New medical standards for drivers*

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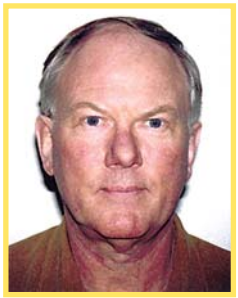

BACKGROUND The national standards for assessing private and commercial vehicle drivers have recently been revised and combined into a single publication 'Assessing Fitness to Drive', published by Austroads. The new publication provides greater clarity of medical criteria for general practitioners and specialists and also details useful management guidelines.
OBJECTIVE This article introduces GPs to the new standards, outlines the key changes and implications for practice, and highlights several medical, legal and ethical issues.
DISCUSSION Assessment of fitness to drive is a common issue in patient management and one that carries significant health, safety and lifestyle consequences both for the drivers themselves and other road users.

Decisions on a patient's fitness to drive a private or commercial vehicle can have profound effects on their lifestyle or livelihood. Such decisions also have significant health and safety implications for the driver and other road users. The decision making process may involve difficult medical, ethical and legal issues. In order to assist general practitioners to assess their patients and advise them appropriately, an extensive revision of the medical standards for private and commercial drivers has been conducted. The new national standards 'Assessing Fitness to Drive'[1] will be circulated to all practising GPs in Australia in September 2003.

The review of the standards was conducted under the auspices of the National Road Transport Commission and involved extensive consultation with the medical profession, regulators, the transport industry and unions. Participating in the review process and providing endorsement of the final standards were the Royal Australian College of General Practitioners, the Australian Medical Association and many specialist societies. Focus groups with GPs were also conducted in order to secure input from those actively involved in assessing fitness to drive.

Combining commercial and private standards

The new standards replace the existing medical standards for private[2] and commercial[3] vehicle drivers and combine the two sets of standards into one user friendly handbook. As well as being of significant practical benefit to examining health professionals, the combining of the standards helps to highlight the difference in risk assessment for the two major classes of licence.

The risk for commercial vehicle drivers is higher than that for private drivers as the former are on the road many hours of the day or night thus increasing their time exposure. The consequences of a crash involving a commercial vehicle are also likely to be more serious, particularly if the vehicle carries passengers or dangerous goods. Therefore, higher medical standards are applied for all commercial vehicle drivers. (See the 'Fitness to drive' quiz page 737 this issue).

The standards are presented in 23 chapters which cover the majority of illnesses/conditions affecting driving, ranging from A for Alcohol to V for Vision. Each chapter begins with notes summarising the relevance of the condi-

*This article is only introductory to the new licensing standards to which reference must be made on any specific issue.

Table 1. Licencing criteria for diabetes

	MEDICAL STANDARDS FOR LICENSING – DIABETES	
Condition	**Private standards**	**Commercial standards**
	(Drivers of cars, light rigid vehicles or motorcycles unless carrying public passengers or bulk dangerous goods)	(Drivers of heavy vehicles, public passenger vehicles or bulk dangerous goods vehicles)
Diabetes controlled by diet alone	A person with diabetes controlled by diet alone may drive without licence restriction and without notification to the Driver Licensing Authority, They should be reviewed by their treating doctor periodically regarding progression of the illness.	A person with diabetes controlled by diet alone may drive without licence restriction and without notification to the Driver Licensing Authority. They should be reviewed by their treating doctor periodically regarding progression of the illness.
Noninsulin requiring type 2 diabetes mellitus	A person with noninsulin requiring diabetes mellitus may drive without licence restriction and without notification to the Driver Licensing Authority, **subject to 5 yearly review** providing they have no complications as per this publication. The criteria for an unconditional licence are **NOT** met: • If the person has end-organ complications which may effect driving, as per this publication, **or** • If the person has 'defined' hypoglycaemic episodes. A **conditional licence** may be granted by the Driver Licensing Authority, taking into account the opinion of the treating doctor/GP, and the nature of the driving task, and **subject to periodic review**: • If the end organ effects and/or hypoglycaemic episodes are satisfactorily treated, with reference to the standards in this publication. In the event of a **defined hypoglycaemic episode** occurring in a previously well controlled person they generally should not drive for six weeks depending on identification of the reason for the episode, and a specialist opinion. In the event of a defined hypoglycaemic episode being associated with a motor vehicle crash the Driver Licensing Authority must be notified.	The criteria for an unconditional licence are **NOT** met: If the person has noninsulin requiring diabetes mellitus on oral hypoglycaemic agents. A **conditional licence** may be granted by the Driver Licensing Authority, taking into account the opinion of a specialist in diabetes or endocrinology, and the nature of the driving task, and **subject to at least annual review:** • If the condition is well controlled and the patient compliant with treatment, **and** • There is an absence of defined hypoglycaemic episodes as assessed by the specialist, the patient has awareness (sensation) of hypoglycaemia, and the patient is taking agents that provide the minimum risk of hypoglycaemia, **and** • There is an absence of end-organ effects which may effect driving as per this publication.
Insulin requiring diabetes mellitus (types 1 and 2)	The criteria for an unconditional licence are **NOT** met: • If the person has insulin requiring diabetes mellitus. A **conditional licence** may be granted by the Driver Licensing Authority, taking into account the opinion of the treating doctor/GP, and the nature of the driving task, and **subject to at least two yearly review:** • If the condition is well controlled, **and** • There is an absence of defined hypoglycaemic episodes and there is awareness of hypoglycaemia sufficient to stop driving a vehicle, **and** • There is an absence of end organ effects which may effect driving, as per this publication. In the event of a defined hypoglycaemic episode occurring in a previously well controlled person they generally should not drive for six weeks depending on identification of the reason for the episode, and a specialist opinion. In the event of a defined hypoglycaemic episode being associated with a motor vehicle crash the Driver Licensing Authority must be notified.	The criteria for an unconditional licence are **NOT** met: If the person has insulin requiring diabetes mellitus. A **conditional licence** may be granted by the Driver Licensing Authority, taking into account the opinion of a specialist in diabetes or endocrinology, and the nature of the driving task, and **subject to at least annual review:** • If the condition is well controlled and the patient compliant with treatment, **and** • There is an absence of defined hypoglycaemic episodes as assessed by the specialist, the patient has awareness (sensation) of hypoglycaemia, and the patient is taking agents that provide the minimum risk of hypoglycaemia, **and** • There is an absence of end organ effects which may effect driving as per this publication. In the event of a defined hypoglycaemic episode occurring in a previously well controlled person they should not drive for a period determined by a specialist. In the event of a defined hypoglycaemic episode being associated with a motor vehicle crash the Driver Licensing Authority must be notified.

tion to the driving task and general advice with respect to patient management. This is followed by a table outlining the medical criteria for licensing. The commercial and private vehicle standards are juxtaposed for ease of reference (Table 1). The criteria guide the GP in making assessments of fitness to drive and advising their patients accordingly.

Licensing criteria and conditional licences

Practitioners familiar with the 2001 edition of 'Assessing Fitness to Drive' for private vehicle drivers (the purple book) will notice two important changes to the standards. Greater clarity is achieved through their expression in terms of specific 'criteria to be met for an unconditional licence' (Table 1). Further guidance is then provided as to the circumstances under which the Driver Licensing Authority (DLA) may consider issuing a conditional licence.

The rephrasing of the standards to identify more specific criteria for unconditional and conditional licences serves to formalise a common and accepted approach to driver licensing and assists the GP in providing advice to their patients. In particular it provides scope for patients with well managed conditions to continue driving while maintaining the required safety standards through appropriate treatment and periodic review.

For example, the treating GP of a private vehicle driver with insulin dependent diabetes may recommend a conditional licence if the patient has good control, an absence of defined hypoglycaemic episodes, an absence of severe end organ effects, and attends for periodic review. This approach enables patients to benefit from careful management of their condition and ongoing improvements in medical treatments. It also takes into account important antidiscrimination considerations.

To assist the DLA in making a reasoned decision about granting a conditional licence, GPs are asked to provide adequate supporting information. Included in Assessing Fitness to Drive 2003 is a proforma (Medical Condition Notification form) designed to facilitate communication between the GP and the DLA, via the patient. The form guides the GP in detailing the necessary information including:

- a statement of the condition which does not meet the criteria for an unconditional licence, eg. noninsulin requiring type 2 diabetes
- a statement of the adequacy of treatment, eg. compliance with medication and diet, absence of end-organ effects relevant to driving, absence of hypoglycaemic episodes, etc, and
- the proposed interval until review of condition regarding driving, eg. two years (as distinct from normal more frequent clinical review).

The nature of the driving task

The DLA will take into consideration the nature of the driving task as well as the medical condition, particularly when granting a conditional licence. For example, the licence status of a farmer requiring a commercial licence for the occasional use of a heavy vehicle may be quite different from that of an interstate multiple combination vehicle driver. The examining GP should bear this in mind when examining a patient and when providing advice to the DLA.

Conditional licences and commercial vehicle drivers

Conditional licences have also been a longstanding feature of commercial vehicle driver licensing. In the new standards the higher risk of this driver category is reflected in the requirement for specialist opinion on recommendations for conditional licences. The accessibility of specialists in rural areas has been addressed with allowances made for initial specialist assessment and ongoing GP review pending approval by the DLA.

Medical criteria changes

Practitioners are encouraged to familiarise themselves with the full content of the book as many areas have been expanded and revised. Medical advances, engineering improvements and antidiscrimination considerations have also resulted in changes to the medical criteria and management recommendations. Key areas include:

Colour vision

The standard for red-vision in commercial drivers has been relaxed. This follows extensive expert opinion that the evidence relating red-blindness to risk of crash is equivocal,[4] plus recognition of the extensive improvements in road engineering regarding red light signals to improve visual cues to those who are red-blind.

Hearing

The chapter on hearing has been revised to permit conditional commercial vehicle driver licences in situations where vehicle modification can provide visual cues to compensate for loss of safety critical auditory cues, eg. additional mirrors and visual technologies to alert drivers to sirens or critical truck operations.

Diabetes

The restrictions on insulin dependent diabetic drivers and commercial driving have been eased in the light of developments in the new insulins and modes of administration leading to increased stability of control.[5]

Vertigo

The chapter on vertigo has been revised to distinguish the different causes of vertigo in relation to their impact on driving. Importantly, the most common disorder, benign paroxysmal positional vertigo, rarely occurs in the horizontal plane which is relevant to driving and so does not affect licence status.

Sleep disorders

Sleep disorders are increasingly recog-

nised as an important contribution to road crashes, but their diagnosis is not always easy.[6] In order to assist diagnosis the Epworth Sleepiness Scale[7] (Figure 1) has been adopted as a screening instrument for these disorders. In simple terms, the normal range is 0–10 with a mean of 'normal sleepiness' being five. A score of greater than 10 requires further questioning, and a score of 16 or greater may represent a significant problem requiring cessation of driving and specialist review.

Because of ongoing advances in medicine and road engineering it is intended the standards be reviewed every five years.

Diagnostic uncertainty

A difficult situation arises when the patient's diagnosis is not clear cut. Chest pains, blackouts, etc can present difficult diagnostic problems and much time may be spent before a clear diagnosis is made and the appropriate standards applied. In the interim, the question arises regarding the person's safety on the road. (See the 'Fitness to drive' quiz page 737 this issue). Generally, commercial vehicle drivers should be advised not to drive during this period until a final diagnosis can be made. Private vehicle drivers need be considered on a case-by-case basis depending on their symptoms and driving needs.

The standards cover a wide range of conditions, but because of individual variations in illness and the complexity of multisystem disease, particularly in the elderly, they cannot cover all situations. In these circumstances the GP should revert to first principals regarding road safety and assess if the patient is a likely to pose a substantial risk to road safety. In some situations such as cognitive impairment, a driver assessment by a DLA approved assessor may aid the decision making process. In others, specialist advice may be sought. The GP faced with any of these situations is advised to keep good notes of their findings and actions.

Name _____

Today's date _____

Your age (years) _____ Your sex (male=M, female =F) _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you put a number of (0 to 3) <u>in each of the eight boxes</u>

Situation	**Chance of dozing**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (eg. theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

THANK YOU FOR YOUR COOPERATION

Figure 1. The Epworth Sleepiness Scale[7] Reprinted with permission: M W Johns, Epworth Sleep Centre, Victoria

Temporary illnesses

The standards are primarily concerned with conditions that will have long term effects on driving. It is assumed doctors will provide sensible advice regarding short term conditions such as after a general anaesthetic or application of mydriatics.

Legal and ethical issues

In framing the standards much attention has been given to legal and ethical issues. They are complicated because of the potential contrasting relationships between doctor-patient, driver-DLA, and doctor-DLA. However, in reality the relationships are clear cut in most states and territories (Figure 2).

- The law in all states requires drivers to inform the DLA of any chronic illness that is likely to affect their driving. This is the driver's responsibility in the

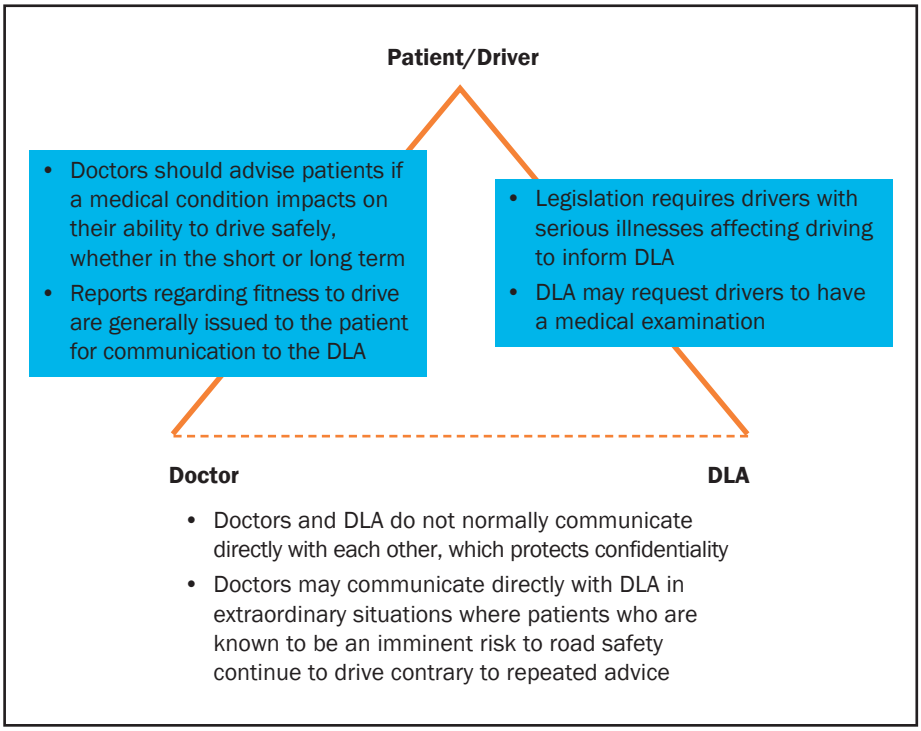

Figure 2. Interactions between patients/drivers, GPs and DLAs

first instance, not the GP's.

- A GP should advise his/her patient of the impact of any illness or treatment on their ability to drive safely, be it temporarily or in the longer term. The GP will normally have no direct dealings with the DLA (except in SA/NT where the law presently [although under review in SA] requires doctors to notify the DLA of serious illnesses which have imminent effects on road safety).
- The rare exception to the GP not having direct dealings with the DLA occurs when the GP is aware that a patient with a serious illness is ignoring repeated advice to cease driving and is an imminent hazard to road safety. The GP may then notify the DLA and be offered indemnity under transport law for so doing (the only exception is WA, where indemnity is not provided [currently under revision]). For example, if a GP has a patient who drives a semi-trailer and becomes aware that the patient has begun to drink heavily and ignores medical advice to cease drinking, then they would be indemnified if they wrote to a DLA advising of the situation. Where possible, this should always be undertaken with the knowledge of the patient. Consulting a medical defence organisation before taking this step would be advisable.

Privacy

All health professionals should be aware of the National Privacy Principles, the Information Privacy Principles and other privacy legislation applicable in their jurisdiction (eg. health records legislation) when collecting and managing patient information and when forwarding such information to third parties.

Practitioners normally do not communicate directly with the DLA. Where the DLA requires a driver to have a medical examination (eg. when applying for a commercial licence), the DLA writes to the driver who, in turn, presents to the GP for examination with the appropriate forms and letter. The doctor conducts the examination and then gives the results of the examination to the patient to forward to the DLA, thus preserving confidentiality. It is important to remember, it is the DLA not the doctor, who grants or withholds a licence. This protects the doctor who is only expected to provide advice in good faith.

Sometimes GPs are faced with an intimidating patient whose licence status is in question on medical grounds. Such situations should be handled, as for other threatening situations, by discussion at first or referral to another doctor or back to the DLA. A GP has no obligation to fill in a form under duress.

Conflict of interest: none declared.

Resources

For guidance in assessing a patient's fitness to drive contact your state or territory DLA. Contact details are provided in Assessing Fitness to Drive 2003.
An electronic version of the standards and an online educational program attracting CPD points is available at: www.austroads.com.au.

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