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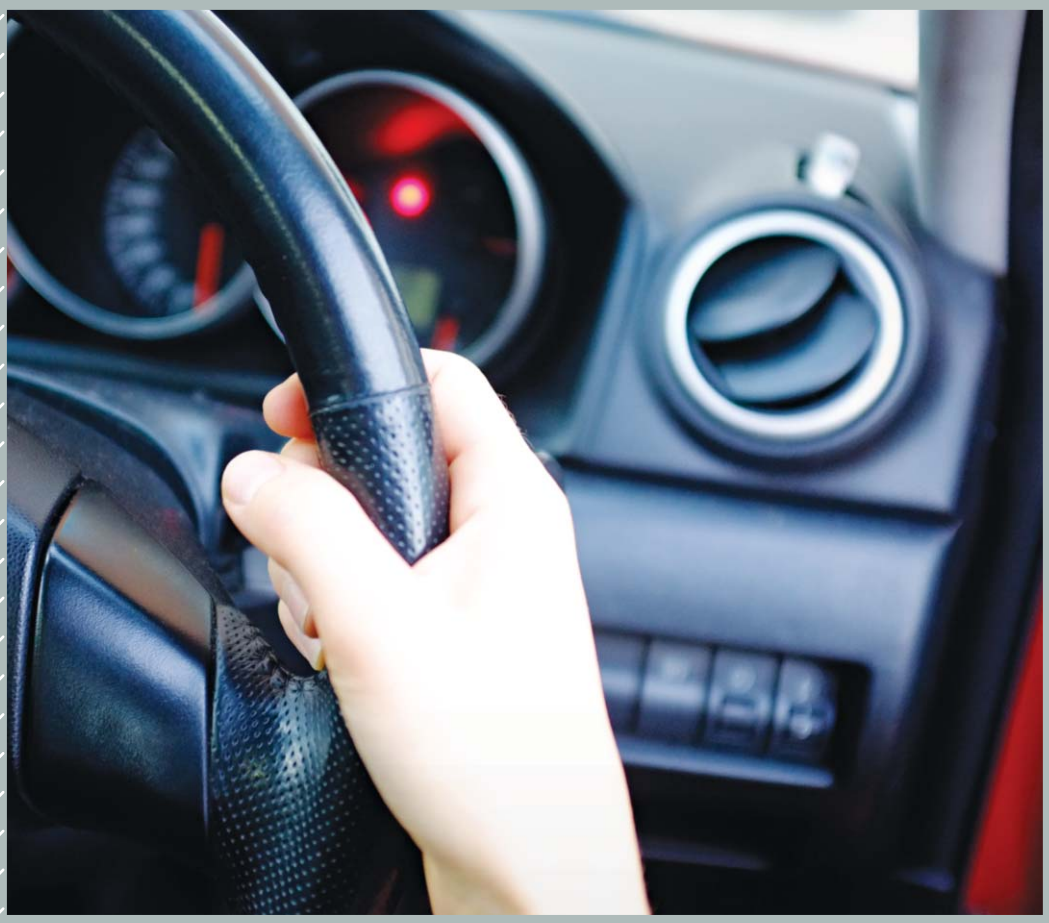

Sláinte agus Tiomáint

Medical Fitness to Drive Guidelines (Group 1 Drivers)

February 2013

An tÚdarás Um Shábháilteacht Ar Bhóithre
Road Safety Authority

Further amendments changes or editions will be made available electronically on **www.rsa.ie**
Health Professional are advised to review **www.rsa.ie** for updates and changes.

Údarás Um Shábháilteacht Ar Bhóithre
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Medical Fitness To Drive Guidelines (Group 1 Drivers) February 2013

National Programme Office for Traffic Medicine
Royal College of Physicians of Ireland (RCPI)/Road Safety Authority (RSA)

Legal Disclaimer

The guidelines for medical fitness to drive *Sláinte agus Tiomáint* ('the Guidelines') have been compiled by the Road Safety Authority in conjunction with the National Programme Office for Traffic Medicine* using all reasonable care and based on expert medical opinion and relevant literature at the time of printing. However, they are published for guidance purposes only and neither the Road Safety Authority nor the National Programme Office for Traffic Medicine nor the Royal College of Physicians of Ireland to which it is also associated accepts responsibility for any consequences arising from their application, including any liability in respect of any claim or cause of action arising out of, or in relation to, the use or reliance on the Guidelines.

Health professionals should keep informed of any changes in health care and health technology that may affect their assessment of drivers. They should also maintain an awareness of any changes in the law that may affect their legal responsibilities.

* *The National Programme Office for Traffic Medicine was established as a joint initiative between the Road Safety Authority and the Royal College of Physicians of Ireland of Ireland, in 2010.*

Foreword

Sláinte agus Tiomáint provides guidance on medical fitness for drivers and highlights the need for all of us to appreciate that the state of our health impacts, to a greater or lesser degree, on our ability to drive safely. Driver fitness is governed by EU law and regulations made in Ireland under the Road Traffic Acts. *Sláinte agus Tiomáint* is an interpretation of these laws; however, the Directive/regulations form the overriding legal basis for driver medical fitness in Ireland.

One of the objectives of *Sláinte agus Tiomáint* is to promote mobility and to do this in a way that is consistent with safety on our roads. Once a driver is aware of any health aspects that impact on driving and follows the advice of their doctor, they can continue to drive in most cases.

It is intended that *Sláinte agus Tiomáint* forms one part of a broader information and communication campaign to increase awareness among medical professionals and the wider public about fitness to drive. *Sláinte agus Tiomáint* was developed by the National Programme Office for Traffic Medicine which has been established as a joint initiative between the Road Safety Authority and the Royal College of Physicians of Ireland. In developing the guidelines, the National Programme Office for Traffic Medicine engaged widely with stakeholders to ensure that they reflect good practice.

The Office is also working to ensure that all doctors, healthcare disciplines, medical professionals, An Garda Síochána and transport professionals have training and support for the practical implementation of the guidelines on the ground. *Sláinte agus Tiomáint* is an important addition to the range of initiatives that ensures we can continue to drive safely on our roads.

Noel Brett CEO
Road Safety Authority

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Údarás Um Shábháilteacht Ar Bhóithre
Road Safety Authority

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Part A: General information

Chapter 1

1.0 Introduction

This publication summarises Irish medical guidelines of fitness to drive. The information in these Guidelines are intended to assist doctors and other healthcare professionals in advising their patients on fitness to drive, requirements for reporting to their Driving Licensing Authority and guidance on review of stability, progression or improvement of these conditions. It should be used by health professionals when:

- Treating any patient who holds a driver licence whose condition may impact on their ability to drive safely. The majority of adults drive, thus a health professional should routinely consider the impact of a patient's condition on their ability to drive safely. Awareness of a patient's occupation or other driving requirements is also helpful.
- Undertaking an examination at the request of a Driving Licensing Authority:
  - Assessing a person whose driving the Driving Licensing Authority believes may be unsafe (*i.e.* 'for cause' examinations).
  - For licence renewal of an older driver.

This publication focuses on long-term health and disability-related conditions and their associated functional effects that may impact on driving. It sets out clear minimum medical requirements for licensing and forms the medical basis of decisions made by the Driving Licensing Authority. This publication also provides general guidance with respect to patient management for fitness to drive.

These medical standards refer to Group 1 licence holders only. Group 1 includes motor cars for private use and motorcycles.

These guidelines are a part of a larger project of the National Programme Office for Traffic Medicine a joint initiative between the Road Safety Authority and the Royal College of Physicians of Ireland. This larger project will encompass Group 2 guidelines, and will develop proposals for supporting medical fitness to drive through education, research and developments such as conditional or restricted licences.

Group 1 Categories A, A1, A2, AM,B, BE, or W i.e motorcycles, cars and tractors (with or without trailer).

Group 2 Categories C, CE, C1, C1E, D, DE, D1 or D1E i.e trucks and buses (without trailer).

The vehicles in Group 2 are regarded as higher-risk vehicles which require a higher standard of physical and mental fitness on the part of the driver.

1.1 Traffic medicine and the compilation of the guidelines

Although the first automobile fatality in the world occurred in Ireland in 1859[1], Traffic Medicine is a relatively new specialism embracing all those disciplines, techniques, and methods aimed at reducing the harm traffic crashes inflict on human beings (International Traffic Medicine Association, 2009). There is also an enabling/rehabilitative element which tries to ensure that transport mobility (an important constituent of well-being and social inclusion) is not hampered, or rendered unsafe, by remediable illness or functional loss.

It involves a wide range of disciplines, with a rapidly increasing research database which encompasses an active process of reflection, debate and consensus to maximise safe mobility. The most visible face of Traffic Medicine in most jurisdictions is the 'medical fitness to drive' aspect of driver licensing. Support for the approach of using evidence-based guidelines is provided by evidence of a significant drop in crashes among drivers when such guidelines are systematically applied[2].

These guidelines represent a synthesis of current research and clinical practice on medical fitness to drive as interpreted by the National Programme Office for Traffic Medicine, a joint initiative of the Road Safety Authority and the Royal College of Physicians of Ireland (see Acknowledgements). The contributors included virtually every medical specialty relevant to medical fitness to drive, as well as associated disciplines, the Irish Patients' Association, the Garda Síochána and the Automobile Association.

We are fortunate to be able to formally work with, and draw on the experience of, the Driver and Vehicle Licensing Authority (DVLA) of the United Kingdom. The Irish guidelines are based on its 'At a Glance Guide to the current Medical Standards of Fitness to Drive', and some of the specialist contributors to the Guidelines are honorary members of the Advisory Panels of the DVLA. These Panels, which meet biannually consist of doctors and other professionals eminent in the respective fields of Cardiology, Neurology, Diabetes, Vision, Alcohol/Substance Misuse and Psychiatry together with lay members. Consequently, both the Irish and UK standards are reviewed and updated regularly. Whilst every effort has been made to ensure the accuracy of the information contained, no guarantees can be given concerning the completeness or up-to-date nature of the information provided in these Guidelines, which are only accurate at the time of publication. Health Professionals should keep themselves up-to-date with changes in medical knowledge and technology that may influence their assessment of drivers, and with legislation that may affect the duties of the health professional or the patient. Therefore, neither the Road Safety Authority nor the National Programme Office for Traffic Medicine nor the Royal College of Physicians of Ireland accept liability whatsoever arising from errors or omissions in the Guidelines.

It is also emphasised that these Guidelines are for use as guidance only, and should be viewed in the context of appropriate Continuing Professional Development on the topic of medical fitness to drive, as well as referral for appropriate specialist advice.

1. *Fallon I, O'Neill D. The world's first automobile fatality. Accid Anal Prev 2005 Jul;37(4):601-3.*
2. *Redelmeier DA, Yarnell CJ, Thiruchelvam D, Tibshirani RJ. Physicians' warnings for unfit drivers and the risk of trauma from road crashes. N Engl J Med. 2012 Sep 27;367(13):1228-36.*

2.0 Roles and responsibilities

Table 1: Roles and responsibilities of drivers, health professionals and driver licensing authorities

Driver

- To report to the Driving Licensing Authority and their insurance provider any long-term or permanent injury or illness that may affect their ability to drive safely: if holding a licence from an EU country other than Ireland, or a recognised country for licence exchange, and developing a condition which could affect safe driving, the driver must contact the licensing authority to arrange for an exchange of their licence.
- To respond truthfully to questions from the health professional regarding their health status and the likely impact on their driving ability.
- To adhere to prescribed medical treatment and monitor and manage their condition(s) and any adaptations with ongoing consideration of their fitness to drive.
- To comply with requirements of their licence as appropriate, including periodic medical reviews.

Health professional

- To assess the person's medical fitness to drive based on the current Sláinte agus Tiomáint medical standards.
- To advise the person regarding the impact of their medical condition or disability on their ability to drive and recommend restrictions and ongoing monitoring as required.
- To advise the person of their responsibility to report their condition to the Driving Licensing Authority if their long-term or permanent injury or illness may affect their ability to drive safely.
- To treat, monitor and manage the person's condition with ongoing consideration of their fitness to drive.
- To report to the Driving Licensing Authority regarding a person's fitness to drive in the exceptional circumstances where there is a risk to the public and the driver cannot or will not cease driving.

Licensing authority

- To make all decisions regarding the licensing of drivers. The Driving Licensing Authority will consider reports provided by health professionals.
- To inform the driving public of their responsibility to report any long-term or permanent injury or illness to the Driving Licensing Authority if the condition may affect their ability to drive safely.
- Will act on reports of third parties, Gardaí, general public and healthcare workers regarding concerns of public safety relating to medical fitness to drive.

2.1 Roles and responsibilities of Driving Licensing Authority

The responsibility for issuing, renewing, suspending, refusing or cancelling a person's driving licence lies ultimately with the Driving Licensing Authority. Licensing decisions are based on a full consideration of relevant factors relating to the driver's health and driving performance record. In making a licensing decision, the authority will seek input regarding a person's medical fitness to drive, either directly from the driver and/or from a health professional. Where appropriate, the authority will also consider unsolicited reports from health professionals, the police or members of the public regarding a person's fitness to drive. Payments for health examinations or assessments related to fitness to drive are not the responsibility of the Driving Licensing Authority.

An appeals mechanism is available for drivers who have been refused a licence on medical grounds. The Driving Licensing Authority will inform drivers of the appeals process when informing them of the licensing decision.

2.2 Roles and responsibilities of drivers

Irish and EU legislation requires that a driver should advise their Driving Licensing Authority of any long-term or permanent injury or illness that may affect their safe driving ability.

Regulations 12 and 20 of the Road Traffic (Licensing of Drivers) Regulations 2006, Statutory Instruments Number 537 of 2006, as amended by the Road Traffic (Licensing of Drivers) (Amendment) (No. 2) Regulations 2010, Statutory Instruments Number 544 of 2010, give effect to Commission Directives regarding medical criteria for certification of fitness to drive.

At licence application and renewal, drivers complete a declaration regarding their health, including whether they have any long-term conditions such as diabetes, epilepsy or cardiovascular disease. Based on this information, the Driving Licensing Authority may request a medical examination to confirm a driver's fitness to hold a driver licence. In the case of medical examinations requested by the Driving Licensing Authority, drivers have a duty to declare their health status to the examining health professional.

Drivers are also required to report to the Driving Licensing Authority when they become aware of a health condition that may affect their ability to drive safely.

A driver should not drive while medically unfit to do so and can be convicted of an offence for doing so. Under Sections 32 and 48 of the Road Traffic Act 1961, drivers should be aware that there may be long-term financial, insurance and legal consequences where there is failure to report an impairment to their Driving Licensing Authority and insurance provider.

Drivers must adhere to prescribed medical treatment and monitor and manage their condition(s) and any adaptations with ongoing consideration of their fitness to drive.

2.3 Roles and responsibilities of health professionals

Patients rely on health professionals to advise them if a permanent or long-term injury or illness may affect their safe driving ability, and whether it should be reported to the Driving Licensing Authority. The health professional has an ethical obligation, and potentially a legal one, to give clear advice to the patient in cases where an illness or injury may affect safe driving ability, and to maximise health and function so as to facilitate ease and safety of driving. There may be options other than complete cessation of driving where a patient presents with a particular condition, a restriction such as a modified breaking system can be coded on the driving licence allowing for safer mobility. In the future the RSA will be providing for additional codes which will include a code for restricting driving to daytime only. Health professionals are advised to note in the medical record the nature of the advice given.

2.3.1 Confidentiality, privacy and reporting to the Driving Licensing Authority

Health professionals have both an ethical and legal duty to maintain patient confidentiality. The ethical duty is generally expressed through codes issued by professional bodies. The legal duty is expressed through legislative and administrative means, and includes measures to protect personal information about a specific individual. The duty to protect confidentiality also applies to the Driving Licensing Authority.

The patient–professional relationship is built on a foundation of trust. Patients disclose highly personal and sensitive information to health professionals because they trust that the information will remain confidential. If such trust is broken, many patients could either forego examination/treatment and/or modify the information they give to their health professional, thus placing their health at risk.

Although confidentiality is an essential component of the patient–professional relationship, there are, on rare occasions, ethically and/or legally justifiable reasons for breaching confidentiality. With respect to assessing and reporting fitness to drive, the duty to maintain confidentiality is legally qualified in certain circumstances in order to protect public safety. The Irish Medical Council guidelines provide for breach of confidentiality if the driver represents a risk to the safety of others, refuses or cannot inform the licensing authority, fails to stop or adapt driving appropriately, and is not amenable to appropriate persuasion and discussion. The health professional should consider reporting directly to the Driving Licence Authority in situations where the patient is either:

- Unable to appreciate the impact of their condition which is impacting on their fitness to drive; *or*
- Unable to take notice of the health professional's recommendations due to cognitive impairment; *or*
- Continues driving despite appropriate advice and is likely to endanger the public.

A positive duty is imposed on health professionals to notify the relevant authority in writing of a belief that a driver is physically or mentally unfit to drive, poses a risk to public safety and is not compliant with professional advice to stop driving. It is preferable that any action taken in the interests of public safety should be taken with the consent of the patient wherever possible and should certainly be undertaken with the patient's knowledge of the intended action to the greatest extent possible. The patient should be fully informed as to why the information needs to be disclosed to the Driving Licence Authority, and be given the opportunity to consider this information. Failure to inform the patient will only exacerbate the patient's (and others') mistrust in the patient–professional relationship.

It is recognised that there might be an occasion where the health professional feels that informing the patient of the disclosure may place the health professional at risk of violence. Under such circumstances, the health professional must consider how to appropriately manage such a situation. In making a decision to report directly to the Driving Licensing Authority, it may be useful for the health professional to consider:

- The seriousness of the situation (i.e. the immediate risks to public safety).
- The risks associated with disclosure without the individual's consent or knowledge, balanced against the implications of non-disclosure.
- The health professional's ethical and professional obligations.
- Whether the circumstances indicate a serious and imminent threat to the health, life or safety of any person.

Examinations requested by a Driving Licensing Authority
When a patient presents for a medical examination at the request of a Driving Licensing Authority, the situation is different with respect to confidentiality. The patient will present with a form or letter from the Driving Licence Authority, requesting an examination for the purposes of licence application or renewal, or as a stipulation of a conditional licence. The completed form will generally be returned by the patient to the Driving Licensing Authority, thus there is no risk of breaching confidentiality or privacy, provided only information relevant to the patient's driving ability is included on the form, and a copy of the form/report should be retained by the assessing clinician.

Privacy legislation
All health professionals and the Driving Licensing Authority should be aware of data protection and other applicable legislation when collecting and managing patient information and when forwarding such information to third parties.

2.3.2 Patient–health professional relationship

It is expected that the health professional will be able to act objectively in assessing a patient's fitness to drive. If this cannot be achieved, for example, where there may be the possibility of the patient ceasing contact or avoiding all medical management of their condition, health professionals should be prepared to disqualify themselves and refer their patient to another practitioner.

2.3.3 Patient hostility towards the health professional

Sometimes patients feel affronted by the possibility of restrictions to their driving or withdrawal of their licence, and may be hostile towards their treating health professionals. In such circumstances, the health professional may elect to refer the driver to another practitioner or may refer them directly to the Driving Licensing Authority without a recommendation regarding fitness to drive. The Driving Licensing Authority recognise that it is their role to enforce the laws on driver licensing and road safety and will not place pressure on health professionals that might needlessly expose them to risk of harassment or intimidation.

2.3.4 Dealing with individuals that are not regular patients

Care should be taken when health professionals are dealing with drivers who are not regular patients. Some drivers may seek to deceive health professionals about their medical history and health status, and may 'doctor shop' for a desirable opinion. If a health professional has doubts about an individual's reason for seeking a consultation, they should consider:

- Asking permission from the individual to request their medical file from their regular health professional.
- Conducting a more thorough examination of the individual than would usually be undertaken.

2.4 Role of the consultant

In most circumstances, medical assessments of drivers can be conducted by a general practitioner. However, if doubt exists about a patient's fitness to drive or if the patient's particular condition or circumstances are not covered specifically by the standards, review by a consultant experienced in the management of the particular condition is warranted and the general practitioner should refer the patient to such a specialist.

If in doubt about the patient's suitability to drive, referral to a further specialist and associated multi-disciplinary team (i.e. physiotherapy, occupational therapy, psychology, optometrist) and/or on-road testing with a driving assessor qualified to assess driving among those with disabilities may be of assistance.

2.4.1 Documentation

Clear documentation of the assessment results and communication with the patient and Driving Licensing Authority is important, as well as maintenance of a record of decisions and advice given to the driver. To aid this process, a Patient Advisory Form is available that provides written information that can be given to the patient and it is also advisable to keep this form on file.

3.0 General considerations for assessing fitness to drive

The aim of determining fitness to drive is to achieve a balance between minimising any driving-related road safety risks for the individual and the community posed by the driver's permanent or long-term injury or illness, and maintaining the driver's lifestyle and employment-related mobility independence. Indeed, for many conditions, remediation and rehabilitation may improve driver comfort and safety.

The following pages outline the general principles and considerations for assessing driver fitness. Also included in this section is a summary of the assessment process. These principles should be considered in conjunction with the specific standards outlined in Part B of this publication.

3.1 Requirements of the driving task

Consideration of the requirements of the driving task is fundamental to assessing a person's medical fitness to drive. The driving task involves a complex and rapidly repeating cycle that requires a level of skill and the ability to interact with both the vehicle and the external environment at the same time. Information about the road environment is obtained via the visual and auditory senses. The information is operated on by many cognitive processes including short and long-term memory and judgement, which leads to decisions being made about driving. Decisions are put into effect via the musculoskeletal system, which acts on the steering, gears and brakes to alter the vehicle in relation to the road.

The overall process is co-ordinated via a complex process involving behaviour, strategic and tactical abilities and personality[3], and adaptive strategies are important in maintaining safe driving in the face of illness and disability[4]. This repeating sequence depends, among other elements, on:

- Vision
- Visio-spatial Perception
- Hearing
- Attention and Concentration
- Memory
- Insight
- Judgement
- Adaptive Strategies
- Reaction Time
- Sensation
- Muscle Power
- Co-ordination

Given these requirements, it follows that many body systems need to be functional in order to ensure safe and timely execution of the skills required for driving.

Table 2: Environmental factors affecting driving performance

Driving tasks occur within a dynamic system influenced by complex driver, vehicle, task, organisational and external road environment factors including:

- The driver's experience, training and attitude.
- The driver's physical, mental and emotional health, including fatigue and the effect of prescription and non prescription (over the counter) medicines.
- The road system, for example, signs, other road users, traffic characteristics and road layout.
- Legal requirements, for example, speed limits and blood alcohol concentration.
- The natural environment, for example, night, extremes of weather and glare.
- Vehicle and equipment characteristics, for example type of vehicle, braking performance and maintenance.
- Personal requirements, trip purpose, destination, appointments, time pressures etc.
- Passengers and their potential to distract the driver.

3. *Fuller R. Towards a general theory of driver behaviour. Accid Anal Prev 2005;37(3):461-72.*
4. *Langford J, Braitman K, Charlton J, Eberhard J, O'Neill D, Staplin L, Stutts J. TRB Workshop 2007: Licensing authorities' options for managing older driver safety practical advice from the researchers. Traffic Inj Prev 2008;9(4):278-81.*

3.2 Medical conditions likely to affect fitness to drive

Given the many causal factors in motor vehicle crashes, the extent to which medical conditions contribute is difficult to assess. There is, however, recognition of the potential for certain conditions to cause serious impairments. *Examples of such conditions include:*

- Blackouts
- Cardiovascular Disease
- Diabetes
- Musculoskeletal Conditions
- Neurological Conditions such as Epilepsy, Dementia and Cognitive Impairment due to other causes
- Psychiatric Conditions
- Substance Misuse/Dependency
- Sleep Disorders
- Vision Problems

Treatments for medical conditions (including drug treatments and others) can also affect driving ability positively or negatively through effects on cognition and reaction time.

Drivers may present to treating health professionals with a range of conditions, some that affect driving temporarily, or may affect the patient's ability to drive at some time in the future, or that are complicated by the presence of multiple conditions. The content of this publication focuses on common conditions known to affect fitness to drive and, in particular, on determining the risk of a patient's involvement in a serious vehicle crash caused by loss of control of the vehicle.

It is accepted that other medical conditions or **combinations of conditions** may also be relevant and that it is not possible to define all clinical situations where an individual's overall function would compromise public safety. A degree of professional judgement, with more extensive assessment or specialist opinion as required, is therefore required in assessing fitness to drive.

Should a clinician require further assessment of a patient (for example, occupational therapy, specialist opinion or on-road test), the doctor in charge of their care should be able to advise the driver whether or not it is appropriate for them to continue to drive during the period until these further assessments have been completed. Patients may be reminded that if they choose to ignore medical advice to cease driving, there could be consequences with respect to their insurance cover.

3.3 Temporary conditions

There is a wide range of conditions that temporarily affect the ability to drive safely. These include conditions such as post major surgery, severe migraine, or injuries to limbs. These conditions are self-limiting and hence do not impact on licence status; therefore, the licensing authority need not be informed. However, the treating health professional should provide suitable advice to such patients regarding driving safely. Such advice should be based on consideration of the likely impact of the patient's condition and their specific circumstances on the driving task as well as their specific driving requirements. Table 3 provides guidance on some common conditions that may temporarily impact on driving ability. Note: this publication does not attempt to address every condition or situation that might temporarily affect safe driving ability. *See following table for examples of management of temporary conditions.*

Table 3: Examples of management of temporary conditions

Condition and impact on driving	Management guidelines
Anaesthesia Physical and mental capacity may be impaired for some time post anaesthesia (including both general and local anaesthesia). The effects of general anaesthesia will depend on factors such as duration of anaesthesia, the drugs administered and the surgery performed. The effect of local anaesthesia will depend on dosage and the region of administration. The use of analgesics and sedatives should also be considered.	In cases of recovery following surgery or procedures under general or local anaesthesia, it is the responsibility of the surgeon/dentist and anaesthetist to advise patients not to drive until physical and mental recovery is compatible with safe driving. • Following minor procedures under local anaesthesia without sedation (e.g. dental block), driving may be acceptable immediately after the procedure. • Following brief surgery or procedures with short-acting anaesthetic drugs, the patient may be fit to drive after a normal night's sleep. • After longer surgery or procedures requiring general anaesthesia, it may not be safe to drive for 24 hours or more.
Post surgery Surgery will impact on driving ability to varying degrees depending on the location, nature and extent of the procedure.	The non-driving period post surgery should be determined by the treating health professionals.
Pregnancy Under normal circumstances pregnancy should not be considered a barrier to driving. However, conditions that may be associated with some pregnancies should be considered when advising patients. These include: • Fainting or light-headedness. • Hyperemesis gravidarum. • Hypertension of pregnancy. • Post caesarean section.	A caution regarding driving may be required depending on the severity of symptoms and the expected effects of medication.
Temporary or short-term vision impairments A number of conditions and treatments may impair vision in the short term, for example, temporary patching of an eye, use of my driatics or other drugs known to impair vision, or eye surgery. For long-term vision problems, refer to Part B, section 7, Vision and eye disorders.	People whose vision is temporarily impaired by a short-term eye condition or an eye treatment should be advised not to drive for an appropriate period.
Deep vein thrombosis and pulmonary embolism While deep vein thrombosis may lead to an acute pulmonary embolus there is little evidence that such an event causes crashes. Therefore there is no licensing standard applied to either condition. Non-driving periods are advised.	The non-driving period after stable or anticoagulation should be determined by the treating health professionals.

3.4 Undifferentiated conditions

A patient may present with symptoms that could have implications for their licence status but the diagnosis is not clear. Investigation of the symptoms will mean there is a period of uncertainty before a definitive diagnosis is made and before the licensing requirements can be confidently applied.

Each situation will need to be assessed individually, with due consideration being given to the probability of a serious disease or long-term or permanent injury or illness that may affect driving, and to the circumstances in which driving is required. However, patients presenting with symptoms of a potentially serious nature, for example, chest pains, dizzy spells or black-outs, or delusional states should be advised not to drive until their condition can be adequately assessed. During this interim period, in the case of private vehicle drivers, no formal communication with the Driving Licensing Authority is required. After a diagnosis is firmly established and the standards applied, normal notification procedures apply, if needed. The health professional should consider the impact on the driver's livelihood and investigate the condition as quickly as possible.

3.5 Multiple conditions and age-related change

Where a vehicle driver has multiple conditions or a condition that affects multiple body systems, there may be an additive or a compounding detrimental effect on driving abilities, for example, in:

- Congenital disabilities such as cerebral palsy, spina bifida and various syndrome.
- Multiple trauma causing orthopaedic and neurological injuries as well as psychiatric sequelae.
- Multi-system diseases such as diabetes, connective tissue disease and HIV.
- Dual diagnoses involving psychiatric illness and drug or alcohol addiction.
- Ageing-related changes in motor, cognitive and sensory abilities together with degenerative disease.
- Fatigue related to cancer and neurological conditions.

Although these medical standards are designed principally around individual conditions, clinical judgement is needed to integrate and consider the effects on safe driving of any medical conditions and disabilities that a patient may present with. For example, glaucoma may cause a slight loss of peripheral vision. If combined with cervical spondylosis and low insight, there is likely to be a substantial reduction in the driver's visual fields and possibly their perceptual abilities, thus increasing the risks of missing important visual information when driving.

Advanced age, in itself, is not a barrier to driving, and functional ability rather than chronological age should be the criterion used in assessing the fitness to drive of older people, although physicians should be mindful that multi-morbidity increases with age[5]. Age-related physical and mental changes vary greatly between individuals but will eventually affect the ability to drive safely. Professional judgement must determine what is acceptable decline (compensated by the patient's long experience and self-imposed limitations on when and where they drive) and what is irreversible, hazardous deterioration in driving-related skills, requiring reporting to the licensing authority. This may require careful consideration and specialist referral. As all possible combinations of disabilities are too numerous to detail here, the following guidelines provide a general approach to assessing these patients:

5. *Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet. 2012 Jul 7;380(9836):37-43.*

- **The driving task**
  First, consider the ergonomics of the driving task. How might the various impairments (sensory, cognitive and musculoskeletal), disabilities and general fitness levels impact on function required to complete driving-related tasks?

- **General functionality**
  Consider to what extent the person is currently able to function with regard to domestic or occupational requirements and what compensatory or coping strategies may have been developed. Information gained from relatives or carers is also likely to be important in this regard. Individuals may be likely to cope better with congenital or slow-onset conditions compared with traumatic or rapidly developing conditions.

- **Clinical assessment**
  The key considerations are:
  - Sensory (in particular visual acuity and visual fields but also cutaneous, muscle and joint sensation).
  - Motor function (including joint movements, strength and co-ordination).
  - Cognition (including attention, concentration, presence of hallucinations and delusions, insight, judgement, memory, problem-solving skills, thought processing and visuospatial skills).

It may be necessary for the health professional to consider medical standards for each condition. However, it is insufficient simply to apply the medical standards contained in this publication for each condition separately, as a driver may have several minor impairments that alone may not affect driving but when taken together may make risks associated with driving unacceptable. It will, therefore, be necessary to integrate all clinical information, bearing in mind the additive or compounding effect of each condition on the overall capacity of the patient to control the vehicle, and to act and react in an appropriate and timely way to emergent traffic and road conditions.

- **Capacity to learn to drive**
  Young people with multiple disabilities may seek the opportunity to gain a driving licence. In order to ensure they receive informed advice and reasonable opportunities for training, it is helpful if they are trained by a driving instructor with experience in the area of teaching drivers with disabilities.

- **Occupational therapy assessment**
  A referral for an assessment by a generalist occupational therapist may be useful. It could request an evaluation of overall functioning (personal, mobility, community and work activities) as well as seek an opinion on general capacity for driving.

- **On-road driving assessment**
  An on-road assessment may also be helpful.

In light of the information given above, the health professional may advise the patient regarding their fitness to drive and provide advice to the Driving Licensing Authority. *The key question is: Is there a likelihood the person will be unable to control the vehicle and act or react appropriately to the driving environment in a safe, consistent and timely manner?*

Where one or more conditions are progressive, it may be important to reduce driving exposure and ensure ongoing monitoring of the patient. The requirement for periodic reviews can be included as recommendations. This is also important for drivers with conditions likely to be associated with future reductions in insight and self-regulation. If lack of insight may become an issue in the future, it is important to advise the patient to report the condition(s) to the Driving Licensing Authority.

3.6 Progressive disorders

Often diagnoses of progressive disorders are made well before there is any need to question whether the patient remains safe to drive (e.g. multiple sclerosis). However, it is advantageous to raise issues relating to the likely effects of these disorders on personal independent mobility early in the management process.

In a mobile society, people frequently make choices about employment, place of residence and recreational and social activities based on the assumption of continued access to a car. Changing jobs, home and social contacts takes a great deal of time and places substantial emotional demands on patients and their families.

It is, therefore, recommended that the patient be advised appropriately where a progressive condition is diagnosed that may result in future restrictions on driving. It is important to give the patient as much lead time as possible to make the lifestyle changes that may later be required. Assistance from an occupational therapist may be valuable in such instances.

3.7 Congenital conditions

People with congenital or childhood conditions may have developed coping strategies that enable safe driving despite their impairment. They will require individual assessment by a specialist and may need tutoring prior to a practical assessment. While they may require specific vehicle modifications, if the condition is static they may not require periodic reviews.

3.8 Medications and driving

The definition of prescription medications for the purpose of these guidelines is recommended as: Licensed medical product for human use requiring to be used in accordance with a prescription or medical product for human use requiring it to be used in accordance with prescription or medical or healthcarer (including pharmacist) advice.

Any medication that acts on the central nervous system has the potential to adversely affect driving skills, although it must be also recognised that many medications, such as anti-parkinsonian medications, anti-inflammatory agents and anti-depressants, may actually make driving safer and more comfortable.

Central nervous system depressants, for example, may reduce vigilance, increase reaction times and impair decision-making in a very similar manner to alcohol. In addition, medications that affect behaviour may exaggerate adverse behavioural traits and introduce risk-taking behaviours.

Acute impairment due to alcohol or drugs (including illicit, prescription and over–the-counter drugs) is managed through specific road safety legislation that prohibits driving over a certain blood alcohol concentration (BAC) or when impaired by drugs. This is a separate consideration to long-term medical fitness to drive and licensing, thus specific medical requirements are not provided in this publication. Dependency and substance misuse, including chronic misuse of prescription drugs, is a licensing issue and standards are outlined in Chapter 6.

Where medication is relevant to the overall assessment of fitness to drive in the management of specific conditions, such as diabetes, epilepsy and psychiatric conditions, this is covered in the respective chapters. Prescribing doctors and pharmacists do, however, need to be mindful of the potential effects of all prescribed and over-the-counter medicines and to advise patients accordingly. *General guidance is provided below*.

3.8.1 General guidance for prescription medicine and driving

While many medicines have effects on the central nervous system most, with the exception of benzodiazepines, tend not to pose a significantly increased crash risk when the medicines are used as prescribed, and once the patient is stabilised on the treatment. This may also relate to drivers' self-regulating their driving behaviour. When advising patients and considering their general fitness to drive, whether in the short or longer term, health professionals should consider the following:

- The balance between potential impairment due to the medicine and the patient's improvement in health on safe driving ability.
- The individual response of the patient — some individuals are more affected than others.
- The type of licence held and the nature of the driving task, *i.e.* commercial vehicle driver assessments should be more stringent.
- The added risks of combining two or more medicines capable of causing impairment, including alcohol.
- The added risks of sleep deprivation on fatigue while driving, which is particularly relevant to commercial vehicle drivers.
- The potential impact of changing medications or changing dosage.
- The cumulative effects of medications.
- The presence of other medical conditions that may combine to adversely affect driving ability.
- Other factors that may exacerbate risks, such as known history of alcohol or drug misuse.

Liaison between prescribing doctors and pharmacists is encouraged in the consideration of advice given to drivers taking medications which may impact on safe driving.

3.8.2 The effects of specific medicine classes

Benzodiazepines
Benzodiazepines, particularly long-acting benzodiazepines, increase the risk of a crash. In many of these cases, benzodiazepines were either abused or used in combination with other impairing substances. If a hypnotic is needed, a shorter-acting medicine is preferred. Tolerance to the sedative effects of the longer-acting benzodiazepines used in the treatment of anxiety gradually reduces their adverse impact on driving skills.

Antidepressants
Although antidepressants are one of the more commonly detected drug groups in fatally injured drivers, this tends to reflect their wide use in the community. The ability to impair is greater with sedating tricyclic antidepressants, such as amitriptyline and dosulepin, than with less sedating serotonin reuptake inhibitors, such as fluoxetine and sertraline, and the mixed reuptake inhibitors. However, antidepressants can reduce the psychomotor and cognitive impairment caused by depression and return mood towards normal. This can improve driving performance.

Antipsychotics
This diverse class of drugs can improve performance if substantial psychotic-related cognitive deficits are present. However, most antipsychotics are sedating and have the potential to adversely affect driving skills through blockade of central dopaminergic and other receptors. Older drugs such as chlorpromazine are very sedating due to their additional actions on the cholinergic and histamine receptors. Some newer drugs are also sedating, such as clozapine, olanzapine and quetiapine, while others such as aripiprazole, risperidone and ziprasidone are less sedating. Sedation may be a particular problem early in treatment and at higher doses.

Opioids
There is little direct evidence that opioid analgesics such as hydromorphone, morphine or oxycodone have direct adverse effects on driving behaviour. Cognitive performance is reduced early in treatment, largely due to their sedative effects, but neuroadaptation is rapidly established. This means that patients on a stable dose of an opioid may not have a higher risk of a crash. This includes patients on buprenorphine and methadone for their opioid dependency, providing the dose has been stabilised over some weeks and they are not abusing other impairing drugs. Driving at night may be a problem due to the persistent miotic effects of these drugs reducing peripheral vision.

4.0 The legal basis for the medical standards

Since January 2013 the Road Safety Authority is the licensing authority with the responsibility of ensuring that all licence holders are fit to drive.

The legal basis of fitness to drive arises from the Road Traffic (Licensing of Drivers) Regulations 2006, Statutory Instrument Number 537 of 2006, as amended in 2010 and associated regulations, as well as the Directive (91/439/EEC) on driving licences. Directive (91/439/EEC) was amended by Directive 2009/112/EC with effect from 15.9.09 and these amendments came into force in Ireland in 2010. *(See table to follow).*

Table 4: Legal considerations for licensing

- **Licensing Authority processes following medical advice**
  Driving licences are issued or maintained by the Driving Licensing Authority on the basis that the driver has not been advised to cease driving by a doctor or healthcare professional on the basis of clinical assessment and the advice contained within these guidelines. Should a driver be advised to cease driving by a doctor or healthcare professional on the basis of clinical assessment and the advice contained within these guidelines, he/she should inform the Driving Licensing Authority if so indicated in these guidelines. It is then a matter for the Driving Licensing Authority to take appropriate action.

- **Appeals**
  Decisions about the granting of a driving licence are a matter for the Driving Licensing Authority and arrangements concerning the review or appeal against such decisions should be taken up with the Driving Licensing Authority.

- **Age limits**
  Group1 Licences are normally issued for a ten-year period subject to expiry at age 70 years, unless restricted to a shorter duration for medical reasons. There is no upper limit but after age 70 renewal is necessary every 3 years, or every year if medical assessment so indicates. All licence applications after 70 currently require a medical report furnished by the applicant.

- **Garda/Army driver licensing**
  Responsibility for determining the standards, including medical requirements, to be applied to Garda/Army vehicle drivers, over and above the Group 1 driving licence requirements, rests with the Garda Commissioner/ Army Director of Services.

- **Taxi drivers**
  The provision of driving licences for small Public Service Vehicles is the responsibility of the Garda Carriage Office. Responsibility for determining the standards, including medical requirements, to be applied to taxi drivers, over and above the Group 1 driving licence requirements, rests with the Garda Commissioner.

Part B: Medical fitness to drive

Chapter 2
Neurological disorders

Neurological Disorders	Group 1 — Car, M/Cycle
Epilepsy Epileptic attacks are the most frequent medical cause of collapse at the wheel. NB: If within a 24 hour period more than one epileptic attack occurs, these are treated as a "single event" for the purpose of applying the epilepsy regulations. Epilepsy includes all events: major, minor and auras.	**The epilepsy regulations apply.** Provided a licence holder/applicant is able to satisfy the regulations, a 3-year licence will be issued normally by the Driving Licensing Authority. Before the age 70 a person must be seizure-free for five years to qualify for a ten-year licence in the absence of any other disqualifying condition. Licence restored if seizure-free for 5 years since the last attack, with medication if necessary in the absence of any other disqualifying condition. *(See appendix to this chapter for full regulations).* ***Driver must notify Driving Licensing Authority.***
First unprovoked epileptic seizure/solitary fit	6 months off driving from the date of the seizure unless there are clinical factors or investigation results which, in the opinion of the treating specialist suggest an unacceptably high risk of a further seizure, i.e. 20% or greater per annum. ***Driver must notify Driving Licensing Authority.***
Epilepsy/epileptic seizures General guidance for **all** neurosurgical conditions if associated with epilepsy or epileptic seizures.	In all cases where epilepsy has been diagnosed, the Epilepsy Regulations apply. These cases will include all cases of single seizure where a primary cerebral cause is present and the liability to recurrence cannot be excluded. An exception may be made when seizures occur at the time of an acute head injury or intracranial surgery. ***Driver must notify Driving Licensing Authority.***
Withdrawal of anti-epilepsy medication and driving	*(See Appendix to this chapter for full regulations).*
Provoked seizures (Apart from alcohol or illicit drug misuse).	*(See Appendix to this chapter for full regulations).*

See Appendix at end of this chapter for epilepsy regulations.

Loss of consciousness/loss of or altered awareness

Excluding Cough Syncope (See Chapter 9)

A full history is imperative to include pre-morbid history, prodromal symptoms, period of time unconscious, degree of amnesia and confusion on recovery. A neurological cause, for example, epilepsy, subarachnoid haemorrhage, can often be identified by the history, examination and the appropriate referral made. The relevant *Sláinte agus Tiomáint* guidelines will then apply. 80% of all cases have a cardiovascular cause and again, these can be determined by history, examination and ECG. Investigate and treat accordingly and use the relevant *Sláinte agus Tiomáint* guidelines.

The remaining cases can be classified under five categories in the following table:

Neurological Disorders	Group 1 — Car, M/Cycle
1. Reflex Vasovagal Syncope Definite provocational factors with associated prodromal symptoms and which are unlikely to occur whilst sitting or lying. Benign in nature.	No driving restrictions.
If recurrent, will need to check the "3 Ps" apply on each occasion (provocation/prodrome/postural). *(If not see Number 3 below).*	Driving Licensing Authority need not be informed.
2. Loss of consciousness/loss of or altered awareness likely to be unexplained syncope but with a high probability of reflex vasovagal syncope. These have no clinical evidence of structural heart disease and a normal ECG.	No driving restrictions. Driving Licensing Authority need not be informed.
3. Loss of consciousness/loss of or altered awareness likely to be cardiovascular in origin (Excluding 1 or 2)**.** **Factors indicating high risk:** A. Abnormal ECG. B. Clinical evidence of structural heart disease. C. Syncope causing injury, occurring at the wheel or whilst sitting or lying. D. More than one episode in previous 6 months. Further investigations such as ambulatory ECG (48hrs), echocardiography and exercise testing may be indicated after specialist opinion has been sought. ** For Pacemakers See Chapter 3*	No driving for 6 months if no cause identified. Can drive 4 weeks after the event if the cause has been identified and treated. ***Driver must notify Driving Licensing Authority.***

See Appendix at end of this chapter for epilepsy regulations.

Neurological Disorders	Group 1 — Car, M/Cycle
4. Presumed loss of consciousness/loss of or altered awareness with seizure markers This category is for those where there is a strong clinical suspicion of a seizure but no definite evidence. *Factors to be considered:* • Unconsciousness for more than 5 minutes. • Amnesia longer than 5 minutes. • Injury. • Tongue biting. • Incontinence. • Remain conscious but with confused behaviour. • Headache post attack.	6 months off driving from the date of an episode of loss of consciousness/loss of or altered awareness. However, if a person has a previous history of epilepsy or a solitary seizure, 12 months' freedom from any further episode of loss of consciousness with seizure markers must be attained. If a person suffers recurrent episodes of loss of consciousness with seizure markers, 12 months' freedom from such episodes must be attained. ***Driver must notify Driving Licensing Authority.***
5. Loss of consciousness/loss of or altered awareness with no clinical pointers. This category will have had appropriate neurological and cardiac opinion and investigations but with no abnormality detected.	No driving for 6 months. ***Driver must notify Driving Licensing Authority.***
Primary/Central Hypersomnias Including Narcoleptic syndromes	Cease driving on diagnosis. Driving may resume when there has been a period of between 3 and 6 months satisfactory control of symptoms with appropriate treatment. If not on appropriate treatment, driving may be allowed subject to a satisfactory objective assessment of maintained wakefulness, such as the Osler test. **Driver must notify Driving Licensing Authority if driving cessation is going to be 6 months or greater.**
Chronic Neurological Disorders E.g. Multiple sclerosis, motor neurone disease, etc., which may affect vehicle control because of impairment of co-ordination and muscle power. See section:Disabled Drivers, Chapter 10.	Providing medical assessment confirms that driving performance is not impaired, can drive. A 1 or 3 year licence may be advised. Should the driver require a restriction to certain controls, the law requires this to be specified on the licence. Due consideration should be given to rehabilitation, specialist on-road assessment and adaptations which may help to adapt to, or overcome, relevant cognitive and physical impairment. ***Driver must notify Driving Licensing Authority.***
Parkinson's disease and other forms of Parkinsonism	Should not drive if condition or functional status is sufficiently impaired so as to impair driving safety and/or there is clinically significant variability in motor function. Due consideration should be given to medication review (with due attention to tendency to drowsiness/sleepiness), rehabilitation, specialist on-road assessment and adaptations which may help to adapt to, or overcome, relevant cognitive and physical impairment. If driving safety not impaired, can continue driving subject to satisfactory reports. Fitness to drive is subject to regular review. ***Driver must notify Driving Licensing Authority.***

Neurological Disorders	Group 1 — Car, M/Cycle
Liability to sudden attacks of unprovoked or unprecipitated disabling dizziness	**Cease driving on diagnosis.** Driving will be permitted when satisfactory control of symptoms achieved. If remains asymptomatic a ten year licence or if over 60 a licence expiring at age 70, can be issued. After age 70 a one or three year licence, subject to medical report, can be issued.
Stroke/TIA	**TIA** NO need to notify Driving Licensing Authority. **Must not drive for 1 month.** **STROKE** **Must not drive for 1 month.** May resume driving after this period if the clinical recovery is satisfactory. There is no need to notify Driving Licensing Authority *unless there is significant residual neurological deficit 1 month after the episode; of particular importance are visual field defects, cognitive defects including visual neglect and inattention and impaired limb function.* Minor limb weakness alone will not require notification unless restriction to certain types of vehicle or vehicles with adapted controls is needed. Due consideration should be given to rehabilitation, specialist on-road assessment and adaptations which may help to adapt to, or overcome, relevant cognitive and physical impairment. Seizures occurring at the time of a stroke/TIA or in the ensuing 24 hours may be treated as provoked for licensing purposes in the absence of any previous seizure history or previous cerebral pathology. Seizures occurring at the time of intracranial venous thrombosis require 6 months free from attacks before resuming driving.

Neurologica Neurological Disorders L Disorders	Group 1 — Car, M/Cycle
Acute Encephalitic Illnesses and Meningitis	1. If no seizure(s), may resume driving when clinical recovery is complete. *(The driver need notify Driving Licensing Authority only if there is significant residual disability).* 2. If associated with seizures during acute febrile illness, no driving for 6 months from the date of seizure(s). *Driver must notify Driving Licensing Authority.* 3. If associated with seizure(s) during or after convalescence, will be required to meet **epilepsy regulations**.
Transient Global Amnesia	Provided epilepsy, any sequelae from head injury and other causes of altered awareness have been excluded, no restriction on driving. Driving Licensing Authority need not be notified.
Arachnoid Cysts Asymptomatic and untreated. Craniotomy and/or Endoscopic Treatment.	No restriction. 6 months off driving. *Driver must notify Driving Licensing Authority.*
Colloid Cysts Asymptomatic and untreated. Craniotomy and/or Endoscopic Treatment.	No restriction. 6 months off driving. *Driver must notify Driving Licensing Authority.*
Pituitary Tumour **Craniotomy**	Provided no visual field defect. *(If visual field loss, see Vision section)* 6 months off driving. *Driver must notify Driving Licensing Authority.*
Transphenoidal surgery/other treatment (E.g., Drugs, Radiotherapy) or untreated.	Drive on recovery.

See Appendix at end of this chapter for epilepsy regulations.

Neurological Disorders	Group 1 — Car, M/Cycle
Benign Supratentorial Tumour E.g. Who Grade 1 Meningiomas Treatment by Craniotomy	6 months off driving when there is no debarring residual impairment likely to affect safe driving. ***Driver must notify Driving Licensing Authority.*** Epilepsy regulations apply if relevant history of seizure(s).
Treatment with Stereotactic Radiosurgery	1 month off driving; can drive when there is no debarring residual impairment likely to affect safe driving. ***Driver must notify Driving Licensing Authority.*** Epilepsy regulations apply if relevant history of seizure(s).
Treatment with Fractionated Radiotherapy	Can drive on completion of treatment, provided that there is no debarring residual impairment likely to affect safe driving. Epilepsy regulations apply if relevant history of seizure(s).
Who Grade I Meningiomas treated by Craniotomy and/or Radiosurgery and/or Radiotherapy Asymptomatic, incidental meningiomas: Untreated	Requires 1 year off driving, dating from the completion of treatment. ***Driver must notify Driving Licensing Authority.*** Epilepsy regulations apply if relevant history of seizure(s). Continue driving.
Benign Infratentorial Tumours E.g. Meningioma with surgery by craniotomy with or without radiotherapy. **Acoustic Neuroma/Schwannoma**	Drive on recovery. Need not notify Driving Licensing Authority unless sudden and disabling giddiness.
Malignant Tumours (including metastatic deposits) and Gliomas Supratentorial Grades 1 and II gliomas	1 year off driving, from time of completion of the primary treatment. ***Driver must notify Driving Licensing Authority.***
WHO Grade III Meningioma	2 years off driving from time of completion of primary treatment. ***Driver must notify Driving Licensing Authority.***

Neurological Disorders	Group 1 — Car, M/Cycle
Grades III and IV Gliomas and Metastatic Deposit(s)	At least 2 years off driving from time of completion of primary treatment. ***Driver must notify Driving Licensing Authority.***
Solitary Metastatic Deposit	If totally excised, can be considered for recommending 1 year licence after completion of primary treatment if free from recurrence and no evidence of secondary spread elsewhere in the body. ***Driver must notify Driving Licensing Authority.***
Infratentorial Tumours **Grade 1**	As for benign tumours: *i.e.* drive on recovery.
Grades II, III & IV	As for Supratentorial tumour.
Medulloblastoma or Low Grade Ependymoma	If totally excised, can be considered for 1 year licence after primary treatment, if free from recurrence.
High Grade Ependymomas, other Primary Malignant Brain Tumours	Normally, a period of 2 years off driving is required following treatment. ***Driver must notify Driving Licensing Authority.***
Metastatic Deposits	Can be considered for driving on a 1 year licence after completion of primary treatment if otherwise well. ***Driver must notify Driving Licensing Authority.***
Malignant Intracranial Tumours in children who survive to adult life without recurrence	Normally, till 70 licence is issued/maintained.

When a low grade glioma is an incidental finding and asymptomatic, the case may be considered on an individual basis for Group 1.

See Appendix at end of this chapter for epilepsy regulations.

Neurological Disorders	Group 1 — Car, M/Cycle
Significant head injury	Usually requires 6—12 months off driving depending on features such as seizures, post-traumatic amnesia, dural tear, haematoma and contusions. There will need to have been a satisfactory clinical recovery and in particular no visual field defect, or cognitive impairment likely to affect safe driving. Due consideration should be given to rehabilitation, specialist on-road assessment and adaptations which may help to adapt to, or overcome, relevant cognitive and physical impairment. *Driver must notify Driving Licensing Authority.*
Spontaneous Acute Subdural Haematoma (Treated by Craniotomy)	6 months off driving if no significant residual disability. If significant residual disability, due consideration should be given to rehabilitation, specialist on-road assessment and adaptations which may help to adapt to, or overcome, relevant cognitive and physical impairment. *Driver must notify Driving Licensing Authority.*
Chronic Subdural (Treated surgically)	Resume driving on recovery if no significant residual disability. If significant residual disability, due consideration should be given to rehabilitation, specialist on-road assessment and adaptations which may help to adapt to, or overcome, relevant cognitive and physical impairment. *Driver must notify Driving Licensing Authority.*
Subarachnoid Haemorrhage 1. No cause found	Provided comprehensive cerebral angiography normal, may resume driving following recovery if no significant residual disability. If significant residual disability, due consideration should be given to rehabilitation, specialist on-road assessment and adaptations which may help to adapt to, or overcome, relevant cognitive and physical impairment. *Driver must notify Driving Licensing Authority.*
2. Due to Intracranial Aneurysm **A. Surgery Craniotomy** **Anterior or Posterior Cerebral Aneurysm.** **With no deficit.**	Driving permitted when clinically recovered from craniotomy. *Driver must notify Driving Licensing Authority.*
With deficit	6 months off driving and then can drive thereafter if no complications. *Driver must notify Driving Licensing Authority.*

See Appendix at end of this chapter for epilepsy regulations.

Neurological Disorders	Group 1 — Car, M/Cycle
Middle Cerebral Aneurysm **With no deficit**	6 months off driving, and then can drive thereafter if no significant complications. *Driver must notify Driving Licensing Authority.*
With deficit	1 year off driving after craniotomy if no significant residual disability. If significant residual disability, due consideration should be given to rehabilitation, specialist on-road assessment and adaptations which may help to adapt to, or overcome, relevant cognitive and physical impairment. *Driver must notify Driving Licensing Authority.*
B. Endovascular treatment	**Cease driving until clinically recovered.** *Driver must notify Driving Licensing Authority.*
C. No treatment *i.e.* Aneurysm responsible for SAH but no intervention	6 months off driving after diagnosis then till can drive thereafter if no significant complications. *Driver must notify Driving Licensing Authority.*
D. Truly incidental **Findings of Intracranial Aneurysm** (Aneurysm has not been responsible for subarachnoid haemorrhage). **No treatment**	No restriction.
Surgery Craniotomy	Resume driving on recovery.
Endovascular treatment	**Cease driving until clinical recovery.**
Endovascular treatment	**Cease driving until clinically recovered.** *Driver must notify Driving Licensing Authority.*

See Appendix at end of this chapter for epilepsy regulations.

Neurological Disorders	Group 1 — Car, M/Cycle
Arteriovenous Malformation **Supratentorial AVMS** **Intracerebral Haemorrhage due to Supratentorial AVM** **A. Craniotomy**	6 months off driving; can drive thereafter when there is no debarring residual impairment likely to affect safe driving. If significant residual disability, due consideration should be given to rehabilitation, specialist on-road assessment and adaptations which may help to adapt to, or overcome, relevant cognitive and physical impairment. *Driver must notify Driving Licensing Authority.*
B. Other treatment (Embolisation or Stereotactic Radiotherapy)	1 month off driving; can drive thereafter when there is no debarring residual impairment likely to affect safe driving.
C. No treatment	As above.
Incidental finding of a supratentorial AVM (no history of Intracranial Bleed) **A. No treatment**	No restriction.
B. Surgical or other treatment	See Above: As for AVM with Intracranial Haemorrhage.
Infratentorial AVMS **Intracranial haemorrhage due to AVM:** **A. Treated by Craniotomy**	Can drive when there is no debarring residual impairment likely to affect safe driving.
B. Embolisation/Stereotactic Radiotherapy	As above.
C. No treatment	As above.

See Appendix at end of this chapter for epilepsy regulations.

Neurological Disorders	Group 1 — Car, M/Cycle
Incidental finding of an Infratentorial AVM **A. No treatment** **B. Surgical or other treatment**	No restriction. Can drive when there is no debarring residual impairment likely to affect safe driving.
DURAL AV FISTULA	Continued driving subject to individual assessment.
Cavernous Malformation **Supratentorial** **A. Incidental**	No restriction.
B. Seizure, no surgical treatment	Epilepsy regulations apply if history of seizure(s).
C. Haemorrhage and/or focal neurological deficit, no surgical treatment	Epilepsy regulations apply if history of seizure(s).
D. Treated by Surgical Excision (Craniotomy)	Can drive when there is no debarring residual impairment likely to affect safe driving. If significant residual disability, due consideration should be given to rehabilitation, specialist on-road assessment and adaptations which may help to adapt to, or overcome, relevant cognitive and physical impairment *Driver must notify Driving Licensing Authority.* Epilepsy regulations apply if history of seizure(s).
E. Treated by radiosurgery irrespective of whether incidental or symptomatic.	6 months off; can drive when there is no debarring residual impairment likely to affect safe driving Epilepsy regulations apply if history of seizure(s). *Driver must notify Driving Licensing Authority.* No restriction. Epilepsy regulations apply if history of seizure(s).
Infratentorial **A. Incidental**	No restriction.
B. With Focal Neurological Deficit or Haemorrhage	Can drive when there is no debarring residual impairment likely to affect safe driving. Epilepsy regulations apply if history of seizure(s).
C. Treated By Surgical Excision (Craniotomy)	As above.

NB. Multiple Cavernoma: no firm evidence of ↑morbidity
Size is not an issue.

See Appendix at end of this chapter for epilepsy regulations.

Neurological Disorders	Group 1 — Car, M/Cycle
Intracerebral Abscess/Subdural Empyema	One year off driving. *Driver must notify Driving Licensing Authority.*
Hydrocephalus	If uncomplicated, can be recommended for continued driving.
Intraventricular Shunt or Extraventricular Drain Insertion or revision of upper end of ventricular shunt or extra-ventricular drain.	6 months off driving. Can be recommended for continued driving thereafter when there is no debarring residual impairment likely to affect safe driving. *Driver must notify Driving Licensing Authority.*
Neuroendoscopic procedures E.g. IIIrd Ventriculostomy	6 months off driving. Can be recommended for continued driving thereafter when there is no debarring residual impairment likely to affect safe driving. *Driver must notify Driving Licensing Authority.*
Intracranial Pressure Monitoring Device Inserted by Burr Hole Surgery.	The prospective risk from the underlying condition must be considered.
Implanted Electrodes Deep brain stimulation for movement disorder or pain	If no complications from surgery and seizure, can drive when there is no debarring residual impairment likely to affect safe driving. *Driver must notify Driving Licensing Authority.*
Implanted Motor Cortex stimulator for pain relief	If aetiology of pain is non-cerebral e.g. trigeminal neuralgia, 6 months off driving. If the aetiology is cerebral e.g. stroke, 12 months off driving. Can then drive when there is no debarring residual impairment likely to affect safe driving.

See Appendix at end of this chapter for epilepsy regulations.

Appendix — Chapter 2

Epilepsy regulations for Group 1

This means that:

1. A person who has suffered an epileptic attack whilst **awake** must refrain from driving for at least **one** year from the date of the attack: driving cannot resume until the driver has had no further seizures while awake for a 12 month period.
2. A person who has experienced seizures exclusively while asleep may be considered for a one year licence despite continuing seizures **only** during sleep, and subject to at least annual review, taking into account information provided by the treating doctor (with appropriate expertise and due consultation as required) as to whether the following criteria are met:

- There have been no previous seizures while awake; *and*
- The first sleep-only seizure was at least 12 months ago; *and*
- The person follows medical advice, including adherence to medication if prescribed.

or

- There have been previous seizures while awake but not in the preceding **one** year; *and*
- Sleep-only seizures have been occurring for at least one year; *and*
- The person follows medical advice, including adherence to medication if prescribed.

and in both cases

3. I. So far as practicable, the person complies with advised treatment and check-ups for epilepsy; *and*
   II. The driving of a vehicle by such a person should not be likely to cause danger to the public.

A specific exception to these are seizures a judged by the treating consultant neurologist as not impairing consciousness or driving ability at any time. An annual licence may be granted by the Driving Licensing Authority subject to at least annual review, taking into account information provided by the treating consultant as to whether the following criteria are met:

- Seizures not impairing consciousness or driving ability at any time have been present for at least one year; *and*
- There have been no seizures of other type for at least one year; *and*
- The person follows medical advice, including adherence to medication if prescribed.

Guidance for clinicians advising patients to cease driving in the case of break-through seizures in those with established epilepsy

In the event of a seizure, the patient must be advised not to drive unless they are able to meet the conditions of the asleep concessions. The patient must be advised **to notify their Driving Licensing Authority**. In exceptional cases (e.g. seizure secondary to prescribing error), a specialist may advise a return after a shorter period.

Guidance for withdrawal of anti-epilepsy medication being withdrawn on specific medical advice

(N.B. This advice only relates to treatment for epilepsy)

From a medico-legal point of view, the risk of further epileptic seizures occurring during this therapeutic procedure should be noted. If an epileptic seizure does occur, the patient will need to satisfy driving licence regulations before resuming driving and will need to be counselled accordingly. The current Epilepsy Regulations require a period of at least one year free of any manifestation of epileptic seizure or attacks whilst awake from the date of the last attack; special consideration is given where attacks have occurred only whilst asleep.

It is clearly recognised that withdrawal of anti-epilepsy medication is associated with a risk of seizure recurrence. A number of studies have shown this, including the randomised study of anti-epilepsy drug withdrawal in patients in remission, conducted by the Medical Research Council Anti-epileptic Drug Withdrawal Study Group. This study shows a 40% increased associated risk of seizure in the first year of withdrawal of medication compared with those who continued on treatment.

Patients undergoing withdrawal of anti-epilepsy medications should be warned of the risk they run, both of needing to cease driving and also of having a seizure which could result in a road traffic accident. Patients should be advised **not** to drive from commencement of the period of withdrawal and thereafter for a period of 6 months after cessation of treatment. A person remains as much at risk of seizure associated with drug withdrawal during the period of withdrawal as in the 6 months after withdrawal.

This advice may not be appropriate in every case. One specific example is withdrawal of anticonvulsant medication when there is a well-established history of seizures only while asleep. In such cases, any restriction in driving is best determined by the specialist concerned, after considering the history. It is up to the patient to comply with such advice.

It is important to remember that the epilepsy regulations are still relevant even if epileptic seizures occur after medication is omitted, for example on admission to hospital for any condition.

Provoked seizures

Provoked or acute symptomatic seizures may be dealt with on an individual basis if there is no previous seizure history. **Seizures associated with alcohol or drug misuse, sleep deprivation or a structural abnormality are not considered provoked for licensing purposes. Similarly, reports of seizures as a side-effect of prescribed medication do not automatically imply that such events should be considered as provoked.** For seizure(s) with alcohol or illicit drugs, please see relevant section in the booklet.

Doctors may wish to advise patients that the period of time likely to be recommended off driving will be influenced inter alia by:

A. Whether it is clear that the seizure had been provoked by a stimulus which does not convey any risk of recurrence and does not represent an unmasking of an underlying liability; *and*

B. Whether the stimulus had been successfully/appropriately treated or is unlikely to occur at the wheel.

In the absence of any previous seizure history or previous cerebral pathology, the following seizures may also be treated as provoked:

- Eclamptic Seizures.
- Reflex Anoxic Seizures.
- An Immediate Seizure (within seconds) at the time of a head injury.
- Seizure in first week following a head injury (see head injury section) at the time of a Stroke/TIA or within the ensuing 24 hours.
- During intracranial surgery or in the ensuing 24 hours.

Seizures occurring during an acute exacerbation of multiple sclerosis or migraine will need to be assessed on an individual basis by a specialist.

Chapter 3
Cardiovascular disorder

A licence holder or applicant must meet the standards for cardiovascular disorder outlined below, and if there is reason to doubt that these are met, the applicant or licence holder should undergo a more detailed examination by a specialist — see Appendix to this chapter.

Cardiovascular Disorders	Group 1 Entitlement ODL — Car, M/Cycle
Angina	**Driving must cease when symptoms occur at rest, with emotion, or at the wheel.** Driving may recommence when satisfactory symptom control is achieved. Driving Licensing Authority need not be notified.
Acute Coronary Syndromes (ACS) defined as: 1. Unstable angina (symptoms at rest with ECG changes) 2. Non STEMI with at least two of the following criteria • Symptoms at rest • Raised Serum Troponin • ECG changes 3. STEMI symptoms with ST elevation on ECG	If **successfully** treated by coronary angioplasty, driving may recommence after 1/52 provided: • No other URGENT revascularisation is planned. (URGENT refers to within 4/52 from acute event) • LVEF is at least 40% prior to hospital discharge. • There is no other disqualifying condition. If not successfully treated by coronary angioplasty, driving may recommence after 4/52 provided: • There is no other disqualifying condition. Driving Licensing Authority need not be notified.
Percutaneous Coronary Intervention (Angioplasty ± stent) **Elective**	***Driving must cease for at least 2 days** Driving may recommence thereafter provided there is no other disqualifying condition. Driving Licensing Authority need not be notified.
CABG	**Driving must cease for at least 4/52** Driving may recommence thereafter provided there is no other disqualifying condition. Driving Licensing Authority need not be notified.

See Appendix at end of this chapter.

Cardiovascular Disorders	Group 1 Entitlement ODL — Car, M/Cycle
Arrhythmia Sinoatrial disease Significant atrio-ventricular conduction defect Atrial flutter/fibrillation Narrow or broad complex tachycardia (See also following sections — Pacemakers are considered separately) NB: Transient Arrhythmias occurring during acute Coronary Syndromes do not require assessment under this Section.	**Driving must cease if the arrhythmia has caused or is likely to cause incapacity.** Driving may be permitted when underlying cause has been identified and **controlled** for at least 4/52. Driving Licensing Authority need not be notified unless there are distracting/disabling symptoms.
Successful Catheter Ablation	**Driving must cease for at least 2/7.** Driving may be permitted thereafter provided there is no other disqualifying condition. Driving Licensing Authority need not be notified.
Pacemaker Implant Includes box change	**Driving must cease for at least 1/52.** Driving may be permitted thereafter provided there is no other disqualifying condition.
Unpaced Congenital Complete Heart Block	**May drive if asymptomatic.**
Atrial Defibrillator Physician/Patient Activated	Driving may continue provided there is no other disqualifying condition. *Driver must notify Driving Licensing Authority.*
Atrial Defibrillator Automatic	Driving may continue provided there is no other disqualifying condition. See also ICD Section.

See Appendix at end of this Chapter.

Cardiovascular Disorders	Group 1 Entitlement ODL — Car, M/Cycle
Implantable Cardioverter Defibrillator (ICD) Implanted for ventricular arrhythmia associated with incapacity	Patients with ICDs implanted for sustained ventricular arrhythmias should not drive for: 1. A period of 6/12 after the first implant. 2. A further 6/12 after any shock therapy and/or symptomatic antitachycardia pacing (see 3A below). 3A. A period of 2 years if any therapy following device implantation has been accompanied by incapacity (whether caused by the device or arrhythmia), **except as in 3B and 3C.** 3B. If therapy was delivered due to an inappropriate cause, *i.e.* a trial fibrillation or programming issues, then driving may resume 1/12 after this has been completely controlled to the satisfaction of the cardiologist. Driving Licensing Authority need not be notified. 3C. If the incapacitating shock was appropriate (*i.e.* for sustained VT or VF) and steps have been taken to prevent recurrence, (e.g., introduction of anti-arrhythmic drugs or ablation procedure) driving may resume after 6/12 **in the absence of further symptomatic therapy.** For 2 and 3A/3C, if the patient has been re-licensed prior to the event, ***Driver must notify Driving Licensing Authority.*** 4. A period of 1/12 off driving must occur following any revision of the electrodes or alteration of anti-arrhythmic drug treatment. 5. A period of 1/52 off driving is required after a defibrillator box change. **Resumption of driving requires that;** 1. The device is subject to regular review with interrogation. 4. There is no other disqualifying condition.

Cardiovascular Disorders	Group 1 Entitlement ODL — Car, M/Cycle
Implantable Cardioverter Defibrillator (ICD) Implanted for ventricular arrhythmia which did not cause incapacity.	If the patient presents with a non-disqualifying cardiac event, i.e. haemodynamically stable non-incapacitating sustained ventricular tachycardia, the patient can drive 1/12 after ICD implantation providing all of the following conditions are met: • LVEF > than 35%. • No fast VT induced on electrophysiological study (RR< 250 msec). • Any induced VT could be pace-terminated by the ICD twice, without acceleration, during the post implantation study. Driving Licensing Authority need not be notified. Should the ICD subsequently deliver ATP and/or shock therapy (except during normal clinical testing) then the licensing criteria on the previous page applies and *Driver must notify Driving Licensing Authority.*
Prophylactic ICD Implant	Asymptomatic individuals with high risk of significant arrhythmia. Driving should cease for 1/12. Driving Licensing Authority need not be notified. Should the ICD subsequently deliver ATP and/or shock therapy (except during normal clinical testing) then the licensing criteria on the previous page applies and *Driver must notify Driving Licensing Authority.*
Ascending/Descending Thoracic and Abdominal Aortic Aneurysm	*Driver must notify licensing authority* of any aneurysm of **6cm** in diameter, despite treatment. Licensing will be permitted subject to **annual review.** Driving may continue after **satisfactory** medical (blood pressure control) or surgical treatment, without evidence of further enlargement. There should be no other disqualifying condition. **An aortic diameter of 6.5cm or more disqualifies from driving.**

See Appendix at end of this chapter.

Cardiovascular Disorders	Group 1 Entitlement ODL — Car, M/Cycle
Chronic Aortic Dissection	Driving may continue after **satisfactory** medical (blood pressure control) or surgical treatment, unless other disqualifying condition. Driving Licensing Authority need not be notified.
Marfan's Syndrome	Driving Licensing Authority need not be notified unless there is aneurysm.
Carotid Artery Stenosis (See also Neurological Section)	Driving Licensing Authority need not be notified.
Peripheral Arterial Disease	Driving may continue provided there is no other disqualifying condition. Driving Licensing Authority need not be notified.
Hypertension	Driving may continue unless treatment causes unacceptable side effects. Driving Licensing Authority need not be notified.
Hypertrophic Cardiomyopathy (HCM) **(See also Arrhythmia, Pacemaker and ICD Sections)**	Driving may continue provided no other disqualifying condition. Driving Licensing Authority need not be notified.
Dilated Cardiomyopathy **(See also Arrhythmia, Pacemaker, ICD and Heart Failure Sections)**	Driving may continue provided no other disqualifying condition. Driving Licensing Authority need not be notified.
Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC) and Allied Disorders **(See also Arrhythmia, Pacemaker and ICD Sections)**	**Asymptomatic** – Driving may continue. Driving Licensing Authority need not be notified. **Symptomatic** – Driving must cease if an arrhythmia has caused or is likely to cause incapacity. Re/licensing may be permitted when arrhythmia is controlled and there is no other disqualifying condition.
Heart Failure	Driving may continue provided there are no symptoms that may distract the driver's attention. Driving Licensing Authority need not be notified.

See Appendix at end of this chapter.

Cardiovascular Disorders	Group 1 Entitlement ODL — Car, M/Cycle
Left Ventricular Assist Devices	**Driving should cease on insertion.** (Re)licensing can be considered on an individual basis 6/12 after device implantation. *Driver must notify Driving Licensing Authority.*
Cardiac Resynchronisation Therapy (CRT) **CRT-P** **CRT-D**	**Driving must cease for at least 1/52 following implantation.** Driving may continue provided there are no symptoms relevant to driving. There is no other disqualifying condition. Driving may be permitted provided the ICD requirements are met. There is no other disqualifying condition.
Heart or Heart/Lung Transplant	Driving may continue provided no other disqualifying condition. Driving Licensing Authority need not be notified.
Heart Valve Disease **(To include surgery, ie replacement and/or repair)**	Driving Licensing Authority need not be notified unless there is aneurysm. Driving Licensing Authority need not be notified
Congenital Heart Disease	Driving may continue provided there is no other disqualifying condition. Following a first licence application or identification of such a condition, specialist assessment may be required before a licence is (re)issued. Certain conditions will require the issue of a medical review licence for 1, 3 years in this instance driver must notify DL.
Syncope **NB: Cough Syncope. See Chapter 7**	*See section: Loss of Consciousness Chapter 2.*
ECG Abnormality **Suspected Myocardial Infarction**	Driving may continue unless other disqualifying condition Driving Licensing Authority need not be notified.
Left Bundle Branch Block	Driving may continue unless other disqualifying condition. Driving Licensing Authority need not be notified.
Pre-Excitation	Driving may continue unless other disqualifying condition. Driving Licensing Authority need not be notified.

See Appendix at end of this chapter.

Appendix — Chapter 3
Group 1 entitlements

Medication
If drug treatment for any cardiovascular condition is required, any adverse effect which is likely to affect driver performance will disqualify.

Exercise testing

Exercise evaluation shall be performed on a bicycle* or treadmill. Drivers should be able to complete 3 stages of the standard Bruce protocol or equivalent **safely**, without anti-anginal** medication for 48 hours and should remain free from signs of cardiovascular dysfunction, viz. angina pectoris, syncope, hypotension, sustained ventricular tachycardia, and/or electrocardiographic ST segment shift which accredited medical opinion interprets as being indicative of myocardial is chaemia (usually >2mm horizontal or down-sloping) during exercise or the recovery period. In the presence of established coronary heart disease, exercise evaluation shall be required at regular intervals not to exceed 3 years.

* Cycling for ten minutes with 20 watt increments/minute to a total of 200W.
** Anti-anginal medication refers to the use of nitrates, beta-blockers, calcium channel blockers, nicorandil, ivabradine and ranolazine **prescribed for anti-anginal purposes or for other reasons e.g. cardio-protection.**

NB: When any of the above drugs are being prescribed purely for the control of hypertension or an arrhythmia then discontinuation prior to exercise testing is not required.

Should atrial fibrillation develop de novo during exercise testing, provided the individual meets all the Driving Licence Authority exercise tolerance test criteria, the individual will be required to undergo an echocardiogram and meet the licensing criteria, just as any individual with a pre-existing atrial fibrillation.

Chest pain of uncertain cause

Exercise testing should be carried out as above. Those with a locomotor disability who cannot comply will require either a gated myocardial perfusion scan, stress echo study and/or specialised cardiological opinion.

Stress Myocardial Perfusion Scan/Stress Echocardiography

The licensing standard requires that:

1. The LVEF is 40% or more.
2. **A.** No more than 10% of the myocardium is affected by reversible ischaemic change on myocardial perfusion imaging.

or

B. No more than one segment is affected by reversible ischaemic change on stress echocardiography.

NB: Full details of Driving Licensing Authority protocol requirements for such tests can be obtained on request.

Coronary Angiography

The functional implication of coronary heart disease is considered to be more predictive for licensing purposes than the anatomical findings. For this reason the exercise tolerance test and where necessary, myocardial perfusion imaging or stress echocardiography are the investigations of relevance for licensing purposes and it is the normal requirement that the standard of one or other of these must be met. Angiography is therefore not commissioned for (re-) licensing purposes. When there remains conflict between the outcome of a functional test and the results of recent angiography, such cases can be considered on an individual basis. However, (re-) licensing will not normally be considered unless the coronary arteries are **unobstructed or the stenosis is not flow limiting and the left ventricular ejection fraction is = to or > 40%.**

'Predictive' refers to the risk of an infarct within 1 year. Grafts are considered as 'Coronary Arteries'.

ETT and Hypertrophic Cardiomyopathy

For the purpose of assessment of hypertrophic cardiomyopathy (HCM) cases, an exercise test falling short of 9 minutes would be acceptable provided:

1. There is no obvious cardiac cause for stopping the test in less than 9 minutes.
2. There is at least a 25mm Hg rise in systolic blood pressure during exercise testing.
3. Meets all other requirements as mentioned in HCM section.

Chapter 4
Diabetes Mellitus

Failure to meet these standards or the presence of any progressive neurological disorder requires the applicant or licence holder to inform the Driving Licensing Authority unless stated otherwise in the text.

Diabetes Mellitus	Group 1 — Car, M/Cycle
Insulin-Treated **See Appendix to this chapter for advice to drivers.**	• Must have awareness of hypoglycaemia. • Must not have had more than one episode of hypoglycaemia requiring the assistance of another person in the preceding twelve months. • There must be appropriate blood glucose monitoring. • Must not be regarded as a likely source of danger to the public while driving. • The visual standards for acuity and visual field must be met.
Temporary Insulin Treatment E.g. Post-Myocardial Infarction, participants in Oral/Inhaled Insulin Trials.	Impaired awareness of hypoglycaemia is defined as, 'an inability to detect the onset of hypoglycaemia because of a total absence of warning symptoms'. If meets the medical standard a 1 or 3 year licence will be issued. Provided they are under medical supervision and have not been advised by their doctor that they are at risk of disabling hypoglycaemia, need not notify Driving Licensing Authority. If experiencing disabling hypoglycaemia, ***Driver must notify Driving Licensing Authority.*** Notify Driving Licensing Authority if treatment continues for more than 3 months or for more than 3 months after delivery for gestational diabetes.

Diabetes Mellitus	Group 1 — Car, M/Cycle
Managed by tablets which carry a risk of Inducing Hypoglycaemia. This includes Sulphonylureas and Glinides **See Appendix to this chapter for advice to drivers.**	Must not have had more than one episode of hypoglycaemia requiring the assistance of another person within the preceding 12 months. It may be appropriate to monitor blood glucose regularly and driver should monitor blood glucose at times relevant to driving to enable the detection of hypoglycaemia. Must be under regular medical review. **If however there has been a hypoglycaemic event in the preceding 12 months,** *Driver must notify Driving Licensing Authority.*
Managed by tablets other than those on the previous page or by non-insulin injectable medication **See Appendix to this chapter for advice to drivers.**	Need not notify Driving Licensing Authority unless develop associated conditions which are relevant to safe driving. E.g. Diabetic eye problems affecting visual acuity or visual field or if insulin required.
Managed by diet alone	Need not notify Driving Licensing Authority unless develop associated conditions which are relevant to safe driving. E.g. Diabetic eye problems affecting visual acuity or visual field or if insulin required.
Impaired awareness of Hypoglycaemia	If confirmed, driving must stop. Driving may resume provided reports show awareness of hypoglycaemia has been regained, confirmed by consultant/GP report.
Eyesight Complications (affecting visual acuity or fields)	*See section: Visual Disorders Chapter 7.*
Renal Disorders	*See section: Renal Disorders Chapter 8.*
Limb Disability E.g. Peripheral Neuropathy	*See section: Disabled Drivers Chapter 10.*

See Appendix at end of this chapter.

Appendix — Chapter 4
Group 1

A guide for drivers with insulin treated diabetes or oral medications with potential for hypoglycaemia (such as sulfonylureas and glinides) who wish to apply for Group 1 licences.

Drivers who have any form of diabetes treated with any insulin preparation or oral medications with potential for hypoglycaemia (such as sulfonylureas and glinides) must inform the Driving Licensing Authority, unless it is temporary insulin treatment during pregnancy for a period of less than 3 months — discuss with your obstetrician or diabetes specialist if this is the case.

Hypoglycaemia

Hypoglycaemia (also known as a hypo) is the medical term for a low blood glucose (sugar) level.

Severe Hypoglycaemia

Severe hypoglycaemia means the assistance of another person is required. The risk of hypoglycaemia is the main danger to safe driving and this risk increases the longer you are on insulin treatment. This may endanger your own life as well as that of other road users. Many of the accidents caused by hypoglycaemia are because drivers carry on driving even though they get warning symptoms of hypoglycaemia. If you get warning symptoms of hypoglycaemia whilst driving, you must always stop as soon as safely possible — **do not ignore the warning symptoms**.

Early symptoms of hypoglycaemia include:

- Sweating, shakiness or trembling, feeling hungry, fast pulse or palpitations, anxiety, tingling lips.

If you don't treat this it may result in more severe symptoms such as:

- Slurred speech, difficulty concentrating, confusion, disorderly or irrational behaviour, which my be mistaken for drunkeness. If left untreated, this may lead to unconsciousness.

Drivers with diabetes treated with insulin or oral medications with potential for hypoglycaemia are advised to take the following precautions:

- You must **always** carry your glucose meter and blood glucose strips with you. You must check your blood glucose before driving and every two hours whilst you are driving.
- In each case if your blood glucose **is 5.0mmol/l or less, or if you are worried that you may experience a hypo during the driving period, take a snack. If lt is less than 4.0mmol/l or you feel hypoglycaemic, do not drive.**
- If hypoglycaemia develops while driving, stop the vehicle as soon as possible.
- You must switch off the engine, remove the keys from the ignition and move from the driver's seat.
- You must not start driving until 45 minutes after blood glucose has returned to normal. It takes up to 45 minutes for the brain to recover fully.
- Always keep an emergency supply of fast-acting carbohydrate such as glucose tablets or sweets within easy reach in the vehicle.
- You should carry personal identification to show that you have diabetes in case of injury in a road traffic accident.
- Particular care should be taken during changes of insulin regimens, changes of lifestyle, exercise, travel and pregnancy.
- You must take regular meals, snacks and rest periods on long journeys. Always avoid.

You must inform the Licensing Authority if:

- You suffer more than one episode of severe hypoglycaemia *(needing the assistance of another person)* within the last 12 months. You must also tell us if you or your medical team feels you are at high risk of developing hypoglycaemia.
- You develop impaired awareness of hypoglycaemia (difficulty in recognising the warning symptoms of low blood sugar).
- You suffer severe hypoglycaemia while driving.
- An existing medical condition gets worse or you develop any other condition that may affect you driving safely.

Chapter 5
Psychiatric disorders

Failure to meet these standards or the presence of any progressive disorder requires the applicant or licence holder to inform the Driving Licensing Authority unless stated otherwise in the text.

Psychiatric Disorders	Group 1 Entitlement ODL — Car, M/Cycle
Anxiety or depression (Without significant memory or concentration problems, agitation, behavioural disturbance or suicidal thoughts).	Driving Licensing Authority need not be notified and driving may continue. *(See note about medication in Appendix at end of this chapter).* ***Driver must notify Driving Licensing Authority if medical advice is to cease driving for 6 months or longer, or if the treating doctor would not sanction a full 10 year licence on medical grounds if licence was being renewed at the time of consultation.***
More severe anxiety states or depressive illnesses (**With** significant memory or concentration problems, agitation, behavioural disturbance or suicidal thoughts). NB: For cases, which also involve persistent misuse of or dependence on alcohol/drugs, please refer to the appropriate section of Chapter 5. Where psychiatric illness has been associated with substance misuse, continuing misuse is not acceptable for licensing.	Driving should cease pending the outcome of medical enquiry. A period of stability depending upon the circumstances will be required before driving can be resumed. Particularly dangerous are those who may attempt suicide at the wheel. ***Driver must notify Driving Licensing Authority if medical advice is to cease driving for 6 months or longer, or if the treating doctor would not sanction a full 10 year licence on medical grounds if licence was being renewed at the time of consultation.***

Psychiatric Disorders	Group 1 Entitlement ODL — Car, M/Cycle
Acute Psychotic disorders of any type NB: For cases, which also involve persistent misuse of or dependence on alcohol/drugs, please refer to the appropriate section of Chapter 6. Where psychiatric illness has been associated with substance misuse, continuing misuse is not acceptable for licensing.	**Driving must cease** during the acute illness. Resumption of driving can be considered when **all** of the following conditions can be satisfied: A. Has remained well and stable with an awareness of fitness to drive. B. Is compliant with treatment. C. Is not suffering from adverse effects of medication which would impair driving. **Drivers who have a history of instability and/or poor compliance will require a longer period off driving.** *Driver must notify Driving Licensing Authority if medical advice is to cease driving for 6 months or longer, or if the treating doctor would not sanction a full 10 year licence on medical grounds if licence was being renewed at the time of consultation.*
Hypomania/Mania NB: For cases, which also involve persistent misuse of or dependence on alcohol/drugs, please refer to the appropriate section of Chapter 5. Where psychiatric illness has been associated with substance misuse, continuing misuse is not acceptable for licensing.	**Driving must cease** during the acute illness. Following an **isolated episode**, resumption of driving can be considered when **all** the following conditions can be satisfied: A. Has remained well and stable with an awareness of fitness to drive. B. Is compliant with treatment. C. Is not suffering from adverse effects of medication which would impair driving. *Driver must notify Driving Licensing Authority if medical advice is to cease driving for 6 months or longer, or if the treating doctor would not sanction a full 10 year licence on medical grounds if licence was being renewed at the time of consultation.* **Repeated changes of mood:** Hypomania or mania are particularly dangerous to driving when there are repeated changes of mood. Therefore, when there have been 4 or more episodes of mood swing within the previous 12 months, at least 6 months stability will be required under condition (A), in addition to satisfying condition (B) and (C)

Psychiatric Disorders	Group 1 Entitlement ODL — Car, M/Cycle
Chronic Schizophrenia and other Chronic Psychoses NB: For cases, which also involve persistent misuse of or dependence on alcohol/drugs, please refer to the appropriate section of Chapter 5 Where psychiatric illness has been associated with substance misuse, continuing misuse is not acceptable for licensing.	The driver must satisfy **all** the following conditions: A. Has remained well and stable with an awareness of fitness to drive. B. Is compliant with treatment. C. Is not suffering from adverse effects of medication which would impair driving. **Continuing symptoms:** Even with limited insight, these do not necessarily preclude licensing. Symptoms should be unlikely to cause significant concentration problems, memory impairment or distraction whilst driving. Particularly dangerous, are those drivers whose psychotic symptoms relate to other road users. ***Driver must notify Driving Licensing Authority if medical advice is to cease driving for 6 months or longer, or if the treating doctor would not sanction a full 10 year licence on medical grounds if licence was being renewed at the time of consultation.Due consideration should be given to specialist on-road assessment if doubt remains about fitness to drive.***
Developmental disorders Includes: Asperger's Syndrome, autism, severe communication disorders and Attention Deficit Hyperactivity Disorder.	A diagnosis of any of these conditions is not in itself a bar to licensing. Factors such as impulsivity, lack of awareness of the impact of own behaviours on self or others need to be considered.

See Appendix at end of this chapter

Psychiatric Disorders	Group 1 Entitlement ODL — Car, M/Cycle
Mild Cognitive Impairment (MCI)	Where there is **no** objective impairment of function MCI does not need to be notified to Driving Licensing Authority. Where there **is** objective impairment of function or specific treatment is required then MCI will not be the cause and doctor should clarify the cause and apply the relevant section of Sláinte agus Tiomáint.
Dementia or any Organic Brain Syndrome	It is extremely difficult to assess driving ability in those with dementia. Those who have poor short-term memory, disorientation, lack of insight and judgement are almost certainly not fit to drive. The variable presentations and rates of progression are acknowledged. Disorders of attention will also cause impairment. A decision regarding fitness to drive is usually based on specialist medical assessment, further assessment by occupational therapy and/or neuropsychology, with a low threshold for an on-road driving assessment. In early dementia when sufficient skills are retained and progression is slow, a licence may be issued subject to annual review. A formal driving assessment may be necessary. *Driver must notify Driving Licensing Authority** *See Section: 2.3.1 Chapter 1.*
Learning disability Severely below average general intellectual functioning accompanied by significant limitations in adaptive functioning in at least 2 of the following areas: communication, self-care, home-living, social/ interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety.	Severe learning disability is not compatible with driving and the licence application must be refused. In milder forms, provided there are no other relevant problems, it may be possible to hold a licence, but it will be necessary to pass the theory test and demonstrate adequate functional ability at the wheel.

See Appendix at end of this chapter.

Psychiatric Disorders	Group 1 Entitlement ODL — Car, M/Cycle
Behaviour disorders Includes post head injury syndrome and Non-Epileptic Seizure Disorder	If seriously disturbed e.g. violent behaviour or alcohol abuse and likely to be a source of danger at the wheel, driving must cease. After medical assessment reports confirm that behavioural disturbances have been satisfactorily controlled, driving can resume. *Driver must notify Driving Licensing Authority.*
Personality disorders	If likely to be a source of danger at the wheel driving must cease. Licensing would be permitted providing medical enquiry confirms that any behaviour disturbance is not related to driving or not likely to adversely affect driving or road safety. *Driver must notify Driving Licensing Authority if medical advice is to cease driving for 6 months or longer, or if the treating doctor would not sanction a full 10 year licence on medical grounds if licence was being renewed at the time of consultation.*

See Appendix at end of this chapter.

Appendix 5

Psychiatric notes

Important Notes
Other psychiatric conditions, which do not fit neatly into the aforementioned classification **will need to be reported to Driving Licensing Authority if causing or felt likely to cause symptoms affecting safe driving.** These would include for example any impairment of consciousness or awareness, any increased liability to distraction or symptoms affecting the safe operation of vehicle controls. The patient should be advised to declare both the condition and symptoms of concern.

It is the relationship of symptoms to driving that is of importance.

- Directive (91/439/EEC) as amended by Directive 2009/112/EC requires member states to set minimum medical standards of fitness to drive and sets out the requirements for mental health in broad terms.
- Theses Directives make a clear distinction between the standards needed for Group 1 (car and motor cycles) and Group 2 (lorries and buses) licences. The standards for the latter being more stringent due to the size of vehicle and the greater time spent at the wheel during the course of the occupation.
- Severe mental disorder for the purposes of these guidelines has defined as including mental illness, arrested or incomplete development of the mind, psychopathic disorder or severe impairment of intelligence or social functioning. The standards must reflect, not only the need for an improvement in the mental state, but also a period of stability, such that the risk of relapse can be assessed should the patient fail to recognise any deterioration.
- Misuse of or dependence on alcohol or drugs will require the standards in this chapter to be considered in conjunction with those of Chapter 6 of this publication.

Medication

- Any person who is driving or attempting to drive on the public highway, or other public place whilst unfit due to any drug, is liable to prosecution (as set out under Section 4 and Section 5 of the Road Traffic Act, 2010).
- All drugs acting on the central nervous system can impair alertness, concentration and driving performance. This is particularly so at initiation of treatment, or soon after and when dosage is being increased. Driving must cease if adversely affected.
- The older tricyclic antidepressants can have pronounced anticholinergic and antihistaminic effects, which may impair driving. The more modern antidepressants may have fewer adverse effects. **These considerations need to be taken into account when planning the treatment of a patient who is a professional driver.**
- Anti-psychotic drugs, including the depot preparations, can cause motor or extrapyramidal effects as well as sedation or poor concentration, which may, either alone or in combination, be sufficient to impair driving. Careful clinical assessment is required.
- The epileptogenic potential of psychotropic medication should be considered particularly when patients are professional drivers.
- Benzodiazepines are the most likely psychotropic medication to impair driving performance, particularly the long acting compounds. **Alcohol will potentiate the effects.**
- Doctors have a duty of care to advise their patients of the potential dangers of adverse effects from medication and interactions with other substances, especially alcohol.
- Drivers with psychiatric illnesses are often safer when well and on regular psychotropic medication than when they are ill. Inadequate treatment or irregular compliance may render a driver impaired by both the illness and medication.

Confidentiality
See Part A, Introduction Chapter 1, Section 2.3.1

Chapter 6
Drug and alcohol misuse and dependence

The presence of any of the conditions listed below requires the applicant or licence holder to inform the Driving Licensing Authority unless stated otherwise in the text.

Alcohol Problems	Group 1 — Car, M/Cycle
Alcohol misuse There is no single definition which embraces all the variables in this condition but the following is offered as a guide: *"A state which, because of consumption of alcohol, causes disturbance of behaviour, related disease or other consequences, likely to cause the patient, his/her family or society harm now, or in the future, and which may or may not be associated with dependence".* Reference to ICD10 F10.1 is relevant.	Persistent alcohol misuse, confirmed by medical enquiry and/or by evidence of otherwise unexplained abnormal blood markers, requires cessation from driving until a minimum 6 month period of controlled drinking or abstinence has been attained, with normalisation of blood parameters. Patient to seek advice from medical or other sources during the period off the road. ***Driver must notify Driving Licensing Authority.***
Alcohol dependence *"A cluster of behavioural, cognitive & physiological phenomena that develop after repeated alcohol use & which include a strong desire to take alcohol, difficulties in controlling its use, persistence in its use despite harmful consequences, with evidence of increased tolerance and sometimes a physical withdrawal state."* Indicators may include a history of withdrawal symptoms, of tolerance, of detoxification(s) and/or alcohol related fits. Reference to ICD10 F10.2 – F10.7. inclusive is relevant.	Alcohol dependence, confirmed by medical enquiry, requires cessation from driving until a 6 month period free from alcohol problems has been attained. Abstinence will normally be required, with normalisation of blood parameters, if relevant. ***Driver must notify Driving Licensing Authority.*** **Return To Driving** Will require satisfactory medical assessment from own doctor(s) and may require independent medical examination and blood tests. Consultant support/ referral may be necessary. *See also under "Alcohol Related Seizures".*

Alcohol Problems	Group 1 — Car, M/Cycle
Alcohol related seizures Seizures associated with alcohol are not considered provoked for licensing purposes.	Following a solitary alcohol-related seizure, cessation from driving for a minimum 6 month period from the date of the event. Should however the seizure have occurred on a background of alcohol the standards for such conditions will need to be satisfied before a new application can be considered. Where more than one seizure has occurred, the Epilepsy Regulations will apply (See Appendix to Neurological disorders chapter 2 for full details).Return to driving should only occur after an appropriate period free from persistent alcohol misuse and/or dependence. Independent medical assessment with blood analysis and consultant reports will normally be necessary.
Alcohol related disorders E.g. Hepatic cirrhosis with neuro-psychiatric impairment, psychosis.	Driving should cease until there is satisfactory recovery and is able to satisfy all other relevant medical standards. *Driver must notify Driving Licensing Authority.*

Drug Misues and Dependence Reference to ICD10 F10.1-F10.7 inclusive is relevant	ODL — Car, M/Cycle
Cannabis Amphetamines. (Note: Metamphetamine Overleaf). Ecstasy Ketamine & other psychoactive substances, including LSD and Hallucinogens.	Persistent use of or dependence on these substances, confirmed by medical enquiry, requires cessation from driving until a minimum 6 month period free of such use has been attained. For Ketamine misuse or dependence, 6 months off driving, drug-free, is required. Independent medical assessment and urine screen arranged may be required. *Driver must notify Driving Licensing Authority.*

Drug Misues and Dependence Reference to ICD10 F10.1-F10.7 inclusive is relevant	ODL — Car, M/Cycle
Heroin **Methadone*** **Cocaine** **Metamphetamine** **Cannabis** **Other illicit Substances**	Persistent use of, or dependence on these substances, confirmed by medical enquiry, requires cessation from driving until a minimum 6 month period free of such use has been attained. Independent medical assessment and urine screen may be required. In addition favourable Consultant or Specialist report maybe required on reapplication. * Applicants or drivers who are complying fully and are stable on a supervised oral Methadone substitution programme may continue to drive, subject to favourable assessment and normally, annual medical review. Applicants or drivers on an oral buprenorphine programme may be considered applying the same criteria. There should be no evidence of continuing use of illicit substances. ***Driver must notify Driving Licensing Authority.***
Benzodiazepines The non-prescribed use of these drugs and/or the use of supra-therapeutic dosage, whether in a substance withdrawal/maintenance programme or otherwise, constitutes misuse/dependence for licensing purposes. The prescribed use of these drugs at therapeutic doses (MIMS/BNF), without evidence of impairment, does not amount to misuse/dependence for licensing purposes (although clinically dependence may exist).	Persistent misuse of, or dependence on these substances, confirmed by medical enquiry, requires driving cessation until a minimum 6 month period free of such use has been attained. Independent medical assessment and urine screen may be required. In addition favourable Consultant or Specialist report may be required on reapplication. ***Driver must notify Driving Licensing Authority.***

Multiple substance misuse and/or dependence — including misuse with alcohol — is incompatible with continued driving.

Drug Misues and Dependence Reference to ICD10 F10.1-F10.7 inclusive is relevant	Group 1 Entitlement ODL — Car, M/Cycle
Seizure(s) associated with drug misuse/dependence Seizures associated with drug misuse/dependence are not considered provoked for licensing purposes.	Following a solitary seizure associated with drug misuse or dependence, driving must cease for a minimum 6 month period from the date of the event. Should however, the seizure have occurred on a background of substance misuse or dependence, the standards for such conditions will also need to be satisfied before return to driving. Where more than one seizure has occurred, the Epilepsy Regulations will apply *(See Appendix Neurological disorders chapter 2 for full details).* Medical enquiry will be required before driving to confirm appropriate period free from persistent drug misuse and/or dependence. Independent medical assessment with urine analysis and consultant reports will normally be necessary. ***Driver must notify Driving Licensing Authority.***

NB: A person who has resumed driving following persistent drug misuse or dependence must be advised as part of their after-care that if their condition recurs they should cease driving and notify their Driving Licensing Authority.

Chapter 7
Visual disorders

A licence holder or applicant must meet the standards for visual acuity and fields (assessed by confrontational visual field test in the first instance) as outlined below, and if there is reason to doubt that these are adequate, the applicant or licence holder should undergo a more detailed examination by a specialist (an ophthalmologist, or orthoptist, or other medical practitioner with a special interest in defects of eyesight, or optometrist).
See Appendix to this chapter, Item A, Elements which should be assessed in more detailed assessment.

Registration as 'blind' with the National Council for the Blind in Ireland will normally be regarded as incompatible with holding a driving licence and the driver must cease driving. However, attention will be given to the standards indicated below in deciding on fitness to drive.

Visual Disorders	Group 1 — Car, M/Cycle
Acuity	Must have binocular visual acuity, with corrective lens as necessary, of at least 0.5 decimal (6/12 on a Snellen chart). If the patient has an illness likely to cause progressive loss of visual acuity the ***Driving Licensing Authority must be notified*** and on the advice of a competent medical authority, a 1 or 3 year licence may be appropriate.
Monocular vision **(Includes the use of one eye only for driving)**	**Complete** loss of vision in one eye (ie. if there is any light perception, driver is not considered monocular). Must notify licensing authority but may drive when clinically advised by a competent medical authority that driver has adapted to the disability **and** the prescribed eyesight standard in the remaining eye can be satisfied **and** there is a normal monocular visual field in the remaining eye, *i.e.* there is no area of defect which is caused by pathology. **Driver must notify Driving Licensing Authority if medical advice is to cease driving for 6 months or longer.**

Visual Disorders	Group 1 — Car, M/Cycle
Visual field defects Disorders such as severe bilateral glaucoma, severe bilateral retinopathy, retinitis pigmentosa and other disorders producing significant field defect including partial or complete homonymous hemianopia/ quadrantanopia or complete bitemporal hemianopia.	**Driving must cease unless** confirmed that the horizontal visual field is at least 120 degrees, the extension is at least 50 degrees left and right and 20 degrees up and down. No defects should be present within a radius of the central 20 degrees. If the patient has an illness likely to cause progressive loss of visual field, ***Driving Licensing Authority must be notified*** and on advice by a competent medical authority, a 1 or 3 year licence may be appropriate. *See item B of Appendix at end of this chapter for guidance on more detailed assessment of visual fields.* *See Appendix C for consideration as an exceptional case if not meeting these standards.*
Diplopia	**Cease driving on detection**. Resume driving on confirmation to the licensing authority that the diplopia is controlled by glasses (with or without a prism) or by a patch which the licence holder undertakes to wear while driving. (If patching, note requirements above for monocularity). **Exceptionally** a stable uncorrected diplopia of appropriate duration (for example, 6 months) or more may be compatible with driving if there is support from a competent medical authority indicating satisfactory functional adaptation. For treated decompensated phoria, driving can resume without informing Driving Licensing Authority.
Night blindness	Acuity and field standards must be met. Cases should be considered on an individual basis by an appropriately qualified medical authority.
Colour blindness	Need not notify licensing authority. Driving may continue with no restriction on licence.

See Appendix at end of this chapter.

Appendix 7

A. Elements which should be assessed in more detailed assessment
Visual acuity, field of vision, twilight vision, glare and contrast sensitivity, diplopia and other visual functions that can compromise safe driving: adjudication determined by clinical judgement.

B. Guidance on formal field of vision testing
The minimum field of vision for safe driving is defined as *"A field of at least 120° on the horizontal measured using a target equivalent to the white Goldmann III4e settings. In addition there should be no significant defect in the binocular field which encroaches within 20° of fixation above or below the horizontal meridian".*

This means that homonymous or bitemporal defects, which come close to fixation, whether hemianopic or quadrantanopic, are not normally accepted as safe for driving.

If a visual field assessment is necessary to determine fitness to drive, a number of tests are possible: in the UK and Australia, for example, a binocular Esterman field is recommended. Monocular full field charts may also be requested in specific conditions. Exceptionally, Goldmann perimetry or equivalent , carried out to strict criteria, will be considered. For an Esterman binocular chart to be considered reliable for licensing, the false positive score must be no more than 20%. When assessing monocular charts and Goldmann perimetry or equivalent, fixation accuracy will also be considered.

Defect affecting central area only
Pending the outcome of current research, the following are generally regarded as **acceptable central** loss as measured by the Esterman field method:

- Scattered single missed points.
- A single cluster of up to 3 adjoining points.

The following are generally regarded as **unacceptable (i.e. 'significant')** central loss as measured by the Esterman field method:

- A cluster of 4 or more adjoining points that is either wholly or partly within the central 20 degree area.
- Loss consisting of both a single cluster of 3 adjoining missed points up to and including 20 degrees from fixation, **and any** additional separate missed point(s) within the central 20 degree area.
- **Any** central loss that is an **extension** of a hemianopia or quadrantanopia of size greater than 3 missed points.

Defect affecting the peripheral areas – width assessment
The following will be disregarded when assessing the width of field:

- A cluster of **up to three** adjoining missed points, unattached to any other area of defect, lying on or across the horizontal meridian.
- A vertical defect of only single point width but of any length, unattached to any other area of defect, which touches or cuts through the horizontal meridian.

C. Exceptional cases

Drivers who have previously held full driving entitlement, removed because of a field defect or visual impairment which does not satisfy the standard, may be eligible to be considered as exceptional cases on an individual basis by a competent medical authority, subject to strict criteria.

The defect must have been:

- Present for at least 12 months.
- Caused by an isolated event or a non-progressive condition and
- There must be no other condition or pathology present which is regarded as progressive and likely to be affecting the visual fields.

In order to meet the requirements of European law, the Driving Licensing Authority will, in addition, require:

- Clinical confirmation of full functional adaptation.
- A satisfactory practical driving assessment, carried out by an appropriately qualified driving assessor, must subsequently be completed.

Note: An individual who is monocular cannot be considered under exceptional case criteria where either visual acuity or visual field standards cannot be reached in the remaining eye.

Chapter 8
Renal disorders

Renal Disorders	Group 1 Entitlement ODL — Car, M/Cycle Group 1 — Car, M/Cycle
Chronic Renal Failure CAPD (Continuous ambulatory peritoneal dialysis) Haemodialysis	No restriction on holding a 10 year licence, or if over 60 a licence that expires at age 70 unless subject to severe electrolyte disturbance or significant symptoms, e.g. sudden disabling attacks of dizziness or fainting or impaired psychomotor or cognitive function when driving should cease until the symptoms are controlled. Hemodialysis patients should not travel distances more than 1—2 days driving time from their home without making arrangements for dialysis at another centre. They should not drive for at least 24 hours after missing a dialysis treatment, and resume driving when dialysis resumed and condition stabilized.
All other Renal Disorders	Need not notify licensing authority unless associated with a relevant disability.

Chapter 9
Respiratory and sleep disorders

Respiratory and Sleep Disorders	Group 1 Entitlement ODL — Car, M/Cycle Group 1 — Car, M/Cycle
Sleep Disorder Including Obstructive Sleep Apnoea Syndrome causing sleepiness while driving. **Helpful driver information can be found at www.rsa.ie**	Driving must cease until satisfactory control of symptoms has been attained. *Driver must notify Driving Licensing Authority.*
Respiratory Disorders Including asthma, COPD (Chronic Obstructive Pulmonary Disease, Cough Sycope).	Driving Licensing Authority need not be notified unless attacks are associated with disabling giddiness, fainting or loss of consciousness.
Carcinoma of Lung	Driving Licensing Authority need not be notified unless cerebral secondaries are present. *(See Chapter 2 for Malignant Brain Tumour)*

Chapter 10
Miscellaneous conditions

Miscellaneous Conditions	Group 1 Entitlement ODL — Car, M/Cycle Group 1 — Car, M/Cycle
Deafness (Profound)	Need not notify Driving Licensing Authority.
Brain Tumours	*Please refer to the appropriate section of Chapter 2.*
Lung Cancer	*Please refer to the appropriate section of Chapter 2.*
Other Cancers For all tumours, fitness to drive depends upon: The prospective risk of a seizure: For Group 1 entitlement, Driving Licensing Authority does not need to be notified unless there are cerebral metastases or significant complications of relevance (See subsequent bullet points for guidance).	

AIDS Syndrome	Driving may continue providing medical enquiries confirm no relevant associated disability likely to affect driving. 1 or 3 year licence with medical review. Need not notify Driving Licensing Authority.
HIV Positive	Need not notify Driving Licensing Authority. *See Section 3.5: Multiple Conditions.*
Age (Older Drivers)	Age is no bar to the holding of a licence and physical frailty is not per se a bar to the holding of a licence. Please see the section 3.5 on multiple morbidity, and relevant specific section for relevant diseases which are more common later in life, such as stroke and dementia. *See Chapter 1: Table 4.*
Hypoglycaemia **From any cause other than the treatment of Diabetes**	If suffering episodes of severe hypoglycaemia should **cease driving** while liable to these episodes. Examples would include after bariatric surgery or in association with eating disorders.

Impairment of cognitive function

E.g. Post Stroke, Post Head Injury, Early Dementia

There is no single or simple marker for assessment of impaired cognitive function, although the ability to manage day to day living satisfactorily is a possible yardstick of cognitive competence. See Section on dementia. Features liable to cause the patient to be a source of danger: poor judgement, visual inattention, easy distractibility, and difficulty performing multiple tasks. In addition, it is important that reaction time, memory, concentration and confidence are adequate and do not show impairment likely to affect driving performance.

Disabled drivers

CARS (Group 1)

Driving is possible in both static and progressive or relapsing disorders but vehicle modification may be needed.

1. Permanent Limb Disabilities/Spinal Disabilities:
   E.g. Amputation, Hemiplegia/Cerebral Palsy, Ankylosing Spondylitis, Severe Arthritis, especially with pain.
2. Chronic Neurological Disorders:
   E.g. Multiple Sclerosis, Parkinson's Disease, Motor Neurone Disease, Peripheral Neuropathy.

Sophisticated vehicle adaptation is now possible and varies from automatic transmission to joy sticks and infra red controls for people with severe disabilities.

The Driving Licensing Authority requires the driver to notify them of which, if any, of the controls required to be modified. The driving licence will then be coded to reflect the modifications.

The National Programme Office for Traffic Medicine is reviewing the current situation of assessments of driving and adaptation of vehicles in Ireland.

Patient Advisory Form

National Driver Licence Service
An tSeirbhís Náisiúnta um Cheadúnais Tiomána

Dear _____

Following your assessment today, _____ /_____ /_____, I am advising you that you need to contact your Driving Licensing Authority to let them know that you have a condition _____ which may impact on your fitness to drive:
I am also advising that:

_____

_____

The philosophy of the NDLS is an enabling one, aiming to maximise mobility of drivers to the greatest extent possible. However, it is important to ensure that an appropriate balance is found between mobility and safety and the NDLS is likely to request you to provide a medical report clarifying your medical fitness to drive once you have notified them. The conditions that require reporting to your Driving Licensing Authority are outlined in the declaration made by you when you applied for, or renewed, your driving licence (see below) and also in the official RSA guidelines for medical fitness to drive, *Sláinte agus Tiomáint*.
You should also clarify with your insurer as to whether or not this condition needs to be reported to them as well. A record of this notification will be held in your medical file here.

Yours sincerely

_____

Medical conditions requiring declaration at application for and renewal of driving licence

1. Diabetes treated by insulin and or sulphonylurea tablets (doctor to advise whether patient is on these or not) no need to tell us if managed by other tablets and or diet
2. Epilepsy
3. Stroke or TIAs with any associated symptoms lasting longer than one month
4. Fits or blackouts
5. Any type of brain surgery, brain abscess or severe head injury involving in-patient treatment or brain tumour or spinal injury or spinal tumour
6. An implanted cardiac pacemaker
7. An implanted cardiac defibrillator (ICD)
8. Repeated attacks of sudden disabling dizziness
9. Any other chronic neurological condition such as multiple sclerosis, motor neurone disease, Parkinson disease and Huntington's disease
10. A serious problem with memory or periods of confusion.
11. Persistent alcohol misuse or dependency
12. Persistent drug misuse or dependency
13. Serious psychiatric illness or mental health problems
15. Sleep Apnoea Syndrome
16. Narcolepsy
17. Any condition affecting the drivers peripheral vision
18. Total loss of sight in one eye
19. Any condition affecting both eyes, or the remaining eye if driver only has one eye (Not including colour blindness or short or long sight)
20. A serious hearing deficiency
21. Any persisting problem with arm(s) or leg(s) which needs driving to be restricted to certain types of vehicle or those with adapted controls
22. Is the driver's vehicle adapted because of a physical disability to enable you to drive
23. Severe learning disability

The above list is not exhaustive

Please note if you are the holder of an EU licence from a country other than Ireland, or hold a licence from a recognised country for licence exchange purposes, you should contact the licensing authority to arrange for a licence exchange and medical report.

FORM D501
Driving Licence Medical Report Form

National Driver Licence Service
An tSeirbhís Náisiúnta um Cheadúnais Tiomána

To drive you must meet certain medical fitness standards. For this purpose vehicles are classed as Group 1 and Group 2. If you are applying for a vehicle in both Groups *(See note 2 overleaf)* please tick Group 1 and 2 on this form. Where an applicant meets the medical criteria for Group 2 vehicles, they will automatically meet the medical criteria for Group 1 vehicles.

Family Name/Surname

First Name(s)

Current Address

Date of Birth

D D M M Y Y Y Y

(Please ✓ the appropriate box)

I wish to undergo a medical examination on foot of my application for a learner permit/driving licence as required by the Road Traffic Acts *(See note 1 overleaf).* My application is for a driving licence/learner permit as a driver of a **Group 1** ☐ or **Group 2** ☐ vehicle. *(See note 2 overleaf).*

If you have in the past suffered or currently suffer from epilepsy, Please indicate the date of your last seizure.

D D M M Y Y Y Y

Signature: .....

(To be signed in the presence of your Medical Practitioner)

D D M M Y Y Y Y

This form must be submitted to a Licensing Authority with an application for a driving licence/learner permit within one month of its completion by a Medical Practitioner.

FOR REFERENCE ONLY

Group 1 Vehicles and Licence Category	Group 2 Vehicles and Licence Category
AM	C
A	C1
A1	CE
A2	C1E
B	D
BE	D1
W	DE
	D1E

FORM D501
Driving Licence Medical Report Form

National Driver Licence Service
An tSeirbhís Náisiúnta um Cheadúnais Tiomána

To be completed by a Medical Practitioner whose name is on the General Register of Medical Practitioners in Ireland.

I, the undersigned registered medical practitioner report that:

- The applicant has signed the declaration in my presence
- I have examined the applicant by reference to the medical fitness standards required by the Road Traffic Acts and in my opinion, the applicant. **(Please ✓ the appropriate box(es) below):**

Meets the prescribed medical fitness standard set out for vehicles in Group 1. **Yes** ☐ **No** ☐

Meets the prescribed medical fitness standard set out for vehicles in Group 2. **Yes** ☐ **No** ☐

Is fit to drive for a period of:

Group 1 Vehicles and Licence Category ☐ **1 year** ☐ **3 years** ☐ **10 years**

Group 2 Vehicles and Licence Category ☐ **1 year** ☐ **3 years** ☐ **5 years** *(See note 3 below with maximum duration of a licence for Group 2 drivers).*

The applicant has a physical disability requiring adaptations be made to a vehicle to meet the requirements of their disability. **Yes** ☐ **No** ☐

The applicant has had a limb prosthesis/orthesis. **Yes** ☐ **No** ☐

The applicant needs to wear corrective lenses while driving. **Yes** ☐ **No** ☐

Is medically unfit to drive. **Yes** ☐ **No** ☐

My opinion as to (INSERT APPLICANTS NAME IN BLOCK CAPITALS) _____
medical fitness is that he/she is fit to drive vehicles of the Group indicated from any date up to four calendar months from today's date.

Signature: .....

Date of Examination:

D	D	M	M	Y	Y	Y	Y

Stamp of Medical Practitioner whose name is on the General Register of Medical Practitioners in Ireland

Medical Practitioner's Telephone Number

EXPLANATORY NOTES

1. *To complete your medical examination you must go to your doctor, have your medical examination and sign this form in the presence of the doctor. When the form is completed by your doctor you must send it to a licensing authority with your learner permit/driving licence application* ***within one month of the date of the medical examination****.*
2. *For medical fitness standards vehicles are classed as being in Group 1 or Group 2. The Table overleaf describes which vehicles are in Group 1 and in Group 2. Further information on each licence category can be found on the licence application form. A higher standard of medical fitness is required of those drivers who hold licences for Group 2 vehicles.* ***Please note that Group standards apply to all categories of vehicles within that Group. Individual categories should not be marked on the table overleaf.***
3. *A person driving a Group 2 category vehicle must be certified as medically fit every five years.*
4. *Applicants over 70 years of age can only be certified as being fit to drive for either one or three years.*

FORM D502
Driving Licence Eyesight Report Form

National Driver Licence Service
An tSeirbhís Náisiúnta um Cheadúnais Tiomána

To drive you must meet certain medical fitness standards. For this purpose vehicles are classed as Group 1 and Group 2. If you are applying for a vehicle in both Groups *(See note 2 overleaf)* please tick Group 1 and 2 on this form. Where an applicant meets the medical criteria for Group 2 vehicles, they will automatically meet the medical criteria for Group 1 vehicles.

Family Name/Surname

First Name(s)

Current Address

Date of Birth

D D M M Y Y Y Y

(Please ✓ the appropriate box)
I wish to undergo an eyesight test on foot of my application for a learner permit/driving licence as required by the Road Traffic Acts. My application is for a driving licence/learner permit as a driver of a: **Group 1** ☐ or **Group 2** ☐ vehicle. *(See note 1 overleaf).*

Signature: .....

D D M M Y Y Y Y

(To be signed in the presence of your Medical Practitioner/Optometrist)

This form must be submitted to a Licensing Authority with an application for a driving licence/learner permit within one month of its completion by a Medical Practitioner or Optometrist.

FORM D502
Driving Licence Eyesight Report Form

National Driver Licence Service
An tSeirbhís Náisiúnta um Cheadúnais Tiomána

To be completed by a Medical Practitioner or Optometrist whose name is in the General Register of Medical Practitioners or in the Register of Optometrists in Ireland.

I, the undersigned registered medical practitioner/registered optometrist (delete as appropriate), report that:

- The applicant has signed the declaration in my presence
- I have examined the eyesight of the applicant by reference to the prescribed standard and in my opinion, the applicant **(Please ✓ the appropriate box(es) below):**

Meets the prescribed eyesight standard set our for vehicles in the Driver Fitness Medical Guidelines for Group 1. **Yes** ☐ **No** ☐

Meets the prescribed eyesight standard set our for vehicles in the Driver Fitness Medical Guidelines for Group 2 **Yes** ☐ **No** ☐
(See notes 3 and 4 overleaf).

Needs to wear corrective lenses to meet the standard set out below. **Yes** ☐ **No** ☐

Should be considered for the duration of:

Group 1 Vehicles and Licence Category ☐ **1 year** ☐ **3 years** or ☐ **10 years**

Group 2 Vehicles and Licence Category ☐ **1 year** ☐ **3 years** or ☐ **5 years** *(Maximum duration of a licence for group 2 driver)*

Fails to meet the standard set out below **Yes** ☐ **No** ☐ *(See notes 3 and 4 overleaf).*

My opinion as to (INSERT APPLICANTS NAME IN BLOCK CAPITALS) _____
eyesight is that the applicant is fit to drive vehicles of the Group indicated from any date up to four calendar months from today's date.

Signature: .....

Date of Examination:

D	D	M	M	Y	Y	Y	Y

Stamp of Medical Practitioner or Optometrist whose name is on the register in Ireland

Medical Practitioner or Optometrist Telephone Number

FORM D502
Driving Licence Eyesight Report Form

NDLS
National Driver Licence Service
An tSeirbhís Náisiúnta um Cheadúnais Tiomána

EXPLANATORY NOTES

1. For medical fitness standards vehicles are classed as being in Group 1 or Group 2. The Table below describes which vehicles are in Group 1 and in Group 2. Further information on each licence category can be found on the licence application form.

Group 1 Vehicles and Licence Category	Group 2 Vehicles and Licence Category
AM 	C 
A 	C1 
A1 	CE 
A2 	C1E 
B 	D 
BE 	D1 
W 	DE 
	D1E 

2. The following is general guidance for the medical or optical professional carrying out the eyesight test. This advice will be superseded by guidance set out in the *Sláinte agus Tiomáint* document which represents the most up to date information on medical fitness standards for drivers in Ireland. All applicants for a driving licence shall undergo a visual acuity and confrontation visual field examination to ensure that they have adequate eyesight for driving power-driven vehicles. Where there is reason to doubt that the applicant's vision is adequate, he/she shall be examined by a specialist (an ophthalmologist, or other medical practitioner with a special interest in defects of eyesight or optometrist). At this examination attention shall be paid, in particular, to the following: visual acuity, field of vision, twilight vision, glare and contrast sensitivity, diplopia and other visual functions that can compromise safe driving.

3. Group 1 Vehicles, Guidance for Medical Professionals the following applies:

A. licensing may be considered in exceptional cases where the visual field standard or visual acuity 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. The applicant should also be subject to a positive practical test.

B. The person shall have a binocular visual acuity, with corrective lenses if necessary, of at least 0,5 (6/12) when using both eyes together. 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. No defects should be present within a radius of the central 20 degrees.

C. When a progressive eye disease is detected or declared, driving licences may be issued or renewed subject to the applicant undergoing regular examination by a competent medical authority.

D. A person who has total functional loss of vision in one eye or who uses only one eye must have a visual acuity of at least 0,5 (6/12), with corrective lenses if necessary. The eyesight examining doctor or optometrist must certify that this condition of monocular vision has existed for a sufficiently long time to allow adaptation and that the field of vision in this eye meets the requirement laid down in paragraph (B).

E. After any recently developed diplopia or after the loss of vision in one eye, there should be an appropriate adaptation period (of at least six months), during which driving is not allowed. After this period, driving is only allowed following a favourable opinion from the eyesight examining doctor or optometrist.

4. Group 2 Vehicles, Guidance for Medical Professional the following applies:

A. The person shall have a visual acuity, with corrective lenses if necessary, of at least 0,8 (6/7.5)in the better eye and at least 0,1 (6/60) in the worse eye. If corrective lenses are used to attain the values of 0,8 (6/7.5) and 0,1 (6/60), the minimum acuity must be achieved either by correction by means of glasses with a power not exceeding plus eight dioptres, or with the aid of contact lenses. The correction must be well tolerated. 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.

B. A learner permit/driving licence should not be issued to a person who suffers from impaired contrast sensitivity or from diplopia.

C. After a substantial loss of vision in one eye, there should be an appropriate adaptation period (of at least six months) during which the person is not permitted to drive. After this period, driving is only permitted following a favourable opinion from the eyesight examining doctor or optometrist.

5. More information about medical fitness standards is available on the www.rsa.ie website under the driver licensing tab.

Notes

Notes

Working To Save Lives

February 2013

Údarás Um Shábháilteacht Ar Bhóithre
Road Safety Authority

Páirc Ghnó Ghleann na Muaidhe, Cnoc an tSabhaircín, Bóthar Bhaile Átha Cliath, Béal an Átha, Co. Mhaigh Eo.
Moy Valley Business Park, Primrose Hill, Dublin Road, Ballina, Co. Mayo.
locall: 1890 50 60 80 fax: (096) 25 252 email: info@rsa.ie website: www.rsa.ie