The Senior Driver

Myths & Facts

Information for Physicians on Assessment & Referral Issues

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The Senior Driver Myths and Facts: Information for Physicians on Assessment and Referral Issues, 2nd Ed.

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Myths & Facts

Older patients present the physician with many challenges. Issues related to driving are some of the most difficult and perplexing for physicians. Challenges always are accentuated when myths are commonplace and they sometimes serve as the basis for action or inaction. This booklet identifies and redresses common myths about older drivers and provides tips to help the physician meet the challenges of the driving issue and to help manage risk.

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Level 1

Myths & Facts

Myth: Senior driving safety is not a problem.

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Myths & Facts

Myth: Driving is a 'right'.

Fact: Driving is not a 'right'. It is a privilege earned through the demonstration of competence.*

- The public has 'rights', and one 'right' is to expect that drivers licensed to use the road are competent to drive.
- The public expects that their safety will be maintained through the identification of medically at-risk drivers and removal of driving privileges from drivers who are found to be medically impaired and unsafe to drive.

* Buhlers v. BC Superintendent of Motor Vehicles http://www.riddell.bc.ca/buhlers.htm

Myth: Older drivers are not a concern to the medical community because few older people drive.

Fact: Among seniors, 77% of men and 45% of women are *licensed* to drive and the majority do drive. *

- By 2020, 1 in every 4 drivers will be 65 or older.
- The proportion of senior women who drive actually increases through the senior years.
- Today's older driver is driving more and longer into old age when impairing medical conditions are most likely to occur.

* Millar, W.J. (1999). Older drivers – a complex public health issue. *Health Reports, 11(2)*, 59-71.

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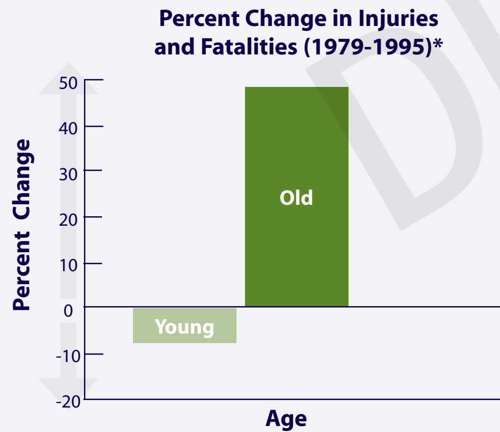
Myth: Older drivers have fewer crashes than younger drivers.

Fact: When the amount of driving is equated, older drivers have as many casualty crashes as high-risk young drivers.

- Between 1979 and 1995, older driver injuries and fatalities due to motor vehicle crashes increased by 47%, but decreased by 8% for younger drivers.



*Transport Canada (1995).

Myth: The crashes of older drivers are mainly 'fender bender' crashes.

Fact: Most older driver crashes are multiple vehicle crashes. When in a crash, older drivers are at increased risk for being injured and killed as a result of the crash.

- Older driver fatal crashes are projected to increase by 155% by 2030.*
- The health and safety of other road users are at risk because most older driver crashes involve multiple vehicles.
- The increased frailty of older drivers (and passengers) makes them more vulnerable in a crash. *, **
- Older driver (and older passenger) crash victims are 4 times more likely to be hospitalized, and recovery is slower and less complete.*

* Lyman, S., Ferguson, S.A., Braver, E.R., & Williams, A.F. (2002). Older driver involvement in police reported crashes and fatal crashes: trends and projections. *Injury Prevention, 8,* 116-120.

** Evans, L. (1988). Older driver involvement in fatal and severe traffic crashes. *Journal of Gerontology: Social Sciences, 43(6),* 5186-5193.

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Myth: For senior drivers, driving in rural areas is safer than in urban areas.

Fact: Two thirds of driver fatalities occur in rural areas. Injuries are more common in urban areas.

* Alberta Traffic Collision Statistics (2003).

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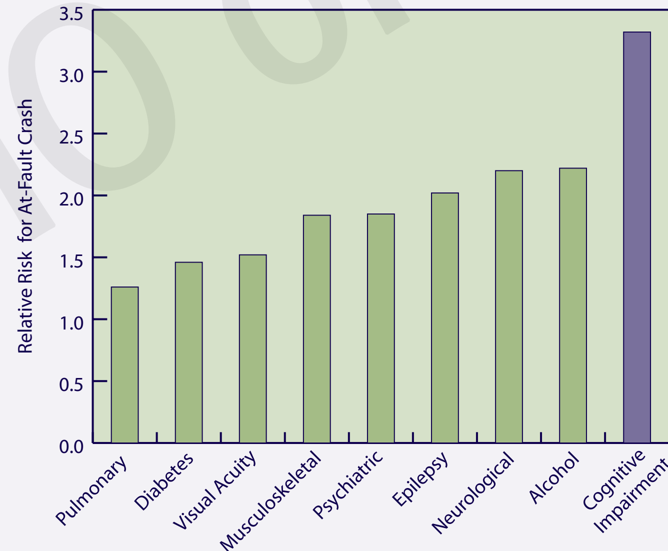
Myth: The increased crash rates of senior drivers are the result of changes associated with aging.

Myths & Facts

Fact: The increased crash rates of senior drivers are primarily due to medical conditions, not age.

- Aging is associated with some reduction in abilities, but those reductions are not sufficient to be the cause of many crashes.
- Aging only seems to be the culprit because many debilitating illnesses are age-associated.
- Many medical conditions can cause cognitive impairment (e.g., diabetes, heart disease, lung disease), and co-morbidities increase the risk.
- Medical conditions are the primary cause of ability declines that can make the patient unsafe to drive.



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* Diller, E., Cook, L., Leonard, D., et al. (1999). *Evaluating drivers licensed with medical conditions in Utah, 1992-1996.* DOT HS 809 023. Washington, DC: National Highway Traffic Safety Administration.

Myths & Facts

Level 2

Myth: Senior driving safety is not the physician's concern.

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Myth: Driving issues are not a physician's responsibility.

Fact: Declines in driving competence occur primarily because of medical conditions. Thus, physicians are the best placed for earliest identification of medically compromised drivers.

- The majority of seniors visit a physician one or more times every year. Thus, physicians are likely to be the first person 'in authority' to encounter a driver who has become medically impaired.
- Families often rely on the physician to assess and make recommendations regarding fitness-to-drive.
- Medically unfit drivers come to the attention of licensing officials primarily **after** crashes or physician reporting.
- The Canadian Medical Association states that physicians "…must always consider both the interests of the patient and the welfare of the community exposed to the patient's driving."* [p. 4]
- When considering driving, the Canadian Consensus Conference on Dementia (1999) recommends that physicians "… should notify licensing bodies of concern regarding competence to drive, even in provinces that have not legislated mandatory reporting."** [p. S8]

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* Canadian Medical Association. (2000). *Determining medical fitness to drive, a guide for physicians*. (6th ed.). Section 1.3. Ottawa, ON: Author.

** Patterson, C.J.S., Gauthier, S., Bergman, H., et al. (1999). The recognition, assessment and management of dementing disorders: Conclusions from the Canadian Consensus Conference on Dementia. *Canadian Medical Association Journal, 160 (Suppl 12)*, S1–15.

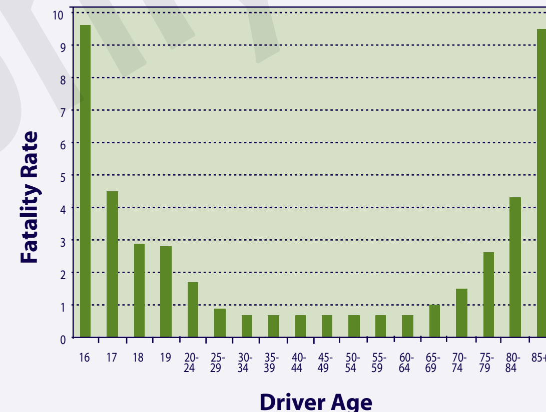
Myths & Facts

Myth: Seniors know when to stop driving. So, decisions about driving should be left to my patients.

Fact: **Many healthy, *cognitively intact* senior drivers do restrict their driving to safer times and places. In spite of this, senior drivers have crash rates per distance traveled that rival those of younger (16-24 year-old) drivers.**

- It is unlikely that the high crash rates of senior drivers are due to normal, age-associated changes in abilities.
- Older drivers with medical impairments (especially those with cognitive impairments) are responsible for the majority of crashes of senior drivers.
- Cognitively *impaired* drivers are likely to have impaired insight and are unlikely to know they are unsafe drivers.
- Crash rates of younger drivers are due to risk taking behaviors; most senior driver crashes are due to medical conditions that affect driving.

Driver Fatality Rate (per 100 million VMT)*



* FARS (2001) and NHTSA (2001).

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Myth: The self-restrictions of senior drivers (e.g., not driving at night or during rush hour) are enough to keep them safe.

Fact: Despite self-restricting to the safest times and places, the crash rates of senior drivers rival those of high risk young drivers when the amount of driving is considered.

- Self-restrictions are effective only when the driver is able to correctly identify ability declines and retains the ability to drive safely.
- Drivers with cognitive impairment often lack insight into their declining abilities.
- When insight is impaired, others, including physicians, must intervene to protect the public from medically impaired, unsafe drivers.

Myth: My patient is safe to drive because he/she drives only in familiar places.

Myths & Facts

Fact: Most crashes of senior drivers occur close to home in familiar locations.

- Driving only close to home does not protect the driver or other road users.
- Impaired decision making for entering traffic or for making left turns is a safety problem in both unfamiliar and familiar locations.
- Medically unsafe drivers too often are unaware of other vehicles or pedestrians, regardless of where they are driving.
- When a driver is unsafe because a medical condition alters mental abilities, he/she is most likely to be unsafe to drive anywhere.

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Myths & Facts

Myth: A driver-refresher course or driver training will overcome a patient's decline in driving ability.

Fact: When mental competence declines, no amount of driver training will restore the ability to drive safely.

- Illnesses that affect mental abilities are the most common causes of ability declines in senior drivers.
- Driver training should be recommended only when the person has the ability to benefit from that training.
- Some physical disabilities can be overcome through adaptive technologies and training.
- When driving ability declines are due to cognitive impairment, driver training can be dangerous, costly, and raise false expectations.

Myth: Having a co-pilot in the car is an acceptable method for maintaining the mobility of cognitively impaired seniors.

Fact: There are no data indicating that a co-pilot enhances driving safety in persons with cognitive impairment.

- Contrary data indicate that dividing attention between the road and a secondary task impairs driving performance.

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Myth: The standard (entry level) road test is okay to use to test a patient's fitness-to-drive.

Fact: The standard road test was not designed to evaluate competence declines associated with medical conditions.

- Standard road tests include scoring of 'bad habit' driving errors that are not indicators of competence. This scoring can unfairly jeopardize the driving privileges of competent drivers.
- Standard road tests focus on basic abilities. Because these over-learned abilities are the last to be lost with many medical conditions, unsafe drivers may be missed.
- Standard road tests fail an unacceptably high percentage of healthy competent drivers.

Myth: A restricted license is all that is needed for safety enhancement.

Fact: No restrictions can overcome the *inability* to drive safely.

- Drivers must retain a significant competence to drive to allow driving restrictions to enhance safety.
- Many medical conditions impair mental abilities and insight.
  - Alcohol-impaired drivers have reduced mental abilities and insight.
  - By analogy, can you think of driving restrictions that would make it acceptable for alcohol-impaired drivers to drive?

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Myths & Facts

Level 3

Myth: Senior driving safety is a concern, but others will deal with it.

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Myth: Cognitive impairment is not a serious issue for older persons.

Fact: Overall, 8% of seniors in Canada have a dementia and another 17% have some form of cognitive impairment.*

- The prevalence of dementia is age-associated:**
  - 2% for ages 65-74
  - 11% for ages 75-84
  - 33% for age 85 and over.
- 17% of seniors have an illness other than dementia that causes cognitive impairment.
- Multiple medical conditions (and medications to treat those conditions) can cause serious cognitive impairment even when none of the conditions taken separately would be sufficient.

* Graham J.E., Rockwood K., Beattie B.L., et al. (1997). Prevalence and severity of cognitive impairment with and without dementia in an elderly population. *Lancet*; *349*, 1793-1796.

** Canadian Study of Health and Aging Working Group. (1994). Canadian Study of Health and Aging: study methods and prevalence of dementia. *Canadian Medical Association Journal*, *150*, 899-913.

Myth: Cognitively impaired patients do not drive.

Fact: More than one half (57%) of drivers with 'some' cognitive impairment are reported to continue to drive and more than one quarter (26%) of drivers with 'serious' cognitive impairment are reported to continue to drive.*

- Cognitive impairment is a serious traffic safety issue. Unfortunately, research indicates that in the primary care setting, dementia is missed in 67% of all affected cases and in over 90% when the impairment is of mild severity.**
- Importantly, cognitive impairment is associated with a 2–5 fold increase in the risk of an at-fault crash.***
- Patients with cognitive impairment are not likely to stop driving on their own as the lack of insight often means they are unaware their driving has declined to an unsafe level.

* Bess, I. (1999). Seniors behind the wheel. *Canadian Social Trends (Statistics Canada Catalogue No. 11-008), 54(2),* 2-7.

** Vancour, V.G., Masaki, K.H., Curb, J.K., & Blanchette, P.L. (2000). The detection of dementia in the primary care setting. *Archives of Internal Medicine*, *160*, 2964-2968.

*** Carr, D.B. (1997). Motor vehicle crashes and drivers with DAT. *Alzheimer Disease and Associated Disorders, 11(Suppl 1)*, 38-41. Friedland, R.P,. Koss, E., Kumar, A., et al. (1988). Motor vehicle crashes in dementia of the Alzheimer type. *Annals of Neurology, 24*, 782-786.

Myths & Facts

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Myths & Facts

Myth: A diagnosis of Alzheimer's disease means the person is not capable of driving safely.

Fact: **Diagnosis alone is not sufficient to determine a person's driving ability.**

- Eventually, every person with Alzheimer's disease (or any other progressively impairing dementia) will have to stop driving.
- However, in the early stages of dementia, as many as *one third* of drivers remain capable of driving.
- Earlier diagnoses and the possible effects of cognitive enhancing drugs make it especially important that driving competence is appropriately evaluated (and re-evaluated at set intervals).
- *Early* planning is the key to ease the transition from driver to non-driver. Physicians can play a key role in this early planning.

Myth: Spouses or family members are good judges of the patient's driving abilities.

Fact: **Research shows that a spouse and/or other family member's judgments of driving performance often are not good sources of information about the patient's driving problems.**

- Spouses and other family members often *underestimate* driving risk and *overestimate* the driver's competence.
- In some cases, there are strong reasons for biased judgments (e.g., denial, dependency).
- In many cases, the changes in driving performance are slow, and this may make it difficult to detect the decline.
- Because the cognitively impaired driver may lack insight and strongly proclaim their competence, the caregiver may try to avoid conflict by denying there is a driving problem.

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Level 4

Myths & Facts

Myth: Senior driving safety is a concern but, as a physician, I'm worried about the consequences.

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Myths & Facts

Myth: If I raise the driving issue, I will lose my patient.

Fact: Research indicates that patients do not change doctors because of referrals for a driving assessment.

- In a study of 117 consecutive patients who were advised to stop driving by their physician, no patient changed doctors.* The key to not losing patients seems to be a referral for an independent driving evaluation.
- External driving evaluations place the physician at arms-length from the driving assessment. This allows the physician to focus on the outcome of the test just as he/she would for any other referral outcome.

* Dobbs, B.M. & Dobbs, A.R. (1996). *The psychological, social, and economic consequences of de-licensing the older driver.* Paper presented at the mid-year meeting of the Older Driver Program Subcommittee of the National Research Council's Transportation Research Board Committee on the Safety and Mobility of Older Drivers, Washington, D.C.

Myth: The MMSE is an effective tool for assessing a patient's fitness-to-drive.

Fact: The MMSE is of very limited utility for predicting crashes or driving performance.

- There is no MMSE cut-off score that assures that your patient is safe to drive.
- The MMSE cannot be used to determine whether a patient is fit-to-drive, although declines may be a red flag for the need to have the patient's driving assessed.
- Some persons scoring very highly on the MMSE (between 25 and 30) have been shown to be very impaired and dangerous drivers.
- An extensive study evaluating senior drivers who crashed versus those with no crashes found a MMSE cutoff score of 24 would have missed 95% of the senior drivers who crashed.*

* Johansson, K. (1997). *Older automobile drivers: Medical aspects.* Unpublished doctoral dissertation, Karolinska Institute, Stockholm.

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Myth: The standard medical exam is adequate for identifying medically impaired drivers.

Fact: The medical exam can 'red flag' medically-at-risk drivers who need further evaluation.

Myth: A 'regular road test' or a rehabilitation driving test is adequate for assessing driver competency.

Fact: A validated performance-based driving assessment is needed.

- A 'regular road test' evaluates overlearned skills and is not suitable for assessing driving competency in the medically impaired driver.
- A rehabilitation driving assessment is important when there are physical handicaps. In those cases, recommendations can be made regarding adaptations for driving, and training using those adaptations.
- DriveABLE™, a university spin-off company, provides scientifically validated testing for drivers with cognitive impairments.*

* Dobbs, A.R. (2005). *The development of a scientifically based driving assessment and standardization procedures for evaluating medically at-risk drivers*. Canadian Multidisciplinary Road Safety Conference XV, Fredericton, NB. (Full reviewed paper available on request.)

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Myths & Facts

Myth: Physician reporting of medically at-risk drivers is not mandatory in Canada.

Fact: Mandatory reporting of medically at-risk drivers is required in all provinces in Canada with the exception of Alberta, Nova Scotia, and Quebec.

- Other provinces (e.g., Alberta) are considering the move to mandatory reporting.
- The Canadian Medical Association recommends that physicians inform their patients if they believe he/she is unfit to drive.* [p. 4]
- The Canadian Consensus Conference on Dementia (1999) recommends that physicians always report unsafe drivers.** [p. S8]

* Canadian Medical Association. (2000). *Determining medical fitness to drive, a guide for physicians*. (6th ed.). Section 1.3. Ottawa, ON: Author.

** Patterson, C.J.S., Gauthier, S., Bergman, H., et al. (1999). The recognition, assessment and management of dementing disorders: Conclusions from the Canadian Consensus Conference on Dementia. *Canadian Medical Association Journal, 160 (Suppl 12)*, S1–15.

Myth: Physicians who do not report medically at-risk drivers cannot be held liable.

Fact: Legal precedents demonstrate that physicians can be held liable for their patient's car crash and for third-party injuries caused by their patient, even in a province not having mandatory reporting.

- If medical reports to the Licensing Authority are not fully disclosing, the physician can be held liable if that patient is in a crash.
- The physician should always report an unfit driver if the patient's medical condition is such that the physician could reasonably expect that it could lead to a crash.
- Failure to advise the patient about driving risks associated with medical conditions is considered negligent behavior.
- A critical issue regarding liability is foreseeability.*

* *Freese v. Lemmon*, 210, NN 2d 576 (Iowa, 1973).

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Myth: Physicians who report patients are open to litigation.

Fact: Physicians are protected from unconditional liability if they report in good faith in Alberta, Manitoba, Newfoundland and Labrador, Nova Scotia, Ontario, Prince Edward Island, Quebec, and the Yukon. Physicians are protected from liability if they act in good faith in New Brunswick and Saskatchewan. Physicians in British Columbia, Northwest Territories, and Nunavut are protected from liablity unless they act maliciously or without reasonable grounds. [p. 13]

* Canadian Medical Association (2006). Determining medical fitness to operate motor vehicles. *CMA Driver's Guide* (7th Edition). Ottawa, ON. http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/WhatWePublish/Drivers_Guide/Section03_e.pdf

Myth: Patients reported as medically at-risk automatically lose their license.

Myths & Facts

Fact: If reported as medically at-risk, individuals undergo a medical review process by the Licensing Authority.

- Physicians do not revoke a driver's license, the Licensing Authority has that responsibility.
- Individuals may be asked to supply further medical information and/or complete a driving assessment before a final licensing decision is made.
- Individual drivers have the right to appeal licensing decisions.
- Physicians have an obligation to report medically at-risk patients to the Licensing Authority.

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Myths & Facts

Myth: Patient information provided by physicians to the Licensing Authority can be accessed by outside agencies or individuals.

Fact: All information sent to the Licensing Authority by a physician is considered confidential.

- Physician consent is needed before any information is released.

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Tips and Advice for Physicians

Tips & Advice

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Topic 1
Keeping records

Tips & Advice

- Driving competency always should be questioned when there is a decline in mental or functional abilities.
- Initiate and maintain driving histories on all your patients, particularly those with chronic medical conditions that may affect driving.
- Document your advice to the patient concerning driving.
- Document your reporting of the patient's medical problems to the Licensing Authority.

Topic 2
Red flags

- Certain medical conditions are 'red flags' for the need for a driving assessment. Be familiar with, and alert for those conditions in your patients.
- A history of crashes or 'near misses' is a red flag that the patient needs to be evaluated for driving competence.

Driving Checklist for Physicians

Date:________________________

Driving Status:
Currently driving ____ Temporarily not driving _____ Not driving _____

If driving:

Driving Patterns: Frequency _____
Previous crashes/citations/near misses _______
History of Becoming Lost While Driving ☐ Yes ☐ No

Medical History
(findings that may affect driving ability):

None	Require driving evaluation	Should stop driving

Physical Examination
(findings that may affect driving ability):

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- Do not assume that your patient and his/her family members are accurate judges of driving competence.
- Many senior drivers assume that their doctor knows that they continue to drive. Therefore, silence from the doctor about driving can be misconstrued as tacit support to continue driving.
- To identify drivers whose abilities have declined to an unsafe level, refer patients for a driving assessment (as you would refer for other diagnostic tests).
- Refer patients for a driving assessment if you are concerned that their medical condition(s) or treatment(s) may affect driving abilities.
- Evaluation using a scientifically validated assessment, as recommended by the Canadian Consensus Conference on Dementia (1999), is critical to protect safe drivers from being falsely identified as unsafe and to accurately identity those who are unsafe.

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Topic 4
Early planning

Tips & Advice

- Most everyone prepares for retirement. Patients also need to start preparing for the day when they may need to retire from driving.
- Life expectancy significantly exceeds safe driving expectancy (for men, 6 years; for women, 10 years). Early planning for driving retirement is critical for continued well-being and independence.*
- With conditions such as dementia, early planning and education on alternative means of transportation may minimize the impact of loss of driving privileges.
- In the early stages of degenerative conditions (e.g., dementia), discuss with the patient and his/her family the need to begin preparing for driving cessation.
- Provide the patient and family with information on alternate sources of transportation.
- Some areas may have support groups to assist medically impaired drivers to accept the need to stop driving. Encourage your patients and family members to attend those groups.

* Foley, D.J., Heimovitz, H.K., Guralnik, J.M., et al. (2002). "Driving life expectancy of persons aged 70 years and older in the United States," *American Journal of Public Health, 92(8),* 1284-1289.

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Topic 5
Conversation starters for physicians and families

Tips & Advice

- In bringing up the issue of a driving evaluation with your patient, an effective approach has been to say, "How do you think you would do on a driving evaluation?" Commonly, the patient responds, "I would do fine." You then could say, "That's great; I'll make a referral for you to …"

The interpersonal relationships are different in every family and conversations about driving will differ. But bringing up the driving topic is almost always difficult. Below are some variations of conversation starters families can consider.

- *Dad, we both have seen things that indicate you are having some problems driving ….*
- *Mom, I'm concerned about your safety and that someone might get hurt …*
- *You've always been straight with me and now I need to be straight with you …*
- *I know how important driving is to you, but I also know how concerned you are about other people …*
- *I know you've been a good driver for a long time, but things have changed …*
- *Dad, I'm really concerned about your driving – you have to stop now before something serious happens …*
- *Mom, you have been such a good driver for so long, let's not let it end with something terrible happening …*

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Tips & Advice

Topic 6
Developing a strategy for discussion of driving cessation with a patient

- **Have family members present if possible**
  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.

- **Have a private setting for the discussion**
  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.

- **Initiate the driving conversation early on in the illness**
  For patients with progressive illnesses such as dementia, initiate the driving conversation early in the course of the condition, before driving becomes a problem. Early discussions also allow patients and family members to prepare for the day when driving is no longer an option.

- **Recognize that self-reports of patients and reports by family members may be biased**
  Be aware that patient and caregiver reports of driving competence often are incongruent with 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 risks of continuing to drive with patients and family members.

- **Focus on the need to stop driving**
  Focus on the need to stop driving, using the driving assessment, if available, as the appropriate focus.

- **Focus on the medical condition rather than past driving records**
  Often the patient will talk about their past good driving record. Acknowledge that accomplishment in a genuine manner, but return to the need to stop driving. Sometimes saying that 'medical conditions can make even the best of drivers unsafe' also can help to refocus the discussion.

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- **Acknowledge past accomplishments but focus on present 'changes'**
  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, acknowledging those accomplishments, but following with, "Things change, let's not talk about the past, we need to focus on the present" can end that line of conversation and refocus the discussion.

- **Ask how the person is feeling**
  Ask how the person is feeling and acknowledge their emotions. Avoid lengthy attempts to convince the person through rational explanations. Rational arguments are likely to evoke rebuttals.

- **Acknowledge the emotional aspects of the stop driving directive**
  It is likely that emotions and feelings of diminished self-worth are a real issue behind resistance to accept advice or direction to stop driving. Explore the feelings with empathy. A focus on the feelings can deflect arguments about the evaluation and the stop driving directive.

- **Confirm understanding**
  Ask the patient what he/she understands from the discussion. It may be important to schedule a second appointment to further discuss the patient's response and explore next steps.

- **Document all discussions**
  Document all discussions about driving in the patient's chart.

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

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