Driving and Dementia
Practical Tips for the Family Physician

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Medico-legal problems related to fitness to drive

CMPA experience, 2005-2009:

- 67 medico-legal cases
- Half were legal actions, half were College complaints
- Decisions in favor of the physician predominated

- 3 principal themes
  - Legal actions involving physician failure to report patient as unfit to drive because of a medical condition
  - Complaints that a report had been made to a provincial licensing authority
  - Complaints related to refusal to support an application for restoration of driving privileges

CMPA 2011
### Specific assessment

Factors that should be considered in the assessment of older drivers spell out the mnemonic SAFEDRIVE.*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Question/Action</th>
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<tbody>
<tr>
<td>Safety record</td>
<td>Is there a history of driving problems?</td>
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<tr>
<td>Attentional skills</td>
<td>Does patient experience lapses of consciousness or episodes of disorientation?</td>
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<tr>
<td>Family report</td>
<td>What are family’s observations of driving ability?</td>
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<tr>
<td>Ethanol</td>
<td>Screen for alcohol abuse</td>
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<tr>
<td>Drugs</td>
<td>Review medication, especially for psychoactive drugs</td>
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<tr>
<td>Reaction time</td>
<td>Are neurologic and musculoskeletal disorders slowing reactions?</td>
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<tr>
<td>Intellectual impairment</td>
<td>Complete Mini-mental State Examination</td>
</tr>
<tr>
<td>Vision</td>
<td>Test for visual acuity</td>
</tr>
<tr>
<td>Executive function</td>
<td>Does the patient have trouble planning and sequencing tasks and self-monitoring behaviour?</td>
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Canadian Medical Association position…

Moderate to severe dementia is a contraindication to driving. Moderate dementia is defined as the inability to independently perform two or more instrumental activities of daily living (including medication management, banking, shopping, telephone use, cooking) or any basic activity of daily living (eating, dressing, bathing, toileting, transferring).

No test, including the Mini-mental State Examination (MMSE) has sufficient sensitivity or specificity to be used as a single determinant of driving ability. However, abnormalities on tests including the MMSE, clock drawing and Trails B should trigger further in-depth testing of driving ability.

- New impairment due to cognition
- Grade B, Level 3 evidence (based on expert opinion)
Activities of Daily Living

INSTRUMENTAL ADL’s
- Manage medications
- Handle money, bills, shop
- Use telephone
- Prepare food

BASIC ADL’s
- Bathe/shower
- Walk
- Toilet
- Transfer (bed/chair)
- Feed self
“Physicians should err on the side of reporting any potentially medically unfit driver.”

- Discretionary reporting in
  - Alberta
  - Nova Scotia
  - Quebec

- MD protection for reporting in all provinces; in most, not admissible as evidence in legal proceedings
CMA Driver’s Guide revisions, 8th Ed…

- Cognitive screening alone cannot determine driving fitness
- It is recommended that physicians administer more than one cognitive screening tool
- In patients with dementia, driving fitness should be reassessed every 6 to 12 months, or more frequently if the cognitive impairment progresses
- The legal duty is to report concerning findings, rather than to assess driving fitness. It’s up to the transportation authorities to decide which patients with dementia or MCI are safe or unsafe to drive.
If cognitive tests such as MMSE, MOCA, Clock, Trails, or other in-office tests are markedly abnormal (where the results are specific and believable)…

- Is the test result consistent with other evidence?
- Use common sense – consider the severity of findings
CMA Driver’s Guide revisions, 8th Ed...

To help you “get off the fence,” ask yourself four questions:

1. Given the results of your clinical assessment, would you get in the car with the patient driving?

2. Given the results of your clinical assessment, would you let a loved one get in a car with the patient driving?

3. Given the results of your clinical assessment, would you want to be crossing a street in front of a car with the patient driving?

4. Given the results of your clinical assessment, would you want to have a loved one cross a street in front of a car with the patient driving?
Questions to Ask the Family

1. Do you or would you feel uncomfortable being a passenger when the person is driving?

2. In the last year has the person had any accidents or near misses or tickets for traffic violations (driving too slowly, failure to stop)?

3. Have you noticed the person self-restricting their driving habits (driving less or only familiar routes, or avoiding driving at night, in bad weather, or busy streets)?

4. Have there been occasions where the person has gotten lost or shown navigational confusion?

5. Have you or others seen unsafe or abnormal driving behavior or are cues/directions needed from a “copilot”?
Considerations in Fitness to Drive

- History of driving accidents or near-accidents*
- Family member concerns*
- Trails A & B – for ‘task switching’, visuospatial and executive function
- Clock draw – for visuospatial and executive function
- Pentagon draw / cube draw – for visuospatial function
- Cognitive test scores – maybe
- CMA guidelines – inability to independently perform 2 instrumental ADLs or 1 basic ADL

* Ask patient and family member separately
Montreal Cognitive Assessment (MoCA) vs. MMSE

MMSE > 26 is normal
MMSE < 26 detects 18% of MCI
78% of mild AD
Specificity 100%

MoCA > 26 is normal
MoCA < 26 detects 90% of MCI
100% of mild AD
Specificity 87%

Use efficient, validated cognitive screening tools that staff can administer
"On the paper are the numbers 1 through 13 and the letters A through L, scattered across the page. Starting with 1, draw a line to A, then to 2, then to B, and so on, alternating back and forth between numbers and letters until you finish with the number 13. I’ll time how fast you can do this. Are you ready? Go.”

If education or language is a concern, ask the patient to write down numbers 1-13 and letters A-L.
Trails B

Tests “task switching”

- Completion time > 3 minutes or 3 or more errors suggests an unsafe driver
- Completion time of 2 – 3 minutes or 2 errors is unclear
- Completion time of < 2 minutes and 0 or 1 error is acceptable

Trails A
Patients with Frontotemporal Dementia or Lewy Body Dementia or Parkinson’s Disease Dementia are generally **UNSAFE** to drive!
Fitness to Drive

The gold standard for assessing driving safety is a comprehensive on-road assessment.
Examples of ways to report to Ministry of Transportation

List the concerning history and/or impaired activities of daily living and cognitive test scores
(minimum legal requirement)

OR

“This is to notify the Ministry of Transportation that the patient is currently under investigation for cognitive concerns and has been advised not to drive until an on-road driving assessment has been performed to determine fitness to drive”
(exceeds legal requirement)
How to tell the patient he or she may be unsafe to drive

1. Be firm and non-negotiable in your instructions.

2. Discuss implications with patient and family.

3. Communicate your legal obligation and intention to notify the MOT, but that any decision to revoke the license rests with the MOT.

4. Explore transportation options.

5. Focus on positives.

6. Provide a written statement.

7. Document and report to MOT.
Dear Mr (Mrs):

It is my legal responsibility to notify the Ministry of Transportation if there is any concern regarding driving safety.

You have undergone assessment at

________________________________________

I am recommending that you do not drive for the following reasons:

________________________________________

________________________________________

_________________________, MD
Follow-up

- For patients with mild dementia who are able to drive, reassessment of driving safety is required every 6 – 9 months

- Discuss eventual need to stop driving
N=100,075, 13% diagnosed with dementia

- For dementia, event rate of crash requiring ER visit reduced from 2.92/1000 to 0.86/1000 annually

- “…the data suggest that practicing physicians may be able to help prevent serious trauma from road crashes.”
Risk Management Considerations

- Inform the patient of your intention and/or obligation to report
- Remind the patient that any decision to revoke the license rests with the MOT
- Caution the patient not to drive until the MOT has made a determination
- Document your assessment, discussion, warning and advice to the patient regarding driving, and your intention to report
- Limit the information in the report to what is required by legislation

  - If the patient says you are not permitted to send this information to the MOT or they will sue you....

  - Address driving issues early!
Further reading


• Canadian Medical Protective Association: Reporting patients with medical conditions affecting their fitness to drive. Originally published December 2010, revised February 2011