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

THURSDAY, 11 SEPTEMBER 2014

Present:

Professor G Cruickshank	(Chairman)
Professor A Marson	
Dr P Reading	
Mr R Macfarlane	
Dr D Shakespeare	

Lay Members:

Ms R Eade

Observers:

Dr C Beattie	DVLNI

Ex-officio:

Dr W Parry	Senior Medical Adviser, DVLA
Dr Ben Wiles	Panel Secretary, Medical Adviser, DVLA
Dr N Lewis	Medical Adviser, DVLA
Dr G Smith	Medical Adviser, DVLA
Mrs C Green	Head of Medical Licensing Policy, DVLA

1. Apologies for absence

Panel Members:

Mr Nelson
Dr A Gholkar
Professor H Morris
Professor P Hutchinson

Lay Member:

Mr C Jones

Observers:

Dr N Delanty
Dr S Mitchell

Ex-Officio:

Mrs S Charles-Phillips.

2. Chairman's remarks

2.1 There has been no meeting of the Scientific Advisory Committee Chairs this year. The Panel Chairmen met in June. The Panel recruitment issue is ongoing. There was a request for a ministerial representative to attend one of the Panels. Mrs Green delineated this further. One member of the Minsters Office has been visiting DVLA to get a better idea of the work involved. She has asked to attend one Panel. The Chair had no objection to this and there were no other objections raised by the other Panel members. The Chair noted that the Panel should give ongoing consideration to the areas covered by the expertise of the Panel members with a view to deciding if any additional areas of expertise need to be covered.

3. Minutes of meeting of 13 March 2014

3.1 Three typographical errors were noted:

Item 10.1 will be changed to 'loss of consciousness or loss of awareness';
Item 13.4 will be changed to 'unless there is a proven indication that they have a better prognosis';
Item 15.3 will be changed 'medicinally has been set on a risk based approach'.

3.2 **Item 12.1** of the minutes initiated discussion surrounding the advice given in the Appendix to Chapter 1 of the 'At a Glance Guide to the Current Medical Standards of

Fitness to Drive' regarding guidance for withdrawal of anti-epileptic medication being withdrawn on specific medical advice. This advice predates the concession for physician directed change in or reduction in medication associated with seizures. The advice from the Panel for individuals who are changing medication and who do not have a seizure, is that

- When there is no reason to suspect the medication that is being started is less efficacious than the previous medication, then there should be no restriction on driving.
- However if there is reason to suspect that less efficacious then the individual should observe 6 months off driving. This is from the start of the changeover process rather than at the end of the transition phase.

4. Update on Panel Recruitment

4.1 Panel require expertise in the following areas: epilepsy, neuro-oncology, stroke and medical statistics.

4.2 There is also a need for general practitioner representation as discussed in previous meetings. CVs have been received for the epilepsy specialist, general practitioner and medical statistician. Neuro-oncology is proving a more difficult speciality in which to obtain an expert.

4.3 Regarding stroke medicine, it is felt that this is an area that Panel need to get to grips with further. It is felt that the issue for the Panel is more regarding the risk of sudden disabling events post stroke rather than fixed neurological defects post stroke. It was suggested to approach the British Association of Stroke Physicians as stroke physicians deal with more stroke cases than neurology departments.

4.4 It was suggested that some of the other Panels may also benefit from a statistician.

4.5 The issue of whether the Panel should be considering dementia was raised. Currently, this lies with the Psychiatry Panel. The point was raised that neurologists and head injury specialists see dementia cases from physical conditions such as head injuries. The issue of whether there needs to clearer guidance regarding dementia and indications of 'red flag' issues for doctors to be aware of was raised. Currently, dementia lies in the remit of the Psychiatry Panel and the Neurology Panel Chair will contact the Psychiatry Panel Chair to attempt to delineate where dementia should fit into DVLA practice.

5. Minutes of the Chairmen's meeting of 19 June 2014

5.1 There were 2 errors in these minutes particularly Item 5.2 which talks about the Medical Advisers continuous medical education and reporting process. This should refer to the revalidation process. Item 5.3 indicates that the appraisal process is being provided by the Faculty of Occupational Medicine whereas it is actually the Society of Occupational Medicine. The Chair highlighted 2 main issues from the minutes of the Chairmen's meeting. The first issue was that he was pleased to see that the research into linking the databases on road traffic accidents and medical conditions was progressing. The second issue was the re-assurance that the Medical Adviser function would remain unchanged.

5.2 Dr Parry discussed the ongoing cross Panel role of the Senior Medical Adviser. He also stressed the support for the Medical Advisers CME activities. Given the nature of the Medical Adviser role, there is very little directly relevant CME available. Discussion ensued regarding the educational value of attendance at Panel meetings. It has in the past been difficult to obtain official recognition for the educational value of attendance at the Panel meetings. This has proved a difficulty with various Royal Colleges. This is an issue for the Panel members more than the DVLA staff. It is one limiting factor which is making it difficult for Panel members and potential Panel members to obtain release from their clinical commitments to attend.

6. Sleep apnoea

6.1 The recent changes to Annex III to Directive 2006/126/EC regarding cardiac diseases, neurological diseases and obstructive sleep apnoea syndrome.

6.2 Three additional sections to the Annex III have been recently introduced. One of these is for cardiovascular disease (not yet finalized) which is discussed in the Cardiology Panel and another one is neurological diseases and the third one is obstructive sleep apnoea syndrome. DVLA will have to make changes to the 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' to demonstrate that this new Annex has been introduced. This is in addition to the changes introduced in 2011 and 2013 for diabetes, epilepsy and vision.

6.3 For obstructive sleep apnoea syndrome the Annex defines moderate and severe obstructive sleep apnoea syndrome and indicates that these 2 conditions when untreated are debarring for driver licensing purposes.

6.4 DVLA will arrange for screening questionnaires to be available to drivers or applicants. This will not perform part of the medical enquiry rather it will be a requirement for the individuals to assess themselves and act accordingly if moderate or severe obstructive sleep apnoea is suspected.

6.5 The Annex also requires that drivers or applicants with moderate or severe obstructive sleep apnoea syndrome under treatment will require periodic medical review. As this states medical review rather than licensing review, DVLA will require the customers to sign a self declaration form similar to that for pacemakers and defibrillators so that although they will be issued a long-term driving licence, they would agree to have regular medical review.

6.6 It should be noted that DVLA has been associated with the Sleep Apnoea Association Trust in developing their guidance which is available on their website.

6.7 It was also stressed that any individual driver has the responsibility to not drive if they know or suspect that they are medically unfit to drive.

6.8 Given the wording of the Annex these standards would apply to both Group 1 and Group 2 licensing and, therefore, more lenient standards could not be applied to Group 1 licensing as in other medical conditions.

6.9 The 'STOP-BANG' screening for OSAS form was recommended. There may be legal and copyright issues regarding its use, however, this is something which will be considered.

6.10 When discussing the paragraph in the Annex on neurological diseases, it was noted that it only refers to sensory or motor deficiencies and the effects of balance and co-ordination. It does not refer to perceptual, cognitive or visual issues. It was noted that this is a separate paragraph in the Annex III and therefore seizures and visual conditions are not included as they are in an earlier paragraph in the Annex.

6.11 It was suggested that there should be a new introductory paragraph to the neurological chapter in the 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' indicating that for any individual with neurological condition issues other than the physical ability such as cognition, vision and seizure risk must be considered. It was felt that it would be reasonable to quote this despite the fact that it would be appearing to go above the minimum requirements of the Directive due to service provision in the UK and the differences between how services are provided in the UK and Europe. The issue of the phrase "unless the application is supported by authorised medical opinion" was raised. This would imply that self declaration cannot be accepted.

6.12 Following on from this, the issue of whether or not there was room for manoeuvre regarding the definition of a serious neurological disease which would require supporting medical opinion ensued. This would still potentially have an impact upon DVLA's work in the sense of requiring more cases to have second series

questionnaires sent to the individual's doctors. *Addendum: This is not defined in the Annex or working group report.*

6.13 Medical policy are checking some issues raised by the Directive further before implementation.

7. Extended period licences

7.1 Further to Item 6.4 of the minutes of the meeting of 13 March 2014 the Panel considered the question to be added to the medical questionnaire forms in order to highlight individuals who were more stable for a prolonged period of time in order to issue them with a 5-year licence rather than a 3-year licence.

7.2 As per the previous minutes, this was being considered for individuals with Parkinson's disease or multiple sclerosis for the first 10 years after the start of symptoms. It was also to be considered for epilepsy cases. At the end of the discussion in the meeting, the suggested wording is "Has your patient been clinically stable for the last 3 years?"

7.3 This wording will require further consideration before the next Panel meeting when it will be discussed again.

8. Clarification regarding transition between asleep and awake with respect of seizures

8.1 Currently DVLA apply the principle of not delineating a specific time after waking for a seizure to be considered as asleep rather the individual situation is reviewed for each case. Panel were asked to confirm whether or not they agreed with this. The consensus was that this was the appropriate way in considering this issue.

9. Grade III gliomas with 1p19q codeletion

9.1 The Panel Chairman gave an update on this. There is data available to indicate that if individuals with this type of malignant tumour are well and seizure free at one year, the morbidity data would suggest that the risk of significant problems is very low for the next 5 years. The issue for driver licensing purposes is that there is not sufficient data available to confirm that the prospective risk of seizure is less than 20% per annum.

9.2 The new WHO classification is likely to record these types of tumours as a separate type in recognition of the 10-year median survival.

9.3 The issue of how stability could be demonstrated was raised. This would require at least 2 scans 6 months apart. It is likely therefore that if the proposed relaxation of the medical standards takes place, individuals would be unlikely to be licensed before the 18-month point (as the stability would be considered present from the date of the second scan) although this would still represent a reduction in the duration of time off driving from the current 2 years after the completion of primary treatment.

9.4 The diagnostic criteria for identifying the favourable prognosis group are not totally clear. They may become clearer with the latest WHO classification criteria.

10. Pineal tumours

10.1 Recently DVLA had a case whereby the individual's consultant indicated that the usual standards for tumours should not apply because of the low epileptogenic nature of pineal tumours.

10.2 It was noted that pineal tumours are a very heterogeneous group and the surgical treatment is far from uniform. It is therefore difficult to come up with specific guidance that would apply in all cases.

10.3 Incidental pineal cysts are considered to be relatively benign and have low epileptogenic potential.

10.4 Pineal tumours are not as benign in nature. They tend to cause problems based upon their size rather than location. It is noted in the statistical data 30% of pineal tumours present with seizures or are found at the time of a seizure on scanning. It is unclear whether or not the pineal tumour was the cause of the seizure.

10.5 The Panel did not support any change in the current standards for pineal tumours. Pineal cysts can be considered in the same way as benign tumours as per the current medical standards.

11. Lymphomas

11.1 Recently DVLA had a case whereby a consultant felt that cerebral lymphomas should not have the same medical standards applied to them as other malignant brain tumours.

11.2 The Panel did not support any change in the medical standards for lymphomas. They are to be treated in the same way as any other malignant brain tumour. *Addendum: Subsequent to the meeting, it was confirmed that these standards also apply to meningeal lymphomas.*

11.3 Related to this is the question of the length of licence given to an individual with a malignant brain tumour, presenting in adulthood, after they have observed the relevant period of time off driving. The Panel felt that individuals should be on medical review licences life-long. Specifically, there should be issues of licences of no more than 3 years' duration. This is because of the eventual relapse or recurrence of the disease.

12. Cases for discussion

12.1 Panel discussed 2 cases, one of a vocational licence holder with an auto-immune encephalopathy. The other was a partially treated epidermoid cyst in a vocational driver.

12.2 The case decisions for these cases were not setting precedent for other cases.

13. Appeal cases since last Panel meeting

13.1 Panel were advised regarding the number of appeal cases relating to neurological conditions.

14. Any other business

14.1 The question regarding general awareness and knowledge of the medical standards of fitness to drive amongst doctors as a whole was raised. DVLA is working on ways to improve knowledge amongst medical practitioners as a whole.

14.2 The issue of an App to automatically update the 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' on doctors computers was raised. There are restrictions on Government communications from Government departments out to the public.

14.3 Following Item 16.1 in the October 2013 minutes it was indicated that in that particular case there was no evidence that stereotactic radio-surgery offered any benefit over formal craniotomy. This was relating to a solitary metastasis. In other parts of the medical standards of fitness to drive, differing standards are applied for stereotactic radio-surgery and formal craniotomy. In the fullness of time as more data becomes available differing standards for more conditions may be applied when there is evidence of benefit.

14.4 The Working Group of the Vision Panel looking at functional adaptation. One of the Panel members is a member of this Working Group. It is unclear how this Working Group is progressing. The Panel member also had, in his clinical practice, an exceptional case. In this case the customer had not received a copy of the driving assessment report and the Panel member raised the issue of whether the driving assessment centres could automatically send a copy of the report to the individual. As the driving assessment centres are independent of DVLA this is an issue that would have to be taken up with the driving assessment centres. Generally, the individuals are sent a copy of the driving assessment report from DVLA and these are available to the individuals upon request. The Panel Chairman will contact the Working Group to discuss how the work of the Working Group is progressing.

14.5 Research Update. Research into the link between road traffic accidents and medical conditions has started. There is a preliminary study to assess the data that has been obtained by linking Stats19 and DVLA databases, is ongoing. The data that is available is proving difficult to anonymise. Within the next month the preliminary analysis will be performed. If after this analysis it is clear that the data will not be complete enough for further analysis, no further research will be performed with this data set. It has been attempted to link up with the Motor Insurance Bureau data, however, this is not proving to be a practical proposition.

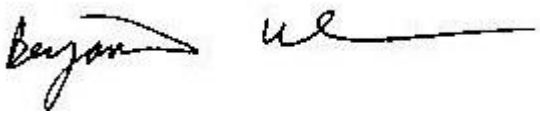
14.6 The second piece of research assessing multiple medical conditions which would not necessarily themselves be debarring but may, in combination, have an impact on fitness to drive has been temporarily put on hold until the other piece of research has been either completed or is fully in process.

14.7 Fatal accident enquiry outcomes. Of the 2 fatal accident enquiries regarding loss of consciousness episodes there have been no recommendations from the Procurator Fiscal regarding DVLA's processes or policies. There has been a fatal accident enquiry involving drug misuse. The Procurator Fiscal suggested that medical assessments including D4 examinations should be performed by the individual's own general practitioner.

14.8 Thanks were expressed to Dr Wiles for stepping in to cover the Panel secretarial role in Dr Lewis's absence on maternity leave.

15. Date and time of next meeting

15.1 It is suggested that the 12 March 2015 be considered by the Panel members as a potential date.



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