FITNESS TO DRIVE:
DRIVER ASSESSMENT WORKSHOP
CPD MEDICINE
MAX RADY COLLEGE OF MEDICINE
JANUARY 10, 2020

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Disclosure of Commercial Support

- Manitoba Public Insurance has provided financial support for the development of this program
- The presenter has received payment from Manitoba Public Insurance for the provision of consulting services and for the delivery of similar CPD programs

Mitigating Potential Bias

- Manitoba Public Insurance is a not for profit organization
- Manitoba Public Insurance does not sell or market any product uniquely to the participants of this CPD event. Its involvement is for the sole purpose of promoting road safety
- The presenter has no commercial interests and does not profit from the operations of Manitoba Public Insurance

Objectives

Upon completion of this CPD event the participant will be able to:

- Explain the Health Care Professional's role in the evaluation of driver fitness, including reporting requirements and methods
- Recognize the national medical standards for some common medical conditions, and how to assess whether a patient meets those standards
- Recall sources of information that can be used to assist in patient evaluation as well as how to access this information
- Recall the Manitoba Public Insurance process for assessing drivers with medical conditions that might affect driving ability

Why create an education program on assessing driver fitness?

- Family Physicians' Attitudes and Practices Regarding Assessments of Medical Fitness to Drive in Older Persons (J. Gen. Intern. Med. 2007 April; 22(4): 531-543
  - More than 45% of Canadian Physicians did not feel confident to assess fitness to drive
  - Majority (88.6%) felt they would benefit from further education in this area

Why create an education program?

- Educating Doctors on Evaluation of Fitness to Drive: Impact of a Case-Based Workshop (Dow & Jacques, J. Continuing Education in the Health Profession, 32(1): 68-73,2012
  - Increase in number of reports submitted by physicians
  - Quality of reports improved
  - Reported high level of satisfaction with workshop

Why create an education program?

- Aging population
- MPI has moved to a 5 year license – potential for less self reporting
- Most medical conditions have the potential to influence driver fitness
- Very few medical school curricula include driver evaluation
- Most Health Care Professionals have received no training in driver evaluation
- Most Health Care Professionals will consider driver fitness only when confronted with a driver's medical form or a crisis following an accident

How concerned should we be?

- The vast majority of crashes related to medical conditions do not result in death or serious injury
- Should we not be focusing on drunk drivers and males 16-25?

Santa Barbara Farmer's Market July 17, 2003

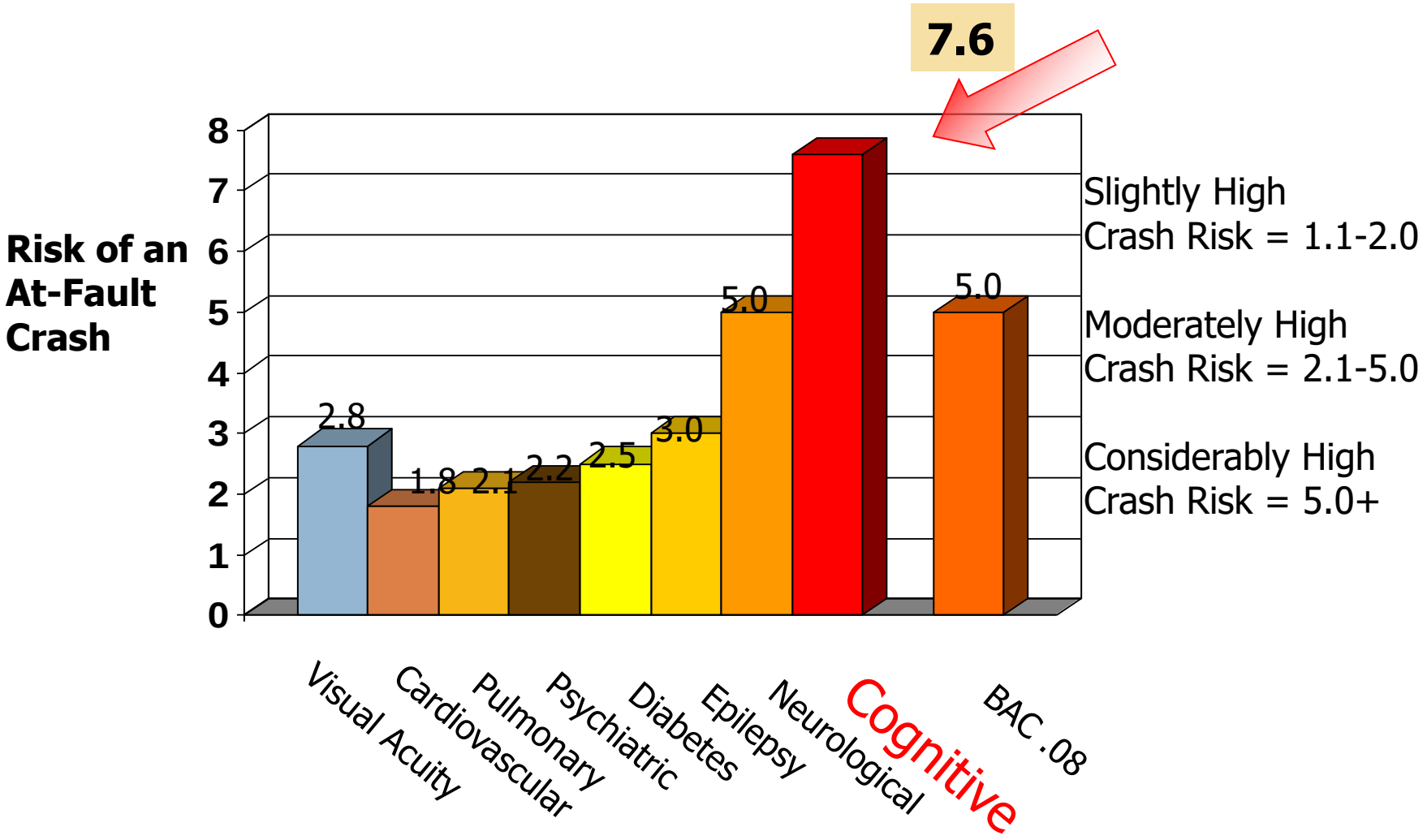
"I pressed the accelerator instead of the brake"

10 fatalities
69 injured
1 driver
15 seconds

How concerned should we be?

- MPI has specific strategies to deal with high risk groups of drivers
- The public demands that MPI do whatever is reasonable to make the roadways as safe as possible

What is the Risk?



(See Vernon, 2002; Vaa 2003; Sagberg, 2003; Charlton 2004; Dobbs, 2002 [Red Flags])

Medical Conditions and Driving

- Temporary Impairment (generally no need to report)
- Persistent (functional) Impairment
- Episodic (risk of sudden incapacitation) Impairment

Persistent (functional) impairments

- Vision
- Neurological Disorders
- Dementia
- Musculoskeletal Disorders
- General Debility – malignancy, chronic pain, CKD, multiple medical conditions, effects of medication

Episodic Impairment

- Seizures
- Syncope
- Arrhythmia
- Aortic Stenosis
- AAA
- Hypoglycemia
- Sleep Disorders

Case 1: Dementia

- A patient indicates to you that she has concerns about her father's (who is also your patient) gradual decline in cognitive function and, in particular, it's effect on his ability to drive safely. He will be seeing you for a physical in one week.

  Appropriate action at this time is to:

  a) Advise the daughter than any citizen can report such concerns to MPI
  b) Immediately report the father to MPI in accordance with Section 157(1) of The Highway Traffic Act
  c) Conduct an assessment at the time of his upcoming visit
  d) a & b
  e) a & c

Manitoba Law

157(1) A duly qualified medical practitioner or optometrist shall report to the registrar the name, address and disease or disability, or any significant change in a previously observed disease or disability, of any person attending upon the duly qualified medical practitioner or optometrist for examination or treatment who is the holder of a valid driver's licence and who, in the opinion of the duly qualified medical practitioner or optometrist, has a disease or disability that may be expected to interfere with the safe operation of a motor vehicle that may be operated with the class of licence or permit held by the person

157(2) No person has a right of action against a duly qualified medical practitioner or optometrist for furnishing to the registrar a report as mentioned in subsection (1)

What does it mean?

- Reporting is mandatory for physicians and optometrists

  Note: Manitoba Law Reform Commission – March 2015

- A reasonable opinion must be formulated
- Physicians do not take away driver licenses. Only the Registrar can grant or cancel
- A recommendation is not required but is very helpful
- No right of action against doctor for submitting a report,

  but ….

  - No protection for not submitting a report

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REPORT TO THE REGISTRAR OF MOTOR VEHICLES CONCERNING THE DISEASE OR DISABILITY OF PERSON PURSUANT TO SECTION 157(1) OF *THE HIGHWAY TRAFFIC ACT*

NAME: _____ **DATE OF BIRTH:** ____ / ____ / ____ (D / M / Y)

ADDRESS: _____

(This report cannot be processed unless the person is properly identified)

BRIEF DESCRIPTION OF DISEASE OR DISABILITY AND DATE OF OCCURRENCE IF APPLICABLE. If vision related, please include uncorrected and corrected visual acuity, pathology and horizontal fields.

_____

_____

_____

RECOMMENDATIONS:

( ) Obtain second medical or optometric opinion. (If referred please indicate name of doctor).

_____

( ) Withdrawal of driving privileges pending further investigation.

_____

( ) Other recommendations (road test etc).

_____

_____ _____

Physician's or Optometrist's Name
(Please print in block letters)

Signature of Reporting Physician or Optometrist

Date: _____ Telephone No.: _____

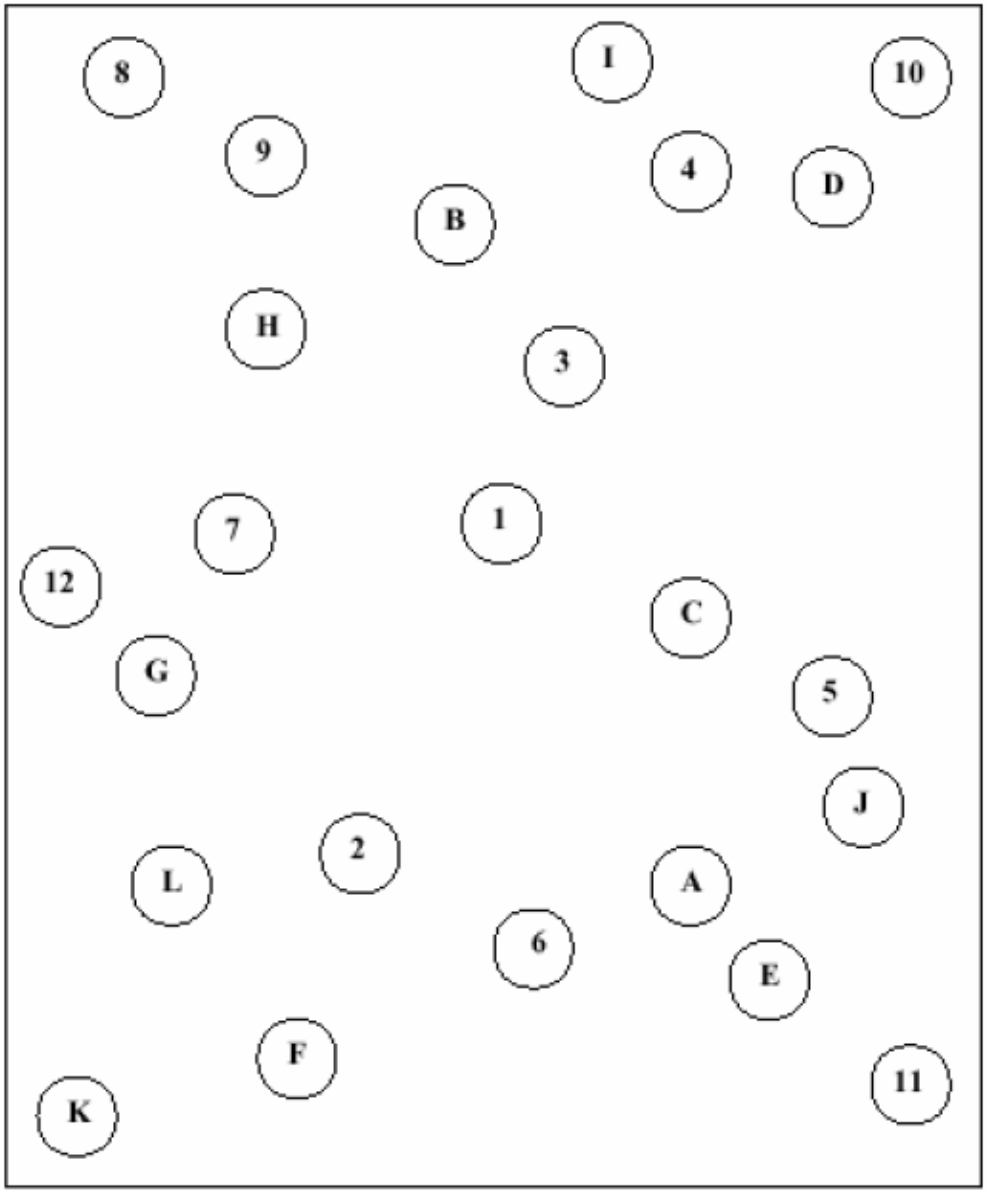
THIS INFORMATION WILL BE DISCLOSED BY MANITOBA PUBLIC INSURANCE TO THE PATIENT UPON REQUEST UNLESS OTHERWISE DIRECTED.

Case 1(cont)

- After your assessment, you conclude that this otherwise healthy 79 year old male has early Alzheimer's Disease. Which of the following in office screening tests will accurately predict the likelihood of a car crash:
  a) MMSE
  b) MOCA
  c) Trails B
  d) Simard MD
  e) None of the above

Trail Making Test Part B

Patient's Name: _____ Date: _____



Case 1 (cont)

- Simard MD – predicts performance on DriveABLE® in office test
- Trails B and clock drawing test – useful, may be a correlation with performance on a road test

Case 1 (cont)

- Appropriate action at this time is to:
  a) Refer to Geriatrics
  b) Recommend license cancellation
  c) Report to MPI with recommendation for DriveABLE® assessment and advise patient accordingly
  d) Monitor and reassess in the office in 6 months

DriveABLE

- Evidence based assessment tool that evaluates driving errors related to cognitive impairment
- In use in North America, Australia, New Zealand, South Korea
- Developed by observing the types of high risk driving errors made by individuals with known dementia and not made by control groups
- Then a road test was designed that would expose candidates to suitable situations. The test is scored based on the number and severity of errors made
- A computer based written test was then developed and performance correlated with performance on the road test

  (ie. designed to predict road test outcome)

DriveABLE

- Does DriveABLE predict the risk of having a crash?
  - Driving record of test group never evaluated, either retrospectively or prospectively
  - Nevertheless the errors made by dementia patients were errors that could have resulted in a crash
  - Therefore the test results are very likely to correlate with future risk
- Is a superior assessment tool available?
  - CanDrive Group

How are drivers reported?

- Health Care Professional referral
  - Unsolicited reports under 157(1)
  - General medical reports – commercial drivers
  - Recall medical reports – known conditions
- Self declaration by drivers
- Third party concerns
  - Police/RCMP
  - Family members
  - Neighbors etc.

MPI process for drivers with dementia

- Once information received, a medical report is requested
  - Driver may be suspended pending the outcome

- Prior to proceeding to DriveABLE, all other CCMTA medical standards must be met
- Drivers are not candidates for DriveABLE if they have physical or vision impairments that may affect driving and/or ability to perform DriveABLE tasks

  e.g. Parkinson Disease patient with cognitive issues

  (refer to DAMP)

In Office Cognitive Assessment

- Winnipeg or Brandon
- Cost is $50
- Driver is asked to complete a series of tasks using a computerized touch screen/touching a button
- Administered by specially trained MPI staff
- Translation protocol
- Family members/caregivers are able to observe

In office Cognitive Assessment

- Potential outcomes:
  - Pass - no further testing necessary

    - will be kept on annual medical recall
  - Inconclusive – must complete on road evaluation
  - Fail – license is cancelled. Can retake once, or proceed to on-road evaluation, or appeal to Medical Review Committee

On Road Evaluation

- Winnipeg or Brandon
- Cost is $75.00
- Completed by specially trained MPI driver examiners
- Conducted on a special road course designed to reveal driving errors associated with cognitive decline
- Potential outcomes:
  - Pass - no further testing required
    - annual medical recall
  - Fail - license cancelled. Cannot retake. Can appeal to Medical Review Commitee

Dementia (cont)

- Impairment in the basic activities of daily living (eg. dressing, hygiene, eating) = no driving!
- N.B. concerns expressed by family members
- Driving errors associated with dementia – drives too slowly, inappropriate stops, lane positioning, unsafe lane changes, trouble with turns
- What about conditional licenses (e.g.. local area only)?
- What about the use of navigators?
- Availability of photo ID for individuals who surrender their license

What to do if:

- A member of your staff reports to you that they have observed your patient driving and have witnessed some worrisome driving behaviours?

- You become aware that your patient is continuing to drive in spite of their license having been recently cancelled because of dementia?

Medical Compliance and Assessments/Driver Fitness, MPI

- Is separate dept from Bodily Injury (Claims)
- Evaluate medical information and co-ordinate functional assessments. Apply CCMTA Medical Standards for Drivers and internal policy
- Assess and determine customer's ability to safely operate a motor vehicle.
- Review medical reports from physicians
  - Receive 50,000 reports annually (~ 2,000 unsolicited)
  - Suspend 1,500 driver's licenses annually
- Driving specific assessments, in-vehicle evaluations, road tests, on-road evaluations specific to vision that fails standards
- Drivers & Vehicle Act and The Highway Traffic Act provides authority

Medical Compliance and Assessments/Driver Fitness, MPI (cont)

- 8 registered nurses – more complex information
- 4 medical clerks – not complex
- Clerical support staff
- Medical Advisor
- Approve, suspend, cancel, declass action
- MPI Health Care Professional Website
- Health Care Professional telephone line (204) 953-4925. Leave message, RN assigned.
- https://www.mpi.mb.ca/Pages/health-care-professionals.aspx

Medical Review Committee

- Separate appeal body not governed by MPI
- Established by legislation
- Provides appeal process in cases where a person's licence has been cancelled or declassed for failing to meet the medical standards
- Conducts hearings to determine if standards applied in fair and equitable manner and whether exception to rule may be made.
- Members include FPs, neurologists, cardiologists, optometrists and nurses
- MPI provides copy of driver's medical file prior to appeal

Case 2 – LV Dysfunction

- 55 year old male with a history of obesity, hypertension, type 2 diabetes, and hyperlipidemia. Suffered an acute MI 3 months ago. Comes in hoping for authorization to return to work (holder of a Class 1 permit – semi-trailer driver). He feels well, is NYHA functional level 1.0
- Your review of the hospital discharge summary reveals he suffered an anterior wall STEMI, treated with a primary PCI. On day 5, prior to discharge, an echocardiogram revealed anterior wall hypokinesis with an LV ejection fraction of 28%.
- You should:
  a) Authorize his return to work
  b) Refer him to cardiology
  c) Advise him that he does not meet the medical standard for a Class 1.0 licence and submit a 157(1) report to MPI
  d) Do not report to MPI because this would have been done by the hospital attending physician

CMA Guide 9th Edition

- Section 14.6 congestive heart failure, left ventricular dysfunction, cardiomyopathy, transplantation

  "Patients with cardiomyopathy, with or without a history of heart failure, potentially pose a risk on the roads"

- Risk of sudden cardiac death correlates with functional (NYHA) class and the LV ejection fraction
- For commercial driving, must be NYHA class 1 or 2 and have an ejection fraction ≥ 35%
- For private driving, must be NYHA class 1,2,or 3

Cardiac Standards

- Based on Canadian Cardiovascular Society (CCS) 2003 Consensus Conference
- Risk of harm formula:
  - Acceptable annual risk of sudden incapacitation
    - Semi-trailer or bus driver - 1 %
    - Taxi or Police car (Class 4) – 4 %
    - Typical Private driver (assumes 8 hrs/week) – 20 %

Lessons from Case 2:

- After an acute MI with significant LV damage (new wall motion abnormality or peak CK >500) an assessment of LV ejection fraction is required for commercial drivers (Class 1-4)
- Don’t assume the other person has reported:
  - “In situations where more than one physician is treating a patient, it is possible for each to assume that one of the others has made a report, when in fact no report has been made. The legislation therefore requires each treating physician to independently comply with the relevant reporting obligation.” CMPA bulletin April 12, 2015

Case 2 - continued

- In this particular case is the prohibition from commercial driving likely to be permanent?
- Is there anything you can do to influence the outcome?

Case 3 – Visual Field Defect

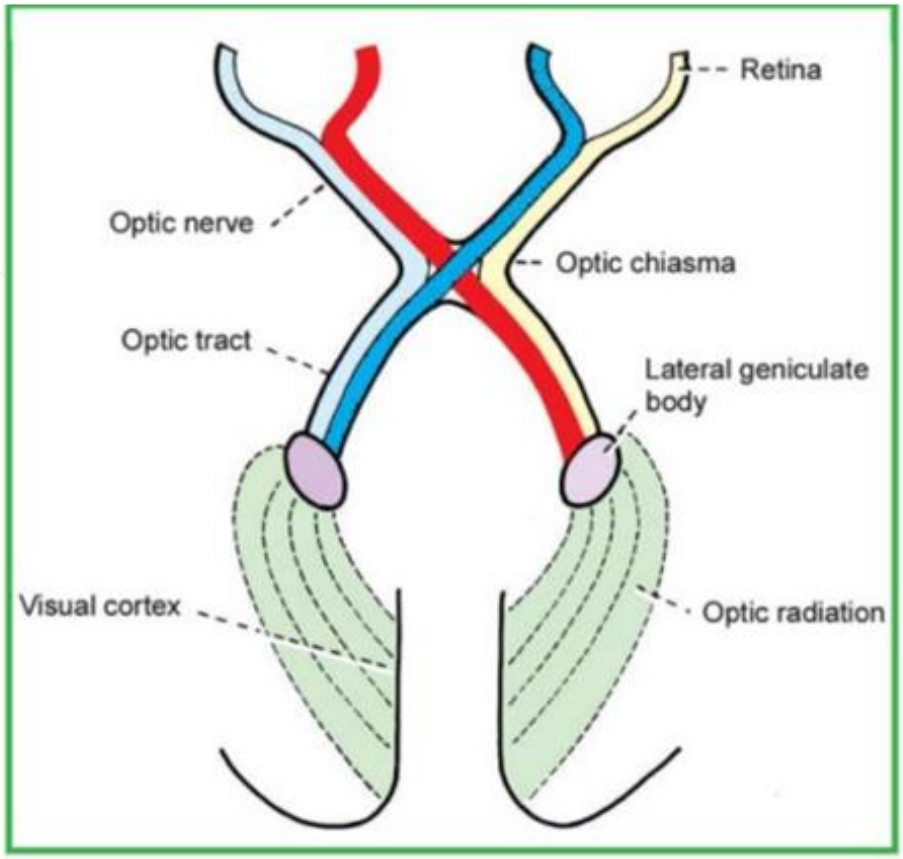
- A 64 year old female with a history of smoking and hypertension complains of a 1 week history of decreased vision, mostly on gaze to the left. Examination is completely normal with the exception of a complete left homonymous hemianopsia (h.h.)

  True or False:

  - Homonymous hemianopsia (loss of one half of the horizontal visual field) is incompatible with driving

False

The Visual Pathway



The optic pathway. Note that the fibres from the medial (or nasal) half of each retina cross over to the optic tract of the opposite side.

Case 3 (cont)

True or False:

- For all drivers with h.h. a report to MPI in accordance with 157(1) is required

True

Blanket Prohibition vs Individual Assessment

- In the past, drivers could be disqualified solely on the basis of a specific diagnosis
  - e.g. Insulin treated diabetics or epileptics prohibited from commercial driving
  - e.g. Narcolepsy and commercial driving
  - e.g. Methadone and commercial driving
  - e.g h.h. – complete disqualification from any class
- Supreme Court of Canada - 1999 - Grismer decision
  - B.C. Superintendent of Motor Vehicles v. B.C. Council of Human rights
  - Grismer had h.h. and was disqualified
  - Supreme Court - diagnosis alone insufficient to disqualify
    - An applicant has the right to an individual assessment offering the opportunity to demonstrate the ability to compensate

Case 3 (cont)

- An individual with h.h. will generally be functionally incapable of driving
- The ability to drive will depend on whether the individual recognizes and understands the nature of the condition and has the ability to scan (move the eyes from side to side), shoulder checks, in order to compensate
- MPI action will be to immediately suspend and refer the driver to DAMP (Driver Assessment and Management Program)
- If the DAMP assessment is favorable, a special road test will be administered

Driver Assessment and Management Program

- Health Sciences Centre – OT department
- A 2 part functional assessment (i.e. not a “test”)
  - in clinic – by OT
  - on road – by a specialized driving instructor
- Assess drivers with:
  - physical impairments (e.g. stroke, MS, Parkinson Disease, spinal cord injury, traumatic brain injury, amputation)
  - visual problems (particularly h.h.)
  - combined physical/cognitive impairments
  - general debility related to multiple medical conditions, including the effect of medications
- Access coordinated by MPI – Medical Compliance and Assessment/Driver Fitness
- Cost - $150.00
- Current wait time – 2 to 3 months

Case 4 - Stroke

- A 76 year old male with a history of hypertension, coronary disease, glaucoma, and mild CKD is admitted to hospital with left side weakness caused by a right sided basal ganglia lacunar infarct. He is discharged after 2 weeks and continues with outpatient physiotherapy. After another 4 weeks he sees you in the office, says he feels great and feels he has completely recovered, other than some clumsiness of his left hand. He has not been driving and wants to know when he can resume.
- You should:
  a) Tell him he is fine and can resume driving without restrictions
  b) Consult neurology
  c) Refer him to DAMP
  d) Submit a 157(1) report with a recommendation that an in-vehicle assessment be conducted

In office assessment of functional ability to drive:

- “Although a clinician is likely able to identify obviously impaired drivers, a clinician’s assessment alone may not be accurate enough to determine driving competency in drivers marginally affected by neurologic disorders”

Drazkowski and Sinden, Driving and Neurologic Disorders, Neurology 2011; 76 (suppl2): 544 -549

Case 4 – (cont)

- An individual who has had a stroke with apparent complete recovery may have subtle physical/perceptual/reaction time residuals that could affect driving ability
- For such cases MPI has developed a special in-vehicle evaluation that focuses on a driver's ability to control the vehicle and appropriately react to common driving situations (the driver will not be penalized for bad habits that would cause failure of an entry level test)
- Patients with other neurological or musculoskeletal disorders can be referred for the same in-vehicle assessment
- Free of charge
- Available anywhere in Manitoba

Case 5 – Obstructive Sleep Apnea (OSA)

- A 45 year old male semi-trailer driver with a history of obesity (weight 120 kg), hypertension, type 2 diabetes, and gout has been assessed by a sleep specialist. He is reported to have daytime sleepiness but denies ever falling asleep at the wheel. The sleep study has revealed moderate OSA with an AHI of 25 events/hour. Which of the following statements is true?
  a) Drivers with OSA have a 2-4 times greater risk of a crash
  b) Measures of daytime sleepiness (Epworth Sleepiness Scale) and severity of sleep apnea are not consistent predictors of driving performance
  c) A driver with OSA who reports sleepiness while driving or who has had a crash associated with falling asleep should not drive any class of vehicle until the condition is successfully treated
  d) Commercial drivers with OSA will be required by MPI to submit an annual medical report
  e) All of the above

OSA and Commercial Driving

- Canadian Thoracic Society and Canadian Sleep Society position paper, Can Respir J Vol 21 No 2 2014
  - OSA diagnosis precludes unconditional certification of commercial drivers
  - Allow commercial driving if:
    1. Untreated OSA with AHI<30

       and

    2. No excessive sleepiness during the major wake period

       or

    3. The OSA is being effectively treated
  - Recertify annually, based on demonstrated compliance with treatment
    - compliance = 4 hrs/night usage on 70% of days over a 30 day period (determined within the previous 90 days)

OSA and Commercial Driving (con't)

- Disqualify if any of the following are met
  - Driver admits to experiencing excessive sleepiness during the major wake period while driving
  - History of a crash associated with falling asleep in the last 5 years if effective therapy has not been instituted
  - Driver has found to be non-compliant with treatment
  - Driver has untreated severe OSA (AHI ≥ 30)

Case 6 – Diabetes and Hypoglycemia

- A 22 year old type 1 diabetic works as a self employed painter and drives a pickup truck (holds class 5 licence). He is on a humalog sliding scale before meals and takes humulin N at bedtime. He reports recent early morning dips in his blood sugar to as low as 2.2. He always gets hypoglycemia warning symptoms and is able to correct by ingesting extra glucose. He has never lost consciousness.
- True or False:
  - This driver should not drive until he has been free of such events for 6 months.

False

Diabetes and Hypoglycemia

- Episode of severe hypoglycemia (results in impairment of consciousness and/or requires outside intervention)
  - Requires licence suspension (all classes) until stable glycemic control is re-established
  - Standard calls for minimum 6 month suspension
  - MPI will consider earlier reinstatement only upon the recommendation of an endocrinologist
- Hypoglycemia unawareness (failure to recognize the autonomic symptoms)
  - Single episode calls for 3 month prohibition (all classes)
  - Individuals with persistent hypoglycemia unawareness are not eligible for a commercial licence

Case 7 – First unprovoked seizure

- A healthy 19 year old female university student has been getting only 4-5 hours sleep nightly while studying for her final exams. She is brought to Emergency after experiencing a 1 minute generalized seizure (witnessed by her roommate) with a 15 minute period of postictal confusion. On arrival she is alert with normal vital signs and a normal examination. Bloodwork and CT head are normal as are a subsequent MRI and EEG. The probability of a further unprovoked seizure in the next 12 months is:

a) 1%
b) 10%
c) 40%
d) 60%

Seizures/Epilepsy

- Standards summarized in CMA Drivers` Guide: Determining Medical Fitness to Operate Motor Vehicles 9th edition
- Section 11.4, Table 2, pages 55-57
  - Available in print or at cma.ca

Type of Seizure	Private Drivers	Commercial Drivers
Single, unprovoked seizure, before a diagnosis	-no driving for 3 months and, -neurological assmt, preferably including EEG (awake and asleep), and appropriate imaging	-no driving private vehicles for 3 months -neurological assmt, including EEG (awake and asleep) and appropriate imaging -if no epilepsy diagnosis, resume professional driving if seizure free 12 months.
After epilepsy diagnosis	Drive if: - 6 months seizure free on medication - physician has insight into patient compliance - physician cautions against fatigue, alcohol	- resume driving if 5 years seizure free (recommendations for individual patients may differ on an exceptional basis)
After surgery to prevent epileptic	- resume driving if 12 months seizure free after surgery with therapeutic drug levels (recommendations for individual patients may differ on an exceptional basis)	- resume driving if 5 years seizure free (recommendations for individual patients may differ on an exceptional basis)
Seizures only in asleep or immediately upon awakening	- drive after 1 year from initial seizure if drug levels are therapeutic	- no driving commercial vehicles for at least 5 years
<u>Medication withdrawal or change</u>:		
Initial withdrawal or change	- no driving for 3 months from the time medication is discontinued or changed	- no driving for 6 months from the time medication is discontinued or changed
If seizures recur after withdrawal or change	- resume driving if seizure free for 3 months	- resume driving if seizure free 6 months (recommendations for individual patients may differ on an exceptional basis)

Type of Seizure	Private Drivers	Commercial Drivers
Long- term withdrawal and discontinuation of medication	- drive any vehicle if seizure free off medication for 5 years with no epileptiform activity within previous 6 months on waking and sleep EEG	
Auras (simple partial seizures)	Drive if: - seizures are unchanged for at least 12 months - no generalized seizures - neurologist approves - no impairment in level of consciousness or cognition - no head or eye deviation with seizures	Drive if: - seizures remain benign for at least 3 years - no generalized seizures - neurologist approves - no impairment in level of consciousness or cognition - no head or eye deviation with seizures
Alcohol –withdrawal-induced seizures	Drive if: - remain alcohol free and seizure free for 6 months - complete a recognized rehabilitation program for substance dependence - compliant with treatment	
Post – traumatic seizures (single, not epilepsy)	- same as for single, unprovoked seizure	
Juvenile myoclonic epilepsy (Janz syndrome)	- no driving any class of vehicle unless taking appropriate anti-seizure medical	

Epilepsy (continued)

- A known epileptic on medication has 12 hours of intractable vomiting due to food poisoning. They experience a typical generalized seizure. The last seizure was 3 years ago, under similar circumstances. For how long should their driving privileges be suspended?
- MPI will consider mitigating circumstances. The quality of the information submitted influences the quality of the licensing decision!

Case 8 – Dried Cannabis (Medical Marijuana)

- A 45 year old semi-trailer driver with no significant past medical history presents requesting completion of his driver medical form. He indicates that he is smoking 1.5 gm/day of dried cannabis that has been prescribed by another physician for his PTSD. Which of the following statements is true:
  a) Tetrahydrocannabinol (THC) is the main psychoactive substance in cannabis and has been associated with an increased risk of crashes.
  b) There is great variation in the euphoric and other effects of cannabis that is independent of gender and weight
  c) Driving while under the influence of marijuana is a criminal offence, even if it is prescribed by a physician
  d) Individuals prescribed medical marijuana can be considered for any class of licence
  e) All of the above

Dried Cannabis (medical marijuana)

- CFPC – Preliminary Guidance Document, September 2014
  - Patients taking dried cannabis should be advised not to drive for at least:
    a) Four hours after inhalation
    b) Six hours after oral ingestion
    c) Eight hours after inhalation or oral ingestion if the patient experiences euphoria
- Average usage is 2.5 gm or 3-4 “joints” per day
  - If this amount is exceeded driving should be avoided completely

- Note: the Impaired Driving Legislation has thresholds for allowable blood levels of THC as well as provision for roadside oral fluid screening for THC

Case 9 – Mental Health

- John is a 42 year old single semi-trailer driver whom you have not seen for 10 years. You receive a call from a community mental health worker indicating John will be coming to see you in a few days and expressing grave concerns about his ability to drive a class 1.0 vehicle. It has come to her attention that John thinks he is the King of Canada, and recently took great exception to the appointment of a new Governor General without his consent. She feels he is psychotic.
- When you see John he is neatly dressed and groomed, oriented x 3, has normal vital signs and a negative physical exam, and a normal mental status exam with the exception of the single delusion described above. With John's permission, you call his employer and are advised that John is definitely odd but he is reliable and he considers him to be the best driver he employs.

Case 9 – (cont)

You should:

a) Send in a 157(1) report recommending suspension and advise John not to drive

b) Because John is not acutely psychotic, no action with respect to his driving status is required

c) Request an urgent psychiatric consultation. If John refuses, certify him under the Mental Health Act

d) None of the above

Mental Health Disorders:

- Individual assessment required
- Absolute contraindications to driving
  - Acute psychosis
  - Acute mania
  - Severe depression (interfering with ability to perform ADL)
  - Plan to harm self or others using a motor vehicle
  - Moderate to severe dementia
  - Substance use disorder, unless in remission

Case 10 – Motorcycle Helmet Exemption

- A 32 year old male complains of chronic neck discomfort that is exacerbated by wind resistance when he wears a motorcycle helmet. He requests that you authorize a permanent helmet exemption. Physical examination and c. spine x-ray are completely normal

  You should:

  a) Grant the exemption

  b) Tell him that motorcycle helmets are designed to be more aerodynamic than the human head

  c) Advise him that the professional standard of practice is that you not authorize a helmet or seatbelt exemption, in spite of the permissive legislation

  d) b+c

Motorcycle Helmet and Seat belt Exemptions:

- College of Physicians an Surgeons of Manitoba – Bylaw 11 – Standards of Practice of Medicine. Schedule C, Seatbelt/Helmet Exceptions:
  - “Since reconfiguration of the seatbelt, the use of padding, or other accommodations are available and acceptable alternatives to non-use of a seatbelt or helmet assembly, and since there are no medical conditions that justify exemptions from using a seatbelt or helmet assembly, a member must not write a seatbelt or helmet exemption".

Motorcycle Helmet and Seatbelt Exemptions:

DON’T DO IT

Driving Cessation

- Males – average 6 years before death
- Females – average 10 years
- CMA Guide 9th edition – section 4.5, page 18-19
  - Strategies for discussing driving cessation

Medico-legal Considerations:

- CMPA experience with fitness to driver matters 2005-2009
  - 67 closed cases
  - Decisions in favor of physicians predominated
  - Three principal themes
    - legal action – failure to report a patient as unfit to drive due to a medical condition
    - complaints that a report has been made
    - Complaints related to refusal to support an application for restoration of driving privileges

CMPA bulletin April 12, 2015

CMPA Risk Management Considerations

- Have you considered the CMA or other organizations' recommendations on medical conditions that may pose a danger when operating a vehicle?
- Have you consulted with colleagues or obtained functional assessment, if appropriate?
- Have you warned the patient not to drive, if appropriate?
- Have you familiarized yourself and complied with the relevant legislation in your jurisdictions?
- Have you informed the patient of your intention and/or obligation to report?
- Have you reminded the patient that any decision to resist or revoke lies with the licensing authority?
- Have you cautioned the patient not to drive (if appropriate) until the licensing authority has made a determination?

CMPA Risk Management Considerations (cont)

- Have you limited the information in the report to what is required by the legislation?
- Have you adequately documented your assessment, discussion, warning, and advice to the patient regarding driving, and whether or not you have made a report?
- Before supporting an application for reinstatement, have you performed the appropriate clinical assessment and documented these?
- When in doubt seek advice from appropriate sources and carefully consider the risk posed to the public if the patient continues to drive

Conclusions

- Sudden Incapacitation
  - Risk of harm formula – 1%, 4%, 20%
- Persistent Impairment
  - Individual assessment
  - Performance on a road test
- Think about fitness to drive
  - at time of comprehensive health review
  - with diagnosis of a new condition
  - with any acute illness or injury
  - after any hospitalization
  - when assisting a patient with a Disabled Parking Permit application
- National medical standards document, go to ccmta.ca, publications, National Safety Code standard 6
- CMA Guide, go to cma.ca, free download for CMA members or available for purchase

MPI Websites – Medical Conditions and Driving

- MPI Health Care Professional website

  https://www.mpi.mb.ca/Pages/health-care-professionals.aspx

- MPI Drivers and Families website

  https://www.mpi.mb.ca/Pages/medical-fitness-review.aspx

- MPI Health Care Professional telephone line 204-953-4925