Assessing Fitness to Drive - Submission Form

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Issue Consideration

Issue	Part (A, B, C)	Section (7.2, 4.2.X, etc).	Page, Figure, or Table	Provide details on the issue and why it needs to be addressed.	If you have a recommendation to the issue, please describe.	Outline anticipated effects of your recommendation for; • health professionals; • driver licencing authorities; or • drivers.	Please provide any supporting evidence or information.	**COMMENTS ON 2021 DRAFT** **Note: some sections numbered differently from 2017 version**
1	B	5 7 9 (8)		Chronic pain is now recognised as a condition in its own right. Yet its mention in this document is cursory, centred very much on (5) musculoskeletal conditions, as is not inappropriate, but not recognising the strong interaction with (7) psychiatric conditions and (8) substance misuse disorders, if not also (8) sleep disorders.	Chronic pain, with a community prevalence of ~20%, is a complex issue, with significant implications for FTD. As chronic pain can embrace musculoskeletal, neurolgical, psychiatric and substance misuse aspects, it is argued that it should be afforded an individual entry in Part B.	• Ready reference for all parties, especially in view of sections 2.2.7 and 2.2.8 if not also 2.2.3 and 2.2.4. • Emphasises a holistic approach, especially with respect to 2.2.7 and 2.2.4 and "combinations of disabilities" (pp. 10-11).		**Chronic pain still not identified as a condition in its own right.** Could easily be added as a dot-point to **2.2.2 Conditions likely to affect driving.** Reiterate: As chronic pain can embrace musculoskeletal, neurological, psychiatric and substance misuse aspects, it is argued that **it should be afforded an individual entry in Part B.**
2	A	2.2.7	10		Chronic pain deserves a dot-point			**Now 2.2. Multiple medical conditions** Reiterate: Chronic pain deserves a dot-point
3	A	2.2.8	11-12	Cannabinoids are now available on prescription in Australia. (Entry on cannabis in section 9.1.2 noted.)	Cannabinoids deserve an individual entry under specific drug classes, especially because of the associated proscription on driving.	Important guidance for health professionals	Faculty document PM10 [rebadged PS10(PM)2018]	Now **2.2.10 Drugs and driving** Good section on cannabinoids added. Noted: "In general, it is against the law for a person to drive with any amount of THC present in bodily fluids (blood, saliva or urine). Currently, there are no exceptions for any jurisdiction across Australia, including therapeutic use, to these laws." However, the section on opioids (p.24) is quite outdated. Reference is made to Royal Australian College of Physicians' *Prescription Opioid Policy: Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use*. This 2009 publication is way out of date**. It would be better to refer to FPM document PS01(PM)2020 (Foreground**

								statement) **.** Its companion Background statement (PM01) is under revision.
								Section 5 Musculoskeletal conditions Specific mention of • the presence of pain that may impede concentration, attention or movement and reduce the level of safety is noted (p. 112) However this is not emphasised sufficiently.
4	B	7.2.4	109	Chronic pain is often comorbid with a psychiatric condition and/or drug or alcohol abuse	Chronic pain deserves a dot-point. Suggest also using the term “analgesics” rather than “painkillers”, especially as the latter is inaccurate.	The comorbidities of chronic pain in this context needs to be emphasised.		**New section 7.2.5 Comorbidities noted.** People with a psychiatric condition and substance misuse (section 9. Substance misuse) or chronic pain (section 5. Musculoskeletal conditions) comorbidities may be at higher risk and warrant careful consideration. The assessment should identify the potential relevance of: • problematic alcohol consumption • use of illicit substances • **chronic pain** • prescription drug abuse (e.g. increased use of benzodiazepines, sedatives or painkillers).
5	B	9.2.1	119	“Chronic misuse of drugs is incompatible with safe vehicle driving.” However reference is made mainly to “…drivers who *misuse* alcohol or other substances (prescribed or illicit)”. (Emphasis added here.)	It is not uncommon for a number of drugs to be prescribed for management of chronic pain. Even when used as prescribed – that is, not misused – there is an increased risk of cognitive, psychomotor and even motor dysfunction.	This section should specifically mention possible consequences of multiple prescribed medicines. Specialist pain medicine physicians should be added to the list of providers of “secondary” opinion.	Section	**Section 9.2.1** This addition noted: “In particular, people with substance use disorder and mental illness, acquired brain injury **or chronic pain comorbiditie**s may have a level of complexity requiring specialist assessment.”
6	B	9.2.3	120	These two paragraphs make excellent points. However, specialist pain medicine physcians may have a major role here, as well as the other craft groups mentioned.	Add specialist pain medicine physician to “addiction medicine specialist or addiction psychiatrist”.	Complex comorbidity of chronic pain conditions often requires assesssment by a specialist pain medicine physician, especially when the main issue with respect to FTD is pain.		**Section 9.2.3** Noted addition of “People using these agents should be referred for assessment by an appropriate specialist such as an addiction medicine specialist, addiction psychiatrist or **pain medicine specialist**. “ However, the reference to “the Royal Australian College of Physicians’ Prescription Opioid Policy: Improving

								management of chronic non-malignant pain and prevention of problems associated with prescription opioid use" is out-of-date, as mentioned above. The FPM paper PS01(PM)2020 should be preferred.
7	A	2	9 (Table 1)	Under the topic of 'anaesthesia', the document refers to "both general and local anaesthesia". According to ANZCA definitions, anaesthesia includes general anaesthesia, regional anaesthesia/analgesia **and sedation**. Sedation may be classified into either conscious sedation where patients maintain sensible verbal communication, or deep sedation whose risks are similar to general anaesthesia. The difference between sedation and anaesthesia may be small and dependent on dosage administered and patient sensitivity. In these cases sedation will impact fitness to drive.	Reference to sedation should also be included in the anaesthesia entry under 'Condition and impact on driving' as well as in the second and third dot points of the associated 'management guidelines.'	Medications used for sedation are not infrequently the same as those administered during anaesthesia and consequently may lead to inadvertent general anaesthesia depending on dosage administered and patient susceptibility.	ANZCA professional document: *PS15 Guideline for the perioperative care of patients selected for day stay procedures* Accompanying background paper, *PS15BP*.	The addition of 'sedation' to the heading in Table 1 is noted. However, sufficient reference to sedation is missing in the body of the table. It needs to be clear that anaesthesia and sedation are on a spectrum and any reference to anaesthesia should include, general, local, and sedation. **Suggested changes are shown below (1.)** .

(1.) Suggested changes to Table 1: Examples of how to manage temporary conditions

Condition and impact on driving	Management guidelines
Anaesthesia and sedation Physical and mental capacity may be impaired for some time post anaesthesia (including ~~both~~ general anaesthesia,~~d~~ local anaesthesia, and sedation). The effects of general anaesthesia will depend on factors such as the duration of anaesthesia, the drugs administered and the surgery performed. The effect of local anaesthesia will depend on dosage and the region of administration. Analgesic and sedative use should also be considered	In cases of recovery following surgery or procedures under general anaesthesia, ~~or~~ local anaesthesia, or sedation, it is the responsibility of the surgeon/dentist and anaesthetist to advise patients not to drive until physical and mental recovery is compatible with safe driving. • Following minor procedures under local anaesthesia without sedation (e.g. dental block), driving may be acceptable immediately after the procedure. • Following brief surgery or procedures with short acting anaesthetic drugs or sedation, the patient may be fit to drive after a normal night's sleep. • After longer surgery or procedures requiring general anaesthesia or sedation, it may not be safe to drive for 24 hours or more.