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RESEARCH ARTICLE

Australian medical practitioners' perspectives about current practice relating to fitness to drive assessment for older people with dementia and mild cognitive impairment: A qualitative study

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Abstract

Objectives: To describe the perspectives of Australian medical practitioners about current practice, and the potential benefit of tools and resources to support fitness to drive assessment for older people with dementia and mild cognitive impairment (MCI).

Methods: Semi-structured interviews with 22 medical practitioners from cognitive/memory clinics, hospitals, general practice and driving fitness assessment services in Australia. Reflexive thematic analysis was conducted.

Results: Two overarching themes were generated: (1) Uncomfortable decisions, describing feelings of discomfort expressed by practitioners about making fitness to drive recommendations, with two subthemes: (a) 'Feeling uncertain' and (b) 'Sticking your neck on the line'; and (2) Easing the discomfort, describing participants' desire for tools/resources to support practitioners to increase comfort with fitness to drive recommendations, with two subthemes: (a) 'Seeking certainty' and (b) 'Focusing on the process' conveying two different perspectives about how this may be achieved. There was a desire for a new in-office assessment tool capable of accurately predicting fitness to drive outcomes and views that an evidence-based clinical pathway could improve practitioners' confidence in decision-making.

Conclusions: Perceptions of discomfort relating to fitness to drive assessment of older people with dementia and MCI exist amongst medical practitioners from health-care settings across Australia. In the absence of a well-validated in-office assessment tool, practitioners may benefit from an evidence-based clinical pathway to guide driving recommendations.

KEYWORDS

aging, automobile driving, clinical decision-making, cognitive dysfunction, dementia

1 | INTRODUCTION

For many older Australians, driving provides independence, enjoyment and freedom.[1] Driving is complex, involving processing of environmental information and planning a response.[2] For people with dementia and mild cognitive impairment (MCI), the ability to drive safely may be compromised, due to cognitive impairment, in sustained and divided attention, processing speed and executive functioning. Internationally, there is consensus amongst experts that people with symptoms of dementia that have progressed to a moderate stage should discontinue driving due to safety concerns.[3] For people with mild dementia and MCI, the extent to which safety is affected is less clear. Studies examining outcomes of an on-road assessment, the main method to inform licencing decisions, have found fail rates of 18%–33% in people with mild dementia[4,5] and 17%–58% in people with MCI,[6,7] which are higher than those of control participants (0%–2% and 7%–29%). These findings suggest that some, but not all, people with mild dementia and MCI demonstrate driving safety concerns. As people with dementia and MCI may have difficulty self-regulating their driving attributable to a lack of insight,[8] there is a need for health professionals to be involved in decision-making about fitness to drive.

In Australia, fitness to drive standards refer to both a medical assessment and a practical assessment, with on- and off-road components, as providing the best assessment of driving skills for people with dementia.[9] A medical assessment may involve a health professional, such as a general practitioner (GP), geriatrician or rehabilitation consultant considering the person's medical/driving history, driving needs and findings from a clinical examination. To assist with the decision-making of fitness to drive recommendations, the medical practitioner may request a practical assessment of functional fitness to drive involving an occupational therapy driving assessment with an off-road component to assess the person's visual, physical and cognitive capabilities, and an on-road assessment of driving skills in a real-world environment.[10] Alternatively, an on-road transport department assessment may be completed. As practical assessments are costly,[11] the challenge for medical practitioners is to determine if a person is safe, unsafe or requires further assessment.

Most research about fitness to drive assessment of people with dementia and MCI in health-care settings has focussed on GPs, who report limited confidence,[12] preferring to seek input from an external assessor.[13] Little is known about the perspectives of practitioners who assess fitness to drive in cognitive/memory clinics, hospitals and driving fitness assessment services. Our aim in this study was to obtain perspectives about current practice relating to fitness to drive assessment for older people with dementia and MCI from medical practitioners working in a variety of health-care settings across Australia. We also sought to gain perspectives about designing tools and resources to support health professionals with fitness to drive assessment.

Policy Impact

Findings from this research will guide the design of a clinical pathway to assist practitioners with applying the national fitness to drive standards. There is an urgent need for policy changes to bring more resources to this area, including additional compensated time for medical fitness to drive assessment, subsidisation of occupational therapy driving assessment and provision of alternative transport options for people who must retire from driving.

Practice Impact

In the absence of a predictive tool capable of accurately predicting fitness to drive outcomes for people with dementia and MCI, practitioners may benefit from an evidence-based clinical pathway to guide fitness to drive recommendations.

2 | METHODS

2.1 | Context

In Australia, the driver is required to report a long-term/permanent medical condition, which may impact on their driving, to the licensing authority.[9] Health professionals assess fitness to drive and advise the patient about the influence of the medical conditions on driving safety. There is variation in legislation regarding reporting requirements by health professionals across Australia, with only South Australia and the Northern Territory having mandatory reporting to the licensing authority when the condition is likely to endanger the public.

2.2 | Design

Qualitative design using semi-structured interviews of medical practitioners from across Australia.

2.3 | Ethical considerations

The study was approved by the Southern Adelaide Local Health Network Human Research Ethics Committee (ID: EC00188 OFR 154.20).

2.4 | Setting

Interviews were conducted with practitioners from health-care settings in Australia.

2.4.1 | General practice

Many older people with cognitive concerns present to their GPs.[14] A GP may provide a diagnosis or refer the person to a specialist for further investigation. For a person with dementia or MCI, the GP is often responsible for coordinating postdiagnostic care,[15] including assessment and/or monitoring of fitness to drive. In some states, where aged-based assessments are mandated (New South Wales, Australian Capital Territory, Queensland and Western Australia), GPs complete regular medical fitness to drive assessments for older patients.[9]

2.4.2 | Memory/cognitive clinics

Older people are commonly diagnosed with dementia or MCI at a health-care clinic such as a 'memory' or 'cognitive' clinic[16] led by specialist practitioners, such as geriatricians. Other disciplines, including nurses and allied health professionals, may have a supporting role. These clinics provide the person and their families with diagnosis, treatment, support and information, which may include a recommendation about fitness to drive.[17]

2.4.3 | Hospitals

Cognitive concerns may be identified during a hospital admission to an acute or subacute service, including a geriatric evaluation management (GEM) unit, providing comprehensive assessments for older people. These services are staffed by multidisciplinary teams of practitioners (geriatricians/rehabilitation consultants/trainees), nursing and allied health professionals. Fitness to drive recommendations may be provided as part of discharge planning.

2.4.4 | Specialised driving fitness assessment clinics

These clinics provide services to determine the influence of a person's medical condition on their driving. Staffing and assessment processes used in these clinics are variable. A practitioner such as a rehabilitation consultant/trainee may complete a medical fitness to drive assessment, followed by a referral for a practical assessment if required.[18]

2.5 | Participants and data collection

A purposive sample of 22 interview participants was recruited by contacting national professional associations and managers from health-care services, who disseminated information about the study to medical practitioners who provide fitness to drive screening or assessment services to people with dementia and/or MCI. An interview guide (refer to Appendix S1) was developed a priori. Interviews were conducted by two researchers, CS ($n=19$) and AB ($n=3$) between 11 November 2020 and 23 September 2021. Further detail about data collection is presented in Appendix S2 using the consolidated criteria for reporting qualitative studies checklist.[19]

2.6 | Data analysis

Reflexive thematic analysis[20,21] was conducted using the six-step guidance outlined by Braun and Clarke.[22] Themes and subthemes were revised and refined following meetings with five of the authors (CS, KL, AB, ZAW, SG). The process of analysis is described in further detail in Appendix S2.

3 | RESULTS

Interviews were conducted with 22 medical practitioners from South Australia ($n=9$), Victoria ($n=4$), New South Wales ($n=3$), Queensland ($n=2$), the Australian Capital Territory ($n=2$), the Northern Territory ($n=1$) and Tasmania ($n=1$). A summary of participants' characteristics is presented in Table 1. Most participants ($n=18$) reported working predominately in clinical roles in the public system, in memory/cognitive clinics ($n=13$), hospital-based settings ($n=13$) and/or driving fitness assessment clinics ($n=4$). Some participants worked predominately in private settings in general practice ($n=3$) or a memory/cognitive clinic setting

TABLE 1 Participant characteristics.

Participant characteristic	
Gender	
Male (*n*, %)	7 (32)
Female (*n*, %)	15 (68)
Years of experience	
Working as a medical practitioner Mean (SD)	18 (9)
Working with patients with cognitive impairment Mean (SD)	13 (8)
Level of seniority	
Trainee (*n*, %)	5 (23)
Consultant/Geriatrician (*n*, %)	17 (77)
Professional background	
Geriatric medicine (*n*, %)	13 (56)
Rehabilitation medicine (*n*, %)	5 (22)
General practice (*n*, %)	5 (22)

($n = 1$). Some also held non-clinical roles as directors/department heads ($n = 3$), dementia clinical educators ($n = 2$) or researchers ($n = 1$).

3.1 | Findings of the interviews

Two major themes were generated: (1) 'Uncomfortable decisions' relates to feelings of discomfort expressed by medical practitioners about making fitness to drive recommendations, with two subthemes: (a) 'Feeling uncertain' and (b) 'Sticking your neck on the line'; (2) 'Easing the discomfort' refers to participants' desire for tools and resources to support practitioners to feel more comfortable with fitness to drive recommendations, with two subthemes, (a) 'Seeking certainty' and (b) 'Focusing on the process' conveying two different perspectives about how this may be achieved. An outline of the themes with examples of quotes is presented in Table 2.

3.2 | Uncomfortable decisions

3.2.1 | Feeling uncertain

Participants commonly expressed discomfort about fitness to drive assessment because they felt uncertain about making fitness to drive recommendations. Many participants described challenges relating to the complexity of fitness to drive assessment.

> I'm always uncertain about someone's fitness to drive...I think it's a really complex area and I always struggle with it...
>
> (P19, Geriatrician)

They reported there was a lack of guidance about the best way to approach driving assessment.

> It's something we deal with every day, or most, but we don't get proper training; maybe because there's no guidance out there.
>
> (P2, Trainee in Geriatric Medicine)

For patients with both dementia and MCI, most participants reported using predictive tools, including the Trails B test,[23] the Clock drawing assessment,[24] the DriveSafe DriveAware[25] and maze tests that have been validated against fitness to drive outcomes. Opinions about these tools were mixed, with many participants expressing scepticism about their validity.

> The validated tools that I have access to– I don't feel there are good ones; we're relying on these assessments, but I don't think...they have any good predictive factor especially in the...early dementia phase.
>
> (P16, Geriatrician)

Many participants reported that scores from these tools were useful to consider in the context of a 'bigger picture' relating to a patient with dementia or MCI, including their vision, physical capabilities, driving history, functional capabilities, self-awareness, collateral information from family and findings from global cognitive assessments such as the Montreal Cognitive Assessment.[26] Some participants stated they did not use predictive tools, or they only used them because there were no alternatives.

Participants from general practice, memory/cognitive clinics and hospitals discussed that having limited time to

TABLE 2 Themes and additional quotes from participants.

Subthemes	Themes and additional quotes
	Uncomfortable decisions
Feeling uncertain	*No one seems to be able to tell us, as GPs, the best way to approach this, so it's really hard.* (P12, GP) *The lack of standardised assessment makes it really hard. I know we've got the fitness to drive guidelines and they're good, but they don't help you to do an assessment and that's what we need.* (P2, Trainee in Geriatric Medicine) *I don't have access to any online driving assessor tools, I would happily use them if I felt that there was something that was well-validated and easy for patients...from non-English speaking backgrounds.* (P19, Geriatrician) *So we've had a look at the DriveSafe DriveAware tool. Look I'm not convinced that it's been validated particularly well... we use that as a tool to say..., if we're clinically quite concerned, don't really want to put them on the road but it's not enough clinically to stop them driving.* (P22, GP and Medical assessor for fitness to drive) *I remember one patient whose family were so insistent that she was fine to drive.... So, we tried the clock face and then the maze...I know none of them are validated. But you think we've got to try ...and make some kind of assessment. Her clock face was terrible, but her maze test was amazing. Then you just go shit. So it's really tricky.* (P12, GP)
Sticking your neck on the line	*I had one patient who was verbally but also physically aggressive... he slammed the door and I was shut in there with him. It was not good... I'm not the only one who has had trouble with that kind of encounter... because of his neurocognitive impairment, I just wasn't able to reach him and get him to see the reasons why he needed the occupational therapy driving test.* (P17, Geriatrician) *Telling someone that they can't drive has a much worse impact than telling someone than they're dying...with the dying one often the patient knows it's coming, whereas with the driving one they don't understand, and they can't understand either...* (P16, Geriatrician) *I'm very torn as a geriatrician trying to promote independence, in taking away someone's independence with that removal of their transport option. The biggest deficit in this area is the lack of appropriate transport substitutes for people when we remove driving, it's appalling.* (P19, Geriatrician) *One lady who lived on her own, she was 25 k's from her nearest neighbour...so you get stuck in this ... this person is going to be stuck home on their own with a cognitive impairment. Every single time it's really hard.* (P15, Geriatrician)
	Easing the discomfort
Seeking certainty	*If we had a test that we could do and they pass or fail, that would make it a lot easier...* (P15, Geriatrician) *If it was a screening tool and it picked up some concerns, then you could refer those people for driving assessments... something that would be an in-room, five-minute, ten-minute thing ...that was a validated tool.* (P9, GP) *I would feel more confident in cancelling people's licenses if there was a well validated tool which I could say this gives me 90 percent confidence that this person has X amount of chance to cause a car accident because that would mean I have clear guidelines... of when to act.* (P16, Geriatrician) *The real issue is we don't have... an off-road assessment to predict those people who need to stop driving or can continue driving and that's what we need.* (P22, GP and Authorised Reviewer)
Focusing on the process	*A process that you'd work through to help you reach a decision, that would help...we have fairly junior trainees in the clinics and on the wards who are having to make these sorts of decisions.* (P5, Geriatrician) *It might just prompt them... have you looked at their (visual) acuity, have you done a MoCA...and, it links onto, well that actually means this.* (P10, Trainee in Rehabilitation Medicine) *You could say, "this is the standardised approach ... that is consistent with national law and recommendations" ... that probably makes that conversation easier ...It's probably helpful for patients ...because they can be given the impression that, "Some doctor came in and waved the wand and said I couldn't drive anymore". You know, where was the process?* (P1, Trainee in Geriatric Medicine) *It would be good to have a universal approach, some guidelines that we could go to our managers and say, look, this is the agreed upon standard and we want to deliver that.* (P17, Geriatrician) *Well, (it would) definitely (be good to know) about the types of pen and paper tools that can be used ... and the literature behind all of those, ...how relatable they are to on road driving assessments, and when you would consider doing an OT driving assessment, how often it needs to be repeated.* (P17, Geriatrician) *Something that links to information (about) where they can refer the patient to, because ... I don't know if people know that we (driving fitness assessment service) exist ...* (P10, Trainee in Rehabilitation Medicine) *It would be useful to have some roleplays using phrases and examples of how to approach some of those difficult scenarios...* (P19, Geriatrician)

assess fitness to drive impacted on their ability to feel certain about a recommendation. Participants who were GPs reported that finding time to screen or diagnose dementia or MCI was, in itself, a challenge.

> Medicare's not set up for dealing with complex medical problems...GPs are...very poorly resourced in terms of time...dementia is incredibly complex...
>
> (P12, GP)

Finding time to assess fitness to drive was described as even more challenging, with GPs feeling pressured to 'slip in' discussions about driving during standard consultations, because fitness to drive consultations were not subsidised by Medicare. One option available to GPs was referring patients for further assessment at a memory/cognitive clinic or a driving fitness assessment clinic. However, access to these clinics was limited due to the cost, waiting times and limited availability of services.

> A public geriatrician or memory clinic, forget it. You'll be waiting a year.
>
> (P12, GP)

Participants from memory/cognitive clinics and hospitals reported that driving safety concerns are commonly raised as an issue for their patients, with GPs often not picking up the concerns, or avoiding driving assessment due to a desire to preserve the doctor–patient relationship. Similarly, many of these practitioners reported having limited time to assess fitness to drive, with busy workloads and competing priorities.

> Junior doctors in the hospital system get very confused about driving, and it's often left up to them to make a notification. Sometimes, because they're so busy, it's the last thing to tick off, and...it might have been done incorrectly.
>
> (P10, Trainee in Rehabilitation Medicine)

Many participants reported referring patients with MCI or dementia for an occupational therapy driving assessment when there were driving safety concerns due to questionable performance in cognitive assessments, impulsive behaviour, lack of self-awareness, driving safety concerns from family and/or lack of time to complete a thorough in-office assessment. Some participants who were geriatricians reported that driving safety concerns were identified more frequently in patients with dementia than those with MCI. Most participants were positive about the value of occupational therapy driving assessments.

> My feeling is that the gold standard is an occupational therapy driving assessment.
>
> (P21, Geriatrician)

However, participants noted that access to these assessments was limited, due to the cost, waiting times, limited availability of services and medical practitioner reluctance to refer due to concerns about occupational therapists' safety. In the absence of these assessments, decision-making was described as particularly challenging.

> It's probably the hardest part of the GP role... you're reliant on a little bit of collateral, ...a bit of hunch, and bit of knowledge of the patient...to get to a point where you go actually... I don't think you should be driving any longer... sometimes a receptionist taps me on the shoulder and says we saw Mr Smith park a car, you need to get his licence from him.
>
> (P8, GP)

3.2.2 | Sticking your neck on the line

Participants also expressed feelings of discomfort relating to their role as fitness to drive assessors due to potential negative outcomes after a driving recommendation for both patients and practitioners. Participants discussed that it was common for patients to have emotive reactions after a recommendation to discontinue driving.

> Often, it's catastrophic for them. It's...like they're grieving in that moment, they go through acceptance and bargaining, and all those processes of grief right then and there in the room with you. It can be very complicated.
>
> (P7, Trainee in Rehabilitation Medicine)

Participants reported that some patients, who demonstrated awareness of the impact of the cognitive impairment on their driving, would be accepting of a recommendation. However, most lacked awareness and understanding of the reasons why the driving was likely to be unsafe. Attempts to console patients were described as futile, with explaining and rationalising not considered useful.

> Where there's no insight those discussions are futile...usually, you sense it... if you're going around in circles... I just take it back to "We are restricted by the regulations in this Austroads book. You unfortunately no longer meet them, you cannot drive from today".
> (P22, GP and Medical Assessor for Fitness to drive)

All participants spoke about situations where the doctor–patient relationship had been negatively impacted, with some patients changing doctors or leaving the service. There were occasional reports of more extreme reactions.

> I have had people who've rung the office 3 times a day for months afterwards saying they're going to kill me...
> (P11, Geriatrician)

There were also reports of patients submitting complaints to formal bodies.

> One patient reported me..., so that was awful... it really set me back a little bit, because...you really stick your neck on the line having to assess people for driving and their reactions to you.
> (P14, Geriatrician)

Practitioners expressed discomfort in knowing that a recommendation to discontinue driving may have a considerable impact on patients' independence due to the lack of alternative transport options. This contradicted their role, as doctors, in recommending activities which are beneficial for people with dementia/MCI.

> It does become a bit of a catch 22 because some of the things I recommend to prevent progression in cognitive impairment need access to the community.
> (P13, Advanced Trainee in Geriatric Medicine)

Practitioners also spoke about the potential serious negative outcomes that may arise if driving safety concerns were missed, or if a poor decision was made, including possible harm to patients and the broader community from a motor vehicle accident. Some participants raised concerns about their practices coming under legal scrutiny.

> I have testified in court on people...that other doctors have let drive who killed people.
> (P11, Geriatrician)

3.3 | Easing the discomfort

3.3.1 | Seeking certainty

All participants responded positively to the idea of having tools and resources to support fitness to drive assessment, with most wanting guidance to help practitioners feel more comfortable with their decisions. A common view was that there is a need for well-validated predictive tool to assist practitioners to feel more certain about fitness to drive recommendations. Some practitioners wanted an in-office tool capable of accurately identifying safe and unsafe drivers.

> I would feel much better... if I had a good tool to assist with detecting if they were safe or unsafe on the road ...
> (P16, Geriatrician)

Others, who were sceptical about the predictive capability of any office-based tool in determining pass/fail outcomes, requested a predictive tool to assist with streamlining referrals for occupational therapy on-road assessments.

> I reckon...there's 60% (of people with dementia) in the middle who we just could never guess, however good we are, who need an occupational therapy driving assessment, but... if you can pick the 10% who should be safe to drive... and... the 20% who definitely shouldn't be driving...
> (P21, Geriatrician)

Participants discussed the importance of developing a predictive tool that is both simple and well-validated.

> It's an interesting balance between a valid tool...and not being too complicated so people on the ground won't use it.
> (P18, Rehabilitation Consultant)

3.3.2 | Focussing on the process

Another common view was that there is a need for an evidence-based clinical pathway to help practitioners feel more confident with the clinical reasoning processes behind their decisions.

> It'd be nice to have a tool, even if you might not use it so strictly... to get everyone thinking

> about what things could be assessed to give everyone a bit more confidence in making a decision...
>
> (P13, Advanced Trainee in Geriatric Medicine)

Participants envisaged a clinical pathway that would encourage practitioners to consider the 'bigger picture' when making a recommendation. They suggested including information about 'red flags' that may indicate driving safety concerns, existing predictive tools and the literature relating to these tools, and ethico-legal considerations. They were also interested in guidance about when, and how, to refer for a practical assessment.

Participants viewed having a universal process to follow as a means of achieving consistency in practice.

> Some would say send everyone to driving clinic, some would say take everyone's license away... having a set of guidelines... would be the only thing really... that gets specialists on the same page...
>
> (P2, Trainee in Geriatric Medicine)

They believed that a pathway may help practitioners to feel more comfortable with communicating with patients about driving safety concerns.

> "We don't want to talk about driving, it's too difficult, they can do it"; I'm sure that happens... guidelines might reduce that sort of thing because it gives... people who are uncomfortable with it clarity.
>
> (P2, Trainee in Geriatric Medicine)

Participants suggested developing a pathway that could be used in various settings, including GP practices, memory/cognitive clinics and hospitals. Some participants suggested tailoring the pathway to suit the different practice settings.

> I think you have different tools...A tool for a GP is ...a couple of prompts...enough to highlight a need to do more...getting GPs to think- has this person's memory changed...
>
> (P8, GP)

4 | DISCUSSION

Our study describes the perceptions of discomfort and uncertainty relating to fitness to drive assessment of older people with dementia and MCI amongst medical practitioners from a variety of health care settings. Our findings build on previous research that similarly describes discomfort relating to fitness to drive assessment for people with cognitive concerns amongst GPs.[9,10] Additionally, our study provides insights into practitioners' views about the potential benefit of additional tools and resources to support health professionals with fitness to drive assessment. All participants agreed that further support is needed, with some wanting a new in-office tool capable of accurately predicting fitness to drive outcomes and others wanting an evidence-based clinical pathway to improve practitioners' confidence in decision-making.

The idea of designing a new tool that is capable of accurately predicting fitness to drive outcomes may be appealing to practitioners. Having a tool that provides a high degree of a certainty that a person's driving does, indeed, pose a risk to public safety may lessen the emotional impact of delivering a recommendation to discontinue driving. It may also provide a simple solution for practitioners who are faced with the challenge of completing fitness to drive assessments with limited time and/or limited access to occupational therapy driving assessments.

Over the past few decades, research has examined the predictive capability of various assessment tools, including the Trails B test,[23] the Clock Drawing Test,[24] the DriveSafe DriveAware[25] and the Snellgrove Maze test.[27] However, no individual assessment tool or assessment battery has been found to definitively predict fitness to drive outcomes for all people with cognitive impairment.[28-30] As fitness to drive assessment is complex, it may not be possible to develop a tool that is both capable of accurately predicting fitness to drive outcomes and simple enough to use in a health-care setting.

In the absence of a well-validated predictive tool, an evidence-based clinical pathway may be useful for guiding practitioners through the complexities of fitness to drive assessment. When designing a pathway, it will be important to consider research evidence from systematic reviews and draw on input from experts through the development of consensus-based recommendations in areas where evidence is lacking. Clinical pathways have been used successfully in other fields for conditions such as diabetes and asthma.[31]

In addition to developing further tools and resources, system-related barriers contributing to practitioners' discomfort must be addressed. Findings from this study and previous research[9,10] highlight that for many practitioners, there is limited time available for completing medical assessments, difficulty accessing occupational therapy driving assessments and a lack of alternative transport options to recommend for people who must retire from driving.

Policy changes are required to bring more resources to this area. There is an urgent need for the medical profession to advocate for funding of occupational therapy driving assessments. These assessments are less expensive than neuroimaging which is routinely used in the work-up to a diagnosis of dementia.[32] Unlike neuroimaging, occupational therapy driving assessments are not usually subsidised by Medicare or covered by health insurance, which can be marginalising for patients who are required to self-fund these assessments.

Our study has provided important insights into the fitness to drive assessment practices of practitioners from various health-care services across Australia. Participants in our sample spoke about using the same assessment process to identify driving safety concerns for patients with both MCI and dementia. We acknowledge that, by definition, there is little or no functional loss in MCI, and for many patients with MCI, driving safety may not be an issue of concern that requires comprehensive assessment. It is important to note that the majority of participants were geriatricians who assess fitness to drive as part of a broader assessment relating to the cognitive capabilities of a patient.[17] Our findings may not reflect the practices of all practitioners who work with patients with MCI. Additionally, our sample did not include practitioners from neurology or psychiatry services. Another limitation is that participants, who expressed interest in this study, may have held more positive views about the value of additional tools and resources than other practitioners because they were interested in fitness to drive assessment.

5 | CONCLUSIONS

Our study describes perceptions of discomfort relating to fitness to drive assessment of older people with dementia and MCI amongst practitioners from various health care settings across Australia. In the absence of a well-validated predictive tool, practitioners may benefit from an evidence-based clinical pathway to support their decision-making.

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CONFLICT OF INTEREST STATEMENT

No conflicts of interest declared.

DATA AVAILABILITY STATEMENT

The data are not publicly available due to privacy or ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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