Driving Regulations and Fitness to Drive for Brain Tumour Patients

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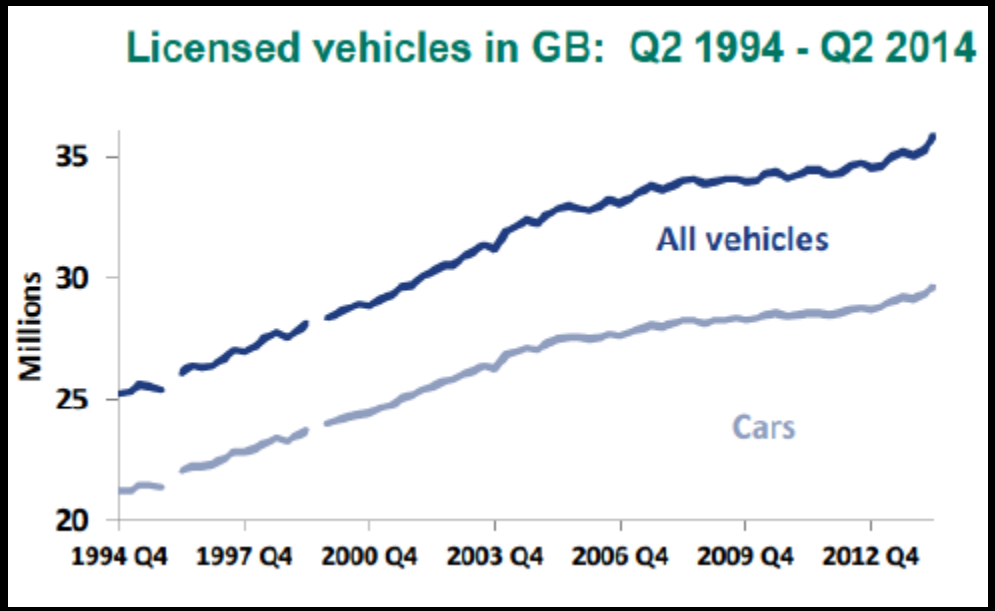
Nurse and AHP Day

Drivers

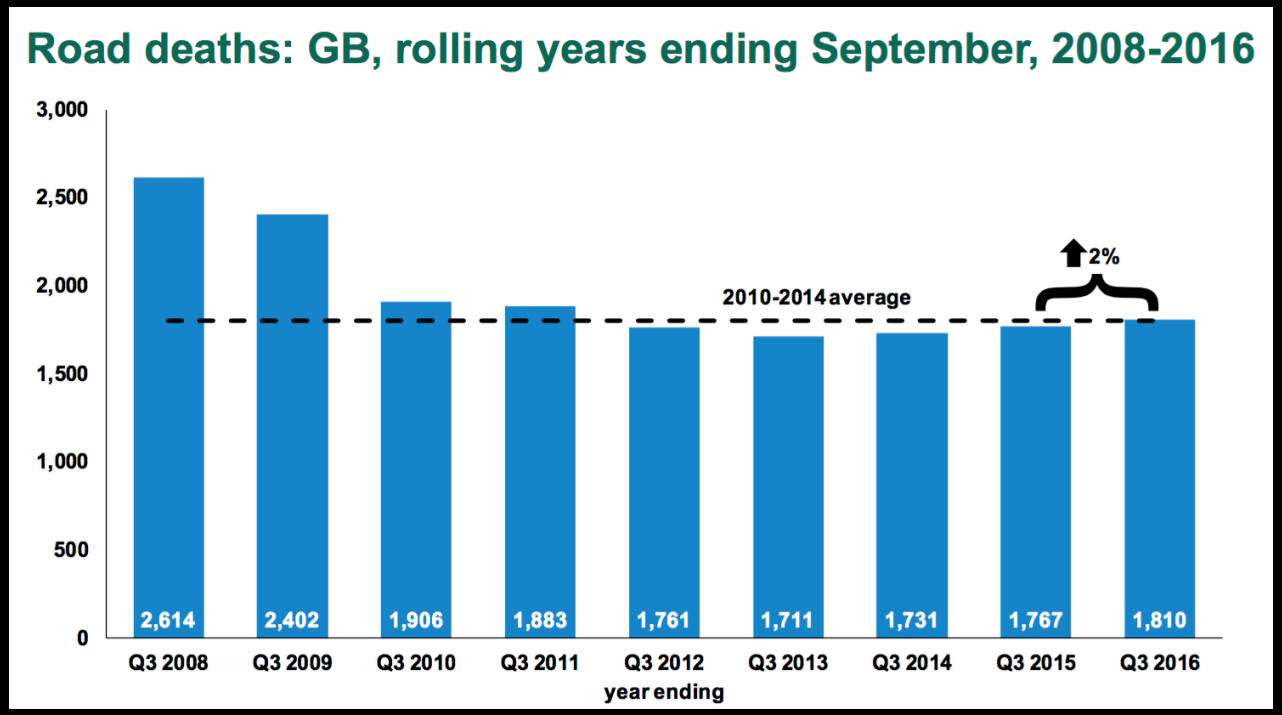
- At the end of Jun 2014 there were a total of 35.8 million vehicles licensed in Great Britain, an increase of 4.2 million (14 per cent) since the end of 2001
- There are 35.4m driving licence holders



Driving Tests Taken in GB
2004/5 vs 2013/14

	2004/5	20013/4
Tests Taken	1,668,000	1,477,585
Tests Passed	706,000	695,580
Pass Rate	42%	47%
% Pop with DL	70%	72%

Injury from Road Traffic Accidents



- **Killed or seriously injured casualties** (KSIs) **increased by 6 per cent** to 25,160 compared with the year ending September 2015.

Injury Risks : Medical Conditions

The top ten most common causes of traffic accidents are:

- Failed to look properly 35%
- Failed to judge other persons's path or speed 18.9%
- Careless, reckless or in a hurry 16.2%
- Loss of control 14.7%
- Poor turn or manoeuvre 14.1%
- Travelling too fast for the conditions 10.2%
- Slippery road due to weather 10.1%
- Pedestrian failed to look properly 7.2%
- Sudden braking 7.2%
- Following too close 6.7%

? Medical Conditions

	Fatal	Serious	Slight	All
Impairment or Distraction	**19.6%**	**14.2%**	**11.1%**	**11.7%**
Impaired by alcohol	9.6%	7.4%	4.7%	5.2%
Distraction in vehicle	2.6%	1.7%	2.1%	2.1%
Fatigue	3.1%	1.8%	1.3%	1.4%
Distraction outside vehicle	1.0%	1.0%	1.5%	1.4%
Illness or disability, mental of physical	3.6%	1.8%	1.2%	1.3%
Impaired by drugs (illicit or medicinal)	2.2%	0.9%	0.4%	0.5%
Not displaying lights at night or in poor visibility	0.4%	0.4%	0.3%	0.3%
Cyclist wearing dark clothing at night	0.4%	0.4%	0.3%	0.3%
Driver using mobile phone	0.8%	0.3%	0.2%	0.2%
Uncorrected, defective eyesight	0.4%	0.2%	0.1%	0.2%

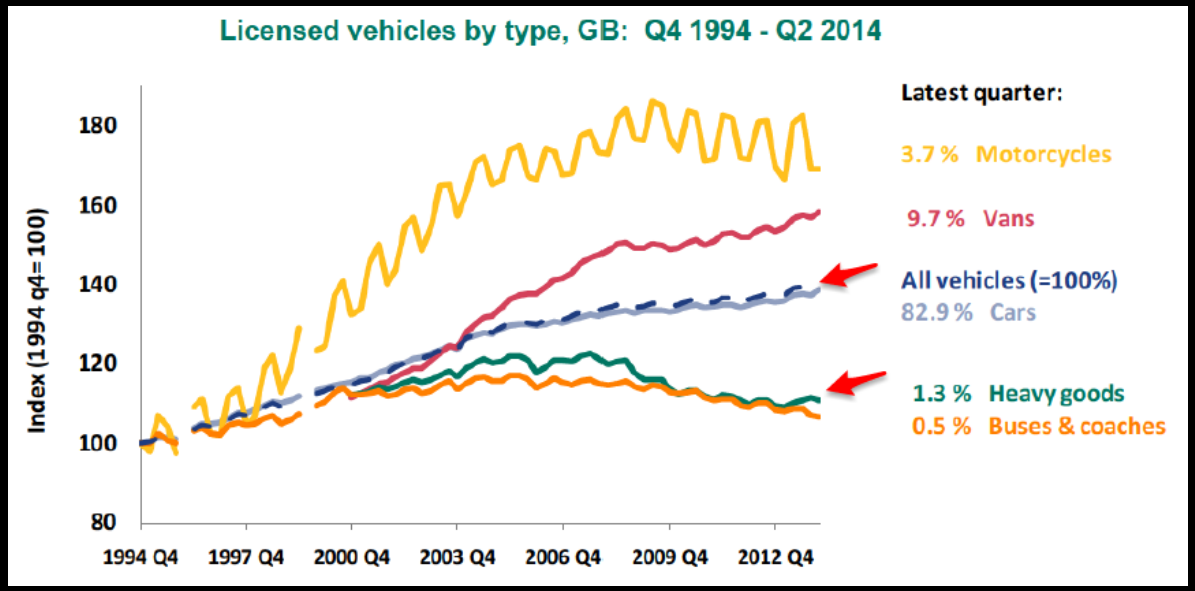
Directly attributed = 10% causative
Indirectly attributed = 5% associated

Injury Risks:

Fatal and serious casualty rates per 100m vehicle Km in GB

	Drivers/Riders	All Casualties*
Cycles	60	62
M.Cycles and Scooters	121	138
Cars	2.6	7
Light Goods	0.8	4
Heavy Goods (>7.5 T)	1.2	8

Vehicle No's and Patterns of Use



Reflects relative road use

Car Drivers : Short trips average time 9.7 min (973)
HGV Drivers : Long trips Vocational

average car driver ~10,000Km/yr
Average HGV driver~100,000Km/yr

Licensing Issues

- Crash risks are highest in new , young, male drivers. There is a small increase late in life.
- Driving brings mobility benefits to all and especially to those with disabilities and for older people
- Advice on fitness to drive should form an integral part of many clinical consultations.
- Current standards have evolved and are based on a mix of evidence , expert opinion and experience in use.
- Currently there is as yet, no direct linkage between accident data and notifiable conditions

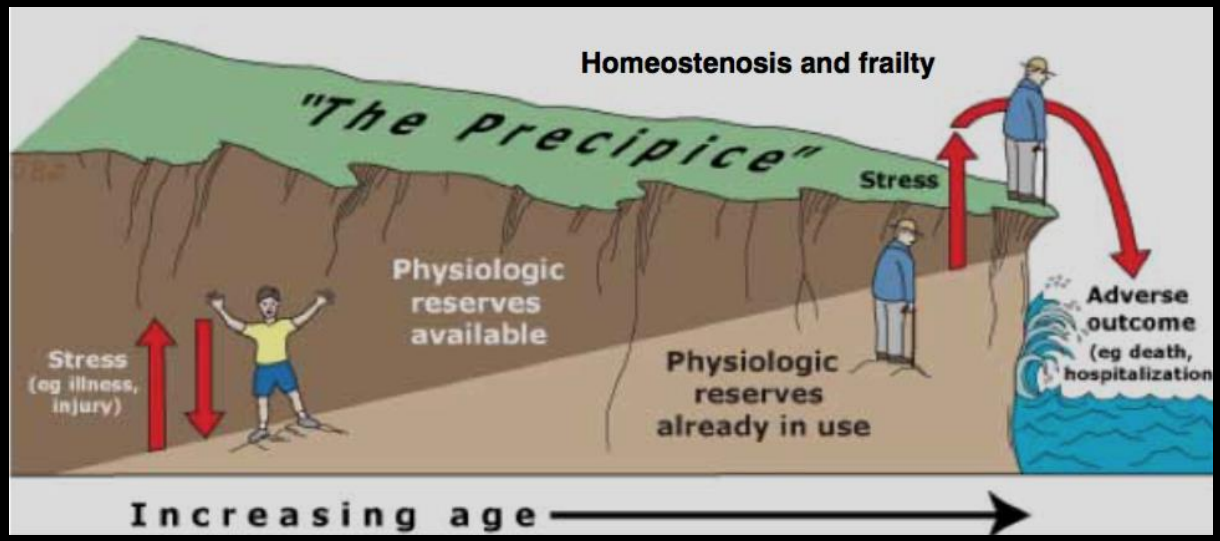


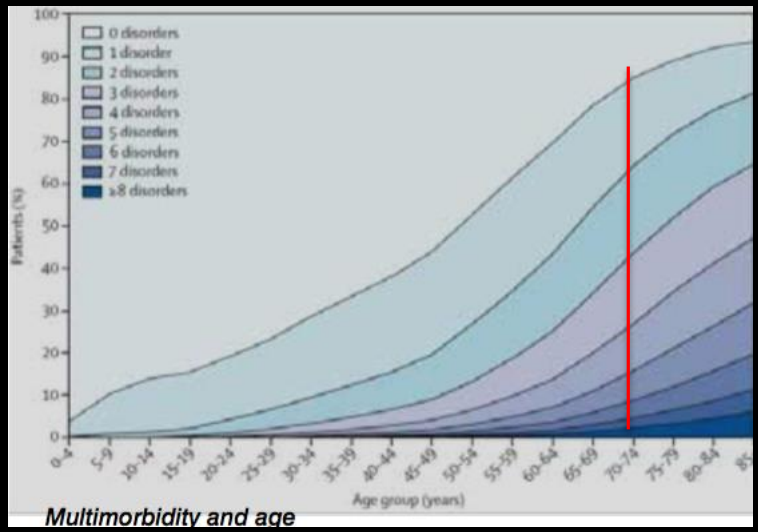

Medical Standards: License Groups

- The medical standards refer to Group 1 and Group 2 licence holders.
- Group 1 includes motor cars and motor cycles.
- Group 2 includes large lorries (category C) and buses (category D).

- The medical standards for Group 2 drivers are very much higher than those for Group 1 because of the size and weight of the vehicle. This also reflects the higher risk caused by the length of time the driver may spend at the wheel in the course of his/her occupation.

DVLA Regulations and age





Multimorbidity and age

Group 1: Age and Retention

- Group1: Licences are normally issued valid until age 70 years (Till 70 licence) unless restricted to a shorter duration for medical reasons
- There is no upper limit but after age 70 a renewal is necessary every 3 years.
- All licence applications require a medical self declaration by the applicant.
- There are ~ 120 drivers over the age of 100y

Group 2: Age and Retention

- Group 2:issued at age 21 years (18 +CPC) and are valid till age 45
- Group 2 licences are renewable thereafter every five years to age 65 years unless restricted to a shorter period for medical reasons.
- From age 65 years, Group 2 licences are renewable annually without upper age limit.
- All Group 2 licence applications must be accompanied by a completed medical application form D4.




THE DRIVING RULE

In the interests of road safety, those who suffer from a medical condition likely to cause a sudden disabling event at the wheel or who are unable to safely control their vehicle from any other cause, should not drive.

Important Questions for Drivers

- 1. Will my neurological condition affect my driving?
- 2. Will I lose my licence and if so, for how long?
- 3. When do I tell the DVLA?
- 4. What and how do I tell the DVLA?
- 5. What happens next?
- 6. When do I get my licence back?
- 7. How do I reapply for my licence?
- 8. When can I start driving again?
- 9. What are my options if I feel I am not being treated fairly?
- 10. What do I do if my consultant is delaying the process?

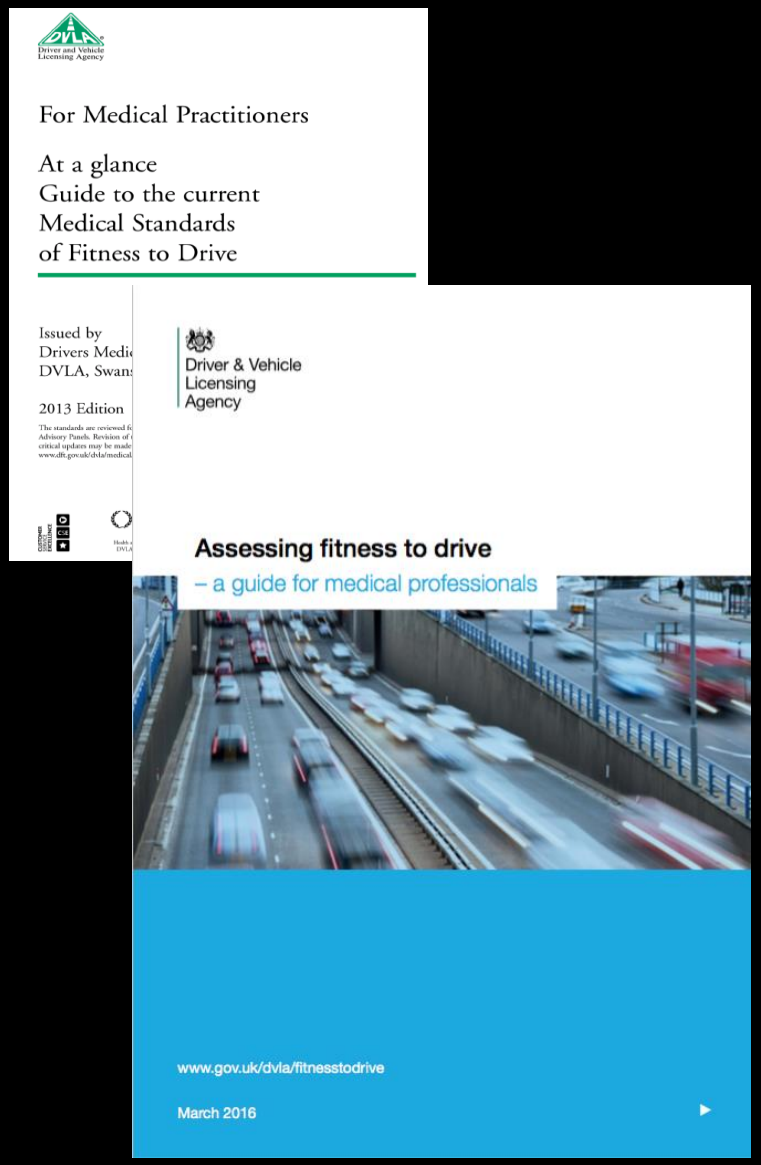
Conditions Requiring Notification

Likely------Sudden Disabling Events*-----Unlikely

- Epilepsy
- Fits or Blackouts
- Repeated attacks of sudden disabling giddiness
- Diabetes controlled by Insulin
- Diabetes controlled by Tablets
- Implanted Cardiac Pacemaker
- Implanted cardiac defibrillator (ICD)
- Angina easily brought on by driving
- Parkinson's Disease
- Narcolepsy or Sleep Apnoea Syndrome
- Stroke – symptoms >1 month
- Brain Surgery
- Head injury requiring in-patient treatment
- Brain Tumour
- Cranial/Brain Irradiation

- Severe learning disability
- Serious problem with memory or episodes of confusion
- Other chronic /progressive neurological conditions
- Persistent drug use or dependency
- Persistent alcohol misuse or dependency
- Serious psychiatric Illness
- Total loss of sight in one eye
- Any condition affecting both eyes* or remaining eye
- Any condition affecting visual fields
- Any persisting limb problem which
- requires driving to be restricted
- to certain types of vehicle

*80% of theses events are cardiac related



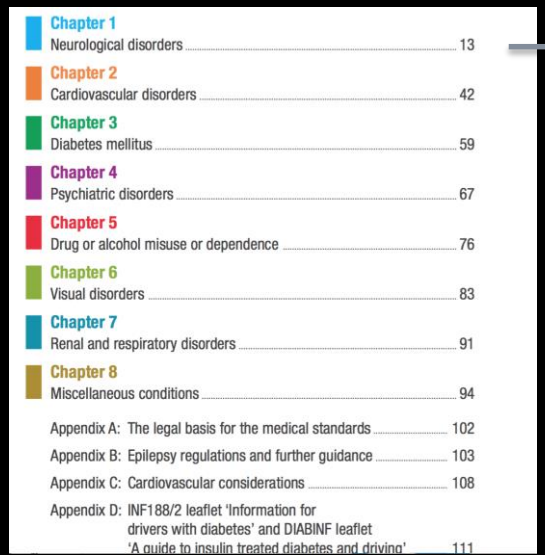
Google UK

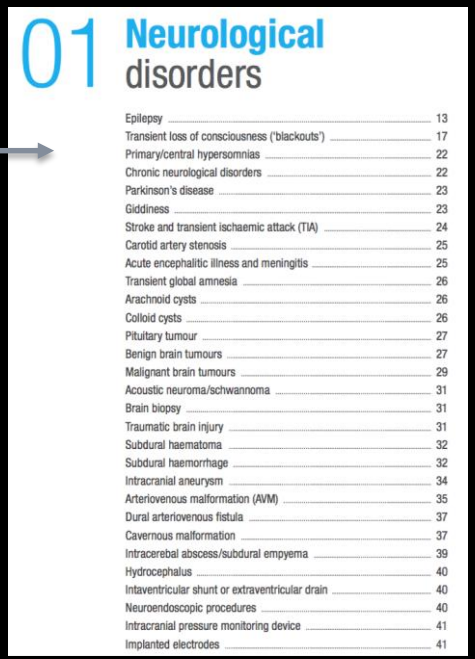
' DVLA Assessing Fitness to Drive' downloadable .pdf

New Format Advice to Doctors

DVLA Information to Patients

- Old ‘A to Z’ of conditions currently being updated- to reflect many changes- UNRELIABLE
- ‘At a Glance….’ now updated and replaced by ‘Assessing Fitness to Drive Aguide for medical professionals’ – This THE Standard
- Easily assessed by patients as downloadable .pdf
- Index to conditions on





Notification to DVLA

- DVLA has the power to withdraw a driving licence
- It is the legal duty of the licence holder or licence applicant to notify DVLA of any medical condition, which may affect safe driving

Notification to DVLA

- Any doctor who is asked for an opinion about a patient's fitness to drive should explain the likely outcome to the patient by reference to this booklet*

  * 'Assessing Fitness to Drive' Medical Rules for drivers.

- If there is any doubt about applying the rules then inform the licence holder/applicant to contact the Drivers Medical Group, DVLA for a decision.

GLASGOW BIN LORRY CRASH

Glasgow bin lorry crash private prosecution plans rejected by Lord Advocate

27-01-2016

GLASGOW

FRANK Mulholland has declined to support victims' families in their bid for the private prosecution of Harry Clarke and it is now likely to be ruled on by High Court judges.

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Glasgow bin lorry FAI: Driver Harry Clarke 'repeatedly lied' to keep jobs and licence, inquiry finds

The inquiry raises awareness of the 'dangers involved in driving if subject to a medical condition which could cause the driver to lose control of a vehicle'.

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Notification to DVLA: Dr's Responsibility

- If you do not manage to persuade patients to stop driving where this is indicated, or you are given or find evidence that a patient is continuing to drive contrary to advice, you should disclose relevant medical information immediately, in confidence, to the medical adviser at DVLA (GMC advice)
- Before giving information to the DVLA you should inform the patient of your decision to do so. Once the DVLA has been informed, you should also write to the patient, to confirm that a disclosure has been made.




DVLA and Neurological Disorders

- DVLA Neurology Panel
- DVLA Medical Advisors 24

- Risk of a disabling event whilst at the wheel
- Group 1 threshold 20%* (cars etc)
- Group 2 threshold 2%* (HGV)

Incidence Seizures and Epilepsy

- ♦ Seizures
  - Incidence: 80/100,000 per year
  - 60% will have a second seizure* > Dx Epilepsy
  - Lifetime incidence: 9%
    (1/3 febrile convulsions)

Potential for 35.4 x 800 = 28,320 drivers to have a seizure in any year !!

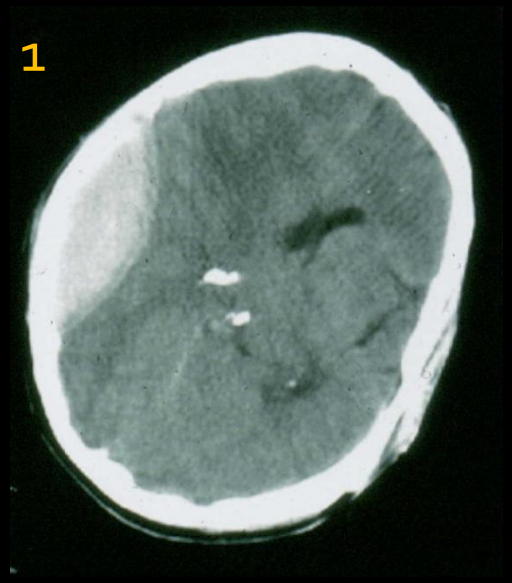
* DVLA / EU Directive III – up to 5y apart

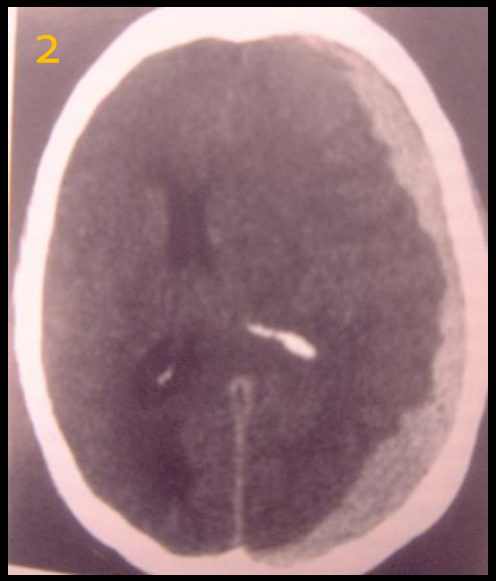
The Epilepsy Regulations

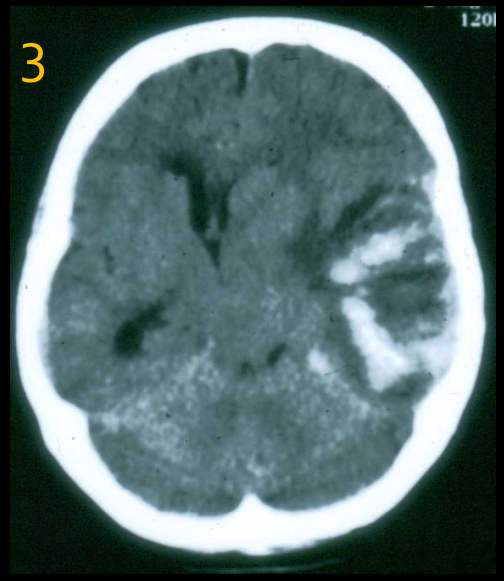
	Group 1 car and motorcycle	Group 2 bus and lorry
Epilepsy or multiple unprovoked seizures	Must not drive and must notify the DVLA. Provided the licence holder or applicant satisfies the regulations, a review licence will usually be issued. If there have been no seizures for 5 years (with medication if necessary), and no other disqualifying condition, a 'til 70 licence is usually restored.	Must not drive and must notify the DVLA. The person with epilepsy must remain seizure-free for 10 years (without epilepsy medication) before licensing may be considered.
First unprovoked epileptic seizure/ isolated seizure	Must not drive and must notify the DVLA. Driving will be prohibited for 6 months from the date of the seizure. Clinical factors that indicate that there may be an increased risk of seizures require the DVLA not to consider licensing until after 12 months from the date of the first seizure.	Must not drive and must notify the DVLA. Driving will be prohibited for 5 years from the date of the seizure. If, after 5 years, a neurologist has made a recent assessment and clinical factors or investigation results (for example, EEG or brain scan) indicate no annual risk greater than 2% of a further seizure, the licence may be restored. Such licensing also requires that there has been no need for epilepsy medication throughout the 5 years up to the date of the licence being restored. If the prospective annual risk of further seizure is greater than 2%, the epilepsy regulations may apply.

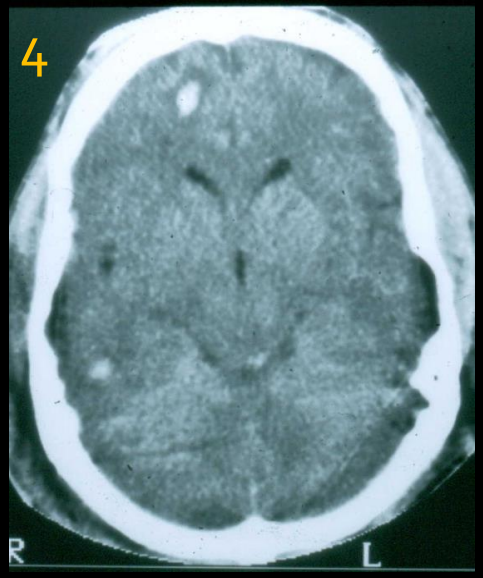
The applicant or licence holder must notify DVLA unless stated otherwise in the text

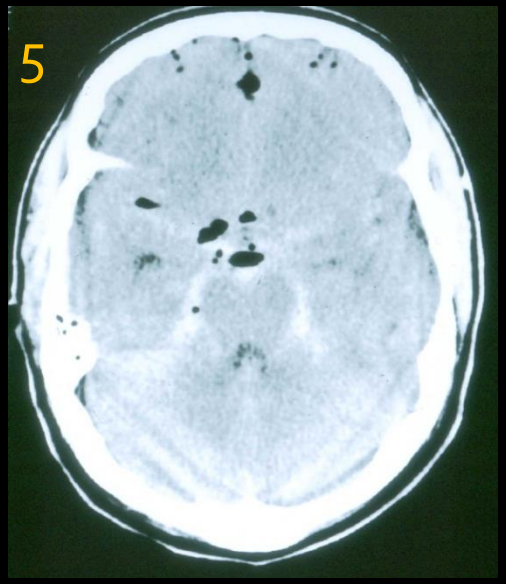
Head Injury: Surgical Indications

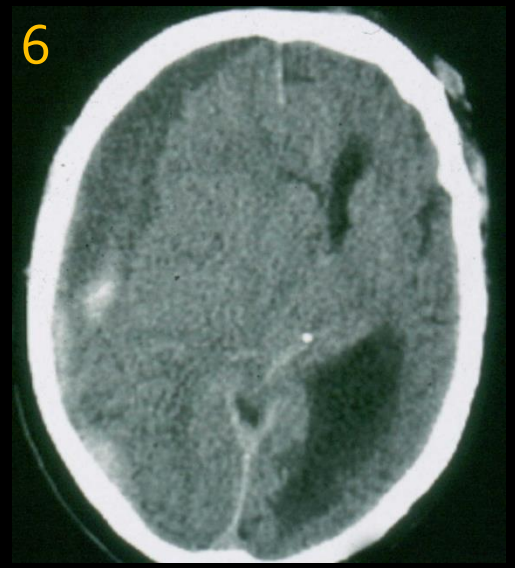












What is Seizure Risk after TBI…?

- Risk of seizures after TBI ~5%
- BUT greatest risk is in first few months
- Our interest is in prospective risk* for an Individual
- BUT all data is population based so very difficult to stratify risk for individuals

* …..in next year

Source Data

- Jennett etal 1980's (pre CT)
- Annegers et al 1998
- Christensen et al 2009

- All are population based studies and hence insensitive to individual risk
- Classification of head injuries into severity varies and is complicated

Jennett: Epilepsy and TBI

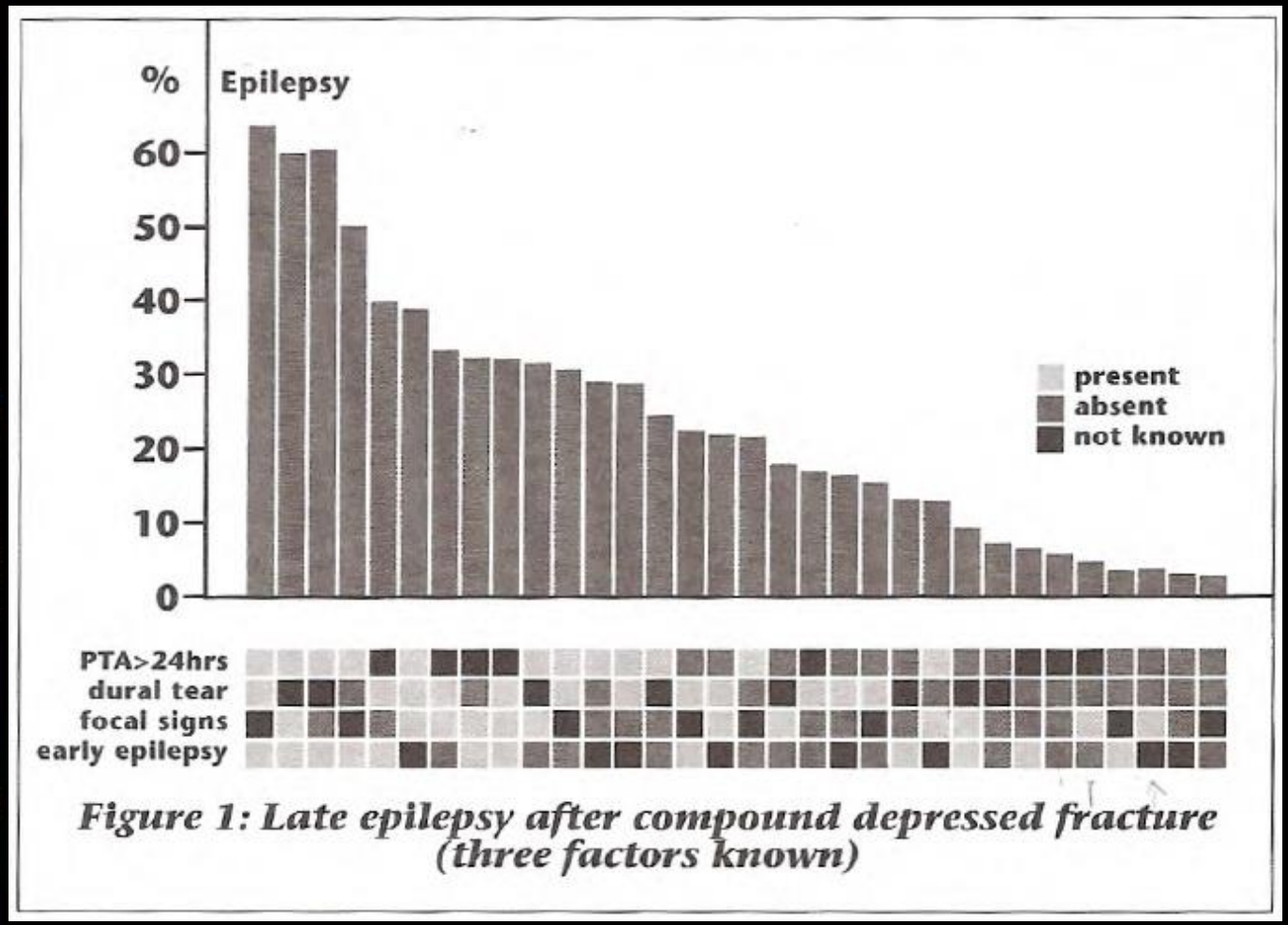


Figure 1: Late epilepsy after compound depressed fracture (three factors known)

Jennett's Original Table of risk of Residual Epilepsy

Initial % Risk of Epilespsy	1	2	3	4	5	6	7	8	9	10	Years after injury
6%	3	2	1.5	1							
10%	5	3	2.5	2	1.5	1					
15%	7	5	4	3	2.5	2	1				
20	10	7	5	4.5	3.5	3	2	1.5	1		
25	13	9	7	6	5	4	2.5	2	1.5	1	
30	16	12	9	7.5	6	5	3	3	2	1	
35	19	14	11	9	7.5	6	4	3.5	2.5	1.5	
40	23	17	13	11	9	7	5	4.5	3	2	
45	27	20	16	14	11	9	6	5	4	2	
50	31	24	19	16	13	11	7	6.5	5	3	
55	35	28	22	19	16	13	9	8	6	3.5	
60	40	32	26	22	18	15	11	10	7	4	

Residual % risk of epilepsy occurring after years of fit-free interval after differ initial risk levels for craniotomy head injury patients (Jennett 1988).

Group I driving is NOT recommended until the risk of fits is below 20% and Group II driving until the current risk of fits is below 2%

For example a head injury victim with an initial risk of epilepsy of 35% would not be able to drive group II until 10 years after injury.

NB: Risk in the next year NOTOverall ie 10y

Temkin .....

TABLE 1. *Factors associated with early posttraumatic seizures*

	Incidence of early posttraumatic seizures (%)
Depressed skull fracture	27
Subdural hematoma	24
Intracerebral hematoma	23
Penetrating head injury	20
Glasgow Coma Scale $\leq$ 10	20
Epidural hematoma	17
Cortical contusion	16
Immediate seizures	28[b]
Linear fracture[a]	6
Posttraumatic amnesia >24 h[a]	12
No or brief unconsciousness[a]	6
No or brief unconsciousness, age younger than 5 years[a]	17

Data are from 196 placebo-treated cases in the authors' series unless indicated otherwise. From Temkin NR, Haglund MM, Winn HR. Post-traumatic seizures. In: Youmans JR, ed. *Neurological surgery.* 4th ed. Philadelphia: WB Saunders, 1996:1834–9, with permission.

[a] Jennett, 1975 (2).

[b] Delayed early seizures.

Annegers 1998

The New England Journal of Medicine

A POPULATION-BASED STUDY OF SEIZURES AFTER TRAUMATIC BRAIN INJURIES

JOHN F. ANNEGERS, PH.D., W. ALLEN HAUSER, M.D., SHARON P. COAN, M.S., AND WALTER A. ROCCA, M.D., M.P.H.

ABSTRACT

Background The risk of seizures is increased after traumatic brain injury, but the extent and duration of the increase in risk are unknown. The purpose of this study was to identify the characteristics of brain injuries that are associated with the development of

We studied post-traumatic seizures in Olmsted County, Minnesota, for the 50-year period from 1935 through 1984, with follow-up extended to the end of 1994. This study is a continuation of our study of post-traumatic seizures during the interval

Annegers

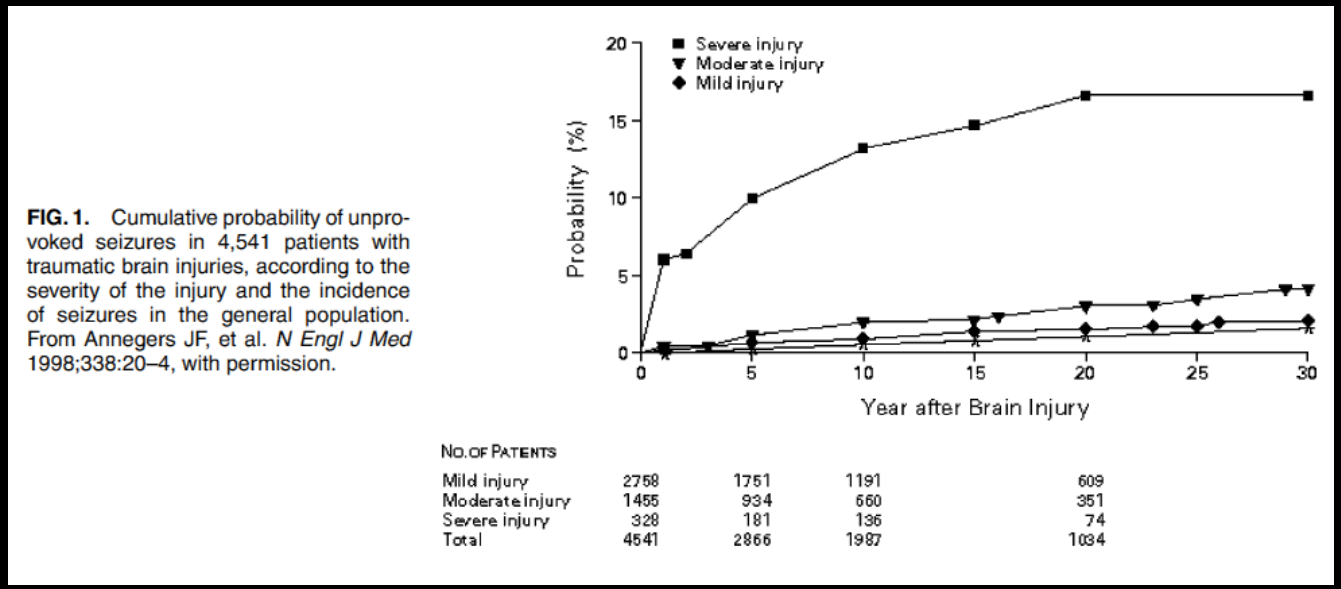
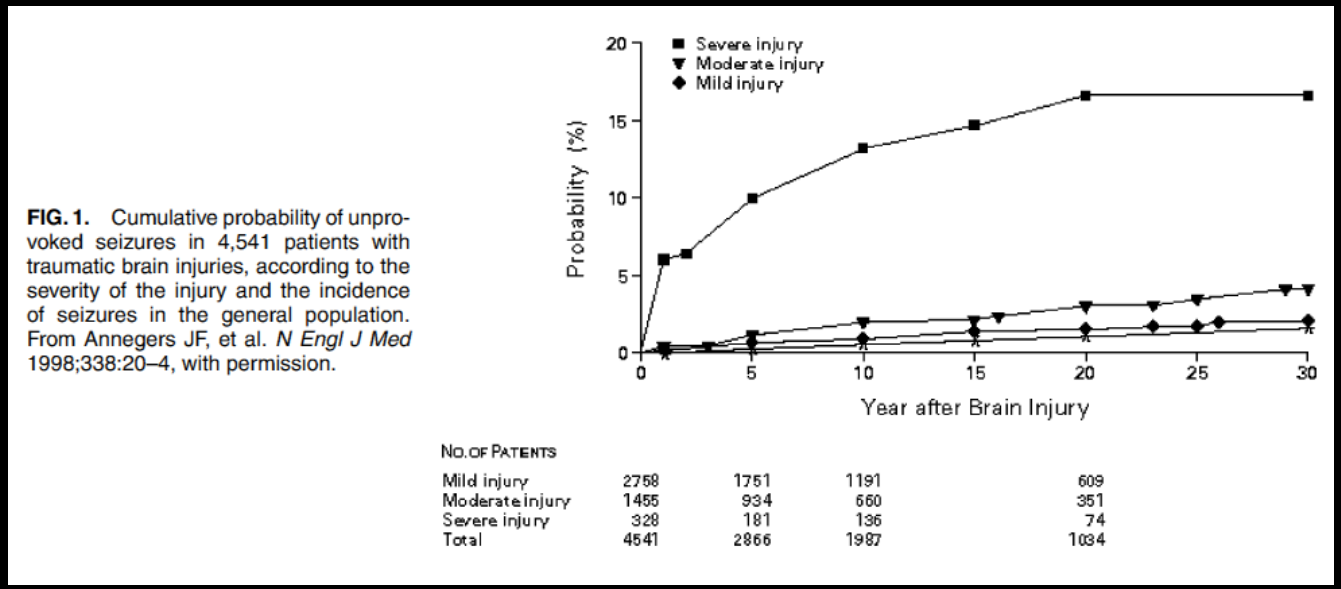


FIG. 1. Cumulative probability of unprovoked seizures in 4,541 patients with traumatic brain injuries, according to the severity of the injury and the incidence of seizures in the general population. From Annegers JF, et al. *N Engl J Med* 1998;338:20–4, with permission.

NO. OF PATIENTS				
Mild injury	2758	1751	1191	609
Moderate injury	1455	934	660	351
Severe injury	328	181	136	74
Total	4541	2866	1987	1034

Annegers



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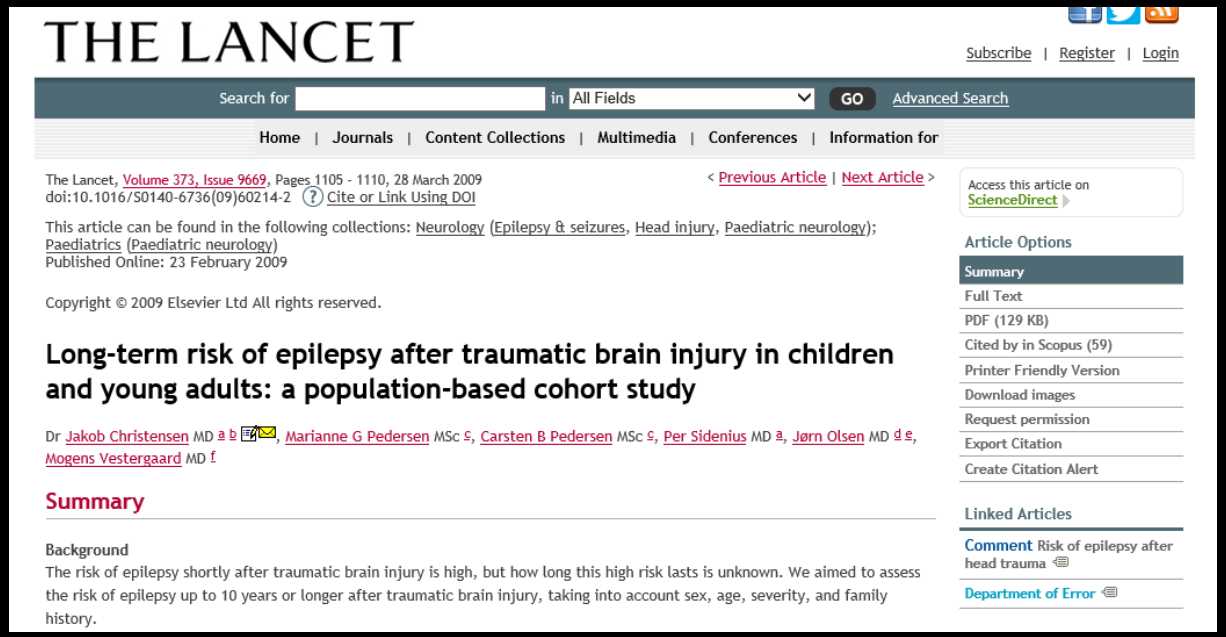
Christensen 2009



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Published Online: 23 February 2009

Long-term risk of epilepsy after traumatic brain injury in children and young adults: a population-based cohort study

Dr Jakob Christensen MD [a] [b], Marianne G Pedersen MSc [c], Carsten B Pedersen MSc [c], Per Sidenius MD [a], Jørn Olsen MD [d] [e], Mogens Vestergaard MD [f]

Summary

Background
The risk of epilepsy shortly after traumatic brain injury is high, but how long this high risk lasts is unknown. We aimed to assess the risk of epilepsy up to 10 years or longer after traumatic brain injury, taking into account sex, age, severity, and family history.

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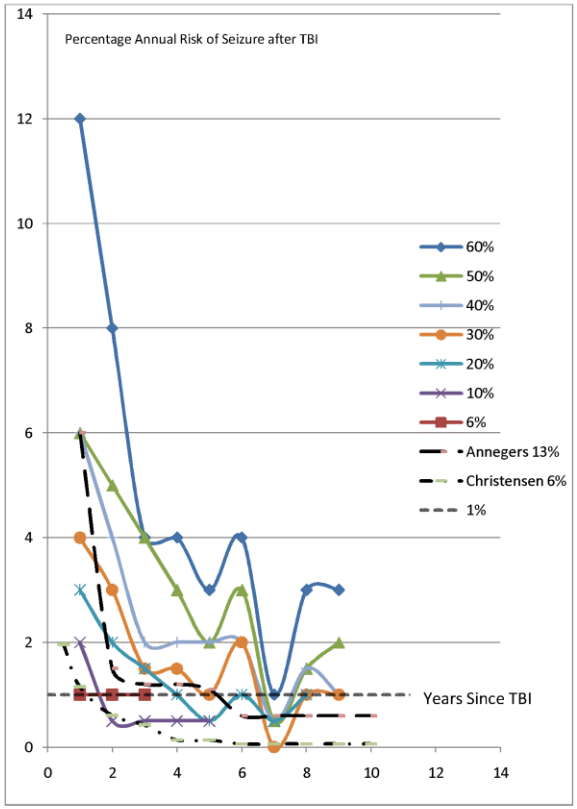
- Department of Error

Summary Table….

	Loss of Consciousness	Post Traumatic Amnesia >24hrs	Focal Signs	Contusion (CT Appearance)	Traumatic Intracranial Haemorrhage	Skull Fracture	Dural Tear	Early Epilepsy	Classification of Severity	10y post TBI risk of Seizure
Jennett (1988)		Present Absent Unknown <u>Egs.</u> Present Present Absent	Present Absent Unknown Present Absent Present		 (Present)		Present Absent Unknown	Present Absent Unknown	presence, absence or unknown of these factors to give a 10yr risk of seizures Ie from 6 to 60%	6- 60% (30%) 20% 13% 3%
Annegers (1998)	>24hrs 30'-24hrs <30'	>24hrs		Present	Present	 Present Absent			<u>Severe</u> one or more of these features <u>Moderate</u> either of these features <u>Mild</u> brief LOC only	13% 2% 1%
Christensen (2009)	?Included in ICD S06.0 Concussion	?Included in ICD	?included in ICD	ICD 06.1, 06.2,06.3 Cerebral contusions, lacerations Traumatic oedema	ICD 06.4-06.9 Extradural Subdural Subarachnoid Cerebellar	ICD 02.0-1,02.7,02.9 Frontal Parietal Orbital Roof Skull Base			<u>Severe</u> one or more of these features <u>Mild</u> ie brief LOC only	~6% >1%

Multiple Plots of 'Annual Risk of seizure' at Time in 'Years after TBI'. The Data for Jennett is derived from Jennett 1988 by calculating the difference in residual risk (10y) between successive years. Jennett expresses 10yr risk of seizures ie severity (see 6 -60% plots), in terms of an aggregate of factors to give an overall beginning risk of developing a seizure. The plots for Annegers (1989) and Christensen(2009) relate to annual risk of epilepsy for their individual classification of 'Severe'.



Cruickshank GS
In *Neurosciences and the Practise of Aviation Medicine* 2011
Ch 16 TBI and Aeromedical Licensing

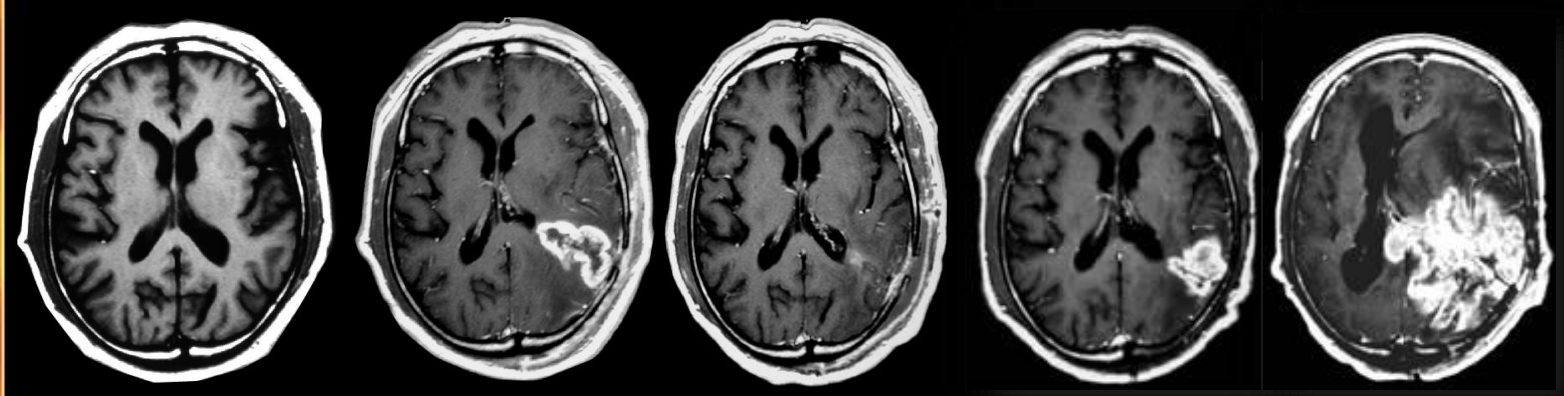
Section 92 of the Road Traffic Act 1988 refers to prescribed, relevant and prospective disabilities.

• A prescribed disability is one that is a legal bar to the holding of the licence. Certain statutory conditions, defined in regulation, may need to be met. An example is epilepsy.

• A relevant disability is any medical condition that is likely to render the person a source of danger while driving. An example is a visual field defect.

• A prospective disability is any medical condition, which, because of its progressive or intermittent nature may develop into a prescribed or relevant disability in the course of time. An example is insulin treated diabetes. A driver with a prospective disability may normally only hold a driving licence subject to medical review in one, two or three years.

Brain Tumours

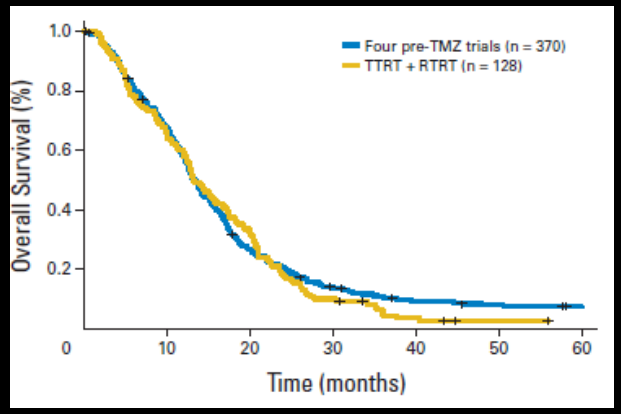


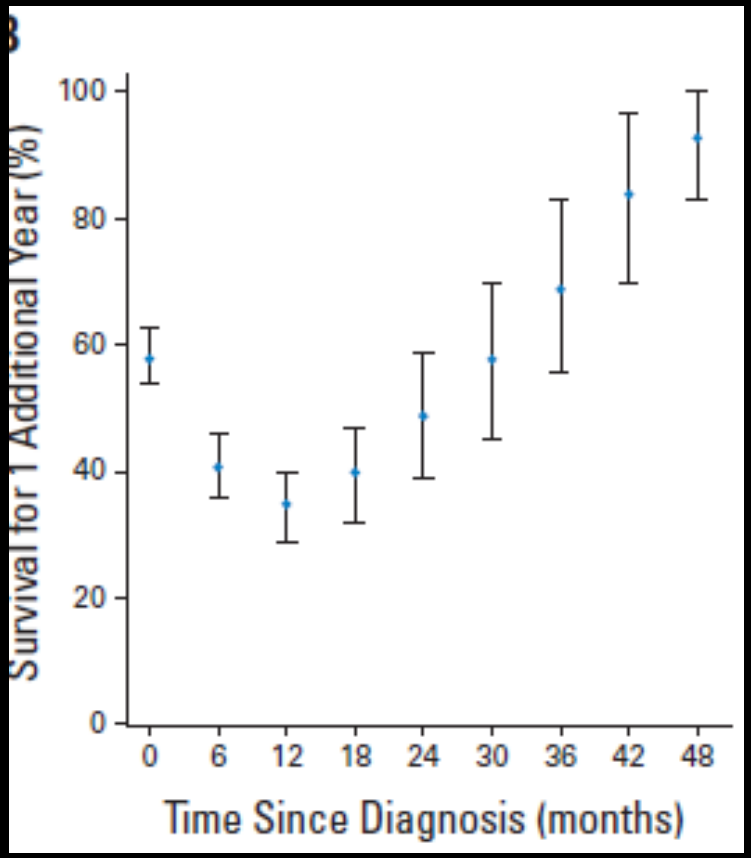
Glioblastoma 18/12

Two Criteria

1. Risk of epilepsy in next year - disease / surgery
2. Risk of progressive morbidity in next year

Assessing Morbidity Risk





Conditional probability of surviving an additional year at various time points

The conditional probability of Survival (...and progressive morbidity) is defined as the probability of surviving to some Y years after diagnosis given survival to some X (X Y) years and can be estimated from Kaplan-Meier data.

For example, the conditional probability of surviving to 4 years given survival to 1 year can be calculated by dividing the 4-year survival rate by the 1-year survival rate

Prados M. et al 2009 JCO

Benign brain tumours

	Group 1 car and motorcycle	Group 2 bus and lorry
Benign supratentorial tumour (WHO grade I meningioma, for example)		
Treated by craniotomy	● Must not drive but need not notify the DVLA. Driving may resume after 6 months provided there is no debarring residual impairment likely to affect safe driving. The epilepsy regulations (see Appendix B, page 103) apply if there is relevant seizure history.	● Must not drive and must notify the DVLA. The licence will be refused or revoked. In the absence of any seizures and with evidence of complete tumour removal, relicensing may be considered 5 years after the surgery. If the tumour is associated with seizure, relicensing will not be considered until 10 years after surgery, provided these years are free from seizures without epilepsy medication. Specialist assessment may be required.
Treated by stereotactic radiosurgery	▲ Should not drive unless, in the view of an appropriate healthcare professional, it is safe to do so. Need not notify the DVLA. Driving may resume after 1 month provided there is no debarring residual impairment likely to affect safe driving. The epilepsy regulations (see Appendix B, page 103) apply if there is relevant seizure history.	● Must not drive and must notify the DVLA. The licence will be refused or revoked. Provided there is evidence of stability on imaging, relicensing may be considered 3 years from completion of the primary tumour treatment. If the tumour is associated with seizure, relicensing will not be considered until 10 years after surgery, provided these years are free from seizures without epilepsy medication. Specialist assessment may be required.
Treated by fractionated radiotherapy	▲ Should not drive unless, in the view of an appropriate healthcare professional, it is safe to do so. Need not notify the DVLA. Driving may resume on completion of treatment provided there is no debarring residual impairment likely to affect safe driving. The epilepsy regulations (see Appendix B, page 103) apply if there is relevant seizure history.	● Must not drive and must notify the DVLA. The licence will be refused or revoked. Provided there is evidence of stability on imaging, relicensing may be considered 3 years from completion of the primary tumour treatment. If the tumour is associated with seizure, relicensing will not be considered until 10 years after surgery, provided these years are then free from seizures without epilepsy medication. Specialist assessment may be required.
WHO grade II meningiomas treated with craniotomy and/or radiosurgery and/or radiotherapy		
	● Must not drive but need not notify the DVLA. Driving may resume 1 year after completion of treatment. The epilepsy regulations (see Appendix B, page 103) apply if there is relevant seizure history.	● Must not drive and must notify the DVLA. The licence will be refused or revoked. In the absence of any seizures and with evidence of complete tumour removal, the DVLA may consider relicensing 5 years after the surgery. If the tumour is associated with seizure, relicensing will not be considered until 10 years after surgery, provided these years are then free from seizures without epilepsy medication.

Malignant brain tumours

– including metastatic deposits and pineal tumours

The standards will apply to first occurrence, recurrence and progression.

Supratentorial

	Group 1 car and motorcycle	Group 2 bus and lorry
WHO grade I or II glioma	Must not drive and must notify the DVLA. Driving may resume 1 year after completion of primary treatment. Where there is imaging evidence of tumour recurrence or progression licensing may be considered if: ▪ there has been a 1 year seizure free period ▪ there is no clinical disease progression. These will apply whether or not chemotherapy has been given. A 1 year license will usually be considered.	Must not drive and must notify the DVLA. The licence will be refused or revoked permanently. Except grade I pineocytoma: relicensing may be considered on an individual basis 2 years after primary treatment, provided MRI imaging is satisfactory.
WHO grade III meningioma	Must not drive and must notify the DVLA. Driving may resume 2 years after the completion of primary treatment.	Must not drive and must notify the DVLA. The licence will be refused or revoked permanently.
WHO grade III or IV gliomas, multiple metastic deposits or primary CNS lymphoma	Must not drive and must notify the DVLA. Driving may resume at least 2 years after the completion of primary treatment.	Must not drive and must notify the DVLA. The licence will be refused or revoked permanently.
Solitary metastatic deposit	Must not drive and must notify the DVLA. Relicensing may be considered 1 year after completion of the primary treatment if there was complete excision, and provided there is no recurrence or evidence of metastasis.	Must not drive and must notify the DVLA. The licence will be refused or revoked permanently.

Infratentorial

	Group 1 car and motorcycle	Group 2 bus and lorry
WHO grade I glioma	● Must not drive and must notify the DVLA. Driving may resume on recovery.	● Must not drive and must notify the DVLA. Relicensing will be considered on individual assessment.
WHO grade II, III or IV glioma	● Must not drive and must notify the DVLA. Driving may resume 1 year (grade II) or 2 years (grades III and IV) after the completion of primary treatment.	● Must not drive and must notify the DVLA. The licence will be refused or revoked permanently.
Medulloblastoma or low-grade ependymoma	● Must not drive and must notify the DVLA. Relicensing may be considered 1 year after completion of the primary treatment if there was complete excision, and provided there is no recurrence.	● Must not drive and must notify the DVLA. Relicensing may be considered 5 years after completion of the primary treatment, provided this period is clinically disease-free, the tumour was **entirely infratentorial** and completely excised.
High-grade ependymoma, other primary malignant brain tumour or primary CNS lymphoma	● Must not drive and must notify the DVLA. Relicensing may be considered normally only after 2 years from completion of the primary treatment.	● Must not drive and must notify the DVLA. The licence will be refused or revoked permanently.
Brain metastases	● Must not drive and must notify the DVLA. Relicensing may be considered 1 year after completion of the primary treatment if the patient is otherwise well.	● Must not drive and must notify the DVLA. Relicensing may be considered 5 years after completion of the primary treatment.
Malignant intracranial tumour in childhood: survival without recurrence	▲ May apply to drive (or continue to drive) but must notify the DVLA. A 'till 70 licence is normally granted or maintained.	● Must not drive and must notify the DVLA. Licence may be granted or reissued based on individual assessment.
Incidental, asymptomatic low-grade glioma on imaging	● Must not drive and must notify the DVLA. There will be an individual assessment for licensing and any licence will initially be under regular, usually annual, review.	● Must not drive and must notify the DVLA. The licence will be refused or revoked. Relicensing may be considered after 1 year if annual clinical assessment is satisfactory and subsequent specialist opinion is that the lesion is not actually a glioma.
Benign infratentorial tumours For example, meningioma treated with craniotomy with or without radiotherapy.	● Must not drive but need not notify the DVLA. Driving may resume on recovery from treatment.	● Must not drive but need not notify the DVLA. Driving may resume on recovery from treatment provided that there is no debarring residual impairment likely to affect safe driving.

DVLA: Advice to the Patient

Once your doctor has told you that you have a brain injury/tumour and you will not be able to drive, you MUST inform the DVLA.
This is a legal obligation and failure to notify DVLA is a criminal offence and you could be punished up to £1000 for not doing so.

The sooner you tell the DVLA, the sooner the medical enquiries into your case can start, avoiding unnecessary delays.

You may also find that your insurance cover could be invalid in the event of a claim. If you don’t inform the DVLA and carry on driving, anyone can report this to the driving agency.

A doctor has a duty to protect your confidentiality as a patient. But over and above this, he or she has a duty of care to protect the public. So, your doctor may also tell the driving agency if you carry on driving when you should not.

DVLA:Reapplying for a driving licence following a medical condition

If your licence was taken away or surrendered for health reasons, you must reapply to DVLA before you start driving again.

Check with your doctor that you can meet the medical standards of fitness to drive before reapplying for your licence.

DVLA will send you a letter when your licence is taken away or surrendered, or if your application for a driving licence is refused. This tells you if there's a period of time you need to wait before getting a new licence.
You can then reapply 8 weeks before the end of this period.
The letter will also tell you if you need to send any evidence of your fitness to drive with your application.




Reasonable Advice…. from your Doctor

- Inform the patient that they have a notifiable medical condition and that they, the patient, must report it to the DVLA.
- The Dr can use ‘At a Glance’ to say when the patient can drive assuming no other factors and give a date.
- The Patient is legally required to notify the DVLA but would be eligible to drive from the agreed date as long as no other barring events occur in the period from seeing the doctor to the agreed date.
- Where the doctor is unsure they could advise against driving until able to confirm situation in say OPD after discharge.




Patient Questions: What and how do I tell the DVLA?

Write a letter with AS MUCH DETAIL AS possible about your diagnosis, including:
Your full name
The type of tumour
The date and circumstances of diagnosis
Any treatment or surgery you have had and when you had it
The name and contact details of your consultant
Your date of birth
Your drivers number

The more information the DVLA medical advisers have, the less need there is for investigation on their part and the quicker the process.
Keep the DVLA informed of any subsequent treatments or developments in your case .

Surrendering Your Licence

You can decide if you want to hand in your licence to the DVLA.
If you did not send your licence back voluntarily, the DVLA will send you a form to complete and ask your permission to contact your doctor for a medical report. They may ask for you to be examined by one of the DVLA's medical practitioners.

The DVLA will then write and tell you whether or not your licence is formally withdrawn or 'revoked' and for how long. They will also ask you to send your licence back.

It is better to hand in your licence voluntarily, because it speeds up the process when you want to get your licence back.
If you have surrendered your licence, you can start driving as soon as you have lodged your application to get your licence back. This can be done two months before end of the period for which you had not been allowed to drive.
This is not the case if your licence had been revoked. In this case you will have to wait until you are declared medically fit before you can start driving again.

To surrender your licence, simply fill in a declaration of voluntary surrender, which you can send off with your letter informing the DVLA of your condition, as well as your current driving licence.

When can I start driving again?

If you had sent your licence back voluntarily:

You can start driving again when you meet the epilepsy driving regulations. This is provided: your doctor agrees that you meet the epilepsy's driving regulations, and you have checked and confirm that the driving agency has received your application.
This means you do not need your new licence before you can start driving.

If you didn't send back your driving licence voluntarily and it was revoked

You can only start driving again once you have been issued with a new driving licence.

Stopping Anticonvulsants

GUIDANCE FOR WITHDRAWAL OF ANTI-EPILEPTIC MEDICATION BEING WITHDRAWN ON SPECIFIC MEDICAL ADVICE
(N.B. This advice only relates to treatment for epilepsy)

It is clearly recognised that withdrawal of anti-epileptic medication is associated
with a risk of seizure recurrence.

Patients should be advised **not to drive from commencement of the period of withdrawal**
and thereafter for a period of 6 months after cessation of treatment

New wording …….

Why is the DVLA Process so slow?

- There are over 250,000 patients that come under these rules across the five specialist panels with around 45,000 on short term one to three year renewable licences.
- The figure is growing by 10% per year as older patients with combined co-morbidities reach 70 and need recertification
- Getting Doctors to handle forms quickly
- Making the Regulations as workable as is Safe and Fair within the Human Rights Act.

Clinical review

- Advice on fitness to drive should form an integral part of many clinical consultations

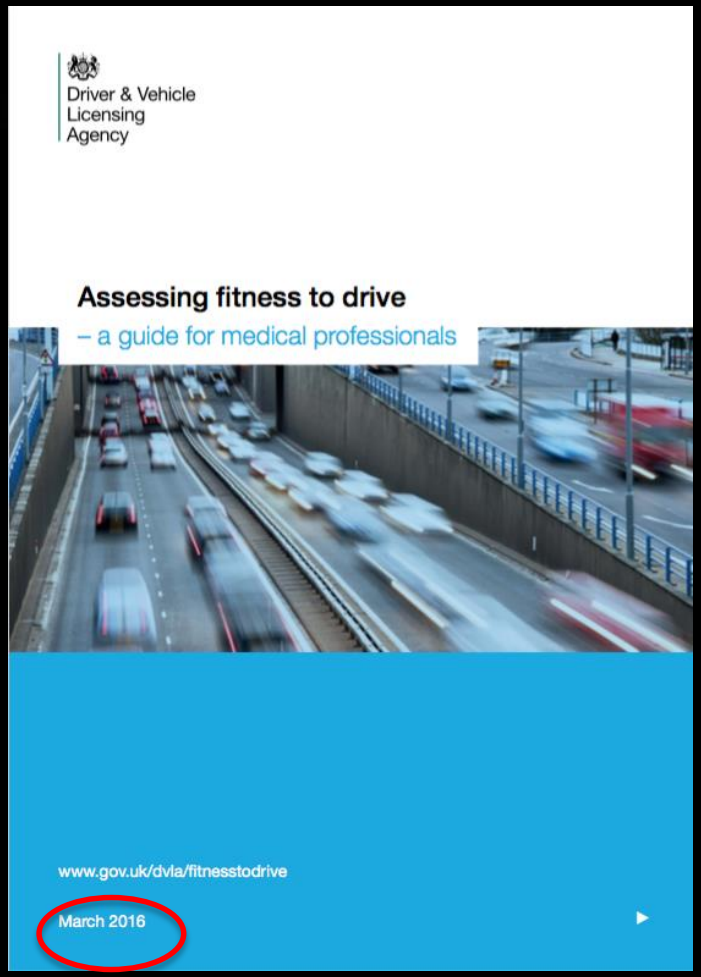
Discuss: GP’s should be patient advocates not gatekeepers or informants on patients !!

Acknowledgments

- Dept For Transport
- DVLA Medical Group
- Medical Advisors

And especially the expert voluntary work of members of:

- The Secretary of State for Transport's Honorary Medical Advisory Panel on Driving and Disorders of the Nervous System



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Check you are looking at latest version:
Altered twice a year !

Acoustic neuroma/schwannoma

	Group 1 car and motorcycle	Group 2 bus and lorry
	▲ May drive and need not notify the DVLA unless there is sudden and disabling giddiness.	▲ May drive and need not notify the DVLA unless there is sudden and disabling giddiness and/or the condition is bilateral.