

# Focus



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The views expressed are those of the authors

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## Driving and vision

Ophthalmologists have responsibilities concerning drivers and the safety of the general public, and these duties have been emphasised both by the GMC and the Royal College of Ophthalmologists<sup>1,2</sup>. The freedom and flexibility of car travel is very important in modern life, though a driving licence is not an absolute right and is subject to controls and safeguards which aim to keep the roads safe. These controls are administered by the DVLA in Great Britain and the DVA in Northern Ireland.

### So what exactly is the DVLA?

The Driver and Vehicle Licensing Agency (DVLA) is an executive agency of the Department for Transport (DfT). DVLA is based in Swansea where it is a major employer. It is responsible for both driver and vehicle licensing in Great Britain. There are at least 43.5 million Group 1 (car/motorcycle) licence-holders in Great Britain and of these 2.2 million also have Group 2 (bus/lorry) licences. Medical cases comprise about 2.3% of licence-holders and are considered by the Drivers' Medical Group (DMG) at DVLA. DMG has a staff of 391, of whom 22 are medical advisers, and has a total running cost of around £21.9 million per annum. DMG processed 734,000 cases in 2012/2013 and this means that nearly 3,000 medical cases per day are processed!

The Secretary of State for Transport, acting through DVLA, has the responsibility to ensure all licence-holders are fit to drive. DVLA publishes a guide to this on its website, called At a Glance Guide to the Current Medical Standards of Fitness to Drive<sup>3</sup>. 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 minutes of panel meetings are also freely available on the DVLA website.

### Visual acuity and visual field standard changes.

The European Eyesight Working Group on New Standards for the Visual Functions of Drivers published its report in May 2005<sup>4</sup>. Subsequently, new minimum

standards for vision and driving were published by the European Commission in August 2009<sup>5</sup>. There has subsequently been public consultation in Great Britain about these, and on 1 May 2012 those vision standards in Great Britain that had previously been below the minimum European standards were amended accordingly, and further amendments to the vision standards came into force on 8 March 2013<sup>6</sup>. In essence there have been changes to both visual acuity and visual field standards for Group 1 and Group 2 drivers.

### Group 1

A minimum binocular visual acuity of 6/12 is now required as well as the ability to read in good light (with corrective lenses if necessary) a vehicle registration plate from a distance of 20 metres (the 'number-plate test'). Biotic (telescope) devices are still not acceptable for driving in Great Britain.

The visual field standards for Group 1 driving require a width of horizontal field of at least 120° (but now with at least 50° on either side of fixation) and no significant defect either within or encroaching into the central 20° from fixation.

Group 1 drivers who have previously held full driving entitlement, removed because of a field defect which does not satisfy the standard, may be eligible to re-apply to be considered as exceptional cases on an individual basis, subject to strict criteria: the defect must have been present for at least 12 months; it must have been caused by an isolated event or a non-progressive condition; there must be no other condition or pathology present which is regarded as progressive and likely to be affecting the visual fields; the applicant has sight in both eyes; there is no uncontrolled diplopia; and there is no other impairment of visual function, including glare sensitivity, contrast sensitivity or impairment of twilight vision.

Those with sight in one eye only must meet the same visual acuity and visual field standards as binocular drivers. Confirmation of adaptation to monocular vision is required.

## Group 2

Drivers should have a visual acuity, with corrective lenses if necessary, of at least Snellen 6/7.5 in the better eye and at least Snellen 6/60 in the worse eye, and this represents a lowering of the standard in the worse eye. If lenses are used to attain these values, correction must be by glasses with power not exceeding plus eight dioptres, or by contact lenses. The correction must be well tolerated. Monocularity is not acceptable. 'Grandfather rights' for visual acuity may be applicable in some circumstances. The horizontal visual field with both eyes should be at least 160°; the extension is now defined and should be at least 70° left and right and 30° up and down. No defects should be present within a radius of the central 30°.

## Some examples

Advice regarding driving should be given or considered at every consultation. What advice would you give in the following cases? The answers are in italics.

**Case 1:** You see a new patient in clinic who has cataract in both eyes. His best corrected acuities are 6/18 right and 6/24 left and three letters on the 6/12 line binocularly. However he tells you that he has tested his own vision and is able to read a number plate at 20m in good light. What advice do you give about driving?

*Answer: Since 1 May 2012 the law requires the ability to read fully 6/12 binocularly in addition to the number-plate test. You should therefore advise him not to drive. He should offer to surrender his licence to DVLA and may re-apply for its restoration following successful cataract surgery.*

**Case 2.** A patient has been referred with a homonymous quadrantanopia due to an occipital stroke. He is minimally symptomatic and this was found at a routine visit to the optometrist. He doesn't mention driving: should you directly ask him?

*Answer: Yes. Unfortunately you must tell him to stop driving immediately and to notify the DVLA. The DVLA will commission an Esterman field; however, he will almost certainly fail this whereupon his licence will be revoked. If there is no other cause of progressive visual loss, if the field defect remains stable after one year and if the patient fully adapts to the field loss, then the 'exceptionality' route may allow the patient to return to driving following an on-road driving assessment. This should not be considered to be an automatic entitlement.*

**Case 3:** An elderly patient with macular degeneration and acuities of 6/36 and 6/60 has been told not to drive and report to DVLA but you are sure that she is still driving.

## What should you do?

*Answer: Your advice not to drive should be clear and repeated and you should consider offering a second opinion. Ultimately if a patient with vision unequivocally below the standard ignores advice not to drive, then your duty to the public overrides duty of confidentiality and you should directly inform DVLA without delay and inform the patient that you have done so. You should not delegate this duty e.g. to the GP.*

**Case 4:** Which of the following patients should notify DVLA of their eye condition:

- (a) A 45-year-old man under observation for ocular hypertension
- (b) A 68-year-old man with glaucomatous field loss in both eyes
- (c) A 75-year-old glaucoma patient with field loss in one eye
- (d) A lorry driver who is on glaucoma drops to both eyes but who has only mild unilateral field loss.

*Answer: (b) and (d). For practical purposes for Group 1 (car drivers) DVLA only needs to know when there is bilateral field loss. However group 2 (lorry/bus) drivers need to notify any degree of field loss even if in one eye only. Eye clinic staff assessing glaucoma follow-up patients either in person or in 'virtual' clinics should remember to consider patients' driving status at each assessment.*

**Case 5:** Your 85-year-old patient with a VIth nerve palsy has given up driving because of diplopia. What is the outlook for driving a car?

*Answer: If this is due to micro-vascular pathology then spontaneous recovery is likely so driving could be resumed when the double vision resolves. Otherwise residual diplopia could be controlled with prisms or a patch, although the DVLA would need to be satisfied that a sufficient period of adaptation had occurred. The exact period of adaptation is likely to vary greatly from one patient to another but may be many months. Lorry/bus drivers are not allowed to use a patch to control diplopia.*

## Summary

Ophthalmologists and eye clinic staff should be familiar with vision standards for driving and any recent changes. Driving should be considered at every consultation and any advice given should be documented in the medical record.

DVLA contact for enquiries from doctors or other health care professionals: [medadviser@dvla.gsi.gov.uk](mailto:medadviser@dvla.gsi.gov.uk)

Correspondence to:

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## References

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