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RACP Submission to the National Transport Commission: Assessing Fitness to Drive review

July 2026

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 24,300 physicians and 9,200 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including occupational and environmental medicine, rehabilitation medicine, general medicine, geriatric medicine, addiction medicine, cardiology, respiratory medicine, neurology, oncology, infectious diseases medicine and others. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the health, safety and wellbeing of patients, the medical profession and the community.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Introduction

The Royal Australasian College of Physicians (RACP) members are key contributors to the effectiveness of national and state Fitness to Drive schemes. As clinical subject matter experts, members provide the advice driver licensing authorities need to make final licensing decisions. We are pleased to provide this submission, based on collated member feedback, to the National Transport Commission's (NTC) Assessing Fitness to Drive Standards review.

The Standards contain medical criteria to guide health professionals in determining whether a person with a medical condition is:

- fit to hold an unconditional licence
- fit to hold a conditional licence (which may involve restrictions or requirements to be monitored through regular health assessments).

For Phase 1 of the update of the Assessing Fitness to Drive Standards, feedback summarised in the table below outlines issues on which the Standards should provide better clarity and guidance, as raised by Fellows from Occupational and Environmental Medicine, Rehabilitation Medicine, Addiction Medicine and General Medicine.

The RACP recommends the NTC address these issues in the revised draft of the Standards.

Issues identified

Section	Issue	Explanatory comments and how to address
2. Cardiovascular conditions	There is a need for a more proactive approach, particularly for commercial vehicle drivers.	Assessing doctors for commercial vehicle drivers should apply the cardiac risk level, similar to the approach for category 1 rail workers.
8. Sleep disorders	There is a need for a more proactive approach, particularly for commercial vehicle drivers	Similarly to the above, diagnosing Obstructive Sleep Apnoea (OSA) in commercial vehicle drivers should be more proactive, and use the STOP-BANG similar to rail. OSA is common in cardiac patients. STOP-Bang is an 8-question screening tool for OSA.
2.2.9. Deep vein thrombosis (DVT) and pulmonary embolism (PE)	Further consideration could be given to the non-driving period (2 weeks).	The Standards recognise there is little evidence that DVT and PE conditions cause road crashes, and that there is significant heterogeneity in patients with thrombosis. Therefore, it was suggested this review reconsider the non-driving period imposed.
3.1. Roles and responsibilities of driver licensing authorities	There is a need to address a financial conflict position for doctors.	Section 3.1 states that payment for fitness-to-drive assessments is generally not the responsibility of licensing authorities. The assessing doctor is therefore paid by the subject patient whose licence they may recommend restricting. The assessing doctor risks losing that patient from the practice. For commercial drivers, employer-commissioned medicals create the reverse pressure. The Standards do not address this dynamic in the system and it would be helpful to have clear guidance.

3.3. Roles and responsibilities of health professionals	This Standard does not deal adequately with the conflict of interests for assessing doctors which arise from the assessment model. The conflicts are inherent and not exceptional as implied in the current Standards. The solutions offered need greater practical and realistic consideration for doctors. A major issue is the need for a clear independent pathway for an objective opinion for difficult cases.	Doctors do not issue the driving license yet carry responsibility for licenses issued. This structural tension between the roles of treating doctor and assessor (de facto gatekeeper for the licensing authority) requires a clear guiding framework for dealing with this. Examples: • The self-disqualification option for doctors has no supporting pathway. Further, the suggested remedy, "refer to another practitioner," is often impractical for complex cases. • Section 3.3.1 discusses trust in the context of confidentiality breaches, but not how the assessment role itself suppresses disclosure by patients and undermines the therapeutic relationship the whole model depends on. Patients who know their treating doctor is also their assessor may withhold symptoms directly relevant to both safety and management, blackouts, hypoglycaemic episodes, cognitive decline. This systemic conflict impacts clinical care. • This system means patients frequently doctor-shop without disclosing they have been advised to drive with conditions etc. • It must be recognised that doctors are harassed or bullied by patients and their families who want a return to driving (RTD) which makes the Standards hard to apply. • Because often the physicians are best placed to interpret the complex cognitive changes that occur following brain injury, for example, and provide continuity of care, disqualifying themselves as the Standards suggest (3.3.2) is not always the most practical solution for good patient care. • There is no funded independent assessment pathway, and no register of assessors willing to take these referrals. • The reality is that transferring the patient to another doctor only transfers rather than resolves the conflict. The next practitioner, then has less clinical knowledge of the patient. • In rural and regional areas there may be no alternative practitioner at all. • Section 3.3.7 mentions independent expert panels, but only as a resource for licensing authorities in borderline decisions, not as an accessible option for clinicians facing a conflict.
3.3.5 Role of Medical Specialists	Referral to a medical specialist where there is limited access.	Where there is limited access to specialists who are needed in the assessment process, such as in rural, remote and regional areas, it was suggested

		that a general practitioner (GP) could refer these patients to a general physician (general specialist). An example was given by a member: for diabetes, patients could be assessed by an endocrinologist or a consultant physician specialising in diabetes. A general physician with satisfactory training and experience could provide a standard for assessing fitness to drive for other conditions.
9. Substance misuse	There is a need for more specific guidelines on "other substances." Regarding Safescript records	Given there are more substances readily available since the 2022 edition, this section should offer greater and more specific guidance on these, including on medicinal cannabis. Currently the Standards focus more on alcohol use disorder for substance dependences. Commercial driver medical assessments should require the driver to give consent for the examining doctor to check their Safescript records, to enable detection of prescription medication misuse or use of impairing substances such as medicinal cannabis

Corrections for 2027 edition

The RACP draws attention to the following:

- Acknowledgements section: Contributing health professional organisations.
  We note that in the 2022 Standards, the RACP is not included as a Contributing health professional organisation following our 2021 submission.
- Organisation title mis-spell (Acknowledgements section: Contributing health professional organisations). As an endorsing organisation the RACP name was incorrect.
  The correct spelling is Royal Australasian College of Physicians (not just Australian).
- Appendix 10. Specialist driver assessors.
  As specialist driver assessors we would like to see the inclusion of the Australasian Faculty of Occupational and Environmental Medicine Physicians (AFOEM) and the Australian and New Zealand Society of Occupational Medicine Inc (ANZSOM).

The RACP trusts the National Transport Commission will consider the issues raised by physicians engaging with the Standards and looks forward to the opportunity to review and comment on the revised Standards.

For any further information, please contact the Dr Kathryn Powell, RACP Policy and Advocacy, unit via policy@racp.edu.au.