

## **INFORMATION ON DRIVING AND DIABETES: NOTE TO HEALTH CARE PROFESSIONALS**

### **1) Questionnaire completion**

When filling in the questionnaire, take care to elicit an exact history of each hypoglycemic episode. It is wise to document this carefully in the patient's records. Primary care teams should consider urgent referral to the secondary care specialist team for patients who have suffered a single severe hypoglycaemia attack requiring assistance, as a second episode within 12 months would result in loss of a Group 1 car driving licence.

### **2) If patients do not report hypoglycaemia**

Hypoglycaemia should be discussed with patients at every visit. Many patients do not inform their doctor about hypoglycaemia. However, reports of hypoglycaemia may be sent from the ambulance team or Accident and Emergency to the patient's registered GP. If a Health Care Professional is aware that a patient has required treatment to manage hypoglycaemia, it would be sensible to see the patient and inquire about the frequency and severity of hypoglycaemia. For Group 1 drivers with two episodes of hypoglycaemia requiring the assistance of another person within the previous 12 months, the doctor must inform the patient that they need to notify the DVA and advise the patient not to drive. A Group 2 driver with one such episode in the previous 12 months should be advised not to drive and to notify the DVA. A referral to specialist care would be appropriate.

### **3) Suspected unconfirmed nocturnal hypoglycaemia**

The suspicion of severe nocturnal hypoglycaemia in a patient sleeping on their own, but not witnessed or treated would not necessarily constitute an episode for reporting. However, if the clinician had concerns it may be appropriate to advise the patient to notify the DVA. Paradoxically, people sleeping on their own, with nocturnal hypoglycaemia, may be advantaged in terms of maintaining their driving licence, although clearly not in terms of overall well-being. Similarly, data while using continuous glucose monitoring devices, or other evidence of hypoglycaemia, may not constitute evidence to stop driving in the absence of symptoms unless the clinician has concerns, however, where hypoglycaemia with reduced awareness is suspected, a referral to specialist care would be appropriate.

### **4) Confirmed asymptomatic biochemical hypoglycaemia**

Some patients describe biochemical evidence of asymptomatic hypoglycaemia on capillary glucose testing or the patient's home glucose monitoring shows episodes of blood glucose below 3 mmol/l. This supports a diagnosis of hypoglycaemic unawareness. Such patients are likely to have cognitive dysfunction during hypoglycaemia, of which they are not subjectively aware and they are at increased risk of severe hypoglycaemia. Such episodes require a clinical response. Any degree of hypoglycaemia must be treated before driving and the patient should not drive until recovery is complete. Evidence of reduced awareness of hypoglycaemia will require treatment regimen review and referral to specialist care would be appropriate. If hypoglycaemia occurring below 3 mmol/l without any subjective awareness is characteristic of the patient's hypoglycaemia experience, the patient may be defined as completely unaware and should report this to the DVA and be advised not to drive.

### **5) Definition of hypoglycaemia unawareness**

There is no clear guidance on this.

- a) For Group 1 drivers, the new regulations allow for a license to be revoked or refused if the patient has impaired awareness and require this if there is a complete unawareness. As there is evidence for cognitive dysfunction around 3 mmol/l, people who are asymptomatic when under this glucose concentration are at risk for impaired performance without awareness. Given the inter-person variability for this and the margin for error in home glucose monitoring, a clinical assessment is needed.
- b) Group 2 drivers are required to have full awareness of hypoglycaemia and any degree of impaired awareness will result in the license being revoked or refused.

## **6) Hypoglycaemia during pregnancy**

Severe hypoglycaemia during pregnancy is counted in the same way as other hypoglycaemia, even though these episodes tend to be concentrated during the first half of pregnancy. Pregnant women should be counseled as previously about the need to monitor their blood glucose before driving.

## **7) Patient responsibilities**

When any doctor is aware that a patient is not fit to drive, they should advise the patient not to drive and to notify the DVA. If the patient does not notify the DVA, you are allowed under GMC guidelines to notify the DVA yourself, however it would be good practice to confirm this conversation in writing to the patient so that there is no doubt about the advice. This should be documented in the patient notes. It is up to the DVA to revoke/renew a license. The doctor may also want to inform the patient that this can affect their insurance.

## **8) Patients on sulphonylureas or glinides**

Drivers with a Group 1 license on insulin are advised to test their blood glucose before driving. For patients on sulphonylureas this would greatly increase the need for testing and associated costs. The greatest risk of hypoglycaemia is in the first 3 months of sulphonylurea treatment, so it seems sensible to maintain current practice and only encourage extra testing in those patients who are starting treatment, experiencing hypoglycaemia or with reduced awareness. A medication review should also take place to reduce the risk.

- a) For Group 1 drivers, the diabetes panel has advised that the frequency of blood glucose monitoring should depend on the clinical context.
- b) For Group 2 drivers, (bus/lorry), on a sulphonylurea or glinide it is required by law to monitor blood glucose at least twice daily and before driving and every 2 hours during the journey using a glucose meter with a memory function. .

## **9) What is a safe blood glucose concentration for driving?**

In a patient with good hypoglycaemia awareness, a normal blood glucose concentration is adequate, although ABCD recommends testing before and at no longer than 120 minute intervals during driving. The consensus is that the blood sugar should be above 5 before starting to drive. For frequent short journeys, repeat testing prior to each journey may not be necessary.

The national medical guidelines of fitness to drive are reviewed twice each year and are published and available to doctors and healthcare professionals in 'At A Glance Booklets' on the DVLA website at Gov.uk. For the most up to date advice: [www.gov.uk/government/publications/at-a-glance](http://www.gov.uk/government/publications/at-a-glance)