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Editorial

Dementia and Driving: A Modern Gordian Knot

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Dementia refers to a syndrome characterised by a progressive deterioration of memory and at least one other cognitive domain (e.g. language, executive function, praxis) which interferes with one's daily function and independence. Epidemiological data indicate the prevalence of dementia to be 6.5% of those aged over 65 [1]. Recent estimates by the World Health Organisation (WHO) claim that 35.6 million people have dementia [2]. Furthermore, the WHO anticipates that the number of people with dementia will double every 20 years, to 65.7 million in 2030 and 115.4 million in 2050 [2]. As our population is ageing, the number of older drivers on our roads is increasing. Of concern is that 30-45% of individuals with dementia continue to drive [3]. Most medical and vehicle licensing authorities concur that individuals living with a dementia cannot drive safely [4,5] but there is a lack of consensus about the impact of mild dementia on the driving capacity [6]. Accordingly, clinicians are faced with an emerging global dilemma about how to balance the promotion of personal mobility of individuals with mild dementia with the promotion of public safety. Add to this, the inadequacy of alternative transport options for older members of the community.

In most Western nations, there is requirement that clinicians report significant impediments to driving safety to a licensing authority. However, as dementia often impairs one's memory and insight, individuals with dementia, one could argue, should be exempt from such expectations. If so, who then is responsible for pursuing licence cancellation of unsafe drivers with dementia: carers; family; friends; clinicians; or government? In most Western countries, clinicians are not responsible for the cancellation of driver licences. Rather, this task is delegated to a government body (e.g. department of motor vehicles (US), driver and vehicle licensing agency (UK), driver licensing authority (Australia)). Mandatory reporting by clinicians of unsafe drivers exists in only a minority of nations.

As legislative requirements vary considerably within and between countries, it behoves clinicians to accustom themselves to local laws and procedures [6]. An additional salient concern of many drivers relates to motor vehicle insurance coverage. It is often suggested that impaired drivers should inform their motor vehicle insurer to ensure that their coverage remains valid. In Australia, motor vehicle insurers only require a valid driver licence and notification of a diagnosis of dementia is not necessary. Failure to do so does not impact negatively upon an individual's cover/policy [7].

A large body of literature addresses the topic of how best to assess the safety of drivers with dementia: the American Academy of Neurology (AAN) [4] and the Australian and New Zealand Society of Geriatric Medicine (ANZSGM) [5] comprehensively reviewed the existing literature regarding assessment of fitness to drive of individuals with dementia. The AAN systematic review concluded that 'there is no test result or historical feature that accurately quantifies driving risk [4]. The ongoing search for a test which is both 100% sensitive and specific is admirable, yet fraught with challenges. First, on road Occupational Therapy driving assessments are often regarded as the gold standard in determining fitness to drive. Yet, individuals with dementia are ill-suited to such an assessment as their condition is both progressive and often accompanied by fluctuations. Neither ANZSGM nor AAN support sole reliance upon occupational therapy assessments in determining driving safety [4,5]. Second, no off-road test, including driving simulation, can accurately recreate the complex nature of the driving task. Third, if an individual with dementia is found to have passed a test then how often must they be retested (e.g. every 6 months)? Forth, if an individual fails a test, will they voluntarily cease driving? Finally, an undue emphasis on testing distracts drivers and clinicians from a more pertinent issue: planning for retirement from driving.

Driving retirement has been shown to have a negative impact upon older drivers, carers, family members and doctor-patient relationship [6]. Empowering older drivers with dementia to plan for driving retirement aligns with the ethical principles of autonomy, beneficence and non-maleficence [6]. The arrangement of alternative forms of transport is crucial when considering retirement from driving. A pre-planned strategy which addresses the transition to non-driving obviates the need for clinicians to insist upon abrupt licence withdrawal when a patient becomes clearly unsafe. Adopting a sensitive approach to a potentially difficult physician-patient encounter is of paramount importance. The advent of a decision aid tailored for drivers with dementia has the potential to serve as a helpful resource [7]. Individuals who read this brief booklet experience reduced decisional conflict and exhibit higher knowledge scores [8]. It would appear that non-threatening engagement trumps more paternalistic, and perhaps alienating, methods.

Thus far, much of the transport safety literature concentrates on how best we can identify unsafe older drivers [9]. Perhaps the time has come to address how we, as a society, can provide pragmatic alternative transport options for our ageing population. In contrast to Alexander's legendary approach to the Gordian Knot [10], the modern dilemma of driving with dementia does not require such dramatic solutions.

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