Frequently, patients will ask whether or when they can drive after they’ve been treated for a fracture, received an injection, or had a procedure on the right lower extremity, and sometimes on the upper extremities. Because I am a great believer in common sense, and because the science on this topic isn’t strong, I tend to avoid making a specific recommendation.

I do usually note whether the problem is the right or left lower leg or whether the upper limb is in a sling or a long-arm cast, but I am not very casual about my answer. “Oh, well, if you want to drive, Mrs. Jones, just tell me what street you are going on so I can take another, less traveled route.” That usually makes the patient think twice and I always get a laugh.

Recently, this problem of driving while impaired from immobilization or weakness secondary to orthopaedic treatment was brought home to me rather dramatically. I woke up one morning with an inflamed, possibly infected, right foot and ankle and was being treated as an outpatient with intravenous vancomycin.

I was put in a “walking boot,” and there was no way I could drive safely, so I switched to a postoperative cast shoe. I couldn’t master driving with that because the wide toe box kept hitting the brake and accelerator at the same time—bad for the car. I am sure others have mastered that feat, but I can’t chew gum and drive at the same time either. As a last resort, I switched to wearing “Crocs.” Although I developed little pockets of edema sticking out of the holes in the Crocs, that was acceptable—I could drive!

The experience made me realize how much independent mobility is lost by not being able to drive. I did not even consider this. No way was I going to ask for a driver! Like most orthopaedists, no matter how many times I failed, I kept trying. You understand, “If plan A fails, immediately go to plan B.”

From me to my patients
I also began to think about the liability, not only from my driving with an impaired lower limb, but from my telling my patients that they could drive. If something catastrophic occurs with them behind the wheel, I can be held liable. The rationale for holding me liable for something that my patient does is similar to the third-party liability that applies to a bartender or healthcare provider who provides alcohol or drugs and ultimately is held responsible for the consumer’s actions.

Furthermore, new guidelines are being reported in the orthopaedic literature using simulation devices. These devices measure and test brake reaction times (BRT), defined as the time necessary to stop the vehicle, to determine when an orthopaedic patient with an extremity or back problem can manage to safely drive an automobile. The “step test,” which involves having a seated patient lift the right foot and place it on a box 6 inches high in time with a metronome, appears to correlate with BRT.

More than 20 articles on this topic have been published during the past 2 years, and AAOS Now has had four reports on this subject. Myself, I can’t remember all the recommendations for each upper and lower extremity bone and joint and procedures, much less all the articles. So I set out to review the literature and make a list of the recommendations on when an orthopaedic patient could drive following a problem, fracture, injection, or procedure for the upper and lower extremities.

Fortunately for me, the article “Driving after Orthopaedic Surgery” by Geoffrey S. Marecek, MD, and Michael F. Schafer, MD, appeared in the November 2013 Journal of the AAOS. They had reviewed the literature and made recommendations regarding the number of weeks before a patient could return to driving. (See the interview with Dr. Marecek on page 6). Thus, thanks to them, my list was easier to complete; and thanks to this editorial, I can give them the credit for it.

Besides the need for us as orthopaedists to do the “right thing” for our patients and to avoid any liability for the consequences of their driving too soon after surgery, this issue has another side. In the world of dysfunctional medicine, The Road Less Traveled: A New Psychology of Love, Traditional Values, and Spiritual Growth is an oft-quoted text by M. Scott Peck, MD. The opening sentence in the book reads, “Life is difficult.” Life becomes even more difficult when patients, especially elderly patients, lose their independence and are not able to drive. This can be a life-changing event for someone who suddenly has to depend on others.

As an orthopaedist, it is important for me to realize this and to inquire if the patient has a “backup” or support person who can drive. Back in 2008, an article in The Journal of Bone and Joint Surgery, “Driving After Musculoskeletal Injury: Addressing Patient and Surgeon Concerns in an Urban Orthopaedic Practice” included a graph (Fig. 1) that dramatically shows the sources of support and assistance for the dependent patient.

Finally, do patients actually follow a doctor’s instructions about driving? Back in 2008, more than a quarter of patients admitted that their doctors opposed their return to driving, and one in five admitted to feeling unsafe even though they kept on driving. The fact that so few patients are compliant may be due to necessity because “Life [without driving] is difficult.”

So what am I going to do with all this information? I plan to take the following steps, and I hope you will do the same:

• Post a list of “when it is OK to drive” times in the office and refer to it.
• Administer the step test in the office if I have a question about a patient’s ability to drive.
• Ask the patient about the hardship that not driving imposes on him or her.
• Before making a decision about driving, determine if the patient has someone on whom he or she can depend for temporary transportation needs.
• Realize that more than half of my patients are not going to be compliant, so I need to document my driving recommendations in the medical record.
• Be empathetic with my dependent patients and realize that life is difficult and that I still may have to go down another “road less traveled”!