To Drive or Not to Drive: Alzheimer's Disease and Driving.

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Learning Objectives

1. Appreciate the risks associated with dementia and driving, and the challenges of assessing this for the clinician.
2. To learn about the limitations of evidence for in-office screening tools and the on-road driving test, and to consider practical opinion-based approaches for assessing the driver with dementia.
3. To learn about the impact of behavioral disturbances on driving in dementia.

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Epidemiology, Context, and Guidelines

Frank

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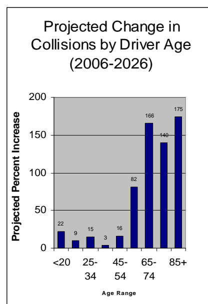
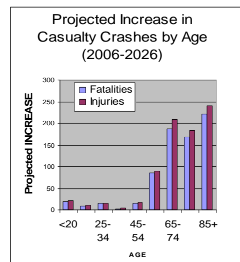
Projections





Source: L'Écuyer et al. (2006). Transport Canada

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A Major Public Health Concern

- When involved in a crash, seniors are over 4 times more likely to be seriously injured and hospitalized than are drivers 16-24 years of age.
- Treatment of injuries to seniors is more costly, recovery slower, less complete.
- Most (3 of 4) crashes involving older drivers are multiple vehicle crashes.

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Assessment of Fitness-to-Drive

The Complexity of the
Medical Driving Evaluation

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It is Not Age

- Medical conditions and medications are the primary cause of declines in older driver competence.
  - Can make even the best of drivers unsafe to drive.
  - Can affect drivers of any age: Increasingly likely as we age.
- Not presence but severity and/or instability of conditions +/- high doses and/or changing doses of medications
- Medical community best placed to first recognize possibly impairing medical conditions.

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Medical Conditions

Any medical condition or medication that results in a change of physical, sensory, mental or emotional abilities has the potential to compromise driving performance.

Physical: weakness; slow / limited movement

Sensory: vision loss; limited feeling in limbs

Cognitive/Perceptual: slowed thinking; decreased attention

Emotional: anxiety, panic reactions

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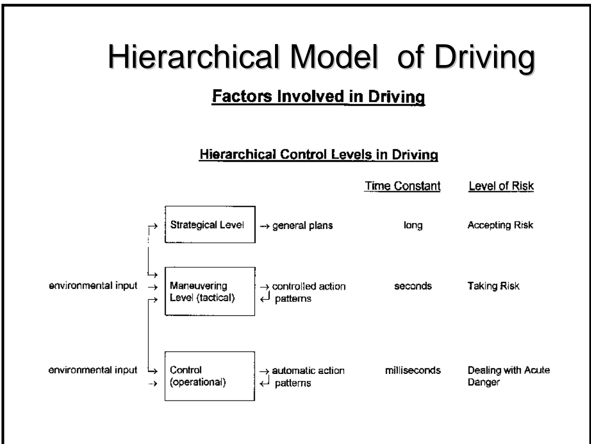

Realistic Conclusions

- No screening or assessment protocol will ever predict 100% of risk of MVC
  - Only test stable intrinsic features
    - operational > tactical, strategic
    - Miss new or fluctuating illness
  - Cannot predict extrinsic factors
    - weather, other drivers, road conditions, car …
  - Full complexity cannot be fully addressed with time available in front-line clinical settings
- Therefore objective is *to improve* not to perfect the assessment of fitness to drive

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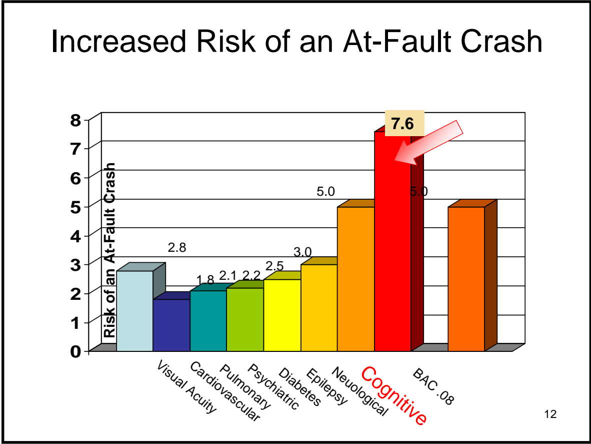

Assessment of Fitness-to-Drive

DEMENTIA & DRIVING

The Facts

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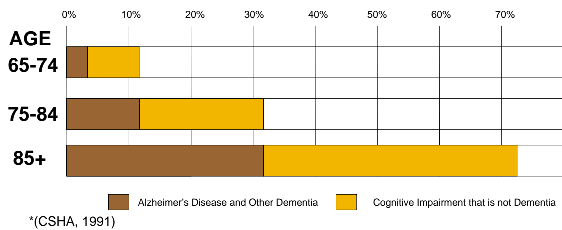
Prevalence of Cognitive Impairment*



*(CSHA, 1991)

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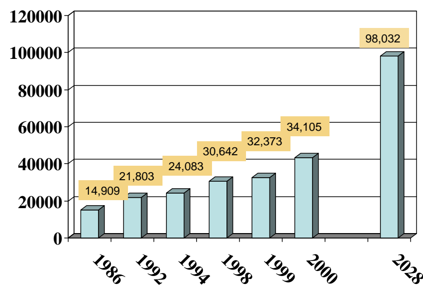
Estimated Numbers of Drivers with Dementia in Ontario[1]



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[1] from Hopkins, et al., (2004)

BUT

- The diagnosis of dementia does *not* automatically mean *no driving*
- The diagnosis of dementia *does mean*:
  - You must ask if the person is still driving
  - You must assess and document driving safety and follow your provincial reporting requirements

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Dementia and Driving

- Consensus statements
  - Swedish (1997)
  - Australian Geriatrics Society (2001)
  - American Academy of Neurologists (2000)
  - AMA and Canadian Medical Association guidelines

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Dementia and Driving

- Conclusions of Consensus statements (cont)
  - Recognize limitations of data
    - those with moderate to severe dementia should not drive (CMA: Moderate = 1 ADL or 2 iADLs impaired due to cognition)
    - individual assessment for those with mild dementia
    - periodic follow-up is required (every 6 - 9 months)
    - “gold standard” is comprehensive on-road assessment

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Expert / Consensus Guidelines

- Limitations of Guidelines
  - Based on expert opinion recommend tests such as MMSE, Clock Drawing, Trails B
  - Do not provide guidance regarding HOW physicians are to apply such tests (e.g. how to respond to different scores, what cut-offs to use, errors = automatic failure …)
    - Operating instructions missing

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Collateral history, persistence and natural history

Mark

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Patient, Family, Doctor

Rater Characteristic	Self-rating	Informant Rating	Physician Rating
Sensitivity	100	81.8	90.9
Specificity	10.7	47.8	60.7
Positive predictive value	46.7	60.0	64.5
Negative predictive value	100	73.3	89.5
Correctly classified	53.2	64.4	74.0

N=75 AD (17 mild; 33 very mild). Rating vs On-Road pass/fail.

Brown et al., J Am Geriatr Soc 2005;53:94-98

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What about the real-world of family practice??

- Cross-Canada survey to 1,000 randomly selected English-speaking family physicians
- 46% response rate.
- 45% not confident in ax driving fitness
- 75% conflict of interest/ impairs doctor-patient relationship
- 69% use the CMA guidelines

Jang et al (2007). Journal of General Int Med; 22: 531-543

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Ontario's doctors are not reporting

- Prevalence of Reportable Conditions.
  - Setting: Trauma Centre, Sunnybrook, 1996-2001
  - 1,605 drivers involved in MVCs
  - On Chart Review, 37.1% had reportable condition - ETOH (72%) Cardiac (23%) Neurol (5%)
  - On database linkage, 80% had reportable condition.
  - 85% of those w reportable condition had seen MD in year prior to MVC

Redelmeier et al, Open Medicine 2008

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Canada

Table 1. Provincial and territorial regulations as of June 2004. *All provinces and territories offer legal protection to physicians who report patients they deem unfit to drive.*

PROVINCE OR TERRITORY	LEGAL OBLIGATION TO REPORT
British Columbia	Mandatory
Alberta	Not mandatory*
Saskatchewan	Mandatory
Manitoba	Mandatory
Ontario	Mandatory
Quebec	Not mandatory*
New Brunswick	Mandatory
Prince Edward Island	Mandatory
Nova Scotia	Not mandatory*
Newfoundland	Mandatory
Northwest Territories	Mandatory
Nunavut	Mandatory

Compiled with the assistance of the Canadian Council of Motor Transportation Administrators and all 13 ministries of transportation.

**Physicians in Alberta, Quebec, and Nova Scotia can use their own judgment regarding reporting unsafe drivers to their ministries of transportation.*

- Supreme Court of Canada decision in 1999 supported that a driver's license could not be suspended on the basis of diagnosis, but only with proof of inability to drive.

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From Molnar et al, Can Fam Phys 2005; 51: 372-9.

Driving Cessation in Dementia

- Objective:
  - To explore the factors affecting the likelihood of driving cessation.
  - In a sample of elderly, community-dwelling people with dementia.
    - Herrmann, Rapoport, Sambrook et al, CMAJ 2006

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Method

- Canadian Outcomes Study in Dementia (COSID).
- 3 year prospective study at 32 sites across Canada.
- 60plus, Resides in community (not seniors residence or LTC), DSM-IV dementia, GDS 5 or less (early or mild).
- Assessed at baseline and every 6 months for 3 years.
- Endpoints: Death, Entry into institution, Study withdrawal, Loss to follow-up.

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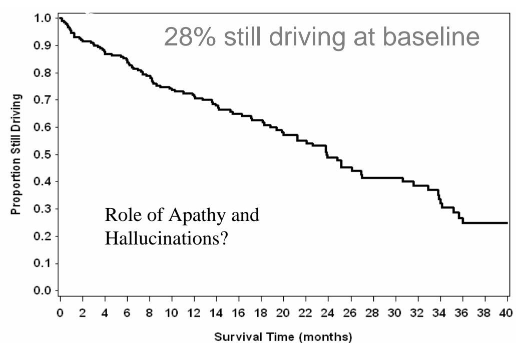
Proportion of Active Drivers with Mild-Moderate Dementia



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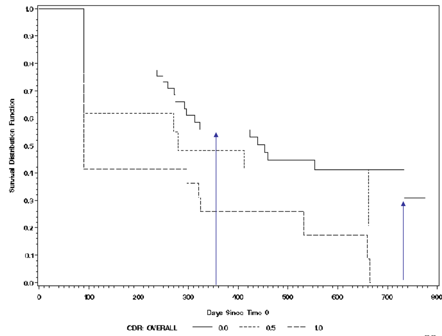
Herrmann, Rapoport, Sambrook et al CMAJ 2006, 175 (6)

Longitudinal Findings: Time to Receive a Rating of 'Unsafe' on the Driving Test by CDR Group.



Duchek et al., J Am Geriatr Soc 2003;51:1342-1347

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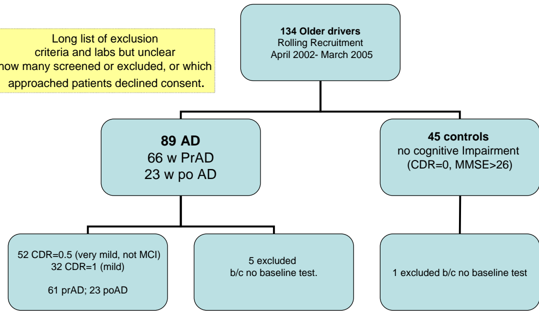
Sample



Ott et al, Neurology 2008

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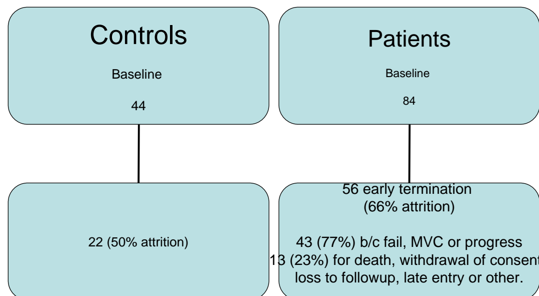
Attrition



Ott et al, Neurology 2008

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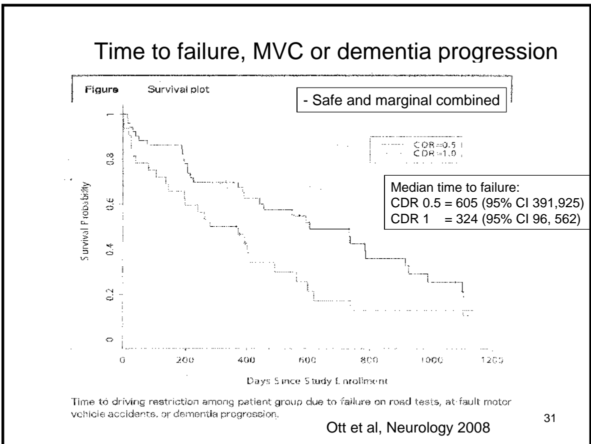
Time to failure, MVC or dementia progression



Time to driving restriction among patient group due to failure on road tests, at-fault motor vehicle accidents, or dementia progression.

Ott et al, Neurology 2008

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Persistance!

- Many patients with mild dementia continue to drive.
- Those that continue to drive persist for years while dementia progresses.
- Behavioral factors may be more significant than cognitive ones wrt driving cessation.

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DEMENTIA & DRIVING

Approach based on clinical acumen

Frank

(based on the work of and discussions with numerous Family Physicians, Geriatricians, Neurologists)

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Dementia and Driving

- **Start by asking older patients if they drive!**
  - Seems simple but most MDs do not ask (too busy, fear of opening Pandora's box... Lack of awareness does not provide legal protection)
- Keep in mind that driving capacity depends on a **GLOBAL CLINICAL PICTURE**:
  - including cognition, function, physical abilities, medical conditions, behavior, driving record ….
  - Therefore, the following approach will move from general questions ⇒ specific cognitive tests.

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Ask Family - Signs of a Potential Problen

- Collisions and/or damage to the car
- Getting lost
- Near-misses with vehicles, pedestrians
- Confusing the gas and brake
- Traffic tickets
- Missing stop signs/lights; stopping for green light
- Deferring right of way
- Not observing during lane changes/ merging
- Others honking/irritated with the driver
- Needing a co-pilot
- New dents in Car

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Five Questions to Ask the Person

Yes	No	Question
☐	☐	1. Are you feeling less confident about driving?
☐	☐	2. In the last year, have you had any accidents or near misses or tickets for traffic violations (driving too slowly / failing to stop)?
☐	☐	3. In the last year, have you restricted your driving habits driving less or only on familiar routes, or avoiding driving at night, in bad weather or on busy streets?
☐	☐	4. Have you ever become lost while driving or forgotten where you were going?
☐	☐	5. At the present, do you feel that you are a safe driver?

Five Questions to Ask the Family

Yes	No	Question
☐	☐	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 on busy streets?
☐	☐	4. Have other friends or your son or daughter ever expressed concern about the person's driving? Are cues/directions ever needed from you as a "copilot"?
☐	☐	5. (To a son or daughter if they have children) Would you feel it was safe if your son/daughter were in a car driving alone with their grand parent?

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Review functions required for driving (would you get in a car with them based on these findings?)

- Cognition
  - vigilance, attention, judgment, insight, planning skills
- Vision
  - visual acuity, depth perception, visual scanning, dynamic acuity, visual fields, night vision, glare accommodation, contrast sensitivity
- Hearing?
- Motor Skills
  - power, coordination, and range of motion of neck and limbs (adequate to operate car?)
- Sensation (can they feel the gas / brake pedals?)

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Review medical conditions that when severe, poorly controlled or changing rapidly can impact on driving

(would you get in a car with them based on these findings?)

- 3Ds: Dementia / Delirium / Depression
- Diabetes
- vision and hearing
- cardiac disease
- Stroke
- Parkinson's
- Arthritis
- Sleep apnea

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Review Medications that may affect driving (especially high doses or changing doses)

- alcohol
- benzodiazepines
- muscle relaxants
- sedating antidepressants and antihistamines
- anticonvulsants
- anticholinergics (next slide)

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Reference List of Drugs with Anticholinergic Effects

- Antidepressants
- Antipsychotics
- Antihistamines/ Antipruritics
- Antiparkinsonian
- Antispasmotics
- Antiemetics

Miscellaneous

Flexeril
Lomotil
Rythmodan
Tagamet
Digoxin
Lasix

The medications in the miscellaneous category have been shown to have anticholinergic properties by radioimmunoassay but are less anticholinergic than the other medications listed. However, they may add to total anticholinergic load.

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Focused Cognitive Assessment

- Many patients will be more comfortable with the idea of driving cessation if the decision is made for physical reasons (e.g. loss of vision, syncope etc.)
- If you have not found a non-cognitive (physical) reason, the proceed to cognitive assessment

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General Functional Overview

Severity:

1. Generally, functional losses stratify severity better than MMSE
   – mild: generally involves only mild losses, e.g., loss of one or two (not more) instrumental activities of daily living (IADLs) (i.e., SHAFT) or MMSE =24 (education >grade eight)

S: Shopping
H: Housework
A: Accounting = finances
F: Food preparation
T: Transportation
(some patients with mild dementia may still be safe to drive)

Also laundry, small machinery and use of telephone

CANADIAN CONSENSUS COMMITTEE GUIDELINES 2006:
Driving is contraindicated in persons who, for cognitive reasons, have an inability to independently perform multiple IADLs or any of the basic ADLs (e.g., toileting, dressing) (grade B/level III)

ADL = activity of daily living

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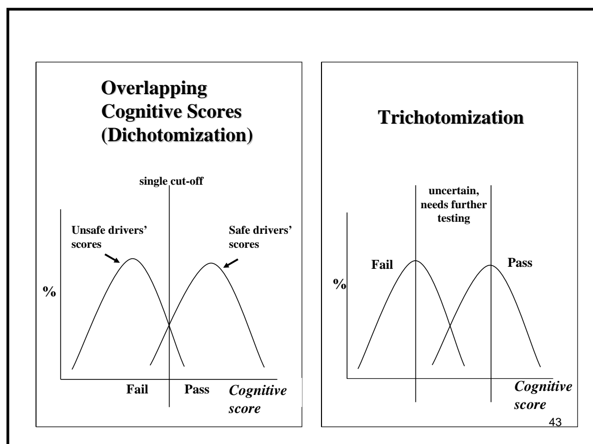
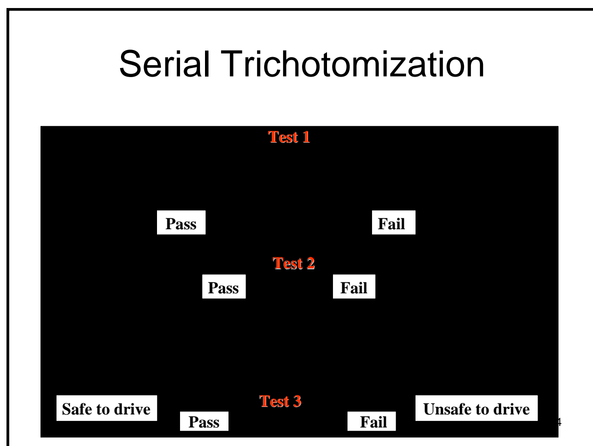


Serial Trichotomization



Applying Trichotomization

- Given the assessment would you get in the car with the patient driving (or would you let a loved one drive with them)?
  - Yes
  - Uncertain
  - Absolutely not

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The MMSE

- There is questionable correlation between driving safety and the MMSE.
- The MMSE (when adjusted for age and education) can provide a rough framework for assessing driving safety. Patients scoring under 20 are likely unsafe to drive.
- Trichotomization (obviously unsafe, uncertain safety, obviously safe) approach may be helpful

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Clock Drawing Test

- A test of Executive Function and Visuospatial function
- Once again Trichotomization (obviously unsafe, uncertain safety, obviously safe) approach may be helpful

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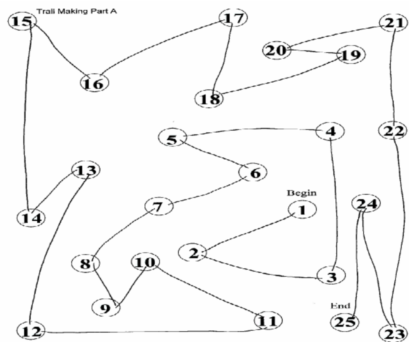
Trails A



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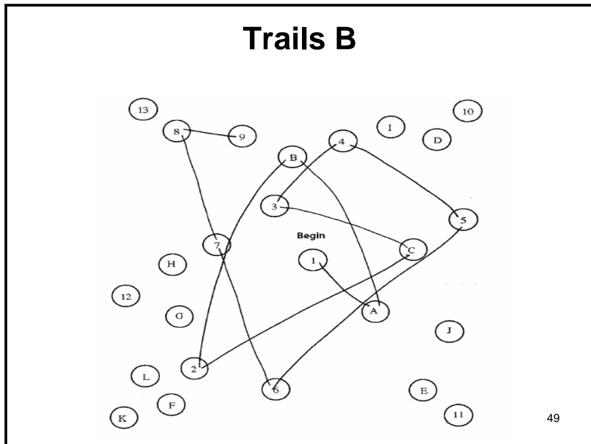
Trails B



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Trails A + B

Trails A and B are tests of memory, visuospatial, attention and executive function. Any errors or scoring below the 10th percentile in the time taken raises concerns about driving safety.

Norms for Trails A and B by age (in seconds) and education

Age	Percentiles: 90th/50th/10th			
	90/50/10	Trails A*	Trails B =Grade 12	Trails B >Grade 12*
65-69	90	25	60	52
	50	37	86	68
	10	53	137	77
70-74	90	26	70	59
	50	38	101	84
	10	61	172	112
75-79	90	27	78	57
	50	46	120	81
	10	70	189	178
80-84	90	31	72	89
	50	52	140	128
	10	93	158	223
85+	90	36	79	70
	50	54	143	121
	10	120	319	240

***Trails A: performance decreases with age but is NOT affected by education**

***Trails B: performance decreases with age AND with education**

A+B does not

necessarily mean that the patient is safe to drive

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TN Tombaugh *Arch clin neuropsychol* 2004;19.pg 203-14

(Failure = error(s) or time <10th percentile)

Red Flags

- Delusions
- Disinhibition
- Hallucinations
- Impulsiveness
- Agitation
- Anxiety
- Apathy
- Depression

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RED FLAGS

Type of dementia:

- frontotemporal dementia (FTD), Parkinson's dementia or Lewy body dementia (LBD) may be unsafe at early stages

Significant visuospatial problems:

- poorly done intersecting pentagon/number placement on clock drawing, etc.

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15-Minute Driving Safety Evaluation

1. Type of dementia: AD, VAD, Mixed AD/VAD, LBD, FTD, Other ____________
2. Severity of dementia: Very mild, Mild, Moderate MMSE_______________
3.

Potential Problem Areas	OK	A Concern:
a. vision		
b. Hearing		
c. Questions for the person		
d. Questions for the family		
e. Insight		
f. Judgement		
g. Visuospatial / Executive function		
h. Trails A/B		
i. Reaction time		
j. Personal ADL, Instrumental ADL		
k. Neurological deficits		
l. Musculoskeletal deficits		

4. Other medical issues/medications ________________________________

SAFE	□	- Reassess in 6 to 9 months
UNSAFE	□	- Ministry of Transportation notification, letter to patient
UNCERTAIN	□	- Specialized assessment (geriatric/OT/neuropsychology) or specialized on road testing

Driving Safety: Quick Six-Item Checklist

1. Family concerns: e.g., what if grandchild is alone with driver?

- Type of dementia: frontotemporal dementia (FTD) or Lewy body dementia (LBD) are unsafe regardless of other factors
- Significant visuospatial problems: poorly done intersecting pentagon/number placement on clock drawing, etc.
- Poor judgment/insight: *e.g., what should you do if…: fire in neighbour's kitchen, approaching yellow light, understanding driving with dementia is a risk*
- Other medical/physical/medication issues: including reaction time (dropping a 12" ruler between thumb and index finger – usually caught by maximum of 9" or so)
- Trails A and B: tests of visuospatial, executive function, attention and speed of processing (generally failed by failing to understand concept of test or by making errors, not by exceeding time limit)

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Key Learning Points

1. If dementia is diagnosed, driving must be asked about, formally assessed, and documented.
2. Physicians can perform a comprehensive driving safety clinical evaluation in approximately 15 to 20 minutes.
3. If you are unsure of safety, refer to specialized assessment or specialized on-road testing.
4. In dementia, driving safety must be reassessed every 6 to 9 months.

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Role of Behavioral Factors

Mark

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Psychotropics and MVCs in Patients with Dementia

Rapoport et al, In Press, JAGS

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Method

- Population-Based
- Case-Crossover Study
- Linked Transportation (Collisions) and Health Data (OHIP, CIHI, ODB)
- From April 1, 1997 to March 31, 2005.

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Subjects

- Age 65 plus with dementia, age 67 plus at collision.
- Dementia
  - Script for ChEI
  - Discharge dx or MD visit
- Excluded:
  - LTC or Palliative Care
  - ETOH, amnestic disorder, delirium, personality disorder, epilepsy.
  - Censored those who did not retain licensure or died.

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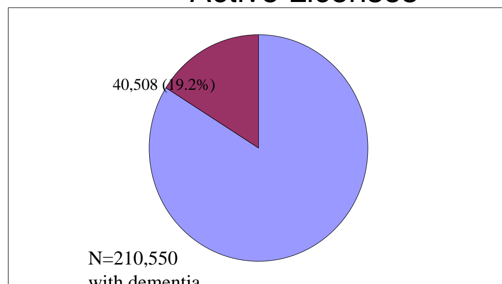
The People: Dementia and Active Licenses



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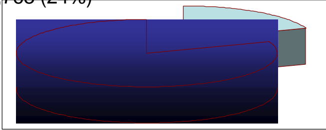
MVCs among those with active licenses



N=40,508 dementia
With active licenses

And 78% of collisions occurred prior to dx of dementia

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Characteristics of 8,690 patients & MVCs

	%
Any Psychotropic	33.0
Benzodiazepine	23.0
Antidepressant	17.8
Antipsychotic	1.6
Other Anticholinergic	37.4
Driving Properly	37.4
At Fault	57.2
Unknown	5.3
Injury	24.4
Property Damage	75.2
Unknown	0.2

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Case-Crossover Analysis

- MVC

Both Years	1,845
Index Year	610
Index year - 1	397
Total	2,852

4 mo exposure window — MVC

4 mo exposure window — MVC (One yr earlier)

OR 1.54, 95% CI 1.35-1.74

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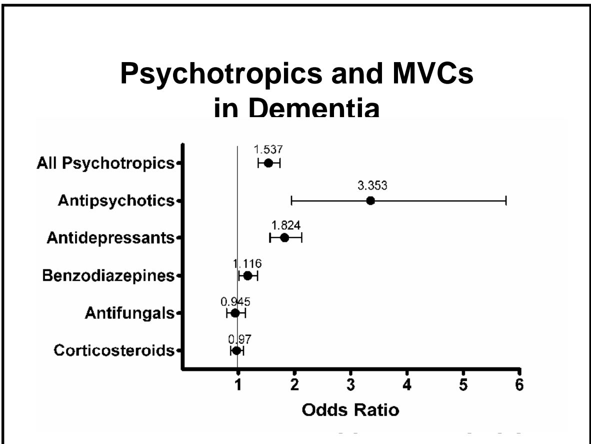
Psychotropics and MVCs in Dementia



Discussion

- Psychotropic medications are associated with more than a 50% increased risk of MVC in patients with dementia.
- Mechanism – Unlikely pharmacological.
  - Expect: BZD > TCA>SSRI
  - Results: SSRI>TCA>BZD
- Rather, the behavioral disturbances leading to the prescriptions themselves are likely significant factors in this association.
  - Recall that apathy and hallucinations predicted driving cessation in COSID study.
- Red flag/warning sign
  - Double-whammy
  - Script/Report

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Driving in dementia: Take Home Points

- Many cognitive skills required.
- Dementia increases crash risk, but also decreases exposure. Not enough info.
- Drivers with dementia are persistent.
- Many patients in the early stages may be safe to drive.
- Cognitive testing limited predictive ability. We need better tools.
- Individualized assessment needed. We need to make this practical and affordable.
- Behavioral changes play a significant role, especially psychosis, apathy and depression.
- Behavioral disturbances in non-Alzheimer's dementia may occur prior to memory impairment
- Legislation - Safety outweighs autonomy, yet doctors are not reporting

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After the Assessment

Mark and Frank

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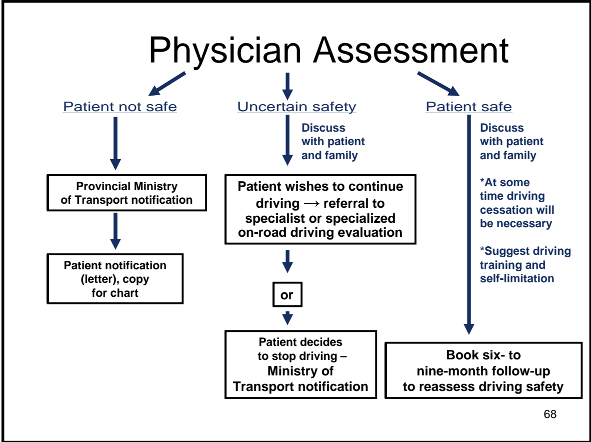

Disclosure techniques

What and How to tell patient when they are unsafe to drive

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Patient Not Fit to Drive (permanent)

- Meet with family first
  - **Do not let them establish a position that is contrary to yours (i.e. avoid creation of an adversarial relationship). Ask them to let you give them all the relevant information before they provide their opinion.**
  - **Explain concern of safety for patient and others in a concrete and empathic fashion.**
  - **Describe findings that make it clear that the patient is not safe to drive.**
  - **Explain that the laws in your jurisdiction require you to report the patient to the Ministry of Transportation – that you have no choice and that to not report would be breaking the law.**

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Patient Not Fit to Drive

- Meeting with family (cont.)
  - Indicate that you are certain that they understand that the goal of the assessment is to prevent an accident that could injure the patient or others, therefore, we cannot wait for an accident to occur – that it would be too late, as many seniors do not survive or recover from MVCS. If others were injured, their parent would have to live with the guilt.
  - Explain that since they are now aware of the risk, they too carry some responsibility.

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Patient Not Fit to Drive

- Meeting with family (cont.)
  - Put the family in a supportive role
    - Thank the family (before they speak) for helping you with this difficult task. Indicate that while it is your legal responsibility to tell their parent, they can be the supportive party that emotionally helps their parent through a difficult time and helps them find transportation alternatives.
      - the good cop / bad cop approach

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If the family doubt your findings

- Explain the guidelines and laws
- Explain the tests used
- Discuss the findings (show them the test results)
- If they are still dubious have them witness repeat performance on the most revealing test

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Patient Not Fit to Drive

- Meet with the patient
  - Have family present but a priori ask them to assume the supportive (good cop) role and let you first disclose.
  - Ask the patient to let you provide all the information first before they speak – avoid creating an adversarial position.
    - Explain that due to the clinical findings, the law mandates that they must cease driving and that while you dislike doing so, you must report them to the Ministry of Transportation – you cannot override or disobey the law.

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Patient Not Fit to Drive

- Meet with the patient (cont.)
  - Give the patient a positive role
    - Recognize they have been a responsible driver and part of being a responsible driver is to hang up the keys BEFORE an MVC.
    - Acknowledge that you know they would never want to hurt others.
  - Acknowledge that it is normal to be unhappy regarding this information

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Patient Not Fit to Drive

- Meet with the patient (cont.)
  - Highlight positives
    - Taking a Taxis is cheaper than maintaining a car, if one drives less than 4000 km/year.
    - They took care of their children and now this is their children's chance to pay them back – it is important for their children to feel they are helping.

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Patient Not Fit to Drive

- If patient continues to argue:
  - Remain firm in instructions not to drive. Do not argue – they may have limited insight.
  - Indicate the chart is a legal document that can be subpoenaed – the chart indicates that they and their family have been notified of their MVC risk. If they are involved in a crash, they may be legally liable and financially responsible.
  - If they threaten a lawsuit, notify CPSO and CMPA, so they can advise and can open files.

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Patient Not Fit to Drive

- THEN ask the patient and family to comment (AFTER outlining lack of choice due to Laws in Ontario and their respective positive roles).
- Once again acknowledge that it is normal to feel bad about this development.

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Patient Not Fit to Drive

- Explore other transportation options.
  - Family – share responsibility between several members. Family should ensure patient gets out of the house
  - Taxi – can get private cell number of driver(s) that was / were particularly helpful and reliable. Plan a day ahead.
  - Volunteer drivers
  - ParaTranspo

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Patient Not Fit to Drive

- If patient is refusing to comply, then meet with family
  - Encourage family to remove opportunity to drive if non-compliant (disable car, remove keys or car). Best to remove car as it is a constant reminder.
  - If patient is in imminent danger to others, CALL Ministry of Transportation physician line indicating need to remove license ASAP and fax in medical form.
  - Call Police???

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Patient Not Fit to Drive

- After the disclosure meeting:
  - Provide a written statement to the patient/family as to why the patient cannot drive, regarding your legal obligations, and intent to notify government authority.
  - Continue to encourage family to remove opportunity to drive if non-compliant.
  - Communicate in writing to your provincial Ministry of Transport. Call MD hotline if the situation is urgent.
  - Document details of disclosure meeting in chart (date, people present, information disclosed)

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Notification About Driving Safety

Name: ______________________________

Date: ______________________________

Address: ____

You have undergone assessment for memory/cognitive problems. It has been found by comprehensive assessment that you have ______________________ dementia. The severity is ________________.

Even with **mild** dementia, compared to people your age, you have an 8 times risk of a car accident in the next year. Even with **mild** dementia, the risk of a serious car accident is 50% within 2 years of diagnosis.

Additional factors in your health assessment raising concerns about driving safety include:

____

____

____

____

As your doctor, I have a legal responsibility to report potentially unsafe drivers to the Ministry of Transport. Even with a previous safe driving record, your risk of a car accident is too great to continue driving. Your safety and the safety of others are too important.

_________________________ M.D. ________________________ Witness

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Concluding Comments

1. If dementia is diagnosed, driving must be asked about, formally assessed, and documented.
2. Physicians can perform a comprehensive driving safety clinical evaluation in approximately 15 to 20 minutes.
3. Focus on behavior and function, not just cognition.
4. If you are unsure of safety, refer to specialized assessment or specialized on-road testing.
5. In dementia, driving safety must be reassessed every 6 to 9 months.

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