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Dizziness, driving, and the Driver and Vehicle Licensing Agency: audit of advice given to patients, and design of a patient information leaflet

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Main Article

Mr J Sinnott takes responsibility for the integrity of the content of the paper

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Abstract

Background. Evidence from the literature shows that clinicians' knowledge of rules and legislation surrounding driving can often be poor. A closed-loop audit was conducted to gauge the level of driving advice given to patients with dizziness.
Methods. The clinical notes of 100 patients referred to the vertigo clinic at a tertiary referral centre were retrospectively searched for evidence of driving advice. Education sessions were undertaken and a patient information leaflet was developed before a second cycle of the audit.
Results and conclusion. The proportion of patients having documented evidence of receiving driving advice increased from 6.3 per cent to 10.4 per cent. It is therefore clear that, despite this improvement, a significant proportion of patients' notes did not contain documentation about driving. This is likely because of many reasons, including individual interpretation by clinicians. This paper provides a reminder of the rules, and discusses their interpretation and implementation in an increasingly medicolegal environment.

Introduction

Driving is central to many people's lives. The removal of a driving licence can impact on wellbeing and economic security, with possible loss of employment and independence. Any clinician bringing into question a person's fitness to drive and potential loss of a licence needs to have a clear understanding of the relevant authorities, rules and legislation.

In the UK, the responsibility for determining a person's fitness to drive rests with the Driver and Vehicle Licensing Agency ('DVLA'). It is a driver's responsibility to inform the Driver and Vehicle Licensing Agency of any relevant changes to their health that may affect their ability to drive. Failure to do so may result in a fine of up to £1000.[1] Furthermore, if a driver is subsequently involved in an accident there is the potential for prosecution.[1]

Physicians have a responsibility to assess and advise patients on fitness to drive, and to remind them of their responsibility to inform the Driver and Vehicle Licensing Agency of relevant health conditions. If a patient was clearly unfit to drive and a clinician did not remind the patient to inform the Driver and Vehicle Licensing Agency, there are potential medicolegal implications. In the event of a fatal accident, it would be possible for a coroner to pass adverse judgement.[2]

There are several high profile cases where medical fitness to drive has been called into question. In 2014, there was a case of a heavy goods vehicle driver in Glasgow who had a blackout and crashed, resulting in six fatalities. The driver was later found not guilty of dangerous driving because he had been symptom-free for four years prior to the accident. In 2016, a driver with dementia whose licence had been revoked drove the wrong way down a motorway for 30 miles resulting in his own and one other fatality. These cases illustrate the difficulty of decision-making surrounding driving, and how, despite best action being taken, consequences can be disastrous.

However, different medical conditions lead to different levels of risk when driving.[3] Fortunately for clinicians, dizziness is relatively low on the scale of health conditions known to affect a person's safety to drive. Conditions such as epilepsy and syncope are more likely to cause harm.[3] It has also been shown that if patients are made aware that a medical condition may affect their ability to drive, they may be less likely to have an accident.[4]

Previous studies have demonstrated that, in general, both doctors' and patients' knowledge of the Driver and Vehicle Licensing Agency rules surrounding driving is poor.[5–7] Furthermore, it has been found that in some clinics involving cases where driving safety is likely to be relevant, driving is not routinely asked about.[8] A UK survey showed that less than 70 per cent of 51 ENT consultants asked patients about their driving history during a vertigo clinic.[2]

Information on medical conditions and driving regulations are available in the Driver and Vehicle Licensing Agency document entitled *Assessing Fitness to Drive – A Guide for Medical Professionals*.[9] This document states that anyone with 'the liability to sudden and unprovoked or precipitated episodes of disabling dizziness' must not drive on presentation, and must inform the Driver and Vehicle Licensing Agency.[9] 'Sudden' is defined as 'without sufficient warning to allow safe evasive action when driving', and 'disabling' is defined as 'unable to continue safely with the activity being performed'.[9] Rules regarding fitness to drive vary depending on the type of driving licence held, with the rules for bus and lorry drivers being understandably stricter. The Driver and Vehicle Licensing Agency guidance[9] is aimed towards medical professionals and leaves some room for expert interpretation.

The advice on the public Gov.UK website is subtly different and somewhat stricter, stating 'You must tell the Driver and Vehicle Licensing Agency if you suffer from dizziness that is sudden, disabling or recurrent'.[1] The key wording difference here is 'or recurrent', which therefore encompasses a broader group of patients. If this advice were to be followed by every patient, it would result in an enormous increase in workload for the Driver and Vehicle Licensing Agency, and in corresponding referrals for vestibular assessment.

Materials and methods

Following a literature search, a retrospective first cycle audit was completed of 100 consecutive patients seen in the vestibular clinic who were referred for vestibular testing. Exclusion criteria included: those aged under 18 years, and patients seen in the vertigo clinic without symptoms of true vertigo (e.g. those with general imbalance). Although the guidelines apply to all patients with dizziness, and not just vertigo, for the purposes of this study it was felt that limiting the review to those with genuine vertigo would highlight a subgroup potentially most at risk when driving.

Electronic letters and clinic documentation were reviewed to assess whether advice regarding driving was documented. Such documentation included statements that the patient: does not drive; has informed the Driver and Vehicle Licensing Agency; has been told to inform the Driver and Vehicle Licensing Agency; and has been told not to drive.

Subsequently, a patient information leaflet summarising the key information required by patients was developed, to aid clinicians in discussions about driving. Departmental teaching was also undertaken. A prospective re-audit was then performed, capturing a further 50 consecutive patients.

Results

In the first cycle, five patients were excluded as they did not fit the inclusion criteria. Of the remaining 95 patients, 6 (6.3 per cent) had documented evidence that they had been given advice regarding driving. There were two group 2 licence holders (heavy goods vehicle and public service vehicle licence holders), both of whom had received advice on driving restrictions.

Following the departmental teaching and introduction of the patient leaflet, a re-audit was completed. There were 50 patients, with 2 exclusions. Of the 48 patients, 5 (10.4 per cent) had documented evidence of receiving driving advice. This represents an almost doubling of the proportion of patients being given driving information, though the absolute proportion is still low.

Discussion

From the results of this audit, it appears that, even with improved education of clinicians, the proportion of patients with vertigo whose notes contain documented advice regarding driving is low. It is possible that some patients in this cohort were given advice (or did not drive) without it being documented. This aside, it is quite likely that, in many cases, clinical judgement was used in determining which patients had symptoms that could be considered as truly 'sudden and disabling'. It is very likely that many patients undergoing vestibular testing had symptoms that were judged to be extremely unlikely to have any effect on driving, and the clinician therefore felt it unnecessary to document any specific information on this subject.

There is, therefore, a question of interpretation: if clinicians follow the advice from the Gov.UK website,[1] and use the criteria of sudden, disabling or recurrent dizziness, then nearly every patient in the dizziness clinic would be advised to inform the Driver and Vehicle Licensing Agency. Most clinicians appear to follow the guidance from the Driver and Vehicle Licensing Agency's *Assessing Fitness to Drive* document, aimed at medical professionals, where dizziness needs to be both sudden and disabling, without any mention of recurrence. In such cases, the patient or clinician, or a combination of the two, make an assessment of the safety surrounding driving. This margin for interpretation seems deliberate on the part of the Driver and Vehicle Licensing Agency, with clinical judgement from the expert clinician hopefully preventing unnecessary distress for the patient.

However, some would prefer more robust rules on what is a sensitive matter, and difficult to assess and discuss in a short clinical appointment. Gheriani *et al.* expressed such concerns regarding the rules for giddiness and driving in Ireland.[10] On one extreme of the spectrum, a very cautious approach in terms of driving safety would be for any patient with a new episode of vertigo, including benign positional paroxysmal vertigo, to be advised to inform the Driver and Vehicle Licensing Agency.[10] However, it is felt that few clinicians would take this stance, which would risk causing a significant amount of unnecessary distress to many patients.

The trust between clinicians and patients is incredibly important. The sensitive nature of the discussion around driving and the removal of a driver's licence must be considered, especially in time-pressured first-appointment vertigo clinics. MacMahon *et al.* identified that only 13 per cent of general practitioners asked about driving before referral to a syncope clinic; this is a similarly low proportion to that found in our study.[8] Difficult conversations must not be avoided when necessary, and clinicians must actively question patients about driving when appropriate. Time must be taken to fully explain the patient's responsibility, and every effort should be made by clinicians to gain satisfactory control of symptoms to enable a licence to be reinstated. There is evidence that vestibular rehabilitation can be useful in the treatment of patients, to allow them to begin driving again.[11]

A patient refusing to inform the Driver and Vehicle Licensing Agency of a medical condition that makes them unsafe to drive creates a challenging situation; fortunately, these cases are rare. The General Medical Council has specific guidance on breaching confidentiality, and recommends that

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doctors make every reasonable effort to persuade the patient to declare their condition to the Driver and Vehicle Licensing Agency.[12] This may require talking, with permission, to the patient's next of kin. The patient may wish to have a second opinion and the clinician should help to arrange this if required. If all efforts have been made, and the clinician perceives that the refusal to stop driving leaves others exposed to a risk of death or serious harm, they are advised to contact the Driver and Vehicle Licensing Agency promptly.[12]

When a patient does inform the Driver and Vehicle Licensing Agency of suffering with dizziness, they will be required to complete a 'DIZ1' form. The Driver and Vehicle Licensing Agency may contact the patient's doctor or consultant, or arrange for an examination. The patient can often keep driving while the Driver and Vehicle Licensing Agency are considering the application. Although the DIZ1 form asks specifically for diagnoses, there is no specific guidance on individual conditions in the Driver and Vehicle Licensing Agency *Assessing Fitness to Drive* document.

Following their declaration, the patient may surrender their licence. It is important to emphasise to patients that surrendering a driving licence is often not permanent, and it can be reinstated after symptoms have been controlled. Reinstating a surrendered licence is more straightforward than reinstating a revoked or refused licence.

For group 2 licence holders (drivers of buses and lorries), the rules are much stricter and the clinician may need to seek specific advice. The potential effect on the patient's employment adds a degree of urgency to such cases.

- Knowledge of rules and legislation around driving and medical conditions is often poor
- Clinicians should remind patients to inform the Driver and Vehicle Licensing Agency of a medical condition that may affect their driving
- Drivers should also be reminded to inform the Agency if dizziness symptoms are sudden and disabling
- There is room for clinician interpretation as to what constitutes 'sudden onset' and 'disabling' symptoms
- Revoking a licence can have an enormous impact on a patient; therefore, all clinicians should have a good understanding of the rules
- A patient information leaflet was useful when discussing driving with patients with dizziness

It is also worth noting that the rules surrounding driving and medical conditions can change. Notably, all patients with Ménière's disease were previously advised not to drive, but this guidance has since been relaxed.

The results of our second audit cycle showed that the proportion of people with sudden and disabling symptoms who received advice about driving increased from 10.1 per cent to 19.2 per cent. The informal feedback we received indicated that a patient information leaflet, which can be read after the consultation, provides a useful summary of the driving regulations, improves retention of information by patients and allows for smoother running of the clinic.

Conclusion

It is clear that the current Driver and Vehicle Licensing Agency guidelines leave a considerable margin for interpretation. We believe that if there is any doubt about a patient's fitness to drive as a result of their dizziness, they should be advised to inform the Driver and Vehicle Licensing Agency. This advice should be documented in the medical notes. A patient information leaflet appears to be a useful aid for clinicians in discussing the sensitive topic of driving safety.

Competing interests. None declared

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