EDITORIAL

Is a Patient Too Sleepy to Drive?

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It is an all too common problem in sleep disorders centers everywhere. A patient is being evaluated for excessive daytime sleepiness. Usually the potential cause is sleep disordered breathing, but other conditions such as narcolepsy or insufficient sleep could be culprits as well. Before treatment, the patient has had their driving restricted. However, now the patient is treated. Is it safe for this individual to operate a motor vehicle or work in a hazardous environment? How do we make this determination? This is an important scientific, public health and public policy question. Accidents caused by sleepy drivers are an important cause of fatalities on the highway, and there have been high profile cases highlighting this problem. This is considered especially important in the transportation industry where an accident may potentially impact large numbers of persons.

In this issue of the Journal are three papers which bear on this topic. As part of their review of motor vehicle accident crash risk and sleep apnea, Ellen et al determined whether daytime sleepiness affected this risk.1 Interestingly, they did not find a consistent relationship between accident rates and subjective sleepiness. This is not necessarily a surprising finding given that there is significant personal and financial incentive for an affected individual to be less than forthcoming about their sleepiness. However, it would indicate that simply asking a person about sleepiness will not be sufficient to assess risk for an accident. If subjective data is inadequate, what about objective testing? The Federal Aviation Administration has adopted this position by their requirement for pilots with sleep apnea to “pass” a maintenance of wakefulness test after having been treated.2 Whether the MWT or its better known cousin the MSLT should be used for this purpose is the subject of this issue’s Pro/Con debate by Arand and Bonnet.3,4 Both raise cogent arguments in defense of their side of the issue. On one side Arand argues that the MWT and MSLT are validated “gold standards” that have been shown in several studies to reflect changes after treatment, but interpretation must occur within a clinical context. On the other side, Bonnet points out that there is no clear dichotomy between values observed in normal persons and those with diseases associated with hypersomnolence, with such evidence being particular lacking for the MWT. However, publication of this debate only highlights the need for more data and better means to assess sleepiness, especially as it pertains to motor vehicle safety. In addition, it emphasizes the danger for misinterpretation and misapplication if these tests are used out of a clinical context.

What do we do until a new or better “widget” is found? Unfortunately, we are left with the current tools at hand. Therefore, tests such as the MWT or MSLT need to be interpreted in the context of an individual patient’s clinical circumstance realizing that there are potential limitations. In addition, as suggested by Parthasarathy et al5 and Arand,6 we, as sleep specialists are in the best position to make such determinations.

REFERENCES