

The Driving Dilemma and the Law: Patients' Striving for Independence vs. Public Safety

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The Driving Delimma

In Volume 6, Issue 5 of *Cognitive Rehabilitation* (September-October, 1988), Engum, Pendergrass, Cron, Lambert, and Hulse (1988) offered an excellent summary of rehabilitation research regarding safe operation of motor vehicles by those who have suffered brain injuries. Dr. Engum and his associates reported on the progress which has been made in construction of operational test batteries to assist the rehabilitation professional in assessing the patient's ability to safely operate a motor vehicle. In the rehabilitation of brain injured patients, the driving decision is one of the last and most important decisions of the health care professional. It requires an analysis of the patient's residual cognitive, physical, and behavioral disabilities and their impact upon the driving task (Michon, 1979). While serving as the gateway to independent adult functioning, the driving privilege is fraught with potential disaster of injury to person and destruction of property. Patients who cannot master the operational, tactical, and strategic skills necessary to safely operate a motor vehicle present a clear risk of injury to themselves, their passengers, pedestrians, and other operators of motor vehicles.

Many health care professionals evaluate their brain injured patient's driving ability without fully considering the implications for the patient or the public at large. Other professionals, possibly overzealously advocating for their patient to be completely reintegrated back into a productive life following brain injury, may grant the brain injured patient permission to drive based upon less than studied and cogent analysis of disabilities. Expanding legal authority suggests that the health care provider's responsibility is not simply to the patient but also to the public. Accordingly, courts and juries appear ready to impose liability on health care professionals for negligent decision-making in allowing their disabled patients to drive. This article will: 1) review some of the case law surrounding a health care professional's decisions regarding patient driving; 2) attempt to state the standard of care which health care professionals must meet in making such decisions; and, 3) provide guidelines for making those decisions reasonably and responsibly.

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Relevant Case Law

In our analysis, the typical fact pattern involves an accident caused by a patient with a known physical or mental disability which arguably impacted upon that patient's ability to safely operate a motor vehicle. In the California case of *Myers vs. Quesenberry*, 144 Cal.App.3d 888 (1983), the defendant physicians were treating the patient, Lexandra Hanson, for diabetes and pregnancy. The physicians knew that Hanson's diabetes had seriously affected two previous pregnancies, resulting in Cesarean sections in both; including one stillbirth. During the most recent pregnancy, Hanson's diabetes could not be stabilized. An office examination on August 5, 1980, revealed that the fetus had died. Dr. Quesenberry advised Hanson to undergo a D & C within 18 hours. Hanson was instructed to drive immediately to the hospital for preliminary laboratory tests. Emotionally distraught, Hanson suffered a diabetic attack and lost control of her car, striking a pedestrian, Myers.

The issue, as framed by the California Court of Appeals, was whether liability may be imposed against a physician for negligently failing to warn a patient of the foreseeable and dangerous consequences of engaging in conduct (driving), which proximately caused injuries to an innocent third party. The Court noted that it was a fundamental principle of tort law that defendants are liable for injuries caused by their failure to exercise reasonable care. Rather than addressing the physician's duty to some third party or to society at large, the Court focused instead upon the special relationship that exists between doctor and patient which may support affirmative duties for the benefit of third persons. In addition, the Court analyzed the important policy consideration of foreseeability, which usually presents a question of fact for the jury.

Noting by analogy that a hospital must exercise reasonable care to control the behavior of a patient who may endanger other persons, the Court reasoned that a physician must also warn a patient if that patient's condition or medication renders certain conduct, such as operating a motor vehicle, dangerous to others. Finding that the victim, Myers, was a foreseeable, but not readily identifiable, victim of Hanson's driving did not, in the Court's opinion, preclude him from stating an action against the physicians for negligently failing to warn Hanson not to drive given her physical and emotional condition. While the physicians could not have effectively warned Myers of the danger presented, they could have easily warned Hanson not to drive. The Court reasoned that having historically complied with her physicians'

professional recommendations, Hanson presumably would have heeded their advice had they warned her not to drive.

The case of *Naidu vs. Laird*, 539 A.2d 1064 (Del. 1988), is even more instructive regarding the obligations which are based upon the special relationship that exists between a health care provider and a patient. The case arises from a wrongful death action brought by the next of kin, Ann Laird, against the defendant, Dr. Naidu, who was a psychiatrist employed at the Delaware State Hospital. On September 6, 1977, Mrs. Laird's husband was killed when his vehicle collided with a vehicle driven by Hilton W. Putney. Putney had a long history of mental illness including 19 separate psychiatric hospitalizations. While in a psychotic state, Putney apparently drove his motor vehicle deliberately into Mr. Laird's vehicle. On two prior occasions, Putney, while psychotic, had been involved in automobile accidents, on one occasion deliberately colliding with a police car. When taking his medication, Putney was generally manageable, appropriate, and capable of semi-independent living. Without his medication, he had violent tendencies which presented a risk of harm to himself and others.

The appellate court upheld the trial court decision in favor of the plaintiff by analyzing the special relationship that exists between the psychiatrist and the patient. The Court stated that a psychiatrist owes an affirmative duty to persons other than the patient to exercise reasonable care in the treatment and discharge of psychiatric patients. Reasonable care is that degree of care, skill, and diligence which a reasonably prudent psychiatrist engaged in a similar practice and in similar conditions would ordinarily have exercised in like circumstances. Encompassed within this affirmative duty, courts have long recognized both a psychiatrist's duty to warn third persons [*Tarasoff vs. Regents of University of California*, 551 p.2d 334, at 344 (1986)] and a duty to control the actions of the mentally ill by taking reasonably necessary precautions [*McIntosh vs. Milano*, 403 A.2d 500, at 514 (N.J. 1979)]. This duty arises only when, in accordance with the standards of the profession, a psychiatrist knows or should know that his patient's dangerous propensities present an unreasonable risk of harm to others. Such a duty requires that the psychiatrist or other mental health professional initiate whatever precautions are reasonably necessary to protect potential victims of the patient. To that end, the psychiatrist or other mental health professional may have a duty to warn potential victims or classes of potential victims and/or control, to some appropriate degree, the actions of the patient.

In analyzing the fact pattern, the Court found that Dr. Naidu:

1) had a long relationship with his patient dating back to 1969; 2) possessed first hand knowledge of Putney's long standing and continuous dangerous propensities; 3) discharged Putney with the realization that he did not follow his medication regimen; and 4) knew or should have known, that Putney would again sink into a psychotic state. Accordingly, the Court affirmed the finding of liability based on the psychiatrist's broad based obligation to protect the public from those who present an unreasonable danger. Since Putney had twice been involved in automobile accidents while in a psychotic state, possessed a driver's license at the time of his release, and could be expected to drive a motor vehicle on the public roadways, it was not unforeseeable that Putney would cease taking his prescribed medication upon release from the institution and again become a danger to himself or others while driving an automobile.

Significantly, in *Naidu*, remoteness in time or space from the defendant psychiatrist's allegedly negligent acts, that is, his treatment and discharge of Putney, did not serve as a bar to liability. Putney was discharged from the hospital on March 22, 1977 and led an uneventful life for five and a half months prior to the accident. Dr. Naidu contended that this time span was sufficient to dissipate any causal connection between Putney's discharge and the fatal accident. The Court adamantly disagreed and stated that the lapse of time is, of itself, not a bar to recovery, but is just one factor to be considered by the jury in determining proximate cause. Absent evidence that Putney's conduct was influenced by some unrelated and independent factor which broke the chain of causation, the Court found that Dr. Naidu's alleged negligence could, as a matter of law, serve as the proximate cause of the accident.

A number of jurisdictions have allowed causes of action against physicians for injuries to third parties caused by patient drivers' who had been negligently treated. In *Wharton Transport Corp. vs. Bridges*, 606 S.W.2d 521 (Tenn. 1980), a truck driver employed by the plaintiff was in a traffic accident in which he injured several people. The plaintiff's company settled with the injured parties and then sued the physician for indemnification alleging that he negligently failed to diagnose the driver's condition and to warn him not to drive. The Tennessee Supreme Court reversed a directed verdict for the defendant, finding the existence of a duty to conduct a pre-employment physical examination in accordance with the recognized standards of acceptable professional practice in the medical profession. The Court stated that it was reasonably foreseeable that if an examination fell below that standard and resulted in certifying an unfit person as

physically qualified to drive in a commercial vehicle, the probable consequences should be a highway accident causing loss or injury to a third party or parties.

In *Freese vs. Lemmon*, 210 N.W.2d 576 (Iowa, 1973), a plaintiff pedestrian was struck and injured by a driver who suffered a seizure and lost control of his vehicle. The complaint alleged that the defendant physician knew that the driver suffered an earlier seizure and negligently failed to diagnose the cause and then warn him not to drive. The Iowa Supreme Court overturned the trial court's order dismissing the complaint. Finding the physician had an obligation to potentially foreseeable, although unidentifiable, third parties, the Court reinstated the action and allowed the issue of the physician's negligence to proceed to trial.

In *Joy vs. Eastern Main Medical Center*, 529 A.2d 1364 (Me. 1987), the patient, just prior to the accident, had been treated for an eye abrasion at the emergency room. The treatment included placing an eye patch over one of the patient's eyes resulting in reduced depth perception. In overruling a summary judgment in favor of the defendant physician, the appellate court reinstated the action. Despite the "obvious" nature of the particular peril that may have caused this accident, the Court could not assume that the patient must have known that his driving would be materially affected. It was possible, the Court stated, that the accident resulted from some effect of the eye patch known to the physician but unknown to the patient. The plaintiff, therefore could recover if he could show that his injuries were proximately caused by the failure of the physician in the medical center to warn the driver of the risks of driving with impaired vision.

Finally, in the case of *Krejci vs. Akron Pediatric Neurology, Inc.*, 511 N.E.2d 129 (Ohio, 1987), the Plaintiff, Deborah Weidrick, died as the result of injuries sustained when the automobile that she was driving was struck by one driven by William Korsmo. The accident occurred when Korsmo suffered an epileptic seizure. The plaintiff, Mary A. Krejci, Weidrick's mother and the administratrix of her estate, filed suit alleging that Dr. Timmons, the neurologist, was negligent in certifying Korsmo's medical condition as being sufficiently controlled to permit him to drive. The Court found that the defendant physician owed a special duty to the public, based upon a statutory scheme which exists in almost all jurisdictions. The state of Ohio issues a restricted license to an individual with a history of episodic impairments of consciousness or losses of muscular control only if that person presents a statement from a licensed physician that his condition is under effective medical control for a consistent period of time. Many states broaden this obligation by statute to include any condition which might affect the mental or physical status of an individual as related to his or her ability to safely operate a motor vehicle. The Court found that the physician in the instant case had a duty to determine, within a reasonable degree of medical certainty, that the patient's condition was, in fact, under effective medical control. The Court distinguished the duty to exercise reasonable care in certifying the patient's condition as opposed to the duty to warn or the duty to control. The Court concluded that the defendants could be liable for negligence in certifying that Korsmo's condition was medically controlled and stable. The Court did not, however, require that a physician report the names of all patients who suffer seizures and cause accidents while driving.

The Standard of Care for Health Care Professionals

Based on an analysis of the above case law, it appears that liability can be imposed when the treating healthcare professional knows or should know that a brain injured patient's cognitive status renders him unsafe to drive. Consider the individual who suffers a right cerebral vascular accident with resultant left hemiparesis, left homonymous hemianopsia and severe visual and perceptual impairments. It is well known in the field of rehabilitation that such individuals are not only unable to scan to the left, but almost universally are oblivious to stimuli in the left visual field. Such individuals do not make the necessary compensatory head movements to adapt for this disability with the result that "out of sight is out of mind". Such individuals clearly present a danger both to themselves and to others on the road. It can be argued that health care professionals have a duty to warn the patient and the patient's family. In addition, knowing of the poor judgment, insight, and impulsivity of left hemiplegics, it is more than likely that such patients will ignore those warnings. Since the danger is so clear, it is arguable that the health care professional has a legal obligation to notify the appropriate authorities at the State Department of Motor Vehicles, so that immediate steps may be taken to revoke the patient's license.

Also to be considered are the impairments both at the tactical and operational level (Michon, 1979) which are known to affect the driving safety of traumatically brain injured individuals. Among the deficits generally noted are general reduction in cognitive control as manifested by disinhibition, distractibility, impulsivity, inattention to detail, inability to shift attention, and reduced response latencies. Also noted are left-right confusion, difficulty with sequencing, deficiencies in figure-ground perception, deficient perception of spatial relationships, poor tracking, diplopia, and other visual field defects. Traumatically brain injured individuals are often noted to suffer from excessive concrete reasoning, poor judgment in problem solving, and impaired executive functions. These later deficits may particularly affect the initiation, planning, and carrying out of activities plus the capacity to evaluate the results and consequences of their actions. The often attendant emotional dyscontrol which may result in temper outbursts, reduced frustration tolerance, increased anger at minor obstacles and frustrations, emotional lability, agitation, and acting out behavior, make the traumatically brain injured individual an extraordinarily dangerous instrumentality on the road. Knowing of the potential risk posed by a brain injured individual, it is quite reasonable to expect that courts will predicate liability upon the health care professional's superior knowledge and resultant failures to warn both those who will control the activities of the patient and the appropriate state motor vehicle administrative authorities. Simple warning a patient who suffers from poor reasoning, poor judgment, and inability to control his or her own behaviors, would not likely discharge the duty of the health care professional.

It appears that an emerging trend in the law will extend to rehabilitation professionals liability for injuries to third parties caused by their cognitively impaired patients. Given the aforementioned precedents, we can soon expect that a court will predicate liability upon the superior knowledge and skill of the rehabilitation professionals as well as upon their unique role and

position, which not only allow them to appreciate the danger but also to curtail or reduce that danger to the public at large. Rehabilitation professionals must, in short, use reasonable care in assessing patients and determining their fitness to drive. If such patients present with cognitive, behavioral, or emotional deficits which would adversely affect their fitness to drive, then, to protect the public, the professional should document, verify, and then report those findings to the appropriate administrative authorities.

Guidelines for Decision-Making in Driving

In assessing those skills relevant to the driving decision, health care professionals will want to show that they adopted and utilized reliable and valid assessment techniques. A number of test batteries have been propounded including those by Jones, Giddens, and Croft (1983); Kewman, Seigerman, Kintner, Chu, Henson, and Reeder (1985); van Zomeren, Brouwer, Rothengatter, and Snoek (1988); and Engum, Pendergrass, Cron, Lambert, and Hulse (1988). These batteries appear to assess a wide variety of cognitive skills necessary to safely operate a motor vehicle. Failure to use one of these batteries or some similar reliable, valid, and relatively comprehensive assessment technique may increase the exposure to potential liability for injuries to brain injured patients and their foreseeable victims. Depending only upon general impressions or intuition in assessing the patient's ability to operate a motor vehicle is no longer reasonable professional conduct.

In our opinion, utilizing assessment batteries like the Cognitive Behavioral Driver's Inventory (1988) will meet the applicable standard of care. Internal reliability, standardization of the assessment procedures, evidence of performance of non-brain injured controls, and validation versus internal criteria such as independent evaluations by certified driving instructors are minimum requirements for any objective battery. The standard of care requires only that an objective, verifiable assessment technique be used, not that any or all decisions be correct. The case law does not require that the health care profession prevent or insure against injuries resulting from vehicle accidents involving disabled individuals. The law only requires that professionals be reasonable, responsible, careful, and consistent in their determinations involving the safety of their patients while driving. The law is often an extension of public sentiment and public policy. For example, the public now demonstrates little or no tolerance for drinking and driving. There is also increasing concern about the advisability of allowing elderly, arguably senile, individuals to drive. Many states have imposed recertification requirements for persons over certain ages. Health care professionals are now being found liable for the injuries caused by certain impaired patients. There is considerable precedent for physicians being found liable for injuries to third parties by patients who have been placed upon medication which impairs their judgment, reaction time, and awareness [*Gooden vs. Tips*, 651 S.W.2d 364 (Texas, 1983); *Kaiser vs. Suburban Transportation System*, 398 P.2d 14 (Wash., 1965)]. Our society must balance: 1) the rights of disabled individuals to enjoy certain activities and maintain as much independence as possible; and 2) the right of the public to be protected from unreasonable danger. Necessary in striking this balance is the rehabilitation profes-

sional who seeks to increase the patient's activities and independence while also, at times, acting as the patient's advocate. However, acting to maximize independence, however well intentioned, without utilizing the reliable, valid, and relatively comprehensive assessment tools now available will unnecessarily result in increased professional liability exposure.

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