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**RACP submission to the National
Transport Commission's Assessing
Fitness to Drive 2021 review**

June 2021

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,863 physicians and 8,830 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

RACP Submission

Thank you for the opportunity to make a submission to the National Transport Commission's (NTC) Assessing Fitness to Drive 2021 review. We understand that the proposed amendments to the AFTD guidelines follow on from initial consultations with stakeholders, including the RACP, and that these changes aim to ensure the standards reflect current medical evidence and practice whilst meeting the practical needs of private and commercial vehicle drivers.

Introduction

The NTC's guidelines on Assessing Fitness to Drive (AFTD) are a valuable resource that aims to improve road safety in Australia by providing health professionals with guidance to:

- assess the fitness of their patients to drive;
- promote responsible behaviour in their patients;
- conduct medical examinations for licensing drivers as required by licensing authorities; and
- provide detail to inform conditional license decisions.

The RACP's Policy & Advocacy Team has consulted with relevant RACP committees to seek expert member input to inform this submission to the AFTD review. Fellows of the RACP's Australasian Faculty of Occupational and Environmental Medicine (AFOEM) who have extensive expertise and experience in the development and implementation of these guidelines have been the main contributors to this feedback.

Feedback

Part A – General Information

Section 2 – Principles of assessing fitness to drive

2.2.10 Drug and driving

The new section on medicinal cannabis is welcome. However, the content presented in this section could be clearer and should focus on providing practitioners with practical information.

We suggest including the following statement to improve clarity: "THC is responsible for the intoxicating effects of cannabis due to its action on CB1 cannabinoid receptors. Whereas CBD has a very wide range of pharmacological actions but no intoxicating effects. There are no restrictions around driving (private or commercial vehicles) while taking CBD-only products."¹

Section 3 Role and responsibilities

Table 2 on page 29 and paragraph 3.3 pages 31-35 cover the roles and responsibilities of health professionals in detail. However, we would suggest adding a very clear statement at the start of the document outlining that the person who is performing the assessment has a responsibility to the wider community and not just to the individual patient.

Part B – Medical standards

Fitness to drive overview flow chart

We recommend adding a paragraph to the flowchart box "unsure of fitness to drive" advising that some Driver Licensing Authorities (DLA) have a medical hotline to discuss problems and that some DLA have a medical panel to assess complicated cases.

Section 1.24 Blackouts of undetermined mechanism

Please see comments below regarding psychogenic epilepsy which should be managed as an "Exceptional Case".

¹ Arnold, Jonathon C., Tamara Nation, and Iain S. McGregor. "Prescribing medicinal cannabis." *Australian Prescriber* 43.5 (2020): 152.

Section 2.2.5 Implantable cardioverter defibrillators (ICD)

The relaxation of the standard previously prohibiting ICD for primary prevention, for example, in HCM hypertrophic cardiomyopathy (HCM) in commercial vehicle drivers is welcome. However, this needs to be made clear in the table regarding HCM, on page 85 and elsewhere.

Section 2.2.6 Aneurysms

The text in this section is helpful. However, the information contained on aneurysms in the table (page 82) is not clearly written and not reflective of the text in section 2.2.6:

Current text in the table	Recommendation for rewording
"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".	This should read - for all other aneurysms the diameter is less than 50 mm.

Table on page 86 - Congenital disorders

The improvement to the table is welcome and we recommend including an additional paragraph in the text regarding congenital conditions would be helpful.

Section 3.2.1 Hypoglycaemia

The additional point in preventing hypoglycaemic episodes is a welcome addition: "(...)wearing a continuous or flash glucose monitor, preferably with an active hypoglycaemia alert or alarm". However, we would recommend clarifying whether this applies only to insulin treated diabetics or to all drivers who have experienced a severe hypoglycaemic event when driving or at any other time.

Section 6.2 Seizures and epilepsy

The Interim Report includes a statement regarding "Psychogenic Non-epileptic Seizures (PNES)". It outlines that in the case of a commercial vehicle driver the default seizure standard applies i.e. exclusion for 10 years. This seems exceptionally severe given that, by definition, it is a psychiatric condition, and the chapter on psychiatry emphasises the need for individualisation of decisions regarding exclusion.

We therefore recommend changing applying the mandatory default standard to management as an **Exceptional Case** thereby permitting individualised management.

Section 7 Psychiatric conditions

We note that there is a relaxation of the monitoring of commercial vehicle drivers with a psychiatric condition as follows (page 168):

" 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. It is **strongly recommended** that a letter to the DLA from the treating psychiatrist agreeing to this management be required and similarly that the GP has also indicated willingness to undertake the considerable responsibilities. I.e., this change of management is simply not at the patient's/driver's discretion. This comment applies equally to the identical change proposed regarding substance misuse.

Section 8 Sleep Disorders

It is disappointing that a more thorough approach to screen for sleep apnoea has not been included in the standard given the importance of sleep apnoea and fatigue in fatal road crashes.

We recommend the NTC reconsiders the evidence regarding screening for "severe" disordered sleep with or without an associated "sleep syndrome". The detection of the truly severe sufferer of disordered sleep (with or without a sleep apnoea syndrome) and instituting treatment is a far better public health outcome not only for

obstructive sleep apnoea (OSA) related fatigue and road traffic accidents, but also for the better management of the inter-related diseases (particularly the management of diabetes, cardiovascular stroke risk, and ischemic heart disease which are highly relevant to the driver population).

The current protocol significantly detracts from good clinical practice based on the current and expanding evidence base concerning disordered sleep. There is a need for implementing a more robust and effective detection protocol than currently exists. This is particularly so, given the growing body of evidence concerning:

1. BMI >40 (or >35 with disease) as a threshold predictor of OSA, and especially when associated with the [Stop-Bang question set](#), (which is far more reliable than the Epworth Sleepiness Scale score - ESS) and
2. The accessibility and reliability of true positive home (Type 3) sleep studies using an average Apnea Hypopnea Index>30 as a threshold criteria. While the Type 3 studies do have a significant 'false negative' rate at lower levels of severity, this issue is readily manageable, and the individual can be managed sensitively by the combination of a trained GP supported by the growing network of sleep specialists.

Whilst advice on recognising key clinical parameters (BMI) is included, it is not a requirement that they be routinely assessed at least for commercial vehicle drivers. Measuring a patient's weight and height to calculate BMI is very straightforward and these simple parameters have been proven to be very useful as a screening tool in the rail industry. We therefore **strongly recommend** that the use of these simple screening criteria be reconsidered for commercial vehicle drivers.

In addition, we note the document indicates that those with ESS scores within 16-24 should receive additional assessment (p.171), and a reference from 2001² is used to suggest that those with ESS 11-16 only have a small increase in crash risk (p.172). However, a 2012 article from Sharwood et al³ showed approximately 41% of truck drivers recruited at Australian truck stops had changes consistent with sleep apnoea using a home detection device, despite only 12% reporting some daytime sleepiness as measured by an ESS >10.

We advise the NTC considers recommending the use of the StopBang questionnaire as a more reliable tool for measuring risk from sleep disorders in drivers than the ESS in conjunction with some biometrics such as BMI to prompt a more thorough assessment.

Section 9. Substance misuse

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. It is **strongly recommended** that a letter to the DLA from the treating specialist be required agreeing to this management and similarly that the GP has also indicated willingness to undertake the considerable responsibilities. I.e. this change of management is simply not at the patients/drivers discretion.

Section 10.2.8 Telescopic lenses (bioptic telescopes)

One of our members has advised that he has had previous discussions with the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) which raised considerable concerns regarding the safety of these devices and indicated that "individual assessment" is not sufficient. It is **strongly recommended** that it be stated "These devices are not acceptable for commercial vehicle drivers." And that the further opinion of RANZCO be sought.

Thank you again for the opportunity to provide feedback to inform the NTC's AFTD 2021 review. Should you require any further information about this submission, please contact Claire Celia, Senior Policy & Advocacy Officer, via Claire.Celia@racp.edu.au.

² Mehta, Atul, et al. "A randomized, controlled study of a mandibular advancement splint for obstructive sleep apnea." *American journal of respiratory and critical care medicine* 163.6 (2001): 1457-1461.

³ Sharwood, L. N., Elkington, J., Stevenson, M., Grunstein, R. R., Meuleners, L., Ivers, R. Q., ... & Wong, K. K. (2012). Assessing sleepiness and sleep disorders in Australian long-distance commercial vehicle drivers: self-report versus an "at home" monitoring device. *Sleep*, 35(4), 469-475.