

New medical standards for commercial and private vehicle drivers

The new guidelines should be useful to all medical practitioners and fair to patients



DRIVING A MOTOR VEHICLE is a complex task involving perception, good judgement, adequate response time and reasonable physical capability. A range of medical conditions, as well as certain treatments, can impair any of these factors. Such impairment may adversely affect driving ability, possibly resulting in a crash causing injury or death (Box).

The newly published *Assessing fitness to drive 2003*² gives guidance to healthcare practitioners faced with various clinical situations. It also provides specific guidance on conducting medical examinations required by the licensing authorities. The overall intent of these national guidelines is to help clinicians:

- identify and manage patients who may not be capable of adequately controlling a vehicle (and who are thus a risk to public safety);
- counsel patients regarding the impact of their condition on their driving ability;
- inform patients of their legal obligations to report long-term or permanent illnesses or injuries likely to affect their driving to the driver licensing authority; and
- if needed, because of inaction by the driver and immediate concerns about public safety, advise the driver licensing authority regarding the patient's fitness to drive.

The new publication replaces the existing booklets *Medical examinations for commercial vehicle drivers (1997)*³ and *Assessing fitness to drive (2001)* for private vehicle drivers,⁴ and combines both these booklets into one reference for ease of use.

The medical criteria for commercial drivers are more stringent than those for private vehicle drivers, reflecting their extensive time on the roads and the likelihood of more serious consequences of loss of control of, say, a petrol tanker or bus compared with a domestic car. These different criteria are set out in colour-coded format throughout the new book.

In addition to combining the standards for commercial and private vehicle drivers, the content has been extensively revised to reflect advances in diagnosis, treatment, and prognosis of various conditions affecting driving ability. For example, increasing recognition of the importance of fatigue and sleep disorders in accidents⁵ has led to inclusion of the Epworth Sleepiness Scale as a screening tool in the health questionnaire,⁶ and the more accurate and cross-culturally validated AUDIT questionnaire has replaced the CAGE questionnaire for alcohol dependency screening.⁷ Similarly, advances in treatment of diabetes, epilepsy, and psychiatric disorders have been incorporated.

Much attention has been given to "conditional licences", whereby a person who does not meet the medical criteria may be supported in retaining a driving licence that is

Case report

An eight-year-old girl was walking with her family on a footpath. A car driven by a driver who had poorly controlled diabetes and was suffering a hypoglycaemic episode mounted the kerb, killed the girl, and injured members of her family. The coroner was critical of the driver who failed to take responsibility for his condition, failed to attend medical appointments and education as requested, ignored the obvious risk of his continuing to drive, and deliberately sought to retain his driver licence by "doctor shopping".

The various doctors involved in the driver's treatment were also criticised for the lack of clarity and consistency of information given to the driver regarding driving restrictions and the lack of action in response to "red flags". They were also criticised for not notifying the driver licensing authority of concerns about the person's continued driving.¹

Although South Australia differs from most states and territories in explicitly requiring a medical practitioner to notify the authorities of patients who have conditions likely to impair driving, the issue has ethical resonances for the profession nationwide:

- doctors have significant medicolegal responsibilities regarding their patients and safe driving, and should act accordingly;
- although doctors must respect patient confidentiality, nearly all states and territories provide indemnity for a doctor to notify the driver licensing authority if an unsafe patient cannot be persuaded to self-notify and continues to drive; and
- conditional licences may be recommended for patients if certain treatment, compliance, response and review criteria are met. This helps ensure the quality of life for the patient. Doctors should be aware of these options.

conditional on supplementary criteria relating to compliance and response to treatment, possible driving restrictions, and a detailed plan for monitoring the patient's condition. This should help in rehabilitation of patients with various conditions, and address concerns about disability discrimination and equal employment opportunity issues.

Several legal and ethical issues are also identified in the guidelines. The book emphasises the legal responsibility of drivers to notify the driver licensing authority if they have any permanent or long-term condition likely to affect their driving ability. The relevant state legislation in this regard is included as an appendix.

The legislation relating to reporting by healthcare practitioners is also summarised in the book. Most states (with the exception of South Australia and the Northern Territory, where legislation is under review) do not require mandatory reporting by healthcare professionals. However, there remains a duty of care in cases where the healthcare practitioner is aware of the patient's continuing driving and there is a definite risk to public safety.⁸ Practitioners who are unsure about confidentiality and notification should consult

their medical defence organisation or state driver licensing authority regarding their legal position.

The introduction of privacy legislation in most states has also been a consideration, and has led to clarification of the information to be recorded and kept by the practitioner (and to be readily available to the patient/driver), as distinct from the medical information to be provided on a “need to know” basis to the licensing authority. The exception is information required to be provided to the authority under law. This has led to new forms and procedures to guide practitioners.

Although overall there is a move to uniformity of licensing procedures in the different states and territories, there are still some important differences. Tables set out these differences for easy reference.

In summary, *Assessing fitness to drive 2003*:

- outlines clear medical criteria for driver capability, based on available evidence and expert medical opinion;
- clearly differentiates national minimum standards for licensing drivers of commercial and private vehicles;
- outlines the legal obligations for medical practitioners and drivers;
- provides medical examination proformas to help guide the assessment process;
- provides a reporting template to guide reporting to the licensing authority if required; and
- provides links to supporting and substantiating information.

The new guidelines have been developed through extensive consultation with the medical profession, the licensing authorities, the trucking industry and unions, and lay groups. The development of the book is one of a series of initiatives by the National Road Transport Commission to create uniformly efficient and safe transportation in Australia.⁹ In recognition of its importance, the book has been

signed into force by the ministers of transport of all states and territories.

The book has been assessed by general practitioners and found to offer clear clinical and procedural advice for various situations. It is intended the new guidelines will be useful to all practitioners, be fair to patients, and contribute to road safety.

Copies of the new guidelines are being distributed to all GPs, and may also be obtained free of charge from state driver licensing authorities. The guidelines are also accessible online from the Austroads website (www.austroads.com.au), and an online tutorial package is being developed to support implementation.

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1. Findings of South Australian Coronial Inquiry, re Bednarek. No 12/01 (0325/1999). 5 October 2001. Available at: www.courts.sa.gov.au/courts/coroner/findings/findings_2001/bednarek.finding.htm (accessed Jun 2003).
2. Assessing fitness to drive, commercial and private vehicle drivers: medical standards for licensing and clinical management guidelines. Sydney: Austroads Inc, National Road Transport Commission, 2003. Available at: www.austroads.com.au
3. Medical examinations of commercial vehicle drivers. Melbourne: National Road Transport Commission and Federal Office of Road Safety, 1997.
4. Assessing fitness to drive: guidelines and standards for health professionals in Australia. Sydney: Austroads Inc, 2001.
5. Horne J, Reyner L. Vehicle accidents related to sleep. *Occup Env Med* 1999; 56: 289-294.
6. Johns MW. Reliability and factor analysis of the Epworth Sleepiness Scale. *Sleep* 1992; 15: 376-381.
7. Saunders J, Aasland O, Amundsen A, Grant M. Alcohol and related health problems among primary care patients. *Addiction* 1993; 88: 349-362.
8. Tobin B, Leeder S, Somerville E. Community versus individual benefit. *Med J Aust* 2002; 176: 279-280.
9. About the NRTC. National Road Transport Commission. Available at: www.nrtc.gov.au (accessed Jun 2003). □

Medical records and population health

The recording process needs to become more efficient, more useful to clinicians and multipurpose

MEDICAL RECORDS SERVE a variety of purposes: they reflect the care process, provide a line of communication between clinicians and health services, and constitute legal evidence of referral, presentation, assessment and care given. If it is not in the medical record, it did not happen! They are also used for quality assurance, casemix funding, deriving statistics on diseases and procedures, and research. However, many clinicians seem to regard record-keeping as a chore. Why is it important and how can it be made more efficient and exciting?

In this issue of the Journal, the report by Lee and colleagues (*page 289*) demonstrates an important use of medical records.¹ Their study of survival of patients after stroke in Western Australia was made possible by linking morbidity data derived from hospital medical records with death reports using unique patient identifiers. This data linkage project and associated efforts to improve the quality

of hospital data are well known in Australia and internationally for their contributions to understanding outcomes of care. Moves to introduce data linking over time and place using probabilistic matching or unique patient identifiers are gathering momentum throughout Australia.²⁻⁴

Studies such as that of Lee and colleagues depend on accurate, consistent coding of information on diseases and procedures from patient medical records. The coding process is multifaceted, involving:

- abstracting from the patient record the diagnoses and procedures to be coded;
- choosing codes for each diagnosis and procedure; and
- “sequencing” (ranking) of codes to identify the principal diagnosis, which determines the diagnosis-related group⁵ for that episode of care.

In Australia, considerable effort has gone into developing standards for the coding process. The National Centre for