Driving assessment for people with dementia

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Clinical question
How should driving safety be assessed in dementia?

Bottom line
Office assessment of driving in dementia is challenging. Guidelines recommend patients with moderate-severe dementia not drive, but not all people with mild dementia should be barred from driving. So, how do we define moderate dementia? And how do we assess which patients with mild dementia are safe to drive? No evidence-supported tests can guide every situation. “Pen and paper” tasks cannot take into account that driving is a well learned task with myriad variables (eg, road conditions, comorbid conditions, medication). Use of screening tools was summarized in an article in the Canadian Geriatrics Society Journal of CME.1

Evidence
• The CMA Driver’s Guide defines moderate-severe dementia as new loss of ability to perform 1 ADL (eg, dressing) or 2 IADLs (eg, shopping) owing to cognitive difficulty.2
• Scores on the Mini-Mental State Examination are not predictive of driving risk or motor vehicle crashes.3,4
• Montreal Cognitive Assessment scores might have better predictive value; in 1 study, a score of 18 or less was associated with greater likelihood of failing on-road assessment, but the predictive ability was not strong enough to recommend it as the sole instrument to identify unfit drivers.4
• Visuospatial tests might be most relevant.5 The clock-drawing test can be helpful, but the type and severity of errors that indicate unsafe driving are not clear.
• Guidelines recommend the Trail Making A and B tests to assess driving. There is support for Trail B cutoffs of 3 minutes for completion or 3 or more errors—the 3 or 3 rule.6,7 Inability to complete the Trail A test in 48 seconds might also suggest need for further driving evaluation.8 However, these are not hard-and-fast rules; decisions about driving safety must consider other findings. Instructions on performing Trail A and B testing have been published by the Canadian Geriatrics Society.9
• Corroborating history is critical, family concerns and history of accidents can help inform decisions.5 Family should be interviewed alone to allow safe disclosure of concerns. Corroborating can also help to determine the degree of functional impairment due to cognitive decline.

Approach
• Consider whether test results are consistent with clinical evidence: Tests are unhelpful unless they fit with patients’ functional abilities and observations from caregivers.
• Know what tests measure: Consider what is being measured and any confounding variables (eg, language barriers, low education, depression, or performance anxiety).
• Consider trajectory: Some conditions might improve (delirium) and others progress (Alzheimer and other dementia).
• Understand your role in reporting to transportation authorities: Usually it is to report concerns to the Ministry of Transportation, not to determine medical fitness to drive.
• Use common sense and examine the severity of findings: Sometimes it is obvious the patient is unsafe to drive (eg, very low test scores, psychotic symptoms).
• Consider qualitative and dynamic aspects of testing: How patients perform tests is as relevant as scores (eg, the clock might be perfect but if it took 10 minutes to complete, there might still be driving concerns).
• Understand cutoffs: There is overlap between scores of “normal” and “impaired.” To avoid overreliance on cutoffs, consider if you would get in a car with the person driving. Would you let a loved one? Would you want to cross the street in front of them? Would you want a loved one to?

Implementation
Screening tools are irrelevant if FPs do not recognize which patients are driving and assess medical conditions that affect safety. The 10-Minute Office-Based Dementia and Driving Checklist has not been well studied but is a handy form covering relevant parts of the assessment.9 A checklist of considerations for driving safety in dementia has been published in Canadian Family Physician.10

Competing interests
None declared

References

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