REVIEW

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"Can I drive, doctor?" LEAN thinking may help us answer the question

R H Thomas, T A T Hughes

The loss of a driving licence can have a devastating effect on an individual's domestic life and work. Driving is a complex composite function comprising a number of other complex composite functions, and it is difficult to predict driving ability just from the traditional neurological examination. We propose the acronym LEAN as an aide-memoire to help structure a suggested driving section in the routine neurological clerking, and to help unpack the concept of "fitness" to drive: Licence status, Eligibility (to drive), Ability (to drive) and Notification requirements (to the licensing authorities), now and in the future; cover most of the important issues and may help ensure that people get the best advice. If there are concerns about someone's driving ability, with or without vehicle adaptations, an assessment in a Disabled Drivers Assessment Unit is recommended.

R H Thomas
Specialist Registrar in Neurology

T A T Hughes
Consultant Neurologist

Department of Neurology, Rookwood Hospital and The University Hospital of Wales, Cardiff, UK

Correspondence to:
Dr R H Thomas
Wales Epilepsy Research Network, Institute of Life Sciences, Swansea University, Singleton Park, Swansea SA2 8PP, UK; Rhys-Thomas@Doctors.org.uk

"Knowledge is of two kinds. We know a subject ourselves, or we know where we can find information on it." Samuel Johnson;[6] so if you don't know, look it up in 'At a glance guide to the current medical standards of fitness to drive'

Neurological conditions may compromise the control of a motor vehicle by causing paroxysmal, fluctuating or fixed disorders of consciousness, cognition, behaviour, sensory processing or motor control. In a routine neurology outpatient consultation a discussion of driving issues, because of the profound domestic and work implications, can be just as complex as any discussion of sexual dysfunction or relationship breakdown; therefore a structured and informed approach should be helpful. All patients need good advice to ensure that they are encouraged to continue driving if it is appropriate to do so, and to stop if it would put them or others in danger. This can be difficult if there are uncertainties about the exact diagnosis, the natural history of the diagnosed condition, the potential relevance of any comorbidities, and how the patient will actually perform at the wheel, with or without appropriate vehicle adaptations; patients with acquired disorders of conduct and behaviour following brain injury can be particularly difficult to advise.

We think that neurologists in routine outpatient clinics need to have a working knowledge of the guidelines and the law, some idea about how to structure the driving part of the consultation, and to be familiar with the sort of things that can, and should, be said. We suggest that this article be read with the excellent UK Driving and Vehicle Licensing Authority (DVLA) guidelines open on the desk, or desk top (http://www.dvla.gov.uk).[1] Recalling details of the DVLA guidelines can be challenging[2] and regular reference to them is highly recommended. They contain a wealth of information, including:

- a description of how the guidelines are compiled
- the legal basis for the medical standards
- the differences between a prescribed (should it be proscribed?), relevant, and prospective disability
- the difference between a Group 1 (cars and motor cycles) and a Group 2 (buses and lorries) licence
- seatbelt exemption
- information about age and driving—some 16-year-olds can apply for a driving licence, healthy 70-year-olds have to re-apply every three years.
- information about police, ambulance and health service vehicle driver licensing and taxi drivers (they need to satisfy both the DVLA and their employer or local authority)
- the responsibilities of the doctor and patient regarding notification (the only section we reproduce here)
- and how the DVLA go about acquiring the information needed to make licensing decisions (which we describe later).

The emphasis of this article is on ensuring that a discussion of driving during a routine consultation has a satisfactory and safe outcome for the patient, and the clinician. We begin by outlining some reasons why the driving part of a consultation can be difficult. We then suggest a simple way of structuring the consultation and the clinician's response to the driving question, and discuss five illustrative cases using the September 2008 version of the DVLA guidelines. We will not attempt to review the interesting work on the neurology and neuropsychology of driving, the fine detail of how different neurological diseases do, or might, affect driving performance (although some examples are given for illustration in the box), or the clever adaptations and technologies that are now available to allow disabled drivers to control a car.

WHAT MAKES THE DRIVING QUESTION DIFFICULT TO ANSWER?

If the clinician isn't prepared for it

If driving is routinely asked about at a designated point of the history taking, both the patient and the doctor are suitably primed to consider, as the remainder of the consultation trundles along, the likely implications of the story told, of the answers to the questions asked, and of the signs elicited. It can be very difficult for clinicians to correctly answer the driving question during the concluding stages of a consultation which has focussed on anatomical and pathological diagnosis, but which has not included a section on driving. However, driving may be the issue of most concern for some patients, and of far greater immediate relevance to

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them than the need for investigations or a change to their prescription.

So, tip one: establish driving status early on, perhaps as part of the social and employment history, to avoid the closing stages of the consultation being ambushed by the driving question.

Fitness to drive is an ambiguous concept

The DVLA guidelines are entitled *Fitness to drive*. In the context of driving it is not clear to us what fitness means. Is it about the time since their last seizure, the frequency of their vertigo, their stamina at the wheel, whether or not they become breathless doing a three-point turn, or their reaction time at 70 mph on the motorway? We think the concept of fitness comprises two related but quite separate issues; first the patient's *eligibility* to drive, and then their *ability* to drive.

The DVLA guidelines are mainly about someone's *eligibility* to drive if they have, or have had, or are likely to have in the future, a particular medical or surgical condition, procedure, or symptom (legal *entitlement* to drive is different and is to do with being old enough, not having too many driving convictions, and so on). When we consult the guidelines we are trying to establish someone's eligibility to drive, according to the law; a dense and complete hemianopia, visual acuity of 6/36 bilaterally, or a recent proven daytime epileptic seizure mean that the person is not eligible, by law, to drive; their ability is not taken into account, and nor does it need to be (in the current system) because they are ineligible.

Some eligibility (or ineligibility) issues are self-evident (blindness, daily seizures, quadriplegia), while others are to some extent arbitrary (such as time required to elapse before driving can recommence after a transient ischaemic attack, or a seizure). The arbitrary element of driving guidelines is reflected in the differences between national guidelines which have been shaped by local historical, sociological and, occasionally, physiological understanding. For example, a number of countries (correct in 2000) require driving cessation after a single seizure (Bulgaria, Central Africa Republic, China, Estonia, Ghana, Korea, India, Japan, some parts of Mexico, Pakistan, Portugal, Rwanda, Singapore, Taiwan, Turkey and Uzbekistan) while at the other extreme Argentina and Ecuador have no formal regulations for people with epilepsy. In Germany, partial seizures without motor activity are not a barrier to driving; presumably they are judged not to affect ability to drive.[3] Some countries have state specific regulations, producing variability even within a nation.

"Can I drive, doctor?" Case 1

A 60-year-old man with a group 1 licence presented with recurrent episodes of sudden and disabling vertigo brought on by head turning to the right, particularly turning over in bed. A diagnosis of benign positional paroxysmal vertigo was made and Cawthorne-Cooksey exercises recommended. He has been symptom-free for three weeks. He uses his car to drive 30 miles per day to and from work.

- **L:** He is a Group 1 licence holder and is driving.
- **E:** Driving should cease on diagnosis but he is eligible to drive "when satisfactory control of symptoms achieved", with no time scale stipulated.
- **A:** His ability is not being questioned.
- **N:** He should inform the DVLA (unless stated otherwise, the licence holder must inform the DVLA).

"Can I drive, doctor?" Case 2

A 49-year-old HGV (Heavy Goods Vehicle Group 2) driver, who works part-time as a taxi driver, had a right middle cerebral artery aneurysm clipped following an aneurysmal subarachnoid haemorrhage. Clinical examination three weeks postoperatively is normal. He asks about driving his car, taxi and lorry.

- **L:** He has a group 1 and 2 licence and is driving.
- **E:** He is eligible to drive his car after six months and his lorry after 18–24 months. The licensing authority for taxis in his own area will have to make a decision about his taxi licence.
- **A:** Without a clinically detectable deficit and with nobody raising concerns about his driving it is difficult to justify suggesting an on-road assessment although visual inattention and dysexecutive type problems brought out by the real-time multi-tasking of driving may be a concern; for this reason a driving assessment may be requested by the DVLA, although this is unlikely if there has been a full clinical recovery.
- **N:** Notification is required.

The rules for driving after a subarachnoid haemorrhage depend on whether a cause was found, the choice of interventional treatment, and the complications; this is definitely one where we need to "know where we can find information on it."[6]

"Can I drive, doctor?" Case 3

A 77-year-old lady, who uses her Mini Metro during daylight hours once a week to go shopping in the local village, has a right anterior cerebral artery infarct. She was in atrial fibrillation and has been warfarinised. Six weeks after the event she has some residual clumsiness of her left leg and is less confident about financial affairs, has erratic anticoagulant control, and for the first time uses a stick to walk outside. She is keen to start driving to the shops again. She has been reapplying for her driving licence every three years since the age of 70, most recently (and successfully) when she was 76.

- **L:** She has a Group 1 licence and was driving regularly before the event. She has been reapplying for her licence every three years since the age of 70 and will have to do so again in two years whatever the outcome of this consultation.
- **E:** People may go back to driving one month after a stroke if the clinical recovery is satisfactory; in her case, it does not seem to be, therefore she should be advised not to resume driving until the DVLA has made a decision.
- **A:** In view of her leg problem, the change in her mobility, and her difficulties with personal finances, we would be concerned about her driving ability. The DVLA is not able legally to take into account the sort of driving the person wishes to resume (Mini Metro or Ford Cosworth). We would recommend a referral to a Driving Assessment Centre, either directly or by the DVLA.
- **N:** Notification is required because of the residual neurological deficit more than a month after the event.

The second issue is the ability of someone who, according to the guidelines, is eligible to drive. Trying to judge, predict or diagnose whether someone with a neurological disorder who is *eligible* to drive will be *able* to drive quickly descends into farce. For the single man (no regular witnesses in the car), with a neurological disorder, who also has a cataract in one eye, osteoarthritis of the wrists and ankles, a tendency to omit his tablets, and 50% hearing loss in both ears, who can say what will happen on the road? He may be eligible to drive according to the DVLA guidelines but will he be able to reverse? What will his three-point turns be like, or his emergency stops?

However, there is a straightforward way to address this issue. If driving ability is being questioned, by health professionals or the family, then there are driving assessment centres (see appendix in DVLA guidelines) which offer a specialist assessment of driving ability for patients with a disability of any sort. Eligibility criteria are also scrutinised at the same visit. The most complete assessments comprise an examination of the visual fields and acuity followed by a battery of neuropsychological tests (language, praxis, numeracy, memory, executive function), a trial on a driving rig or computer simulator, and then an on-road assessment with an experienced driving instructor.

The idea of on-road driving assessments for people with neurological disability was developed and promoted by motivated members of patient groups who wanted car driving, with or without adaptations to the vehicle, to be an option for people with disability; without such support and guidance many would be prevented from driving. FORUM, the body representing all driving assessment centres, recognise 17 centres nationwide (http://www.mobility-centres.org.uk).[4] Curiously, there are no nationally recognised standards for on-road testing in the UK, although there are plans to address this. Advice about vehicle access (for the patient and their wheelchair) and vehicle adaptations is also available. Patients can self-refer (but not in Scotland) and pay, or be referred by National Health Service clinicians or the DVLA, and not pay. A report is produced which is sent to the patient and the referral source, but not automatically to the DVLA (unless they have requested the assessment), something of which all concerned should be aware.

The degree to which tests of cognitive function and driving simulators can predict on-road performance is the subject of much interesting research which is beyond the scope of this article. However, it seems that even if surrogate indices cannot accurately predict driving ability (for example, able at 20 mph to the local shopping centre, or at 70 mph along roads through the Welsh mountains?), they will be able to screen out those who are very likely to fail an on-road driving assessment.[5]

So if eligibility is being questioned, we look it up. If ability is being considered, we suggest asking someone to test it! We are not convinced that there is a need to look for and validate surrogate indices of the ability to do emergency stops and three-point turns, get dressed and do up your own shoe laces, or to play a bassoon or do a Rubik's cube, when they can be tested so easily.

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It may force the clinician to reconsider his or her confidence in a provisional diagnosis and make diagnostic uncertainty more difficult to manage

Indirectly, but with stunning effect, the driving question may uncover a gap in the structure and thinking of a consultation and/or make the clinician question his or her confidence in the clinical heuristic they are putting together. We are used to defending our thinking about the anatomy and pathology of a clinical diagnosis, or the reasons for requesting a particular test, but the driving question sails effortlessly past this secure territory, straight to the immediate implications for the patient. The stakes are high, and diagnostic speculation may have implications far beyond the tests and follow-up required. Therefore it is imperative that if our opinion means that driving restrictions may apply—temporarily or permanently, with or without DVLA notification—we will want to be absolutely certain that every word has been correctly interpreted, and that the differential diagnosis is justified and supported by very clear and reproducible evidence. However straightforward or complex the mechanism of a single transient ischaemic attack (TIA), patients can't drive for four weeks, end of story, and we need to tell them because the DVLA do not need to be informed.

The situation is no less awkward when the question encounters a diagnostic black hole; the patient still needs information of some sort to help him or her decide about communications with the DVLA, employer, insurance company, friends and family. Are we the only clinicians who feel a slight sense of relief on hearing that driving, employment, child care and solo rock-climbing are not issues for the patient with unexplained episodes of loss of consciousness?

Ill-informed replies may come back to haunt us

Initial comments and provisional advice, however tentatively volunteered, may be the only message the patient or family take in, or act upon, in relation to driving. This can cause chaos in future consultations when diagnoses are made or refuted, particularly if a licence has already been revoked, a job lost, or the new car given to the son-in-law. Cautious optimism, or pessimism, may be misconstrued, wilfully or unwittingly, and lead to future consultations in which we may feel obliged to join a patient's campaign to get their licence back, or in which we have to break bad (driving) news.

It can be difficult, even with the guidelines on the desk

It can be difficult to find the right answer even if the question seems straightforward and the guidelines are open on the desk. For example, the rules for intracranial aneurysms vary according to site, complications of rupture, treatment and complications of treatment. Throughout the guidelines, group 1 and group 2 licence holders are considered separately,

"Can I drive, doctor?" Case 4

A 45-year-old postman had a traumatic brain injury 14 months ago after falling over the handlebars of his bicycle. CT scanning on arrival in A&E demonstrated a fresh extradural haemorrhage. He underwent a craniotomy for evacuation of the haematoma and after an uneventful period of neurosurgical monitoring was transferred to your team for rehabilitation. He became independently mobile at an early stage but had become prone to outbursts of anger and frustration and found it difficult to organise his personal and financial affairs. On discharge he tried to return to his job but found organisational and sorting tasks very difficult and colleagues found him irascible and unpredictable. He is not on any regular medication. He wants to drive his car. He has not informed the DVLA about his head injury. His wife catches your eye and whispers, "He's not the man I married. I can't get through to him. All he does is sit and watch television. If I suggest he does something, he flies into a rage."

- **L:** He had a Group 1 driving licence but has not gone back to driving yet.
- **E:** He had an extradural haematoma and a craniotomy and he has new behavioural and conduct problems suggesting that brain damage occurred; therefore he is not eligible to drive for at least one year after the craniotomy, and he will have to meet the DVLA psychiatric standards as well as the neurological ones.
- **A:** In this situation we think it is impossible to predict driving ability. We would be concerned that he has at least a dysexecutive syndrome and that this will only get worse when he is faced with the challenge of driving. We would suggest an on-road assessment.
- **N:** He should be advised on discharge from hospital not to drive and to inform the DVLA. If it comes to the attention of the clinician that he is driving and/or that he has not informed the DVLA then the GMC guidelines quoted on page 76 should be followed. If this leads to a breakdown in the therapeutic relationship then it may be appropriate to ask a colleague to take over the management of the neurological condition, without the encumbrance of the driving issue.

doubling the amount of relevant information. The clinician has to be familiar with the layout of the guidelines and the exact details of the condition and its management to give a prompt and correct reply in outpatients.

We are the eyes and ears of the DVLA

Following a consultation it may be acceptable to decline to answer the driving question and to suggest the patient telephones the DVLA for advice. This is certainly preferable to misinformation, but in the real-time consultation it can be curiously difficult for the knowing clinician, eager not to lose the patient's confidence, to claim or confess ignorance about such an arrestingly important issue. However, referring the patient to the DVLA without giving relevant advice is definitely not an option if it becomes obvious that the patient is ineligible to drive; we are obliged to tell them, and furthermore we are obliged to act, if it becomes clear that our advice has been, or will be, ignored. The UK General Medical Council (GMC) guidelines are clear about our duty to the patient and the DVLA, and we think they deserve reproduction here:

The DVLA is legally responsible for deciding if a person is medically unfit to drive. They need to know when driving licence holders have a condition, which may now, or in the future, affect their safety as a driver.

Therefore, where patients have such conditions, you should:

- *Make sure that the patients understand that the condition may impair their ability to drive. If a patient is incapable of understanding this advice, for example because of dementia, you should inform the DVLA immediately.*
- *Explain to patients that they have a legal duty to inform the DVLA about the condition.*

If the patients refuse to accept the diagnosis or the effect of the condition on their ability to drive, you can suggest that the patients seek a second opinion, and make appropriate arrangements for the patients to do so. You should advise patients not to drive until the second opinion has been obtained.

If patients continue to drive when they are not fit to do so, you should make every reasonable effort to persuade them to stop. This may include telling their next of kin, if they agree you may do so.

If you do not manage to persuade patients to stop driving, or you are given or find evidence that a patient is continuing to drive contrary to advice, you should disclose relevant medical information immediately, in confidence, to the medical adviser at the DVLA.

Before giving information to the DVLA you should inform the patient of your decision to do so. Once the DVLA has been informed, you should also write to the patient, to confirm that a disclosure has been made.

So, driving issues make for an interesting consultation. The inchoate clinical opinion and plan put to the test by an arrestingly important question, the answer to which is not to be found in the traditional medical comfort zones but which the doctor may be held accountable for if it is not in keeping with the DVLA guidelines; and if we think our advice is being ignored we are obliged to do something about it!

"Can I drive, doctor?" Case 5

A 34-year-old lady had a saggital sinus thrombosis with a seizure at presentation. She was on the oral contraceptive at the time and found to have protein C deficiency. She has made a full recovery. You see her six weeks after the event. She wants to drive her eight-seater minibus to take children from her Girl Guide group on weekly visits to local attractions.

- **L:** She has a Group 1 licence.
- **E:** She is eligible to drive six months after a seizure occurring at the time of diagnosis of intracranial venous thrombosis.
- **A:** Nobody has questioned her driving ability and in the absence of a neurological deficit there seems to be no justification to do so.
- **N:** She should inform the DVLA.

THE DVLA: HOW THEY GET THEIR INFORMATION AND HOW THEY COME TO A DECISION

Knowing how the DVLA goes about getting the information on which it bases its decisions may help clinicians anticipate the information they are asked to provide in future reports. Medical advisers at the DVLA address two questions to assess "fitness" to

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drive, a construct we have already expressed our reservations about:

- What is the risk of a sudden disabling event?
- Can the patient control their vehicle safely at all times?

To start answering these questions the patient is initially asked to complete a DVLA self-assessment questionnaire to provide basic information and details of all the medical attendants involved. In addition to diagnosis and treatment, it specifically asks about cognitive, visual, limb and sleep problems. At this stage a licensing decision may be made, for example if a driver declares a recent seizure following a craniotomy. Usually the family doctor or consultant is asked to complete a second form. This includes questions about the diagnosis, the occurrence and dates of seizures, cognitive impairment, sensory inattention, visual field defects, motor impairment, daytime sleepiness, and alcohol and drug abuse. If the consultation is not conducted with an awareness of the sort of driving-related information the DVLA is going to require, it can be difficult to provide it subsequently; this may contribute to under-reporting of relevant deficits, something which is recognised by DVLA physicians.

Using this information and without any formal assessment of driving ability, the DVLA may agree to the person continuing to drive, although this may be time limited. If the patient has a relatively stable neurological disorder (for example, Charcot-Marie-Tooth disease) the DVLA may offer a three-year review licence. If the diagnosis suggests that deterioration is highly likely (for example, motor neuron disease), a one-year licence may be offered. If the DVLA is still concerned about driving ability and/or the appropriateness of adaptations they may recommend or request more detailed reports from clinicians and/or a formal driving assessment in a Driving Assessment Centre.

LEAN THINKING IN THE DRIVING CONSULTATION

To ensure that the driving issue is properly discussed, we suggest that it be given its own heading in the clinical history, perhaps within or after the social history, and that four issues are routinely considered using the acronym LEAN to provide structure to the consultation and the following discussion. The table suggests how it might appear in the notes.

TABLE Using the acronym to structure the consultation

	Present	Future
Licence status		
Eligibility		
Ability (with or without adaptations)		
Notification		

Licence

The first issue is to establish the patient's licence and driving status. We have already mentioned the difference in the guidelines between a group 1 and a group 2 licence. All licence holders have to re-apply for their licence when they reach a certain age—for example, 70 years for all drivers, 45 years for group 2 licence holders—a fact which can come in useful when driving issues need to be discussed. Some people will need to be made aware that if they have a progressive or degenerative condition, the DVLA may not issue a licence after a period of time has elapsed—for example, one year after the diagnosis of motor neuron disease. Also, if they become ineligible to drive according to the guidelines, they will have to surrender their licence, temporarily or permanently.

The DVLA encourages doctors to use medadviser@dvla.gsi.gov.uk to get advice.

Eligibility

The second issue is the patient's eligibility to continue driving in the light of the consultation you have just had. Eligibility can be looked up in the DVLA guidelines. Patients may be eligible to drive immediately, for example, after recovery from an episode of

BOX Examples of diagnosis specific driving research

Diagnosis	Effect on driving
Alzheimer's disease	Drivers with Alzheimer's disease have impaired identification of landmarks and road-signs. This leads to more safety errors, perhaps by increasing the cognitive load.[7]
Parkinson's disease	Drivers with Parkinson's disease are rated as "less safe" than age-matched controls by driving instructors. More than half would have failed a standard driving test. Errors occur when targeted, swift movements are needed. Unsafe drivers do not have sufficient insight into their ability.[8]
Head injury	The commonest reason for not returning to driving following a head injury is post-traumatic epilepsy. Of those that return to driving about two thirds report memory impairment and about one half behavioural change (such as anger, aggression or irritability). Not everyone who is ineligible is told that they should not drive and 5/563 drove despite knowing they should not, or had been advised that they should not drive.[9]
Epilepsy	Epilepsy surgery is a further barrier to returning to driving for people with seizures. A significant minority of people have their visual fields reduced by the surgery, sufficient to fail the assessments.[10]
Stroke	Using the pre-driving assessment of the Belgian Road Safety Institute (medical examination, visual and neuropsychological test and an on-road test) predictors of "fitness to drive" (again meaning ability) have been sought.[11]

transient global amnesia, or at some time in the future, for example, one month after a TIA, or one year after a seizure while awake. They may be currently ineligible because of a fixed neurological impairment, for example, a complete homonymous hemianopia, or become ineligible if an event occurs in the future, for example, an epileptic seizure.

Ability

The third issue is their driving ability, with or without adaptations. If the patient, the family, you, another health professional or the DVLA have legitimate concerns about driving ability then we recommend referral to a driving assessment centre. Research tools designed to assess driving ability are, for the most part, diagnosis-specific (box); however, not every patient who requires driving advice fits into a neat diagnostic category. Some who are eligible will be found to have severe difficulty controlling a car; the real-time, multi-tasking nature of driving may bring out visual inattention or dysexecutive-type problems which escaped detection during static bedside assessment. Driving lessons and a second assessment will be recommended for some of those who fail the driving assessment, but others will be advised not to drive again. For those with progressive neurological conditions it is worth pointing out to them that their ability may change in the future. The ineligible are not given an opportunity to have their ability tested in the current system.

Notification

The final issue is whether or not it is necessary for the patient to inform the DVLA immediately about a diagnosis (for example, epilepsy) or in the future (for example, after a year has elapsed without a seizure). If the patient has any illness with an ongoing liability to cause functional impairment, he or she has a legal obligation to inform the DVLA. Some conditions do not need DVLA notification, for example, a single TIA. The neurologist should also mention that patients may need to inform their motor vehicle insurance company.

CONCLUSIONS

Driving is an important part of everyday life and doctors are uniquely well-placed to give good, and bad, advice. We have put forward some reasons why it may not be straightforward to advise people and suggest a way of helping both the doctor and patient to structure a discussion and so ensure that sensible advice is given.

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REVIEWER'S COMMENT

Historically, in the UK, assessment of fitness to drive has been based solely on the diagnosis. Epilepsy was the first medical condition to be declared an absolute bar to driving, following an accident in the 1930s when a driver who was deemed to have suffered a fit at the wheel drove into the crowd watching the Changing of the Guard at Buckingham Palace, killing an onlooker. This

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remained the case until the 1960s when a driver with undeclared epilepsy crashed into the car of the then Minister for Transport, Barbara Castle. A review of the regulations concluded that the epilepsy standard was unnecessarily strict, and eventually led to the present-day requirement for a car driver to be free from any manifestation of daytime seizures for one year before being licensed. Over the years, medical standards for other conditions have gradually been added, the general basis always being whether or not the individual can be considered to be able to drive safely at all times, and to have an acceptably low risk of suffering a sudden and disabling event at the wheel.

The ability to drive legally is a very important aspect of normal, everyday life for a large proportion of the adult population. While the UK Road Traffic Act does place the primary responsibility for disclosure of medical conditions to the DVLA on the licence holder, rather than the doctor, the patient should be made aware that he or she has a disorder which may affect their ability to drive safely. What is the point in spending hundreds of pounds on brain imaging to diagnose an occipital infarct if no assessment of the visual fields is made so the patient can be advised that he or she might have difficulty in driving safely? It is no longer acceptable to make a diagnosis without considering the logical consequences in terms of activities of daily living and the safety of the patient/driver, both in terms of personal risk and that of the wider community. It should be possible to agree on the format, perhaps using guidelines similar to the Bolam principle for informed consent, for recording the "driving discussion" in every patient's notes, as suggested by Thomas and Hughes. This will become increasingly important with litigation becoming more common following road traffic accidents in which a medical cause is identified.

The UK General Medical Council is currently consulting with interested parties on the disclosure of personal health information without patient consent. While this in the driving context may cause difficulties with the doctor–patient relationship, is it not fair to consider the wider population and whether the doctor has a duty of care to the public in terms of road safety? If it is a question of the patient disagreeing with the doctor's recommendation that he or she should no longer drive, then the doctor can always contact the DVLA on the patient's behalf for an assessment to be made.

Dr Judith Morgan, Medical Adviser, DVLA

PRACTICE POINTS

- Driving is a composite function comprising a number of other composite functions.
- The DVLA guidelines are an excellent source of information about whether someone is eligible to drive.
- It is very difficult to give an informed opinion about driving ability using information from the traditional clinical assessment.
- If someone's ability to drive is being questioned we recommend that a formal assessment of driving is requested in one of the Disabled Drivers Assessment Units in the UK.
- By considering **L**icence status, **E**ligibility, **A**bility (with or without adaptations) and **N**otification requirements (LEAN), the clinician and the patient should cover the important driving issues.

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