

Medical record prompts improve the frequency and documentation of dizziness and driving conversations in the ENT balance clinic

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Main Article

Lisa Burrows takes responsibility for the integrity of the content of the paper

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Abstract

Background. Driving capacity is affected by vestibular disorders and the medications used to treat them. Driving is not considered during medical consultations, with 92 per cent of patients attending a centre for dizziness not discussing it with the doctor.

Objective. To investigate if medical record prompts facilitate dizziness and driving conversations in ENT balance clinics.

Methods. A questionnaire was designed to reflect the current standards of practice and advice given regarding driving and dizziness during balance clinic consultations.

Results. Medical record prompts facilitated the improved frequency and recording of shared decision-making conversations about driving and dizziness in 98 per cent of consultations.

Conclusion. This study highlights the benefits of medical record prompts for documented and accurate shared decision-making conversations surrounding dizziness, vertigo, vestibular conditions and driving. This potentially improves safety for all road users, and protects the patient and clinician in the event of road traffic accidents and medico-legal investigations.

Introduction

Driving capacity can be affected by many medical conditions, including kidney disease, stroke, diabetes, concussion, migraine and inner-ear vestibular disorders,^{1–6} and by medications.^{7–11} Patients with dizziness, vertigo or balance disorders, especially younger patients, women, and patients with Ménière's disease, regularly experience limitations related to driving. This means people are often unable to work,^{12–15} and it has a significant impact on their lifestyle.^{16–19} It is surprising that there is a reported lack of knowledge at patient and practitioner level.^{17,18} Consequently, driving was not considered in 92 per cent of patients attending a centre for dizziness and balance disorders.¹⁹ However, given its importance, the topic of driving and dizziness or vertigo should always be addressed in those presenting with these symptoms,²⁰ and in patients taking medication that causes dizziness or drowsiness,²⁰ as data are consistent regarding the effects of medications used for dizziness and vertigo on driving ability.^{6–10,21–23}

Vestibular disorders have been shown to negatively affect driving ability in most studies, with a low risk of bias,^{16,17,22} and any associated anxiety or mood disorders – prevalent in vestibular disorders – may also affect driving.¹⁶ A systematic review revealed a significant heterogeneity in studies reporting driving performance, with contradictory results,²¹ which makes giving accurate, condition-specific advice more challenging.^{22–24} Furthermore, there can be a fear of implications where legislation appears over-cautious.^{23,24} There are similarities in findings for those with benign paroxysmal positional vertigo (BPPV), who can resume driving following successful repositioning manoeuvres. These individuals report significant degrees of controllability and predictability; for example, dizziness only comes on when getting in or out of a lying-flat position, which is not related to driving a car.^{1,12,13,15,19} However, one study did suggest that almost as many people with BPPV had problems that limited driving as those who did not,²² emphasising the importance of communication during consultations.

This is a neglected area of assessment. Providing a driving capacity leaflet facilitated only marginally improved levels of documented discussion of driving and dizziness in people with vestibular disorders attending ENT or neuro-otology clinics.¹⁸ It is therefore of value to audit and collect data on the accuracy of assessment and advice given regarding dizziness and driving. Medical records need to be accurate considering the legal implications, and there is a need for conversations in order to increase awareness about driving with dizziness. It is noteworthy that people without vestibular disorders are in fact more likely to be involved in traffic offences and road traffic accidents.^{1,25,26} It has been highlighted that drivers with vestibular conditions modify their driving habits to compensate.^{13,14,19,22}

A survey of otolaryngologists²⁵ indicated that 64 per cent believed that patients stopped driving when warned it was dangerous, and patients were more likely to be advised to stop

if dizziness was constant and/or severe.' Conversely, patients did not always take the advice, with 52 per cent reporting they would continue to drive but more safely, 4 per cent would continue as usual, and only 11 per cent would not drive and consequently became more aware leading to fewer accidents.^{24–26}

Guidelines concerning dizziness and driving vary worldwide, and even within the European Union where a common driving licence is used but each country produces different guidance.²⁷ Within the UK, there are specific recommendations for conditions such as Ménière's disease, migraine and vestibular schwannoma,²⁸ however, the advice regarding symptom characteristics for many other conditions, such as vestibulopathy and BPPV, is more generic (i.e. based on predictability, controllability or three months of no symptoms).^{28,29} Other factors impacting driving capacity associated with dizziness and vestibular disorders relate to the environment (e.g. weather, traffic and road distractions), the characteristics of the individual concerned (e.g. physical, cognitive and spatial abilities, self-awareness, and age) and the needs of the person (e.g. related to work, social life, shopping, leisure activities).

The Driver and Vehicle Licensing Agency in the UK requires dizziness to be controllable or predictable, or requires three months without dizziness outside of this criteria, to drive a car.^{20,28} In order to drive a heavy goods vehicle or passenger transport vehicles (bus or coach), there are stricter regulations.^{20,28} A self-declaration of fitness to drive system is in place for all UK drivers, and clinicians can report directly to the Driver and Vehicle Licensing Agency UK if they become aware of drivers who are neglecting to inform the Driver and Vehicle Licensing Agency after being advised it would be unsafe or illegal to drive.²⁸ Therefore, appropriate information-gathering in patient records (in line with current best practice) should be patient-orientated, and include best practice assessment of dizziness and balance, as outlined in clinical practice guidelines and as recommended for the assessment of the dizzy patient.^{30–33} This typically includes: patient-orientated medical records, audiological examination (audiogram, tympanogram, otoscopy and tinnitus screening), cranial nerve examination, visuo-ocular motor screening, head impulse testing, positional tests, falls risk assessment, strength, sensation and co-ordination testing of postural stability, and, where necessary, vestibular function tests, blood tests and imaging.^{30–33}

Background

The Southport and Ormskirk Balance Clinic, in collaboration with Aintree Balance Clinic, produced, trialled and revised a leaflet on 'Dizziness and Driving', outlining Driver and Vehicle Licensing Agency UK guidance. This was available for use for 12 months. In addition, driving capacity prompts were introduced to the ENT balance clinic assessment proforma, with the aim of ensuring that all patients were screened, and appropriate individualised advice offered regarding dizziness and driving in line with Driver and Vehicle Licensing Agency UK guidelines.^{20,28} This involved shared decision-making conversations³² and accurately recorded communications. Sharing information with service managers and clinicians within clinics where dizziness and driving should be discussed potentially informs best practice and service improvements. Discussions within the multidisciplinary team (MDT) support the processes, as physiotherapists did not have the legal

framework to give 'fit to work' or 'fit to drive' notes at the time of the data collection.

Aim

This study aimed to retrospectively audit current practice and documentation standards in the consultant physiotherapist led ENT balance clinic relating to fitness to drive and dizziness.

Objectives

To generate knowledge on: (1) the use of prompted screening questions specifically for dizziness and driving; (2) appropriate patient information gathered to have an informed, shared decision-making conversation about driving capacity and self-declaration processes; (3) appropriate action taken where needed; and (4) clinician training required to support shared decision-making conversations around dizziness and driving with safe, legal practice.

Materials and methods

Questionnaire design

An electronic data collection questionnaire was designed, to reflect current standards of practice and advice with regard to driving and dizziness (Driver and Vehicle Licensing Agency UK). The questions were piloted and further refined by the MDT before use.

Data collection

Data were collected via a retrospective electronic questionnaire, between June 2021 and September 2021, from the 71 most recent consecutively discharged patients at one National Health Service (NHS) Trust across two sites, following face-to-face appointments in the consultant physiotherapist led ENT balance clinic. Data were anonymised and stored on a password-protected NHS computer and account with a remote drive, which will be deleted within appropriate time scales for data protection, in line with Trust policy. Bárány Society diagnostic criteria for vestibular disorders were used.³³

Completing the survey took approximately 10 minutes per patient record, and a target of 50 records surveyed was set. The survey had 12 questions in two sections: (1) identification and demographics (questions 1–3), and (2) care pathway and documentation standards (questions 4–12). All questions collected quantitative data.

Section one gathered information on anonymised number identification, age and gender. Section two collected information on diagnosis, subjective history content, objective examination content, investigations, diagnosis, dizziness and driving, medication management, follow up, onward referrals, and whether records were appropriately signed and dated.

Data analysis

All data were downloaded from electronic data collection forms onto an Excel® spreadsheet. Incomplete data were excluded, and the results were reviewed for analysis.

Results

There was no incomplete dataset. Seventy-one consecutive datasets were gathered. Twenty-seven per cent of patients

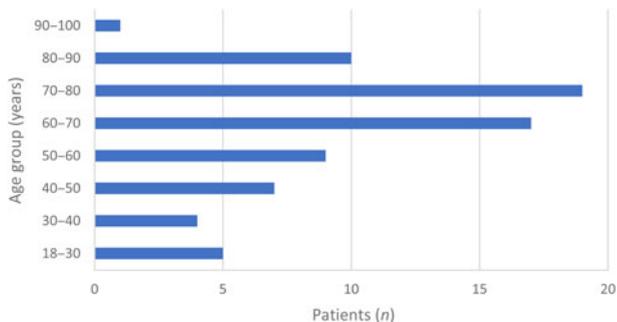


Figure 1. Number of patients in each age group.

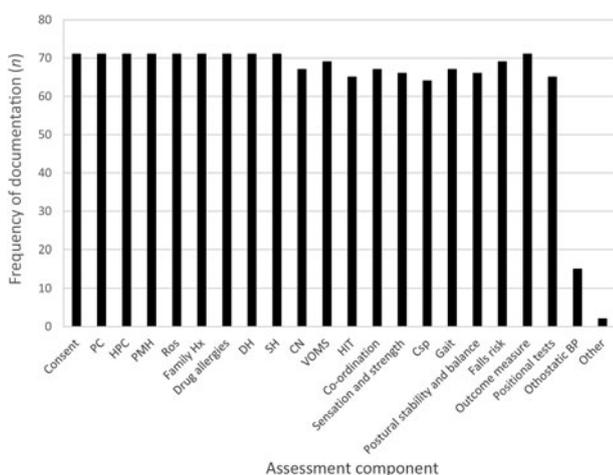


Figure 2. Assessment components documented. PC = presenting complaint; HPC = history of presenting complaint; PMH = past medical history; Ros = review of systems; Family Hx = family history; DH = drug history; SH = social history; CN = cranial nerve examination; VOMS = visuo-ocular motor screening; HIT = head impulse testing; Csp = cervical spine range; BP = blood pressure

were aged 70–80 years (Figure 1); 68 per cent of all patients were female and 32 per cent were male. All 71 patients (69 out-patients and 2 in-patients) had appropriate subjective and objective assessments (Figure 2), and 69 patients had audiological testing (audiogram, otoscopy, tinnitus screen and tympanogram), as part of the initial out-patient appointment. Thirteen patients (4 males and 9 females) had no driving licence; 4 of these 13 did not drive because of other medical reasons (i.e. cerebellar metastases, stroke, poor vision and a cardiac condition). Four out of 58 patients had a driving licence but had made the decision not to drive (reasons cited for not driving included: a previous road traffic accident, their own choice because they did not like driving, no car and reduced confidence). A shared decision-making conversation was recorded in 98 per cent ($n = 69$) of records pertaining to dizziness, vertigo and driving capacity. Those without documented conversations ($n = 2$) were in-patients for whom the out-patients medical records prompt was not available.

The type and number of further investigations are highlighted in Figure 3. Magnetic resonance imaging and blood tests were the most common further investigations ($n = 22$ for both). Diagnoses made included: multi-pathology, in 23 per cent ($n = 16$) (Figure 4); BPPV, in 18 per cent ($n = 13$); vestibular migraine, in 11 per cent ($n = 8$); medication, in 11 per cent ($n = 8$); presbyvestibulopathy, in 7 per cent ($n = 5$); central vascular causes, in 4 per cent ($n = 3$); unilateral vestibular hypofunction, in 3 per cent ($n = 2$); central lesion, in 3 per

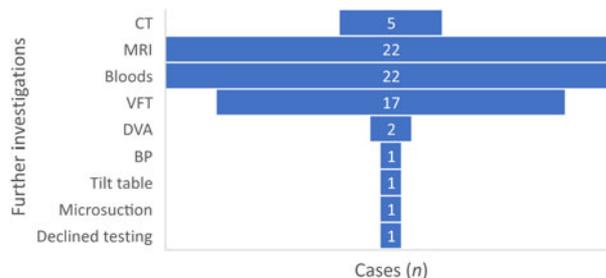


Figure 3. Further investigations arranged following initial assessment. CT = computed tomography; MRI = magnetic resonance imaging; VFT = vestibular function testing; DVA = dynamic visual acuity; BP = blood pressure

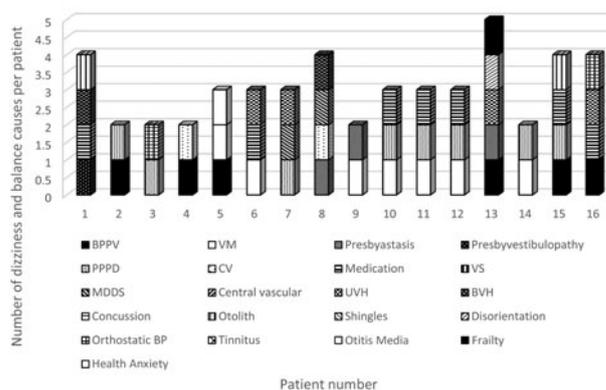


Figure 4. Sixteen patients (23 per cent) presenting with multiple causes of dizziness and balance. BPPV = benign paroxysmal positional vertigo; VM = vestibular migraine; PPPD = persistent postural perceptual dizziness; CV = central vascular disease; VS = vestibular schwannoma; MDDS = mal de débarquement syndrome; UVH = unilateral vestibular hypofunction; BVH = bilateral vestibular hypofunction; BP = blood pressure

cent ($n = 2$); presbyastasis, in 3 per cent ($n = 2$); cardiovascular disease, in 3 per cent ($n = 2$); shingles (Ramsay Hunt syndrome), in 3 per cent ($n = 2$); general disorientation (i.e. no identified cause fitting diagnostic criteria), in 3 per cent ($n = 2$); persistent postural perceptual dizziness, in 1 per cent ($n = 1$); vestibular schwannoma, in 1 per cent ($n = 1$); partial bilateral vestibular hypofunction, in 1 per cent ($n = 1$); concussion, in 1 per cent ($n = 1$); otolith dysfunction, in 1 per cent ($n = 1$); resolved symptoms, with no diagnosis given, in 1 per cent ($n = 1$); and mal de débarquement syndrome, in 1 per cent ($n = 1$).

Documented self-reporting of symptom control meant that 58 patients had the legal capacity to drive, with symptoms of dizziness and vertigo being described as predictable ($n = 6$), controllable ($n = 3$) or both (predictable and controllable) ($n = 49$). Focusing on the most common diagnoses (i.e. BPPV, vestibular migraine and multi-pathology) (Figure 5), patients considered symptoms to be: predictable (BPPV, $n = 2$; vestibular migraine, $n = 2$; and multi-pathology, $n = 1$), controllable (BPPV, $n = 3$; vestibular migraine, $n = 0$; and multi-pathology, $n = 1$), or both controllable and predictable (BPPV, $n = 10$; vestibular migraine, $n = 9$; and multi-pathology, $n = 10$).

Medication management plus dizziness and drowsiness advice was recorded in 30 records. Thirty-five patients were advised on current medication use and the potential for dizziness or drowsiness to affect driving capacity. Six patients required no medication management. All patients were offered information leaflets pertaining to Driver and Vehicle Licensing Agency UK guidelines; however, none wished to take a leaflet away with them.

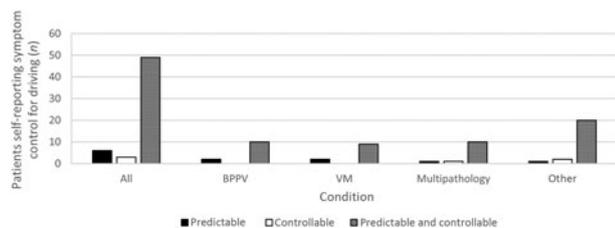


Figure 5. Condition-specific documented self-reporting of symptom control for driving. BPPV = benign paroxysmal positional vertigo; VM = vestibular migraine

Discussion

Regular use of prompts in medical records resulted in improved frequency of assessment for fitness to drive, in line with Driver and Vehicle Licensing Agency UK guidelines. Appropriate documentation was cited in 98 per cent of all consultations, with 100 per cent of out-patients having their fitness to drive assessed and recorded within consultations. Medication, dizziness and drowsiness were discussed with those patients prescribed medication, improving patient awareness and possibly the safety of all road users.^{7,8,21,26}

Most people with dizziness and imbalance described their symptoms as predictable (e.g. the symptoms only occurred when the individual performed certain movements, or they had a warning sign), controllable (not severe enough to be disabling), or both predictable and controllable, following shared decision-making discussions³² to explore these parameters. Patients with BPPV, vestibular migraine or multi-pathologies have similar symptom reports of dizziness or vertigo in terms of predictability and controllability.³³ Possible reasons for the results include the potential consequences if a person is advised to stop driving (e.g. in terms of work, social life, leisure activities, financial requirements), which may mean that patients do not accurately report their symptoms, especially considering that many have been shown to not follow the driving advice given by ENT medics.^{24,25} However, this is difficult to prove given the lack of objective condition-specific data relating to vestibular conditions and driving capacity for comparison.^{21–23} In this study, a shared decision-making conversation³² was based on symptom characteristics discussed earlier in the consultation, without the patient being aware that it may impact a conversation about driving capacity at the end of the consultation.

Relevant information in medical records for medico-legal or Driver and Vehicle Licensing Agency requests was present and complete in 98 per cent of records, potentially protecting the patient and clinician in the event of a driving capacity report request. No person in the cohort was advised to stop driving (all car drivers), potentially because a shared decision was made based on an open and frank discussion of symptom characteristics. No patients had a heavy goods vehicle or bus or coach licence, which possibly reflects the older average age of those studied. There was no recorded diagnosis of Ménière's disease, which has specific Driver and Vehicle Licensing Agency UK criteria.²⁸ Although there is no specific Driver and Vehicle Licensing Agency UK guidance for vestibular migraine, the condition may adhere to the same criteria for driving as the Driver and Vehicle Licensing Agency UK guidance for migraine,²⁸ and it is concerned with sudden (unpredictable) and disabling (uncontrollable) symptoms. In this study, all vestibular migraine patients reported dizziness and imbalance as either predictable (with a warning sign) or both predictable and controllable (not disabling, not severe

or still in control), allowing patients to avoid driving at the time of an attack or having time to pull over safely.

Lack of formal training (pre- and post-graduate) for all health professionals regarding regulations leaves clinicians with reduced confidence and poor knowledge,^{17,18,34} possibly contributing to a lack of shared decision-making as reported in other studies.²² However, medical record prompts and improved knowledge through the development of a regional leaflet and MDT discussions in this study showed that 98 per cent of patients were engaged in a driving and dizziness discussion, potentially improving the safety for all road users²⁶ and protecting the clinician in the event of medico-legal requests.

More condition-specific data are required to inform shared decision-making conversations associated with fitness to drive and vestibular disorders. Driving simulation may be a way of collecting such data within a safe environment.

- Driving capacity can be affected by vestibular disorders and the medications used to treat them
- Medical record prompts increase the frequency and recording of dizziness and driving capacity shared decision-making conversations to 98 per cent in ENT balance clinic consultations
- Improved frequency of driving capacity shared decision-making conversations potentially improves safety for all road users
- It also protects the patient and clinician in the event of medico-legal report requests

No patient wished to take an information leaflet with them, as trialled in a previous study,¹⁸ and since only marginal improvements were seen using leaflets, it could be suggested that medical record prompts with shared decision-making conversations are more effective. This potentially reflects existing knowledge, the benefits of effective shared decision-making conversations, or, conversely, a reduced awareness or care for the safety regulations, although no documentation was found to support this. Indeed, two patients described stopping driving prior to the consultation because of a road traffic accident and the fact that they did not feel safe to drive, demonstrating responsible actions by patients with dizziness.

Benefits

Medical record prompts improve the frequency and documentation of dizziness and driving capacity conversations. More patients are aware of issues related to driving whilst dizzy or drowsy, and therefore the risk of being involved in road traffic accidents decreases significantly.²⁶ Accurate documentation supports the writing of Driver and Vehicle Licensing Agency UK and medico-legal report requests. Person-centred advice on driving capacity with dizziness can be formulated through shared decision-making conversations.

Limitations

This is a single-centre retrospective audit of subjective symptom presentations; the results may not be an accurate representation of how vestibular disorder symptoms can objectively influence driving capacity. Variation of symptom severity, frequency and duration between patients makes it hard to generalise advice on dizziness and driving. Risk of bias is high because of the retrospective collection of data that is not blinded and is performed by one clinician; the study therefore needs repeating in a multicentre, multi-clinician, multi-investigator trial.

Conclusion

This study highlights the potential benefits of medical record prompts for documented and accurate shared decision-making conversations surrounding dizziness, vertigo, vestibular conditions and driving. This potentially improves safety for all road users, and protects the patient and clinician in the event of medico-legal report requests.

Competing interests. None declared

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