Drinking and driving

Background and epidemiology: Driving a motor vehicle while under the influence of alcohol continues to be an important public health problem. In 2000 in Canada 3162 people were killed in motor vehicle collisions.[1] Alcohol was a contributing factor in 33.8% of these deaths. Of the additional 18 402 drivers who were seriously injured 18.3% had been drinking.

Younger people are at greater risk of death and injuries resulting from alcohol-related crashes than are older people. Of the fatally injured drivers aged 26–35 years in 2000, 28.0% had a blood alcohol concentration (BAC) above the legal limit of 0.08%. With age, this proportion dropped to 5.9%.[1] Although rates of involvement in alcohol-related crashes among new drivers (16 and 17 years old) are similar to those among drivers over 25, the younger drivers are 3 times as likely, per kilometer driven, to die.[2,3]

Clinical implications: Physicians can play a significant role in reducing the rates of injury and death from impaired driving. For patients with a history of driving suspensions or vehicular crashes, physicians should consider the possibility of alcohol abuse and impaired driving. Alcohol dependence is common among people convicted of impaired driving.[4] The CAGE and AUDIT questionnaires[5,6] are easy to administer and are reasonably sensitive tools for detecting alcohol dependence, although less so for abuse.[7] Patients of driving age, particularly those between 20 and 40 years, should be screened for symptoms of alcohol and drug abuse.

Although there are few data to reinforce the danger of driving under the influence of other drugs, patients should be informed that any illicit drug, alone or in combination with alcohol, can have adverse effects on motor skills.[8,9] Furthermore, alcohol increases the sedative effects of many common therapeutic agents, including benzodiazepines, narcotics and some tricyclic antidepressants.[10]

Patients found to have alcohol dependence or who are experiencing alcohol withdrawal should not be allowed to drive any motor vehicle. The CMA's guide for determining medical fitness to drive[11] recommends that such patients, as well as those who have experienced seizures related to alcohol withdrawal, must be substance and seizure free for 12 months before driving can be recommended.

When faced with an intoxicated patient in an emergency department or clinic who is at risk of driving, the physician is advised to recommend against it and attempt to arrange alternative means of transportation. If the patient is unwilling to cooperate, law enforcement officers should be involved immediately.

Failure of a physician to report a patient who is unfit to drive is an offence. Recent legal cases have found physicians liable for this reason.[12,13] The decisions of the court emphasized that the responsibility of the physician to the public transcends the individual therapeutic relationship.

Prevention: An important shift in social mores has occurred over the past 40 years with regard to drinking and driving. This change — from "One for the road" to "Who is the designated driver?" — has been due in large part to community groups such as Mothers Against Drunk Drivers (MADD). The concerted efforts of MADD and similar programs have also encouraged policy changes, including minimum legal drinking age laws, a policy of zero tolerance BAC for new drivers, graduated licensing programs for new drivers and stronger law enforcement.[14]

Questions remain regarding the effectiveness of lowering the BAC from the current 0.08% to 0.05%. Canada, with a legal limit of 0.08%, has almost 3 times the rate of deaths involving legally impaired drivers as does Germany, which has a limit of 0.05%. Although geographic and cultural factors may explain some of the difference, support is growing for lowering Canada's level to 0.05%.

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