

93-11-3225
MOTC-IOT-92SAD12

我國職業駕駛執照考領及 持用有效條件之檢討



交通部運輸研究所
中華民國九十三年三月

93-11-3225
MOTC-IOT-92SAD12

我國職業駕駛執照考領及 持用有效條件之檢討

著者：林豐福、張開國、葉祖宏

交通部運輸研究所
中華民國九十三年三月

我國職業駕駛執照考領及持用有效條件之檢討

著 者：林豐福、張開國、葉祖宏

出版機關：交通部運輸研究所

地 址：台北市敦化北路 240 號

網 址：www.iot.gov.tw/chinese/lib/lib.htm

電 話：(02)23496789

出版年月：中華民國九十三年三月

印 刷 者：良機事務機器有限公司

版(刷)次冊數：初版一刷 150 冊

本書同時登載於交通部運輸研究所網站

定 價：100 元

展 售 處：

交通部運輸研究所運輸資訊組・電話：(02)23496880

三民書局重南店：台北市重慶南路一段 61 號 4 樓・電話：(02)23617511

三民書局復北店：台北市復興北路 386 號 4 樓・電話：(02)25006600

國家書坊台視總店：台北市八德路三段 10 號 B1・電話：(02)25787542

五南文化廣場：台中市中山路 6 號・電話：(04)22260330

新進圖書廣場：彰化市 中正路二段 5 號・電話：(04)7252792

青年書局：高雄市青年一路 141 號 3 樓・電話：(07)3324910

交通部運輸研究所出版品摘要表

出版品名稱：我國職業駕駛執照考領及持用有效條件之檢討			
國際標準書號 (或叢刊號)	政府出版品統一編號 1009300468	運輸研究所出版品編號 93-11-3255	計畫編號 MOTC-IOT-92SAD12
主辦單位：運輸安全組 主管：林豐福 計畫主持人：林豐福 研究人員：張開國、葉祖宏 聯絡電話：(02) 2349-6856 傳真號碼：(02) 2545-0429			研究期間 自 92 年 06 月 至 92 年 11 月
關鍵詞：職業駕駛執照、定期審驗、醫療狀況			
摘要： <p>本研究係依據交通部指示，研議職業駕駛執照之報考及使用年齡限制，是否宜由現行規定之 60 歲放寬至 65 歲。研究中針對國外制度與相關文獻蒐集，輔以國內有限文獻作為基礎，探討包括駕駛人年齡與功能狀態、駕駛人年齡與事故發生、駕駛人醫療狀況與事故發生及國外駕照管理制度等課題，據以歸納職業駕駛人駕照有效性之管制元素與管理方式，作為研擬我國職業駕照管理可行方案之參考。</p> <p>本研究考量技術困難性，建議方案區分為短期修正方案與長期推動方向。其中短期修正方案主要內容為：職業駕駛人仍維持 60 歲限齡之通則性限制，但比照小型車職業駕駛人之除外規定，有條件延長其他職業駕駛人年齡至 65 歲，延長年限部份採取每年審驗乙次，並建議採取更為嚴格的審驗機制，包括增加行為層面管制、新增與高齡者安全駕駛相關之體格檢查與體能測驗項目，以作好風險管控。並建議方案執行策略須從法令修正、醫療專業諮詢、行政流程設計與道安講習實施規劃等課題進行細部規劃。短期修正方案較現行制度並非具有絕對優勢，係考量公平性前提下之可能修正措施之一，現行制度是否必須修正屬交通部政策性決定。</p> <p>長期推動方向則建議包括逐漸納入個案審查基礎之精神、針對職業駕駛人業別或駕駛車輛特性規劃審驗標準、「生理功能」與「駕駛行為」審驗並重、監理單位成立「駕駛人醫療委員會」、建立普通駕照管理之定期審驗制度等課題。</p>			
出版日期	頁數	定價	本出版品取得方式
93 年 03 月	134	100	凡屬機密性出版品均不對外公開。普通性出版品，公營、公益機關團體及學校可函洽本所免費贈閱；私人及私營機關團體可按定價價購。
機密等級： <input type="checkbox"/> 限閱 <input type="checkbox"/> 機密 <input type="checkbox"/> 極機密 <input type="checkbox"/> 絕對機密 (解密【限】條件： <input type="checkbox"/> 年 月 日解密， <input type="checkbox"/> 公布後解密， <input type="checkbox"/> 附件抽存後解密， <input type="checkbox"/> 工作完成或會議終了時解密， <input type="checkbox"/> 另行檢討後辦理解密) <input checked="" type="checkbox"/> 普通			
備註：本研究之結論與建議不代表交通部之意見。			

**PUBLICATION ABSTRACTS OF RESEARCH PROJECTS
INSTITUTE OF TRANSPORTATION
MINISTRY OF TRANSPORTATION AND COMMUNICATIONS**

TITLE: PROPOSED REVISION OF THE TEST AND HOLDING REQUIREMENTS FOR THE OCCUPATIONAL DRIVER LICENSES			
ISBN(OR ISSN)	GOVERNMENT PUBLICATIONS NUMBER 1009300468	IOT SERIAL NUMBER 93-11-3255	PROJECT NUMBER MOTC-IOT-92SAD12
DIVISION: Safety Division DIVISION DIRECTOR: Fong-Fu Lin PRINCIPAL INVESTIGATOR: Fong-Fu Lin PROJECT STAFF: Kai-Kuo Chang, Tsu-Hurng Yeh PHONE: 886-2-23496856 FAX: 886-2-25450429			PROJECT PERIOD FROM June 2003 TO November 2003
KEY WORDS: Occupational Driver License, Regular Fitness-to-drive Checking, Medical Condition			
ABSTRACT: <p>This research was conducted under the instruction of Ministry of Transportation and Communications (MOTC) to justify whether the present regulations about age limit 60 for the occupational drivers could be extended to age 65. Based on the review of foreign systems, literatures, and limited domestic work, the associations between driver age, functional capabilities, accident involvements, and medical conditions were collected. These associations were used to summarize the essential items to check the validity of occupational driver license so that the feasible system for regulating the safety of the drivers could be generated.</p> <p>Limited by the technical difficulties of constructing the medical examination standards in a short time, this study proposed short-term measures and long-term suggestions on the revision of the present system, respectively. The short-term scheme covers the following requirements.</p> <ol style="list-style-type: none"> 1. The general rule for the age limit of occupational drivers was still suggested to be 60 years, as the status quo. 2. To follow the precedent of taxi drivers' regulation, the other kinds of occupational drivers might be extended to 65 years under stricter fitness-to-drive checking and the checking interval was set to be one year for drivers aged 60 or over. 3. The revised fitness-to-drive checking should include risky behavior checking, medical checkup, and physical examination to reduce the accident risk. <p>Four implementation strategies for the short-term scheme were proposed as well, including the amendment of related rules, the consultation of the medical professionals, the redesign of the management flow, and the planning of the safety lectures. However, the short-term measures were not superior to the present system in all aspects. Since it simply dominated the present scheme in the equity principle, whether the present system needed revision would be a policy decision of the MOTC.</p> <p>In addition, we proposed the following long-term suggestions for the improvements of occupational drivers' fitness-to-drive.</p> <ol style="list-style-type: none"> 1. To take the individual basis into the checking mechanism instead of the general age limit. 2. To set the examination standards according to drivers' occupation or vehicle classification. 3. To emphasize the functional capabilities and driving behavior under equal consideration. 4. To establish the Medical Committee under the Driver and Vehicle Licensing Agency. 5. To set up the regular checking scheme on the fitness-to-drive for the ordinary drivers. 			
DATE OF PUBLICATION March 2004	NUMBER OF PAGES 134	PRICE 100	CLASSIFICATION <input type="checkbox"/> SECRET <input type="checkbox"/> CONFIDENTIAL <input checked="" type="checkbox"/> UNCLASSIFIED
The views expressed in this publication are not necessarily those of the Ministry of Transportation and Communications.			

目錄

一、前言.....	1
二、我國駕照考審驗制度與問題分析.....	3
2.1 我國駕照考驗規定.....	3
2.2 我國駕照審驗規定.....	4
2.3 問題分析.....	5
三、職業駕駛人特性分析.....	7
3.1 營業車輛與職業駕照數基本資料.....	7
3.2 我國職業駕駛人年齡分佈.....	7
3.3 美國職業車輛駕駛人年齡分佈.....	9
四、國外制度與文獻探討.....	11
4.1 駕駛人年齡與生理功能.....	11
4.2 駕駛人年齡與事故發生.....	12
4.3 駕駛人醫療狀況與事故發生.....	16
4.4 國外駕照管理制度.....	18
五、駕照有效條件管理元素.....	24
5.1 年齡管制.....	24
5.2 醫療狀況檢查.....	24
5.3 體格與體能檢查.....	25
5.4 駕駛知識測驗.....	25
5.5 道路駕駛測驗.....	25
5.6 違規記點紀錄及道安講習運用.....	26
5.7 小結.....	26
六、我國職業駕照有效條件檢討與方案研擬.....	27
6.1 檢討課題.....	27
6.2 方案研擬與比較.....	28
七、結論與建議.....	38
7.1 結論.....	38
7.2 建議.....	41
參考文獻.....	42
附錄一 交路字第 09200060841 號函	
附錄二 美國各州駕照更新期間與條件	
附錄三 英國 “At a Glance to the Current Medical Standards of Fitness to Drive”	
附錄四 92 年 12 月 9 日召開座談會會議記錄	
附錄五 簡報資料	

圖目錄

圖 2.1 我國小型車駕照考領程序之流程圖.....	3
圖 3.1 美國商業運輸駕駛人之年齡分佈.....	10
圖 4.1 美國駕駛人年齡與事故發生率分析圖.....	14
圖 4.2 美國駕駛人年齡與事故死亡率分析圖.....	15

表目錄

表 3.1 民國 91 年底營業車輛登記數.....	7
表 3.2 民國 91 年底職業駕照登記數.....	7
表 3.3 計程車駕駛人年齡分佈百分比.....	8
表 3.4 遊覽車駕駛人年齡分佈百分比.....	9
表 4.1 老化所致車輛操作能力降低之相關生理損傷.....	12
表 4.2 民國 85/87 年自用小客車駕駛人發生交通事故機率.....	13
表 4.3 民國 89 年自用小客車駕駛人發生交通事故機率.....	13
表 4.4 民國 87/89 年機車駕駛人發生交通事故機率.....	13
表 4.5 流行病學研究駕駛人特定醫療狀況之相對事故風險.....	17
表 4.5 流行病學研究駕駛人特定醫療狀況之相對事故風險(續).....	18
表 4.6 駕駛執照更新條件之國際比較.....	19
表 4.6 駕駛執照更新條件之國際比較(續).....	20
表 6.1 職業駕照有效性之審驗條件短期修正方案.....	35
表 6.2 職業駕照有效性之審驗條件方案優劣比較分析表.....	36

我國職業駕駛執照考領及持用有效條件之檢討

一、前言

本案依據交通部中華民國 92 年 6 月 13 日交路字第 09200060841 號函略：「有關邇來迭有職業駕駛員職業工（公）會建議職業駕駛執照之報考及使用年齡限制應由現行規定之 60 歲放寬至 65 歲乙案，...。」辦理。交通部於同函說明一隨附各單位所提意見，及說明二強調各相關機關與工會團體對前述放寬年限規定之建議甚為分歧，且涉及公共運輸安全與醫療專業判斷，特指示本所納入研究，俾作為政策修訂參考（如附錄一）。

依據我國現行道路交通安全規則（以下簡稱道安規則）第 54 條規定，職業駕駛執照每三年審驗乙次，駕照審驗的內容主要要求駕駛人須重新體檢；同規則第 76 條並規定職業駕照使用最高年齡限制為 60 歲，而年滿 60 歲仍願意繼續執業之小型車職業駕駛人，採每年審驗一次，體檢時多增加了「心電圖檢查」與「胸部 X 光檢查」，申請延長最高至 65 歲【1】。

我國對於職業駕照審驗，除依道安規則第 64 條體格檢查項目外，並以年齡限制 60 歲作為駕照有效與否之積極條件，雖然職業駕駛人執行業務多涉公眾利益與安全，影響層面廣，但由於近年來國人平均壽命及國內醫療技術等均較以往提昇，且個人健康狀況差異甚大，以 60 歲作為統一之限制標準，是否過於嚴格，值得從駕駛人年齡、醫療狀況（medical condition）、生理功能差異與交通安全績效等諸多觀點及關聯性切入，以檢討我國職業駕照有效性之管理是否適當。

鑑於國內少有文獻針對人體醫療狀態與交通安全關聯研究觀點進行通盤性瞭解，本案主要採國外制度與相關文獻蒐集，輔以國內有限文獻作為探討之基礎，包括駕駛人年齡與功能狀態（functional capability）、駕駛人年齡與事故發生、駕駛人醫療狀況與事故發生

及國外駕照管理制度等課題，期能歸納職業駕駛人駕照有效性之管制元素與管理方式，作為研擬我國職業駕照管理可行方案之參考。

二、我國駕照考審驗制度與問題分析

2.1 我國駕照考驗規定

有關駕照之考驗規定於道路交通安全規則第三章中，其中與駕駛人資格條件特別有關者包括第 60 條（考照年齡與經歷限制）、第 62 條（不得參加考驗之情形）、第 64 條（體格檢查與體能測驗標準）等【1】。茲以圖 2.1 小型車駕照考領程序流程圖為例，呈現駕照考領所需程序與條件，另對於大型車考驗除第 60 條規範特定經歷方得報考較高之車種及職業駕照報考需年滿 20 歲有別於普通駕照年滿 18 歲規定外，其餘規定均適用之。

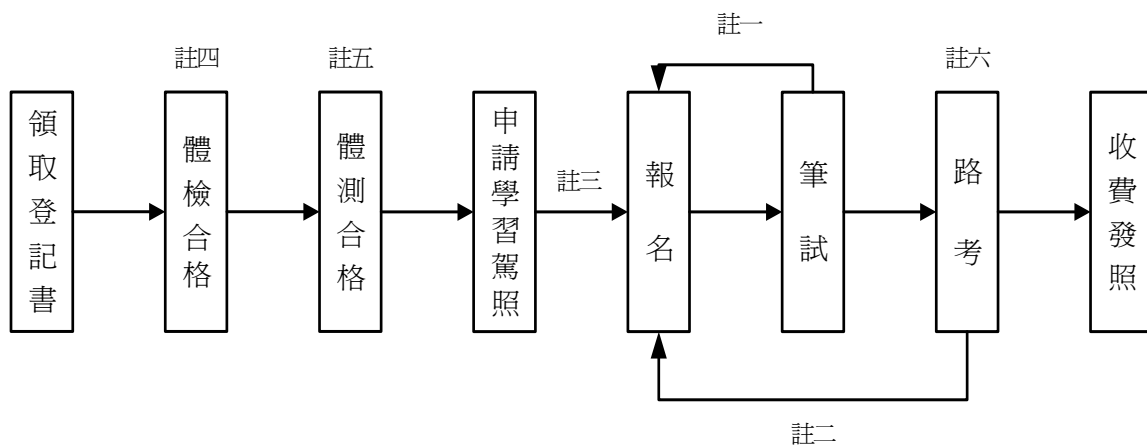


圖 2.1 我國小型車駕照考領程序之流程圖

資料來源：【2】

- 註：1、筆試：筆試包括交通規則與機械常識，報名普通駕駛執照者，免考機械常識，筆試不合格者（交通規則低於 85 分、機械常識低於 60 分）七天後才能重新報考。
- 2、路考不合格者（低於 70 分）七天後才能重新報考。
- 3、應考小型車普通駕照者，須有學習駕照三個月以上之經歷；但經立案合格之駕訓班訓練結訓者，得縮短為三十五天以上之經歷。

- 4、體格檢查可直接至各監理單位(設有代檢處)辦理，或至公立醫院或衛生機關或公路監理機關指定醫院或委託代理團體為之。體格檢查標準：(1)視力：兩眼裸視力達〇·六以上者，且每眼各達〇·五以上者，或矯正後兩眼視力達〇·八以上，且每眼各達〇·六以上者；(2)辨色力：能識別紅、黃、綠色者；(3)聽力：能辨別音響者；(4)四肢：四肢健全無殘缺者；(5)活動能力：全身及四肢關節活動靈敏者；(6)疾病：無精神耗弱、目盲、癲癇、或其他足以影響汽車駕駛之疾病者；(7)其他：無酒精、麻醉劑及興奮劑中毒者。
- 5、體能測驗標準：(1)視野左右兩眼各達 150 度以上者；(2)夜視無夜盲症者。體檢與體測合格有效期限：自合格日起一年內，逾期無效。
- 6、路考項目：(1)倒車入庫；(2)曲線進退(小型車普通駕駛執照，後退壓管不扣分)；(3)平行路邊停車；(4)曲巷調頭(小型車普通駕駛執照免考)；(5)狹橋(小型車免考)；(6)上下坡道；(7)換檔穩定測試；(8)斑馬線；(9)鐵路平交通；(10)岔路口；(11)全程道路行駛。

注意事項：報考小型車職業駕駛執照者，若已領有小型車普通駕駛執照滿三個月，其應考之筆試項目為機械常識，路考項目為：1. 曲線進退；2. 曲巷調頭。

2.2 我國駕照審驗規定

道安規則第 52 條規定，駕照每六年換照乙次，此項規定屬「行政換照」性質，亦即並未針對駕駛人是否適合駕駛之狀況進行審查。目前對於駕駛人健康狀況存在審驗機制者主要為職業駕駛人，道安規則第 54 條規定職業駕駛人需每三年審驗乙次，第 60 條及第 76 條並通則性規定職業駕照考領與持用有效期間統一訂為 60 歲，小型車職業駕駛人駕照持用有效期間則可視審驗結果延長至 65 歲之除外規定【1】。

職業駕駛人執行業務常涉及公眾利益與安全，且其工作性質經常必須長時間從事駕駛活動，因此對於職業駕駛人的身體與健康狀況有必要特別加強注意，以瞭解職業駕駛人是否能夠繼續勝任其工作。事實上，對職業駕駛採比較嚴格之查驗制度，對於道路其他使用者或搭乘者，均能有較高的安全保障。

依據全國公路監理電腦越區異動連線作業要點，職業駕駛人現行駕照審驗的內容主要包括駕駛人之重新體檢，體檢需經公立醫院、衛生機關、公路監理機關之體檢室或勞保醫院體檢合格，體檢內容包括身高（必須高於 160 公分）、體重、雙眼視力（視力合格標準：兩眼裸視目力達 0.6 以上，每眼各達 0.5 以上者；矯正後兩眼視力達 0.8 以上者，每眼各達 0.6 以上者）、辨色力、四肢是否健全、活動能力、有無惡疾及兩耳聽力等九項。體檢表自體檢日起三個月有效，駕駛人必須在期限內參加審驗，逾期必須重檢，此外，對於年滿 60 歲仍願意繼續執業之小型車職業駕駛人，因考慮其身體機能與健康狀況的衰退，並且為加強保障乘客之乘車安全，多增加了「心電圖檢查」與「胸部 X 光檢查」，檢查結果必須是「正常」或「合於健康標準」，方為合格，並且每年審驗一次，最高至 65 歲。

2.3 問題分析

對於職業駕駛人之駕照管理，國內現行制度存在「年齡」與「體格檢查」兩項審查機制，年齡限制以 60 歲為標準（小型車職業駕駛人最高可放寬至 65 歲），「體格檢查」則以考照時所要求之項目為準（小型車職業駕駛人延長年限時須新增兩項）。針對我國現行職業駕照管理制度提出下列幾項問題：

1. 現行審查機制是否充分之問題

目前職業駕照採「年齡」與「體格檢查」兩項審查機制，對於確保職業駕駛人安全績效在程序與項目上是否充分，其他管制機制如透過筆試或路考，或駕駛人特定醫療狀況作為限制條件是否可行與必要，有進一步檢討之空間。

2. 特定年齡作為限制標準之問題

以特定年齡為統一限制考領與持用標準，可能因個人生理功能與健康狀況差異甚大，對於部份職業駕駛人產生限制過嚴的問題，因此，以「年齡」作為絕對標準是否合乎公平原則的確值得探討。即便行政管理需要訂定統一年限，在醫療水準與平均壽命提昇下，以 60 歲作為門檻是否過於嚴格，亦值得商榷。

3.體格檢查項目與方式能否充分反映安全績效之問題

現行職業駕照審驗時之體格檢查項目雖與考照之規定相同，但有無惡疾（包括精神耗弱、目盲、癲癇、或其他足以影響汽車駕駛之疾病者）所可能產生之交通安全問題往往無法透過現行審驗機制所訂之體檢方式加以反映，且隨著年齡老化，確實可能形成足以影響汽車駕駛之疾病（如高血壓、糖尿病），但相關規則中並未加以明訂。

4.駕照審驗時間間隔之問題

現行職業駕照審驗以三年為一期，由於年齡老化在生理功能退化與特定疾病的發展上有加速的可能，訂定三年為一期是否普遍適合所有駕駛人以符管理目的，亦值得加以考量。

三、職業駕駛人特性分析

3.1 營業車輛與職業駕照數基本資料

表 3.1 及表 3.2 分別為我國民國 91 年底營業車輛與職業駕照登記數。營業車輛以營業小客車（即計程車）佔 48.83% 最多，其次為營業大貨車佔 35.27%；職業駕照亦以職業小型車駕照之 38.44% 最多，職業大貨車駕照之 28.71% 次之。

表 3.1 民國 91 年底營業車輛登記數

	小貨車	小客車	大貨車	大客車	合計
自用	690,750	4,888,050	82,649	2,326	5,663,775
營業	10,228 (4.93%)	101,286 (48.83%)	73,156 (35.27%)	22,753 (10.97%)	207,423 (100%)
合計	700,978	4,989,336	155,805	25,079	5,871,198

資料來源：【3】

表 3.2 民國 91 年底職業駕照登記數

	小型車	大貨車	大客車	聯結車	合計
普通	8,831,124	460,205	80,093	21,949	9,393,371
職業	212,859 (38.44%)	158,954 (28.71%)	81,264 (14.67%)	100,656 (18.18%)	553,733 (100%)
合計	9,043,983	619,159	161,357	122,605	9,947,104

資料來源：【3】

3.2 我國職業駕駛人年齡分佈

有關職業駕駛人年齡分佈，基本可從兩種資料上解讀，其一是以監理單位之職業駕照登記駕駛人所呈現之年齡分佈，目前官方並無定期公佈此統計數據，此類數據亦往往無法完全反應從事相關行業的年齡分佈。另一統計資料係針對特定營業車輛營運狀況之調查，從中再進一步獲得駕駛該類車輛之駕駛人基本資料，目前交通部統計處每兩年定期針對計程車與遊覽車進行調查，並出版「台灣

地區計程車營運狀況調查報告」及「台灣地區遊覽車營運狀況調查報告」，因樣本佔母體比例很高（計程車約 45%、遊覽車約 25%），十分具參考價值，但並非完全涵蓋所有營業車種，特定駕駛人基本資料如貨車、公車等無法獲得。

以下以交通部統計處民國 91 年公佈之計程車及遊覽車營運狀況中有關駕駛人年齡分佈資料進行分析（如表 3.3 及 3.4）。計程車部份，民國 88 年至 90 年之平均年齡增加 1.6 歲，且 50-59 歲駕駛者之比例有明顯增加現象，民國 90 年駕駛人 40-49 歲者佔 40.5% 最高，其次為 50-59 歲之 27.6%，60-65 歲經過延長年限者亦佔有相當之比例(5.8%)。遊覽車部份，民國 88 年至 90 年之平均年齡增加 0.8 歲，且 40 歲以上駕駛人之比例略有增加，民國 90 年駕駛人 40-49 歲者佔 50.8% 最高，其次為 30-39 歲之 30.2%，50-59 歲亦佔有 16.9%。

從兩種不同性質車輛之職業駕駛人比較，計程車駕駛人年齡分佈似較遊覽車為高，此或許部份反映遊覽車常需長途駕駛，使得駕駛人於特定年齡後因體力不易負荷而逐漸退出此行業，因此整體而論，駕駛人是否繼續從事職業駕駛之工作，駕駛執照持用之有效條件管制似並非係最主要決定因素，從事職業駕駛所需之體力、本身意願與競爭能力、運輸業市場機制與所從事行業別的影響可能更大。

表 3.3 計程車駕駛人年齡分佈百分比

年齡分佈	年份	
	90 年	88 年
20-29 歲	1.7%	4.0%
30-39 歲	24.1%	28.6%
40-49 歲	40.5%	40.7%
50-59 歲	27.6%	21.8%
60-65 歲	5.8%	4.4%
66 歲以上	0.4%	0.4%
平均年齡	45.6 歲	44.0 歲

資料來源：【4】

表 3.4 遊覽車駕駛人年齡分佈百分比

年齡分佈	年份	
	90 年	88 年
20-29 歲	2.0%	2.0%
30-39 歲	30.2%	36.9%
40-49 歲	50.8%	45.4%
50-59 歲	16.9%	15.4%
60 歲以上	0.1%	0.3%
平均年齡	43.3 歲	42.5 歲

資料來源：【5】

3.3 美國職業車輛駕駛人年齡分佈

以 1995 年美國為例，圖 3.1 中顯示，貨車駕駛人（truck driver）55 歲以上者佔 12.1%，65 歲以上者佔 2.3%；公車駕駛人（bus driver）55 歲以上者佔 24.9%，65 歲以上者佔 8.2%；計程車駕駛人（taxicab driver and chauffeurs）55 歲以上者佔 25.4%，65 歲以上者仍佔 10.8%。從美國經驗似可發現，由於行業別之差異，需體力與耐力之貨車駕駛人，其高齡駕駛人之比例相對於公車與計程車駕駛人明顯為低，值得注意的是，美國因無駕駛年齡限制而係透過如醫療檢查等其他機制管理職業駕駛人駕照，因此，公車與計程車駕駛人超過 65 歲以上者之比例仍高。另從監理部門之駕照登記觀察，1995 年美國 56 歲以上職業駕駛人佔 8.7%，66 歲以上則佔 3.9%。

與我國相較，由於美國職業駕駛照審核非以年齡作為限制條件，因此超過 65 歲以上高齡駕駛人仍有相當比例，尤其在公車與計程車駕駛人比例甚高，然美國對於職業駕駛人有執行較嚴格的工時規定，使得部份高齡駕駛人仍能勝任其工作為可能原因之一。

Table 2. Age of Selected Commercial Transportation Occupations

Occupation	Total aged 16+	Aged 55 +	Aged 65+	%55+	% 65+
Truck drivers	2,861,	347	66	12.1%	2.3%
Bus drivers	526	131	43	24.9%	8.2%
Taxicab drivers & chauffeurs	213	54	23	25.4%	10.8%
Railroad conductors & yardmasters	33	6	0	18.2%	0.0%
Locomotive operating occupations	51	6	0	11.8%	0.0%
RR brake, signal, and switch	17	5	0	29.4%	0.0%
Ship captain & mates*	33	5	1	15.2%	3.0%
Sailors & deck hands	26	2	0	7.7%	0.0%
Marine engineers	3	0	0	0.0%	0.0%
Bridge, lock, & lighthouse tenders	4	1	1	25.0%	25.0%
<i>Source 1995 Bureau of the Census' Current Population Survey</i>					
<i>*Numbers in "1000s"</i>					
<i>* excluding fishing boats</i>					
Age of Individuals Holding Commercial Drivers Licences	Total aged 15+	Aged 56 +	Aged 66 +	%56+	%66+
	7,747,519	676,729	301,173	8.7%	3.9%
<i>Source American Motor Vehicle Association 1995</i>					
Age of Locomotive Engineers	Total all ages	Aged 55 +	Aged 65 +	%55+	%65+
	20,856	3,153	99	15.1%	0.5%
<i>Source National Railway Labor Conference 12/94</i>					
Age Distribution of Airmen of Medically Certified 1st, 2nd, 3rd Class Airmen					
	Total all ages	Aged 55 +	Aged 65 +	%55+	%65+
Air Transport Pilots	143,398	12,608	714	8.8%	0.5%
Commercial Pilots	162,284	28,402	8591	17.5%	5.3%
General Aviation	308,388	64,486	23678	20.9%	7.7%
<i>Source Civil Aeromedical Institute 12/94</i>					

圖 3.1 美國商業運輸駕駛人之年齡分佈

資料來源：【6】

四、國外制度與文獻探討

受限於國內醫療系統與交通安全關聯性研究尚在萌芽階段，為進一步瞭解前一節所述國內現行職業駕照管理制度所存在值得檢討之處，以下主要從國外制度與相關文獻，同時輔以納入少部份國內已有之研究作為分析基礎。

4.1 駕駛人年齡與生理功能

與駕駛能力相關的生理功能主要包括感覺（sensory）、認知（cognitive）與運動（psychomotor）技巧。感覺功能如視力、聽力會隨老化而衰退；認知功能包括注意力、記憶力與學習能力，也會隨著老化過程而退化；運動功能如反應時間會隨老化變慢，但高齡駕駛人也常利用經驗來補償其在功能上退化所帶來之影響。另外，雖然個人差異極大，肌肉強度通常在 60 歲後急速降低，工作能力亦在 70 歲後明顯降低，常態的老化過程也常伴隨著身體的組成、體液、器官系統、心臟與呼吸系統的退化。表 4.1 為與因老化所帶來車輛操作能力降低之相關生理損傷。

此外，本研究召開學者專家座談會中，有專家提出對比視力，如進入隧道時因光、暗變化影響視力，年輕人需要 0.1 秒恢復，老年人要 0.4-0.5 秒，甚至更久才能恢復，若因道路視距不良將十分危險，此為一般視力檢查無法檢測出；對光的耐受能力，老年人在夜間視力差，對光點產生之炫光耐受力亦差；對動、靜態物體之判斷，老年人亦較差，一般而言，40 歲開始會緩慢衰退，50-60 歲以後會加速明顯衰退，60-70 歲會衰退相當程度。聽力是 30 歲以後開始會衰退，但是對於高頻的部份衰退，中低頻部份不易衰退（此部份與表 4.1 文獻中所述略有落差），但到 70 歲以後，高中低頻全部衰退，對於音源容易誤判。反應能力大概從 50 多歲開始衰退，50 幾歲有 1/3 的人肌肉會開始萎縮（參見附錄四中李世代醫師發言內容）。

根據國外研究，老化過程涉及複雜的基因與環境影響之交互作用，與年齡相關的功能改變，人與人之間差異極大，且隨著年齡增加其間之變異性更大，因此，因老化所致個人間生理功能的極端異質性，支持著高齡駕駛人是否適合駕駛，必須以個人的基礎進行評估的論點。

表 4.1 老化所致車輛操作能力降低之相關生理損傷

感覺功能	認知功能	運動功能
1.視力 ◎遠方視力降低 ◎較不易聚焦於近方物體 ◎85 歲以上較易出現白內障、青光眼 ◎需較大照明 ◎對炫光較敏感 ◎夜間視力耗傷 ◎到 50 歲前視野由 170 度逐漸減少至 140 度 ◎靜態視力約 50 歲開始逐漸退化而後加速 ◎由於視力與對比敏感度退化致對視覺刺激反應力降低 2.聽力 ◎較不易聽到低與高頻率音調 ◎較不易分辨音調之差異	1.感知 ◎對於忽略無關刺激之困難性增加 ◎擷取與處理資訊能力降低 ◎空間方向感與視覺運動整合能力降低 2.記憶與學習 ◎75 歲後學習率降至 20 歲之一半 ◎75 歲前年齡差異對學習能力影響有限 ◎短期記憶能力降低 3.注意力 ◎分散(divide)注意能力降低 ◎選擇性(selective)注意力之搜尋與瀏覽能力降低 4.智力 ◎一般智力水準仍能維持到較老年齡 ◎有關思考與理解能力之流動(fluid)智力影響較大 ◎有關從經驗中學習能力之結晶(crystallized)智力影響較小 ◎語言能力能維持至 70 歲後逐漸降低	1.反應時間 ◎一般運動能力降低多因較慢的視野與中央處理所致 ◎完成工作時間較長 ◎動作的速度與動作複雜度呈反向相關 ◎簡單反應時間略慢 ◎刺激與決策越複雜，與年輕人反應時間之差異性越大 ◎高齡者常靠動作正確性與一致性代替反應速度降低 2.強度與工作能力 ◎抓力、肩部與背部強度降低 ◎持續施力的能力降低 ◎運動之活動能力受限 ◎70 歲之工作能力降至 20 歲一半 ◎肌肉強度 60 歲前隨年齡緩慢降低，而後急遽下降 ◎女性較男性、下肢較上肢及快速運動較慢速運動之強度損失較大 ◎70 歲前強度的損失主要係因未使用

資料來源：【6】

4.2 駕駛人年齡與事故發生

1.交通事故發生機率

本所採用交通部統計處針對全國自用小客車車主及機車車主進行之抽樣問卷調查資料，建立高齡駕駛人之交通事故發生機率分析結果如表 4.2 至表 4.4。其中 60 歲以上高齡者，不論何種曝光量程度，發生交通事故之機率均較低，當曝光量增加時，高齡者與年輕

者間發生交通事故之機率差距，似乎有稍微擴大之情形，在自用小客車駕駛人部份約為年輕者之 0.55~0.80 倍間，在機車部份為年輕者之 0.55~0.75 倍間。顯示國內 60 歲以上高齡族群的事故發生率並未較高。

表 4.2 民國 85/87 年自用小客車駕駛人發生交通事故機率

(民國85及 87年調查)	平均每星期行駛里程					
	小於50km	50~未滿 100km	100~未滿 150km	150~未滿 200km	200~未滿 250km	250km 及以上
未滿60歲	0.11023	0.13849	0.17455	0.16051	0.18384	0.23683
60歲以上	0.06174	0.07867	0.10098	0.09220	0.10686	0.14151

資料來源：【7】

表 4.3 民國 89 年自用小客車駕駛人發生交通事故機率

(民國89年調 查)		平均每月行駛里程					
		小於250km	250~未滿 500km	500~未滿 750km	750~未滿 1000km	1000~未滿 1250km	1250km 及以上
男 性	未滿60歲	0.16468	0.19860	0.23641	0.22086	0.24441	0.28717
	60歲以上	0.11580	0.14135	0.17058	0.15847	0.17687	0.21112
女 性	未滿60歲	0.19164	0.22959	0.27130	0.25423	0.28005	0.32636
	60歲以上	0.13606	0.16526	0.19829	0.18464	N.A	0.24348

資料來源：【7】

表 4.4 民國 87/89 年機車駕駛人發生交通事故機率

(民國87/89年調 查)		平均每天行駛時間		
		小於0.5 hr.	0.5 hr.~未滿1 hr.	1 hr.及以上
男 性	未滿60歲	0.08582	0.12481	0.16837
	60歲以上	0.06119	0.09011	0.12326
女 性	未滿60歲	0.11393	0.16342	0.21711
	60歲及以上	0.08197	0.11944	0.16147

資料來源：【7】

另從國外文獻顯示（參見圖 4.1），每千人持照之涉入交通事故數，在 60 歲前，呈現隨年齡增加而減少；60 歲以上高齡者，男性隨年齡增加其事故涉入數仍大略維持穩定不變，女性則呈小幅度增加後略降。總體而言，相同年齡男性事故涉入率均高於女性。

因此，從年齡角度觀察，高齡駕駛者雖因老化易造成功能的衰退，然未如預期的是，在國內外均並未顯示具有較高之事故發生率，國外部份研究認為，高齡者可能為避免因功能衰退所帶來的風

險，而充分運用其經驗及採取避險的補償策略，致事故發生率未如想像中高【8】。

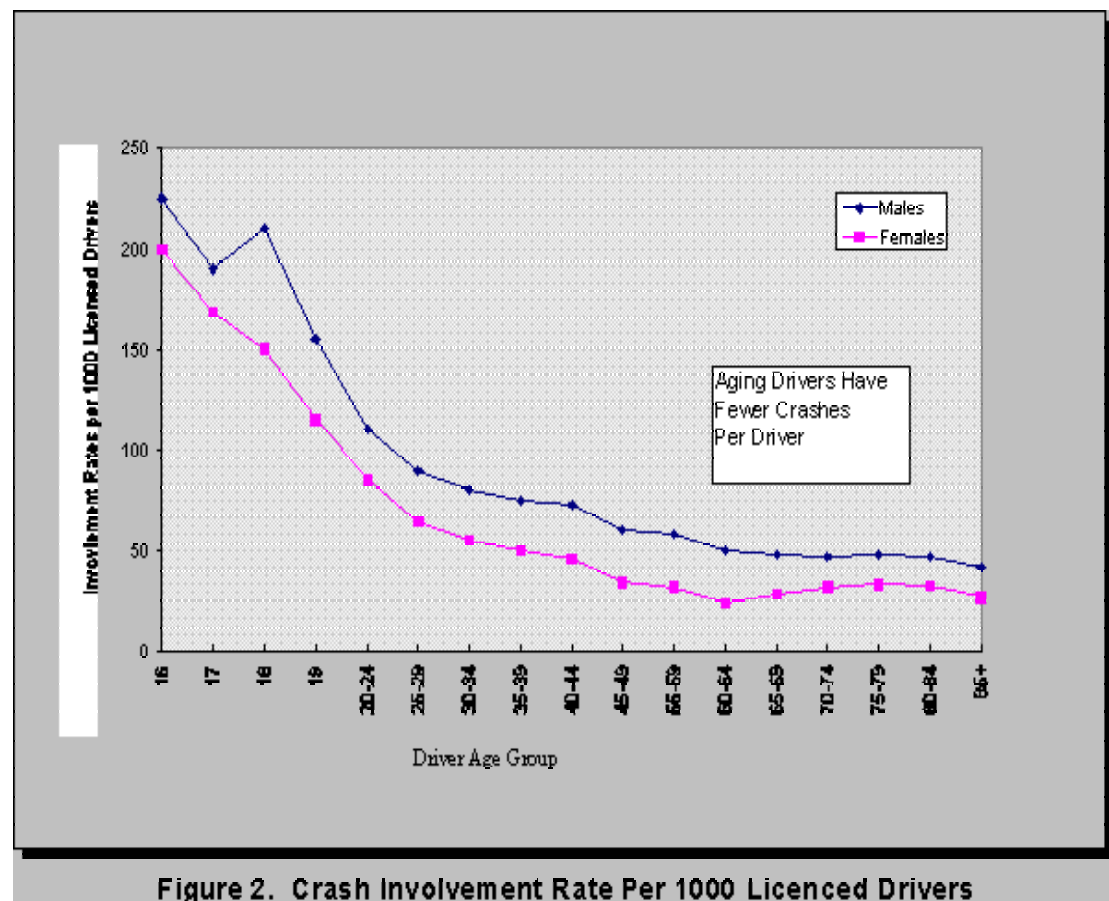


圖 4.1 美國駕駛人年齡與事故發生率分析圖

資料來源：【6】

2. 交通事故發生嚴重性

國內研究指出利用警政署民國 89 年事故統計資料中單一車輛事故所產生的死亡風險，在控制其他變因下，四輪以上汽車及機車駕駛人死亡風險均隨年齡增加而遞增，其中，四輪以上汽車之 60 歲駕駛人死亡風險是 20 歲的 2.05 倍，而機車之 60 歲駕駛人死亡風險是 20 歲的 1.65 倍【9】。

國外研究針對不同年齡每千人交通事故死亡人數，在超過 55 歲時亦呈現隨年齡明顯增加的趨勢（如圖 4.2）。國外研究指出此與年老駕駛人較脆弱（fragility），對於外傷抵抗能力較差所致。

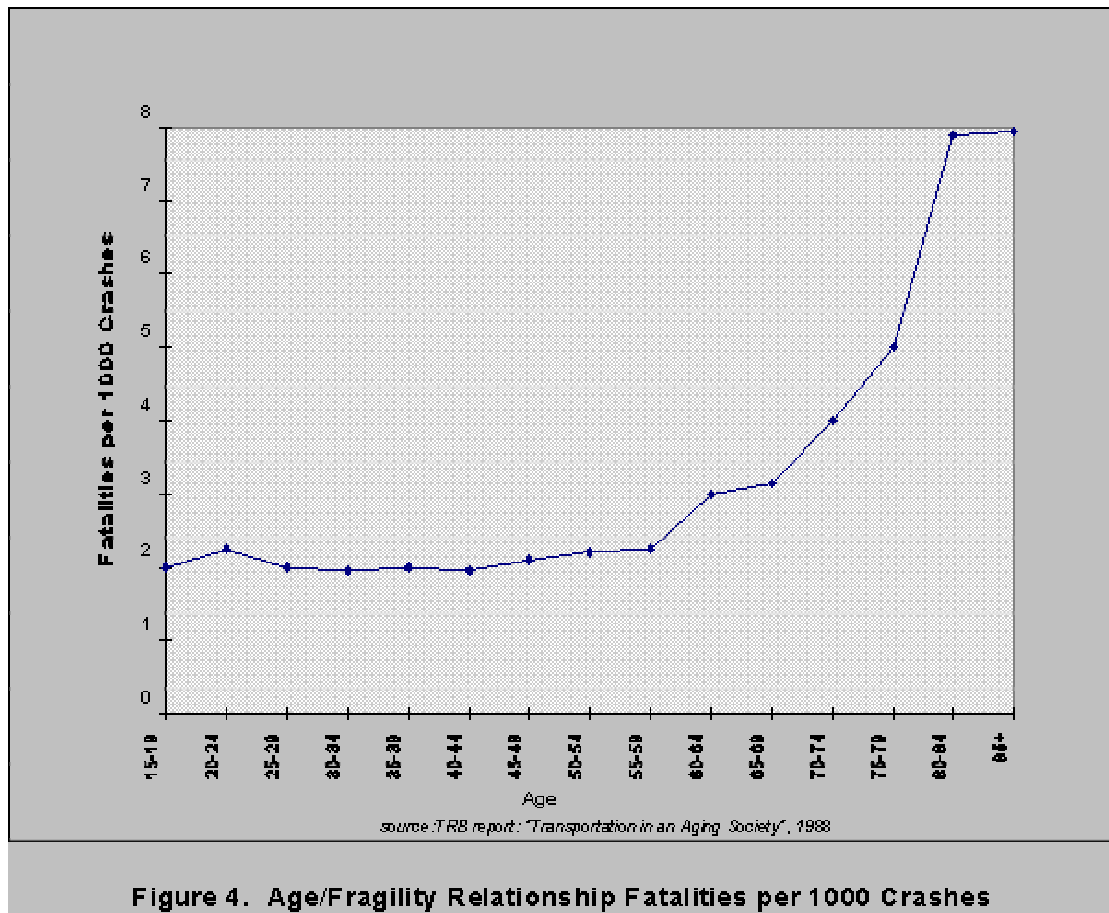


Figure 4. Age/Fragility Relationship Fatalities per 1000 Crashes

圖 4.2 美國駕駛人年齡與事故死亡率分析圖

資料來源：【6】

3.小結

從國內外相關研究多指出，交通事故的發生機率在年輕族群均顯得最高，此可能與傾向冒險駕駛行為或缺乏經驗密切相關，但隨著年齡老化致生理功能退化之老年族群未呈現相對較高之風險，部份研究認為可能與年老者因自知功能退化反而容易採取補償策略（即避免夜間、複雜環境等不利駕駛因素）。對於交通事故傷害嚴

重性，國內外研究均顯示年老者相對死亡風險較高，此與其身體對外傷承受能力降低相關。

雖然從所蒐集到之實證研究結果並無法支持隨年齡老化所產生之生理機能退化，會明顯增加事故發生的風險，但必須注意的是相關資料均針對一般駕駛人，一般駕駛人因老化所能採取的補償策略往往非工作時間長、為生計為目的或受雇性質的職業駕駛人所能自行決定。而年齡老化所致生理機能退化確實於許多文獻顯示會影響駕駛者的控制與處理能力，因此，對於職業駕駛人老化是否亦無較高的事故發生機率，必須更多研究佐證。

4.3 駕駛人醫療狀況與事故發生

除駕駛人年齡與事故發生或嚴重性可能相關外，駕駛人的特定醫療狀況與交通事故發生亦為文獻上的研究重點，主要原因在於特定疾病常可能發展成駕駛安全操作所需的運動與認知等功能之負面影響，如白內障、青光眼可能直接影響視力功能；糖尿病長期病患亦可能影響視力，甚至控制不良者造成低血糖昏厥而影響駕駛安全。

從流行病學的角度觀察，表 4.5 歸納以往研究對駕駛人特定醫療狀況與交通事故發生之關聯性，研究結果之相對風險(RR)或勝算比(OR)均為流行病學衡量兩組相對風險的指標，其中 RR 係事故發生率已知前提下之衡量指標，OR 為事故發生率雖未知，但知道抽樣中事故發生人數與不發生人數的比例。

表 4.5 顯示特定醫療狀況包括阿茲海默症、癲癇、白內障、糖尿病、青光眼、足部異常、跌倒、持續背痛、心臟疾病、腿足部遇冷發冷、滑囊炎、腎臟疾病及使用抗憂鬱/焦慮藥物等項目，值得注意的是，所謂「醫療狀況」似並非完全代表一特定「疾病」，如容易跌倒、腿足部發冷等，研究上之所以除特定疾病外，亦包含非疾病之醫療狀況，主要應為希望包括駕駛安全操作所需之人體功能變化

之各種影響因子，以作為駕駛人安全管理的依據。從國外實證研究發現，所列各種醫療狀況均會提高事故風險，其中又以阿茲海默症、癲癇、白內障、糖尿病、青光眼、足部異常、跌倒與滑囊炎等的影響較為顯著（RR 或 OR 多在 2 倍以上）。

表 4.5 流行病學研究駕駛人特定醫療狀況之相對事故風險

醫療狀況	文獻出處	研究結果
阿茲海默症 (Alzheimer's Disease)	Evans, Funkenstein, Albert, Scheer, Cook, Herbert, Hennekens, and Taylor(1989)	估計美國 65 歲以上老人 11.6% ，85 歲以上老人 47.8% 有阿茲海默症 患阿茲海默症前 3 年較所有駕駛人平均事故率略高，但低於 16-24 歲群之事故率；患阿茲海默症第 4 年則升高至所有駕駛人平均事故率的 2 倍
	Salzberg and Moffat(1998)	老年駕駛人有 psychiatric condition(Alzheimer's, bipolar disorders, dementia, 及 confusion/memory loss)其涉入事故與違規風險是控制組的 4 倍，及該調查州所有駕駛人平均事故率的 1.35 倍
癲癇 (Epilepsy/ Seizure Disorder)	Hu, Young, and Lu(1989)	採用美國健康統計國家中心估計，美國人每千人約有 3.8 人有癲癇
	Diller, Cook, Leonard, Reading, Dean, and Vernon (in press)	癲癇者其駕照條件未受限制，其事故發生率是控制組的 1.81 倍(所有事故)及 2.11 倍(有責事故)； 癲癇者其駕照條件受限制，其事故發生率是控制組的 1.55 倍(所有事故)及 2.47 倍(有責事故)
白內障(Cataracts)	Owsley, Stalvey, Wells, and Sloane (1999)	白內障與涉入事故顯著相關： 1.控制行駛曝光量：RR(相對風險)=2.48 2.控制其他疾病：RR=2.49
糖尿病 (Diabetic Retinopathy/ Diabetes)	Owsley, Ball, McGwin, Sloane, Roenker, White, and Overley (1998)	糖尿病事故風險高出 5 倍以上
	Koepsell, Wolf, McCloskey et al. (1994)	糖尿病老年駕駛人 OR(勝算比)=2.6 糖尿病(胰島素治療)老年駕駛人 OR=5.8 糖尿病(口服藥物治療)老年駕駛人 OR=3.1 糖尿合併冠狀心臟病老年駕駛人 OR=8.0
青光眼(Glaucoma)	Owsley, Ball, McGwin, Sloane, Roenker, White, and Overley (1998)	青光眼與涉入事故顯著相關：RR=5.20 (其中男性 RR=9.81；女性 RR=5.14)
	Owsley, McGwin, and Ball (1998)	青光眼組與控制組相較：RR=3.6
	Hu, Trumble, Foley, Eberhard, and Wallace (1998)	僅男性老年人之青光眼組事故風險顯著較高：OR=1.7
足部異常 (Foot Abnormalities)	Marottoli, Cooney, Wagner, Doucette, and Tinetti (1994)	三項以上足部異常者與負面駕駛事件顯著相關：RR=2.0

資料來源：【10】

表 4.5 流行病學研究駕駛人特定醫療狀況之相對事故風險(續)

跌倒(Falls)	Sims, Owsley, Allman, Ball and Smoot (1998)	過去兩年內跌倒紀錄與事故風險顯著相關：RR=2.6
持續背痛 (Persistent Back Pain)	Hu, Trumble, Foley, Eberhard, and Wallace (1998)	持續背痛與事故風險顯著相關： RR=1.25 (每年行駛 3000 英哩) RR=1.54 (每年行駛 9000-18000 英哩)
	Foley, Wallace, and Eberhard (1995)	持續背痛與事故風險顯著相關： 駕駛人 68 歲以上組 RR=1.4
心臟疾病 (Cardiac Conditions (Irreg. Heartbeat))	Stewart, Moore, Marks, May and Hale (1993)	心律不整與涉入事故顯著相關：OR=1.83
腿足部遇冷發冷 (Feet/Legs Cold on Exposure to Cold)	Stewart, Moore, Marks, May and Hale (1993)	腿足部發冷與涉入事故顯著相關：OR=1.82
滑囊炎(Bursitis)	Stewart, Moore, Marks, May and Hale (1993)	滑囊炎與涉入事故顯著相關：OR=2.18
腎臟疾病 (Renal Disease (Protein in urine))	Stewart, Moore, Marks, May and Hale (1993)	蛋白尿與涉入事故顯著相關：OR=1.84
使用抗憂鬱/焦慮藥物 (Use of Antidepressant/ Antianxiety drugs)	Hu, Trumble, Foley, Eberhard, and Wallace (1998)	抗憂鬱藥物使用與涉入事故顯著相關(僅男性)：RR=1.98
	Hemmelgarn, Suissa, Huang, Boivin, Pinard (1997)	抗焦慮藥物連續使用一年與涉入事故顯著相關：RR=1.26

資料來源：【10】

4.4 國外駕照管理制度

1.各國駕照審驗管理制度比較

職業駕照管理屬整體駕照管理制度之一環，因此單獨蒐集職業駕照管理制度往往更加困難，就所蒐集資訊中顯示，許多國家對於職業駕駛人考照年齡、醫療檢查頻率、醫療檢查標準，甚至持用年齡，均較普通駕照規定嚴格。

表 4.6 所示各國駕駛執照更新條件之國際比較，部份國家普通駕照無需於特定期間更新，包括比利時、法國、德國及瑞典等；部份國家駕照更新係在駕駛人 70 歲以上才須進行，包括丹麥、英格蘭、盧森堡、荷蘭、紐西蘭、葡萄牙等；部份國家則在駕駛人 70 歲以下即要求駕照更新，包括愛爾蘭、芬蘭、義大利、斯洛伐尼亞、日本

及我國。在必須換照的國家，普通駕照更新條件除我國屬「行政換照」並未就駕駛人適駛狀態進行醫療檢查外，其他各國似均需視力檢查或醫療檢查之證明作為駕照更新的條件。

至於職業駕照更新條件，就所蒐集之資料中，美國職業駕駛人執行州際運輸及英國職業駕駛人，均有更為嚴格的醫療檢查標準或駕照更新頻率。義大利及盧森堡則採年齡上限，進一步限制職業駕照持用年齡，此與我國採年齡限制具相似處，惟義大利採 60 歲限齡並可放寬至 65 歲，與我國小型車職業駕駛人近似；盧森堡則採 70 歲年齡上限較我國規定寬鬆。

綜合上述國際間駕照管理制度比較，少部分國家，其普通駕照無需更新似較我國寬鬆。多數國家則採用「重點式」管理，即針對高齡者(如 70 歲)採取較我國嚴格的駕照更新期間與醫療檢查等措施。至於職業駕照部分，我國有固定每 3 年審驗制度，主要檢查以考照所需之體格檢查為主，似較國外針對特定疾病或醫療狀況所需之醫療檢查來得寬鬆，但我國採用 60 歲年齡限制卻相對較為嚴格。

表 4.6 駕駛執照更新條件之國際比較

國家	駕照更新程序	駕照更新時間	普通駕照更新條件	職業駕照更新條件
美國	有	各州規定不同，以 4 年最多，其次為 5 年，少部份州規定 2 年、3 年、8 年、10 年更新(參見附錄二)	35 個州規定每次更新及 1 個州規定 50 歲以上更新需視力檢查	執行州際運輸，聯邦規定職業駕駛人每 2 年進行體格檢查，握力、四肢缺陷、糖尿病需胰島素治療、癲癇病史等不得駕駛商用車輛，視力、聽力、藥物及酒精測試亦須執行；州內運輸無需適用聯邦規定
加拿大	有	各省規定不同，多集中於 3-5 年	2 個省規定每次更新需視力檢查	N/A
比利時	無	無需更新	無	N/A
丹麥	有	70 歲，有效期 4 年 71 歲，有效期 3 年 72-79 歲，有效期 2 年 80 歲以上，有效期 1 年 特定疾病，有效期可能縮短	需醫師證明	N/A
英格蘭	有	70 歲以上強制更新	超過 70 歲，需醫師證明及視力測驗	1. 45 歲到 65 歲間，每 5 年需醫療檢查 2. 65 歲以上，每年需醫療檢查 * 職業駕駛人有更嚴格之醫療標準

資料來源：【6】及本研究整理

表 4.6 駕駛執照更新條件之國際比較(續)

愛爾蘭	有	不管年齡，每年更新	70 歲起，需健康證明	N/A
芬蘭	有	1. 45 歲起，每 5 年更新，有效期最多(或少於)5 年 2. 70 歲起駕照失效，後續有效期由醫師決定	1. 45 歲起，每 5 年需醫療檢查，包括一般性健康狀態與視力 2. 更新需醫療檢查，同時由兩人擔保其能力	N/A
法國	無	無需更新	無	N/A
德國	無	更新並非由年齡決定	無	N/A
義大利	有	1. 50 歲前，每 10 年更新 2. 50-69 歲，每 5 年更新 3. 70 歲起，每 3 年更新	更新需醫療證明，且超過 65 歲該證明有效期可能更短	60 歲起不得駕駛公車與長途客運，具醫療證明者最高可延長至 65 歲
盧森堡	有	70 歲，有效期 5 年至 75 歲	N/A	70 歲起，不得繼續持有商用車輛駕照
荷蘭	有	70 歲，有效期 5 年	依據身體狀況，醫療證明有效期可能更短，需視力檢查	N/A
紐西蘭	有	70 歲以下，無需更新 71 歲，有效期 5 年 76 歲以上，有效期 2 年	1. 71 歲起，需醫療檢查與視力檢測 2. 76 歲起，除醫療檢查與視力檢測外，尚需道路駕駛測驗	N/A
葡萄牙	有	70 歲起，有效期 2 年	70 歲起，每 2 年需醫療檢查	N/A
瑞典	無	無需更新	無	N/A
斯洛伐尼亞	有	65 歲起，有效期最多 3 年	65 歲起，至少每 3 年需醫療檢查	N/A
日本	有	1. 優良駕駛人： 未滿 70 歲，有效期 5 年 70 歲，有效期 4 年 71 歲以上，有效期 3 年 2. 優良駕駛人以外者： 有效期 3 年	需接受適性測驗（體格及體能檢查），駕照更新者並須接受講習，75 歲以上更新另接受特別講習。	需接受適性測驗（體格及體能檢查），對於視力有較嚴格之規定，駕照更新者並須接受講習，75 歲以上更新另接受特別講習。
中華民國	有	不管年齡，有效期 6 年	更新屬行政換照，無需提供體檢證明	職業駕照以 60 歲為持用限制，60 歲以下每 3 年審驗乙次，需提供體檢證明。小型車職業駕照最高放寬至 65 歲，超過 60 歲每年一審，體檢項目增加「心電圖檢查」與「胸部 X 光檢查」

資料來源：【6】及本研究整理

2. 駕駛人醫療狀況與駕照管理制度

國外普通駕照管理制度的核心，多以個人醫療狀況作為審查依據，而非採取統一限制年齡的做法，此制度的基礎或與相關研究指出：「老化係一緩慢漸進的過程，個人間之差異性極大，且隨著年齡增加，其間之差異性變異會更大。」有關，尤其國外許多先進國家早已邁入高齡化社會，提昇高齡者機動性無異為重視人權的基本

表徵。因此，「年齡」在國外係作為審查駕駛人醫療狀況輔助要素，通常高齡者需更為頻繁的醫療檢查以證明其是否適合駕駛。

至於職業駕照，國外做法較為分歧，英、美等國仍依循普通駕照管理精神，僅對於醫療檢查頻率與標準採取更為嚴格的限制，「年齡」輔以作為決定醫療檢查的基準，而非絕對限制的統一標準；但義大利、盧森堡則採用年齡上限，此與我國類似，此做法可大幅減少監理與醫療機關的行政成本，但公平性容易被質疑。但思考放寬國內職業駕照年齡限制，若未與其他適當管理措施搭配，極可能增加駕駛人個人與社會大眾之風險，因此，國外先進國家如何將駕駛人醫療狀況與駕照管理制度連結，以發揮體格或醫療檢查的實質功能，確實值得我國借鏡。

以下針對英國駕駛人醫療狀況與駕照管理制度概念進行探討，作為擬訂國內改善方案與策略的參考【11、12、13】。

- (1)申請駕照時，普通駕駛人必須自己聲明其是否有申請表中所載之特定醫療狀況，職業駕駛人則必須隨附繳交由醫師簽署之醫療報告。一般而言，駕駛人醫療小組（Drivers Medical Group）會依據駕駛人所提聲明或報告審核，但不排除依據提出之申請經當事人同意向其家庭醫師查證，或安排指定之地區醫院檢查，或執行駕駛評估、視力或駕駛測驗等。取得駕照後，醫療狀況惡化或發展出新的醫療狀況，駕駛人必須通知駕駛人醫療小組，未通知者是一犯罪行為同時將被罰 1000 英鎊罰金。
- (2)駕駛人醫療小組屬於駕駛人與車輛證照管理機構（Driver and Vehicle Licensing Agency, DVLA），負責針對駕駛人的不同醫療狀況，審核是否符合駕駛的醫療標準（medical standards），以提昇交通安全，DVLA 聘請合格的醫療專家（Medical Advisers），並由行政人員支援其工作。
- (3)駕駛人醫療小組審核權係由道路交通法（Road Traffic Act, 1988）及機動車輛（駕駛執照）規則（Motor Vehicles(Driving Licenses) Regulation, 1999)授權。

- (4)醫療標準的產生是由國務院（Secretary of State）指派數個專家小組（Advisory Panels）針對安全駕駛所需之醫療標準提供專家建議，數個專家小組依據醫療專業之不同而區隔，包括心臟學（Cardiology）、神經學（Neurology）、糖尿病（Diabetes）、視力（Vision）、酒精/藥物濫用（Alcohol/Substance Abuse）及精神病學（Psychiatry）。各小組每年召開兩次會議，依據醫學研究與醫學科學進展來審定駕照審核之醫療標準。
- (5)醫療標準製作成手冊（名稱：At a Glance Guide to the Current Medical Standards of Fitness to Drive（附錄三：摘錄））分送全國的醫師及醫療顧問。
- (6)貨車與公車職業駕駛人，因車輛尺寸與重量，及駕駛時間長之考量，故設定較高之醫療標準。因此，駕照審核標準區分為普通駕照（屬 Group1）及職業駕照（屬 Group2）兩種。
- (7)職業駕照所適用之較高標準之額外規則包括駕駛 3.5-7.5 噸貨車（C1 類駕照）、9-16 人座迷你巴士（D1 分類）、大型貨車（Large Goods Vehicle, LGV）、客車（Passenger Carrying Vehicles, PCV），適用時機包括：
- a)第一次考領上述任一種駕照。
 - b)C1 及 D1 駕照更新。
 - c)LGV 及 PCV 駕照在 45 歲至 65 歲間每 5 年更新。
 - d)LGV 及 PCV 駕照在 65 歲以上每年更新。
- (8)駕駛人醫療小組之審核結果可能包括下列幾項：
- a)更新後可保留原駕照或通過新照申請。
 - b)若醫療檢查在未來有需要，會發給 1、2 或 3 年到期的駕照，到期日前會主動通知駕照更新。
 - c)發給車輛經特別改裝之駕照，以協助克服駕駛時之生理障礙。

d)未能符合醫療標準時，吊銷駕照或申請駕照遭到拒絕。提出作成此決定之醫療解釋，並告知駕駛人或申請人向法院上訴的權利。

五、駕照有效條件管理元素

綜合前述分析，並參酌本所「駕駛執照換（補）發與審驗規定現況探討及制度改善之研究」，本案提出駕照有效條件管理的幾項重要元素包括年齡管制、醫療狀況檢查、體格與體能檢查、駕駛常識測驗、道路駕駛測驗、違規記點紀錄及道安講習運用等，分述如後。

5.1 年齡管制

採用「年齡上限」作為駕照持用的條件，僅少數國家針對職業駕駛人有此規定，對於絕大部分國家之普通駕駛人及部份國家之職業駕駛人，年齡係作為醫療狀況審核頻率與標準的相對參考基準。採用年齡上限的優點在於可大幅節省行政成本，具行政執行的便利性與明確性，但對於個別差異性很難兼顧，公平性容易遭受質疑。相對而言，若年齡係作為輔助基準，其他管制措施如醫療檢查、審核機制等必須能有效配合，方能減少高齡駕駛人在生理功能退化或醫療狀況惡化所帶來的風險。

5.2 醫療狀況檢查

國外許多先進國家對於高齡者之駕照更新往往搭配著醫療檢查，此項制度完善與否在於醫療系統與監理系統能否有效結合。我國道安規則 62 條雖訂有特定疾病（包括患有精神耗弱、目盲、癲癇等），與酒精、麻醉劑及興奮劑之中毒者不得考領駕照之規定，以及同規則 76 條不符體格體能狀態時駕照必須繳回，但實務上不僅疾病項目未盡完善，亦缺乏有效機制與明確標準能針對駕駛人特定醫療狀況監測判斷。此部份若需納入管理系統，有待醫療專家與行政部門作更明確的規劃。

5.3 體格與體能檢查

依我國「體格與體能檢查」之範圍與定義，與「醫療狀況檢查」在項目上有所重疊，例如道安規則第 64 條所界定之體格檢查除視力、辨色力、聽力、四肢、活動能力等，亦包括疾病及其他項目，但日本的適性測驗包括視力、色彩識別能力、深度視力、聽力及運動能力等項目，並未包含特定疾病或醫療狀況項目。本研究之所以特別提出區別，係認為大多數「醫療狀況檢查」需由專科醫師進行評估，所需時間及成本均可能甚高，而「體格與體能檢查」可由監理單位本身或透過醫師進駐協助即可迅速完成，此區別在未來制度設計與執行方式，恐需有不同資源、行政成本等考量。

5.4 駕駛知識測驗

法令修正、駕駛安全知識的演進，均可能使駕駛人對於新的發展在認知上有所落差，因此，考照所需的筆試，在部份狀況下有其應用價值，如部份國家駕駛人駕照被吊扣或嚴重違規成為臨時駕照，須經筆試通過後方能恢復原駕照權利，美國有 4 個州及加拿大有 2 個省，在駕照更新時亦須經筆試測驗。因此，筆試亦可考量作為駕駛人持照有效條件之一。

5.5 道路駕駛測驗

駕照更新必須經過道路駕駛測驗的例子在國際上並不多見，主要是駕駛技能一旦學成，不容易一夕間退化，駕駛人若生理功能退化，應可透過體格體能檢查察覺，此或許是道路駕駛測驗未被廣泛運用的主因。紐西蘭規定駕駛人於 76 歲起若需繼續持用駕照，除醫療檢查與視力檢測外，尚需道路駕駛測驗，因此對於高齡駕駛人以道路駕駛測驗檢核其駕駛能力，仍可加以思考。

5.6 違規記點紀錄及道安講習運用

違規記點紀錄在許多國家係作為駕照吊扣、吊銷之依據，如英國、德國及我國，事實上，駕照被吊扣吊銷所違反之記點或違規行為往往具累犯性質及重大危險性。違規記點，甚至肇事紀錄，若從積極管理角度，未必需待駕照吊扣吊銷之嚴重事件發生時方可加以運用，對於常有違規或發生事故傾向或特定駕駛人（如高齡者或職業駕駛人），違規與事故紀錄即可於駕照更新時進行積極介入管理。另道安講習亦可於駕照更新時作為法令與駕駛安全常識教育之媒介，日本即規定駕照更新時須接受講習，優良駕駛人講習時間又較優良駕駛人以外之人為短，75 歲以上更新駕照並另接受特別講習。

5.7 小結

上述所提駕照有效條件管理的幾項重要元素，主要係歸納各國經驗所得，如何搭配運用最為有效，應視各國交通環境與國情，並不容易界定可量化衡量的指標。我國現行駕照更新制度，在前述六大項管制元素中，充其量僅採用年齡管制、醫療狀況檢查、體格與體能檢查前三項，其中醫療狀況檢查不論在項目、機制與先進國家相較均有很大落差，如何從上述元素中建立適合我國的駕照更新機制或職業駕照更新年齡是否放寬，均應從策略層面整體思考，本研究認為需從公平性、風險控制、技術困難性、社會與行政成本等課題檢討，以研擬不同之建議方案。

六、我國職業駕照有效條件檢討與方案研擬

針對職業駕駛員工（公）會所提建議：「職業駕駛執照之報考及使用年齡限制由現行規定之 60 歲放寬至 65 歲。」若僅單方面放寬年齡，透過 3 年一期的現行審驗機制，能否有效監測高齡駕駛人因生理功能退化或醫療狀況惡化所可能帶來事故風險增加，值得疑慮。因此，方案的研擬必須有相關配套措施，從公平性、風險控制、技術困難性及社會與行政成本等綜合考量，才能研擬有效可行的方案。

6.1 檢討課題

茲將本研究所構思之公平性、風險控制、技術困難性、社會與行政成本等課題綜述如後：

1. 公平性

採用年齡限制，對於高齡職業駕駛人個人老化程度與醫療狀況差異性往往無法兼顧，亦即可能抹煞部份健康良好之駕駛人繼續工作的權利。但年齡限制亦有減少行政成本與明確執行的優點，同時年齡限制越嚴格，因駕駛人老化所致功能退化而產生的事故風險越低。因此，取消或放寬年齡限制，除非能搭配完善的個案審查機制，增加的公平性可能造成事故風險增加之犧牲代價。

2. 風險控制

放寬職業駕照考領及持用年齡，若維持現行機制，確有可能增加事故風險，因此採用此項建議，風險控制的概念十分重要。增加風險控制的能力，行政部門可從前述各項駕照管理相關管制元素加以構思，亦即放寬年齡對於風險控制有不利影響時，必須尋求正向控制風險的措施來搭配，以尋求平衡。

3.技術困難性

本研究所歸納各項駕照管理之管制元素，許多並未於國內實施或落實，如「醫療狀況檢查」可能涉及複雜的醫療專業、標準的設定及不同專業領域的結合等，在國外或許能有效運作，國內現階段可能存在甚高的技術障礙，必須透過廣泛的研究、諮詢、規劃等方式逐步克服。因此，技術困難性在相關配套措施研擬時必須加以考量。

4.社會與行政成本

配套措施越嚴密，可能代表駕駛人個人及行政機關所需付出的社會及行政成本越高，當然，鬆散的管理若造成交通事故增加，亦會大幅增加社會成本。因此，相關措施可能帶來的社會與行政成本亦必須納入思考。

5.其他相關課題

放寬職業駕駛年限，可能使部分高齡駕駛人願意繼續留在就業市場，但勞基法規定雇主有權要求受雇者於 60 歲強制退休，對於超過 60 歲駕駛人會否因駕照限齡延長，使這類駕駛人於勞動市場在薪資、權益保障上處於弱勢？同時造成業者為節省成本而大量僱用高齡駕駛人，造成就業市場之衝擊？此涉及勞工政策與運輸業管理，非本研究探討重點，僅在此略作提醒。

6.2 方案研擬與比較

由於部份管制元素涉及較高的技術困難性，如「醫療狀況檢查」項目涉及複雜的醫療專業、醫療標準及跨領域的合作等，因此短期內不易全面推動。在方案研擬部份，本研究針對短期內有調整可能性的措施，與現況進行比較，並建議短期調整方案所需之執行

策略；長期方案部份，則對於未來可能需要進行調整的方向提出建議。

1. 短期方案規劃

國外有關職業駕照管理制度，不論是著重於採個案基礎審驗者（高齡者審查趨嚴），或是通案採用年齡限制，「年齡」均為制度設計上所考量的重要元素。基於我國在職業駕駛人駕照管理係採「年齡限制」之通則規定，短期內若轉變成個案審查為基礎，因技術困難性、所需成本與其他相關配合事項均不易達成，可行性低，因此「年齡管制」仍是現階段必須採用的原則。

至於職業駕駛人之年齡限制，若強調公平性原則，對於現行制度採 60 歲為上限（小型車職業駕駛人除外）規定是否過於嚴格，將面臨檢討之需要。若未來政策上決定放寬此年齡限制，本研究建議現階段僅針對非屬小型車之職業駕駛人最高年齡延長至 65 歲，另小型車職業駕駛人仍以現行規定最高年限至 65 歲，暫不宜再向上延長，理由如後：

- (1) 非屬小型車之職業駕駛人年齡延長至 65 歲，目前已有小型車職業駕駛人之管理前例可循，對於風險控制較有把握。
- (2) 參考國外制度，採用年齡限制較為嚴格的義大利，亦以限制 60 歲為原則，具醫療證明合格者最高可延長 65 歲。
- (3) 65 歲為國內公務人員屆齡退休的上限，最高延長至 65 歲較符合國人對於工作年齡限制的普遍認知。
- (4) 依據行政院衛生署統計，民國 90 年我國男性平均壽命 72.9 歲，女性 78.8 歲，相較民國 57 年道安規則公佈該年男性 65.2 歲，女性 70.0 歲確有增加，然相較先進國家德、日等國仍有少 3 至 5 歲差距，以男性為主的職業駕駛工作年限，似不宜過度延長（如 70 歲）接近其平均壽命。
- (5) 平均壽命的延長並不表示健康的平均壽命延長，以具體證據來看，日本平均壽命 81 歲，但健康餘命僅 74.5 歲，中間落

差為 6.5 歲，而台灣平均壽命約 75 歲，健康餘命則不到 70 歲，貿然提昇至 70 歲證據不足夠，需要進一步評估（參見附錄四）。

若比照小型車職業駕駛人，其他職業駕駛人年齡均最高可延長至 65 歲，必須針對 61-65 間之職業駕駛人研擬風險控制的配套措施，以降低高齡職業駕駛人因生理功能退化所可能引發的風險，本研究採用的邏輯如後：

- (1) 因其他職業駕駛人所操控的車輛困難度較高、體能要求也相對較高，影響層面往往更為廣泛（如大客車駕駛人肩負眾多乘客安全），應比 61-65 歲之小型車職業駕駛人有更為嚴格的風險控制措施。
- (2) 所增加之「醫療狀況」或「疾病」項目檢查，必須影響事故風險明顯且可立刻執行者，詳細項目之確定與執行可行性應多徵詢醫療專業意見後決定（如心電圖、運動心電圖、胸部 X 光、青光眼、白內障、及其他慢性疾病可能影響駕駛安全等項目或疾病之檢查）。
- (3) 風險控制除著重於生理功能衰退或具有重大疾病影響行車安全外，亦加強駕駛行為層面之風險管控（如增加過去 3 年內經駕照吊扣者禁止延長，或取得延長資格後，若有重大違規事件即取銷其資格，以及換照前須實施道安講習）。
- (4) 現行道安規則第 64 條所規定申請駕照時須符合之體能測驗項目包括視野及夜盲症檢查，均未納入職業駕照審驗項目，因此建議 60 歲以下之職業駕駛人審驗時應將之納入，以符合管理的一致性與安全性。依據國外研究顯示，隨年齡增加，駕駛人除視野及夜視能力有明顯衰退現象外，肌力、耐力、關節活動度、肢體的活動力、握力、下肢的踩踏力等體能狀態，對於所從事職業駕駛工作之安全性亦十分重要，因此，60 歲以上延長年限之職業駕駛人，其審驗之體能測驗

項目除符合現行道安規則第 64 條規定外，應考量有更為嚴格的標準，有關詳細項目之確定與執行可行性應多徵詢醫療專業意見後決定。

依照上述理由及原則，本研究所研擬之修正方案與原方案之差異分列如後（見表 6.1）：

A. 原方案：維持現況。

- (1) 通則：職業駕照人限齡 60 歲，每三年審驗乙次，審驗內容為現行道安規則第 64 條體格檢查項目。
- (2) 例外規定：小型車職業駕駛人最高可延長至 65 歲，超過 60 歲每年審驗乙次，審驗內容為現行道安規則第 64 條體格檢查項目，並增加心電圖及胸部 X 光檢查。

B. 修正方案：放寬年齡限制，增加審驗項目（小型車職業駕駛人增加體能測驗項目）。

- (1) 通則：職業駕照限齡 60 歲，每三年審驗乙次，審驗內容為現行道安規則第 64 條體格檢查與體能測驗項目（視野及夜盲症檢查）。
- (2) 例外規定 1（除小型車外之其他職業駕駛人）：

職業駕駛人經審驗合格最高可延長至 65 歲，每年審驗乙次。審驗內容為：

A) 行為層面：

- a. 過去 3 年內經駕照吊扣者禁止延長，或取得延長資格後，若有重大違規事件即取銷其資格；
- b. 換照前須實施道安講習。

B) 體格檢查：

- a. 現行道安規則第 64 條基本之體格檢查項目；
- b. 增加部份重要且可立刻執行之「醫療狀況」或「疾病」項目檢查，不合格者禁止延長（如心電圖、胸部 X

光、青光眼、白內障、慢性病是否獲得穩定控制等)。

C) 體能測驗：

- a. 現行道安規則第 64 條基本之體能測驗項目；
- b. 增加部份重要且可立刻執行之之「體能測驗」項目，不合格者禁止延長（如肌力、耐力、關節活動度、肢體的活動力、握力、下肢的踩踏力等）。

(3) 例外規定 2（小型車職業駕駛人）：

小型車職業駕駛人最高可延長至 65 歲，超過 60 歲每年審驗乙次，審驗內容為：

- A) 現行道安規則第 64 條體格檢查項目、心電圖及胸部 X 光檢查（維持現行規定）；
- B) 增加現行道安規則第 64 條體能測驗項目（視野及夜盲症檢查）。

表 6.2 將上述兩方案列表呈現，另從公平性、風險控制、技術困難性、社會與行政成本等四個項目進行比較。在公平性方面，修正方案因放寬年齡限制故較佳。另修正方案雖增加除小型車職業駕駛人外的其他職業駕駛人在 61-65 歲間有繼續駕駛的機會，但審驗配套措施較為嚴格，故風險控制相近。同時為強化這些駕駛人的風險控制，所增加的配套措施包括監理措施（如吊扣駕照之管控、道安講習）與檢驗措施（如新增醫療檢查項目與檢查成本），均將增加修正方案的技術困難性及社會與行政成本。依據表 3.2，民國 91 年底職業駕照登記數（不含小型車職業駕駛人）合計 340,874，若採用 61-65 歲小型車職業駕駛人所佔 5.8% 之一半（即 2.9%）作為 61-65 歲其他車種職業駕駛人之比例，初估每年約增加 9,885 人次必須進行審驗，此人次可作為所增加社會與行政成本之概略參考。

表 6.1 職業駕照有效性之審驗條件短期修正方案

駕照有效 審驗條件		原方案 (維持現況)	短期修正方案
通則 規定	1.年齡規定	限齡 60 歲	限齡 60 歲 (經審驗通過最高可延長至 65 歲)
	2.審驗年期	每三年	每三年
	3.審驗項目	道安規則第 64 條 體格檢查項目	1. 道安規則第 64 條體格檢查項目 2. 增加現行道安規則第 64 條體能測驗項目 (視野及夜盲症檢查)
職業駕 駛人超 過 60 歲 特殊規 定(小型 車職業 駕駛人 除外)	1.年齡規定	—	經審驗通過最高可延長至 65 歲
	2.審驗年期	—	每年
	3.審驗項目	—	A) 行為層面： a. 過去 3 年內經駕照吊扣者禁止延長，或取得延長資格後，若有重大違規事件即取銷其資格 b. 換照前須實施道安講習 B) 體格檢查*： a. 現行道安規則第 64 條基本之體格檢查項目 b. 增加部份重要且可立刻執行之「醫療狀況」或「疾病」項目檢查，不合格者禁止延長 (如心電圖、胸部 X 光、青光眼、白內障、慢性病是否獲得穩定控制等) C) 體能測驗*： a. 現行道安規則第 64 條基本之體能測驗項目 b. 增加部份重要且可立刻執行之「體能測驗」項目，不合格者禁止延長 (如肌力、耐力、關節活動度、肢體的活動力、握力、下肢的踩踏力等)
小型車 職業駕 駛人超 過 60 歲 特殊規 定	1.年齡規定	經審驗通過最高可延長至 65 歲	同原方案
	2.審驗年期	每年	同原方案
	3.審驗項目	1. 道安規則第 64 條體格檢查項目 2. 心電圖 3. 胸部 X 光	1. 道安規則第 64 條體格檢查項目 2. 心電圖 3. 胸部 X 光 4. 增加現行道安規則第 64 條體能測驗項目 (視野及夜盲症檢查)

註：有關修正方案之新增體格檢查與體能測驗項目、檢測標準與執行可行性，建議應再徵詢醫療專業意見後決定。

表 6.2 職業駕照有效性之審驗條件方案優劣比較分析表

審驗方案 比較項目*	原方案 (維持現況)	短期修正方案
公平性	較低	較高(較佳)
風險控制	相近	相近 (註：放寬逾 60 歲以上職業駕駛人可能增加總交通事故發生次數，但上述更為嚴格之配套審驗措施，可能使 61-65 歲駕駛人相較 60 歲以下者之平均事故發生率相近或更低)
技術困難性	較低(較佳)	較高
社會與行政成本	較低(較佳)	較高

註：比較項目涉及其他相關課題如勞工政策與運輸業管理等，因非屬本研究範圍，故未納入。

2. 短期方案執行策略

若上述修正方案的基本架構能取得共識，則該方案執行策略建議如後：

- (1) 法令修正：修正道安規則第 64 條、第 76 條有關體格檢查與體能檢查項目規定、審驗程序與相關條文規定（如駕照吊扣者禁止延長，或取得延長資格後若有重大違規事件即取銷其資格）、處罰條例有關換照前道安講習之授權，以及其他相關法規之規定。
- (2) 醫療專業諮詢：針對新增之體格檢查與體能測驗項目、標準與審驗方式所需之專科醫師類別、檢查所需時間、成本、判斷難易性與執行可行性等諮詢醫療專業意見後決定，並設計審驗所需之專用體格檢查與體能測驗表。
- (3) 行政流程設計：審驗所需之證件、駕照吊扣之歷史紀錄查核或取得延長資格後若有重大違規事件時之資格取銷，與道安講習安排等進行流程設計，使能符合實務行政作業需求。

- (4) 道安講習實施規劃：應針對參與審驗者之高齡特性，規劃符合有助於其駕駛風險控制之道安講習授課時間、講習進行方式與講習內容（如高齡者生理功能退化、限制與駕駛安全之關聯、及符合高齡特性之道路安全駕駛因應對策）等要項。

3. 長期方案推動方向

歐美先進國家許多採用個案審查為基礎，有其值得我國思考或部份借鏡之處，惟其所需之醫療專業作為支持與龐大的成本，則是我國必須考量是否適合國內狀況與時機。有關長期方案，目前就細節部份具體規劃尚有困難，但可提出長期推動方向，以為未來職業駕照管理甚或普通駕照管理制度之參考。

有關長期推動方向如後：

(1) 逐漸納入個案審查基礎之精神：

在保障個人工作權與交通安全維護之權衡下，個案審查為基礎，理想上將可就個人健康狀況進行合理的判斷，符合公平正義原則，應屬長期努力目標。惟駕駛人個人所需付出的成本，社會所承擔的醫療檢驗成本，以及監理單位增加的行政成本勢將十分可觀，如何能在成本有效控制下，達到風險控制的目的，尚待未來努力，此外資源的整合可能攸關制度之成敗，如健保對於個人醫療紀錄能在不違反個人資料保護法下，透過數位資訊整合應用，將可大幅降低醫療檢查成本。此外，高齡者固為個案審查之重點對象，特殊駕駛人（如事故頻繁者）或特定醫療狀況發生在較低年齡時（如視力衰退、視野變窄），亦須於制度中進行設計規劃。

(2) 針對職業駕駛人業別或駕駛車輛特性規劃審驗標準：

職業駕駛人依其執業業別可區分客運與貨運，駕駛車輛亦存在實體之明顯差異，此涉及營運特性、營運工時、車輛操作特性與安全影響範圍等不同特性，國內仍缺乏具體數據或資料以為細

部規劃審驗標準之參考，此部份在國外如英國針對大型車職業駕駛人、義大利針對客車駕駛有更為嚴格的審驗規定，我國未來審驗制度可就此部份進行更為精緻的制度設計。

(3) 「生理功能」與「駕駛行為」審驗並重：

所謂體格、體能或醫療狀況檢查均屬駕駛人生理功能的條件檢視，第五單元所述駕照有效管制元素，尚包括如駕駛人違規與肇事紀錄、道安講習運用等駕駛行為層面因素，長期而言，審驗制度應加強淘汰具不良駕駛行為者之功能，使職業駕駛人審驗制度發揮查核駕駛人「生理功能」與「駕駛行為」之雙重功能。

(4) 監理單位成立「駕駛人醫療委員會」：

對於體格、體能或醫療狀況等駕駛人功能特性如何影響駕駛之安全性，不僅涉及醫療專業，亦會隨著研究與時空演進。就短期修正方案所涉新增體格檢查與體能測驗項目、檢測標準與執行可行性而言，即需廣泛徵詢醫療專業意見，長期而言，監理單位實有必要參考英國的做法，成立「駕駛人醫療委員會」，由不同領域專科醫師與交通安全專家組成委員會，建立駕駛人安全駕駛之醫療檢查項目與標準，並定期就國內外醫學、交通安全研究或相關案例等檢討駕駛人審驗項目與標準之合宜性，作為法令修正與實務作業調整之參考。此委員會功能主要在建立相關醫療標準與建議作業制度，而非進行實質審查，有關體格與體能檢查仍由適當之醫療單位執行，醫療檢查結果則為監理單位審驗駕照是否通過之必要條件之一。

(5) 建立普通駕照管理之定期審驗制度

相對國際而言，我國職業駕照管制因採年齡限制，其管制效果應不比其他各國寬鬆，但普通駕照部份仍處於「行政換照」方式，並無審驗功能，面對國內民國 50-60 年代第一代機動車輛駕駛人之逐漸高齡化，普通駕照管理之定期審驗制度，在不久的未來應是無可迴避的議題。國際趨勢對於普通駕駛人在管理上未如職業駕駛人嚴格，但審查機制多半存在，最常採用者即為視力檢

查，因此普通駕照之審驗亦應納入長期規劃的標的。另短期而言，對於高齡普通駕駛人與高風險之特殊駕駛人亦可考量優先推動，此部份請參考本所「駕駛執照換(補)發與審驗規定現況探討及制度改善之研究」報告內容。

七、結論與建議

7.1 結論

1. 有關延長職業駕駛人駕照有效年限，涉及駕駛人年齡與功能狀態、駕駛人年齡與事故發生、駕駛人醫療狀況與事故發生等關聯課題，本研究參考國內外相關文獻與駕照管理制度，歸納職業駕照有效性之管制元素，研擬短期修正方案與長期推動方向。
2. 現行道安規則規定駕照每六年換照乙次係屬「行政換照」性質，因此普通駕照部份並未針對駕駛人健康或適駛狀況進行查核，目前存在審驗機制者主要為職業駕駛人，規定每三年審驗乙次及職業駕照考領與有效期間上限為 60 歲，另對於 60 歲以上小型車職業駕駛人在通過每年乙次審驗者，最高延長至 65 歲有除外規定。
3. 我國現行職業駕照管理制度存在之問題包括：現行審查機制是否充分、特定年齡作為限制標準、體格檢查項目與方式能否充分反映安全績效、以及駕照審驗時間間隔合適性等。
4. 我國計程車與遊覽車駕駛人年齡分布主要集中於 40-49 歲，接近屆齡規定之 60-65 歲計程車駕駛人佔 5.8%，50-59 歲遊覽車駕駛人佔 16.9%。與我國相較，美國職業駕駛照審核未以年齡上限為限制條件，因此超過 65 歲以上高齡駕駛人在公車與計程車方面仍有相當之比例。
5. 駕駛能力相關的生理功能包括感覺、認知與運動技巧等，均會隨著老化呈現不同程度的退化現象，但根據國外研究，老化過程涉及複雜的基因與環境影響之交互作用，與年齡相關的功能改變，

人與人之間差異極大，且隨著年齡增加其間之變異性更大，因此必須以個人的基礎進行評估。

6. 國內外研究多指出，交通事故的發生機率在高齡族群未呈現相對較高之風險，此或與其採取補償策略有關。另交通事故傷害嚴重性，高齡者相對死亡風險較高，與其身體對外傷承受能力降低相關。針對一般駕駛人之相關實證研究結果無法支持隨年齡老化會增加事故發生風險，但一般駕駛人所能採取的補償策略往往非職業駕駛人所能自行決定，因此職業駕駛人老化是否亦無較高的事故發生機率，必須更多研究佐證。
7. 國外流行病學實證研究發現，許多醫療狀況均會提高事故風險，其中以患有阿茲海默症、癲癇、白內障、糖尿病、青光眼、足部異常、跌倒與滑囊炎等的相對事故風險較高，多在控制組的 2 倍以上。
8. 駕照更新制度之國際比較方面，普通駕照部份，少數國家無需更新似較我國寬鬆；多數國家則採用「重點式」管理，即針對高齡者採取較我國嚴格的駕照更新期間與醫療檢查措施。職業駕照部分，我國有固定每 3 年審驗制度，主要檢查以考照所需之體格檢查為主，似較國外針對特定疾病或醫療狀況所需之醫療檢查來得寬鬆，但我國採用 60 歲年齡限制卻相對較為嚴格。
9. 英、美等國對於職業駕照係採個人基礎進行審查，在醫療檢查頻率與標準採取更為嚴格的限制，「年齡」是輔助作為決定醫療檢查的基準，而非絕對限制的統一標準。若要延長國內職業駕照年齡限制，同時控制所可能增加的事故風險，國外先進國家如何將駕駛人醫療狀況與駕照管理制度連結，以發揮體格或醫療檢查的實質功能，值得我國參考。

10. 本研究所歸納駕照有效條件管理的重要元素包括年齡管制、醫療狀況檢查、體格與體能檢查、駕駛常識測驗、道路駕駛測驗、違規記點紀錄及道安講習運用等。
11. 延長職業駕駛年限的修正方案研擬，必須有相關完整的配套措施，並從公平性、風險控制、技術困難性及社會與行政成本等項目綜合考量，才能研擬出具體可行的方案。
12. 本研究考量技術困難性，區分方案為短期修正方案與長期推動方向。其中短期修正方案主要內容在於，職業駕駛人仍維持 60 歲限齡之通則性限制，但比照小型車職業駕駛人之除外規定，有條件延長其他職業駕駛人年齡至 65 歲，採取每年審驗乙次，並建議採取更為嚴格的審驗機制，包括增加行為層面管制、新增與高齡者安全駕駛相關之體格檢查與體能測驗項目，以作好風險管控。
13. 與維持現況相較，短期修正方案在公平性方面較佳，風險控制相近，但技術困難性、社會與行政成本等兩個項目相對較差。此外，放寬職業駕駛年限，可能涉及勞工政策與運輸業管理，惟非本研究探討範疇，未予列入評估。另本研究初估短期修正方案每年約增加 9,885 人次必須進行審驗。

7.2 建議

1. 短期修正方案較現行制度並非具有絕對優勢，係考量公平性前提下之可能修正措施之一，現行制度是否修正屬政策性決定。若交通部政策性決定延長職業駕駛年限且短期修正方案的基本架構取得共識，後續推動工作建議移請公路總局、台北市監理處、高雄市監理處等監理機關研處，並建議方案執行策略須從法令修正、醫療專業諮詢、行政流程設計與道安講習實施規劃等課題進行細部規劃。
2. 短期方案中建議針對延長年限之職業駕駛人採取更為嚴格的審驗機制，新增審驗方向區分行為層面、體格檢查、體能測驗等在本研究召開之座談會似多為出席代表接受（惟各工會代表見解較不相同），然其中所列舉項目僅屬本研究蒐集與初步參酌座談會出席代表發言重點綜合之意見，未來實際執行項目研訂，仍建議由上述監理機關廣泛徵詢醫療專業意見後定案。
3. 本研究建議長期推動方向包括逐漸納入個案審查基礎之精神、針對職業駕駛人業別或駕駛車輛特性規劃審驗標準、「生理功能」與「駕駛行為」審驗並重、監理單位成立「駕駛人醫療委員會」、建立普通駕照管理之定期審驗制度等。
4. 關於建立普通駕照管理之定期審驗制度雖非本研究主要焦點且建議納入長期方向建立完整制度後推動，惟為預防普通駕照人安全管理出現漏洞，對於高齡普通駕駛人與高風險之特殊駕駛人之定期審驗機制，可考量優先推動。

參考文獻

1. 交通部道安委員會與台北市監理處編印，交通管理常用法令彙編，中華民國 91 年 12 月。
2. 交通部運輸研究所，駕駛執照換(補)發與審驗規定現況探討及制度改善之研究，中華民國 91 年 3 月。
3. 交通部統計處，中華民國 91 年交通統計要覽，中華民國 92 年 7 月。
4. 交通部統計處，台灣地區計程車營運狀況調查報告，中華民國 91 年 8 月。
5. 交通部統計處，台灣地區遊覽車營運狀況調查報告，中華民國 91 年 9 月。
6. Department of Transportation (US), Improving Transportation for a Maturing Society, DOT-P10-97-01, January 1997.
7. 林豐福，張開國，賴靜慧，「台灣 60 歲以上機車駕駛者之交通事故發生機率模式」，第 4 屆機車交通與安全研討會論文集，中華民國 92 年 11 月。
8. DTRL (UK), Road Safety Research Report No. 25 — Older Drivers: A Review, September 2001.
9. 林豐福，張開國，葉祖宏，「單一車輛事故駕駛人死亡風險模式建構」，中華民國運輸學會第 17 屆論文研討集，中華民國 91 年 12 月。
10. NHTSA, Safe Mobility for Older Drivers, DOT HS 808 853, April 1999.
11. DVLA (UK), A Leaflet for UK Driver Licensing System, June 2003.
12. DVLA (UK), A Medical Rules, www.dvla.gov.uk/drivers/dmed1.htm, June 2003.
13. DVLA (UK), At a Glance to the Current Medical Standards of Fitness to Drive, January 2003.

我國職業駕駛執照考領及持用有效條件之檢討

一、前言.....	1
二、我國駕照考審驗制度與問題分析.....	3
2.1 我國駕照考驗規定.....	3
2.2 我國駕照審驗規定.....	4
2.3 問題分析.....	5
三、職業駕駛人特性分析.....	7
3.1 營業車輛與職業駕照數基本資料.....	7
3.2 我國職業駕駛人年齡分佈.....	7
3.3 美國職業車輛駕駛人年齡分佈.....	9
四、國外制度與文獻探討.....	11
4.1 駕駛人年齡與生理功能.....	11
4.2 駕駛人年齡與事故發生.....	12
4.3 駕駛人醫療狀況與事故發生.....	16
4.4 國外駕照管理制度.....	18
五、駕照有效條件管理元素.....	24
5.1 年齡管制.....	24
5.2 醫療狀況檢查.....	24
5.3 體格與體能檢查.....	25
5.4 駕駛知識測驗.....	25
5.5 道路駕駛測驗.....	25
5.6 違規記點紀錄及道安講習運用.....	26
5.7 小結.....	26
六、我國職業駕照有效條件檢討與方案研擬.....	27
6.1 檢討課題.....	27
6.2 方案研擬與比較.....	28
七、結論與建議.....	38
7.1 結論.....	38
7.2 建議.....	41
參考文獻.....	42
附錄一 交路字第 09200060841 號函	
附錄二 美國各州駕照更新期間與條件	
附錄三 摘錄英國 “At a Glance to the Current Medical Standards of Fitness to Drive”	
附錄四 92 年 12 月 9 日召開座談會會議記錄	

我國職業駕駛執照考領及 持用有效條件之檢討

交通部運輸研究所

中華民國 93 年 01 月

附錄一 交路字第 09200060841 號函

運輸安全組

交通部 函

附錄一

受文者：運輸研究所

速別：普通件

密等及解密條件：普通

發文日期：中華民國九十二年六月十三日

發文字號：交路字第09200060841號

附件：如說明 (092006084-1-AA.WDL)

Handwritten signature

大 4/20

本案擬辦方式如左：

機關地址：10042 台北市長沙街一段二號
傳真：23899887

鄭賜榮

1. 由本組蒐集國內外有關職業駕駛人年齡或資格管制相關作法，以及年齡、健康因素與駕駛安全之參考價值文獻資料。
2. 整理相關資料，研擬討論題綱，於92年12月前召開產官學研座談會，將會議結論及相關資料報部後送部（錄送部併陳）。
3. 文詳圖為存查。

主旨：有關邇來迭有職業駕駛員職業工（公）會建議職業駕駛執照之報考及使用年齡限制應由現行規定之六十歲放寬至六十五歲乙案，請依說明事項辦理，請查照。是。此致

秘書室(研考)

王任林 謹啟

林豐福

張開

張開

祖宏

文收總所研運 0920005083 號
中華民國 92 年 6 月 16 日

一、查道路交通安全規則第七十六條第一項第四款規定：「職業駕駛人年滿六十歲者，駕駛本國車輛，迅速將駕駛執照繳回當地公路監理機關」，惟邇來迭有職業駕駛員職業工會以現今人體生體機能、平均壽命及醫療技術等較以往進步為由，建議職業駕駛人之報考及使用年齡應延至六十五歲，故本部前以九十二年四月二十一日交路字第092000390號函（諒達）再次請相關機關與工會團體等提供處理意見，其相關意見彙整如附件。

二、經查各相關機關及工會團體對職業駕駛執照之考領及使用年齡限制是否予延長至六十五歲之意見甚為分歧，且由於本案之議題除涉及公共運輸安全之考量外，尚涉駕駛人年齡超過六十歲後，其體能及生理狀況是否足以勝任駕駛工作之醫療專業判斷，為期瞭解上開限制之規定

保存年限	永久	十年	五年	年
勾選		✓		
檔號	F302			



裝

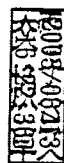
訂

線

是否有修正延長至六十五歲之必要，俾做為本部政策修訂之參考，請貴所納相關研究計畫辦理。

正本：運輸研究所

副本：



附錄二 美國各州駕照更新期間與條件

**Table 4. Jurisdictions Requiring In-person Renewal and Conditions
as of 1994**

U.S. States		
		Mandatory
Jurisdiction	Interval/Conditions	Vision Test
Alabama	4 years	no
Alaska	5 years	yes
Arizona	4 years	no
Arkansas	4 years	yes
California	4 years (poor drivers), 12 years (good drivers), at age 70+ in-person renewal only	yes
Colorado	2 years if age 16, 3 years if age 18, 5 years after age 21, 4 years for CDL	no
Connecticut	4 years, 6 months if public service operator & age 70	no
Delaware	5 years	yes
District of Columbia	4 years, at age 70, physician certificate required plus reaction test, at age 75, additional knowledge/road tests (optional)	yes
Florida	4 years, 6 years if no convictions within 3 years	yes
Georgia	4 years	no
Hawaii	2 years if ages 15-24 including knowledge and signs test, 2 years at age 65+ includes knowledge and signs test every 4 years, 4 years ages 25-64	yes
Idaho	4 years	yes
Illinois	4 years, 2 years at age 81-86, 1 year at age 87+; written and road test	no
	at 69+	
Indiana	4 years, 3 years at age 75	yes
Iowa	2 years if under 18 or 70+, 2 or 4 years between ages 18-69	yes
Kansas	4 years includes open book written test	yes
Kentucky	4 years	no
Louisiana	4 years	yes
Maine	4 years, at age 40+ every 12 years, at age 65+ every 4 years	no
Maryland	5 years	yes
Massachusetts	4 Years	yes
Michigan	4 years (good drivers) includes knowledge and sign tests,	yes
	2 years (drivers with moving violation in last 4 years)	
Minnesota	4 years	yes
Mississippi	4 years	no
Missouri	3 years	yes
Montana	4 years	yes
Nebraska	4 years	yes
Nevada	4 years	yes
New Hampshire	4 years, at age 75+, knowledge and road test	yes
New Jersey	4 years	no
New Mexico	4 years, 1 year at age 75+	yes
New York	4 years	yes
North Carolina	5 years; knowledge testing	yes
North Dakota	4 years	yes
Ohio	4 years	yes
Oklahoma	4 years	no
Pennsylvania	4 years	no
Oregon	8 years, 4 year cycle with one mail renewal	yes at age 50
Rhode Island	5 years, 2 years at age 68+	yes
South Carolina	4 years	yes
South Dakota	5 years	yes
Tennessee	5 years	no
Texas	4 years	yes
Utah	10 years, mail renewal acceptable every other cycle (5 years) if no more than 4 convictions in preceding 5 years, 5 years at age 64+	yes
Vermont	2 and 4 years	no
Virginia	5 years	yes
Washington	4 years	yes
West Virginia	4 years	no
Wisconsin	4 years	yes
Wyoming	4 years	yes
Canadian Provinces		
		Mandatory
Jurisdiction	Interval/Conditions	Vision Test
Alberta	5 years; medical at age 75+	no
British Columbia	2 and 5 years	no
Manitoba	4 years for photo only	no
New Brunswick	4 years	no
Northwest Territories	5 years	no
Nova Scotia	3 years	no
Ontario	3 years	yes
Prince Edward Island	3 years	yes
Quebec	2 years	no
Saskatchewan	5 years	no
Yukon	3 years	no

**附錄三 摘錄英國 “ At a Glance to the Current
Medical Standards of Fitness to Drive”**

For Medical Practitioners

At a glance Guide to the current Medical Standards Of Fitness to Drive

Issued by
Drivers Medical Group
DVLA, Swansea

August 2003



INVESTOR IN PEOPLE

Health at Work: The Corporate Standard Winners DVLA is an Equal Opportunities Employer
An executive agency of the Department for Transport



CONTENTS

	SUMMARY OF AMENDMENTS	1
	INTRODUCTION	2-5
Chapter 1	NEUROLOGICAL DISORDERS	6-14
Chapter 2	CARDIOVASCULAR DISORDERS	15-21
Chapter 3	DIABETES MELLITUS	22
Chapter 4	PSYCHIATRIC DISORDERS	23-26
Chapter 5	DRUG AND ALCOHOL MISUSE AND DEPENDENCY	27-30
Chapter 6	VISUAL DISORDERS	31-33
Chapter 7	RENAL DISORDERS	34
	RESPIRATORY DISORDERS	34
	SLEEP DISORDERS	34
Chapter 8	MISCELLANEOUS CONDITIONS	35
	ELDERLY DRIVERS	35
Annex 1	DRIVING ASSESSMENT FOR DISABLED DRIVERS	36
Annex 2	DISABLED DRIVERS' ASSESSMENT CENTRES	37-38
Annex 3	WITHDRAWAL OF ANTI-EPILEPTIC MEDICATION	39
	EPILEPSY REGULATIONS	40
	INDEX OF MEDICAL CONDITIONS	41

AT A GLANCE GUIDE TO THE CURRENT MEDICAL STANDARDS OF FITNESS TO DRIVE

August 2003 SUMMARY OF AMENDMENTS

CHAPTER 1 NEUROLOGICAL DISORDERS – also contains cosmetic changes

- Page 7 - Liability to sudden disabling giddiness – “Labyrinthine disorders” deleted
- Page 11 - Item 2(b) Other Treatment – Group 1

CHAPTER 2 CARDIOVASCULAR DISORDERS – also contains cosmetic changes

- Page 16 - Implantable Cardioverter Defibrillator (ICD) – Group 1, Item 4
- Page 17 - Peripheral Arterial Disease – Group 2
- Page 20 - Caveat – 1st paragraph
- Exercise Testing

CHAPTER 4 PSYCHIATRIC DISORDERS – also contains cosmetic changes

- Page 24 - Chronic Schizophrenia – “& other Chronic Psychoses” added to title

CHAPTER 6 VISUAL DISORDERS – also contains cosmetic changes

- Page 31 - 1st Paragraph
- Acuity – Group 1
- Monocular Vision – Group 1, Item 3
- Page 32 - Blepharospasm – Groups 1 and 2

CHAPTER 7 RENAL/RESPIRATORY DISORDERS

- Page 34 - Cough Syncope – Group 2

CHAPTER 8 MISCELLANEOUS CONDITIONS

- Page 35 - Malignant Tumours – “..... Respiratory Disorders” added to title
- AIDS Syndrome – Group 2

ANNEX 2 DISABLED DRIVERS’ ASSESSMENT CENTRES

- Page 37-38 - Amendments to various addresses/telephone numbers etc

ANNEX 3 GUIDANCE FOR WITHDRAWAL OF ANTI-EPILEPTIC MEDICATION BEING WITHDRAWN ON SPECIFIC MEDICAL ADVICE

- Page 39 - Paragraph 4 - addition
- Provoked seizures – bullet point 4

AT A GLANCE BOOKLET - INTRODUCTION

This booklet summarises the national medical guidelines of fitness to drive and is available to all doctors and health care professionals. It is also freely available on DVLA's website.

The information in the booklet will assist doctors in advising their patients whether or not their medical condition is notifiable to DVLA and of the likely outcome of medical enquiries.

In the interests of road safety, those who suffer from a medical condition likely to cause a sudden disabling event at the wheel or are unable to safely control their vehicle from any other cause, should not drive.

- **Compilation of the Guidelines.**

These guidelines represent the interpretation and application of the law in relation to fitness to drive following advice from the Secretary of State's Honorary Medical Advisory Panels. The Panels consist of doctors eminent in the respective fields of Cardiology, Neurology, Diabetes, Vision, Alcohol/Substance Abuse and Psychiatry together with lay members.

The Panels meet twice yearly and the standards are reviewed and updated where indicated. **This booklet is, therefore, only accurate at the time of going to press.**

It is also emphasised that this booklet is for use as guidance only. Whilst it provides some idea of the anticipated outcome of a medical enquiry, the specific medical factors of each case will be considered before an individual licensing decision is reached.

- **The Legal basis for the medical standards.**

The Secretary of State for Transport acting through the medical advisers at the Drivers Medical Group, DVLA, has the responsibility to ensure that all licence holders are fit to drive.

The legal basis of fitness to drive lies in the EC Directives on driver licensing, the Road Traffic Act 1988 and subsequent regulations including, in particular, the Motor Vehicles (Driving Licences) Regulations 1999.

Section 92 of the Road Traffic Act refers to prescribed, relevant and prospective disabilities.

- A prescribed disability is one that is a legal bar to the holding of the licence. Certain statutory conditions, defined in regulation, may need to be met. An example would be epilepsy.
- A relevant disability is any medical condition that is likely to render the person a source of danger while driving. An example would be a visual field defect.
- A prospective disability is any medical condition, which, because of its progressive or intermittent nature may develop into a prescribed or relevant disability in the course of time. An example would be insulin treated diabetes. A driver with a prospective disability may normally only hold a driving licence subject to medical review in one, two or three years.

Sections 92 and 93 of The Road Traffic Act also cover drivers with physical disabilities who require adaptations to their vehicle to ensure its safe control. The adaptations required are now coded and entered on the licence. (See Annex 1/2)

- **Licence Groups**

The medical standards refer to Group 1 and Group 2 licence holders.

Group 1 includes motor cars and motor cycles.

Group 2 includes large lorries (category C) and buses (category D). The medical standards for Group 2 drivers are very much higher than those of Group 1 because of the size and weight of the vehicle and also the length of time the driver may spend at the wheel in the course of his/her occupation.

All drivers who obtained entitlement to Group 1, category B (motor car) before 1 January 1997 have additional entitlement to category **C1 and D1**.

C1 is a medium size lorry of weight between 3.5 and 7.5 tonne. D1 is a minibus of between 9 and 16 seats, not for hire or reward.

Holders of C1/D1 entitlement retain the entitlement until their licence expires or it is medically revoked. On renewal the higher medical standards applicable to Group 2 will apply.

Under certain circumstances volunteer drivers can drive a minibus of up to 16 seats without having to obtain category D1 entitlement. Individuals should consult DVLA for a detailed fact sheet.

- **Age limits**

Licences are normally issued until age 70 unless restricted to a shorter duration for medical reasons as indicated above. There is no upper limit but after age 70 renewal is necessary every 3 years.

A person in receipt of the higher rate of disability living allowance may apply for a licence (Group 1 category B) from age 16, instead of the usual lower age limit of 17.

Excepting in the armed forces and certain PCV licences, Group 2 licences, lorries (category C) or buses (category D) are normally issued at age 21 and valid till age 45. Group 2 licences are renewable thereafter every five years to age 65 unless restricted to a shorter period for medical reasons.

From age 65 the licences are renewable annually without upper age limit.

- **Ambulance and Health Service Vehicle Driver Licensing**

The NHS Trust, Primary Care Trust or Health Service body in each area is responsible for determining the standards, including medical requirements, to be applied to ambulance and health service vehicle drivers, over and above the driver licensing requirements.

- **Taxi Licensing**

The House of Commons Transport Select Committee on Taxis and Private Hire Vehicles recommended in February 1995 that taxi licence applicants should pass a medical examination before a licence could be granted.

Responsibility for determining the standards, including medical requirements, to be applied to taxi drivers, over and above the driver licensing requirements, rests with the Public Carriage Office in the Metropolitan area and the Local Authority in all others areas.

- **Notification to DVLA**

It is the duty of the licence holder or licence applicant to notify DVLA of any medical condition, which may affect safe driving. On occasions however, there are circumstances in which the licence holder cannot, or will not do so.

The GMC has issued clear guidelines* applicable to such circumstances, which state:

- “1. The DVLA is legally responsible for deciding if a person is medically unfit to drive. They need to know when driving licence holders have a condition, which may, now or in the future, affect their safety as a driver.
2. Therefore, where patients have such conditions, you should:
 - Make sure that the patients understand that the condition may impair their ability to drive. If a patient is incapable of understanding this advice, for example because of dementia, you should inform the DVLA immediately.
 - Explain to patients that they have a legal duty to inform the DVLA about the condition.
3. If the patients refuse to accept the diagnosis or the effect of the condition on their ability to drive, you can suggest that the patients seek a second opinion, and make appropriate arrangements for the patients to do so. You should advise patients not to drive until the second opinion has been obtained.
4. If patients continue to drive when they are not fit to do so, you should make every reasonable effort to persuade them to stop. This may include telling their next of kin.

- 5 If you do not manage to persuade patients to stop driving, or you are given or find evidence that a patient is continuing to drive contrary to advice, you should disclose relevant medical information immediately, in confidence, to the medical adviser at DVLA.
- 6 Before giving information to the DVLA you should inform the patient of your decision to do so. Once the DVLA has been informed, you should also write to the patient, to confirm that a disclosure has been made.”

*(*Reproduced with kind permission of the General Medical Council)*

- **Application of the Medical Standards**

Once the licence holder has informed DVLA of their condition and provided consent, medical enquiries will be made, as required. The Secretary of State, in practice DVLA, is unable to make a licensing decision until all the available relevant medical information has been considered. It may therefore be a relatively lengthy process to obtain all necessary reports and, during this period, the licence holder normally retains legal entitlement to drive under Section 88 of the Road Traffic Act.

However, by reference to this booklet, the doctor in charge of their care should be able to advise the driver whether or not it is appropriate for them to continue to drive during this period. Patients may be reminded that if they choose to ignore medical advice to cease driving, there could be consequences with respect to their insurance cover. Doctors are advised to document formally and clearly in the notes the advice that has been given.

Where the licence has been revoked previously for medical reasons then Section 88 entitlement does not apply.

On receipt of all the required medical evidence, the medical adviser at DVLA will decide whether or not the driver or applicant can satisfy the national medical guidelines and the requirements of the law. A licence is accordingly issued or revoked/refused. **The Secretary of State in the person of DVLA’s medical advisers alone can make this decision.**

Any doctor who is asked for an opinion about a patient’s fitness to drive should explain the likely outcome by reference to this booklet but refer the licence holder/applicant to Drivers Medical Group, DVLA for a decision.

- **Driving after surgery**

From a licensing point of view drivers do not need to notify DVLA unless medical conditions likely to affect safe driving persist for longer than 3 months (but please see Neurological and Cardiovascular Disorders Sections for exceptions).

Therefore, drivers wishing to drive after surgery should establish with their own doctors when it is safe to do so.

Any decision regarding returning to driving must take into account several issues. These include recovery from the surgical procedure, recovery from anaesthesia (sedation and cognitive impairment), the distracting effect of pain, impairment due to analgesia (sedation and cognitive impairment) as well as any physical restrictions due to the surgery or underlying condition.

It is the responsibility of the driver to ensure that he/she is in control of the vehicle at all times and to be able to demonstrate that is so, if stopped by the police. It might also be reasonable for the driver to check his/her insurance policy before returning to drive after surgery.

- **Further advice on fitness to drive**

Doctors may enquire in writing, or may speak to one of the medical advisers during office hours, to seek advice about a particular driver (identified by an M number) or about fitness to drive in general. After office hours there is an answer-phone and it would be helpful if doctors could indicate a time when it would be convenient for a return call.

An Internet version of this document is available at <http://www.dvla.gov.uk> which includes an e-mail facility for use by medical professionals only.

In addition, DVLA's topic specific medical enquiry forms are available on the website and may be downloaded in pdf format. These may be used by drivers/applicants to notify DVLA of their condition, to support an application and to provide consent for medical enquiry. Currently, the completed forms must be forwarded to the Agency by post.

(Address for enquiries
in England, Scotland
and Wales)

The Medical Adviser
Drivers Medical Group
DVLA
Longview Road
Morriston
SWANSEA SA99 1TU

(Address for enquiries
in N. Ireland)

Driver and Vehicle Licensing
Northern Ireland
Castlerock Road
COLERAINE
BT51 3TB
Tel: 028 703 41369

Email: medadviser.dvla@gtnet.gov.uk

© Crown copyright – DVLA 1993, 1998, 1999, 2001, 2002, 2003

DVLA has no objection to this document being cited in part or in whole for the specific guidance of doctors and patients. However the document must not be reproduced in part or in whole for commercial purposes.

This booklet is published by the Department for Transport. It describes the law relating to medical aspects of driver licensing. In particular, it advises members of the medical profession on the medical standards which need to be met by individuals to hold licences to drive various categories of vehicle. The Department has prepared the document on the advice of its Advisory Panels of medical specialists.

The document provides the basis on which members of the medical profession advise individuals on whether any particular condition could affect their driving entitlement. It is the responsibility of the individual to report the condition to the DVLA in Swansea. DVLA will then conduct an assessment to see if the individual's driving entitlement may continue or whether it should be changed in any way. (For example, entitlement could be permitted for a shorter period only, typically three years, after which a further medical assessment would be carried out by DVLA).

CHAPTER 1

NEUROLOGICAL DISORDERS

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
<p>EPILEPSY Epileptic attacks are the most frequent medical cause of collapse at the wheel. NB: If within a 24 hour period, more than one epileptic attack occurs, these are treated as a “single event”, for the purpose of applying the epilepsy regulations. Epilepsy includes all events, major, minor and auras.</p>	<p>The Epilepsy Regulations Apply. Provided a licence holder/applicant is able to satisfy the regulations, a 3-year licence will be normally issued. Till 70 restored if seizure free for 7 years with medication if necessary in the absence of any other disqualifying condition. (See Annex 3 for full regulation)</p>	<p>Regulations require a driver to remain free of epileptic attacks for at least 10 years without anticonvulsant medication in that time.</p>
<p>FIRST EPILEPTIC SEIZURE/SOLITARY FIT Also see under:</p> <ol style="list-style-type: none"> 1) Fits associated with misuse of alcohol or misuse of drugs whether prescribed or illicit. 2) Neurosurgical conditions. 	<p>One year off driving with medical review before restarting driving. Till 70 restored provided no further attack and otherwise well. (Special consideration may be given when the epileptic attack is associated with certain clearly identified non-recurring provoking cause).</p>	<p>Following a first unprovoked seizure, drivers must demonstrate 10 years freedom from further seizures, without anticonvulsant medication in that time.</p> <p>1) Following a solitary seizure associated with either alcohol or substance misuse or prescribed medication, a 5 year period free of further seizures, without anticonvulsant medication in that time, is required. If there are recurrent seizures, the epilepsy regulations apply.</p>
<p>WITHDRAWAL OF ANTI-EPILEPTIC MEDICATION AND DRIVING</p>	<p>(See * annex 3)</p>	<p>(See * annex 3)</p>
<p>PROVOKED SEIZURES (apart from alcohol or illicit drug misuse)</p>	<p>(See ** annex 3)</p>	<p>(See ** annex 3)</p>
<p>NARCOLEPSY/CATAPLEXY</p>	<p>Cease driving on diagnosis. Driving will be permitted when satisfactory control of symptoms achieved, then 1, 2 or 3-year licence with regular medical review. Till 70 restored after at least 7 years of good control.</p>	<p>Generally considered unfit permanently, but if a long period of control has been established licensing may be considered on an individual basis.</p>

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
<p>CHRONIC NEUROLOGICAL DISORDERS</p> <p>e.g. Parkinson's disease, Multiple Sclerosis, muscle and movement disorders including motor neurone disease, likely to affect vehicle control because of impairment of co-ordination and muscle power. See also Driving assessment for disabled drivers.</p>	<p>Providing medical assessment confirms that driving performance is not impaired, can be licensed. A short period licence may be required. Should the driver require a restriction to certain controls, the law requires this to be specified on the licence.</p>	<p>Recommended refusal or revocation if condition is progressive or disabling. If driving would not be impaired and condition stable, may be licensed subject to annual review.</p>
<p>LIABILITY TO SUDDEN ATTACKS OF UNPROVOKED OR UNPRECIPITATED DISABLING GIDDINESS</p> <p>e.g. Meniere's disease</p>	<p>Cease driving on diagnosis.</p> <p>Driving will be permitted when satisfactory control of symptoms achieved. If remains symptom free, Till 70 restored.</p>	<p>Recommended refusal or revocation if condition disabling. If condition stable, must be symptom free and completely controlled for at least 1 year before re-application.</p>
<p>CEREBROVASCULAR DISEASE:</p> <p>including stroke due to occlusive vascular disease, spontaneous intracerebral haemorrhage, TIA and amaurosis fugax</p>	<p>Must not drive for at least 1 month. May resume driving after this time if the clinical recovery is satisfactory. There is no need to notify DVLA unless there is residual neurological deficit 1 month after the episode; in particular, visual field defects, cognitive defects and impaired limb function. Minor limb weakness alone will not require notification unless restriction to certain types of vehicle or vehicles with adapted controls is needed. Adaptations may be able to overcome severe physical impairment (Annex 1, 2).</p> <p>A driver experiencing multiple TIAs over a short period of time may require 3 months freedom of further attacks before resuming driving and should notify DVLA.</p> <p>Epileptic attacks occurring at the time of a stroke/TIA or in the ensuing 24 hours may be treated as provoked for licensing purposes in the absence of any previous seizure history or previous cerebral pathology.</p> <p>Seizures occurring at the time of cortical vein thrombosis require 6 months freedom of attacks before resuming driving.</p>	<p>Recommended refusal/ revocation for at least 12 months following a stroke or TIA. Can be considered for licensing after this period if there is a full and complete recovery and there are no other significant risk factors. Licensing will also be subject to satisfactory medical reports including exercise ECG testing.</p>

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
ACUTE ENCEPHALITIC ILLNESSES AND MENINGITIS	<p>1) If no seizure(s), may restart driving when clinical recovery is complete. No need to notify DVLA.</p> <p>2) If associated with seizures during acute febrile illness, recommended off driving for at least 6 months from the date of seizure(s). Till 70 then reissued.</p> <p>3) If associated with seizure(s) during or after convalescence will be required to meet epilepsy regulations.</p> <p>(See Annex 3)</p>	<p>1) As for Group 1 provided no residual disabling symptoms, and clinical recovery is complete.</p> <p>2) Must stop driving and notify DVLA.</p> <p>(a) Meningitis - 5 years freedom from seizures without anticonvulsant medication.</p> <p>(b) Encephalitis - 10 years freedom from seizures without anticonvulsant medication.</p> <p>3) Must stop driving, notify DVLA and meet current epilepsy regulations before driving resumes.</p> <p>(See Annex 3)</p>
TRANSIENT GLOBAL AMNESIA	<p>Provided epilepsy, any sequelae from head injury and other causes of altered awareness have been excluded, no restriction on driving. DVLA need not be notified Till 70 retained.</p>	<p>A single confirmed episode is not a bar to driving, the licence may be retained. If two or more episodes occur, driving should cease and DVLA be notified. Specialist assessment required to exclude all other causes of altered awareness.</p>
<p>EPILEPSY/EPILEPTIC SEIZURES</p> <p>General guidance for ALL neurosurgical conditions if associated with epilepsy or epileptic seizures</p>	<p>In all cases where epilepsy has been diagnosed the epilepsy regulations must apply. These cases will include all cases of single seizure where a primary cerebral cause is present and the liability to recurrence cannot be excluded. An exception may be made when seizures occur at the time of an acute head injury or intracranial surgery.</p>	<p>In all cases where a “liability to epileptic seizures” either primary or secondary has been diagnosed the specific epilepsy regulation for this group must apply. The only exception is a seizure occurring immediately at the time of the acute head injury or intracranial surgery, and not thereafter and/or where no liability to seizure has been demonstrated. Following head injury or intracranial surgery, the epilepsy risk must fall to 2% per annum or less before returning to vocational driving.</p>
<p>BENIGN SUPRATENTORIAL TUMOUR</p> <p>e.g. meningioma, etc.</p> <p>SURGICAL TREATMENT BY CRANIOTOMY</p> <p>Untreated incidental finding</p>	<p>One year off driving. A short period licence may be required when re-licensed initially.</p> <p>Asymptomatic tumours found incidentally need not affect Group 1 driving.</p>	<p>Recommended refusal or revocation. New application may be considered, provided at least 10 years since surgery, with evidence of complete removal or cure. Specialist assessment may be required.</p>

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
<p>PITUITARY TUMOUR</p> <ul style="list-style-type: none"> CRANIOTOMY TRANSPHENOIDAL SURGERY/OTHER TREATMENT (e.g. drugs, radiotherapy) or Untreated 	<p>Provided no visual field defect (if visual field loss see Vision section)</p> <ul style="list-style-type: none"> Resume driving when clinically recovered. Drive following recovery. 	<p>Provided no visual field defect (if visual field loss see Vision section)</p> <ul style="list-style-type: none"> 6 months off driving. As for Group 1
<p>BENIGN INFRATENTORIAL TUMOURS (posterior fossa)</p> <p>SURGICAL TREATMENT</p>	<p>Resume driving following recovery and retain Till 70 licence.</p>	<p>As for Group 1 provided no residual disabling symptoms.</p>
<p>GLIOMAS & MALIGNANT TUMOURS (including secondary deposits)</p> <p>NB: Supratentorial or Brainstem</p> <p>Grades 1 and 2</p> <p>Grades 3 and 4</p> <p>Medulloblastoma or Low Grade Ependymoma</p> <p>High Grade Ependymomas, Other Primary Malignant Brain Tumours and Secondary Deposits</p> <p>MALIGNANT INTRACRANIAL TUMOUR IN CHILDREN WHO SURVIVE TO ADULT LIFE WITHOUT RECURRENCE</p>	<p>1 year off driving and then a review licence.</p> <p>At least 2 years off driving after treatment, although some drivers may require a longer period and then a review licence.</p> <p>NB: When a low grade glioma is an incidental finding and asymptomatic, the case can be considered on an individual basis for Group 1 driving.</p> <p>If totally excised, can be considered for licensing 1 year after primary treatment, if free of recurrence.</p> <p>A period of up to 2 years required following treatment, depending on histology, tumour spread and seizures.</p> <p>Normally Till 70 licence.</p>	<p>Recommended permanent refusal or revocation.</p> <p>Recommended permanent refusal or revocation.</p> <p>If entirely infratentorial, can be considered for licensing when disease free for 5 years.</p> <p>Recommended permanent refusal or revocation.</p> <p>Individual assessment: see above as for “Benign Supratentorial Tumour”.</p>

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
<p>SERIOUS HEAD INJURY Acute intracerebral haematoma requiring surgery or compound depressed fracture or dural tear with more than 24 hours post-traumatic amnesia.</p> <p>ALSO SEE UNDER:</p> <ol style="list-style-type: none"> 1) Intracranial haematoma 2) Personality disorders 3) Burr hole surgery 4) Driving assessment for disabled drivers 	<p>6 – 12 months off driving.</p> <p>Where consciousness was lost but with none of the complications specified in the first column and clinical recovery is full and complete, driving may resume without notifying DVLA.</p>	<p>Recommended refusal or revocation. Specialist assessment to determine if and when driving may restart, depending on significant reduction of prospective epilepsy risk, and to ensure driving performance not likely to be impaired.</p>
<p>INTRACRANIAL HAEMATOMA</p> <p>Extradural – requiring craniotomy but NO cerebral damage</p> <p>Extradural – requiring craniotomy and WITH cerebral damage.</p>	<p>6 months off driving</p> <p>1 year off driving</p>	<p>Recommended refusal or revocation. Return to driving will depend on Specialist assessment (when epilepsy risk is 2% per annum or less).</p> <p>Recommended refusal or revocation. Return to driving will depend on Specialist assessment (when epilepsy risk is 2% per annum or less).</p>
<p>Acute Subdural</p> <ul style="list-style-type: none"> - burr holes - Craniotomy 	<p>6 months off driving.</p> <p>1 year off driving.</p>	<p>Recommended refusal or revocation. Return to driving will depend on Specialist assessment (when epilepsy risk is 2% per annum or less).</p>
<p>Chronic Subdural</p>	<p>Resume driving on recovery.</p>	<p>6 months – 1 year off depending on features.</p>
<p>Acute Intracerebral</p> <ul style="list-style-type: none"> - burr holes - Craniotomy 	<p>6 months off driving.</p> <p>1 year off driving.</p>	<p>Recommended refusal or revocation. Return to driving will depend on Specialist assessment (when epilepsy risk is 2% per annum or less).</p>

NEUROSURGICAL DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
SUBARACHNOID HAEMORRHAGE see also intracranial haematoma)		
1. NO CAUSE FOUND	Provided comprehensive cerebral angiography normal – resume driving following recovery. Till 70 licence.	Provided comprehensive cerebral angiography normal: 6 months off driving and may regain licence if symptom free.
2. DUE TO INTRACRANIAL ANEURYSM		
(a) SURGERY CRANIOTOMY Anterior or posterior cerebral aneurysm		
With NO deficit	Driving permitted when clinically recovered from craniotomy	1 year off driving
With deficit	6 months off driving. Till 70 restored if no complications	Recommended refusal or revocation. Specialist assessment to determine when driving may start – when epilepsy risk is 2% per annum or less.
Middle Cerebral Aneurysm		
With NO deficit	Driving permitted 6 months after craniotomy	18 months – 2 years off driving
With deficit	1 year off driving	Recommended refusal or revocation. Specialist assessment to determine when driving may start – when epilepsy risk is 2% per annum or less.
(b) OTHER TREATMENT e.g. Embolisation and all other non-craniotomy procedures including GDC coils.	Cease driving until clinically recovered.	Recommended refusal or revocation. (Must demonstrate lesion completely ablated with no residual abnormal vessels). Specialist assessment (including comprehensive normal angiography) to determine when driving may restart – when epilepsy risk is 2% per annum or less.
(c) NO TREATMENT ie Aneurysm present but no intervention.	6 months off driving then Till 70 if no complications	Licensing dependent upon the site and size of aneurysm.

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
<p>(d) TRULY INCIDENTAL FINDINGS OF INTRACRANIAL ANEURYSM (no history of subarachnoid haemorrhage)</p> <p>NO TREATMENT</p> <p>SURGERY CRANIOTOMY</p>	<p>Retain Till 70 licence</p> <p>Resume driving on recovery</p>	<p>Retain: dependent on reports detailing the size and site specification and no other disbarring condition.</p> <p>Recommended 1 year off driving.</p>
<p>3. DUE TO INTRACRANIAL ARTERIOVENOUS MALFORMATION (Angioma/AVM which have bled)</p>		
<p>(a) SURGERY CRANIOTOMY</p>	<p>1 year off driving. Review licence with Till 70 restored after 4 years.</p>	<p>Recommended refusal or revocation until lesion is completely removed or ablated and 10 years seizure free from last definitive treatment.</p>
<p>(b) OTHER TREATMENT (Embolisation or stereotactic radiotherapy)</p>	<p>Cease driving until satisfactory recovery. 1, 2 or 3 year licence with regular medical review. Till 70 restored if completely ablated.</p>	<p>Recommended refusal or revocation until lesion complete radiological ablation and 10 years seizure free from last definitive treatment.</p>
<p>(c) NO TREATMENT ie. Angioma present but no intervention</p>	<p>One month off driving. When clinical recovery is satisfactory – 1, 2 or 3 year licence issued initially.</p>	<p>Recommended permanent refusal or revocation.</p>
<p>(d) INCIDENTAL FINDING OF INTRACRANIAL AVM/ANGIOMA (no history of subarachnoid haemorrhage)</p> <p>NO TREATMENT</p> <p>SURGICAL/OTHER TREATMENT</p>	<p>Retain Till 70</p> <p>Period off driving depending on type of treatment (if any) – see section 3a, b above.</p>	<p>Recommended refusal or revocation.</p> <p>Recommendation depending on type of management – see 3a, b above.</p>

NEUROSURGICAL DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
INTRACEREBRAL ABSCESS/ SUBDURAL EMPYEMA	One year off driving, high risk of developing epilepsy.	Recommended refusal or revocation. Very high prospective risk of epilepsy. May consider if 10 years from treatment and no seizure.
HYDROCEPHALUS	If uncomplicated, Till 70 licence.	Can be issued with a licence if uncomplicated and no associated neurological problems.
INTRAVENTRICULAR SHUNT Insertion of or revision of upper end of V.P. shunt	Recommended 6 months off driving after shunt insertion, then, if symptom free, Till 70 restored.	Assessment required, cases considered individually.
INTRACRANIAL PRESSURE MONITORING DEVICE Inserted by Burr hole surgery.	(The prospective risk from the underlying condition must be considered also)	(The prospective risk from the underlying condition must be considered also)
NEUROENDOSCOPIC PROCEDURES	May require up to 6 months off driving.	Will require individual assessment.
IMPLANTED ELECTRODES: DEEP BRAIN STIMULATION FOR MOVEMENT DISORDER	If no complications from surgery and seizure free, fitness can be assessed on residual symptomatology.	If no complications from surgery, seizure free and underlying condition non-progressive, fitness can be assessed on any residual symptoms.
IMPLANTED MOTOR CORTEX STIMULATOR FOR PAIN RELIEF	One year off after implantation, then issued with a 3-year licence	Refuse or revoke

LOSS OF CONSCIOUSNESS/LOSS OF OR ALTERED AWARENESS

A full history is imperative to include pre-morbid history, prodromal symptoms, length of time unconscious, degree of amnesia and confusion on recovery.

A neurological cause, for example, epilepsy, SAH, can often be identified by the history, examination and the appropriate referral made. The relevant DVLA guidelines will then apply.

50% of all cases have a cardiac cause and again, these can be determined by history, examination and ECG. Investigate and treat accordingly and use the relevant DVLA guidelines.

The remaining cases can be classified under five categories in the FOLLOWING TABLE:

NEUROLOGICAL DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
<p>1. Simple Faint</p> <p>Definite provocation factors with associated prodromal symptoms and which are unlikely to occur whilst sitting or lying.</p> <p>Benign in nature.</p> <p>If recurrent, will need to check the 3 “Ps” apply on each occasion (provocation/prodrome/postural). (If not see Section 3).</p>	<p>No driving restrictions.</p> <p>DVLA need not be notified.</p>	<p>No driving restrictions</p> <p>DVLA need not be notified.</p>
<p>2. Loss of consciousness/ loss of or altered awareness likely to be unexplained syncope and low risk of re-occurrence</p> <p>These have no relevant abnormality on CVS and neurological examination and normal ECG.</p>	<p>Can drive 4 weeks after the event.</p>	<p>Can drive 3 months after the event.</p>
<p>3. Loss of consciousness/ loss of or altered awareness likely to be unexplained syncope and high risk of re-occurrence</p> <p>Factors indicating high risk:</p> <ul style="list-style-type: none"> (a) abnormal ECG (b) clinical evidence of structural heart disease (c) syncope causing injury, occurring at the wheel or whilst sitting or lying (d) more than one episode in previous six months. <p>Further investigations such as ambulatory ECG (48hrs), echocardiography and exercise testing may be indicated after specialist opinion has been sought.</p>	<p>Can drive 4 weeks after the event if the cause has been identified and treated.</p> <p>If no cause identified, then require 6 months off.</p>	<p>Can drive after 3 months if the cause has been identified and treated.</p> <p>If no cause identified, then licence refused/revoked for one year.</p>
<p>4. Unwitnessed (presumed) loss of consciousness/loss of or altered awareness with seizure markers</p> <p>The category is for those where there is a strong clinical suspicion of epilepsy but no definite evidence.</p> <p>The seizure markers act as indicators and are not absolutes – unconsciousness for more than 5 mins.</p> <ul style="list-style-type: none"> - amnesia greater than 5 mins - injury - tongue biting - incontinence - remain conscious but with confused behaviour - headache post attack 	<p>1 year refusal/revocation.</p>	<p>5 years refusal/revocation.</p>
<p>5. Loss of consciousness/loss of or altered awareness with no clinical pointers</p> <p>This category will have had appropriate neurology and cardiac opinion and investigations but with no abnormality detected.</p>	<p>Refuse/revoke 6 months.</p>	<p>Refuse/revoke 1 year.</p>

CHAPTER 2

CARDIOVASCULAR DISORDERS

CARDIOVASCULAR DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
ANGINA	<p>Driving must cease when symptoms occur at rest or at the wheel.</p> <p>Driving may recommence when satisfactory symptom control is achieved.</p> <p>DVLA need not be notified.</p>	<p>Refusal or revocation with continuing symptoms (treated and/or untreated)</p> <p>Re/licensing may be permitted when free from angina for at least 6/52, provided that the exercise test requirements can be met and there is no other disqualifying condition.</p>
ANGIOPLASTY (elective)	<p>Driving must cease for at least 1/52.</p> <p>Driving may recommence thereafter provided there is no other disqualifying condition.</p> <p>DVLA need not be notified.</p>	<p>Disqualifies from driving for at least 6/52.</p> <p>Re/licensing may be permitted thereafter provided that the exercise test requirements can be met and there is no other disqualifying condition.</p>
<p>ACUTE CORONARY SYNDROMES including MYOCARDIAL INFARCTION and irrespective of treatment **</p> <p>defined for Group 1 licences, to include all three of the following criteria:</p> <ul style="list-style-type: none"> • Persistent or recurrent cardiac pain • Cardiac troponin release positive • Electrocardiographic changes 	<p>Driving must cease for at least 4/52.</p> <p>Driving may recommence thereafter provided there is no other disqualifying condition.</p> <p>DVLA need not be notified.</p>	<p>** For Group 2 licences, ALL acute coronary syndromes are considered relevant.</p> <p>Disqualifies from driving for at least 6/52.</p> <p>Re/licensing may be permitted thereafter provided that the exercise test requirements can be met and there is no other disqualifying condition.</p>
CABG	<p>Driving must cease for at least 4/52.</p> <p>Driving may recommence thereafter provided there is no other disqualifying condition.</p> <p>DVLA need not be notified.</p>	<p>Disqualifies from driving for at least 6/52.</p> <p>Re/licensing may be permitted thereafter provided that the exercise test requirements can be met and there is no other disqualifying condition.</p>
<p>ARRHYTHMIA</p> <p>Sinoatrial disease</p> <p>Significant atrio-ventricular conduction defect</p> <p>Atrial flutter/fibrillation</p> <p>Narrow or broad complex tachycardia</p> <p>(See also following Sections)</p> <p>NB: Transient Arrhythmias occurring during acute coronary syndromes do not require assessment under this Section.</p>	<p>Driving must cease if the arrhythmia has caused or is likely to cause incapacity.</p> <p>Driving may be permitted when underlying cause has been identified and controlled for at least 4/52.</p> <p>DVLA need not be notified unless there are distracting/disabling symptoms.</p>	<p>Disqualifies from driving if the arrhythmia has caused or is likely to cause incapacity.</p> <p>Driving may be permitted when the arrhythmia is controlled for at least 3/12, provided that the LV ejection fraction is good (ie LVEF is >0.4), and there is no other disqualifying condition.</p>

CARDIOVASCULAR DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
<p>PACEMAKER IMPLANT</p> <p>Includes box change</p>	<p>Driving must cease for at least 1/52.</p> <p>Driving may be permitted thereafter provided there is no other disqualifying condition.</p>	<p>Disqualifies from driving for 6/52.</p> <p>Re/licensing may be permitted thereafter provided there is no other disqualifying condition.</p>
<p>SUCCESSFUL CATHETER ABLATION</p>	<p>Driving must cease for at least 1/52.</p> <p>Driving may be permitted thereafter provided there is no other disqualifying condition.</p> <p>DVLA need not be notified.</p>	<p>Disqualifies from driving for 6/52.</p> <p>Re/licensing may be permitted thereafter provided that there is no other disqualifying condition.</p>
<p>ATRIAL DEFIBRILLATOR Physician/patient activated</p>	<p>Driving may continue provided there is no other disqualifying condition.</p> <p>See ICD Section</p>	<p>Re/licensing may be permitted provided that the arrhythmia section is met and there is no other disqualifying condition.</p>
<p>ATRIAL DEFIBRILLATOR Automatic</p>	<p>Driving may continue provided there is no other disqualifying condition.</p> <p>See ICD Section</p>	<p>Permanently bars</p>
<p>IMPLANTABLE CARDIOVERTER DEFIBRILLATOR (ICD)</p>	<p>Driving may occur when the following criteria can be met:</p> <ol style="list-style-type: none"> 1) The first device has been implanted for at least 6 months. 2) The device has not administered therapy (shock and/or symptomatic antitachycardia pacing) within the last 6/12 (except during formal clinical testing). 3) Any previous therapy following device implantation has not been accompanied by incapacity (whether caused by the device or arrhythmia) in the preceding 2 years unless the underlying cause has been identified and controlled. 4) A period of 1 month off driving must occur following any revision of the device (generator and/or electrode) or alteration of anti-arrhythmic drug treatment. <p>NB. A period of 1 week off driving is required after reinsertion of a defibrillator box, provided that the settings remain unchanged.</p> <ol style="list-style-type: none"> 5) The device is subject to regular review with interrogation. 6) There is no other disqualifying condition. 	<p>Permanently bars</p>

CARDIOVASCULAR DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
<p>PROPHYLACTIC ICD IMPLANT</p> <p>(See Appendix to this section for FULL details)</p>	<p>Asymptomatic individuals with high risk of significant arrhythmia. If with a non-disqualifying cardiac event:</p> <ul style="list-style-type: none"> • LVEF greater than 35% • No fast VT induced on electrophysiological study (RR <250 msec) • Induced VT could be terminated by the ICD twice, without acceleration, during the post implantation study. <p>One month off driving. DVLA need not be notified.</p>	<p>Permanently bars</p>
<p>ARRHYTHMOGENIC RIGHT VENTRICULAR DYSPLASIA (ARVD) AND ALLIED DISORDERS</p> <p>(See also arrhythmia, pacemaker and ICD sections)</p>	<p>Asymptomatic – Driving may continue.</p> <p>DVLA need not be notified.</p> <p>Symptomatic – Driving must cease if an arrhythmia has caused or is likely to cause incapacity. Re/licensing may be permitted when arrhythmia is controlled and there is no other disqualifying condition.</p>	<p>Asymptomatic – Driving must cease but may be permitted following Specialist electro-physiological assessment provided that there is no other disqualifying condition.</p> <p>Symptomatic – permanently bars</p>
SYNCOPE	See section entitled “Loss of Consciousness” (Chapter 1)	See section entitled “Loss of Consciousness” (Chapter 1)
HYPERTENSION	<p>Driving may continue unless treatment causes unacceptable side effects.</p> <p>DVLA need not be notified.</p>	<p>Disqualifies from driving if resting BP consistently 180 mm Hg systolic or more and/or 100 mm Hg diastolic or more.</p> <p>Re/licensing may be permitted when controlled provided that treatment does not cause side effects which may interfere with driving.</p>
<p>PERIPHERAL ARTERIAL DISEASE</p> <p>Including Abdominal Aortic aneurysm</p>	<p>Driving may continue unless other disqualifying condition.</p> <p>DVLA need not be notified</p>	<p>Re/licensing may be permitted provided that:</p> <ul style="list-style-type: none"> • there is no symptomatic myocardial ischaemia • the exercise test requirements can be met and • the aneurysm, where present, is not >5.5 cm in diameter and there is no other disqualifying condition. <p>When exercise testing cannot be completed to the required level, specialist cardiological opinion may be required.</p>

CARDIOVASCULAR DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
THORACIC AORTIC ANEURYSM including MARFAN'S SYNDROME and AORTIC DISSECTION	Driving may continue unless other disqualifying condition. DVLA need not be notified.	Disqualifies from driving if the aortic transverse diameter is >5.0 cm Re/licensing may be permitted following satisfactory repair unless there is other disqualifying condition.
HYPERTROPHIC CARDIOMYOPATHY (H.C.M) (See also arrhythmia, pacemaker and ICD sections)	Driving may continue provided no other disqualifying condition. DVLA need not be notified.	Disqualifies from driving if symptomatic. Re/licensing may be permitted provided that the following criteria can be met and there is no other disqualifying condition: 1) He/she is asymptomatic. 2) There is no family history of sudden cardiomyopathic death. 3) The cardiologist can confirm that the HCM is anatomically mild. 4) No serious abnormality of heart rhythm disturbance has been demonstrated, ie ventricular tachyarrhythmia excluding isolated VPBs. 5) Hypotension does not occur during exercise testing.
DILATED CARDIOMYOPATHY (See also arrhythmia, pacemaker, I.C.D and heart failure sections)	Driving may continue provided no other disqualifying condition. DVLA need not be notified	Disqualifies from driving if symptomatic. Re/licensing may be permitted provided that there is no other disqualifying condition.
HEART OR HEART LUNG TRANSPLANT	Driving may continue provided no other disqualifying condition. DVLA need not be notified	Disqualifies from driving if symptomatic. Re/licensing may be permitted provided that the exercise test requirement can be met, the LV function remains good (ie LVEF is >0.4) and there is no other disqualifying condition.
HEART VALVE DISEASE (to include surgery, ie replacement and/or repair)	Driving may continue provided no other disqualifying condition. DVLA need not be notified	Disqualifies from Driving: 1) whilst symptomatic. 2) For 12 months after cerebral embolism following which Specialist assessment is required to determine licensing fitness. Re/licensing may be permitted provided that there is no other disqualifying condition.

CARDIOVASCULAR DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
HEART FAILURE	Driving may continue provided there are no symptoms that may distract the driver's attention. DVLA need not be notified	Disqualifies from driving if symptomatic. Re/licensing may be permitted provided that the LV ejection fraction is good (ie LVEF is >0.4), the exercise test requirements can be met and there is no other disqualifying condition.
CONGENITAL HEART DISEASE	Driving may continue provided there is no other disqualifying condition. DVLA need not be notified.	Disqualifies from driving when complex or severe disorder(s) is(are) present. Those with minor disease and others who have had successful repair of defects or relief of valvular problems, fistulae etc may be licensed provided that there is no other disqualifying condition. * Further details available from DVLA on request.
ECG ABNORMALITY Suspected myocardial infarction Left Bundle Branch Block _____ PRE-EXCITATION	Driving may continue unless other disqualifying condition.	Re/licensing may be permitted provided that there is no other disqualifying condition and the exercise test requirements can be met. _____ May be ignored unless associated with an arrhythmia (see Arrhythmia Section) or other disqualifying condition.

APPENDIX

GROUP 1 – PROPHYLACTIC ICD IMPLANT

The device has been implanted in those asymptomatic individuals considered to be at high risk of significant arrhythmia as a result of relevant family history or other condition, i.e. prior to implantation a symptomatic arrhythmia has not occurred (See “PRIMARY PREVENTION” in N.I.C.E. guidance, September 2000).

In addition, devices implanted in patients presenting with a non-disqualifying cardiac event e.g. a haemodynamically stable episode of ventricular tachycardia (VT) post infarction, may be considered as “prophylactic” subject to the following criteria:

- LVEF greater than 35%
- No **fast** VT induced on electrophysiological study (RR < 250 msec)
- Induced VT could be terminated by the ICD twice, without acceleration, during the study.

Thus, this subgroup will need a post-ICD implant study, where (slow) VT is induced and terminated twice by the device without acceleration.

CAVEAT

If the most recent symptomatic arrhythmia has occurred 2 years or more prior to the ICD implantation, then the ICD is regarded as prophylactic, provided that the anti-arrhythmic medication is continued.

Following implantation, driving must cease for 1/12 and may recommence thereafter subject to satisfactory outpatient review at that time.

NB: Should the ICD subsequently deliver ATP and/or shock therapy (except during formal clinical testing) then the usual ICD criteria apply and DVLA should be notified.

GROUP 1 AND 2 ENTITLEMENTS

MEDICATION

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

GROUP 2 ENTITLEMENT ONLY

LICENCE DURATION

An applicant or driver who has, after cardiac assessment, been permitted to hold either LGV or PCV licence will usually be issued with a short term licence (maximum duration 3 years) renewable on receipt of satisfactory medical reports.

EXERCISE TESTING

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

* cycling for ten minutes with 20 watt increments/minute to a total of 200W

** Anti-anginal medication refers to the use of nitrates, B-blockers, Nicorandil and calcium antagonists.

prescribed for anti-anginal purposes or for other reasons such as cardio-protection.

Any of these medicines which are prescribed **specifically for the control of hypertension &/or arrhythmia** need **NOT** be discontinued prior to exercise testing.

If the cause of the chest pain is in doubt, an exercise test should be carried out as above. Those with a locomotor disorder who cannot comply will require specialist cardiological opinion.

CORONARY ANGIOGRAPHY (within the preceding 12 months)

In coronary heart disease, angiography is not required for (re-)licensing purposes. If angiography has been undertaken, (re-)licensing will not normally be permitted if the left ventricular ejection fraction is equal to or ≤ 0.40 on contrast angiography, OR if there is significant proximal, unrelieved coronary arterial stenosis affecting the left main stem, equal to or $\geq 50\%$ diameter and/or the proximal left anterior descending equal to or $\geq 75\%$ diameter, as measured by QUANTITATIVE CORONARY ANGIOGRAPHY.

CHAPTER 3
DIABETES MELLITUS

DIABETES MELLITUS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
<p>INSULIN TREATED</p> <p>Diabetic drivers are sent a detailed letter of explanation about their licence and driving by DVLA.</p>	<p>Must recognise warning symptoms of hypoglycaemia and meet required visual standards. 1, 2 or 3 year licence.</p>	<p>New applicants on insulin or existing drivers are barred in law from driving HGV or PCV vehicles from 1/4/91. Drivers licensed before 1/4/91 on insulin are dealt with individually and licensed subject to satisfactory annual Consultant assessment. Regulation changes in April 2001 allow “exceptional case” drivers to apply for or retain their entitlement to drive class C1 vehicles (3500-7500kgs lorries) subject to annual medical examination.</p>
<p>TEMPORARY INSULIN TREATMENT</p> <p>e.g. gestational diabetes, post-myocardial infarction, participants in oral/inhaled insulin trials.</p>	<p>May retain licence but should stop driving if experiencing disabling hypoglycaemia.</p> <p>Notify DVLA again if treatment continues for more than 3 months.</p>	<p>Legal bar to holding a licence while insulin treated. May reapply when insulin treatment is discontinued.</p>
<p>MANAGED BY DIET AND TABLETS</p> <p>Diabetic drivers are sent a detailed letter of explanation about their licence and their driving by DVLA.</p>	<p>Will be able to retain Till 70 licence unless develop relevant disabilities e.g. diabetic eye problems affecting visual acuity or visual field or if insulin required.</p>	<p>Drivers will be licensed unless they develop relevant disabilities e.g. diabetic eye problem affecting visual acuity or visual fields, in which case either recommended refusal or revocation or short period licence. If becomes insulin treated will be recommended refusal or revocation.</p>
<p>MANAGED BY DIET ALONE</p> <p>Diabetic drivers are sent a detailed letter of explanation about their licence and driving by DVLA.</p>	<p>Need not notify DVLA unless develop relevant disabilities e.g. Diabetic eye problems affecting visual acuity or visual field or if insulin required.</p>	<p>Drivers will be licensed unless they develop relevant disabilities e.g. diabetic eye problem affecting visual acuity or visual fields, in which case the application will be refused or the licence revoked.</p>
DIABETIC COMPLICATIONS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
<p>Frequent hypoglycaemic episodes likely to impair driving</p>	<p>Cease driving until satisfactory control re-established, with consultant/GP report.</p>	<p>See above for insulin treated. Recommended refusal or revocation.</p>
<p>Impaired awareness of Hypoglycaemia</p>	<p>If confirmed, driving must stop. Driving may resume provided reports show awareness of hypoglycaemia has been regained, confirmed by consultant/GP report.</p>	<p>See above for insulin treated. Recommended refusal or revocation.</p>
<p>Eyesight complications (affecting visual acuity or fields)</p>	<p>See Section: Visual Disorders</p>	<p>See above for insulin treated and Section: Visual Disorders.</p>
<p>Renal Disorders</p>	<p>See Section: Renal Disorders</p>	<p>See Section: Renal Disorders</p>
<p>Limb Disability e.g. peripheral neuropathy</p>	<p>See Section: Disabled Drivers at Annex 1</p>	<p>As Group 1</p>

CHAPTER 4

PSYCHIATRIC DISORDERS

PSYCHIATRIC DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
<p>ANXIETY OR DEPRESSION</p> <p>(without significant memory or concentration problems, agitation, behavioural disturbance or suicidal thoughts).</p>	<p>DVLA need not be notified and driving may continue. (See note about medication below).</p>	<p>Very minor short-lived illnesses need not be notified to DVLA. (See note about medication below).</p>
<p>MORE SEVERE ANXIETY STATES OR DEPRESSIVE ILLNESSES</p> <p>(with significant memory or concentration problems, agitation, behavioural disturbance or suicidal thoughts)</p>	<p>Driving should cease pending the outcome of medical enquiry. A period of stability depending upon the circumstances will be required before driving can be resumed. Particularly dangerous are those who may attempt suicide at the wheel.</p>	<p>Driving may be permitted when the person is well and stable for a period of 6 months. Medication must not cause side effects, which would interfere with alertness or concentration. Driving is usually permitted if the anxiety or depression is long-standing, but maintained symptom-free on doses of psychotropic medication which do not impair. DVLA may require psychiatric reports.</p> <p>NB: It is the illness rather than the medication, which is of prime importance, but see notes on medication.</p>
<p>ACUTE PSYCHOTIC DISORDERS OF ANY TYPE</p>	<p>Driving must cease during the acute illness. Re-licensing can be considered when all of the following conditions can be satisfied:</p> <ul style="list-style-type: none"> (a) Has remained well and stable for at least 3 months. (b) Is compliant with treatment. (c) Is free from adverse effects of medication which would impair driving. (d) Subject to a favourable specialist report. <p>Drivers who have a history of instability and/or poor compliance will require a longer period off driving.</p>	<p>Driving should cease pending the outcome of medical enquiry. It is a requirement that the person must be well and stable for a minimum of 3 years with insight into their condition before driving can be resumed. At that time, DVLA will usually require a Consultant examination. Any psychotropic medication should be of minimum effective dosage and not interfere with alertness, concentration, or in any other way impair driving performance. There should be no significant likelihood of recurrence.</p>

PSYCHIATRIC DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
<p>HYPOMANIA/MANIA</p> <p>NB: For cases which also involve persistent misuse of or dependency on alcohol/drugs, please refer to the appropriate section of Chapter 5.</p>	<p>Driving must cease during the acute illness. Following an isolated episode, re-licensing can be reconsidered when all the following conditions can be satisfied:</p> <ul style="list-style-type: none"> (a) Has remained well and stable for at least 3 months. (b) Is compliant with treatment. (c) Has regained insight. (d) Is free from adverse effects of medication which would impair driving. (e) Subject to a favourable specialist report. <p>REPEATED CHANGES OF MOOD: Hypomania or mania are particularly dangerous to driving when there are repeated changes of mood. Therefore, when there have been 4 or more episodes of mood swing within the previous 12 months, at least 6 months stability will be required under condition (a), in addition to satisfying conditions (b) to (e).</p>	<p>Driving must cease pending the outcome of medical enquiry. The person must be well and stable for a minimum of 3 years with insight into their condition before driving can be resumed. At that time, DVLA will usually require a Consultant examination. Any psychotropic medication should be of minimum effective dosage and not interfere with alertness, concentration or in any other way impair driving performance. There should be no significant likelihood of recurrence.</p>
<p>CHRONIC SCHIZOPHRENIA & Other Chronic Psychoses</p> <p>NB: For cases which also involve persistent misuse of or dependency on alcohol/drugs, please refer to the appropriate section of Chapter 5.</p>	<p>The driver must satisfy all the following conditions:</p> <ul style="list-style-type: none"> (a) Stable behaviour for at least 3 months. (b) Is adequately compliant with treatment. (c) Remain free from adverse effects of medication which would impair driving. (d) Subject to a favourable specialist report. <p>Continuing symptoms: Even with limited insight, these do not necessarily preclude licensing. Symptoms should be unlikely to cause significant concentration problems, memory impairment or distraction whilst driving. Particularly dangerous, are those drivers whose psychotic symptoms relate to other road users.</p>	<p>Driving must cease pending the outcome of medical enquiry. The person must be well and stable for a minimum of 3 years with insight into their condition before driving can be resumed. At that time, DVLA will usually require a Consultant examination. Any psychotropic medication should be of minimum effective dosage and not interfere with alertness, concentration or in any other way impair driving performance. There should be no significant likelihood of recurrence.</p>

PSYCHIATRIC DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
DEMENTIA OR ANY ORGANIC BRAIN SYNDROME	<p>It is extremely difficult to assess driving ability in those with dementia. Those who have poor short-term memory, disorientation, lack of insight and judgement are almost certainly not fit to drive.</p> <p>The variable presentations and rates of progression are acknowledged. Disorders of attention will also cause impairment. A decision regarding fitness to drive is usually based on medical reports.</p> <p>In early dementia when sufficient skills are retained and progression is slow, a licence may be issued subject to annual review. A formal driving assessment may be necessary. (See Annex 1 and 2)</p>	Refuse or revoke licence.
LEARNING DISABILITY means a state of arrested or incomplete development of mind, which includes severe impairment of intelligence and social functioning.	Severe learning disability is not compatible with driving and the licence application must be refused. In milder forms, provided there are no other relevant problems, it may be possible to hold a licence, but it will be necessary to demonstrate adequate functional ability at the wheel.	Recommended permanent refusal or revocation if severe. Minor degrees of learning disability when the condition is stable with no medical or psychiatric complications may be compatible with the holding of a licence.
PERSISTENT BEHAVIOUR DISORDER (including post head injury syndrome and psychopathic disorders and Non-Epileptic Seizure Disorder).	If seriously disturbed e.g. violent behaviour or alcohol abuse and likely to be a source of danger at the wheel, licence would be revoked or the application refused. Licence will be issued after medical reports confirm that behavioural disturbances have been satisfactorily controlled.	Recommended refusal or revocation if associated with serious behaviour disturbance likely to make the individual be a source of danger at the wheel. If the person matures and psychiatric reports confirm stability then consideration would be given to restoration of the licence but Consultant Psychiatrist report would be required.

PSYCHIATRIC NOTES

- The 2nd EC Directive requires member states to set minimum medical standards of fitness to drive and sets out the requirements for mental health in broad terms.
- The Directive makes a clear distinction between the standards needed for Group 1 (cars and motorcycles) and Group 2 (lorries and buses) licences, the standards for the latter being more stringent due to the size of vehicle and the greater time spent at the wheel during the course of the occupation.
- Severe mental disorder is a prescribed disability for the purposes of Section 92 of the Road Traffic Act 1988. Regulations define “severe mental disorder” as including mental illness, arrested or incomplete development of the mind, psychopathic disorder or severe impairment of intelligence or social functioning. The standards must reflect, not only the need for an improvement in the mental state, but also a period of stability, such that the risk of relapse can be assessed should the patient fail to recognise any deterioration.
- Misuse of or dependency on alcohol or drugs will require the standards in this chapter to be considered in conjunction with those of Chapter 5 of this publication.

MEDICATION

- Section 4 of the Road Traffic Act 1988 does not differentiate between illicit or prescribed drugs. Therefore, any person who is driving or attempting to drive on the public highway, or other public place whilst unfit due to any drug, is liable to prosecution.
- All drugs acting on the central nervous system can impair alertness, concentration and driving performance. This is particularly so at initiation of treatment, or soon after and when dosage is being increased. Driving must cease if adversely affected.
- The older tricyclic antidepressants can have pronounced anticholinergic and antihistaminic effects, which may impair driving. The more modern antidepressants may have fewer adverse effects. **These considerations need to be taken into account when planning the treatment of a patient who is a professional driver.**
- Anti-psychotic drugs, including the depot preparations, can cause motor or extrapyramidal effects as well as sedation or poor concentration, which may, either alone or in combination, be sufficient to impair driving. Careful clinical assessment is required.
- The epileptogenic potential of psychotropic medication should be considered particularly when patients are professional drivers.
- Benzodiazepines are the most likely psychotropic medication to impair driving performance, particularly the long acting compounds. **Alcohol will potentiate the effects.**
- Doctors have a duty of care to advise their patients of the potential dangers of adverse effects from medication and interactions with other substances, especially alcohol.
- Drivers with psychiatric illnesses are often safer when well and on regular psychotropic medication than when they are ill. Inadequate treatment or irregular compliance may render a driver impaired by both the illness and medication.

CONFIDENTIALITY

When a patient has a condition which makes driving unsafe and the patient is either unable to appreciate this, or refuses to cease driving, GMC guidelines advise breaking confidentiality and informing DVLA. [GMC Confidentiality Handbook]

PATIENTS UNDER SECTION 17 OF THE MENTAL HEALTH ACT

Before resuming driving, drivers must be able to satisfy the standards of fitness for their respective conditions and be free from any effects of medication, which will affect driving adversely.

CHAPTER 5

DRUG AND ALCOHOL MISUSE AND DEPENDENCY

ALCOHOL PROBLEMS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
<p>ALCOHOL MISUSE</p> <p>There is no single definition which embraces all the variables in this condition but the following is offered as a guide:</p> <p>“ a state which, because of consumption of alcohol, causes disturbance of behaviour, related disease or other consequences, likely to cause the patient, his/her family or society harm now, or in the future, and which may or may not be associated with dependency”.</p> <p>Reference to ICD10 F10.1 is relevant.</p>	<p>ALCOHOL MISUSE</p> <p>Persistent alcohol misuse, confirmed by medical enquiry and/or by evidence of otherwise unexplained abnormal blood markers, requires licence revocation or refusal until a minimum six month period of controlled drinking or abstinence has been attained, with normalisation of blood parameters.</p> <p>Patient recommended to seek advice from medical or other sources during the period off the road.</p>	<p>ALCOHOL MISUSE</p> <p>Persistent alcohol misuse, confirmed by medical enquiry and/or by evidence of otherwise unexplained abnormal blood markers, requires revocation or refusal of a vocational licence until at least one year period of abstinence or controlled drinking has been attained, with normalisation of blood parameters.</p> <p>Patient recommended to seek advice from medical or other sources during the period off the road.</p>
<p>ALCOHOL DEPENDENCY</p> <p>“A cluster of behavioural, cognitive & physiological phenomena that develop after repeated alcohol use & which include a strong desire to take alcohol, difficulties in controlling its use, persistence in its use despite harmful consequences, with evidence of increased tolerance and sometimes a physical withdrawal state.”</p> <p>Indicators may include a history of withdrawal symptoms, of tolerance, of detoxification(s) and/or alcohol related fits.</p> <p>Reference to ICD10 F10.2 – F10.7 inclusive is relevant.</p>	<p>ALCOHOL DEPENDENCY</p> <p>Alcohol dependency, confirmed by medical enquiry, requires licence revocation or refusal until a one year period free from alcohol problems has been attained. Abstinence will normally be required, with normalisation of blood parameters, if relevant.</p> <p>LICENCE RESTORATION</p> <p>Will require satisfactory medical reports from own doctor(s) and may require independent medical examination and blood tests, arranged by DVLA.</p> <p>Consultant support/referral may be necessary.</p> <p>See also under “Alcohol related seizures”</p>	<p>ALCOHOL DEPENDENCY</p> <p>Vocational licensing will not be granted where there is a history of alcohol dependency within the past three years.</p> <p>LICENCE RESTORATION</p> <p>Will require satisfactory medical reports from own doctor(s) and may require independent medical examination and blood tests, arranged by DVLA.</p> <p>Consultant support/referral may be necessary.</p> <p>See also under “Alcohol related seizures”</p>

ALCOHOL PROBLEMS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
Alcohol Related Seizure(s)	Following a solitary alcohol-related seizure, a licence will be revoked or refused for a minimum one year period from the date of the event. Where more than one seizure has occurred, consideration under the Epilepsy Regulations will be necessary.	Following a solitary alcohol-related seizure, a licence will be revoked or refused for a minimum five year period from the date of the event. Licence restoration thereafter requires:
-	Medical enquiry will be required before licence restoration to confirm appropriate period free from persistent alcohol misuse and/or dependency. Independent medical assessment with blood analysis and consultant reports will normally be necessary.	<ul style="list-style-type: none"> • No underlying cerebral structural abnormality • Off anti-epileptic medication for at least 5 years • Maintained abstinence from alcohol if previously dependent • Review by an addiction specialist & neurological opinion.
ALCOHOL RELATED DISORDERS : e.g: hepatic cirrhosis with neuro-psychiatric impairment, psychosis.	Driving should cease. Licence normally recommended to be refused/revoked until there is satisfactory recovery and is able to satisfy all other relevant medical standards.	Where more than one seizure has occurred or there is an underlying cerebral structural abnormality, the Vocational Epilepsy Regulations apply. (See Annex 3) Licence recommended to be refused/revoked.

HIGH RISK OFFENDER SCHEME for drivers convicted of certain drink/driving offences and meeting any of the following:

- (a) One disqualification for driving, or being in charge of a vehicle, when the level of alcohol in the body equalled or exceeded:
 - (i) 87.5 microgrammes per 100 millilitres of breath, or
 - (ii) 200 milligrammes per 100 millilitres of blood, or
 - (iii) 267.5 milligrammes per 100 millilitres of urine.
- (b) Two disqualifications within the space of ten years for drinking and driving, or being in charge of a vehicle whilst under the influence of alcohol.
- (b) One disqualification for refusing/failing to supply a specimen for analysis.

DVLA will be notified of such offenders by the courts. When an application for licence re-instatement is made, an independent medical examination will be conducted, which includes a questionnaire, serum AST, GGT and MCV assay and may include further assessments as indicated. If favourable, a "Till 70" licence is restored for Group I and a recommendation can be made regarding the issue of a Group II licence.

If a High Risk Offender has a previous history of alcohol dependency or persistent misuse, but has satisfactory examination and blood tests, a short period licence is issued for ordinary and vocational entitlement but dependent on their ability to meet the standard as specified.

A High Risk Offender found to have a current history of alcohol misuse/dependency and/or unexplained abnormal blood test analysis will have the application refused.

DRUG MISUSE AND DEPENDENCY	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
Reference to ICD10 F10.1-F10.7 inclusive is relevant.		
Cannabis Amphetamines Ecstasy & other psychoactive substances, including LSD and Hallucinogens	The persistent use of or dependency on these substances, confirmed by medical enquiry, will lead to licence revocation or refusal until a six month period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, may be required.	Persistent use of or dependency on these substances will lead to refusal or revocation of a vocational licence until at least a one year period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, will normally be required.
Heroin Morphine Methadone* Cocaine	Persistent use of, or dependency on these substances, confirmed by medical enquiry, will lead to licence refusal or revocation for a minimum one year period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, may be required. In addition favourable Consultant or Specialist report may be required on reapplication. * Applicants or drivers complying fully with a Consultant supervised oral Methadone maintenance programme may be licensed, subject to favourable assessment and, normally, annual medical review. Applicants or drivers on an oral buprenorphine programme may be considered applying the same criteria.	Persistent use of, or dependency on these substances, will require revocation or refusal of a vocational licence until a minimum three year period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, will normally be required. In addition favourable Consultant or Specialist report will be required before relicensing. *Applicants or drivers complying fully with a Consultant supervised oral Methadone maintenance programme may be considered for an annual review licence once a minimum three year period of stability on the maintenance programme has been established, with favourable random urine tests and assessment. Expert Panel advice will be required in each case
Benzodiazepines		
The non-prescribed use of these drugs and/or the use of supra-therapeutic dosage, whether in a substance withdrawal/maintenance programme or otherwise, constitutes misuse/dependency for licensing purposes. The prescribed use of these drugs at therapeutic doses (BNF), without evidence of impairment, does not amount to misuse/dependency for licensing purposes (although clinically dependence may exist).	Persistent misuse of, or dependency on these substances, confirmed by medical enquiry, will lead to licence refusal or revocation until a minimum one year period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, may be required. In addition favourable Consultant or Specialist report may be required on reapplication.	Persistent misuse of, or dependency on these substances, will require revocation or refusal of a vocational licence for a minimum three-year period. Independent medical assessment and urine screen arranged by DVLA, will normally be required. In addition favourable Consultant or Specialist report will be required before relicensing.
Multiple substance misuse and/or dependency – including misuse with alcohol – is incompatible with licensing fitness		

DRUG MISUSE AND DEPENDENCY Reference to ICD10 F10.1-F10.7 inclusive is relevant.	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
Seizure(s) associated with drug misuse/dependency	<p>Following a solitary seizure associated with drug misuse or dependency, a licence will be refused or revoked for a minimum one-year period from the date of the event. Where more than one seizure has occurred, consideration under the Epilepsy Regulations will be necessary.</p> <p>Medical enquiry will be required before licence restoration to confirm appropriate period free from persistent drug misuse and/or dependency. Independent medical assessment with urine analysis and consultant reports will normally be necessary.</p>	<p>Following a solitary seizure associated with drug misuse or dependency, a licence will be revoked or refused for a minimum five-year period from the date of the event.</p> <p>Licence restoration thereafter requires:</p> <ul style="list-style-type: none"> • No underlying cerebral structural abnormality • Off anti-epileptic medication for at least 5 years • Maintained abstinence from drugs if previously dependent • Review by an addiction specialist & neurological opinion. <p>Where more than one seizure has occurred or there is an underlying cerebral structural abnormality, the Vocational Epilepsy Regulations apply. (See Annex 3)</p>

NB: A person who has been re-licensed following persistent drug misuse or dependency must be advised as part of their after-care that if their condition recurs they should cease driving and notify DVLA Medical Branch.

CHAPTER 6

VISUAL DISORDERS

The law states that: A licence holder or applicant is suffering a **prescribed disability** if unable to meet the eyesight requirements, i.e. to read in good light (with the aid of glasses or contact lenses if worn) a registration mark fixed to a motor vehicle and containing letters and figures 79 millimetres high and 57 millimetres wide (i.e. pre 1.9.2001 font) at a distance of 20.5 metres or 79 millimetres high and 50 millimetres wide at a distance of 20 metres (i.e. post 1.9.2001 font). If unable to meet this standard, the driver must not drive and the licence must be refused or revoked.

Partial sight registration will normally be regarded as incompatible with holding a driving licence and should be notified. However, attention will be given to the standards indicated below in deciding on fitness to drive.

VISUAL DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
ACUITY	Must be able to meet the above prescribed eyesight requirement.	New applicants are barred in law if the visual acuity, using corrective lenses if necessary, is worse than 6/9 in the better eye or 6/12 in the other eye. Also, the uncorrected acuity in each eye MUST be at least 3/60. * / *** Grandfather Rights below.
CATARACT Includes severe bilateral cataracts, failed bilateral cataract extractions and post cataract surgery where these are affecting the eyesight.	Must be able to meet the above eyesight requirement. In the presence of cataract, glare may prevent the ability to meet the number plate requirement, even with apparently appropriate acuities.	Must be able to meet the above prescribed acuity requirement. In the presence of cataract, glare may prevent the ability to meet the number plate requirement, even with appropriate acuities.
MONOCULAR VISION (includes the use of one eye only for driving)	Complete loss of vision in one eye. Must notify DVLA but may drive when clinically advised that 1) driver has adapted to the disability and 2) the prescribed eyesight standard in the remaining eye can be satisfied and 3) there is a normal monocular visual field in the remaining eye.	Complete loss of vision in one eye or corrected acuity of less than 3/60 in one eye. Applicants are barred in law from holding a Group 2 licence. **/*** Grandfather Rights below.
VISUAL FIELD DEFECTS Disorders such as severe bilateral glaucoma, severe bilateral retinopathy, retinitis pigmentosa and other disorders producing field defect including partial or complete homonymous hemianopia/quadrantanopia or complete bitemporal hemianopia.	Driving must cease unless confirmed able to meet recommended national guidelines for visual field. (See end of Chapter for full definition)	Normal binocular field of vision is required.

* **Must have held the Group 2 licence on either 01.04.1991 or 01.03.1992 and be able to complete a satisfactory certificate of experience to be eligible. If obtained first Group 2 licence between 02.03.1992 and 31.12.1996 uncorrected visual acuity may be worse than 3/60 in one eye.**

** **Group 2 licence must have been issued prior to 01.01.1991 in knowledge of monocularly.**

*** Monocularly is acceptable for C1 applicants who passed the ordinary driving test prior to 01.01.1997 if they satisfy the number-plate test and the visual field requirement for the remaining eye.

VISUAL DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
DIPLOPIA	<p>Cease driving on diagnosis. Resume driving on confirmation to the Licensing Authority that the diplopia is controlled by glasses or by a patch which the licence holder undertakes to wear while driving. (If patching, note requirements above for monocularly).</p> <p>Exceptionally a stable uncorrected diplopia of 6 month's duration or more may be compatible with driving if there is consultant support indicating satisfactory functional adaptation.</p>	Recommended permanent refusal or revocation if insuperable diplopia. Patching is not acceptable.
NIGHT BLINDNESS	Acuity and field standards must be met. Cases will be considered on an individual basis.	Group 2 acuity and field standards must be met and cases will then be considered on an individual basis.
COLOUR BLINDNESS	Need not notify DVLA. Driving may continue with no restriction on licence.	Need not notify DVLA. Driving may continue with no restriction on licence.
BLEPHAROSPASM	<p>Consultant opinion required. If mild, driving can be allowed subject to satisfactory medical reports. Control of mild blepharospasm with botulinum toxin may be acceptable provided that treatment does not produce debarring side effects such as uncontrollable diplopia. DVLA should be informed of any change or deterioration in condition. Driving is not permitted if condition severe, and affecting vision, even if treated.</p>	<p>Consultant opinion required. If mild, driving can be allowed subject to satisfactory medical reports. Control of mild blepharospasm with botulinum toxin may be acceptable provided that treatment does not produce debarring side effects such as uncontrollable diplopia. DVLA should be informed of any change or deterioration in condition. Driving is not permitted if condition severe, and affecting vision, even if treated.</p>

FIELD OF VISION REQUIREMENT FOR THE HOLDING OF GROUP 1 LICENCE ENTITLEMENT

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

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

DVLA requires a binocular Esterman field to determine fitness to drive. Monocular full field charts may also be requested in specific conditions. Exceptionally, Goldman perimetry carried out to strict criteria will be considered. The Secretary of State's Advisory Panel for Visual Disorders and Driving advises that, for an Esterman binocular chart to be considered reliable for licensing, the false positive score must be no more than 20%. When assessing monocular charts and Goldman perimetry, fixation accuracy will also be considered.

Defect affecting central area ONLY (Esterman) for GROUP 1 ENTITLEMENT

For Group 1 licensing purposes, pending the outcome of current research, the following are generally regarded as **acceptable central** loss:

- Scattered single missed points
- A single cluster of up to 3 contiguous points

For GROUP 1 licensing purposes the following are generally regarded as **unacceptable (i.e. ‘significant’) central** loss:

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

Exceptional cases for GROUP 1 ENTITLEMENT

Group 1 drivers who have a field defect, which does not satisfy the standard, can be considered as exceptional cases on an individual basis, subject to strict criteria. The defect must be **both** non-progressive **and** caused by a non-progressive condition **and** there must be no other progressive condition present which is likely to affect the visual fields. In order to meet the requirements of European law, DVLA will, in addition, require confirmation of full functional adaptation, together with a satisfactory practical driving assessment.

PERIPHERAL DEFECT

The following will be disregarded when assessing the width of field:

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

CHAPTER 7

RENAL/RESPIRATORY DISORDERS

RENAL DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
CHRONIC RENAL FAILURE CAPD (Continuous ambulatory peritoneal dialysis) Haemodialysis	Issue of licence dependent on medical enquiries. No restriction on holding a Till 70 licence unless subject to significant symptoms, e.g. sudden disabling attacks of giddiness or fainting or impaired psychomotor or cognitive function when the licence may be revoked or the application refused.	Drivers with these disabilities will be assessed individually by DVLA Medical Unit.
All other renal disorders	Need not notify DVLA unless associated with a relevant disability.	Need not notify DVLA unless associated with significant symptoms or a relevant disability.

RESPIRATORY DISORDERS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
SLEEP DISORDERS Including Obstructive Sleep Apnoea syndrome causing excessive daytime / awake time sleepiness	Driving must cease until satisfactory control of symptoms has been attained, confirmed by medical opinion.	Driving must cease until satisfactory control of symptoms has been attained, with ongoing compliance with treatment, confirmed by consultant / specialist opinion. Regular, normally annual, licensing review required.
COUGH SYNCOPE	Driving must cease until liability to attacks has been successfully controlled, confirmed by medical opinion.	Driving must cease. If there is any chronic respiratory condition, including smoking, will need to be free of syncope/pre-syncope for 10 years. Individuals identified as having asystole in response to coughing, can be considered once a pacemaker has been implanted.
RESPIRATORY DISORDERS including asthma, COPD (Chronic Obstructive Pulmonary Disease)	DVLA need not be notified unless attacks are associated with disabling giddiness, fainting or loss of consciousness.	As for Group 1 licence.
CARCINOMA OF LUNG	DVLA need not be notified unless cerebral secondaries are present. (See Chapter 1 for malignant brain tumour)	Driving should cease until 2 years has elapsed from the time of definitive treatment. Driving may resume providing treatment satisfactory and no brain scan evidence of intracranial metastases.

CHAPTER 8

MISCELLANEOUS CONDITIONS

MISCELLANEOUS CONDITIONS	GROUP 1 ENTITLEMENT	GROUP 2 ENTITLEMENT
MALIGNANT tumours with a high likelihood of developing cerebral metastasis (please also see Respiratory Disorders)	DVLA need not be notified unless cerebral secondaries are present. (See Chapter 1 for malignant brain tumours)	Cases will be considered on an individual basis.
AIDS Syndrome	Driving may continue providing medical enquiries confirm no relevant associated disability likely to affect driving. 1, 2 or 3-year licence with medical review	Cases will be assessed on an individual basis. In the absence of any debarring symptoms CDT count will need to be maintained at 200 or above for at least 6 months to be eligible.
HIV positive	Need not notify DVLA.	Need not notify DVLA

AGE (Elderly driver)	Age is no bar to the holding of a licence. DVLA requires confirmation at age of 70 that no medical disability is present, thereafter a 3-year licence is issued subject to satisfactory completion of medical questions on the application form. Notwithstanding, as ageing progresses, a driver or his relative(s) may be aware that the combination of progressive loss of memory, impairment in concentration and reaction time with possible loss of confidence, suggest consideration be given to cease driving. Physical frailty is not per se a bar to the holding of a licence.	Re-application with medical confirmation of continuing satisfactory fitness is required at age 45 and 5-yearly thereafter until 65, when annual application is required.
DEAFNESS (PROFOUND)	Need not notify DVLA. Till 70 issued/retained.	Of paramount importance is the proven ability to be able to communicate in the event of an emergency by speech or by using a device e.g. a MINICOM. If unable so to do the licence is likely to be refused or revoked.

Annex 1

DISABLED DRIVERS

LGV/PCV (Group 2)

Some disabilities **may** be compatible with the driving of large vehicles if mild and non-progressive. Individual assessment will be required.

CARS (Group 1)

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

- | | |
|------------------------------------|---|
| 1) Permanent Limb Disabilities: | e.g. Amputation, Hemiplegia/Cerebral Palsy,
Severe Arthritis, especially with pain |
| 2) Chronic Neurological Disorders: | e.g. Multiple Sclerosis, Parkinson's Disease,
Motor Neurone Disease, peripheral neuropathy |

Sophisticated vehicle adaptation is now possible and varies from automatic transmission to joy sticks and infra red controls for people who are severely disabled.

The DVLA will need to know which, if any, of the controls require to be modified and will ask the patient to complete a simple questionnaire. The driving licence will then be coded to reflect the modifications. A list of assessment centres is appended, which will be able to give advice should the licence holder require it.

NB: A person in receipt of the higher rate mobility component of the Disability Living Allowance may hold a driving licence from 16 years of age.

IMPAIRMENT OF COGNITIVE FUNCTION

e.g. post stroke, post head injury, early dementia

There is no single or simple marker for assessment of impaired cognitive function although the ability to manage day to day living satisfactorily is a possible yardstick of cognitive competence. In-car assessments, on the road with a valid licence, are an invaluable method of ensuring that there are no features present liable to cause the patient to be a source of danger, e.g. visual inattention, easy distractibility, and difficulty performing multiple tasks. In addition it is important that reaction time, memory, concentration and confidence are adequate and do not show impairment likely to affect driving performance.

COGNITIVE DISABILITY

Group 2 Impairment of cognitive functioning is not usually compatible with the driving of these vehicles.

Mild cognitive disability may be compatible with safe driving and individual assessment will be required.

BATTERY OPERATED PAVEMENT VEHICLES (CLASS 3)

Drivers of battery operated pavement vehicles, ie those capable of no more than 4 miles per hour do not need a driving licence. Although there is no legal eyesight requirement, the operator should be able to read a car's registration number from a distance of 12.3 metres (40 ft).

SEATBELT EXEMPTION

There is overwhelming evidence to show that seatbelts prevent death and serious injury in road traffic accidents. For this reason, the law makes it compulsory for car occupants to wear seatbelts, where fitted. One exception allowed by legislation is if the car occupant has a valid exemption certificate, which confirms it is inadvisable on medical grounds to wear a seatbelt. The certificates are issued by medical practitioners, who will need to consider very carefully the reasons for exemption, in view of the weight of evidence in favour of seatbelts. Medical Practitioners can obtain supplies of the relevant certificates and guidance leaflets from the Department of Health, PO Box 777, London SE1 6XH; Tel: 08701 555455 (NHS Responseline); Fax: 01623 724524; Email: doh@prologistics.co.uk. Further enquiries should be made to: Department for Transport, Road Safety Division 1, Zone 2/11, Great Minster House, 76 Marsham Street, London SW1P 4DR; Tel: 020 7944 2046; Email: david.peagam@dft.gsi.gov.uk

Annex 2

**FORUM
DISABLED DRIVERS' ASSESSMENT CENTRES**

CORNWALL MOBILITY CENTRE

Tehidy House, Royal Cornwall Hospital,
Truro,
Cornwall TR1 3LJ

Tel: 01872 254 920
Fax: 01872 254 921
www.cornwallmobilitycentre.co.uk

DERBY REGIONAL MOBILITY CENTRE

Kingsway Hospital,
Kingsway, Derby DE22 3LZ

Tel: 01332 371 929
Fax: 01332 382 377
www.derbyregionalmobilitycentre.co.uk

DISABILITY ASSESSMENT TEAM (DART)

Ditton Ward, Preston Hall Hospital
London Road
Aylesford
Kent ME20 7NJ

Tel: 01622 795 719
Fax: 01622 795 720

KILVERSTONE MOBILITY ASSESSMENT CENTRE

2 Napier Place,
Thetford,
Norfolk IP24 3RL

Tel: 01842 753 029
Fax: 01842 755 950
www.kmacmobil.org.uk

**MOBILITY ADVICE AND VEHICLE
INFORMATION SERVICE (MAVIS)**

Department for Transport (DfT),
'O' Wing, Macadam Avenue,
Old Wokingham Road, Crowthorne,
Berkshire RG45 6XD

Tel: 01344 661 000
Fax: 01344 661 066

www.mobility-unit.dft.gov.uk/mavis.htm

MOBILITY CENTRE

Specialist Neurological Rehabilitation Services Division,
Hunters Road,
Newcastle Upon Tyne NE2 4NR

Tel: 0191 219 5694
Fax: 0191 219 5693
www.nap.nhs.uk/snrs

**MOBILITY SERVICE OF THE DISABLED
LIVING CENTRE (WEST OF ENGLAND)**

The Vassall Centre,
Gill Avenue, Fishponds,
Bristol BS16 2QQ

Tel: 0117 965 9353
Fax: 0117 965 3652
www.dlcbristol.org

Revised August 2003

OXFORD DRIVING ASSESSMENT CENTRE

Oxford Centre for Enablement
Nuffield Orthopaedic Centre NHS Trust,
Windmill Road,
Headington, Oxford OX3 7LD

Tel: 01865 227 600
01865 737 400 (direct no. for driving assessments)
Fax: 01865 227 294

**QUEEN ELIZABETH'S FOUNDATION
MOBILITY CENTRE**

Damson Way, Fountain Drive
Carshalton, Surrey SM5 4NR

Tel: 0208 770 1151
Fax: 0208 770 1211
www.qefd.org/mobilitycentre
Email: info@mobility-qu.org

REGIONAL DRIVING ASSESSMENT CENTRE

Westheath Hospital
Rednal Road
Birmingham B38 8HR

Tel: 0121 627 8228
Fax: 0121 627 8629

SCOTTISH DRIVING ASSESSMENT SERVICE

Astley Ainslie Hospital,
133 Grange Loan,
Edinburgh EH9 2HL

Tel: 0131 537 9192
Fax: 0131 537 9193

**WALES MOBILITY AND DRIVING
ASSESSMENT SERVICE**

The N Wales Disability Resources Centre
Glan Clwyd Hospital,
Bodelwyddan
Denbighshire LL18 5UJ

Tel/Fax: 01745 584 858

**WALES MOBILITY AND DRIVING
ASSESSMENT SERVICE**

The S Wales Disability Resources Centre
Rookwood Hospital,
Fairwater Road,
Llandaff, Cardiff CF5 2YN

Tel/Fax: 029 2055 5130

**WILLIAM MERRITT DISABLED LIVING CENTRE
AND MOBILITY SERVICES**

St Mary's Hospital,
Green Hill Road,
Armley, Leeds LS12 3QE

Tel: 0113 305 5288
Fax: 0113 231 9291

WRIGHTINGTON MOBILITY CENTRE

Wrightington Hospital,
Hall Lane, Appley Bridge,
Wigan, Lancs WN6 9EP

Tel/Fax: 01257 256 409

Annex 3

GUIDANCE FOR WITHDRAWAL OF ANTI-EPILEPTIC MEDICATION BEING WITHDRAWN ON SPECIFIC MEDICAL ADVICE

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

From a medico-legal point of view, the potential risk of further epileptic seizures occurring during this therapeutic procedure should be noted. If an epileptic seizure does occur, the Law will not permit your patient to continue to hold a licence until the driver or applicant is able to satisfy the Epilepsy Regulations. These currently require a period of 1 year free of any manifestation of epileptic seizure or attacks occurring whilst awake, but special consideration is given where sleep only attacks have occurred.

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

The Secretary of State's Honorary Medical Advisory Panel on Driving and Disorders of the Nervous System has recommended that patients should be warned of the risk they run, both of losing their driving licence and also of having a seizure which could result in a road traffic accident. The Panel advises that patients should be advised **not** to drive from commencement of the period of withdrawal and thereafter for a period of 6 months after cessation of treatment. The Panel considers that a person remains as much at risk of seizure associated with drug withdrawal during the period of withdrawal as in the 6 months after withdrawal.

This advice may not be appropriate in every case. One specific example would be withdrawal of anticonvulsant medication when there is a well-established history of seizures, only while asleep. In such cases, any restriction in driving is best determined by the physicians concerned, after considering the history. It is up to the patient to comply with such advice. For DVLA to revoke the licence during the period of withdrawal would be both restrictive and unnecessarily bureaucratic.

It is important to remember that if medication is omitted, e.g. on admission to hospital for non epileptic conditions, and epileptic seizures occur, then the person will be required to meet the epilepsy regulations.

PROVOKED SEIZURES:

For Group 1 and possibly Group 2 drivers or applicants, provoked or symptomatic seizures, apart from those caused or precipitated by alcohol or illicit drug misuse, can be dealt with on an individual basis by DVLA if there is no previous seizure history. For provoked seizure(s) with alcohol or illicit drugs please see relevant section in the booklet.

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

- a) whether a " liability to epileptic seizures " has been demonstrated, or precipitated specifically as a result of the provoked episode and,
- b) whether the provoking or precipitating factor(s) has been successfully or appropriately treated or removed.

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

- reflex anoxic seizures
- an immediate seizure (within seconds) at the time of a head injury
- seizure in first week following a head injury, which is not associated with any damage on CT scanning, nor with post traumatic amnesia of longer than 30 minutes
- at the time of a stroke/TIA or within the ensuing 24 hours
- during intracranial surgery or in the ensuing 24 hours.

Seizures occurring during an acute exacerbation of Multiple Sclerosis or migraine will be assessed on an individual basis by the department.

THE CURRENT EPILEPSY REGULATIONS FOR GROUP 1 AND GROUP 2 ENTITLEMENT

GROUP 1

The Motor Vehicles (Driving Licences) Regulations 1999, prescribe epilepsy as a relevant disability for the purposes of Section 92(2) of the Road Traffic Act 1988.

This means that:

- (a) A person who has suffered an epileptic attack whilst **awake** must refrain from driving for **one** year from the date of the attack before a driving licence may be issued;

OR

- (b) A person who has suffered an attack whilst **asleep** must also refrain from driving for **one** year from the date of the attack, unless they have had an attack whilst asleep more than three years ago and have not had any awake attacks since that asleep attack.

AND

- (c) In any event, the driving of a vehicle by such a person should not be likely to cause danger to the public.

GROUP 2

During the period of **10 years** immediately preceding the date when the licence is granted the applicant/licence holder should be:

- 1) free from **any** epileptic attack

AND

- 2) have not required medication to treat epilepsy

AND

- 3) should not otherwise be a source of danger whilst driving.

In addition "**The liability to seizures arising from a cause other than epilepsy**" is a prescribed disability. An individual suffering a solitary seizure must normally satisfy the above regulations, except where a solitary seizure occurs in relation to alcohol/drug or substance misuse (see Chapter 5). In addition, someone with a structural intracranial lesion who has an increased risk of seizures will not be able to drive vehicles of this group until the epilepsy risk has fallen to at least 2% per annum, the level recommended by the Panel which permits compliance with the regulations.

INDEX OF MEDICAL CONDITIONS

ABSCCESS (INTRACEREBRAL)	13	HEMIANOPIA	31
ACUITY	31	HIV	35
ACUTE CORONARY SYNDROMES	15	HYDROCEPHALUS	13
AGE (ELDERLY DRIVERS)	35	HYPERTENSION	17
AIDS	35	HYPOGLYCAEMIA	22
ALCOHOL MISUSE/DEPENDENCY	27	HYPOMANIA/MANIA	24
ALCOHOL SEIZURES/DISORDERS	28	ICD	16,17,20
AMAUROSIS FUGAX	7	INTRACRANIAL PRESSURE MONITOR	13
ANEURYSM (INTRACRANIAL)	11-12	INTRAVENTRICULAR SHUNT	13
ANEURYSM (AORTIC)	17-18	LEARNING DISABILITY	25
ANGINA (STABLE OR UNSTABLE)	15	LOSS OF CONSCIOUSNESS	13-14
ANGIOGRAPHY (CORONARY)	21	MALIGNANT TUMOURS	9, 35
ANGIOMA	12	MARFAN'S SYNDROME	18
ANGIOPLASTY	15	MENIERE'S DISEASE	7
ANXIETY	23	MENINGIOMA	8
ARRHYTHMIA	15	MENINGITIS	8
ARTERIOVENOUS MALFORMATION	12	MONOCULAR VISION	31
ASTHMA	34	MOTOR CORTEX STIMULATOR	13
ATRIAL DEFIBRILLATION	16	MOTOR NEURONE DISEASE	7, 36
BENIGN INFRATENTORIAL TUMOUR	9	MULTIPLE SCLEROSIS	7, 36
BENIGN SUPRATENTORIAL TUMOUR	8	MUSCLE DISORDERS	7
BURR HOLE SURGERY	10	MYOCARDIAL INFARCTION	15, 19
BLEPHAROSPASM	32	NARCOLEPSY	6
CABG	15	NIGHT BLINDNESS	32
CAPD (continuous ambulatory peritoneal dialysis)	34	NEUROENDOSCOPIC PROCEDURES	13
CARCINOMA OF LUNG	34	PACEMAKER IMPLANT	16
CARDIOMYOPATHIES	18	PARKINSONS DISEASE	7, 36
CATAPLEXY	6	PERIPHERAL NEUROPATHY	22, 36
CATARACT	31	PERIPHERAL ARTERIAL DISEASE	17
CATHETER ABLATION	16	PERSISTENT BEHAVIOUR DISORDER	25
CEREBROVASCULAR DISEASE	7	PITUITARY TUMOUR	9
COPD (chronic obstructive pulmonary disease)	34	PRE-EXCITATION	19
CHRONIC NEUROLOGICAL DISORDERS	7, 36	PROVOKED SEIZURES	6, 39
COLOUR BLINDNESS	32	PSYCHIATRIC NOTES	26
CONGENITAL HEART DISEASE	19	PSYCHOSES	23-24
COUGH SYNCOPE	34	RENAL DISORDERS	34
DEFIBRILLATOR – CARDIOVERTER	16	RESPIRATORY DISORDERS	34
DEAFNESS	35	SCHIZOPHRENIA	24
DEMENTIA	25	SEIZURES	6,39,40
DEPRESSION	23	SLEEP DISORDERS	34
DIABETES – ALL ASPECTS	22	STROKES/TIAs	7
DIPLOPIA	32	SUBARACHNOID HAEMORRHAGE	11
DISABLED DRIVERS	36	SUBDURAL EMPYEMA	13
DISABLED DRIVERS ASSESSMENT CENTRES	37-38	SUBSTANCE MISUSE	29
DRUG MISUSE/DEPENDENCY	29-30	SYNCOPEAL ATTACKS	17
ECG ABNORMALITY	19	TRANSIENT GLOBAL AMNESIA	8
ENCEPHALITIC ILLNESSES	8	TRANSIENT ARRHYTHMIAS	15
EPILEPSY	6, 8, 39	TRANSPHENOIDAL SURGERY	9
EPILEPSY REGULATIONS	40	VENTRICULAR DYSPLASIA	17
EXERCISE TESTING	20	VERTIGO	7
FAINT (Simple)	14	VISUAL ACUITY	31
FIT (Solitary/First)	6	VISUAL FIELD DEFECTS	31
GIDDINESS	7		
GLAUCOMA	31		
GLIOMAS	9		
HAEMATOMA – INTRACRANIAL	10		
HAEMATOMA – INTRACEREBRAL	10		
HEAD INJURY	10		
HEART FAILURE	18-19		
HEART TRANSPLANT	18		
HEART VALVE DISEASE	18		

附錄四 92 年 12 月 9 日召開座談會會議記錄

五、討論：

臺北市汽車駕員職業工會

1、建議小型車職業駕駛人由現行延長至65歲放寬到可延長至70歲；其他職業駕駛人由現行60歲放寬到可延長至65歲。

2、短期修正方案中有關職業駕駛人（不含小型車職業駕駛人）對於體檢的審驗項目太過複雜，會造成醫療資源浪費，由公立醫院審驗現行項目即可達到目的。

3、高齡者若能通過審驗即可繼續持用職業駕照，其風險未必較年輕者高，反而年輕駕駛人容易衝動，事故發生率高。

4、職業道德與交通安全講習十分重要，連大陸的駕駛學校都能落實交通安全講習。

中華民國駕駛員職業工會全國聯合會

1、不贊成短期修正方案中有關職業駕駛人（不含小型車職業駕駛人）前8年經駕照吊扣者，禁止延長駕照年限，過去紀錄與駕駛人未來可否延長年限未必直接關聯。

2、職業駕駛人取得駕照多年，對於相關交通規則均很清楚，故不贊成短期修正方案中有關職業駕駛人（不含小型車職業駕駛人）換照前講習。

3、糖尿病用胰島素治療與否應與駕駛安全無關，不贊成短期修正方案中有關職業駕駛人（不含小型車職業駕駛人）新增糖尿病用胰島素治療者禁止延長年限之審驗項目。

4、不贊成短期修正方案中有關職業駕駛人（不含小型車職業駕駛人）新增青光眼、白內障之審驗項目，此規定將增加檢查之麻煩，且有此兩項眼疾者視力表即看不清楚，故用視力表檢核即可。

台北市交通局

1、職業駕駛人駕駛年齡放寬本局原則上採支持的態度，但計程車要延長至70歲要再聽聽各位意見。

2、若短期方案有關職業駕照年齡放寬可行性高的話，建議將報告中有關長期納入普通駕照定期審驗之構想，評估其一併改列為短期內推動之可行性，尤其道安規則修訂頻繁，可利用六年一次換照時機透過審驗機制補強。

交通部公路總局

1、對於職業駕駛年齡是否延長本局無預設立場。
2、對於報告中長期面建議由監理單位成立駕駛人醫療委員會有不同的看法，現在是專家的社會，監理單位應負責駕駛技能審查，有關駕駛人醫療審驗應由醫療專家訂定項目、標準，監理單位則依據審驗結果的證明單進行准予報考駕照或進行審核。

內政部警政署

1、在執法角度與立場，希望違規少，肇事次數能有效降低。對於超過 60 歲以上職業駕駛人是否因視力或反應變差，致違規與肇事機會增加尚需評估。
2、有關職業駕照延長只要有醫療機構嚴格把關與證明，確保駕駛人生理功能沒變差，即贊成延長。

衛生署國民健康局

1、若要開放職業駕照延長年限，後續配套措施一定要十分謹慎，因為涉及老化的現象與醫療專業。
2、勞委會有指定 300 多家醫院針對一般勞工健康檢查項目檢查，亦有針對特殊項目或職業病進行檢查者，但由於攸關勞工權益，許多勞工並不服檢查或鑑定結果，此非第一線檢查醫師所能承受，因此鑑定或審驗標準之建立相當重要。

3、建議專業機制要層次化，目前檢查都是很基本的檢查項目，若要提昇，許多檢查項目要再重新認定，因此若真要延長職業駕照年限，醫療專業的諮詢非常重要與必要，尤其涉及駕駛人權益，若無完善的醫療專業支持，後續爭議將層出不窮。

王子蓓科長

1、實務上最大問題是駕駛人若有精神狀況的問題，由現行審驗機制獲知很困難，如民眾反映遭遇精神狀況有問題的計程車駕駛人，該精神狀況問題可能係偶現性，不易查證，因此職業駕駛人精神狀況如何檢查也是一項必須注意的課題。

2、有關報告中由監理單位成立駕駛人醫療委員會之建議，希望醫療歸醫療，交通歸交通，由醫療機關審視駕駛人是否符合標準，不宜由監理單位成立醫療委員會進行判別，如此將耗費人力且不經濟。

3、審驗標準十分重要，目前小型車職業駕駛人可至 55 歲，大型車職業駕駛人僅可至 50 歲，此制度設計應是所需職業駕駛能力上有所不同，若考量放寬，有關審驗與配套措施若能符合此能力檢定標準，則贊成延長職業駕照年限。

4、有關駕照吊扣並非在 50 歲以後才會發生，應與駕照吊扣吊銷制度對於處理駕駛人行為問題進行結合，故單獨作為禁止延長之審驗標準並不妥適。

5、駕照審驗係針對駕駛人健康狀況為主，對於駕駛人安全管理有其功能之限制性，職業駕駛人工作環境的影響可能更大，如超時駕駛如何管制可思考一併提出，效果可能更大。

6、有關考領普通駕照後，可能一輩子也不會再接觸相關法令，故建議普通駕照長期亦應有再教育之回訓機制。

曾平毅教授

1、駕照定期換發或職業駕照審驗應包括下列基本目的：

(1) 重新檢查駕駛人健康狀況包括視力、聽力及精神狀況是否能安全駕駛，即駕車之條件，另可採取相關限制條件配合如駕照加註需戴眼鏡或不得夜間駕駛。

(2) 讓駕駛人利用機會熟悉交通法令，如日本透過換照前之簡素講習，並區分優良與非優良駕駛人，優良駕駛人講習時間可縮短。

(3) 定期更換最新照片，增加駕照容易辨識性與專業性。

(4) 清理違規紀錄、參加講習或進行相關行政處分的執行。

(5) 利用駕照更新，引進防止駕照變造的技術。

(6) 資料與地址變更及更新。

2、我國駕照的年限換照乙次，德國不用更換但透過其他機制管制、英國必須自行陳述，若未據實以報因而肇事要負刑責，與我國設計均不同。我國職業駕照審驗早期是10年，後來變為15年，現在又要進一步考慮延長年限，但是否延長應視職業駕駛人能否適合繼續擔任該項工作。

3、根據運研所委託本人研究，針對國內眼科醫師公會醫師所作調查，建議50歲以前，每5年檢查乙次；50-59歲，每10年檢查乙次；60歲以上，每年檢查乙次。另家醫科醫師的觀點與眼科醫師相近。

4、若要考慮延長職業駕駛人年齡，可接受採個案審查的概念，但配套措施所需之審驗項目設計十分重要。若以事故率來看，無足夠證據顯示高齡者比較危險，故事故率暫不宜作為考量原因，但最可怕的是駕駛人本身不知道自己是否適合駕駛。

5、有關報告中短期修正方案：

(1) 過去10年內無駕照吊扣者，可加以思考。

(2) 體能測驗項目，與年齡特別有關，故增加體能測驗有其必要。

(3) 用檢驗項目來表示(如心電圖、胸部X光檢查)較清楚，若採疾病名稱可能要透過很多判斷程序。

(4) 換照前道安講習個人並不支持，主要是職業駕駛人換照時點可能不同。

(5) 小型車職業駕駛人年齡限制不宜貿然再向上延長，反倒是所建議其他職業駕照延長至65歲之審驗項目應思考小型車職業駕駛人一併適用。

林麗嬋教授

- 1、年齡並非唯一因素，駕駛時間長短可能對安全影響更為重要。
- 2、對於計程車駕駛人是否可延長至70歲有探討空間。有關報告中台灣地區小客車肇事率部份，係以駕駛時間（平均每月或每星期行駛里程）作分類，無法反應肇事過程中駕駛者開了幾個小時，因此駕駛工時管理應更受關心，若將計程車駕駛人延長至70歲，就所呈現資料，暫時無足夠理由支持。且民國85/87年資料中60歲以上小客車駕駛人應屬經濟條件較佳者，若計程車爭取開放高齡駕車，其經濟條件未必較佳，經濟條件差異是否造成肇事因素的影響值得考量。
- 3、配套措施雖採吊扣者禁止延長年限，但更重要的是，未來配套措施應嚴格規定駕駛工時與短暫休息時間，以避免因老化致注意力不易長時間集中而肇事。
- 4、有關道安規則第22條體能測驗項目包括視野與夜盲症似有不足，尚應包括肌肉強度與握力等與駕駛相關的動作評估，另建議方案中明確敘述體能測驗檢查項目來區分。

李世代醫師

- 1、國人平均壽命延長是否意味工作時數亦須延長？在此澄清一點，國人平均壽命確實延長，但並不是健康良好也延長，而往往是照顧需要的延長，也就是平均所延長的壽命並不能作為延長其擔任駕駛工作所需。
- 2、報告書第6頁尚需增加對比視力，如進入隧道時因光、暗變化影響視力，年輕人需要0.1秒恢復，老年人要0.4-0.5秒，甚至更久才能恢復，若因道路視距不良將十分危險，此為一般視力檢查無法檢測出；對光的耐受能力，老年人在夜間視力差，對光點產生之炫光耐受力亦差；對動、靜態物體之判斷，老年人亦較差，一般而言，60歲開始會緩慢衰退，70-80歲以後會加速明顯衰退，80-90歲會衰退相當程度。聽力是30歲以後開始會衰退，但是對於高頻的部份衰退，中低頻部份不易衰退，報告中寫低頻可能要更正，但到70歲以後，高中低頻全部衰退，對於音源容易誤判。反應能力大概從50多歲開始衰退，60幾歲有1/3的人肌肉會開始萎縮。
- 3、有關生理功能，報告中多為美國研究，日本與我國均為東方人，其經驗可能更有參考價值。體能測驗除視野與夜盲症檢測外，尚應包括肌力、耐力、關節活動度、肢體的活動力、握力、下肢的踩踏力等，才能完整檢測駕駛所需的功能。

4、就短期方案中所述項目，心電圖、胸部X光雖非最好的項目但不能不列；糖尿病用胰島素治療若能受到穩定控制還是能駕駛，因此可能會產生爭議，如同尿毒症之洗腎者是否允許駕駛？高血壓者是否限制？可採用「慢性病是否穩定控制」進行規範，由醫療院所作綜合性研判。至於青光眼及白內障，一個影響中間視力，一個影響週邊視力，只寫病名並不夠，患青光眼者到年紀大時眼壓會慢慢升高，當然不一定會高到20以上，但介於臨界狀態很難判斷，眼壓高至一定程度當然不宜駕駛；白內障區分有六個等級晶狀體的透明度，一般人不是0度而是一度，到老年時可能界介於10、20度，30、40度時即無法看到東西，無法通過視力，在條件差的駕駛環境，其視力會更差。

5、駕駛行為屬蠻重要的駕駛要件，駕駛行為若不理想，年輕時即不應允許駕駛，建議應納入。

6、有關精神狀況就醫時無法檢測出，應以精神病過去的就醫紀錄作為判斷，同時精神病患會服用很多影響中樞神經的藥物而影響駕駛安全。

7、有出席者提出小型車職業駕駛人提高至70歲，以具體證據來看，日本平均壽命81歲，但健康餘命僅74.5歲，中間落差為6.5歲，而台灣平均壽命74歲，健康餘命則不到70歲，貿然提昇至70歲證據不足夠，要進一步評估。

8、有關建議成立駕駛人醫療委員會，基本上安全辦的機制還是需要，至於什麼名稱、成員組成可再研議。

9、勞委會勞安所曾針對駕駛進行相關研究，針對公車駕駛測試陽明山路段，不到80歲者即會力不從心，一般人90幾歲生理功能即會走下坡，因此審驗的功能十分重要。

劉樹泉醫師

1、肯定主辦單位所作之研究，因不單考慮老人生理狀況，已將道路安全相關環境影響因素儘量納入。

2、研究中從執行面的角度思考修正方案可否推動，基本上贊成，因不單考量公平性，亦包括社會或行政成本等因素。但隨著人口老化，高齡駕駛不易避免，因較嚴格的檢驗所避免部份事故發生，其所帶來的經濟效益可能較付出的成本更大，因此成本部份不必考慮太多。

3、未來真正的配套措施十分重要，此不僅涉及駕駛人安全，亦涉及一般民眾的安全，李世代委員提到計程車若要延長至70歲必須審慎，所提理由十分充分，個人很贊成，延長駕駛年限必須注意風險性有多大。不管是年輕人或高齡者，在

道路駕駛所面臨的問題均很類似，當我們覺得更安全、身體更健康時，在行為面可能容易被忽略與改變，例如車輛操控性能、路況與環境更理想，反而可能因為過於自信，憑藉以往經驗，使事故發生機會增加。

4、老人耐力問題應包括在測試範圍中，如運動心電圖、耐力測試可檢測較長時間駕駛所必須具備的能力，較可客觀控制個人危險因素。整體而言，60歲以後大部份器官都在退化，但退化並不表示功能一定不良，因此建議體能測驗項目應包括所有道路駕駛人較好。

5、道安講習應需涵蓋於換照要件中，駕駛安全不僅與個人健康相關，與駕駛人所想、所認為的行為因素亦十分相關，道路上駕駛即是一種行為的表現，道安講習內容應包括何種情況下駕駛比較安全，以及環境與生理功能變化後應如何駕駛，因此贊成將行為因素納入，如何執行屬行政措施不再細部評論。

交通部道安委員會

1、本次座談會讓我們對於老人的議題有更多深入的瞭解，同時也可補充曾平毅教授先前所完成運研所研究案中的部份內容，使本部路政司就不論是職業或普通駕照之高齡換照問題，將更加正視。

2、先前路政司已函請各單位針對是否延長職業駕駛年限表示意見，本會在此不再說明，僅就運研所研提短期方案與策略建議補強：

(1)與會代表多強調老年人視力衰退，是否可比照勞動基準法，針對性別或童工之特殊時段限制概念，規範特殊駕駛時段限制，如針對特定駕駛人禁止夜間駕駛。

(2)依據實際經驗，現行體檢過程似乎不夠嚴謹，因此有關職業駕駛人審驗之生理功能檢測，建議有關審驗所需之醫療機構的配合機制、檢驗標準或指定單位應更加強說明。

(3)推動策略係結合配套措施，應強調措施若有變動，推動策略亦應有所調整。

(4)有關換照前道安講習樂於支持，因為法規修正太過頻繁、交通政策亦在更新，並應就是否須修正道路交通管理處罰條例24條提出建議。

3、有關換照前道安講習之課程規劃請一併建議。

4、有關長期策略建議推動普通駕照定期審驗，時程上可往前推，並考量納入貴所92年出版之「駕駛執照換(補)發與審驗規定現況探討及制度改善之研究」有關90歲以上對於普通駕照定期審驗之建議，併案來推動。

交通部路政司

- 1、普通駕照是否定期審驗，本司正在研議中。
- 2、職業駕照延長年限，在安全、風險控管上非常重要，因此年齡放寬雖能增加公平性，但配套之條件資格應加強，以確保安全性。
- 3、有關延長至95歲或70歲，運研所綜合與會代表意見後應會有定案的結果。
- 4、建議考量配套措施有關項目及標準、配對之處罰規定，並應考慮實務執行之可行性。

臺北市汽車駕員職業工會

- 1、駕駛人可否駕駛應為健康的考量而非年齡的考量，因此健康檢查不通過即可判別。
- 2、研究中應增加61-65歲計程車駕駛人之事故資料，該類駕駛人事故可能較年輕駕駛人更低，並考量健康檢查能通過之66-70歲計程車駕駛人之工作權與無法就業的社會問題，甚至可採禁止夜間駕駛來控制風險。
- 3、就實際狀況來看，95歲職業駕駛人看起來比90歲年輕的也很多，駕駛技術之經驗豐富，安全性應無問題，且能通過體檢如心電圖、胸部X光、高血壓檢查等項目，對於身體狀況許可、有能力高齡職業駕駛人應給予支持。

主席

臺北市汽車駕駛員職業工會本次發言與前次發言建議職業小型車駕駛人駕駛年限進一步放寬至70歲之主要意見內容相同，此部份本研究案中未建議進一步延長，是否係因為交通部交辦時係以「六十歲延長至六十五歲」為範圍，致本所接受此任務時係依來文要求內容辦理，或係因為如同前面幾位學者專家所提，現階段無充分客觀證據能作為評估判斷是否對道路交通安全衝擊過大，以致未進一步放寬，請運安組同仁先作解釋。

本所運安組

職業駕照放寬至 65 歲目前不建議再向上延長，已考慮計程車駕駛人在內，主要係因目前並無充分證據當計程車駕駛人進一步延長至 70 歲能作好其風險管控，四點理由如後（參見報告 6.2 節）：

- 1、所有職業駕駛人年齡延長至 65 歲，目前已有小型車職業駕駛人之管理前例可循，對於風險控制較有把握。
- 2、參考國外制度，採用年齡限制較為嚴格的義大利，亦以限制 60 歲為原則，具醫療證明合格者最高可延長至 65 歲。
- 3、65 歲為國內公務人員屆齡退休的上限，最高延長至 65 歲較符合國人對於工作年齡限制的普遍認知。
- 4、依據行政院衛生署統計，民國 90 年我國男性平均壽命 72.9 歲，相較民國 57 年道安規則公佈該年男性 65.2 歲雖有增加，然似不宜過度延長（如 70 歲）接近其平均壽命。尤其前面有專家學者補充，平均壽命的延長並不表示健康的平均壽命延長，更顯示駕駛人工作年限不宜太接近其平均壽命。

主席

主辦組建議現階段延長至 65 歲後暫不宜再向上延長，主要係考量無充分客觀證據可作好風險控管，因此本階段主要鎖定職業小型車駕駛人以外的職業駕駛人先從 60 歲延長至 65 歲，至於是否可延長至 70 歲，似可下一階段再處理，不宜太過冒進，以避免嚴重衝擊國內之交通安全，相信這也不是大家所樂見的。

本所運安組張開國副組長

1、前面學者專家所提意見個人十分受用，尤其李世代醫師提出國人平均壽命延長並非表示健康良好也延長而能延長工作年限，因此若貿然延長至太高年限，不知是愛他還是害他？另劉樹泉醫師提出高齡駕駛人較嚴格的檢查所產生的社會成本會增加，但所帶來社會效益會更高。

2、事實上，年齡未必重要，反而是檢查項目很重要，甚至有必要透過衛生署有關個人就醫紀錄作綜合評判，因此在此在實際執行面若無法立刻進行比較嚴格的檢查，或許就有必要以年齡作為一個限制條件。各位所提意見我們都會充分考量，將來相關措施如何搭配會以更具體的方式提供交通部參考。

中華民國駕駛員職業工會全國聯合會

1、與會曾教授與幾位醫師提出許多看法，個人表示贊成，但本研究報告似乎太學術化，與現實脫節太遠。駕駛員超時工作，交通法令本身即規定不得超過八小時，超時是市場需求面的問題，需求面問題很難用法令規範，且並非本案所討論主要範疇，建議不必在此討論。

2、體格、體能檢查如何做，幾位醫師提出之見解雖正確，但實務上很難處理，應考量實際執行之可行性。持普通大型車駕照違規從事職業大客車業務，違規罰責較職業駕駛人輕，若單方面加重職業駕駛人管制，反而可能使駕駛人流向普通大客車駕照，如此其體格狀況誰來規範？不如利用現行基本規定進行檢查，並可增加視野與夜視能力等體能測驗項目，可行性較高。

3、同意增加體能測驗，但白內障與青光眼則不需要，高齡職業駕駛人多能自律，生理狀況若無法勝任（如夜間駕駛、超時駕駛）應不會去開車，公司老闆也不會允許，不必過於憂慮，措施應簡單、易行。

4、放寬職業駕照持用期間延長年限已爭取二〇年，為何高齡駕駛人仍需去從事駕駛工作，係社會福利制度不足，必須爭取工作權。

5、過去〇年吊扣紀錄禁止延長不合理，本公會強烈反對，建議可修正為取得延長資格後，若有重大違規事件即取銷其資格。

6、可針對66-70歲計程車駕駛人增加檢查項目，配合放寬。

六、主席結論

1、與會代表均可理解，站在工會立場係反映駕駛朋友生計上的需要，所提出要延長駕照有效年限之意見。有關職業駕駛人生計問題或運輸業管理問題，涉及法令、政策、措施，以及公部門、業者與駕駛本身等，牽涉層面甚廣，本案所涉相關法規之修訂，必須考量可否加以落實之實際執行層面，避免守法者必須付出大量成本，但不守法者確能無需遵守遊戲規則，相關問題必須公私部門共同努力。然必須強調的是，本案所談職業駕照年限之延長，主要係針對駕駛人持照與用照資格進行檢核，其功能性並無法完全解決現實面所有問題。

2、健全職業駕駛環境，在安全確保之前提下儘量照顧到生計上的需要，是政府相關機關努力的目標，雖無法立即達成，但我們絕對有誠意來繼續努力，在法規合理前提下，期盼業者及職業駕駛人來共同配合，讓不守法者逐漸於市場消失。

3、各位所提意見縱使無法於現階段完全滿足，但本所主辦組會將各位意見詳實紀錄，針對報告可加以修正之部份進行修正，同時短期方案的配套措施也盡可能力求周延。

七、散會（中午十二時二十分）

交通部路政司

交通部道安委員會

交通部公路總局

臺北市政府交通局

高雄市政府交通局（未派員）

中華民國駕駛員職業工會全國聯合會

中華民國汽車運輸業駕駛員工會全國聯合會

中華民國遊覽車客運商業公會全國聯合會

臺北市汽車駕駛員職業工會

臺灣省汽車駕駛員職業工會聯合會

中華民國計程車駕駛員工會全國聯合會

中華民國計程車運輸合作社全國聯合社

本所運管組

運安組

林福山

王小芸

吳志冰

鄭修祥

劉祐祥 孫高勝

沈錦泉 吳光祥 永昌

鄭以賜 劉知忠 曾金遠 曾國義

洪雲忠 賴靜慧 田慶民

吳熙仁 周文祥

「我國職業駕駛執照考領及持用有效條件之檢討」座談會會議紀錄

一、開會時間：九十二年十二月九日（星期二）上午十時

二、開會地點：交通部運輸研究所五樓會議室

三、主持人：鄭副所長賜榮

林任國代

四、出席者：

耕莘醫院中老年科劉樹泉醫師

台北護理學院長期照顧研究所李世代醫師

陽明大學臨床護理研究所林麗嬋教授

警察大學交通系曾平毅教授

台北市監理處王子蓓科長

行政院勞工委員會（未派員）

行政院消費者保護委員會（未派員）

行政院衛生署國民健康局

內政部警政署

紀錄：葉祖宏

葉祖宏

劉樹泉

林麗嬋

曾平毅

王子蓓

林任國

陳旭

附錄五 簡報資料

我國職業駕駛執照考領 及持用有效條件之檢討

交通部運輸研究所
中華民國93年02月

1

報告大綱

- 前言
- 我國駕照考審驗制度與問題分析
- 職業駕駛人特性分析
- 國外制度與文獻探討
- 駕照有效條件管理元素
- 我國職業駕照有效條件檢討與方案研擬
- 結論與建議

2

前言 (1/2)

● 依據

- 交通部民國92年6月13日交路字第09200060841號函

● 檢討課題

- 職業駕駛執照之報考及使用年齡限制由現行規定之60歲放寬至65歲

● 現行規定(職業駕駛執照)

- 道安規則第54條：每3年審驗乙次、體檢
- 道安規則第60條：考領需年滿20歲，最高60歲
- 道安規則第76條：
 - 職業駕照最高使用年齡限制為60歲
 - 小型車職業駕駛人超過60歲，每年審驗一次，最高可延長至65歲，體檢時增加「心電圖檢查」與「胸部X光檢查」

3

前言 (2/2)

● 本案研究取向

- 主要採國外制度與相關文獻蒐集，輔以國內有限文獻作為探討之基礎
- 從駕駛人年齡、醫療狀況、生理功能差異與交通安全績效等觀點及關聯性切入

● 具體內容

- 短期修正方案
- 短期方案執行策略
- 長期推動方向

4

我國駕照考審驗制度與問題分析 (1/2)

● 我國駕照考驗規定

● 與駕駛人資格條件特別有關者

- 第60條（考照年齡與經歷限制）、第62條（不得參加考驗之情形）、第64條（體格檢查與體能測驗標準）

● 我國駕照審驗規定

- 道安規則第52條規定，駕照每六年換照乙次（「行政換照」）
- 目前存在審驗機制者主要為職業駕駛人
 - 道安規則第54條規定職業駕駛人每3年審驗乙次
 - 道安規則第60條及第76條通則性規定職業駕照考領與持用有效期間統一訂為60歲，小型車職業駕照持用有效期間則視審驗結果最高延長至65歲之除外規定

5

我國駕照考審驗制度與問題分析 (2/2)

● 問題分析

- 現行審查機制（年齡、體檢）是否充分
- 特定年齡作為限制標準
- 體檢項目與方式能否充分反映安全績效
- 駕照審驗時間間隔

6

職業駕駛人特性分析 (1/2)

● 營業車輛與職業駕照數基本資料

- 營業車輛以營業小客車（即計程車）佔48.83% 最多，其次為營業大貨車佔35.27%
- 職業駕照以職業小型車駕照之38.44% 最多，職業大貨車駕照之28.71% 次之

● 我國職業駕駛人年齡分佈

- 計程車部份，民國90年駕駛人40-49歲者佔40.5% 最高，其次為50-59歲之27.6% ，60-65歲經過延長年限者亦佔有相當之比例(5.8%)
- 遊覽車部份，民國90年駕駛人40-49歲者佔50.8% 最高，其次為30-39歲之30.2% ，50-59歲亦佔有16.9%

7

職業駕駛人特性分析 (2/2)

- 從事職業駕駛工作，駕駛執照持用之有效條件管制似並非係最主要決定因素，從事職業駕駛所需之體力、本身意願與競爭能力、運輸業市場機制與所從事行業別的影響可能更大

● 美國職業車輛駕駛人年齡分佈

- 貨車駕駛人 (truck driver)
55歲以上者佔12.1% ，65歲以上者佔2.3%
- 公車駕駛人 (bus driver)
55歲以上者佔24.9% ，65歲以上者佔8.2%
- 計程車駕駛人 (taxicab driver and chauffeurs)
55歲以上者佔25.4% ，65歲以上者仍佔10.8%

8

國外制度與文獻探討

- ✻ 年齡與生理功能
- ✻ 年齡與事故發生
- ✻ 醫療狀況與事故發生
- ✻ 國外駕照管理制度

9

年齡與生理功能

- ✻ 與駕駛能力相關的**生理功能**主要包括
感知 (sensory)、認知 (cognitive) 與
運動 (psychomotor) 技巧
- ✻ 感知功能如**視力、聽力**；認知功能包括**注意力、記憶力與學習能力**；運動功能如**反應時間**均會隨老化而衰退，但**高齡駕駛人**常以**經驗補償**功能退化之影響
- ✻ 國外研究認為高齡駕駛人是否適合駕駛，需以**個人基礎**進行評估
 - ✱ 老化過程涉及複雜的**基因與環境影響之交互作用**
 - ✱ 年齡相關的功能改變，**人與人之間差異性極大**
 - ✱ 隨著年齡增加其間**差異性之變異更大**

10

年齡與事故發生

- 交通事故的發生機率
 - 年輕族群最高(傾向冒險或缺乏經驗)
 - 生理功能退化之高齡族群並未呈現相對較高風險(採取補償策略)
- 交通事故傷害嚴重性
 - 高齡者相對死亡風險較高(對外傷承受能力降低)
- 一般高齡駕駛人採取補償策略，非職業駕駛人所能自行決定(工作時間長、生計、受雇性質)
- 職業駕駛人老化(生理機能退化)是否亦無較高的事故發生機率，必須更多研究佐證

11

醫療狀況與事故發生

- 本研究所蒐集特定醫療狀況包括
 - 阿茲海默症、癲癇、白內障、糖尿病、青光眼、足部異常、跌倒、持續背痛、心臟疾病、腿足部遇冷發冷、滑囊炎、腎臟疾病及使用抗憂鬱/焦慮藥物等項目
- 以上各種醫療狀況均會提高事故風險，其中又以阿茲海默症、癲癇、白內障、糖尿病、青光眼、足部異常、跌倒與滑囊炎等的影響較為顯著(RR或OR多在2倍以上)

12

國外駕照管理制度 (1/3)

● 普通駕照更新(換照)

- 無需於特定期間更新，包括比利時、法國、德國及瑞典等
- 在駕駛人70歲以上才須進行，包括丹麥、英格蘭、盧森堡、荷蘭、紐西蘭、葡萄牙等
- 在駕駛人70歲以下即要求駕照更新，包括愛爾蘭、芬蘭、義大利、斯洛伐尼亞、日本及我國

● 在必須換照的國家，普通駕照更新條件

- 僅我國屬「行政換照」並未就駕駛人適駛狀態進行醫療檢查
- 其他各國均需視力檢查或醫療檢查之證明作為駕照更新的條件

13

國外駕照管理制度 (2/3)

● 職業駕照更新條件

- 美國職業駕駛人執行州際運輸及英國職業駕駛人，均有更為嚴格的醫療檢查標準或駕照更新頻率
- 義大利及盧森堡則採限制職業駕照持用年齡上限，此與我國採年齡限制具相似處，惟義大利採60歲限齡並可放寬至65歲，與我國小型車職業駕駛人近似；盧森堡則採70歲年齡上限較我國規定寬鬆。

14

國外駕照管理制度 (3/3)

- 普通駕照部份，少部分國家無需更新似較我國寬鬆，多數國家則採用「重點式」管理，即針對高齡者(如70歲)採取較我國嚴格的駕照更新期間與醫療檢查等措施
- 職業駕照部份，我國有固定每3年審驗制度，主要檢查以考照所需之體格檢查為主，似較國外針對特定疾病或醫療狀況所需之醫療檢查來得寬鬆，但我國採用60歲年齡限制卻相對較為嚴格

15

駕照有效條件管理元素

- 年齡管制
- 醫療狀況檢查
- 體格與體能檢查
- 駕駛知識測驗
- 道路駕駛測驗
- 違規記點紀錄及道安講習運用

16

我國職業駕照有效 條件檢討與方案研擬

☀ 檢討課題

- 公平性
- 風險控制
- 技術困難性
- 社會與行政成本
- 其他相關課題

17

我國職業駕照有效 條件檢討與方案研擬

- ☀ 短期方案研擬
- ☀ 短期方案比較
- ☀ 短期方案執行策略
- ☀ 長期方案推動方向

18

短期方案研擬

駕照有效審驗條件		原方案(維持現況)	修正方案
1.年齡通則規定		限齡60歲	限齡60歲(經審驗通過最高可延長至65歲)
2.審驗年期		每三年	每三年
3.審驗項目		道安規則第64條體格檢查項目	1. 道安規則第64條體格檢查項目 2. 道安規則第64條體能測驗項目
職業駕駛人超過60歲特殊規定(小型車職業駕駛人除外)	1.年齡規定	—	經審驗通過最高可延長至65歲
	2.審驗年期	—	每年
	3.審驗項目	—	1.行為層面 2.體格檢查 3.體能測驗
小型車職業駕駛人超過60歲特殊規定	1.年齡規定	經審驗通過最高可延長至65歲	同原方案
	2.審驗年期	每年	同原方案
	3.審驗項目	道安規則第64條體格檢查項目 心電圖 胸部X光	道安規則第64條體格檢查項目 道安規則第64條體能測驗項目 心電圖 胸部X光

19

短期方案比較

方案比較項目	原方案 (維持現況)	修正方案
公平性	較低	較高(較佳)
風險控制	相近	相近 (註：放寬逾60歲以上職業駕駛人可能增加總交通事故發生次數，但更為嚴格之配套審驗措施，可能使61-65歲駕駛人相較60歲以下者之平均事故發生率相近或更低)
技術困難性	較低(較佳)	較高
社會與行政成本	較低(較佳)	較高

20

短期方案執行策略

- 法令修正
 - 道安規則、道安講習辦法、處罰條例
- 醫療專業諮詢
 - 體檢所需時間、成本、醫療狀況判斷難易、設計審驗專用表格
- 行政流程設計
 - 審驗所需證件、駕照吊扣查核、道安講習安排等流程化設計
- 道安講習實施規劃
 - 規劃適當之講習時間、內容與方式

21

長期方案推動方向

- 逐漸納入個案審查基礎之精神
- 針對職業駕駛人業別或駕駛車輛特性規劃審驗標準
- 「生理功能」與「駕駛行為」審驗並重
- 監理單位成立「駕駛人醫療委員會」
- 建立普通駕照管理之定期審驗制度

22

結論


- 與維持現況相較，短期修正方案之公平性較佳，風險控制相近，但技術困難性、社會與行政成本等兩個項目相對較差。
- 初估短期修正方案每年約新增加9,885人次(以非職業小型車之職業駕駛人之2.9%估計)必須進行審驗

23

建議

- 短期修正方案
 - 基本架構取得共識並經交通部認可
 - 後續推動工作建議移請公路總局、台北市監理處、高雄市監理處等監理機關研處
 - 建議方案執行策略從法令修正、醫療專業諮詢、行政流程設計與道安講習實施規劃等課題進行細部規劃設計
- 本研究所提 5項駕照審驗長期推動方向建議交通部逐步推動

24



簡報完畢
敬請指教

25