Insulin-treated diabetes and motorised transport: key factors for patient and clinician


Professor Shaw’s article in this issue of Practical Diabetes is a timely review of the occupational and regulatory matters in respect of diabetes and the use of motorised transport, especially since the DVLA approval with the European Commission harmonisation of driving standards. There is little published guidance in this important area and I am sure many clinicians will use this article as reference in their clinics.

This is an area fraught with medico-legal risk for both the clinician and patient. Adding a hypoglycaemic agent to a patient’s treatment may appear to be an easy decision for a clinician but, as Professor Shaw discusses, medication with a hypoglycaemic risk could have major implications on an individual’s employment, independence or liberty. Many may consider the newer therapies as easier options that are less-risk alternatives to sulphonylureas, glinides and insulin.

Centres should have policies to ensure that patients who are drivers have been supplied with and trained on the use of blood glucose meters before commencing sulphonylureas/glinides. On application or renewing Group 2 licences, a driver may name their GP as the regular reviewer of their diabetes. As part of a three-stage process, the DVLA will request that the GP reports on their diabetes management and complications. This will also involve examining a driver’s last three months of blood glucose readings from the memory of the patient’s meters. If a GP is unfamiliar with the many different types of meters available, they may feel more comfortable if a joint consultation is arranged with their practice nurse.

After road traffic incidents, such meters could be forensically analysed and, in the absence of testing at times appropriate to driving or driving despite inappropriate glucose levels, the driver may be potentially exposed to prosecution.

The article highlights that over-assiduous local medicines management policies have attempted to restrict test strip prescriptions as cost reduction exercises. Diabetes UK has been running advocacy campaigns to address this issue, but it is obvious that such policies should not apply to drivers.

The article reminds us that occupation and whether this involves use of motorised transport should become standard questioning as part of the diabetes annual review in both primary and secondary care. Similar precautionary principles can also be applied to extreme sports (scuba-diving, climbing), elite athletes and those individuals who work at heights (construction industry).

Clinicians should also be aware of the groups who are susceptible to hypoglycaemia unawareness which include: those prone to frequent episodes of hypoglycaemia; long duration of diabetes; intensive insulin therapy when the patient aims for unrealistic tight glycaemic control or in pregnancy were exacting control is necessary; spinal cord injury; and autonomic neuropathy. Although poor visual acuity will be identified by opticians and ophthalmologists, Professor Shaw advises that GPs and diabetologists need to take into consideration the impact of severe neuropathy and whether it has become a danger in a patient’s ability to use pedal and hand controls safely.

Clinical records need to thoroughly document this information, advice given and the details of patient information leaflets issued, such as those produced by TREND-UK. Clinicians need to be observant of the DVLA at a glance guide to the current medical standards of fitness to drive.

Professor Shaw is optimistic that there is less occupational discrimination but opportunities should be offered in young adult diabetes clinics to discuss driving in general as well as careers advice. Having the salient information enables them not to be unrealistic in their occupational choices and avoids disappointment.

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