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Main Article

Driving and otolaryngology: do we know the rules?

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Abstract

Certain medical conditions may affect one's ability to drive safely. In the United Kingdom, the Driver and Vehicle Licensing Agency (DVLA) issues guidelines outlining which medical conditions drivers must notify them of. In order to assess our knowledge of, and ability to apply, the current DVLA guidelines with regard to otolaryngological conditions, a postal survey was sent to all otolaryngologists in Scotland. The responses obtained suggest that the current DVLA guidelines are not well understood or easily applied, and it is recommended that all otolaryngologists familiarize themselves with these guidelines in order to better advise their patients with regard to driving.

Key words: Automobile Driving; Social Control Policies; Great Britain; Sleep Apnoea Syndromes; Vertigo

Background

Loss of one's driver's licence significantly affects participation in many aspects of modern, car-orientated life.[1] In the United Kingdom, the Driver and Vehicle Licensing Agency (DVLA) issues guidelines relating to medical conditions that may render a driver unsafe. It is currently not a statutory obligation of the doctor to inform the DVLA directly of any patient they feel may have problems with driving. Instead, it is the physician's role to advise patients of their obligation to inform the DVLA of any new or deteriorating medical conditions that may affect their ability to drive. Under section 94 of the Road and Traffic Safety Act 1988, the licence holder must inform the DVLA if 'he is suffering from a relevant or prospective disability which he has not previously disclosed' or if 'a relevant or prospective disability from which he has at any time suffered has become more acute since the licence was granted'. Failure to pass on this information is a criminal offence and currently is penalized by a fine of up to £1000.[2]

In otolaryngology practice, there are, fortunately, few conditions that render a driver unsafe on medical grounds. The obvious exceptions to this are the dizzy patient and those with obstructive sleep apnoea and hypopnoea syndrome (OSAHS).

Aim

We aimed to assess Scottish ENT surgeons' knowledge of the current DVLA guidelines on fitness to drive relating to otolaryngological conditions.

Methods

A literature review was performed to establish what was known on the subject of otolaryngological conditions and driving. The DVLA medical team was contacted to establish which otolaryngological conditions, in their opinion, should prompt a patient to inform the DVLA.

A postal survey was sent to all ENT consultants and specialist registrars as well as to all staff and associate specialist (SAS) otolaryngologists in Scotland. A short series of statements was given, with one set relating to the dizzy patient and driving and the other set relating to obstructive sleep apnoea and driving. The clinician was asked to circle 'yes' if they agreed with the statement, 'no' if they disagreed with the statement or 'don't know' if they were unsure about the statement. The survey was then returned in a pre-paid envelope and the results analysed.

Results

Ninety postal surveys were sent out to all ENT consultants, specialist registrars and SAS doctors in Scotland. Forty-eight surveys were returned, giving a disappointing response rate of 53 per cent.

Taking each statement individually, the results are summarized in Table I along with the 'correct' answer according to the DVLA medical advisor (see discussion, below).

One person completing the survey did not answer any of the questions relating to sleep apnoea, stating that they never saw such patients.

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TABLE I
POSTAL SURVEY RESULTS

Statement	Response			'Correct' answer*
	Yes (%)	No (%)	Don't know (%)	
1st set				
Any patient with relapsing vertigo lasting more than 3 months is legally required to inform the DVLA	46	19	35	True
Any patient with sudden-onset, disabling dizziness of any aetiology should be instructed to inform the DVLA	44	21	35	True
Patients with benign paroxysmal positional vertigo should be advised to inform the DVLA	8	56	36	True
Heavy goods vehicle (HGV) drivers with relapsing vertigo who have not had an attack for 3 months need not inform the DVLA	17	31	52	False
2nd set				
HGV drivers with proven OSAHS should be told not to drive	62	17	21	False (if treated)
All patients with an Epworth Sleepiness Score (ESS) of more than 11 should be advised to inform the DVLA	13	36	51	True
Patients using CPAP should be told not to drive	6	68	26	False
Snorers with a history suggestive of OSAHS but an ESS less than 11 should be reported to the DVLA	2	62	36	False (should self-report)
Patients completing the ESS stating that they are at moderate to high risk of dozing in the car when stopped for a few minutes should be advised to inform the DVLA	36	32	32	True

*Correct answer according to the Driver and Vehicle Licensing Agency (DVLA) medical advisor. OSAHS = sleep apnoea and hypopnoea syndrome; CPAP = continuous positive airways pressure

Discussion

At the time of writing, the current DVLA medical rules were available in booklet form or online at the DVLA website (www.dvla.gov.uk). There were no sections in the current guidelines relating specifically to otolaryngological conditions, although a limited index of medical conditions was available which referred the clinician to the most appropriate section. The otolaryngological conditions listed in the index were vertigo, Ménière's disease, sleep disorders and deafness.

The regulations relating to driving and hearing loss stated that there was no requirement to inform the DVLA, even for profound deafness, provided the patient was able to communicate in the event of an emergency by either speech or a device (e.g. Minicom).

Regarding vertigo and Ménière's disease, the DVLA stated that any patient with the '. . .liability to sudden attacks of unprovoked or unprecipitated disabling giddiness, e.g. Ménière's disease' should notify them. The patient must cease driving on diagnosis, although for type one licence holders (i.e. car or motorcycle) the licence would be restored upon control of symptoms. For type two licence holders (i.e. large goods vehicles) the situation differed, with recommendation for refusal or revocation of the current licence if the condition was likely to be of sudden onset or disabling, with reapplication permitted if symptom-free for more than one year.[2]

Currently, there is no clear consensus on what constitutes satisfactory symptom control. This concern was raised by Gheriani *et al*. regarding the assessment of vertigo sufferers using the Irish Department of Transportation's guidelines. They felt that these current guidelines allowed doctors too large a margin for error regarding assessment of vertigo sufferers, and they recommended the creation of a special medical advisory body attached to the driving and licensing authority to help overcome this.[3] There are currently no good objective tests available to assess 'giddiness' that correlate well with symptom severity and thus the impact on the patient's ability to function. One stance could therefore be that any patient with new-onset vertigo of any aetiology, including benign paroxysmal positional vertigo, should be advised to inform the DVLA.

In patients with chronic, stable disequilibrium, the situation is less clear. Most patients with chronic vestibular disorders have intermittent, transient spells of vertigo of varying intensity, with no loss of consciousness. Although these patients may be less prone to sudden attacks, it does not necessarily follow that chronically dizzy patients are any safer to drive as a result of their disequilibrium. The simplest attitude to adopt would be to recommend DVLA notification when in any doubt as to a patient's possibly impaired driving ability due to any form of dizziness, especially when considering type two license holders.

There is evidence that untreated and therefore undiagnosed OSAHS is associated with an increased risk of road traffic accidents.[4,5] When considering patients with suspected or proven obstructive sleep

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apnoea, the DVLA guidelines suggest notification by any patient with 'sleep disorders including obstructive sleep apnoea or any condition resulting in excessive daytime/awake time sleepiness'.[2] Type one licence holders must cease driving until satisfactory control of symptoms has been achieved, confirmed by a medical opinion. Type two licence holders must demonstrate ongoing compliance with treatment, confirmed by a specialist, as well as undergo regular, normally annual, licensing review. This guidance, whilst helpful in cases with definitive polysomnography, relies on a diagnosis having been established. It does not give clear guidance to the otolaryngologist assessing the snoring patient with features suspicious of, but not necessarily diagnostic of, OSAHS.

There is currently no sensitive, office-based, objective assessment tool for correlating reported symptoms with the likelihood of OSAHS. In addition, a recent study by Dreher *et al*. demonstrated no correlation between severity of obstructive sleep apnoea and clinical history or examination findings in snorers.[6] The clinically validated Epworth Sleepiness Scale (ESS) is widely used in current otolaryngological practice. Although this subjective score correlates weakly with severity of OSAHS, it can be used to subdivide patients into categories of daytime and awake time sleepiness, with a score of less than 11 being considered as normal, 11–14 being mild, 15–18 being moderate and 18 or more being severe daytime and awake time sleepiness. The DVLA guidelines do not take into account this spectrum of sleepiness, and it is left to the discretion of the clinician as to what is considered to be 'excessive daytime/awake time sleepiness'. It could be argued that any patient with an ESS of 11 or more should be advised to contact the DVLA. With waiting times for sleep studies of over two years in many centres, it remains the duty of the otolaryngologist to make a judgement regarding fitness to drive at the time of the initial assessment. It is the authors' current practice to refer all patients with an ESS of more than 11 for further investigation (in the form of full polysomnography) as well as to advise them to contact the DVLA. This approach may also be advocated for patients who do not necessarily score as highly on the ESS but who have other worrying features suggestive of OSAHS.

In the UK, it remains the responsibility of the patient to inform the DVLA of any condition their doctor feels may impinge on their ability to drive. However, whilst a physician's duty lies primarily with the welfare of their patient, there is also a wider civil duty to the safety of the public at large. Following a fatal accident involving a patient with dementia, the General Medical Council (GMC) updated their regulations regarding confidentiality, recommending that medically unfit drivers be reported to the DVLA if they are incapable of understanding their inability to drive safely.[3,7] This was qualified by adding that every effort should be made to convince the patient not to drive, including options for a second opinion and involving next of kin. If, thereafter, the patient continues to drive, the GMC recommend verbal and written notification to the patient of the doctor's intent to inform the DVLA.

The results of our survey demonstrate, through the wide variation in answers and large proportion of 'don't know' responses, that the current guidelines relating to driving are either not well known or not easily applied by ENT surgeons in Scotland. This implies that our current practice as a profession is failing to comply with regulations that are in place to ensure road safety for both drivers and the general public. The statements presented in our survey were not designed necessarily to have a right or wrong answer but instead to test respondents' awareness of what regulations currently existed. It is clear that the current UK guidelines relating to otolaryngological conditions and driving rely heavily on the discretion of clinicians and their subjective assessment of a patient's likely ability to drive. This leaves a very large margin for error and results in patients and the public being put at risk.

Conclusion

It is recommended that otolaryngologists familiarize themselves with the current DVLA guidelines for driving with medical conditions. Each patient's case should be considered on its individual merits as, in their current form, the DVLA guidelines still rely heavily on the discretion of the individual practitioner. Whilst the legal burden to inform the DVLA remains with the patient, it is essential that patients receive, as early as possible, adequate explanation and advice regarding driving in order to prevent unnecessary risk to the patient and to the wider public.

- **This survey assessed Scottish otolaryngologists' knowledge of the current UK guidance on regulations concerning driving and otolaryngological conditions**
- **The responses obtained suggest that the current DVLA guidelines are not well understood or easily applied**
- **The two most common otolaryngological conditions causing problems with driving are vertigo and obstructive sleep apnoea**

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