



**United States Department of Transportation  
FEDERAL MOTOR CARRIER SAFETY ADMINISTRATION**

## **Meeting Summary**

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The Medical Review Board (MRB) of the U.S. Department of Transportation's Federal Motor Carrier Safety Administration (FMCSA) convened on October 6, 2008, at the Embassy Suites Hotel in Alexandria, Virginia. The meeting was open to the public.

**Board Members Present:**

Kurt Hegmann, MD, Chairperson  
Gunnar Andersson, MD  
Barbara Phillips, MD  
Matthew Rizzo, MD

**Board Member Absent:**

Michael Greenberg, MD, Co-Chairperson

**FMCSA Staff:**

\*Mary D. Gunnels, Ph.D., Director, Office of Medical Programs  
Elaine Papp, Chief, Office of Medical Programs  
Quynh Do  
Mark Johnson  
Linda Phillips  
Pearlie Robinson  
Chanel Winston

\* *Designated Federal Official (DFO)*

**FMCSA Contractors:**

Jennifer Musick, Axiom Resource Management, Inc.  
Purvi Shah, Axiom Resource Management, Inc.  
Margo Weeks, Axiom Resource Management, Inc.  
Stephen Tregear, DPhil, Manila Consulting Group, Inc.  
Jessica Williams, Manila Consulting Group, Inc.  
James Reston, Ph.D., MPH, ECRI Institute

**Members of the Public:**

Mariann Cameron, Cameron Air Products & Chemicals, Inc.  
Natalie Hartenbaum, American College of Occupational and Environmental Medicine (ACOEM)  
Gary Moffitt, Road Ready, Inc.  
Abigail Potter, American Trucking Associations  
Joel Whiteman, Road Ready, Inc.

**Call to Order**

Mary D. Gunnels, Ph.D., Director, Office of Medical Programs, FMCSA, called the ninth public meeting of the Medical Review Board (MRB) to order, noting that she is the DFO for the meeting. She announced there would be formal presentations of evidence report findings on the topics of hearing and vestibular function, and psychiatric disorders, followed by public comments, and MRB discussion and deliberation on each topic. She introduced Kurt Hegmann, MD, as the Chairperson of the MRB.

Dr. Gunnels requested that attendees complete the evaluation form they were given 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](http://www.mrb.fmcsa.dot.gov).

**MRB Approval of July 2008 Meeting Summary**

As the first item of business, Dr. Hegmann called for approval of the minutes of the eighth public meeting of the MRB held on July 18, 2008. The minutes were unanimously approved.

**Presentation of Evidence Report Findings: Hearing, Vestibular Function and Commercial Motor Vehicle (CMV) Driver Safety**  
**Stephen Tregear, DPhil**

Stephen Tregear, DPhil, Manila Consulting Group, Inc., presented an overview of the evidence report findings on hearing, vestibular function and CMV driver safety. He discussed the current regulations on hearing and referenced a report from the Federal Highway Administration published in 1976, which concluded, "Persons who are deaf or who suffer from moderate hearing loss cannot be licensed to operate CMVs in interstate commerce."

Dr. Tregear noted that a previous evidence report on this topic published in 1993 reported that the evidence was inconsistent and thus no conclusion about the safety of individuals with hearing loss could be drawn at that time. He noted for the current evidence report, the research team conducted a literature search aimed at answering the following key questions:

**Key Question #1:** Are individuals with hearing loss (defined as hearing thresholds of 40 dB or greater at 500 to 3000 Hz) at an increased risk for a crash?

**Key Question #2:** Is the forced-whisper test a valid measure of hearing ability?

**Key Question #3:** Are individuals with a vestibular dysfunction (any condition that causes dizziness and/or vertigo) at an increased risk for a crash?

**Key Question #4:** How long after the most recent episode of vertigo until it is safe to drive?

**Key Question #5:** Which treatments have been shown to effectively treat individuals with Ménière's disease (or other vestibular diseases that cause dizziness)?

**Key Question Responses**

**Key Question #1: Are individuals with hearing loss (defined as hearing thresholds of 40 dB or greater at 500 to 3000 Hz) at an increased risk for a crash?**

In the literature search for Key Question #1, three studies were found. Two of the studies were case-control studies and one was a cohort design. One of the studies was low quality and the other two studies were moderate quality. The case-controlled studies compared individuals to determine if there was an increase in crash risk between the two groups. The cohort study reported on the crash rates between individuals with hearing loss versus a matched group of individuals without hearing loss.

The findings of the three studies were assessed individually. The first study compared individuals in three categories of hearing loss (i.e., mild, moderate, and severe), though the definitions of these categories were not reported. The data suggest that individuals who are hearing impaired, particularly moderately hearing impaired and above, are at an increased risk for a crash. The findings from the second study did not show an increased crash risk. The crash risk among hearing impaired individuals was nearly equivalent to normal hearing individuals. The data from the third study indicated an increased crash risk for individuals with hearing loss, although this was not statistically significant. The author reported on the impact of hearing aids on driving ability. The data indicate that hearing aid users have the same crash risk as non-hearing aid users.

Dr. Tregear said that when the data from these studies are combined the findings are inconclusive. The newer, more recently published studies suggest there may be an increased crash risk for individuals with hearing loss; however, when taken as a whole, the evidence remains inconclusive. It is unclear whether individuals with a hearing deficit are at an increased risk for a crash.

**Key Question #2: Is the forced-whisper test a valid measure of hearing ability?**

Four diagnostic studies were found that addressed Key Question #2. The authors of these studies evaluated various hearing tests compared to pure-tone audiometry. The ideal test would correlate completely with audiometry. The studies ranged from moderate to low quality.

Dr. Tregear explained that overall, the sensitivity of the forced-whisper test at five feet is 100 percent. This means that most cases of poor hearing will be detected by the test. However, the specificity of the test is low, which indicates that a large number of individuals with normal hearing may fail the test. He concluded that the forced-whisper test is a viable screening test; however, the test is limited in value as a diagnostic tool. The strength of evidence supporting this conclusion is moderate.

**Key Question #3: Are individuals with a vestibular dysfunction (any condition that causes dizziness and/or vertigo) at an increased risk for a crash?**

During the literature search, only one study was found that addressed Key Question #3. The study was a low quality, retrospective cohort design, which compared 51 individuals with no vestibular dysfunctions to 34 individuals with benign paroxysmal positional vertigo, 27 individuals with chronic vestibulopathy, and 48 individuals with Ménière's disease. Study participants were asked whether they had any difficulty driving.

The findings revealed that individuals with vestibular dysfunction have difficulty with basic driving tasks (e.g., driving alone, changing lanes, and parking). The authors did not report any specific data on crash risk. The best available evidence suggests that individuals with vestibular dysfunction experience difficulty in driving; however, the evidence is insufficient to determine whether these difficulties translate into an increased crash risk.

**Key Question #4: How long after the most recent episode of vertigo until it is safe to drive?**

No studies were found that met the inclusion criteria for Key Question #4. Therefore, this question could not be answered. Dr. Tregear noted that the only evidence available regarding vertigo shows there is no increased crash risk.

**Key Question #5: Which treatments have been shown to effectively treat individuals with Ménière's disease (or other vestibular diseases that cause dizziness)?**

In the review of the literature addressing Key Question #5, researchers looked for evidence from randomized control trials (RCTs) and systematic reviews of RCTs. Dr. Tregear pointed out that while vertigo does have an impact on driver ability, there is currently no evidence to show that this condition ultimately leads to an increase in crash risk. Dr. Tregear also pointed out that some treatments are available for the diseases that cause vertigo, but the side effects of these treatments can cause additional problems related to driving. For example, surgical treatments can destroy an individual's ability to hear, which may cause an individual to be unable to drive based on the current hearing standard.

Based on an analysis of the best available data, Dr. Tregear's group found that the only current treatment option that was found to have a consistently positive impact on vertigo was the drug betahistine. Dr. Tregear noted that due to a paucity of data, the impact of other drugs (such as diuretics, diphenidol, intratympanic gentamicin), or surgery (e.g., endolymphatic shunt surgery) precluded his team from drawing any conclusions about the impact of these interventions on vertigo.

Dr. Hegmann expressed appreciation to Dr. Tregear for his presentation and asked the MRB members if they had any questions.

**MRB Questions and Discussion on Hearing and Vestibular Function**

Barbara Phillips, MD, asked whether the research for Key Question #1 related to commercial drivers or amateur drivers. Dr. Tregear said they were all amateur drivers. Dr. Phillips asked if the outcomes (crash) and variables (hearing) were measured objectively or self-reported. Dr. Tregear said that one study was self-reported and the other two studies were medically confirmed, but not defined in the study. Dr. Phillips pointed out that it is unknown if the forced-whisper test or audiometry was used to measure the outcomes and variables in two of these studies. Dr. Tregear agreed with this clarification.

Dr. Hegmann asked if there is a difference in the degree of accuracy of the reported findings in epidemiological research when the questions are purely subjective. Dr. Tregear said there was no difference in this particular case because the data were self-reported. He noted that when responding to a self-report questionnaire, there is a lot of pressure for an individual to give a biased answer when their livelihood depends on being a safe driver.

Dr. Hegmann asked which would be more likely to produce an accurate response—a question asking whether a person has a hearing deficit, or a question asking whether a person has a hearing aid. Dr. Tregear said that a question about whether a person has a hearing aid would be more accurate. Dr. Hegmann pointed out that the studies seem to indicate that the presence of a hearing aid does not necessarily protect the driver from a crash. Dr. Tregear concurred.

Dr. Gunnels asked what the hearing requirements are in the international community. Dr. Tregear said in the United Kingdom, an individual with profound hearing loss is not allowed to drive. In

Sweden they allow an individual to drive regardless of hearing ability. The rules in Australia, Canada, and New Zealand are similar to the standards in the United States.

Noting no further comments from the MRB, Dr. Hegmann turned the meeting over to Dr. Gunnels for public comments on hearing and vestibular function.

Before taking public comments, Dr. Gunnels provided an update on the status of current rulemakings. She announced that the final rule to merge the medical certificate with the Commercial Driver's Licensing Information System (CDLIS) and the proposed rule for the National Registry of Certified Medical Examiners (NRCME) are with the Office of Management and Budget and are expected to be approved this fall. Dr. Gunnels will continue to provide updates at future MRB meetings regarding the status of these rules. In addition, FMCSA is actively working to consider all of the MRB recommendations and moving forward with formal rulemakings on several topics. Any proposed changes would apply to 49 CFR Part 391.41, and potentially Part 392.3—the enforcement aspect related to the medical rules.

Dr. Gunnels invited public comments on hearing and vestibular function.

### **Public Comments on Hearing, Vestibular Function and CMV Driver Safety**

Natalie Hartenbaum, MD, ACOEM, asked about the status of the frequently asked questions, advisory criteria, and updated guidance.

Dr. Gunnels said that changes to the Web site are in review and should be available later this year. She noted that there is a lot of data system planning and development work in progress. She also reported that the first couple of chapters of the Medical Examiner Handbook have been posted on the NRCME Web site ([www.nrcme.fmcsa.dot.gov](http://www.nrcme.fmcsa.dot.gov)) and that more work is being planned for the Medical Expert Panels (MEP) and the MRB for the next 12 months on the topics of psychiatric disorders, musculoskeletal disorders, and sleep-related conditions. She added that the NRCME Role Delineation Study has been completed and is posted online. The Medical Examiner Performance Study is in progress.

Noting no further comments, Dr. Gunnels turned the meeting over to Dr. Hegmann for MRB deliberations on hearing and vestibular function.

### **MRB Deliberations on Hearing, Vestibular Function and CMV Driver Safety**

#### **Recommendation #1: Hearing Standards**

Gunnar Andersson, MD, proposed that FMCSA retain the current standards on hearing. He explained that there is little interest in this area as all of the research is from 15 to 20 years ago or more. Dr. Hegmann said that despite the improvements in technology and hearing aids, there is no evidence to support improvement in this area. Dr. Andersson concurred.

The motion was approved with a three to one vote.

Dr. Phillips noted that some of the strongest data indicate that having a hearing aid appears to be associated with increased crash risk whether the driver is wearing it or not. She moved that commercial drivers who require hearing aids to meet the hearing standard be considered to have a condition that should be included in the general recommendations for fitness for duty that was presented at the July 2008 MRB meeting 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
3 +++	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/m<sup>2</sup>, 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, major psychiatric illness (as defined pending formal review by the MRB), and other conditions as identified by FMCSA.

+++ Evaluation to be conducted by a commercial driver medical examiner (CDME) who is a licensed medical doctor (MD) or doctor of osteopathy (DO).

Noting no second to this motion, Dr. Hegmann said that the MRB would continue discussion on this item.

During discussion, Dr. Andersson said that using a hearing aid normalizes hearing, and it would be more of a concern if a person has a hearing deficit, but does not use a hearing aid. Dr. Phillips reiterated that the evidence indicates that having a hearing aid is associated with increased risk of crash and that having a hearing aid is a stronger crash risk indicator than having hearing loss.

Matthew Rizzo, MD, asked about the logic of giving the same consideration to an individual who has hearing loss that has been treated as an individual who has an impairment that has not been treated.

Dr. Phillips pointed out that the evidence represents a statistically significant finding that having a hearing aid is associated with increased crash risk, whether or not the person used the hearing aid. She added that it was the strongest positive finding in the literature review. Dr. Hegmann added that use of a hearing aid was statistically positive in the study conducted by Ivers as well.

Dr. Phillips noted that the studies were based on 15- to 20-year-old hearing aids. Dr. Andersson stated that it is also unknown whether the hearing aid was actually beneficial in any of the cases studied.

Dr. Hegmann asked the MRB if there was an alternate motion as a result of this discussion. No alternate motion was proposed. He asked if there were any other motions or further discussion on this topic.

**Recommendation #3: Further Research**


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

Dr. Rizzo made the following motion:

The MRB recommends that FMCSA convene an MEP on the issue of hearing, vestibular function and CMV driver safety.

The MRB unanimously approved this motion.

Dr. Gunnels asked the MRB to explain what the fitness for duty recommendation is, and whether the MRB considers it becoming formal guidance or regulation in the near future.

Dr. Hegmann explained that having multiple conditions or impairments may be more likely to preclude an individual from driving than a single condition alone. He noted that this recommendation is a draft and the MRB recommended that FMCSA convene an MEP to refine the details. The MRB proposed a shorter duration of certification based on number of conditions and that individuals with complex medical profiles should be examined by a trained and licensed MD or DO. He added that some conditions would remain on this list regardless of treatment unless the condition was completely resolved.

Dr. Rizzo said that a hearing aid is a surrogate for hearing loss, not the condition itself and that it should not be included on the list of conditions. Dr. Andersson added it is actually a resolution of one condition—hearing loss. Dr. Hegmann reminded him that the evidence does not support that idea. Dr. Phillips said that this discussion demonstrates that an MEP is needed for this issue.

Noting no further deliberation on this topic, Dr. Hegmann introduced Dr. James Reston for his presentation of the evidence report findings on Psychiatric Disorders and CMV Driver Safety.

### **Presentation of Evidence Report Findings: Psychiatric Disorders and CMV Driver Safety James Reston, Ph.D., MPH**

Dr. James Reston, ECRI Institute, began his presentation by noting that the current medical qualification standards state a person is physically qualified to drive a CMV if that person has no mental, nervous, organic, or functional disease or psychiatric disorders likely to interfere with the driver's ability to operate a CMV safely. He explained that the goal of this evidence report was to assess the potential risk of a motor vehicle crash among individuals with the following psychiatric disorders: psychotic disorders, mood disorders, anxiety disorders, and personality disorders. The following key questions were addressed.

**Key Question #1:** Are individuals with a psychiatric disorder at an increased risk for motor vehicle crash? If so, are there specific psychiatric disorders that present a particularly high risk?

**Key Question #2:** Are individuals using psychotherapeutics for a psychiatric disorder at an increased risk for crash when compared to individuals not using psychotherapeutics?

**Key Question #3:** What traits associated with personality disorders are associated with reductions in motor vehicle driver safety?

### **Key Question Responses**

**Key Question #1: Are individuals with a psychiatric disorder at an increased risk for motor vehicle crash? If so, are there specific psychiatric disorders that present a particularly high risk?**

During the literature review, eight studies were found that met the inclusion criteria. None of the studies specifically included CMV drivers, so the degree to which the findings can be generalized to the CMV driver population is unclear. Seven of the studies were cohort and one was a case-controlled study. The average quality of the studies was low. The cohort studies compared drivers with psychiatric disorders to a control population without psychiatric disorders. The case-controlled study compared the prevalence of psychiatric disorders among drivers who crashed to drivers who did not crash.

Dr. Reston indicated that though there was a trend toward an increased crash risk, the evidence concerning crash risk for drivers with psychiatric disorders was inconclusive. However, the possibility of an increased risk of crash for some drivers with psychiatric disorders could not be ruled out. He noted that more research would be needed to determine crash risk as the strength of the evidence they found was only minimally acceptable.

Dr. Reston explained that the specific subgroups of psychiatric disorders were investigated separately to determine if any represented a higher risk than others. He presented the findings for each disorder.

#### Psychotic Disorders

Four studies were found that included data specifically for patients with psychotic disorders. The data were combined in a meta-analysis, which revealed that there is not a statistically significant difference between the groups of individuals with psychotic disorders and those individuals without these disorders. The quality of these studies was low. The available evidence does not suggest an increased crash risk for individuals with psychotic disorders when compared to individuals without these disorders, but an increased crash risk cannot be ruled out.

#### Mood Disorders

Three studies were found that separately reported results for patients with depression or manic depression. Two of the studies indicated a trend of increased risk of crash for individuals with these conditions; however, neither study showed a statistically significant difference. The studies were all low quality. The evidence suggests the possibility that individuals with mood disorders are at an increased risk for a motor vehicle crash when compared with drivers who do not have mood disorders, but more evidence is needed to reach a firm conclusion.

#### Anxiety Disorders

Only one study reported on crash risk for individuals with anxiety disorders. The study found an elevated crash risk, but it was not statistically significant. Therefore, a conclusion cannot be made regarding the effect of anxiety disorders on crash risk.

#### Personality Disorders

Three studies reported data for patients with personality disorders. The data were combined in a meta-analysis, but no statistically significant difference was found. Therefore, a conclusion cannot be made regarding the effect of personality disorders on crash risk.

### **Key Question #2: Are individuals using psychotherapeutics for a psychiatric disorder at an increased risk for crash when compared to individuals not using psychotherapeutics?**

Researchers investigated the potential link between psychotherapeutic drugs and crash risk. Dr. Reston noted that the side effects associated with psychotherapeutic drugs may affect cognitive and psychomotor abilities that could contribute to crash risk. He explained that there are three main categories of psychotherapeutic drugs: anxiolytics, antipsychotics, and antidepressants. He reported the findings for each group.

### Anxiolytics

Nine studies were found that met the inclusion criteria. None of the studies specifically included CMV drivers, so the degree to which the findings can be generalized to the CMV driver population is unclear. Six of the studies were case-control studies, two were cohort studies, and one was a survey design. The average quality of the studies was moderate.

Benzodiazepines are the largest class of anxiolytic drugs and the only anxiolytics evaluated in crash studies. Five of the nine studies reported data for anxiolytics and hypnotics separately. All nine studies were analyzed and a subgroup analysis was performed on the studies containing separate data for anxiolytics. The findings from the meta-analysis of the nine studies revealed a statistically significant increase in crash risk associated with benzodiazepine use. The findings of the analysis of the five studies with separate data on anxiolytics supported the larger analysis.

Dr. Reston concluded that benzodiazepine use is associated with an increased crash risk. Evidence also indicates that crash risk may be greater during the first week of benzodiazepine use. He explained that this is because it can take awhile for a patient to adjust to the use of a benzodiazepine. Additionally, crash risk may be greater among benzodiazepine users who are 40 years old or younger. Overall, the strength of the evidence from these studies was minimally acceptable.

### Antipsychotics

One study on antipsychotics found no excess crash risk within 2 to 4 weeks of an index prescription of antipsychotics. However, the possibility of increased crash risk cannot be ruled out. Dr. Reston concluded that the evidence concerning crash risk associated with antipsychotic use is inconclusive and more studies are needed to resolve this question.

### Antidepressants

Seven of nine studies that reported on benzodiazepine use also evaluated antidepressant use and crash risk. These studies investigated two types of antidepressants: tricyclic antidepressants (TCAs) and selective serotonin re-uptake inhibitors (SSRIs). Three studies evaluated TCAs only, two studies evaluated both, and two studies did not specify the type of antidepressants evaluated. The data from six of the seven studies were combined in the initial analysis. Dr. Reston noted that although the data from this analysis suggest increased crash risk, the difference was not statistically significant.

A subgroup analysis was conducted on the data from the studies that reported on TCA use separately. The findings suggested an increased crash risk with those agents; however, the evidence was inconclusive. Dr. Reston noted that these studies may not be reflective of current practice as patients are more likely to be prescribed an SSRI, which was not well represented in these studies.

### **Key Question #3: What traits associated with personality disorders are associated with reductions in motor vehicle driver safety?**

Key Question #3 assessed the relationship between certain traits associated with personality disorders and crash risk. Twenty-one studies were found that met the inclusion criteria. The average quality of the studies was low. Dr. Reston explained that only two studies focused on select driver populations (taxi and bus drivers). He noted that the generalizability of the remaining studies to the CMV driver population was unclear.

Dr. Reston explained that a qualitative assessment of the evidence suggested that individuals with traits associated with personality disorders are at an increased risk for a crash compared to drivers

who do not have a trait associated with a personality disorder. These traits include aggression, hostility, impulsivity, disregard for law, and various other psychological symptoms.

Inconsistencies in the methodologies of these studies preclude an evidence-based conclusion regarding the strength of the relationship between these traits and crash risk. The evidence suggests a link, but better quality studies are needed to address this question.

### **MRB Questions and Discussion on Psychiatric Disorders**

Dr. Hegmann expressed appreciation to Dr. Reston for his presentation. He noted that the MRB has not received input from the MEP on this topic; therefore, further action on this item will be carried forward to the next meeting.

Dr. Gunnels asked for clarification on the definition of personality disorders. She also asked for input regarding the use of multiple medications in the treatment of psychiatric disorders as FMCSA has seen a lot of issues raised on this topic.

Dr. Hegmann explained that this has partly been addressed in the MRB's recommendations on schedule II medications. He noted that benzodiazepines are specifically mentioned as well as other habit-forming medications. The MRB made a motion at the July 2008 meeting regarding the fitness for duty standard, which included psychiatric disorders. The MRB has not taken a position on the issue of combinations of medications or multiple medications. Dr. Hegmann stated that the MRB would like the input of an MEP on this issue.

Dr. Gunnels highlighted some of the recommendations from the MEP proceeding on schedule II medications and then asked Dr. Reston to provide a definition of "personality disorder."

Dr. Reston cited the current definition from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV)*: "A class of mental disorders characterized by rigid and ongoing patterns of thought and action. These patterns are referred to as fixed fantasies. The inflexibility and pervasiveness of the behavioral patterns often lead to serious personal and social difficulties as well as general function impairment." He explained that there are a number of different personality disorders, such as paranoid personality disorder, anti-social personality disorder, schizoid personality disorder, and borderline personality disorder.

Regarding the use of multiple medications, Dr. Reston noted that it was obvious that there were a lot of the patients taking multiple medications in these studies. However, it was not clear whether multiple medications would necessarily put them at an increased crash risk. Only one study suggested that there was an excess risk for an individual using multiple medications.

Dr. Phillips stated there is a concern about how different types of medications interact with each other. If a person is taking an antihypertensive agent and psychotropic agent, and both are metabolized by the liver, the effects of each can be magnified. She added that this is what the MRB was addressing in the fitness for duty recommendation. The MRB would appreciate input from a pharmacotherapeutics panel.

Dr. Hegmann agreed with Dr. Phillips comments; however, he clarified that the MRB has not incorporated anything regarding the number of medications in the fitness for duty recommendation. Dr. Rizzo added that more information and study will be needed before the MRB can consider adding medications to their fitness for duty recommendation.

Noting no further discussion, Dr. Hegmann turned the meeting over to Dr. Gunnels for public comments on psychiatric disorders.

### **Public Comments on Psychiatric Disorders and CMV Driver Safety**

Dr. Hartenbaum stated that there are concerns with the use of multiple medications, but developing guidance on how to evaluate these individuals may not be possible—it may just require good clinical judgment. However, the use of multiple medications does suggest something more than a mild condition, especially if the medications have similar side effects.

Gary Moffitt, MD, Road Ready, Inc., noted the importance of obtaining medical records for the driver when there is a psychiatric issue. For example, the driver may indicate a major depressive issue such as bipolar disorder and report it is stable, but the medical records reveal the driver was hospitalized three times in the past year with psychotic episodes.

Dr. Moffitt said that Road Ready has a database of over 50,000 driver physicals and is conducting studies for FMCSA comparing this data to FMCSA crash data. He noted that various conditions reflect different failure rates on the DOT physical examination. He reported that in the Road Ready data, the failure rate for psychiatric conditions was higher than the failure rate for other conditions. He explained this by saying that there is not much guidance on psychiatric disorders, and in his experience, medical examiners have a tendency to fail drivers with these conditions more readily. He noted that the most common reason these drivers fail is because they do not have a letter of clearance from their treating psychiatrist or they are on benzodiazepines or a stimulant medication.

Dr. Hegmann expressed appreciation to Dr. Moffitt for the information he presented and asked if he could include it in a letter, so the MRB can review it more closely and potentially incorporate it into decision making for future recommendations. Dr. Moffitt said he would be happy to provide the letter. He added that dealing with multiple medication use will continue to be a challenge as drivers are routinely prescribed more than one medication.

Noting no further comments, Dr. Gunnels turned the meeting over to Dr. Hegmann for deliberations on psychiatric disorders.

### **MRB Discussions and Deliberations on Psychiatric Disorders**

Dr. Hegmann invited discussion and deliberations of the MRB on the topic of psychiatric disorders. Dr. Andersson stated that input is needed from the psychiatric field before the MRB considers any motions on this topic.

Noting no further discussion, Dr. Hegmann indicated that action on this topic will be deferred to the January 12, 2009 MRB meeting.

### **Adjournment**

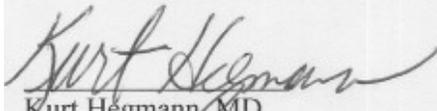
Dr. Hegmann adjourned the meeting at 10:28 a.m.



**CERTIFICATION**

The minutes were approved by the Medical Review Board on January 12, 2009  
(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

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