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 7 April 2016

Present:

Professor G Cruickshank	Chairman
Professor A Marson	
Mr R Macfarlane	
Professor P J Hutchinson	
Dr A R Gholkar	
Professor J Duncan	
Dr Paul Reading	
Professor Huw R Morris	

Lay Members:

Mr C Jones

Ex-officio:

Dr S Mitchell	Civil Aviation Authority
Dr N Delanty	National Programme Office for Traffic Medicine,Dublin
Dr B G R Wiles	Panel Secretary, DVLA
Dr W Parry	Senior Medical Adviser, DVLA
Mr J Donovan	Medical Licensing Policy, DVLA
Mrs S Charles-Phillips	Business Change and Support, DVLA
Dr S Bell	Chief Medical Officer Maritime and Coastguard Agency

1. Apologies for absence

Professor A Al-Shahi Salmon

Dr D Shakespear

Dr C Tudur Smith

Mr R Nelson

Mr L Coucher

Mr Paul Green

Northern Ireland representative

2. Changes to agenda:

- Due to the unavailability of colleagues, the discussion regarding the on-line notification process was deferred.
- Item 10 was entered onto the agenda before the new version of the medical standards was published. Due to the change in the layout of the standards with more emphasis upon multiple events, discussion of this item was no longer necessary.
- Item 14 was discussed with item 8.

3. Chairman's remarks

3.1 The Chairman announced the resignation from the Panel of Ms Rona Eade (lay member) after a change in her job prevented her from continuing. Thanks were expressed and the Chair has written to her personally.

3.2 The Chairman thanked Professor Huw Morris for his work on the Panel as he is due to retire from the Panel after this meeting.

3.3 Congratulations were expressed to Dr Lewis on the recent birth of her child.

3.4 The ongoing review of Panel activities is due to report soon and the structure of the Panels may change. The report is due to be released and discussed at the Panel Chairmen's meeting in June.

3.5 The new version of the medical standards, Assessing Fitness to Drive, has been released.

4. Panel recruitment

4.1 This is currently on hold until after the review into Panel activities has been completed and the report released.

4.2 Panel is aware of the areas of expertise that are lacking in the Panel and, looking to the future, there will need to be consideration of what other areas need development.

5. Minutes of the Panel meeting 12 March 2015

5.1 Apart from the fact that there are two item 19, the minutes were considered as accurate. The second item 19 will be changed to item 22.

5.2 The reference to the changes in the standards in item 8 being in red could be confusing as the Panel bundle was in black and white. The on line version will be clarified and changed as necessary.
Addendum: after the meeting, the public domain version of the minutes have been checked and are in colour.

6. Matters arising from the minutes

6.1 Item 2: Discussion ensued regarding whether or not there was any plan to increase the age of renewal of the driving licence from 70 to 75. It was noted that this suggestion caused some surprise amongst the insurance industry. Mr Donovan clarified that this suggestion is not being taken forward as there is no evidence to back up the safe implementation of this.

6.2 Item 7: There has been no further meeting of the Vision Panel Working Group.

6.3 Item 11: Two scenarios regarding asleep seizures were discussed:

1. An individual who has multiple asleep only seizures and then after a period of five years freedom from seizures has another asleep seizure.
2. An individual who has solitary asleep seizures more than five years apart.

In scenario 1, the epilepsy regulations would apply in their entirety so the sleep concession would apply.

In scenario 2, if the clinician(s) felt that this pattern represented epilepsy (a diagnosis of oligoepilepsy was suggested), then the epilepsy regulations would apply in their entirety, including the sleep concessions. If the clinician(s) felt that it was not epilepsy, the isolated seizure regulations would apply- hence a period of time off driving would be required.

6.4 Item 18. Professor Duncan presented his data regarding the situation of individuals who have an established pattern of seizures that don't affect consciousness nor have an influence on the ability to act after surgery to prevent their previous type of epilepsy (usually tonic-clonic seizures). These individuals would be barred from driving under the current EU legislation.

6.5 The data comes from Professor Duncan's unit at the National Hospital for Neurology and Neurosurgery, Queen's Square. This unit is performing surgery on

approximately 300 patients per year. The data has been preliminarily analysed and the results are:

- For individuals who have never had an incapacitating seizure pre-surgery and have ongoing auras, the risk of having an incapacitating seizure in the next year is 4.8%.
- For individuals who have had incapacitating seizures pre-surgery and have ongoing auras, the risk of having an incapacitating seizure in the next year is 11.3%.

6.6 It is accepted that the risk of such seizures may decrease over time and this data has not been analysed to review this. There is however some statistics from this data set to indicate that for the second group the risk of having a seizure in the next two years in 20% and the next 3 years 27%.

6.7 Whilst these figures are less than the 20% annual risk that is used as a guide for Group 1 licensing, the second group was a sample of 100 patients and the confidence intervals are not known. It was suggested that, in order to obtain a more statistically meaningful dataset, using American datasets may be useful. The problem with this is that the American datasets don't consider auras as seizures as these are predominantly not a restriction for driving.

6.8 Gratitude was expressed to Professor Duncan for this work and in order to take it forward, the data will be passed to Dr Tudur-Smith and Professor Marson.

7. New OSAS rules and procedures

7.1 The EU Directive Annex regarding OSAS became enforceable on 1st January 2016. This has been discussed in panel meetings over the previous few years. The definitions and requirements are prescriptive in the Annex.

7.2 There have been concerns in clinical practice about the application of the new Annex. A collaboration of interested stakeholders has written to DVLA with their concerns and included a letter from the chairman of the EU working group that was tasked with advising the EU commission prior to the introduction of the Annex.

7.3 Their concern was that the Annex was not being interpreted by DVLA correctly. Their concerns were:

1. AHI is a poor guide to sleepiness and poorly correlates to the severity of OSAS.
2. The O_2 Desaturation Index is more commonly used than AHI in clinical practice and the two are difficult to correlate.
3. That DVLA appears to be not primarily interested in sleepiness, especially excessive daytime sleepiness or sleepiness sufficient to affect safe driving.
4. The requirement for three yearly follow up would put pressure upon secondary care services.

7.4 In response it must be said:

1. AHI is prescribed in the EU Annex and therefore must be included in our standards.
2. DVLA/DfT cannot be seen to favour one method of assessing OSAS severity as this could provide an unacceptable commercial benefit.
3. The Annex refers to "…improvement in sleepiness, if any,…" so DVLA must be concerned about sleepiness as well as any other symptoms. The Annex also does not refer to excessive sleepiness nor sleepiness that would affect safe driving so DVLA could not refer to this as opposed to any sleepiness as it would be applying lower standards than the EU Annex.
4. The follow up requirement is prescribed in the Annex, DVLA does not specify how this review is to be performed therefore it is the individual clinician's responsibility to decide how this is done and could be based upon the servicing records of the CPAP machines.

7.5 The collaboration has asked for a meeting with DVLA but no decision has been made regarding this by DVLA. It must be noted that DVLA has no discretion to make any changes given the legislation. If there is evidence that the EU Annex does not represent the findings of the working group, then this is something that should be taken up directly with the commission.

7.6 It was noted that clinically, most OSAS patients present with overt sleepiness. It was noted that before a diagnosis of OSAS is made, the standards for excessive sleepiness must be followed which would temporarily prevent driving.

7.7 Concerns were expressed that Group 2 (Vocational) drivers were not required to have specialist reviews and potential under diagnosis if sufferers were not to present for assessment. The Annex make no difference between Group 1 and Group 2 drivers apart from the yearly or 3 yearly review periods.

8. Head Injury and Seizure risk

8.1 Two particular questions were put to Panel:

1. Do head injuries that cause a small SAH in isolation require a period of time off driving?
2. Is PTA a useful factor in assessing the severity of head injuries?

In the first scenario, for Group 1 licences, a period of time off driving is not required. For Group 2, if there are no cortical lesions, these would need individual assessment but there is no data to indicate what features should be considered.

In the second scenario, Panel do agree that PTA is a useful factor but, in their clinical opinion, do not feel that it would occur in isolation.

8.2 For general guidance, a qualitative summary of the papers by Jennet, Annergers, Englander and Christensen was presented.

8.3 The Jennet and Annergers papers were before CT scanning was widely available and therefore not directly transposable into guidelines for specific cases. The Christensen paper was felt to not distinguish between different types of head injury (e.g. different types of contusions) to be comparable with the other papers and not useful for DVLA practice. Professor Marson is trying to get hold of the original data for the Christensen paper to see if (with Dr Tudur-Smith) any useful guidelines can be drawn up.

8.4 It was noted that this data would be useful for other areas such as aviation medicine and seafarers.

8.5 The risk factors in the Jennet study (LOC/PTA >24 hours, early epilepsy, dural tear and depressed skull fracture) are useful for indicating higher risk groups.

8.6 Previously, Panel have advised that most Group 2 drivers with non-mild head injuries would have to observe at least 2 years off driving. If all 4 of the Jennet risk factors are present, this period of time would be 4-5 years.

8.7 It was mentioned that one of Professor Hutchinson’s colleagues is trying to get funding to perform a study which would provide guidance as necessary.

8.8 It was suggested that DVLA could start to collect data from cases to be anonymously analysed as part of this.

8.9 Professor Hutchison has reviewed a number cases for DVLA and has kept a record of the advice that he has given. He will forward this to DVLA along with a list of the factors he uses to assess seizure risk. This may be able to be used as part of the research.

9. FAI in Glasgow

9.1 Following the well documented case of the bin lorry driver who crashed his lorry in central Glasgow in December 2014 killing 6 people, the Fatal Accident Inquiry heard evidence from many experts and Dr Parry attended for DVLA.

9.2 There was scrutiny of the (then) DVLA standards regarding episodes of loss of consciousness. It was documented that they were unclear and difficult to navigate. The issue of recurrence of events was noted as especially unclear.

9.3 There was stress placed upon the 3 “Ps” for the issue of provocation.

9.4 There was a clear need to review the layout of the guidelines which was performed by Dr Parry and a medical journalist. The result is the new “Assessing Fitness to Drive”. The Panel Chair commented on the clarity of the new publication and acknowledged the work DVLA had carried out on this. The Panel Chair was also particularly impressed with the re-written loss of consciousness guidelines which were felt to be much clearer than previously.

9.5 There is now direct evidence that DVLA have addressed the issues from the FAI.

9.6 It is now clear that if there is more than one episode, there must be clinical investigations into the cause.

9.7 Concerns were raised by as to whether or not the onus on notification might change from the licence holder to the doctor. There has been no such change.

9.8 The GMC guidance upon notification that is supplied to doctors will be made more robust and will be circulated to doctors in the near future.

9.9 Panel members were asked to forward any concerns or issues with the new guidance to Dr Parry.

9.10 It was suggested that Panel would benefit from a presentation by an expert in syncope and any suggestions should be made to Dr Parry.

10. Cancer with a risk of cerebral metastasis

10.1 Currently the standards require a Group 2 driver with non-small cell cancer of a stage higher than T1N0M0 to observe a period of 2 years off driving.

10.2 This is because of the risk of developing cerebral metastases which may present with seizures. This is essentially stopping an individual driving before there is evidence of them having a debarring condition.

10.3 Given the following reasons:

- the high risk of seizures
- the short life expectancy
- hence the high annual risk of seizures

it was felt not unreasonable to maintain such a requirement for licensing however the period of time off driving could be reduced to 1 year. If an individual can demonstrate 1 year free from seizures then the evidence suggests that they are in a better prognosis subgroup.

10.4 It was noted that:

- after a diagnosis of a cerebral metastasis is made, 20-25% of individuals will have a seizure.
- the presenting issue for cerebral metastasis is a seizure in 7-10% of cases.

10.5 The journal papers referenced are:

The management of brain metastases in non-small cell lung cancer. Owen S and Souhami L. Frontiers in oncology September 2014 Volume 4 Article 248.
Survival of patients with non-small cell lung cancer after a diagnosis of brain metastases. Ali A, Goffin JR, Arnold A, Ellis PM. Current Oncology August 2013 Volume 20 pp 300-306.

11. LOC with seizure markers and underlying cause

11.1 There is an anomaly in the standards in that if an individual has a seizure (with no history of epilepsy) with an underlying cause, they have to observe 1 year off driving but if the event was an episode of loss of consciousness with seizure markers they observe 6 months off driving.

11.2 The Panel felt to increase this to 1 year is appropriate.

12. Benign supratentorial Grade I tumours

12.1 Currently the standards indicate that for Grade I meningioma a period of 6 months off driving after the completion of primary treatment is required. For Grade II meningiomas, a period of 1 year is required.

12.2 The question to Panel was does this apply to all benign tumours because that is how the standards read.

12.3 Meningiomas are by definition non-parenchymal tumours.

12.4 Panel feel that benign parenchymal tumours should require 1 year off driving.

13. Joint meeting with the Psychiatry Panel regarding Dementia

13.1 Approximately 8 years ago there was an attempt to review dementia with the Psychiatry Panel.

13.2 There are national guidelines on dementia management being produced.

13.3 The psychiatry panel would like to set up a joint meeting with the Neurology

13.4 Panel to discuss dementia and how to manage cases with respect of driver licensing.

13.5 Panel were happy to do this.

13.6 DVLA will liaise between the panels to set up a meeting.

14. Cases for discussion

14.1 Panel considered 2 cases: a Vocational driver with a head injury (considered with the item regarding head injury and seizure risk) and an Ordinary driving licence holder with epilepsy.

14.2 There were no general guidelines that could be taken from these cases.

15. Any Other Business

15.1 Dr Parry raised two issues.

15.1.1 The first concerned a question raised by an intensive care consultant regarding the "Post ICU Syndrome".

15.1.2 The question put to Panel was should there be any different or new standards for this.

15.1.3 The general consensus was that the underlying pathology or ongoing impairment should dictate the relevant medical standards.

15.2 The second issue was regarding Arnold-Chiari malformations.

15.2.1 Currently there are no specific standard for these.

15.2.2 The A to Z guide for the public indicates that if they have an Arnold-Chiari malformation, they should notify DVLA.

15.2.3 It is possible that these may present with functional impairment or unpredictable dizziness but these are already covered in the standards.

15.2.4 It was felt that this could be removed from the A to Z as the symptoms themselves would be sufficient to alert drivers to notify DVLA.

16. Date and time of next meeting

The proposed date is the 27 October 2016.

DR B G R Wiles M.B., Ch.B., MBA, DOccMed
Panel Secretary

11 April 2016