
Driving licence and alcohol – what is the threshold?

INVITERT KOMMENTAR

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Clinical judgement and ambiguity about what constitutes high-risk and harmful alcohol consumption create uncertainty for doctors, who have to balance their dual role as clinician and expert assessor while also maintaining responsibility for patient care.

In a study published in this edition of the Journal of the Norwegian Medical Association, Lid et al. asked general practitioners (GPs) in the Norwegian county of Rogaland about their assessments of harmful alcohol use and fitness to drive (1). The GPs reported that it could be difficult to discuss alcohol use with patients and expressed concern about the implications for the doctor-patient relationship if they reported patients deemed unfit to drive to the County Governor. They also expressed uncertainty about what constitutes harmful alcohol use in this context, and considered the driving licence regulation and associated guide to be unclear.

Since 2016, and in line with the Norwegian Directorate of Health's fitness to drive guide, GPs have been responsible for assessing whether a patient meets the medical fitness requirements of the driving licence regulation (2). The County Governor therefore no longer has to process large numbers of exemption applications, but retains responsibility for appeals. As driving licence assessments are primarily undertaken by GPs, this is regarded as one of the many tasks that have been transferred to GPs in recent years.

Lid et al. raise concerns about whether the fitness to drive guide is sufficiently clear and whether it improves health care and contributes to road safety. The GPs in the study found it challenging that discretionary assessments cannot be supported by objective tests or blood analyses with defined cut-off thresholds. Some GPs were concerned about potential sanctions if they failed to comply with the mandatory reporting or made poor discretionary judgements. This uncertainty and sense of vulnerability among GPs is noteworthy in itself and warrants further discussion within the medical community.

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It is not only the participants in this study who struggle with the practical application of the driving licence regulation and associated guide. The County Governor for Trøndelag carried out a regulatory inspection into compliance with mandatory reporting for fitness to drive in spring 2022, and the findings support concerns about the application of the guide (3). In the inspection, GPs reported that assessments of alcohol use were particularly challenging, and it was found that GPs did not sufficiently investigate patients' alcohol consumption before reporting to the County Governor. As many as 40 % of reports were insufficiently substantiated and documented, resulting in adverse consequences for patients' legal safeguards. Many GPs also failed to notify the County Governor when a patient was deemed unfit to drive, or refrained from issuing a temporary driving ban even in cases of confirmed high alcohol consumption. It was evident that GPs were uncertain about when mandatory reporting should be triggered and were unable to follow the advice in the guide on assessing patients' alcohol use. The inspection also revealed that many GPs lacked adequate routines for assessment and follow-up after a temporary driving ban had been lifted.

There is reason to believe that the findings would be similar in other parts of Norway. Part of the uncertainty may stem from the concept of a 'temporary driving ban', which, even when issued in writing, could be perceived by patients as less legally binding. The guide is also very extensive and can be cumbersome and time-consuming to use. By reporting to the County Governor, GPs at least fulfil their mandatory reporting obligation and avoid criticism.

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The County Governor does not publish data on the annual number of reports received on patients deemed unfit to drive due to alcohol use. Most GPs are familiar with the use of PEth testing (phosphatidylethanol) in the follow-up of patients seeking to document abstinence after losing their driving licence, and a large number of PEth tests are performed in primary care. Only the Innlandet Hospital Trust, serving a population of 400,000 (7 % of the Norwegian population), analyses over 7000 PEth samples annually (personal

communication from Vibeke Fredagsvik, customer adviser at the Department of Diagnostics, Innlandet Hospital Trust, 8 April 2026). Around 5000 of these are ordered by primary care, but it is unknown how many are ordered specifically to assess alcohol consumption prior to potential reporting to the County Governor.

In the study by Lid et al., GPs described the use of clinical judgement as particularly challenging. Clinical judgement is developed through the interplay between knowledge and practical experience. GPs are often knowledgeable about patients' overall health status and should therefore be well placed to make such discretionary assessments. Doctors learn effectively in groups, and both the fitness to drive guide and the use of clinical judgement are well suited to small-group learning. Nevertheless, there is clear cause for concern regarding the practical application of the guide. A schematic overview of the alcohol-related section of the fitness to drive guide could simplify GPs' work, and training courses in fitness to drive assessments may be needed to ensure more consistent practice.

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Targeted guidance on the driving licence regulation and clarification of the fitness to drive guide could improve the quality of this work, strengthen patients' legal safeguards and improve road safety. The article by Lid et al. demonstrates that the fitness to drive guide is not an effective tool for GPs and has limitations that impact on fitness to drive assessments. The authorities would be well advised to take these findings seriously.

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