The Australian and New Zealand Society of Occupational Medicine Inc. (ANZSOM)

Review of AFTD 2021

Submission from the Australian and New Zealand Society of Occupational Medicine – June 2021

The Australian and New Zealand Society of Occupational Medicine (ANZSOM) is the professional society for those who practice or have an interest in the fields of occupational medicine, occupational nursing and workplace health more generally. The Society seeks to advance the knowledge, practice and standing of occupational health by providing opportunities for professional development, networking and partnerships. ANZSOM works closely with the Royal Australasian College of Physicians (through the Australasian Faculty of Occupational and Environmental Medicine).

Many of our members are involved in the assessment of commercial vehicle drivers and other safety critical workers (e.g. rail safety workers, maritime pilots) in relation to their fitness for duty and return to work. Their skill set in this regard includes risk assessment of driving and other tasks, the impact of health conditions and considerations for safe return to work following illness or injury. They consider both short and long-term impacts. Assessing Fitness to Drive is a very familiar resource for this work, as is the equivalent resource for rail safety workers (National Standard for Health Assessment of Rail Safety Workers). They are therefore in good position to comment on aspects of AFTD that need improvement particularly regarding assessment of commercial vehicle drivers.

This paper reflects inputs from the Working Group established in 2019 and the broader membership who were invited to contribute. The main focus of the comments is with regard to **commercial** vehicle driving. It is considered that because commercial vehicle driving is potentially of high risk particular clarity regarding fitness for such licensing is warranted in the standards.

In regard to education, ANZSOM is planning to include a one-day workshop on Assessing Fitness to Drive for Commercial vehicle Drivers as a satellite course at their Annual Scientific Meeting. This will likely commence in 2022.

Comments on draft AFTD 2021

Section	Page	Feedback
1.3.3 Fitness for Duty	6	In the absence of a fitness for duty standard for commercial vehicle drivers, AFTD will be used for this purpose. It is suggested that this paragraph be reworded to that effect and perhaps provide some brief guidance as to how the criteria might be applied for fitness for duty. For further comment, please see 8 Sleep disorders below.
Evidence base	9	In addition to the MUARC report, which focuses mainly on crash risk, there is an array of additional evidence that has informed the approach to management of fitness to drive for various conditions and more generally. Suggest a para to this effect be included.
4 Licensing and medical fitness to drive	36-39	Feedback from one of our members has recommended inclusion in Table 3 of more specific information about periodic assessment requirements for vehicle types by jurisdictions. This would help connect the requirements outlined in section 4.3. While this table may not be able to accommodate much more information, the third column could be expanded to "Applicable standard (private or commercial) and periodic assessment requirements, with cross referencing to Appendix 1. An example is included at the end of this submission. The flow of this whole section may be improved by bringing forward to section 4.1 some of the content from 4.2 as it is 4.2 that positions the risk-based decision about which standard applies.
2.2.10 Medicinal cannabis (cannabinoids)	22	This section on a problematic new drug is welcome. However, the discussion is verbose and discursive with little clear information to guide the practitioner. Suggest the following be clearly stated: Delta-9-tetrahydrocannabinol (THC) impairs driving performance and can increase crash risk. These effects are more pronounced in people who use THC occasionally and can last for up to eight hours with oral THC products. There is no evidence that cannabidiol (CBD) impairs driving. Patients using

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		THC-containing products should avoid driving and other safety-sensitive tasks (e.g. operating machinery), particularly during initiation of treatment and in the hours immediately following each dose. Patients may test positive for THC even if they do not feel impaired, and medical cannabis use does not currently exempt patients from mobile (roadside) drug testing and associated legal sanctions. CBD-only medications appear to pose no traffic safety risk, although CBD is unlikely to ameliorate THC-induced impairment Arkell etal **AJGP** Vol. 50, No. 6, June 2021 357-62  Arkell cannabis AJGP-06-2021-Focus We recommend the following be clearly stated: "THC should not be in medicinal cannabis used by commercial vehicle drivers. State/Territory Health Department regulations regarding medicinal cannabis must also be complied with."
Part B Fitness to drive overview – flowchart	57	This figure is largely a repetition of Figure 3 on page 44 but without the advice provided in the final boxes. It would make sense to repeat the figure in its entirety as the additional information is important and readers are unlikely to read the document from cover to cover.
2.1.4 Blackouts of undetermined origin	61	Please see comments below regarding psychogenic epilepsy which should be managed as an "Exceptional Case"
2.2.2 Exercise testing	65	The Bruce protocol is recommended for formal exercise testing. Suggest amend to "The Bruce protocol, is recommended for formal exercise testing. Where a patient is not capable of performing a treadmill test due to a medical condition, for example osteoarthritis of the knee, an equivalent stress test may be used. The additional sentence takes into account some people who have difficulty walking on a treadmill, for example osteoarthritis of the knee.
2.2.5 ICD	85	The relaxation of the standard previously prohibiting ICD for primary prevention, for example,

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		in Hypertrophic Cardiomyopathy (HCM) in commercial vehicle drivers is welcome. However, this needs to be made clear in the table regarding HCM, page 85 and elsewhere as required. The implementation strategy for this change will be important.
2.2.6 Aneurysms	82	The text is helpful but the table content (page 82) could be more clearly stated. "in the case of atherosclerotic aneurysm or aneurysm associated with the bicuspid aortic valve, the aneurysm diameter is less than 55 mm; **or** - the aneurysm diameter is less than 50 mm". It is suggested this last point be amended as follows: - for all other aneurysms the diameter is less than 50 mm.
(No Number) Congenital cardiac disorders	86	The improvement to the table is welcome. However, an additional paragraph in the text regarding congenital conditions explaining this would be helpful. This would be consistent with the general approach to provide a narrative explanation in the body of the chapter so the criteria in the table are more clearly understood.
3.2.1 Hypoglycaemia	93-94	The additional point in preventing hypoglycaemic episodes is welcome "…wearing a continuous or flash glucose monitor, preferably with an active hypoglycaemia alert or alarm". However, please clarify does this apply only to insulin treated diabetics and particularly if they are commercial vehicle drivers? These devices are expensive so advice should be focused.
6.2 Epilepsy – Psychogenic Non-epileptic seizures	126-146	"Psychogenic Non-epileptic seizures (PNES)" appears not to be included in the draft Standard. However, it would be a useful addition because PNES is by no means uncommon. By contrast, the Interim Report does address this condition and recommends that in commercial vehicle drivers the default seizure standard applies i.e. exclusion for 10 years. This seems exceptionally harsh given that, by definition it is a psychiatric condition, and the chapter on psychiatry emphasises the need for individualisation of decisions regarding exclusion. It is recommended

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		that such cases be managed as per the epilepsy standard for **Exceptional Cases** thereby permitting individualised management**.** There should be identical wording and cross-reference in the psychiatry chapter.
7 Psychiatry	168	It is noted there is a relaxation of the monitoring of commercial vehicle drivers with a psychiatric condition as follows: * Where a condition is considered stable and well managed, the driver licensing authority may agree to ongoing periodic review by the person's regular general practitioner with the cooperation of the psychiatrist. The initial allocation of a conditional licence must, however, be based on an assessment and information provided by the psychiatrist. This relaxation permitting review of commercial vehicle drivers with a psychiatric condition by a person's GP will need to be carefully managed, and therefore it warrants some text in the chapter itself, potentially under a heading of commercial vehicle drivers so that the considerations for commercial vehicle drivers can be pulled together in one cohesive paragraph. This could emphasise the importance of ongoing collaboration between the treating health professionals. It is suggested the wording in the table be amended as follows: * Where the treating psychiatrist considers a driver's condition to be stable and well managed, and the driver has good insight, the driver licensing authority may agree to ongoing periodic review by the person's regular general practitioner by mutual agreement of all practitioners concerned. The initial allocation of a conditional licence must, however, be based on an assessment and information provided by the psychiatrist. This comment applies equally to the change proposed regarding Substance misuse.
8 Sleep Disorders	170-178	Our previous submission highlighted the importance of sleep disorders in commercial vehicle drivers and the need to support health professionals in proactively identifying and managing this risk.

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		The clearer inclusion of BMI and predictive comorbidities such as diabetes and hypertension are welcome. The content could however be made clearer and more concise in terms of the approach to assessment and when a sleep study should be conducted. It would be helpful to include a statement and reference describing BMI as a predictor of sleep apnoea, rather than just listing it as a clinical feature. The Colquhoun et al study cited (16) found 91% of train drivers referred to a sleep study based on their clinical risk factors (BMI) were diagnosed with obstructive sleep apnoea. The dot points on page 172 would benefit from review, for example the point 'fatigue or sleepiness during the duty period' imply we are talking about commercial vehicle drivers but that is not clear.
9. Substance misuse	179 186	The inclusion of medicinal cannabis (2.2.10 also see comments above) requires cross-referencing. Also, careful wording regarding distinction of medicinal and recreational uses. It is noted that similar to psychiatry there is to be a relaxation of the monitoring of commercial vehicle drivers with substance misuse. (Page 186). This relaxation permitting review of commercial vehicle drivers with a substance misuse condition by a person's GP will need to be carefully managed, and therefore it warrants some text in the chapter itself, potentially under a heading of commercial vehicle drivers so that the considerations for commercial vehicle drivers can be pulled together in one cohesive paragraph. This could emphasise the importance of ongoing collaboration between the treating health professionals. Changes are suggested as follows: Where the treating specialist considers a driver's condition is ~~considered~~ stable and well managed, and the driver has good insight, the driver licensing authority may agree to ongoing periodic review by the person's regular general practitioner ~~with cooperation~~ by mutual agreement of all practitioners concerned. ~~the other specialists~~. The initial granting of a conditional licence must, however, be based on assessment and advice

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		provided by the addiction medicine specialist or addiction psychiatrist.
10.2.8 Telescopic lenses (bioptic telescopes)	195	Discussions with RANZCO have raised considerable concerns regarding the safety of these devices. They are prescribed for patients with much reduced visual acuity and the device itself reduces visual field. It is not considered that "individual assessment" is sufficient for commercial vehicle driving. It is **strongly recommended** that it be stated "These devices are not acceptable for commercial vehicle drivers.". The further opinion of RANZCO should be sought.

Table 3: Choice of standard and assessment requirements according to vehicle/licence type

NATIONAL LICENCE CLASSES		APPLICABLE STANDARD & PERIODIC ASSESSMENT REQUIREMENTS ~~WHICH STANDARD TO APPLY (private or commercial)~~
Motorcycle (R) 	Motorbike or motortrike	Private standards apply unless the driver holds or is applying for an authority to carry **public passengers for hire or reward**, in which case the commercial standards apply. Public passenger vehicle drivers are subject to periodic assessment based on jurisdictional requirements (refer Appendix 1)
Car (C) 	Vehicle not more than 4.5 tonnes GVM (gross vehicular mass) and seating up to 12 adults including the driver.	Private standards apply unless the driver: • holds or is applying for an authority to carry **public passengers for hire or reward** (e.g. taxi driver). Refer Appendix 1 for periodic assessment requirements by jurisdiction. • is undertaking a medical assessment as a requirement under an **accreditation scheme** (these may also require periodic assessment) • holds or is applying for an authority to carry **bulk dangerous goods**. Refer Appendix 1 for periodic assessment requirements by jurisdiction. • driver holds or is applying to hold authority to be a **driving instructor**. Refer Appendix 1 for requirements by jurisdiction including periodic assessment. ~~(may vary between jurisdictions).~~ In these cases the commercial standards apply.
Light rigid (LR) 	Any rigid vehicle greater than 4.5 tonnes GVM or a vehicle seating more than 12 adults, that is not more than 8 tonnes, plus a trailer of no more than 9 tonnes GVM.	
Medium rigid (MR) 	Any two-axle rigid vehicle greater than 8 tonnes GVM.	Commercial standards apply at all times. Refer Appendix 1 for periodic assessment requirements by jurisdiction.
Heavy rigid (HR) 	Any rigid vehicle with three or more axles greater than 8 tonnes GVM.	
Heavy combination (HC) 	Prime mover + single semi-trailer greater than 9 tonnes GVM and any unladen converter dolly trailer.	
Multiple combination (MC) 	Heavy combination vehicle with more than one trailer.	

Note:

- *A person who does not meet the commercial vehicle medical requirements may still be eligible to retain a private vehicle driver licence. In such cases, both sets of standards may need to be consulted.*
- *The standards are intended for application to drivers who drive within the ambit of ordinary road laws. Some drivers, such as emergency service and first responder vehicle drivers (e.g. ambulance, fire, police), are given special exemptions from these laws. Due to the nature of the work performed by these drivers (e.g. carrying passengers who may be unrestrained on stretchers or in locked vans, working shifts, under pressure) they should have a risk assessment and an appropriate level of medical standard applied by the employer. As a minimum they should always be considered under the commercial driver category.*