RESPONSE TO THE
DEPARTMENT FOR TRANSPORT
AND
DRIVER AND VEHICLE LICENSING AGENCY
CONSULTATION

“PROPOSALS TO AMEND DRIVING LICENCE STANDARDS FOR
VISION, DIABETES AND EPILEPSY”
Proposals to Amend Driving Licence Standards for Vision, Diabetes and Epilepsy

This is the response of the Royal Society for the Prevention of Accidents (RoSPA) to the joint Department for Transport and the Driver and Vehicle Licensing Agency’s consultation on “Proposals to Amend Driving Licence Standards for Vision, Diabetes and Epilepsy”. It has been produced following consultation with RoSPA’s National Road Safety Committee and Road Safety Advisory Group.

RoSPA thanks the DfT and the DVLA for the opportunity to comment on the proposals.

Introduction
The UK’s driver licensing rules are based on the second European Directive on Driving Licences (91/439/EEC), which harmonised rules throughout the European Economic Area for the mutual recognition and exchange of Member State licences. It also specified minimum medical standards for driving licences, although Member States may impose stricter standards if they choose to do so. The Third European Directive on Driving Licences (2006/126/EC), to be implemented by 19 January 2013, contains the same minimum medical standards for the issue of driving licences, although it increases the frequency of medical checks for Group 2 (medium and large lorries, buses and coaches) drivers.

Officials and medical experts across the European Union have reviewed the standards for vision, diabetes and epilepsy, as a result of which, revised minimum standards were adopted on 25 August 2009 in the form of Directives: 2009/112/EC and 2009/113/EC (“the medical directives”), which came into force on 15 September 2010, amending the 2nd and 3rd Driving Licence Directives respectively.

In Great Britain, the Honorary Medical Advisory Panels for vision, diabetes and neurology have considered how the medical directives compare with existing UK standards. For the most part, the medical directives relax or more precisely define existing EU minimum medical standards. Where the Panel has advised that this is consistent with road safety, the Government is recommending that the new standards are adopted.

The government propose that new applicants for driving licences will need to meet the new medical standards when the domestic legislation it comes into force, and that existing licence holders would need to meet the new medical standards when they need to renew their driving licence when they reach 70 years of age in GB, or earlier if they require renewal of a short period licence on medical grounds. In Northern Ireland, existing driving licence holders would need to meet the new standards at their next 10 year licence renewal, or earlier if they require renewal of a short period licence on medical grounds.

Group 2 drivers (medium or large lorries, buses or coaches) are assessed when they reach 45 years of age, and then every five years thereafter. These drivers would need to meet the new medical standards when they reach 45 years, or at their next five yearly check (sooner if they have short period medical licences) if they are already 45 years old when the legislation comes into force. However, with effect from the first photocard renewal after January 2013, Group 2 drivers will be assessed every five years irrespective of age.
VISION

Group 1 Drivers (vehicle categories A and B, including 2 or 3–wheeled vehicles, cars and light vans up to 3.5 tonnes)

In the UK, all applicants for a driving licence must pass an appropriate test to ensure that they have adequate visual acuity for driving motor vehicles. In the UK, the “number plate test” is used: applicants must be able to read (with corrective lenses if necessary) a vehicle number plate, in good daylight, from a distance of 20 metres (or 20.5 metres for old style number plates).

This measures visual acuity at the standard of Snellen 6/10 (decimal 0.6). The UK standard is higher than the minimum EU visual acuity standard, which is Snellen 6/12 decimal 0.5 for drivers with binocular vision. Only where there is reason to doubt that an applicant’s vision is adequate, are they required to be examined by a competent medical authority.

Proposal
The government propose to amend the UK standard to match the minimum EU standard of decimal 0.5, by reducing the distance at which the number plate has to be read to approximately 17.5 metres. They also propose that only new style number plates can be used in the driver’s test, as the vast majority of number plates are now the new style format. The reference to the old style number plates would be removed from the Regulations.

RoSPA Response
RoSPA does not support the proposed reduction in the vision standard.

The method used in the UK to provide the “appropriate assessment” of vision is the Number Plate Test, which driving test candidates take at the start of their practical driving test by reading a vehicle number plate from a distance of approximately 20 metres (or 20.5 metres for old style number plates). This is already a very crude test of a person’s eyesight, and can be affected by lighting and weather conditions or by the examiner’s estimate of 20 metres, and it does not test for field of vision (peripheral vision). To make such a crude, flawed test even weaker by reducing the distance from 20 metres to 17.5 metres does not make sense.

Although, it is a relatively small reduction and it seems unlikely that it would significantly increase the number of drivers with inadequate eyesight, this change would not improve road safety in anyway. It does have the potential, however small, to increase the number of drivers with poorer vision than is currently required in this country.

As Member States are permitted to impose stricter medical standards than the minimum standards set by the EU Directives, RoSPA believes that the current UK standards should be retained.
A more fundamental question is whether the Number Plate Test should be replaced by a proper medical eyesight test conducted by a qualified optometrist or medical practitioner.

RoSPA is aware of concerns raised by the Optical Confederation (a coalition of the Association of British Dispensing Opticians, the Association of Contact Lens Manufacturers, the Association of Optometrists, the Federation of Manufacturing Opticians, and the Federation of Ophthalmic and Dispensing Opticians) who believe that the Number Plate Test is an unfair and unreliable test of visual acuity. The Confederation has cited research evidence that casts doubt on whether the current Number Plate Test distance of 20 metres is actually comparable to the Snellen standards required by the EU Directive or by the UK’s current higher standard. They are also concerned about the variability of the Test caused by differing lighting and weather conditions or by the examiner’s estimate of 20 metres. The Optical Confederation, therefore, believes that the Number Plate test should be replaced with a proper assessment of visual acuity performed under controlled conditions.

This, of course, would impose costs on motorists (including those whose eyesight meets the required standards) who would have to pay for the tests (although many drivers already have regular eyesight checks, so would not face additional costs). The justification for a formal medical eyesight test is also hampered by the lack of hard evidence of the proportion of accidents or injuries that are caused, or partly caused, by drivers with poor vision, or how many of these would be prevented by a mandatory, medical eyesight check. The lack of evidence may be partly due to under-reporting of vision as a contributory factor as it is not routinely assessed after accidents.

RoSPA believes that the case for a proper eyesight test (when applying for a provisional licence and when renewing a licence at 70 years of age) should be investigated, including an assessment of its likely effectiveness in reducing the number of accidents and casualties caused by drivers with poor vision, and the likely number of drivers who would have to pay for eyesight tests that they would not otherwise need to take, even though they have no eyesight problems. A review of eyesight tests for driving in other countries would also be helpful.

RoSPA suggests that opportunities are sought to remind drivers of the importance of regular eyesight tests because changes in eyesight are often gradual and can be imperceptible for some individuals until their eyesight has actually deteriorated substantially. Advice could be provided when drivers are required to renew motoring documents, such as their photocard licence, insurance, MOT, etc.

There is also evidence\(^1\) that health professionals need more help in assessing health conditions, including eyesight, which may affect the way in which someone drives during routine consultations, and to enable them to provide appropriate and sensitive advice, which could, of course, include the need to have an eyesight test.

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\(^1\) “Attitudes of Health Professionals to Giving Advice on Fitness to Drive”, Road Safety Research Report No. 91, DfT, 2010
Exceptional Cases
UK law currently allows licensing to be considered for group 1 drivers in exceptional cases where there is a horizontal field defect, on an individual basis, subject to strict criteria. There are no exceptions allowed to the visual acuity standard measured by the number plate test. All exceptional cases are assessed to confirm that the applicant is not a source of “danger to the public”.

The new EU standards allow for “exceptional cases” where the visual acuity standard or visual field standard cannot be met. In such cases, the driver should undergo examination by a competent medical authority to demonstrate that there is no other impairment of visual function, including glare, contrast sensitivity and twilight vision.

Proposal
The government does not intend to provide for exceptions to the rules on visual acuity at present but will keep this under review.

RoSPA Response
RoSPA agrees that exceptions to the visual acuity test should not be allowed.

Visual Field in Both Eyes
The visual field is the area that a person can see without shifting their gaze. In the UK, driving licences are not issued or renewed if, during the medical examination, it is shown that the person’s horizontal field of vision is less than 120 degrees, subject to limited exceptionality. UK law allows for exceptional cases for visual field defects in some circumstances will continue.

The new EU standards state that the horizontal visual field should be at least 120 degrees; the extension should be at least 50 degrees left and right and 20 degrees up and down, and there should be no defects within a radius of the central 20 degrees. They also allow for “exceptional cases” where the visual field standard cannot be met. In such cases, the driver should undergo examination by a competent medical authority to demonstrate that there is no other impairment of visual function, including glare, contrast sensitivity and twilight vision.

Proposal
This standard is mandatory and, therefore, the government propose to implement it fully whenever a full visual examination is carried out. However, they propose to continue to allow limited exceptionality cases where there is a horizontal field defect, on an individual basis, subject to strict criteria, and to ask the Honorary Medical Advisory Panel on Vision to consider an appropriate minimum qualifying field of vision standard that should be met

Until further research into the standards for the measurement of contrast sensitivity, twilight vision and glare sensitivity is available to enable precise standards to be set, guidance to doctors will be that all these elements of vision should be assessed whenever a detailed examination is undertaken, by way of the current UK test – is the person a “danger to the public”? 
RoSPA Response
It is not clear what comprises an “exceptional case” and so it is difficult to judge whether the exceptionality should continue. However, RoSPA is not aware of any evidence that the existing exceptions have created road safety problems and, therefore, do not object to this being retained.

Progressive Eye Disease
The medical directives require drivers with a progressive eye disease to take regular examinations. Existing UK law already treats such progressive eye conditions as a “prospective disability” and requires the individual to undergo regular reviews.

Total Functional Loss of Vision in One Eye (Monocular Vision)
The existing EU standard for those who have total functional loss of vision in one eye or who use only one eye is that there should be visual acuity of at least decimal 0.6, normal field of vision and a period of adaptation. This is reflected in the UK by the number plate test measuring decimal 0.6 and the detailed guidance given to doctors.

However, the new EU Standards the same as the standards for drivers with binocular vision (i.e. decimal 0.5), which is lower than the current UK standard. The requirement for an adaptation period is retained.

Proposal
The government propose to amend the UK standard to match the minimum EU standard of decimal 0.5, by reducing the distance at which the number plate has to be read to approximately 17.5 metres. Where there has been a recent substantial or total loss of vision in one eye, an adaptation period will be required, the length of which will vary according to individual circumstances.

RoSPA Response
As stated above, RoSPA does not support the proposed reduction in the vision standard. Although, the consultation paper states that “there should be no adverse impact on road safety arising from the small relaxation in the visual acuity standard for the functioning eye”, it appears to offer no evidence for this claim.
Group 2 Drivers (vehicle categories C, and D (and sub categories of C1 and D1), including medium and large lorries and buses and coaches

The medical licensing standards for lorry and bus drivers are more stringent than for Group 1 drivers.

**Visual Acuity for those with Binocular Vision (vision in both eyes)**

The current EU standard requires drivers who apply for, or to renew, a Group 2 licence to have a visual acuity, with corrective lenses if necessary, of at least Snellen 6/7.5 (decimal 0.8) in the better eye and at least Snellen 6/12 (decimal 0.5) in the worse eye.

When corrective lenses are used to attain a minimum acuity of 6/7.5 (decimal 0.8) and 6/12 (decimal 0.5), either:

a) the uncorrected acuity in each eye must reach Snellen 3/60 (decimal 0.05); or
b) the corrected minimum acuity must be achieved by means of glasses with a power not exceeding plus or minus eight dioptres (unit of measurement of optical power of a lens) or with the aid of contact lenses. The glasses or contact lenses must be well tolerated (“the spectacles requirement”).

UK law currently requires a standard of Snellen 6/9 in the better eye and 6/12 in the worse eye. Where corrective lenses are used, the uncorrected acuity in each eye must reach Snellen 3/60 (decimal 0.05), although the correction must be well tolerated.

**The new EU standards New EU Rules**

The new EU standards lowers the standard required in the worse eye from decimal 0.5 to decimal 0.1, but the better eye standard remains the same. The spectacles requirement in paragraph b above is mandatory and an uncorrected visual acuity standard can no longer be used as an alternative to the spectacles requirement.

**Proposal**

The government propose to slightly raise the standard required for the better eye from Snellen 6/9 to 6/7.5. Although, this may mean that some vocational drivers could lose their Group 2 entitlement on renewal, even though their eyesight has not changed, the standard is only slightly higher so the number of people likely to be affected is expected to be minimal. The government also proposes to lower the worse eye standard to decimal 0.1 to match the new EU rules.

Also to match the EU Rules, the government propose to remove the uncorrected acuity standard (the uncorrected acuity in each eye must reach Snellen 3/60) from the regulations, and to adopt the spectacles requirement which is now mandatory. The reason for the later is that very strong corrective lenses can distort vision. Drivers who wear spectacles to meet eyesight standards will need to provide evidence (such as an optician’s prescription) to demonstrate that their spectacles meet the requirement. Medical advice is that very few people who meet the current UK “uncorrected acuity standard” would not be able meet the spectacles standard.
RoSPA Response
RoSPA accepts some of the changes must be implemented because they are mandatory parts of the new EU Directives. However, they are a relaxation of the current UK standard, and where it is possible, we believe the higher UK standards should be retained, even if they are higher than the EU minimum requirements.

Visual Field for those with Binocular Vision (vision in both eyes)
In the UK, Group 2 driving licences are not issued, to or renewed for, applicants or drivers without a normal binocular field of vision or those suffering from diplopia. The New EU Rules set a more precise definition: the horizontal visual field with both eyes should be at least 160 degrees; the extension should be at least 70 degrees left and right and 30 degrees up and down. No defects should be present within a radius of the central 30 degrees.

Proposal
The government proposed to implement the new EU standards because they provide a precise definition of the required standard for visual field.

RoSPA Response
RoSPA supports the proposal.

Impaired Contrast Sensitivity
Contrast sensitivity is the ability to perceive differences between an object and its background. The new EU Rules require that driving licences must not be issued to, or renewed for, applicants suffering from impaired contrast sensitivity, but they do not state how impaired contrast sensitivity should be measured. As this is a new requirement, and standards for impaired contrast sensitivity are not available, it is not currently contained in UK law.

Proposal
The Honorary Medical Advisory Panel on Vision will consider the need for research into contrast sensitivity and the results will be published when available. In the meantime, detailed examinations of eyesight will consider contrast sensitivity and apply the current general test – i.e., is the person likely to be a “source of danger to the public”?

RoSPA Response
In the absence of precise standards, measurements or research, this seems the only practical option.
**Substantial Loss of Vision in One Eye for those with Binocular Vision (vision in both eyes)**

A substantial loss of vision in one eye is not currently specified in the UK, however, Group 2 drivers who suffer a loss of vision in one eye have to meet the minimum acuity of Snellen 6/7.5 (decimal 0.8) in the better eye and Snellen 6/12 (decimal 0.5) in the worse eye to retain their licence.

The new EU Rules require that after a “substantial loss” of vision in one eye, there should be an appropriate adaptation period during which the driver/applicant is not allowed to drive. Driving is only allowed after a favourable opinion from vision and driving experts.

**Proposal**
The government propose to adopt the EU standard, but not to set a standard period of time for the adaptation period, but allow the length of time to vary according to individual circumstances.

**RoSPA Response**
RoSPA supports the proposal.

It is very likely that most people would require time to adjust to a sudden substantial loss of vision, and the time will vary between people. We suggest that a medical expert be required to recommend the length of the adaptation period and to confirm that the driver has been able to adjust before the period is declared complete, and the driver is able to drive again.

**Cost of Eye Examinations**
Eye examinations are generally paid for by licence applicants because they are often conducted by optometrists who are not registered medical practitioners and even where the examination is by a medical practitioner regulations allow the applicant to be charged for examinations relating to visual acuity or visual field. We propose to amend regulations to make it clear that the Secretary of State is not required to pay for the examination of any visual impairment, regardless of who carries it out.

**RoSPA Response**
RoSPA supports the proposal.
DIABETES MELLITUS

Group 1 Drivers (vehicle categories A and B, including 2 or 3-wheeled vehicles, cars and light vans up to 3.5 tonnes)

Recurrent Severe Hypoglycaemia
Severe hypoglycaemia means the assistance of another person is needed. Recurrent hypoglycaemia is defined as a “second severe hypoglycaemia during a period of 12 months.” UK law requires drivers who have had frequent hypoglycaemic episodes to cease driving. Their licence may be refused or revoked if they are considered “a source of danger to the public”. If control has been re-established, a licence can be issued or renewed. However, the New EU Rules state that drivers experiencing recurrent severe hypoglycaemia shall not be issued a licence.

Proposal
The UK is obliged to adopt this standard. Research indicates that recent severe hypoglycaemia seems to be predictive for future incidents. The government intend to amend guidance and/or regulations to make the new standard clearer.

RoSPA Response
RoSPA supports the proposal.

Impaired Awareness of Hypoglycaemia
Impaired awareness of hypoglycaemia means an inability to detect the onset of hypoglycaemia due to a total absence of warning symptoms. In the UK, drivers with impaired awareness are required to cease driving, until awareness has been regained. The new EU Rules state that driving licences shall not be issued to, nor renewed for, applicants or drivers who have impaired awareness of hypoglycaemia.

Proposal
The UK must adopt this standard, and the government propose to amend guidance and/or regulations to make the new standard clearer.

RoSPA Response
RoSPA supports the proposal.

Treatment with Medication
In the UK, drivers with diabetes treated with insulin are required to notify the DVLA, but drivers with diabetes treated by medication are not required to do so unless there is a complicating factor, such as hypoglycaemia or a visual field defect. However, the new EU Rules state that even drivers whose diabetes is treated with tablets and who do not suffer complications must have a medical review at least every 5 years.

Proposal
In the UK, a doctor should not prescribe medication indefinitely without reviewing the patient at least every 12 months. Thus, the government propose to implement the EU Rules by amending the letter issued to Group 1 drivers with tablet treated diabetes. They will not be required to notify DVLA on an ongoing basis provided a regular prescription or medical review is taking place.

RoSPA Response
RoSPA supports the proposal, which provides a very practical solution.
**Group 2 Drivers (vehicle categories C, and D (and sub categories of C1 and D1), including medium and large lorries and buses and coaches**

**Insulin Treated**

In the UK, drivers with insulin treated diabetes are not licensed to drive any Group 2 category of vehicle, except category C1 (a vehicle which has a maximum authorised mass (MAM) between 3.5 tonnes and 7.5 tonnes with a trailer up to 750kg). In exceptional cases, a person with insulin treated diabetes, who is over 18 years old; may be licensed. Such cases are subject to annual review.

The new EU Rules allow drivers who are being treated for diabetes, which carries a risk of hypoglycaemia (that is, with insulin and some tablets), may apply for a licence to drive all Group 2 categories provided the following specific criteria are met:
- There has not been any severe hypoglycaemic event in the previous 12 months;
- The driver has full hypoglycaemic awareness;
- The driver must show adequate control of the condition by regular blood glucose monitoring, at least twice daily and at times relevant to driving;
- The driver must demonstrate an understanding of the risks of hypoglycaemia;
- There are no other debarring complications of diabetes.

**Proposal**

The government, on the advice of the Honorary Medical Advisory Panel on Diabetes, proposes to adopt the new EU rules, even though they are a relaxation of the UK’s current regime. However, the Panel has recommended making this subject to an annual review by an expert diabetologist, which is more stringent than the EU minimum requirement of a three yearly review. For diabetes treated with medication other than insulin which carries a risk of inducing hypoglycaemia the Panel recommends accepting a doctor’s report.

**RoSPA Response**

RoSPA agrees with the proposal, provided the Honorary Medical Advisory Panel on Diabetes’ recommendation for an annual review by an expert diabetologist is also implemented.

**Severe Hypoglycaemia**

In the UK, drivers must immediately report any significant change in their condition, which would trigger a reassessment of their licensing status. Frequent hypoglycaemic episodes likely to impair driving will lead to revocation. The New EU Rules require that a severe hypoglycaemic event during waking hours, even unrelated to driving, should be reported, which should trigger a reassessment of the licensing status.

**Proposal**

The current UK regulations and guidance are compatible with the EU standard, but the government intend to amend to the UK rules to make it clearer that a severe hypoglycaemic episode even when not driving will lead to a reassessment.

**RoSPA Response**

RoSPA supports the proposal.
EPILEPSY
Epilepsy is defined in the EU Medical Directives as having had two or more epileptic seizures, less than five years apart. A person who suffers from epilepsy may qualify for a driving licence if they have been free from any epileptic attack for one year.

Solitary Seizure
An abnormal paroxysmal neuronal discharge in the brain causing abnormal function. Such solitary seizures, whether epileptic in nature, or not, are distinguished from the new EU definition of epilepsy and are subject to different rules in the medical directives.

Provoked Seizure
A provoked epileptic seizure is defined as one which has a recognisable causative factor that is reliably avoidable. A person who suffers from a provoked epileptic seizure can be declared able to drive on an individual basis, subject to neurological opinion.

UK Definitions
“Epilepsy” is not defined in UK regulations so would have its normal medical meaning. In practice, however, the UK already distinguishes between recurrent epileptic attacks, a single seizure and provoked seizures in the guidance for medical professionals, although not in regulations.

Group 1 Drivers (vehicle categories A and B, including 2 or 3–wheeled vehicles, cars and light vans up to 3.5 tonnes)

Two or More Seizures
Currently in the UK, drivers must be free from epileptic attack for at least 12 months (although different rules apply to seizures only occurring in sleep). The New EU Rules also state that drivers must be free from epileptic attack for at least 12 months in the case of waking seizures.

Proposal
As the current UK standard for waking seizures is identical to the EU standard it will be retained.

RoSPA Response
RoSPA supports the proposal.

First Seizure
The driver or driving licence applicant who has had a first seizure must notify DVLA. This will result in six months off driving from the date of the seizure, if the licence holder has undergone assessment by an appropriate specialist and no relevant abnormality has been identified on investigation, a normal driving licence (valid until age 70 years) is restored, provided there is no further attack and the individual is otherwise well.

Under the New EU Rules, an applicant who has had a first unprovoked epileptic seizure can be declared able to drive after a period of six months without seizures, if there has been an appropriate medical assessment. National authorities may allow drivers with recognised good prognostic indicators to drive sooner.
Proposal
Based on expert medical advice, the government does not intend to allow drivers with recognised good prognostic indicators to drive sooner than the current six months. The current UK standard will be retained.

RoSPA Response
RoSPA supports the proposal.

Seizures Exclusively in Sleep
The current UK standard requires a person who has epilepsy, and has suffered an attack whilst asleep, to refrain from driving for at least one year from the date of the attack. However, if they have had an asleep attack more than three years previously (and have had no attacks whilst awake since that original attack whilst asleep) they may be licensed even though attacks whilst asleep may continue to occur. If an attack whilst awake subsequently occurs, the normal epilepsy rules apply and require at least one year off driving from the date of the most recent attack.

The New EU Rules propose that drivers who have had asleep seizures only, and have never had an awake seizure, will be required to establish an asleep-only pattern over one year rather than three years. Where a further attack while awake occurs, a one year seizure free period is then required again before re-licensing.

Proposal
The government, based on medical advice, propose to adopt the less stringent EU Rules for drivers who have had asleep seizures only. Drivers with a history of both asleep and awake attacks, the current standard for asleep seizures remains unchanged.

RoSPA Response
RoSPA supports the proposal.

Seizures without Influence on Consciousness or the Ability to Act
Under the Current UK standard, drivers who suffer seizures without influence on consciousness, or the ability to act, are subject to the normal epilepsy rules and must not drive for one year from the last attack. However, the New EU Rules allow, subject to expert opinion, a driver or applicant whose seizures are deemed to have no effect on consciousness, and do not cause any functional impairment, to be declared fit to drive provided a pattern has been established over a one year period, even if they continue to have these seizures - and there is no historical evidence of any other form of seizure. If there is an occurrence of any other type of seizure, a one year period free of any further event is required before licensing can be considered.

Proposal
Based on advice from the Honorary Medical Advisory Panel on Neurology, the government proposes to adopt the EU standard by amending the necessary regulations.

RoSPA Response
RoSPA has no objection to the proposal.
Seizures Occurring During Physician-Advised Change, Reduction or Withdrawal of Anti-Epilepsy Therapy

In the UK, patients are advised not to drive from commencement of the period of withdrawal of medication and for a period of six months after cessation of treatment. Where a driver’s medication is reduced and they have a seizure, normal epilepsy rules apply and they will require one year off driving.

Under the New EU Rules, patients may be advised not to drive from the commencement of the period of withdrawal and for a period of six months after cessation of treatment. Seizures occurring during physician-advised change or withdrawal of medication require three months off driving if the previously effective treatment is reinstated.

Proposal

The current UK standard matches the EU rules for the period off driving following withdrawal or cessation of treatment. However, based on advice from the Honorary Medical Advisory Panel on Neurology, the government does not propose to adopt the shorter three months period of not driving for drivers who suffer a seizure during physician-advised change, reduction or withdrawal of their medication, but to set a six months period. The Honorary Medical Advisory Panel on Neurology did not believe that the available evidence indicated that the risk was acceptable three months after medication was re-established.

RoSPA Response

RoSPA supports the proposal, including the adoption of a six month period of not driving, rather than three months, for driving for drivers who suffer a seizure during physician-advised change, reduction or withdrawal of their medication.

Group 2 Drivers (vehicle categories C, and D (and sub categories of C1 and D1), including medium and large lorries and buses and coaches

The new EU rules largely reflect existing UK rules, and so there is only one proposed change to the current UK standards.

Two or More Seizures

Where a person suffers two or more seizures which are more than 5 years apart, before applying for a licence, the new EU rules do not treat this as “epilepsy” as defined, but as a single solitary seizure requiring a 5 year seizure free period. However, if a person suffers two or more seizures within 5 years after being granted a licence, they come within the definition and therefore must have a 10 year seizure free period before being licensed.

Proposal

The government proposes to require a 10 year seizure free period in all cases where there has been two or more seizures less than 10 years apart because this is more consistent with fairness between different classes of driver and road safety. This means the UK will have a higher standard than the EU minimum but one which is the same as our existing standard and is considered by the Panel of experts to be justified.

RoSPA Response

RoSPA supports the proposal.
OTHER CHANGES
There are a number of medical conditions not referred to in the EU medical directives, but which are subject to minimum standards in the driving licence directives, where Group 1 drivers who notify DVLA may be issued with an ordinary licence without the need for ongoing review by DVLA.

Proposal
The government proposes to further clarify and expand this advice in relation to specific conditions (i.e. serious renal failure, organ transplant and artificial implant). The DVLA will advise drivers that permission to not notify continues only as long as they are free from symptoms affecting their ability to drive and that provided that they continue to undergo regular medical checks.

This is unlikely to create any difference in practice since drivers receiving regular medication or treatment, for instance renal dialysis, will have to be under the ongoing care of their GP or other doctor.

RoSPA Response
RoSPA supports the proposal.

Fitness to Drive
A final point RoSPA wishes to make concerns the role of health professionals in assessing fitness to drive. Although there is comprehensive guidance for medical practitioners about how to assess fitness to drive, there is still a need for more help for health professionals about using the guidance and what measures they can take to help their patients who are, or are becoming, unfit to drive.

A Department for Transport study, “Attitudes of Health Professionals to Giving Advice on Fitness to Drive” exploring how fitness to drive issues were taught in medical schools in the UK, found considerable variety in the extent to which they covered the medical aspects of fitness to drive within their curriculum, and indeed whether it was included at all.

A questionnaire survey of health professionals from many different professional groups, found that almost all (87%) were aware of the DVLA Guidelines and 80% said that they had consulted the guidelines over the previous two years. They reported that they were most likely to advise patients about fitness to drive issues if they had epilepsy, fits or black outs, or a stroke. The respondents felt that discussing fitness to drive issues with patients was very important; most believed that they had a “duty of care” to do this with their patients and that it was part of their role. However, knowledge was variable about whose role it was to advise patients and who had the legal responsibility to do so. Most also identified a need for better training or clearer guidelines about giving advice. Two in five respondents agreed that they did not have sufficient knowledge about fitness to drive issues.
The study also tested how health professionals would react when confronted with situations requiring them to advise a patient about their fitness to drive. The health professionals were shown a paper or video scenario in which a patient had a medical condition which affected or might affect their fitness to drive, and in which the health professional would need to decide whether the patient was fit to drive. Less than 10% of the health professionals scored all of the paper scenarios correctly, although two thirds scored one or two correctly. The most common mistake was a bias towards rating patients who should have been told they were unfit to drive as borderline or fit to drive.

After watching video scenarios in which pseudo-patients described a health condition that would render them unfit to drive, as well as a lifestyle that involved driving, clinicians were asked what advice they would give the patients. They were not informed that the study was investigating advice on fitness to drive. Concerns about fitness to drive were expressed unprompted in only one quarter of the scenarios. Where driving was not mentioned by the clinician as a main concern, 60% of the clinicians mentioned it after ten minutes (but this is generally a longer time than a standard consultation). Most driving advice given by the clinicians was non specific.

In interviews with these medical professionals, several GP’s said that driving is not relevant to the majority of their consultations. Other reported barriers to advising patients about fitness to drive were assuming that older patients did not drive, a lack of knowledge, the complexity of the guidelines, uncertainty over whose responsibility it is to advise patients about fitness to drive, patient resistance or denial, the risk of negative consequences to the patient, such as loss of well-being or livelihood, and the risk of jeopardising the doctor-patient relationship.

This suggests that health professionals need more help in assessing health conditions which may affect the way in which someone drives and to enable them to provide appropriate and sensitive advice. Given that many health professionals may not raise fitness to drive issues during medical consultations, drivers can be encouraged to raise the effects of health conditions on driving.

RoSPA thanks the DfT and the DVLA for the opportunity to comment on the proposals. We have no objection to the contents of RoSPA’s response being reproduced or attributed.

Road Safety Department
Tel: 0121 248 2000
www.rospa.com