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

23 MARCH 2015

Present:

Professor D Cunningham Owens (Chairman)
Dr G Jones

Lay Members:

Mr B Alexander

Ex-officio:

Dr P Fearon	National Programme Office for Traffic Medicine, Dublin
Dr W Parry	Senior Medical Adviser, DVLA
Dr A White	Panel Secretary, DVLA
Dr K Davies	Medical Adviser, DVLA
Mrs S Charles-Phillips	Business Change and Support, DVLA
Mrs J Leach	Medical Licensing Policy, DVLA

1. Introduction and Apologies for absence

Apologies were received from Professor S Banerjee, Dr P Connelly, Dr T Beanland, NI representative, Professor Glyn Lewis, Dr T Jagathesan.

2. Minutes of the last meeting held on 22 September 2014

The minutes are accepted as a true record of the proceedings.

3. Matters arising from the minutes

The role of a Deputy to act for the Chair in the case of a clash of commitments was discussed once more; further expressions of interest will be canvassed for this role. Unfortunately a number of external committee commitments clash and this has resulted in the Panel being unrepresented in previous years.

The Panel was informed that the new drug driving legislation had gone live in March 2015 and that the first arrests were made under the legislation within a day. There was a brief discussion around the lowering of the alcohol level relating to drink drive convictions in Scotland this is now set as 50 mg/100 ml of blood as compared to 80 mg/ml in the rest of the United Kingdom.

The Panel sought clarification around the issue of driving whilst on section 17 leave during a compulsory admission to hospital. It was reiterated that as a general principle compulsory detention in hospital would preclude driving and this would include driving whilst on leave during the acute phase of an illness. Consideration could be given to driving in the situation of prolonged section 17 leave during the pre-discharge or rehabilitation phase of the admission. An individual assessment of such cases would be appropriate.

4. Medical Standards for Group 2 licensing

Historically, episodes of severe mental ill health including schizophrenia, mania, hypomania, psychosis, and delusional disorders have required an extended period of observation and stability of three years when licensing for Large Goods Vehicles (LGV) and Passenger Carrying Vehicles (PCV) was considered.

In medical standards across the board there has been a gradual reduction in the observation periods required for many conditions, for example isolated seizures, episodes of loss of consciousness and some brain tumours; there has also been a more inclusive approach to licensing including the licensing of Group 2 drivers treated with insulin.

The Panel decided that it was appropriate to review the standards applicable to these illnesses with a view to a reduction in the observation period required. Potentially there is a positive effect on employment and financial security for the driver and there may be an increased notification of ill health if a prolonged period of revocation was not feared. The Panel was informed that approximately 230 Group 2 drivers had their licences revoked for a 3 year period in the 12 months preceding the Panel.

There was a prolonged discussion around various options and periods of required stability. Consensus was obtained that licensing would be permitted when a 12 month period of stability had been attained providing various requirements could be met.

These would require that driving ceased during the acute phase of the illness and that licensing would be considered when the following conditions could be satisfied:

a. The licence holder had remained well and stable for at least 12 months.
b. The licence holder was fully engaged with treatment.
c. The licence holder had regained insight into their condition.
d. The licence holder was free from any adverse effects of medication which would impair driving.
e. The licence holder was subject to a favourable specialist report.

It was decided that a 12 month period of stability would be appropriate as this would allow for a one year cycle of possibly significant anniversaries which could act as triggers to a relapse and would hopefully encompass those drivers subject to a rapid cycling illness.

In certain situations for example where a history of relapsing remitting illness was present a longer period than 12 months may be required. Such cases would be subject to individual assessment at DVLA. Once again the importance of regaining insight into any condition was stressed.

It was agreed that the At a Glance Guide would be amended to reflect these changes. DVLA will monitor the effect of these proposed changes and report back to Panel.

The proposed changes to the Group 2 standards are significant and methods of dissemination were discussed. DVLA will seek to liaise with the Royal College of Psychiatrists around publicity and the educations of Health Professionals about the planned changes. The use of Social Media by DVLA to inform about the changes was also discussed.

It was highlighted that there would be potential implications to the alcohol and drugs standards applicable to Group 2 driving as well.

5. Cognitive Impairment and Dementia Guidelines

The Panel was informed of the ongoing work at Newcastle regarding guidelines around Mild/minimal Cognitive Impairment (MCI) and Dementia. DVLA will be represented at these discussions later in the year.

The Early Presentation of Cognitive Impairment, the Older Driver and Driving Assessments

The Panel was informed of an increase in trends for referrals and the notification of drivers causing concern to the Police and/or concerned third parties. Frequently, but not invariably these concerns involve more elderly drivers. In this situation medical enquires are usually instigated and reports sought from the licence holder's doctors. The index events from such notifications often report a degree of confusion at the time of the incident or a history of low grade driving incidents, often insufficient to come to the attention of the authorities, insurers or medical profession. The nature of the notification and the information contained provides sufficient grounds for the opening of the medical enquiry process.

In the course of medical enquiries the licence holder has frequently been asked to attend for a practical on road driving assessment usually at a FORUM accredited assessment centre.

It has been the Panel opinion over the years that the act of driving a complex mechanical vehicle in a chaotic fluid environment such as road traffic which involves the processing of multiple stimuli can act to highlight early cognitive issues that may not have formally presented in the formal clinical situation. It has been the considered opinion over the years that the on road driving assessment represented the gold standard for determining the ability to drive safely.

However the scenario of a driver being referred for a driving assessment where there is no formal diagnostic label in the medical notes occurs or where the concerns list only age related frailty. Guidance was sought from Panel for this situation.

A wide ranging discussion took place which highlighted a number of inconsistencies. There was a degree of disbelieve that the absence of a formal diagnostic label in the records could be taken to indicate the absence of a medical problem. It was recognized that a diagnostic label is a threshold that has to be achieved and that with the various constraints imposed by presentations and consultations that a medical problem may well exist some time before a diagnostic label is attached and formally recorded. This is of relevance in cognitive impairments of all types where there may be a lack of recognition of the impairment by the patient/driver. This lack of a diagnosis has been recognized by the Government, indeed there is a well publicised drive to increase the early diagnosis of such problems by General Practitioners.

Panel recognized that the concerns of third parties especially those of family members and those closely involved with the driver should not be dismissed purely because of a lack of medical qualification. Indeed the close proximity and involvement of the family and neighbours may well be of particular relevance when medical contact has been limited or brief.

Concerns were expressed over the apparent inconsistencies of the handling of such cases. A driving incident that when committed by a younger driver results in prosecution may instead end in referral to DVLA for medical investigations in an older driver even when no relevant conditions are identified at the time of the incident bar age. There was a perception that referral to DVLA was an alternative and quicker means of disposal than prosecution.

Concern was expressed over the apparent fixation on a diagnostic label in the medical records rather than an assessment of the functional impairment of the driver. There was discussion around the issue of the Test of Competence however this was inconclusive.

The complexities of assessing the older driver were also discussed. The point was made that in such situations there was rarely one simple categorical diagnosis and that there may well be a gradual and cumulative impairment due to multiple pathologies, for example cognitive slowing; weakness and stiffness secondary to muscular skeletal problems and mild visual impairment none of which may be debarring by themselves in isolation but which may have a cumulative effect that would significantly affect the ability to control a vehicle. A holistic functional assessment and judgement was recommended and required.

New Ongoing Topics

6. ECT advice

It was decided to add a small advisory section to the At a Glance Guide concerning driving and Electro Convulsive Therapy (ECT). This would reiterate the previous advice that the seizure aspect of ECT would not be debarring and that the underlying mental health issue would be the determine factor. In general driving would not be advised during an acute illness treated with ECT. Driving could recommence once the required medical standards for the underlying condition were able to be met.

The scenario of driving during maintenance ECT was discussed this would be permissible however the Royal College of Anaesthetists guidelines on driving after day case surgery using general anaesthetic agents should be followed.

7. Persistent Delusional Disorder

Panel was asked to consider the advice in the At a Glance Guide regarding chronic psychotic disorders and persistent delusional disorders. Discussion took place around the classification of such disorders and a general review of the headings and titles of the At a Glance Guide will take place. There will be no modification to the standards; in the case of car driving a 3 month period of stability would still be required. A review licence will be issued initially.

8. Recruitment Update

The Panel was informed of potential recruits to the panel, a number of suitable candidates have been identified.

9. Research Update

DVLA provided Panel with an update on any research proposals. Previously areas of research had been identified firstly looking at the relationship between medical conditions and road traffic collisions and secondly for the effects of multiple, small medical conditions on driving. Regrettably liaison with Insurance Industry was unachievable and the research will not now take place.

10. Any Other Business

It was with some regret that the Panel received news that Professor Glyn Lewis would not be seeking to stand for a second term as a Panel Member. His sage advice will be missed by Panel and the Panel extends its heartfelt thanks for his attendance and contributions over the years.

11. Date and Time of Next Meeting

The next meeting was confirmed as 5 October 2015

Dr A M White MB.BCh.
Panel Secretary

26 March 2015