

AAA Basic Best Practices for Medical Advisory Boards

1. Every state should have a medical advisory/medical review board.
2. The board should be comprised of physicians and other health-care professionals. These include, but are not limited to, occupational therapists, nurses, gerontologists and physicians – especially ophthalmologists, neurologists, geriatricians, psychiatrists, cardiologists, endocrinologists and primary care providers such as internal and family medicine doctors. In addition, because of the policy advisory role of medical advisory boards, it's advisable to include stakeholders representing aging, motoring, disability and other relevant communities.
3. Members of the medical advisory board should meet in person or by teleconference or videoconference for discussions on the state's medical review program.
4. The board should review cases to assist divisions of motor vehicles in making an initial determination of fitness to drive for individuals who come to the attention of the medical review department as being potentially at risk – especially complex cases where administrative review is insufficient.
5. The medical advisory board should have authority to recommend customized/restricted licenses to allow driving privileges under safe conditions – i.e., daytime, speed-restricted or area-restricted – when possible, instead of merely revoking licenses altogether.
6. The board should have the authority to recommend periodic medical re-examinations and/or road tests of drivers as needed to ensure those with progressive medical conditions are able to continue driving safely.
7. Physicians and other medical advisory board professionals who review cases should be financially compensated, rather than serve on a volunteer basis. Medical personnel can be employed as DMV staff or paid as consultants and compensated according to accepted hourly rates for the profession.
8. Board members should be immune from liability from individuals for whom they make licensing recommendations, and all health-care professionals who report drivers in good faith should be immune from liability from their patients.
9. Individual board members should be able to review cases and make licensing recommendations without a consensus by a panel of board members (requiring a panel for all cases is less efficient and more costly). A panel of board members can be utilized for more complex cases as needed.
10. The board should develop medical guidelines for licensing within the state. Ideally, states should work with health-care professionals to develop national medical guidelines using the American Medical Association's *Physician's Guide for Assessing and Counseling Older Drivers* as a starting point.*

These recommendations were developed in consultation with traffic safety and medical experts and following review of the Summary of Medical Advisory Board Practices based on NHTSA and AAMVA's survey of licensing agencies in the U.S. NHTSA and AAMVA published a comprehensive report titled "Strategies for Medical Advisory Boards and Licensing Review." This report can be found at www.nhtsa.dot.gov/people/injury/research/MedicalAdvisory/.

* AAMVA has a three-year cooperative agreement project with NHTSA to develop recommended national medical guidelines. States and medical professionals will work together to produce guidelines that are medically sound, uniform and feasible for states to implement.

** AAA recently worked with the National Committee on Uniform Traffic Laws and Ordinances to create recommendations regarding medical advisory boards. Access NCUTLO at www.ncutlo.org/.