

unthinking demand to be told everything breeds mistrust.

The press protects its sources so why should not the employer protect the victim of chance? To do otherwise also encourages cover-up. Misinformation does not only arise from malice on the part of the originator but also from premature enforced disclosure of what are literally half-truths. Any consequent lack of clarity sows seeds for misinterpretation by the recipient.

Too much information can overwhelm. Knowledge is often best gained from an appropriately controlled flow through a good teacher. Paternalism implies advising whilst withholding some information for the benefit of the recipient. I can imagine situations where I would welcome this. Paternalism may not be for Dr Kemm, but he cannot deny that trust is essential for a successful paternalistic relationship. It is perhaps because the modern cult of the individual encourages neither trust nor humility that paternalism now has such a bad name.'

His reply led to an animated conversation about paternalism. Perhaps the editor will agree to publish it one day.

Coemgenus

Driving restrictions after stroke: doctors' awareness of DVLA guidelines and advice given to patients

Editor – The recent letter by Goodyear and Roseveare (*Clin Med* January/February 2003, pp86–7) highlights the poor standard of advice given about fitness to drive by many clinicians. (Incidentally, the stroke and TIA standards quoted are for car drivers: they are more stringent for the drivers of large vehicles.) A parallel study of psychiatric patients, showing similar results, was published recently.¹ The widespread failure to provide appropriate advice about driving and other safety critical tasks reflects the low priority this issue is currently given within the clinical consultation. In turn, this prevents both patients and society from achieving a sound balance between personal mobility and public safety. Those working in transport and occupational medicine are very

familiar with this common shortcoming.

There are several initiatives underway to address this.

- A considerable programme of research to improve the evidence base on certain common safety critical conditions such as diabetes, cognitive impairment and visual defects is in progress. This will provide a clearer rationale for advice to patients and may even enable some of those now restricted to be considered fit to drive.
- Funding has been allocated to produce better guidance for health professionals. This will cover acute conditions, recovery from surgery and the use of medication, as well as medical licensing standards. A series of complementary patient information leaflets, downloadable from the Internet, is also envisaged.
- Studies of the attitudes of health professionals to advice on driving safety are proposed to identify the barriers to its provision and how they can best be overcome.

There is already close cooperation with clinical specialists on driving standards through the Secretary of State's six Honorary Medical Advisory Panels on Fitness to Drive. The provision of a clearer understanding of safety critical fitness throughout clinical training, coupled with improved information and raised awareness should, it is to be hoped, make sound advice on preventing accident risk to self and others an integral, and even perhaps an auditable, part of good medical practice.

Reference

- 1 Wise I, Watson J. Postal survey of psychiatrists' attitudes to driving and mental illness. *Psychiat Bull* 2001;25: 345–9.

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Editor – The audit by Goodyear and Roseveare (*Clin Med* January/February 2003, pp86–7) was very interesting. However, the authors failed to differentiate between Group 1 (Ordinary) and Group 2

(Vocational) driving requirements. They have only mentioned about the requirements for Group 1/Ordinary driving licence holders. People with Group 2 entitlement cannot drive for 12 months following a stroke/TIA. They can be considered for licensing after this period if there is a full recovery, provided there is a satisfactory medical report including an exercise ECG testing. This is to identify any significant underlying coronary artery disease in a patient who has already had a stroke/TIA.

We are currently doing the same audit because we too felt that this information is very scanty in the case notes. We have incorporated in our 'stroke care pathway checklist' the driving status and the advice given, in order to remind doctors to establish the driving status and give appropriate advice.

Reference

- 1 Drivers Medical Unit, DVLA. *For medical practitioners: at a glance guide to the current medical standards of fitness to drive*. Swansea: DVLA, July 2002.

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Consent with understanding: a movement towards informed decisions

Editor – In the recent paper by Mayberry and Mayberry (*Clin Med* November/December 2002, pp 523–6), the authors rightly affirm that the basis of informed consent is 'the need to understand the information ... and an ability to retain that information for a period'.

A gynaecologist colleague recently informed me that, in view of the recent drive for full information for informed consent, the routine practice in his department is to list on the consent form every possible complication. Even for the most minor procedures, such phrases as 'rarely, perforation of the uterus, colon or bladder' and 'very rarely, death' are used. The onus of imparting this information usually falls on the hapless SHO, who is often very