THE SENIOR DRIVER

Myths & Facts

INFORMATION FOR HEALTH CARE PROFESSIONALS, PATIENTS, AND FAMILIES ON ASSESSMENT AND REFERRAL ISSUES, 3RD EDITION

THE SENIOR DRIVER MYTHS & FACTS: INFORMATION FOR HEALTH CARE PROFESSIONALS, PATIENTS, AND FAMILIES ON ASSESSMENT AND REFERRAL ISSUES, 3RD EDITION

Bonnie Dobbs, PhD
Director, Medically At-Risk Driver Centre
Professor, Department of Family Medicine
University of Alberta

Tara Pidborochynski, MSc
Research Coordinator, Medically At-Risk Driver Centre
Department of Family Medicine
University of Alberta

Meghan Linsdell, MSc
Research Coordinator, Medically At-Risk Driver Centre
Department of Family Medicine
University of Alberta

The 3rd Edition of *The Senior Driver Myths & Facts* is based upon materials used in previous versions. The authors would like to thank Dr. Allen Dobbs, Barbara Carstensen, Dr. Jean Triscott, Dr. Doug Duke, and Theresa Genge for their contributions to previous versions.

Design and formatting of 1st Edition: Lime Design Inc.
Design and formatting of 2nd Edition: some production!
Design and formatting of 3rd Edition: Lime Design Inc.

Published by: The DR Group, Edmonton, Alberta
Printed by: Capital Colour Press, Ltd.

ISBN-10: ISBN 0-9781959-1-4
ISBN-13: ISBN 978-0-9781959-1-5
ISBN-13: ISBN 978-0-9781959-2-2

ISSUES RELATED TO DRIVING are some of the most difficult and perplexing for health care professionals and for patients and their families. Challenges associated with the driving issue often are heightened because myths are commonplace. This booklet identifies and remedies common myths about senior drivers and provides tips and advice to help health care professionals and their patients and families meet the challenges associated with the driving issue and to help manage risk.

CONTENTS

Myth:

Senior driving safety is not a problem.

Myths & Facts

MYTH Driving is a 'right'.

FACT Driving is not a 'right'. It is a privilege earned through the demonstration of competence.[1,2]

- 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.

[1] Buhler v. BC Superintendent of Motor Vehicles. (1999). Retrieved from http://www.canlii.org/en/bc/bcca/doc/1999/1999bcca114/1999bcca114.html

[2] Canadian Council of Motor Transport Administrators. (2013). *Determining driver fitness in Canada – Part 1: A model for the administration of driver fitness programs and Part 2: CCMTA medical standards for drivers.* (13th ed.). Ottawa, ON: Author.

MYTH Older drivers are not a concern because few older people drive.

FACT 75% of people 65 years of age and older (3.25 million seniors) in Canada had a driver's license in 2009; 89% of senior males and 63% of senior females in Canada were licensed to drive in 2009 and the majority do drive.[3]

- By 2020, 1 in every 4 drivers in Canada will be 65 or older.
- Although a large number of senior women have never driven, this will change dramatically in the future since currently nearly as many women as men 45 to 64 years of age have a driver's license.
- Today's older driver is driving more and longer into old age when impairing medical conditions are most likely to occur.

[3] Turcotte, M. (2012). *Profile of seniors transportation habits* (Catalogue No. 11-008-X). Ottawa, ON: Statistics Canada.

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 an increased risk for being injured and killed as a result of the crash.**[4,5]

- 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 older passengers) makes them more vulnerable to injuries and fatalities when in a crash.[4,5]
- Older driver (and older passenger) crash victims are 4 times more likely to be hospitalized, with their recovery slower and less complete.[4]
- Older driver fatal crashes are projected to increase by 155% by 2030.[4]

[4] 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*(2), 116–120.

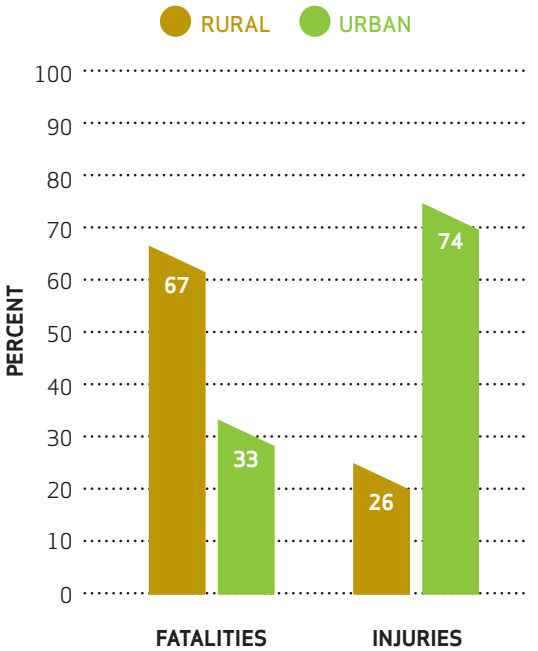
[5] Li, G., Braver, E. R., & Chen, L. H. (2003). Fragility versus excessive crash involvement as determinants of high death rate per vehicle-mile of travel among older drivers. *Accident Analysis & Prevention*, *35*(2), 227–235.

Myths & Facts

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

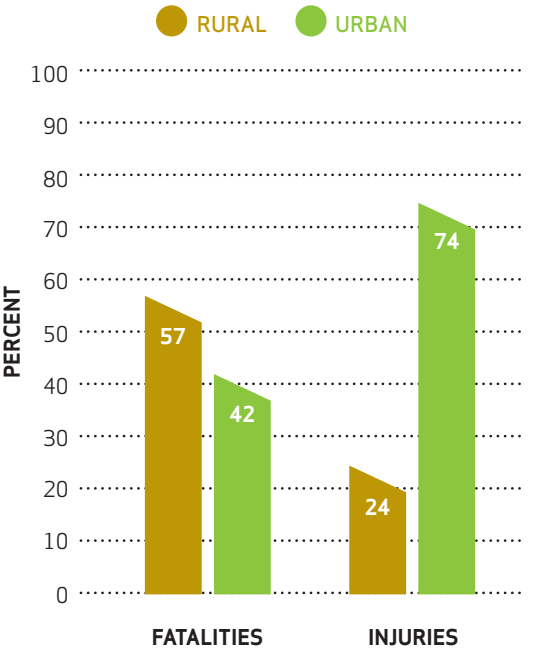
FACT Two-thirds of driver fatalities as a result of motor vehicle crashes occur in rural areas, with injuries more common in urban areas.[6,7]

PERCENT OF FATALITIES AND INJURIES DUE TO MOTOR VEHICLE CRASHES IN RURAL AND URBAN AREAS (**ALBERTA**)[6]

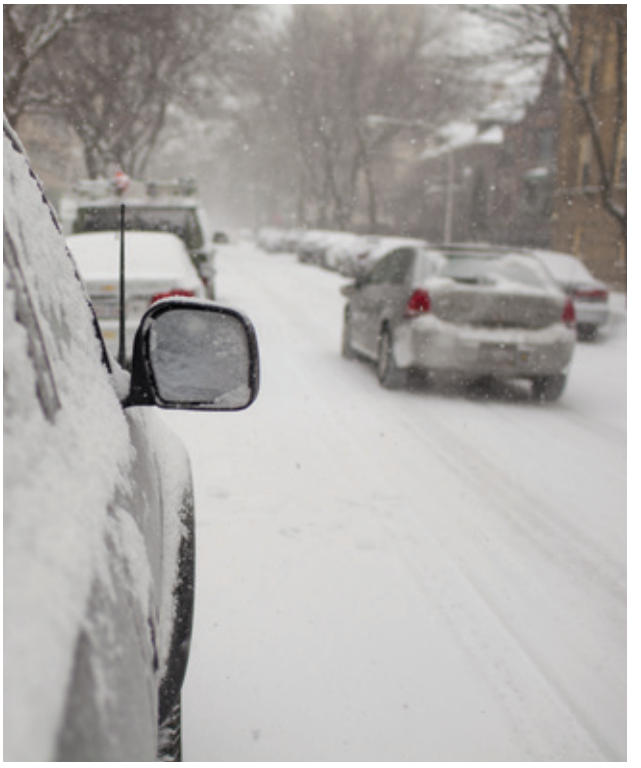


[6] Alberta Transportation. (2013). *Alberta traffic collision statistics*. Edmonton, AB: Author.

PERCENT OF FATALITIES AND INJURIES IN RURAL AND URBAN AREAS (**CANADA**)[7]



[7] Transport Canada. (2013). *Canadian motor vehicle traffic collision statistics 2013*. Ottawa, ON: Author.



MYTH **The higher crash rates* of senior drivers are the result of changes associated with aging.**

FACT **The higher 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.[8]

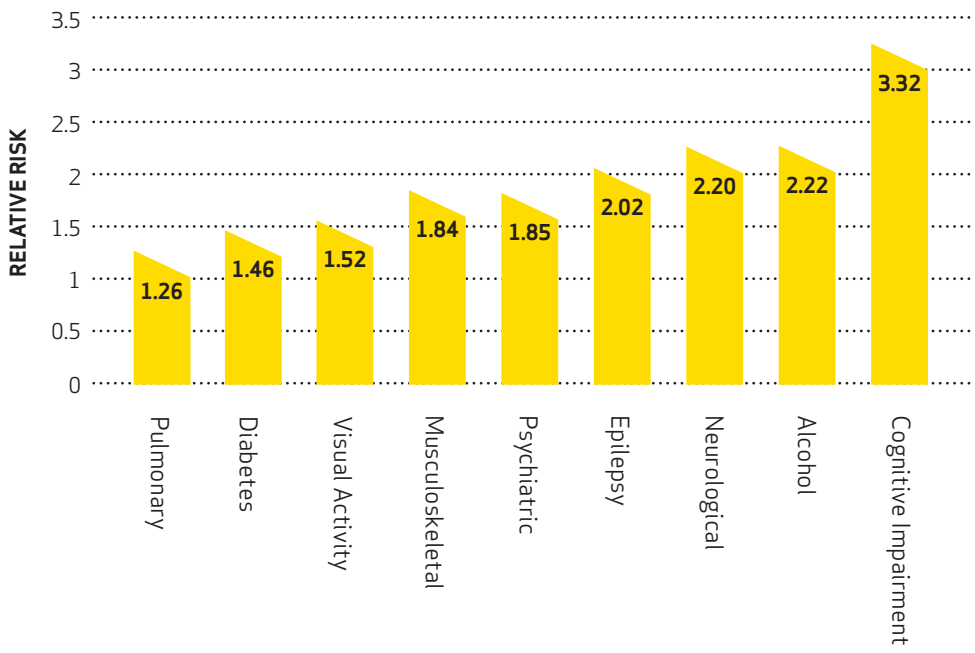
* Based on miles driven.

- The presence of multiple medical conditions (co-morbidities) also increase with age.[8]
- Many illnesses (e.g., heart disease, lung disease, dementia) can affect a person's ability to drive safely.[9]

[8] Public Health Agency of Canada. (2014). *The Chief Public Health Officer's report on the state of public health in Canada 2014. Public health in the future*. Ottawa, ON: Author.

[9] 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.

RELATIVE RISK FOR AT-FAULT CRASHES FOR SELECTED MEDICAL CONDITIONS[9]



LEVEL 2

Myth:

Senior driving safety is not the physician's concern.

Myths & Facts

MYTH **Driving issues are not a physician's responsibility.**

FACT **Declines in driving competence occur primarily because of medical conditions. Physicians are best placed for earliest identification of medically compromised drivers.**

- The majority of seniors visit a physician one or more times every year.[10] Thus, physicians are likely to be the first person 'in authority' to encounter a driver who has become medically impaired.
- Families often rely on physicians 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 that will be exposed to the patient's driving." [p. 3][11]
- When considering driving, the Canadian Medical Association states that physicians have a statutory duty to report patients whom they believe to be unfit to drive to the relevant provincial or territorial motor vehicle licensing authority. This duty to report is owed to the public. [p. 10][11]

[10] Canadian Institute for Health Information. (2011). *Health care in Canada, 2011: A focus on seniors and aging*. Ottawa, ON: Author.

[11] Canadian Medical Association. (2012). *Determining fitness to drive, a guide for physicians* (8th ed.). Ottawa, ON: Author.

MYTH **Seniors know when to stop driving. So, decisions about driving should be left to the individual.**

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 travelled that rival those of younger (16-24 year-old) drivers. Seniors over 85 years of age have the highest driver fatality rate of any age group.[12]**

- 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 impairment) are responsible for the majority of crashes among senior drivers.

- Cognitively impaired drivers are likely to have impaired insight and are unlikely to know they are unsafe drivers.[13]

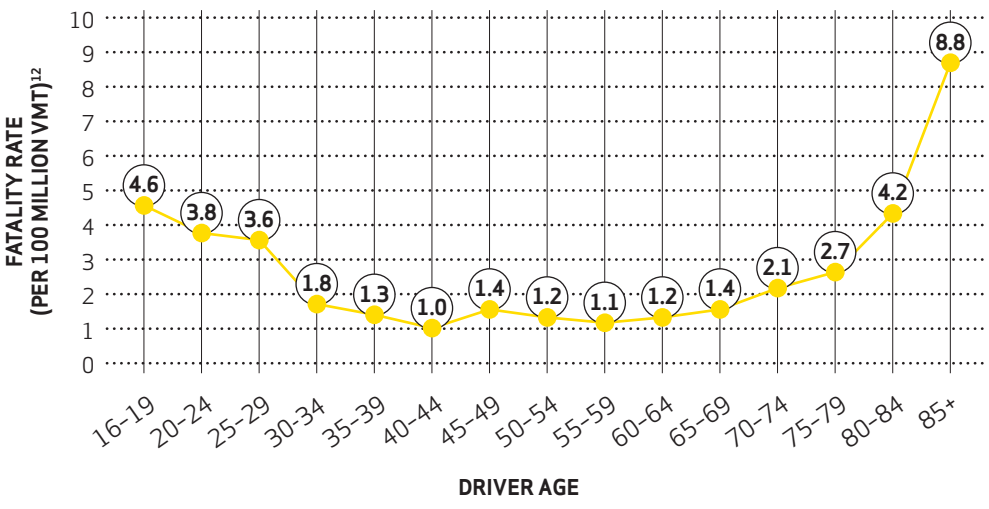
- The high crash rates of younger drivers are mainly due to risk-taking behaviours; many senior driver crashes are due to medical conditions that affect driving.[14,15]

[12] Insurance Institute for Highway Safety (IIHS). (2014). *Fatality facts 2013. Older people.* Arlington, VA: Author.

[13] Wild, K., & Cotrell, V. (2003). Identifying driving impairment in Alzheimer disease: A comparison of self and observer reports versus driving evaluation. *Alzheimer Disease and Associated Disorders*, *17*(1), 27–34.

[14] Bates, L. J., Davey, J., Watson, B., King, M. J., & Armstrong, K. (2014). Factors contributing to crashes among young drivers. *Sultan Qaboos University Medical Journal*, *14*(3), e297–305.

[15] Carr, D. B., Schwartzberg, J. G., Manning, L., & Sempek, J. (2010). *The physician's guide to assessing and counseling older drivers* (pp. 58–66). Chicago, IL: American Medical Association, National Highway Traffic Safety Administration.



Myths & Facts

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.[16]

- Self-restrictions are effective only when the driver is able to correctly identify ability declines **and** retains the ability to drive.
- Drivers with cognitive impairment often lack insight into their declining abilities.[17]
- When insight is impaired, others, including family members and physicians, must intervene as medically impaired drivers are an individual, as well as public health, safety concern.[16,17]

[16] Insurance Institute for Highway Safety (IIHS). (2014). *Fatality facts 2013. Older people.* Arlington, VA: Author.

[17] Wild, K., & Cotrell, V. (2003). Identifying driving impairment in in Alzheimer disease: A comparison of self and observer reports versus driving evaluation. *Alzheimer Disease and Associated Disorder*, *17*(1), 27–34.

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

FACT **Most crashes of senior drivers occur close to home in familiar locations.**

- Only driving 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.[18,19]
- Medically impaired drivers often are unaware of other vehicles or pedestrians, regardless of where they are driving.[18,19]
- When a driver is unsafe because of a medical condition that alters cognitive abilities, he/she is most likely to be unsafe to drive anywhere.

[18] Mayhew, D. R., Simpson, H. M., & Ferguson, S. A. (2006). Collisions involving senior drivers: High-risk conditions and locations. *Traffic Injury Prevention*, *7*(2), 117–124.

[19] Cicchino, J. B., & McCartt, A. T. (2015). Critical older driver errors in a national sample of serious U.S. crashes. *Accident Analysis and Prevention*, *80*, 211–219.

Myths & Facts

MYTH A driver refresher course or driver training will overcome a medically impaired patient's decline in driving ability.

FACT When cognitive competence declines, no amount of driver training will restore the ability to drive safely.

- Illnesses that affect cognitive abilities are the most common causes of ability declines in senior drivers.[20]
- Driver training should be recommended only when the patient 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 deficits, 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.

- However, data indicate that dividing attention between the road and a secondary task impairs driving performance.[21]

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

[21] Young, K., & Regan, M. (2007). Driver distraction: A review of the literature. In I. J. Faulks, M. Regan, M. Stevenson, J. Brown, A. Porter, & J. D. Irwin (Eds.), *Distracted driving* (pp. 379–405). Sydney, NSW: Australasian College of Road Safety.

MYTH **The standard (entry level) road test is okay to use to test a medically impaired patient's fitness-to-drive.**

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

- 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.[22]
- 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.[22]
- Standard road tests fail an unacceptably high percentage of healthy competent drivers.[22]

[22] Dobbs, A. R., Heller, R. B., & Schopflocher, D. (1998). A comparative approach to identify unsafe older drivers. *Accident Analysis and Prevention*, *20*(3), 363–370.

MYTH **A restricted license is all that is needed for safety enhancement.**

FACT **No driving or license restrictions can overcome the inability to drive safely.**

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

LEVEL 3

Myth:

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

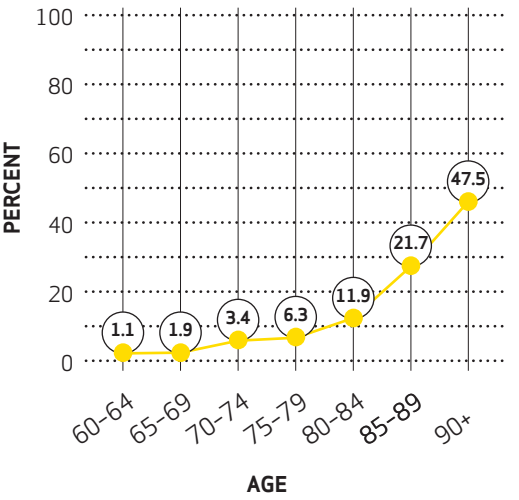
Myths & Facts

MYTH Cognitive impairment is not a serious issue for older persons.

FACT Overall, cognitive impairment affects 14.9% of Canadian seniors.[23]

- The prevalence of dementia is age-associated.[24]
  - 1.1% for ages 60-64
  - 3.4% for ages 70-74
  - 11.9% for ages 80-84
  - 47.5% for ages 90+

PREVALENCE OF DEMENTIA BY AGE GROUP[24]



- Multiple medical conditions (and medications to treat those conditions) can cause serious cognitive impairment even when a condition on its own would not be sufficient to cause impairment.[25]

[23] Alzheimer Society. (2012). *A new way of looking at the impact of dementia in Canada*. Ottawa, ON: Author.

[24] World Health Organization. (2012). *Dementia: A public health priority*. Retrieved from http://apps.who.int/iris/bitstream/10665/75263/1/9789241564458_eng.pdf?ua=1

[25] Sagberg, F. (2006). Driver health and crash involvement: A case-control study. *Accident Analysis and Prevention*, *38*(1), 28–34.

MYTH **Cognitively impaired patients do not drive.**

FACT **More than one-half (54%) of drivers with 'some' cognitive impairment are reported to continue to drive and more than one-third (36%) of drivers with 'serious' cognitive impairment are reported to continue to drive.[26]**

- Cognitively impaired drivers are 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% of all affected cases when the impairment is of mild severity.[27]
- Importantly, cognitive impairment is associated with at least a 2-fold increase in the risk of a crash.[28]
- Patients with cognitive impairment are not likely to stop driving on their own as cognitive impairment often results in a lack of insight which means that they are unaware their driving has declined to an unsafe level.[29]

[26] Turcotte, M. (2012). *Profile of seniors transportation habits* (Catalogue No. 11-008-X). Ottawa, ON: Statistics Canada.

[27] Valcour, 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*(19), 2964–2968.

[28] Carr, D. B., & Ott, B. R. (2010). The older adult driver with cognitive impairment. *Journal of the American Medical Association*, *303*(16), 1632–1641.

[29] Mak, E., Chin, R., Ng, L. T., Yeo, D., & Hameed, S. (2015). Clinical associations of anosognosia in mild cognitive impairment and Alzheimer's disease. *International Journal of Geriatric Psychiatry*. doi: 10.1002/gps.4275

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.[30]
- 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. Families and physicians can play a key role in this early planning.

[30] Breen, D. A., Breen, D. P., Moore, J. W., Breen, P. A., & O'Neill, D. (2007). Driving and dementia. *British Medical Journal*, *334*, 1365–1369.

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

FACT Research shows that a spouse and/or family member's judgments of driving performance often are not good sources of information about the driving problems of the individual with dementia.[31]

- Spouses and other family members often underestimate driving risk and overestimate the driver's competence.[32]
- 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.

[31] Wild, K., & Cotrell, V. (2003). Identifying driving impairment in Alzheimer disease: A comparison of self and observer reports versus driving evaluation. *Alzheimer Disease and Associated Disorder*, *17*(1), 27–34.

[32] Dobbs, B., Carr, D. B., & Morris, J. C. (2002). Management and assessment of the demented driver. *The Neurologist*, *8*, 61–70.

LEVEL 4

Myth:

Senior driving safety is a concern, but as a physician, I don't have the resources to address it.

Myths & Facts

MYTH If a physician raises the driving issue, he/she will lose their 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.[33]
- Referral for an external driving evaluation provides physicians with independent information that can be helpful for decision making.
- 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.

[33] 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 Subcommittee of the National Research Council's Transportation Research Board Committee on the Safety and Motility of Older Drivers, Washington, DC.

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.[34]

- There is no MMSE cut-off score that assures that your patient is safe to drive.[34]
- Although the MMSE should not be used to determine whether a patient is fit-to-drive, lower scores may be a red flag for the need to have the patient's driving assessed.
- An extensive study evaluating senior drivers with crashes to those with no crashes found a MMSE cut-off score of 24 would have missed 95% of the senior drivers who crashed.[35]

[34] Laycock, K. M. (2011). Driver assessment: Uncertainties inherent in current methods. BCMJ, *53*(2), 74–78.

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

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

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

MYTH A standard road test is adequate for assessing driving competency of patients with physical or cognitive impairments.

FACT Validated performance-based specialized driving evaluations are needed.

- A 'standard (entry level)' road test evaluates over-learned skills and is not suitable for assessing driving competency in the cognitively 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.
- A specialized driving evaluation is important when there are cognitive declines, with the specialized driving evaluation focused on declines in abilities that have been shown to be associated with cognitively impaired drivers.

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 and territories in Canada with the exception of Alberta, Nova Scotia, and Quebec.

- The Canadian Medical Association recommends that physicians inform their patients if they believe he/she is unfit to drive and report to the appropriate Licensing Authority.[36]

[36] Canadian Medical Association. (2012). *CMA driver's guide. Determining medical fitness to operate motor vehicles* (8th ed.). Ottawa, ON: Author.

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 that does not have mandatory reporting.[37]

- If medical reports to the Licensing Authority are not fully disclosing, the physician can be held liable if that patient is in a crash.[38]
- 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.[38]
- Failure to advise the patient about driving risks associated with medical conditions and possible medication side effects can be considered negligent behaviour.[38]
- A critical issue regarding liability is foreseeability.[39]

[37] American Medical Association. (2010). *Physician's guide to assessing and counseling older drivers* (Report No. DOT HS 811 298). Washington, DC: U.S. Department of Transportation, National Highway Traffic Safety Administration.

[38] Kryworuk, P. W., & Nickle, S. E. (2004). Mandatory physician reporting of drivers with medical conditions: Legal considerations. *Canadian Journal of Cardiology*, *20*(13), 1324–1328.

[39] Freese v. Lemmon, 2010, NN2d576 (Iowa, 1976). Retrieved from http://law.justia.com/cases/iowa/supreme-court/1973/55498-0.html

MYTH Physicians who report patients as medically at-risk to drive are open to litigation.

FACT Physicians are protected from unconditional liability if they report in good faith in 7 of the 10 provinces and 1 Territory (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, the Northwest Territories, and Nunavut are protected from liability unless they act maliciously or without reasonable grounds.[40]

[40] Canadian Medical Association. (2012). *CMA driver's guide. Determining medical fitness to operate motor vehicles* (8th ed.). Ottawa, ON: Author.

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

FACT If reported as medically at-risk, the individual undergoes a medical review process by the Licensing Authority.

- Physicians have a legal obligation to report medically at-risk patients to the Licensing Authority in all provinces and territories in Canada with the exception of Alberta, Nova Scotia, and Quebec.
- Physicians do not revoke a patient's driver's license. Rather, the Licensing Authority has that responsibility.
- Individuals may be asked to supply further medical information and/or complete a driving evaluation before a final licensing decision is made.
- The individual driver has the right to appeal licensing decisions.

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.

→ Patient consent is needed before any information is released.

Tips & Advice

for Patients, Families, and Health Care Professionals

Topic 1 //

Early planning

- Most everyone prepares for retirement. Individuals 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, 7 years; for women, 10 years). Early planning for driving retirement is critical for continued well-being and independence.[41]
- Consider creating an 'advanced driving directive' to let your health care professional and family know of your wishes for your driving and mobility future. An example of an 'advanced driving directive' can be found at **www.mard.ualberta.ca**
- In the early stages of degenerative diseases (e.g., dementia), discuss the need to begin preparing for driving cessation.
- With conditions such as dementia, early planning and education on the identification and use of alternate sources of transportation may minimize the impact of the loss of driving privileges.

- Search for information on alternate sources of transportation. An online listing of alternate transportation service providers can be found at **www.mard.ualberta.ca**
- Some areas may have specialized Driving Cessation Support Groups to assist medically impaired drivers to accept the need to stop driving.[42] Encourage patients and family members to attend those groups.

[41] Foley, D. J., Heimovitz, H. K., Guralnik, J. M., & Brock, D. B. (2002). Driving life expectancy of persons aged 70 years and older in the United States. *American Journal of Public Health*, *92*(8), 1284–1289.

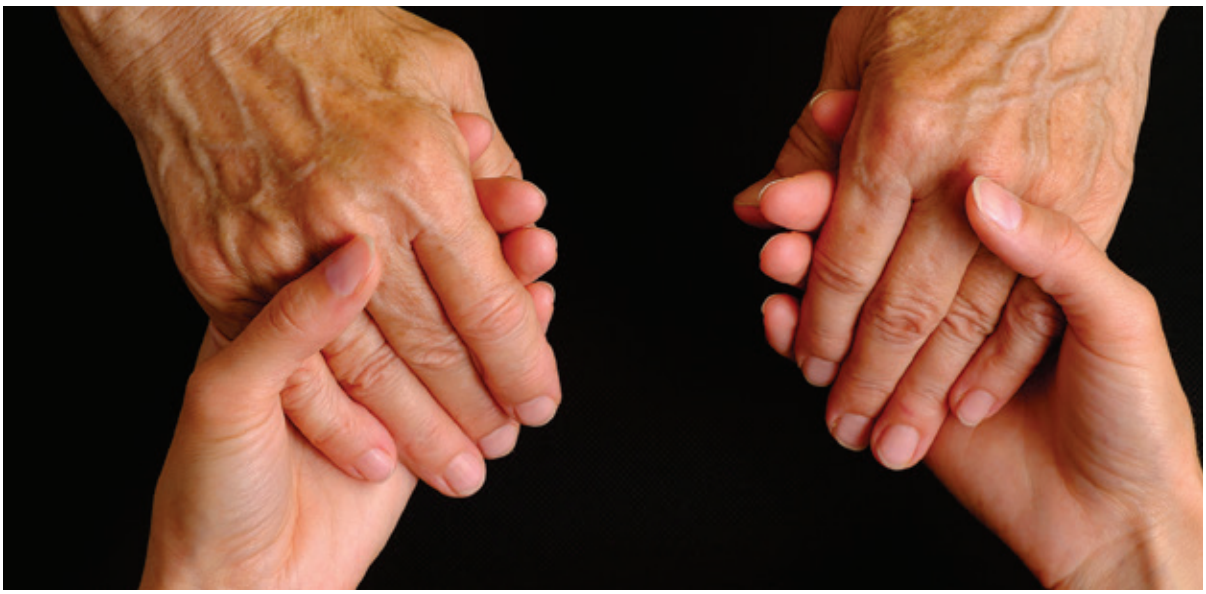
[42] Dobbs, B. M., Harper, L. A., & Wood, A. (2009). Transitioning from driving to driving cessation: The role of specialized driving cessation support groups for individuals with dementia. *Topics in Geriatric Rehabilitation*, *25*(1), 73–86.

Topic 2 //

Conversation starters for families

Interpersonal relationships are different in every family and conversations about driving will differ. 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…"



Topic 3 //

Developing a strategy for discussing driving cessation with your family

- **Initiate the driving conversation early on in the illness.**

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

- **Focus on the medical condition rather than past driving records.**

  Often individuals with dementia will talk about their past good driving record. Acknowledge that accomplishment in a genuine manner, but return to the need to stop driving. Saying, "Remember your doctor told you that medical conditions can make even the best of drivers unsafe" also can help to refocus the discussion.

Topic 4 //

Making plans to stay mobile

- Develop a separate bank account for public transportation, taxis, and alternate transportation services and think of this as your 'Mobility Account'.
- Look into other transportation options available in your community, such as public transportation, taxis, being driven by friends/family, and other alternate transportation services.
- A comprehensive listing of alternate transportation services providers throughout Alberta is available at **www.mard.ualberta.ca**
- Additionally, guides for staying mobile and independent are available at **www.mard.ualberta.ca**

TIPS FOR HEALTH CARE PROFESSIONALS

Topic 5 //

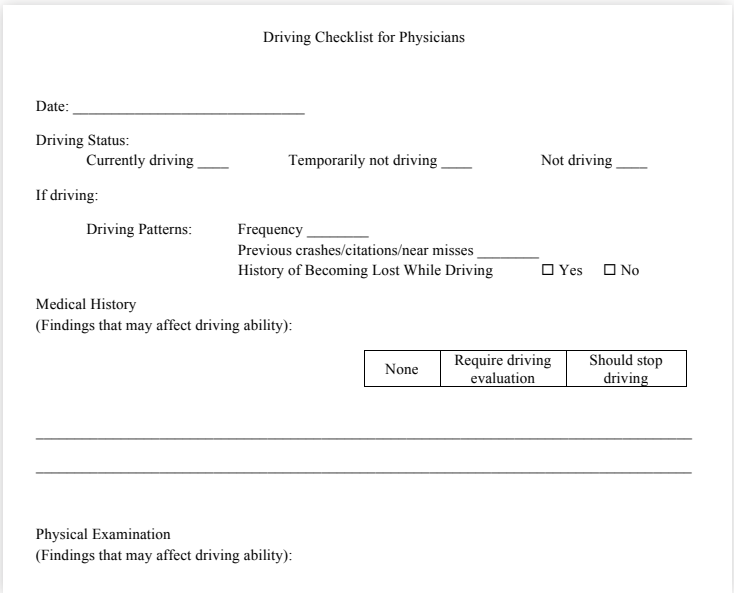
Keeping records

- Driving competency always should be questioned when there is a decline in cognitive or functional abilities.
- Initiate and maintain driving histories on all your patients, particularly those with chronic medical conditions that may affect driving.
- Consider adding a Driving Menu in the patient's Electronic Medical Record. This allows you to track the progression of your patient.
- Document your advice to the patient concerning their driving.
- Document your reporting of the patient's medical problems to the Licensing Authority.

Topic 6 //

Red flags

- Certain medical conditions are 'red flags' for the need for a specialized driving evaluation. 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):

Topic 7 //

Assessment

- 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 specialized driving evaluation (as you would refer for other diagnostic tests).

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 …"

- Refer patients for a specialized driving evaluation if you are concerned that their medical condition(s) or treatment(s) may affect their driving abilities.
- Using a scientifically validated specialized driving evaluation is critical to protect safe drivers from being falsely identified as unsafe and to accurately identify those who are unsafe.

Topic 8 //

Developing a strategy for discussing driving cessation with a patient

- **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 understand that the patient needs to stop driving.
- **Have a private setting for the discussion.** Whenever possible, the appointment should be in this 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 about driving competence 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., specialized driving evaluation, record of motor vehicle crashes or 'near misses') can be helpful. Include discussions on the risks of continuing to drive with patients and family members.
- **Focus on the need to stop driving, using results from a driving evaluation, 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.

Continued...

TIPS FOR HEALTH CARE PROFESSIONALS

Developing a strategy for discussing driving cessation with a patient

Continued...

- **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, acknowledge 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 patient is feeling and acknowledge their emotions.** Avoid lengthy attempts to convince the patient 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 about driving in the patient's chart.**
- **Provide resources for alternate forms of transportation.** An online listing of alternate forms of transportation can be found at **www.mard.ualberta.ca**

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

Notes

MARD
Medically At-Risk
Driver Centre

6-40 University Terrace
University of Alberta
Edmonton AB, T6G 2T4
780.492.6273
www.mard.ualberta.ca