Driving to Work – How Driver Fitness Is Defined

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In 1921 around one million people in the UK were registered to drive. By 2012 this figure had climbed to 36 million. The explosion in road use proved a catalyst for the development of rules and regulations that govern the medical fitness of people to drive. In the UK, the Driving and Vehicle Licensing Agency (DVLA) sets a minimum medical standard of fitness. Driving is a complex activity that requires a combination of physical and cognitive skills that can be adversely impaired by a wide range of fitness and health conditions.

For some people driving a vehicle is an inseparable part of their job. Being fit to drive defines their ability to work. Insurers have historically offered “commercial drivers” increased terms for Income Protection (IP), limited levels of benefit or offered policies with an “own or suited” occupation definition of disability only. The reason for this is to limit the potential adverse effect on IP claims of minor conditions that prevent people from driving. Where driving-is-the-job and the-job-is-driving this “seatbelt and braces” approach seems far from flexible.

Recognising the attraction of “own” occupation definition products, some UK insurers have announced a different approach. One company will write all individual IP on an own occupation basis explicitly including heavy goods vehicle (HGV) drivers, taxi drivers, delivery drivers, driving instructors and paramedic drivers. Although sound in principle, the move may make it increasingly more difficult to establish IP claimants’ fitness to drive without appropriate physical assessment. To explain why, this article considers the roles and responsibilities of drivers and doctors in relation to fitness to drive.

Fitness to drive

An at-a-glance guide to the current UK medical standards of fitness to drive is available on-line. Epilepsy is rated as high-risk, and dementia – even in mild form – impairs driving ability and can increase crash risk. Drivers with diabetes are at higher risk of acute collapse at the wheel than non-diabetics. Insomnia, sleep apnoea, hearing impairment and the cognitive symptoms of MS all represent increased risk. Progressive neurological disorders that affect motor, visual spatial and executive skills can compromise driver safety. Psychiatric illness may impair driving ability due to reduced attention and poor impulse control, while medication can sometimes compound such difficulties. There is a known association between driving for work and stress, while musculoskeletal disorders that restrict neck and limb movement have a slight association with increased crash risk.
When an individual is diagnosed with a medical condition that has the potential to cause a sudden disabling event or render them unable to control a vehicle safely, his or her attending physician must tell them not to drive. The driver has a legal responsibility to inform the DVLA immediately if the individual develops a “notifiable” medical condition or if an existing one worsens. After a notification, the DVLA should make a decision within weeks, but this can extend to months in more complex cases.

Interestingly, there is nothing to prevent drivers who are technically unfit in the opinion of their doctors, from continuing to drive pending a decision by the DVLA. To tell a patient he or she is effectively out of work with immediate effect is yet another difficult conversation for a doctor to have. An outline of a typical case is shown in Figure 1 and highlights some of the potential complications.

**Figure 1 – Case review**

A 59-year-old man developed visual disturbance of sudden onset. He drove to the doctor’s surgery without difficulty but complained he did not feel completely well. His visual acuity was unaffected but on visual field testing by confrontation he was found to have left sided homonymous hemianopia causing loss of half the visual field in both eyes. A small occipital stroke was suspected (he was immediately referred to hospital where this diagnosis was later confirmed on CT scan).

It was the doctor’s duty to tell him not to drive again, to leave his car parked at the surgery and to inform the DVLA and his employer immediately. The patient revealed he was an HGV driver of 20 years, with an unblemished safety record, and requested the doctor to withhold the medical findings as he feared he would lose his job.

It is a driver’s legal obligation to inform the authorities. The doctor correctly advised that he would contact the DVLA if the patient did not do so himself because he posed an immediate danger to other road users. (Although correct from a moral perspective this placed a strain on the patient-doctor relationship.)

It took three months for the advisory panel to decide, based on appropriate optometry evaluation, that the HGV licence should be suspended for one year after which time a re-application could be made. The doctor continued to sign him as unfit for work. The driver’s IP policy did not cover “own” occupation fully so he inevitably lost out financially pending redeployment at work.

**Unfit to drive**

The disclosure is processed by the Drivers Medical Group who establishes whether or not a driver who has declared a medical condition satisfies the medical standards required for safe driving. Specialist medical advisors are employed by the DVLA to accomplish this task. The possible outcomes of the deliberations are:

1. Retain the license or be issued a new one;
2. A new licence issued for 1, 2 or 3 years with a future review of medical fitness;
3. A new licence that stipulates a person may only drive vehicles adapted with special controls that allow them to overcome the effects of their condition;
4. The licence is revoked and a new application is refused.

The DVLA can also investigate a person’s fitness to drive if the police report concern over his or her well-being following a road incident or if the driver has been convicted of a drink or drug related offence.

Each year, the DVLA assesses over 700,000 fitness-to-drive cases. Around 49,000 of these result in the licence being revoked for some reason. The numbers of licenses revoked on the grounds the person is unable to meet the required medical standards of fitness to drive are shown in Table 1.

**Table 1 – Licence revocations due to a medical condition, 2010–2013**

<table>
<thead>
<tr>
<th>Year</th>
<th>Group 1 vehicles</th>
<th>Group 2 vehicles</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>2010</td>
<td>13110</td>
<td>1660</td>
<td>14770</td>
</tr>
<tr>
<td>2011</td>
<td>14665</td>
<td>2014</td>
<td>16660</td>
</tr>
<tr>
<td>2012</td>
<td>16156</td>
<td>2876</td>
<td>19032</td>
</tr>
<tr>
<td>2013</td>
<td>13777</td>
<td>2902</td>
<td>16679</td>
</tr>
</tbody>
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The decision of the DVLA is legally binding under the terms of the Road Traffic Act (1988) and the Motor Vehicles (Driving Licences) Regulations (1999), that also make provision for a banned driver to appeal, if it remains worthwhile for them to do.
so. Figures show a significant increase in challenges, although the overall number remains small. Perhaps surprisingly, in 2013 77% of Group 1 and 89% of Group 2 vehicle licence holders who appealed were successful in overturning a revocation (see Tables 2 and 3).

Table 2 – Group 1 vehicle appeals

<table>
<thead>
<tr>
<th>Year</th>
<th>Appeals</th>
<th>Successful</th>
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<tbody>
<tr>
<td>2010</td>
<td>418</td>
<td>327</td>
</tr>
<tr>
<td>2011</td>
<td>1696</td>
<td>1337</td>
</tr>
<tr>
<td>2012</td>
<td>2740</td>
<td>2151</td>
</tr>
<tr>
<td>2013</td>
<td>3736</td>
<td>2889</td>
</tr>
</tbody>
</table>

Table 3 – Group 2 vehicle appeals

<table>
<thead>
<tr>
<th>Year</th>
<th>Appeals</th>
<th>Successful</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>36</td>
<td>24</td>
</tr>
<tr>
<td>2011</td>
<td>117</td>
<td>91</td>
</tr>
<tr>
<td>2012</td>
<td>264</td>
<td>206</td>
</tr>
<tr>
<td>2013</td>
<td>577</td>
<td>514</td>
</tr>
</tbody>
</table>

Failure to inform the DVLA could result in the driver receiving a £1,000 fine, prosecution (the individual is involved in a motor vehicle accident) and loss of insurance cover. The penalties for continuing to drive after having a licence revoked on medical grounds or being refused renewal, include a possible prison sentence of up to six months, penalty points endorsed on a driving licence, disqualification from driving or a fine of up to £5,000.

Development of regulations

The governance of driving evolved over time. Originally, the responsibility for registering vehicles fell to local county councils throughout the UK under the terms of the Motor Car Act (1903). The system was taken into government control in 1969 and was, at that time, operated through 180 registration offices countrywide. It was only finally fully centralised in 2013 with the creation of the DVLA based in Swansea, South Wales.

Driver registration was also introduced in 1903, although compulsory licence testing did not follow until 1934 with the introduction of the Motor Traffic Regulations (1935). Licences were issued by local authorities and were renewable every three years. Computerisation of records commenced in 1971 that linked driver data with the Police National Computer and subsequently the validity of licences was extended up to a driver’s 70th birthday.

The recognition that different standards were required for drivers of vehicles carrying passengers or heavy goods brought about the introduction of a specific passenger service vehicle (PSV) licence in 1931 and compulsory testing of HGV drivers in 1935. The rules were modified further by the Road Safety Act (1967) that paved the way for regulations covering the licensing and testing of all new HGV drivers.

Today the Department for Transport has overall responsibility for road safety in partnership with 21 different agencies and public bodies. Notable are two executive agencies: the Driver and Vehicles Standards Agency (DVSA) responsible for improving UK road safety, setting standards for drivers and for the roadworthiness for vehicles, and the DVLA that maintains a comprehensive register of all drivers and vehicles.

The regulations describe conditions in detail, including epilepsy, strokes, other neurological and mental health conditions, physical disabilities and visual impairments. The medical standards are set by expert advisory panels. Separate panels cover each major medical
condition; neurological, cardiovascular, diabetes mellitus, psychiatric disorders, drug and alcohol misuse, visual, renal, respiratory disorders and miscellaneous conditions.

These panels meet at regular intervals to review the guidelines in light of changing medical practice. Particular note is taken of the higher medical standards of fitness required for HGV and PSV drivers, reflecting the size and weight of these vehicles and the time commercial drivers spend at the wheel during the course of their occupation.

Conclusion
The process is well-established and well-run on the whole, and once a decision has been made by the DVLA, and accepted, it is legally enforceable. There can be periods of indecision and ambiguity, however. One difficulty arises during the period immediately after an attending physician has advised a person to stop driving and to inform the DVLA. Due to the process time for certain cases, a doctor would certify a patient as unfit to work if his or her occupation involved driving (this would not include travelling to and from their place of work).

There is also some conflict in decision making where the loss of a licence could have significant adverse effect on a person’s life or that of his or her family. Currently, the decision to revoke a licence is confined to factual information gathered from the applicant and the attending physician.

A number of Disability Driving Assessment centres are dotted across the UK, but these are underutilised. In future, it may be both necessary and important to expand such facilities to allow for adequate assessment of medically impaired drivers’ capabilities. With this sort of initiative, comes the need for appropriate validation and accreditation of the testing system used, and of course there is inevitable cost. Unanswered questions at this time include where such testing centres would be placed, who would administer them and who would bear the cost.

It is in the interest of government to become involved and committed to the debate, particularly given the impact of an ageing population and our seemingly insatiable desire to use motor vehicles. It is in the interests of insurers to understand how their adjudication of IP claims from commercial drivers links to levels of fitness and assessment set by government. A final question is whether a medical assessment of fitness-to-drive should be introduced in the future and if this should include a practical evaluation – only time will tell.

About the author
Dr John Delfosse has been a practicing family doctor for over 25 years. He has a particular interest in ophthalmology, ENT and sports medicine. He began work in insurance medicine more than 15 years ago. He gained the Diploma in Disability Assessment Medicine in 2002. John joined Gen Re in London as a consulting medical officer in 2009.