

National Safety Code

Standard 6: Determining Driver Fitness in Canada

Part 1: A Model for the Administration of Driver
Fitness Programs

Part 2: CCMTA Medical Standards for Drivers

2026 Update

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Foreword

Driving a motor vehicle in Canada is a privilege that may be accorded to an individual by the driver licensing authority of the province or territory in which they live. In order to exercise a privilege such as driving, the individual must meet the specified criteria including the demonstration of an acceptable level of competence. To qualify for a driver's licence an individual must, among other requirements, be able to demonstrate medical fitness to drive.

Part 1 of this document explains how Canadian jurisdictions perform their role in assessing the medical fitness of drivers while Part 2 contains the *Canadian Council of Motor Transport Administrators (CCMTA) Medical Standards for Drivers*.

This document is the result of a lengthy and intensive process, begun in 2006 and results in the first publication in 2012 that reflects CCMTA's commitment to:

- base its medical standards on the best evidence available,
- focus on functional ability to drive rather than exclusively on medical diagnoses, and to
- respond to case law establishing that Canadian licensing authorities must assess individually each driver's fitness to drive.

These guidelines and standards reflect Canadian jurisdictions' continuing commitment to public safety while allowing drivers to drive as long as they can demonstrate safe driving practices.

Acknowledgements and Thanks

The production of this document was a result of a collaboration of representatives of all of the provinces and territories and many individuals from these jurisdictions with various expertise contributed to the final product.

However, CCMTA would also like to specifically thank the province of British Columbia which provided the model for driver fitness, the scientific framework upon which these standards are based.

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BACKGROUND

Chapter I Introduction

I.1 Objective

Many jurisdictions throughout the world publish their medical standards for drivers. For some, their publication is a simple compendium of the standards with little or no explanations. Others provide detailed guidelines on the interpretation of the standards.

The working group that produced this document were unable to identify any jurisdictional publications that examine the procedures used by the driver licensing authority to apply the standards. Consequently, Part 1 of this document is a model for and applied by Canadian driver-licensing authorities in the determination of fitness to drive. Application of the guidelines contained in Part 1 will facilitate a consistent approach to driver fitness decision-making by provincial and territorial government driver licensing authorities across Canada.

Part 2 of this document contains the medical standards themselves as well as the supporting material clarifying the reasons for the standard including background material on the medical conditions and their effects upon driving.

I.2 How this document is organized

This document consists of 4 sections:

Background

Provides the context for the standards outlined in Parts 1 and 2.

Part 1: A Model for the Administration of Driver Fitness Programs.

Provides guidelines and a process model for driver-licensing authorities to follow during the driver fitness determination process.

Part 2: CCMTA Medical Standards for Drivers.

Contains the standards for the different medical conditions that may influence driving fitness and provincial/territorial contact information.

Appendices

- *Appendix 1: Canadian Driver Licence Classes*, describes the vehicles that may be driven by commercial and non-commercial drivers
- *Appendix 2: Reciprocity Agreement between Canada and the United States* contains information on the letters between Canada and the US that outline the driver fitness expectations for Canadian commercial vehicle drivers that drive in the U.S.
- *Appendix 3: Provincial/Territorial Contact Information*

Chapter II The authority for the CCMTA standards

II.1 Canadian Council of Motor Transport Administrators

The Canadian Council of Motor Transport Administrators (CCMTA) coordinates all matters dealing with the administration, regulation and control of motor vehicle transportation and highway safety. Membership includes representation from provincial and territorial governments as well as the federal government of Canada.

CCMTA supports its members' vision to have the safest and most efficient movement of people and goods by road in the world. It is the custodian of the National Safety Code, as reflected in its mission.

Through a collective consultative process, CCMTA makes decisions on administration and operational matters dealing with licensing, registration and control of motor vehicle transportation and highway safety.

CCMTA's 14 members are elected from all provincial/territorial governments as well as the federal government. CCMTA is accountable to:

- the Council of Deputy Ministers and Ministers responsible for Transportation and Highway Safety for providing advice and making recommendations on matters relating to transportation and highway safety
- the provinces, territories and the federal government, for promoting a better understanding and cooperation in all matters related to transportation and highway safety among each other, as well as other organizations where there exists a mutual interest
- its stakeholders, for maintaining an ongoing dialogue and consultation to ensure CCMTA is responsive and informative

CCMTA maintains a relationship with stakeholders from the private sector and other government departments through its Associate program. These individuals provide expertise and opinions in the development of strategies and programs.

CCMTA's Vision is to have the safest and most efficient movement of people and goods by road in the world.

II.2 Mandate of the CCMTA Driver Fitness Overview Group (DFOG)

The Driver Fitness Overview Group reports to the *CCMTA Program Committee on Drivers and Vehicles*. Members are a mix of various types of expertise on driver fitness and consist of administrators and health care professionals representing the licensing authorities.

The mandate of the CCMTA DFOG is to derive a set of driver fitness policies for jurisdictional use that incorporate the best ideas and principles included in the literature and to maintain its currency through periodic review. ***Balancing road safety and mobility needs of Canadians through collaborative development and application of best-evidence driver medical fitness standards and operational processes.***

Specific responsibilities include:

- Recommending uniform medical standards to be used by administrators in assessing medical fitness to operate a motor vehicle
- Coordinating and communicating research that informs the maintenance of the CCMTA guide medical standards
- Sharing operational information, processes, and efficiencies, as well as research and best practice
- Developing strategies for all driver medical fitness assessments using a driver fitness model based on a functional approach to determine the impact on the functions of driving
- Coordinating the work of any specific sub-groups
- Maintaining and managing the CCMTA Medical Standards document
- Act as liaison on behalf of CCMTA with other organizations (e.g.: Canadian Medical Association, U.S. Federal Highway Administration (FMCSA), medical specialty societies). Also liaise with all CCMTA standing committees. Representatives from these committees and organizations may be invited to participate in the proceedings of the group
- Act as a clearing house for all activities under its purview
- Identifying areas of concern and direct activities accordingly

II.3 The relationship between individual Canadian jurisdictions' driver fitness policies and the CCMTA standards

All Canadian provinces and territories have the authority to establish their own driver fitness policies and procedures. All have a medical review board or unit acting in an advisory capacity to the jurisdiction's licensing body on medical matters that may affect a person's fitness to drive. However, in order to support a consistent approach to driver fitness across the country, the provinces and territories have agreed to publish the CCMTA Medical Standards for Drivers.

In 1985, medical standards for drivers were included as part of the National Safety Code (NSC) initiative undertaken to achieve uniformity among the provinces and territories on many aspects relating to the administration of drivers and vehicles. The rationale to achieve uniformity is that licence transfers upon a change of province of residence should not be complicated by divergent medical requirements.

The classification of driver licences adopted by the provinces and territories as part of the NSC is shown in Appendix 1 and is used by all the Canadian jurisdictions except Ontario.

A Medical Advisory Committee (MAC), comprised of physicians appointed by each jurisdiction, was created to identify and reconcile interprovincial medical standard variances and produce a harmonized standard. The basis for developing the harmonized medical standards was primarily publications from the Canadian Medical Association (CMA) and other medical speciality associations.

In 2000, CCMTA created a Driver Fitness Project Group to carry out a standards review that focused on risk, compensation, accommodation, functional focus and how to apply each medical standard. This approach reflected recent trends relating to evidence-based medicine rather than consensual standards in determining an individual's fitness to drive.

The Driver Fitness Overview Group in 2008 was given a mandate to:

- (i) consolidate the work of the MAC and Driver Fitness Project Group to avoid duplicate work, duplicate reporting and record keeping and to house all medical-related issues under the same umbrella, and
- (ii) produce one central CCMTA medical document.

In 2011 the Driver Fitness Overview Group developed new driver fitness standards in conjunction with subject-matter experts including researchers, general practitioners, medical specialists and administrators from Canadian driver licensing authorities. The standards are intended as a guide in establishing basic medical qualifications to drive for both commercial and non-commercial drivers and are intended for use by both physicians and driver licensing authorities.

Although no jurisdiction in Canada is legally required to adopt the CCMTA standards, the majority have been adopted by the driver licensing authorities. This achieves a uniformity of standards across Canada which supports both road safety and inter-provincial/territorial harmonization.

All medical standards, and subsequent changes, contained in Part 2 of this document are approved by all the jurisdictions through a balloting process that requires a two thirds majority for approval.

II.4 The relationship between Canadian jurisdictions' driver fitness standards for commercial drivers, the CCMTA standards and the North American Free Trade Agreement

Under the North American Free Trade Agreement (NAFTA), on March 30, 1999, the United States and Canada agreed that the medical provisions for drivers of commercial motor vehicles (CMVs) of U.S. Federal Motor Carrier Safety Regulations (FMCSRs) and the Canadian National Safety Code (NSC) are equivalent (see Appendix 2).

Three exceptions for Canadian drivers were specified by the United States authorities in this reciprocity agreement: those who are (i) insulin-treated diabetics, (ii) hearing impaired at a defined level, or (iii) have a history of epilepsy are not permitted to operate CMVs in the United States although such individuals are allowed to drive commercial vehicles in Canada.

Also, drivers from either country operating under a medical waiver or who are operating under medical grandfather rights are prohibited from operating in the other country.

Because the reciprocity agreement between the United States and Canada identifies the CCMTA standards as the standard for commercial drivers, this means that regardless of individual provincial or territorial standards, **drivers of CMVs must conform to the CCMTA standards if they wish to drive a CMV in the United States.**

Commencing in January 2012, both countries agreed to adopt a unique identifier code to be displayed on the licence and the driving record to identify a commercial driver who is not qualified to operate a CMV in the other country.

In Canada, the identifier code is “W”, and defined as: “restricted commercial class – Canada only”. In the United States, the identifier code “V” will indicate the U.S. driver is only allowed to drive in the U.S. and is not medically qualified to drive in Canada.

On September 24, 2019, both Canada and the United States agreed to remove the Code W identifier for Canadian drivers with insulin-treated diabetes which is well controlled. These commercial motor vehicle drivers can now drive in Canada and the United States.

Chapter III Roles and responsibilities in driver fitness

All Canadian jurisdictions work in partnership with physicians, health care professionals and other agencies to implement and administer driver fitness programs. The following paragraphs illustrate the roles and responsibilities of key participants in assessing and determining driver fitness.

III.1 Government driver-licensing authorities

On a day-to-day basis, government driver-licensing authorities make the final driver fitness decision as to whether a driver is fit to drive.

III.2 Health professionals

Health professionals play a key role in identifying and assessing drivers who may be unfit to drive. In some jurisdictions they have a legal duty (mandatory reporting) to report certain medical conditions. Even in jurisdictions without mandatory reporting by physicians, ethical guidelines may describe situations in which the physician is required to submit a report to the driver-licensing authority.

Health professionals also conduct assessments and provide information to the driver licensing authority regarding a driver's health and extent of impairment. Sometimes health professionals are asked to comment directly on driving ability.

Medical specialists may be called upon to provide written or oral opinions when a driver asks for a review of the driver fitness decision.

III.3 Allied health professionals

Other allied health professionals such as occupational therapists, driver rehabilitation therapists and physiotherapists may be asked to conduct assessments of drivers and comment on the driver's functional ability to drive. In some jurisdictions, driver licensing authorities may accept reports initiated by allied health professionals because of driver fitness concerns.

Chapter IV A changing approach to determining driver fitness

Before 2012 the CCMTA medical standards were based on the diagnostic model. That is, the standards were based primarily on the medical condition and the presumed group characteristics of people with that condition rather than on how the medical condition affected the functions necessary for driving on an individual basis. In terms of an evidentiary basis, the standards reflected the consensus opinion of practicing medical specialists.

Three developments have had a significant effect on the procedure for the administration of driver fitness programs and the medical condition guidelines:

1. A Supreme Court of Canada decision established the requirement to individually assess drivers. The '*Grismer*'¹ case held that each driver must be assessed according to the driver's own personal abilities rather than presumed group characteristics.
2. Nationally and internationally, driver licensing authorities are adopting a functional approach to driver fitness. This means assessing the effect of a medical condition on the physical, cognitive and sensory functions necessary for driving.
3. CCMTA has increased its emphasis on using research evidence, where it exists, as the basis of its driver fitness standards. Each medical condition in Part 2 is included because the best available evidence shows that the medical condition causes impairment of one or more of the functions necessary for driving or has been associated with an elevated risk of crash or impaired driving performance.

The model for this work was drawn from British Columbia's approach to medical conditions and fitness to drive which in turn was based on an integrated review by Dr. B. Dobbs who was contracted by British Columbia.

The guiding principles articulated on the following pages reflect the CCMTA's changing approach to driver fitness and are the foundation of the new standards in Part 2.

Chapter V Guiding principles

The assessment of driver fitness is guided by four principles. By following these principles, Canadian driver licensing authorities will ensure that drivers are given the maximum licensing privilege possible taking into account their medical condition, its effect on the functions necessary for driving, and the driver's ability to compensate for the condition. These principles are the foundation of the *Administration of Driver Fitness Programs* in Part 1 of this document.

V.1 Principle 1 - Risk management

V.1.1 Principle

Driver licensing authorities will administer their driver fitness programs using a risk management approach.

¹ British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights), [1999] 3 S.C.R. 868

V.1.2 Discussion

Risk is often defined as the likelihood of an uncertain event occurring multiplied by the consequences if the event were to take place. This means that a highly likely event with serious consequences is a greater risk than an unlikely event with minor consequences. Risk management is the process of identifying risks and taking action to minimize either the likelihood or the consequences of an event.

Unfortunately, there is no reliable method of calculating risk as it relates to fitness to drive. The effects of a medical condition may be specific to an individual and the ability to compensate for the medical condition may also vary by individual. As well, because the driving environment is complex and continuously changing, it is difficult to determine exactly what level of impairment means a person is not fit to drive. Because of these limitations, driver licensing authorities cannot precisely calculate the risk presented by a driver with a particular medical condition.

Despite the fact that this risk cannot be precisely calculated, driver licensing authorities can still use a risk management approach when conducting activities associated with their driver fitness programs. In *Grismer*, the Supreme Court of Canada indicated that people with some level of functional impairment may have a driver's licence because society can tolerate a degree of risk in order to permit a wide range of people to drive.

V.2 Principle 2 - Functional approach

V.2.1 Principle

Driver fitness determinations will no longer be based solely on diagnosis but primarily on functional ability to drive.

V.2.2 Discussion

Although there are some exceptions to this general principle, a functional approach to determining driver fitness means that when making driver fitness determinations, the focus is on the effect that a medical condition has on the functions necessary for driving rather than making a decision based solely on the diagnosis. This is because many medical conditions may result in a wide range of impairment – from mild to severe – and drivers may vary in their own ability to compensate for the impairment.

V.3 Principle 3 - Individual assessment

V.3.1 Principle

Driver fitness determinations will be based on the individual driver's characteristics and abilities rather than the presumed group characteristics and abilities of people with that medical condition.

V.3.2 Discussion

The *Grismer* decision held that each driver must be assessed according to the driver's own personal abilities rather than presumed group characteristics.

However, the driver fitness standards outlined in Part 2 are based on presumed group characteristics of individuals with a given medical condition. However, consistent with the decision in *Grismer*, driver licensing authorities must make driver fitness determinations on an individual basis. This means that the standards are the starting point for decision-making, but they may not apply to every individual. This takes into account that in some situations, individuals who would otherwise not be fit to drive have learned strategies, or utilize devices, to compensate for their functional impairment. For example:

- a driver with limited peripheral vision may use the strategy of turning their head (scanning) to the left and right to ensure that they cover the full field of view, or
- a driver who is unable to use their lower limbs may have their vehicle modified for hand controls.

Conversely, an individual who on the face of the standard would be fit to drive may be found unfit. For example:

- a driver with a visual defect may lack insight into the effects that their medical condition has on their driving and therefore cannot compensate properly for this impairment. Because of their lack of insight, this driver would not be fit to drive.

V.4 Principle 4 – Reviewing and considering the best information available

V.4.1 Principle

Driver licensing authorities will review and consider the best information available when making driver fitness determinations.

V.4.2 Discussion

For each driver, driver licensing authorities will gather the available information they require in order to determine fitness. Depending upon the nature and the degree of the functional impairment, the information may include results of specialized functional assessments that clearly indicate whether or not an individual is fit to drive, such as a road test or an occupational therapist's evaluation. For other impairments there may be no assessment tools available that can accurately measure the effects of a medical condition on the functions necessary for driving. For example, in the case of drivers with episodic impairments, driver licensing authorities have to rely on the results of medical assessments that incorporate

statistical risk analysis and informed opinion about the risk of a reoccurrence as the best information available for determining fitness to drive.

Driver licensing authorities will generally rely on the medical standards to make driver fitness determinations. However, because each individual is unique, authorities must also review and consider other available and relevant information when making driver fitness determinations.

PART 1:

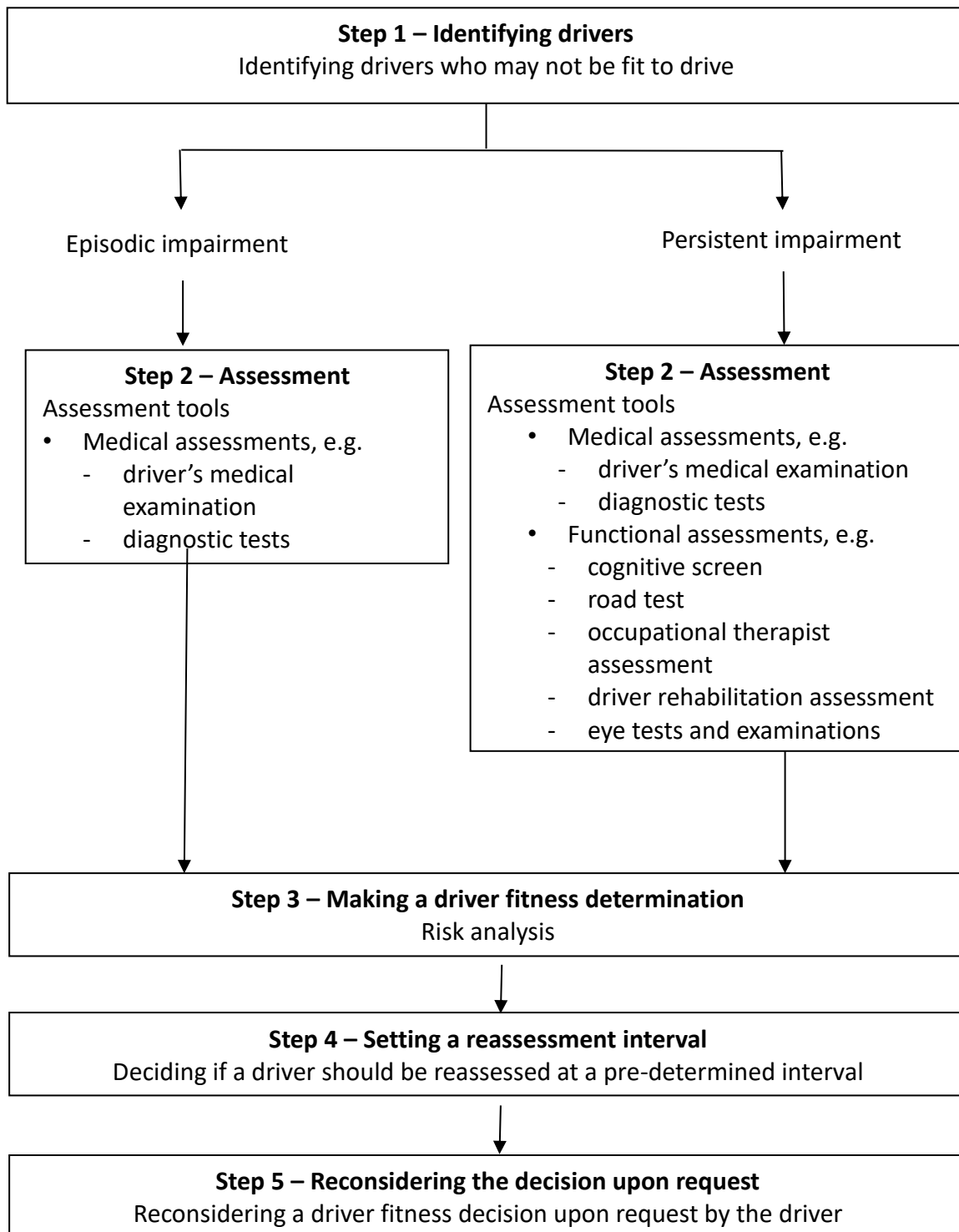
A MODEL FOR ADMINISTRATION OF DRIVER FITNESS PROGRAMS

Chapter VI Introduction

Individual territorial and provincial driver licensing authorities administer their driver fitness programs in a variety of ways. However, to support the consistent use of the medical standards, guidelines for the administration of driver fitness programs have been articulated by DFOG. These guidelines have been organized under five key activities:

1. identifying drivers who may not be fit to drive
2. assessing drivers: assessment tools
3. making a decision regarding driver fitness: risk analysis
4. deciding if a driver should be reassessed at a pre-determined interval, and
5. reconsidering a driver fitness decision upon a request by the driver.

Model for the Administration of Driver Fitness Programs



Chapter VII Definitions

Assessment	means using any kind of test or examination to gather information about a driver's functional ability to drive. Assessments may be either functional or medical (see definitions of these terms) and lead to a driver fitness determination.
Authority	See definition of 'driver licensing authority'
Cognitive assessment	means an assessment that has been specifically designed to assess impairment of the cognitive functions needed for driving. A cognitive assessment may include a battery of in-office tests or a functional driving evaluation.
Cognitive screen	means the use of a test or tests that have been specifically designed to screen for impairment of the cognitive functions needed for driving. A cognitive screen is the first step in determining cognitive fitness to drive. Depending on the results of a cognitive screen, a complete cognitive evaluation may be required.
Commercial driver	means a driver with a commercial class licence (Class 1-4) as determined by the licensing authority, or a driver deemed to be a commercial driver as determined by the licensing authority.
Condition	means that a restriction on an individual or an individual's licence has been imposed by the driver licensing authority. The terms 'condition' and 'restriction' are used interchangeably in many Canadian jurisdictions. For the purposes of these guidelines, a licensing 'condition' includes the concept of 'restriction'. All driver licensing authorities use conditions on a driver licence as part of their driver fitness program. These are generally enforceable at roadside: example: 'wear corrective lenses' Some driver licensing authorities also place conditions on the individual driver. These are not enforceable at roadside: example: 'you must not drive if your dialysis treatment is delayed or circumstances do not allow you to maintain your dialysis schedule'
Credible report	means a report that provides objective information about a driver's driving ability, e.g., information about observed driving infractions (running a stop sign) or poor driving (failure to notice pedestrians; not staying in lane). A credible report may also be a

report of damage to a driver's car that a driver cannot explain. Credible reports may come from any source including health care professionals, the police, front-line licensing staff, family members or other concerned members of the public.

Driver

means any person with any class of a valid, suspended or cancelled driver licence or a person applying for any class of driver's licence

Driver licensing authority

means the body within each province or territory that makes driver fitness determinations.

Driving record

includes:

- the length of time an individual has been licensed
- driving offences
- driving sanctions applied
- current and past licence conditions
- motor vehicle related Canadian Criminal Code convictions
- crash history, and
- past road test results.

Functional assessment

is any kind of assessment that involves direct observation or measurement of the functions necessary for driving. Functional assessments may include but are not limited to:

- paper-pencil cognitive screen
- computer-based cognitive assessments
- road tests
- occupational therapist assessment
- driver rehabilitation assessment, and
- vision tests and examinations

Medical assessment

is any kind of assessment that provides information regarding an individual's health and/or their response to, or compliance with, treatment. Medical assessments include:

- driver fitness assessments completed by health care professionals including specialists
- diagnostic imaging
- diagnostic tests, and
- medical specialists are physicians who have completed advanced education and clinical training in a specific area of medicine (their specialty area). Examples of medical specialists include neurologists, psychiatrists, internal medicine

Medical condition	is any injury, illness, disease or disorder. Impairment resulting from medications and/or treatment regimes that have been prescribed are considered an integral component of medical conditions. General debility and a lack of stamina are also considered as medical conditions that may impair the functions necessary for driving.
Non-commercial driver	means a driver with a non-commercial class licence (class 5 and/or 6 or 7) as determined by the driver licensing authority.
Incidence	means the annual number of new cases of a medical condition. (i.e., There were 1000 cases in 2016.)
Prevalence	means the global occurrence of a medical condition. (i.e., 9% of the male population over 60 have sleep apnea.)
Reassessment	is the process of making a new fitness determination for a driver with a previously assessed medical condition. Reassessment is at the discretion of the driver licensing authorities at the expiration of a scheduled reassessment interval or at any time in response to a credible report indicating that a driver may not be fit to drive.
Restriction	see definition of 'Condition'.
Road Test	a practical evaluation of driving fitness conducted on public roads. (Does not include driving simulator or closed-circuit evaluations.) Different road tests may be tailored to evaluate specific groups: 1. Novice driver road tests: These tests are designed for novice drivers who wish to obtain a driver's licence for the first time. Their objective is to determine if the novice driver has mastered driving techniques and the rules of the road. 2. Competency road tests for experienced drivers: These tests are designed for experienced drivers whose fitness to drive has been put in doubt because of a functional impairment that may be physical, sensorial or cognitive. The tests are administered by occupational therapists, driving instructors or licensing authority evaluators to ascertain if the driver's impairment renders their driving unacceptable for safety reasons.

Chapter VIII Key concepts

The following are explanations of the key concepts underlying these guidelines. An understanding of these concepts is necessary in order to use the guidelines effectively.

VIII.1 Functional ability and driving outcomes

Cognitive

Individuals with progressive or irreversible declines in cognitive function cannot compensate for an impairment.

Motor

Research on motor functions and driving indicates considerable variability in the association between the different motor functions and driving outcomes. Overall, the research suggests that a significant level of impairment in motor functions is needed before driving performance becomes unsafe.

Sensory – vision

Results from studies investigating the relationship between visual abilities and driving performance are, for the most part, equivocal. It may be, as suggested for motor abilities, that a significant level of visual impairment is needed before driving performance is affected.

Sensory – hearing

Impaired hearing has not been demonstrated to influence driving. Most hearing-impaired drivers are conscious of their impairment and compensate by being more cautious and alert and by making more use of their mirrors than drivers with normal hearing. However, the ability to hear or communicate is of paramount importance for the operation of certain commercial vehicles including a passenger bus, ambulance and other emergency vehicles or vehicles transporting dangerous material.

VIII.2 Types of impairments

The types of impairments described below are described as if they existed in isolation from each other. In practice, however, a person may have more than one type of impairment and, under some circumstances, an impairment that was initially identified as transient, may become persistent. As well, some conditions, in particular, mental illness, can be both persistent and

episodic. Finally, episodic impairments, for example epilepsy, may result in sudden incapacitation when an event occurs.

Transient impairment

Transient impairments are a temporary compromise of the functional ability to drive where there is little or no likelihood of a recurring episodic or ongoing persistent impairment.

Examples of transient impairments are:

- the after-effects of surgery, e.g., the time to recover from the anaesthetic and the surgery itself
- fractures and casts, post-orthopedic surgery
- concussion
- conscious sedation (short-term)
- invasive medical tests
- injury
- use of orthopedic braces (including neck), and
- infections.

Driver fitness programs do not need to know when a driver has experienced a transient impairment and do not assess drivers with transient impairments. In these cases, a doctor may rely on best practices to tell a patient, for example, “don’t drive for 6 weeks after your abdominal surgery.” The Canadian Medical Association (CMA) Guide for Physicians when Determining Fitness to Drive, 10th edition contains guidelines for physicians for many transient or “temporary” impairments associated with a range of medical conditions.

Persistent impairment

A persistent impairment is an ongoing or continuous impairment to a function necessary for driving. The potential effects of persistent impairments on the functions necessary for driving are generally **measurable**, **testable** and **observable**. Although the condition may be progressive, the progression is usually slow and sudden deterioration is unlikely. Persistent impairments may be stable, e.g., loss of a leg, or progressive, e.g., arthritis.

Episodic impairment

An episodic impairment is the result of a medical condition that does not have any ongoing measurable, testable or observable effects on the functional ability to drive but that may result in an unpredictable sudden or episodic impairment of the functions needed for driving.

For example, the medical condition that gives rise to the impairment may be testable, e.g., the size of an abdominal aortic aneurysm, or known, e.g., epilepsy, but the precipitating event that

negatively effects the functional ability to drive, e.g., the rupture of the aneurysm or an epileptic seizure, is not predictable.

Sudden incapacitation

Sudden incapacitation means the abrupt loss of the functions necessary for driving. It may be the result of a total or partial loss of consciousness, overwhelming pain, seizures, syncope, hypoglycemia or another episodic event.

VIII.3 Important considerations when determining fitness

Insight

For any driver, insight (also referred to as self-awareness) is an important factor. Deciding not to drive because you are not feeling well is not only a sign of good judgement, it is also a sign that you are aware of the effects that your temporary condition causes for your driving.

In the context of a driver with a medical condition, insight means that a driver:

- is aware of their medical condition
- understands how the condition may impair their functional ability to drive, and
- has the judgment and willingness to comply with their treatment regime and any conditions of licensing.

Physicians will often use terms such as “impaired awareness,” or “lack of awareness of impairment” on a medical assessment to indicate that an individual lacks insight.

An individual’s level of insight is a critical consideration when assessing the risk of an episodic impairment of functional ability due to a psychiatric disorder. Because of this, there is a specific guideline regarding insight in the Psychiatric Disorders standard.

Compensation

Compensation is the use of strategies or devices by a driver to attenuate the functional effects of an impairment caused by a medical condition. Treatment for a condition with medications is not a type of compensation. Possible compensation strategies for many medical conditions are included in Part 2 of this document.

Persistent impairments

Whether an individual can compensate for a persistent impairment depends upon the function that is impaired. Individuals with impairments in motor function, vision or hearing may be able

to compensate for those impairments. Individuals with progressive or irreversible declines in cognitive function are incapable of compensating for an impairment whether it is cognitive, physical or sensorial.

Episodic impairments

An individual cannot compensate for an episodic impairment except by avoiding known precipitating factors.

VIII.4 Functions needed for driving

The functions necessary for driving can be categorized as either cognitive, motor or sensory (vision and hearing). Sensorimotor functions are a combination of sensory and motor functioning and are considered as a subset of motor functions. Sensorimotor functions are, for the most part, reflexive or automatic, e.g., the response to your hand being placed on a hot stove or the ability to sit upright.

Within each category, the functions that are most relevant to the driving task are described in the tables below. Although the functions necessary for driving are described individually, **driving is a complex perceptual-motor skill that usually takes place in a rapidly changing environment that requires the functions to operate together.**

Cognitive functions needed for driving		
Function	Description	Example in the driving context
Divided attention	the ability to attend to two or more stimuli at the same time	responding to the roadway ahead while being able to identify stimuli in the periphery
Selective attention	the ability to attend to one or more important stimuli while ignoring competing distractions	isolating the traffic light from among other environmental stimuli
Sustained attention (vigilance)	the capacity to maintain an attentional activity over an extended period	attending to the roadway ahead for the entire duration of the trip
Short-term or passive memory	the temporary storage of information, or the brief retention of information	remembering roadway sign information such as that related to freeway exits or construction areas; signs related to caution ahead, etc.

Cognitive functions needed for driving

Function	Description	Example in the driving context
Working memory (the active component of short-term memory)	the ability to manipulate information with time constraints/taking in and updating information	processing environmental information related to the driving task on a busy freeway
Long-term memory	memory for personal events (autobiographical memory) and general world knowledge (semantic memory)	knowing: • your way from home to the grocery store • the meaning of traffic signs, and • the rules of the road • where you lived as a child
Choice/complex reaction time	the time taken to respond differentially to two or more stimuli or events	responding when a cat darts onto the edge of the road at the same time a pedestrian steps onto the roadway
Tracking	the ability to visually follow a stimulus that is moving or sequentially appearing in different locations	visually following other cars on the road or a pedestrian crossing the road
Visuospatial abilities	processes dependent on vision such as the recognition of objects, the ability to mentally rotate objects and determinations of relationships between stimuli based on size or color	understanding where a tree and other objects are in relation to the car, parking a car in a crowded parking lot
Executive functioning (see also central executive functioning below)	those capabilities that enable an individual to successfully engage in independent, purposeful, and self-serving behaviours. Disturbances in executive functioning are characterized by disturbed attention, increased distractibility, deficits in self-awareness, and preservative behaviour.	deciding when to make an unprotected left-hand turn in traffic

Cognitive functions needed for driving

Function	Description	Example in the driving context
Central executive functioning (see also executive functioning above)	that part of working memory that is responsible for 'supervising' many cognitive processes including encoding (inputting information from the external world), storing information in memory, and retrieving information from memory. Central executive (CE) functioning includes abilities such as planning and organization, reasoning and problem solving, conceptual thought, and decision making. CE functioning is critical for the successful completion of tasks that involve planning or decision making and that are complex in nature	making a left turn at an uncontrolled intersection
Visual information processing	the processing of visual information beyond the perceptual level (e.g., recognizing and identifying objects and decision making related to those objects). Visual information processing involves higher order cognitive processing. However, because of the visual component, references to visual information processing often are included within the visual domain.	recognizing if an object in the road ahead is a paper bag or a child

Motor functions needed for driving (including sensorimotor)

Function	Description	Example in the driving context
Coordination	the ability to execute smooth, accurate, controlled movements	executing a left turn, shifting gears, etc.
Dexterity	readiness and grace in physical activity; especially skill and ease in using the hands	inserting keys into the ignition, operating vehicle controls, etc.
Gross motor abilities	gross range of motion and strength of the upper and lower extremities, grip strength, proprioception, and fine and gross motor coordination	being able to depress the brake or the accelerator, sudden turning of the steering wheel in an emergency
Range of motion	the degree of movement a joint has when it is extended, flexed, and rotated through all of its possible movements	range of motion of the extremities (e.g., ankle extension and flexion) is needed to reach the gas pedal and brake and upper body range of motion (e.g., shoulder and elbow flexion) is necessary for turning the steering wheel; range of motion of the head and neck is necessary for looking at the side and rear for vehicles and for identifying obstacles at the side of the road or cars approaching from a side street.
Strength	the amount of strength a muscle can produce	depressing the brake pedal
Flexibility	the ability to move joints and muscles through their full range of motion. Muscle strength and flexibility often go hand in hand.	getting in and out of the car, operating vehicle controls, fastening the seat belt, reversing
Reaction time	the amount of time taken to respond to a stimulus	depressing the brake pedal in response to a child running out on the roadway, swerving to avoid an animal on the road

Sensory functions needed for driving – Vision

Function	Description	Example in the driving context
Acuity	acuteness of vision or perception i.e., the capacity to see small objects at a distance	reading directional signs
Visual field	an individual's entire spatial area of vision when fixation is stable, i.e., the extent of the area that an individual can see with their eyes held in a fixated position	seeing cars approaching from the left or right
Contrast sensitivity	the ability to perceive differences between an object and its background, e.g., the ability to detect a gray object on a white background or to see a white object on a light gray background	seeing traffic lights or cars at night
Glare recovery	the process in which the eyes recover visual sensitivity following exposure to a source of glare	adapting to the reflection of the sun from a car dashboard or oncoming headlights when driving at night
Perception	the process of acquiring, interpreting, selecting, and organizing sensory information	

Sensory functions needed for driving – Hearing

Function	Description	Example in the driving context
Hearing	Ability to perceive sound	The ability to communicate is of paramount importance for the operation of certain commercial vehicles that transport dangerous cargoes as well as emergency vehicles and those transporting passengers.

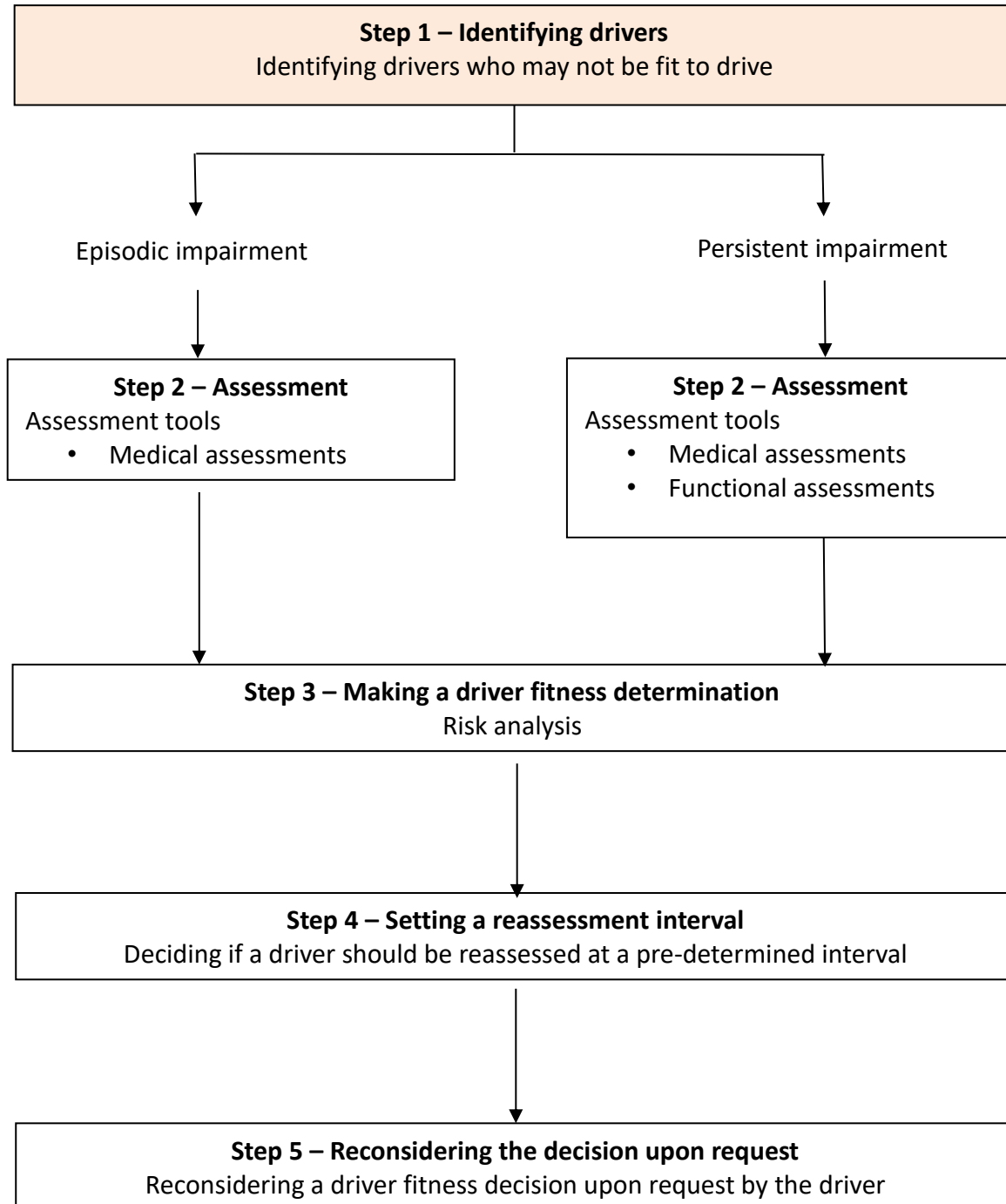
Chapter IX Identifying drivers who may not be fit to drive

IX.1 Overview

Identifying drivers who may not be fit to drive and who therefore pose a risk to public safety is a key function of driver licensing authorities.

The driver fitness medical standards in Part 2 of this document support authorities by identifying the most common medical conditions that are of concern. This model does not include transient impairments because there is little or no likelihood of a recurring episodic or ongoing persistent impairment. In addition, by the time that the driver-licensing agency learns of a transient impairment it may have resolved.

Model for the Administration of Driver Fitness Programs



IX.2 All drivers

Model Standard

Provincial and territorial driver licensing authorities use screening mechanisms to identify individuals whose functional ability to drive may be impaired by a medical condition. This section will use examples to demonstrate the differences between standards for commercial and non-commercial drivers as well as the supporting information that accompanies the standards in Part 2 of this document.

Rationale for a screening standard

All Canadian jurisdictions have the legal authority to examine a driver's fitness and ability to drive. Authorities are specifically concerned with individuals whose fitness and ability to drive may be impaired by medical conditions. This includes individuals who may be impaired by medications or treatment regimes prescribed as treatment for a medical condition, general debility or a lack of stamina.

IX.3 Non-commercial drivers (Class 5, 6, 7)

Model Screening Standard

Drivers with Class² 5, 6 or 7 licences will be screened for medical conditions that may affect driving as follows:

- (a) at age 75
- (b) at age 80
- (c) every 2 years over age 80
- (d) or more frequently at discretion of the driver licensing authority.

Rationale

The functional effects associated with aging are well documented. For most healthy, aging drivers these effects are unlikely to lead to unsafe driving in the short term. However, aging is also associated with increased risk for a broad range of medical conditions, such as visual impairments, musculoskeletal disorders, cardiovascular disease, diabetes, and cognitive

² For definitions, see NSC 4 – Driver Licensing Classification System

impairment and dementia. These medical conditions and the medications used to treat them may affect fitness to drive.

There is a particularly strong association between cognitive impairment and dementia and impaired driving performance. A large, national population-based study done in Canada in 1991 showed that 25% of the population 65 and older have some form of cognitive impairment or dementia, rising to 70% for those 85 and older.

Because of the association between age and many chronic medical conditions, aging drivers are more likely to have one or more of these conditions. A 2013 study of Quebec drivers demonstrated that 67% of drivers aged between 70 and 79 had at least one of the principal medical conditions recognised to effect driving.³ This study also found that the average number of multiple chronic conditions increases with age.

With an increased rate of multiple medical conditions, there is also a greater likelihood that aging drivers will be taking multiple medications. With each additional medication taken there is an increased risk of side effects and adverse interactions between medications which may affect fitness to drive. While in many cases the adverse effects may be temporary or avoidable, there may be a persistent impairment of the functions needed for driving.

As a group, older drivers are less likely to be involved in a crash than other age groups. However, older drivers are at increased risk for at-fault crash or of being seriously injured or dying in a crash.

Statistics from British Columbia show that at about age 70, the ratio of at-fault crashes begins to rise, climbing to 2.5 for drivers who are 81 and older.

An examination of driver fatality rates, adjusted for driving exposure or total distances travelled on an annual basis, indicates that there are two high risk age groups: ages 16 to 19 and 65 and older. Older drivers are also more likely to be injured in a crash and to incur more severe injuries than younger drivers.

Unlike younger driver crashes, most traffic fatalities involving older drivers occur during the daytime, on weekdays, and in safe road conditions, with most the crashes involving another vehicle.

IX.4 Commercial drivers

Model Screening Standard

- i) Drivers with Class 1 – 4 licences will be screened for medical conditions that may affect driving as follows:
 - (a) up to age 45, every 5 years
 - (b) from age 45 to age 65, every 3 years, and
 - (c) from age 65, annually
 - (d) or more frequently at discretion of the driver licensing authority.

Rationale

The rationale under ‘non-commercial drivers’, in Section 4.3.1 also applies to commercial drivers. In addition, commercial drivers drive a variety of vehicles including large trucks, passenger carrying vehicles such as buses and emergency vehicles. Commercial drivers also spend many more hours at the wheel, often under far more adverse driving conditions, than do the drivers of non-commercial vehicles. They are usually unable to select their hours of work and cannot readily abandon their passengers or cargo should they become unwell when on duty. Drivers operating emergency vehicles are frequently required to drive while under considerable stress by the nature of their work, and often in inclement weather where driving conditions are less than ideal. Should a crash occur, the consequences are much more likely to be serious, particularly where the driver is carrying passengers or dangerous cargo such as propane, chlorine gas, toxic chemicals or radioactive substances.

Because of this greater time spent at the wheel, commercial drivers are routinely screened at regular intervals, even if there is no evidence that the driver has a known or possible medical condition.

IX.5 Cancellling or restricting a licence because of an immediate public safety risk

Model Standard

- i) If information obtained at any time reveals an immediate risk to public safety, authorities may direct that a licence be cancelled or restricted without further assessment.
- ii) If an authority has cancelled or restricted a licence because of an immediate public safety risk, the program may review the decision once further information is received.

Rationale

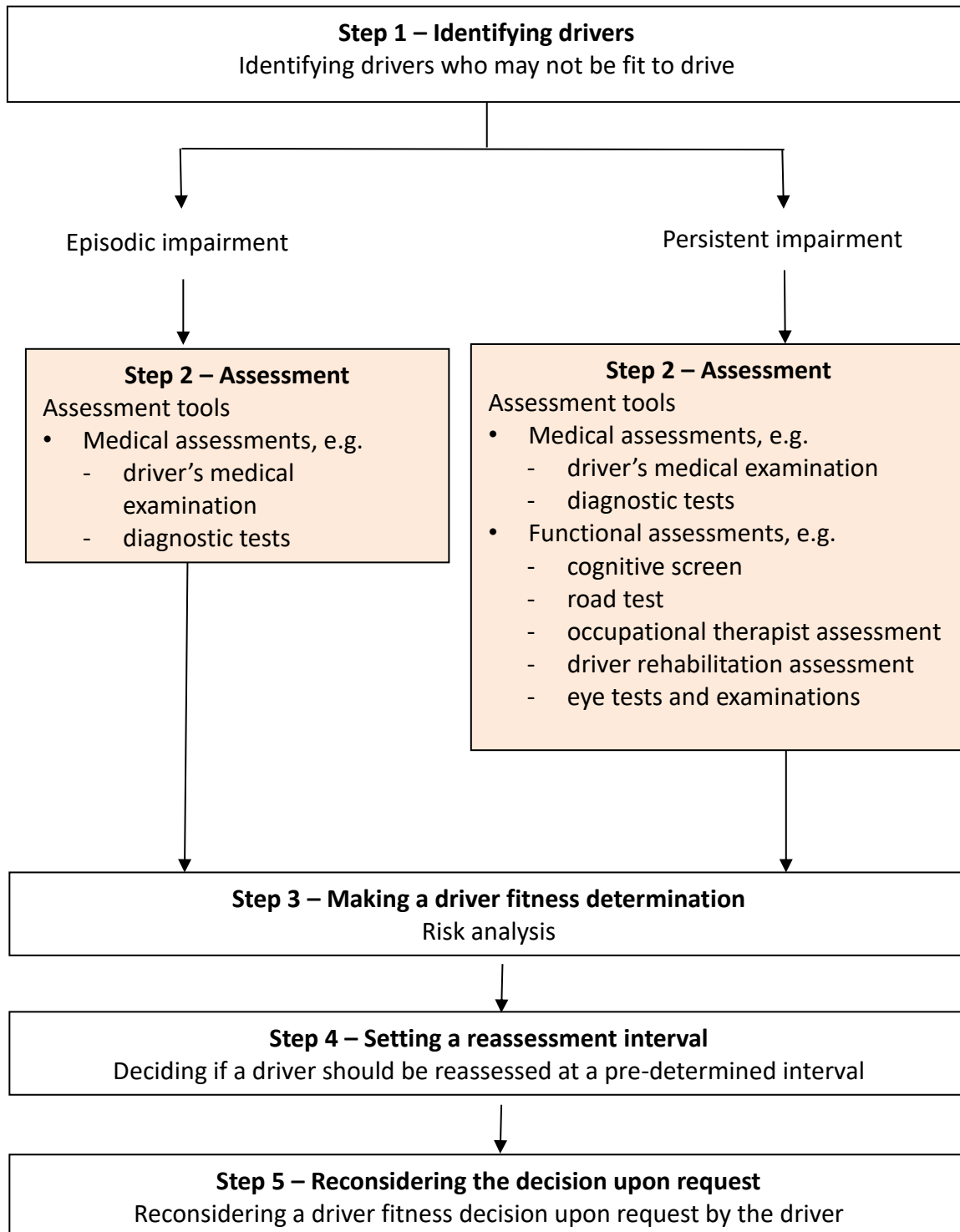
In most cases, authorities will not direct that a licence be restricted or cancelled based only on preliminary information. However, there are times when cancellation or restriction may be warranted prior to further assessment. For example, a credible report may indicate that an individual's functional ability to drive is severely impaired. The licencing authority would cancel the driver's licence for public safety reasons and could review the decision once further information was received.

Chapter X Assessing fitness to drive

X.1 Overview

Assessing fitness to drive means using any kind of test or examination to gather information about a driver's functional ability to drive. Driver licensing authorities have a variety of tools at their disposal to assess the effects of medical conditions on the functions necessary for driving. These can be categorized as either medical or functional assessments. The appropriate type of assessment depends both upon the function that is impaired and the nature of the impairment.

Model for the Administration of Driver Fitness Programs



X.2 Requesting functional assessments

Model

- i) If an authority decides further information on a driver's functional ability to drive is necessary in order to make a driver fitness determination, the licencing authority may request a functional assessment.
- ii) An authority may request a functional assessment of an individual with a persistent impairment; a functional assessment is not appropriate for a driver who has only episodic impairments.

Rationale

Consistent with the functional approach to driving fitness, a driver licensing authority may request an assessment of an individual's functional ability to drive whenever that information is necessary in order to make a driving fitness determination.

Persistent and episodic impairments

Whether or not a functional assessment is appropriate depends upon the type of impairment. Because persistent impairments are measurable, testable and observable, it is possible to assess an individual's functional ability to drive through observation by a physician or other health care practitioner or an OT or driver rehabilitation specialist. Because episodic impairments are not measurable or testable, there is no way to functionally assess how the impairment affects an individual's ability to drive.

X.3 Requesting medical assessments

Model

- i) If an authority decides that further information on a driver's medical condition(s) or the driver's response to, or compliance with, treatment is required, the licencing authority will request a medical assessment.

Rationale

Since medical conditions may not remain stable, driver licensing authorities must ensure that the medical information that will serve to establish a driver's fitness to drive is current and reflects faithfully the driver's health and compliance with treatment at the time the decision on licence status is made.

X.4 Assessing the cognitive functions needed for driving

Model

- i) Generally, further information on an individual's cognitive function will be required when a credible report indicates that:
 - (a) there may be some loss of cognitive function
 - (b) there is some loss of cognitive function and it is unknown whether the individual possesses sufficient cognitive function to drive, or
 - (c) the driver has a medical condition at a stage usually associated with a loss of cognitive function, or that a previously known impairment has become more pronounced.
- ii) Authorities may use the results of cognitive screens or cognitive assessments to screen for, or assess, impairment of the cognitive functions needed for driving.
- iii) When the result of a cognitive screen is indeterminate, authorities may request a cognitive assessment of a driver.
- iv) Authorities may use the best available methods to assess possible cognitive impairment of the functions needed for driving.
- v) Notwithstanding standards 5.4.2 to 5.4.4, an authority may request an occupational therapist or driver rehabilitation specialist assessment, or a gerontologist assessment, or a road test for a driver with a persistent cognitive impairment who may not be fit to drive.

Rationale

Cognitive screens

Historically, there has been a lack of reliable screening tools for the identification of individuals whose cognitive impairment or dementia poses a risk for adverse driving outcomes. Scores on mental status tests such as the Mini Mental Status Exam (MMSE) or the Montreal Cognitive Assessment (MoCA) are sometimes used for making decisions about driving competency. However, there is now a significant amount of evidence indicating that, while the MMSE and similar tests are useful as tools for identifying cognitive decline, they are not good predictors of an individual's driving competence, particularly for those whose cognitive impairment is less severe. In addition, the scores of these tools are very sensitive to language ability and education. The *Determining Medical Fitness to Operate Motor Vehicles, CMA Driver's Guide* 10th edition states that no cognitive tests or battery of tests alone have sufficient sensitivity or

specificity to be used as a single determinant of driving ability. However, abnormalities on tests including the MMSE, clock drawing and Trails B should trigger further in-depth testing of driving ability.

Standard neuropsychological or cognitive tests such as Trails A, Trails B, Digit Span, or the MoCA designed to assess cognitive functions (e.g., attention, memory, executive functioning) also are used to identify potentially compromised drivers. However, although these standardized tests sometimes correlate with measures of driving performance (e.g., on-road performance, crash rates), the absence of a strong and consistent relationship, as well as the lack of established cut points for categorizing drivers as ‘safe’ and ‘unsafe’, preclude using these tests as the sole determinant of driving competency at this time.

Recent research has focused on the development of useful, simple tools that will permit health care professionals to identify the potentially compromised driver. At this time these efforts are on-going.

Standard road tests

Standard road tests are conducted by provincial and territorial driver examiners who assess whether a novice driver has mastered the skills needed for driving to determine if a licence should be issued. Standard road tests are designed to confirm that a driver possesses the basic functional ability to operate a vehicle safely. In contrast, specialized assessments focus on evaluating both functionality and overall driving competency, particularly when there are concerns about impairment or diminished capacity. To address this need, several jurisdictions have developed road tests for experienced drivers, often referred to as “competency road tests”.

X.5 Assessing motor function

Model

- i) Generally, further information on a driver’s motor function will be required when a credible report indicates that there is some loss of motor function and:
 - (a) it is unknown whether the individual possesses sufficient movement and strength to perform the motor functions necessary for driving the types of motor vehicles permitted under the class of licence held or applied for
 - (b) it is unknown whether pain associated with a medical condition, or the medications used to treat a medical condition, adversely affect the individual’s motor function, and/or
 - (c) it is unknown whether the individual can safely operate the type of motor vehicles permitted under the class of licence held or applied for using the vehicle

modifications and devices that may be required to compensate for their functional impairment.

- ii) Authorities may request a road test where the licencing authority needs to confirm that the individual is able to use adaptive driving equipment or vehicle modifications.
- iii) Authorities may request an occupational therapist or driver rehabilitation specialist assessment if further information is required on an individual's motor function and a road test alone will not be able to provide the required information.

Rationale

Research on motor functions and driving indicates considerable variability in the association between the different motor functions and driving outcomes. Overall, the research suggests that a significant level of impairment in motor functions is needed before driving performance is affected to an unsafe level.

Occupational therapist or driver rehabilitation specialist assessments

Occupational therapists and other specialists with expertise in driver rehabilitation are trained to perform both in-office and on-road assessments of an individual's functional ability to drive. Driver rehabilitation specialists are trained to evaluate an individual's ability to compensate for motor deficits during simulated and on-road testing and determine requirements for adaptive driving equipment and vehicle modifications.

X.6 Assessing sensory function – vision

Model

- i) Further information on a driver's visual function will be required when a credible report indicates that there is some loss of visual function and:
 - (a) it is unknown whether the individual possesses sufficient vision necessary for driving the types of motor vehicles permitted under the class of licence held or applied for
 - (b) it is unknown whether pain associated with the condition, or the medications used to treat the condition, adversely affect the individual's visual function, and/or
 - (c) it is unknown whether the individual can safely operate the type of motor vehicles permitted under the class of licence held or applied for using the vehicle modifications and devices that may be required to compensate for their functional impairment.
- ii) Authorities will request an occupational therapist or driver rehabilitation specialist assessment, which will generally include an on-road assessment if further information is required or whether a driver's vision is such that they are fit to drive.

iii) Authorities may require a functional evaluation for a visually impaired individual that will usually include an on-road assessment. Some jurisdictions have developed their own road tests for the visually impaired while others refer these clients to specialists or occupational therapists.

Rationale

Although there are tools that measure, for example, visual acuity and visual fields, the vision standards for driving are based on consensus opinion of subject matter experts. Research has not identified what level of vision impairment renders a person unable to drive safely.

The loss of certain visual functions can be compensated for adequately, particularly in the case of long-standing or congenital impairments. When a person becomes visually impaired, the capacity to drive safely varies with their ability to compensate. Thus, there are people with visual deficits who do not meet the vision standards for driving but who can drive safely. Because of this, further assessment may be required for drivers who do not meet the stated vision standards.

X.7 Assessing sensory function – hearing

Model

5.7.1 Further information on a driver's hearing function can be obtained when a report indicates that there is some loss of function and the driver's licence includes classes that are affected by the hearing standard.

Rationale

There are several tools that measure hearing performance, for example audiometric tests and the forced whisper test. However, research has shown that loss of hearing does not affect crash risk.

The focus of the hearing standards is the ability to hear or communicate since this capacity is of paramount importance if a vehicle transporting dangerous goods is involved in a crash or a situation that could endanger the public requiring the driver to interact verbally with the authorities, police or the public in an emergency.

X.8 Assessing drivers with multiple functional impairments

Standard

i) If an authority decides that more than one of the functions necessary for driving needs to be assessed, the licencing authority will request functional assessments in the following order:

- (a) assessments of cognitive function
- (b) assessments of sensory function, and
- (c) assessments of motor function.

ii) If the results of an assessment indicate that an individual's cognitive, motor or sensory function is impaired to the extent that the individual is not fit to drive, the licencing authority may make a driver fitness determination without requesting further assessments of the other functions necessary for driving. Whenever possible, the cumulative effects of multiple functional impairments should be evaluated rather than evaluating each impairment separately.

Rationale

Some drivers may have impairments of more than one of the functions necessary for driving. In this situation, the licencing authority prioritizes requests for functional assessments based on the functions that may be impaired. Because a driver cannot compensate for cognitive impairment, if an individual's cognitive function may be impaired that function will be assessed first. Sensory functions are assessed next, followed by motor functions. If an assessment indicates that a function is impaired, and a driver is not fit to drive there is no need to continue with further assessments of the other functions that may be impaired.

X.9 Assessing drivers with multiple medical conditions

Model

i) If a driver has multiple medical conditions that result in a cumulative or combined effect on the functions necessary for driving such that the medical conditions cannot be considered individually or independently, the licencing authority may request functional assessments (where applicable) of each function that may be impaired, even if the medical condition standards for each identified medical condition indicate that the individual is fit to drive.

ii) Authorities should request functional assessments of individuals with multiple medical conditions that cannot be considered independently, unless the driver fitness standards for any of the identified medical conditions clearly indicate that the individual is not eligible for a licence.

Rationale

The functional effects of multiple medical conditions on driver fitness is very important. Research results indicate that drivers with multiple medical conditions are, in general, at higher risk for at-fault crashes than those with a single medical condition.

The standards in Part 2 each focus on a single medical condition, e.g., cardiovascular disease, and the standards are written as if an individual only had one medical condition. This is because the number of combinations of illnesses and medications is simply too large and varied to make possible the development of comprehensive standards that cover every single eventuality.

This means that applying individual standards to the driver with multiple conditions may not permit the licencing authority to adequately evaluate the driver's fitness to drive. While the standards for each individual medical condition may indicate that the individual is eligible for a licence, if the medical conditions have a cumulative effect on the functional ability to drive, the individual may not be eligible.

X.10 Time period during which assessments are valid

Model

i) Generally, an authority will accept the results of any assessment conducted within the previous one-year period, even if completed for another purpose, if it provides the required information. Longer periods may be accepted by the licencing authority depending upon the type of assessment and the stability of the driver's condition.

Rationale

Assessments may be costly and time-consuming for drivers, authorities and health care providers. If an assessment has already been conducted that provides the information required for a driver fitness determination, there is no need for an individual to be re-assessed, so long as the results of the assessment are still reliable. Because many conditions are progressive, and an individual's abilities may change over time, assessment results generally only continue to be reliable for a limited period after completion of the assessment.

X.11 Time limits for drivers to complete assessments

Model

i) Whenever a driver licensing authority requests an assessment, it will inform the individual of the time period within which the assessment must be completed.

ii) Upon request, a driver licensing authority may extend the period for an individual to comply with a request for an assessment. In considering whether to extend the time period, the licensing authority will consider information from the driver regarding the circumstances that necessitate an extension, such as

- (a) work commitments
- (b) the driver's location,
- (c) the driver's degree of mobility,
- (d) availability of assessors, and/or
- (e) known delays for an appointment.

iii) If a driver does not comply with a request for an assessment within the time period or extension:

- (a) the licensing authority will direct that the driver's licence be cancelled, in the case of a driver who is already licensed, or
- (b) will direct that a licence not be granted, in the case of an individual who has applied for a licence.

Rationale

Both for public safety and administrative fairness reasons, driver fitness determinations must be made as soon as possible after an individual is identified. A driver's licence is a privilege. Where further information is required to make a determination, this means individuals must comply with requests for assessments in a timely fashion. If an individual does not comply with a request for an assessment, jurisdictions have the authority to direct the licence be suspended or cancelled.

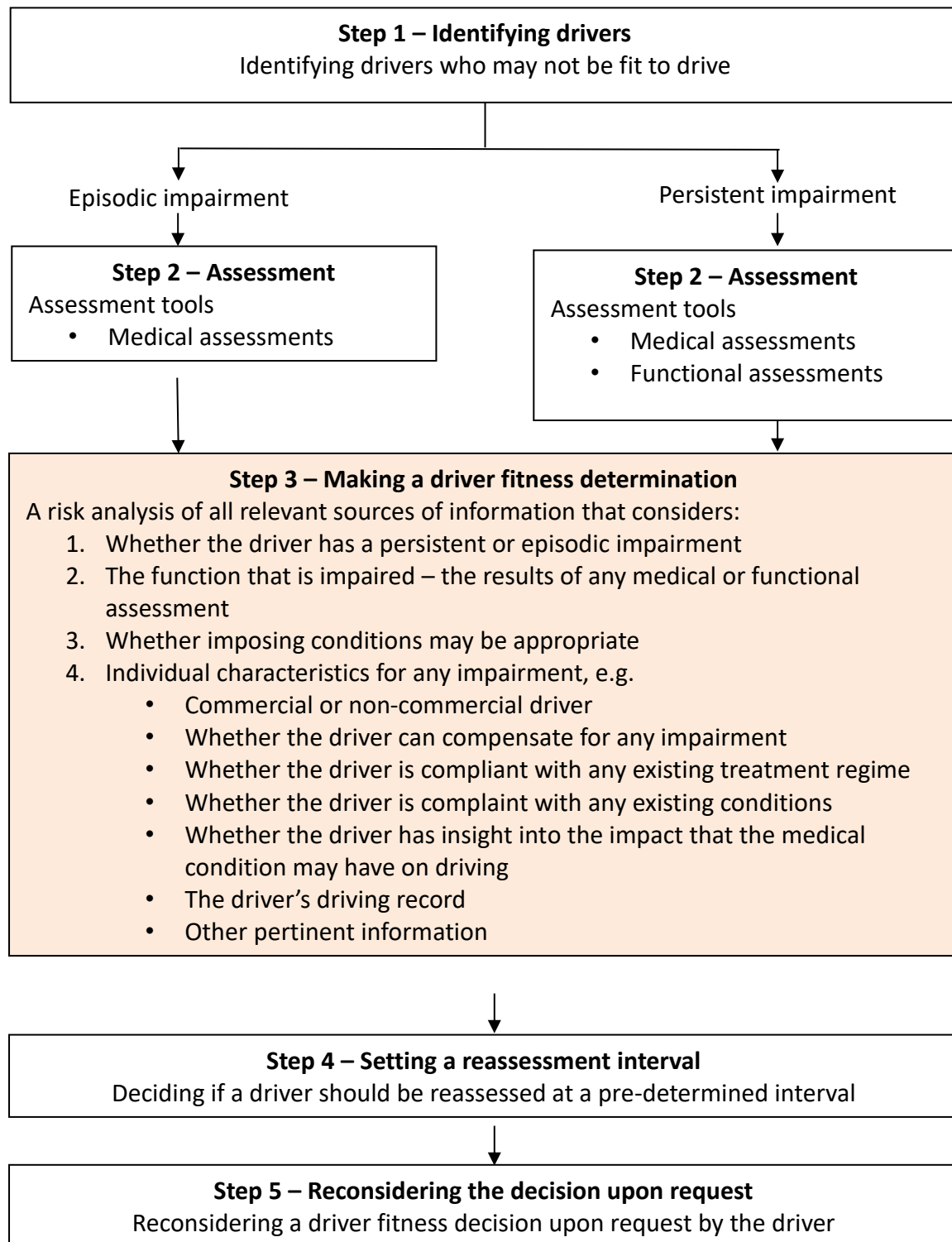
Chapter XI Making a driver fitness determination

XI.1 Overview

When making a driver fitness determination, a driver licensing authority will review all the information it has received, will consider the degree of risk presented by a driver and will determine whether that individual should be licensed. In some cases, an individual can only be licensed if they comply with certain conditions that will reduce the level or risk of impairment. Driver licensing authorities may place conditions on an individual's licence if they are necessary to ensure the safe operation of a motor vehicle.

The standards outlined in Part 2 are based, when possible, on the best available evidence regarding degree of risk and identify where the use of conditions may be appropriate to reduce risk; they guide decision-makers in determining the degree of risk presented by individual drivers.

Model for the Administration of Driver Fitness Programs



XI.2 Sources of information to consider for making a driver fitness determination

Model

- i) Driver licensing authorities will make driver fitness determinations based on the medical standards and using a risk assessment analysis that considers:
 - (a) whether the individual has a persistent or episodic impairment
 - (b) the function that is impaired – the results of any medical or functional assessments
 - (c) whether imposing conditions may be appropriate, and
 - (d) the individual characteristics and abilities of each driver, for example:
 - whether the driver is a commercial or non-commercial driver
 - whether the driver can compensate for any impairment
 - whether the driver has insight into their medical condition and how it may affect their functional ability to drive
 - whether the driver is compliant with any prescribed treatment regime
 - whether the driver is compliant with any existing conditions,
 - the driver's driving record, and
 - any other information relevant to driving privileges.

Rationale

Each driver is unique, and drivers may have multiple medical conditions or medical conditions which are not addressed in the driver fitness standards, authorities also review and consider other available and relevant information when making driver fitness determinations.

XI.3 Considering persistent impairments

Model

- i) An authority will make a driver fitness determination for an individual with a persistent impairment based on observable and measurable evidence of functional impairment.
- ii) In general, if a review of the information collected during assessment for an individual with a persistent impairment indicates no functional impairment, or a level of functional impairment that does not affect the individual's ability to drive safely, the individual may be licensed.

Rationale

Because drivers with persistent impairments are continuously impaired, authorities can make determinations for drivers with persistent impairments based on observable and measurable evidence of functional impairment.

XI.4 Considering episodic impairments

Model

- i) A driver licensing authority will make a driver fitness determination for an individual with an episodic impairment based on the probability and consequences of an event of functional impairment occurring.

Rationale

Because drivers with episodic impairments are not continuously impaired, authorities cannot make determinations for individuals with episodic impairments based on observable and measurable evidence of functional impairment. Instead, they must rely on a risk analysis that considers the probability and consequence of impairment when making a driver fitness determination for an individual with an episodic impairment. To assist authorities in performing this analysis, the driver fitness standards for medical conditions that result in episodic impairments incorporate expert opinion regarding at what level of disease severity the medical condition may result in a functional impairment.

XI.5 Considering imposing conditions

Model

- i) If a driver licensing authority determines that an individual must:
 - (a) stop driving in specific circumstances
 - (b) take prescribed medications
 - (c) comply with a specific treatment regime
 - (d) report a change in their medical condition
 - (e) attend medical follow-up
 - (f) only operate vehicles during daylight hours
 - (g) only operate certain types of vehicles
 - (h) only operate vehicles in certain geographic areas
 - (i) only operate vehicles under a certain speed
 - (j) only carry certain types of cargo
 - (k) wear specific devices, and/or

- (l) use specific vehicle modifications or adaptations to be licensed, the licencing authority will impose those conditions on the individual or the individual's licence.
- ii) Without information to the contrary, authorities will assume that a driver will comply with a condition. However, if the information obtained from assessments indicates that the driver is not likely to be compliant with any conditions that are required to be licensed, the individual may not be eligible for licensing.

Rationale

Generally, authorities will refer to the medical standards to determine the conditions that are required. However, because the driver fitness standards may not always apply in individual circumstances, authorities may impose conditions that are not contemplated by the standards.

If the risk associated with a medical condition of a certain severity level is high, and the risk cannot be reduced through the use of conditions, the standards indicate that an individual is not eligible for licensing.

XI.6 Considering specific requirements for commercial drivers

Model

- i) When determining whether an individual can be licensed as a commercial driver, a driver licensing authority will consider:
 - (a) the number of hours an individual with that type of licence typically spends driving
 - (b) any physical requirements (e.g., load securement) associated with the operation of motor vehicles allowed under that type of licence, and
 - (c) any information provided by the driver or the driver's employer regarding:
 - the types of vehicles they will be operating, and
 - how many passengers they will carry and for what purpose.
- ii) If a driver is not fit to be licensed as a commercial driver, the licencing authority will consider whether the driver is fit as a non-commercial driver.

Rationale

The class of licence held or applied for is a key consideration when making a driver fitness determination. Commercial drivers spend many more hours at the wheel than non-commercial drivers. Commercial drivers may also be called upon to undertake heavy physical work such as loading or unloading their vehicles, realigning shifted loads and putting on and removing chains. Because the physical and endurance requirements for commercial drivers are generally more

onerous than for non-commercial drivers, the driver fitness standards often specify different standards for commercial and non-commercial drivers.

XI.7 Considering whether the driver can compensate

Model

- i) Driver licensing authorities will consider whether a driver can compensate for their functional impairment when making a driver fitness determination.
- ii) A driver cannot compensate for an episodic impairment.
- iii) Whether an individual can compensate for a persistent impairment depends upon the functional ability that is impaired. Individuals with impairments in motor function, vision or hearing may be able to compensate for those impairments unless there is a cognitive limitation. Individuals with progressive or irreversible declines in cognitive function cannot compensate for a cognitive impairment.
- iv) In general, an individual who can compensate for their functional impairment is fit to drive if their cognitive, sensory and motor functions are acceptable.

Rationale

In some situations, drivers who would otherwise not be fit to drive have learned strategies, or utilize devices, that reduce or eliminate their functional impairment. For example:

- a driver with limited peripheral vision may use the strategy of turning their neck to the left and right to ensure they have a full field of view, or
- a driver who is unable to use their lower limbs may have their vehicle modified for hand controls.

In keeping with the decision in *Grismer*, and CCMTA principles, driver licensing authorities must make driver fitness determinations on an individual basis that are based on the results of individual assessments. In general, if a review of assessment results and the individual's driving record indicates that a driver can compensate for their functional impairment, the driver is fit to drive.

XI.8 Considering insight

Model

- i) If a driver licensing authority decides that conditions are required in order for an individual to be fit to drive, it will review:

- (a) medical assessments on file that indicate that the driver has, or does not have, insight into their medical condition or its effects on the functions necessary for driving
- (b) medical assessments on file that indicate that the driver is non-compliant with their prescribed treatment regime or medications
- (c) the driver's driving record indicates the individual has been non-compliant with conditions in the past, and
- (d) any credible reports that indicate that the driver has been non-compliant with conditions in the past.

ii) Without information to the contrary, an authority will assume that an individual has insight into their medical condition and its effects on their driving. However, if the information obtained indicates that the driver lacks insight, the individual may not be fit to drive.

Rationale

One key factor for determining whether a driver is fit to drive is the driver's level of insight. This is because drivers with good insight are more likely to be diligent about their treatment regime, to seek medical attention when needed, and to avoid driving when their condition is likely to impair their functional ability to drive.

An individual's level of insight is a critical consideration when assessing the risk of an episodic impairment of functional ability due to a psychiatric disorder. Because of this, there is a specific guideline regarding insight in the Psychiatric Disorders chapter.

XI.9 Considering compliance with existing treatment regime

Model

- i) If a driver is currently being treated for a medical condition, the licencing authority will review any medical assessments or other information that indicates that the driver is non-compliant with their prescribed treatment regime or medications. If the information obtained indicates that the driver is not compliant with any existing treatment regime that is required to be fit to drive, the driver is not fit to drive.
- ii) Without information to the contrary, a driver licensing authority will assume that a driver is complying with their existing treatment regime.

Rationale

Individuals who are diligent about their treatment regime are more likely to have good insight into their medical condition, to seek medical attention when needed, and to avoid driving when

their condition is likely to impair their functional ability to drive. In addition, compliance with the prescribed treatment may be essential for the maintenance of driver fitness.

XI.10 Considering compliance with existing conditions of licence

Model

- i) If a driver currently has licence conditions, the licencing authority will review any information that indicates that the driver is non-compliant with the conditions. If the information obtained indicates that the driver is not compliant with any condition that is required to be fit to drive, the driver is not fit to drive.
- ii) Without information to the contrary, a driver licensing authority will assume that a driver is in compliance with their existing licence conditions.

Rationale

A key consideration when determining if a driver is fit to drive is compliance with current licence conditions. Because conditions are only imposed if required for driver fitness, if a driver is not in compliance with existing conditions they should not be licensed.

XI.11 Considering the driving record

Model

- i) Where driving records are available, authorities will review a driver's driving record for any information that indicates whether the identified medical conditions impair the functions necessary for driving. Authorities will review:
 - (a) whether there has been a deterioration, improvement or no change in driving safety (i.e., crashes, penalty points and infractions) that can be linked to:
 - the date of onset
 - the date of diagnosis, and/or
 - the date the driver began a new treatment regime, prescribed medication or compensation strategy, and
 - (b) any evidence on file (e.g., police reports) that indicates that incidents were related to the individual's medical conditions.

Rationale

An individual's driving record may indicate that a medical condition is affecting their functional ability to drive. A lengthy, clean driving record for a driver with a long-standing medical condition may be evidence of:

- a low level of impairment
- an ability to compensate,
- a condition that is well controlled, or
- not driving actively.

A driving record with multiple crashes may indicate functional impairment.

Chapter XII Reassessment

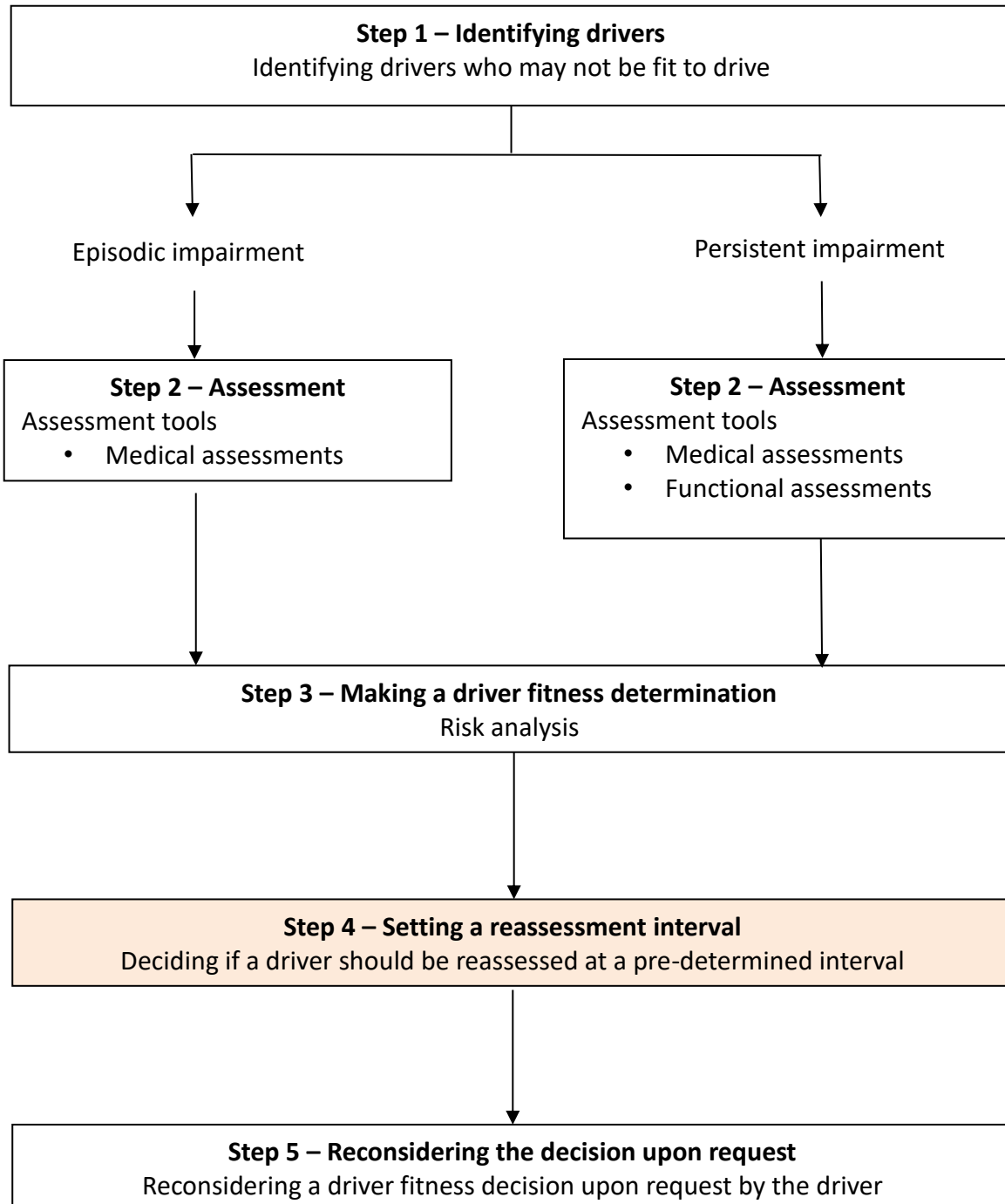
Reassessment is the process of making a new determination of fitness for a driver with a previously reported medical condition. Reassessment is initiated by driver licensing authorities at the expiration of a scheduled reassessment interval or at any other time in the discretion of the licencing authority.

For some medical conditions, a reassessment interval is provided in the standards. In those circumstances where a reassessment interval is not provided, or where individual circumstances may require a different interval, e.g., when the individual has multiple medical conditions, the licencing authority will review the relevant information to determine whether the driver's level or risk of impairment may increase and the times period over which this increase may take place.

Where a reassessment interval is provided in the standards, it is a general guideline. However, if, in the opinion of the treating physician, other medical professional or the driver licensing authority, the driver should be reassessed at a different frequency, then an alternate reassessment interval can be set.

However, commercial drivers must be reassessed at a minimal frequency interval as indicated in Chapter 23.

Model for the Administration of Driver Fitness Programs



XII.1 Routine reassessment intervals – commercial drivers

Model

i) Unless a different reassessment interval is set because of a medical condition, authorities will routinely identify commercial drivers for a review of driver fitness at the time of licence application and then at the following intervals:

- (a) up to age 45, every 5 years
- (b) from age 45 to age 65, every 3 years, and
- (c) from age 65, annually
- (d) or more frequently at discretion of the driver licencing authority.

Rationale

See Part 1, Chapter VIII, section VIII.4 ‘Commercial Drivers’.

XII.2 Routine reassessment intervals – non-commercial drivers

Model

i) Unless a different reassessment interval is set because of a medical condition, authorities will routinely identify non-commercial drivers⁴ for a review of driver fitness, for example:

- (a) at age 75
- (b) at age 80, and
- (c) every 2 years over age 80
- (d) or more frequently at the discretion of the driver licencing authority.

Rationale

See Part 1, Chapter VIII, section VIII.3 ‘Non-commercial drivers’

⁴ For definitions, see NSC 4 – Driver Licensing Classification System

XII.3 Determining whether reassessment is required (other than routine)

Routine reassessment intervals are a minimum standard for reassessment. There may be instances, however, when drivers should be reassessed more frequently.

Model

- i) To determine whether reassessment is required, the licencing authority will consider:
 - (a) the driver fitness standard(s) for the relevant medical condition(s)
 - (b) the date of onset, diagnosis and/or treatment of the medical condition, if known
 - (c) the severity of the medical condition
 - (d) whether the condition is stable and, if so, the period of stability
 - (e) whether the condition is progressive and, if so, the rate of progression
 - (f) whether the condition is controlled
 - (g) where appropriate, the date of the next routine reassessment (i.e., age-related or commercial driver routine)
 - (h) whether the individual has been compliant with any prescribed treatment regime, conditions or restrictions
 - (i) the results of any functional assessments
 - (j) the individual's driving record, and/or
 - (k) the recommendation of a physician.

- ii) Generally, reassessment will be required if:
 - (a) the driver has a medical condition that is progressive
 - (b) the driver fitness determination is based upon the effectiveness of a prescribed treatment regime and it is unknown whether the treatment regime is likely to continue to be effective
 - (c) the driver fitness determination is based upon the effectiveness of a prescribed treatment regime and it is unknown whether the individual is likely to comply with the treatment regime
 - (d) the medical condition results in episodic impairment, the driver fitness determination is based upon an individual having a period of stability without an episodic event, and it is unknown whether the medical condition is likely to continue to be stable
 - (e) the medical condition results in an episodic impairment, the driver fitness determination is based upon a pattern of episodes, e.g., nocturnal seizures or auras, and it is unknown whether the pattern of episodes is likely to continue
 - (f) it is recommended by a physician, and/or
 - (g) the driver fitness standard for that medical condition indicates that reassessment is required.

Rationale

A driver licensing authority schedules a reassessment when the licencing authority decides an individual can be licensed but may require follow-up assessment in the future to ensure the driver's level or risk of impairment has not increased.

XII.4 Setting the reassessment interval

Model

- i) If an authority determines that an individual can be licensed, the licencing authority will also decide whether reassessment is required and, if so, what the reassessment interval should be.

- ii) A driver licensing authority will not schedule a reassessment for a commercial driver if the driver's next scheduled routine re-assessment will provide the licencing authority with the necessary opportunity for reassessment.

- iii) A driver licensing authority can set any reassessment interval that is appropriate for a particular driver. A driver licensing authority will schedule a reassessment in 1 year if:
 - (a) a driver's cognitive function is impaired, and the level of cognitive impairment is likely to increase over time
 - (b) the driver fitness determination is based upon the effectiveness of a prescribed treatment regime and it is unknown whether the treatment regime is likely to continue to be effective
 - (c) the driver fitness determination is based upon the effectiveness of a prescribed treatment regime and it is unknown whether the individual is likely to comply with the treatment regime
 - (d) the medical condition results in episodic impairment, the driver fitness determination is based upon an individual having a period of stability without an episodic event, and it is unknown whether the medical condition is likely to continue to be stable
 - (e) the medical condition results in an episodic impairment, the driver fitness determination is based upon a pattern of episodes, e.g., nocturnal seizures or auras, and it is unknown whether the pattern of episodes is likely to continue.

iv) In most other circumstances where reassessment is required, an authority will schedule a reassessment interval depending upon the likely rate of progression of the medical condition(s).

Rationale

Reassessment intervals of less than 1 year are generally not scheduled, because most medical conditions do not substantially progress in such a short period of time. However, because of the rapid decline in cognitive function associated with many conditions, one-year intervals, or less, are usually scheduled for individuals with cognitive impairments. One-year intervals are also scheduled for individuals with episodic impairments where it is unknown if the stability of the condition, the pattern of episodes or the effectiveness of treatment is likely to change. This is because a period of one year is usually sufficient to determine whether such a change is likely to occur in the future.

PART 2:

CCMTA

MEDICAL STANDARDS FOR DRIVERS

Summary of Chapters and Medical Conditions

Chapter Number	Chapter Title	Conditions/Contents
1	Introduction	
2	Medical conditions at-a-glance	
3	Cardiovascular disease and disorders	Cardiovascular diseases
4	Cerebrovascular disease	Cerebrovascular diseases
5	Chronic renal disease	Renal diseases
6	Cognitive impairment	Cognitive impairment Dementia
7	Diabetes – Hypoglycemia	Diabetes, Hypoglycemia
8	General debility and lack of stamina	Chronic fatigue syndrome, malabsorption syndromes, malignancies, chronic pain
9	Hearing loss	
10	Intracranial tumours	Intracranial tumours
11	Musculoskeletal conditions	Musculoskeletal
12	Neurological disorders	Multiple Sclerosis (MS), Cerebral Palsy (CP), Parkinson's
13	Peripheral vascular diseases	Abdominal Aortic Aneurysm (AAA), Aortic dissection, Deep Vein Thrombosis (DVT) – Pulmonary embolism, Peripheral arterial disease - severe claudication
14	Psychiatric disorders	Mood disorders, Attention Deficit Hyperactivity Disorder (ADHD), Schizophrenia, Personality disorders
15	Drugs, alcohol and driving	Opioids, Antidepressants, Antiepileptics, Antihistamines, Antipsychotics, Sedatives, Stimulants, Alcohol dependence
16	Respiratory diseases	Chronic obstructive pulmonary disease (COPD)
17	Seizures and epilepsy	Seizures, epilepsy, alcohol induced seizures
18	Sleep disorders	Narcolepsy, Sleep Apnea (Obstructive Sleep Apnea [OSA])
19	Syncope	
20	Traumatic brain injury	Traumatic brain injuries
21	Vestibular disorders	Vertigo, dizziness
22	Vision impairment	Vision impairment

23	Medical Review for Drivers	Frequency of medical review
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Chapter 1: Introduction

1.1 Purpose of this part

The medical conditions chapters in this part of the document:

- identify what medical conditions may have an impact on an individual's fitness to drive
- highlight the risk of impairment and crash associated with certain medical conditions
- identify compensation strategies, devices and/or training that may be used to compensate for the effects of a medical condition on driving, and
- include driver fitness standards to assist authorities in determining whether an individual with a medical condition should be licensed and, if so, the appropriate reassessment interval.

1.2 Source of the medical condition chapters

The medical standards in this part used, as a starting point, documentation originally developed by British Columbia for medical conditions and fitness to drive which in turn was based on an integrated review by Dr. B. Dobbs.

The medical standards were subsequently further developed by medical advisors and administrators from Canadian provincial driver licensing bodies using sources such as the Canadian Medical Association (CMA) publication *Determining Medical Fitness to Operate Motor Vehicles, 10th edition* and the Canadian Cardiovascular Society (CCS) 2023 Guidelines on the Fitness to Drive.

The driver licence classes in these standards are based on the CCMTA Classified Driver Licensing System. In general, classes 1-4 are referring to commercial drivers and classes 5-7 as non-commercial drivers.

1.3 Medical condition chapter template

Below is the template used for the medical condition standards chapters. It is annotated to explain what type of information is found in each section of the template.

NAME OF MEDICAL CONDITION

About the medical condition

Information about the medical condition to assist driver fitness authorities in understanding and applying the guidelines for assessment.

Prevalence

Information about the prevalence of the medical condition, which is relevant to the frequency that it may appear as an issue for licensing.

Medical condition and adverse driving outcomes

Conclusions on the general findings of research on the link between the medical condition and adverse driving outcomes.

Effect on functional ability to drive

Information on the specific effects of the medical condition on the functional abilities needed for driving. This section includes the following table:

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
The medical condition and any distinct presentations or variations of the condition	Whether the functional impairment is persistent or episodic, and whether a medical assessment and/or functional assessment is required	The primary functional abilities affected by the medical condition: cognitive, motor, or sensory	The assessment tool to be used, e.g., cognitive road test.

Compensation

Information about whether or not a driver can compensate for the functional impairment caused by medical conditions through the use of strategies or devices. Treatment for a condition, e.g., medication, is not a type of compensation.

Guidelines for assessment

This section names the medical condition and any distinct presentations or variations that require an individual standard. A standard may be for all licence classes (non-commercial classes 5-7 and commercial classes 1-4), for non-commercial drivers only, or for commercial drivers only.

Additional background information about the medical condition may be included here to help provide context for the standard and other information in the following table.

Standard	The requirements that must be met in order to be licensed
Conditions for maintaining licence	Description of any conditions for maintaining a licence. Conditions are ongoing requirements that the driver must meet in order to maintain the licence. For example, ‘wear corrective lenses’ or ‘do not drive if your dialysis regime is delayed’.
Reassessment	Description of a suggested period on how often an individual will be reassessed after being found eligible for a licence. Where a reassessment period is mandatory it is also reflected in the standard. Where there is no particular reassessment period for the medical condition, then reassessment is “routine.”
Information from health care providers	Description of any information about the medical condition or functional ability that an authority usually requests when applying the standard. This information will come from medical and functional assessments and is supplied by from physicians, driver rehabilitation specialists or other health care providers. Specific information that may be requested includes a professional’s opinion regarding: • whether the individual has insight into the impact their medical condition may have on driving • whether the individual is compliant with their current treatment regime • if known or applicable, whether the individual is compliant with any current conditions for maintaining a licence
Rationale	A brief description of the rationale for the guide.

Chapter 2: Medical conditions at-a-glance

For each major medical condition identified in the medical condition chapters, the following table identifies:

- whether the resulting impairment is persistent or episodic
- the chapter where the specific information is available

Condition	Chapter Reference	Type of Impairment	
		Persistent	Episodic
Abdominal Aortic Aneurysm	13		X
Aortic dissection	13		X
Cardiovascular diseases	3	X	X
Cerebrovascular diseases	4	X	X
Cognitive impairment	6	X	
Diabetes – Hypoglycemia	7		X
Drug/alcohol use	15	X	X
DVT – Pulmonary embolism	13		X
General debility and lack of stamina	8	X	
Hearing loss	9	X	
Intracranial tumours	10	X	X
MS, Cerebral Palsy, Parkinson's	12	X	X
Musculoskeletal	11	X	
Narcolepsy	18	X	X
Peripheral arterial disease-severe claudication	13	X	
Psychiatric disorders	14	X	X
Renal diseases	5	X	
Respiratory diseases	16	X	
Seizures and epilepsy	17		X
Sleep apnea	18	X	X
Syncope	19		X
Traumatic brain injuries	20	X	X
Vestibular disorders	21	X	X
Vision impairment	22	X	

Chapter 3: Cardiovascular disease and disorders

3.1 About cardiovascular disease

Overview

Cardiovascular disease is an umbrella term used to describe a variety of disorders relating to the heart and blood vessels.

Coronary artery disease

Coronary artery disease, which is also called coronary, ischemic or atherosclerotic heart disease, is characterized by the presence of atherosclerosis in the arteries of the heart. Atherosclerosis is the progressive build-up of fatty deposits called plaque, which narrows the coronary arteries and reduces blood flow to the heart. Complications of coronary artery disease include:

- angina (pain or discomfort due to lack of oxygen to the heart muscle)
- myocardial infarction (heart attack), and
- ischemic cardiomyopathy (permanent damage to the heart muscle).

Disturbances of cardiac rhythm

Disturbances of cardiac rhythm, or arrhythmias, include:

- tachycardia (rapid heart rate)
- bradycardia (slow heart rate)
- fibrillation or flutter (abnormal twitching of the heart muscle), and
- heart block.

These arrhythmias may arise from the heart muscle itself or the conduction system and are often secondary to underlying heart disease.

Valvular heart disease

Disease affecting the heart valves may result in stenosis and regurgitation and is associated with an increased risk of thromboembolism.

In valvular stenosis, the valve opening is smaller than normal due to hardening or fusing of the valve's leaflets. This may cause the heart to have to work harder to pump blood through the valves. In valvular regurgitation or "leaky valve", the valve does not close tightly enough, allowing some blood to leak backwards across the valve. As the leak worsens, the heart has to work harder to make up for the leaky valve, and less blood may flow to the rest of the body. Stenosis and regurgitation may coexist.

Individuals who have undergone valve replacement surgery are subject to a certain irreducible incidence of late complications such as thromboembolism, dehiscence, infection and mechanical malfunction.

Heart failure

Heart failure usually is a chronic, progressive condition in which the heart is unable to pump the quantity of blood required to meet the body's needs. It is generally the result of heart disease but may be secondary to non-cardiac conditions such as fluid overload and anemia.

The severity of heart failure can be assessed by measuring the fraction of blood being pumped out of the left ventricle with each beat. This is expressed as a ratio called the left ventricle ejection fraction (LVEF). Healthy individuals generally have an LVEF greater than 55%.

The New York Heart Association (NYHA) functional classification system provides a simple, clinical measure for assessing the degree of heart failure. This system describes the effect of cardiovascular disease on an individual's general physical activity, according to the categories shown in the following table.

Category	Description
I	No symptoms and no limitation in ordinary physical activity. Comfortable at rest.
II	Mild symptoms and slight limitation during ordinary activity. Comfortable at rest.
III	Marked limitation in activity due to symptoms, even during less-than-ordinary activity. Comfortable only at rest.
IV	Severe limitations. Experiences symptoms even while at rest.

Cardiomyopathy

Cardiomyopathy refers to a change in the size, strength or flexibility in the heart muscle. These changes can reduce the amount of blood being pumped out of the heart and may lead to heart failure. Cardiomyopathy is associated with an increased risk of arrhythmias.

3.2 Prevalence

Cardiovascular disease is a major cause of death, disability and health care costs in Canada. In 2023, cardiovascular disease accounted for approximately 18% of all deaths in Canada, which has declined significantly since the late 1990s but remains the second leading cause of death of Canadians across all age groups and the leading cause of death for Canadians 85 years and older.

3.3 Cardiovascular disease and adverse driving outcomes

Research indicates that drivers with cardiovascular disease as a whole have a higher risk for adverse driving outcomes than those without cardiovascular disease. However, there is relatively little research on the effects of specific cardiovascular disorders and driving outcomes.

Per the Canadian Cardiovascular Society (CCS) 2023 Guidelines on the Fitness to Drive, the recommendations for driving eligibility are made on the basis of a comparison with the previously stated threshold, but the risk estimates are made on the basis of the best and most recent available evidence. This evidence was used to estimate risk of sudden incapacitation or a reasonable surrogate, as described in the introductory section, when this evidence was lacking. However, the evidence does not speak to the actual risk of driving or collision rates associated with the cardiac diagnosis, the benefit of driving cessation, or the effect of the system of mandatory reporting of and formal license suspension for such patients.

3.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach ⁵	Primary functional ability affected	Assessment tools
Coronary artery disease Arrhythmias Valvular heart disease Cardiomyopathy	Episodic impairment: Medical assessment – likelihood of impairment	All – sudden incapacitation	Medical assessments
Heart failure	Persistent Impairment: Functional assessment	Can affect Motor Sensory and Cognitive function May also result in general debility or lack of stamina	Medical assessments Functional Assessment
	Episodic impairment: Medical assessment – likelihood of impairment	All – sudden incapacitation	Medical assessments Specialist's report
Post cardiac arrest Post-operative cognitive decline (POCD)	Persistent Impairment: Functional assessment	Can affect Motor Sensory and Cognitive function May also result in general debility	Medical assessments Functional Assessment

⁵ See Part 1 for a discussion of the use of functional assessments for driver licensing decisions.

The effect of cardiovascular disease on an individual's functional ability to drive may be episodic or persistent.

Episodic impairment

The potential episodic impairment is a partial or complete loss of consciousness that incapacitates the driver. This may be caused by a variety of cardiovascular events such as:

- bradyarrhythmias
- tachyarrhythmias
- myocardial disease (massive myocardial infarction)
- left ventricular myocardial restriction or constriction
- pericardial constriction or tamponade
- aortic outflow tract obstruction
- aortic valvular stenosis, or
- hypertrophic obstructive cardiomyopathy.

Persistent impairment

Individuals with cardiovascular disease, such as heart failure, may develop persistent cognitive impairment, loss of stamina or general debility as a result of a reduction of oxygen to the brain, organs and tissues. Cardiac arrest may also cause persistent cognitive impairment where a loss of blood to the brain causes brain damage. Post-operative cognitive decline may occur in individuals that have undergone intracardiac procedures (e.g., valve surgery) or extracardiac procedures (e.g., coronary artery bypass graft (CABG) surgery).

3.5 Compensation

Individuals with cardiovascular disease cannot compensate for their functional impairment.

3.6 Guidelines for assessment

These standards are based on recommendations contained in the Canadian Cardiovascular Society (CCS) 2023 Guidelines on the Fitness to Drive. The guidelines are based on an acceptable threshold for annual risk of sudden incapacitation of 1% or less for commercial drivers and 22% or less for private drivers. It is recognized that exceptions can be made to the recommended standards if the treating cardiologist estimates the annual risk of sudden incapacitation to less than one percent.

For CCS recommendations for transient conditions (waiting periods) see Section 3.6.44 which forms part of the standards.

3.6.1 New York Heart Association (NYHA) Classification IV – All drivers

STANDARD	Not eligible for any classes of licence if: • assessed as New York Heart Association (NYHA) Class IV
Conditions for maintaining licence	N/A
Reassessment	N/A
Information from health care providers	• NYHA classification
Rationale	CCS recommendation

3.6.2 Congenital heart defects – All drivers

STANDARD	Eligible for all classes of licence if: • they meet any standards related to a specific cardiovascular condition or event
Conditions for maintaining licence	None
Reassessment	• Where the defect has been repaired and the treating physician does not indicate any concerns, as per routine • More frequently at the discretion of the licencing authority
Information from health care providers	• Whether or not the defect has been repaired • Presence of any specific cardiovascular condition or event or risk of condition or event that may impair functional ability to drive
Rationale	Congenital heart defects are not specifically addressed in the CCS recommendations. This standard is included here to assist where a congenital heart defect is reported to an authority. The nature of congenital heart defects and their treatment is variable; therefore, there are no driver fitness standards specifically for them.

3.6.3 Acute Coronary Syndromes – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if:
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	• they have an angiographic demonstration of less than a 70% reduction in the diameter of the left main coronary artery, or • where they have a 70% or greater reduction in the diameter of the left main coronary artery, it has been successfully treated with revascularization • the waiting periods have been met (Section 3.6.44)
Conditions for maintaining licence	None
Reassessment	• Every 5 years or as per routine, whichever is more frequent • More frequently at the discretion of the licencing authority
Information from health care providers	• Extent of reduction in the left main coronary artery • Where applicable, result of treatment with revascularization
Rationale	CCS recommendation

3.6.4 Acute Coronary Syndromes – Commercial drivers

STANDARD	Eligible for a commercial licence if: • they have an angiographic demonstration of less than a 50% reduction in the diameter of the left main coronary artery, or • where they have a 50% or greater reduction in the diameter of the left main coronary artery, it has been successfully treated with revascularization • providing the applicable waiting periods are met (3.6.44)
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• Extent of reduction in the left main coronary artery • Where applicable, result of treatment with revascularization
Rationale	CCS recommendation

3.6.5 Asymptomatic coronary artery disease or stable angina – All drivers

STANDARD	Eligible for all classes of licence
Conditions for maintaining licence	None
Reassessment	• Every 5 years or as per routine, whichever is more frequent • More frequently at the discretion of the licencing authority
Information from health care providers	• Confirmation that coronary artery disease is asymptomatic, or angina is stable
Rationale	CCS recommendation

3.6.6 Coronary Artery Bypass Graft (CABG) surgery – Non-commercial drivers

Guidelines	Eligible for a non-commercial licence if: • it has been 1 month or more since CABG surgery
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• Date of CABG surgery
Rationale	CCS recommendation

3.6.7 Coronary Artery Bypass Graft (CABG) surgery – Commercial drivers

STANDARD	Eligible for a commercial licence if: • it has been 3 months or more since CABG surgery
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• Date of CABG surgery
Rationale	CCS recommendation

3.6.8 Premature atrial or ventricular contractions – All drivers

STANDARD	Eligible for all classes of licence if: • they have no associated impaired level of consciousness caused by cerebral ischemia
Conditions for maintaining licence	None
Reassessment	• Where there is no underlying cardiovascular disease, as per routine • More frequently at the discretion of the licencing authority
Information from health care providers	• Confirmation that there is no impaired level of consciousness caused by cerebral ischemia
Rationale	CCS recommendation

3.6.9 Ventricular fibrillation (VF) with no reversible cause – Non-commercial drivers

This standard applies to non-commercial drivers who have ventricular fibrillation (VF) with no reversible cause. It does not apply to drivers who have VF due to any of the following reversible causes:

- VF within 24 hours of myocardial infarction
- VF during coronary angiography
- VF with electrocution, or
- VF secondary to drug toxicity.

If VF has a reversible cause, it is considered a transient condition, see 3.6.11.

STANDARD	Eligible for a non-commercial licence if: • it has been 3 months or more since their last episode
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• Date of last episode of ventricular fibrillation
Rationale	CCS recommendation

3.6.10 Ventricular fibrillation (VF) with no reversible cause – Commercial drivers

This standard applies to commercial drivers who have ventricular fibrillation (VF) with no reversible cause. It does not apply to drivers who have VF due to any of the following reversible causes:

- VF within 24 hours of myocardial infarction
- VF during coronary angiography
- VF with electrocution, or
- VF secondary to drug toxicity.

If VF has a reversible cause, it is considered a transient condition. The CCS recommendation for VF with a reversible cause is included in 3.6.11.

STANDARD	Not eligible for a commercial licence
Conditions for maintaining licence	N/A
Reassessment	N/A
Information from health care providers	N/A
Rationale	CCS recommendation

3.6.11 Ventricular Tachycardia (VT)/Ventricular Fibrillation (VF) due to a reversible cause – All drivers

Examples of reversible cause of VT/VF include but are not limited to:

- VF within 24 hours of myocardial infarction
- VF during coronary angiography
- VF with electrocution, and
- VF secondary to drug toxicity

Reversible cause VF recommendations over-rule the VF (no reversible cause) recommendations if the reversible cause is treated.

STANDARD	Eligible for all classes of licence if: • Underlying condition has been successfully treated.
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• Whether the underlying condition causing VT/VF has been successfully treated
Rationale	CCS recommendation

3.6.12 Hemodynamically unstable Ventricular Tachycardia (VT) or VT with impaired level of consciousness – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • It has been 3 months since the last episode, and • the underlying condition has been successfully treated
Conditions for maintaining licence	None
Reassessment	• Every 5 years or as per routine, whichever is more frequent • More frequently at the discretion of the licencing authority
Information from health care providers	• Whether the underlying condition causing VT has been successfully treated
Rationale	CCS recommendation

3.6.13 Hemodynamically unstable Ventricular Tachycardia (VT) or VT with impaired level of consciousness – Commercial drivers

STANDARD	Not eligible for a commercial licence
Conditions for maintaining licence	N/A
Reassessment	N/A
Information from health care providers	N/A
Rationale	CCS recommendation

3.6.14 Sustained Ventricular Tachycardia (VT) with structural heart disease without impaired level of consciousness in patients without Implantable Cardioverter Defibrillator (ICD) – Non-commercial drivers

Sustained VT is VT that lasts for greater than 30 seconds and/or results in hemodynamic compromise within 30 seconds.

STANDARD	Eligible for a non-commercial licence if: • it has been 3 months or more since their last episode of sustained VT
Conditions for maintaining licence	None
Reassessment	• Where the driver's condition is controlled and stable, every 5 years or as per routine, whichever is more frequent • More frequently at the discretion of the licencing authority
Information from health care providers	• Date of last episode of sustained VT
Rationale	CCS recommendation

3.6.15 Sustained Ventricular Tachycardia (VT) with or without impaired level of consciousness - Commercial drivers

Sustained VT is VT that lasts for greater than 30 seconds and/or results in hemodynamic compromise within 30 seconds

STANDARD	Not eligible for a commercial licence
Conditions for maintaining licence	N/A
Reassessment	N/A
Information from health care providers	N/A
Rationale	CCS recommendation

3.6.16 Sustained Ventricular Tachycardia (VT) with structurally normal heart (i.e., Idiopathic VT) without impaired level of consciousness – Non-commercial drivers

Sustained VT is VT that lasts for greater than 30 seconds and/or results in hemodynamic compromise within 30 seconds.

STANDARD	Eligible for a non-commercial licence if: • it has been 1 week or more since their last episode of sustained VT, • with satisfactory control
Conditions for maintaining licence	None
Reassessment	• Annually or more frequently at the discretion of the licencing authority
Information from health care providers	• Date of last episode of sustained VT • Whether the driver has been successfully treated
Rationale	CCS recommendation

3.6.17 Non-sustained Ventricular Tachycardia (VT) – All drivers

This standard applies to all drivers who have non-sustained ventricular tachycardia (VT).

Non-sustained VT means VT having a cycle length of 500 msec or less and lasting less than 30 seconds without hemodynamic collapse.

STANDARD	Eligible for all classes of licence
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	None
Rationale	CCS recommendation

3.6.18 Supraventricular tachycardia (SVT), atrial fibrillation (AF) or atrial flutter (AFL) with no impaired level of consciousness – All drivers

This standard applies to all drivers who have had paroxysmal:

- supraventricular tachycardia (SVT)
- atrial fibrillation (AF), or
- atrial flutter (AFL)

with no associated impaired level of consciousness.

STANDARD	Eligible for all classes of licence
Conditions for maintaining licence	None
Reassessment	• Initial reassessment at 5 years or as per routine, whichever is more frequent. If no further recurrences after 5 years, then as per routine • More frequently at the discretion of the licencing authority
Information from health care providers	None
Rationale	CCS recommendation

3.6.19 Supraventricular tachycardia (SVT), atrial fibrillation (AF) or atrial flutter (AFL) with impaired level of consciousness – All drivers

This standard applies to all drivers who have had paroxysmal:

- supraventricular tachycardia (SVT)
- atrial fibrillation (AF), or
- atrial flutter (AFL)

with an associated impaired level of consciousness.

STANDARD	Eligible for all classes of licence if: • Satisfactory control of the condition
Conditions for maintaining licence	None
Reassessment	• Initial reassessment at 5 years or as per routine, whichever is more frequent. If no further recurrences after 5 years, then routine • More frequently at the discretion of the licencing authority
Information from health care providers	• Date of last occurrence of paroxysmal SVT, AF, or AFL with impaired level of consciousness • For drivers with paroxysmal SVT, whether it has been successfully treated with radiofrequency ablation • For drivers with paroxysmal AF, whether they have had AV node ablation and pacemaker implantation • For drivers with paroxysmal AFL, whether they have had a successful isthmus ablation with proven establishment of bidirectional isthmus block
Rationale	CCS recommendation

3.6.20 Sinus node dysfunction – All drivers

STANDARD	Eligible for all classes of licence if: • they have no impaired level of consciousness • where they have impaired level of consciousness (sick sinus syndrome) or symptomatic pauses (greater than or equal to 5 seconds) during atrial fibrillation (pauses during atrial fibrillation or conversion pauses); no restrictions if treated with appropriate pacemaker therapy
Conditions for maintaining licence	None
Reassessment	• Every 5 years or as per routine, whichever is more frequent • More frequently at the discretion of the licencing authority
Information from health care providers	• Whether the driver has associated symptoms • Where the driver has associated symptoms, whether they have been successfully treated with a pacemaker
Rationale	CCS recommendation

3.6.21 Atrioventricular (AV) or intraventricular block – All drivers

STANDARD	(a) Drivers with (i) isolated first degree AV block (ii) isolated right bundle branch block (RBBB) (iii) isolated left anterior or posterior fascicular block (iv) left bundle branch block (LBBB) (v) bifascicular block (vi) second-degree AV block/Mobitz I (vii) first-degree AV block + bifascicular block, or (viii) congenital third-degree AV block are eligible for all classes of licence if: • they have had no associated impaired level of consciousness If impaired level of consciousness occurred, disqualified until appropriate cardiac implantable electronic device therapy. (b) Drivers with (i) second degree AV block; Mobitz II (distal AV block) (ii) alternating LBBB and RBBB, or (iii) acquired third degree AV block are not eligible for any class of licence until appropriate pacemaker therapy is in place.
Conditions for maintaining licence	None
Reassessment	• Every 5 years or as per routine, whichever is more frequent • More frequently at the discretion of the licencing authority
Information from health care providers	• The specific nature of the atrioventricular or intraventricular block • Where the driver has • left bundle branch block (LBBB) • bifascicular block • second degree AV block/Mobitz I • first degree AV block + bifascicular block, or • congenital third degree AV block whether the driver has had any associated impaired level of consciousness
Rationale	CCS recommendation

3.6.22 Permanent pacemakers – All drivers

For drivers with loss of consciousness, refer to standard applicable to loss of consciousness.

STANDARD	Eligible for all classes of licence if: • it has been 1 week or more since pacemaker implant
Conditions for maintaining licence	• Regularly check pacemaker at a pacemaker clinic and do not drive if there is a pacemaker malfunction
Reassessment	• Every 5 years or as per routine, whichever is more frequent • More frequently at the discretion of the licencing authority
Information from health care providers	• Whether the driver has experienced any episodes of impaired level of consciousness since the implant • Whether the results of a post-implant ECG show normal sensing and capture
Rationale	CCS recommendation

3.6.23 Implantable Cardioverter Defibrillator (ICD) used as primary prophylaxis – Non-commercial drivers

For patients who decline an ICD, refer to the standard for heart failure or the underlying condition.

STANDARD	Eligible for a non-commercial licence if: • it has been 1 week or more since ICD implant
Conditions for maintaining licence	• Regularly check ICD at a device clinic and do not drive if there is an ICD malfunction • Report to the authority if you experience an impaired level of consciousness or disability as a result of ICD therapy
Reassessment	• Where the driver's condition is controlled and stable, every 5 years or as per routine, whichever is more frequent • More frequently at the discretion of the licencing authority
Information from health care providers	• Date of ICD implant (if applicable)
Rationale	CCS recommendation

3.6.24 Declined an Implantable Cardioverter Defibrillator (ICD) or have an ICD implanted – Commercial drivers

This standard applies to commercial drivers who:

- have had an implantable cardioverter defibrillator (ICD) used as a primary prophylaxis, or
- have declined an ICD recommended as primary prophylaxis

When used as a primary prophylaxis, the ICD is implanted to prevent sudden cardiac death in individuals considered to be at high risk but who have not had an episode of ventricular arrhythmia.

Individuals whose ICD also regulates pacing for bradycardia must also meet the standard for permanent pacemakers in 3.6.22.

STANDARD	Not eligible for a commercial licence* *All recommendations are subject to cardiologist incorporating patient-specific considerations, and risk factors for arrhythmias and syncope. *Drivers with ICDs or declining an ICD are disqualified from commercial driving on the basis of their underlying condition (e.g., ventricular dysfunction, history of ventricular arrhythmia) rather than the ICD itself.
Conditions for maintaining licence	N/A
Reassessment	N/A
Information from health care providers	N/A
Rationale	CCS recommendation – an ICD may sometimes be implanted in low-risk patients. Individual cases may be made for allowing a commercial driver to continue driving with an ICD provided the annual risk of sudden incapacitation is felt to be 1% or less.

3.6.25 Implantable Cardioverter Defibrillator (ICD) used as secondary prophylaxis for sustained Ventricular Tachycardia (VT) without impaired consciousness – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • it has been 1 week or more since ICD implantation
Conditions for maintaining licence	• Regularly check ICD at a device clinic and do not drive if there is an ICD malfunction • Report to the authority if you experience an impaired level of consciousness or disability as a result of ICD therapy
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• Date of ICD implant • Date of last episode of sustained VT • Has driver experienced an impaired level of consciousness since ICD implant
Rationale	CCS recommendation

3.6.26 *Appropriate* Implantable Cardioverter Defibrillator (ICD) shock or any ICD therapy – Non-Commercial drivers*

This standard applies to non-commercial drivers where:

- ICD therapy (shock or antitachycardia pacing [ATP]) has been delivered and there is an associated impaired level of consciousness, or has been delivered during sleep where an impaired level of consciousness cannot be ascertained, or the therapy delivered by the device was disabling, or
- ICD therapy has been delivered and there is no associated impaired level of consciousness

STANDARD	Eligible for a non-commercial licence With an impaired level of consciousness or during sleep • may resume driving 3 months after event Without impaired level of consciousness • may resume driving one week after event *With inappropriate ICD therapy, no restriction.
Conditions for maintaining licence	• As per the standard for the underlying cardiovascular condition
Reassessment	• As per the standard for the underlying cardiovascular condition
Information from health care providers	• Date of the event
Rationale	CCS recommendation

3.6.27 *Implantable Cardioverter Defibrillator (ICD) therapy (shock or antitachycardia pacing [ATP]) has been delivered – Commercial drivers*

STANDARD	Not eligible for a commercial licence
Conditions for maintaining licence	N/A
Reassessment	N/A
Information from health care providers	N/A
Rationale	CCS recommendation

3.6.28 Implantable Cardioverter Defibrillator (ICD) implanted as secondary prophylaxis for Ventricular Fibrillation (VF) or Ventricular Tachycardia (VT) with impaired level of consciousness – Non-commercial drivers

This standard applies to non-commercial drivers who have had an implantable cardioverter defibrillator (ICD) implanted as a secondary prophylaxis for VF or VT with an impaired level of consciousness.

When used as a secondary prophylaxis, the ICD is implanted to prevent sudden cardiac death in individuals who have suffered a cardiac arrest or who suffer from malignant arrhythmias that do not respond readily to medical treatment.

Individuals whose ICD also regulates pacing for bradycardia must also meet the standard for permanent pacemakers in 3.6.22.

STANDARD	Eligible for a non-commercial licence if: • it has been 3 months since their last incapacitating event
Conditions for maintaining licence	• Regularly check ICD at a device clinic and do not drive if there is an ICD malfunction • Report to the authority if you experience an impaired level of consciousness or disability as a result of ICD therapy
¾Reassessment	• Where the driver's condition is controlled and stable, every 5 years or as per routine, whichever is more frequent • More frequently at the discretion of the licencing authority
Information from health care providers	• Date of last episode of sustained symptomatic VT or syncope judged to be likely due to VT or cardiac arrest
Rationale	CCS recommendation

3.6.29 Electrical storm greater than or equal to three Ventricular Tachycardia (VT) or Ventricular Fibrillation (VF) events in 24 hours – Non-Commercial

STANDARD	Disqualified for up to 6 months after event. Eligible for a non-commercial licence if: • Expert evaluation determines eligibility in return to driving.
Conditions for maintaining licence	None
Reassessment	• Routine or at the discretion of the licencing authority

Information from health care providers	• Date of last occurrence and treatment undertaken
Rationale	CCS recommendation; note that the recommendation in CCS is under the umbrella of electrical storms with ICD; however electrical storms can occur under other conditions.

NEW	<i>3.6.30 Electrical storm greater than or equal to three Ventricular Tachycardia (VT) or Ventricular Fibrillation (VF) events in 24 hours - Commercial</i>
STANDARD	Not eligible for a commercial licence.
Conditions for maintaining licence	N/A
Reassessment	N/A
Information from health care providers	N/A
Rationale	CCS recommendation

3.6.31 Inherited heart disease – Non-commercial drivers

This standard applies to non-commercial drivers with the following inherited heart diseases:

- Brugada Syndrome
- Long QT Syndrome, and
- Arrhythmogenic right ventricular cardiomyopathy
- Other arrhythmogenic cardiomyopathies
- Inherited hypertrophic cardiomyopathy (if non-inherited go to Standard 3.6.37 *Heart failure – Non-commercial drivers*) and
- Lamin cardiomyopathy

STANDARD	Generally eligible for a non-commercial licence if: • it has been 3 months or more since they have experienced any event causing an impaired level of consciousness, unless cardiologist provides rationale for a reduced period • driver meets Canadian Cardiovascular Society Guidelines, Table 4. Recommendations for fitness to drive for patients with inherited arrhythmias and cardiomyopathies (CCS, 2023)
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• Confirmation that the condition has been investigated and treated by a cardiologist • Date of last event causing an impaired level of consciousness (if applicable)
Rationale	CCS recommendation

3.6.32 Inherited heart disease – Commercial drivers

This standard applies to commercial drivers with the following inherited heart diseases:

- Brugada Syndrome
- Long QT Syndrome, and
- Arrhythmogenic right ventricular cardiomyopathy
- Other arrhythmogenic cardiomyopathies
- Inherited hypertrophic cardiomyopathy (if non-inherited go to Standard 3.6.38 *Heart failure – Commercial drivers*) and
- Lamin cardiomyopathy

STANDARD	Generally not eligible for a commercial licence. May be eligible if: • an assessment by a cardiologist indicates that the annual risk of sudden incapacitation is 1% or less, and • driver meets Canadian Cardiovascular Society Guidelines, Table 4. Recommendations for fitness to drive for patients with inherited arrhythmias and cardiomyopathies (CCS, 2023)
Conditions for maintaining licence	N/A
Reassessment	N/A
Information from health care providers	Percent (%) annual risk of sudden incapacitation
Rationale	CCS recommendation

3.6.33 Medically treated valvular heart disease – Non-commercial drivers

This standard applies to non-commercial drivers with medically treated:

- aortic stenosis
- aortic regurgitation
- mitral stenosis
- mitral regurgitation
- tricuspid regurgitation

STANDARD	Eligible for a non-commercial licence if: • aortic stenosis assessed as NYHA Class I-II • assessed as Class I-III ○ aortic regurgitation ○ mitral stenosis ○ mitral regurgitation ○ tricuspid regurgitation
Conditions for maintaining licence	None
Reassessment	• Every 5 years or as per routine, whichever is more frequent • More frequently at the discretion of the licencing authority
Information from health care providers	• NYHA classification
Rationale	CCS recommendation

3.6.34 Medically treated valvular heart disease – Commercial drivers

This standard applies to commercial drivers with medically treated:

- aortic stenosis
- aortic regurgitation
- mitral stenosis
- mitral regurgitation
- tricuspid regurgitation

STANDARD	Eligible for a commercial licence if: Aortic stenosis/regurgitation • they are assessed as NYHA Class I • they have a left ventricle ejection fraction (LVEF) greater than or equal to 50% • there has been no impaired level of consciousness Mitral regurgitation • they are assessed as NYHA Class I • they have a left ventricle ejection fraction (LVEF) greater than or equal to 50% • there has been no impaired level of consciousness • there is no history of pulmonary hypertension or systemic embolism Mitral stenosis • they are assessed as NYHA Class I • there has been no impaired level of consciousness Tricuspid regurgitation • they are assessed as NYHA Class I • they have no right-sided HF or symptomatic sustained arrhythmia • they have no right-sided ventricular dysfunction • they have a left ventricle ejection fraction (LVEF) greater than or equal to 50%
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• NYHA classification • Left ventricle ejection fraction (LVEF) • Whether the driver has had an episode of impaired level of consciousness
Rationale	CCS recommendation

3.6.35 Surgically treated valvular heart disease – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: Post-surgical valve replacement (aortic, tricuspid, mitral) or post-surgical valve repair (aortic) may resume driving 1 month post procedure if: • they are assessed as NYHA I-III • aortic valve replacement and repair requires stable QRS duration, and no high-grade AV block in the absence of pacemaker Post surgical valve repair (tricuspid, mitral) may resume driving 48 hours post procedure • they are assessed as NYHA I-III
Conditions for maintaining licence	None
Reassessment	• Every 5 years or as per routine, whichever is more frequent • More frequently at the discretion of the licencing authority
Information from health care providers	• NYHA classification • Type and date of surgical treatment
Rationale	CCS recommendation. Note that the CCS guidelines do not specify guidance for aortic valve repair; however, requirements to be able to resume driving for aortic valve replacement are applicable to aortic valve repair.

3.6.36 Surgically treated valvular heart disease – Commercial drivers

STANDARD	Eligible for a commercial licence if: Surgical valve replacement (aortic, tricuspid, mitral) or surgical valve repair (aortic) may resume driving 3 months post procedure, • they are assessed as NYHA I • LVEF greater than or equal to 30% • aortic valve replacement and repair requires stable QRS duration, and no high-grade AV block in the absence of pacemaker Surgical valve repair (tricuspid, mitral) may resume driving 1 month post procedure, • they are assessed as NYHA I • LVEF greater than or equal to 30%
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• NYHA classification • Type and date of surgical treatment • Left ventricle ejection fraction (LVEF)
Rationale	CCS recommendation. Note that the CCS guidelines do not specify guidance for aortic valve repair; however, requirements to be able to resume driving for aortic valve replacement are applicable to aortic valve repair.

3.6.37 Heart failure – Non-commercial drivers

This standard includes:

- non-inherited cardiomyopathies (for inherited cardiomyopathies see Standard 3.6.31)
- left ventricular dysfunction

STANDARD	Eligible for a non-commercial licence if: • they are assessed as NYHA Class I or III • they are not receiving outpatient or home intermittent inotropes
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• NYHA Classification • Whether the driver is receiving intermittent outpatient or home inotropes or using a left ventricle assist device
Rationale	CCS recommendations

3.6.38 Heart failure – Commercial drivers

This standard includes:

- non-inherited cardiomyopathies (for inherited cardiomyopathies see Standard 3.6.32)
- left ventricular dysfunction

STANDARD	Eligible for a commercial licence if: • they are assessed as NYHA Class I or II • they have an LVEF of greater than or equal to 30% • they are not receiving intermittent outpatient or home inotropes
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• NYHA Classification • LVEF • Whether the driver is receiving intermittent outpatient or home inotropes or using a left ventricle assist device
Rationale	CSS recommendations

3.6.39 Left ventricular assist device (LVAD) – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • they are assessed as NYHA Class I or II, and • cardiologist report indicates stable for 2 months post implantation
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• NYHA Classification • Whether the driver is receiving intermittent inotropes or using an LVAD • Date of LVAD implant
Rationale	CCS recommendation

3.6.40 Left Ventricular Assist Device (LVAD) – Commercial drivers

STANDARD	Not eligible for a commercial licence
Conditions for maintaining licence	N/A
Reassessment	N/A
Information from health care providers	N/A
Rationale	CCS recommendation

3.6.41 Heart transplant – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • it has been 6 weeks or more since their discharge following transplant • they are assessed as NYHA Class I or II, and • they are on stable immunosuppression therapy
Conditions for maintaining licence	• Have an annual medical follow-up
Reassessment	• Where the driver's condition is controlled, stable and asymptomatic, then every 5 years or as per routine, whichever is more frequent • More frequently at the discretion of the licencing authority
Information from health care providers	• Date of the driver's discharge following transplant • NYHA Classification • Whether the driver is on stable immunosuppression therapy
Rationale	CCS recommendation

3.6.42 Heart transplant – Commercial drivers

STANDARD	Eligible for a commercial licence if: • it has been 6 months or more since their discharge following transplant • they are assessed as NYHA Class I • they have a left ventricular ejection fraction (LVEF) of greater than or equal to 50% • they are on stable immunosuppression therapy, and • they have no active ischemia
Conditions for maintaining licence	• Have an annual medical follow-up, including a non-invasive test of ischemic burden
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• Date of the driver's discharge following transplant • NYHA Classification • LVEF • Whether the driver is on stable immunosuppression therapy • Whether the driver has active ischemia
Rationale	CCS recommendation

3.6.43 *Syncope*

The standards for syncope are included in Chapter 19.

3.6.44 Canadian Cardiovascular Society Recommended Waiting Periods (2023)

A. Coronary artery disease (CAD) – waiting periods

Condition	Non-commercial	Commercial
ACS: PCI performed		
MI, LVEF ≤ 40%	1 month	3 months
MI, LVEF > 40%	2 weeks	1 month
ACS without MI (unstable angina)	48 hours	7 days
ACS: PCI not performed		
MI	1 month	3 months
ACS without MI (unstable angina)	7 days	1 month
PCI (in a non-ACS context)	48 hours	
Cardiac surgery		
CABG surgery	1 month	3 months
Notes:		
ACS = acute coronary syndrome		
CABG = coronary artery bypass graft		
CAD = coronary artery disease		
LVEF = left ventricular ejection fraction		
MI = myocardial infarction		
PCI = percutaneous coronary intervention		

Waiting periods do not account for any underlying cardiac conditions that may be associated with ACS, MI or cardiac surgery. Please refer to the appropriate medical standard for relevant wait times and eligibility (for example, heart failure).

B. Disturbances of cardiac rhythm, arrhythmia devices and procedures

Catheter ablation and EPS - waiting times

Condition	Non-commercial	Commercial
Catheter ablation procedure EPS with no inducible sustained ventricular arrhythmias	48 hours after procedure if no new conduction disturbance, dysrhythmias, or exacerbation of underlying condition	48 hours after procedure if no new conduction disturbance, dysrhythmias, or exacerbation of underlying condition
<u>Note:</u> EPS = electrophysiology study		

C. Rhythm and devices: cardiac implantable electronic devices, bradyarrhythmias, and tachyarrhythmias

Pacemaker - waiting times

Condition	Non-commercial	Commercial
Permanent pacemaker		
Transvenous and leadless pacemakers, without impaired consciousness or high-grade atrioventricular (AV) block	No restriction*	
Transvenous and leadless pacemakers, with previous impaired consciousness or high-grade AV block	Disqualified for 1 week after implantation, after which patient may resume driving	
Generator change	No restriction*	
Upgrade/lead revision	If there is a prior history of impaired level of consciousness or high-grade atrioventricular block, patient is disqualified for 1 week, after which patient may resume driving Otherwise, no restriction*	

*All procedures (including those marked as “No restriction”) are subject to driving restrictions relating to appropriate recovery from hospitalization, site of intervention, vascular access, and the anesthesia provided (i.e., general anesthesia or sedatives).

ICDs* - waiting times

Condition	Non-commercial	Commercial
Subcutaneous ICD	Same recommendations as for primary and secondary prophylaxis with transvenous devices	Disqualified
Generator change	No restrictions	Disqualified
Upgrade/lead revision	1 week after procedure	Disqualified
Note: ICD = implantable cardioverter defibrillator		

*All recommendations are subject to physician judgment, incorporating patient-specific considerations and risk factors for arrhythmias and syncope. Furthermore, all recommendations are based on devices with satisfactory operational parameters (i.e., normal functionality). In cases of suboptimal capture thresholds and sensing, unusual programming, or compromised device functionality, restrictions should be at the discretion of the treating physician.

All procedures (including those marked as “No restriction”) are subject to driving restrictions relating to appropriate recovery from hospitalization, site of intervention, vascular access, and the anesthesia provided (i.e., general anesthesia or sedatives).

Bradyarrhythmias -waiting times

Condition	Non-commercial	Commercial
Sinus node dysfunction		
Atrial fibrillation with conversion pauses (≥ 5 seconds) or conversion pauses with impaired level of consciousness	Disqualified until appropriate pacemaker therapy is in place	

Chapter 4: Cerebrovascular disease

4.1 About cerebrovascular disease

Cerebrovascular disease is disease involving the blood vessels supplying the brain.

Transient ischemic attack (TIA)

A transient ischemic attack (TIA) is a brief episode of neurological dysfunction caused by a temporary state of reduced blood flow to the brain. The symptoms of a TIA are similar to a cerebrovascular accident (CVA; described below) but are temporary, typically lasting less than one hour and no more than 24 hours. The most common cause of a TIA is a blood clot. Blood clots originating in the heart (cardioembolism) account for approximately one-third of identifiable causes of TIA and CVA, with atrial fibrillation being the most common underlying cause of cardioembolic TIA or CVA. A TIA is considered to be a warning sign that a CVA may be imminent. Following a TIA, the risk of having a CVA is 10-20% in the first 90 days with nearly half of CVAs occurring within the first 48 hours, with a 1-year risk of nearly 6%, 5-year cumulative risk of 12.5%, and 10-year cumulative risk of nearly 20%. The Canadian TIA Score can be used to determine risk for early subsequent stroke in patients with a suspected TIA or minor CVA.

Cerebrovascular accident (CVA)

A cerebrovascular accident (CVA) or stroke is defined as rapidly developing clinical signs of focal or global disturbance of cerebral function, with symptoms lasting 24 hours or longer, or leading to death, with no apparent cause other than of vascular origin. A CVA can be classified as either ischemic or hemorrhagic. Ischemic CVA refers to a CVA caused by thrombosis or embolism, and accounts for 85% of all CVAs. Hemorrhagic CVAs are caused by an intracerebral hemorrhage (bleeding within the brain) or subarachnoid hemorrhage (bleeding between the inner and outer layers of the tissue covering the brain).

The symptoms of a CVA vary depending on what part of the brain is affected. The most common symptom is weakness or paralysis of one side of the body with partial or complete loss of voluntary movement or sensation in a leg or arm. There can be speech problems and weak face muscles. Numbness or tingling is very common. A CVA can affect:

- balance
- vision
- swallowing
- breathing, and
- level of consciousness.

Visual or spatial neglect is a common consequence of a CVA. With neglect, damage to the brain causes an individual to ignore one side of their visual field or their body, even if they retain sensation and function. Neglect is usually a result of a stroke affecting the right hemisphere of the brain, therefore causing neglect of the left side. Visual neglect occurs in 33% to 85% of all strokes affecting the right hemisphere.

The prognosis for recovery following a CVA is related to the severity of the CVA and how much of the brain has been damaged. Most functional recovery occurs within the first two months following a CVA.

The risk of a subsequent CVA is approximately 4% per year, with a 10-year cumulative risk of 43%. In the first six months following a CVA, the risk of a subsequent CVA is approximately 9%.

Cerebral aneurysm

A cerebral aneurysm is the localized dilation or ballooning of a cerebral artery or vein resulting from weakness in the wall of the affected vessel. Most cerebral aneurysms have no associated symptoms until they become large or rupture. The majority (50% to 80%) remain small and do not rupture.

Symptoms associated with larger aneurysms include:

- sudden severe headache
- nausea and vomiting
- visual impairment, and
- loss of consciousness.

The risk of rupture increases with the size of the aneurysm. A rupture results in subarachnoid or intracerebral hemorrhage, leading to alterations in consciousness including:

- syncope
- seizures
- visual impairment, and
- respiratory or cardiovascular instability.

Treatment of unruptured cerebral aneurysms is controversial. Treatment options include observation and surgical procedures to prevent blood from flowing into the aneurysm. Risks of surgery include possible damage to other blood vessels, potential for aneurysm recurrence and rebleeding, and post-operative CVA. Successful surgery reduces the risk of rupture.

4.2 Prevalence

Transient ischemic attack

The results of a survey published in 2000 by the National Stroke Association found that 500,000 adults (18 years of age and older) in Canada had been diagnosed with a TIA. A population-based study in Alberta found the age-adjusted incidence of TIA to be between .04% and .07% (44 and 68 per 100,000) annually.

The risk factors for a TIA are similar to those for a CVA (see below).

Cerebrovascular accident

As of Statistics Canada data from 2023, CVAs are the 4th leading cause of death in Canada and account for approximately 4% of all deaths in Canada. Of the 40,000 to 50,000 Canadians who have a CVA each year, approximately 14,000 will die.

The risk factors for a CVA include, but are not limited to:

- high blood pressure
- cigarette smoking
- heart disease
- carotid artery disease
- diabetes
- heavy use of alcohol
- atrial fibrillation
- sleep apnea
- obesity
- physical inactivity

In general, risk also increases with age, with those in their 70s and 80s at the greatest risk.

Cerebral aneurysm

Prevalence rates for cerebral aneurysm are unclear because they are often asymptomatic. Autopsy studies indicate a prevalence rate in the adult population between 1% and 5%, with 5% being a widely cited figure.

Under age 40, cerebral aneurysms affect equal numbers of males and females, but are rarely seen in infants and children. Over age 40, more females than males are affected. The peak age for clinical manifestation of cerebral aneurysm is between 55 and 60.

4.3 Cerebrovascular disease and adverse driving outcomes

Transient ischemic attack

There has been little research on the relationship between TIAs and adverse driving outcomes.

Cerebrovascular accident

Sudden onset symptoms while driving are the cause of accidents in about 1.5 per thousand accidents. The most important accident-causing illnesses are epilepsies and cardiovascular diseases. Strokes are the cause of 7% of accidents caused by sudden onset symptoms.

In studies that considered the effects of persistent impairments from CVAs as measured by fitness to drive assessments, 50% or more of the subjects who had a CVA were assessed as unfit to drive. Surveys of drivers who had a CVA indicate that more than half did not resume driving after their CVA.

Cerebral aneurysm

No studies were found that considered the relationship between cerebral aneurysm and adverse driving outcomes. However, sudden incapacitation as the result of a ruptured aneurysm is contraindicated to driving and no compensation can be made during the event.

4.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Transient ischemic attack (TIA)	Episodic impairment (risk for stroke): Medical assessment – likelihood of impairment	Variable – sudden cognitive, motor or sensory impairment	Medical assessments
Cerebrovascular accident (CVA)	Persistent impairment: Functional assessment	Variable – cognitive, motor or sensory	Medical assessments Functional assessment
Cerebral aneurysm	Episodic impairment (risk of rupture): Medical assessment – likelihood of impairment	All – sudden impairment	Medical assessments
	Persistent impairment (where symptomatic): Functional assessment	Variable – cognitive, motor or sensory	Medical assessments Functional assessment

Transient ischemic attack

The primary concern for licensing is the potential for a subsequent CVA. The greatest risk is in the first 90 days following the TIA.

Cerebrovascular accident

The primary concern for licensing is the potential for a persistent impairment of functional ability following a CVA. Depending on what part of the brain is affected, cognitive, motor and/or sensory functions may be impaired.

Cerebral aneurysm

The primary concern for licensing is the risk of an episodic impairment caused by rupture of the aneurysm. Generally, this risk is not considered significant for licensing purposes unless the aneurysm is symptomatic or has been identified as requiring surgical intervention.

A large or leaking cerebral aneurysm could result in a persistent impairment of cognitive, motor and/or sensory functions depending on its size and location.

4.5 Compensation

Drivers who have experienced a persistent impairment of motor or sensory function may be able to compensate. An occupational therapist, driver rehabilitation specialist or other medical professional may recommend specific compensatory vehicle modifications or restrictions based on an individual functional assessment. The effectiveness of individual vehicle modifications may be determined through a road test.

Some examples of compensatory mechanisms are shown in the following table.

Motor impairment	Sensory (vision) impairment
• Spinner knob or steering wheel device • Devices to operator secondary controls, e.g. turn signal and horn • Hand controls • Left-foot accelerator • Restriction to automatic transmission • Downgrade from commercial to non-commercial driving	• Adapted scanning strategies, e.g. degree and frequency of head/trunk rotation • Adapted mirrors, e.g. left, right, rear • Camera and/or sensors for enhanced observations, e.g. side and rear view

4.6 Guidelines for assessment

4.6.1 Transient ischemic attack (TIA) – All drivers

STANDARD	Eligible for all classes of licence if: • complete medical assessment shows no residual effects • any underlying cause has been addressed with appropriate treatment • conditions for maintaining a license are met.
Conditions for maintaining licence	• Remain under regular medical supervision and follow any prescribed diagnostic or treatment regime • Report any further TIAs to the licencing authority
Reassessment	• Reassess in one year if the TIA occurred within the past 12 months. If TIA occurred more than one year ago, or the medical information indicates no residual effects, any underlying cause has been addressed with treatment, and no post TIA seizure has occurred, re-assessment may occur in accordance with commercial or age-related re-assessment unless a shorter reassessment interval is recommended by the treating physician.
Information from health care providers	• Date of the TIA • Whether the driver remains under regular medical supervision • Opinion of treating physician whether the driver follows any prescribed diagnostic or treatment regime
Rationale	The primary driver concern with a TIA is the risk for a cerebrovascular accident (CVA) after a TIA. By definition, there are no persistent impairments associated with a TIA. The risk for a CVA is greatest immediately after the TIA and decreases significantly over time. Subject matter experts recommended a minimum no-driving period of two weeks, with appropriate follow-up and treatment.

4.6.2 Cerebrovascular accident (CVA) – All drivers

STANDARD	Eligible for all classes of licence if: • Complete medical assessment shows no residual effects • any underlying cause has been addressed with appropriate treatment • a post CVA seizure has not occurred • the functional abilities necessary for driving are not impaired, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Remain under regular medical supervision and follow your physician's advice regarding treatment • Report any further CVAs to the licencing authority (Note that additional conditions may be required, depending upon the nature of any functional impairment and the ability of the driver to compensate)
Reassessment	• Reassess in one year if the CVA occurred within the past 12 months. If CVA occurred more than one year ago, or the medical information indicates no residual effects, any underlying cause has been addressed with treatment, and no post CVA seizure has occurred, re-assessment may occur in accordance with commercial or age-related re-assessment unless a shorter reassessment interval is recommended by the treating physician.
Information from health care providers	• Date of the CVA • Opinion of treating physician whether any underlying cause has been addressed with appropriate treatment • Whether the driver has experienced a post CVA seizure • Opinion of treating physician whether there may be significant residual loss of the functional abilities necessary for driving, and if yes, the results of any functional assessments the physician carried out, e.g., cognitive screen • Whether the driver remains under regular medical supervision • Opinion of treating physician whether the driver is compliant with the physician's advice regarding treatment
Rationale	The primary driver fitness concern with a CVA is the potential for a persistent impairment. Subject matter experts recommended a

	minimum no-driving period of one month, with appropriate follow-up and treatment.
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4.6.3 Cerebral aneurysm that requires surgical repair – All drivers

STANDARD	Not eligible for any class of licence
Conditions for maintaining licence	N/A
Reassessment	N/A
Information from health care providers	N/A
Rationale	The primary concern with a cerebral aneurysm is the risk of rupture. Where the risk of rupture is such that surgery is recommended to repair the rupture, a driver is not eligible for a licence.

4.6.4 Surgery to repair a cerebral aneurysm – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • it has been at least 3 months since the surgery, and • the driver has no symptoms of the aneurysm, or • if the driver continues to have symptoms, the symptoms do not impair the functional abilities necessary for driving
Conditions for maintaining licence	None
Reassessment	• If the driver has no symptoms of the aneurysm, routine • Otherwise, to be determined on an individual basis
Information from health care providers	• Date of the surgery • Whether the driver experiences any symptoms of the aneurysm, and if yes, a description of the symptoms • Opinion of treating physician if any symptoms impair the functional abilities necessary for driving, and if yes, the results of any functional assessments the physician carried out
Rationale	Successful surgical treatment for a cerebral aneurysm significantly reduces the risk of rupture. A waiting period of 3 months after

	surgery is imposed to allow for an assessment of the effectiveness of the surgery or any complications of surgery. The impact of any symptoms caused by the aneurysm or by complications from surgery should be assessed.
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4.6.5 Surgery to repair a cerebral aneurysm – Commercial drivers

STANDARD	Eligible for a commercial licence if: • it has been at least 6 months since the surgery, and • the driver has no symptoms of the aneurysm, or • if the driver continues to have symptoms, the symptoms do not impair the functional abilities necessary for driving
Conditions for maintaining licence	None
Reassessment	• If the driver has no symptoms of the aneurysm, routine • Otherwise, to be determined on an individual basis
Information from health care providers	• Date of the surgery • Whether the driver experiences any symptoms of the aneurysm, and if yes, a description of the symptoms • Opinion of treating physician whether any symptoms may impair the functional abilities necessary for driving, and if yes, the results of any functional assessments the physician carried out, e.g., cognitive screen
Rationale	The waiting period for commercial drivers is longer than that for non-commercial drivers in order to provide more certainty about the success of surgery prior to a return to driving.

Chapter 5: Chronic renal disease

5.1 About chronic renal disease

Overview

Chronic renal (kidney) disease is a progressive disease involving deterioration and destruction of renal nephrons, with a progressive and usually permanent loss of renal function. Diabetes, hypertension, and glomerulonephritis are leading causes of chronic renal disease. It is divided into five stages of increasing severity.

5.2 Prevalence

Per the Canadian Kidney Foundation and the International Society of Nephrology Global Kidney Health Status, approximately 1 in 10 Canadians have chronic kidney disease (CKD), with undiagnosed prevalence likely much higher. By 2050, over 6.2 million Canadians are projected to have CKD. In 2023, prevalence of treated kidney failure in Canada was 1416 cases per million people, which was higher than the global average.

5.3 Chronic renal disease and adverse driving outcomes

No studies were found that considered the relationship between chronic renal disease and adverse driving outcomes except for the complication of cognitive impairment that may occur in severe renal disease. A 2018 review identified one study demonstrating that 40% of 186 surveyed patients on hemodialysis felt uncomfortable driving and that 1/3 of those patients were involved in motor vehicle collisions (MVC) since starting dialysis. Of the patients who felt comfortable driving, more than 75% were found to be at increased driving risk. A second study reported that 15% of patients on hemodialysis were involved in MVCs over a three year span. Additional information on cognitive impairment's effects on fitness to drive is included in Chapter 6.

Severe renal disease may also lead to general debility. Although renal disease is not addressed specifically in the chapter on multiple medical conditions, severe renal disease will produce the same effects upon fitness to drive. Patients with renal disease often have multiple medical conditions which are addressed in Chapter 8.

Some dialysis patients may be unfit to drive immediately following a treatment. However, a global limitation on driving for all dialysis patients is not justified in the literature. It should be noted that the CMA Driver's Guide recommends that physicians be made aware that the placement of catheters should always allow the wearing of seatbelts since most patients will use motor vehicles for transportation to and from the facility.

5.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach ⁶	Primary functional ability affected	Assessment tools
Chronic renal disease (Stage 3 and 4) End-stage renal disease	Persistent impairment: Functional assessment	Variable - Cognitive and Motor May also result in general debility	Medical assessments Functional Assessment
Renal transplant	Persistent impairment: Functional assessment	Variable - Cognitive and Motor	Medical assessments Functional Assessment

Cognitive impairment

Evidence suggests that cognitive impairment is associated with chronic renal disease and that with increasing disease severity there is also a corresponding decrease in cognitive functioning, which may impair functional ability to drive.

The highest risk of cognitive impairment is for those with End-stage renal disease (ESRD) (stage 5). There is a small body of literature indicating that ESRD is associated with diminished perceptual motor-coordination, impairments in intellectual functioning including decreased attention and concentration, and memory impairments. Some studies indicate that individuals with ESRD have a 2 to 7 times higher prevalence of cognitive impairment and dementia compared to the general population.

There is also evidence of a significant risk of cognitive impairment for those in Stage 3 and 4 of chronic renal disease. There is no evidence to suggest that risk of cognitive impairment in the early stages (stage 1 and 2) is significant enough to impair driving.

Research indicates that cognitive impairment ranging from mild to severe is common and often undiagnosed in dialysis patients. In particular, between 30% and 47% of older patients undergoing treatment by hemodialysis or peritoneal dialysis were classified as cognitively impaired. Multiple studies indicate that physicians have a tendency to underestimate cognitive impairment in patients undergoing dialysis.

⁶ See Part 1 for a discussion of the use of functional assessments for driver licensing decisions.

Improvement in cognitive performance has been reported in individuals who have undergone a kidney transplant.

General debility

Drivers with chronic renal disease, particularly end-stage renal disease, may develop general debility resulting in a loss of stamina required to support the functions necessary for driving.

5.5 Compensation

Drivers with chronic renal disease are not able to compensate for their functional impairment.

5.6 Guidelines for Assessment

5.6.1 Renal disease - All Drivers

STANDARD	Eligible for all classes of licence
Conditions for maintaining licence	None
Reassessment	None
Information from health care providers	None
Rationale	Eligibility is not based on diagnosis of renal condition, however, individuals with chronic renal failure may have sequelae of the condition which would be captured under other medical standards such as cognitive impairment and general debility.

Chapter 6: Cognitive impairment

6.1 About cognitive impairment

Cognitive impairment, also called cognitive dysfunction, neuropsychological impairment or neurocognitive disorder, refers to any impairment of a cognitive function such as:

- memory
- attention
- language
- problem solving, or
- judgment.

Cognitive impairment may have any number of causes including:

- brain trauma
- anoxia (lack of oxygen to the brain)
- infection
- toxicities, or
- degenerative, metabolic or nutritional diseases.

The presentation of cognitive impairment is variable depending on the cognitive functions affected and the degree of impairment. Cognitive impairment may progress to dementia, it may remain stable, or there may be a recovery of normal cognitive function.

Dementia

Dementia refers to a disorder characterized by memory impairment in conjunction with one or more other cognitive deficits. In North America, the most commonly used criteria for the diagnosis of a dementia are those articulated by the American Psychiatric Association.

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition Text Revision, (DSM-5-TR) retained the term “dementia” from the previous edition for continuity but replaced it officially with “major neurocognitive disorder”. It points out that dementia is generally associated with the older individual while a neurocognitive disorder was the term used for younger individuals with the same symptoms. Therefore DSM-5-TR advocates using the same term for individuals of all ages who manifest major cognitive limitations. However, since dementia is still an accepted term according to DSM-5-TR and is the term most commonly used by researchers and licensing authorities in referring to

this condition, for simplicity it will continue to be used in this chapter. Neurocognitive disorders will be used when referring to all types of cognitive limitations.

The defining features of dementia are:

- A. Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:
 1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and
 2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.
- B. Cognitive deficits interfere with independence in everyday activities (i.e., at a minimum, requiring assistance with complex instrumental activities of daily living such as paying bills or managing medications).
- C. The cognitive deficits do not occur exclusively during the context of a delirium.
- D. The cognitive deficits are not better accounted for by another mental disorder (e.g., major depressive disorder, schizophrenia).

Dementia has many causes and more than 100 types of dementia have been documented. The five most common types of dementia are:

- Alzheimer's disease
- vascular dementia (multi-infarct dementia)
- mixed Alzheimer's and vascular dementia
- major or minor neurocognitive disorders with Lewy bodies (Lewy body dementia), and
- frontotemporal dementia (Pick's disease or Pick's complex). Frontotemporal dementia may not meet all of the criteria noted for dementia, especially in the early stages, but may still result in significant functional impairment.

These types of dementia are all progressive and irreversible, and are characterized by impairments in multiple cognitive functions.

In Alzheimer's disease, the most common form of dementia, the earliest cognitive symptoms include difficulties in:

- recent memory
- word finding
- confrontation naming
- orientation, and
- concentration.

Characteristics of later stages include:

- slowed rates of information processing
- attentional deficits
- disturbances in executive functions, and
- impairments in language, perception and praxis.

Less commonly, neurocognitive disorders can result from:

- head injury and trauma
- brain tumours
- depression
- hydrocephalus (excessive accumulation of cerebrospinal fluid (CSF) in the brain)
- bacterial and viral infections
- toxic, endocrine and metabolic causes, or
- anoxia.

Some of these neurocognitive disorders may be reversible. Specific examples of reversible causes of dementia include:

- thyroid deficiency or excess
- vitamin B12 deficiency
- chronic alcoholism
- abnormal calcium levels
- dementia associated with celiac disease, and
- intracranial space-occupying lesions.

Treatment for dementia has become available over the last decade with cognition enhancing drugs and other treatments. These drugs seem to improve symptoms of the disease in some stages of dementia, but their therapeutic effect is variable.

Mild cognitive impairment

Mild cognitive impairment (MCI) (mild neurocognitive disorder according to DSM-5-TR) is a term that usually refers to the transitional state between the cognitive changes associated with normal aging and the fully developed clinical features of dementia. The diagnostic criteria for MCI are evolving but in general it describes a cognitive decline that presents no significant functional impairment.

A simple summary of factors in determining degree of Dementia and Mild Cognitive Impairment include:

Mild Cognitive Impairment (MCI) <i>(Some memory impairment but dementia not definitively diagnosed)</i>	Mild Dementia <i>(Mild neurocognitive disorder)</i>	Moderate Dementia <i>(Major neurocognitive disorder)</i>	Severe Dementia <i>(Major neurocognitive disorder)</i>
Forgets name, location of objects May have trouble finding words May have difficulty traveling to new locations May have difficulty with problems at work	Has difficulty with complex tasks or instrumental activities of daily living (e.g., finances, shopping, planning dinner, cooking, taking medication, telephoning etc.)	Has difficulty with basics activities of daily living (e.g., eating, dressing hygiene) Needs help choosing and putting on clothing Requires prompting and assistance when bathing	Decreased ability to use toilet and is incontinent Vocabulary limited Loses ability to walk and sit Unable to smile

Delirium

Delirium is a condition characterized by a disturbance of consciousness and a change in cognition that occurs over a relatively short period of time, usually hours to days.

Common causes of delirium include:

- vascular disorders (e.g., stroke, myocardial infarct)
- infections (e.g., urinary tract, chest)
- drugs (e.g., analgesics, sedatives, alcohol, illicit drugs), and
- metabolic disorders (e.g., renal failure, hepatic failure, endocrine disorders).

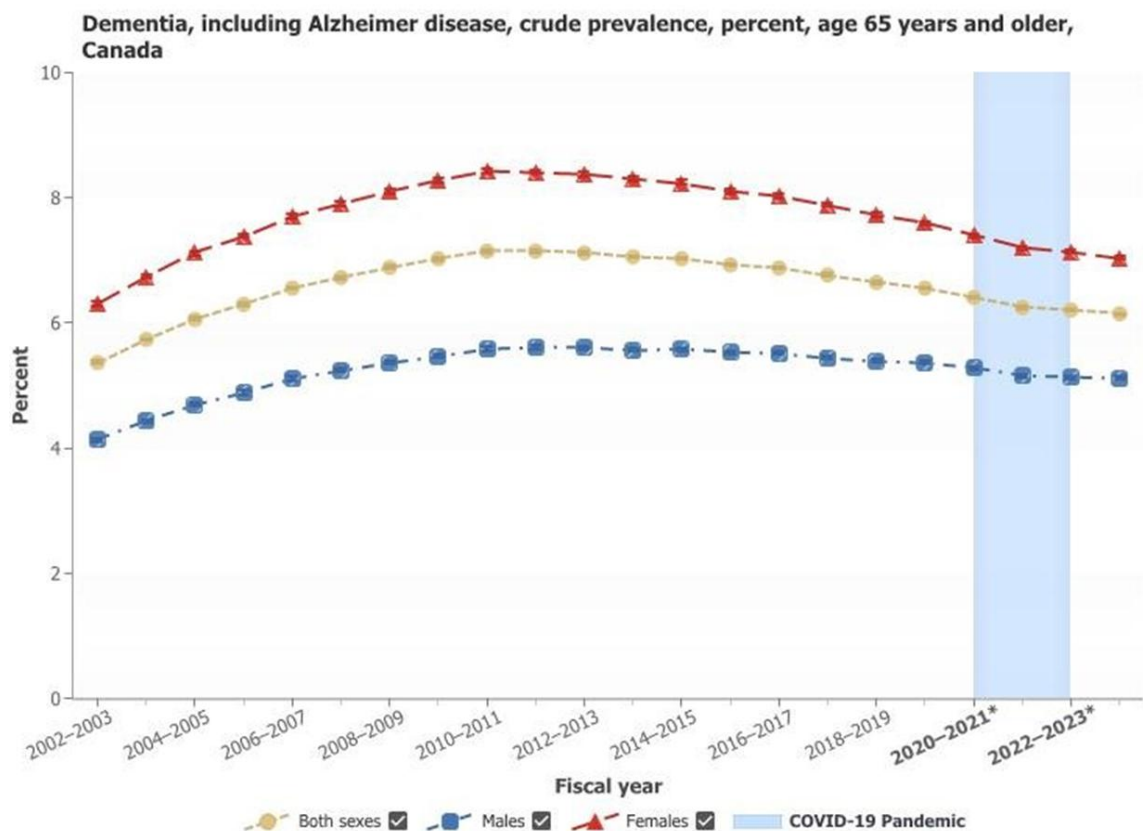
Although the symptoms of delirium may be similar to dementia, delirium is temporary and therefore considered a transient impairment for licensing purposes.

6.2 Prevalence

Canadian prevalence rates for all types of cognitive impairment are not available, in part because of the lack of definitive criteria for the definition of mild cognitive impairment, particularly the cut-off for diagnostic test scores. Studies from the United States have reported mild cognitive impairment that ranges between 9.9% and 35.2% for adults aged 75 and older depending on the cut-off used in the study. According to 2020 data from the Alzheimer Society of Canada, in the general population, approximately 8% of Canadians 65 and over have dementia and another 17% have some form of cognitive impairment.

The incidence of dementia in Canada is 43/1,000 for adults aged 65 to 79 and rises with age to 212/1,000 for those aged 85 and older. It is more prevalent in females than males, at an approximate ratio of 2:1.

As of 2017-18, almost 452,000 Canadians aged 65 years and older were living with diagnosed dementia, an increase of almost 10,000 than in the previous year. The risk of developing dementia increases with age, doubling every 5 years between the ages of 65 and 84. While less than 1 percent of Canadians between the ages of 65 and 69 are living with dementia, this number increases to around 25 percent for those aged 85 and over.



Canadian Chronic Disease Surveillance System data files provided by provinces and territories, as of April 2025.
Public Health Agency of Canada, Health Infobase <https://health-infobase.canada.ca>

*Many CCDSS measures, such as chronic condition incidence, were influenced by the COVID-19 pandemic. Changes in such measures may be driven by multiple factors, including (but not limited to) differences in healthcare seeking behaviour, the availability and use of healthcare services, as well as true changes in health status. As such, CCDSS measures should be used cautiously when making inferences about population health during the COVID-19 pandemic. For the purposes of interpreting the estimates in this data tool, the COVID-19 pandemic period is defined as fiscal years 2020-2021 to 2022-2023. This timeframe aligns with the World Health Organization's declaration of COVID-19 as a public emergency of international concern from January 30, 2020, to May 5, 2023. Guidance for data users on examining the impacts of the COVID-19 pandemic on CCDSS measures during the pandemic period can be accessed at the CCDSS website.

Figure 6.2-1. Crude prevalence of dementia, including Alzheimer's disease, in Canadians aged ≥ 65 years

6.3 Cognitive impairment, dementia and adverse driving outcomes

A systematic review of the scientific literature on cognitive impairment and its effect upon fitness to drive was conducted in the context of a revision of the CMA Driver's Guide. It produced a series of evidence-based guidelines for the determination of fitness to drive for those with a cognitive impairment. It emphasises that each assessment must evaluate the individual's specific impairments and that, depending on the nature of the impairment, fitness to drive may not be compromised in some individuals. While the guidelines specifically address dementia, they should be considered when assessing any cognitive impairment. Special attention should be paid to the degree of insight or judgement that the driver with a cognitive impairment has as to the effects of their impairment on their fitness to drive.

The guidelines are:

1. Dementia often has a direct effect upon fitness to drive, and clinicians should address cognitive compromises that may impact fitness to drive.
2. Diagnosis of dementia alone is not sufficient to withdraw driving privileges.
3. Severe dementia is an absolute contraindication to driving.
4. It is unlikely that safe driving can be maintained in the presence of moderate dementia (e.g. the additional presence of basic activities of daily living [ADLs] impairments) and is to be strongly discouraged. If the patient desires to drive, they should be formally assessed and monitored very carefully.
5.
 - a. People with dementia with progressive loss of two or more instrumental ADLs (IADLs) due to cognition (but no basic ADL loss) are at higher risk of driving impairment.
 - b. A formal assessment and ongoing monitoring of fitness to drive is recommended in this situation if the patient wishes to continue driving.
6.
 - a. No in-office test or battery of tests including global cognitive screens (e.g. mini mental state examination [MMSE], Montreal Cognitive Assessment [MoCA]) have sufficient sensitivity or specificity to be used as a sole determinant of driving ability *in all cases*.
 - b. However, abnormalities on these tests may indicate a driver at risk who is in need of further assessment.
 - c. Substantially impaired scores which are typically associated with moderate to severe dementia may preclude safe driving.
 - d. If concerns or uncertainty still exists, a specialist opinion should be sought.
7. Patients with dementia who are deemed fit to continue driving should be re-evaluated every 6 to 12 months or sooner, if indicated.
8.
 - a. Any clinician who has concerns but is uncertain whether a patient's cognitive problems may adversely affect driving, should refer the patient for a functional driving assessment, either through an occupational therapy evaluation or directly to the licensing authority.
 - b. If there are clear aspects of the history, physical examination and cognitive examination that place the patient and public at high risk for crash or impairment, the patient and informant/caregiver should be advised not to drive, and this conversation (including date and participants) should be documented in the clinical record.
 - c. Clinicians should be aware of the legal reporting requirements in their jurisdiction, mindful of their professional ethical imperatives, and strive to ensure that mechanisms to remove unsafe drivers from the road are sensitive, timely and effective.
9.
 - a. Caregivers are able to predict driving safety more accurately than can the patients themselves, although in some circumstances, the caregivers may have a vested interest in preserving the patient's autonomy beyond a safe window...
 - b. Hence, caregiver concern about driving impairment should be taken seriously and the possibility of a conflict of interest in preserving driving autonomy must be taken into consideration if such caregiver concern is absent.

10. Medical comorbidities, physical frailty and the use of multiple medications are also factors that must be taken into consideration when assessing fitness to drive.
11. We recommend a formal evaluation if behavioural disturbances (e.g. agitation, personality change, psychosis) are concerning for interfering with safe driving.
12. Patients with prominent language impairment, e.g. primary progressive aphasia or other aphasia in the context of dementia, cannot be adequately screened with typical language-based tests and require a specialized assessment possibly from a speech therapist or neuropsychologist, functional assessment (IADLs, ADLs) and/or a formal driving assessment.
13. As with many disabling progressive diseases that lead to driving cessation, conversation regarding eventual retirement from driving should be held as early as possible.
14. a. Driving cessation has been associated with social isolation, depression, and other adverse health outcomes.
b. Therefore, after a person with dementia has stopped driving, it is important to monitor for these problems longitudinally.

The systemic review added the following comments on general considerations when assessing fitness to drive for someone with a cognitive impairment:

Recent crashes and voluntary self-restriction of driving to less-complex situations are also considerations that should raise concern that a patient with dementia may be no longer safe to drive.

6.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Cognitive impairment of all types including dementia	Persistent impairment: Functional assessment	Cognitive	Medical assessments Functional assessment

Cognitive impairments of any nature may, or may not, affect driver fitness since there is no uniform range of effects. There is no standard set of limitations, and they can vary greatly from one person to the other.

In the case of MCI the effects may be subtle and difficult to assess in an office setting. Judgement and insight are important for driving yet the usual battery of tests used to assess the extent of cognitive limitations do not evaluate these functions. Hence, a functional driving assessment is usually the most appropriate means of assessing the effects of the cognitive limitations upon driving unless severe dementia has been demonstrated.

6.5 Compensation

Drivers with cognitive impairment or dementia are not able to compensate for their functional impairment.

Requiring the cognitively-impaired driver to be accompanied by another person (co-pilot) or the imposition of geographical or any other restrictions (conditional licences) are not permitted.

6.6 Guidelines for assessment

6.6.1 Cognitive impairment including dementia – All drivers

STANDARD	Eligible for all classes of licence if: • complete medical assessment indicates cognitive functions necessary for driving are not impaired, or • where required, functional driving assessment shows condition does not affect ability to drive • conditions for maintaining a licence are met
Conditions for maintaining licence	Reassessment annually or as required Requiring the cognitively-impaired driver to be accompanied by another person (co-pilot) or the imposition of geographical or any other restrictions (conditional licences) are not permitted.
Reassessment	• Reassess annually if a driver has a progressive cognitive impairment including dementia • Otherwise, routine
Information from health care providers	• Nature or cause of the cognitive impairment • Opinion of treating physician whether the cognitive impairment may be progressive • Various tools such as OT driving assessments, cognitive screens and road tests may be helpful in assessing whether an individual with cognitive impairment is eligible to hold licence.
Rationale	Functional assessment may be required to determine if individual can drive safely. Driving is a complex task. Generally, those unable to perform their activities of daily living (ADLs) as a result of cognitive impairment or dementia may not be eligible to drive.

6.6.2 Severe Dementia

STANDARD	Not eligible for any class of licence
Conditions for maintaining licence	N/A
Reassessment	N/A
Information from health care providers	N/A
Rationale	Driving is a complex task. Those with severe dementia are unable to perform their activities of daily living (ADLs) and are not eligible to drive.

Chapter 7: Diabetes - Hypoglycemia

7.1 About diabetes and hypoglycemia

Diabetes

Diabetes is a chronic and progressive disease characterized by hyperglycemia (high blood glucose). It appears in two principal forms:

- type 1 diabetes, formerly called insulin-dependent diabetes mellitus (IDDM) or juvenile diabetes, and
- type 2 diabetes, formerly called non-insulin-dependent diabetes mellitus (NIDDM) or adult-onset diabetes.

Type 1 and type 2 differ in the underlying defect, and type of therapeutic control. Other types of diabetes not discussed in detail here include gestational diabetes, other specific types (those due to genetic defects in β -cell function, genetic defects in insulin action, diseases of the exocrine pancreas, drug or chemical induced diabetes, etc.), and pre-diabetes.

Type 1 diabetes

Type 1 diabetes can occur at any age, but it primarily appears before age 30. It is characterized by the inability to produce insulin and often more marked fluctuations in blood glucose. Daily insulin injections are always required to manage type 1 diabetes.

Type 2 diabetes

Type 2 diabetes usually occurs in individuals over the age of 40. Risk factors such as obesity, the prevalence of which is on the rise in young Canadians, increase the chance that it will occur earlier in life. It is characterized by an impaired ability to recognize and utilize insulin, and eventually diminished insulin production. Therapeutic control often is achieved by diet alone or in combination with antihyperglycemic agents (alternatively referred to as oral hypoglycemics), but people with type 2 diabetes whose blood glucose cannot be controlled in this way require treatment with insulin.

Hypoglycemia

Anyone who requires treatment with insulin is at risk of hypoglycemia. Those with type 2 diabetes treated with insulin secretagogues (medications that stimulate the secretion of insulin, such as sulfonylureas) or metformin (an oral medication that enhances the effect of insulin) also may experience hypoglycemia, although the frequency with these treatments is lower than with insulin.

Hypoglycemia may occur for a number of reasons, including reduced food intake, unusual level of physical exertion, and alteration of insulin dose.

Hypoglycemia can result in two types of symptoms, neurogenic (autonomic) and neuroglycopenic.

Neurogenic symptoms of hypoglycemia

The body's immediate response to low blood sugar is to secrete hormones that counteract insulin, including adrenaline. The presence of adrenaline causes neurogenic (or autonomic) symptoms such as tremulousness, palpitations, anxiety, sweating, hunger and paresthesia (tingling and numbness). People with diabetes learn to recognize these symptoms as evidence of hypoglycemia and respond by consuming sugary liquids or starchy foods to increase their blood glucose level.

Neuroglycopenic symptoms of hypoglycemia

Neuroglycopenic symptoms are the direct result of impaired brain function due to low glucose levels. These symptoms include confusion, weakness or fatigue, severe cognitive failure, seizure and coma. As the blood glucose level falls, higher cortical function (insight, judgment, calculation, speech and memory) is the first to be affected. Next, a person will experience stupor, characterized by confusion, slurred speech, slow reaction times, poor judgment and lack of coordination. If the level continues to fall, there will be loss of consciousness, seizures and potentially brain damage or death.

Hypoglycemia unawareness

Hypoglycemia unawareness is the inability to recognize the autonomic symptoms of hypoglycemia or a failure of such warning signs to occur prior to impaired brain function. If the initial autonomic symptoms caused by the release of adrenaline are missed, a person experiencing hypoglycemia can only rely on the neuroglycopenic symptoms as an indicator of low blood glucose. Because these symptoms appear in the context of cognitive impairment, they are not easily recognized by the hypoglycemic individual and may delay or prevent self-treatment.

Severe hypoglycemia

Severe hypoglycemia is commonly defined as hypoglycemia that requires outside intervention to abort, or that produces an alteration in level of consciousness or loss of consciousness. The altered or reduced level of consciousness prevents a person experiencing severe hypoglycemia from taking appropriate action.

7.2 Prevalence

According to the most recent data available, in 2023 about 9.4% (about 3.7 million) of Canadians were living with diabetes. Prevalence increases with age and is higher among males both overall and in most age groups.

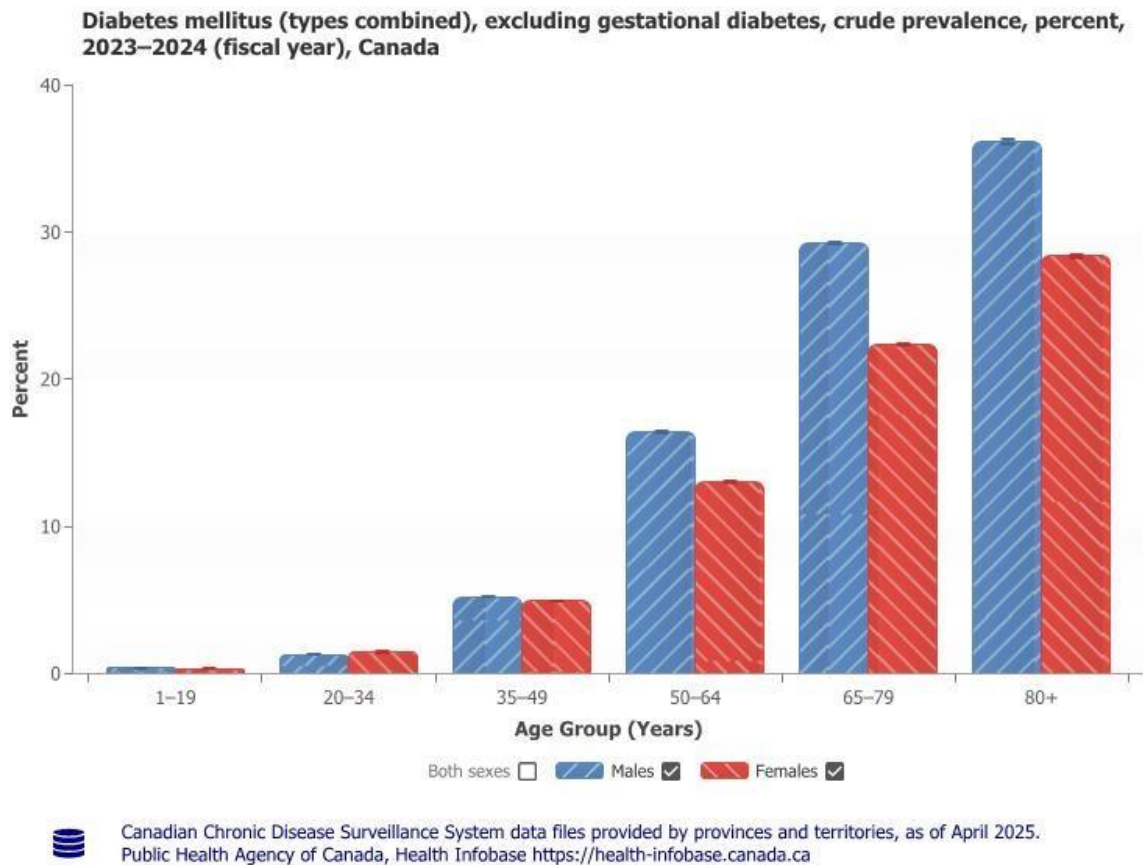
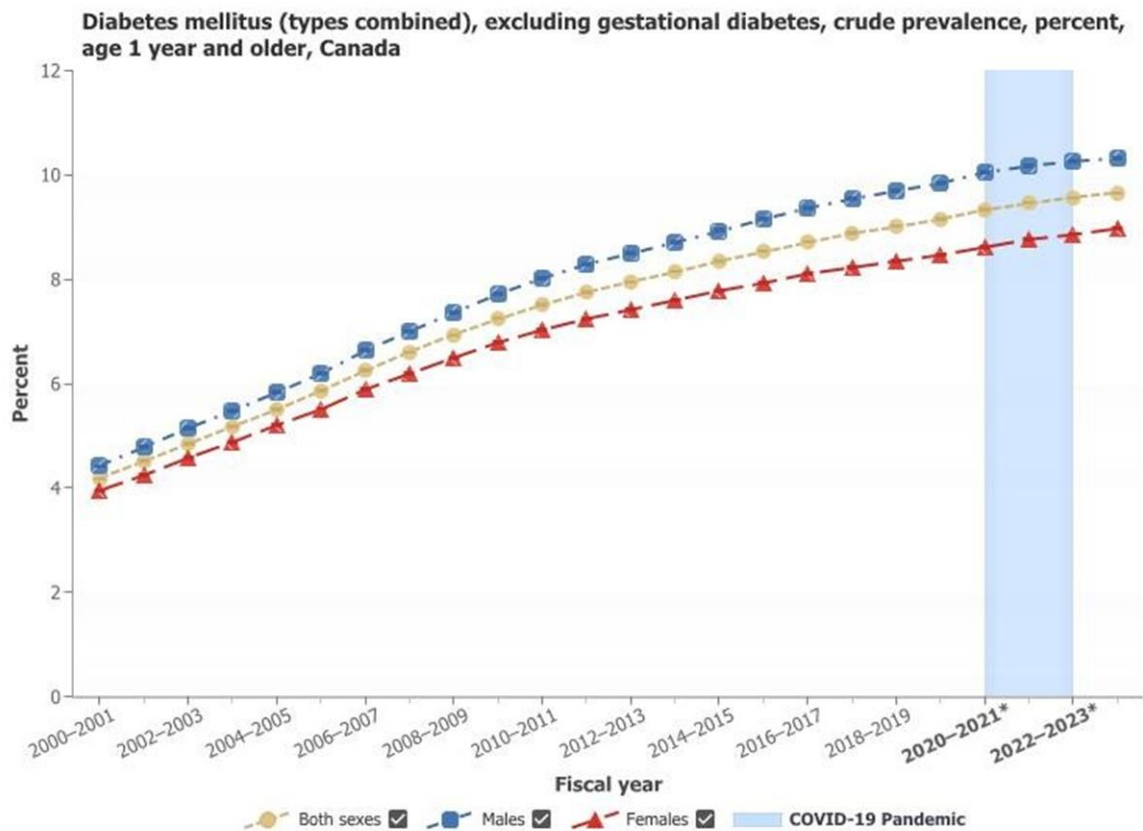


Figure 7.2-1. Crude prevalence of diabetes by age-group and sex, 2023-2024

Between 2000-2001 and 2023-2024 there was a relative increase of 77.7% in the age-standardized prevalence of diagnosed diabetes. This trend is explained by an increase in the prevalence of obesity combined with the longer life expectancy of Canadians. The trend is expected to continue in coming years.



Canadian Chronic Disease Surveillance System data files provided by provinces and territories, as of April 2025.
Public Health Agency of Canada, Health Infobase <https://health-infobase.canada.ca>

*Many CCDSS measures, such as chronic condition incidence, were influenced by the COVID-19 pandemic. Changes in such measures may be driven by multiple factors, including (but not limited to) differences in healthcare seeking behaviour, the availability and use of healthcare services, as well as true changes in health status. As such, CCDSS measures should be used cautiously when making inferences about population health during the COVID-19 pandemic. For the purposes of interpreting the estimates in this data tool, the COVID-19 pandemic period is defined as fiscal years 2020-2021 to 2022-2023. This timeframe aligns with the World Health Organization's declaration of COVID-19 as a public emergency of international concern from January 30, 2020, to May 5, 2023. Guidance for data users on examining the impacts of the COVID-19 pandemic on CCDSS measures during the pandemic period can be accessed at the CCDSS website.

Figure 7.2-2. Crude prevalence of diabetes mellitus (types combined; excluding gestational diabetes) in Canadians aged ≥ 1 year

7.3 Diabetes and adverse driving outcomes

The management of diabetes has improved since the introduction of self-monitoring with the domestic glucometer in the 1980s and this improvement has had a marked effect on the crash risk of drivers with diabetes. Historically, studies conducted before and during the introduction of the self-monitoring glucometer demonstrated a marked increase in crash risk for drivers treated with insulin when compared to drivers without diabetes, while those treated with oral antihyperglycemic drugs had a smaller increase. Today, this is no longer the case, as both treatment regimens have the same degree of crash risk, which is further discussed below.

In addition, new types of insulin with lower rates of associated hypoglycemia, new insulin pumps, and improvements in insulin delivery have lowered the risks associated with older insulin products. Improved understanding of the principles of treatment and

management for newer non-insulin drugs for type 2 diabetes (with very low rates of hypoglycemia) have also contributed to less use of insulin and sulfonylureas in people with type 2 diabetes.

A recent systematic review of the literature on the effects of diabetes on motor vehicle crash involvement did not find any studies examining the effects of the new categories of drugs available for treating diabetes or the new methods that can monitor blood glucose levels constantly using, for instance, a smartphone app, although these have resulted in less individuals with type 2 diabetes going on insulin. Newer glucose measuring devices offer continuous or near-continuous blood sugar monitoring and alarms for impending hypoglycemia.

However, recent studies have noted that the crash risk of drivers with diabetes treated with insulin whose disease is stable has decreased to the point that there is no longer a statistically significant difference in crash risk between drivers with diabetes stably treated with insulin and those treated with oral antihyperglycemics, and the risk is now almost the same as a driver without diabetes.

When a driver suffers a hypoglycemic episode at the wheel, there will be a slowing of reaction times and the processing of information that may affect driving abilities. If the episode is severe enough, it may lead to a loss of contact with their surroundings and can result in a partial or complete loss of consciousness. Such an event may have adverse consequences for the driver, the other occupants of their vehicle and the other road users and pedestrians in the vicinity. Consequently, the identification of drivers subject to hypoglycemic events at the wheel is a preoccupation of driver licensing agencies.

Although coroners' reports on traffic deaths routinely identify a hypoglycemic event as the immediate cause of death, the only recent publications that have studied the direct effects of hypoglycemia on driving performance have been conducted on simulators given the ethical obstacles to evaluating on-road performance for drivers with induced hypoglycemia. Several recent studies have demonstrated that driving abilities are degraded when comparing a driver with low blood sugar to their performance at normal levels. However, the observations note less rigorous lane-keeping and slower reaction times without being able to relate these observations to modifications of crash risk.

Thus, while it has been clearly demonstrated that hypoglycemia will degrade performance, the degree to which it will affect crash risk has not been established. However, increased crash risk is likely in those with diabetes that is not well-controlled, and a hypoglycemic event at the wheel is to be avoided if at all possible; a driver subject to sudden hypoglycemic events should not drive until their control of their condition is stable enough to render such an event unlikely.

Clinical experience has shown that people with persistent hyperglycemia, such as can occur in severe renal disease, may experience cognitive limitations that will disappear

once the hyperglycemia has been controlled. Further research on this situation is required.

7.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Severe hypoglycemia	Episodic impairment: Medical assessment – likelihood of impairment	All – sudden incapacitation	Medical assessments

For individuals with diabetes, both acute and chronic complications of the disease may affect fitness to drive.

Hyperglycemia may cause blurred vision, confusion, and eventually diabetic coma. For the purposes of this standard, these are considered transient impairments.

The neuroglycopenic symptoms associated with severe hypoglycemia can significantly impair the sensory, motor and cognitive functions required for driving. There are studies that suggest that mild hypoglycemia may also impair these functions.

While it is clear that the risk of hypoglycemia is an important consideration when assessing the fitness of drivers with diabetes, research indicates that the chronic complications of diabetes are more likely to be responsible for impaired fitness to drive than episodic incidents of hypoglycemia. Over time, people with diabetes often develop co-morbidities caused by their prolonged exposure to hyperglycemia. These complications of diabetes include retinopathy, neuropathy, nephropathy, cardiovascular disease and peripheral vascular disease. Therefore, the effect of chronic complications always must be considered when assessing fitness to drive for people with diabetes.

7.5 Compensation

As severe hypoglycemia is an episodic impairment, a driver cannot compensate.

7.6 Guidelines for Assessment

7.6.1 Type 2 diabetes – All drivers

- treated with diet and exercise alone or
- oral medication - non insulin secretagogues medication, e.g. metformin

STANDARD	<u>All drivers</u> eligible for any licence class if: • has good understanding of their condition • routinely follows their physician’s instructions about diet, medication, glucose, glucose monitoring and hypoglycemia prevention • conditions for maintaining a licence are met
Conditions for maintaining licence	• remains under regular medical supervision to ensure that any progression in their condition or development of chronic complications does not go unattended • stops driving and treat themselves immediately if hypoglycemia is identified or suspected • does not drive until at least 40 minutes after successful treatment if glucose level is between 2.5 and 4.0 mmol/L • report to the licencing authority if begins insulin therapy
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• Description of treatment
Rationale	Drivers with diabetes who are not treated with insulin or insulin secretagogues are at little or no risk for hypoglycemia. Because diabetes is a progressive condition, these drivers must remain under medical supervision and undergo a reassessment at the discretion of the licencing authority. Drivers who begin insulin therapy are required to report because of the significant increase in risk for hypoglycemia associated with insulin therapy. The requirement to report is intended to ensure that drivers on insulin therapy meet the more stringent driver fitness standards and conditions for driving.

7.6.2 Type 1 or type 2 diabetes treated with insulin or insulin secretagogues – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • they understand their diabetic condition and the close interrelationship between insulin and diet and exercise, and • Routinely follow their physician's instructions about diet, medication, glucose monitoring, and hypoglycemia prevention and management • conditions for maintaining a licence are met
Conditions for maintaining licence	• Remains under regular medical supervision to ensure that any progression in their condition or development of chronic complications does not go unattended • Stops driving immediately if hypoglycemia is identified or suspected • Does not drive when glucose level is below 4.0 mmol/L • Does not drive until at least 40 minutes after successful treatment of hypoglycemia, and blood glucose level has increased to at least 5.0 mmol/L • When driving, tests blood glucose immediately before driving and approximately every 4 hours while driving, and have an available source of rapidly absorbable glucose
Reassessment	• If blood glucose levels and treatment are not stable, reassess more frequently at the discretion of the licencing authority
Information from health care providers	• Description of treatment • Opinion of treating physician whether the driver understands their diabetic condition and the close interrelationship between insulin and diet and exercise
Rationale	Drivers with diabetes who are treated with insulin or insulin secretagogue therapy are at risk for hypoglycemia. In addition to the conditions regarding how to avoid severe hypoglycemia while driving that apply to drivers treated with insulin secretagogues, there are additional conditions for checking and monitoring blood glucose. These conditions are based on guidelines published by the Diabetes Canada.

7.6.3 Type 1 or type 2 diabetes treated with insulin or insulin secretagogues – Commercial drivers

STANDARD	Eligible for a commercial licence if: • the driver has demonstrated good knowledge of the condition and its management and monitoring, and assessment indicates effective blood glucose control • annual medical review • conditions for maintaining a licence are met
Conditions for maintaining licence	• Carries a blood glucose self-monitoring equipment and an available source of rapidly absorbable glucose • Remains under regular medical supervision to ensure that any progression in their condition or development of chronic complications does not go unattended • Stops driving immediately if hypoglycemia is identified or suspected • Does not drive when glucose level is below 4.0 mmol/L • Does not drive until at least 40 minutes after successful treatment of hypoglycemia and blood glucose level has increased to at least 5.0 mmol/L • When driving, tests blood glucose immediately before driving and approximately every 4 hours while driving, and have an available source of rapidly absorbable glucose
Reassessment	• Annually
Information from health care providers	• Description of treatment • Whether the driver has demonstrated competence in blood glucose measurement and interpretation • Opinion of treating physician whether the driver's work schedule is compatible with their insulin regimen • Whether blood tests indicate uncontrolled diabetes • Whether there has been a significant change in insulin therapy. If there has been a significant change in insulin therapy, whether

	monitoring and assessment indicate a stable and effective blood glucose control. • Whether there is evidence of inadequate self-monitoring of blood glucose or inadequate knowledge of the causes, symptoms and treatment of hypoglycemic reactions
Rationale	Commercial drivers who are treated with insulin or insulin secretagogue therapy are at increased risk of experiencing hypoglycemia while driving. This is due to both their high level of driving exposure and to the nature of the driving task, which may make it more difficult for them to manage their blood glucose. The standard is focused on ensuring that these drivers have stable blood glucose levels and that they understand their condition and are able to effectively monitor and manage their blood glucose.

7.6.4 Episode of severe hypoglycemia – Non-commercial drivers

Applies also to severe hypoglycemia while sleeping

STANDARD	Eligible for a non-commercial licence if: • No further episodes of severe hypoglycemia within the past 6 months • Earlier re-licensing can be considered if an appropriate specialist indicates that glycemic control has been re-established • conditions for maintaining a licence are met
Conditions for maintaining licence	• must test blood glucose immediately before driving and approximately every hour while driving • Does not drive until at least 40 minutes after successful treatment of hypoglycemia and blood glucose has increased to at least 5.0 mmol/L. • Must refrain from driving immediately if they experience severe hypoglycemia while driving, and notify their health-care provider as soon as possible
Reassessment	• Reassess based on opinion of the treating physician or at the discretion of the licencing authority
Information from health care providers	• Date of the hypoglycemic episode • Opinion of treating physician whether stable glycemic control has been re-established
Rationale	Severe hypoglycemia indicates a lack of glycemic control and the potential for further hypoglycemic episodes. Once control is re-established and driving resumes, more stringent glucose monitoring conditions are required temporarily to mitigate the increased risk of hypoglycemia.

7.6.5 Episode of hypoglycemia unawareness within past year – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • has been 3 months since the episode • treating physician indicates glycemic awareness regained and have stable glycemic control • conditions for maintaining a licence are met
Conditions for maintaining licence	• must test blood glucose immediately before driving and approximately every hour while driving • Does not drive until at least 40 minutes after successful treatment of hypoglycemia and blood glucose has increased to at least 5.0 mmol/L. • Must refrain from driving immediately if they experience severe hypoglycemia while driving, and notify their health-care provider as soon as possible
Reassessment	• Reassess based on opinion of the treating physician or at the discretion of the licencing authority
Information from health care providers	• Date of the episode • Opinion of treating physician whether glycemic awareness has been regained • Opinion of treating physician whether the driver has stable glycemic control
Rationale	Hypoglycemia unawareness greatly increases the risk for hypoglycemia while driving. This standard requires that glycemic awareness be re-established before driving resumes. Once awareness and glucose stability are re-established, more stringent glucose monitoring guidelines are required temporarily to mitigate the increased risk of hypoglycemia.

7.6.6 Persistent hypoglycemia unawareness – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • has been 3 months since the last episode of hypoglycemia • treating physician indicated stable glycemic control and takes steps to ensure they do not become hypoglycemic while driving • conditions for maintaining a licence are met
Conditions for maintaining licence	• must test blood glucose immediately before driving and approximately every hour while driving • Does not drive until at least 40 minutes after successful treatment of hypoglycemia and blood glucose has increased to at least 5.0 mmol/L. • Must refrain from driving immediately if they experience severe hypoglycemia while driving, and notify their health-care provider as soon as possible
Reassessment	• Reassess based on opinion of the treating physician or at the discretion of the licencing authority
Information from health care providers	• Date of the last episode • Opinion of treating physician whether stable glycemic control has been re-established • Opinion of treating physician whether driver is willing and able to take steps to ensure they do not become hypoglycemic while driving
Rationale	Persistent hypoglycemia unawareness presents the greatest risk for hypoglycemia while driving. The standard permits non-commercial drivers to continue to drive provided they are able to maintain stable blood glucose levels and follow more stringent glucose monitoring requirements.

7.6.7 Episode of severe hypoglycemia – Commercial drivers

Applies also to severe hypoglycemia while sleeping

STANDARD	Eligible for a commercial licence if: • No further episodes of severe hypoglycemia within the past 6 months • Earlier re-licensing can be considered if an appropriate specialist indicates that glycemic control has been re-established • conditions for maintaining a licence are met
Conditions for maintaining licence	• must test blood glucose immediately before driving and approximately every hour while driving • Does not drive until at least 40 minutes after successful treatment of hypoglycemia and blood glucose has increased to at least 5.0 mmol/L. • Must refrain from driving immediately if they experience severe hypoglycemia while driving, and notify their health-care provider as soon as possible
Reassessment	• Reassess based on opinion of the treating physician or at the discretion of the licencing authority
Information from health care providers	• Date of the hypoglycemic episode • Opinion of treating physician whether stable glycemic control has been re-established • Statement from treating physician that driver has provided a blood glucose log of at least 4 readings per day for 30 days, in which less than 5% of the readings are below 4.0 mmol/L
Rationale	Severe hypoglycemia indicates a lack of glycemic control and the potential for further hypoglycemic episodes. Once control is re-established and driving resumes, more stringent glucose monitoring conditions are required temporarily to mitigate the increased risk of hypoglycemia.

7.6.8 Episode of hypoglycemia unawareness in the last year – Commercial drivers

STANDARD	Eligible for a commercial licence if: • has been 3 months since the episode • treating physician indicates glycemic awareness regained, has stable glycemic control and authority determines are fit to drive • conditions for maintaining a licence are met
Conditions for maintaining licence	• must test blood glucose immediately before driving and approximately every hour while driving • Does not drive until at least 40 minutes after successful treatment of hypoglycemia and blood glucose has increased to at least 5.0 mmol/L. • Must refrain from driving immediately if they experience severe hypoglycemia while driving, and notify their health-care provider as soon as possible
Reassessment	• Reassess based on opinion of the treating physician or at the discretion of the licencing authority
Information from health care providers	• Date of the episode • Statement from treating physician that driver has provided a blood glucose log of at least 4 readings per day for 30 days, in which less than 5% of the readings are below 4.0 mmol/L • Opinion of treating physician whether glycemic awareness has been regained • Opinion of treating physician whether the driver has stable glycemic control
Rationale	Hypoglycemia unawareness greatly increases the risk for hypoglycemia while driving. This standard requires that glycemic awareness be re-established before driving resumes. Once awareness and glucose stability are re-established, more stringent glucose monitoring guidelines are required temporarily to mitigate the increased risk of hypoglycemia.

7.6.9 Persistent hypoglycemia unawareness – Commercial drivers

STANDARD	Not eligible for a commercial licence
Conditions for maintaining licence	N/A
Reassessment	N/A
Information from health care providers	N/A
Rationale	Persistent hypoglycemia unawareness presents the greatest risk for hypoglycemia while driving. Given the increased driving exposure associated with commercial driving, individuals who have persistent hypoglycemia unawareness are not fit to drive.

Chapter 8: General debility and lack of stamina

8.1 About general debility and lack of stamina

General debility

General debility is a state of general weakness or feebleness that may be a result of one or more medical conditions that produce symptoms such as pain, fatigue, cachexia and physical disability, or deficits in attention, concentration, memory, development and/or learning.

Some of the medical conditions included in this part may be commonly associated with general debility (e.g., end stage renal disease), and in these cases this is noted in the medical condition chapter. However, general debility is more usually associated with multiple medical conditions or extreme old age. Medications used to treat various medical conditions may also produce effects that contribute to general debility.

Common medical conditions not included in this document that may result in general debility are:

- anorexia nervosa or other related eating disorders
- chronic fatigue syndrome
- malabsorption syndromes (e.g., cystic fibrosis, Crohn's disease) and malnutrition
- acquired immunodeficiency syndrome (AIDS)
- chronic infections (e.g., tuberculosis (TB), human immunodeficiency virus (HIV))
- malignancies
- conditions resulting in chronic pain
- metabolic diseases such as: thyroid diseases, pituitary diseases and adrenal diseases.

Lack of stamina

Stamina is the physical or mental strength to resist fatigue and tiredness and maintain functional ability over time. Lack of stamina is not the same as general debility. While drivers with general debility do not have sufficient stamina to drive, drivers suffering from a lack of stamina may not be suffering from general debility.

Generally, concerns about stamina only arise in extreme old age or when a driver has a condition that results in a persistent impairment. For drivers with co-morbidities, stamina may be a particular concern.

Some of the medical conditions in this part may be commonly associated with a lack of stamina (e.g., heart failure), and in these cases this is noted in the medical condition chapter.

8.2 Prevalence

No data is available on the prevalence of general debility in the Canadian population because of the vagueness of the term which covers a vast array of the end-stages of chronic diseases, often in combination.

A factor in general debility is the presence of multiple conditions. In 2019, 9.0% of the general population reported having been diagnosed with at least 2 of the five major chronic conditions (cancer, diabetes, cardiovascular disease (heart disease and/or stroke) and chronic respiratory diseases (asthma and/or chronic obstructive pulmonary disease)), while 19.3% reported having been diagnosed with at least 2 of the 10 most common chronic diseases (heart disease; stroke; cancer (ever had); asthma; chronic obstructive pulmonary disease; diabetes; arthritis; Alzheimer disease or other dementia; mood disorders; and anxiety disorders).

8.3 General debility, lack of stamina and adverse driving outcomes

Most driver licensing agencies consider the effects of medical conditions on fitness to drive separately, although the presence of several conditions in the same individual is recognised as possibly producing a synergistic effect, where the total effect of the multiple conditions is greater than the sum of the effects of each separate condition. A systematic review identified a number of studies that examined the effects of combinations of medical conditions on fitness to drive and, although the general quality of the studies was fair (the scale was poor, fair, or good), the studies rated as good demonstrated that the presence of two or more medical conditions believed to influence fitness to drive resulted in higher crash risk.

Another study demonstrated that crash risk increases with the number of concomitant conditions:

Number of medical conditions	Adjusted crash risk (CI=95%)
0 (Reference)	1.00 (Reference)
1	1.18 (1.16-1.20)
2	1.35 (1.32-1.38)
3	1.48 (1.44-1.53)
4 or more	1.55 (1.49-1.60)

Other studies produced similar results. Thus, it may be concluded that multiple medical conditions may have an effect on fitness to drive that increases with the number of conditions. Depending on the different conditions involved, the increase may vary from one person to another. Consequently, medical fitness to drive evaluations must be holistic, considering the combined effects of all the conditions rather than evaluating each one separately or simply adding up the number of conditions and using the estimated total to determine fitness to drive. Since the combination of medical

conditions and their functional effects can vary from one driver to another, each evaluation must be individualised.

Multiple medical conditions may result in general debility and a loss of stamina. Literature on the effects of general debility and loss of stamina on fitness to drive is limited to opinion and consensus documents. As a result, each case must be assessed individually.

Other miscellaneous conditions that may affect fitness to drive, such as delirium and morbid obesity, will require individualised evaluations.

8.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
General debility Lack of stamina	Persistent impairment: Functional assessment	Cognitive and Motor	Medical assessments Functional assessments

Both a lack of stamina and general debility may impair a driver's motor and/or cognitive functions necessary for driving.

A driver suffering from a lack of stamina may experience:

- fatigue
- physical disability, and/or
- cognitive impairment such as loss of attention, concentration and memory.

A driver suffering from general debility may experience:

- pain
- fatigue/poor stamina
- cachexia - a condition marked by loss of appetite, weight loss, muscular wasting, and general mental and physical debilitation
- physical disability, and/or
- cognitive impairment such as loss of attention, concentration and memory.

8.5 Compensation

A driver cannot compensate for general debility or a lack of stamina that impairs the functions necessary for driving.

8.6 Guidelines for assessment

8.6.1 General debility, lack of stamina including multiple medical conditions – All drivers

STANDARD	Eligible for all classes of licence if: • the results of a functional assessment indicate that the functions necessary for driving are not impaired
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• Description of any cognitive and/or motor impairments • Results of functional assessment
Rationale	May include one or more cognitive or motor impairments. Licensing decisions should be based on individual functional assessments.

Chapter 9: Hearing loss

9.1 About hearing loss

Hearing loss is categorized as either conductive or sensorineural. Conductive hearing loss involves abnormalities in the external or middle ear, including the ear canal, eardrum or ossicles. A blockage or other structural problem interferes with how sound gets conducted through the ear, making sound levels seem lower. In many cases, conductive hearing loss can be corrected with medication or surgery.

Sensorineural hearing loss typically results from permanent damage to the inner ear (cochlea) or the auditory nerve. Typically, it is gradual, bilateral, and characterized by the loss of high-frequency hearing. Sensorineural hearing loss is permanent and often is helped with hearing aids. Profound deafness can be treated with cochlear implants. Sensorineural hearing loss accounts for 90% of all hearing loss.

9.2 Prevalence

In 2022, the Statistics Canada Canadian Survey on Disability (CSD) indicated that 5.6% of Canadians 15 years of age and older have some type of hearing difficulty. The prevalence of hearing loss increases with age. In the 2022 Canadian Survey on Disability, 13.5% of people 65 years and older reported hearing problems. Hearing loss is more common in females than males in those 15 to 44 years old, but more common in males than females in those 45 years and older.

9.3 Hearing loss and adverse driving outcomes

The effects of hearing loss on the ability to safely operate a motor vehicle are not well established. Although the overall body of literature examining the relationship between hearing loss and driving is small, since the 1990's there has been an increasing amount of research in this area. The results are equivocal. Some studies report an association between impairments in hearing and adverse driving outcomes while others have not found an association.

Although variability in methodology makes it difficult to draw conclusions across studies, results from studies indicate that, for the majority (70%) of study measures, no significant relationship was found between hearing loss and adverse driving outcomes (e.g., crashes, violations, convictions).

9.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Hearing loss	Persistent impairment: Functional assessment	Sensory - Hearing	Audiometric assessment

The effect of hearing loss on functional ability to drive has not been established.

9.5 Compensation

Drivers with hearing loss may compensate for this impairment using auditory aids.

9.6 Guidelines for Assessment

9.6.1 Hearing loss – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence
Conditions for maintaining licence	None
Reassessment	• Routine
Information from health care providers	None
Rationale	There is insufficient evidence to support a minimum hearing requirement for non-commercial drivers.

9.6.2 Hearing loss – Commercial drivers

STANDARD	Eligible for class 2 and 4 driver licence, and classes 1, 3 and 5 when transporting dangerous goods, if either: • Perceives a forced whispered voice at not less than 5 (1.5 metres) feet with or without the use of a hearing aid or, • Hearing loss no greater than 40dB averaged at 500, 1000, and 2000 Hz in their better ear
Conditions for maintaining licence	• Wear hearing aid, if the driver must wear a hearing aid in order to meet the hearing standard
Reassessment	• Routine
Information from health care providers	• Results of a recent auditory testing
Rationale	For Classes 5 and 6, hearing loss should not constitute a barrier to driving ability. While the ability to hear or communicate is of paramount importance for the operator of a passenger bus, ambulance or other emergency vehicles (i.e. Classes 2 and 4), there are a number of factors which suggest it is inappropriate to apply the same requirement to the operator of a Class 1 or 3 motor vehicle. Consequently, it is suggested that the holder of a Class 2 or 4 driver licence and the operators of emergency vehicles be required to meet a hearing standard. It is also recommended individuals who hold a Class 1, 3 or 5 licence <u>and</u> are engaged in the transportation of dangerous goods meet the medical requirements corresponding to Classes 2 and 4 as stated above. While it is agreed that a degree of hearing would be beneficial for all motor vehicle operators, in the absence of empirical data, the totally deaf individual who is able to successfully complete the driving tests should be permitted to obtain or hold a Class 1, 3, 5 or 6 licence. The US FMCSA whisper test is described as follows: - For the whispered voice test, the individual should be stationed at least 5 feet from the examiner with the ear being tested turned toward the examiner. - The other ear is covered. - Using the breath which remains after a normal expiration, the examiner whispers words or random numbers such as 66, 18, 23, etc. - The examiner should not use only sibilants (s-sounding test materials). - The opposite ear should be tested in the same manner.

Chapter 10: Intracranial tumours

10.1 About intracranial tumours

Intracranial tumours are tumours that develop inside the cranium, the upper portion of the skull that protects the brain. Primary tumours are those which originate from within the cranium and metastatic tumours are those which result from cancers which spread (metastasize) from other parts of the body. Metastatic tumours are by far the more common type of intracranial tumour in adults, 10 times more common than primary tumours.

Primary tumours may be classified as either benign (non-cancerous) or malignant (cancerous). Malignant tumours are graded on a scale of 1 to 4, with grade 4 being the most severe, based on how abnormal they are compared to normal tissue and how quickly they are likely to grow and metastasize.

Typically, the treatment options for intracranial tumours are surgery, radiation and chemotherapy, alone or in combination, regardless of whether the tumour is primary or metastatic, benign or malignant. For primary tumours, the probability of successful treatment depends on a number of factors, including the type of tumour, size and location.

Treatment will rarely cure a metastatic tumour, and the goal of treatment is generally to reduce symptoms, increase length of survival and improve quality of life. Impairments associated with intracranial tumours vary depending on the tumour type, location and rate of growth, and can affect cognitive, motor or sensory functions.

Examples of possible impairments include:

- cognitive impairment
- epilepsy
- personality changes
- focal weakness, and
- sensory disturbances.

The presentation of impairments may be progressive or variable.

10.2 Prevalence

The Brain Tumour Registry of Canada (BTRC)'s Survival and Prevalence Report 2010-2017 (published in 2022) estimated that as of 2018, 37,575 Canadians were living with a primary central nervous system (CSN) tumour. Of those, approximately 20.6% were malignant, and prevalence was slightly higher in males than females. The three most common types of primary malignant brain tumours overall were glioblastoma, pilocytic

astrocytoma, and oligodendroglioma. Males and females had similar survival time for most tumour types, with shorter survival time associated with increased age. For non-malignant tumours, overall prevalence was higher in females than males.

Metastatic brain tumours are more frequent than primary tumours and occur at some point in 20-40% of people with cancer. The incidence of metastatic brain tumours is increasing as cancer patients live longer. While Canadian data is unavailable, the annual global age-standardized incidence of primary malignant brain tumours is about 3.7/100 000 for males and 2.6/100 000 for females. Rates are higher in more developed countries (males, 5.8 and females, 4.1/100 000), possibly due to better detection and diagnostic methods.

In the US, the overall rate for all brain tumours (primary and metastatic) in 2025 (encompassing data from 2018 to 2022) was about 26/100 000 people.

10.3 Intracranial tumours and adverse driving outcomes

A 2024 systematic review analyzed three studies involving over 19,000 participants with malignant or non-malignant brain tumours in the US and Finland. While one study found no significant difference in motor vehicle crash (MVC) rates among brain tumour patients, two others using driving simulation and cognitive testing identified impairments in memory and visual attention as contributing factors to increased driving risk. These findings support the need for individualized assessments of fitness to drive, taking into account the specific functional impairments caused by brain tumours.

Studies on the various functional impairments that may be caused by intracranial tumours are addressed in the chapters on the specific impairments.

10.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Intracranial tumour	Persistent impairment: Functional assessment	Variable – cognitive, motor or sensory	Medical assessments Functional assessment
	Episodic impairment: Medical assessment – likelihood of impairment	Variable – sudden impairment (seizures)	Medical assessments

An intracranial tumour may result in a persistent cognitive, motor or sensory impairment, or an episodic impairment (seizures), or both.

10.5 Compensation

Drivers who have experienced a persistent impairment of motor or sensory function may be able to compensate. An occupational therapist, driver rehabilitation specialist or other medical professional may recommend specific compensatory vehicle modifications or restrictions based on an individual functional assessment.

Some examples of compensatory mechanisms are shown in the following table.

Motor impairment	Sensory (vision) impairment
• Spinner knob or steering wheel device • Devices to operate secondary controls e.g. turn signal and horn • Hand Controls • Left foot accelerator • Restriction to automatic transmission	• Adapted scanning strategies e.g. degree and frequency of head/trunk rotation • Adapted mirrors –e.g. left, right, rear, • Cameras and/or sensors for e.g. side and rearview observation

10.6 Guidelines for assessment

10.6.1 Intracranial tumour – All drivers

If a driver has seizures as a result of an intracranial tumour, also see the standards in Chapter 17.

STANDARD	Eligible for all classes of licence if: • movement and strength are sufficient to perform the functions necessary for driving • cognitive and visual functions necessary for driving are not impaired • any pain associated with the condition, and any treatment for the condition, do not impair the functional abilities necessary for driving • where required, a road test or other functional assessment indicates that the driver is able to compensate for any loss of functional ability necessary for driving, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Only drive vehicles that have the permitted modifications and devices required to compensate for functional impairment
Reassessment	• Routine
Information from health care providers	• Whether the driver suffers from seizures as a result of the tumour. See the standards under Chapter 17 if seizures are present. • Opinion of treating physician on whether the driver has a loss of movement or strength that may affect functional ability to drive • Opinion of treating physician on whether pain or treatment may adversely affect functional ability to drive • Opinion of treating physician on whether the driver suffers from diplopia and/or a visual field deficit that may affect functional ability to drive. See the standards under Chapter 22 if the treating physician indicates that either of these conditions may be present. • Results of cognitive assessment • Where required, the results of a functional assessment
Rationale	The potential functional impairments associated with an intracranial tumour are variable.

Chapter 11: Musculoskeletal conditions

11.1 About musculoskeletal conditions

This chapter is concerned with diseases or injuries that have a persistent impact on the musculoskeletal system. Musculoskeletal refers to the system of muscles, tendons, ligaments, bones, joints, cartilage and other connective tissues. The musculoskeletal system is responsible for body movement and stability. Examples of chronic musculoskeletal conditions that may have a persistent impact on driving are:

- diseases of the joints, e.g., rheumatoid arthritis and osteoarthritis
- disabilities of the spine, e.g., degenerative disc disease or permanent injuries
- deformity, e.g., scoliosis, and
- loss of limb or absent/impaired limb function.

Some musculoskeletal conditions, or procedures to treat the conditions, may result in temporary impairment of the functions necessary for driving, including fractures, temporary braces and casts, hip and knee replacements, and various orthopedic surgeries. These are considered transient impairments and authorities do not assess drivers with transient impairments.

11.2 Prevalence

Although musculoskeletal injuries are common, the majority are transient and heal without causing permanent disability. Consequently, statistics on the prevalence and incidence of musculoskeletal conditions in general are difficult to obtain because of the broadness of the category and the diversity of conditions within the category. Research suggests that musculoskeletal conditions are a leading cause of pain and physical disability.

One source of statistics on injuries in Canada is the Injury and Trauma Emergency Department and Hospitalization Statistics compiled by the Canadian Institute for Health Information (CIHI). Their statistics cover relatively serious injuries as those who suffer minor injuries will not be hospitalized and may not even consult a physician. According to their latest report, in 2017-2018 there were 599/100 000 hospitalizations for musculoskeletal injuries in Canada. Their report notes that, for instance, only 4% of those with sports injuries who consulted at the emergency department were hospitalized, with concussion accounting for 94%. The same holds true for all injuries where their compilation of the statistics for six provinces (PE, NS, ON, MN, SK and AB) and YK reveals that there were 2 096 583 consultations of which 5% were hospitalized in 2017-2018. More recent data available from CIHI for 2023-2024 suggests that rates of injury-related hospitalizations have increased over time, with the greatest increase among individuals aged 65 to 84 years due to falls; however, the more recent dataset does encompass a broader range of injury types than just musculoskeletal.

Arthritis is an umbrella term referring to a group of more than 100 medical conditions. Two of the most common forms of arthritis are osteoarthritis (OA) and rheumatoid arthritis (RA). It is estimated that 9.6% of males and 18.0% of females 60 years of age and older worldwide have symptomatic OA. In Canada as of 2024, according to the Canadian Chronic Disease Surveillance System (CCDSS), approximately 13.9% of adults aged 20 years and older are diagnosed with OA. Prevalence increases with age and affects females more than males, with 38% of females aged 60-79 and 56% of those aged 80 and older affected, compared to 29% of males aged 60-79 and 43% of those aged 80 and older affected.

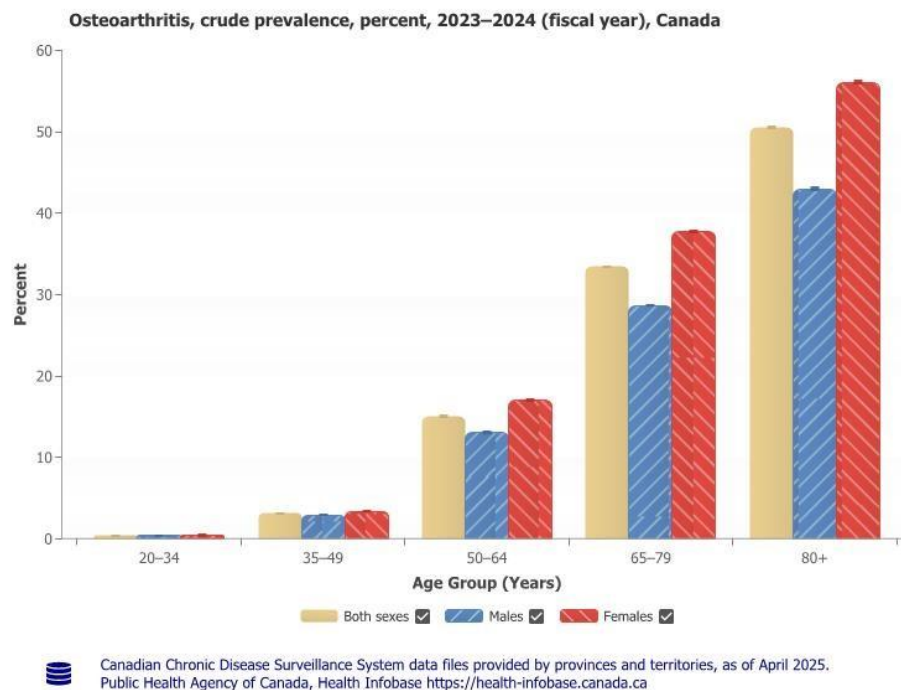
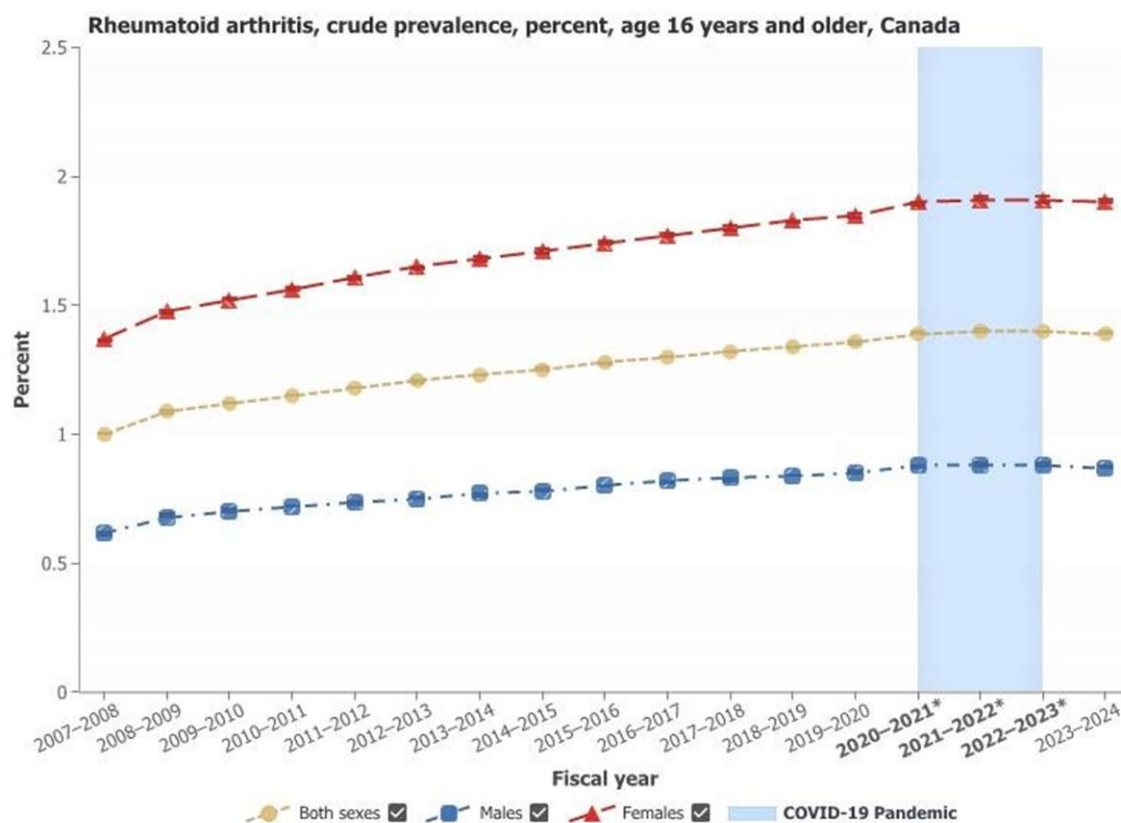


Figure 11.2-1. Crude prevalence of osteoarthritis (OA) by age-group and sex, 2023-2024

Rheumatoid Arthritis (RA) also has a worldwide distribution with an estimated prevalence of 1 to 2%. Both the incidence and prevalence of RA increase with age and both are two to three times greater in females than in males. In Canada, data from CCDSS for 2024 shows a prevalence of 1.4% for both sexes in line with global estimates, with an approximately two-fold higher prevalence in females (1.9%) versus males (0.9%). Prevalence has increased over time from 1.0% in 2007-2008, with the disparity between females and males remaining stable over time. Similar to OA, prevalence of RA also increases with age.



Canadian Chronic Disease Surveillance System data files provided by provinces and territories, as of April 2025.
Public Health Agency of Canada, Health Infobase <https://health-infobase.canada.ca>

*Many CCDSS measures, such as chronic condition incidence, were influenced by the COVID-19 pandemic. Changes in such measures may be driven by multiple factors, including (but not limited to) differences in healthcare seeking behaviour, the availability and use of healthcare services, as well as true changes in health status. As such, CCDSS measures should be used cautiously when making inferences about population health during the COVID-19 pandemic. For the purposes of interpreting the estimates in this data tool, the COVID-19 pandemic period is defined as fiscal years 2020-2021 to 2022-2023. This timeframe aligns with the World Health Organization's declaration of COVID-19 as a public emergency of international concern from January 30, 2020, to May 5, 2023. Guidance for data users on examining the impacts of the COVID-19 pandemic on CCDSS measures during the pandemic period can be accessed at the CCDSS website.

Figure 11.2-2. Crude prevalence of rheumatoid arthritis (RA) in Canadians aged 16 years and older

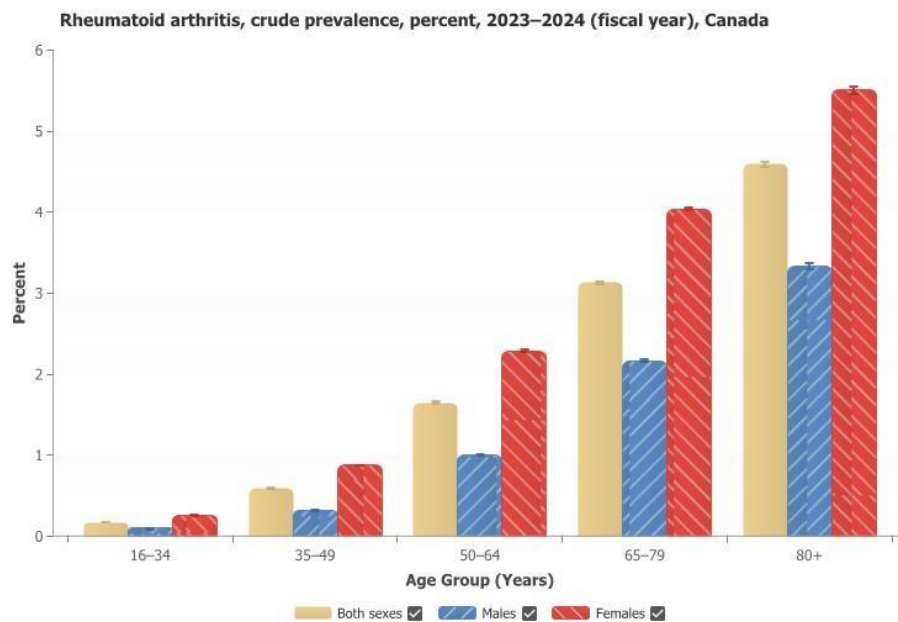


Figure 11.2-3. Crude prevalence of rheumatoid arthritis (RA) by age-group and sex, 2023-2024

11.3 Musculoskeletal conditions and adverse driving outcomes

Studies on the effects of musculoskeletal conditions mostly examine the effects of immobilisations on driving performance. Overall, the conclusions drawn from these studies is that a driver with a temporary immobilisation of a leg, a hand or an arm should be counselled not to drive if it interferes with driving. Cervical immobilisation will limit movements of the head and, although there are no studies examining its effect on crash risk, drivers with a cervical immobilisation should also be counselled to refrain from driving. Research also suggests that the removal of an immobilisation may reveal pain, incomplete weight-bearing ability or residual stiffness that may preclude driving for several weeks. Each case should be evaluated individually.

In general, since temporary immobilisations are only applied for relatively short periods, learning to compensate for the loss of function is unlikely. However, because temporary immobilisations are worn for such short periods, action by a licensing agency is not necessary for obvious practical reasons although a patient with a temporary immobilisation who insists on driving may be reported to the agency by their physician if they consider it will compromise road safety.

The permanent loss of an arm or a leg (through amputation or loss of function) requires a considerable period of rehabilitation for adequate compensation to be acquired. The studies suggest that long-term immobilisations and permanent loss of a hand, arm or leg may require an occupational therapist's evaluation and possible adaptations to the

automobile while permanent loss of any limb or joint is incompatible with driving a motorcycle or a scooter.

Finally, medications, particularly those used to alleviate pain, may degrade driving performance and their effects must be included in any assessment.

11.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach*	Primary functional ability affected	Assessment tools
Loss of limb/absent or impaired limb function	Persistent impairment: Functional assessment	Motor	Medical assessments
Diseases of the joints			Functional assessment
Disabilities of the spine			
Deformity			

* See Part 1 for a discussion of the use of functional assessments for driver licensing decisions.

Drivers operating motor vehicles of any class must be able to carry out many complex muscular movements swiftly, accurately and repeatedly in order to control a vehicle properly. Truck and bus drivers must also have good muscular strength and functional range of motion in both their arms and legs in order to handle these heavier vehicles.

Musculoskeletal conditions may cause a persistent impairment of motor functions necessary for driving. The specific impact on functional ability varies by condition and type of impairment. Functional abilities that may be affected include:

- muscular strength
- range of motion
- flexion and extension of upper and lower extremities
- joint mobility, and
- trunk and neck mobility.

Osteoarthritis (OA) has a considerable effect on functional ability, with the extent of the disability associated with the location and severity of the disease. For example, the risk for disability (defined as needing help walking or climbing stairs) attributable to OA of

the knee is as great as that attributable to cardiovascular disease, and is greater than that due to any other medical condition in the aged population.

Functional disability is the major consequence of rheumatoid arthritis. Drivers with RA often experience a substantial loss of mobility due to pain and joint destruction. In the few studies that have examined the relationship between RA and driving performance, 25% - 50% of individuals with RA reported difficulties with aspects of the driving task such as steering, cornering, reversing, head turns and shoulder checks.

11.5 Compensation

Drivers with musculoskeletal conditions may be able to compensate for functional impairment through strategies and/or vehicle modifications.

Strategies

For loss of limb, a driver may compensate through the use of a prosthetic device when driving. Other strategies that do not require vehicle modifications may also be used to compensate, for example, rotating the upper body in order to check side view mirrors if the driver's neck lacks sufficient mobility. The effectiveness of individual strategies may be determined through a road test.

Vehicle modifications

Drivers with musculoskeletal conditions may be able to compensate for a functional impairment by driving a vehicle with modified driving equipment (see table below).

An occupational therapist, driver rehabilitation specialist or medical professional may recommend specific compensatory vehicle modifications based on an individual functional assessment. They are familiar with the full range of possible vehicle modifications and what is appropriate for the type of musculoskeletal condition. Listed below are examples of some possible vehicle modifications.

Musculoskeletal condition	Possible vehicle modifications
Some degree of loss of movement of the head and neck	Adapted mirrors, e.g. left, right, rear Cameras and/or sensors for enhanced observations, e.g. side and rear view
Amputation, absent or impaired lower limb function	Use of prosthesis or brace to operate pedals Licence restricted to automatic transmission
Amputation, absent or impaired upper limb function of either arm	Spinner knob or steering wheel device Devices to operate secondary controls, e.g. turn signal and horn

There is little empirical research that considers the relationship between vehicle modifications and adverse driving outcomes. The effectiveness of individual vehicle modifications may be determined through a road test.

11.6 Guidelines for assessment

11.6.1 Loss of upper or lower extremities – All drivers

STANDARD	Eligible for all classes of licence if: • a functional assessment which may include a road test indicates ability to compensate for any loss of functional ability required for driving, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Only drive vehicles that have the permitted modifications and devices required to compensate for functional impairment
Reassessment	• If the loss of limb is due to a progressive medical condition, reassess as per the standards for that condition • Otherwise, routine
Information from health care providers	• Results of a road test in a vehicle with the permitted modifications or devices required • Health professional's opinion as to whether the driver has insight into the impact their loss of limb may have on driving
Rationale	The impact of a loss of limb on fitness to drive is variable and must be determined by an individual functional assessment.

11.6.2 Chronic musculoskeletal condition – All drivers

Chronic musculoskeletal conditions include diseases of the joints, disabilities of the spine and deformity.

STANDARD	Eligible for all classes of licence if • the driver retains sufficient movement and strength to perform the functions necessary for driving • pain associated with the condition, or the drugs used to treat the condition, do not adversely affect ability to drive safely • where required, a road test or other functional assessment indicates ability to compensate for any loss of functional ability required for driving, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Only drive vehicles that have the permitted modifications and devices required to compensate for any functional impairment
Reassessment	• Routine
Information from health care providers	• Opinion of treating physician on whether the driver has a loss of range of motion or strength that may affect functional ability to drive • Opinion of treating physician on whether pain or drugs may adversely affect functional ability to drive • Where required, the results of a functional assessment • Opinion of treating physicians as to whether the driver has insight into the impact their condition may have on driving • History of compliance with prescribed treatment regime • If known or applicable, whether the driver is compliant with any current conditions of licence related to their condition
Rationale	The impact of a chronic musculoskeletal condition on fitness to drive is variable and must be determined by an individual functional assessment.

Chapter 12: Neurological disorders

12.1 About neurological disorders

Neurological disorders can affect the brain, spinal cord, nerves and muscles. They can affect an individual's ability to think, see, communicate, move, and sense and coordinate movements. While any number of conditions fall within the category of neurological disorders, this chapter focuses on three common disorders: multiple sclerosis, Parkinson's disease and cerebral palsy.

Multiple sclerosis

Multiple sclerosis (MS) is an autoimmune disorder in which the immune system attacks the myelin of the central nervous system (brain and spinal cord), resulting in inflammation, demyelination and axonal damage. Myelin is an essential insulation sheath of the nerve processes (axons). If it is damaged, signal transmission is slowed. Demyelination can ultimately result in permanent axonal damage in the form of scarring called gliosis.

MS has an unpredictable and chronic course, leading to numerous physical and cognitive impairments. The cause is complex and is still under investigation, but is thought to involve both genetic susceptibility and environmental triggers. There are three clinical types of MS:

- Relapsing – Remitting (RRMS),
- Secondary Progressive (SPMS), and
- Primary Progressive (PPMS).

It is estimated that approximately 90% of individuals are initially diagnosed with RRMS. It is characterized by unpredictable attacks (relapses) followed by periods of months to years with no new clinical signs of disease activity (remissions). Relapses are characterized by autoimmune attack of the CNS myelin, and remissions are characterized by the body's innate repair of myelin. During the disease course, this cycle of relapse and remission will transition to secondary progressive MS (SPMS) for the majority of patients, at which point remissions cease to occur and accumulated disabilities become permanent and the body becomes less and less able to repair myelin. Approximately 10% of people initially present with primary progressive MS (PPMS) at disease onset; symptoms in these patients simply worsen over time with no periods of remission.

Parkinson's disease

Parkinson's disease (PD) belongs to a group of conditions called motor system or movement disorders, which result from the slowly progressive loss of dopamine-producing brain cells. The lack of dopamine, a neurotransmitter, interferes with the

transmission of messages from the brain to nerve cells that control muscle movement and coordination. It can result in motor impairment (tremor or rigidity), and in later stages, in cognitive or autonomic dysfunction. PD is chronic and progressive, and while the specific cause is unknown, it is believed that both genetic and environmental factors contribute to the development of the disease.

Cerebral palsy

Cerebral palsy (CP) refers to any one of a number of neurological disorders that appear in infancy or early childhood and are the result of damage to, or impaired development of, the motor centres of the brain. It is a non-progressive disorder that permanently affects body movement and muscle coordination.

12.2 Prevalence

Multiple sclerosis (MS)

The prevalence of MS in Canada is among the highest in the world, with studies reporting prevalence rates from 55 to 250 per 100,000. The 2023 Atlas of MS from the MS International Federation estimated the prevalence in Canada as 250 per 100,000, with 2024 data from the Canadian Chronic Disease Surveillance System (CCDSS) reporting prevalence of 0.29% in people 20 years and older.

Globally, MS affects females 2-3 times more often than males, with Canadian estimates from the MS Society of Canada indicating that 75% of people living with MS are female. The average age of diagnosis is 43 years.

Parkinson's disease (PD)

In Canada, the CCDSS gathers data on Parkinson's disease and other Parkinsonism that represent a small cohort of other neurological diseases with symptoms that overlap with Parkinson's disease. As of 2024, the prevalence was estimated at 0.54%, with males affected approximate 1.5 times more than females. Prevalence increases with age, with the highest incidence amongst people 65 years and older.

Cerebral palsy (CP)

According to the Canadian Cerebral Palsy Registry, the prevalence of CP in Canadian infants is approximately 2 to 2.5 in 1000 live births. It is the most common physical disability in childhood, with over 80,000 Canadians living with the disorder as of 2020. While the incidence of CP has shown a slight decline in recent years, the overall number of individuals living with C P has increased, largely due to improved survival rates among affected newborns as care and treatment have advanced.

12.3 Neurological disorders and adverse driving outcomes

Multiple sclerosis

The research on MS and driving remains limited. However, some recent studies support that driving performance may be impaired by functional deficits, including cognitive impairment, caused by MS. One European study that used a driving simulator noted that compared to control participants, people with MS had more driving accidents, slower reaction times, more driving errors, and lower driving safety scores. In that study, cognitive impairment, particularly working memory, was significantly associated with poor driving outcomes.

Parkinson's disease

There is a small but consistent body of research indicating that functional deficits associated with Parkinson's disease or its treatment may impair driving performance. Emerging evidence suggests that multidisciplinary assessments are critical for evaluating fitness to drive, and that some individuals with Parkinson's disease may face increased risks or barriers related to driving.

Cerebral palsy

Research on cerebral palsy and driving outcomes remains limited; however, recent studies have begun to explore how functional impairments, particularly cognitive and motor deficits, may affect driving ability in individuals with CP. Emerging evidence suggests that multidisciplinary assessments are critical for evaluating fitness to drive, and that some individuals with CP may face increased risks or barriers related to driving.

12.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Multiple sclerosis Parkinson's disease Cerebral palsy	Persistent impairment: Functional assessment	Variable – cognitive, motor or sensory	Medical assessments Functional assessment

Multiple sclerosis

MS can affect motor, visual and cognitive functioning. The major symptoms associated with MS that may affect driving are:

- ataxia (wobbliness, incoordination and unsteadiness)
- impaired proprioception (ability to perceive the body's position in space)
- spasticity (involuntary muscle spasms)
- muscle weakness
- fatigue
- chronic pain
- vision problems, and
- cognitive impairment.

Vision problems are common, affecting up to 80% of individuals with MS at some point.

Visual symptoms associated with MS include:

- nystagmus (rapid, involuntary eye movement)
- diplopia (double vision)
- blurred vision
- scotoma (abnormal blind spot), and
- diminished contrast sensitivity.

Cognitive impairment, particularly associated with information processing speed, is also common, affecting between 45% and 65% of those with the disease.

Medications used to treat MS that may affect driving include:

- corticosteroids
- NSAIDS
- antiepileptics
- antidepressants
- antispasticity drugs, and
- opioids.

See Chapter 15, Drugs, alcohol and driving, for more information on these medications.

Parkinson's disease

PD can affect motor, visual and cognitive functioning. Common motor symptoms include:

- tremor
- rigidity
- bradykinesia/akinesia (slowness or absence of movement/rapid repetitive movements), and
- postural instability.

Visual impairments such as contrast sensitivity, diplopia (double vision) and impaired eye movement are sometimes seen in PD and related movement disorders. Cognitive symptoms may include:

- psychiatric conditions such as depression, impulse control disorders and psychosis
- sleep disturbances
- psychomotor slowing (slow response and reaction time)
- cognitive impairment, and
- dementia.

In addition to the symptoms noted above, fatigue and sleep disturbances are common in those with PD.

The symptoms of PD are often treated with medications including levodopa, dopamine agonists and MAO-B inhibitors. These medications can cause side effects including sleepiness, sleep attacks (sudden, overwhelming sleepiness with little or no warning signs) and visual hallucinations, which may affect driving.

A further consideration for driving is the fluctuation in the effects of medication. Individuals with advanced PD may experience periods of reduced symptom control (wearing off) near the time of their next dose of medication.

Cerebral palsy

CP can affect motor, visual, and cognitive functioning. The primary effects of CP are:

- ataxia (wobbliness, incoordination and unsteadiness)
- weakness and spasticity (involuntary muscle spasms), and
- altered muscle tone that is either too stiff or too floppy.

CP can also cause a loss of visual acuity or slowed visual tracking, as well as cognitive impairments such as impaired judgment and slow processing or reaction times.

12.5 Compensation

Drivers who have experienced a persistent impairment of motor or sensory function may be able to compensate. An occupational therapist, driver rehabilitation specialist or other medical professional may recommend specific compensatory vehicle modifications or restrictions based on an individual functional assessment.

Some examples of compensatory mechanisms are shown in the following table.

Motor impairment	Sensory (vision) impairment
• Spinner knob or steering wheel device • Devices to operate secondary controls e.g. turn signal and horn	• Adapted scanning strategies e.g. degree and frequency of head/trunk rotation • Adapted mirrors –e.g. left, right, rear,

• Hand Controls • Left foot accelerator • Restriction to automatic transmission	• Cameras and/or sensors for e.g. side and rearview observation
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12.6 Guidelines for assessment

12.6.1 Neurological disorder – All drivers

STANDARD	Eligible for all classes of licence if: • range of motion, strength and coordination are sufficient to perform the functions necessary for driving • cognitive functions necessary for driving are not impaired • any pain associated with the condition, and any drugs used to treat the condition, do not impair the functional abilities necessary for driving • where required, a road test or other functional assessment indicates that the driver is able to compensate for any loss of functional ability necessary for driving, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Only drive vehicles that have the permitted modifications and devices required to compensate for functional impairment
Reassessment	• Reassess a minimum of every 5 years if the disorder is progressive (e.g., MS or PD) • Routine if the disorder is not progressive (e.g., CP)
Information from health care providers	• Opinion of treating physician on whether the driver has a loss of range of motion, strength or coordination that may affect functional ability to drive • Opinion of treating physician on whether pain or drugs may adversely affect functional ability to drive • Where required, the results of cognitive assessment • Where required, the results of a functional assessment
Rationale	The potential functional impairments associated with neurological disorders are variable.

Chapter 13: Peripheral vascular diseases

13.1 About peripheral vascular diseases

Overview

The term peripheral vascular diseases (PVDs) refers to circulatory disorders involving any of the blood vessels outside the heart, e.g. arteries, veins and lymphatics of the peripheral vasculature. The four subcategories of PVDs that have the greatest relevance for driving are:

- peripheral arterial disease
- aneurysms
- dissections, and
- deep vein thrombosis.

Peripheral arterial disease

Peripheral arterial disease (PAD) is characterized by partial or complete failure of the arterial system to deliver oxygenated blood to peripheral tissue. Atherosclerosis is the primary underlying cause of PAD. Other causes include thromboembolic, inflammatory or aneurismal disease. Although PAD can affect both upper and lower extremities, lower extremity involvement is more common. A large majority (70% to 80%) of individuals with PAD are asymptomatic. For those individuals who are symptomatic, symptoms can progress from intermittent claudication (pain while walking) to rest/nocturnal pain, to necrosis/gangrene. Only 1% to 2%, however, progress to limb amputation within 5 years of the original diagnosis.

Aneurysms

An aneurysm is defined as a localized abnormal dilation of an artery by 50% or more above the normal size. While an aneurysm can form on any blood vessel, aneurysms of the aorta are of greatest concern for driving because of the risk of rupture and resulting sudden incapacitation. Abdominal aortic aneurysm (AAA) is the most common but aneurysms of the thoracic aorta also occur.

Aortic dissection

An aortic dissection occurs when circulating blood enters the aortic wall through a tear in the inner layer of the aorta and then is forced between the layers of the aorta forming a space between the layers occupied by blood. A dissection may proceed to a rupture or may be contained within the aorta. Dissections occur in diseased aortas (existing aneurysms or certain congenital syndromes such as Marfan's syndrome) but also may occur in normal aortas. There is no effective way to predict that a dissection might occur so that it is not possible to develop standards for licensing based on any

measurable parameters. Aortic dissection is the most common but dissection of other arteries can occur.

Deep vein thrombosis

Deep vein thrombosis (DVT) occurs when a thrombus (blood clot) forms within a deep vein, most commonly in the calf. Three main factors (known as Virchow's triad) can contribute to deep vein thrombosis: injury to the vein's lining, an increased tendency for blood to clot, and slowing of blood flow.

13.2 Prevalence

Peripheral arterial disease

Estimates of the prevalence of PAD depend on populations studied and study methodology. The general prevalence rate is reported to be up to 19%. However, because most individuals remain asymptomatic, the true overall prevalence rate may be higher. The prevalence of PAD increases with age and with prolonged exposure to smoking, hypertension, high cholesterol, and diabetes.

Recent studies indicate that PAD affects approximately 20% of adults 55 years of age and older and an estimated 27 million persons in North America and Europe. Intermittent claudication is the most common symptom associated with PAD. The prevalence of intermittent claudication increases dramatically with age. The incidence in the general population is less than 1% of those under the age of 55, and increases to 5% for those 55 to 74 years of age. At younger ages, the prevalence rate is almost twice as high for males as for females but, at the older ages, the difference between males and females is reduced. Risk factors for lower extremity PAD are:

- age less than 50 years, with diabetes and one other atherosclerosis risk factor (smoking, dyslipidemia, hypertension or hyperhomocysteinemia)
- age 50 to 69 years and history of smoking or diabetes
- age 70 years and older
- leg symptoms with exertion (suggestive of claudication) or ischemic rest pain
- abnormal lower extremity pulse examination, and
- known atherosclerotic coronary, carotid or renal artery disease.

Abdominal aortic aneurysms

The prevalence of abdominal aortic aneurysm (AAA) has decreased in the last 20 years, mostly related to a reduced rate of cigarette use and improved cardiovascular risk management. Prevalence increases with age, and the current estimated prevalence for individuals aged 66 and older is 1-5%. Males experience a higher prevalence than females, with prevalence among males aged 65-80 estimated at 4-6%, which is 4-6 times higher than in females in the same age group. Ninety percent of individuals with an AAA have a history of smoking. The likelihood of an AAA developing in a first degree relative

of an individual with an AAA is up to 20%. Individuals with an AAA invariably have vascular comorbidities, including coronary and cerebrovascular disease and the risk of death from these comorbidities is greater than the risk of death from aneurysm rupture.

Aortic dissections

Aortic dissection is an acute, potentially life-threatening event rather than an ongoing condition, and therefore consideration of prevalence is of limited value. Annual incidence, however, is estimated at 2.6 to 4.6 in 100,000 in North America. The true incidence is likely higher, as many cases lead to sudden death prior to a hospital diagnosis being made. Type A aortic dissections involving the ascending aorta are more common than Type B involving the descending aorta, at a ratio of approximately 2 to 1. The most common risk factor is hypertension, which is present in 70-85% of people who experience an aortic dissection. Incidence is higher in males and increases with age.

Deep vein thrombosis (DVT)

An estimated 33 000 people are affected by DVT each year in Canada. Up to one-third of people that experience an initial DVT may experience a recurrence within 10 years. Approximately one-third of patients with DVT will also develop a pulmonary embolism, which is the obstruction of the pulmonary artery, or a branch of it leading to the lungs, by a blood clot. DVT prevalence increases significantly with age, with the incidence rising sharply after age 45 and doubling with each decade after age 40.

13.3 Peripheral vascular diseases and adverse driving outcomes

There are no studies that consider a relationship specifically between peripheral vascular diseases and risk of crash. A 2024 study considered vascular conditions as part of a broader analysis of medical conditions affecting driving, noting that functional impairments associated with vascular diseases may impact driving performance.

13.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Peripheral arterial disease – severe claudication	Persistent impairment: Functional assessment	Sensorimotor Motor	Medical assessments Functional assessment
Abdominal aortic aneurysm	Episodic impairment: Medical assessment – likelihood of impairment	All – sudden incapacitation	Medical assessments

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
DVT - may result in pulmonary embolism	Episodic impairment: Medical assessment – likelihood of impairment	All – sudden incapacitation	Medical assessments

Peripheral arterial disease (PAD)

For drivers with peripheral arterial disease, the chronic outcomes of the disease will rarely affect driving ability. The symptoms of lower extremity PAD such as coldness or numbness in the foot or toes and, in the later stages, pain while the extremity is at rest, may affect the sensory and motor functions required for driving.

In general, the degree of impact will be determined by disease severity. For example, drivers who are asymptomatic or have mild to moderate claudication are unlikely to have symptoms that would affect driving. Drivers whose disease has progressed to the severe claudication stage or higher may have functional impairment sufficient to interfere with the lower extremity demands of operating a motor vehicle (e.g., awareness of foot placement, pedal pressure, motor strength, etc.).

Abdominal aortic aneurysm (AAA)

The concern for drivers with AAA is the risk of rupture which, when it occurs, results in sudden incapacitation in the vast majority of cases. The challenge is to identify those individuals with an unruptured AAA and to offer corrective treatment based on characteristics that suggest that there is a significant risk of rupture. Factors associated with increased risk include:

- Transverse diameter: the risk of rupture rises with an increase in transverse diameter of the aneurysm.
- Annual risk of rupture is 5.3% for aneurysms 5.5-7.0 cm in diameter. The annual risk has been reported to be >20% for larger aneurysms >7 cm in diameter but more recent studies suggest that the risk in this group may be lower, in the range of 6.3% per year. However, studies of rupture rates in such very large aneurysms are limited by small numbers of subjects. It therefore is difficult to define a threshold for eligibility for non-commercial licensing.
- Sex: the risk of rupture for AAA's 4.5-5.4 cm in transverse diameter is higher in females than males but this is offset by an increase in operative mortality in females so that there is no good evidence for a different diameter threshold for surgery in females. Furthermore, natural history studies suggest that aortic aneurysms have a tendency to rupture at smaller diameters in all smaller stature individuals, regardless of sex. Recent and limited evidence suggest that diameter indexed to body size and/or consideration of biomechanical and morphological parameters may be a better predictor of the risk of rupture, but additional study is required and diameter remains the clinical standard for prediction of rupture risk.
- Shape of the aneurysm: saccular aneurysms are at greater risk of rupture at a lower diameter than fusiform or symmetrical AAAs so that surgery is generally recommended at a lower diameter but there is no specific threshold.
- Presence of symptoms: symptoms such as abdominal or back pain or tenderness on palpation are felt to be associated with an increased risk of rupture but the evidence is weak.
- Rate of growth: it is generally recommended that surgery is indicated if an AAA increases in size by >1 cm per year.

The consensus among experts, based on strong scientific evidence, is that surgery is indicated for any AAA greater than or equal to 5.5 cm in transverse diameter.

Deep vein thrombosis

For drivers with deep vein thrombosis (DVT), acute complications may affect driving ability. The primary concern with DVT is the risk of sudden incapacitation due to a pulmonary embolism.

13.5 Compensation

Drivers are not able to compensate for the effects of an AAA, aortic dissection or DVT. Drivers with an amputation resulting from PAD may be able to compensate for functional impairment through strategies and/or vehicle modifications. For example:

- for loss of limb, a driver may compensate through the use of a prosthetic device when driving
- drivers with PAD may be able to compensate for a functional impairment by driving a vehicle that has been modified to address their impairment. Compensatory vehicle modifications can include modifications to driving controls (e.g., hand controlled throttle and brake).

An occupational therapist, driver rehabilitation specialist or other medical professional may recommend specific compensatory vehicle modifications based on an individual functional assessment.

13.6 Guidelines for assessment

13.6.1 Peripheral arterial disease – All drivers

If a driver has lost a limb due to peripheral arterial disease, also see standard 11.6.1.

STANDARD	Eligible for all classes of licence if: • the peripheral arterial disease is successfully treated
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licencing authority
Information from health care providers	• Opinion of treating physician on whether there is severe claudication or foot and leg symptoms that may impair functional ability to drive • Where required, the results of a functional assessment • Opinion of the treating physician regarding whether the driver has insight into the impact their medical condition may have on driving • Whether the driver is compliant with their current treatment regime
Rationale	Where peripheral arterial disease results in a functional impairment, the impact of the impairment on driving should be determined by an individual functional assessment.

13.6.2 Abdominal aortic aneurysm (AAA) – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • the diameter of the aneurysm is less than 7 cm, <u>and</u> • surgery has not been recommended by a vascular surgeon on the basis of factors such as the shape of the aneurysm, rate of growth, and presence of symptoms Exceptions can be made if, in the opinion of the vascular surgeon, the annual risk of rupture is not acceptable for non-commercial driving (generally greater than 20%)
Conditions for maintaining licence	• Regular review by a physician
Reassessment	Reassessment periods depend on the size of the AAA. Suggested frequencies are: • If the diameter is over 5 cm, reassess annually • If the diameter is between 4 and 5 cm, reassess every 2 years • If the diameter is between 3 and 4 cm, reassess every 5 years
Information from health care providers	• Size of aneurysm or dissection • Whether imminent rupture is suspected
Rationale	The primary concern with AAAs is the risk of rupture resulting in sudden incapacitation. Non-commercial drivers are not eligible for a licence if the annual risk of rupture is estimated to be greater than 20%.

13.6.3 Abdominal aortic aneurysm (AAA) – Commercial drivers

STANDARD	Eligible for a commercial licence if: • the diameter of the aneurysm is less 5.5 cm, and • surgery has not been recommended by a vascular surgeon on the basis of factors such as the shape of the aneurysm, rate of growth, and presence of symptoms Exceptions can be made if, in the opinion of a vascular surgeon, the annual risk of rupture is not acceptable for commercial drivers (generally greater than 1%)
Conditions for maintaining licence	• Regular review by a physician
Reassessment	Reassessment periods depend on the size of the AAA. Suggested frequencies are: • If the aneurysm is greater than 4 cm, reassess annually • If the aneurysm is between 3 and 4 cm, reassess every 3 years
Information from health care providers	• Size of aneurysm or dissection • Whether condition is regularly reviewed
Rationale	The primary concern with AAAs is the risk of rupture causing sudden incapacitation. Commercial drivers are not eligible for a licence if the annual risk is estimated to be greater than 1%.

13.6.4 Treated abdominal aortic aneurysm (AAA) – All drivers

STANDARD	Eligible for all classes of licence if: • the abdominal aortic aneurysm or dissection has been treated with open surgery or endovascular repair, and • the treating physician supports a return to driving
Conditions for maintaining licence	None
Reassessment	• After open surgery every five years • After endovascular repair, one follow-up after one year, then every 5 years if stable
Information from health care providers	• Opinion of the treating physician that the treatment was successful and that complications have not developed.
Rationale	After open repair North American and European authorities recommend follow up CT scanning every five years in order to ensure that an aneurysm has not developed at the graft anastomoses and to ensure that a new AAA has not developed at a different level. A CT scan is recommended one year after endovascular repair in order to determine that significant complications have not developed.

13.6.5 Deep vein thrombosis – All drivers

STANDARD	Eligible for all classes of licence if: • treated with an anticoagulant, and • treating physician states that the treatment is effective
Conditions for maintaining licence	None
Reassessment	• Routine
Information from health care providers	• Whether the driver is being treated with an anticoagulant • Treating physician's opinion that the DVT has been successfully treated • Whether the driver has insight into the impact their medical condition may have on driving • Whether the driver is compliant with their current treatment regime
Rationale	The primary concern with DVT is the risk of sudden incapacitation due to a pulmonary embolism

Chapter 14: Psychiatric disorders

14.1 About psychiatric disorders

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5-TR), published by the American Psychiatric Association, contains a standard classification system of psychiatric disorders for health care professionals in the United States and Canada. It classified psychiatric disorders into diagnostic categories. A previous edition (APA, 2000) utilized five axes, but that multi-axial system was removed from the most recent edition.

Delirium, dementia, and other cognitive disorders

The effects of delirium, dementia and other cognitive disorders on driving are covered in Chapter 6, 'Cognitive Impairment including Dementia'. It is worth noting that the DSM-5-TR has relabeled dementia as "Major Neurocognitive Disorder", and more subtypes (e.g., Lewy Body dementia) are described, organized by the cause, time course, domains affected, and associated symptoms. The DSM-5-TR retains the term dementia as an alternative to Major Neurocognitive Disorder.

Substance-related disorders

Substance-use disorders refer to the taking of a drug of abuse (including alcohol), despite significant substance-related problems, including medical (e.g., liver disease), physiological (e.g., tolerance and withdrawal), psychological (e.g. cravings), and social (e.g. negative impact on work, school, or home life). Substance-induced disorders refer to a category of apparent behavioral disturbance presumably related to ingestion of a substance (e.g., intoxication or withdrawal), or mental disorder (e.g., substance/medication-induced depressive disorder). Substances include alcohol, amphetamines, cannabis, cocaine, hallucinogens, sedatives, hypnotics and anxiolytics.

The effects of drugs commonly prescribed for medical conditions are addressed in Chapter 15, Drugs, alcohol and driving.

Depressive disorders – Major Depressive Disorder, or Persistent Depressive Disorder (Dysthymia)

Major Depressive Disorder is characterized by one or more episodes of depressed mood or loss of interest in usual activities, as well as four additional symptoms of depression, with the episodes lasting for two or more weeks. Additional symptoms of depression include:

- Change in appetite
- Sleep disturbances
- Restlessness or being slowed down
- Decreased energy or fatigue
- Feelings of worthlessness or excessive guilt,
- Suicidal thoughts, and
- Poor concentration or difficulty making decisions.

Persistent depressive disorder (dysthymia) refers to a condition in which mood is persistently depressed for at least 2 years, along with at least two other symptoms such as low self-esteem, hopelessness, appetite or sleep changes, fatigue, difficulty concentrating or making decisions.

Other depressive disorders include:

- Disruptive Mood Dysregulation Disorder
 - a diagnosis characterized by severe and recurrent verbal or physical temper outbursts.
 - Generally, this is a diagnosis made in childhood, and “should not be made for the first time after age 18 years”, but is included here since it may persist into adulthood.
- Premenstrual Dysphoric Disorder
 - Characterized by symptoms such as mood instability, irritability, depressed mood, or anxiety occurring in conjunction with the majority of menstrual cycles.
- Depressive disorders induced by substances/medications or medical conditions

Bipolar Disorders

Bipolar I Disorder is characterized by one or more manic episodes, with or without a history of major depressive episodes. Bipolar II Disorder is similar, but instead of manic episodes, major depressive episodes alternate with hypomanic episodes. Hypomanic episodes are different from manic episodes, as they are of shorter duration, and are not associated with significant impairment in functioning, psychosis or a need for hospitalization.

Cyclothymia is similar to Bipolar II Disorder except that symptoms of depression have not met full criteria for a major depressive episode.

Other disorders in the bipolar spectrum are those felt to be due to drugs, substances or other medical conditions.

Anxiety disorders

There are a number of anxiety disorders classified in the DSM-5-TR, including:

- Generalized Anxiety Disorder
- Specific phobias
- Social Phobia
- Panic Disorder.

Symptoms include intense and prolonged feelings of fear or distress that occur out of proportion to the actual threat or danger. The feelings of distress also must be sufficient to interfere with normal daily functioning.

Obsessive compulsive disorder, acute stress disorder, and post-traumatic stress disorder are considered in DSM-5-TR in separate categories from Anxiety Disorders, although it is acknowledged that anxiety is a common feature of these as well.

Obsessive Compulsive Disorder is characterized by recurrent obsessions (“recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted”) and/or compulsions (“repetitive behaviors or mental acts that an individual feels driven to perform...”).

Acute Stress Disorder and Posttraumatic Stress Disorder (PTSD) refer to the development of symptoms after exposure to a traumatic event. Symptoms include intrusive memories, avoidance of reminders of the trauma, alterations in mood, memory or arousal. The duration of Acute Stress Disorder is up to one month after the trauma, and the duration of PTSD is more than one month after the trauma.

Attention-Deficit/Hyperactivity Disorder

Attention-Deficit/Hyperactivity Disorder (ADHD) is characterized by inappropriate degrees of inattention, impulsivity and hyperactivity that begin in childhood. ADHD is one of the most common neurobehavioral disorders of childhood and can persist through adolescence and into adulthood.

Although many individuals with ADHD show symptoms of both inattention and hyperactivity-impulsivity, there may be a predominance of either inattention or hyperactivity-impulsivity. This variability of presentation is reflected in the three major classifications of the disorder:

- Combined Type (exhibiting both inattention and hyperactivity-impulsivity)

- Predominately Inattentive Type, and
- Predominately Hyperactivity-Impulsivity Type.

The symptoms of hyperactivity and impulsivity tend to diminish over time so that many adults will present with primary symptoms of inattention only.

Schizophrenia

The effects of schizophrenia on the individual can be profound. Common symptoms include delusions and hallucinations, thought disorders, lack of motivation and social withdrawal. The symptoms of schizophrenia are generally divided into three broad categories:

- Positive or “psychotic” symptoms are characterized by delusions (fixed false beliefs), or hallucinations (“perception-like experiences that occur without an external stimulus”).
- Disorganised, illogical or bizarre thoughts, speech or behaviours.
- Negative symptoms are typically characterized by diminished emotional expression or a decrease in motivation and initiation of activities.

The onset of schizophrenia can occur at any age, but most typically appears in early adulthood. Many individuals with schizophrenia have recurring acute positive psychotic symptoms (delusions or hallucinations), or disorganization throughout their life, which are typically separated by intervening periods in which they usually experience residual or negative symptoms.

Personality disorders

There are a number of personality disorders identified in the DSM-5-TR, including:

- Borderline Personality Disorder
- Schizotypal Personality Disorder
- Anti-social Personality Disorder, and
- Narcissistic Personality Disorder.

Onset typically occurs during adolescence or in early adulthood. The disorders affect thought, emotion, interpersonal relationships and impulse control. The disorders are characterized by “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, (and)...is stable over time...”

Intellectual Disability (Intellectual Developmental Disorder)

The DSM-5-TR defines intellectual disability as deficits in intelligence and adaptive functioning, with onset during childhood development. Individuals with this disorder must also meet the cognitive impairment standard.

Suicidal ideation

Suicidal ideation is defined as having thoughts of suicide or of taking action to end one's own life, irrespective of whether the thoughts include a plan to commit suicide or an actual attempt. Studies indicate that the majority of all suicides are associated with psychiatric disorders.

14.2 Prevalence

Mood Disorders (Major Depressive Disorder, Bipolar Disorder, Dysthymic Disorder) and Anxiety Disorders

Mood and anxiety disorders are among the most common mental illnesses in the general population. According to Statistics Canada's 2022 Mental Health and Access to Care Survey, 14.0% of the Canadian population aged 15 years and over met the criteria for a major depressive episode, 3.4% for bipolar disorder, and 13.3% for generalized anxiety disorder, at some point during their lifetime. Within the 12 months prior to the survey, 7.6% of the same population met the criteria for a major depressive episode, 2.1% for bipolar disorder, and 5.2% for generalized anxiety disorder.

The prevalence of mood and anxiety disorders increased substantially between 2012 and 2022, showing approximately 20-30% rise in lifetime prevalence for major depressive episode and bipolar disorder, and approximately 40-60% rise in 12-month prevalence. Generalized anxiety disorder lifetime prevalence showed approximately 50% rise from 2012 to 2022, and approximately 100% rise in 12-month prevalence. The increased prevalence of both mood and anxiety disorders was most notable in youth aged 15-24, particularly amongst females.

Studies have consistently documented higher rates of depression among females than among males at an approximate ratio of 2:1, but the sex ratio for bipolar disorder is approximately equal.

12-month prevalence of selected mood and anxiety disorders, by age and gender, 2022

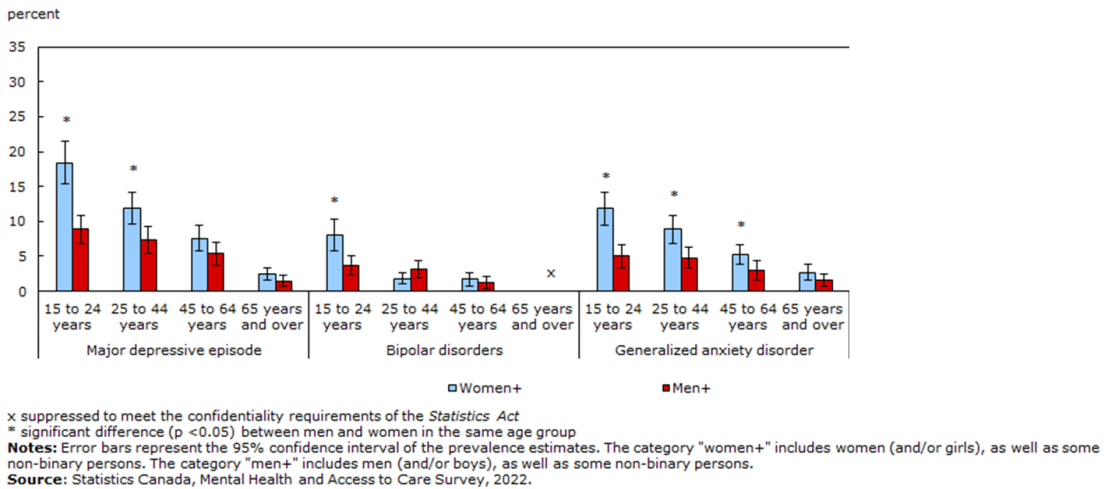


Figure 14.2-1. 12-month prevalence of major depressive episode, bipolar disorder, and generalized anxiety disorder in Canadians 15 years and older, 2022

Attention-Deficit/Hyperactivity Disorder

Prevalence rates of ADHD vary, depending on the diagnostic criteria used, the setting (e.g. general population vs. clinic sample) and the reporter (e.g. parent, teacher, self). The prevalence ADHD in Canadian adults is estimated to be between 2.9-4.4%. It is estimated that the majority of those with ADHD in childhood continue to meet diagnostic criteria in adulthood, with estimates varying between 60-75%.

Schizophrenia

Prevalence of schizophrenia was estimated to be 1.0% in Canadians 10 years and older, based on 2024 data released by the Canadian Chronic Disease Surveillance System (CCDSS). Lifetime prevalence between males and females is similar; however, age of onset for males is earlier, typically in the late teens to early 20s, while it is later for females, typically in the late 20s to early 30s. Diagnosis prior to 12 years and after 40 years does occur but is uncommon.

Personality disorders

Epidemiological studies show a range of prevalence of personality disorder from 9.0% to 15.7% in international studies of community-based populations.

Suicidal ideation

According to Statistics Canada's 2019 Canadian Community Health Survey (CCHS) on Mental Health, in 2019, more than 1 in 10 Canadians aged 15 and older (12%), representing about 3.7 million people, indicated they had considered suicide in their lifetime. Females (13%) were slightly more likely than males (11%) to have had suicidal thoughts in their lifetime. Of those in 2019 who had contemplated suicide in their

lifetime, 23% (843,500 people) reported having seriously contemplated suicide in the previous 12 months.

In 2022, 4,850 people died of suicide in Canada, corresponding to a rate of approximately 12.5 people for 100,000. Suicide rate amongst males was nearly 3 times higher than females, and just over half of deaths occurred in middle aged adults 30-59 years old.

14.3 Psychiatric disorders and adverse driving outcomes

Psychiatric disorders consist of numerous individual disorders, making it difficult to conduct studies on a particular disorder in relation to driving outcomes as there may be relatively few patients with a given single disorder that continue to drive. Furthermore, studies that have been published tend to concentrate on human factors such as vigilance and speed of information processing rather than the effects of the disorder on crash risk.

A 2021 systematic review of the literature on psychiatric disorders and crash risk “identified a very narrow number of studies that examined the risk of MVC associated with drivers with psychiatric disorder, of very limited quality, including ten studies rated ‘poor’, ten studies rated ‘fair’, and only three studies rated ‘good’. Each study took a different approach to this research topic, more than half of the studies used a subjective measure of either psychiatric disorder or MVC, and few adjusted for important confounding factors such as alcohol or distance travelled.”

Thus, conclusions based on these studies are not definitive, but they do support the consensus that psychiatric disorders increase crash risk to an extent that justifies suspending driving privileges, at least during periods of acute symptoms or adjustments of medications. Since it is impossible to define with precision the exact characteristics of people with a psychiatric disorder that are most at risk of involvement in a MVC, as with any condition that affects insight, judgement and cognition, assessment of fitness-to-drive must be conducted on an individual basis.

Medications used to treat many psychiatric disorders are known to influence fitness to drive. In fact, at least initially, the effects of the psychiatric drugs may accentuate those of the disorder. Even the treatment of minor manifestations of a disorder like anxiety may affect fitness to drive with the use of benzodiazepines, especially in older drivers. The same is true when these types of drugs are used for sleep disorders. The effects of drugs are addressed in Chapter 15, Drugs, driving and alcohol.

There are no studies that examine when a person with a psychiatric disorder whose condition has been judged to render them unfit to drive may start to drive again.

14.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Mood disorders Anxiety disorders ADHD Schizophrenia	Persistent impairment: Functional assessment	Cognitive Psychomotor	Medical assessments Functional assessment
	Episodic impairment: Medical assessment – likelihood of impairment	Cognitive Psychomotor	Medical assessments
Personality disorders	Persistent impairment: Functional assessment	Affective	Medical assessments
	Episodic impairment: Medical assessment – likelihood of impairment	Affective	Medical assessments

Note: Psychomotor functions affect the coordination of cognitive processes and motor activity.

Psychiatric disorders can result in either a persistent or episodic impairment of the functions necessary for driving.

The role of insight

A driver's level of insight is a critical consideration when assessing the risk of an episodic impairment of functional ability due to a psychiatric disorder.

Drivers with good insight are more likely to be diligent about their treatment regime and to seek medical attention and avoid driving when experiencing acute episodes and have the judgment and willingness to adapt their driving to these limitations.

Poor insight may be evidenced by non-compliance with treatment, trivializing the driver's role in a crash or repeated involuntary admissions to hospital, often as a result of discontinuing prescribed medication.

Affect

Affect refers to the observed expression of emotion. The ability to manage one's affect is an important functional component of safe driving performance. Affect includes:

- emotional intelligence
- impulse control/emotional control
- frustration threshold
- agitation, and
- impulsivity and/or mood control/management.

Psychomotor

Psychomotor functions affect the coordination of cognitive processes and motor activity. Abnormalities can include agitation, restlessness, pacing, aimless activity or slowing down of movements or thought. In this document, psychomotor function will be considered as one of the functional abilities needed for driving for drivers with psychiatric disorders.

Mood disorders - Major Depressive Disorder, Bipolar Disorder, Dysthymia

Cognitive abilities that may be affected by mood disorders include:

- attention and concentration
- memory
- information processing
- reaction time, and
- psychomotor functioning.

Anxiety disorders

The research on the effects of anxiety disorders on functional ability is limited. Findings from studies examining the effects of anxiety disorders on cognitive functioning are equivocal. Neurobiological studies suggest that medial and temporal lobe structures are affected in anxiety disorders. These are structures that are responsible for memory and higher order executive functioning. From a clinical perspective, the potential for diminished attention or perseverating on errors (including “freezing”) in the face of unexpected risks on the road may be of concern for driving.

Attention-Deficit/Hyperactivity Disorder

The pattern of deficits in adults with ADHD is similar to that in children and adolescents. One of the primary cognitive functions that may be affected is the ability to sustain attention, particularly when performing demanding cognitive tasks. In addition to attentional impairments, individuals with ADHD often experience other cognitive deficits such as difficulties with:

- planning and forethought
- flexibility
- problem solving
- working memory, and
- response inhibition.

Symptoms of ADHD referenced in the DSM-5-TR that may be relevant to driving include:

Inattention examples

- often fails to give close attention to details or makes careless mistakes in school work, work or other activities
- often has difficulty sustaining attention in tasks or play activities
- often is easily distracted by extraneous stimuli

Hyperactivity-impulsivity examples

- often is “on the go” or acts as if “driven by a motor”
- often has difficulty awaiting his or her turn

Schizophrenia

Apart from the core symptoms of psychosis (delusions, hallucinations, disorganized thoughts and behavior), apathy and neuropsychological deficits associated with schizophrenia may impact driving. The degree of functional impairment associated with schizophrenia varies between the acute and residual phases of the disorder.

Neuropsychological functions that may be impaired include:

- attention
- executive function
- spatial abilities
- memory, and
- motor and tactile dexterity.

Personality disorders

The characteristics of personality disorders most likely to affect driving include:

- affectivity (e.g., aggression, frustration, anger)
- interpersonal functioning (e.g., failure to conform to social norms, reckless disregard for the safety of others), and
- poor impulse control.

Suicidal ideation

Suicidal ideation is an important consideration regarding drivers with psychiatric disorders because of the risk of traffic suicide.

Pharmacological treatment

In addition to the direct effects of psychiatric disorders on functional ability to drive, the impact of pharmacological treatment is an important consideration when assessing drivers. The effects of drug treatment are considered in Chapter 15, Drugs, alcohol and driving.

14.5 Compensation

Drivers with psychiatric disorders may be able to compensate for their impairments if treated and/or stabilized. Functional assessment may be required.

14.6 Guidelines for assessment

14.6.1 Psychiatric disorder– All drivers

STANDARD	Eligible for all classes of licence if: • the condition is stable • the driver has sufficient insight to stop driving if condition becomes acute • the functional abilities necessary for driving are not impaired • a treating physician supports a return to driving, for drivers who have stopped driving due to a psychiatric disorder, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Stop driving and report to the licencing authority if hospitalized due to a psychiatric disorder • Remain under regular medical supervision and comply with prescribed psychotropic medication regime or other recommended treatment
Reassessment	• Routine, or more frequently at the discretion of the licensing authority.
Information from health care providers	• Opinion of treating physician whether the condition is stable and controlled • Opinion of treating physician whether the driver has sufficient insight to stop driving if condition becomes acute • Opinion of treating physician whether the functional abilities necessary for driving may be persistently impaired by the condition or its treatment, and if yes, the results of a functional assessment • Whether the driver remains under regular medical supervision • Details of any prescribed psychotropic medication regime or other recommended treatment and opinion of treating physician whether the driver is compliant with the treatment • A specialist's report supporting a return to driving, for drivers who have stopped driving due to a psychotic episode • Date of most recent psychotic episode • Opinion of treating physician as to the appropriate reassessment interval
Rationale	Given the nature of psychiatric disorders, assessment must rely primarily on the clinical judgment of health care professionals involved in treatment. Where the disorder results in a persistent impairment, the impact of that impairment should be functionally assessed.

Chapter 15: Drugs, alcohol and driving

15.1 About drugs, alcohol and driving

It is increasingly clear that psychotropic (capable of affecting the mind, emotions or behaviour) drugs contribute to impairment in driving performance. It has been estimated that at least 10% of all people killed or injured in crashes were taking psychotropic medication, which might have been a contributory factor to the crash.

According to Public Safety Canada's Annual National Data Report to Inform Trends and Patterns in Drug-Impaired Driving, as of 2012, 39.24% of drivers fatally injured in motor vehicle accidents tested positive for drugs (includes legal and illicit drugs).

This chapter focuses on drugs that are commonly prescribed or used to treat medical conditions, and that are known to have psychotropic effects or potential side effects that could impair functional ability to drive. While alcohol is not used to treat medical conditions, information related to alcohol and driving is included.

Opioids (narcotics)

Opioids are derived from natural opium or a synthetically produced equivalent and are used primarily for moderate to severe pain relief.

Alcohol

Alcohol is a depressant drug that has both sedative and disinhibitory effects. It also impairs a driver's judgement, reflex control and behaviour towards others. According to the *CMA Driver's Guide (10th Edition)* and *The Chief Public Health Officer's Report on the State of Public Health in Canada 2015 – Alcohol Consumption in Canada*, people who are regular users of alcohol, withdrawal from alcohol may trigger seizures and cause other health problems such as liver disease, cancer, heart disease, and diabetes or neurological complications. Alcohol use in conjunction with medications or other illicit substances can create synergistic impairment that increases the risk of road safety.

Antidepressants

Antidepressants are used in the treatment of major depression and a variety of other conditions such as chronic pain, anxiety, eating disorders, personality disorders and obsessive compulsive disorder. Classes of antidepressants include:

- tricyclic antidepressants (TCAs)
- serotonin antagonist-reuptake inhibitor (SARIs)

- selective serotonin-reuptake inhibitors (SSRIs)
- dual action agents (DAAs)
- atypical antidepressants
- monoamine oxidase inhibitors

Antiepileptics

Antiepileptics (also referred to as anticonvulsants) are used in the treatment of epilepsy, as well as other conditions such as mood disorders and pain.

Antihistamines

Antihistamines inhibit the activity of histamine, a protein involved in many allergic reactions. They are commonly prescribed to alleviate the symptoms of allergic reactions.

Antipsychotics

Antipsychotics are used primarily in the management of serious mental disorders such as schizophrenia, bipolar disorder and organic psychoses (psychiatric symptoms arising from damage to or disease in the brain). The two major groups of antipsychotics are the “typical” or conventional antipsychotics, introduced in the early 1950s, and the “atypical” antipsychotics, introduced in the early 1990s and later.

Cannabis

Although the use of cannabis was legalised in Canada in 2018, it could be prescribed by physicians since a 2002 court decision mandating legal access for medical purposes. Tetrahydrocannabinol (THC) is the principal psychoactive constituent in cannabis and is responsible for most of its effects on driving. Its effects include delays in decision-making and information processing, but the extent of these effects can vary widely according to the concentration of THC. Over the past fifty years the concentration of THC has been increased through cultivation from 1% to more than 30%. The concentration of THC will have a major role in the extent of its effects upon the individual.

Recommendations from the Canadian Medical Association (CMA) include limiting medical cannabinoid use in general, but also outline potential restricted use in a small subset of medical conditions for which there is some evidence (neuropathic pain, palliative and end-of-life pain, chemotherapy-induced nausea and vomiting, and spasticity due to multiple sclerosis or spinal cord injury).

Non-steroidal anti-inflammatories

Non-steroidal anti-inflammatory drugs (NSAIDs) are used for pain relief, the reduction of fever, and to reduce inflammation. NSAIDs often are used in the treatment of mild to moderate pain, inflammation and fever in both acute and chronic conditions, such as:

- rheumatoid arthritis and osteoarthritis
- gout
- metastatic bone pain
- headaches and migraines
- mild to moderate pain due to inflammation and tissue injury (e.g., pain associated with tooth extraction, root canal, sports injuries, etc.), and
- menstrual pain.

Sedatives and hypnotics

Sedative and hypnotic drugs are central nervous system depressants. They are used to treat anxiety, insomnia, alcohol withdrawal, as muscle relaxants, and as anticonvulsants. The major categories are barbiturates, benzodiazepines and a new class of non-benzodiazepine sedatives called Z drugs.

Benzodiazepines can be divided into short acting, (those with a short half-life of 2 to 4 hours), which generally are used to treat insomnia, intermediate acting (those with half-life of 12-24 hours) and long-acting (those with a long half-life of >24 hours), which are used to treat anxiety.

Stimulants (for ADHD and narcolepsy)

Stimulants are the primary treatment for ADHD and narcolepsy. They increase the levels of certain neurotransmitters, primarily dopamine and norepinephrine, in the brain to improve focus, attention, and wakefulness.

15.2 Prevalence

Opioids

In 2018, a Statistics Canada survey showed that 12.7% of Canadians age 15 and older reported they used opioid pain relievers, including prescribed and non-prescribed use, in the past 12 months. Amongst those, 9.6% reported they engaged in problematic use of opioids.

According to a 2019 report from the Canadian Institute for Health Information (CIHI) that utilized available data from Ontario, Saskatchewan, British Columbia, and Manitoba, almost 1 in 8 people were prescribed opioids in 2018. This represented a decreased trend in the number of prescriptions from 2013.

Alcohol

In Canada, alcohol is the most widely consumed psychoactive drug except for caffeine. In 2023, 79% of Canadians aged 15 and older reported consuming alcohol in the past 12 months.

In 2024, just over 19% of Canadians reported drinking heavily on one occasion at least once a month in the previous year. Heavy drinking is defined as drinking 5 drinks or more for males and 4 drinks or more for females on one occasion.

According to the Traffic Injury Research Foundation, Road Safety Monitor 2024: Drinking and Driving in Canada, 11.4% of Canadians admitted to driving after consuming any amount of alcohol in the past 30 days, and 5.94% indicated they had driven when they thought they were over the legal limit in the past 12 months.

Antidepressants

The most commonly used classes of antidepressants are SSRIs, dual action agents and tricyclics. The prevalence of individuals receiving antidepressants from community pharmacies in 2023 was 16.4%, up from 15.4% in 2019. Approximately 6.67 million Canadians received antidepressant prescriptions. The most recently available data indicates that of people who had a major depressive episode in the past year, 40.4% were taking antidepressants.

Antiepileptics

No data on the prevalence of antiepileptic drug use in Canada is available. As of 2024, epilepsy itself has a prevalence rate of 1.0% in the Canadian population with 0.7% identified as having active epilepsy, per the Canadian Chronic Disease Surveillance System (CCDSS). The incidence of epilepsy in 2024 was 62 cases per 100,000 people, with the highest incidence in young children and seniors. Because of the variability of the presentation of epilepsy among those diagnosed, and the use of antiepileptic drugs for conditions other than epilepsy, it is difficult to extrapolate the prevalence of anticonvulsant drug use based on the prevalence and incidence of epilepsy.

Antihistamines

The general use of antihistamines is difficult to ascertain. However, it has been estimated that allergic conditions that may be treated with antihistamines affect 10% to 25% of the population.

Antipsychotics

Prevalence statistics on antipsychotic use in Canada are available through national prescription monitoring systems, and in 2022, approximated 4% of Canadians were

estimated to have received antipsychotic prescriptions. Atypical antipsychotics were more commonly prescribed.

Non-steroidal anti-inflammatories

NSAIDs are among the most commonly used pharmacological agents, with 10 million prescriptions dispensed annually in Canada. The use of NSAIDs is predicted to increase with the aging population due to the association between age and musculoskeletal disorders such as osteoarthritis and rheumatoid arthritis.

Cannabis

In 2018 the use of cannabis was legalised. In 2023, 32% of Canadians aged 15 and older reported having used cannabis within the last 12 months.

Sedatives and hypnotics

Data from the 2022 Canadian Centre on Substance Use and Addiction (CCSA) Sedatives Drug Summary indicated that the percentage of those who had used a sedative was approximately 10% among Canadians 15 and older, and increased with age to 13% among Canadians 65 and older. Use is higher in females (approximately 14%) compared to males (approximately 7%).

Benzodiazepines are the most commonly used class of sedatives across all demographic groups.

Stimulants

No data is available on the prevalence or incidence of the use of stimulants as a treatment for ADHD in Canada. An indication of the use of stimulants for ADHD may be gleaned from the prevalence of the condition itself. Research indicates that ADHD affects from 5-9% of children and 2.9-4.4% of adults. Of adolescents and adults with ADHD, 76% achieve a therapeutic response with stimulant medication.

15.3 Psychotropic drugs, alcohol and adverse driving outcomes

Opioids

Research indicates that the use of opioids can adversely affect driving performance, with the degree of impairment dependent on the particular opioid used, dosage, previous use and developed tolerance, and time of day taken. Opioid-involved motor vehicle traffic fatalities have increased over the past 2 decades. These findings suggest that the receipt of prescription opioids, even at doses ≤ 60 MME/day, is associated with an increased risk of motor vehicle crashes.

Alcohol

Alcohol's effects are dose dependent and differ among individuals. Impaired driving is the leading cause of criminal death in Canada. According to the Traffic Injury Research Foundation, 459 Canadians died in fatal accidents involving alcohol in 2021, which was approximately one quarter of all fatalities in motor vehicle accidents in Canada. The number of Canadians killed in road crashes involving a drinking driver increased by 14% from 2021 to 2022, rising from 457 to 521 fatalities.

In 2025, less than three in four (71.8%) of Canadians considered drinking and driving a very or extremely serious problem, the lowest level in two decades. Since 2022, police-reported alcohol-impaired driving incidents no longer closely tracks with self-reported behaviour.

Self-reported drinking and driving behaviours increased sharply in 2025, with approximately one in ten (9.2%) of drivers admitting to driving when they believed they were over the legal limit, up from 5.9% in 2024. Among approximately one in ten drivers who admitted driving over the legal limit in 2025, approximately one quarter (27.7%) had been drinking at bars, and (24.2%) had been drinking with friends and relatives.

Alcohol-related crashes, however, remain far below the levels recorded in the 1990s, with fatalities involving a drinking driver declining by 51.7% between 1996 and 2022

Antidepressants

Currently, there is little evidence to associate SSRIs or dual action agents with impaired driving performance. Although limited, research indicates that the use of tricyclic antidepressants is associated with impairments in driving performance. This is evidenced by elevated crash rates, as well as measures of on-road performance and laboratory tests of psychomotor and cognitive functioning. For older drivers, use of antidepressants may increase the risk of crash due to adverse effects such as sedation, dizziness, or blurred vision.

Antiepileptics

In general, individuals with epilepsy have an increased risk for adverse driving outcomes, which may be caused by either the episodic impairment (seizures) or persistent impairments caused by the condition or treatment. Many classes of drugs may be used to treat epilepsy as well as combinations of drugs. Driving outcomes would depend on which medications are used in the treatment. Note that antiepileptics may also be prescribed for other conditions, such as chronic pain management, migraine, or as mood stabilizers.

Antihistamines

Research indicates that the use of older antihistamines may impair driving performance. However, newer antihistamines used in therapeutic doses do not appear to increase the risk of adverse driving outcomes.

Antipsychotics

Studies examining the driving performance of individuals treated with antipsychotics (primarily those with schizophrenia) indicate that those treated with atypical antipsychotics perform better than those treated with typical antipsychotics. However, less than 33% of those on atypical antipsychotics and 5% to 11% of those on typical antipsychotics were found to have adequate driving performance. It should be noted that these results are based on functional tests conducted in a laboratory setting, and the relationship of these results to actual driving performance has not been established. Further, it is difficult to determine the relative impact of the underlying condition and antipsychotic treatment on driving performance.

Cannabis

Recent Canadian research confirms that acute cannabis use impairs driving performance and may increase the risk of crashes. A 2024 systematic review examined the impact of recreational cannabis legalization on traffic injuries in Canada and the US, including 7 studies conducted between 2019 and 2023. Of these, 4 studies reported an increase in traffic injuries after cannabis legalisation, while 3 found no significant change; however, the authors noted that differences in study quality and regional variation complicated interpretation of the data overall. In earlier studies, meta-analysis completed in 2016 found that cannabis elevated the relative risk of crashing to 1.3, a rather modest amount and about the same as the case of antidepressants according to the study. An earlier Canadian systematic review from 2012 found that cannabis use elevated the relative risk of a crash to 1.92. Of note, these studies did not differentiate between medical and recreational use of cannabis.

Although legalisation of cannabis is predicted to result in increased crashes, five years after legalisation in Washington and Colorado the increase in crashes was less than in the neighbouring states where cannabis remained illegal according to a 2017 study by the Insurance Institute for Highway Safety (IIHS).

No matter whether the cannabis is used for medical or recreational reasons, **driving under the influence of cannabis is an offence under the Criminal Code of Canada**. No one should drive within 6 to 8 hours following the inhalation of cannabis (smoking or vaping) or within 8 to 12 hours following oral ingestion (edibles).

Non-steroidal anti-inflammatories

There is a small body of literature related to the effects of NSAIDs on driving performance. These studies indicate that the use of NSAIDs is associated with an increased risk of crash, particularly in older drivers.

Sedatives and hypnotics

Research indicates that the use of sedatives and hypnotics is associated with a significant risk for adverse driving outcomes. According to the National Drug Driving Research Project, which collected data from 4,976 injured drivers treated in 15 trauma centres across Canada between January 2018 and May 2021, CNS depressants, including benzodiazepines, were found in about one in five drivers (20.7%), with a greater prevalence in females (23.9%) than males (19.1%). The highest prevalence of CNS depressants was found in drivers over the age of 55 (24%).

Stimulants (for ADHD)

There is some indication that pharmacological treatment of ADHD with stimulants may have a positive effect on driving performance. However, research in this area has primarily relied on driving simulators to measure outcomes. A few studies have investigated the relationship between pharmacological treatment of ADHD and on-road performance, but methodological limitations, including small sample size (< 20 in all cases), limit the findings.

15.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Use of psychotropic drugs	Persistent impairment: Functional assessment	Cognitive	Medical assessments Functional Assessment

Authorities should be primarily concerned with the persistent cognitive impairment associated with the effects or side effects of medication used for ongoing treatment of medical conditions. Potential temporary impairments from short term treatment or changes in dosage or type of medication are considered transient impairments for licensing purposes. Where an individual is taking multiple drugs (polypharmacy), authorities must also consider the potential compounding effects. Where relevant, authorities should also consider the potential compounding effect of the use of alcohol or illicit drugs.

Opioids

The use of opioids results in depression of the central nervous system. Possible effects on the functions necessary for driving include:

- blurred vision
- poor night vision
- slowed reaction times
- sedation
- tremors
- muscle rigidity
- impairment of short term/working memory and attention, and
- disorientation or hallucinations.

The effects of opioids on an individual depend on a number of factors, including the length of use, dosage and propensity for abuse or addiction. Tolerance is an important consideration in that adverse effects may be evident during acute use but diminish as tolerance develops.

Alcohol

Alcohol is a depressant drug which slows down the brain and body. Effects on function necessary for driving may include but are not limited to:

- reduced reaction times
- blurred or double vision
- altered depth perception
- reduced judgement and insight
- blunted alertness
- reduced motor co-ordination.

Antidepressants

The effects of antidepressants on cognitive ability vary by therapeutic class. Depression itself may result in cognitive impairment. While the use of antidepressants may improve cognitive function, the side effects may include cognitive impairment, including:

- impairment of thought processing
- attention deficits
- indecisiveness, and
- impairment of psychomotor function.

Therefore, distinguishing between the effects of the disorder and the side effects of antidepressants may be a challenge.

Tricyclic antidepressants

The major side effects of tricyclic antidepressants (TCAs) that may affect driving are anticholinergic effects, such as confusion or blurred vision, and sedating effects.

Selective serotonin-reuptake inhibitors

Selective serotonin-reuptake inhibitors (SSRIs) generally have fewer side effects than TCAs. Nonetheless, some studies have shown impairments in both cognitive and psychomotor functioning in individuals using SSRIs.

Dual action antidepressants

Research indicates new dual action antidepressants (DAAs), atypical antidepressants (the most recently introduced class of antidepressants), have fewer side effects than TCAs or SSRIs, but cognitive impairment associated with depression and/or treatment may still be present.

Antiepileptics

Antiepileptics (also referred to as anticonvulsants) may impair motor and sensory functions, producing:

- ataxia (lack of coordination; unsteadiness)
- nystagmus (uncontrollable rapid eye movement)
- poor concentration
- slowed thinking
- blurring and double vision, and/or
- tremor.

Disruption of normal cognitive function is a frequent and pervasive side effect of anticonvulsant drugs. A variety of cognitive abilities may be affected, including memory, reaction time, executive functioning and problem solving.

The known side effects of first generation anticonvulsant drugs (phenobarbital, phenytoin, benzodiazepines and valproate) include sedation and cognitive dysfunction. Adverse cognitive effects, including impairments in memory and attention, are also evident with the use of more recently introduced anticonvulsant drugs (e.g., topiramate), though these generally have fewer side effects.

Antihistamines

Histamine is involved in many brain functions, including the waking-sleep cycle, attention, memory, learning and excitation. The effects of antihistamines differ depending on their generation. Older antihistamines are associated with profound sedation, impaired psychomotor function and blurred vision. Newer antihistamines are largely free from the sedating effects of the older antihistamines. However, at high doses, significant side effects have been reported, though still less pronounced than those associated with older antihistamines.

Beta-blockers

Common side effects of beta-blockers include tiredness, sleep disturbances and dizziness. Less common side effects relevant to driving include impairments in attention, mental flexibility (executive functioning) and memory.

The available evidence indicates that impairments in cognitive functioning can be a side effect of beta-blockers. However, results from the majority of studies indicate that there is little in the way of evidence to indicate that beta-blockers negatively impact cognitive performance in the general population of beta-blocker users.

Cannabis

The euphoric phase induced by THC affects judgement. Additional effects are time distortion, relaxation, exaggeration of sensory experiences and loss of inhibitions. The longer-lasting motor and cognitive effects affect coordination and short-term memory. Physical effects can include flushing and red eyes.

Use of dried cannabis leaves through inhalation or ingestion is known to produce psychoactive effects that may affect driving for up to 24 hours. Driving under the influence of cannabis is illegal according to the Criminal Code of Canada and drivers using cannabis in a medical context (medical marijuana) should be advised not to drive for at least 6 hours following inhalation or at least 8 hours for ingestion, and preferably for at least 24 hours, after use of the substance.

Many users of “medical marijuana” exceed the average usage rates (1.5 grams or 3 joints a day) by considerable margins. Drivers using “medical marijuana” in quantities exceeding the average usage rates should be counselled to avoid driving completely during periods of over-average consumption.

Antipsychotics

Research suggests that atypical antipsychotic drugs may improve cognitive functioning in individuals with schizophrenia compared to treatment with typical antipsychotics. Nonetheless, the research indicates that even with atypical antipsychotics, individuals still experience residual cognitive impairments.

Non-steroidal anti-inflammatories

In general, the analgesic and anti-inflammatory effects of NSAIDs result in improvements in functional abilities (e.g., reduction in pain and stiffness in those with osteoarthritis, resulting in increased physical function and improvements in quality of life). However, there is a suggestion that the use of NSAIDs can impair cognitive ability.

Sedatives and hypnotics

The adverse effects of sedatives and hypnotics may include:

- sedation
- drowsiness
- cognitive and psychomotor impairment
- impaired coordination
- vertigo
- dizziness, and
- blurred or double vision.

Impairments are greater with higher dosages and with drugs that have a longer half-life. Those using sedatives and hypnotics are subject to developing dependency, addiction and increasing tolerance of the effects. Because of this, Health Canada advises that these drugs should only be used for short periods (e.g., less than 2 months for anxiety; 7 to 10 days for insomnia). Nonetheless, research indicates that long term use is not uncommon. Long term adverse effects of benzodiazepine may include cognitive decline, unwanted sedation and impaired coordination.

Stimulants (for ADHD and narcolepsy)

There is some indication that stimulants may have a positive effect on driving performance. However, the effect of stimulant medication on the functional ability of drivers with ADHD is unclear because of the methodological limitations of research to date.

15.5 Compensation

A driver can't compensate for the effects of psychotropic drug use.

15.6 Guidelines for assessment

15.6.1 Medication – Prescribed - All Drivers

This standard applies to prescribed medication including psychotropic drugs and prescribed medical marijuana

STANDARD	Eligible for all classes of licence if: • The functional abilities necessary for driving are not impaired, and • Where required, a functional assessment shows that the side effects of medication does not affect ability to drive Drivers on a formal methadone maintenance program must provide an addictions specialist report, in addition to meeting the above requirements.
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licensing authority
Information from health care providers	• Types of psychotropic drugs used • Details of underlying medical conditions • Opinion of treating physician whether the individual is non-compliant or misuses psychotropic drugs • Functional impairment, if any
Rationale	The use of a psychotropic drug does not mean that a driver is not eligible for a licence. Where there is some evidence of a persistent cognitive impairment associated with the stable use of a drug, an individual assessment of the effect of the drug is required to determine licence eligibility.

15.6.2 Medication – Non Prescribed (Over the Counter) – All drivers

STANDARD	Eligible for all classes of licence if: • The functional abilities necessary for driving are not impaired, and • Where required, a functional assessment shows the side effects of medication do not affect ability to drive.
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licensing authority
Information from health care providers	• Types of drugs used • Details of underlying medical conditions • Opinion of treating physician whether the individual is non-compliant or misuses drugs • Functional impairment, if any
Rationale	The use of a psychotropic drug does not mean that a driver is not eligible for a licence. Where there is some evidence of a persistent cognitive impairment associated with the stable use of a drug, an individual assessment of the effect of the drug is required to determine licence eligibility.

15.6.3 Substance Use Disorder - All drivers

This applies to all drivers who have a diagnosis of substance use disorder and/or alcohol use disorder (not in remission).

STANDARD	Eligible for all classes of licence if: • Meets the criteria for remission and/or has abstained from the substance for 12 months. • Earlier re-licensing may be considered upon favourable recommendation from an addictions specialist and/or treating physician recognized by the licensing authority, and the successful completion of a drug rehabilitation program. • The functional abilities necessary for driving are not impaired. • Where required, a road test or other functional assessment shows that the functional abilities for driving are not impaired.
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licensing authority
Information from health care providers	• Types of drugs used • Details of underlying medical conditions • Opinion from an addictions specialist and/or treating physician recognized by the licensing authority • The successful completion of a substance abuse rehabilitation program and • Report on whether the individual is abstinent / and or in remission
Rationale	These substances are known to potentially impair the ability to operate a motor vehicle safely

15.6.4 Alcohol, Cannabis and Driving – All drivers

STANDARD	Impaired individuals are not permitted to drive any class of motor vehicle
Conditions for maintaining licence	None
Reassessment	• Routine or more frequently at the discretion of the licensing authority
Information from health care providers	N/A
Rationale	Alcohol is known to impair the ability to operate a motor vehicle safely. Medical marijuana (cannabis) is known to impair the ability to operate a motor vehicle safely. In general, individuals should not drive for at least 6 hours after inhaling or at least 8 hours after ingesting medical marijuana and not drive at all if consuming 3 or more joints a day.

Chapter 16: Respiratory diseases

16.1 About respiratory diseases

Overview

A number of respiratory diseases may interfere with the safe operation of a motor vehicle by causing reduced oxygen flow to the brain and subsequent cognitive impairment, including impairments in attention, memory, decision making and judgement. Respiratory diseases that are most likely to affect cognitive functioning are those that are chronic in nature.

This chapter focuses on one of the most prevalent respiratory diseases, chronic obstructive pulmonary disease (COPD). However, other respiratory diseases also have the potential to impair driving due to reduced oxygen flow to the brain; where this is the case, the standards in this chapter also apply to them.

Chronic obstructive pulmonary disease

COPD refers to a group of diseases characterized by obstructed air flow, such as emphysema and chronic bronchitis. Emphysema and chronic bronchitis frequently coexist and the term COPD is often applied to individuals suffering from these two disorders.

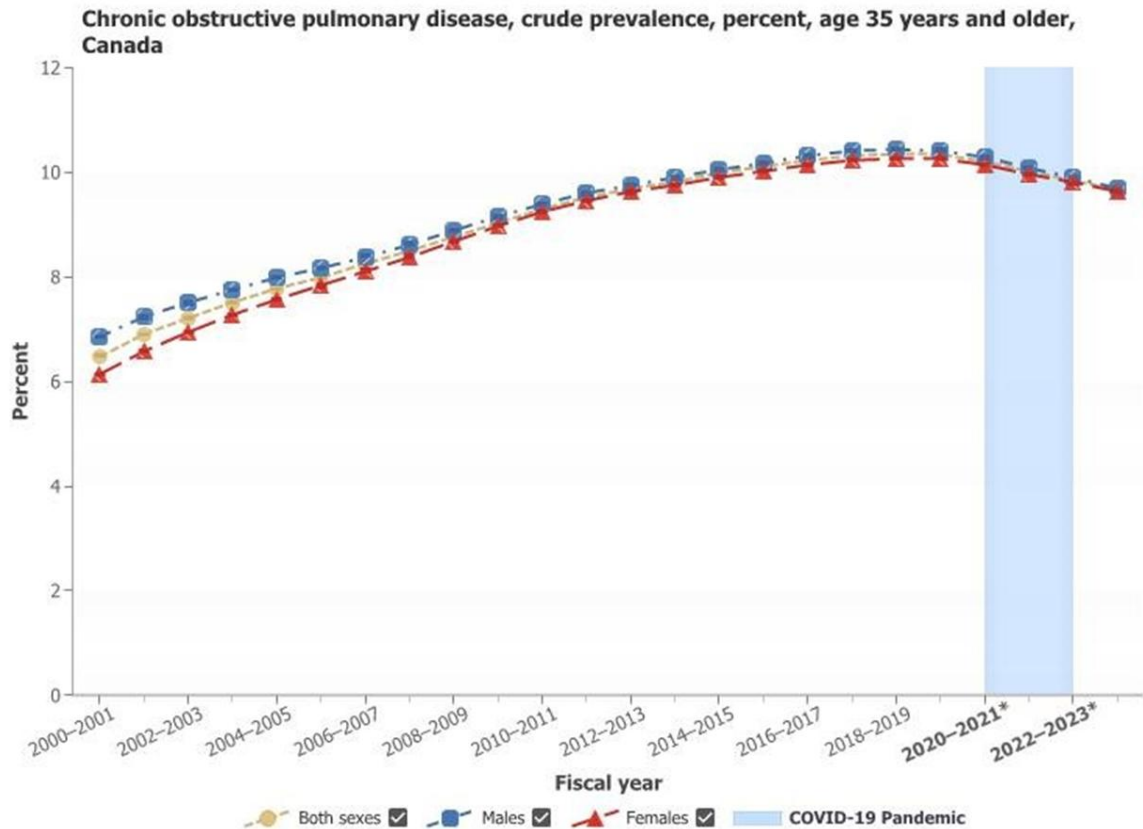
The level of general impairment caused by respiratory diseases is commonly described as mild, moderate, or severe, as described in the table below.

Level of Impairment	Symptoms	Nature of General Impairment
Normal	None	None
Mildly Impaired	Dyspnea when walking quickly on level ground or when walking uphill; ability to keep pace with people of same age and body build walking on level ground, but not on hills or stairs.	Usually not correlated with diminished ability to perform most jobs
Moderately Impaired	Shortness of breath when walking for a few minutes or after 100m walking on level ground	Progressively lower levels of lung function correlated with diminished ability to meet the daily demands of many jobs

Level of Impairment	Symptoms	Nature of General Impairment
Severely Impaired	Too breathless to leave the house, breathless when dressing. The presence of untreated respiratory failure.	Unable to meet the physical demands of most jobs, including travel to work

16.2 Prevalence

The aging population in Canada has led to an increase in the number of people living with COPD, rising from approximately 6.5% in 2000 to 9.7% in 2024 in Canadians 35 years and older, according to the Canadian Chronic Disease Surveillance System (CCDSS). Prevalence increases with age; of those living with COPD in 2024, prevalence among Canadians 65-79 years was 17.3%, and among those 80 years and older was 24.1%.



Canadian Chronic Disease Surveillance System data files provided by provinces and territories, as of April 2025.
Public Health Agency of Canada, Health Infobase <https://health-infobase.canada.ca>

*Many CCDSS measures, such as chronic condition incidence, were influenced by the COVID-19 pandemic. Changes in such measures may be driven by multiple factors, including (but not limited to) differences in healthcare seeking behaviour, the availability and use of healthcare services, as well as true changes in health status. As such, CCDSS measures should be used cautiously when making inferences about population health during the COVID-19 pandemic. For the purposes of interpreting the estimates in this data tool, the COVID-19 pandemic period is defined as fiscal years 2020-2021 to 2022-2023. This timeframe aligns with the World Health Organization's declaration of COVID-19 as a public emergency of international concern from January 30, 2020, to May 5, 2023. Guidance for data users on examining the impacts of the COVID-19 pandemic on CCDSS measures during the pandemic period can be accessed at the CCDSS website.

Figure 16.2-1. Crude prevalence of chronic obstructive pulmonary disorder (COPD) in Canadians aged 35 years and older

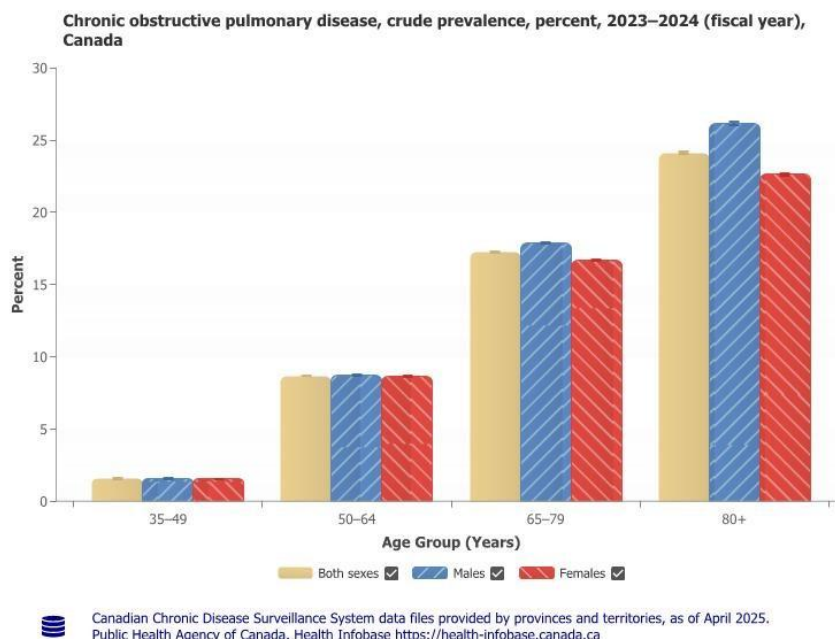


Figure 16.2-2. Crude prevalence of chronic obstructive pulmonary disorder (COPD) by age-group and sex, 2023-2024

16.3 Respiratory diseases and adverse driving outcomes

Historically, respiratory specialists concurred in believing that respiratory diseases had little impact on driving fitness. Medical fitness-to-drive standards concentrated on functional impairments caused by moderate or severe respiratory ailments and some jurisdictions were concerned about the secure storage of oxygen cylinders for drivers requiring supplemental oxygen.

This perspective is reflected in the limited number of studies examining the relationship between respiratory diseases and motor vehicle crash risk. Notably, a 2013 Canadian study included respiratory conditions, among several other conditions, and found a statistically significant increase in crash risk of 1.21 for drivers with respiratory disease; other multi-condition studies did not include respiratory disease in analysis, and respiratory disease was not among the 8 conditions with the greatest effect on crash risk listed in the Monash University’s Accident Research Centre report.

While the scientific literature remains somewhat divided, the 2023 Canadian Medical Associate Driver’s Guide acknowledges that chronic respiratory diseases, particularly

those causing hypoxia, can impair cognitive function, attention, and decision making. These impairments may in turn affect driving safety. Based on that and the consensus of respiratory specialists, functional impairments that result from severe respiratory disease is important for driver licensing authorities to consider, particularly when these impairments include psycho-motor slowness, reduced attention, and/or cognitive deficits.

16.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach ⁷	Primary functional ability affected	Assessment tools
COPD or other respiratory disease	Persistent impairment: Functional assessment	Cognitive May also result in general debility	Medical assessments Functional Assessment

Research indicates that drivers with COPD are at risk of cognitive impairment due to chronic hypoxemia. For those with cognitive impairment, the impairment tends to be greater for more complex and demanding cognitive tasks. This cognitive impairment may affect a driver's functional ability to drive.

Drivers with COPD also may develop general debility resulting in a loss of stamina required to support the functions necessary for driving.

Older drivers with COPD are more at-risk for functional impairment because they may experience:

- age-related declines in blood flow to the brain
- disease-related declines in arterial oxygen content, and
- both age and disease-related declines in physical activity which can exacerbate deconditioning.

16.5 Compensation

Drivers with COPD may be able to compensate for their functional impairment by using supplemental oxygen.

⁷ See Part 1 for a discussion of the use of functional assessments for driver licensing decisions.

16.6 Guideline for assessment

16.6.1 Mild impairment – All drivers

STANDARD	Eligible for all classes of licence
Conditions for maintaining licence	None
Reassessment	• Routine
Information from health care providers	• Pulmonary function testing result <u>or</u> statement that the level of impairment resulting from the respiratory disease is mild
Rationale	Mild impairment due to respiratory disease is unlikely to cause significant impairment of the functions needed for driving.

16.6.2 Moderate impairment – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence
Conditions for maintaining licence	None
Reassessment	• Routine, or more frequently at the discretion of the licensing authority
Information from health care providers	• Pulmonary function testing result <u>or</u> statement that the level of impairment resulting from the respiratory disease is moderate
Rationale	Moderate impairment due to respiratory disease is unlikely to cause significant impairment of the functions needed for non-commercial driving. Reassessment is required to monitor for an increase in impairment that may affect ability to drive.

16.6.3 Severe impairment – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • a functional assessment indicates sufficient functional ability
Conditions for maintaining licence	None
Reassessment	• Routine, or more frequently at the discretion of the licensing authority
Information from health care providers	• Results of functional assessment • Pulmonary function testing result <u>or</u> statement that the level of impairment resulting from the respiratory disease is severe • Whether the driver has insight into the impact their condition may have on driving
Rationale	Severe impairment due to respiratory disease may cause significant impairment of the functions needed for driving, including cognitive impairment. Licensing decisions should be based on an individual functional assessment.

16.6.4 Requiring supplemental oxygen – Non-commercial drivers

This guideline applies to non-commercial drivers who require supplemental oxygen while at rest.

STANDARD	Eligible for a non-commercial licence if: • a road test while using supplemental oxygen indicates sufficient functional ability, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Only drive while using supplemental oxygen
Reassessment	• Routine or more frequently at the discretion of the licensing authority
Information from health care providers	• Results of functional assessment • Pulmonary function testing result <u>or</u> statement that the level of impairment resulting from the respiratory disease requires supplemental oxygen

	• Whether the driver has insight into the impact their condition may have on driving • History of compliance with prescribed treatment regime • If known or applicable, whether the driver is compliant with any current conditions of licence
Rationale	Drivers who require supplemental oxygen due to respiratory disease may have significant impairment of the functions needed for non-commercial driving, including cognitive impairment. Licensing decisions should be based on an individual functional assessment, including ability to drive while using supplemental oxygen.

16.6.5 Moderate impairment or requiring intermittent supplemental oxygen – Commercial drivers

STANDARD	Eligible for a commercial licence if: • a functional assessment indicates sufficient functional ability
Conditions for maintaining licence	None
Reassessment	• Routine, or more frequently at the discretion of the licensing authority
Information from health care providers	• Functional impairment, if any • Pulmonary function testing result <u>or</u> statement that the level of impairment is moderate • Whether the driver has insight into the impact their condition may have on driving • History of compliance with prescribed treatment regime
Rationale	Moderate impairment due to respiratory disease may cause significant impairment of the functions needed for driving. Licensing decisions should be based on an individual functional assessment.

16.6.6 Severe impairment or requiring continuous supplemental oxygen – Commercial drivers

STANDARD	Not eligible for a commercial licence
Conditions for maintaining licence	N/A
Reassessment	N/A
Information from health care providers	N/A
Rationale	Severe impairment or a requirement for continuous supplemental oxygen due to respiratory disease generally indicates significant impairment of the functions needed for commercial driving.

Chapter 17: Seizures and epilepsy

17.1 About seizures and epilepsy

Seizures

A seizure is caused by a sudden electrical discharge in the brain. A seizure does not always mean that a person falls to the ground in convulsions. It can be manifested in various ways, including:

- feelings of being absent
- visual distortions
- nausea
- vertigo
- tingling
- twitching
- shaking
- rigidity of parts of the body or the entire body, or
- an alteration or loss of consciousness.

Seizures may occur in people who do not have epilepsy. These non-epileptic seizures are often referred to as provoked seizures. Some are caused by transient factors with no structural brain abnormality such as:

- fever
- low blood sugar
- electrolyte imbalance
- head trauma
- meningitis
- simple fainting, and
- alcohol or drug toxicity or withdrawal.

Others are caused by conditions where there is a structural brain abnormality such as a:

- tumour
- stroke
- aneurysm, or
- hematoma.

Provoked seizures are not epilepsy, and they resolve after the provoking factor has resolved or stabilized.

Sometimes people appear to have seizures, even though their brains show no seizure activity. This phenomenon is called a psychogenic non-epileptic seizure (PNES),

sometimes referred to as a pseudoseizure, and is psychological in origin. Some people with epilepsy have PNES in addition to their epileptic seizures. Other people who have PNES do not have epilepsy at all.

Epilepsy

Epilepsy refers to a condition characterized by recurrent (at least two) seizures, which do not have a transient provoking cause. The cause of the epileptic seizures may be known or unknown (idiopathic). About two-thirds of epilepsy in young adults is idiopathic, but more than half of epilepsy in those 65 and older has a known cause. Known causes of epilepsy include permanent structural brain abnormality such as scarring from:

- stroke
- prior surgery
- head injury
- infections
- tumours
- aneurysms, or
- arteriovenous malformations.

Types of seizures

Seizures are divided into two main categories: partial (also called focal or local) seizures and generalized seizures. A partial seizure is a seizure that arises from an electrical discharge in one part of the brain. A generalized seizure is caused by discharges throughout the brain.

Partial seizures

There are three types of partial seizures:

- simple partial seizures
- complex partial seizures, and
- partial seizures (simple or complex) that evolve into secondary generalized seizures (see below).

The difference between simple and complex seizures is that individuals experiencing simple partial seizures retain awareness during the seizure, whereas those experiencing complex partial seizures lose awareness during the seizure.

Symptoms of partial seizures depend on which part of the brain is affected. They may include one or more of the following:

- head turning

- eye movements
- mouth movements
- lip smacking
- drooling
- apparently purposeful movements
- rhythmic muscle contractions in a part of the body
- abnormal numbness
- tingling and a crawling sensation over the skin
- sensory disturbances such as smelling or hearing things that are not there, or
- having a sudden flood of emotions.

Individuals who have partial seizures, especially complex partial seizures, may experience an aura, i.e., unusual sensations that warn of an impending seizure. An aura is actually a simple partial seizure. The aura symptoms an individual experiences and the progression of those symptoms tend to be similar every time.

Generalized seizures

Types of generalized seizures and their symptoms are listed in the table below.

Type of Generalized Seizure	Symptoms
Absence	Brief loss of consciousness
Myoclonic	Sporadic (isolated), jerking movements
Clonic	Repetitive, jerking movements
Tonic	Muscle stiffness, rigidity
Tonic-clonic or 'grand mal'	Unconsciousness, convulsions, muscle rigidity
Atonic	Loss of muscle tone

Most common seizures

The three most common types of seizures in adults are:

- generalized tonic-clonic or grand mal seizures
- complex partial seizures, and
- simple partial seizures.

Approximately one-third of all individuals with epilepsy have complex partial seizures, with the prevalence increasing to one-half in those with epilepsy who are 65 and older.

Recurrence of seizures

The estimated risk of a recurrence after an initial unprovoked seizure ranges from 23% to 71%, with the average risk of recurrence for adults being 43%. If the seizure is idiopathic (i.e., the cause is unknown) and the individual's electroencephalogram (EEG) and central nervous system (CNS) imaging are normal, the risk of recurrence is significantly reduced. This is reflected in the solitary seizure standard for private and commercial driving. Individuals who experience a partial seizure and have an abnormal EEG or other neurological abnormality, have an increased risk for seizure recurrence. A family history of epilepsy also increases the risk of recurrence.

Treatment for seizures and epilepsy

Seizure patterns in individuals with epilepsy may change over time, and seizures may eventually stop. Epilepsy is generally treated with antiepileptic drugs (also referred to as anticonvulsants) and is sometimes treated with surgery to remove the source of epilepsy from the brain. Recent studies indicate that more than half of newly diagnosed individuals with epilepsy can achieve seizure control with antiepileptic drugs. Many of those who achieve seizure control are eventually able to stop taking antiepileptic drugs and remain seizure-free. However, the relapse rate with drug withdrawal is at least 30% to 40%. For a further discussion of the impact of antiepileptics on driving, see Chapter 15, Drugs, alcohol and driving.

17.2 Prevalence

As of 2024, epilepsy had a prevalence rate of 1.0% in the Canadian population with 0.7% identified as having active epilepsy, per the Canadian Chronic Disease Surveillance System (CCDSS). The incidence of epilepsy in 2024 was 62 cases per 100,000 people, with the highest incidence in young children and seniors.

17.3 Seizures, epilepsy and adverse driving outcomes

A 2021 systematic review of the scientific literature on crash risk associated with seizures and epilepsy identified eleven studies that examined epilepsy and crash risk of which five reported increased risk, three reported similar risk to controls and three reported inconclusive evidence. However, despite the heterogeneity of the study methods and participants, the review concluded that epilepsy is associated with a low-to-moderate increase in crash involvement. It also noted that the results support requirements for a three to six-month seizure-free period before the resumption of driving after an epileptic seizure although the crash risk associated with either period is similar. The greatest risk for a repeat seizure is during the first month and it decreases rapidly during the second month. Thus, the six-month period is not more advantageous than the three-month period, as both include the critical initial period after which the risk of a repeat seizure is low.

There were no studies on non-epileptic seizures.

In a 2013 study, with a large database, it was found that epilepsy was associated with the highest crash risk in their study. An internal Société de l'assurance automobile du Québec (SAAQ) study that examined combinations of medical conditions believed to affect fitness to drive found that a combination of epilepsy and locomotor disease doubled crash risk while some other combinations also increased crash risk to a lesser extent.

17.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Seizures Epilepsy	Episodic impairment: Medical assessment – likelihood of impairment	Variable – sudden impairment	Medical assessments

The primary consideration for drivers with epilepsy is the potential for a seizure causing a sudden impairment of cognitive, motor or sensory functions, or a loss of consciousness while driving.

17.5 Compensation

As seizures and epilepsy cause an episodic impairment of the functions necessary for driving, a driver cannot compensate.

17.6 Guideline for assessment

Rationale for all epilepsy and seizure standards

The general approach of the guideline for drivers with epilepsy or who experience seizures is that seizures must be controlled as a prerequisite to driving.

Most of the guidelines include a requirement for a seizure-free period. The purpose of this requirement for a provoked seizure is to establish the likelihood that the provoking factor has been successfully treated or stabilized. For an unprovoked seizure, the purpose is to allow time to assess the cause, and where epilepsy is diagnosed, to establish the likelihood that

- a therapeutic drug level has been achieved and maintained
- the drug being used will prevent further seizures, and
- there are no side effects that may affect the driver's ability to drive safely.

The guidelines identify exceptions to the requirement to remain seizure free for non-commercial drivers who have epilepsy and who have only simple partial seizures, or seizures that only occur while they are asleep or immediately upon awakening.

17.6.1 Provoked seizure caused by a structural brain abnormality – All drivers

If more than one seizure occurs, then the epilepsy standards may be applicable (see 17.6.6 through 17.6.15).

This standard applies to drivers who have experienced one provoked seizure caused by a structural brain abnormality such as:

- a brain tumour
- stroke
- subdural hematoma, or
- aneurysm.

STANDARD	Eligible for all classes of licence if: • they have undergone a neurological assessment to determine the cause of the seizure, and epilepsy is not diagnosed • it has been 6 months since the provoking factor stabilized, resolved, or was corrected, with or without treatment, and they have not had a seizure during that time • the treating neurologist or neurosurgeon indicates that further seizures are unlikely
Conditions for maintaining licence	None
Suggested Reassessment	• If a seizure occurred within the past 12 months, reassess in 1 year • If a seizure occurred more than 1 year ago, or if no further seizures are reported after the initial reassessment, reassess in 5 years • If no further seizures are reported during those 5 years, at the discretion of the licencing authority.
Information from health care providers	• Date of the last seizure • Description of the type of seizure • Whether a neurological assessment has been conducted and the results of the assessment • Date that the provoking factor stabilized, resolved or was corrected • Details of the driver's treatment regime • Opinion of treating physician on whether the driver is compliant with their treatment regime • Opinion of treating physician on whether further seizures are likely. Depending on the nature of the provoking factor, the opinion of a neurologist may be required to determine the risk of further seizures.

Rationale	The primary consideration for drivers who experience seizures is the potential for a seizure causing a sudden impairment of cognitive, motor or sensory functions, or a loss of consciousness while driving. The purpose of a seizure-free period requirement for a provoked seizure is to establish the likelihood that the provoking factor has been successfully treated or stabilized.
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17.6.2 Provoked seizures with no structural brain abnormality – All drivers

This standard applies to drivers who have experienced provoked seizures caused by a:

- toxic illness
- adverse drug or alcohol reaction, and substance use disorder* is not diagnosed
- trauma, or
- other cause that is not associated with a structural brain abnormality.
(for example psychogenic non epileptic seizure (PNES))

* Note if substance use disorder is diagnosed, then 17.6.3 would apply

STANDARD	Eligible for all classes of licence if: • they have undergone a neurological assessment to determine the cause of the seizure, and epilepsy is not diagnosed • the provoking factor has stabilized, resolved, or been corrected, with or without treatment, and • the treating physician indicates that further seizures are unlikely
Conditions for maintaining licence	None
Reassessment	• Routine
Information from health care providers	• Description of the type of seizure • Whether a neurological assessment has been conducted and the results of the assessment • Opinion of treating physician on whether the provoking factor has stabilized, resolved or been corrected • Opinion of treating physician on whether further seizures are likely. Depending on the nature of the provoking factor, the opinion of a neurologist may be required to determine the risk of further seizures.

Rationale	The primary consideration for drivers who experience seizures is the potential for a seizure causing a sudden impairment of cognitive, motor or sensory functions, or a loss of consciousness while driving. The general approach of the guidelines for drivers who experience seizures is that seizures must be controlled as a prerequisite to driving and/or the provoking factor has stabilized, resolved, or has been corrected.
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17.6.3 Alcohol Withdrawal Seizures – All drivers

STANDARD	Eligible for all classes of licence if: • the treating physician has confirmed that the cause of the seizure was alcohol withdrawal (i.e., the driver is not epileptic) • they have undergone addiction treatment and have received a favourable report from an addiction counsellor • the criteria for licence reinstatement are met in accordance with the Substance Use Disorder Standard (see 15.6.3)
Conditions for maintaining licence	• Follow up regularly with treating physician and comply with any prescribed treatment regime • Cease driving and report to the licencing authority and treating physician if driver has a seizure
Reassessment	• Reassess in one year • If no further seizures are reported after the initial reassessment, reassess in five years • If no further seizures are reported during those five years, then routine
Information from health care providers	• Description of the cause of the seizure • Date of the last seizure • Details of treatment regime • Date of abstinence • Whether the driver has undergone addiction treatment • Report from an addiction counsellor and / or treating physician whether the driver is compliant
Rationale	The primary consideration for drivers who experience seizures is the potential for a seizure causing a sudden impairment of cognitive, motor or sensory functions, or a loss of consciousness while driving. The purpose of a seizure-free period requirement for a provoked

	seizure is to establish the likelihood that the provoking factor has been successfully treated or stabilized.
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17.6.4 Single unprovoked seizure – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • Complete neurological assessment has been conducted to determine the cause of the seizure, and epilepsy is not diagnosed, and • CNS imaging and EEG results do not suggest an increased likelihood of seizure reoccurrence.
Conditions for maintaining licence	None
Reassessment	• If the seizure occurred within the past 12 months, reassess in one year • If the seizure occurred more than one year ago, or if no further seizures are reported after the initial reassessment, reassess in five years • If no further seizures are reported during those five years, then routine
Information from health care providers	• Date of the seizure • Description of the type of seizure • Whether a neurological assessment has been conducted and the results of the assessment
Rationale	The primary consideration for drivers who experience seizures is the potential for a seizure causing a sudden impairment of cognitive, motor or sensory functions, or a loss of consciousness while driving. The purpose of a seizure-free period requirement for an unprovoked seizure is to allow time to assess the cause and establish seizures are controlled as a prerequisite to driving.

17.6.5 Single unprovoked seizure – Commercial drivers

STANDARD	Eligible for a commercial licence if: • it has been at least 12 months since the seizure occurred, and • Complete neurological assessment has been conducted to determine the cause of the seizure, and epilepsy is not diagnosed, and • CNS imaging and EEG results are satisfactory
Conditions for maintaining licence	None

Reassessment	• Reassess in one year • If no further seizures are reported after the initial reassessment, then routine
Information from health care providers	• Date of the seizure • Description of the type of seizure • Whether a neurological assessment has been conducted and the results of the assessment
Rationale	The primary consideration for drivers who experience seizures is the potential for a seizure causing a sudden impairment of cognitive, motor or sensory functions, or a loss of consciousness while driving. The purpose of a seizure-free period requirement for an unprovoked seizure is to allow time to assess the cause and establish seizures are controlled as a prerequisite to driving.

17.6.6 Epilepsy – Non-commercial drivers

This standard applies to non-commercial drivers who have been diagnosed with epilepsy, with the following exceptions:

- If the epileptic seizures only occur while the driver is asleep, or immediately after awakening, standard 17.6.7 applies.
- If the driver only experiences simple partial seizures, standard 17.6.8 applies.
- If the driver has had surgery for epilepsy, standard 17.6.9 applies.
- If the driver has changed effective medication, standard 17.6.10 applies.

STANDARD	Eligible for a non-commercial licence if: • It has been at least 6 months since the last seizure occurred while on antiepileptic medication OR it has been at least 6 months since the last seizure occurred without antiepileptic medication if the driver has been assessed by a neurologist who is of the opinion that the risk of having a seizure without antiepileptic medication is low • Waiting period may be reduced to no less than 3 months on neurologist's recommendation if rationale is provided
Conditions for maintaining licence	• Routinely follows treatment regime, avoids seizure threshold-lowering behaviour(s), and physician's advice regarding prevention of seizures • Driver must cease driving and report to the licencing authority and physician if has a seizure

Reassessment	• Reassess in one year if a seizure occurred within the past 12 months • Otherwise, routine
Information from health care providers	• Date of the last seizure • Details of the driver's treatment regime, including length of time the driver has been on antiepileptic medication • Opinion of treating physician on whether the driver is compliant with their treatment regime
Rationale	The general approach of the guidelines for drivers with epilepsy or who experience seizures is that seizures must be controlled as a prerequisite to driving. The purpose of a seizure-free period requirement where epilepsy is diagnosed is to establish the likelihood that a therapeutic drug level has been achieved and maintained; the drug being used will prevent further seizures, and there are no side effects that may affect the individual's ability to drive safely.

17.6.7 Epilepsy with seizures only while asleep or upon awakening – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • it has been 6 months since the last seizure, or • the driver is experiencing seizures but seizure pattern has been consistent for at least 1 year - and therefore no seizure free waiting period required • AND conditions for maintaining a licence are met
Conditions for maintaining licence	• Routinely follow treatment regime and physician's advice regarding prevention of seizures, if the driver is treated • Routinely follow physician's advice regarding continued monitoring of your seizures and avoids seizure threshold-lowering behaviour(s) • Report to the licencing authority and physician if the pattern of seizures changes
Reassessment	• Routine
Information from health care providers	• Description of the seizure pattern • Whether the seizure pattern has been consistent for at least 1 year • Details of the driver's treatment regime • Opinion of treating physician on whether the driver is compliant with their treatment regime
Rationale	The purpose of a seizure-free period requirement for drivers with epilepsy with seizures only while asleep or upon awakening is to establish seizures are controlled or seizure pattern has been consistent for a prescribed time as a prerequisite to driving.

17.6.8 Epilepsy with simple partial seizures – Non-commercial drivers

This standard applies to non-commercial drivers with epilepsy who only experience simple partial seizures (no impairment in level of consciousness), the symptoms of which do not impair their functional ability to drive.

STANDARD	Eligible for a non-commercial licence if: • it has been 6 months since the last seizure, or • the driver is experiencing seizures but the seizure pattern has been consistent for at least 1 year- and therefore no seizure free waiting period required and ○ favourable assessment from the treating physician or neurologist ○ no impairment in level of consciousness or cognition ○ no head or eye deviation with seizures • AND conditions for maintaining a licence are met
Conditions for maintaining licence	• Routinely follow treatment regime, avoids seizure threshold-lowering behaviour(s), and physician's advice regarding prevention of seizures, if the driver is treated • Must report to the licencing authority and physician if the symptoms of seizures change
Reassessment	• Routine
Information from health care providers	• Description of the symptoms of the seizures • Whether the symptoms of the seizures have been consistent for at least 1 year • Details of the driver's treatment regime • Opinion of treating physician on whether the driver is compliant with their treatment regime
Rationale	The purpose of a seizure-free period requirement for drivers with epilepsy with simple partial seizures is to establish seizures are controlled or seizure pattern has been consistent for a prescribed time as a prerequisite to driving.

17.6.9 Surgery for epilepsy – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • they have not had a seizure for 12 months after surgery • taking anti-epileptic medication as directed by physician • waiting period may be reduced to 6 months upon neurologist recommendation • conditions for maintaining a licence are met
Conditions for maintaining licence	• Routinely follow treatment regime, avoids seizure threshold-lowering behaviour(s), and physician's advice regarding prevention of seizures. • Cease driving and report to authority and physician if a seizure occurs.
Reassessment	• At discretion of licencing authority.
Information from health care providers	• Date of last seizure • Details of driver's treatment regime • Opinion of treating physician on whether the driver is compliant with their treatment regime
Rationale	The purpose of a seizure-free period requirement for drivers with epilepsy who had a surgery is to establish seizures are controlled as a prerequisite to driving.

17.6.10 Surgery for Epilepsy – Commercial Drivers

STANDARD	Eligible for a commercial licence if: • they have not had a seizure for 5 years after surgery with or without anti-epileptic medication • waiting period may be reduced to 3 years upon neurologist/specialist recommendation • conditions for maintaining a licence are met
Conditions for maintaining licence	• Routinely follow treatment regime, avoids seizure threshold-lowering behaviour(s), and physician's advice regarding prevention of seizures. • Cease driving and report to authority and physician if a seizure occurs.
Reassessment	• At discretion of licencing authority.

Information from health care providers	• Date of last seizure • Details of driver's treatment regime • Opinion of treating physician on whether the driver is compliant with their treatment regime if applicable
Rationale	The purpose of a seizure-free period requirement for drivers with epilepsy who had a surgery is to establish seizures are controlled as a prerequisite to driving.

17.6.11 Epilepsy with medication change – Non-commercial drivers

This standard applies to non-commercial drivers with epilepsy who undergo a prescribed change to, or withdrawal from, an effective antiepileptic medication. This standard only applies where the driver's treatment was effective (i.e., their epilepsy was controlled) prior to the change to, or withdrawal from, medication. This means they should not have had a seizure for at least six months prior to the change or withdrawal of medication. If their treatment prior to the change was not effective, then guideline 17.6.6 applies.

STANDARD	Eligible for a non-commercial licence if: • it has been 3 months since the change or withdrawal and they have not had a seizure during that time, and • the conditions for maintaining a licence are met Non-commercial drivers who have a seizure after a change to, or withdrawal from, antiepileptic medication are eligible for a licence if • they re-establish a previously effective treatment regime • the treating physician indicates that further seizures are unlikely, • it has been 3 months since the previously effective treatment regime was resumed and they have not had a seizure during that time • conditions for maintaining a licence are met
Conditions for maintaining licence	• Routinely follow treatment regime, avoids seizure threshold-lowering behaviour(s), and physician's advice regarding prevention of seizures • Cease driving and report to the licencing authority and your physician if you have a seizure
Reassessment	• If a seizure occurred within the past 12 months, reassess in one year • If no seizures occurred within the past 12 months, or if no seizures are reported after the initial reassessment, reassess in five years • If no seizures are reported during those five years, then routine
Information from health care providers	• Date of the medication change or withdrawal • Date of the last seizure • Details of the driver's treatment regime • Opinion of treating physician whether the driver is compliant with their treatment regime • Opinion of treating physician whether further seizures are likely

Rationale	The general approach of the guidelines for drivers with epilepsy or with medication change for epilepsy, or who experience seizures is that seizures must be controlled as a prerequisite to driving.
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17.6.12 Epilepsy – Commercial drivers

This standard applies to commercial drivers, who have been diagnosed with epilepsy, except:

- whose seizure only occur while they are asleep or immediately after awakening, and (17.6.13)
- who have only simple partial seizures (no impairment in level of consciousness), the symptoms of which do not impair their functional ability to drive (17.6.14).

See guideline 17.6.15 for commercial drivers who meet this standard and then change medication.

STANDARD	Eligible for a commercial licence if: • they have not had a seizure with or without medication for 5 years, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Routinely follows treatment regime, avoids seizure threshold-lowering behaviour(s), and physician's advice regarding prevention of seizures • Cease driving and report to the licencing authority and physician if a seizure occurs
Reassessment	• Routine
Information from health care providers	• Date of the last seizure • Details of the driver's treatment regime, including length of time the driver has been on or off antiepileptic medication • Opinion of treating physician on whether the driver is compliant with their treatment regime

Rationale	The general approach of the guidelines for drivers with epilepsy or who experience seizures is that seizures must be controlled as a prerequisite to driving. The purpose of a seizure-free period requirement where epilepsy is diagnosed is to establish the likelihood that a therapeutic drug level has been achieved and maintained; the drug being used will prevent further seizures, and there are no side effects that may affect the individual's ability to drive safely.
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17.6.13 *Epilepsy with seizures only while asleep or upon awakening - Commercial drivers*

STANDARD	Eligible for a commercial licence if: • the driver is experiencing seizures but the seizure pattern has been consistent for at least 5 years • no prolonged postictal impairment in wakefulness
Conditions for maintaining licence	• Routinely follow treatment regime, avoids seizure threshold-lowering behaviour(s), and physician's advice regarding prevention of seizures, if the driver is treated • Routinely follow physician's advice regarding continued monitoring of your seizures • Report to the licencing authority and physician if the pattern of seizures changes
Reassessment	• Routine
Information from health care providers	• Description of the seizure pattern • Whether the seizure pattern has been consistent for at least 5 years • Details of the driver's treatment regime • Opinion of treating physician on whether the driver is compliant with their treatment regime
Rationale	The primary consideration for drivers with epilepsy is the potential for a seizure causing a sudden impairment of cognitive, motor or sensory functions, or a loss of consciousness while driving. The general approach of the guidelines for drivers with epilepsy who experience seizures while asleep or upon awakening is to establish seizures are controlled or seizure pattern has been consistent for a prescribed time as a prerequisite to driving.

17.6.14 *Epilepsy with simple partial seizures - Commercial drivers*

STANDARD	Eligible for a commercial licence if: • it has been 5 years since the last seizure, or • the driver is experiencing seizures but the seizure pattern has been consistent for 3 years – and therefore no seizure free waiting period required and ○ favourable assessment from neurologist to drive ○ no impairment in level of consciousness or cognition ○ no head or eye deviation with seizures • And conditions for maintaining a licence are met
Conditions for maintaining licence	• Routinely follow treatment regime, avoids seizure threshold-lowering behaviour(s), and physician's advice regarding prevention of seizures, if the driver is treated • Must report to the licencing authority and physician if the symptoms of seizures change
Reassessment	• Routine
Information from health care providers	• Description of the symptoms of the seizures • Whether the symptoms of the seizures have been consistent for at least 3 years • Details of the driver's treatment regime • Opinion of treating physician on whether the driver is compliant with their treatment regime
Rationale	The purpose of a seizure-free period requirement for drivers with epilepsy with simple partial seizures is to establish seizures are controlled or seizure pattern has been consistent for a prescribed time as a prerequisite to driving.

17.6.15 Epilepsy with medication change - Commercial drivers

This standard applies to commercial drivers with epilepsy who undergo a prescribed change to, or withdrawal from, an effective antiepileptic medication. This standard only applies where the driver's treatment was effective (i.e., their epilepsy was controlled) prior to the change to, or withdrawal from, medication. This means they must first meet guideline 17.6.12 before this standard will apply.

STANDARD	Eligible for a commercial licence if: • it has been 6 months since the prescribed change or withdrawal and they have not had a seizure during that time, and • the conditions for maintaining a licence are met Commercial drivers who have a seizure after a prescribed change to, or withdrawal from, antiepileptic medication are eligible for a licence if: • it has been 6 months since the prescribed change or withdrawal and they have not had a seizure during that time • they have re-established a previously effective treatment regime • the treating physician indicates that further seizures are unlikely, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Routinely follow treatment regime, avoids seizure threshold-lowering behaviour(s), and physician's advice regarding prevention of seizures • Cease driving and report to the licencing authority and physician if seizure occurs
Reassessment	• Routine
Information from health care providers	• Date of the medication change or withdrawal • Date of the last seizure • Details of the driver's treatment regime • Opinion of treating physician on whether the driver is compliant with their treatment regime • Opinion of treating physician on whether further seizures are likely

Rationale	The purpose of a seizure-free period requirement for drivers with epilepsy with medication change is to establish seizures are controlled as a prerequisite to driving.
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Chapter 18: Sleep disorders

18.1 About sleep disorders

Sleep disorders involve any difficulties related to sleeping, including:

- difficulty falling asleep (insomnia) or staying asleep
- falling asleep at inappropriate times
- excessive total sleep time, or
- abnormal behaviours associated with sleep.

This chapter focuses on the most common forms of sleep disordered breathing, particularly obstructive sleep apnea, and on narcolepsy.

In addition to sleep disorders, a number of other factors such as work schedules or lifestyle choices may result in inadequate nocturnal sleep. Regardless of the cause, the risks of excessive sleepiness for driving safety are similar.

Sleep disordered breathing

Sleep disordered breathing consists of three distinct clinical syndromes:

- obstructive sleep apnea-hypopnea syndrome (OSAHS): apnea-hypopnea caused by repeated closure of the throat or upper airway during sleep. This is the most common form of sleep disordered breathing. In the medical standards in this section, obstructive sleep apnea-hypopnea syndrome is referred to as OSA.
- central sleep apnea-hypopnea syndrome (CSAHS): includes types of apnea-hypopnea caused by a neurological problem that interferes with the brain's ability to control breathing during sleep, as well as high altitude periodic breathing and apnea-hypopnea due to drug or substance abuse.
- sleep hypoventilation syndrome (SHVS): a type of sleep disordered breathing characterized by insufficient oxygen absorption during sleep. It usually occurs in association with restrictive lung disease in morbidly obese individuals, respiratory muscle weakness or obstructive lung disease such as COPD.

Obstructive sleep apnea-hypopnea syndrome (OSA)

With OSA, the tissue and muscles of the upper airway repetitively collapse during sleep, reducing or preventing breathing. As oxygen levels in the blood fall, arousal causes the airway to re-open. Although individuals with OSA often remain asleep, their sleep patterns are disrupted. These sleep disturbances result in excessive daytime sleepiness. Impairments in cognitive function are common in individuals with OSA and these may include difficulties in attention, concentration, complex problem solving, and short-term recall of verbal and spatial information.

Sleep monitoring is used to confirm a diagnosis of OSA. The preferred test used in diagnosis is nocturnal polysomnography. This test involves monitoring a number of physiological functions, such as brain activity, respiration, heart activity and oxygenation of the blood, while an individual is sleeping. A diagnosis of sleep apnea is based on the apnea-hypopnea index (AHI), where apnea is defined as a cessation of airflow lasting at least 10 seconds and hypopnea is defined as a reduction in airflow with a decline in blood oxygen level lasting at least 10 seconds. Generally, an individual is diagnosed with sleep apnea if they have greater than 5 apnea/hypopnea episodes per hour of sleep. There are a number of scales used to measure the severity of OSA. A scale based on the AHI describes the following levels of severity:

- Mild: 5 to 14 events per hour
- Moderate: 15 to 30 events per hour
- Severe: more than 30 events per hour.

Although nocturnal polysomnography is considered to be the best test for the diagnosis of OSA, a number of other tests may be used by sleep specialists to assist in evaluation or diagnosis. Overnight oximetry is similar to polysomnography, but only measures oxygen level and heart rate. Results from overnight oximetry alone are not considered adequate to diagnose OSA.

A number of tests are used to evaluate daytime sleepiness. These include the Maintenance of Wakefulness Test (MWT), the Multiple Sleep Latency Test (MSLT) and the Epworth Sleepiness Scale (ESS). MWT measures the level of daytime drowsiness based on how long a person can remain awake during the day under controlled conditions. The MSLT is similar to the MWT, but measures how long it takes a person to fall asleep when taking daytime naps, rather than how long they can stay awake. The ESS is a subjective test in which a person is asked to rate on a scale of 1 to 4 the likelihood that they would fall asleep in different situations, such as when watching TV, riding in a car or engaging in conversation.

Treatment options for OSA include:

- lifestyle changes such as weight loss, alcohol abstinence or change in sleep position
- the use of oral appliances
- the use of a nasal continuous positive airway pressure (CPAP) device,
- bariatric surgery (for morbidly obese individuals), and
- in rare cases, corrective upper airway surgery.

CPAP is the most effective treatment, and the only one which has been shown to reduce the risk of motor vehicle crashes. A CPAP machine blows heated, humidified air through a short tube to a mask worn by the individual while sleeping. As the individual breathes, air pressure from the CPAP machine holds the nose, palate and throat tissues open.

An immediate reduction (usually within 2 weeks) in daytime sleepiness is often reported with CPAP treatment, although studies indicate that approximately 6 weeks of treatment are required for maximum improvement in symptoms. Medical consensus supports the resumption of driving after 2 weeks of treatment. Estimates of compliance with CPAP treatment vary depending on how it is measured. Subjective rates of compliance based on self-report are higher than objectively determined rates. A 2021 study found that approximately 50% of individuals were compliant long-term with their prescribed CPAP protocol.

OSA Indicators

During periodic medical assessments it is essential the examining physician screen for sleep disorders risk factors. The Federal Motor Carrier Safety Administration (FMCSA) Expert Panel Recommendations on Obstructive Sleep Apnea and Commercial Motor Vehicle Driver Safety (2008) reflected the following on OSA.

Symptoms suggestive of OSA:

- Chronic loud snoring
- Witnessed apneas or breathing pauses during sleep
- Daytime sleepiness

Risk factors for OSA:

- Male
- Advancing age
- BMI > 28 kg/m² (BMI - Body Mass Index)
- Small jaw
- Large neck size (≥17 inches male, ≥15.5 inches female)
- Small airway
- Family history of OSA

Conditions associated with OSA:

- HBP (High Blood Pressure) or HTA (Hypertension Arterial)
- Type 2 diabetes
- Hypothyroidism

OSA Assessment

Patients with severe OSA, who have been involved in a crash in which their medical condition was a causal factor, are at high risk of having more accidents if they are not treated successfully. Even without having experienced a crash, severe sleep apnea has been identified as a factor that increases crash risk. Consequently, commercial drivers who have experienced a crash associated with falling asleep, or report they have experienced excessive sleepiness while driving, should be advised to stop driving immediately pending completion of sleep studies and effective treatment.

Furthermore, licensing agencies must decide if commercial drivers with OSA risk factors associated with the symptoms listed are fit to hold class 1, 2, 3 or 4 driver licences pending a sleep expert assessment given current waiting times for sleep studies.

Treated OSA is subject to annual medical review by the licensing agency for all Class 1, 2, 3 and 4 driver licence holders.

Narcolepsy

Narcolepsy is a chronic neurological disorder in which the brain is unable to regulate sleep-wake cycles normally. It is characterized by excessive daytime sleepiness and may also cause cataplexy (abrupt loss of muscle tone), hallucinations and sleep paralysis. There is no known cure. The symptoms of narcolepsy relevant to driving are sleepiness and cataplexy.

The excessive daytime sleepiness of narcolepsy comprises both a background feeling of sleepiness present much of the time and a strong, sometimes irresistible, urge to sleep recurring at intervals through the day. This desire is heightened by conducive or monotonous circumstances, but naps at inappropriate times, such as during meals, are characteristic. The naps associated with narcolepsy usually last from minutes to an hour and occur a few times each day. Potential secondary symptoms related to sleepiness may include visual blurring, diplopia and cognitive impairment. Cognitive impairment may include difficulties with attention and memory.

Cataplexy refers to an abrupt loss of skeletal muscle tone. It is estimated that 60% to 90% of individuals with narcolepsy experience cataplexy. During a cataplexy attack, which can last up to several minutes and occur several times a day, an individual remains conscious but is unable to move. Generalized attacks can cause an individual to completely collapse, although the muscles of the diaphragm and the eyes remain unaffected. Partial attacks, which affect only certain muscle groups, are more common than generalized attacks. Laughter or humorous events are a common trigger of cataplexy attacks, although anger, embarrassment, surprise or sexual arousal can also trigger an attack.

As there is no cure, treatment for narcolepsy is focused on the control of sleepiness and cataplexy where present.

18.2 Prevalence

Studies on sleep disorders are a recent phenomenon that concentrates on obstructive sleep apnea (OSA). Evidence on the effects of narcolepsy, insomnia and hypersomnia are limited.

A 2021 systematic review of the literature on the effects of sleep disorders on fitness to drive identified more than 4 000 articles on the subject of which 37 were judged to have met all the inclusion criteria. Five of the studies examined narcolepsy and hypersomnia, two addressed insomnia and the remaining 30 were on sleep apnea and its treatment. Eleven of the studies of OSA also looked specifically at the effects on crash risk of the various treatments, the majority of which concluded that continuous positive airway pressure (CPAP) and uvulopalatopharyngoplasty (UPPP) reduced crash risk when compared to untreated OSA.

Studies of OSA that were rated as “good” in the qualitative analyses demonstrated significantly increased crash risk for drivers with severe OSA that ranged from 2.36 (CI 95%: 1.62-3.44) to 7.30 (CI 95%: 1.8 - >25). One study found that CPAP treatment decreased crash risk to a level comparable to drivers without a sleep disorder while others found that observation of the approved CPAP treatment reduced crash risk by 70-82%.

Collectively these studies show that untreated moderate to severe OSA increased crash risk while adherence to the recommended CPAP protocol (at least four hours a night) reduced crash risk to a level that may, in some cases, be comparable to drivers without a sleep disorder. However, in all cases crash risk is lower for the driver with moderate or severe OSA who complies with the recommended CPAP treatment protocol.

The studies of narcolepsy and hypersomnia all concluded that these conditions increased crash risk while the studies of insomnia were inconclusive. There are no studies on the effects of treatment for narcolepsy, hypersomnia, or insomnia.

18.3 Compensation

Drivers with sleep disorders are not able to compensate for their impairment. Recently, a number of warning systems for drowsy drivers have been developed. These systems are designed to detect drowsiness by monitoring the driver’s eye movement, head movement or other physical activity, or by sensing when a vehicle is drifting on the road. When drowsiness is suspected, a warning system alerts the driver. These systems are in various stages of development and production.

Research on the effectiveness of drowsy driving warning systems is limited. The existing research indicates that these technologies show promise as a means to warn drivers of fatigue or drowsiness. However, it is recognized that alertness is a complex phenomenon, and no single measure alone may be sensitive and reliable enough to quantify driver fatigue. Further research and development is required before the use of these warning systems can be applied in driver licensing decisions.

18.4 Sleep disorders and adverse driving outcomes

Numerous studies have investigated the relationship between OSA and adverse driving outcomes. OSA may cause daytime drowsiness and reduced concentration, symptoms that can negatively affect driving safely. OSA is also of special concern for the commercial driver who often drives long distances with few breaks and whose work schedule may not be conducive to healthy sleep hygiene.

The majority of studies indicate that individuals with OSA have a 2 to 4 times greater risk for a crash, and the crashes result in more severe injuries. Although numerous tests are available to measure daytime sleepiness, the research also indicates that measures of daytime sleepiness and the severity of sleep apnea are not consistent predictors of impairments in driving performance.

Unlike OSA, there are few studies on narcolepsy and adverse driving outcomes. Although limited, this research suggests that narcolepsy is also associated with elevated crash rates.

18.5 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
OSA Narcolepsy	Episodic impairment: Medical assessment – likelihood of impairment	All – sudden incapacitation Cognitive – reduced alertness	Medical assessments
	Persistent impairment: Functional assessment	Cognitive	Medical assessments Functional Assessments

18.6 Guideline for assessment

18.6.1 Obstructive Sleep Apnea (OSA) – All drivers

STANDARD	Eligible for all classes of licence if: • has untreated obstructive sleep apnea with an Apnea-Hypopnea Index (AHI) < 30, and does not admit to daytime sleepiness, or • Drivers with severe obstructive sleep apnea (AHI ≥ 30) are disqualified from driving unless the condition is successfully treated, OR the driver has been assessed by a sleep specialist who is of the opinion that there is a low risk of a sleep related crash • Any driver with OSA, regardless of severity, who has experienced a crash within the previous 5 years associated with falling asleep or sleepiness while driving must provide evidence that the OSA is successfully treated.
Conditions for maintaining licence	• All commercial drivers must file periodic mandatory medical reports to assess their fitness to hold a commercial licence. • Non-commercial drivers are assessed for fitness to drive on a case by case basis, taking into account the treating physician's specific recommendations. • Cease driving and report any episodes of sleep at the wheel to the treating physician and the licencing authority.
Reassessment	• At the discretion of the licencing authority for non-commercial drivers, • Annual medical review for commercial drivers with OSA.
Information from health care providers	• History of sleep at the wheel within the past five years • Opinion of treating physician whether the driver understands the nature of the condition and the potential impact on driving
Rationale	The primary concerns with OSA are daytime sleepiness (risk of sleep while driving) and persistent cognitive impairment. Determining who is at risk of adverse driving outcomes due to daytime sleepiness is problematic. Because existing measures of daytime sleepiness and the severity of sleep apnea are not consistent predictors of impairments in driving performance, the standard looks to driver history of sleep at the wheel for identifying current risk of sleep while driving. The standard also emphasizes the responsibility of the driver to be attentive to the risk for daytime sleepiness.

18.6.2 Narcolepsy – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • there have been no daytime sleep attacks or cataplexy, with or without treatment, during the past 12 months. • Earlier re-licensing may be considered upon favourable recommendation from sleep specialist
Conditions for maintaining licence	None
Reassessment	• At the discretion of the licencing authority
Information from health care providers	• Type of treatment • Whether there have been daytime sleep attacks within the past 12 months • Whether there have been episodes of cataplexy within the past 12 months
Rationale	The general approach of the standard for drivers with narcolepsy is that attacks must be controlled as a prerequisite to driving. Where a driver is treated, the standard includes a requirement for an attack-free period to establish the likelihood that: • a therapeutic drug level has been achieved and maintained • the drug being used will prevent further attacks, and • there are no side effects that may affect the driver's ability to drive safely. The episodic risk of a sleep attack or cataplexy while driving is addressed in the requirement for a 12 month period without an episode prior to driving. The length of this no driving period is based on consensus medical opinion in Canada.

18.6.3 Narcolepsy – Commercial drivers

This standard applies to drivers who are diagnosed with narcolepsy

STANDARD	Generally not eligible for a commercial licence. May be eligible if: • demonstrated effective treatment • sleep specialist supports driving commercial vehicles • there have been no daytime sleep attacks or cataplexy during the last 12 months • earlier re-licensing may be considered upon favourable recommendation from a sleep specialist
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Conditions for maintaining licence	• remain under regular medical supervision • do not drive commercial vehicle for long hours, overnight or on irregular shifts. • A jurisdiction may consider having a sleep specialist review and approve the driver's work schedule and having a sleep specialist review and support driving commercial vehicles
Reassessment	• At discretion of licencing authority.
Information from health care providers	• Type of treatment • Multiple Sleep Latency Test (MSLT) demonstrating effective treatment • Whether there have been daytime sleep attacks or episodes of cataplexy within past 12 months.
Rationale	Consensus medical opinion in Canada indicates that the risks from increased driving exposure associated with commercial driving are such that drivers with narcolepsy may not drive. However, CMA Driver's Guide 10th edition also indicates people with narcolepsy, who are able to maintain a regular sleep-wake cycle, may be able to drive commercial vehicles during the day, over short routes. The recommendation for licensing commercial drivers with narcolepsy in the CMA Guide is a consensus recommendation based on clinical grounds.

Chapter 19: Syncope

19.1 About syncope

Syncope refers to a loss of consciousness, usually resulting from a temporary reduction in blood flow to the brain. The onset of syncope is relatively rapid and recovery is generally prompt, spontaneous and complete. The non-medical term for syncope is fainting.

Syncope has many different causes, including cardiovascular disease and neurological disorders. In some cases, no underlying cause can be found.

The following are the major types of syncope:

- vasovagal syncope
- postural syncope, and
- cardiac syncope.

The most common types of syncope are vasovagal (neurocardiogenic) and cardiac syncope.

Vasovagal syncope

Vasovagal or neurocardiogenic syncope refers to syncope that is triggered by an exaggerated and inappropriate nervous system response to a particular stimulus. The response is characterized by alterations in heart rate and blood flow, with a subsequent reduction in blood pressure. The stimulus can be any of a wide range of events such as:

- dehydration
- intense emotional stress
- anxiety
- fear
- pain
- hunger, or
- the use of alcohol or drugs.

Stimuli can also include forceful coughing, turning of the neck or wearing a tight collar (carotid sinus hypersensitivity), or urinating (micturition syncope).

Postural syncope

Postural syncope is syncope that results from a sudden drop in blood pressure immediately after standing or sitting up. It can be a side-effect of some medications or may be caused by dehydration or medical conditions such as Parkinson's disease.

Cardiac syncope

Cardiac syncope refers to syncope caused by cardiac conditions such as:

- valvular heart disease
- chronic heart failure, or
- arrhythmias (bradycardias or tachycardias).

Cardiac arrhythmias are the most common cause of cardiac syncope.

19.2 Prevalence

The prevalence of syncope is difficult to determine. One study reported that 3% of males and 3.5% of females had at least one episode of syncope over a 26 year period. According to the Canadian Cardiovascular Society, syncope is a common condition with a lifetime risk greater than 35%, affecting males and females equally. Higher rates of syncope are reported in older individuals. A Canadian multicenter study found that syncope accounted for 1% of emergency department visits, with higher hospitalization rates among older adults.

19.3 Syncope and adverse driving outcomes

The 2023 Canadian Cardiovascular Society Guidelines state that the overall risk of serious injury or death from syncope while driving is very low (< 1% per year). A 2022 study found that patients with first-episode syncope had no significant increase in motor vehicle crash risk compared to matched emergency department controls over the span of one year. Similarly, a 2023 study showed that recent syncope was not associated with being responsible for crashes except possibly in the case of cardiac syncope, and a second 2023 study found that even drivers who had a crash during a syncopal episode did not exhibit a markedly higher risk of subsequent crashes with the important caveat that this was not true when they lacked documented driving advice. As such, though the risk may be low, consideration of syncope by licensing authorities remains important.

19.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Syncope	Episodic impairment: Medical assessment – likelihood of impairment	All – sudden incapacitation	Medical assessments

Syncope causes an episodic impairment of all the functions necessary for driving.

19.5 Compensation

As syncope causes an episodic impairment of the functions necessary for driving, compensation does not apply.

19.6 Guideline for Assessment

19.6.1 Single or recurrent episode of typical vasovagal syncope – All drivers

Typical vasovagal syncope is a vasovagal syncope that occurs when standing and is preceded by warning signs that are sufficient to allow a driver to pull off the road before losing consciousness.

STANDARD	Eligible for all classes of licence
Conditions for maintaining licence	None
Reassessment	• Routine
Information from health care providers	• Description of the type of syncope
Rationale	CCS recommendation.

19.6.2 Single episode of unexplained syncope or atypical vasovagal syncope – Non-commercial drivers

Atypical vasovagal syncope is a vasovagal syncope that occurs in the sitting position or is not preceded by warning signs that are sufficient to allow a driver to pull off the road before losing consciousness.

STANDARD	Eligible for a non-commercial licence if: • it has been at least 1 week since the last episode of syncope, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Report to the licencing authority and your physician if you have another episode of syncope
Reassessment	• Reassess in one year if an episode occurred within the past 12 months • Otherwise, routine
Information from health care providers	• Description of the type of syncope • Date of the last episode of syncope

Rationale	CCS recommendation. Note that atypical vasovagal syncope is not discussed in the CCS guidelines; however, recommendations remain the same.
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19.6.3 Syncope with a reversible cause or treated – Non-commercial drivers (e.g. orthostatic, hemorrhage, or dehydration)

STANDARD	Eligible for a non-commercial licence if: • it has been at least one week since the last episode of syncope, and • the cause has been successfully treated Refer to the appropriate standard if syncope treated with implanted device (pacemaker, ICD).
Conditions for maintaining licence	• Report to the licencing authority and your physician if you have another episode of syncope
Reassessment	• Routine, unless reassessment is required because of the underlying medical condition or treatment
Information from health care providers	• Description of the cause of the syncope • Opinion of the treating physician whether the treatment was successful
Rationale	CCS recommendation.

19.6.4 Syncope with a reversible cause or treated - Commercial drivers (e.g. orthostatic, hemorrhage, or dehydration)

STANDARD	Eligible for a commercial licence if: • it has been at least one month since the last episode of syncope, and • the cause has been successfully treated Refer to the appropriate standard if syncope treated with implanted device (pacemaker ICD).
Conditions for maintaining licence	• Report to the licencing authority and your physician if you have another episode of syncope
Reassessment	• Routine, unless reassessment is required because of the underlying medical condition or treatment
Information from health care providers	• Description of the cause of the syncope • Opinion of the treating physician whether the treatment was successful
Rationale	CCS recommendation.

19.6.5 Situational syncope with an avoidable trigger* – Non-commercial drivers

*Avoidable trigger (e.g., micturition syncope, defecation syncope)

STANDARD	Eligible for a non-commercial licence if: • it has been at least one week since the last episode of syncope
Conditions for maintaining licence	None
Reassessment	• Routine
Information from health care providers	• Description of the type of syncope • Date of the last episode
Rationale	CCS recommendation.

19.6.6 Situational syncope with an avoidable trigger* – Commercial drivers

*Avoidable trigger (e.g., micturition syncope, defecation syncope)

STANDARD	Eligible for a commercial licence if: • it has been at least one month since the last episode of syncope
Conditions for maintaining licence	None
Reassessment	• Reassess in one year if an episode occurred within the past 12 months • Otherwise, routine
Information from health care providers	• Description of the type of syncope • Date of the last episode of syncope
Rationale	CCS recommendation.

19.6.7 Recurrent atypical vasovagal or recurrent unexplained syncope – Non-commercial drivers

This guideline applies to non-commercial drivers who have had two or more episodes of atypical vasovagal syncope, or unexplained syncope within a 12 month period.

Atypical vasovagal syncope is a vasovagal syncope that occurs in the sitting position or is not preceded by warning signs that are sufficient to allow a driver to pull off the road before losing consciousness.

STANDARD	Eligible for a non-commercial a licence if: • it has been at least three months since the last episode of syncope, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Report to the licencing authority and your physician if you have another episode of syncope
Reassessment	• Reassess in one year if an episode occurred within the past 12 months • Otherwise, routine
Information from health care providers	• Description of the type of syncope • Date of the last episode of syncope
Rationale	CCS recommendation. Note that atypical vasovagal syncope is not discussed in the CCS guidelines; however, recommendations remain the same.

19.6.8 Single or recurrent unexplained, single or recurrent atypical vasovagal syncope – Commercial drivers

This standard applies to commercial drivers who have had:

- single or recurrent atypical vasovagal syncope, or
- single or recurrent unexplained syncope

Atypical vasovagal syncope is a vasovagal syncope that occurs in the sitting position or is not preceded by warning signs that are sufficient to allow a driver to pull off the road before losing consciousness.

STANDARD	Eligible for a commercial licence if: • it has been at least 12 months since the last episode of syncope
Conditions for maintaining licence	• Routinely follow your treatment regime and physician's advice regarding prevention of syncope • Report to the licencing authority and your physician if you have another episode of syncope
Reassessment	• Reassess in one year • After initial reassessment, routine
Information from health care providers	• Description of the type of syncope • Date of the last episode of syncope • Opinion of treating physician whether the driver is compliant with the treatment regime and the physician's advice regarding prevention of syncope
Rationale	CCS recommendation.

Chapter 20: Traumatic brain injury

20.1 About traumatic brain injury

Traumatic brain injury (TBI) is a nondegenerative, non-congenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical and psychosocial functions, with an associated diminished or altered state of consciousness. The leading causes of TBI are falls and motor vehicle crashes.

Descriptions of the severity of a TBI reflect the length of time a person is unconscious or lacks awareness of their environment. Mild TBI indicates only a brief change in mental status or consciousness, while severe TBI describes an extended period of unconsciousness or amnesia after the injury.

TBI can result in a wide range of impairments, which will vary depending on the severity and location of the injury, and the age and general health of the injured person.

Possible sensory impairments include:

- visual field deficits
- visual neglect
- diplopia, and
- loss of sensation or hearing.

Possible motor impairments include:

- paralysis
- paresis (partial loss of movement or impaired movement), and
- slowed reaction times.

Possible cognitive impairments include deficits in:

- attention
- memory
- executive functioning
- processing speed, and
- visuo-spatial abilities, including visual memory.

Behavioural impairments are common, including disorders affecting mood and impulse control. Sleep disturbances, sleep apnea and fatigue are also commonly reported. TBI is also associated with epilepsy.

Anosognosia (unawareness of impairment) is common in individuals with TBI, particularly in those with moderate to severe TBI, and is of particular concern for driving. Research suggests that anosognosia is more frequently associated with cognitive and behavioural impairments than with physical deficits.

20.2 Prevalence

Rates of incidence and prevalence of TBI are difficult to determine due to a lack of uniformity in definitions and reporting methods. Incidence of TBI in Canada is estimated at 165,000 people that sustain a TBI annually, or approximately 500 per 100,000. It is estimated that more than 1.5 million Canadians live with a TBI, which may be conservative given many are suspected to go undiagnosed. Rates increased with age, largely due to the increased risk of falls.

20.3 Traumatic brain injury and adverse driving outcomes

Numerous studies have examined the relationship between TBI and driving outcomes. Although few studies have examined crash rates, the existing research indicates higher rates of crashes and traffic violations for those who have experienced a TBI. Historically, studies indicated that approximately 50% of those experiencing a TBI did not resume driving after the TBI; however, more recent data from longitudinal studies show higher return rates with 65% returning to driving after 1 year and 70% after 2 years after moderate to severe TBI. Research examining road test results indicates that approximately 30-40% of individuals who have experienced a TBI will fail a subsequent road test. A 2025 Ontario study found that mild TBI increases crash risk by approximately 49% compared to controls, especially in the first month post-injury.

20.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Traumatic brain injury	Persistent impairment: Functional assessment	Variable – cognitive, motor or sensory	Medical assessments Functional assessment
	Episodic impairment: Medical assessment – likelihood of impairment	Variable – sudden impairment (epilepsy)	Medical assessments

Traumatic brain injury may result in a persistent cognitive, motor or sensory impairment, or an episodic impairment (epilepsy), or both.

20.5 Compensation

Drivers who have experienced a persistent impairment of motor or sensory function may be able to compensate. An occupational therapist, driver rehabilitation specialist or other medical professional may recommend specific compensatory vehicle modifications or restrictions based on an individual functional assessment.

Some examples of compensatory mechanisms are shown in the following table.

Motor impairment	Sensory (vision) impairment
• Spinner knob or steering wheel device • Devices to operate secondary controls e.g. turn signal and horn • Hand Controls • Left foot accelerator • Restriction to automatic transmission	• Adapted scanning strategies e.g. degree and frequency of head/trunk rotation • Adapted mirrors –e.g. left, right, rear, • Cameras and/or sensors for e.g. side and rearview observation

20.6 Guidelines for assessment

20.6.1 Traumatic brain injury – All drivers

If a driver has epilepsy as a result of a TBI, also see the standards in Chapter 17: Seizures and epilepsy.

STANDARD	Eligible for all classes of licence if: • movement and strength are sufficient to perform the functions necessary for driving • cognitive and visual functions necessary for driving are not impaired • any pain associated with the condition, and any treatment for the condition, do not impair the functional abilities necessary for driving • where required, a functional assessment indicates that the driver is able to compensate for any loss of functional ability necessary for driving, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Only drive vehicles that have the permitted modifications and devices required to compensate for functional impairment
Reassessment	• Routine
Information from health care providers	• Whether the driver suffers from epilepsy as a result of the TBI. See the standards under Chapter 17 if epilepsy is present. • Opinion of treating physician on whether the driver has a loss of movement or strength that may affect functional ability to drive • Opinion of treating physician on whether pain or treatment may adversely affect functional ability to drive

	• Opinion of treating physician on whether the driver suffers from diplopia and/or a visual field deficit that may affect functional ability to drive. See the standards under Chapter 22: Vision impairment if the treating physician indicates that either of these conditions may be present. • Where required, the results of a functional assessment
Rationale	The potential functional impairments associated with traumatic brain injury are variable.

Chapter 21: Vestibular disorders

21.1 About vestibular disorders

The vestibular system - or balance system - is a sensory apparatus localized in the inner ears. It provides information to the nervous system about a person's movement and orientation in space. Vestibular input contributes to:

- control of balance
- gaze stabilization so that a person can see clearly while moving, and
- spatial orientation so that a person knows their position with reference to gravity.

Vestibular disorders may result in:

- vertigo
- dizziness
- disturbed vision such as involuntary eye movement, and
- illusory movement of the visual world as a result of head movement.

A hallmark of vestibular disorders is vertigo, a term that refers to the sensation of spinning or whirling resulting from a disturbance in balance (equilibrium). Most commonly an attack of vertigo generally lasts less than one minute (30 seconds is typical) but it may last up to 60 minutes. A small number of people may experience vertigo lasting as long as 24 hours and an even smaller number may experience vertigo lasting up to, or beyond, 30 days.

Disorders of the vestibular system are classified as either peripheral or central.

Peripheral vestibular disorders

Peripheral disorders are characterized by episodic fluctuating symptoms; the dominant symptom is 'true spinning vertigo', that is the sensation of motion when no motion is occurring relative to earth's gravity. Peripheral vestibular disorders typically occur as a single acute episode or as recurrent acute episodes. However, complete bilateral hypofunction may result in severe and constant disequilibrium and motion sensitivity. The most common peripheral vestibular disorders and the typical duration of an episodic event are shown in the following table.

Disorder	Duration
benign paroxysmal positioning vertigo (BPPV)	20-30 seconds
vestibular neuronitis (labyrinthitis)	Tends to be single attack lasting days to weeks
Meniere's Disease	20 minutes – 24 hours

Less common peripheral vestibular disorders are described in the following table.

Disorder	Description
Drop Attacks (Tumarkin's Otolithic Crisis)	Sudden, spontaneous fall to the ground without prior warning
Complete bilateral vestibular hypofunction (absence of function)	May result in severe and constant disequilibrium and motion sensitivity

Central vestibular disorders

Central vestibular disorders generally arise from underlying persistent medical conditions. Because of this, they are more likely to produce prolonged continuous non-specific dizziness. They are characterized by difficulty in interpretation of vestibular, visual and proprioceptive (the unconscious perception of movement and spatial orientation arising from stimuli within the body itself) inputs. Gaze stabilization and posture during locomotion may also be affected.

Common persistent medical conditions that can cause persistent central vestibular dysfunction are:

- cerebrovascular disease
- cervical vertigo
- epilepsy
- multiple sclerosis
- normal pressure hydrocephalus
- paraneoplastic syndromes (a response to the effects of a tumour in the body), and
- traumatic brain injury.

Common episodic medical conditions that are not related to structural brain disease but that may cause central vestibular disorders, and typical episode duration, are shown in the following table.

Disorder	Duration
migraines	a few seconds to hours
psychogenic vertigo/anxiety (hyperventilation syndrome)	a few seconds to hours

21.2 Prevalence

Peripheral vestibular disorders are more common than central vestibular disorders. Age-related decrements in vestibular function are well documented and are likely due to degeneration at both the central and peripheral level. BPPV is reported as a common underlying cause of impairments in balance with aging.

A 2005 study on the frequency of moderate or severe vertigo and dizziness reported that 36.2% of females and 22.4% of males had experienced vertigo or dizziness at some point in their life. More recent data supports this, indicating that lifetime prevalence of Canadians 40 years and older is up to 35% overall.

One study identified that 32.5% of people with Meniere's disease developed drop attacks (Tumarkin's otolithic crisis), which typically occur in a flurry during a period of 1 year or less. No patient in the study required treatment for the drop attacks. Most people with this have a spontaneous remission of the drop attacks.

The consequences of vertigo and dizziness can be disabling, with 25% of patients reporting anxiety disorders, 41% reporting disruption of daily activities, and 6-21% quitting a job due to their symptoms.

21.3 Vestibular disorders and adverse driving outcomes

There is little empirical research on the effects of vestibular disorders on crash risk. Nonetheless driving ability is dependent on the normal functioning of the vestibular mechanism to sense movement and position.

21.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Vestibular disorders resulting in episodic impairment, including: - migraines - psychogenic vertigo/anxiety (hyperventilation syndrome) - benign paroxysmal positioning vertigo (BPPV) - Meniere's Disease - vestibular neuronitis (labyrinthitis) - drop attacks (Tumarkin's Otolithic Crisis)	Episodic impairment: Medical assessment – likelihood of impairment	Sensorimotor	Medical assessments
	Persistent impairment: Functional assessment	Cognitive	Medical assessments Functional assessment
Vestibular disorders resulting in persistent impairment, including: - complete bilateral vestibular hypofunction (absence of function), or - vestibular disorder resulting from an underlying persistent medical condition.	Persistent impairment: Functional assessment	Sensorimotor Cognitive	Medical assessments Functional assessment

The functional effects associated with vestibular disorders can occur suddenly and with sufficient severity to make safe driving of any type of vehicle impossible.

People with vestibular disorders become disoriented more easily by extraneous visual stimuli or visual noise. This means that drivers are more likely to have difficulty driving in reduced visual conditions such as driving at night or in the rain.

Rapid head movements are also likely to elicit vertigo in people with vestibular disorders. This means that tasks such as parking a car, manoeuvring in a parking space, lane maintenance and lane changes, and entering traffic may be risk factors for the onset of vertigo.

Research also indicates that damage to the vestibular system results in cognitive deficits in people with both peripheral and central vestibular disorders. People with vestibular disorders exhibit a range of cognitive deficits including those that are spatial and non-spatial. The cognitive deficits do not appear to be related to any particular episode of vertigo or dizziness and the deficits may occur even in those people who have no symptoms of dizziness or postural deficits.

Central vestibular disorders

The majority of central vestibular disorders have a persistent impact on driving because they arise from underlying persistent medical conditions. However, two common causes of central vestibular disorders - migraines and hyperventilation syndrome - are episodic in nature with short disease duration.

Peripheral vestibular disorders

Peripheral vestibular disorders are generally more episodic with, in general, shorter disease duration. However, drivers with complete bilateral vestibular hypofunction (absence of function) may have severe and constant disequilibrium and motion sensitivity forever. These drivers may have more difficulty driving, particularly during evening hours or on bumpy roads, and may not be safe to drive.

21.5 Compensation

Drivers with vestibular disorders are not able to compensate for their functional impairment.

21.6 Guideline for assessment

21.6.1 Recurrent episodes of vertigo that occur with warning symptoms – All drivers

This may include drivers with:

- benign paroxysmal positioning vertigo (BPPV)
- Meniere's disease
- vestibular neuronitis (labyrinthitis)
- migraines, or
- psychogenic vertigo/anxiety (hyperventilation syndrome).

STANDARD	Eligible for all classes of licence if: • warning symptoms do not themselves impair ability to drive • warning symptoms are of a sufficient duration to allow a driver to safely pull off the road, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Stop driving whenever experiencing warning symptoms and do not resume driving until all symptoms associated with the episode have subsided
Reassessment	• Routine
Information from health care providers	• Description of warning symptoms and effect on functional ability • Whether the driver has insight into the impact their vestibular dysfunction may have on driving • History of compliance with prescribed treatment regime • If known, whether the driver is compliant with any current conditions of licence related to their vestibular dysfunction
Rationale	The risk from an episodic vestibular dysfunction can be mitigated where the episode is consistently preceded by warning symptoms that are not incapacitating and which last long enough for a driver to safely stop their driving until the episode is over.

21.6.2 Recurrent episodes of vestibular dysfunction that occur without warning symptoms – All drivers

This may include drivers with:

- benign paroxysmal positioning vertigo (BPPV)
- Meniere’s disease
- vestibular neuronitis (labyrinthitis)
- migraines, or
- psychogenic vertigo/anxiety (hyperventilation syndrome).

STANDARD	Eligible for all classes of licence if: • it has been at least 6 months since an episode of vestibular dysfunction • the treating physician or specialist indicates that their symptoms have been controlled or have abated, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Immediately stop driving and report to the licencing authority and treating physician if experiencing an episode of vestibular dysfunction
Reassessment	• Routine
Information from health care providers	• Date of last episode of vestibular dysfunction • Treating physician’s opinion as to whether the symptoms have been controlled or have abated • Treating physician’s opinion as to whether the driver has insight into the impact their vestibular dysfunction may have on driving • History of compliance with prescribed treatment regime • If known or applicable, whether the driver is compliant with any current conditions of licence related to their vestibular dysfunction
Rationale	Where episodes of vestibular dysfunction are not preceded by warning symptoms or the warning symptoms are not sufficient to allow the driver to safely stop driving, evidence that further episodes are unlikely to occur is required to mitigate the risk. Consensus medical opinion suggests that this evidence should include a minimum period of 6 months without an episode and opinion of the treating physician that this episode-free period reflects effective treatment or abatement of the episodes.

21.6.3 Drop attacks (Tumarkin's otolithic crisis) – All drivers

STANDARD	Eligible for all classes of licence if: • it has been at least 6 months since experiencing a drop attack, or • the treating physician indicates that the attacks have been successfully treated, and • conditions for maintaining a licence are met
Conditions for maintaining licence	• Immediately stop driving and report to the licencing authority and treating physician if experiencing a drop attack
Reassessment	• If attack has occurred in past 12 months, reassess in one year • If no new attacks after initial reassessment, then routine reassessment for commercial drivers and reassess after 5 years for non-commercial drivers • If no new attacks upon subsequent reassessment, then routine
Information from health care providers.	• Date of last drop attack <u>or</u> opinion of treating physician as to success of treatment • Treating physician's opinion as to whether the driver has insight into the impact their condition may have on driving • History of compliance with prescribed treatment regime • If known or applicable, whether the driver is compliant with any current conditions of licence related to their vestibular disorder
Rationale	For drop attacks, which occur without warning, evidence that further attacks are unlikely to occur is required to mitigate the risk. Consensus medical opinion suggests that this evidence should be an opinion from the treating physician that the driver has been successfully treated or that 6 months has passed without an attack.

21.6.4 Single episode of vestibular dysfunction – transient impairment – All drivers

STANDARD	Eligible for all classes of licence
Conditions for maintaining licence	None
Reassessment	• Routine
Information from health care providers.	None
Rationale	A single episode of vestibular dysfunction is a transient impairment.

21.6.5 Vestibular disorder resulting in a persistent impairment – All drivers

STANDARD	Eligible for all classes of licence if: • functional assessments indicate ability required for driving safely
Conditions for maintaining licence	None
Reassessment	• To be determined on an individual basis
Information from health care providers.	• Results of functional assessment • Treating physician's opinion as to whether the driver has insight into the impact their vestibular disorder may have on driving • History of compliance with prescribed treatment regime • If known or applicable, whether the driver is compliant with any current conditions of licence related to their vestibular dysfunction
Rationale	Persistent vestibular dysfunction may cause significant impairment of the functions needed for driving. Decisions about driver fitness should be based on an individual functional assessment.

Chapter 22: Vision impairment

22.1 About vision impairment

Vision impairment is defined as a functional limitation of the visual system and can be manifested as:

- reduced visual acuity
- reduced contrast sensitivity
- visual field loss
- loss of depth perception
- diplopia (double-vision)
- visual perceptual difficulties, or
- any combination of the above.

This chapter focuses on common vision impairments and medical conditions and treatments that can cause vision impairments.

Common vision impairments

Impaired visual acuity

Visual acuity is the ability of the eye to perceive details. It can be described as either static or dynamic. Static visual acuity, the common measure of visual acuity, is defined as the smallest detail that can be distinguished in a stationary, high contrast target (e.g., an eye chart with black letters on a white background). When tested, it is reported as the ratio between the test subject's visual acuity and standard "normal" visual acuity. Normal visual acuity is described as 20/20 or 6/6 in metric. A person with 20/40 vision (6/12 metric) needs to be 20 feet (6 metres) away to distinguish detail that a person with normal vision can distinguish at 40 feet (12 metres). The standard Snellen chart for measuring visual acuity and a table of standard ratings is included in 22.7.1

Dynamic visual acuity is the ability to distinguish detail when there is relative motion between the object and the observer. Given the nature of driving, dynamic visual acuity would seem to be more relevant to licensing decisions than static visual acuity. However, barriers to the use of dynamic visual acuity for decision-making include:

- the absence of a practicable method of testing dynamic visual acuity
- limited research on its relevancy for driving, and
- the lack of established levels of dynamic visual acuity required for driving safely.

Myopia, hyperopia, presbyopia and astigmatism (refractive errors)

Myopia, hyperopia, presbyopia and astigmatism are conditions associated with reduced visual acuity. They are known as refractive errors and are the result of errors in the focusing of light by the eye.

Myopia (nearsightedness) is a condition in which near objects are seen clearly but distant objects do not come into proper focus. Individuals with normal daytime vision may experience “night myopia.” Night myopia is believed to be caused by pupils dilating to let more light in, which adds aberrations that result in nearsightedness. It is more common in younger individuals and people who are myopic.

Hyperopia (farsightedness) is a condition in which distant objects are seen clearly but close objects do not come into focus. Age-related farsightedness is called presbyopia. It is not a disease, but occurs as a natural part of the aging process of the eye and usually becomes noticeable as an individual enters their early to mid -40s.

Astigmatism is a visual condition that results in blurred vision. It commonly occurs with other conditions such as myopia and hyperopia.

Visual field loss

The visual field is the extent of the area that a person can see with their eyes held in a fixed position, usually measured in degrees. The normal binocular (using both eyes) visual field is 135 degrees vertically and 180 degrees horizontally.

The visual field can be divided into central and peripheral portions. Central vision refers to vision within 30 degrees of the point of fixation or gaze. The macula, a small area in the centre of the retina, is responsible for fine, sharp, straight-ahead central vision.

Peripheral vision allows for the detection of objects and movement outside the scope of central vision.

Visual field impairment refers to a loss of part of the normal visual field. The table and diagram on the following two pages provide further information on various types of visual field defects. The term “scotoma” refers to any area where the area of lost visual field is surrounded by normal vision.

Hemianopia, vision loss in one half of the visual field, or quadrantanopia, vision loss in one quarter of the visual field, can occur as a result of a stroke, trauma or tumour. They are not usually caused by a problem with the eye itself.

An important consideration related to hemianopia is the potential for anosognosia. Anosognosia is a condition in which a person with an impairment caused by a brain injury is unaware of the impairment. Research indicates that hemianopic anosognosia is relatively frequent, occurring in approximately two-thirds of those with hemianopia.

Unawareness of visual field deficits has an obvious negative impact on safe driving performance.

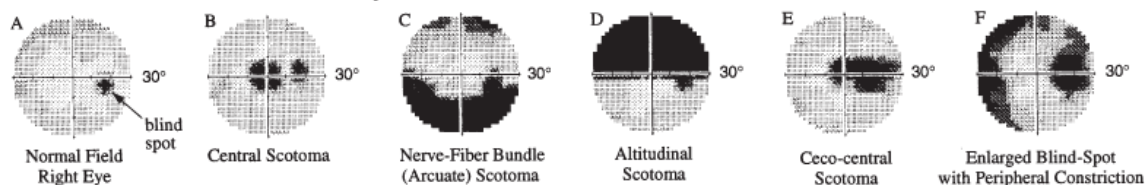
Types of visual field defects ⁸		
Type	Description	Causes
Altitudinal field defect	Loss of all or part of the superior or inferior half of the visual field, but in no case does the defect cross the horizontal median	More common: Ischemic optic neuropathy, hemibranh retinal artery occlusion, retinal detachment Less common: Glaucoma, optic nerve or chiasmal lesion, optic nerve coloboma
Arcuate scotoma	A small, arcuate-shaped field loss due to damage to the ganglion cells that feed into a particular part of the optic nerve head, which follows the arcuate shape of the nerve fibre pattern; the defect does not cross the horizontal median	More common: Glaucoma Less common: Ischemic optic neuropathy (especially nonarteritic), optic disk drusen, high myopia
Binasal field defect (uncommon)	Loss of all or part of the medial half of both visual fields; the defect does not cross the vertical median	More common: Glaucoma, bitemporal retinal disease (e.g., retinitis pigmentosa) Rare: Bilateral occipital disease, tumour or aneurysm compressing both optic nerves
Bitemporal hemianopia	Loss of all or part of the lateral half of both visual fields; the defect does not cross the vertical median	More common: Chiasmal lesion (e.g., pituitary adenoma, meningioma, craniopharyngioma, aneurysm, glioma) Less common: Tilted optic disks Rare: Nasal retinitis pigmentosa
Blind-spot enlargement	Enlargement of the normal blind spot at the optic nerve head	Papilledema, optic nerve drusen, optic nerve coloboma, myelinated nerve fibres at the optic disk, drugs, myopic disk with a crescent
Central scotoma	A loss of visual function in the middle of the visual field, typically affecting the fovea centralis	Macular disease, optic neuropathy (e.g., ischemic, Leber's hereditary, optic neuritis), optic atrophy (e.g., from tumour compressing the nerve, toxic/metabolic disease) Rare: Occipital cortex lesion
Homonymous hemianopia	Loss of part or all of the left half or right half of both visual fields; the defect does not cross the vertical median	Optic tract or lateral geniculate body lesion; temporal, parietal, or occipital lobe lesion of the brain (stroke and tumour more common; aneurysm and trauma less common). Migraine may cause a transient homonymous hemianopia
Constriction of the peripheral fields leaving only a small residual central field	Loss of the outer part of the entire visual field in one or both eyes	Glaucoma, retinitis pigmentosa or some other peripheral retinal disorder, chronic papilledema after panretinal photocoagulation, central retinal artery occlusion with cilioretinal artery sparing, bilateral occipital lobe infarction with macular sparing, nonphysiologic vision loss, carcinoma-associated retinopathy

⁸ From <http://www.merck.com/mmpe/sec09/ch098/ch098a.html> - Adapted from *The Wills Eye Manual*, Douglas J. Rhee, M.D. and Mark F. Pyfer, M.D. © 1999 by Lippincott Williams & Wilkins.

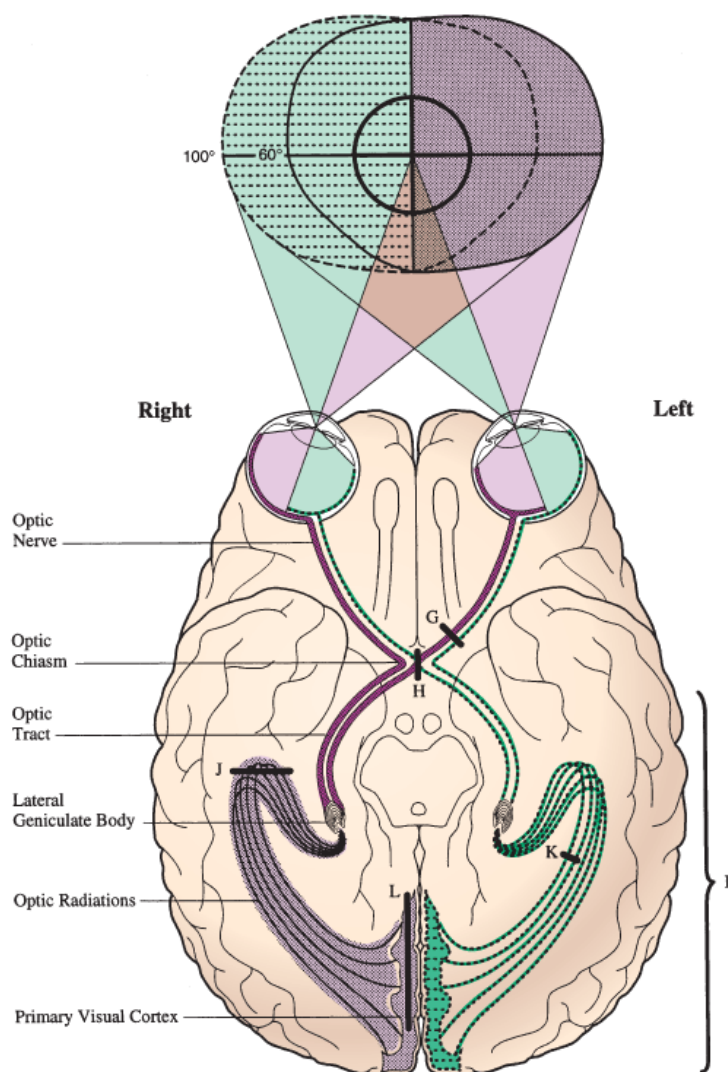
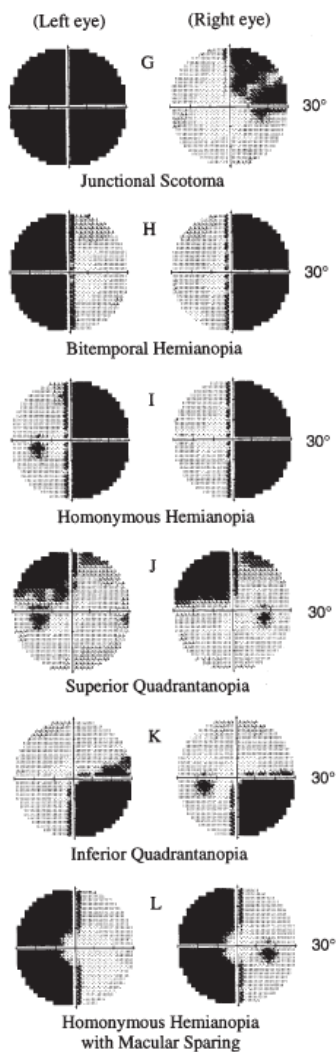
Types of visual field defects ⁸		
Type	Description	Causes
		Rare: drugs

Visual field defects diagram⁹

Monocular Prechiasmal Field Defects:



Binocular Chiasmal or Postchiasmal Field Defects:



⁹ Source National Eye Institute

Blindness/low vision

Total blindness is the complete lack of vision and is often described as no light perception. A person may be considered “blind” even though they have some vision. There is no universally accepted level of visual acuity to define blindness. In North America and most of Europe a person is considered to be legally blind if their visual acuity is 20/200 (6/60) or less in the better eye with the best correction possible, or if their visual field is less than 20 degrees in diameter. The World Health Organization (WHO) defines “low vision” as visual acuity between 20/60 (6/18) and 20/400 (6/120) or a visual field between 10 and 20 degrees in diameter. The WHO definition of “blindness” is visual acuity less than 20/400 (3/60) or a visual field less than 10 degrees.

Monocular vision/Loss of stereoscopic depth perception

Monocular vision refers to having vision in one eye only and is associated with the loss of stereoscopic vision. Stereoscopic vision, in which the brain processes information from each eye to create a single visual image, is integral to depth perception in those with binocular vision.

Impaired colour vision

Individuals with impaired colour vision (colour blindness) lack a perceptual sensitivity to some or all colours. These impairments are usually congenital and, in general, drivers learn to compensate for the inability to distinguish colours when driving.

Impaired contrast sensitivity

Visual contrast sensitivity refers to the ability to perceive differences between an object and its background. Depending on the cause, a loss of contrast sensitivity may or may not be associated with a corresponding loss of visual acuity. Declines in contrast sensitivity are associated with normal aging, and can also result from conditions such as:

- cataracts
- age-related macular degeneration
- glaucoma, and
- diabetic retinopathy.

Impaired dark adaptation and glare recovery

Dark adaptation refers to the process in which the visual system adjusts to a change from a well-lit environment to a dark environment. Glare recovery refers to the process in which the eyes recover visual sensitivity following exposure to a source of glare, such as oncoming headlights when driving at night.

Prolonged dark adaptation is associated with normal aging and results in decreased visual acuity at night. It may also be the result of a medical condition, and where severe, may be referred to as “night blindness.” Night blindness may be caused by a number of medical conditions including:

- retinitis pigmentosa
- vitamin A deficiency
- diabetes
- cataracts, or
- macular degeneration.

As with dark adaptation, individuals require a longer time to recover from glare as they age. Cataracts and corneal edema are also associated with prolonged glare recovery. Individuals may also experience prolonged glare recovery following laser assisted in situ keratomileusis (LASIK) or panretinal laser photocoagulation (PRP) surgery.

A number of illnesses can affect glare recovery time, with prolonged recovery times reported in individuals with diabetes, vascular disease and hypertension. Retinal conditions with demonstrated relationships to prolonged glare recovery include age-related maculopathy, “cured” retinal detachment and central serous retinopathy.

Diplopia

Diplopia (double vision) is the simultaneous perception of two images of a single object. These images may be displaced horizontally, vertically or diagonally in relation to each other.

Diplopia can be binocular or monocular. Binocular diplopia is present only when both eyes are open, with the double vision disappearing if either eye is closed or covered.

Monocular diplopia is also present with both eyes open, but unlike binocular diplopia, the diplopia persists when the problematic eye is open and the other eye is closed or covered.

Binocular diplopia, or true diplopia, is an inability of the visual system to properly fuse the images viewed by each eye into a single image. It may be caused by the physical misalignment of the eyes (strabismus) or diseases such as Parkinson’s disease or multiple sclerosis. Two of the most common causes of binocular diplopia in people over 50 are thyroid conditions, such as Grave’s disease, and cranial nerve damage.

Monocular diplopia is not caused by misalignment, but rather by problems in the eye itself. Astigmatism, dry eye, corneal distortion or scarring, vitreous abnormalities, cataracts and other conditions can cause monocular diplopia.

Nystagmus

Nystagmus is an involuntary, rapid, rhythmic movement of the eyeball. The movements may be horizontal, vertical, rotary or mixed. Nystagmus which occurs before 6 months of age is called congenital or early onset, whereas that occurring after 6 months is labelled acquired nystagmus. Early onset nystagmus may be inherited, or the result of eye or visual pathway defects. In many cases, the cause is unknown. Causes of acquired nystagmus are many and it may be a symptom of another condition such as stroke, multiple sclerosis, or even a blow to the head.

Many individuals with nystagmus have significant impairments in their vision, with some having low vision or legal blindness.

Medical conditions causing vision impairments

Cataracts

A cataract is an opacification or clouding of the crystalline lens of the eye, which blocks light from reaching the retina. Cataracts may be due to a variety of causes. Some are congenital, but few occur during the early years of life. The majority of cataracts are the result of the aging process. The presence of a cataract can interfere with visual functioning by decreasing acuity, contrast sensitivity and visual field.

Diabetic retinopathy

Diabetic retinopathy is the most common eye disease in those with diabetes, results in significant impairments in vision (blurred vision, vision loss) and is a leading cause of blindness in adults. It is caused by changes in the blood vessels of the retina (microvascular retinal changes) as a result of the disease.

There are two types of diabetic retinopathy: background (non-proliferative) and proliferative. Background retinopathy reflects early changes in the retina and often is asymptomatic. However, it may result in decreased visual acuity. Background diabetic retinopathy can progress into a more advanced or proliferative stage.

Proliferative retinopathy is the result of retinal hypoxia (lack of oxygen to the retina) and carries a much graver prognosis. The lack of oxygen to the retina results in a proliferation of new vessels in the retina or on the optic disc (neovascularization). Without treatment, the new vessels can leak blood into the centre of the eye, resulting in blurred vision. Fluid (exudate) also can leak into the centre of the macula (that part of the eye where sharp, straight-ahead vision occurs), a condition called macular edema. The leakage causes swelling of the macula, resulting in blurred vision. Macular edema can occur at any stage of diabetic retinopathy, but is more likely to occur as the disease progresses. Research indicates that approximately half of those with proliferative retinopathy also have macular edema.

An example of the effects of diabetic retinopathy on vision is shown below¹⁰.



Normal vision



Vision of individual with diabetic retinopathy

Glaucoma

Glaucoma is a group of diseases characterized by increased intraocular pressure. The increased pressure can lead to optic nerve damage, resulting in blindness. Types of glaucoma include adult primary, secondary, congenital and absolute glaucoma. Open angle glaucoma, a type of adult primary glaucoma, is the most common. It is often referred to as the “silent blinder” because extensive damage may occur before the patient is aware of the disease. Early diagnosis and treatment are important for the prevention of optic nerve damage and visual field loss (primarily peripheral vision) due to glaucoma.

An example of the effects of glaucoma on vision is shown below¹¹.



Normal vision



Vision of individual with
glaucoma

¹⁰ Source National Eye Institute - http://www.nei.nih.gov/resources/strategicplans/neiplan/frm_impairment.asp

¹¹ Source National Eye Institute - http://www.nei.nih.gov/resources/strategicplans/neiplan/frm_impairment.asp

Age-related macular degeneration (ARMD)

Age-related macular degeneration (ARMD) is associated with the advanced stages of age-related maculopathy, or disease of the macula. The macula is the central portion of the retina and is responsible for central vision in the eye. Most individuals with maculopathy have impairments in their central vision. Those with ARMD, however, experience a progressive destruction of the photoreceptors in the macula, resulting in profound central vision loss.

ARMD has two forms, dry and wet. The dry form is the result of atrophy to the retinal pigment, resulting in vision loss due to the loss of photoreceptors (rods and cones) in the central portion of the eye. High doses of certain vitamins and minerals have been shown to slow the progression of the disease and reduce associated vision loss.

Wet ARMD (neovascular or exudative) is due to abnormal blood vessel growth in the eye, leading to blood and protein leakage in the macula. The bleeding, leaking and scarring from these blood vessels eventually result in damage to the photoreceptors, with a rapid loss of vision if left untreated. Treatment for wet ARMD has improved. Recent pharmaceutical advancements have resulted in compounds that, when injected directly into the vitreous humor, can cause regression of the abnormal blood vessels, leading to an improvement in vision.

An example of the effects of ARMD on vision is shown below¹².



Normal vision



Vision of individual with macular degeneration

Retinitis pigmentosa

Retinitis pigmentosa is the term given to a group of hereditary retinal diseases that result in the degeneration of rod and cone photoreceptors. The diseases cause progressive visual loss, ending in blindness. Night blindness is an early symptom of retinitis pigmentosa, followed by a constriction of the peripheral visual field. Loss of central vision typically occurs late in the course of the illness.

¹² Source National Eye Institute - http://www.nei.nih.gov/resources/strategicplans/neiplan/frm_impairment.asp

Typically, symptoms are not prominent in childhood, but with progressive degeneration of the photoreceptor cells, vision is gradually lost during adolescence and adulthood.

22.2 Prevalence

Common vision impairments

Blindness/low vision

Based on WHO classifications, the prevalence of low vision and blindness in Canada is 35.6 and 3.8 per 10,000 individuals, respectively. Among individuals with some vision loss (vision worse than 20/40), cataract and visual pathway disease were the most common causes, together accounting for 40% of visual impairment. Age-related macular degeneration and other retinal diseases were the next most common causes of vision loss, with diabetic retinopathy and glaucoma less frequently encountered as causes of visual impairment.

Myopia, hyperopia, presbyopia and astigmatism (refractive errors)

The prevalence of visual conditions such as astigmatism, hyperopia, myopia and presbyopia in Canada is difficult to determine due to the absence of population based studies evaluating the ocular health of Canadians.

Night myopia is relatively common among younger individuals, with an estimated prevalence of 38% in those 16 to 25 years of age.

Monocular vision, impaired contrast sensitivity, impaired dark adaptation and glare recovery

There are no data on the prevalence of monocular vision, impaired contrast sensitivity or impaired dark adaptation and glare recovery.

Visual field loss including hemianopia

Research indicates that the prevalence of visual field loss for those age 16 to 60 years is between 3% and 3.5%, rising to 13% for those 65 and older.

Diplopia

There are no data on the prevalence of diplopia.

Nystagmus

Although the prevalence of nystagmus is not accurately known, the condition is believed to affect around 1 in 5,000 individuals.

Medical conditions causing vision impairments

Cataracts

Canadian data on the prevalence of cataracts are lacking, but statistics from the United States indicate that approximately 17% of Americans aged 40 years and older have a cataract on at least one eye. Cataracts frequently occur bilaterally (in both eyes), with the prevalence of bilateral cataracts greater among females than males. Overall prevalence of cataracts increases with age, leading to increasing prevalence in the future as the population ages. United States census estimates project that the prevalence of cataracts will increase by 50% by the year 2020.

Cataracts are more common in females and affect Caucasians somewhat more frequently than other races, particularly with advancing age. Risk factors for age-related cataracts include:

- diabetes
- prolonged exposure to sunlight
- use of tobacco, and
- use of alcohol.

Diabetic retinopathy

Individuals with both Type 1 and Type 2 diabetes are at-risk for diabetic retinopathy. Diabetic retinopathy is the most common cause of incident blindness in people of working age, with an estimated prevalence of 25% for people with diabetes in Canada as of 2022. A study from the United States indicates that, after 20 years from the onset of diabetes, over 90% of people with Type 1 diabetes and more than 60% of people with Type 2 diabetes will have diabetic retinopathy.

Glaucoma

Glaucoma prevalence in Canadians aged 40–79 varied between 0.7% and 10.3% depending on definition used. 16.3% of Canadians were labeled “glaucoma suspects.” Nearly 40% of Canadians with definite glaucoma were unaware of having glaucoma. Those at increased risk for developing glaucoma include Blacks, those over the age of 60 and individuals with a family history of glaucoma.

Glaucoma is one of the leading causes of blindness, accounting for between 9% and 12% of all cases of blindness. The rate of blindness from glaucoma is between 93 and 126 per 100,000 population 40 years or older.

Age-related macular degeneration (ARMD)

In Canada using 2010 data, more than two million people over the age of 50 have some form of ARMD, with the numbers projected to triple in the next 25 years due to the aging of the population. Dry ARMD is more common than wet ARMD, accounting for 85% of all cases of ARMD. The greatest risk factor for acquiring macular degeneration is age. Other risk factors include:

- gender (females more at risk than males)
- race (Caucasians more at risk than Blacks)
- smoking, and
- family history.

Retinitis pigmentosa

The worldwide prevalence of retinitis pigmentosa is approximately 1 in 4,000. Based on this prevalence rate, approximately 8,500 individuals in Canada currently suffer from retinitis pigmentosa.

22.3 Vision impairments and adverse driving outcomes

Common vision impairments

Impaired visual acuity

There is a considerable body of research examining the relationship between static visual acuity and driving performance. Despite the obvious importance of vision when driving, research has failed to find a strong relationship between the two. One of the primary reasons for this is methodological. Given that most jurisdictions have minimum vision requirements for licensing, individuals with significant vision impairments are not licensed and therefore not included in measures of driving performance.

Monocular vision

Research on monocular vision and driving is limited, with most studies conducted before 1980. The evidence suggests that monocular drivers have higher crash and traffic violation rates.

Impaired contrast sensitivity

In general, the available research suggests that impairments in contrast sensitivity are associated with impairments in driving performance. However, those associations are insufficient to support specific decisions regarding loss of contrast sensitivity and continued driving. More research is required to develop screening tools for contrast sensitivity that are valid and reliable in the driver fitness context.

Impaired dark adaptation and glare recovery

Despite its obvious relevance to safe driving performance, there is little in the way of research to assist the medical community or authorities in making decisions related to dark adaptation, glare recovery and driving.

Visual field loss including hemianopia

A significant body of literature now exists on the relationship between visual field loss and driving performance, as measured either by crashes, on-road performance or simulator studies. Few studies have been done on hemianopia and driving. Taken together, the results from the on-road and crash literature suggest that visual field deficits can and do compromise driving performance. However, the current body of evidence fails to inform on the extent of deficit in the visual field that must be present before driving is impaired.

Diplopia and Nystagmus

There is little or no research on diplopia or nystagmus and driving performance.

Medical conditions causing vision impairments

Cataracts

Results on the impact of cataracts on driving performance are mixed, with some studies showing increased risk of crashes, ranging from 1.3 to 2.5 times higher than those without cataracts. However, other studies have failed to find an association between cataracts and crash rates. Results from studies that have examined self-reported difficulties in driving performance are more uniform, with the majority of participants reporting difficulties in many aspects of driving.

Notably, cataract surgery results in an improvement in visual functioning. However, a significant percentage of drivers continue to report difficulties in driving, particularly at night. An important consideration is when driving can safely resume following cataract surgery. Unfortunately, there is a paucity of data to inform on this issue. Of equal importance are the effects of wait times for cataract surgery on visual functions related to driving. Current literature indicates wait times of 6 months or longer result in decrements in vision that may have an impact on safe driving performance.

Diabetic retinopathy

The majority of research on diabetic retinopathy and driving is concerned with the effects of laser surgery (PRP) for proliferative diabetic retinopathy on visual fields. PRP reduces the risk of severe visual loss in proliferative diabetic retinopathy but also is associated with visual field loss and reductions in peripheral vision.

Glaucoma

There is evidence that drivers with glaucoma are at a significantly greater risk for impaired driving performance than those without the disease, likely due to loss of visual field.

Age-related macular degeneration (ARMD) and retinitis pigmentosa

There is little research on the relationship between ARMD or retinitis pigmentosa and driving performance.

22.4 Effect on functional ability to drive

Condition	Type of driving impairment and assessment approach	Primary functional ability affected	Assessment tools
Vision impairment	Persistent impairment: Functional assessment	Sensory - Vision	Medical assessments Visual assessment field test Functional assessment

Drivers with impaired visual acuity may lack the ability to perceive necessary details while driving. Visual field impairments may interfere with driving by limiting the area that a driver can see.

Drivers with reduced contrast sensitivity may have difficulty seeing traffic lights or cars at night. Limitations in research and testing preclude standards for impairments in contrast sensitivity, dark adaptation or glare recovery, although some individuals with these impairments may not be able to drive safely.

22.5 Compensation

The loss of certain visual functions can be compensated for adequately, particularly in the case of long-standing or congenital impairments. When a person becomes visually impaired, the capacity to drive safely varies with the ability to compensate. As a result, there are people with visual deficits who do not meet the vision standards for driving but who are able to drive safely.

Corrective lenses

Most drivers can compensate for a typical loss of visual acuity from myopia, hyperopia, astigmatism or presbyopia by wearing eyeglasses or contact lenses.

Telescopic lenses/other low vision aids

Telescopic (bioptic) lenses are sometimes used to assist drivers with low vision. A telescopic lens typically is mounted at the top half of a regular spectacle lens, and provides the driver with a magnified view of objects (e.g., text or detail of traffic signs that otherwise could be seen only at distances too short for a safe or timely stop). For the most part, the driver views the road

through the spectacle lens, looking intermittently through the telescopic lens to read road signs, determine the status of traffic lights or scan ahead for road hazards.

Although telescopic spectacles, hemianopia aids and other low vision aids may enhance visual function, there are significant limitations associated with their use in driving a motor vehicle. These include the loss of visual field, magnification causing apparent motion and the illusion of nearness. There has been little research to evaluate the use of telescopic lenses for driving by drivers with low vision. Although limited, studies indicate that drivers with low vision who drive with telescopic lenses have higher crash rates.

Individualized Assessment

The loss of some visual functions can be compensated for adequately, particularly in the case of long-standing or congenital impairments. When an individual becomes visually impaired, the capacity to drive safely varies with their compensatory abilities. As a result, there may be individuals with visual deficits who do not meet the vision standards for driving but who are able to drive safely. On the other hand, there may be individuals with milder deficits who do meet the vision standards but who cannot drive safely.

In these situations, it is recommended that the individual undergo a special assessment for the fitness to drive. The decision on fitness to drive can only be made by the appropriate licensing authorities.

When an individual special assessment is indicated, the licensing authority may take into consideration the following factors:

1. Favourable reports from the ophthalmologist or optometrist and evidence of stable visual condition; the presence of other visual limitations due to existing eye conditions, such as contrast sensitivity, may be taken into account.
2. The driving record/history.
3. Absence of other significant medical contraindications.
4. Relevant professional references.
5. Results of a standardized functional driving assessment.
6. Where appropriate, the issuance of a restricted or conditional licence, including permits exclusive to a single class of vehicles to ensure road safety.

Functional assessments are particularly useful for individuals with brain injury or other complex conditions affecting visual performance, where compensatory abilities may vary.

22.6 Guidelines for assessment

22.6.1 Impaired visual acuity – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • visual acuity is not less than 20/50 (6/15) with both eyes open and examined together, and • the conditions for maintaining a licence are met
Conditions for maintaining licence	• Wear corrective lenses while driving, if a driver requires corrective lenses in order to meet the standard above
Reassessment	• Routine if the condition causing the visual acuity loss is not progressive • To be determined on an individual basis for drivers with impaired visual acuity that is progressive such as cataracts, macular degeneration, glaucoma and diabetic retinopathy
Information from health care providers	• Uncorrected and corrected standard rating of visual acuity for both eyes open and examined together. Standards for testing visual acuity are outlined in 22.7.1
Rationale	There is little research evidence regarding the level of visual acuity required for driving fitness. The minimum acuity requirement in the standard is based on consensus medical opinion in Canada.

22.6.2 Impaired visual acuity – Commercial drivers

STANDARD	Eligible for a commercial licence if: Class 4 (Taxi) and 5 (commercial) - visual acuity is not less than 20/40 (6/12) with both eyes open and examined together. Worse eye not less than 20/200 (6/60). Class 1-4 (Emergency) - visual acuity is not less than 20/30 (6/9) with both eyes open and examined together. Worse eye not less than 20/100 (6/30).
Conditions for maintaining licence	Wear corrective lenses while driving, if a driver requires corrective lenses in order to meet the standard above
Reassessment	- Routine if the condition causing the visual acuity loss is not progressive - To be determined on an individual basis for drivers with impaired visual acuity that is progressive such as cataracts, macular degeneration, glaucoma and diabetic retinopathy
Information from health care providers	Uncorrected and corrected standard rating of visual acuity for both eyes open and examined together. Standards for testing visual acuity are outlined in 22.7.1
Rationale	There is little research evidence regarding the level of visual acuity required for driving fitness. The minimum acuity requirement in the standard is based on consensus medical opinion in Canada.

22.6.3 Visual field loss – Non-commercial drivers

STANDARD	Eligible for a non-commercial licence if: • visual field is at least 120 continuous degrees along the horizontal meridian and 15 continuous degrees above and below fixation with both eyes open and examined together
Conditions for maintaining licence	None
Reassessment	• Routine if the condition causing the visual field loss is not progressive (e.g., eye trauma, stroke, head injury) • To be determined on an individual basis for drivers with medical conditions that cause progressive visual field loss, such as: ○ retinitis pigmentosa ○ diabetic retinopathy ○ vascular retinopathy ○ glaucoma, or ○ brain tumour
Information from health care providers	• Binocular field print using an approved visual field testing technique. Standards for testing visual field loss are outlined in 22.7.2
Rationale	There is little research evidence regarding the level of visual field required for driving fitness. The minimum visual field requirement in the standard is based on consensus medical opinion in Canada.

22.6.4 Visual field loss – Commercial drivers

STANDARD	Eligible for a commercial licence if: Class 4 (Taxi) and 5 (commercial) • visual field is at least 120 continuous degrees along the horizontal meridian and 15 continuous degrees above and below fixation with both eyes open and examined together Class 1-4 (Emergency) • visual field is at least 150 continuous degrees along the horizontal meridian and 20 continuous degrees above and below fixation with both eyes open and examined together
Conditions for maintaining licence	None
Reassessment	• Routine if the condition causing the visual field loss is not progressive (e.g., eye trauma, stroke, head injury) • Reassess drivers with diabetic retinopathy annually • To be determined on an individual basis for drivers with other medical conditions that cause progressive visual field loss, such as: ○ retinitis pigmentosa ○ vascular retinopathy ○ glaucoma, or ○ brain tumour
Information from health care providers	• Binocular field print using an approved visual field testing technique. Standards for testing visual field loss are outlined in 22.7.2
Rationale	There is little research evidence regarding the level of visual field required for driving fitness. The minimum visual field requirement in the standard is based on consensus medical opinion in Canada.

22.6.5 Loss of stereoscopic depth perception or monocular vision – All drivers

STANDARD	Eligible for all classes of licence if: - standards for visual acuity and visual fields are met - the treating ophthalmologist or optometrist indicates sufficient time has elapsed since loss of stereoscopic depth perception to allow the driver to adjust and compensate for the change in vision. - Where required, a road test or other functional assessment indicates the driver is able to compensate for any loss of functional ability necessary for driving, and - the conditions for maintaining a license are met
Conditions for maintaining licence	None
Reassessment	Routine
Information from health care providers	- Date of loss of stereoscopic depth perception - Opinion of a vision specialist whether the driver has adjusted and compensated for the change in vision
Rationale	Drivers with monocular vision can compensate for the loss of stereoscopic depth perception by using visual cues, such as the relative size of objects, and generally have adequate depth perception for everyday activities such as driving. The Canadian Ophthalmological Society notes that a driver who has recently lost the sight of an eye or stereoscopic vision may require a few months to recover the ability to judge distance accurately.

22.6.6 Diplopia – All drivers

This guideline applies to drivers with diplopia within the central 40 degrees of primary gaze (i.e., 20 degrees to the left, right, above, and below fixation).

STANDARD	Eligible for all classes of licence if: • the diplopia can be corrected using prism lenses so that they no longer have diplopia within the central 40 degrees of primary gaze • visual acuity and visual fields are met with prisms • the treating ophthalmologist or optometrist indicates that adequate adjustment has occurred, and • when required a functional assessment indicates the driver is able to compensate for any loss of functional ability necessary for driving
Conditions for maintaining licence	• Wear corrective lenses while driving (if a driver requires prism lenses)
Reassessment	• Determined on an individual basis if the diplopia is the result of a progressive condition; as recommended by the treating physician or in accordance with the reassessment standard for that medical condition. • Otherwise, routine
Information from health care providers	• Description of corrective mechanism • Opinion of vision specialist whether adequate adjustment has occurred
Rationale	Consensus medical opinion in Canada indicates that an individual who has diplopia within the central 40 degrees of primary gaze is not eligible for a licence unless they can compensate for this impairment by wearing an eye patch or prism lenses while driving.

22.6.7 Impaired colour vision

STANDARD	Eligible for all classes of licence if: • Drivers can discriminate between different traffic lights
Conditions for maintaining licence	None
Reassessment	• Routine
Information from health care providers	• Opinion of treating physician whether a lack of insight or cognitive impairment impairs the ability to compensate
Rationale	Impaired colour vision is usually congenital and in general, drivers learn to compensate for the inability to distinguish colours when driving.

22.7 Standards for testing visual functions

22.7.1 Visual acuity

The distance visual acuity of drivers should be tested using the refractive correction (spectacles or contact lenses) that they will use for driving. The examiner should assess visual acuity under binocular (both eyes open) conditions. It is recommended that visual acuity be assessed using a Snellen chart (see below) or equivalent at the distance appropriate for the chart under bright photopic lighting conditions of 275 to 375 lux (or greater than 80 candelas/m²). Charts that are designed to be used at 3 meters or greater are recommended.

Snellen chart and standard ratings of visual acuity



Standard ratings in feet and metres	
Feet	Metres
20/200	6/60
20/100	6/30
20/70	6/21
20/50	6/15
20/40	6/12
20/30	6/9
20/25	6/7.5
20/20	6/6
20/15	6/4.5
20/10	6/3

22.7.2 Visual field

When a confrontational field assessment is carried out to screen for visual field defects the following procedure should be used at a minimum:

1. The examiner is standing or seated approximately 0.6 m (2 feet) in front of the examinee with eyes at about the same level.
2. The examiner asks the examinee to fixate on the nose of the examiner with both eyes open.
3. The examiner extends his or her arms forward, positioning the hands halfway between the examinee and the examiner. With arms fully extended, the examiner asks the examinee to confirm when a moving finger is detected.
4. The examiner should confirm that the ability to detect the moving finger is continuously present throughout the area specified in the applicable visual field standard. Testing is recommended in an area of at least 180° horizontal and 40° vertical, centred around fixation.

If a defect is detected, the driver should be referred to an ophthalmologist or optometrist for a full assessment. During a full assessment, binocular testing is required and the following techniques are acceptable:

1. Goldmann III/4e and V4e isopters
2. Humphrey Esterman test
3. Humphrey 81, 120, 135, or 246 point screener. Set test strategy to single intensity or 3 zone and all other parameters to standard. Two zone Humphrey testing is inadequate.
4. Medmont 700 Driving Field
5. Other visual field techniques will be accepted if appropriate.

Please note:

Goldman, Esterman and Humphrey 135 are the only tests that will test 150 degrees of horizontal vision as required for professional (class 1 to 4) drivers.

22.7.3 Contrast sensitivity

Assessment of contrast sensitivity is recommended for applicants referred to an ophthalmologist or optometrist for vision problems related to driving. Contrast sensitivity may be a more valuable indicator of visual performance in driving than Snellen acuity. The Canadian Ophthalmological Society therefore encourages increased use of this test as a supplement to visual acuity assessment.

Contrast sensitivity can be measured by means of several commercially available instruments:

- the Pelli-Robson letter contrast sensitivity chart
- either the 25% or the 11% Regan low-contrast acuity chart
- the Bailey-Lovie low-contrast acuity chart, or
- the VisTech contrast sensitivity test.

The testing procedures and conditions recommended for the specific test used should be followed.

Chapter 23: Medical Review for Drivers

The functional declines associated with aging are well documented. These functional declines in healthy aging drivers are unlikely to lead to unsafe declines in driving performance, except in the case of extreme old age. However, aging is also associated with increased risk for a broad range of medical conditions, such as visual impairments, musculoskeletal disorders, cardiovascular disease, diabetes, and cognitive impairment and dementia. These medical conditions and medications used to treat them may affect fitness to drive.

Because of the association between age and many chronic medical conditions, aging drivers are more likely to have one or more of these conditions. A 2003 survey found that 33% of Canadians age 65 and older had 3 or more chronic medical conditions. The survey also found that the average number of chronic conditions increases with age.

All Canadian jurisdictions have the legal authority to examine a driver's fitness and ability to drive. Authorities are specifically concerned with individuals whose fitness and ability to drive may be impaired by medical conditions. This includes individuals who may be impaired by medications or treatment regimes prescribed as treatment for a medical condition, general debility or a lack of stamina.

As a result, Canadian jurisdictions have developed a medical review for drivers as noted below:

STANDARD	Recommended Frequency of Medical Review
	Class 1, 2, 3, 4 • On application • At least every 5 years to age 45, and • thereafter every 3 years to age 65 • annually at 65 and over Class 5 and 6 and 7 • at age 75 and 80 • every 2 years over age 80

PART 3:

APPENDICES

Appendix 1: Canadian Driver Licence Classes

The National Safety Code (NSC) in Canada is a set of 16 standards developed by the member jurisdictions of CCMTA in consultation with the motor carrier industry to ensure road safety and facilitate the safe and efficient movement of people and goods across Canada.

The NSC is designed to create a comprehensive code of minimum performance standards for the safe operation of passenger and commercial vehicles. It has a specific focus on those responsible for the operation of commercial vehicles on the road, including trucks, buses, tractors and trailers

NSC Standard 4 – The Classified Driver Licensing is comprised of seven distinct licence classes, each designating a certain type of vehicle in accordance with the degree of capability necessary for its operation. In summary:

- Classes 1 to 4 are generally described as commercial classes of driver licence.
- Class 5 is required to drive a passenger vehicle
- Class 6 is required for driving a motorcycle
- Class 7 is a learner/instructional driver licence

Please see NSC Standard 4 (Classified Driver Licensing System) for additional details on the standard.

Appendix 2: Reciprocity Agreement Between Canada and the United States

Effective April 1, 1992, the US Department of Transport required all American commercial drivers to hold an American Commercial Drivers Licence (CDL).

In preparation for this requirement, a reciprocity agreement between Canada and the US was completed in 1989. This ensured that commercial driver's licences issued by Canadian provinces and territories under the National Safety Code Standards are recognised in the US. In fact, to ensure the one driver, one licence concept, the holder of a provincial or territorial commercial driver licence is prohibited from obtaining a CDL. The US Federal Register of Tuesday, May 23, 1989 proclaimed the Reciprocity Agreement.

Subsequently on December 30, 1998, Canada and the US signed reciprocity letters on medical fitness requirements for operators of commercial motor vehicles. The elements prescribed in the reciprocity agreement related to Canadian provinces and territories adhering to the National Safety Code (NSC) and that the licensing and testing standards were deemed equivalent to US standards. A similar evaluation by jurisdictions deemed the US CDL to be equivalent to the NSC.

Letters between the US and Canadian federal governments were used as the agreement, and when taken together constituted the understanding between Canada and the US respecting reciprocity of commercial driver licences.

By virtue of the agreement, the two countries medical standards were deemed equivalent with the exception of the requirements regarding (Cdn) (i) insulin-dependent diabetic drivers, (ii) hearing impaired drivers, (iii) drivers with epilepsy and (iv) drivers operating under a medical waiver or who are operating under medical *grandfather rights* who are prohibited from operating in international commerce.

Both countries agreed to adopt a unique identifier code to be displayed on the licence and the driving record to identify a commercial driver who is not qualified or disqualified from operating a commercial vehicle in the other country.

In December 2001, CCMTA agreed the Canadian identifier would be "W", and defined as: "restricted commercial class - Canada only". In December 2008, FMCSA announced it will implement the identifier "V" which will indicate the US driver is only allowed to drive in the US and is not medically qualified to drive in Canada. The identifier "V" was implemented on January 2014.

As part of the Canada – US agreement commercial drivers (Class 1, 2, 3 and 4 licence holders) are required to file a satisfactory medical report on application, every 5 years to age 45, at least every 3 years from age 46 to 65 and annually thereafter.

On September 24, 2019, both Canada and the United States agreed to remove the Code W identifier for Canadian drivers with insulin-dependent diabetes who are well controlled. These commercial motor vehicle drivers can now drive in Canada and the United States.

Appendix 3: Provincial/Territorial Contact Information

Provincial/Territorial contact information for reporting potentially unfit drivers*

Driver assessment centres and rehabilitation resources can also be located in your area by contacting these offices.

ALBERTA

Monitoring and Compliance Branch
Alberta Transportation and Economic Corridors
Government of Alberta
Main Floor, Twin Atria Building
4999–98 Avenue
Edmonton AB T6B 2X3
Email: driver.fitness@gov.ab.ca
<https://www.alberta.ca/driver-fitness-monitoring.aspx>

BRITISH COLUMBIA/COLOMBIE-BRITANNIQUE

RoadSafetyBC
PO Box 9254, Stn Prov Gov
Victoria BC V8W 9J2
Email: RoadSafetyBC@gov.bc.ca
Tel (250) 387-7747
Toll free (855) 387-7747
Fax (250) 952-6888
<https://www2.gov.bc.ca/gov/content/transportation/driving-and-cycling/roadsafetybc/medical-fitness/medical-prof/med-standards>

MANITOBA

Driver Fitness
Manitoba Public Insurance
Box 6300
Winnipeg MB R3C 4A4
Tel (204) 985-1900
Toll free (866) 617-6676
Fax (204) 953-4992
Email: driverfitness@mpi.mb.ca
<https://www.mpi.mb.ca/Pages/health-care-professionals.aspx>

NEW BRUNSWICK/NOUVEAU-BRUNSWICK

Registrar of Motor Vehicles
Department of Justice and Public Safety
Motor Vehicle Branch
20 McGloin Street
PO Box 6000
Fredericton NB E3B 5H1
Tel (506) 453-2410
Fax (506) 462-2130
[Driving licensing, records and permits - gnb.ca](https://www.gnb.ca)

NEWFOUNDLAND AND LABRADOR/TERRE-NEUVE-ET-LABRADOR

Medical Review Officer
Motor Registration Division
Digital Government and Service NL
149 Smallwood Drive
St. John's NL A1N 1B5
Tel (877) 636-6867
Fax (709) 729-4360
<https://www.gov.nl.ca/dgsnl/departement/drivers-contact/>

NORTHWEST TERRITORIES/TERRITOIRES DU NORD-OUEST

Compliance & Licensing
Department of Infrastructure
Government of the Northwest Territories
Box 1320
Yellowknife NT X1A 2L9
Tel (867) 767-9088
Fax (867) 873-0120
<https://www.inf.gov.nt.ca/en>

NOVA SCOTIA/NOUVELLE-ÉCOSSE

Transportation and Infrastructure Renewal
Road Safety Division
1672 Granville Street 6th floor
PO Box 1652

Halifax, NS B3J 2Z3
Tel (902) 424-5732
Fax (902) 424-0772
<https://novascotia.ca/sns/rmv/licence/medicals.asp>

NUNAVUT

Motor Vehicles Division
Department of Economic Development and Transportation
Government of Nunavut
PO Box 10
Gjoa Haven NU X0B 1J0
Tel (867) 360-4615
Fax (867) 360-4619
<https://gov.nu.ca/edt/fag/where-can-i-get-drivers-licence>

ONTARIO

Driver & Vehicle Services
Driver Medical Review Office
Ministry of Transportation
77 Wellesley Street W Box 589
Toronto ON M7A 1N3
Tel (416) 235-1773
Toll free (800) 268-1481
Fax (416) 235-3400 or (800) 304-7889
Email: drivermedicalreview@ontario.ca
<http://www.ontario.ca/driverimprovement>

PRINCE EDWARD ISLAND/ÎLE-DU-PRINCE-ÉDOUARD

Department of Transportation and Infrastructure
Driver Records Section
Highway Safety Division
Box 2000
Charlottetown PE C1A 7N8
Tel (902) 368-5210 or (902) 368-5234
Fax (902) 368-5236
Email: driverrecords@gov.pe.ca
<http://www.gov.pe.ca/forms/pdf/2682.pdf>

QUEBEC/QUÉBEC

Service de l'évaluation médicale et du suivi du comportement
Société de l'assurance automobile du Québec
333, boul. Jean-Lesage
CP 19500 succursale Terminus
Québec QC G1K 8J5
Tel (418) 643-5506; outside Quebec (800) 561-2858
Fax (418) 643-4840
www.saaq.gouv.qc.ca

SASKATCHEWAN

Saskatchewan Government Insurance
Medical Review Unit
2260–11th Avenue, 3rd floor
Regina SK S4P 2N7
Tel (306) 775-6176
Toll free (844)-855-2744 x 6176
Fax (306) 347-2577 or (866) 274-4417
Email: mruinquiries@sgi.sk.ca
www.sgi.sk.ca/individuals/medical/index.html

YUKON

Driver Sanctions Coordinator
Motor Vehicles
Highways and Public Works
Government of Yukon
Box 2703 (W-22)
Whitehorse YT Y1A 2C6
Tel (867) 667 3563
Toll free (800) 661-0408 ext. 5315
Fax (867) 393 7448
Email: motor.vehicles@gov.yk.ca