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Personal columns

Mental disorder and professional driving

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Recently several cases have drawn our attention to problems associated with professional driving and mental disorder. All drivers are responsible for informing the licensing authority of any disability likely to cause them to drive hazardously. *Medical Aspects of Fitness to Drive* (Raffle (ed.), 1985) gives detailed guidelines to help doctors advise their patients. Those relating to ordinary licence holders appear intuitively correct and most psychiatrists would give similar advice without reading them. However, the guidelines for vocational drivers, especially holders of Public Service Vehicle (PSV) and Heavy Goods Vehicle (HGV) licenses, are more stringent because of the serious consequences when accidents occur. The guidelines follow those of the Royal College of Psychiatrists, revised in 1983.

(1) Subnormality or psychopathy should lead to a complete bar.

(2) An acute psychosis, schizophrenia, manic-depressive or other depressive psychosis, alcoholism or drug addiction should lead to a five year bar (ten years in the case of hypomania).

(3) Mental disorders requiring psychotropic medication should lead to a bar until the patient has been symptom-free and off medication for six months.

(4) Any driver off sick for more than 28 days should be required to undergo a medical examination.

(5) Organic psychosyndromes should lead to an absolute bar.

Although these guidelines are not legally binding medical advisers at the Driver and Vehicle Licensing Centre (DVLC) draw heavily on them. If they were adhered to strictly, most licence holders with a psychiatric disorder would need to inform the DVLC of their condition. Although responsibility for contacting the authority lies firmly with the licence holder, he or she will only do so if personally aware of the significance of the medical condition. This, by implication, places some responsibility on the patient's physician. It may also lead to confusion when a general practitioner is prescribing for a patient on the advice of a specialist. In our experience, employers are not always aware of a driver's psychiatric condition and even if they are informed, they may not follow the guidelines. Medical advisers at the DVLC appear able to show some flexibility in their interpretation of the guidelines but they are not always involved.

The evidence for any relationship between mental disorder and road traffic accidents falls into three categories: the anecdotal, epidemiological, and experimental. Anecdotal evidence may be the most influential. Commonsense suggests that manic drivers may be over confident, that paranoid drivers may drive badly because of their delusions, and that neurotic drivers may present a hazard because of anxiety or indecisiveness. Although it is easy to identify individual cases supporting these beliefs, many ordinary people drive equally badly.

Silverstone (1988) has reviewed the epidemiological evidence. He concluded rates are increased two to fourfold in the elderly due to dizziness, faints, poor memory, or impaired concentration; there is no evidence of increased accident rates in schizophrenia or mania; there is an association between depression and increased single vehicle fatalities, possibly suicides; patients suffering from psychoneuroses are involved in 50% more accidents; benzodiazepine users have more accidents; personality disordered individuals, particularly if they have aggressive and irresponsible traits, have a greatly increased rate of accidents, up to six times that of the general driving population; the links between excess alcohol and accidents are, of course, well known, as is the high rate of alcoholism in persistent drunk drivers.

However, in a review of drug use and its links with road traffic accidents, Sabey (1988) concluded that there was limited evidence of any such association as control groups of drivers took as many drugs as accident-involved drivers. There has been much experimental work on the effects of drugs on driving performance. Driving is a complex task involving decision making, risk assessment, memory, short-term information handling and motor skills. There is disagreement on whether real driving, simulated

driving, or batteries of tests provide the most valid information. O'Hanlon (1988) argued that only real driving performance can measure the effects of drugs, whereas Hindmarch (1988) suggested that the small but significant impairments produced by drugs will not show on overlearned tasks such as driving and that batteries of laboratory tests are necessary. Another difficulty in assessing the clinical importance of drug induced psychomotor impairments is that tests are usually performed on subjects who have taken the drug for only a few days.

Doctors should be familiar with the guidelines contained in *Medical Aspects of Fitness to Drive* but many will be unaware of the particularly stringent guidelines applied to vocational drivers. This will become even more important if, as in Canada, patients, or their victims, begin to sue doctors for failure to advise patients on their fitness to drive (Coopersmith, 1989).

In practice the restrictions will often mean the end of a driving career and could make some people reluctant to seek treatment which might lead to increased risks. There is a special difficulty if a patient will not notify the authority of a disability. Doctors should then follow the advice of the General Medical Council, so that confidential notification may be made to the medical adviser at DVLC without the patient's consent if the doctor feels it is in the public interest.

We wonder if the regulations are excessively restrictive given the limited empirical evidence of increased accident rates in people with psychiatric disorders and believe that informed debate on this issue is required.

References

COOPERSMITH, H. G. (1989) Determining medical fitness to drive: physicians' responsibilities in Canada. *Journal of Canadian Medical Association*, **140**, 375–378

HINDMARCH, L. (1988) A pharmacological profile of fluoxetine and other antidepressants on aspects of skilled performance and car handling ability. *British Journal of Psychiatry*, **153**, (suppl. 3), 99–104.

O'HANLON, J. F. (1988) Are actual driving tests necessary for evaluating drug safety? *International Clinical Psychopharmacology*, **3**, (suppl. 1) 81–85.

RAFFLE, A. (ed) (1985) *Medical Aspects of Fitness to Drive*. London: The Medical Commission on Accident Prevention.

SABEY, B. (1988) The drugs (medicines) driving situation in the UK. *International Clinical Psychopharmacology*, **3**, (suppl. 1) 1–12.

SILVERSTONE, T. (1988) The influence of psychiatric disease and its treatment on driving performance. *International Clinical Psychopharmacology*, **3**, (suppl. 1), 59–66.

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The search for 'the medical model'

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This article attempts to describe a senior manager's search for 'the medical model' in psychiatry in two large provincial teaching units. I was brought to a number of realisations and moved to write this article by watching the film 'Awakenings'*. This portrays with great sympathy and effectiveness the angst and real pain suffered by a neurologist watching his patients in relapse and being powerless to help them. This was reminiscent of many of my consultants describing their own feelings.

*This film was reviewed by Anthony David, *Psychiatric Bulletin*, 1991, **15**, 522–523.

Policymakers – white, male, 40s graduates from the '60s – know what is wrong in psychiatry. They confidently assert the medical model, (which, while never being defined, really meant organic treatment of organic symptoms with an organic cause) the psychiatrists, and institutionalisation. Likewise having done most of my reading and thinking in the 1960s, I was aware that all of the problems of mental illness centred around the existence of 'the medical model' and recalcitrant and backward psychiatrists. Having worked briefly in the field of learning disabilities and had some of these suspicions confirmed, I went to work in mental health. I was only too ready to hear