Assessing Fitness to Drive - Submission Form

Contact Name	Organisation	Phone	Email
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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.	Please provide any other comment you have on this issue.
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. While this focus is not inappropriate, it fails to recognise the strong interaction with (7) psychiatric conditions and (9) 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, neurological, psychiatric and substance misuse aspects, 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).		
2	A	2.2.7	10		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	*PM10 Statement on "Medicinal Cannabis" with particular reference to its use in the management of patients with chronic non-cancer pain* [rebadged PS10(PM)2018]	
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.		
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.		
6	B	9.2.3	120	These two paragraphs make excellent points. However, specialist pain medicine physicians 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 assessment by a specialist pain medicine physician, especially when the main issue with respect to FTD is pain.		
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,	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*	The advice otherwise aligns with ANZCA professional documents PS15 and accompanying background paper PS15BP.

				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.			Accompanying background paper, *PS15BP*.	

*Insert a new row as required.

Discovery Work

Policy and Advocacy Please describe any current policies, position statements or other advocacy activities undertaken by your organisation in relation to fitness to drive or transition to non-driving.
Please identify needs and opportunities in this regard for your organisation. e.g. • promotion and implementation of current policies / position statements; • development of new policies / position statements; • other advocacy opportunities

Awareness raising for members Please describe any current or recent activities aimed at raising awareness among your members regarding fitness to drive or transition to non-driving.
Please identify areas of need in relation to awareness raising for your members, as well as any opportunities to improve awareness raising. For example: • What key messages need to be communicated about fitness to drive? • What other key messages need to be communicated? • What mechanisms of communication are available through your organisation? • What opportunities are there to link with Austroads communication?

Member education Please describe any current or recent activities aimed at improving knowledge and skills of your members regarding fitness to drive or transition to non-driving.
Please identify areas of need in relation to education of your members, as well as any opportunities for your organisation or for Austroads and the NTC to improve education. For example: • What aspects of managing fitness to drive need to be the focus of education? • Do your members understand the medical condition reporting process and responsibilities? • How can fitness to drive education be integrated into your current education offerings?

Information Resources Please describe any resources developed or promoted by your organisation to support members in managing fitness to drive and transition to non-driving.
Please identify areas of need in relation to resources, as well as any opportunities for your organisation or Austroads and the NTC to improve access to appropriate resources. • Are members aware of supporting resources available through Austroads or licensing agencies? • Are members aware of resources available through consumer and patient support organisations? • Are additional resources required to facilitate / support the fitness to drive process?

Content accessibility Please describe any issues you experience accessing the AFTD medical criteria or supporting information. What design elements (figures, diagrams, tables, etc) are useful and should be preserved or expanded in the next edition?
Please nominate ways to improve access and general use of the AFTD content for health professionals? • Is there value in trying to have the content integrated into practice or patient management software? • Would online CPD training units be useful? • What other types integration should we consider?