Psyciatrists’ responsibilities with regards to patients’ fitness to drive

Mehboob Yaqub, Shajahan Ismail, Sally Babiker, T. S. Sathyanarayana Rao

Higher Psychiatric Trainee (ST6), Inpatient Psychiatry, Tickhill Road Site, Rotherham Doncaster and South Humber NHS Foundation Trust, Rotherham, 2Foundation Trainee, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, UK, 1Consultant Psychiatrist Argyll House, Sheffield Health and Social Care NHS Trust, UK (Resigned) and Currently Associate Professor in Psychiatry, Chettinad Health and Research Institute, Kelambakkam, 3Department of Psychiatry, JSS Medical College Hospital, JSS University, Mysore, Karnataka, India

Driving has become a near universal and essential part of human life. Many of those who are no longer able to drive have a significant impact on their lives in the form of loss of independence, compromise with work, personal interests, and activities.[1]

Driving is a complex skill. It is dependent on several cognitive aspects and executive functioning of a human brain (i.e., information processing, attention, concentration, memory, impulse control, judgment, anticipation, problem-solving, and hazard perception).[2] Many psychiatric disorders lead to impairment in the level of cognitive and executive functioning required for safe driving.[3] Moreover, psychotropic medications can also cause disruption in perception, information processing, and overall psychomotor activity.[4,5] Driving is impaired not only as a direct effect of mental illnesses but also medications have a significant role. Cost of traffic accidents attributable to impairment by medication in Europe is estimated to be about 6.3 billion euros every year.[6]

De Las Cuevas and Sanz studied 208 patients in Spain seen in psychiatric outpatient clinics with stable psychiatric conditions and reported that nearly 80% of the patients had cognitive scores which would not allow obtaining or renewal of a driving license. None of the driving patients notified to the relevant authorities about their psychiatric conditions and only 10% recognized that their ability to drive was somehow damaged.[7]

DRIVING, RISK TO PUBLIC SAFETY, AND MENTAL HEALTH SERVICES

Risk to public safety from road traffic accidents (RTAs) cannot be denied. RTAs do involve patients with mental illnesses but are usually reported in a sensational way, with potential to swing public opinion against those mentally ill and the mental health services caring for them [Figure 1].

In England and Wales, legislation to govern the general issues related to driving licenses exists in the form of Road Traffic Act 1988.[8] The Driver and Vehicle Licensing Agency (DVLA) has provided a detailed guidance for medical practitioners, and mental disorders are addressed under the same set of guidelines. General Medical Council (GMC), UK has published the following advice for medical practitioners in this regard,[9] which is as follows:

• DVLA is legally responsible for deciding if a person is medically unfit to drive. This means they need to know if a driving license holder has a condition or is undergoing treatment that may now, or in the future, affect their safety as a driver.
• Doctors should seek the advice of an experienced colleague or the DVLA’s medical adviser if they are not sure whether a patient may be unfit to drive. Doctors should keep under review any decision that they are fit, particularly if the patient’s condition or treatments change. The DVLA’s publication for medical practitioners, at a glance guide to the current medical standards of fitness to drive,[10] includes information about a variety of disorders and conditions that can impair a patient’s fitness to drive.
• The driver is legally responsible for informing the DVLA about such a condition or treatment.
• If a patient has such a condition, doctors should explain to the patient that the condition may affect their ability to drive and they have a legal duty to inform the DVLA about their condition.
• If the patient is incapable of understanding this advice, for example, because of dementia, doctors should inform the DVLA immediately.
• GMC further advises that the confidentiality should be breached if patients continue to drive.

THE CLINICAL AUDIT AND CLINICAL SETTING

Considering the current guidelines for the medical practitioners, a complete clinical audit cycle was carried out to see whether the mental health practitioners were assessing their patients’ fitness to drive and addressing the issue as guided by the relevant agencies and legislation.
Four general adult community mental health teams were covering the mental health needs of Sheffield City Council (the United Kingdom). Each of these community teams included an access and assessment service, home treatment team, and recovery team comprising consultant psychiatrists, trainee doctors, community psychiatric nurses, nurse assistants, and approved mental health professionals (social workers). There was understandably a considerable overlap among the caseload of the access and assessment service, home treatment team, and recovery teams. All the three authors were working for the recovery team covering the South-West sector of the Sheffield. All the new referrals were received at a single point of access and depending on the needs of the clients, they were allocated to the relevant teams following initial assessments by the access and assessment team. All the patient case records were in electronic form which could be accessed by staff having specific training and permission to access the data relevant to their work and caseloads.

MATERIALS AND METHODS

An audit tool was devised based on GMC’s guidelines as mentioned above. The following five standards were included in the audit tool:

- Mental health professionals should find out whether patient is driving
- Mental health professionals should discuss with patients whether it is appropriate and safe for them to continue driving
- Mental health professionals should advise patients about their legal duty to inform DVLA about their condition
- Mental health professionals should check with patient at follow-up whether they stopped driving after advice
- Mental health professionals should check with patient at follow-up whether they informed DVLA about their condition.

After obtaining approval from the local clinical governance team, all the new referrals to the team from March 31 backward were retrospectively studied. Patients seen at least once by a psychiatrist/medical practitioner since referral during the current event were included. New patients and new episodes were focused to ensure the relative ease of data collection. Review by a psychiatrist/medical practitioner at least once was necessary, as the GMC guidelines are about the medical practitioners. Data collection took place during May 2014.

RESULTS AND INTERVENTIONS

Sample characteristics are shown in Table 1. Only five patients had any documentation in some form, whether they were driving during the current/most recent episode of care with the mental health services. Three out of these five patients were still driving as they were not advised whether or not to drive and there was no record if they were advised about their legal responsibility to inform DVLA of their condition. Two patients were not driving during the current or most recent episode, one of whom had to be reported to DVLA at the start of the episode as she had ignored advice and was grossly unsafe to drive, while another had lost confidence in her driving, and had in fact been advised by a nonmedical member of the team to try and drive. Compliance with the standards was significantly lacking as shown in Table 2. It was recommended that there was an urgent need to improve compliance by education of clinicians to raise awareness about these guidelines and stress the need to comply with the standards.

As a part of intervention plan, the results were presented within the community mental health team (as oral presentation) and at the local school of psychiatry conference (as poster presentation) to educate colleagues about the need to comply with GMC guidelines about patients’ fitness to drive. Small group meetings were held to educate staff within team and small posters of the clinical audit results were displayed for staff in prominent areas in the building with high staff traffic. Small posters were designed and displayed in all clinic rooms, reminding the clinicians and staff about the need to speak to clients about driving [Figure 2]. Re-audit was carried out 1 year later.

Re-audit was carried out using the same methodology. Data were collected retrospectively during May 2015. Table 1 shows the sample characteristics.

![Figure 1: Media reporting on road traffic accidents involving mentally ill patients](image-url)
Results showed that the interventions had improved compliance to standards [Table 2], but there was a need for further significant improvements in compliance. Further recommendations and interventions were planned. Results were presented to the team members and later at the Royal College of Psychiatrists’ International Congress 2015 as poster presentation. Team members were invited to give suggestions about how the compliance can be improved further.

Results were sent to the local clinical governance team as a report. Posters targeting staff awareness were left displayed as before. Results of the clinical audit cycle were presented at the National Health Services (NHS) Trust wide “Quality Improvement Group” meeting. The reports and recommendations were forwarded to the higher managerial and business planning team. It was recommended to the team to make some changes in the assessment and documentation process to ensure that the relevant information is made a compulsory record without which an electronic assessment record cannot be saved. Re-audit was recommended to be done after 1 year.

**DISCUSSION**

DVLA explains that it is the duty of the driving license holder or license applicant to notify the DVLA of any medical condition which may affect safe driving. Failure to do so is an offence under the Road Traffic Act, 1988.[8] However, clinicians are best placed to advise the patients about this responsibility while making a diagnosis and prescribing medications.[9] DVLA has published a detailed list[10] of medical and psychiatric conditions with advice about whether to stop driving with immediate effect and start driving only when the treating clinician is confident that patient’s illness will not have an impact on their ability to drive safely.

In our audit, as shown in Table 2, there was a poor compliance with the standards among assessing clinicians, but the most worrying finding in the results was the absence of any records whether patient was a driver. It was indeed far from following good practice guidelines. Whether driving

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**Table 1: Sample characteristics for Audit and Re-audit**

|                      | Audit (n=40) | Re-audit (n=50) |
|----------------------|-------------|-----------------|
| Age range (patients) | 18-65 years | 20-67 years     |
| Male/Female          | 15/25       | 27/23           |
| Diagnosis            |             |                 |
| Psychotic disorders  | 3           | 18              |
| Depression           | 24          | 24              |
| Anxiety disorders    | 15          | 12              |
| Personality disorders| 3           | 8               |
| Developmental disorders | 3    | 7               |
| Epilepsy             | 1           | 1               |

**Table 2: Combined Audit and Re-audit results**

| Standard                                             | Compliance on Audit | Compliance on Re-audit |
|------------------------------------------------------|----------------------|------------------------|
| Medical practitioners to find out whether patient is driving | 12.5%                | 38%                    |
| Medical practitioners to discuss with patients whether it is appropriate and safe for them to continue driving | 2.5%                 | 22%                    |
| Medical Practitioners to advise patients about their legal duty to inform DVLA about their condition | None                 | 14%                    |
| To check with patient at follow up whether they stopped driving after advice | None                 | 16%                    |
| To check with patient at follow up whether they informed DVLA about their condition | None                 | 14%                    |

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**Figure 2: Posters displayed in clinic rooms as reminders for staff**
for leisure, commuting to work, or driving for professional purposes, implications can be serious if mental illness is of a nature or severity to affect patients’ ability to drive. Once again, diagnosing and treating clinician is best placed to make that judgment, discuss with patient, and record the discussion in notes.

It must be realized that clinicians need to balance the need to breach confidentiality against actual risk of driving with mental illness, which is clearly stressed by GMC. However, education of patients by clinicians about their legal duties about driving is still advised by GMC.

Part of the problems in following these guidelines may be the lack of clarity among clinicians about guidelines and their worries about the possible legal consequences of giving incorrect or inadequate advice about driving. Niveau and Kelley–Puskas have also reported about the concerns of clinicians about ethical issues surrounding objective decisions regarding the need to breach confidentiality. On the other hand, some clinicians may feel little responsible in determining their patients’ fitness to drive. In either case, raising awareness among clinicians is the answer to this problem.

In our clinical audit cycle, nonclinical staff expressed their concern during small group meetings that they should not be expected to be in a position to make a judgment on patients’ fitness to drive, and it was more clinicians/medical practitioners’ duty to first make a relevant diagnosis and make a judgment in this regard. However, it is now necessary with the rapidly changing environment within the NHS for nonmedical members of the teams to make such judgments while working as the front line staff with all their experience in mental health services, as they may be the only professionals to see a patient for a long time without access or need for a review by medical practitioners/medical staff. Moreover, the guidance by the DVLA is very clear and does not necessarily need a decision by a medical member of staff. Hence, ongoing audits and regular awareness raising activities to comply with standard guidelines are necessary and that the “teams” on the whole rather than only “medical practitioners” are responsible for it.

CONCLUSION

Our clinical audit demonstrated the need to improve awareness among mental health teams that they have role, though indirectly, with regard to their patients’ fitness to drive. However, confidentiality issues and lack of awareness of the guidelines in this regard are significant hindering factors to this good practice. Moreover, there may be fears of adverse effects to the therapeutic relationship with patients. These factors reflect the need for organizational level changes in practice instead of relying on individual practices.

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