Are the proposed changes to Assessing Fitness to Drive appropriate? Please comment on matters relevant to the topic and provide evidence (i.e., data, research or documentation) to support your views. Where possible, also provide a proposed solution (i.e., corrective wording) to the issues identified.

The Mild Cognitive Impairment section under Dementia page 120 could be improved. The information is not necessarily accurate. It indicates memory is usually the domain impaired, this is not the case. Many times when vascular impairment is the cause of MCI there is slow processing and reduced attention but not necessarily a prominent memory impairment. In fact slow processing speed and reduced attention are domains imperative for driving and therefore a practical assessment is likely required. Also, other health factors contributing to the MCI should be considered including; sleep apnoea, depression, chronic pain and cardio-vascular disease (diabetes, stroke and other emerging motor deficits as well). I think the phrase 'case by case basis' would be a very useful one in this area, depending upon domains of impairment, driving history and level of insight into cognitive changes.

"However, the characteristic neuropsychological profile of vascular cognitive impairment, particularly subcortical ischaemic vascular disease, is believed to frequently include early impairment of attention and executive function, with slowing of motor performance and information processing.31, 70 Episodic memory is believed to be relatively spared compared with that in Alzheimer's disease.32 Other cognitive functions are variably affected dependent on the pathological substrate in individual cases." O'Brien, J., T., et al (2003). Vascular Cognitive Impairment. The Lancet: Neurology, 2, 2, 2003, page 89-98. https://doi.org/10.1016/S1474-4422(03)00305-3

I understand there has also been submissions from the CDAMS (Cognitive Dementia and Memory Service) network in Victoria regarding the addition of terms such as prodromal and preclinical dementia. In my opinion, this will create confusion for general practitioners and anyone who is not a specialist in the field. Prodromal dementia could be captured under MCI and pre-clinical dementia as identified using biomarkers +/- subtle cognitive changes not impacting function. https://practicalneurology.com/articles/2019-june/preclinical-prodromal-and-dementia-stages-ofalzheimers-disease

In the dementia section it also appears that people are eligible to hold a commercial licence – this doesn't seem like it should be correct… Surely people driving a bus or a taxi should have a diagnosed dementia…

Please describe your experience using the current Assessing Fitness to Drive medical criteria or supporting information. What sections or content are most valuable? How could the document and support materials be improved?

As an OT driver assessor I need to regularly support doctors with interpretation of the guidelines. For some reason, doctors don't realise that they are providing an opinion on whether the patient is medically fit to hold a licence to drive, they want to defer the decision to OT after practical assessment. It needs to be emphasied in the guidelines that practical driver assessment is only

appropriate if the patient is medically fit to be tested and the medical fitness should be established prior to a practical/functional assessment of driving skills. Also I think it's important to stipulate in writing that OT Driver Assessors have the right to a safe working environment and this needs to be considered prior to referral for a practical assessment. I've sustained whiplash multiple times from the driving instructor having to brake suddenly with patients who have dementia. This is a significant factor in considering whether I will consider employment in such a role. The OT's right to a safe working environment is an actual right whereas doctors seem to think patients have the 'right' to undertake a practical assessment which is not the case and should be stipulated.

Also, when OT's recommend a practical re-assessment in 12 months - doctors should be encouraged to consider this when the periodic medical review is requested. eg. many times the GP will write on the 12mth medical report that practical reassessment is not required and the licencing authority accept this. Then family call the OT Driver Assessor concerned that a reassessment has not occurred. Then the whole cycle starts again and I have to contact the GP and tell them how to complete the medical report and explain that a reassessment is required (despite having posted my report to the doctor 12 months prior clearly recommending an on-road reassessment).

What support or training could be provided to health care professionals to increase usage and knowledge of the guidelines?

Neurologists rarely consider how cognitive problems impact driving and they rarely consider cognition when assessing fitness to drive. There is a significant body of education required for Neurologists. Education in this area could be conducted in conjunction with the Stroke Foundation.

Many medical practitioners need support and education regarding how to fill in the medical report form. They don't know how to translate their clinical reasoning into the form and don't understand what the various boxes mean. This is more a state by state issue than national.

Written concise resources would be useful doctors often don’t have time to read the guidelines book, they’d rather just ask and be told what to do which isn’t good enough.

I think a dedicated hotline for medical practitioners to call and get advice would be useful.

I also think it would be useful if there were more dedicated advertising campaigns regarding road safety and medical conditions. This would make discussion of medical issues impacting driving more broadly understood in society.

Red flags for conditions likely to impair driving would be useful for GPs. Seizures and eyesight are reasonably well understood, why isn’t the impact of peripheral neuropathy well understood?