Fitness to drive

GP perspectives of assessing older and functionally impaired patients

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Background

General practitioners have expressed concern about their ability to assess patients' driving fitness. This study explores GP perspectives regarding assessing fitness to drive in older and functionally impaired patients.

Method

We held face-to-face interviews with seven metropolitan GPs and a focus group with nine rural GPs. Data were analysed using thematic analysis.

Results

General practitioners were unsure whether they or driving authorities should have responsibility for assessing patients' fitness to drive; recognised that driving is important for maintaining independence; described referral to an occupational therapist as useful, and expressed concern about the lack of access to alternative forms of transport and also about privacy issues. Opinion was divided about the merits of the VicRoads Medical Report Form and the usefulness of the Austroads guide.

Discussion

This qualitative study suggests that some GPs may find assessing fitness to drive to be challenging and problematic in general practice. Further resources and education could assist these GPs to increase their confidence and competence in assessing a patient's fitness to drive.

Keywords

doctor-patient relations, confidentiality; medico-legal/jurisprudence, aging; education, health (to lay people), health services

General practitioners in Australia and Canada have expressed concerns about their ability to assess patients' fitness to drive.[1,2] When a medical condition that can affect driving is newly diagnosed, it is essential that the GP discusses this with their patient and encourages them to self report to driver licensing authorities if appropriate.[3] Importantly, not all patients will volunteer details that are relevant to their fitness to drive and some may choose not to report their condition.[4] Doctors have also expressed concern about the impact of medicolegal issues on their practice,[5] including patient confidentiality[6] and meeting legislative requirements in relation to fitness to drive.[6]

Mandatory assessment programs targeting older drivers exist in all licensing jurisdictions in Australia, except Victoria.[4,7] Some authors have suggested that mandatory age-based testing targeting older drivers is ineffective at reducing crash risk[8–13] and is discriminatory.[9] In addition to re-assessment requirements currently in place, any Australian driver of any age can be required to demonstrate fitness to continue driving through a range of assessments.[7] Importantly, there is no universally accepted definition of 'older' across all Austroads jurisdictions or across research settings in the studies of 'older' drivers discussed in this article.

Research suggests that while some older drivers self monitor their driving ability,[14,15] others fail to plan for driving cessation.[16] Interestingly, research suggests that older drivers may be safer than is commonly believed.[17] Therefore impairment, not age, may be the key to determining driving ability,[18] although not all functional impairment necessarily reduces the individual's ability to drive safely.[11] Importantly, certain medical conditions and medications may impact on fitness to drive.[19] The former are outlined in *Table 1*.[7,20]

Whether impairment impacts on fitness to drive can be difficult to assess in the consulting room, particularly as there is a lack of evidence based information to help GPs make decisions.[21,22] In addition, the consequences of ceasing driving may be significant as individuals will need to rely on alternative forms of transport.[10] For some, particularly for older people, these may be limited[9,23] and has the potential to increase pedestrian fatalities.[24] Research suggests that GPs want more education on how to assess fitness to drive, particularly for the 'grey' areas, such as early cognitive decline.[1,25]

Study aims

This study aimed to: investigate how GPs recognise and manage older patients' fitness to drive; examine GP attitudes and beliefs about their role as assessors of patients' fitness to drive, including the barriers and facilitators to the assessment and management process; assess GPs' experiences in assessing patients and providing reports to driving authorities; and to identify the further educational needs of GPs regarding assessment of driving competence in older patients.

Method

Following a review of the literature, including studies conducted in New South Wales[2] and Canada,[1] we developed a semistructured interview schedule comprising 12 questions (*Table 2*). Participants were recruited in 2009 through an advertisement about the study in the weekly newsletter/fax of two Victorian divisions of general practice (DGP); one metropolitan with a membership of approximately 550 GPs, and one rural with a membership of approximately 105 GPs. These divisions were selected to gain

some understanding of the challenges in both metropolitan and rural Victoria and because there were links between the research team and these divisions. Seven GPs (three men and four women) from the metropolitan DGP (7/550) and nine GPs (six men and three women) from the rural DGP (9/105), responded to the invitation. Participating GPs were not asked to provide demographic data. Face-to-face interviews were held with the metropolitan GPs and a focus group was held with the rural GPs. The interviews and focus group were conducted by two members of the research team (KJ and PS). Interviews lasted approximately 30–45 minutes and the focus group lasted approximately 90 minutes. All were audiotaped and transcribed verbatim by an external organisation. Data were analysed using thematic analysis,[26–28] and verified independently by the two investigators who conducted the interviews and focus group. When there was a difference of opinion, the issues were discussed until agreement was reached.

Ethics approval to conduct this study was obtained from Monash University Human Research Ethics Committee.

Findings

Four main themes emerged from the focus group and interviews:

- the role of the GP in assessing fitness to drive
- decision making around when and how to make an assessment
- managing the consequences of the assessment
- the use of forms and guidelines, and the need for GP education and other resources.

Comments made by GPs are identified as [GP1 to GP7], and comments made by GPs who participated in the focus groups are identified as [FG1 to FG9].

The role of the GP in assessing fitness to drive

General practitioners felt they probably missed many cases where patients were not fit to drive '… I think it takes something fairly drastic for me to even think about it.' [GP5] One reported routinely asking patients about their driving. For others, the issue was usually 'flagged' by several factors including medical conditions, family or friends becoming concerned about the patient's safety on the road, and the 75+ Health Check prompting questions about driving capacity.

Opinion about whether GPs should have responsibility for assessing patients' fitness to drive was divided. Reasons for having the responsibility included '... we are paid a lot of money to do a job and that's part of the job, we have the responsibility to do it.' [FG2]

Table 1. Medical conditions that may impact on fitness to drive[7,20]

- Alcohol dependency
- Anaesthesia
- Cancer
- Cardiovascular conditions
- Cognitive impairment
- Diabetes
- Drugs (illicit and prescription)
- Epilepsy
- Gastrointestinal disorders
- Hearing
- Metabolic and endocrine disorders
- Musculoskeletal disorders
- Neurological conditions
- Pregnancy
- Psychiatric illness
- Renal failure
- Respiratory diseases
- Sleep disorders
- Vestibular disorders
- Vision and eye disorders

Reasons for not having the responsibility included GPs not '… having that capacity, and that's why I don't think it's fair to get [GPs] to decide whether they [the patient] should drive or not' [GP7] and that GPs are not '… in the best position to know how they actually drive on the road.' [FG1]

Inconsistency regarding the process and recommendations from driving authorities was raised as an issue. While GPs felt they have a role in referring to other services, patients did not always attend these appointments. Some felt that mandatory licence re-testing should be required for people aged over 65 years with the responsibility for assessing fitness to drive resting with driving authorities.

Decision making around when and how to make an assessment

When and how driving capacity was brought up was described as an important issue. Some GPs used driving assessment forms to assist in the discussion; one purposefully raised the issue so patients could prepare for when they would stop driving. Another stated '… I wait for them to have an accident, because the greatest indicator of another accident is an accident and the greatest motivator to restrict or stop driving is an accident, when the patient is driving.' [GP1] Regardless of

Table 2. Semistructured interview schedule

- Thinking about driving in the elderly, specifically, what are some of the dilemmas you face between caring for a patient and reducing risk to the community?
- How do you recognise elderly patients' fitness to drive and do you think you miss causes of suboptimal competence to drive?
- Would you routinely raise the topic with elderly patients (how proactive are you in screening for driving competence)?
- How do you broach the subject with an elderly person? What if you think they are of doubtful competence – what would you do then?
- What other community resources would help you in assessing elderly patients who might be problem drivers? What is your experience with occupational therapist assessments?
- What difficulties emerge when family members contact you to assist in getting the patient to give up their licence voluntarily?
- Do you think that GPs should be the assessors of their own patients given a possible conflict of loyalty? How comfortable are you with this role?
- Do you have any problems with the forms or with the assessment itself?
- Which patients are more 'difficult' to advise? For example, what do you do with those with early or mild dementia who might be of borderline competence to drive?
- How do you assist elderly patients who have had their licences revoked?
- If you advise patients to give up driving, do they generally follow your advice, and on the occasions that they do not, how do you handle this?
- What else should we be asking about this topic that you think is important and that we might not have covered?

how and when the issue was raised, generally GPs found it very difficult.

Asking a family member for support was described as another approach. Having a family member accompany the patient when the issue was to be discussed was valued because this helped GPs to gather a reasonably accurate driving history. General practitioners reported that family members sometimes '… phoned on the sly' [GP3] or '… contacted you surreptitiously,' [FG7] or gave permission to open the conversation with the patient '… if the patient will allow it and ask the family member to bring it up, it makes it easier.' [GP2]

Managing the consequences of the assessment

Asking patients to stop driving

General practitioners described assessing fitness to drive as challenging, as it can bring up a lot of anxiety for patients. Similarly, GPs recognised that having a drivers licence is important to many people for social and mental wellbeing and maintaining independence; '… I know that I'm effectively cutting their legs off when I tell them that they can't drive … even though I've tried to explain that I'm doing it from their safety point of view.' [GP5]

Taking away the licence '… is something which could really break up a doctor-patient relationship.' [GP2] General practitioners felt that this decision could change the patient-doctor relationship '… may potentially fracture the relationship you have with the patient.' [GP4] Thus the matter needed to be raised '… in a way that doesn't betray that patient trust and rapport you have with them.' [GP4]

General practitioners described finding it difficult to cancel their patients licences because while the patients hadn't '… actually left me, they've just been very angry, so the visits after that aren't as comfortable as they were beforehand.' [GP6]

General practitioners described discussing driving assessments as causing anxiety for patients '... it's such a threatening thing for them … because it means such a lot of people will not be able to drive [FG5] but '… just being elderly is not a reason to tell people they can't drive.' [FG3]

No participants mentioned having patients disregard their advice, but if patients did not follow up, GPs said they would contact the authority (in this case VicRoads) with their concerns '… there was one guy who was epileptic who was driving, who I did [report to VicRoads] and I told him I would.' [GP 4]

Managing the borderline cases

Some patients were described as being more difficult than others to advise '… the extremes are easy, it's the bits in the middle where it doesn't quite fit or just scrapes over the line each time; they're the hard ones.' [FG1]

General practitioners reported that often the more challenging situations to deal with included '… the early dementia patients' [FG1] because they were often the patients '… with the least insight into their driving inability.' [FG2] Managing these cases were described as problematic unless '… you've got family support and once there's family support or third party support then I think it becomes quite easy to step in.' [GP3] Some patients were described as resistant to relinquishing their licence '… in fact, the ones with the biggest problems have the least insight into their driving ability.' [FG2]

Referrals to specialists in driving fitness

General practitioners found that patients who were borderline benefitted from being referred to an occupational therapist (OT) for further assessment. Few GPs referred patients to medical specialists for driving assessments, but OTs were unanimously described as an invaluable resource … 'the OT's judgement was trusted and they were deemed to be tremendously helpful [FG3] '… I think they [patients] need to have an OT driving test … I'm much keener to let an independent OT come in and do the assessment.' [FG8] Despite the GPs' positive views of their value, OT assessments were described as underutilised because they are expensive and availability is limited, particularly in rural areas.

Cost was described as a consideration for patients issued with a conditional licence because '… it has to be reviewed every year, so they go and pay $300 to be reassessed.' [FG9] To overcome some of the cost and confusion, it was suggested there should be a Medicare rebate and '… an appeal system that takes cost into account.' [FG6]

Options for patients with revoked licences

Concern was expressed by all respondents about lack of alternative forms of transport, particularly in rural areas where '… [public transport is] virtually nonexistent for a lot of people, particularly out of town.' [FG3] Taxis were also difficult to access '… in smaller towns, you have to call up a taxi 15 kilometres away to go down the street 1 kilometre to get your groceries.' [FG6]

Family involvement to assist with meeting patients' weekly needs, such as shopping and other social interaction, was described as varied, depending on family commitments. While GPs in the metropolitan area thought their areas were reasonably well serviced, they identified difficulties using public transport '… the issue is getting to the bus stops, getting on, and the balance problem when the bus or tram goes off.' [GP2]

Some had tried to get half price taxi vouchers for their patients because '… someone who has had their licence taken off them you almost feel automatically justifies for a taxi voucher.' [GP5] But the majority of participants commented about the new restrictions regarding taxi vouchers meant that even frail elderly people in rural areas were ineligible.

General practitioners did not find council services to be readily available or helpful to patients with revoked licences. Metropolitan GPs were not aware of any community services to aid older people. In rural areas, the Red Cross was mentioned as a possible provider, but their services were not available on a regular basis. Another option was '… a community service package where you might get a carer for once a week, but it's not readily available to get [a lift] to a doctor's appointment or do something.' [FG5]

Privacy

Privacy was described as a concern '… the million dollar question is whether the patient knows what the family's thinking, and because my duty is to the patient … it comes back to privacy and informed consent issues.' [GP2]

All the GPs agreed that privacy was about the patient rather than the family.[6] Sometimes family members refused to give the GP permission to advise the patient that the family has spoken to them. This was a difficult situation to manage.

The use of forms and guidelines and the need for GP education and other resources

Forms and guidelines

Opinion was divided on the merits of the VicRoads Medical Report Form.[12] Problems included: lack of free-text space to write details about the patient or driving conditions, and having to hand write the form, which made it difficult to keep an electronic record. A single form for both private and commercial licences was also criticised. Patients

requesting that forms be completed and signed during the last minutes of the consultation was also described as frustrating, as GPs generally did not have time to properly complete the form.

The GPs were ambivalent about the usefulness of the Austroads guide.[12] The majority had never used it, and the few who had found it useful but difficult to refer to in a short consultation. The key message was that the guidelines needed to be clearer, particularly regarding how to assess and manage patients diagnosed with dementia, when patients should be sent for a driving assessment with an OT, when restrictions could be suggested, and how GPs should advise patients to relinquish their licence.

Further GP education and resources

General practitioners wanted more information for patients about cheap alternative transport options in their area, and suggested a low cost refresher driving course be available for drivers. They said they would welcome education and resources such as an online education activity, a short 'one page' reference for their desk and a decision aid that could be uploaded on to their medical software to quickly distinguish between fit and potentially unfit drivers.

Discussion

General practitioners in this study highlighted areas they felt were difficult for them to manage, including the impact on the patient-doctor relationship, particularly as a consequence of the GP being the person who makes the final decision about whether a patient is fit to drive or not. Other authors have highlighted similar issues,[29] particularly regarding patients with cognitive impairment.[30] Further, GPs felt that they did not undertake assessments on a systematic basis, and rarely refer to specialists or OTs. The primary reason given for not referring to OTs was limited availability, particularly in rural areas.

While some of the GPs in this study were ambivalent about their role in assessing driving, most acknowledged that realistically, driving assessments do take place in the general practice setting. The GPs believed that it was probably their responsibility to undertake driving fitness assessments on their patients, particularly on health grounds. However, while they might be able to state what a patient's medical problems are, it was evident that these GPs felt they may not be able to accurately determine patients' on-road skills. Other authors have acknowledged that this can be a difficult task, and more evidence based guidance is needed.[16,29,30] Similar to the findings of Jang et al,[1] GPs in this study opined that they should not be the final arbiters of driving competence and that others with expertise such as OTs should be making a final decision.

Medicolegal issues, particularly privacy, was a concern for GPs, particularly when, for example, family members wished to discuss issues with the GP, but did not want the GP to disclose the source of information to the patient. This echoes other reports of doctors' concerns about the impact of medicolegal issues on their practice.[5,6]

The GPs in this study felt it was not easy to find a satisfactory solution for the difficult consultations that arise with patients with whom they have to discuss issues around continuing to drive; GPs regularly conduct 'difficult consultations'. However, similar to previous findings,[1,2] this sample of GPs reported they felt compromised between being an advocate for the patient and needing to take community interests into account at the same time.

There are several limitations to this study. First, the authors made no attempt to collect demographic data from participating GPs so there is no way to determine whether this sample is representative of the rest of the GP population in Australia. Also, as busy GPs were asked to answer an advertisement in order to participate in this study, the sample may be biased toward GPs with an interest in the topic. Nonetheless, this study reveals that, in this group of GPs, assessing fitness to drive in general practice is problematic. Although publications and reports exist about crash statistics in the elderly, assessing driving competence including mandatory reporting and community and older driver attitudes to driving, only one publication was found that surveyed GPs in Australia about their attitudes to older drivers.[2]

Conclusion

This study outlines challenges faced by a group of Victorian GPs when conducting driving assessments. Further education, supported by resources such as alerts within medical software, a computer based template and materials for patients and their families, could assist GPs to increase their confidence and competence in assessing a patient's fitness to drive.

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