

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

12 MARCH 2009

Present:	Professor Charles P Warlow	Chairman
	Professor I Whittle	
	Professor G Cruickshank	
	Dr L Nashef	
	Professor P E M Smith	
	Professor A G Marson	
	Dr P Reading	
	Mr R Macfarlane	
	Mr P Hutchinson	
	Professor P Williamson	
	Dr D Shakespeare	
Lay members:	Mrs M Cooper	
Ex-officio:	Dr R Thomas	Research Fellow, University Hospital of Wales
	Dr C Beattie	DVA
	Dr H G Major	Senior Medical Adviser, DVLA
	Dr K Watts	Medical Adviser, DVLA
	Ms C Fuge	Drivers Policy Group, DVLA
	Dr J E Morgan	Panel Secretary/Medical Adviser, DVLA

1. Apologies for Absence

Professor C J Mathias, Dr S Short, Mrs J Wightman, Dr P Collins Howgill,
Dr T Crayford, Mr B Jones.

2. Chairman's Remarks

The Chairman welcomed the new members and explained the structure of Panel meetings and the particular issues faced by the individual Secretary of State Panels. New members were informed that the Chairman is due to retire at the end of 2009, and that Dr Tim Crayford is now in post as the Chief Medical Officer to the Department for Transport. A proposal had been discussed at the recent Chairmen's

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Honorary Medical Advisory Panel as a whole. If they are quoted, they should be reproduced
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meeting to alter the format of Panel meetings and their frequency. All Panels should hold at least a single meeting in the Autumn but with the option of an extra Spring meeting as the need demands. It is envisaged that this Panel will continue to require meetings on a twice yearly basis.

The meeting of the Secretary of State for Transport's Honorary Medical Advisory Panel Chairmen on 4 February 2009 was summarised for the members, with particular information on recruitment to Panel membership, the assessment of risk standards and the commissioning and publication of research.

A detailed discussion took place concerning the appropriateness of the 20% per annum (Group 1) and 2% per annum (Group 2) risk of a sudden and incapacitating event in drivers and its measurement. It was agreed that a better understanding of risk assessment is needed and, in particular, whether all events of a certain type (eg. epilepsy, cerebrovascular etc) are likely to be equally incapacitating. There was a general appreciation of the need for the Department to prioritise its research to maximise the benefits on road safety. The ability of the Medicines and Health-Related Products Agency to provide evidence relevant to driving risk and medication was debated but no conclusion was reached.

3. Minutes of the Meeting of 18 September 2008

The minutes of the meeting of the 18 September 2008 were accepted as accurate.

Discussion took place concerning the need for accurate data collection on the contribution of medical causes to road accidents: this is considered essential to informing proposals for future research into areas of medically-related road traffic accidents.

It was agreed that a joint meeting of the Panels on Cardiovascular Disorders and Disorders of the Nervous System would be extremely helpful in reviewing the appropriate licensing standards and their application after cerebrovascular events. It

was again noted that further expertise in the field of vascular risk assessment would be advantageous for this Panel, particularly as the Chairman will be retiring at the end of the year.

4. Matters Arising

4a. Recurrence Risk of Sleep-Related Seizures

A presentation on this topic was made to the Panel by Dr Rhys Thomas, Research Fellow at the University Hospital of Wales. Members discussed the statistical basis of the papers presented and the relevance of the information to the 20% and 2% risk standards (Group 1 and Group 2 respectively) of a sudden and disabling event for drivers.

It was agreed that further research into this area would be welcomed. Professor Williamson offered to review the relevant papers and it was agreed that the topic would be discussed again in the future.

4b. Appropriate Licensing Standards after Solitary Seizure

It was confirmed that the Motor Vehicles (Driving Licences) Regulations 1999 prescribe epilepsy for the purposes of the Road Traffic Act and stipulate that, for a Group 2 licence holder, a period of 10 years' freedom from any manifestation of seizure, in addition to 10 years without anti-epilepsy medication, is required. In the case of a solitary seizure and Group 2 licensing, the appropriate standard is that the ongoing liability to a further seizure should be no greater than 2% per annum.

The Panel agreed that it would be appropriate to reduce the time off driving after a solitary seizure for a Group 1 licence to 6 months and to 5 years for Group 2 licensing. Medical review with confirmation that there was no relevant medical abnormality present on assessment and investigation would be required in both cases.

Discussion took place regarding the relevance of alcohol and lack of sleep to the provocation of seizures: general agreement was reached that whilst epilepsy specialists recognise that these factors may unmask a liability in someone with a predisposition to seizures, they could not be accepted as being the cause of a provoked seizure with regards to licensing standards because of the inability to quantify threshold levels.

4c. Seizure Recurrence after Cessation of Anti-epileptic Drugs

The Panel expressed a need for clarification of the precise nature of the information required to reach a recommendation on the appropriate observation period, off driving, in these circumstances. It was agreed that the following should be clarified:

- i) The current guidance following withdrawal of anti-epilepsy medication on medical advice is that a person should refrain from driving during the period of withdrawal and for 6 months after cessation of treatment. The Panel requested guidance on the evidence for the appropriateness of this standard.
- ii) The Panel required evidence to determine the appropriate time off driving when, having suffered a seizure following physician-directed reduction or withdrawal of medication, the previously effective medication has been resumed.

Further possible questions were debated: agreement was reached that information on the availability of data regarding reduction in treatment with Carbamazepine and Lamotrigine would be useful.

4d. Coiling of Aneurysms

Professor Warlow confirmed that information had been obtained from one of the authors of the ISAT trial concerning the seizure risk following coiling of aneurysms. There are 2,000 patients in the trial which has shown that though the re-bleeding risk is very low following either clipping or coiling of aneurysms, the data currently available have shown that the seizure-risk is 50% less following coiling than after clipping of aneurysms. Over time, more data should become available on absolute risk.

4e. Data Collection

Dr Major confirmed that there is no over-riding legal impediment to the use of licensing data for prospective research, provided that it is used for the purposes for which registration is held: this would include road safety. In addition, any data exchange must be fully secure and outcomes anonymised. Collection of data on the medical contribution to or causation of road accidents remains inherently problematic. Panel members were reminded that Dr Crayford was of the view that an application for Section 60 PIAG exemption under the 2001 Health and Social Care Act could address ethical issues. A general discussion took place concerning the research opportunities for all Panels and there was agreement that the duration of follow-up studies may need to be long, ie. in the region of 10 years, due to the infrequency of serious road traffic accidents in individual drivers. It was confirmed that a large sample size would also be necessary.

5. Acceptable Risk Standards for Group 1 and Group 2 Licensing

Agreement was reached that wider publicity of the standards regarding the acceptable risk levels of a sudden and incapacitating event (20% and 2% per annum for Group 1 and Group 2 respectively) would be beneficial to professional colleagues in particular. All members agreed that it was important to have standards in line with those of the other Secretary of State's Panels and that the exact wording of any advice was critical regarding the likelihood of any event causing an accident; in addition, it was important to emphasise the general principles behind driver licensing. The Panel emphasised that information should be given to remind doctors

that it is the per annum risk of an incapacitating event which was important rather than the cumulative risk.

6. Vascular Risk Workshop

It was explained that the final report of this workshop is expected to be published on the Department for Transport website along with other research reports later this year. General discussion took place on the analysis of data and whether risk factors are assessed individually or if the combined risk of a licence holder/applicant is assessed. It was confirmed that the DVLA has no legal authority to screen licence holders for risk unless there is a declared medical condition. Panel members were informed that a driving licence is a qualified right under Human Rights legislation: any refusal on medical grounds must have a legal basis, taking into consideration the recognised risk of the medical condition and the proportionate risk presented to road safety by that medical condition.

There was general discussion concerning the safety of the older driver in the context of vascular risk, and agreement that any risk should be balanced against the advantages of accessibility and encouragement to remain independent and mobile for as long as safely possible.

7. Amendments to Annex 3, EC Driver Licence Committee

An amendment to the minimum health standard for epilepsy and driving, set out in the second Directive on driving licences (91/439/EC), is currently progressing through the EC legislative process, following a vote at the meeting of the Committee on 5 February.

A detailed discussion by the Panel considered possible options for change to the national standards for driving, once any new EC legislation comes into force. DVLA will consider the Panel's advice and recommendations before seeking ministerial views

It was confirmed that individual Member States can impose standards which are stricter than the EC Amendments, but cannot adopt standards which are less restrictive. There was general agreement that it was important to distinguish between standards which are in regulation and those which are advised by the individual Panels and are adopted as recommendations into the, 'At a glance Guide to the current Medical Standards of Fitness to Drive'.

8. Case for Discussion

This concerned a licence holder who suffered a seizure during a lumbar plexus block with Bupivacaine. There was unanimous agreement that in this particular case, the seizure had been provoked by the anaesthetic agent and that the licence holder should be allowed to retain both Group 1 and Group 2 driving licences.

9. Research Update

It was confirmed that the following research is to be published on the Department for Transport website at the earliest opportunity:

- i) Analysis of Risk Outcomes for Cardiac Conditions.
- ii) The Attitudes of Health Professionals to Giving Advice on Fitness to Drive.
- iii) Systematic Review of the Probability of Future Seizures after an Initial Seizure or Other Event Creating an Increased Future Risk.
- iv) Expert Consensus Workshop on Driving Safety and Vascular Disease – Final Report.
- v) The Role of Carbohydrate Deficient Transferrin (CDT) as an alternative to Gamma Glutamyl Transferase (GGT) as a marker of continuous drinking in High Risk Drivers.

The expectation is that the research will be published later this year. A detailed discussion took place concerning proposals for future DfT research. Panel members were advised that prioritisation of a Panel's research requests will need to be

undertaken by the Panel members before submitting for wider consideration at the annual Chairmen's meeting. It was confirmed that some funding has been identified by the Department for research into medical fitness to drive in the coming year. There was current uncertainty about how longer-term research could be funded. Members agreed that data were needed by all the Panels regarding medical causation of road traffic accidents. Agreement was reached that it could be advantageous to involve patient organisations in any research, eg. into head injuries.

Members concluded that research into head injuries and the consequences for driving should be the main priority for this Panel and that discussion should take place in the Autumn meeting to agree the actual proposal of the Panel for research funding.

10. Reference Papers

No new reference papers were presented to the Panel.

11. Appointment of new Panel Members

See item 2 – Chairman's Remarks.

12. Any Other Business

12a. Advice for Reduction in Anti-Epileptic Medication

Discussion took place to agree the Panel advice about driving when anti-epilepsy drugs are being reduced but without the intention to withdraw the medication completely. It was confirmed that an assessment should be made by an epilepsy specialist concerning the probability of the individual suffering further seizures and that a licence holder should not drive until confirmation had been obtained that the risk of any further seizures was acceptable. (This will be advisory and not set in regulations.)

12b. New Amendments to the ‘At a glance Guide to the current Medical Standards of Fitness to Drive’

Agreement was reached that the appropriate period off driving for a Group 2 licence holder having undergone surgical craniotomy to treat a middle cerebral artery aneurysm which had been responsible for a subarachnoid haemorrhage should be 18 months if there was no deficit present.

Agreement was reached that the standards for Group 1 driving after a first epileptic seizure/solitary fit could be reduced to 6 months off the road when there had been appropriate medical review, with no relevant medical abnormality found on assessment, and where it was decided that anti-epilepsy drugs were not necessary. It was agreed that the appropriate period off driving under a Group 2 entitlement should be 5 years for persons in the good prognosis group.

The following features are consistent with a person having a good prognosis:

- No relevant structural abnormality of the brain on imaging;
- No epileptiform activity on EEG;
- No anti-epilepsy drugs;
- Support of the neurologist;
- Seizure risk considered to be 2% or less per annum (for Group 2 licensing).

Changes are to be made to the standards for ‘Loss of consciousness/loss of or altered awareness’, to achieve consistency with the standards for a first epileptic seizure/solitary fit, ie. 6 months off for Group 1 and 5 years for Group 2, both with similar caveats as for solitary seizures.

A discussion took place on the need for evidence in order to consider the modification to other published guidelines.

12c. Individual correspondence received by Panel members

Panel members were advised that if correspondence is received from individual licence holders, it should be forwarded to the Panel Secretary at DVLA for reply.

13. Date and Time of Next Meeting

1 October 2009.

DR J MORGAN MB BCh DRCOG DDAM
Secretary to the Honorary Medical Advisory Panel
on Driving and Disorders of the Nervous System