DRAFT

MINUTES OF THE MEETING OF THE SECRETARY OF STATE FOR TRANSPORT'S HONORARY MEDICAL ADVISORY PANEL ON DRIVING AND DISORDERS OF THE NERVOUS SYSTEM

8th November 2012

Present:	Professor G Cruickshank	(Chairman)
	Professor P E M Smith	
	Professor A G Marson	
	Dr P Reading	
	Mr R Macfarlane	
	Mr P Hutchinson	
	Professor P Williamson	
	Dr D Shakespeare	
	Mr Richard Nelson	
	Dr A R Gholkar	
	Professor H R Morris	
	Mr Charlie Jones	
	Ms Rona Eade	
Ex-officio:	Professor John Stradling	Director of Oxford Sleep Unit.
	Dr Norman Delanty	National Programme Office for Traffic Medicine, Dublin
	Dr C Beattie	Occupational Health Service, Northern Ireland
	Mr Paul Collins-Howgill	Civil Aviation Authority
	Ms Jan Chandaman	Policy Branch, DVLA
	Ms Sue Charles	Medical Business Change, DVLA
	Dr K Watts	Panel Secretary/Medical Adviser, DVLA
	Dr J Lever	Panel Secretary/Medical Adviser, DVLA
	Dr N Lewis	Medical Adviser, DVLA

1. **Apologies for Absence**

   Dr S Short
   Professor P Rothwell
   Dr J Morgan

2. Chairman's remarks and welcome to new members.

The 2 new Lay members were welcomed to the meeting.

Prof Cruickshank was unable to attend the SAC meeting, 6/11/12, but shall liaise with Prof Griffiths, Cardiac Panel Chair, with regard to points raised. Of importance the meeting highlighted potential difficulties of Hospital Trusts releasing members to attend meetings. It was also indicated that these and other Panel meetings were excellent ways of gaining CPD/CME points and a valuable resource for the Medical Advisers in particular in helping to understand the decision making processes for policy. Panel support was given for Medical Advisers to attend the meetings for CME for the purposes of revalidation. Panel members were urged to accept invitations to lecture at the DVLA if invited.

3. Minutes of the meeting held 1st March 2012

Changes – page 2, 1st paragraph - Mr Nelson had received correspondence from the CMO urging Trusts to release staff to attend meetings.

Minutes accepted to be otherwise correct.

4. Minutes of the Panel Chairmen's meeting 21st June 2012

A number of issues were discussed but in particular the importance of the interface between the Panels with regard to prospective risks of overlapping conditions. It was stressed that without a Senior Medical Adviser interaction between the Panels would be difficult.

The Panels need to know the DFT agenda issues.

Funding for research is tight and unfortunately the Panels were only given a few days to respond to ideas for research and therefore were unable to do so. The Panels need to continue to push for research.

The Chairmen shall meet annually.

Dr Shakespeare highlighted issues around item 2a.2 with regard to drug/ driving and whether documentation would be needed to be held by the licence holder if taking prescribed medication. The Panel was informed that Kim Wolfe was a member of the group and that a report should be issued by Christmas.

5. **Matters arising**

5a. Professor Smith and Professor Marson were thanked for their valuable input into the Annex III changes. The regulations are due to undergo the 2nd lawyer check and it is hoped that it shall be laid before Parliament and become law early in the New Year.

Prof Cruickshank reiterated the Panel's concerns with the delay in the process and that these are real issues as there are a number who would benefit from the changes and it appears that diabetes always wins and epilepsy is on the back foot. As a result he has

drafted a further letter to the Minister to voice these concerns. Rona Eade stated that the Epilepsy Society run a helpline and they are receiving calls with regard to requests for what the changes are going to be and when. Both Ms Eade and Mr Jones (Council Member of the National Law Society) shall be copied into the correspondence. All relevant stakeholders shall be advised when this becomes Law.

5b Following discussion with regard to the standards for endovascular coiling of aneurysms in Group 1 drivers it was agreed that for all types within this category driving could commence on clinical recovery. A statement shall be added to the neurology section to provide guidance with regard to the clinical factors that need to be considered when deciding if recovery has been sufficient to allow safe driving. Dr Shakespeare agreed to help with this guidance.

There needs to be consistency throughout the "At a Glance Guide to the Current Medical Standards of Fitness to Drive" with the statements made to enable doctors and licence holders to have a full understanding of and to be able to apply the standards correctly. If the primary treatment for the haemorrhage is endovascular but a surgical procedure has been undertaken as well eg shunt, craniotomy for haematoma removal, then the surgical procedure is the paramount treatment.

5c General agreement that the new letter was an overall improvement but suggestions for improvement were made -

The law may allow you to drive.
Change 'should check with your doctor' to 'must check with your doctor'.
Put bullet point 3 to the first point of the letter.
Put the Section 88 note at the top.
Put the sentence regarding police in bold.
Add a statement advising that if drive against medical advice that their insurance may be invalid.

5d The SAC were concerned that Trusts may potentially not allow attendance at meetings. It is the GMC's opinion that it is part of contractual requirement if asked to act on a committee at this level. Fortunately this is not currently a problem for the Neurology Panel.

6 Stroke and TIA

Prof Rothwell was unable to attend the meeting but he forwarded further tabular information with regard to future cardiovascular risks following a cerebrovascular event. Unfortunately the tables do not include seizure risk although it is known that the risk is higher in those with haemorrhagic stroke and very low post TIA. Professor Williamson has reviewed the data and at 6 months the risk of a further cerebrovascular event is $>2\%$ and therefore the revocation period following a stroke/TIA cannot be reduced. Further discussion centred around further evaluation of the data and the need for Kaplan Meier

curve data and confidence limits, to allow conditional probabilities for the next year to be determined at any interval from the initial CVA or TIA, and to request further data on the following-

- Is there any age at which subsequent reapplication for a vocational licence should be refused due to the increased risk of a cerebrovascular or cardiovascular event or seizures in those that have had a primary event.

- What is the risk following the 1st stroke of either a further cardiovascular or cerebrovascular event, seizure or any sudden and disabling event to include age and carotid stenosis level and how long would it take for the risk to decrease to less than 2%.

Current standards to remain in force until the subject data has been evaluated.

7 Stereotactic radiosurgery for meningiomas.

Due to time constraints this item was not discussed and shall be reviewed at the next meeting.

8 Parkinson's disease.

Prof Morris gave an overview of Parkinson's disease and the factors relevant to driving. It is a progressive disease but with a wide spectrum of symptoms between patients. Symptoms vary on a day to day basis but there is likely to be a persistent impairment of driving. After 5 years of treatment there is likely to be a fluctuation of symptoms despite treatment.

The main concerns are

Slowness of movement and unpredictable motor response
Visuo-perceptual problems
Hallucinations
Executive frontal problems
Memory and judgement
Excessive sleepiness (disease and medication)
Freezing in <5%

In simulator studies the main problems have been slow reactions, veering and not stopping at signals. There is mixed evidence with regard to accident risk but it is likely to be increased. A lot of patients do self regulate their driving. Those patients with a deep brain stimulator are able to drive as they have been very well assessed prior to insertion and will not have any cognitive impairment and obviously the stimulator significantly improves the motor symptoms.

Excellent suggestions were made to improve the questionnaires and these shall be circulated once drafted. The suggestions shall also be incorporated into the other chronic neurological questionnaires.

9 Obstructive sleep apnoea syndrome.

Professor Stradling from the Oxford Sleep Unit was invited by the Panel to provide an overview of obstructive sleep apnoea syndrome and to discuss his concerns that he has with regard to the reporting of the disease and the outcomes as a result of this. As there is no specific test for sleepiness a lot of the information is subjective. It is the presence of micro sleeps, inattention and frontal lobe issues that are of importance. One fifth of all accidents may have a sleep related factor. It was agreed that the wording may need to be changed to 'excessive sleepiness severe enough to likely impair safe driving'. The Panel was informed that a working group has been set up by the EU to look into sleep apnoea and the report should be available next June and as a result formal changes may need to be undertaken. It was agreed that Prof Stradling shall be included in the circulation list of the report when member states are asked for comments. It was also agreed that greater emphasis was needed with regard to the information leaflet sent to drivers. The questionnaires shall not be changed until the EU working group has reported.

10 Seizures secondary to prescribed medication.

Prior to the change in the standard for isolated seizure to 6 months off there was an exception for seizures definitely associated with prescribed medication. The Panel was asked whether the revocation period could now be reduced further in view of the fact that isolated seizures themselves only attract a 6 month ban. Due to the difficulties with regard to assessing whether a prescribed medication has either been the direct cause or has unmasked an underlying tendency it was felt that the revocation period could not be reduced any further and therefore there are no exceptional criteria now.

11 Cases for discussion.

7 cases were discussed. The main points raised were:

- amyloid spells should be treated as per TIA standards
- Following treatment for a grade 3 tumour and if has remained seizure free for 2 years the risk of deterioration in the next year is low (34% down to 25% therefore less than 10% per annum).
- Pineal parenchymal tumours cannot be assumed to be entirely benign and radiotherapy is the standard treatment as they can metastasise via CSF seedlings. Should be off for 1 year following treatment and then annual licence if otherwise satisfactory.

- Neurosarcoidosis is unlikely to present with a sudden and disabling event and the risk of acute relapse in CNS disease is low. As it is not a chronic progressive disease can be licensed for both categories although advised annual licence for vocational.
- Following diagnosis and/or reoccurrence of a CNS lymphoma the refusal/ revocation period should be 2 years an ordinary driving licence.
- Further information and guidance with regard to the exceptional long standing field criteria have been requested by Panel members.

12 Any other business.

Brief overview with regard to a proposal for 10 year licences. It was agreed to defer this item until more evidence was available but unlikely to be of benefit to neurological conditions.

13 date of next meeting is 14th March 2013 at Great Minster House.

DR J LEVER MBBS DA DRCOG DOccMed
Joint Panel Secretary

14th November 2012