

*IMPAIRED DRIVING IN OLDER ADULTS
ETHICAL CHALLENGES FOR HEALTH CARE PROFESSIONALS*

*A Report by the National Ethics Committee
of the Veterans Health Administration*

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Founded in 1986, the National Ethics Committee (NEC) of the Veterans Health Administration (VHA) is an interdisciplinary group authorized by the Under Secretary for Health through the National Center for Ethics in Health Care. The NEC produces reports on timely topics that are of significant concern to practicing health care professionals. Each report describes an ethical issue, summarizes its historical context, discusses its relevance to VHA, reviews current controversies, and outlines practical recommendations. Previous reports have been useful to VHA professionals as resources for educational programs, guides for patient care practices, and catalysts for health policy reform. Scholarly yet practical, these reports are intended to heighten awareness of ethical issues and to improve the quality of health care, both within and beyond VHA.

Committee Members: Arthur Derse, MD, JD (Chair); Lawrence Biro, EdD; Susan Bowers, MBA, David Casarett, MD, Jeannette Chirico-Post, MD; Sharon P. Douglas, MD; Gwendolyn Gillespie, MSN, RN, APN; Kathleen A. Heaphy, JD; Ware Kuschner, MD; Michael McCoy, MDiv; Heather Ohrt, MD; Judy Ozuna, ARNP, MN, CNRN; Peter Poon, JD, MA; Cathy Rick, RN, CNA, CHE; Randy Taylor, PhD, MBA

Ex Officio: Ellen Fox, MD

Consultant to the Committee: Michael J. O'Rourke

Staff to the Committee: Bette-Jane Crigger, PhD; Michael Ford, JD

Chief Ethics in Health Care Officer: Ellen Fox, MD

The National Ethics Committee is also grateful to the following individuals, who contributed their expertise in reviewing drafts of this report:

Richard Marottoli, MD, Director, Geriatrics and Extended Care Line, VA New England Health Care System

Susan G. Cooley, PhD, Chief, Geriatric Research and Evaluation, Office of Geriatric & Extended Care (114)

Barbara Sigford, MD, National Director, Physical Medicine and Rehabilitation

Karen Rasmussen, MD, Integrated Ethics Program Officer, Portland VAMC

Pamela Bergbigler, MS, Rehabilitation Specialist, McGuire VA Medical Center, Richmond

Executive Summary

America's love affair with the automobile has given many of us enormous personal mobility and independence. Today's drivers have strong expectations that they will continue to enjoy the freedom and convenience of driving well into old age. But older drivers' desire to drive isn't always supported by ability to do so safely. Functional impairments and medical conditions associated with aging can seriously impair an individual's performance behind the wheel and so pose risks of significant harm to the individual him- or herself as well as to other people.

This report analyzes the ethical challenges around impaired driving in older adults, including patients with Alzheimer's disease and related types of dementia. It discusses health care professionals' responsibilities to patients and the public, explores the emerging professional consensus regarding management of patients at risk for impaired driving, and offers practical guidance to help VHA health care professionals address these ethical challenges in day-to-day patient care. The report discusses:

1. Signs health care professionals should look for when assessing and managing patients for impaired or unsafe driving.
2. Actions a health care professional should take if he or she suspects that the patient may be an unsafe driver.
3. Guidance for helping a patient with impaired skills continue to drive safely as long as possible.
4. Actions to take if the health care professional believes the patient can no longer drive safely.
5. Strategies for dealing with a patient who is unsafe but refuses to stop driving.
6. Actions to take when reporting an unsafe driver.

Introduction

America's love affair with the automobile has given many of us enormous personal mobility and independence. Today's drivers have strong expectations that they will continue to enjoy the freedom and convenience of driving well into old age. But older drivers' desire to drive isn't always supported by ability to do so safely. Although drivers over age 65 generally have fewer accidents overall than drivers in other age groups, they tend to have more accidents per mile driven.¹ Moreover, older drivers are more likely to be seriously injured or killed when they are involved in accidents.^{1,2} They're also likely to do more of their driving in more dangerous environments, such as rural and suburban settings.¹

Functional impairments and medical conditions associated with aging, such as impaired vision, cognitive deficits, decreased mobility, chronic pain, decreased reflex time, and polypharmacy,² † can seriously impair an individual's performance behind the wheel and so pose risks of significant harm to the individual him- or herself as well as to other people. At some stage in their aging process, many older patients and the health care professionals who care for them will face difficult decisions about driving safety, retirement from driving, and driving privileges.‡ This presents a special challenge for VA, since nearly half of VA's 7.8 million enrollees are over 65.

One of the many medical conditions that puts older drivers at risk is Alzheimer's disease (AD). In the United States, it is estimated that the prevalence of AD or a related disorder is 2 percent of those aged 65 to 74, 19 percent of those aged 75 to 84, and 47 percent of those aged 85 and older.¹ In VA, it is estimated that by the end of fiscal year 2007 over 280,000 VA enrollees will have some form of dementia, including over 165,000 who will be actively receiving health care services in VHA. By 2010 those figures are projected to rise to nearly 318,000 and 193,000 respectively.³

For health care professionals, the responsibility of managing patients at risk for unsafe driving raises ethical challenges in balancing dual professional obligations to promote patient well-being and to protect public health. Some older patients will be so compromised that continued driving is clearly not in their best interest, collapsing the clinician's ethical distinction between duties to the patient and duties to the public. Some at risk older drivers will voluntarily stop driving on their own. But many will continue to drive. In these situations, health care professionals must make clinical judgments about whether the patient is at risk for being a hazard on the road, how serious that risk is, and how best to address the question of driving skills and/or privileges in the individual's particular circumstances.

This report by the Veterans Health Administration's National Ethics Committee analyzes the ethical challenges around impaired driving in older adults, including patients with AD and related types of dementia. It explores the emerging professional consensus regarding management of patients at risk for impaired driving and offers practical guidance to help VHA health care professionals address these ethical challenges in day-to-day patient care.

† Many medical conditions and treatments can impair driving ability among older adults. For a comprehensive discussion of impaired driving, see the American Medical Association's Physician's Guide to Addressing and Counseling Older Drivers, available at <http://www.ama-assn.org/ama/pub/category/10791.html>.

‡ There is anecdotal evidence that impaired driving performance related to post-traumatic stress disorder and/or traumatic brain injury may be an emerging and potentially large-scale problem for combat veterans of Operation Iraqi Freedom and Operation Enduring Freedom. These patients are likely to raise unique issues that are beyond the scope of the present analysis.

What's at Stake for Patients & Families

Retiring from driving can be difficult for anyone. With the loss of mobility comes some measure of loss of autonomy and independence. For many, not being able to drive means not being able to participate as before in activities outside the home, having fewer social contacts, participating less in community life.^{1,4} There's evidence that driving cessation is associated with increased symptoms of depression.^{1,5,6,7,8,9}

For individuals with AD or other progressive dementia, the losses may be felt even more sharply. These individuals face a profound existential challenge when mental capacity erodes more quickly than the loss of self-identity grounded in everyday activities, including driving.¹⁰ As the individual loses insight about his or her abilities and is not able to understand that once routine activities are no longer appropriate, he or she may struggle to maintain self-identity and self-esteem by resisting new limitations.

The clinical recommendation to discontinue driving has far-reaching effects. Not only does such a recommendation abridge the patient's autonomy; it also can have adverse consequences for people close to the patient. Family members and caregivers often face the stressful task of enforcing the recommendation to discontinue driving.^{1,4,11} Intimate associates may be called on to provide or arrange for alternate transportation. Though public transportation can be an excellent option, unfortunately, adequate and safe public transportation is not universally available in the United States. Even when it is, it may not be a viable option for many older adults, such as individuals with cognitive deficits who become lost or easily confused.¹ Further, people who previously relied upon the former driver for transportation (most often, the former driver's elderly spouse) may themselves become housebound and experience diminished quality of life.^{1,12,13}

Health Care Professionals' Responsibilities to Patients & the Public

Health care professionals' fiduciary relationship with their patients encompasses obligations to promote the individual patient's health, autonomy, and quality of life. Health care professionals equally have duties to protect their patients from harm, to respect patient privacy, and to safeguard patient confidential information.^{2,12,14} At the same time, health care professionals have a duty to protect the public health, including protecting third parties from being harmed by a patient's unsafe driving. In some jurisdictions the duty to protect the public health obligates health care professionals to report patients with certain medical, psychiatric, or psychological conditions to state licensing authorities, as these conditions are known to contribute to or result in unsafe driving.

Recommending that a patient who is no longer able to drive safely stay off the road can serve the interests of both the patient and the public. The question is whether safety for the patient and others comes at an unjustifiably high cost to the patient's autonomy, quality of life, or privacy. To be ethically justified, the burdens of a health care professional's recommendation that an older patient discontinue driving must be proportionate to the actual personal and public safety that can reasonably be expected to occur.^{12,15}

To make well-grounded, ethically justifiable recommendations about driving, health care professionals must assess the patient in an effort to determine how great a risk the patient's continuing to drive will pose, how likely it is that the patient's compromised driving capacity will result in harm (to the patient or third parties), what steps if any can be taken to mitigate the risk, and what consequences driving cessation might have for the patient and his or her intimate associates. Health care professionals should routinely evaluate older drivers to determine their risk for driving impairment, refer patients for assessment of driving performance when appropriate, support patients to develop or maintain safe driving skills, and counsel them about decisions to continue or

retire from driving, including helping them plan for the day when they will no longer drive.² The goal should be to support the patient to drive safely and to restrict his or her driving only to the extent necessary and only as a last resort.^{2,16,17,18}

Key Questions for Health Care Professionals

The following questions help clarify health care professionals' ethical responsibilities with respect to assessing and managing patients for impaired or unsafe driving:

- What signs should I look for?
- What should I do when I suspect my patient may be an unsafe driver?
- How can I help my patient continue to drive safely if his/her skills are impaired?
- What should I do when I believe my patient can no longer drive safely?
- What if my patient is unsafe but refuses to stop driving?
- When should I report an unsafe driver?

What Signs Should I Look For?

Health care professionals should proactively identify risk factors for unsafe driving in their older patients and remain alert for any alteration in patients' physical, mental, or behavioral function that might indicate an underlying medical condition or progression of a known diagnosis. Risk factors for impaired or unsafe driving include uncorrectable deficit to vision that impedes ability to read signs or see cars or pedestrians clearly; decreased mobility that cannot be corrected for by medical interventions or alterations to the vehicle; cognitive deficits that result in loss of judgment, confusion, or decreased executive function (e.g., inability to decide a course of action quickly, follow complex directions); uncontrolled medical disorders that can cause patients to suddenly lose consciousness or control of the vehicle (e.g., seizure disorders, narcolepsy, angina); and use of medications that decrease mental acuity or physical function as either a direct effect or a side-effect.² Signs that may indicate physical or mental decline requiring further diagnostic evaluation and/or treatment include poor grooming and hygiene, difficulty performing visual tasks, falls, new incontinence of bowel or bladder, evening agitation ("sundowning"), change in personality, or unexplained weight loss.

What Should I Do When I Suspect My Patient Is at Risk of Driving Unsafely?

When there is evidence that an older driver has risk factors for unsafe driving, the first step is to take a focused driving history. Health care professionals should corroborate the older driver's responses with family members, friends, or caregivers if at all possible.^{2,18,19,20} (They should first obtain the patient's permission to contact these individuals.)

Take a focused driving history

For example, ask the patient [family member/caregiver]:

- Do you [does the patient] ever get lost while driving?
- Have you [has the patient] ever forgotten where you were going?
- Have you [has the patient] gotten any tickets in the past 2 years?
- Have you [has the patient] had any near misses or crashes in the past 2 years?
- Have you [has the patient] ever damaged the side mirrors on the car?
- Do other drivers ever honk or make indecent gestures at you [at the patient]?
- Do you [does the patient] ever fail to notice or misread traffic signs?
- Do you [does the patient] rely on a "co-pilot" to help you [help him/her] drive?

Adapted from: AMA 2003²; Perkinson et al. 2005¹¹; CMA 2006¹⁸; VA 2005²¹

For patients who carry a diagnosis of dementia, VHA's Dementia Safety Review Workgroup encourages health care professionals to use VA Form 10-0435, Firearms and Driving Questionnaire, as part of a focused driving risk assessment. It should be noted that some patients with dementia, including those with early-stage AD, may still be able to drive safely.^{1,4,17,22,§} Indeed, older drivers with mild dementia have fewer accidents per year than drivers between the ages of 16 and 24.^{1,23}

If any of the driving history questions are answered in the affirmative, indicating that the patient may be at risk for unsafe driving, the health care professional should probe further to elicit circumstances and details, and proceed with a thorough medical evaluation, including a routine medical history and physical and review of medications and medication side effects. In addition, office-based testing should be performed to evaluate specific driving-related capacities such as visual acuity, muscle strength, and cognitive skills.² While there is general agreement in the professional community that various office-based tests can be helpful in identifying patients whose driving performance may be impaired,^{2,19} there is not clear professional consensus about which specific diagnostic tests are most useful.^{1,2,22,25,26} Nonetheless, the AMA has recommended the following tests of vision, cognitive function, and motor function: Snellen E chart and confrontation testing; Trail-Making test (Part B) and Clock-Drawing Test; and rapid pace walk, manual test of range of motion, and manual test of motor strength.² For patients with dementia, there is evidence that neuropsychological tests highlighting visuospatial skills, attention, and reaction time correlate most meaningfully with actual driving performance.²⁷

When office-based evaluations suggest that a patient may be at risk for impaired driving, but the patient wants to continue driving, it is important to evaluate the patient's driving skills in more detail.

How Can I Help My Patient Continue to Drive Safely If His or Her Skills Are Impaired?

The goal of promoting well-being and quality of life for older drivers argues for health care professionals to use the least restrictive interventions available to ensure the patient's safety. Health care professionals should discuss with the patient (and family if appropriate) ways in which the individual can minimize driving risk. Some recommendations for minimizing risk include driving only during daylight hours, avoiding routes that involve busy intersections or left turns if possible, being extra careful to check the blind spot when changing lanes, keeping the car in good condition, and taking a driver safety class.²

Help patients drive safely for as long as possible:

Discuss safe driving with your patient

Explain how to take medications so they don't affect driving ability

Help the patient identify limitations or habits that pose driving risks and think of steps to minimize them.

Remember that patients with dementia may overestimate their skills.

Share tips for safe driving—

- Always drive safely
 - plan ahead (route, best time to drive, etc.)
 - wear your seat belt correctly
 - drive at the speed limit
 - pay attention to traffic at all times
 - keep proper distance from the car in front of you
 - be extra careful at intersections
 - check your blind spot when changing lanes or backing up
 - don't multi-task while driving
- Keep your car in good, road-worthy condition
- Know where you can find a ride if you need one
- Take a driver safety class

Refer the patient to a driving rehabilitation specialist

Adapted from AMA
2003²

§ One recent clinical review suggested that crash risk remains "acceptably low for up to three years after the onset of dementia, by which time most patients have stopped driving."²³

When clinical assessment indicates that an older patient has impaired driving skills but is not so severely impaired that immediate driving cessation is called for, health care professionals should also refer the patient to a driving rehabilitation specialist (DRS) for on-road (functional) assessment.^{2,18,28} The DRS can work with the patient and family members or caregivers to identify deficits in the individual's driving skills and can provide specific instruction and training to modify driving practices, demonstrate safe driving techniques, and follow up as needed.^{2,28}

It is important to recognize that on-road tests have limitations, in that they generally ask the driver to respond to specific instructions and are carried out in a testing vehicle over a fixed course; they are not observations of an individual's spontaneous driving behavior in his or her own vehicle and usual driving environment.²⁷ Also, they assess driving skill at a single moment in time—but the driving skills of older patients, especially those with dementia, deteriorate over time, thus calling for periodic reassessment.¹ The National Highway Transportation Safety Administration suggests that given the “good day, bad day” nature of AD, at-risk drivers with early AD should be assessed multiple times in multiple settings.^{1 **}

Under VA policy, all VA enrollees who qualify for health care in the Veterans Health Care System may be eligible for driving rehabilitation benefits.²⁹ VHA Handbook 1173.16, Driver Rehabilitation for Veterans with Disabilities Program Procedures, defines driver rehabilitation for the disabled as a “Professional Services Medical Training Program designed to provide professional evaluation and instruction for eligible veterans in the safe, competent utilization of special add-on equipment, and mastery of specific skill and techniques to effectively drive a motor vehicle, independently, and in accordance with State Department of Motor Vehicles (DMV) regulations.” As a practical matter, the potential demand for driving rehabilitation services for the aging veteran population may raise significant challenges in VA's resource-constrained environment. Although all patients, including “mature drivers” and individuals with dementia, are eligible for these services when needed, the primary focus of driving rehabilitation in VHA is to provide services to patients who have significantly impaired motor function, such as patients with diagnoses of spinal cord injury, hemiplegia and other neurological conditions (e.g., Parkinson's), amputation, and orthopedic-related conditions.³⁰ In FY 2006 these conditions accounted for some 68 percent of all referrals for driving assessment and rehabilitation, while 16 percent were for “mature drivers,” 5 percent for patients with psychiatric diagnoses (including post-traumatic stress disorder), and 11 percent for “other” conditions not falling into one of the categories established in policy.³¹ Although we note resources as a potential concern, the ethics of resource allocation issues related to driving rehabilitation services is beyond the scope of this document.

As with any referral to specialty services, the health care professional should explain why the referral is being made and what it is expected to accomplish for the patient.² Explaining the referral can also help patients and family members begin thinking more critically about the patient's driving skills. Health care professionals may wish to encourage the patient to identify potential safety concerns, think about modifying driving habits, and identify alternative transportation resources, particularly in discussion with family members or caregivers.^{2,9,19}

What Should I Do When I Believe My Patient Can No Longer Drive Safely?

At some point, patients' functional capacities may deteriorate to the point that continuing to drive poses a significant risk not only to themselves but to others as well. When that point is reached, health care professionals' obligation to protect patient well-being takes precedence over the obligation to respect patient autonomy. At the same time, the obligation to protect public health

** The NHTSA does not offer guidance about how to determine an overall rating of driving ability based on multiple tests, however.

overshadows the fiduciary responsibilities to the individual patient. Health care professionals must then recommend that the individual retire from driving. In some jurisdictions health care professionals also have a legal obligation to report unsafe older drivers.

Knowing just when a patient has reached the point when he or she should no longer drive is challenging. As we've noted, the tools available for assessing functional capacities and driving-related skills are not perfect predictors of older patients' ability to drive safely. At present, there are no clear-cut, objective criteria to identify just which patients truly must no longer drive.

Clinical judgment plays a critical role in the determination of when a particular patient should stop driving entirely. The recommendation to stop is not one to be made lightly, but neither is it one a health care professional can avoid when a preponderance of factors indicate that a patient poses a significant risk by continuing to drive. Health care professionals must weigh multiple factors, including the patient's clinical status; knowledge of the patient's (and family's) situation; resources available to mitigate the impact of driving cessation and help sustain good quality of life; and the potential impact of a recommendation to stop driving on the patient-professional relationship. But the overriding concern must be the health care professional's assessment of the actual risk that the patient's compromised driving capacity will result in harm to third parties. Health care professionals have a responsibility to treat all patients consistently and fairly—equal concern is due the most sympathetic and the most difficult of patients alike in balancing the life-altering effects of driving cessation for individual patients against the welfare of the patient's intimate associates and the public.

When health care professionals have been supportive in helping patients maintain safe driving skills for as long as possible, but at the same time have prepared the patient to ultimately retire from driving, the transition to nondriving status should not come as a surprise. Nonetheless, conversations about driving cessation are often difficult for all involved. In particular, patients with progressive forms of dementia often lose insight into their behaviors as their disease progresses and may deny that they have problems driving and resist the recommendation to stop. Because these patients may also have lost the capacity to manage their emotions, conversations with them about driving cessation may provoke anger and be confrontational.¹

To the extent possible, health care professionals should actively involve the patient in discussion about the recommendation to discontinue driving, for several reasons. First, involving the patient demonstrates respect. Second, patients have a right to be involved in decisions that affect their lives, even when they have diminished ability to appreciate the reasons for such a recommendation. Third, involving the patient helps to maintain the integrity of the health care professional-patient relationship. Finally, involving the patient may also make it more likely that he or she will abide by the decision.^{2,24} Since the decision to retire from driving has important

To make difficult conversations easier:

- Talk about having the patient "retire" from driving, not "stop" or "quit"
- Focus on the shared goal of safe mobility—e.g., "We both want to make sure you can get around without having anything bad happen."
- Help the patient identify reasons for not driving—e.g., "When do you think someone should retire from driving?"
- Acknowledge the patient's accomplishments, but help him/her focus on the present and future—e.g., "I know you've had lots of experience as a driver, but things have changed. Let's not talk about the past. We need to focus on the future."
- Acknowledge how the patient is feeling; don't try to convince through rational arguments
- Help the patient identify alternatives to driving—e.g., "Let's think about how you can get around without a car."

Adapted from: AMA 2003²;
Jett et al. 2005²⁴; CMA 2006¹⁸

implications for family members, health care professionals should also seek to involve them in the decision-making process,^{2,11,27} if the patient agrees.

The AMA recommends that health care professionals use the language of driving “retirement” to help normalize the experience and set a more positive tone.² Health care professionals should acknowledge the shared goal of safe mobility and explain concretely the reasons for the recommendation that the patient no longer drive, openly (but sensitively) discussing why the patient’s driving is not safe.² It may be more persuasive to focus on the safety of others the patient cares about—for example, grandchildren, neighbors’ children the patient is fond of, even family pets—than to stress the patient’s own safety or the safety of anonymous other drivers or pedestrians^{11,24} Writing a prescription “Do Not Drive,”² or giving the patient and family a written explanation of why the individual must no longer drive,¹⁸ can help reinforce the recommendation. Formal agreements between the patient and his or her family that the individual will not attempt to drive give family members a tool to help them help the patient adhere to the recommendation.¹¹

However, a recommendation to stop driving differs importantly from other recommendations a health care professional may make in that it is not offered in the context of shared decision making. Unlike a treatment recommendation, which a competent patient has the right to refuse, if the patient’s driving is so impaired as to warrant a recommendation to stop, a health care professional has an obligation to take steps to override the decision of a patient who continues driving when he or she has been counseled not to.

What If My Patient Is Unsafe But Refuses to Stop Driving?

When an unsafe older driver continues to drive despite counseling to stop, health care professionals should investigate why the patient isn’t following the recommendation. Is it because he/she doesn’t accept that there is a problem? Have they forgotten the recommendation to stop driving? Are they unable to arrange alternative transportation or services to meet their basic needs?^{19,27}

In some cases, further counseling by the physician about why it is important for the patient retire from driving may be sufficient to resolve the issue. Other cases may require referral to social work, community aging services, or similar services for assistance in creating a viable transportation plan for the patient and dependent family members. If repeated counseling is ineffective and the patient persists in unsafe driving, it may be beneficial to engage family members or caregivers to help the patient comply with the clinician’s recommendation to refrain from driving.^{2,19} The AMA suggests that in the interest of the patient’s safety it may be appropriate for the health care professional to seek appointment of a legal guardian to enforce driving retirement.²

Finally, health care professionals may need to report unsafe drivers to state licensing authorities, especially when all other efforts to explain their recommendations and counsel the patient and family have failed.

When Should I Report an Unsafe Driver?

Health care professionals themselves cannot revoke a patient’s driving privileges; they only alert the state licensing authority that an individual is a risk for unsafe driving. The state licensing authority decides whether driving privileges will be revoked. Currently only six states (California, Delaware, Nevada, New Jersey, Oregon, and Pennsylvania) require health care professionals to report drivers deemed unsafe due to medical conditions, and the criteria for reporting differ across these jurisdictions.^{1,2} Other states do not require reporting, but instead encourage and authorize health care professionals to report any impaired driver. Due to the variability in state law for reporting impaired drivers, VHA’s Office of the Medical Inspector instructed all Veterans Integrated Service

Networks (VISNs) to provide guidance to VA facilities and health care professionals about applicable state laws on driving and dementia.³²

However, health care professionals may have ethical responsibilities beyond their legal responsibilities. Even when there is no legal requirement for health care professionals to report unsafe drivers, the duty to protect public health may argue that they should do so. Specifically, health care providers have an ethical responsibility to report unsafe drivers (within the constraints of the law) when the benefits to the patient and to the public outweigh the burdens to the patient.^{12,15} In assessing the benefits and burdens of reporting an unsafe driver, health care professionals should consider:

- how great a harm (to self or others) the patient's driving poses; and
- how likely it is that the harm will actually occur (i.e., that the patient will be involved in an accident)

Once a health care professional decides that he or she has an ethical responsibility to report a patient who continues to drive unsafely, he or she should discuss this decision with the patient before the reporting takes place. Health care professionals should stress their commitment to the patient's well-being, including not only physical safety but also privacy. The Canadian Medical Association also suggests giving the patient a written statement explaining the decision and the health care professional's legal responsibility.¹⁸

Because disclosure of medical information without patient consent carries risks of breach of confidentiality, VA facilities must clarify for employees when and how information about unsafe drivers may be disclosed to state authorities. Where state law requires reporting, VA privacy policy permits disclosure of protected health information to a state department of motor vehicles.³³ The facility must have on file a standing written request letter that outlines the state reporting law and the data required to be reported. Where state law does not require reporting, VA policy allows the facility to report medically unsafe drivers if the state department of motor vehicles will provide such a standing request letter. The facility may disclose only the information outlined in the standing written request letter.

Given the wide variation in reporting requirements and authorization to report across jurisdictions, VHA health care professionals who have questions about whether they must or can report a medically unsafe driver should seek guidance from their facility privacy officer, regional counsel, or the Office of General Counsel.

Life After Driving

Driving retirement is a life-altering event that can have significant impact on the lives of patients, their families, and their communities. Although there is, in the words of one retired driver, "life after driving,"⁹ patients—and their intimates—must make major adjustments to meet transportation needs, remain engaged with friends and the community, and maintain quality of life.

How great a risk does the patient's driving pose?

Consider the patient's driving habits:

- How often does the patient drive?
- Does he/she drive at night, in poor weather, or in other challenging conditions?
- Does he or she drive in risky environments, such as on high-speed roadways; on routes that involve complex or especially busy intersections; near schools or other public gathering places?
- Does he or she often have passengers?
- Given the nature and degree of impairment in the patient's driving-related skills (including his or her judgment), how likely is it that he or she will be involved in an accident?
- How likely do you believe he or she is to be involved in an accident that results in significant injury to the patient or to others?

Thus health care professionals should take very seriously their obligations to identify and counsel potentially unsafe drivers, recommend that unsafe drivers retire from driving, and—as a last resort—report unsafe drivers to appropriate authorities. The goal in addressing driving safety with patients whose skills are becoming impaired should be to support the patient to drive safely for as long as possible, help the individual plan in advance for the day when he or she will retire from driving, and ease the transition to nondriving status to the extent possible for patients and their family members and caregivers.

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