United States Department of Transportation
FEDERAL MOTOR CARRIER SAFETY ADMINISTRATION

Meeting Summary

The Medical Review Board (MRB) of the U.S. Department of Transportation's Federal Motor Carrier Safety Administration (FMCSA) convened on January 12, 2009, at the Embassy Suites Hotel in Alexandria, Virginia. The meeting was open to the public.

MRB Members Present:
Kurt Hegmann, MD, Chairperson
Michael Greenberg, MD, Co-chairperson
Gunnar Andersson, MD
Barbara Phillips, MD
Matthew Rizzo, MD

Medical Expert Panel Representative:
Abiodun Akinwuntan, Ph.D. – Stroke Panel

FMCSA Staff:
Rose A. McMurray, Chief Safety Officer and Assistant Administrator
Larry W. Minor, Associate Administrator for Policy and Program Development
[*]Mary D. Gunnels, Ph.D., Director, Office of Medical Programs
Elaine Papp, Chief, Office of Medical Programs
Linda Phillips
Pearlie Robinson

[*]*Designated Federal Official (DFO)*

FMCSA Contractors:
Glenna Tinney, Axiom Resource Management, Inc.
Purvi Shah, Axiom Resource Management, Inc.
Mary Johnson, Axiom Resource Management, Inc.
Jennifer Musick, Axiom Resource Management, Inc.
Lonnie Weiss, Weiss Consulting, LLC.
Stephen Tregear, DPhil, Manila Consulting Group, Inc.
Jessica Williams, Ph.D., MPH, Manila Consulting Group, Inc.

Members of the Public:
Della Antista-Finkelstein, Respira Medical
Christie Cullinan, American Trucking Associations
Sandy Harding, American Academy of Physician Assistants (AAPA)
Jeff Heinrich, Professional Driver Medical Depots (PDMD)
John McElligott, American College of Occupational and Environmental Medicine, PDMD
Lisa McElligott
Gary Moffitt, Road Ready, Inc.

Stan Roberts, AAPA
Arleen Saenger, Federal Aviation Administration
Carl Soderstrom, Maryland Motor Vehicle Administration
Melissa Therault, Owner-Operator Independent Drivers Association
Joel Whiteman, Road Ready, Inc.

Call to Order

Mary D. Gunnels, Ph.D., Director, Office of Medical Programs, FMCSA, called the 10th public meeting of the MRB to order, noting that she is the DFO for the meeting. She announced the meeting would begin with a special presentation to the MRB, followed by a presentation on the findings of the evidence report on stroke and commercial motor vehicle (CMV) driver safety, and a presentation of the Stroke Medical Expert Panel (MEP) recommendations. Dr. Gunnels said these presentations would be followed by a designated public comment period and MRB deliberation on stroke and CMV driver safety. She noted that after the MRB deliberations on stroke there would be a second public comment period to hear comments on the National Registry of Certified Medical Examiners (NRCME) proposed rule.

Dr. Gunnels requested that attendees complete the evaluation form before leaving the meeting. She also announced that a detailed summary of the meeting would be prepared and posted on the MRB Web site at www.mrb.fmcsa.dot.gov.

Dr. Gunnels introduced and welcomed Rose A. McMurray, Chief Safety Officer and Assistant Administrator of FMCSA and Larry W. Minor, Associate Administrator for Policy and Program Development. She turned the meeting over to Ms. McMurray for the special presentation to the MRB.

MRB Plaque Presentation

Ms. McMurray expressed her appreciation to the MRB and presented each member with a plaque. She noted that this would be the last meeting for Michael Greenberg, MD, and Matthew Rizzo, MD, and thanked them for the service they provided to the Agency for the past 3 years. She expressed appreciation to MRB Chairperson, Kurt Hegmann, MD, Gunnar Andersson, MD, and Barbara Phillips, MD for their contributions and continuing service on the MRB.

Following the presentation, Dr. Gunnels turned the meeting over to Dr. Hegmann for the first item of business.

MRB Approval of October 6, 2008 Meeting Summary

Dr. Hegmann called for approval of the minutes of the ninth public meeting of the MRB held on October 6, 2008. The minutes were unanimously approved.

Presentation of Evidence Report Findings: Stroke and CMV Driver Safety
Jessica Williams, Ph.D., MPH

Jessica Williams, Ph.D., Manila Consulting Group, Inc., presented an overview of the evidence report findings on stroke and CMV driver safety. She explained that a stroke is a sudden neurological deficiency resulting from cerebral infarction or hemorrhage. Stroke has the potential to impair cognitive and motor skills that are required for safe driving, creating the potential to increase the risk of a motor vehicle crash. Transient ischemic attacks (TIA) are brief episodes of

neurologic deficit, having a vascular cause that resolves without any residual effect within 24 hours. Individuals who have had a TIA may also be at greater risk for subsequent stroke.

Dr. Williams explained that because these factors pose a potential risk to public safety, FMCSA seeks current and accurate information to guide the development of regulations and to answer the following questions: Do individuals who have experienced a stroke present a threat to road safety? Should these individuals be precluded from driving a CMV? In order to answer these two overarching questions, three targeted key questions were posed and assessed through a series of systematic reviews.

Key Question #1: Among individuals who have experienced a TIA, what is the risk of experiencing a future stroke?

Key Question #2: Are individuals who have experienced a stroke at an increased risk for a motor vehicle crash (crash risk or driving performance)?

Key Question #3: If so, can neuropsychological testing of individuals who have experienced a stroke predict crash risk?

Key Question Responses

Key Question #1: Among individuals who have experienced a TIA, what is the risk of experiencing a future stroke?

The literature search identified 13 studies that met the inclusion criteria for Key Question #1; none of which specifically enrolled CMV drivers. Eight of the studies were case control design and five were cohort design. The quality of the case control studies was low and the quality of the cohort studies was moderate. The case control studies compared the prevalence of TIA among individuals who had experienced a stroke to those who had not. The cohort studies compared the incidence of stroke among individuals who had or had not experienced a TIA.

The findings revealed that individuals are at an increased risk for stroke following a TIA when compared to their counterparts who did not experience a TIA. The strength of this evidence is strong. The increased stroke risk is highest immediately following a TIA up to 1 month, then the risk decreases exponentially. The strength of this evidence is moderate.

Key Question #2: Are individuals who have experienced a stroke at an increased risk for a motor vehicle crash (crash risk or driving performance)?

During the literature search, six studies were found that addressed Key Question #2. Three studies directly assessed crash risk, and three studies indirectly assessed crash risk through on-road tests or driving simulation tests. None of the studies specifically enrolled CMV drivers. Five of the studies were cohort design and one was a case control design. None of the studies reported on the severity of stroke. Two of the three crash studies controlled for driving exposure, and the outcomes for all of the studies were based on direct observation or record rather than self-report. The overall quality of these studies was moderate.

The evidence suggests that drivers who suffered a stroke are at an increased risk of a crash. However, due to the differences across these studies, the precise size of this risk could not be determined.

Key Question #3: If so, can neuropsychological testing of individuals who have experienced a stroke predict crash risk?

Twelve studies were found that met the inclusion criteria for Key Question #3. None of these studies specifically enrolled CMV drivers. Most of the studies were cohort design and evaluated the ability of various neuropsychological tests to predict the outcomes of an on-road test or driving evaluation. None of the studies evaluated actual crash as an outcome. The overall quality of the studies was moderate. The findings of these studies could not be combined in a meta-analysis because each study used different neuropsychological tests and a different set of potential predictor variables.

Eleven of the 12 studies found that one or more of the neuropsychological tests were significant predictors of the outcomes of on-road tests or driving evaluations among stroke patients. Several of the neuropsychological tests examined in the evidence base were found to be significant outcome predictors in more than one study. These tests include: the Figure of Rey Test, the Dot Cancellation Test, the Road Sign Recognition Test, the What Else Is in the Square Test, and the Motor-Free Visual Perception Test.

The findings indicate that certain neuropsychological tests may predict the outcome of driving performance measured by an on-road test or driving evaluation. The strength of this conclusion is moderate. However, whether these neuropsychological tests can predict actual crash risk cannot be determined from the currently available evidence.

Dr. Williams concluded her presentation noting that the evidence indicates that individuals are at an increased risk for stroke following a TIA. This increased risk is highest immediately following the TIA up to 1 month, and then deceases exponentially. She pointed out that at 3 years after a TIA the level of risk still remains higher when compared to individuals who have never experienced a TIA. The evidence also suggests that drivers who have suffered a stroke are at an increased risk for crash. She added that certain neuropsychological tests may predict the outcome of driver performance measured by an on-road test or driving evaluation; however, whether these tests can predict actual crash risk has not been determined.

Dr. Hegmann thanked Dr. Williams for her presentation and asked the MRB if they had any questions.

MRB Questions and Discussion on Stroke

Dr. Phillips asked how much higher is the risk of stroke 3 years after a TIA, compared to a person who has not had a TIA. Dr. Williams explained that the risk of stroke is at least 1.5 times higher for individuals who have had a TIA. She added that it is normal with any type of adverse event (e.g., smoking, seizure disorder) that the increased risk does decrease over time, but it will never reach the level of somebody who has never been exposed to the risk.

Dr. Hegmann said the upper confidence level on that particular point estimate was much higher and asked Dr. Williams to clarify what that means for the benefit of the public. Dr. Williams explained that when doing risk assessments, it is ideal to find a central point or value that indicates the exact risk. The data for this study were very heterogeneous, so a random effects meta-analysis was used to look at the distribution of risk among the different studies. The minimum or most conservative estimate of risk is reported because the actual precise risk cannot be determined.

Dr. Hegmann said in this particular case the exact level of risk is unknown, but the data indicate that it is between 1.5 to 15 times increased risk 3 years after a TIA. He added that the 95 percent confidence interval indicates a 95 percent certainty that the risk will fall into that range. Dr. Williams concurred with Dr. Hegmann's clarification.

Dr. Rizzo asked if the types of TIAs were stratified to determine which type of TIA is more likely to result in a stroke. Dr. Williams said they were not able to stratify the types of TIAs as they varied considerably across the studies. Dr. Rizzo asked about the risk of a stroke occurring while a person is driving. Dr. Williams said that this particular evidence only assessed the risk of stroke following a TIA; it did not consider whether the individuals were driving at that time.

Presentation of MEP Recommendations: Stroke and CMV Driver Safety
Abiodun Akinwuntan, Ph.D.

Abiodun Akinwuntan, Ph.D., presented the recommendations of the Stroke MEP. He explained that the panel was convened by FMCSA to provide recommendations based on the MEP members' experience, expertise, and the data provided in the evidence report. The MEP made the following recommendations:

Recommendation #1: Single TIA and CMV Driver Certification

- The MEP recommends that all individuals who have experienced a single TIA be immediately excluded from driving a CMV.
- Individuals who have remained free from recurrent TIA or stroke for a period of at least 1 year and who are otherwise physically qualified may be considered qualified to drive a CMV.
    - Such individuals must demonstrate that they are likely to be able to perform their normal duties by undergoing a thorough evaluation of their physical and mental function by a qualified neurologist.
    - The certification process should include an on-road driving evaluation, as required in 49 CFR §391.31 for new truck drivers. Considering the length, width, weight, and other difficulties, including seeing objects in the blind angle and the special spatial requirements of driving a CMV, an on-road test after a 1-year cessation due to a TIA or stroke should be mandatory.

Recommendation #2: Preventative Treatment Following Single TIA or Minor Stroke Event

- Individuals who receive immediate (secondary) prophylactic treatment following a TIA may be at reduced risk for TIA or stroke recurrence compared to those who do not receive treatment, or receive treatment later. At this time, however, the MEP recommends that such individuals be treated in the same manner as individuals who have not received treatment (see Recommendation 1).

Recommendation #3: Stroke and CMV Driver Certification

- The MEP recommends that all individuals who have experienced a single stroke be excluded from driving a CMV.
- Provided an individual is otherwise physically qualified, individuals who have remained free from recurrent stroke for a period of at least 1 year may be considered qualified to drive a CMV.
    - Such individuals must demonstrate that they are likely to be able to perform their normal duties by undergoing a thorough evaluation of their physical and mental function by a qualified neurologist. Individuals who have experienced severe disabling stroke resulting in their needing assistance or supervision in the

activities of daily living are to be disqualified from driving due to the severity of their impairments.
    - The certification process should include an on-road driving evaluation, as required in 49 CFR §391.31 for new truck drivers. Considering the length, width, weight, and other difficulties, including seeing objects in the blind angle and the special spatial requirements of driving a CMV, an on-road test after a 1-year cessation due to a TIA or stroke should be mandatory.

Recommendation #4: Occurrence of Seizures Consequent to Stroke

- Individuals who experience a seizure following a stroke should not be certified as physically qualified to drive a CMV.

Recommendation #5: Annual Recertification

- Individuals who have experienced a TIA or stroke and who have been certified as being physically qualified to drive a CMV (Recommendations 1 through 3) should be recertified on an annual basis.
    - The annual recertification process should include a thorough neurologic assessment performed by a qualified neurologist.
    - Driving history should also be considered and should include the number of total miles driven, traffic violations, and crash involvement (at fault or not at fault).
    - Any history of TIA or stroke recurrence, history of traffic violation, or history of involvement in an "at fault" accident will result in permanent disqualification from operating a CMV.

Recommendation #6: Neuropsychological Tests and On-road Evaluation

- Off-road tests shown to predict driving ability after stroke are: the Figure of Rey Test; the Dot Cancellation Test, the Road Sign Recognition Test, the Square Matrix tests from the Stroke Driver Screening Assessment (SDSA), and the Motor-Free Visual Perception Test. However, the MEP is of the opinion that while neuropsychological tests may provide a reasonable guide as to which person will likely pass a driver evaluation test, on-road evaluation should remain the gold standard for certification.
- It is the opinion of the MEP that one must not only confirm that the physical and mental function of individuals who have experienced a TIA or stroke are such that they are likely to be able to operate a CMV, but that such individuals demonstrate that they are able to operate a CMV by performing an on-road evaluation.

Recommendation #7: Undertake Research as to How Stroke Affects CMV Safety

- The MEP recommends that FMCSA consider the relative lack of high quality studies specific to stroke and CMV driver safety and in particular the association between TIA, stroke, and CMV driver crash.
- The MEP recommends that FMCSA consider funding additional studies to investigate the United States adapted version of the SDSA in predicting on-road performance of drivers, including CMV drivers after TIA and stroke.

MRB Questions and Discussion on Stroke

Dr. Hegmann said he understood that the data indicate that at 1 month following a TIA, the risk of recurrence is 65 times higher than the risk for individuals who have not had a TIA. At 1 year following a TIA, the central point estimate is 12-fold with a confidence interval indicating a 95 percent certainty that the risk is between 6- and 15-fold. Dr. Akinwuntan concurred with Dr. Hegmann's clarification.

Dr. Rizzo asked if a change to the existing regulations for drivers who have had a stroke could be supported based on the available evidence. Dr. Akinwuntan stated that there was not enough evidence that looked at the recurrence risk of a stroke beyond the term of the current recommendation. He pointed out that a few studies indicated the chance of a recurrent stroke is much higher after a hemorrhage than an infarction, which is particularly true for subarachnoid hemorrhages and brain hemorrhages. He added that there is a greater chance of stroke recurring after an arterial thrombotic infarction and a lesser chance after a lacunar infarction. However, the general trend is similar to that of TIA, which shows that the chance for recurrence is much higher within the first year. The MEP recommendation for drivers who have experienced a stroke was based on the evidence that indicates a decreased risk rate after 1 year.

Dr. Rizzo asked if there is evidence that the on-road driving test predicts crash risk, and if this evidence is better than neuropsychological test outcomes. Dr. Akinwuntan said no evidence was found that on-road tests predict crash risk. He explained that this is probably because stroke patients who are likely to return to driving are confident they are able to drive again and have probably taken and passed a driving assessment. He said that there are limited studies in this area, and no evidence was available on how performance during the on-road test predicts crash risk.

Noting no further questions from the MRB, Dr. Hegmann thanked Dr. Akinwuntan for his presentation and turned the meeting over to Dr. Gunnels for public comments on stroke.

Public Comments on Stroke

John McElligott, MD, Chief Medical Officer, PDMD, asked if the testing being recommended is technician driven or doctor driven. He added that this could possibly add a burden to what is already occurring at the clinical level. Dr. Akinwuntan said there is evidence that these tests are able to predict an individual's ability to drive after a stroke or TIA. It is recommended that the tests be administered by neuropsychologists who have special training in the interpretation of the data collected from these tests.

Dr. Hegmann added that the MRB has previously recommended that a functional evaluation be developed. This recommendation was made during the April 7, 2008, MRB meeting, and a summary of this meeting is available on the MRB Web site at www.mrb.fmcsa.dot.gov/.

Dr. Rizzo said neuropsychological testing could be particularly valuable because there are so many factors to consider with stroke (i.e., size, location, and acuteness of the lesion).
Dr. Akinwuntan explained that neuropsychological testing assesses the cognitive and perceptual skills of an individual, but the relation of these tests to actual driving is not very strong. However, they have remained consistently predictive of driving ability after stroke. That is why the stroke MEP recommended the ultimate test be the on-road test because that is the single test that combines all the cognitive and perceptual skills in an integrated manner and in a setting where all skills are being used.

Dr. Rizzo asked if neurological tests could be used as a screening tool before an individual proceeds to an on-road test. Dr. Akinwuntan said yes—it is actually the preferred way to use neuropsychological tests. He added that neuropsychological tests have also been shown to be useful for identifying other problems that are not physically obvious. For example, if a patient does not perform well during the neuropsychological test, it may help focus on and identify skills to look for during the on-road test.

Dr. Rizzo said he noticed the neuropsychological tests seem to favor visual perception tests, but there are a few tests that measure decision making, memory, language, or speed of processing. He asked whether the absence of evidence in these areas speaks to the lack of utility of these tests. He added that assessing these areas, which could be affected by stroke, may be important for driving. Dr. Akinwuntan noted that these tests do have memory, time-dependent, and visual spatial organization components. It is recommended that a neuropsychologist administer and interpret the tests because a variety of information can be obtained from the results. He added that there are no specific tests for each of these skills, but rather the neuropsychological test just assesses a part of them.

Dr. Rizzo asked if some of these tests, such as the Rey Complex Figure Test are useful in predicting driving in patients with Alzheimer's disease. Is a test like this broadly useful in stroke as well as in other neurological conditions? Dr. Akinwuntan explained that the Rey Complex Figure Test was developed for children with developmental problems. However, it has been used more for stroke, not only for driving, but also to look at memory and recall, visual spatial organizations, as well as cognitive thought processing. It is also used in other neurological problems such as Parkinson's disease and multiple sclerosis. He noted that there is strong evidence that this test is able to predict driving performance for stroke patients, but there is not as much evidence that this test is useful in predicting driving performance for these other conditions.

Dr. Greenberg asked if the value of these neuropsychological tests would be enhanced or affirmed by having baseline data, or do the tests stand alone? Would pre-event scoring be important in grading or interpreting post-event testing?

Dr. Akinwuntan explained that researchers in this field give a weighted value to each of these tests using the best model prescribed for each test to predict on-road performance. However, there is no clear evidence that would allow us to make a conclusion about baseline test scores. The evidence indicates that these tests are useful in predicting driving performance after stroke; however, it is up to the neuropsychologist and the medical team involved in the assessment of the individual's driving abilities to determine how they use the data.

MRB Deliberations on Stroke and CMV Driver Safety

Dr. Hegmann invited discussion and deliberation of the MRB on the topic of stroke and CMV driver safety, at which time Dr. Rizzo made the following motion:

Recommendation #1 Stroke
The MRB recommends to FMCSA that the following changes be made to the current guidance about stroke (first outlined in the report of the Conference on Neurologic Diseases and Commercial Driving, 1988):

- To be qualified to drive at the appropriate time after a stroke (1 or 5 years depending on the type of stroke) requires an examination by a neurologist who is an MD or DO, in addition to a commercial driver medical examiner (CDME) examination by an MD or DO.
    - If the neurologist identifies cognitive or neuromuscular deficits, then a neuropsychological evaluation or functional evaluation, respectively, shall be performed.
    - Functional evaluation could include aspects previously recommended by the MRB. (Musculoskeletal Disorders and CMV Driver Safety, April 7, 2008)
    - Neuropsychological evaluation could include aspects recommended by the MEP (Stroke and CMV Driver Safety, January 12, 2009).

- Subsequent re-evaluations should be done on at least an annual basis by a neurologist who is an MD or DO, in addition to a CDME examination by an MD or DO.

The MRB unanimously approved this motion.

Dr. Rizzo made the following motion:

Recommendation #2: TIAs

- The MRB recommends that commercial drivers who have had a TIA should not drive for 1 year.
  - To be qualified to drive after a TIA requires an examination by a neurologist who is an MD or DO, in addition to a CDME examination by an MD or DO.
  - Re-evaluations should be done on at least an annual basis by a neurologist who is an MD or DO, in addition to a CDME examination by a MD or DO.

This motion was unanimously approved.

Dr. Phillips made the following motion:

Recommendation #3 Fitness for Duty

- The MRB recommends that stroke and TIA be included in the fitness for duty matrix drafted by the MRB during the July 18, 2008 meeting (and subsequently amended) as follows:

Recommendation #2: Evaluation of Fitness for Duty*[*]*

- *The MRB recommends that FMCSA use the following as a draft proposal for evaluation of fitness for duty among drivers with multiple physical and medical conditions, and also recommends that FMCSA convene a panel of experts to further refine the following proposal:*

Number of Conditions ****	***Certification***
0 or 1	Maximum 2 years
2 +++	Maximum 1 year
2 +++	Maximum 6 months
≥ 4 +++	Not eligible until resolution of at least one condition

*****Diabetes mellitus requiring medication, cardiovascular disease, hypertension, dysrhythmias, obstructive sleep apnea (OSA), body mass index (BMI) > 35 kg/m2, opioid or benzodiazepine use, renal disease, pulmonary disease with pulmonary function test (PFT) abnormality, epilepsy seizure free for >10 years, musculoskeletal disease requiring medical, surgical or prosthetic treatment, requirement for visual exemption, stroke, TIA, major psychiatric illness (as defined pending formal review by the MRB), and other conditions as identified by FMCSA.*

+++ Evaluation to be conducted by a CDME who is a licensed MD or DO.

The MRB unanimously approved this motion.

[*] The MRB unanimously approved this motion during the July 18, 2008 MRB Meeting.

Dr. Andersson made the following motion:

Recommendation #4: Future Research

- The MRB urges FMCSA and the scientific community to conduct research on the effects of neurologic disease and stroke on driving ability and crash.

This motion was unanimously approved.

Dr. Greenberg made the following motion:

Recommendation #5: Educational Standards for CDMEs

- The MRB recommends that FMCSA implement minimum educational standards for qualifying CDMEs. The MRB recommends the following minimum professional qualifications: physicians (MD or DO), advanced practice nurses (APNs), or physician assistants (PAs).

The MRB unanimously approved this motion.

Dr. Gunnels said according to 49 CFR §390.5, driver physical examinations can be performed by any practitioner that is licensed by his/her State to perform physical examinations. She added that not all States allow APNs to perform examinations. Dr. Hegmann noted that the recommendation was phrased in terms of minimum qualifications, which covers that concern. Noting no further discussion or motions from the MRB, Dr. Hegmann turned the meeting back to Dr. Gunnels for public comments.

Before inviting public comments, Dr. Gunnels provided an update on current FMCSA activities. She thanked all who have expressed interest in serving on the MRB and noted that the Secretary of Transportation will soon appoint two new members to replace Dr. Rizzo and Dr. Greenberg. Dr. Gunnels also reported that the rule to merge the medical certificate with the commercial driver's license (CDL) is final and will be effective January 30, 2009. All States should be prepared to begin full implementation of this rule within 3 years of this date. The notice of proposed rulemaking or NPRM to establish a National Registry has been published, and the public comment period closes on January 30, 2009. She encouraged the public to submit comments. FMCSA intends to have a public forum later this year to discuss the proposed NRCME. Finally, she mentioned that FMCSA wants to ensure a more transparent process; and therefore, will be posting new information on the FMCSA Web site. She invited the public to visit the new Reports page on the FMCSA Web site.

Following her comments, Dr. Gunnels invited the public to make comments related to the proposed NRCME or any topic discussed during the meeting.

General Public Comments

Stan Roberts, PAC, MPH, representing AAPA, highlighted his background and experience noting that he is a PA and has been a CDME for 17 years. He explained that his comments specifically relate to the fitness for duty recommendations made by the MRB at the July 18, 2008 MRB meeting that propose CDMEs be licensed MDs or DOs for those individuals with diabetes or two or more stipulated medical conditions. This now potentially includes stroke and TIA. If these recommendations are adopted by FMCSA, it would significantly restrict the ability of PAs to continue to provide services to CMV drivers. The AAPA requests that the MRB reconsider this recommendation and that FMCSA not adopt these recommendations as official policies or put into its regulations or guidelines. He added that Federal regulations, FMCSA testimony to

Congress, and the FMCSA and MRB Web sites indicate that the recommendations made by the MRB and the decisions made by the FMCSA will be evidence-based. However, it is the position of the AAPA that this particular MRB recommendation is not evidence-based.

Mr. Roberts explained that PAs are skilled in performing specific medical duties within their scope of practice. PAs perform medical examinations, formulate diagnoses, establish and manage treatment regimens, including prescribing medications for patients with a wide variety and complexity of medical conditions. The AAPA is unaware of any evidence to show that a driver medically certified by a PA is any more likely than a driver certified by a physician to be involved in a truck or bus crash as a result of an inappropriate medical certification decision.

Mr. Roberts added that if FMCSA adopts these recommendations, PAs will be effectively eliminated as CDMEs because of the likely high prevalence of diabetes and two or more medical problems in the CMV driver population. There is reason to believe that half of the 4 to 6 million commercial drivers have two or more medical problems. He noted that FMCSA estimates 4 to 6 million drivers will require examinations and approximately 40,000 CDMEs will be needed to provide the examinations. If 27,000 PAs and 80,000 APNs are not allowed the opportunity to become certified and function as full-fledged CDMEs, it will make access to care problems worse.

Mr. Roberts concluded his comments requesting that the MRB and FMCSA engage the AAPA if issues related to PAs arise in their deliberations or are included in future meeting agendas. He noted that a copy of his comprehensive written comments have been submitted to the MRB and NRCME public dockets.

Dr. Hegmann said there are a few issues in the previous comment that he would like to address. First, it is not known how many individuals have more that one medical condition, but it would certainly not preclude half of CMV patients from being seen by a PA. Second, scheduling problems are relatively unlikely to occur because these numbers of conditions would be known and so the individual scheduling would know in advance whether they needed to schedule with a physician or PA CDME. Third, the issue of needing 40,000 examiners is under question because based on recent survey data, if those individuals performing 500 examinations per year were replicated, then only about 10 percent of that 40,000 amount would be needed.

John McElligott, MD, PDMD, said his organization has been researching the trucking profession for 15 years. He added that PDMD has the largest study ever done in trucking with almost 2,000 driver participants. Dr. McElligott commented that truckers do not have a schedule and given the hours of service rules, it is almost prohibitive. He noted that 6,000 drivers seen at his clinics for CDME examinations during a 2-year period were all walk-ins. He said these truckers would not be able to receive healthcare services without APNs and PAs.

Dr. Hegmann said that the MRB is concerned about the safety on the highways of the United States. Today's news indicates that there have been no fatalities in the airline industry for the past 2 years. However, in trucking, there have been approximately 4,800 deaths per year and 250,000 crashes with injuries. The morbidity burden is enormous. He explained that the MRB is looking at every single option to reduce the number of fatalities on the highways—updating the medical standards is one of those options. The MRB values PAs as part of the team to help work towards reducing the degree of injuries and diseases in the population.

Adjournment

Noting no further comments, Dr. Hegmann adjourned the meeting at 10:38 a.m.

CERTIFICATION

~~The minutes were approved by the Medical Review Board on _____.~~
(Date)

We hereby certify that, to the best of our knowledge, the foregoing minutes are accurate and complete.

Kurt Hegmann, MD
Chairperson
Medical Review Board

Mary D. Gunnels, Ph.D.
Designated Federal Official
Medical Review Board