Physician Reporting of Impaired Drivers: A New Trend in State Law?

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The State of Oregon recently enacted legislation that increases physician responsibility for reporting medically at-risk drivers. The legislation comes at a time when the public is closely scrutinizing the question of the elderly and driving and the role of physicians in the reporting of potentially dangerous drivers. The evolution of Oregon's law is somewhat unique and offers an opportunity to examine what perhaps is to come in other states. The law broadened the role of the physician in assessment and reporting of impaired drivers. It also opened the door for new tort, that of "negligent failure to report," before input from physicians and other health care providers led to important revisions in the final statute. Physicians must look to current statutes to guide the legislative process in their own states, so that new law aimed at maintaining safe highways also preserves the physician-patient relationship and allows for a collaborative assessment of driving skill in the physician's office.

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"Elders Behind the Wheel,"[1] a July 27, 2003, editorial in *The New York Times*, places the spotlight on the complexities involved in the question of the elderly and driving. The July 16 event in which an 86-year-old man inexplicably lost control of his vehicle and plowed through a Santa Monica, California, farmers' market, killing 10 people and injuring many more,[2] puts the most dramatic light on a problem that has been smoldering as most states experience deadly collisions involving the elderly. Such situations lead to law suits, court decisions, and statutory changes that inexorably draw the medical profession farther into the decision-making process about a patient's license to operate a motor vehicle.

As the *Times* editorial states, "Doctors, too, need to play a role."[1] Doctors, of course, have for many years played a role in the assessment of specific impairments that relate to driving, but the question now is what type of role will be required of physicians as the population ages and more of these tragic events occur. This analysis begins with a description of a lawsuit recently filed in an Oregon court. We will then look at the evolution of the Oregon law as it relates to physicians' reporting of potentially dangerous drivers. Our examination of the Oregon law will review the controversies and implications of the law as it evolved. In addition, we will discuss the national context in which Oregon's law emerged and reveal how examination of neighboring state statutes influenced the most recent revisions to Oregon's physician reporting law. Finally, we will discuss the potential difficulties that may emerge as state legislators consider new statutes to protect the public against medically at-risk drivers.

While the headlines speak about terrible tragedies such as the Santa Monica case, it is the individual drivers, physicians, and lawmakers who will have to sort through this evolving legal tangle. We believe that an understanding of this evolution will be of value to physicians, including psychiatrists, in other jurisdictions, because what has occurred in Oregon has already occurred in several other jurisdictions and will soon be debated in most jurisdictions in the country.

Oregon Law

On August 4, 2001, an 80-year-old male driver made a U-turn on an interstate highway in Oregon and collided head-on with an oncoming car, killing a young woman and her son and severely injuring her

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daughter. The elderly man subsequently pled guilty to two counts of criminally negligent homicide and one count of felony assault and was sentenced to 5 years' probation. His driver's license was suspended. His insurance company settled with the young woman's family, but the matter was not yet put to rest. The family then filed suit against the driver's primary care physician and his clinic for $6.1 million, claiming that they were negligent for failing to take steps to keep their patient off the road. The suit is ongoing. The family's lawyer contends that the physician and clinic failed to monitor the various prescription medications and medical conditions that could impair their patient's ability to drive, and further failed to report the man to the Oregon Department of Motor Vehicles (DMV) as a potentially dangerous driver.[3]

In 2001, the Oregon Legislature passed a bill that required mandatory reporting of potentially impaired drivers by their physicians. The case we have described was filed just at the time when Oregon's DMV began writing an administrative rule for the new law. Until this statutory change, Oregon maintained a narrow role for physicians in reporting of potentially dangerous drivers. Only those health care providers qualified to treat disorders of the nervous system were required to report those patients with conditions "characterized by momentary or prolonged lapses of consciousness or control."[4] The 2001 Oregon Legislature broadened both the list of health care providers required to report potentially impaired drivers and the range of impairments that are reportable. As part of a national trend, legislators were looking to expand the role physicians play in determining eligibility for driving privileges.

Prior to 2001, Oregon statutes included a limited role for physicians in ensuring highway safety. The statute stated:

> All persons authorized by the State of Oregon to diagnose and treat disorders of the nervous system shall report immediately to the Department of Transportation every person over 14 years of age diagnosed as having a disorder characterized by momentary or prolonged lapses of consciousness or control that is, or may become, chronic [Ref. 4].

Oregon's 1999 Legislature approved a resolution directing the DMV to convene a committee, the Older Driver Advisory Committee, to study the effects of aging on driving ability.[5] The committee reviewed research on the assessment of the older driver and also reviewed feedback from meetings with the general public in developing a final report with suggestions for legislative changes. Among the committee's 26 recommendations was the suggestion that the existing statute be revised to expand both the list of medical conditions reportable to the DMV and the list of health care providers required to report.[6] Based on this report, the DMV proposed legislation that was enacted by the 2001 Legislature.[7] The committee began with a focus on older drivers, but ended up making recommendations covering all drivers.

The Department of Transportation, "in consultation with medical experts and experts on cognitive or functional impairments," was directed to define which physicians and health care providers would be required to report those "cognitive and functional impairments. . .[that] are likely to affect a person's ability to safely operate a motor vehicle."[7] The DMV brought together physicians, occupational therapists, physical therapists, psychologists, and rehabilitation specialists for a series of meetings to identify those cognitive and functional abilities needed for safe driving and to discuss how impairment of these abilities might be identified and reported. The committee was also concerned about both liability and confidentiality. Although the law provided immunity from civil liability for physicians and health care providers who report to DMV in "good faith," the statute did not provide protection for those providers who chose not to make a report.[7] This was viewed as a potential avenue for new tort, that of negligent failure to report. Committee members also raised concerns that the law required physicians to perform assessments beyond their scope of practice, thus encouraging defensive reporting to guard against suits for inadequate assessment. Despite these concerns, the law was scheduled to go into effect January 1, 2003. Because of questions raised in the committee, the DMV decided to implement the law in one area of the state beginning in March 2003 so that they could gain experience with the implementation of the law and with the volume of reports filed by Oregon health care providers. At this time, the Oregon Medical Association began a dialogue with the DMV to address the potential tort created by the law. Study of regional reporting laws was undertaken and draft legislation proposed.

Among the Western states, the 2001 Oregon driving statute was found to be unique. Only Montana's statutes approaches the breadth of conditions to be reported by Oregon physicians. However, Montana's law remains a voluntary-reporting law. Montana code reads:

> Any physician who diagnoses a physical or mental condition that, in the physician's judgment, will significantly impair a person's ability to safely operate a motor vehicle may voluntarily report the person's name and other information relevant to his condition to the department of justice [Ref. 8].

The Montana code also provides liability protection beyond that which was to be provided under the Oregon statute:

> . . .Any physician reporting in good faith is immune from any liability, civil or criminal, that otherwise might result by reason of his actions pursuant to 37-2-311. . . . No action may be brought against a physician for not making a report. . . [Ref. 9].

The remaining Western states either lack mandatory reporting laws (Alaska, Colorado, Hawaii, Idaho, Utah, Washington, and Wyoming) or have narrowly defined mandatory reporting comparable with Oregon's old law. California requires the reporting of drivers with conditions characterized by lapses of consciousness,[10] and Nevada requires the reporting of drivers with severe visual impairment.[11]

The Western states also vary in their liability protection for physicians who voluntarily report conditions that might impair driving. Only Montana specifically provides protection for physicians making a voluntary report that would violate physician-patient confidentiality.[9] Colorado, Utah, and Wyoming also provide limited civil liability protection for health care providers who make a report (Ref. 12, pp 85, 137–8, 146). The Colorado statute speaks specifically to those circumstances in which medical advice is solicited to determine whether a person is physically or mentally able to operate a motor vehicle safely.

> No civil or criminal action shall be brought against any physician or optometrist licensed to practice in this state for providing a written medical or optometric opinion. . .if such physician or optometrist acts in good faith and without malice [Ref. 13].

Utah's statute is similar, protecting from damages "a health care professional or other person who becomes aware of physical, mental or emotional impairment. . .and reports this information to the division in good faith. . ." (Ref. 14).

In 2003, the 72nd Oregon Legislative Assembly proposed revision to the Oregon physician reporting statute to address concerns of the Oregon Medical Association legal counsel who noted that the law created new tort possibilities. House bill 2986 added text stating: "If a designated physician or health care provider does not make a report, that person shall be immune from civil liability that might otherwise result from not making the report".[15]

This addition sought to eliminate the possibility that physicians would be charged with negligent failure to report. The revision included a statement that attempted to ensure that the physician's report would be used solely for the purposes of determining whether the patient should continue driving:

> A report filed by a physician or health care provider under ORS 807.710 is confidential and may not be admitted as evidence in any civil or criminal action. A report described in this subsection may be used in an administrative hearing or an appeal from an administrative hearing in which an issue is the qualification of a person to operate a motor vehicle [Ref. 15].

These proposed revisions were approved by the legislature and resulted in a current statute that is being phased in across Oregon's counties this year.

The National Context

Nationally, physicians have been wrestling with these matters for some time. In 1993 the American Psychiatric Association (APA) issued a position paper on the role of psychiatrists in assessing driving ability that asserted that although psychiatric patients may experience symptoms that can interfere with the ability to operate a motor vehicle safely, psychiatrists have no special expertise in assessing a patient's specific ability to drive. The APA concluded that psychiatrists should not be expected to make such assessments in the course of clinical practice. Although the APA encouraged psychiatrists to advise patients about the potential impact on their driving of their illnesses and treatments, the statement clearly emphasized the importance of confidentiality in the psychiatrist-patient relationship and asserted that the psychiatrist should not be required to report patient information to state departments of motor vehicles. The APA advocated permissive reporting laws and immunity from liability for those psychiatrists who submit reports in those cases in which "clear-cut evidence exists of significant driving impairment" that might make a report "socially desirable."[16]

In 1996, the American Medical Association's House of Delegates referred a resolution to their Board of Trustees that questioned the ethics implications of requiring emergency department physicians to report impaired drivers.[17] In 1999, the AMA's Ethical and Judicial Affairs Council issued several recommendations for physicians regarding the recognition and reporting of driving impairments. As in the APA statement, the AMA report emphasized that the determination of the inability to drive safely is the responsibility of the state depart-

ments of motor vehicles. The AMA report, however, went beyond the APA recommendations by encouraging physicians not only to discuss driving with patients, but also to assess those physical and mental impairments that might adversely affect driving and to consider potential interventions that might address these impairments. In addition, they encouraged reporting of those situations in which "clear evidence of substantial driving impairment implies a strong threat to patient and public safety."[17] At the same time, the AMA also stressed the importance of confidentiality in the physician-patient relationship.

The AMA, in partnership with the National Highway Traffic Safety Administration, has since created a physician handbook for an office-based approach to the question of medical fitness to drive. The handbook has been constructed as a guide for physicians on how to address these increasing responsibilities for driver assessment, by providing information on in-office assessment tools, driver rehabilitation resources, community programs for at-risk drivers and individual state reporting requirements (Ref. 12, pp 1–226).

Discussion

It is not surprising that concerns regarding the safety of medically at-risk drivers are being closely examined. The number of persons 65 years of age and older is projected to double over the next 30 years, growing to 70 million nationwide by 2030.[18] And physicians are in a unique position to recognize those impairments that may affect a person's ability to drive safely.[19,20] Physician attention to driving safety should be increased as the population ages, and physicians must know much more about what can be done to evaluate patients' driving skills. More importantly, however, physicians should be involved in the legislative process as these laws are created so that questions of physician liability, physician-patient privilege, and confidentiality are all addressed.

Without input from physician participants, Oregon's law might have left the door open for new tort and might have pushed physicians into defensive reporting of questionably impaired drivers while physician skill at in-office assessment remained in its infancy. Although the current law has yet to be put to the test, it is to be hoped that its current resemblance to Montana's statute will allow physicians to weigh public safety carefully against confidentiality and allow for thoughtful assessment of patients' capabilities with emerging in-office assessment tools or referral to driving specialists. Decisions regarding who is considered a capable driver again rest with the DMV. In addition, reports are appropriately designated only for the purposes of helping the DMV in their determination and cannot be utilized to prosecute either the physician or patient.

It is essential for physicians and patients to be aware that in the wake of sensational accidents and loss of innocent lives, legislation will swiftly follow. Laws should enhance the physician-patient relationship by avoiding adversarial mandatory reporting statutes through encouragement of voluntary reporting with liability protections for reports made and for decisions not to report. Only in such an environment will physicians be able to broaden their assessment skills while building an alliance with aging drivers.

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