

# 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, 12 MARCH 2015

### Present:

Professor G Cruickshank                      Chairman  
Professor A Marson  
Dr P Reading  
Mr R Macfarlane  
Professor P Hutchinson  
Dr D Shakespeare  
Dr A Gholkar  
Professor H Morris

### Lay Members:

Mr C Jones  
Ms R Eade

### Ex-officio:

Dr S Mitchell                      Civil Aviation Authority  
Dr C Beattie                      DVLNI  
Dr N Delanty                      National programme Office for Traffic Medicine, Dublin  
Dr N Lewis                      Panel Secretary, Medical Adviser, DVLA  
Dr B Wiles                      Medical Adviser, DVLA  
Dr C Maginnis                      Medical Adviser, DVLA  
Dr S Rees                      Medical Adviser, DVLA  
Mrs J Leach                      Medical Licensing Policy, DVLA  
Mr A Griffiths                      Business Change and Support, DVLA

### 1. Apologies for absence

Mr R Nelson  
Dr W Parry

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## 2. Chairman's Remarks

The panel was reminded that approval had been given for a ministerial representative to attend the panel meetings.

## 3. Panel Recruitment

Mrs Leach of DVLA advised the Panel that ministerial authority has been granted to appoint four new members to the Panel, in the roles of epilepsy specialist, medical statistics, general practice and stroke medicine.

A suitable candidate is being sought to fulfil the requirement for a neuro-oncologist on the Panel. It is anticipated that a potential candidate(s) will soon be proposed.

## 4. Minutes of Meeting of 11 September 2014

4.1 It was agreed that the wording of the final paragraph of Item 3.2 should be changed to 'However, if there is reason to suspect that the medication being started is less efficacious, then the individual should observe six months off driving. This is from the **end** of the changeover process.' This would maintain consistency with advice currently provided in the At a Glance stating that for drug withdrawal patients should be advised not to drive from commencement of the period of withdrawal and thereafter for a period of six months **after cessation of treatment**.

4.2 With regards to Item 4.5, the Chairman advised that he has been in discussion with the Psychiatry Panel Chairman and that it has been agreed that this topic (dementia) will be referred for discussion at the Chairmen's meeting.

4.3 A brief discussion again confirmed that for some attendees, Panel meetings provide an excellent opportunity for learning and for informing work practice and can therefore justifiably be considered as providing Continuing Medical Education (CME). Although for some members, being released from clinical duties to attend

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the meetings does not pose a problem, for others, permission to be released from other commitments is granted on the understanding that the meeting will fulfil the need for CME. It was acknowledged however that Royal Colleges, if asked, may not officially sanction the meetings for CME.

4.4 The wording of the last sentence of Item 6.4 will be changed to ‘This will not form part of the medical inquiry, rather, individuals will be encouraged to assess themselves and take appropriate action if moderate or severe obstructive sleep apnoea is suspected.’

4.5 It was agreed that in relation to grade III gliomas with 1p19q co-deletion (Item 9) and in relation to stereotactic radio-surgery (Item 14.3), the new Panel member who is an expert in medical statistics will be asked to review the statistical data and help determine whether the relevant current medical standards should be changed. This will therefore not be able to be considered further until after the appointment of the new members.

4.6 Dr Shakespeare provided a brief update to the Panel, explaining that discussion by the Working Group of the Vision Panel is on-going and warning that this Working Group is concentrating solely on hemianopias and not on any other type of debarring visual field defect.

## **5. Clarification of Minute 10.2 from March 2014 Meeting**

Panel agreed that the current wording may be ambiguous and to record accurately the conclusion reached by the Panel, it should be changed to the following:

“Possibility of different standard if there are changes in the nature of the blackouts.

The Panel felt that there was no reason to change the medical standards as the event should be considered on its merits. Essentially, if an individual had episodes with reliable prodrome and then an episode without prodrome the standards should be followed for each

black out separately, on its own merits. It was noted that involvement from the Cardiology Panel in reviewing the syncope standards will be appropriate.”

## **6. Extended Period Licensing**

Mrs Leach updated the Panel with news that the ability to issue Extended Period Licences should come into law by April 2015, thereby enabling DVLA to issue licences valid for up to a maximum of ten years for certain conditions. The current maximum duration for a medical review licence is three years. It has been proposed that for Group 1 drivers with Multiple Sclerosis or Parkinson’s disease, five year licences may be appropriate in some circumstances; this would be for drivers who have previously been issued with a three year licence and who have demonstrated that their condition remains stable. Five year licences would not be issued after the first fifteen years from onset of the condition. Panel also agreed that for Group 1 drivers with epilepsy, where currently three year licences would normally be issued, instead it would be appropriate to issue five year licences. This would therefore include drivers who are able to meet various concessions, such as the ‘sleep concession’ and ‘permitted seizure’ concession.

## **7. Sleep Apnoea**

To ensure that the new regulations [in Annex III to Directive 2006/126/EC] regarding obstructive sleep apnoea syndrome are met, applicants will be directed to self-assessment tools and to seek further advice from their doctors if it is suspected that they are at risk of moderate or severe obstructive sleep apnoea syndrome. Concern was raised that basing assessment on an apnoea-hypopnoea index (AHI) score, as outlined in the Annex, may lead to drivers who do not pose a significant risk to road safety being stopped from driving. A proposal was made to adopt the use of the phrase ‘excessive sleepiness severe enough to affect driving’, however Panel was advised that this would lead to the use of a lower standard than is permitted by the Annex, and therefore would not be acceptable. The Panel was also reminded that the Annex does not differentiate, in terms of the medical standards, between Group 1 and Group 2, other than requiring more frequent review for Group 2 licensing.

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## 8. Clarification about Current Interpretation and Application of Regulations regarding Isolated Seizures

8.1 Panel was reminded that legislation states:

*(2D) An isolated seizure is prescribed for the purposes of section 92(2) of the Traffic Act as a relevant disability in relation to an applicant for, or a holder of, a Group 1 licence*

*(a) in a case where there is an underlying causative factor that may increase future risk, where such a seizure has occurred during the previous one year period; and*

*(b) in any other case, where such a seizure has occurred during the previous 6 month period.*

And that in October 2013 Panel advised that the MESS data indicates that drivers with a previous history of epilepsy (>5 years since last seizure) with/without abnormal EEG, who are treated as having had an isolated seizure would fall into the medium or high risk category for further seizures. It is therefore accepted that for there to be a medium to high risk, there must be some underlying causative factor causing this increased risk.

8.2 If it is agreed that such patients have an underlying seizure disorder which may increase future risk, then the isolated seizure will need to be followed by a 12 month driving ban, as this is in legislation. Equally, drivers with no previous seizure history who have an isolated seizure will need to stop driving for 12 months if there is imaging/EEG evidence of an underlying causative factor/underlying seizure disorder which may increase future risk. The 6 month driving ban is only for cases of isolated seizure where there is no underlying causative factor that may increase future risk.

8.3 For Group 2 licensing there is no distinction between isolated seizures with underlying causative factor and those without. Driving is not permitted for 5 years regardless.

8.4 There was a long and frank discussion in which it was noted that there would be very many patients with isolated seizure in whom there would be evidence of some underlying causative factor that may increase the risk to some degree. It was argued that if the risk of further seizures does not amount to greater than a 20% risk, then a six month driving ban rather than a twelve month ban should be permitted. Factors such as age, EEG or MRI findings, medication, previous history would all affect risk of future seizures and cases should be considered on an individual basis so that those for whom the risk is considered to be less than 20% are only stopped from driving for six months rather than for twelve.

8.5 It was agreed that in general the basic principles applied by the Panel to determine the medical standards for neurological conditions allow for a 20% risk of a sudden and disabling event for Group 1 licensing and a 2% risk for Group 2. However, where the medical standards have been prescribed in law, the DVLA and Medical Advisers making licensing recommendations on behalf of the Secretary of State for Transport are obliged to act in accordance with the law, even if the 20% and 2% principles do not apply.

8.6 In order to allow re-licensing after six months for cases of isolated seizure with an underlying causative factor that may increase future risk but to no greater than 20%, the wording of the law would need to be challenged. A proposition was therefore made to address this matter with the DfT lawyers and if necessary to return to the European Commission about the issue. Mrs Leach agreed to undertake this work and to try to find out how the law is being interpreted in other European countries.

8.7 A suggestion was also made that it may be possible to redefine the terms used in legislation such that ‘may increase risk’ is taken to mean ‘increases risk to greater than 20%’. Mrs Leach will ask the lawyers about this.

8.8 It was agreed that in the meantime licensing decisions would be made in accordance with the wording of the legislation. Where a driver has had an isolated seizure and there is an underlying causative factor that **may increase** future risk, 12 months off driving is required.

## 9. Review of At a Glance Wording for Isolated Seizures

9.1 Closely related to Item 8 above, the Panel was asked to consider the wording in AAG for (Group 1) isolated seizure as it may be interpreted as setting a lower standard than is permitted by European legislation or may be misleading.

9.2 AAG refers to 20% risk. Regardless of the estimate of percentage risk, the time frames of 6 or 12 months off for isolated seizure are set in legislation and are based upon the presence or absence of an underlying causative factor which ‘may’ increase future risk. Therefore, even if it is agreed that risk has been reduced below 20%, eg. by use of medication, a 12 month driving ban would still be required if there is an underlying causative factor that **MAY INCREASE** future risk.

9.3 AAG may be interpreted as suggesting that if the risk of further seizures is less than 20% then a 6 month ban will suffice, but this would be at odds with the legislation for cases in which there has been an isolated seizure with an underlying causative factor that may increase risk. AAG currently states: *“6 months off driving from the date of the seizure. If there are clinical factors or investigation results which suggest an unacceptably high risk of a further seizure, ie. 20% or greater per annum, this will be 12 months off driving from the date of the seizure.”*

9.4 As further legal advice is due to be sought in relation to this issue (see Item 8), no changes to the At A Glance were advised at this stage.

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## 10. Provoked Seizures

10.1 With regards to provoked seizures, the At a Glance guide states: *“For Group 1 and possibly Group 2 driver or applicants, provoked or acute symptomatic seizures may be dealt with on an individual basis by DVLA if there is no previous seizure history.”*

10.2 Panel was asked whether therefore a seizure cannot be considered to have been provoked if there is any previous history of seizures/epilepsy? AAG suggests this to be the case but EU legislation defines provoked seizures with no reference to previous history: “provoked seizure” means a seizure which has a recognisable causative factor which is reliably avoidable and which is not a medication adjustment seizure. Panel was also asked whether a seizure could be classed as provoked if there is a previous history of a provoked seizure?

10.3 Panel advised that it may be possible to have more than one provoked seizure and agreed that the wording in the At A Glance guide should therefore be changed to: *“For Group 1 and possibly Group 2 drivers or applicants, provoked or acute symptomatic seizures may be dealt with on an individual basis by DVLA if there is no previous history of unprovoked seizure.”*

10.4 Panel also advised that in circumstances where there may be grounds to consider a seizure as provoked but where there has been a previous history of unprovoked seizure(s), these cases should be referred to a Panel member or to the Panel for further consideration.

## 11. Visual Inattention

11.1 Panel was asked whether medical standards could be set in relation to visual inattention.



11.2 It was noted that whilst there cannot be adaptation to visual inattention, there may be improvement in the condition and visual inattention may resolve. It was also confirmed that drivers with visual inattention could not be considered as ‘exceptional cases’ if there is also a debarring visual field defect, because the criteria for exceptionality stipulate that there must be no other impairment of visual function. It was agreed that visual field testing is not an adequate assessment of inattention and that for visual inattention to be detected clinically, there would usually necessarily be a significant and obvious abnormality.

11.3 The consensus of the Panel was that clinically apparent visual inattention should be debarring for Group 1 and Group 2 licensing. It was felt that there is no evidence to allow for degrees of visual inattention. Questions about visual inattention may need to be added to some of the questionnaires which DVLA sends to doctors.

## **12. Estimating the Risk of a Sudden and Disabling Event Following a Head Injury (20% and 2%)**

12.1 Panel was asked whether there have been any recent studies which may help to provide guidance on how to calculate/estimate the risk of a sudden and disabling event in a driver who has suffered a head injury? There is particular difficulty in assessing eligibility for Group 2 licensing as the medical standards require an estimate of the risk.

12.2 With regards to Group 1 licensing concern was expressed that the wording in the At a Glance Guide may lead to unrealistic expectations. However, it was generally agreed that the wording in the At a Glance Guide should remain unchanged as this allows a degree of discretion for individual cases. Panel advised that if all of the criteria for a severe head injury as defined in the Jennett study are present (dura has been torn, post traumatic amnesia is greater than 24 hours and early epilepsy has occurred) then driving should cease for 12 months, but if the head injury is less severe then six months off driving would usually be appropriate.

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12.3 Panel suggested that if within the first six months of a head injury, doctors should usually advise their patients that they do not meet the medical standards, and if cover to drive under Section 88 is under consideration, their patients should accordingly be advised that within the first six months after the injury they cannot be considered to have cover to drive under Section 88, unless the head injury was very minor.

12.4 With regard to Group 2 licensing, further guidance or a change to the medical standards cannot be advised until more evidence becomes available. It was noted that by five years, and sometimes after two or three years following a head injury, when there has been a full recovery with no residual functional deficit, licensing can usually be permitted for Group 2. However, if all of the high-risk factors for head injury were present, Panel members would be very uncomfortable if a licence were issued at three years. The difficulties finding funding for the necessary research were noted, but it is hoped that funding will be found so that a study similar to the Jennett study can be undertaken now that better imaging techniques are available.

### **13. Secondary CNS lymphoma**

13.1 AAG states that for primary CNS lymphoma the medical standard is “*At least 2 years off driving from time of completion of primary treatment*”. Panel was asked to confirm whether it should also be the same standard for cases where it is not a *primary* CNS lymphoma? Or, for licensing purposes, should CNS lymphoma with a primary elsewhere be treated in the same way as metastatic brain tumours *i.e.* for a solitary metastatic deposit a driver can be considered for licensing one year after completion of primary treatment and for multiple metastases, two years after completion of primary treatment?

13.2 Panel clarified that for CNS lymphoma, whether primary or secondary, the risks remain the same and the medical standards should therefore also be the same, requiring two years off driving following completion of primary treatment.

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## 14. Medical Standards Relating to Primary Lung Cancers

14.1 Panel was asked to consider whether the current medical standard remains in-line with the best available evidence. In brief, the Panel felt that yes, it is. It was explained that the current standards are based on the risk of seizures and the risk of developing morbidity at any given time. Whilst it was acknowledged that the literature will need to be reviewed by a statistician and a neuro-oncologist, it was also agreed that at present there is insufficient evidence to inform a change in the standards.

## 15. Clarification of minutes from March 2014 meeting section 10.1

15.1 Due to a forthcoming appeal case clarification was sought with regards to the following advice from Panel: *“10.1 Page 10, Section 6, ‘At a Glance guide to the Current Medical Standards of Fitness to Drive’ - (time limit). For category 6 of the loss of consciousness or loss of awareness, the medical standards will be altered to mirror the loss of consciousness with seizure marker standards”*.

15.2 In accordance with this advice the medical standards for Group 2 drivers who have had two or more episodes of loss of consciousness/loss of or altered awareness without reliable prodromal symptoms state: *If the episodes have been within the last 10 years then licence revoked or refused for 10 years or until the risk has been reduced to less than 2% per annum.*

15.3 For the forthcoming appeal case, a Group 2 licence was revoked for five years (old standards) because the decision was made prior to the advice from Panel. Can Panel assist in providing evidence or an explanation that can be used in court to justify why the standard has been increased to ten years off driving as would have been the case had there been seizures?

15.4 Panel advised that it was because there is an underlying assumption that the episodes may have been seizures and it therefore makes sense to apply the same standards.

## **16. Cases for Discussion**

Two cases were discussed. One of the cases highlighted the difficulty Medical Advisers face due to the medical standards and paucity of evidence to inform licensing decisions and address challenges to the licensing decisions for Group 2 drivers with head injury. Case discussions also led to the confirmation that an asymptomatic hamartoma, which does not affect the visual field would not, in itself, be debarring for Group 2 licensing.

## **17. Appeal Cases since the last Panel Meeting**

The Panel was provided with data regarding the number of summonses and appeals involving neurological cases, the medical conditions involved and the current status of the appeal.

## **18. Any Other Business**

Panel was shown a copy of the information leaflet available to the public which explains about Section 88 of the Road Traffic Act:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/367690/INF188X6\\_221014.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/367690/INF188X6_221014.pdf)

## **19. Date and Time of Next meeting**

The proposed date for the next meeting is 17 September 2015.



**DR N LEWIS**  
Panel Secretary  
18 March 2015