Medical Risk Management Advisor

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Assessing Impaired Drivers

Primary Care Physicians & Specialists Have a Role

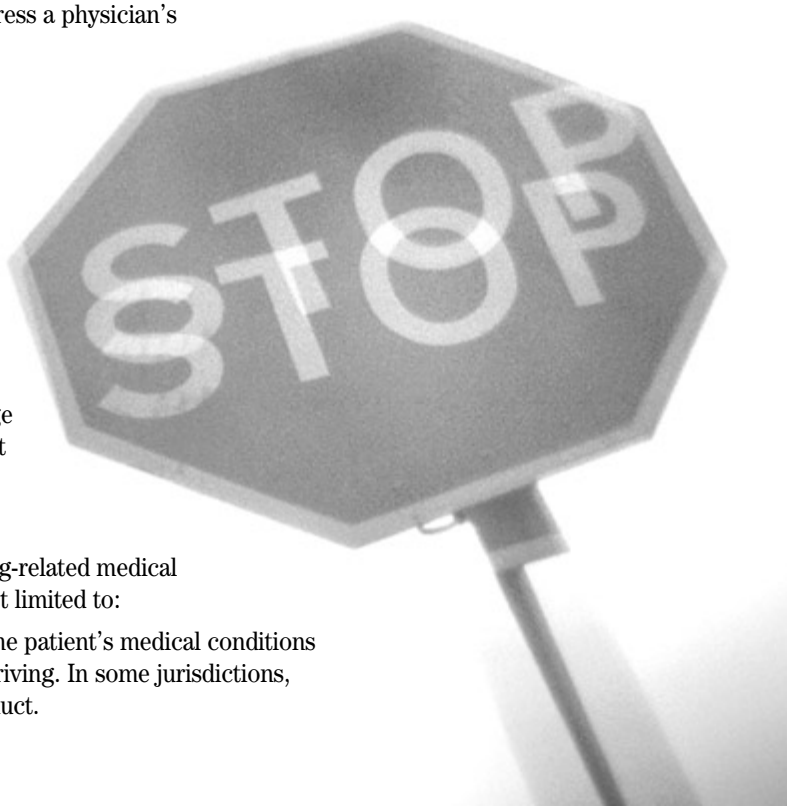
IN THIS ISSUE

A 68-year-old man with hypertension and congestive heart failure complains of occasional lightheadedness. You detect an irregular heartbeat and perform a history, physical exam, and order lab tests to determine the cause of the atrial fibrillation. When asked to schedule a follow-up appointment for the next week, he says he is not available because he will be driving out of town to visit his family. What do you do?

Despite decades of research, there is no accurate screening test to identify the drivers who will have an accident because of an underlying medical condition. Many approaches have been tried, but the false positive rate has been too high for the tests to have been useful.

However, the American Medical Association (AMA) recognizes motor vehicle-related trauma as a major public health problem and has developed ethics and health policies that address a physician's responsibilities related to impaired drivers and auto injuries:

- Impaired Drivers and Their Physicians (E-2.24)
- Licensing People to Drive (H-15.972)
- Automobile-Related Injuries (H-15.990)
- Medical Advisory Boards in Driver Licensing (H-15.995)



While primary care physicians may be in the best position to assess the medical fitness of a person's ability to drive, specialists may also have a responsibility to discuss driving with their patients. Ophthalmologists, neurologists, psychiatrists, physiatrists, orthopedic surgeons, emergency room physicians, rheumatologists, and other specialists manage conditions, prescribe medications and perform procedures that may have a significant impact on driving skills.

Legal and Ethical Duties

A physician's legal and ethical responsibilities regarding driving-related medical screening, counseling, and assessment may include, but are not limited to:

- *Protecting the Patient:* Experts suggest that you discuss the patient's medical conditions and any side effects of medications that may impair their driving. In some jurisdictions, failure to advise patients may be considered negligent conduct.

(continued on page 2)

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- *Protecting Public Safety:* Physicians have also been found liable for third-party injuries resulting from auto accidents caused by their patients due to a physician's failure to warn about the effects of medical conditions or medications.
- *Confidentiality and Exceptions for State Reporting Laws:* Physicians should be aware of confidentiality laws, and any exceptions for mandatory reporting of impaired drivers to state agencies, such as departments of motor vehicles. States with mandatory reporting laws may provide immunity to the reporting physician. Some states require reporting for specified medical conditions such as epilepsy and dementia. If discretionary reporting laws exist, a physician may wish to obtain their patient's consent before disclosing medical information to authorities.

Barriers to Conducting Driving Assessments

Focus groups conducted with family practice physicians identified the following barriers to assessing their patients' driving capabilities:

- liability concerns;
- the unclear role of physicians;
- the emotional effect on patients losing their independence;
- dealing with angry patients; and
- the inadequate predictive value of tests.

The physicians uniformly agreed that an assessment protocol, which includes tests correlating with driving performance, would be valuable for use in the office setting.

To address a need for better-defined guidelines, the AMA—with support from the National Highway Traffic Safety Administration—developed a guide which contains valuable information, including a decision tree to aid in office-based screening, and a sample battery of tests useful in assessing key functions used in driving.

Screening to Identify Patients at Risk

Screening might include observing a patient for poor hygiene and grooming; difficulty in walking or getting into and out of chairs; difficulty in visual tasks; and difficulty with attention, memory, and comprehension. Physicians should be alert to medical conditions or medications which may impair driving, or symptoms that may indicate impaired abilities. A physician may also consider performing a driving history to inquire about a patient's driving habits, such as the frequency, length and reason for trips; location of trips; types of roads used; whether the patient uses another individual in the car as a navigator; frequency of getting lost; and the number of recent crashes, tickets, or near misses.

Medical Conditions That May Impair Driving

- **Vision: cataracts, diabetic retinopathy, glaucoma, macular degeneration**
- **Cardiovascular: arrhythmias, congestive heart failure, valvular disease**
- **Cerebrovascular: stroke, subarachnoid hemorrhage, syncope**
- **Neurologic: multiple sclerosis, Parkinsons's disease**
- **Psychiatric: depression, anxiety disorders, psychotic illness**
- **Metabolic: hypothyroidism, hyperthyroidism, Type I-II diabetes mellitus**
- **Musculoskeletal: arthritis, foot abnormalities, spinal limitations**
- **Peripheral Vascular: deep vein thrombosis, aneurysm**
- **Respiratory: asthma, chronic obstructive pulmonary disease, sleep apnea**
- **Anesthesia and Surgery: use of general, local, or epidural anesthesia**
- **Renal: chronic renal failure, renal transplant**

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(continued on page 3)

Document concerns in the medical record regarding the patient's driving.

Functional Assessment of Driving-Related Abilities

Based on a patient's screening, a formal battery of tests can aid in assessing key functions related to driving. To assess *vision*, a physician may consider using the Snellen Chart to test for visual acuity and confrontational testing to test visual fields. For *cognitive skills*, the Trail-Making Test and the clock drawing test, using Freund Clock Scoring, may be considered. *Motor skills* such as strength and balance can be assessed using a rapid pace walking test; range of motion can be tested by performing a series of neck, hand, and foot exercises; and motor strength can be assessed by manually flexing/extending a patient's limbs, and asking them to resist the movements.

Classes of Medications with Potential to Affect Driving Performance

- Anticholinergics
- Antiparkinsonians
- Anticonvulsants
- Antipsychotics
- Antidepressants
- Benzodiazepenes and other sedatives/anxiolytics
- Antiemetics
- Muscle relaxants
- Antihistamines
- Narcotic analgesics
- Antihypertensives
- Stimulants

When a Patient Refuses Assessment

Driving is not just a privilege, it is often a necessity. If a patient refuses to undergo a functional assessment to test driving abilities, the following "tips" may be helpful:

- *Encourage* the patient to complete a self-assessment.
- *Counsel* the patient on safe driving.
- *Document* concerns in the medical record regarding the patient's driving and your counseling of the patient regarding safe driving. Include supporting documentation from the patient's presentation, screening, medical history and medications. Document a patient's refusal to participate in an office-based assessment or to follow other recommendations.
- *Follow-up* at the next appointment regarding the status of driving habits.
- *Involve family members or caregivers* when appropriate.

Despite a physician's best efforts, a patient may continue to experience functional deficits. A physician may consider referring a patient to a driver rehabilitation specialist who can perform a more in-depth functional assessment and evaluate actual driving performance. The driving specialist may recommend that a patient continue driving with/without further restrictions or interventions, recommend adaptive techniques and devices, or that the patient retire from driving. In addition, a physician may communicate the availability of classroom refresher courses, such as the "Driver Safety Program" for motorists over 50 years which is sponsored by the American Association of Retired Persons.

Across th

Alabama

$20.3 Million Verdict for Failure to Diagnose Bacterial Meningitis

In a bench trial, a U.S. district judge awarded the plaintiff and her son $20.3 million in damages after finding that an emergency department (ED) physician failed to diagnose the boy with bacterial meningitis. The plaintiff took her feverish five-week-old son to the ED at a county hospital in a federally designated impoverished area. A physician affiliated with the U.S. Department of Health and Human Services saw the baby in the ED, ran some tests, and discharged the baby with instructions to return if the baby did not improve. No septic exam was performed.

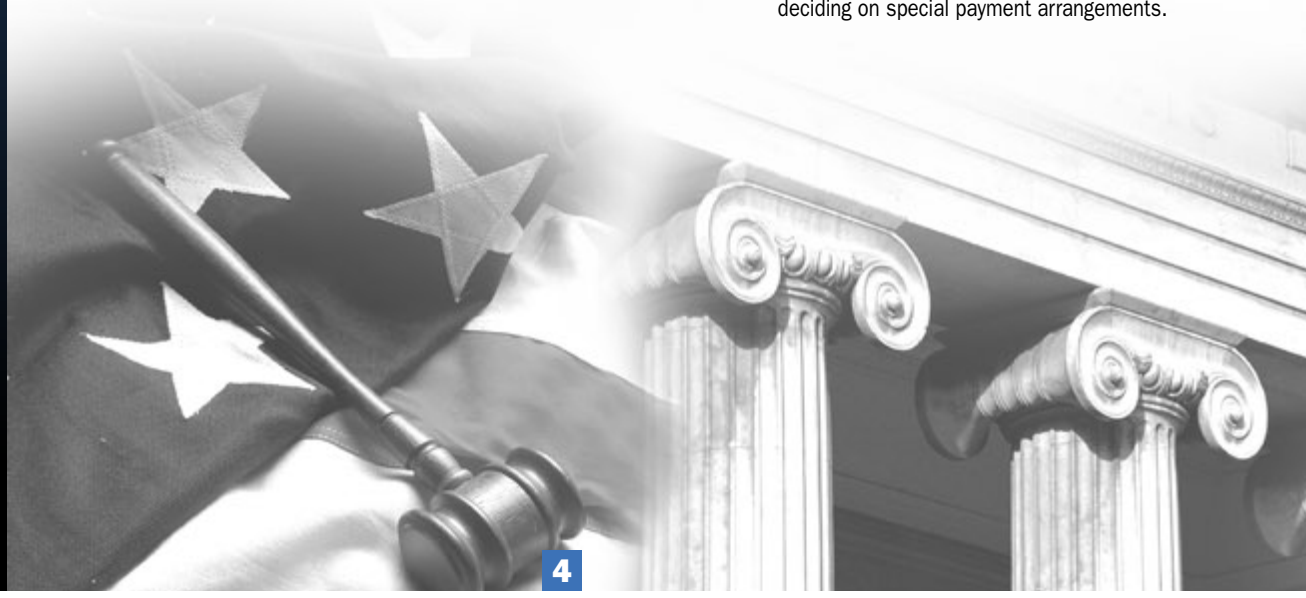
The plaintiff alleged that had the exam been done, the result would have shown bacterial meningitis and there would have been a 95 percent chance of successful treatment. Additionally, the plaintiff alleged the physician added information to the medical record two days after the baby was discharged. The baby suffers from multiple medical problems and the plaintiff claims the baby is severely and permanently disabled. (*Perry Austin, Jr., by and through his Mother, Tiffani Bennett v. U.S.A.,* U.S. District Court, Northern District of Alabama. Western Division, Case No. CV-00-C-1797-W).

Florida

Physician Shortage Strikes Florida Emergency Departments

While the debate continues in the media, hospital administrators are getting all the proof they need that physicians are leaving Florida, restricting their practices or retiring early. For example, *The Palm Beach Post* reported in March that a stroke patient was diverted forty miles to a second hospital because there was no neurosurgeon available at the first hospital. The newspaper further reported that Palm Beach County hospitals are struggling to find neurosurgeons willing to treat emergency department (ED) patients. Not only have neurosurgeons left the area, but some neurosurgeons have stopped covering EDs.

In July, the *Orlando Sentinel* reported hospitals have fewer on-call physicians and are struggling to provide emergency services. Physicians formerly providing on-call coverage to several hospitals are limiting themselves to one or two hospitals or dropping privileges altogether in order to avoid on-call requirements. The American College of Emergency Physicians states there is shortage of on-call specialists across the United States. What are hospitals doing? Some hospitals are paying physicians a supplement to provide on-call coverage. A group of ob-gyns in California reports they pay into a special fund to subsidize the hiring of contract ob-gyns for on-call coverage. Whatever steps you take, experts suggest consulting with a healthcare or fraud and abuse attorney before deciding on special payment arrangements.



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Michigan

Can Patients Decline Emergency Treatment?

A Michigan court recently addressed the question whether an emergency department physician should provide lifesaving care to a competent patient who declines treatment. In *Tate* v. *Botsford General Hosp.,* No. 245081, 2004 WL 915030 (Mich.App. Apr. 29, 2004) (per curiam), a 70-year-old male drove to the hospital presenting with an upset stomach and nausea. At some point, the patient decided he wanted to go to another hospital, but was eventually restrained, placed on a ventilator tube, and treated.

While there was dispute over the exact order of events, the emergency department (ED) physician indicated the patient had been administered Compazine and suffered a potentially life threatening allergic reaction, necessitating emergency care.

The patient sued for false imprisonment and the trial court dismissed, finding the patient had developed a life threatening condition which mandated emergency treatment.

The appellate court reversed and reiterated previous Michigan case law which held that a "competent adult has the right to decline all forms of medical intervention including lifesaving treatment." The court found there was no dispute the patient was competent when he initially presented to the ED, but there was conflicting evidence regarding his competence later in the visit. Since the patient's competence was a question of fact, the case was remanded back to the trial court for hearing.

Ohio

Ohio Physicians Hit by Huge Verdicts Back-to-Back

The Ohio medical community was shell-shocked by two recent huge verdicts rendered almost back-to-back—to the tune of $40 million dollars. A Lucas County jury awarded $10 million to a patient who suffered an adverse outcome during a surgical procedure. And a Cuyahoga County jury rendered a $30 million verdict in a birth injury lawsuit, $15 million of which was a noneconomic award. At press time, the motion for a new trial in the $30M Cleveland (Cuyahoga County) case was granted by the court, citing irregularities by the plaintiff's counsel in support of the judge's decision.

Doctor Backlash

Physicians and hospitals across the country are growing angry and frustrated by malpractice lawsuits and the plaintiff attorneys who bring them. The following excerpts, culled from a variety of newspaper, magazine, and radio/TV reports, depict the growing frustration on the part of physicians and hospitals.

- An Ohio physician notified 50 medical malpractice plaintiffs' attorneys that he would refuse to see them and their family members as patients. (Only one of the lawyers on the mailing list was a current patient.) When the physician's position became public, he indicated he received "hundreds" of calls and letters from patients and physicians in support of his position and a number of sharply worded rebukes from trial lawyers.
- A South Carolina surgeon introduced a resolution at the June 2004 AMA Annual Meeting suggesting the AMA inform members that, except as otherwise required by law or professional regulation, it is *not* unethical to refuse care to plaintiff attorneys and their spouses. Most attendees did not agree and spoke out strongly against the resolution. The surgeon withdrew the resolution before delegates had a chance to vote. He noted the proposed resolution was meant to raise awareness of the issue.
- A New Hampshire neurosurgeon told the president of that state's Trial Lawyers' Association he would not treat him for elective surgery because the lawyer had lobbied against limits on malpractice lawsuits. The neurosurgeon *did* say he would treat the attorney if it was an emergency situation. The physician explained his position by indicating that he believes if someone takes a position harmful to your welfare, you have a right not to do business with them.
- The daughter of a Mississippi state representative was refused treatment by a plastic surgeon because the representative had opposed limits in damage lawsuits against physicians in Mississippi.
- A website, *DoctorsKnow.US,* which profiled plaintiff patients, lawyers, and expert witnesses, was launched by a Texas radiologist in early 2004. The stated purpose of the website was to discourage frivolous lawsuits. The website was shut down when the media began reporting that patients listed on the site were having difficulty obtaining medical care.
- A Texas hospital dismissed a nurse because her husband worked for a law firm that handles medical malpractice litigation. Hospital personnel told the nurse that her skills were not in question, but because she benefits from the law firm's success, her access to hospital information presented a conflict of interest.
- A Mississippi physician sent a letter to a patient suggesting she find another physician when he learned that the patient worked for a plaintiffs' law firm. The physician's letter indicated he wasn't sure he could treat her in an objective fashion.
- Colleagues voted to remove a New Jersey physician from a hospital's chief-of-staff position because he supported a medical malpractice reform plan that many physicians and the state medical society opposed.
- A Florida hospital announced it is revising its employee code-of-conduct to prohibit staff from testifying on behalf of plaintiffs. Employees are permitted to testify on behalf of defendant doctors/hospitals.
- A West Virginia physician sued the West Virginia Trial Lawyers' Association alleging the association engaged in the initiation of frivolous, non-meritorious and malicious lawsuits against physicians. The physician filed the suit without the aid of an attorney. The suit was dismissed, but the physician is working on an appeal.
- The Ohio State Medical Association has formed a Frivolous Lawsuit Committee. The committee is actively seeking information on egregious lawsuits to use as test cases in the courts in order to focus attention on the issue of frivolous lawsuits. The cases will seek reimbursement to physicians for financial damages, including court costs, arising from frivolous lawsuits.
- A Pennsylvania gynecological oncologist recently obtained an out-of-court settlement against a Pennsylvania plaintiff attorney for faulty judgment. The attorney had filed a malpractice claim without consulting a qualified medical expert. The attorney ultimately settled for an undisclosed amount and issued a statement indicating she now realized that experts are necessary since medical outcomes may appear to be improper care, when in fact there is no negligence.

These examples help illustrate the frustrations that exist between today's medical and judicial systems. The strong emotions of everyone involved continue to fuel the search for answers.

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ProNational

Medical Economics **recently conducted a survey asking over 8,100 physicians what they would tell their children if the children expressed an interest in the law as a profession. 54 percent of the physicians responded they would recommend the law as a profession, yet only 36 percent indicated they felt the law to be a respected profession. Interestingly, experience appears to have had an effect on these results. Physician respondents who were most likely to consider the law a respected profession were under the age of 35, while physicians who think lawyers are not to be trusted have been in practice six to ten years.**

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Older Drivers

The older population is expected to double by 2030, at which time one in five Americans will be age 65 and older. Motor vehicle crashes are the number one cause of unintentional injury-related deaths in the 65-74 year age group, and the second leading cause in the 75-84 year age group. Older drivers are more likely than younger drivers to be killed in accidents relative to the number of miles they drive—even though drivers age 75 and over are involved in only about three percent of all crashes. Accidents involving older drivers generally result in injuries to themselves, rather than to others. Fragility is the largest single cause of mortality in older drivers, often leading to chest injuries. Older- driver crashes often involve multiple vehicles that occur at intersections and involve left-hand turns. The accident is usually caused by the older driver's failure to heed signs and grant the right-of-way.

Summary

Physicians can help their patients maintain a high level of fitness, enabling them to preserve safe driving skills later in life and protecting them against serious injuries in the event of a crash. By adopting preventive practices such as assessing patients for medical fitness to drive, recommending safe driving behaviors, suggesting driving rehabilitation, or recommending driving limitations as needed, physicians can contribute to driving safety and ease the transition to driving retirement, if and when it becomes necessary.

Resources

"Physician's Guide to Assessing and Counseling Older Drivers." Copies of the 2003 guide can be downloaded or ordered on-line through the American Medical Association (http://www.ama-assn.org/ama/pub/category/10791.html). Phone: 800/621-8335.

The Association for Driver Rehabilitation Specialists has an on-line directory of members providing services in assessment, rehabilitation or vehicle modification (http://www.aded.net). Phone: 800/290-2344.

Self-assessments: "Safe Driving for Older Adults," National Highway Traffic Safety Administration, DOT # HS 809 493 (www.nhtsa.dot.gov/people/injury/olddrive). Phone: 888/327-4236; "Am I a safe driver?" available on-line only, American Medical Association (http://www.ama-assn.org/ama/pub/category/9118.html). Phone: 800/621-8335.

The "Driver Safety Program," American Association of Retired Persons, a refresher course specially designed for motorists aged 50 and older. An on-line directory of locations is available (www.aarp.org/drive). Phone: 888/687-2277.

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