

Navigating the pathway to ceasing driving—A voyage of discovery

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Abstract

Background: Ceasing driving for older people is a life transition and can be associated with a sense of loss and decreased wellbeing. Nurses can play a key role in supporting the older person to manage the transitions, especially as the work involved in ceasing driving is often hidden. For example, finding alternative and accessible means of travel and maintaining mobility. Travel itself can be viewed as essential, for example attending health appointments and shopping. Discretionary travel may not be viewed as essential, but provides an important means of maintaining activity and social connection.

Method: A case study is presented of Mike's journey in ceasing driving. The concept of transition helps in co-creating with Mike his journey of discovery. Semi-structured interviews took place with Mike over a six-month period and a journey pathway created, which was subject to further iterations during subsequent interviews.

Results: Ceasing driving involves a number of transitions encompassing a series of losses, managing uncertainty, problem-solving and learning new skills. Being able to access and adapt to maintain mobility and travel are influenced by structural and environmental barriers.

Conclusion: The World Health Organization's strategy to create age-friendly cities and communities is admirable. Like any other strategy this is a long-term plan, and in meantime action needs to happen to support older people in ceasing driving and creating a non-driving life and limit a decrease in well-being. Starting conversations on transitional travel planning is proposed, with nurses playing a central role in making this process happen.

KEYWORDS

driving, mobility, older person, travel, well-being

1 | INTRODUCTION

The ability to travel is essential for health and well-being (Mackett, 2017). Travel can be classed in a number of ways, as 'essential, for example food shopping or attending a medical appointment' (Davey, 2007). In contrast, discretionary travel is for

enjoyment, and engaging in activities requiring mobility in the environment (Dickerson et al., 2019), and this type of travel is sometimes unplanned. Discretionary travel can impact well-being positively through managing negative emotions such as low mood (simply through 'getting out of the house'). Facilitating physical activity, being able to spend time in nature or with friends, and enabling

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participation and contributing to the local community and society are all potential outcomes from travel. Limiting or decreasing discretionary travel, which most car owners take for granted, can lead to a reduction in well-being (Chihuri et al., 2016).

Most people who drive a car will 'outlive their driving expectancy (men by about six years and women by about ten years)' (Kerschner, 2009) pp. 176. Often, people do not plan for the transition to ceasing driving and travel planning in the future (Shope et al., 2019). They may avoid conversations about ceasing driving (Hansen et al., 2020). According to Pachana et al. (2017) being a driver is about self-identity—personal and social identity—as ceasing driving may result in change and loss of identity, 'thinking of oneself as now old' (pp. 1598).

Travel may become more challenging due to physical and cognitive impairment (Mackett, 2017). For example, a range of long-term health conditions, for example Parkinson's disease, stroke, arthritis, dementia or macular degeneration, may impact a person further and require driving cessation, as well making the use of public transport problematic (Dickerson et al., 2019); It is not only the physical changes that can impact on travel planning but also cognitive abilities, deciding to use public transport, and the planning required to achieve that (Risser et al., 2015). Thinking about the route, the availability of modes of travel and communicating with others either face to face or electronically (Mackett, 2017).

The built environment is a crucial factor in influencing mobility in older people and the ability of the older person to navigate the environment is referred to as 'spatial independence' (Burholt et al., 2016) 'the freedom and choice to access public physical space' (pp. 2). Where people live can affect how they can walk around their neighbourhood, for example paving, safety of the environment associated with fear of crime (Dickerson et al., 2019). Nurses working in the community will be very familiar with a particular neighbourhood and able to assess the safety concerns that an older person may have.

In ceasing driving, accessing other modes of transport for travel is essential, for example the location of age-friendly bus stops (Dickerson et al., 2019). Regular bus services may not be available in certain rural communities (Dickerson et al., 2019). Being given a lift by a family member or friend may only be considered and accepted if viewed by the older person as important or essential travel, rather than discretionary travel (Davey, 2007; Liddle et al., 2017).

Ceasing driving is often described as a transition (Musselwhite & Shergold, 2013). Transitions occur over time and comprise changes in one's actual or perceived situation (Schumacher et al., 1999), and in this paper Mike's transition to becoming a non-driver. Previously used in healthcare research, understanding a transition or transitions can provide opportunities for identifying strategies to support people through changes in their life circumstances and in identifying potential risks for adverse outcomes (Davidson et al., 2007; Davies, 2005; Lindmark et al., 2019; Schumacher et al., 1999).

According to Bridges (2009), transition is the psychological orientation one makes to come to terms with the change or changes in a person's life. Bridges' model accounts for three stages of transition;

Implications for practice

- Ceasing driving can have a negative impact on older adult well-being leading to social isolation and depression.
- Transition as a concept can be a useful framework for understanding the complexity of ceasing driving, but understanding that it is not a linear process, but consists of multiple transitions.
- It is important to understand that for the retiring driver, there is a lot of work and some of this work may be hidden and not visible to nurses. Work encompassing letting go, managing uncertainty, making decisions, problem-solving, learning new skills and negotiation with other people.
- The nurse can support the older person by having conversations about the options and resources available in creating a non-driving future.
- Nurses can advocate at both a local community level and policy level to influence transport and mobility options for older people in preparing for a non-driving future.
- Further research is required to identify the education and resources that nurses need to support older people in ceasing driving.

What does this research add to existing knowledge in gerontology?

- Transition as a concept can be a useful framework for understanding the complexity of ceasing driving, but understanding that it is not a linear process, but consists of multiple transitions is required.
- What are the implications of this new knowledge for nursing care with older people?
- It is important to understand that for the retiring driver there is a lot of work and some of this work may be hidden and not visible to nurses.
- Nurses' can support the older person by having conversations about the options and resources available in creating a non-driving future.

How could the findings be used to influence policy, or practice or research or education?

- Nurses are advocates and can influence at a local community level and national policy level for transport and mobility options for older people in preparing for a non-driving future.
- Further research is required to identify the education and resources that nurses need to support older people in ceasing driving.

letting go, a period associated with loss, the neutral zone, a period associated with uncertainty and new beginnings, where new behaviours are tried out, modified or relinquished. Transitions can be

associated with a deep learning curve (Adler & Castro, 2019). Not all transitions are equally meaningful, but those that are lead to significant changes in a person's life with an opportunity for growing stronger from experience (Adler & Castro, 2019).

The purpose of this paper is to present a case study of how an older person (Mike) has overcome the challenges of ceasing driving. In doing so, we explore the transitions that Mike experienced the losses, uncertainty and the learning that took place during his voyage of discovery, as he overcame structural and system barriers. New knowledge gleaned from understanding the complexity of transitioning to ceasing driving has the potential to be used to support older people who are quitting driving and provide understanding for health professionals, particularly nurses working with older people in the community. We argue that the transition framework can create opportunities for constructing conversations about navigating the future as a non-driver, moving between alternative modes of transport (Musselwhite et al., 2015). However, we identify the limitations of transition as a framework and the need for nurses to continually assess where the older person is in their transition experience.

2 | METHOD—CASE STUDY

This case study developed as part of a larger study exploring older people's well-being (Waterworth et al., 2019). Ceasing driving or even thinking about stopping driving was a concern for some of our participants. Follow-up interviews with participants had been part of the ethics approval for the well-being study (Auckland Ethics Committee Ref. O18277). As Mike, a co-author of this paper, was the only participant

who had ceased driving and was still attempting to manage his situation, the opportunity to explore in more depth his experiences. The impact of the journey was framed by Mike as a 'voyage of discovery'.

In presenting Mike's transition experience, we acknowledge the strengths that Mike has used to achieve a non-driving identity. Four meetings occurred with Mike over a six-month period, incorporating semi-structured audio-recorded interviews at his home. Conducting interviews at his home provided visual information about his neighbourhood (Carroll et al., 2019), for example when he talked about using public transport, we could observe the distance to the bus stop and the terrain.

Analysis of Mike's first interview was conducted by (name) creating an initial journey map (Wheedon & Ahlberg, 2014) and applying Bridges model as a lens for further exploration with Mike. At subsequent interviews in meeting with Mike, the journey map was subject to a number of iterations until the final map (Figure 1) was created. As each iteration was developed with Mike, Bridges transition model was considered with him and the recognition that a number of transitions were occurring. Including how environmental structures and systems were creating barriers adding more complexity to the transition. We acknowledge that Figure 1 may appear complicated, but it does reflect Mike's journey of discovery from driver to non-drive, including the structural and system barriers.

3 | FINDINGS

Mike was 87 years old at the time of interview, and a widower, having lost his wife more than 13 years ago. He was a New Zealand veteran

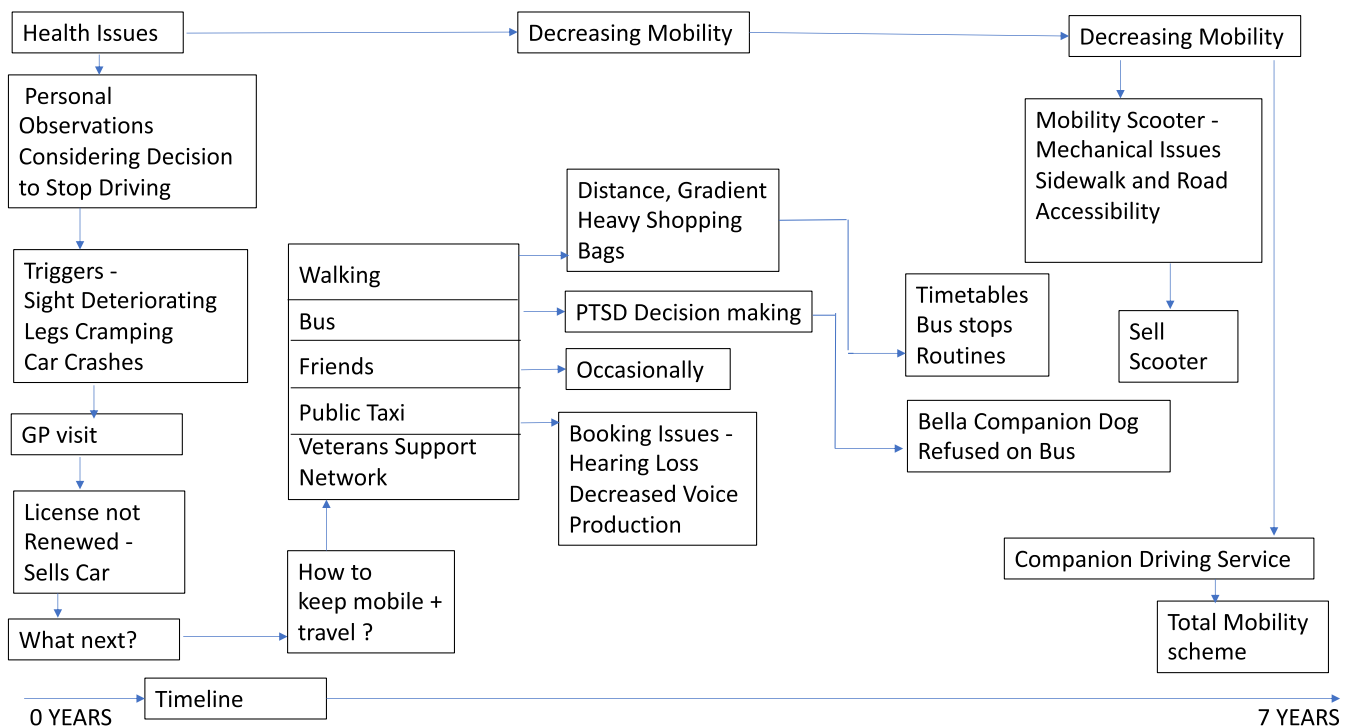


FIGURE 1 Journey map

who served in Vietnam. As a result, he incurred severe hearing loss and post-traumatic stress disorder (PTSD). Mike was diagnosed with Parkinson's disease in 2006 and macular degeneration in 2015. He has two sons living in New Zealand.

3.1 | First transition

Letting go or endings is the first phase of Bridges' model. Involving awareness of changes in life circumstances with several disruptions to how things have been. It involves relinquishing some ways of being and doing. Recognising that it is time to let go is not an easy process. For Mike, this involved several events or triggers, and signalling the time was right to cease driving. He had increasing concerns about driving safely, the impact this could have on his own and other people's safety.

He considered the growing risk of road traffic accidents occurring. With acute macular degeneration (AMD) in his right eye, he could not see what was happening on the right side at stop signs. Impairments in driving and safety risks are acknowledged for people with AMD (Wood et al., 2018). Parkinson's disease may impact driving safely on a number of levels (Rizzo et al., 2010). For Mike, he experienced two freezes at the wheel, as his right leg and right arm seized going around a tight bend in the road. He also experienced a period of inattention at the wheel resulting in a minor collision with a police car.

In New Zealand, when drivers reach the age of 75, then at 80 and every second birthday after that, they must visit their general practitioner (GP) and obtain a medical certificate stating they are fit to drive. Mike was due to have his fitness to drive medical, but with his safety concerns, he decided to discontinue driving. His GP was supportive of the decision. No longer legally able to drive Mike sold his car. However, he did not receive any further information about what was available in preparation for his non-driving future. Mike acknowledges the support of his GP about his health issues, but as he said,

10 minutes is a GP appointment time, and providing counselling or advice for ceasing driving is not their priority.

The loss of spontaneity, freedom of choice and movement meant that Mike could not go anywhere he pleased, and spur of the moment activities were no longer possible.

3.2 | Neutral zone

Redefining the situation is about managing the uncertainty that occurs in the neutral zone. Exploring options and making informed choices reflects Mike's attitude of,

If you go into a situation you have to have a way out of it.

As a veteran, Mike had some support for travel from Veteran's Affairs. This support meant reimbursement was possible for transport to approved health appointments and for surface or air travel away from Auckland to anywhere in New Zealand, a benefit that non-veterans cannot expect.

However, due to his deafness and PTSD, communication by telephoning for taxis, making himself understood, and having to deal with different people each time, was a barrier to his mobility. He had support from friends who could take him shopping, but Mike was uncomfortable asking and being 'beholden' to people.

One of Mike's key strengths is his ability to solve problem and consider options. He had always been a walker, so walking to the shops was still possible for him in the early phase. The distance to the local supermarket was two kilometres, which initially may not seem a long distance, but on the return journey, the terrain was steep at specific points. Mike considered his options for carrying shopping, and his initial choice was to use a backpack.

3.3 | Second transition

However, Mike was aware that at some point, walking to the supermarket would no longer be possible. Gradually, he became less able to walk the distance to the supermarket and the bus became a necessary option, reflecting further losses.

With a bus stop 200m downhill from his home, and still able to walk that distance, he considered using the buses. Executing decisions with PTSD may not be easy (Armenta et al., 2018), and it took Mike six weeks to 'psych himself up' before he could attempt his first bus journey.

Mike had a companion dog, Bella, and a letter from his GP stating that Mike 'could not function without her' (this was due to PTSD, but unstated in the GP's note). Bella, however, was not legally certified as a companion dog under the New Zealand transport authority rules, as only Guide dogs/disability assist dogs wearing a specific collar/jacket as an identifier. There was no recognition of 'invisible disablements' and the need for mental health companion dogs. Some bus drivers accepted the GP's letter, and Mike was allowed on the bus with Bella, but other drivers did not and he was refused entry. Mike experienced rising tension when boarding a bus with Bella, anticipating refusal to travel.

Although the buses could be an option, learning about their routes and timetables and getting home with shopping bags on the bus was still problematic. Unable to see buses approaching from his 'home' stop, he had to stand on the opposite side of the road to see when it was coming. Getting back to the stop meant moving quickly to re-cross the road in time, or miss the bus. Travelling on the bus could also be a lengthy journey, something that Mike had to consider when attending appointments.

Mike experienced continual battles with the transport authorities about taking Bella on the bus. His mobility was decreasing due to his Parkinson's disease and the deterioration in the walkways, which had become dangerous with his decreasing mobility. Walkways were

steep, with irregular steps, no handrails, poor lighting and slippery due to decaying vegetation underfoot.

3.4 | Third transition

When Mike could no longer walk out of the house and use the bus, he decided to get a mobility scooter. The mobility scooter was another option that in theory enabled him to have his independence and allow him to take control of his mobility and travel with Bella. He secured Bella in a carrier on his lap and went to the park and shopping mall. Learning to ride the mobility scooter was not a problem. However, navigating the steep terrain, uneven footpaths, risky crossings and thoughtlessly parked cars or other clutter was problematic (Figure 2).

Despite the scooter being the type of vehicle marketed as an 'all-terrain' vehicle, it became evident this was not the case, and after 9 months and two episodes of the motor burning out, Mike decided to sell it. With his increased impairment, he was less able to look after it, for example maintenance issues such as pumping up the tyres.

3.5 | Fourth transition

Subsequently, Mike started to use a specialised mobility service that he believes caters to his needs. That does not mean that he can use the personal mobility service all the time, as he said, 'he would be broke, so going where I want when I want is quite limited'. It was during this time that, through a chance comment by a stranger, he found out about the New Zealand Total Mobility Scheme (TMS). The scheme was developed in 1981 as part of the Disability Action Plan (Ministry of Social Development, 2019). It was designed to complement public transport services and provide subsidised licensed taxi

services for people with disabilities so they could participate in their communities. The application involves ringing the transport authority within a person's region and asking for details of an appropriate disability agency that support the scheme. The person then contacts the agency to arrange and complete an assessment. The assessment also includes a visit to a general practitioner to confirm the disability. Applying for a TMS is not a straightforward process and help may be required to work through the processes to obtain a TMS card. There is also a time delay as people have to wait to receive their card. For Mike, assistance in applying for the scheme was achieved by the facilitator of his Parkinson's disease support group, who completed and submitted the application for Mike.

Mike's new beginning for now, means he has reached a point in his life where he still feels in control and independent. As issues have arisen, Mike has had to review his situation, manage the uncertainty, explore options and make decisions. Moving to an environment that was flat and easier to get to local shops and other amenities was not something Mike wanted at the time. He acknowledges that he is better off financially without a car, as there are no maintenance or service costs, and he no longer has the stress of driving a car.

Mike accepts that his aspirations, needs, and desires are constrained, but he prefers his life space as it is.

In considering his life at this point, he says,

I never feel lonely, but I am isolated geographically. I do have a lot of social contact: personal cares, neighbours, friends and the Royal NZ Artillery Association. I have family contact with my sons. I have enough contact with people, and I can go where I like using the private transport option, and if it is Veteran Affairs treatment-related, I can get that money back. If I want to go over to the Shopping Mall, it will cost me \$15 each way, which is reasonable, on my budget.



FIGURE 2 Obstruction to path

4 | DISCUSSION

Ceasing driving as a transition is complex, and there can be positive and negative outcomes. Importantly, we see, in Mike's case, the temporality of his changes and the multiple transitions he was experiencing. Meleis et al. (2000) note the difficulties of putting boundaries on the period of transitions, as there are critical points or turning points. Whilst appearing initially as a linear process, it is not linear but a constant state of weighing up alternatives (costs and benefits of alternative forms of transport) to maintain mobility and travel.

Mike's resilience was evident, in reaching a period of stability in a new routine or way of travelling, which was then subject to further change as he encountered deteriorating health, and ongoing structural and system barriers in navigating his non-driving life to maintain his mobility and travel. His transition was a succession of adaptations and adjustments as he let go of one way of being mobile in travelling, learning and managing the uncertainty of the new

modes. Within his journey of discovery, there is evidence of how he manages to deal with services, negotiating and trying to influence services. Similar to other research on managing adversities (Canvin et al., 2009), we see the hidden work that goes on and is generally unrecognised.

Kerschner (2009) cites the Beverly Foundation research on older persons' transportation, identifying the five A's: availability, acceptability, accessibility, adaptability, affordability. Each of these can be applied to Mike's multiple transitions and the learning that is required as part of these processes, weighing up the costs and benefits, searching for information and knowing who to contact. However, whilst public transport may be available, the physical environment may present obstacles and barriers.

Living in an area of numerous long, steep gradients means that walking can become more problematic. Mainly, if there are no age-friendly bus stops, for example bus stops with adequate shelter, seating and lighting to benefit the older adult (Glicksman et al., 2014). Using mobility devices, for example mobility scooters, can also be problematic due to environmental conditions.

The World Health Organization's Age-Friendly World strategy (2018) <https://www.who.int/ageing/age-friendly-world/en/> encompasses a campaign to create age-friendly cities and communities. The need to improve the environment and create age-friendly communities, with appropriate transport options, acknowledged (Dickerson et al., 2019).

Transport authorities making decisions without consultation with the local community can also affect a person's independence for travel. For example, in 2018, the transport authority decided to move bus stops providing very little notice of these changes or consultation with potential users. Temporary movement of bus stops, for example for road works, can also have a negative impact on older people's transport options (Figure 3).

Older adults may start to self-regulate their driving as they begin to come to terms with ceasing driving (Bird et al., 2017). Self-regulation may be a way of reducing anxiety associated with driving. Nurses' assessing how the person may already be making adjustments to their driving can be a trigger point to start the conversation about alternatives. Determining, for example, whether public transport would be an alternative, but noting that it may not be convenient and may not respond to travel needs should be part of the conversation (Bird et al., 2017).

Schumacher et al. (1999) refer to healthy and unhealthy transitions consisting of processes that can influence the person's health and well-being. For example, an unhealthy transition to ceasing driving may result in the person becoming isolated if they have not developed the skills, relationships and resources to maintain the continuity of their activities and connectedness with others. Indeed, resources specifically financial, if limited will limit travel options (Vivoda et al., 2020). In Mike's transition, most of the barriers were structural or systems and not individual coping mechanisms.

Providing information that is not only accessible, but also understandable and actionable is required. Nurses would be able



FIGURE 3 Bus stop notice

to provide specific information, depending on the older person's needs, of the community resources available. For example, voluntary driver support services, discounted mobility transport services with subsidised rates. For Mike, finding out about the discounted mobility service only occurred at a later period (Figure 1), and from a conversation with a member of the general public. Nurses can work with the person considering their learning needs and testing out the options for and with the older person. Option appraisal (Peace et al., 2011) was an essential process for Mike as he continually assessed his situation, made decisions and then took action, as he discovered the person-environment-travel fit.

Bridges' framework provides a starting point into the transition experience when we review Mike's journey. A starting point for nurses is to understand the process of transition, and initially, how the older person may already be considering the losses associated with a non-driving future. For example, how they will manage in the future without a car to maintain their mobility and travel. In this paper, we have highlighted the complexity of transition, showing how it may not be a linear process, requiring the nurse to assess on an ongoing basis where the older person may be in their transition experience. The factors that we identified highlight the risk moments and potential ways to recognise and manage these. Importantly, viewing transition to non-driving as a linear process ignores the multiple changes that were evident. In Mike's case, the neutral zone and new beginnings that Bridges refers to were

an ongoing part of his experience. Periods of stability in which he could view a new beginning, for example by using the bus, changed throughout his journey.

Exploring Mike's transition highlights several events triggering the decision to cease driving. He was cognitively intact in understanding the risks and safety issues and was ready to transition from being a driver to a non-driver. As such, Mike was in control of his ceasing driving journey. For those people who are forced to cease driving on medical grounds, the ability to plan and start to make the adjustments required is highly problematic, and they experience worse health outcomes, such as depression (Chihuri et al., 2016). It is recognised that general practitioner's experience difficulties in making decisions about completing the assessment of older people's fitness to drive (Butler et al., 2020). In Mike's case, his GP was supportive of his decision to cease driving. No further information on what was available to support his non-driving future was provided, and Mike did not expect his GP to provide the information.

A systematic review of intervention approaches for driving cessation in older adults found limitations in the three studies, although they acknowledged they were promising (Rapoport et al., 2017). Of these studies, only one included drivers without dementia and was a group psychoeducational programme (Liddle et al., 2014). However, Dickerson et al. (2019) note the importance of an individual approach to supporting people with ceasing driving. This approach to consider the individual clearly fits with nursing's focus on person-centred practices.

We acknowledge the limitations of the single case study (Gray, 2018) and of applying a specific model of transition as a lens for analysis. Mike had no family involvement in his voyage of discovery, yet we know that family members can face difficulties in their roles in supporting driving cessation (Liddle et al., 2017). However, the in-depth exploration with Mike as a co-author of this paper has shown the work involved in ceasing driving is often hidden: letting go, making decisions, learning, problem solving, exploring options, negotiating with people and applying for schemes—can all be time-consuming. A recent scoping review in this journal (Savoie et al., 2022) notes the need for further research addressing the nurses' role in supporting older adults with road safety.

Choices are based on knowing what is available and how to access the information, and whilst the transport authority does provide information on-line about ceasing driving, this does not mean that it is accessible, acceptable, understandable or actionable. Nurses can have a key role in supporting the older person to determine whether they can access information, find the format acceptable, understandable and critically actionable. The absence of age-friendly transport policies requires transport authorities to consider policy changes to integrate the voices of older people as partners in decision-making processes. Whilst we live in a car-dependent society, environmental changes are requiring that we think about limiting car use, with the potential for changing attitudes and consider alternative transport (Liddle et al., 2017). Electric cars are here and more adaptations with increasing safety features for all drivers has developed. Yet, these developments also come with limitations and cost.

5 | CONCLUSION

Whilst we wait for age-friendly community developments to arrive, what would be important now is to start the conversation on transitional travel planning. Nursing fits well into starting this conversation and at different levels. Raising the issue in local communities provides the opportunity for consultation with older people, transport providers, health professionals, government organisations and local authorities. In considering Mike's journey, there are numerous opportunities for nurse involvement, particularly for those nurses working with older people and working with people with long-term conditions. Nurses have a central role in supporting older people to navigate the health system and drive action (Kagan, 2021). Further research is required to understand the nurses' role in supporting older people with ceasing driving, what is working well for them and where there are gaps in the support and training they may need.

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CONFLICT OF INTEREST

There is no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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