Section 4
Driving cessation

Alert box

Despite research that shows that life expectancy exceeds driving expectancy by 9.4 years for women and 6.2 years for men,* most current drivers do not plan well for driving cessation.

4.1 Overview

Driving plays a central role in the daily lives of many people, not only as a means of meeting transportation needs, but also as a symbol of autonomy and competence. The prerogative to drive often is synonymous with self-respect, social membership and independence.

Driving cessation can result from a gradual change in driving behavior (i.e., restrictions leading to driving cessation) or as the result of a sudden disabling event (e.g., a stroke) or due to a progressive illness (e.g., dementia). However, decisions to stop driving often are complex and are affected by a number of factors. Sometimes drivers voluntarily stop driving; other times driving cessation is involuntary.

4.2 Voluntary driving cessation

Voluntary driving cessation refers to self-induced changes in driving practices that are made for reasons other than the revocation of a licence or other strong influence from external sources.

A number of general factors are associated with voluntary driving cessation.

- Age — older people are more likely to stop driving of their own accord.
- Gender — women are more likely to give up driving voluntarily.
- Marital status — those who are single, widowed or divorced are more likely to stop driving than those who are married.
- Socioeconomic status — those in lower income brackets are more likely to stop driving.
- Education — people with lower levels of education are more likely to stop driving.

*Foley DJ, Heimovitz HK, Guralnik JM, Brock DB. Driving life expectancy of persons aged 70 years and older in the United States. *Am J Public Health* 2002;92(8):1284-9.

- Place of residence — urban dwellers are more likely to stop driving than those living in rural areas.

These general factors can assist physicians in anticipating who might be more comfortable giving up driving privileges when it becomes medically advisable to stop driving.

Some jurisdictions have initiated programs that use continued driving privileges as a means to motivate people to remain active and maintain their health. One such "wellness" program in the Beauce region of Quebec has shown that older drivers will make efforts to maintain their driving permits when the possibility of prolonging their driving privileges through a healthy lifestyle is explained to them. Similar programs that do not use the maintenance of driving privileges as an incentive were much less successful in influencing healthy lifestyle and habits.

4.3 Involuntary driving cessation

Involuntary driving cessation occurs when a licence is revoked or outside sources (physician, family members) bring their influence to bear. Involuntary driving cessation often is due to the presence of one or more medical conditions or the medications used to treat those conditions.

The most difficult situation physicians face is when a patient is functionally incapable of driving safely, but perceives him- or herself as competent to drive. Physician interventions include frank but sensitive discussions with the patient (with or without the patient's family), referral for a driving evaluation and reporting to the licensing authority. Counseling on alternative means of mobility is needed. For those with cognitive impairment, "through the door" service as opposed to regular "door to door" public transportation will be needed. For progressive illnesses (e.g., dementia), early discussions can help the person and family plan for the inevitable need to stop driving.

Involuntary driving cessation is more likely to be required when awareness of ability declines or is impaired (e.g., dementia). Factors associated with involuntary driving cessation include

- Gender — men are more likely to require outside intervention to cease driving.
- Insight — those with impaired insight are more likely to continue to drive and require intervention.

These factors can assist physicians in predicting who may be resistant to discussions about the need for driving cessation or who will be resistant to and non-compliant with advice or a directive to stop driving. In addition to patients, families also may lack insight into the impact of an illness on driving. Family members may have other reasons for having the person continue to drive (loss of mobility for both patient and caregivers, fear of increased caregiver burden, etc.). Education and support for caregivers and other family members frequently are necessary.

Specialized support groups may be available to assist patients and caregivers make the transition between being a driver and becoming a "non-driver."

4.4 Strategies for discussing driving cessation*

It is important to recognize the consequences of driving cessation for both patients and families. The following suggestions will help physicians develop a strategy before meeting with the patient to discuss driving cessation.

- Before the appointment, consider the patient's impairments. It may be important to ask if the spouse or other caregiver can be present. This can provide emotional support and help to ensure that the family understands that the person needs to stop driving.
- Whenever possible, the appointment should be in a private setting where everyone can be seated. Always address the patient preferentially, both in the initial greeting and in the discussion.
- For patients with progressive illnesses, such as dementia, discuss driving early in the course of the condition, before it becomes a problem. Early discussions also allow patients and family members to prepare for the day when driving is no longer an option.
- Be aware that patient and caregiver reports of driving competence often do not reflect actual competence. Evidence of impaired driving performance from an external source (e.g., driving assessment, record of motor vehicle crashes or "near misses") can be helpful. Include a discussion of the risks of continuing to drive with the patient and family members.
- Focus on the need to stop driving, using the driving assessment, if available, as the appropriate focus.
- Often the patient will talk about his or her past good driving record. Acknowledge that accomplishment in a genuine manner, but return to the need to stop driving. Sometimes saying "medical conditions can make even the best drivers unsafe" also can help to refocus the discussion.
- It is common for drivers, especially those who are older, to talk about a wide range of accomplishments that are intended, somehow, to show there could not be a problem now. Again, acknowledge those accomplishments, but follow with "Things change. Let's not talk about the past. We need to focus on the present" to end that line of conversation and refocus the discussion.
- Ask how the person is feeling and acknowledge his or her emotions. Avoid lengthy attempts to convince the person through rational explanations. Rational arguments are likely to evoke rebuttals.
- It is likely that emotions and feelings of diminished self-worth are a real issue behind resistance

*Adapted from The Pallium Project. (2006). *Clinical engagement of medically at-risk driving*. Edmonton, AB: Author.

to accept advice or direction to stop driving. Explore these feelings with empathy. A focus on the feelings can deflect arguments about the evaluation and the stop-driving directive.

- Ask the patient what he or she understands from the discussion. It may be important to schedule a second appointment to discuss the patient's response further and explore next steps.
- Document all discussions about driving in the patient's chart.

4.5 Compliance

An important consideration with involuntary driving cessation is the issue of compliance. Research indicates that as many as 28% of people with dementia continue to drive despite failing an on-road assessment. Family members play a pivotal role in monitoring and managing compliance with a stop-driving directive. Numerous suggestions have been made to assist family members in getting a patient to stop driving, including hiding the keys, disabling the car, canceling the insurance or selling the car. However, the evidence of the success of these interventions is largely anecdotal.