions are fulfilled:



a) accredited medical conclusion 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 jeopardize flight safety;



b) relevant ability, skill and experience of the applicant and operational conditions have been given due consideration; and



c) the licence is endorsed with any special limitation or limitations when the safe performance of the licence holder's duties is dependant on compliance with such limitation or limitations



DEFINITIONS

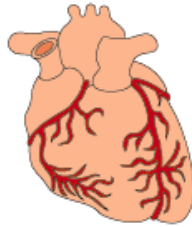
Medical Examiner: A physician with training in Aviation Medicine and **practical knowledge and experience of the aviation environment**, who is designated by the Licensing Authority to conduct medical examinations of fitness of applicants for licences or ratings for which medical requirements are prescribed



Medical Examiners must be trained and shall also receive refresher training in Aviation Medicine; Must demonstrate competency before designation. Must have practical knowledge and experience of the conditions in which licence holders carry out their duties

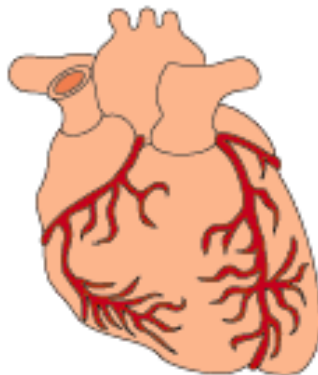
Case studies

1. Orthopaedic – airline captain (40 years) dislocation right wrist
2. Orthopaedic – military pilot (45 years) fused cervical vertebrae, Class 1 applicant
3. Metabolic – airline pilot (40 years) glycosuria ++
4. Psychiatric – probationary air traffic controller (22 years), anxiety and depression
5. Neurological – airline captain (48 years) loss of consciousness
6. Oncology – airline pilot (52 years) pleural effusion
7. Vision – airline captain (53 years) colour deficient
8. Cardiovascular – private pilot (63 years) CVA 15 years ago
9. Oncology – airline pilot (42 years) renal carcinoma
10. Oncology – air traffic controller (46 years) leiomyoma
11. Cardiovascular – airline pilot (55 years) myocardial infarction
12. Orthopaedic – commercial or private (any age) below elbow amputation
13. Psychiatric – commercial pilot (37 years) ? alcohol problem



Cardiac SARP's & Cases

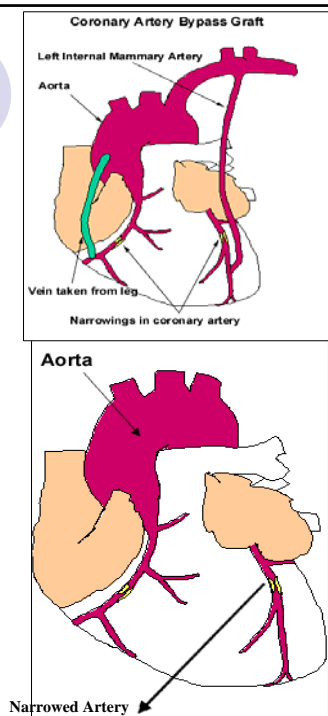
The applicant shall not possess any abnormality of the heart, congenital or acquired, which is likely to interfere with the safe exercise of the applicant's licence and rating privileges.



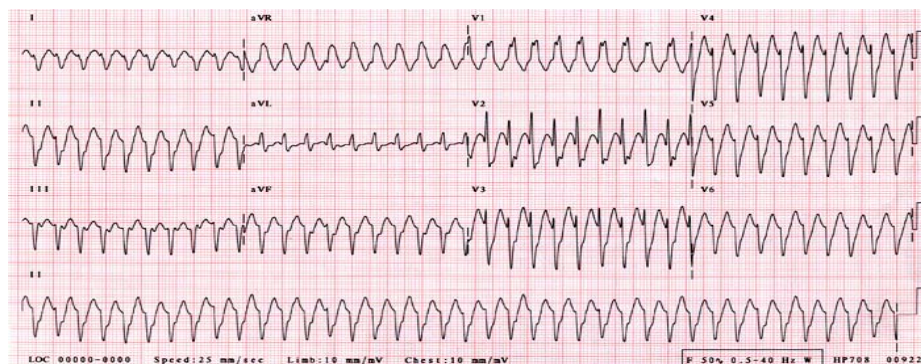
There shall be no significant functional nor structural abnormality of the circulatory system.

Cardiac:

An applicant who has undergone CABG or Angioplasty (with/without stenting) or other cardiac intervention or who has a history of myocardial infarction or who suffers from any other potentially incapacitating cardiac condition shall be assessed as unfit unless the applicant's cardiac condition has been investigated and evaluated in accordance with best medical practice and is assessed not likely to interfere with the safe exercise of the applicant's licence or rating privileges

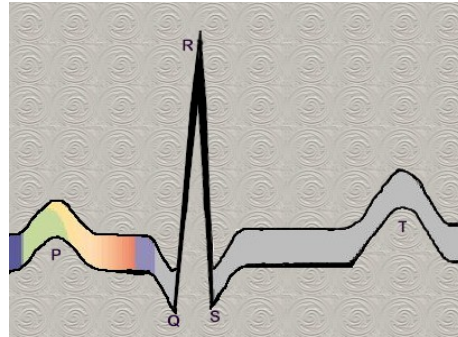


An applicant with an abnormal cardiac rhythm shall be assessed as unfit unless the cardiac arrhythmia has been investigated and evaluated in accordance with best medical practice and is assessed not likely to interfere with the safe exercise of the applicant's licence and rating privileges.



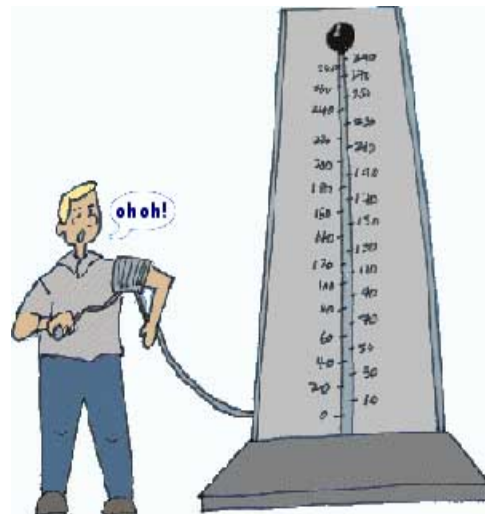
3. ECG Requirements:

- At Initial medical examination
- Once every two years after age 50



The systolic and diastolic blood pressures shall be within normal limits

The use of drugs for the control of high blood pressure is disqualifying except for those drugs, the use of which is compatible with the safe exercise of the applicant's licence and rating privileges



11. Case Studies for Licencing

1. 55 year old airline Captain.
2. Had acute myocardial infarct – admitted to Changi General Hospital on 12 December 2004. Diagnosed to have anterior myocardial infarct. Treated with IV rTPA.
3. Cardiac cath. Done on 16 Dec. 2004. Findings: Significant stenosis of proximal LAD and obtuse marginal branch of left circumflex. Right coronary artery was reported as non dominant with a 100% stenosis in the mid segment.
4. Echo ejection fraction was 55%.

? Decision



Treatment:

- On 22 December 2004, Mr. S underwent angioplasty
- Two drug eluting stents were placed in the LAD and a third in the obtuse marginal branch.
- The right coronary was not intervened as it was considered non dominant.

What would be your advise to the pilot at this point?

Follow up:

- Myocardial perfusion imaging scan done on 22 July 2005.
- Scan evidence of small non-transmural infarct in the inferior and inferoseptal wall of the left ventricle (stress defect represented 10% of the left ventricle by polar map quantitation).
- No residual ischaemia at Stage 5 Bruce Protocol.
- Rest Gated scan showed normal LV size and function.
- LVEF 71%.
- A repeat angiogram done on 26 August 2005, showed that the stents are still patent with TIMI grade 3 flow. The right coronary, reportedly non-dominant, showed the same stenosis in the mid-part. It was deemed that the right coronary did not require any intervention either percutaneously or operatively.

?Decision

Other Parameters:

- Mr. S is not hypertensive and BP readings during his hospitalisations were normal.
- No arrhythmias noted.
- He is not a diabetic.
- He says that he has never smoked.
- Current medications: He is on Plavix and Cardiprin.
- His GP reports that Mr. S is fit and well and exercises daily.
- The lipid profile done on 19 August 2005: Total Cholesterol 118 mg/dL; HDL 48 mg/dL; LDL 54 mg/dL; TG 81 mg/dL.



Some Additional Considerations:

- The Initial medical report stated an anterior myocardial infarct whereas the Myocardial perfusion scan showed an inferior and infero-septal infarct. The scan did not pick up the anterior infarct. Could the patient have had a silent infarct or is this finding artefactual?
- CAMB Cardiologist: Indicated that the right coronary artery appeared to be co-dominant and not non-dominant.
- The absence of anterior and the presence of scan evidence of the inferior/inferoseptal infarcts were also noted.
- He noted that the OM branch of the left circumflex is ectatic and there is no apposition of the stent to the vessel wall.



An opinion was sought from Prof. Michael Joy (UK): He stated the following:-

- The right coronary artery bears a significant proximal stenosis of 80 to 85% following which there is a good right ventricular branch, which back fills the right coronary territory distal to the obstruction below the origin of this vessel.
- Occlusion of the right coronary artery would almost certainly lead to further infarction.
- There is evidence of possible limited anterior reversible anterior ischaemia on the MIBI scan
- There is some concern about the stent in the OM1, as part of the stent lies within the ectatic part of the vessel.



Decision:

Pilot offered the option of getting further treatment

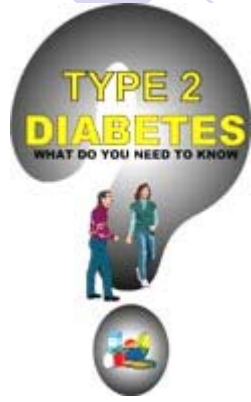
Current Decision: Unfit Class I

Metabolic, Nutritional or Endocrine disorders

Applicants with metabolic, nutritional or endocrine disorders that are likely to interfere with the safe exercise of their licence and rating privileges shall be assessed as unfit.

Applicants with insulin treated diabetes mellitus shall be assessed as unfit

5. Diabetes:



Applicants with non insulin treated diabetes shall be assessed as unfit unless the condition is shown to be satisfactorily controlled by diet alone or by diet combined with oral anti-diabetic medication, the use of which is compatible with the safe exercise of the applicant's licence and rating privileges.

3. Case Studies for Licencing

1. 40 year old pilot with airline xxx
2. Urine exam during routine medical for licencing: Glucose ++
3. No other abnormality

What would you do at this point?

Referred to Endocrinologist:

1. Diagnosed to have Type II Diabetes
2. On diet control

What would be your decision at this time?

Decision:

Unrestricted Class I

Annual review by Endocrinologist



2 years later: Oral hypoglycaemic agent added to treatment.

No abnormality otherwise

What would be the decision now?

Decision:

Multicrew ; No other restriction

Annual review by Endocrinologist

6 years later: Requires Insulin to achieve control.

Good control after stabilization

? Decision





Orthopaedics



Orthopaedics

The applicant shall not possess any abnormality of the bones, joints, muscles, tendons or related structures which is likely to interfere with the safe exercise of the applicant's licence and rating privileges.

Note.— Any sequelae after lesions affecting the bones, joints, muscles or tendons, and certain anatomical defects will normally require functional assessment to determine fitness.

1. Case Studies for Licencing

1. 40 year old airline Captain flying with airline XXX
2. Fall on outstretched right hand October 2004 during layover
3. Injuries: Scapho-Lunate dislocation right wrist
4. Reconstruction of wrist done surgically
5. Subsequently developed avascular necrosis of Lunate with severe pain
6. Stiff right wrist with only 20 degrees of flexion. Persistent pain
7. Also found to have left wrist Scapho- Lunate Disassociation – unstable left wrist
8. Will require: Fusion of right wrist and Scapho- lunate ligament augmentation. No guarantee of functionality after surgery
9. Now 1 year and 7 months since injury
10. ? Decision

Decision:

Functional Assessment:

1. Unable to operate aircraft controls
2. Persistent pain

Decision:

- Currently Unfit for Class I assessment
- Can be considered post surgery depending upon functionality at that point of time

2. Case Studies for Licencing

1. 45 year old ex Air Force pilot now applying to have a Class I assessment
2. During career in Air Force – ejected and sustained cervical spine injury resulting in fusion of C3 and C4.
3. No neurological deficits
4. Movements of neck: Some restriction in flexion and extension. Lateral rotation normal
5. No other abnormalities

What would your aeromedica decision be (Class 1, other classes, cabin crew)?



Assessment Considerations:

Functional cockpit assessment : 777 aircraft

On looking up had to push upper body back about 10 degrees to achieve full view of console– This was done naturally without discomfort (behavioural adaptation). No other problems.

? Decision

Decision: Fit Class I

1. Multicrew – No other restriction
2. Functional assessment if changing to other aircraft



Psychiatry

1. Psychiatry:

Mental and Behavioural disorders as classified by **WHO -- ICD 10**

- an organic mental disorder
- a mental or behavioural disorder due to use of psychoactive substances; this includes dependence syndrome induced by alcohol or other psychoactive substances
- schizophrenia or a schizotypal or delusional disorder
- a mood (affective) disorder
- a neurotic, stress-related or somatoform disorder
- a behavioural syndrome associated with physiological disturbances or physical factors



Psychiatry (cont'd)

- A disorder of adult personality or behaviour, particularly if manifested by repeated overt acts
- mental retardation
- a disorder of psychological development
- a behavioural or emotional disorder with onset in childhood or adolescence
- a mental disorder not otherwise specified

The image shows a newspaper article snippet with two columns of text and two portraits of psychiatrists. The article title is 'Mentally ill? Experts differ'. The left column features a portrait of Stephen Phang and a quote: 'It deepened my suspicions that he was not mentally normal.' The right column features a portrait of Ang Ah Ling and a quote: 'He was in full control of his thoughts and actions.' The article discusses a murder case involving a man accused of hacking his wife to death. Overlaid on the article is the text 'Subjectivity of Psychiatric Diagnosis' in large yellow letters and 'Worrisome' in smaller yellow letters at the bottom.

'It deepened my suspicions that he was not mentally normal.'
EXPERT DEFENCE WITNESS STEPHEN PHANG (left), consultant psychiatrist at the Institute of Mental Health, on chopper murder accused G. Krishnasamy Naidu

'He was in full control of his thoughts and actions.'
EMERITUS CONSULTANT PSYCHIATRIST ANG AH LING (right), attached to the IMH and Woodbridge Hospital, on Krishnasamy

Mentally ill? Experts differ

Accused knew it was 'wrong and bad' to kill wife: prosecution witness

BY ELENA CHONG

...clear about why he had killed his wife, which he knew was "wrong and bad".

...Krishnasamy had said she had made him very angry for talking to others about him, calling him mad and having him committed to the IMH, said Dr Ang.

...The accused said he would give testimony in court. He had no recollection of the killing, but he said he had no idea what he had done.

...He said he had killed her because he was angered by her infidelity, and because she was defiant and provocative, even after he had forgiven her for her three other affairs in 1987, 2000 and 2001.

...Dr Ang said there was nothing unusual about Krishnasamy's pattern of checking on his wife, including visiting her factory and calling her on her cellphone, in the light of his previous marriages with her.

...Dr Ang said that Krishnasamy went about planning the killing, showed he was in full control of his thoughts and actions. Defence counsel Peter Fernando will cross-examine Dr Ang on Monday.

Subjectivity of Psychiatric Diagnosis

Worrisome

4. Case Studies for Licencing

1. 22 year old probationary Air Traffic Controller
2. Well until progression to Aerodrome part of ATC course
3. Symptoms of worry, nervousness, palpitations and headaches especially when in simulated control of aircraft
4. Developed symptoms of anxiety and depression
5. Subsequently mood deteriorated and she became preoccupied with her physical health
6. ? Decision

Decision:

Reviewed by psychiatrist:

1. Suffers from Adjustment Disorder with depressive features.
2. Despite treatment she has not been able to come out of her fears of air traffic control and the possibility of dangers of air accidents. Had intractable fear and associated depression.

Decision: Unfit for Class III assessment



Neurology

Applicant Shall Have No Established Medical History or Clinical Diagnosis of the Following:

- A progressive or non-progressive disease of the nervous system, the effects of which, are likely to interfere with the safe exercise of the applicant's licence and rating privileges
- epilepsy; or
- any disturbance of consciousness without satisfactory medical explanation of the cause

The applicant shall not have suffered any head injury, the effects of which, are likely to interfere with the safe exercise of the applicant's licence and rating privileges



5. Case Studies for Licencing

1. 48 year old airline Captain
2. 2007 Collapse and loss of consciousness while walking with colleagues after breakfast during duty stopover in Tahiti. Fractured rib during fall.
3. Similar episode 2002 in Taipai during duty stopover. Reflighted, after positive tilt table testing.
4. Similar 1997 in Perth during duty stopover. Reflighted.
5. Past episodes of 'fainting': Fainted in school assembly 17years; Fainted at restaurant 18/19 years; Fainted partner's amniocentesis; Past near-fainting during school assemblies and church services.





Further work up:

Normal: General examination, cranial nerves examination, CNS examination, CT Head (1995 & 2000), ECG x 3, MRI (2000), Sleep EEG (2000), stress ECG (2007), Echocardiogram (2007).

EEG. theta activity (1995) reinterpreted as non specific changes (2000).

Postural Hypotension. No postural hypotension (1995). Tilt table abnormalities, 10s asystole (2007). [Further tilt table evaluations during appeal proceedings ... different protocols. One positive and another not].

Working diagnosis: Recurrent neurocardiogenic syncope

Decision?



Decision

'Unfit' all classes

Rationale

Approx 20% pa incapacitation likelihood
No protective features in cockpit
No reliable identifiable precipitants to syncope
No reliable medical / surgical risk mitigation

Sequelae

A couple of years of courtroom experience
Finally CAA won-out, after appeal to High Court

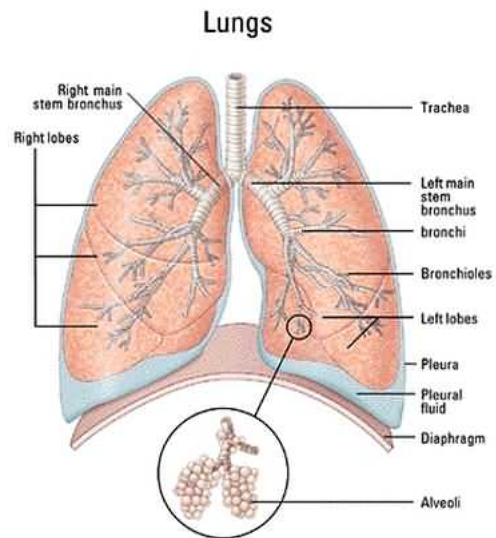


● ○ ● ○ ●

Pleural Effusion ? Oncology

● ○

There shall be no disability of the lungs nor any active disease of the structures of the lungs, mediastinum or pleurae likely to result in incapacitating symptoms.



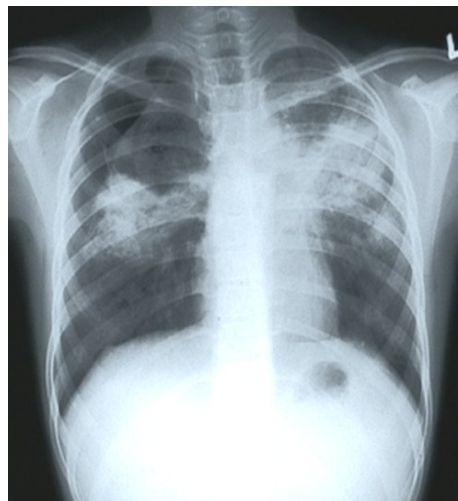
Applicants with chronic obstructive pulmonary disease shall be assessed as unfit unless the applicant's condition has been investigated and evaluated in accordance with best medical practice and is assessed not likely to interfere with the safe exercise of the applicant's licence and rating privileges.

Applicants with asthma causing significant symptoms or likely to cause incapacitating symptoms shall be assessed as unfit.

The use of drugs for control of asthma shall be disqualifying except for those drugs, the use of which is compatible with the safe exercise of the applicant's licence and rating privileges.

Applicants with active pulmonary tuberculosis shall be assessed as unfit.

Applicants with quiescent or healed lesions, known to be tuberculous, or presumably tuberculous in origin, may be assessed as fit.



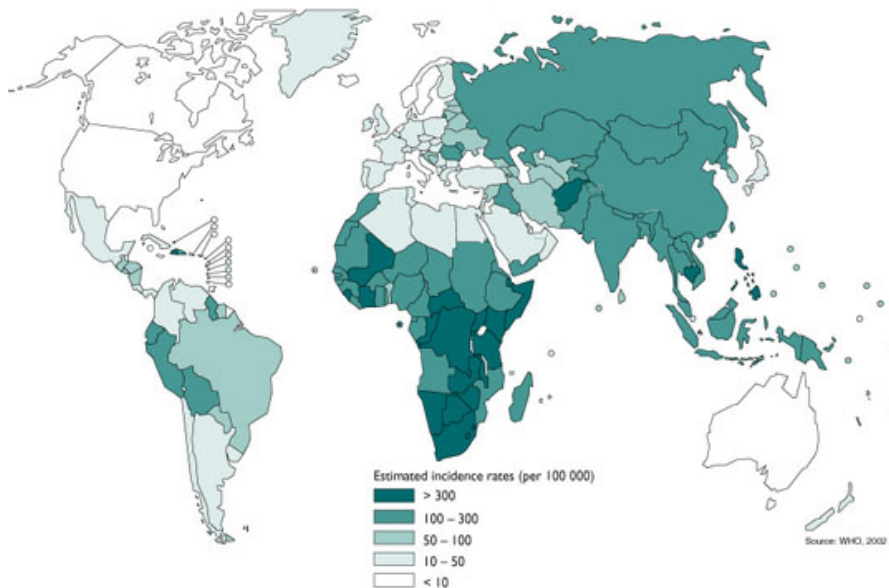
4. Chest X-ray:

No Longer Routinely Required



Note: Periodic chest radiography is usually not necessary but may be a necessity in situations where asymptomatic pulmonary disease can be expected.

Countries where TB is still endemic



6. Case Studies for Licencing

1. 52 year old airline Captain
2. Smoker for >20 years
3. Asymptomatic
4. At routine medical examination for licensing, found to be a little breathless on climbing stairs. Examination =absent breath sounds right side
5. Chest X-ray: Massive right pleural effusion
6. ? Decision at this point

Further work up:

1. Referred to Tertiary treatment Hospital. The pleural effusion was drained – blood stained fluid.
2. CT scans suggested possible gastric malignancy with regional lymph node involvement.
3. He had 3 successive gastroscopies over the next one month, with biopsies of the suspected lesion.
4. All the biopsies were negative for malignancy.
5. He was then advised to have an exploratory laporatomy and likely gastrectomy.
6. What do you do at this point ?– pilot asks you how this will impact on his ability to return to fly.
7. Generally well. Has even put on some weight. Stopped smoking. Appetite not affected.



Continued work up:

2nd opinion.

- He was seen by another surgeon 3 months after the first presentation.
- A repeat CT scan showed only a soft tissue swelling of the posterior wall of the stomach. There were no other findings.
- The lungs had fully expanded and there were no lesions in the chest.

Working diagnosis now: lymphoma, foreign body perforation, inflammatory or infective lesion as well as carcinoma of the stomach.



Continued work up:

- Repeat gastroscopy was again inconclusive.
- Laparoscopy was done on 31 Jan. 2005. At laparoscopy aside from the thickened posterior wall of the stomach, no other abnormalities were seen.
- Biopsies of the thickened wall of the stomach as well as an enlarged lymph node excluded malignancy and tuberculosis. Subsequent specimen microscopy indicated granulation tissue with inflammatory infiltrate.
- No clear aetiology could be demonstrated.
- The impression was that the Capt. had suffered an inflammatory lesion in the stomach possibly from a foreign body penetration giving rise to the signs noted earlier.



Follow up:

1. 6 months after first presentation he remained well and had put on some weight.
2. Clinical examination was unremarkable.
3. Blood parameters including tumour markers were normal.
4. CT scan done on 21st March 2005 again did not show any abnormality aside from the thickened wall of the stomach.

Conclusion: He probably had a reactive pleural effusion secondary to the inflammatory lesion on the posterior wall of the stomach.

Decision: Fit for Class I assessment (multi crew)
3 monthly follow up x 1 year

2 Years later: Well; On annual review



Vision & Colour Vision

8. Vision:

Standards revised in 2001

- No limit to uncorrected distant visual acuity

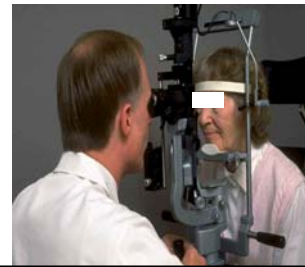
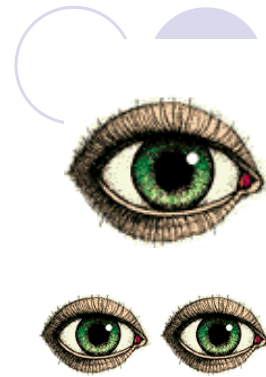
- Corrected Vision

- *6/9 or better in each eye separately

- *6/6 or better binocular

- If uncorrected distant visual acuity is worse than 6/60 applicant shall be required to do full ophthalmic examination at initial assessment and every 5 yearly after that.

- Refractive surgery -- must be free of any sequelae likely to interfere with safe exercise of licence and rating privileges. (Annual review by ophthalmologist)



Where the standard of visual acuity (6/9 in each eye separately and 6/6 binocular vision) **can be obtained only with correcting lenses**, the applicant may be assessed as fit provided that:

- correcting lenses are worn during the exercise of privileges

- In addition, a pair of suitable correcting spectacles is kept readily available.



Differential surgery to the eyes to achieve good distant visual acuity in one eye and good reading ability in the other eye **NOT** acceptable: Lenses will have to be worn to correct the differential.

•Normal fields of vision

•Normal binocular function



Colour Vision

6.2.4 Colour perception requirements

6.2.4.1 Contracting States shall use such methods of examination as will guarantee reliable testing of colour perception.

6.2.4.2 The applicant shall be required to demonstrate the ability to perceive readily those colours the perception of which is necessary for the safe performance of duties.

6.2.4 Colour perception requirements

6.2.4.3 The applicant shall be tested for the ability to correctly identify a series of pseudoisochromatic plates in daylight or in artificial light of the same colour temperature such as that provided by CIE standard illuminants C or D65 as specified by the International Commission on Illumination (CIE).

6.2.4.4 An applicant obtaining a satisfactory result as prescribed by the Licensing Authority shall be assessed as fit. An applicant failing to 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. Applicants who fail to meet these criteria shall be assessed as unfit except for Class 2 assessment with the following restriction: valid daytime only.

Note.— Guidance on suitable methods of assessing colour vision is contained in the Manual of Civil Aviation Medicine (Doc 8984).

7. Case Studies for Licencing

1. 53-year-old airline Captain.
2. Had a repeat colour lantern test done on his routine renewal medical examination (he was not able to pass the pseudo-isochromatic colour plates). He was deemed color safe at initial medical examination earlier.
3. This time the result indicated he was colour unsafe

Decision at this time?



Work up:

- Referred to ophthalmologist for workup.
- ERG was suggestive of bilateral maculopathy.
- Both rods and cones affected diffusely with consistent delays in scotopic, photopic and flicker ERGs.
- Impression is one of retinal dystrophy consistent with a picture of early Retinitis Pigmentosa.

Decision: Unfit for Class I Assessment



Neurology: CVA

8. Case Studies for Licencing

1. 63 year old male non-diabetic non-smoker Private Pilot
2. Wealthy! Owns a high performance pressurised single-engine aircraft and uses it for IFR carriage of business passengers all over the country.
3. Brainstem CVA / stroke 15 years ago at age 48
4. Long term treated hypertension, from prior to CVA. Mild LVH at time of stroke.
5. In good health with normal functional capacity in every respect.





Further work up:

Normal: General examination, cranial nerves examination, CNS examination, CT Head, ECG, MRI & MRA, EEG, stress ECG.

Stress Echocardiogram: No evidence of reversible ischaemia. Mild LVH consistent with long term treated hypertension.

Working diagnosis: Hypertensive applicant with past history (15years) of a stroke and full rehabilitation

Decision



Decision

Class 2 restricted medical certificate issued (third party and operational risk reduction)

Rationale

Combined residual cerebro- cardio- vascular risk in 7 – 8%pa range

No-ischaemia stress echo allows reduction in cardiac risk component

Residual incapacitation risk in 2 – 4% pa range.

Sequelae

Probably some more courtroom experience ... appeal filed
Well resourced. Several neurologists reporting risk lower than assessed by CAA. Personalised report from lead author of the major Netherlands stroke study individualising his risk to 1.25%pa.

Still a 'live' case and under review by another epidemiologist.





Oncology

9. Case Studies for Licencing

1. Mr. X is a 42-year-old pilot with XYZ Airways.
2. Picked up to have left renal cell carcinoma incidentally, following an ultrasound of the abdomen (done for epigastric discomfort, in Phuket) in Jan 2006.
3. CT Scan done in Singapore on 2 Feb. 2006 showed a 4cm x 3.8cm mass arising from the upper and mid poles of the left kidney. No invasion of the renal vein. No para aortic or retroperitoneal lymphadenopathy seen. Liver and spleen normal; No adrenal enlargement noted. No ascites and no pulmonary nodules.
4. ? What would you do for this pilot



Treatment and Follow Up:

- He underwent a laparoscopic left radical nephrectomy on 13th Feb. 2006.
- Final histology showed Stage 1 left renal carcinoma (Chromophobe type).
- The tumor was confined within the renal capsule and the surgical margins were free of tumor (these include the ureteral margin, renal vessels, renal pelvis and perinephric fat.)

Summary: Stage 1 Chromophobe Renal Cell Carcinoma. There is no pre or postoperative evidence of metastasis. He has had a curative resection done and has recovered well. Recovery was especially rapid in view of the laparoscopic procedure used for the resection. 3 months later presents for relicensing consideration

? Decision



Assessment Considerations:

A Stage 1 Chromophobic renal cell tumor confined to the renal capsule, with dimensions below 7cm, without invasion of the renal vessels and without any evidence of metastasis has an excellent prognosis. The disease specific 5-year survival rate is recorded at 95 %.

Decision:

Fit for Class I assessment subject to:

- Multicrew
- 3 monthly follow up by uro-oncologist for the 1st year, 6 monthly follow up in the second year and annually after that.
- CT abdomen at the first review.

10. Case Studies for Licencing

1. 46 year old ATCO.
2. She was first seen at KK Hospital in March 2005 when she was diagnosed to have uterine fibroids.
3. In June 2005 she had laparotomy and myomectomy done. The histology showed inflammatory myofibroblastic tumour and leiomyoma.

? Decision

Subsequent Follow Up

1. In Jan 2006 at her 2nd post operative review she complained of right groin swelling and clinical findings as well as an MRI showed the presence of multiple masses in the pelvis and nodules in the abdominal wall.
2. A staging laparotomy on 16 Jan 2006, with total hysterectomy, bilateral salpingo-oophorectomy and removal of abdominal wall nodules, was carried out.
3. The histology showed leiomyosarcoma and she was staged at Stage IVB.
4. Post -op chemotherapy was also given.

? Decision

- At the last review on 1 Aug. 2006 there was no clinically detectable disease
- The bone scan and hip X-rays also showed no evidence of recurrence.

Considerations For Decision Making:

- Prognosis is guarded in view of the stage and histology of the tumour.
- She will require frequent reviews and multiple sessions of chemotherapy for the expected recurrences.
- She remains quite weak and has not gained any weight.
- Psychologically she is very traumatised as she has been told that the prognosis is poor and may not survive for more than 24 months.
- She has given up thoughts of returning to work and would like to spend time with her family.

Decision: Unfit for Class III assessment

12. Case Studies for Licencing



? Decision,
Class 1, 2, 3,
cabin crew

13. Case Studies for Licencing

- 37 year old air taxi pilot, 3000 hours
- 3 drink driving offences
- GGT, MCV, CDT normal
- No evidence of alcohol dependence

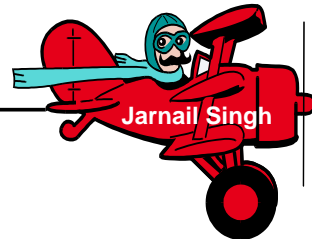
? Decision

Issues

- No problems with flying
- Not an alcohol problem?
- ? Personality disorder
- Psychological tests?



**Thank you for your
kind attention!**



Jarnail_singh@caas.gov.sg

Civil Aviation Authority of Singapore