Victorian Institute of Forensic Medicine

Clinical Communiqué

VOLUME 2. ISSUE 3.
September 2015 Edition
ISSN 2204 - 0099

CONTENTS

Editorial	1
Case #1 The Price of Ignorance	2
Case #2 History Repeating	3
Case #3 A Risk Unseen	5
Expert Commentary: Assessing Fitness to Drive in Australia	6

PUBLICATION TEAM

Editor in Chief: Nicola Cunningham
Consultant Editor: Joseph E Ibrahim
Managing Editor: Alexander Gillard
Designer: Clair Richards
Web Designer: Andrea Hince

Address: Department of Forensic Medicine, Monash University,
Victorian Institute of Forensic Medicine
65 Kavanagh St, Southbank VIC 3006

Honorary Advisory Board: Adam O'Brien, Carmel Young, David Ranson

FREE SUBSCRIPTION

The Department of Forensic Medicine Monash University and the Victorian Institute of Forensic Medicine will publish the CLINICAL COMMUNIQUÉ on a quarterly basis. Subscription is free of charge and will be sent electronically to your preferred email address.

If you would like to subscribe to the CLINICAL COMMUNIQUÉ, please go to:

www.vifmcommuniques.org/subscribe

Next Edition: December 2015

EDITORIAL

In this issue of the Clinical Communiqué we explore, for the first time in our publication, the important subject of fitness to drive. It is a question that is commonly raised for the patient who has had a seizure, stroke or degenerative muscular condition, but how often is it considered for the patient presenting to hospital with drug and alcohol-related problems, or for the patient suffering from a delusional disorder, or a 'temporary' medical condition such as a pulmonary embolus?

This is an area of practice that is pertinent to every healthcare professional and is not solely limited to a small group of medical experts whose role it is to determine a person's suitability to hold a licence. Whether a patient is fit to drive is a clinical question, which should be posed every time we see a patient, whether in an acute hospital, outpatient, or general practice setting.

Many medical, psychiatric and toxicological conditions are capable of impairing a driver's attention, decision-making abilities and reaction times. When the impairment is subtle or intermittent, the assessment of fitness to drive can be made even more difficult.

Across the country, there is no uniform approach to the reporting and assessment of fitness to drive, and the strengths and weaknesses of the various State-based systems have been strongly debated for many years. What is agreed is that assessing fitness to drive is a complex and challenging task for healthcare professionals. It is a heavy responsibility to bear. It can be a confronting scenario to advise your patient they should not hold a license, to recommend that they lose a vital part of their independence, mobility, and at times, their income. It can also be devastating to discover that one of your patients has been involved in a motor vehicle crash as a result of the medical condition you have been treating, and you had not considered the issue of driving or identified a significant risk.

This is also the first issue where senior forensic physicians at the Victorian Institute of Forensic Medicine (VIFM) have contributed to the expert commentary and two of the case summaries. The guest authors are all gazetted approved experts under Section 57 of the Road Safety Act (VIC) and medical consultants to VicRoads on matters of fitness to drive.

Each case has been selected to represent a different jurisdiction and involve a diverse range of medical conditions and practitioners. The common theme between them is that they were all, as one coroner noted, "an accident waiting to happen." The first case depicts the condition of hypoglycaemic unawareness, the second is best described by the adage – "everything that happens once can never happen again, but everything that happens twice will surely happen a third time." The final case is one to reflect on what might happen when your patient leaves the consultation room.

The inquests in fitness to drive cases have a distinctive format in that the investigation does not centre on the history and circumstances of the deceased. Instead, the purpose of the inquests is to examine the medical background and behaviour of the living – the drivers involved in the collisions.

vmia Risk Management and Insurance

MONASH University

VERITAS OMNIA VINCIT

ACKNOWLEDGEMENTS

This initiative has been made possible by collaboration with the Department of Forensic Medicine (DFM), Monash University, Victorian Institute of Forensic Medicine (VIFM) and Victorian Managed Insurance Authority (VMIA).

REPRODUCTION & COPYRIGHT

This document may be reproduced in its entirety for the purposes of research, teaching and education and may not be sold or used for profit in any way. You may create a web link to its electronic version.

Permission must be obtained for any modification or intended alternative uses of this document. If referring to this publication, the following citation should be used:

Clinical Communiqué [electronic resource]: Department of Forensic Medicine, Monash University, Victorian Institute of Forensic Medicine. Available at: www.vifmcommuniques.org

DISCLAIMER

All cases that are discussed in the Clinical Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed. We have made every attempt to ensure that individuals and organizations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of Victorian Managed Insurance Authority, the individual Coroner, the Coroners Court, Department of Health, Department of Forensic Medicine, Victorian Institute of Forensic Medicine or Monash University. If you would like to examine the case in greater detail, please contact us and we will provide the relevant website for the Coroners Court jurisdiction.

FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to: clinical.communique@vifm.org

CASE #1 THE PRICE OF IGNORANCE

Case Number:
CD 32/03 and CD 29/03 ACT
Case Précis Author:
Dr Sanjeev Gaya
DMJ, FCFM (RCPA), MForensMed

CASE SUMMARY

In the early afternoon of Monday, 10 February 2003, Mr T, an insulin-requiring diabetic, drove his car into the back of a stationary car at a red traffic light, killing its pregnant passenger. A blood glucose level (BGL) test at the collision site revealed that Mr T was hypoglycaemic (BGL 1.4 mmol/L). Subsequent crash reconstruction demonstrated that Mr T had hardly slowed down before the collision. Although unable to recall the details of the collision, Mr T told police that he could not have been hypoglycaemic because he had not experienced the symptoms of hypoglycaemia at the time of the collision.

INVESTIGATION

An inquest found that at the time of the collision Mr T had had diabetes mellitus for six years. Following a hospital admission in November 2000 with ketoacidosis, a life-threatening complication of diabetes, Mr T moved overseas a few months later. While overseas he did not drive and he rarely tested his BGL, even though he had checked it 3-4 times weekly while living in Australia. Mr T returned to Australia a month before the collision. He resumed driving, but did not test his BGL because his meter was in storage following his relocation. Thus, Mr T had not tested his BGL for at least 4 weeks before the collision. His insulin regimen had remained unchanged for the 2 years before the collision.

Mr T's inability to sense the symptoms and signs of a low BGL and to take appropriate remedial actions suggested to the endocrinologist that he had developed hypoglycaemic unawareness.

An endocrinologist told the coroner at inquest that a low BGL in combination with the presence of ketones in Mr T's urine indicated that he had an inadequate carbohydrate intake during that day. Mr T's inability to sense the symptoms and signs of a low BGL and to take appropriate remedial actions suggested to the endocrinologist that he had developed hypoglycaemic unawareness.

The endocrinologist further stated that the onset of hypoglycaemic unawareness is insidious, developing over weeks or months, and occurring when a person has 1 or 2 periods of low BGL per day for a sustained period.

CORONER'S FINDING

The coroner concluded that it was likely that Mr T, at the time of the crash, had developed hypoglycaemic unawareness due to inadequate monitoring of his diabetes, particularly when he was overseas.

Driving is not a right, but a privilege. As this case illustrates, subtle effects of a fairly common medical condition in a driver can disastrously impact on the driver and other road users.

The coroner made several recommendations in relation to the licensing of private vehicle drivers who have insulin-requiring diabetes. The recommendations outlined the expected frequency of attendances at specialist reviews, the required medical documentation, and the driving restrictions that should be imposed in the event of hypoglycaemic episodes or non-compliance with the regulations.

AUTHOR'S COMMENTS

Driving is not a right, but a privilege. As this case illustrates, subtle effects of a fairly common medical condition in a driver can disastrously impact on the driver and other road users. For this reason, it is incumbent on both drivers and their healthcare professionals to further extend their therapeutic relationship to consider the impact of their conditions and treatments on driving.

RESOURCES

American Diabetes Association: Diabetes and driving. Diabetes Care 2013; 36 (Suppl. 1): S80–S85.

http://care.diabetesjournals.org/content/35/Supplement_1/S81.full.pdf

Section 14.3 Driving – General practice management of type 2 diabetes – 2014–15. Melbourne: The Royal Australian College of General Practitioners and Diabetes Australia, 2014. Available at:

http://www.racgp.org.au/your-practice/guidelines/diabetes/14-management-of-other-impacts-of-diabetes/143-driving/

KEYWORDS

Fitness to drive, diabetes, hypoglycaemia, hypoglycaemic unawareness, endocrinologist

CASE #2 HISTORY REPEATING

Case Number:
D0081/2012 NT
Case Précis Author:
Dr Nicola Cunningham
FACEM, FFCFM (RCPA), MForensMed

CLINICAL SUMMARY

Mr W was a 29 year old driver of a vehicle that was stationary or moving very slowly in an outbound lane of a highway when it was struck from behind by another vehicle in May 2012. The impact caused Mr W's vehicle to propel forwards and spin around, rupturing the fuel tank which then exploded. The doors were jammed shut as a result of the damage so despite the valiant attempts of passing motorists, Mr W was unable to be extricated from the vehicle and died at the scene. The other vehicle, driven by Mr S, a 67 year old male, collided with five more vehicles before it finally stopped. Mr S was not injured in the series of collisions.

PATHOLOGY

A forensic odontologist using dental records formally identified Mr W. An autopsy was performed and the pathologist gave the cause of death as severe burns.

INVESTIGATION

Mr S was charged with driving in a manner dangerous occasioning death. The prosecution was terminated when the Crown accepted a defence of mental impairment. Mr S entered into a non-custodial supervision order that prohibited him from applying for a driver's license without the prior consent of the Court.

Mr S was assessed as being fit to drive on a routine review by his GP. It was shortly after this that the first of the three incidents occurred.

Following the criminal proceedings, a coronial inquest was conducted to examine how it came to be that Mr S was granted a driver's licence, and to identify what steps could be taken to prevent a similar event.

Mechanical problems, excessive speed, weather and road conditions were all ruled out in the preliminary investigation as contributing factors to the crash. Mr S tested negative for alcohol and illicit drugs.

Mr S's general practitioner (GP) was called to give evidence at the inquest. Expert testimony was heard from the Registrar of Motor Vehicles, representatives from the Department of Health, a neurologist, and a geriatrician.

The coroner found that Mr S should never have been granted a license in 2012, and that his presence on the road was an accident waiting to happen.

It was revealed that Mr S had been involved in three other motor vehicle incidents in the 18 months leading up to the fatal collision. The first two were multi-vehicle crashes, both occurring when Mr S drove into the back of a car at an intersection, triggering a chain of collisions. Police had attended, and Mr S was charged with driving in a manner dangerous. On the third occasion, Mr S drove off the road going around a corner. Police noted that he was confused at the scene and he was conveyed to hospital where he was investigated for a 'syncopal' or blackout episode.

Mr S's medical history was examined. He had a metallic aortic valve replacement, and was on anticoagulant medication. In 2008 he suffered a stroke affecting his right occipital parietal region. The treating team had notified the Motor Vehicle Registry (MVR) and his license had been suspended. It was reinstated 3 months later following a favourable occupational therapy on-road assessment. In 2010, Mr S was assessed as being fit to drive on a routine review by his GP. It was shortly after this that the first of the three incidents occurred. In November 2011, after driving off the road, the hospital team assessing Mr S notified the MVR of the circumstances and his license was once again suspended. A cardiology review was unremarkable. An outpatient EEG was ordered. Two months later the GP reported to the MVR that Mr S had passed the medical examination for fitness to drive.

The GP was aware of the blackout incident but had no knowledge of the two prior multi-vehicle collisions and further medical investigations were pending. In January 2012, the MVR granted Mr S a conditional license that required annual medical reviews. The MVR did not know of the two multi-vehicle collisions.

The neurologist reviewed the medical files and the results of an EEG for Mr S that was conducted after Mr W's death. He proposed that Mr S suffered from complex partial epileptic seizures and that all the collisions were caused by the seizures. The neurologist was asked to examine Mr S prior to the inquest and he testified that Mr S also appeared to be suffering from a dementing illness.

A court appointed geriatrician who had examined Mr S for the criminal proceedings presented his evidence at the inquest. He opined that the initial stroke was likely to have been complicated by anosognosia (lack of insight or understanding that anything is wrong), left sided visual neglect, and complex partial seizures. Each of these, in particular the visual neglect, may have contributed to the crashes.

In order to perform a comprehensive assessment, health professionals need to have all the relevant medical and driving history. Information sharing between health professionals and their patients, the police and the transport authorities, is crucial to making well-informed decisions.

The MVR told the coroner at inquest that at the time of the incidents, police did not routinely advise the MVR of non-commercial drivers involved in crashes where no convictions, court orders or demerit points were issued. If the MVR required a criminal history report, the applicant had to sign an authority permitting the MVR to obtain the information from the police.

CORONER'S FINDINGS

The coroner found that Mr S should never have been granted a license in 2012, and that his presence on the road was an accident waiting to happen. The system failures that contributed to the fatal crash included the MVR being unaware of the previous collisions at the time of granting his licence, and the limited information his GP had regarding his medical conditions and the previous collisions.

Each patient must be assessed on individual merit with reference to relevant publications to assist in formulating the safest approach.

The coroner noted that since the crash, there had been some areas of improvement in the system for recognising and assessing fitness to drive. Applicants were required to include traffic offences and crash history in forms provided to medical practitioners. Forms that applicants submitted to the MVR included consent for the Registrar to obtain details from health professionals and police of their health and driving records (including crash involvement).

The coroner made a number of recommendations that included a Medical Review Panel be set up for the purpose of rendering expert advice to the MVR regarding complex fitness to drive cases, and a system be put in place whereby the review panel would have full access to health and police records for an applicant.

EDITOR'S COMMENTS

In order to perform a comprehensive assessment, health professionals need to have all the relevant medical and driving history. Information sharing between health professionals and their patients, the police and the transport authorities, is crucial to making well-informed decisions. Each patient must be assessed on individual merit with reference to relevant publications to assist in formulating the safest approach.

There are two key National bodies that provide the oversight to driving regulations and fitness to drive guidelines in Australia:

(i) Austroads - the Association of Australian and New Zealand Road Transport and Traffic Authorities. All Australian road transport and traffic authorities are members of this body. The association publishes medical standards for drivers of private and commercial vehicles.

(ii) The National Transport Commission. This was established pursuant to the National Transport Commission Act 2003 (Commonwealth). It is the body that formulated the Australian Road Rules, which establish rules for driving and driving behaviour offences in all Australian States and Territories.

RESOURCES

Carmody J, Traynor V, Iverson D. Dementia and driving – An approach for general practice. Australian Family Physician 2012; 41 (4): 230-233. Available at:

http://www.racgp.org.au/afp/2012/april/dementia-and-driving/

Charlton J. Koppel S, Odell M, Devlin A, Langford J, O'Hare, M, Kopinathan C. Andrea D, Smith G, Khodr B, Edquist J, Muir C, Scully M. Influence of chronic illness on crash involvement of motor vehicle drivers: 2nd edition, 2010. Monash University Accident Research Centre. MUARC Report No. 300. Available at: http://www.monash.edu.au/miri/research/reports/muarc300.pdf

KEYWORDS

Fitness to drive, epilepsy, stroke, neurologist, dementia, geriatrician

CASE #3 A RISK UNSEEN

Case Number:
COR\02 1031 QLD
Case Précis Author:
Dr Angela Sungaila
JD, FFCFM (RCPA), MForensMed

CLINICAL SUMMARY

Mr B, the deceased, was an indigenous man struck by a car on a road in front of a hotel. He was part of a large crowd, which had spilled onto the roadway in front of the hotel during NAIDOC (National Aborigines and Islanders Day Observance Committee) week celebrations in 2002. Mr B's injuries were catastrophic and immediately fatal.

PATHOLOGY

At autopsy it was found that Mr B had avulsion of his brain stem and upper cervical cord with a fracture of his proximal cervical spine. The coroner's concern in this case was more to do with the cause of the collision than the nature of Mr B's death.

INVESTIGATION

The focus of the investigation was to determine which of the three possibilities was the most likely explanation for why the driver ran into the group of people – had it been too dark for a competent and careful driver to see the people on the road? Had the driver failed to keep sufficient lookout? Or had the driver's eyesight made their driving dangerous?

The stretch of road outside the hotel was four lanes divided by a median strip. On the night of Mr B's death there were probably in excess of 100 people in the hotel car park and intermittently on the road.

The driver of the car was an elderly woman, Mrs A. She was driving past the hotel at 2:30 am and claimed that she did not see the group of people on the road before she hit three of them killing Mr B. Immediately after the collision she was assaulted by a number of people who were part of the group. In the first instance, the police were concerned with this charge of assault consequently resulting in scant attention to Mrs A's role in the death of Mr B.

The subsequent investigation found that the speed of her car was 51-58km/h. The street lighting was approximately 50 metres each side of the collision site but a spotlight illuminating the car park of the hotel was switched off. It was conceded that lighting was poor but the evidence of other drivers in the vicinity that night was that they saw people on the road and managed to stop in time.

There were reports of conflicting statements made by Mrs A to police and medical staff in the hours following the event. She first claimed that she had "looked at the traffic lights and away from the road for one second", then said that the people "ran out in front of her giving her insufficient time to stop". She later described there were "multiple people on the road who she saw at the last moment".

A critical part of the investigation was the discovery of Mrs A's impaired vision. She claimed privilege at giving evidence at the inquest on the grounds of self-incrimination. The inquest was adjourned so that the investigators could obtain expert evidence from an ophthalmologist and another doctor who had seen her. Unfortunately Mrs A died before the inquest resumed. On resumption, evidence presented revealed that Mrs A had consulted various medical practitioners relating to her eyesight. A hospital doctor earlier in the year of the collision advised her strongly not to drive when she was found to have cataracts in both eyes with visual acuities of 6/36 in each eye (i.e. she could only identify symbols that a normal sighted person could identify from 36 metres when she was 6 metres from the symbols). Mrs A saw an ophthalmologist who advised that she should undergo surgery. She told her ophthalmologist that she was not driving. She saw her general practitioner a few months later who tested her eyesight again and recorded her visual acuity as being 6/36 (right eye) and 6/60 (left eye). Two days before the collision, Mrs A's ophthalmologist reviewed her and noted that her cataracts had worsened.

CORONER'S FINDINGS

The coroner found that the lighting of the road at the time did not fully explain why Mrs A did not see the group of people sooner. Of greater significance was the fact that she had cataracts and significantly impaired visual acuities in both eyes.

The dominant factor in the collision causing Mr B's death was Mrs A's poor vision. The coroner concluded that while Mrs A had a moral obligation to notify the driving authority, there was no legal obligation to do so. He found that at least four medical practitioners knew that Mrs A had insufficient vision to drive but none of them notified the driving authority. If they had done so, it was likely that Mrs A would have been compelled to forfeit her licence thus reducing her likelihood to drive.

The coroner recommended that there be compulsory reporting by medical practitioners of impaired drivers.

AUTHOR'S COMMENTS

Mrs A's vision at the time of the accident was 6/36 in each eye. 'Austroads' standards require visual acuity equal to or better than 6/12. The guidelines allow some discretion in applying the standard however a licence will not be issued if visual acuity is worse than 6/24.

The laws around reporting have since changed, and under today's legislation, Mrs A would have an obligation to notify her impaired vision to the authority. Her doctors would not. Non-disclosure by the patient of their medical condition might result in tragic outcomes for themselves and possibly others.

RESOURCES

https://www.vicroads.vic.gov.au/licences/medical-conditions-and-driving/medical-conditions/visual-impairment

Jet's Law (QLD) - In 2004, a driver with epilepsy had a seizure and crashed into the car that 22 month old Jet was travelling in. Jet was killed by the impact and his brother and mother were severely injured in the crash. Medical condition reporting legislation was introduced in QLD after the tragic death and named Jet's Law. See 'Part 6 - Jet's law: eligibility for licences and reporting of particular medical conditions'. Transport Operations (Road Use Management—Driver Licensing) Regulation 2010, page 75. Queensland Parliamentary Counsel. Available at: https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/T/TrantOpRUDLR10.pdf

KEYWORDS

Fitness to drive, mandatory reporting, cataracts, impaired vision, ophthalmologist, older driver

EXPERT COMMENTARY

ASSESSING FITNESS TO DRIVE IN AUSTRALIA

Associate Professor Morris Odell
Senior Forensic Physician and Head, Clinical Forensic Medicine, VIFM
Associate Professor of Forensic Medicine, Monash University

Driving a motor vehicle is a complex task involving many aspects of motor and cognitive function. A wide range of conditions are capable of reducing a person's ability to control a motor vehicle and therefore licensing authorities have an obligation to control eligibility for licensing based on fitness to drive. This extends to considerations of culpability and responsibility when a crash occurs. Studies of the impact of natural disease and/or drug therapy on crash rates have found a low crash rate from these causes compared to other factors such as drink-driving. Despite this, questions of medical fitness to drive can assume enormous importance in legal proceedings after a crash.

The tasks of routine driving are 'over learned', but consideration must be given to a person's ability to respond to unusual or emergency situations, which cannot be tested easily.

Fitness to drive is difficult to assess in a medical consulting room. While conditions such as epilepsy, diabetes or poor vision have obvious effects on driving, other conditions such as musculoskeletal impairments or subtle psychological deficits are harder to assess. Fitness must be considered in the context of the effect of the condition on the ability to perform the tasks of driving. The tasks of routine driving are 'over learned', but consideration must be given to a person's ability to respond to unusual or emergency situations, which cannot be tested easily. The cognitive and neuro-psychological demands of driving are far greater in situations such as night driving or attempting to navigate a complex unfamiliar route so there must be an adequate functional reserve in order to cope with these situations.

Transport authorities publish medical guidelines for fitness to drive. These are formulated with the often-conflicting intentions of preserving individual freedom and maximizing public safety.

Guidelines encompass a range of medical conditions involving most organ systems. They address questions of eligibility for various types of licences as well as criteria for allowing driving to recommence after an illness or during treatment.

In Australia the licensing criteria are set out in the Austroads booklet 'Assessing Fitness to Drive'.

There are differences in the demands of driving commercial vehicles compared to cars and because the consequences of a collision may be more severe, there are different requirements based on the type of licence held by the driver. Commercial vehicles are usually heavier, and may be carrying passengers or dangerous goods such as fuel, chemicals or explosives. Drivers spend more time driving and may be subject to irregular hours which impact on the ability to eat, sleep or take medication. Therefore a higher level of risk assessment is implied in commercial licensing guidelines. In Australia the licensing criteria are set out in the Austroads booklet 'Assessing Fitness to Drive'. These apply throughout Australia even though individual states are responsible for their own licensing policies.

Licensing authorities can request a driver to undergo medical and other assessments as a condition for granting a licence. In some Australian states (NSW, SA, TAS, ACT), there are mandatory reviews based on age, which become more frequent as the driver ages. In others, such as Victoria, there are no compulsory reviews for drivers unless the licensing authority is aware of a medical condition.

In South Australia and the Northern Territory it is compulsory for health professionals to report medically unfit drivers to the licensing authority, and coroners and others have recommended that mandatory reporting be introduced in other jurisdictions. These laws have been criticized on the grounds that they involve doctors inappropriately in the policing process, lead to dishonesty and mistrust of their doctors by patients, and only bring a small number of drivers to the attention of the authorities, many of whom could already have become known in other ways.

A study from Canada comparing two nearby jurisdictions with and without mandatory reporting found no difference in the crash risk of drivers with epilepsy.

There have also been concerns expressed regarding possible negligence charges against doctors who fail to carry out a full driving assessment on every patient. In most Australian states, all persons (including healthcare practitioners) are indemnified from civil action if, acting in good faith, they notify the licensing authority of a driver suffering from a condition which could adversely affect their driving skills. An obligation also exists for drivers to inform the licensing authority of any condition likely to adversely affect the ability to drive.

In areas where there is no compulsory reporting, practitioners still have a responsibility to inform patients about conditions or medications that may affect their driving skills and encourage them to self-report. Despite this, patients may choose not to report their condition for various reasons and may not inform their doctor.

Concerns regarding confidentiality and negative impacts on the doctor-patient relationship may make this a very difficult decision and it may be necessary for reporting to be done anonymously.

Although reporting may not be mandatory, practitioners need to consider informing licensing authorities in cases where patients continue to drive against all advice to the contrary. Concerns regarding confidentiality and negative impacts on the doctor-patient relationship may make this a very difficult decision and it may be necessary for reporting to be done anonymously.

RESOURCES

Assessing Fitness to Drive - for commercial and private vehicle drivers. Austroads 2012. Available at: http://www.austroads.com.au/drivers-vehicles/assessing-fitness-to-drive.

Black A, Lai N. Epilepsy and driving in South Australia - An assessment of compulsory notification. Med Law 1997; 16: 253-267.

Marks, P. Disease, drugs and alcohol induced driving impairment: the law and the medicine. Med Leg J 1998; 66: (Pt 3) 109-115.

McLachlan R, Starreveld E, Lee M. Impact of mandatory physician reporting on accident risk in epilepsy. Epilepsia 2007; 48: 1500-1505.