

DRIVING WITH DEMENTIA: THE NECESSITY OF A COMPREHENSIVE REPORTING SCHEME

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More than simply a rite of passage, obtaining a driver's license is an imperative step in asserting one's independence and self-reliance. However, as drivers age and their physical and mental capabilities begin to decline, many families and caregivers for the elderly are faced with the difficult choice of restricting driving privileges. The lack of a uniform rule on when an elderly person is no longer capable of driving, as well as who should make that decision and on what basis, has fostered only confusion and resentment. The uncertainty is only exacerbated by the numerous and often well-publicized incidents of deadly accidents involving elderly drivers. Fairness to our seniors and our society demands decisive action on this complex issue. This Note recommends comprehensive reform nationally to state licensing practices, as well as physician reporting requirements, to adopt a uniform system of elderly driver evaluation. First, analyzing the shortfalls of the current system, this Note then illustrates how this far-reaching reform balances both the independence of seniors and the interests of society. Following the diagnosis and mandatory reporting of certain cognitive impairments, state driving facilities will employ driving rehabilitation specialists to thoroughly assess driving capabilities and impose any applicable restriction. Individualized evaluation based on standardized criteria respects both the needs of elders and the safety of the public.

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I. Introduction

In 2011, a seventy-four-year-old woman attempting to park in front of a restaurant drove her car through the wall and killed a man and a woman and injured two others.¹ In 2012, an eighty-seven-year-old man killed three people when he drove the wrong way down a highway in New York.² While trying to execute a left-hand turn, a seventy-eight-year-old woman hit a teenage pedestrian and then fled the scene of the accident.³ Another seventy-eight-year-old woman with dementia stole a car and caused a three-car crash in 2014.⁴ Despite accounting for only a fraction of actual automobile accidents in the United States,⁵ stories like these often make headlines with significant attention focused on the age of the driver.⁶ Questions frequently arise about the fitness of elderly drivers and who is responsible when an unfit elderly driver gets behind the wheel.⁷ Should the driver take the blame? The caregiver? The driver's doctor? In 2010, the children of a man killed in an accident sued the driver's physician.⁸ The doctor had diagnosed the driver with mild dementia but failed to report it to the California Department of Motor Vehicles.⁹ It is common for a particularly tragic accident to lead to public calls for legislation regulating

1. Allison Jagow, *Driver in Cheeburger Cheeburger Crash Cited*, WGRZ.COM (Sept. 28, 2011, 2:27 PM), <http://amherst.wgrz.com/news/news/59315-driver-cheeburger-cheeburger-crash-cited>.

2. *Three Killed in I-190 Crash on Grand Island*, WGRZ.COM (July 10, 2012, 7:57 PM), <http://www.wgrz.com/news/article/174121/37/Three-Killed-in-I-190-Crash-on-Grand-Island> [hereinafter *Three Killed in I-190 Crash*].

3. Oren Yaniv, *Brooklyn Woman, 78, Charged with Hit and Run that Killed Teen Claims She Thought Ball Struck Her Car: Lawyer*, DAILY NEWS, <http://www.nydailynews.com/new-york/nyc-crime/woman-78-charged-fatal-crash-claims-ball-struck-car-article-1.2019662> (last updated Nov. 21, 2014, 7:24 PM).

4. Justin Zaremba, *Woman with Dementia Stole Vehicle, Caused 3-car Crash in Jefferson, cops say*, NJ.COM (June 18, 2014, 9:52 AM), http://www.nj.com/morris/index.ssf/2014/06/woman_with_dementia_stole_vehicle_caused_3-car_crash_in_jefferson_cops_say.html.

5. *Driving and Dementia: Health Professionals Can Play Important Role*, NAT'L INST. ON AGING (June 1, 2002), <http://www.nia.nih.gov/alzheimers/features/driving-and-dementia-health-professionals-can-play-important-role>.

6. See Yaniv, *supra* note 3; *Three Killed in I-190 Crash*, *supra* note 2; Jagow, *supra* note 1.

7. Lisa Brodoff, *Planning for Alzheimer's Disease with Mental Health Advance Directives*, 17 ELDER L. J. 239, 240 (2010).

8. Alan Zaremba, *Doctor Not Responsible for Patient's Fatal Crash*, O.C. JURY RULES, L.A. TIMES (Sept. 7, 2012), <http://articles.latimes.com/2012/sep/07/local/la-me-0907-elderly-drivers-20120907>.

9. *Id.*

elderly drivers.¹⁰ Unfortunately for the public and legislatures, elderly driving and the mechanics of why it can be so dangerous are not well understood.

The issues associated with elderly drivers cover a wide range of both physical and cognitive complications. As we age, our ability to perform complex cognitive tasks, such as driving, is greatly impacted.¹¹ Of the cognitive impairments, dementia can pose more risks than most other changes, such as changes in vision, perception, attention, and reaction times.¹² Dementia affects memory, attention span, judgment, and ability to adapt to changing circumstances.¹³ The cognitive effects can make driving with a diagnosis of dementia especially dangerous, but dementia itself is difficult to specifically diagnose.¹⁴ There are significant differences between early-stage dementia and later stages, as well as differences between dementia and Alzheimer's disease.¹⁵ A diagnosis of dementia without proper testing and screening tells caregivers and authorities very little about the abilities of the patient.¹⁶

This Note advocates for legislation creating a uniform physician reporting and state screening process across the country for drivers suffering from dementia and for adopting a set of uniform liability laws. This legislation would require an increase in state participation, as well as an increase in the availability of driving rehabilitation specialists for evaluation and treatment. The primary goal of the legislation is to find a balance between a physician's duty to their patient

10. See generally *Three Killed in I-190 Crash*, *supra* note 2 (noting an online petition has been started to require older drivers to be retested); Stoldt Ziegler, *Retest Elderly Drivers in the State of New York!*, CARE2 PETITIONS, <http://www.thepetitionsite.com/1/theretestingofelderlydriversinnys/> (calling via petition for the retesting of older drivers in the state of New York in response to an accident in which an elderly driver hit and killed a motorcyclist).

11. *The State of Aging and Health in America 2013*, CTRES. FOR DISEASE CONTROL & PREVENTION 4 (2013), http://www.cdc.gov/features/agingandhealth/state_of_aging_and_health_in_america_2013.pdf.

12. Brian Ott & Lori Daiello, *How Does Dementia Affect Driving in Older Patients?*, 6 AGING HEALTH 77, 78 (2010).

13. *What is Dementia?*, ALZHEIMER'S ASS'N, <http://www.alz.org/what-is-dementia.asp> (last visited Feb. 29, 2016).

14. *Id.*

15. *Stages of Dementia*, DEMENTIA CARE CENT., <http://www.dementiacarecentral.com/aboutdementia/facts/stages> (last visited Feb. 29, 2016).

16. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP'T OF TRANSP., DEMENTIA FACT SHEET FOR MEDICAL PROFESSIONALS (Jan. 2013), http://www.nhtsa.gov/staticFiles/nti/pdf/920lc_DementiaFS_010813_vla.pdf.

and the physician's duty to society to keep impaired drivers off the road.

Part II of this Note assesses the population of elderly drivers and the risks they pose to themselves and others. The impact dementia and Alzheimer's disease has on driving ability as patients age is also discussed, as well as the difficulties faced in diagnosing and treating these cognitive problems. Medical conditions associated with general aging are also considered separately from dementia. A brief overview of current state laws regarding mandatory physician reporting for potentially impaired drivers is given, as well as a comparison to procedures in other countries.

An in-depth analysis in Part III of this Note focuses on the competing societal interests at stake and the difficulties of finding a balance between the autonomy necessary for a working patient-doctor relationship and the necessity to keep potentially hazardous drivers off of the roads. The effectiveness of current laws in the United States, as well as in other countries, is addressed with a look at driving accident rates, prevention, and liability jurisprudence. Finally, the benefits and burdens of implementing a uniform legislative scheme of mandatory reporting and standardized evaluation procedures will be evaluated.

Part IV of this Note recommends a uniquely balanced approach to reporting and evaluation that envisions a national push for a mandatory reporting scheme coupled with a comprehensive evaluation system. This approach will alleviate the burdens on caregivers and physicians and reduce the risk to society of unsafe drivers on the road, while still ensuring that healthy and able patients retain their independence and ability to drive.

II. Background

With the senior population growing at an unprecedented rate, the concern over driving capabilities will only increase.¹⁷ In the United States, at least thirty-three million drivers are over the age of sixty-five.¹⁸ By 2020, there will be an estimated forty million licensed driv-

17. CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 11, at 3.

18. *Facts & Research*, SENIORDRIVING.AAA.COM, <http://seniordriving.aaa.com/resources-family-friends/conversations-about-driving/facts-research> (last visited Feb. 29, 2016).

ers that are over the age of sixty-five.¹⁹ Overall, senior drivers tend to be safer drivers than other age groups due to the fact that they tend to drive fewer miles;²⁰ there is also a sharp increase in automobile accidents after age seventy per mile traveled.²¹ Drivers over age seventy are more likely than younger drivers to be involved in multi-vehicle crashes,²² and among people age sixty-five and older, motor vehicle crashes are one of the leading causes of “accidental” injury or death.²³ The number of traffic sign and right-of-way violations, as well as the occurrence of intersection collisions, increases as drivers age.²⁴ The increase in violations and accidents is attributable to a decline in reaction time, vision, and attention.²⁵ Cognitive impairment, especially dementia and Alzheimer’s disease, can lead to deficits in reaction times and attention.²⁶ Elderly drivers with some form of cognitive impairment, especially some form of dementia (including Alzheimer’s disease) have a two to five times higher risk of crashing than those of their control groups matched for age.²⁷

A. Dementia and Other Aging Ailments

Dementia is different from other ailments associated with aging because it is not a specific disease, like diabetes.²⁸ The term dementia covers a broad range of symptoms²⁹ and there is no single test that doctors can use to determine when a patient has dementia, or the se-

19. University of Florida, *Smart Features for Older Drivers*, AAA, <http://newsroom.aaa.com/wp-content/uploads/2013/11/SmartFeatures-FactSheet.pdf> (last visited Feb. 29, 2016).

20. *What Risks Do Older Drivers Pose to Traffic Safety?*, RAND INST. FOR CIV. JUST. (2007), http://www.rand.org/content/dam/rand/pubs/research_briefs/2007/RAND_RB9272.pdf.

21. *Older Drivers*, INS. INST. FOR HIGHWAY SAFETY, <http://www.iihs.org/iihs/topics/t/older-drivers/fatalityfacts/older-people> (last visited Feb. 29, 2016).

22. *Older Drivers, Elderly Driving, Seniors at the Wheel*, SMARTMOTORIST.COM, <http://www.smartmotorist.com/traffic-and-safety-guideline/older-drivers-elderly-driving-seniors-at-the-wheel.html> (last visited Feb. 29, 2016).

23. Richard A. Marottoli & Joseph F. Coughlin, *Walking the Tightrope: Developing a Systems Approach to Balance Safety and Mobility for an Aging Society*, 23 J. OF AGING & SOC. POL’Y 372, 373 (2011).

24. Ott & Daiello, *supra* note 12.

25. *Id.*

26. Melissa Wayne, Monika White & Melinda Smith, *Understanding Dementia*, HELPGUIDE.ORG (Jan. 2016), <http://www.helpguide.org/articles/alzheimers-dementia/understanding-dementia.htm>.

27. Ott & Daiello, *supra* note 12.

28. *What is Dementia?*, *supra* note 13.

29. Wayne, White & Smith, *supra* note 26.

verity of their case.³⁰ Dementia and Alzheimer's disease are diagnosed through comprehensive medical examinations that consist of mental status testing, complete physical and neurological exams, and other tests, including blood tests, to rule out any other possible causes of cognitive impairment.³¹ The most common symptoms associated with a dementia diagnosis are impairments in the following areas: memory, communication, attention and ability to focus, and judgment and reasoning.³² Almost all forms of dementia, including Alzheimer's disease, are progressive, meaning they will worsen as patients age.³³ This is significant because a diagnosis of dementia does not automatically mean that a patient is unfit to drive,³⁴ but the progressive nature of the disease and symptoms requires monitoring from the point of diagnosis to ensure that the patient retains his or her ability to function behind the wheel.³⁵ Currently, there is no cure or treatment that can stop the progression of dementia.³⁶ Early diagnosis and monitoring, as well as some treatments to moderate symptoms, are the only options for patients with a diagnosis.³⁷ However, there is no designated diagnosis or age at which a line can be drawn to separate those that are able to drive from those who cannot.³⁸

Apart from a dementia diagnosis, older drivers exhibit other traits that put them at an increased risk for accidents. Age diminishes eyesight and muscles atrophy,³⁹ which can make controlling a car more difficult. Changes in vision make judging distances and speed of oncoming traffic challenging.⁴⁰ Older drivers also suffer from more medical problems in general, which leads to an increased consumption of medications that can interfere with driving abilities.⁴¹

30. *Diagnosis of Alzheimer's Disease and Dementia*, ALZHEIMER'S ASS'N, http://www.alz.org/alzheimers_disease_diagnosis.asp (last visited Feb 29, 2016).

31. *Diagnosis of Alzheimer's Disease*, *supra* note 30; *Dementia*, MEDICINET.COM, <http://www.medicinenet.com/dementia/page3.htm> (last visited Feb. 29, 2016).

32. *What is Dementia?*, *supra* note 13.

33. *Id.*

34. See U.S. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., *supra* note 16.

35. See Deniz Erten-Lyons, *When Should Patients with Alzheimer Disease Stop Driving?*, *NEUROLOGY* 70 e45, e45 (Aug. 1, 2008).

36. *What is Dementia?*, *supra* note 13.

37. See *id.*

38. Kanoelani Kane, *Driving Into the Sunset*, 25 *HAW. L. REV.* 59, 63 (2002).

39. S. M. Salvi et al., *Ageing Changes in the Eye*, *POSTGRADUATE MED. J.* 581, 581-87 (2006), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2585730>.

40. Kane, *supra* note 38, at 63.

41. John C. Bodnar, *Are Older Americans Dangerously Driving Into the Sunset?*, 72 *WASH. U. L. Q.* 1709, 1710-11 (1994).

B. Elderly Driver Risks

The increased risk of elderly drivers with dementia puts a strain on society to find the proper balance between public safety and individual autonomy. In American society, driving provides independence, increases social and other life opportunities, and even reduces depression in elderly patients.⁴² Concern about elderly driving abilities continues to grow, especially among the younger population,⁴³ and public debate regarding licensing laws is renewed each time an elderly driver is involved in a publicized car accident.⁴⁴ Most states have recognized that elderly drivers pose a risk to public safety and have enacted special license renewal procedures and reporting policies for drivers as they age.⁴⁵ Doctors are at the heart of this debate with an obligation to provide the best care for their patients, but also with a duty to keep society safe.⁴⁶ Physicians function best when they have a relationship of trust with their patients.⁴⁷ That relationship can be jeopardized when physicians are in the position of deciding when to report a patient as a potential driving risk.⁴⁸ As stated previously,

42. Marottoli, *supra* note 23, at 373.

43. *Older Drivers, Elderly Driving, Seniors at the Wheel*, *supra* note 22.

44. See, e.g., *Statistics on Accidents Involving Elderly Drivers*, WGRZ.COM (July 11, 2012, 1:09 PM), <http://archive.wgrz.com/news/article/174275/1/Statistics-On-Accidents-Involving-Elderly-Drivers> (an article published following the report of an accident involving an elderly driver focusing on issues relating to elderly drivers and discussing the general danger elderly drivers pose to the public).

45. *State by State Look at Driving Rules for Older Drivers*, CLAIMS J. (Sept. 19, 2012), <http://www.claimsjournal.com/news/national/2012/09/19/213818.htm>. States are split in how they renew licenses. Some states eliminate the ability to renew by mail after a certain age. Others require a written, on-road, or eye exam before the license can be renewed. Some simply require older drivers to renew their license more often after a certain age. Nineteen states have no additional or specific provisions for older drivers. A few states have implemented a voluntary reporting program in which anyone (or almost anyone) can make a report of a potentially unsafe driver. Pennsylvania has a system of "auditing" drivers in which it randomly selects drivers to pass a physical evaluation before they are allowed to renew their license. The state of Wisconsin has a policy in place in which a doctor's report of an unsafe driver will result in an immediate cancellation of the driver's license and the driver will have to appeal to get his driving privileges back.

46. *Opinion 5.05-Confidentiality*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion505.page>? (last visited Feb. 29, 2016).

47. *Opinion 10.01-Fundamental Elements of the Patient-Physician Relationship*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.page>? (last visited Feb. 29, 2016); Telephone Interview with Susan J. Rottenda, Clinical Program Coordinator, GRECC, VA Health Care System (Sept. 17, 2014).

48. Mark Rapoport et al., *Sharing the Responsibility for Assessing the Risk of the Driver with Dementia*, CAN. MED. ASS'N J. 599, 599 (2007).

the American population is aging at a drastic rate,⁴⁹ with more people than ever facing the challenges associated with elderly-onset medical conditions, especially dementia.⁵⁰ The current state of legislation in the United States provides no clear guidelines for doctors or their patients in how these issues should be addressed.

C. Legal Status of Mandatory Reporting Laws

Many states allow voluntary reporting of potentially unsafe drivers to the state Department of Motor Vehicles (DMV) which can trigger a driving evaluation.⁵¹ Currently, only thirteen states have a mandatory reporting requirement for physicians when their patient exhibits certain defects that could impair their driving abilities.⁵² Of those states, the most common trigger for reporting is a patient experiencing lapses of consciousness.⁵³ Only California and Pennsylvania mention dementia or Alzheimer's disease specifically.⁵⁴

Physicians who report risk a double-edged sword of liability. A physician may be liable both for reporting and thereby breaching confidentiality and for not reporting when the patient is later involved in an accident.⁵⁵ The confidentiality standards involved in the doctor-patient relationship mean that when the law does not authorize the reporting of dangerous drivers, physicians are unlikely to do so.⁵⁶ The risk of liability for not reporting is low, but there are severe consequences for breaching confidentiality laws, including criminal and

49. Jennifer M. Ortman et al., *An Aging Nation: The Older Population in the United States*, U.S. CENSUS BUREAU (May 2014), <https://www.census.gov./prod/2014pubs/p25-1140.pdf>.

50. CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 11, at 3.

51. *State by State Look at Driving Rules for Older Drivers*, *supra* note 45.

52. Rapoport et al., *supra* note 48, at 600.

53. *Id.*

54. *Id.*

55. *HIPAA Violations and Enforcement*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/hipaahealth-insurance-portability-accountability-act/hipaa-violations-enforcement.page?> (last visited Feb. 29, 2016) (physician liability for breaching confidentiality requirements of federal law); Lee Black, *Physicians' Legal Responsibility to Report Impaired Drivers*, 10 AM. MED. ASS'N J. OF ETHICS 393, 394 (2008) (liability rare when reporting is not required). Cf. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN. & AMA, *Ethical and Legal Responsibilities of the Physician in PHYSICIAN'S GUIDE TO ASSESSING AND COUNSELING OLDER DRIVERS* 59, 60, <http://www.aarp.org/content/dam/aarp/livable-communities/plan/transportation/older-drivers-guide.pdf> (physicians have faced liability for third party accidents when they failed to report dangerous conditions).

56. Kane, *supra* note 38, at 72.

civil liability.⁵⁷ In every state and at the federal level, the law requires a sanctioned exception in order for physicians to breach confidentiality.⁵⁸ Therefore, if driver impairment is not one of those exceptions authorized by the state, physicians could face liability for reporting potentially dangerous drivers.⁵⁹ Through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal government has regulated the confidentiality requirements of the patient-doctor relationship.⁶⁰ These confidentiality requirements include exceptions for public safety, such as instances of child abuse, highly infectious diseases, and gunshot wounds.⁶¹ To confuse matters for physicians, many state laws regarding the reporting of potentially dangerous conditions are vague when it comes to driving and dementia,⁶² leaving doctors in the precarious position of attempting to discern whether they are required, or even authorized, to make a report.

The basic systems of elderly driver regulation in the states have been categorized in four ways: 1) treating elderly drivers no different than any other group of drivers (essentially making no exceptions or increased monitoring for drivers as they age); 2) decreasing the time between renewal evaluations for drivers after a certain age; 3) allowing, but not mandating, that physicians report potentially dangerous drivers to the authorities; and 4) mandating that doctors report certain symptoms to the DMV.⁶³ In Oregon, physicians are protected from civil liability both for reporting and not reporting.⁶⁴ Pennsylvania, along with requirements to report dementia-related impairments,⁶⁵ has adopted a system in which physicians are only protected from civil liability in situations in which they do report to licensing authorities.⁶⁶ Apart from the laws themselves, the American Medical Association's (AMA) *Code of Medical Ethics* describes the physician's

57. Black, *supra* note 55, at 394.

58. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936; Black, *supra* note 55, at 394; Kane, *supra* note 38, at 63.

59. Health Insurance Portability and Accountability Act, *supra* note 58; Black, *supra* note 55, at 394; Kane, *supra* note 38, at 63.

60. *Health Information Privacy: HIPAA Administrative Simplification Statute and Rules*, U.S. DEP'T OF HEALTH & HUM. SERVS., <http://www.hhs.gov/ocr/privacy/hipaa/administrative/index.html> (last visited Feb. 29, 2016); Kane, *supra* note 38, at 68.

61. Kane, *supra* note 38, at 69.

62. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN. & AMA, *supra* note 55, at 4.

63. Kane, *supra* note 38, at 69-72.

64. Black, *supra* note 55, at 393.

65. *Id.* at 393-94.

66. *Id.* at 394.

responsibility of recognizing drivers who pose a “strong threat to public safety and which ultimately may need to be reported” to the DMV.⁶⁷

By comparison, every province in Canada, except Alberta, has mandatory reporting laws for physicians to report potentially dangerous drivers to the licensing authorities.⁶⁸ Specifically, British Columbia requires physicians to report any drivers the physician deems unfit to drive, but who refuse to give up their license.⁶⁹ The United Kingdom, despite having no mandatory reporting laws,⁷⁰ recommends that patients who exhibit traditional symptoms of dementia, such as disorientation, impaired memory, and lack of judgment are “almost certainly not fit to drive.”⁷¹

Outside of the legislative and legal systems, the AMA and the Department of Highway Safety have formal recommendations for physicians to follow when assessing driver competency and reporting.⁷² The AMA and the American Academy of Neurology state that “[t]he physician’s role is to report medical conditions that would impair safe driving as dictated by his or her state’s mandatory reporting laws. . . . The determination of the inability to drive safely should be made by the state’s Department of Motor Vehicles.”⁷³ The Department of Highway Safety’s recommendations are equally unhelpful because they only provide guidelines with no set standards.⁷⁴ Their guidelines consist of a recommendation that physicians do a cognitive analysis, but only recommend to the state that the patient needs further evaluation.⁷⁵ That evaluation is then out of the physician’s control.⁷⁶

67. AMA Code of Medical Ethics, *Opinion 2.24-Impaired Drivers and Their Physicians*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion224.page?>; Black, *supra* note 55, at 394.

68. Rapoport et al., *supra* note 48, at 600. See also *Physicians’ Duty to Report Patients*, MINISTRY OF TRANSPORTATION, <http://www.mto.gov.on.ca/english/dandv/driver/medical-review/physicians.shtml> (last visited Feb. 29, 2016) (describing a physician’s duty to report the clinical condition of the physician believes has a condition that would make it dangerous for him or her to drive).

69. Rapoport et al., *supra* note 48, at 600.

70. *Id.*

71. *Id.*

72. U.S. NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., DEP’T OF TRANSP., DOT HS 811 210, DRIVER FITNESS MEDICAL GUIDELINES (2009), http://ntl.bts.gov/lib/31000/31100/31148/6061_MedicalReviewGuide_10-1_v2a.pdf.

73. AM. MED. ASS’N, *supra* note 62.

74. U.S. NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., *supra* note 72.

75. *Id.* at 5.

76. *Id.*

III. Analysis

There are many possible reasons why there is no comprehensive set of legislation or guidelines for the reporting and monitoring of elderly drivers at risk due to dementia in the United States. First, driving requirements are set at the state level.⁷⁷ All physicians, even those who work for the federal government, must adhere to the state reporting requirements.⁷⁸ Second, there is a distinct difference between public and private hospitals and caregivers.⁷⁹ Private practice physicians can simply send a letter to the DMV asking them to revoke a license, but because of the liability issues, risk to the relationship, and no requirement to do so, they rarely report.⁸⁰ Federal employees, for example, the Department of Veteran Affairs (VA), send letters to state DMVs asking them to review a patient, but they cannot force any action.⁸¹

Additionally, there is the problem with dementia diagnosis, especially between mild and moderate dementia.⁸² Diagnosis of dementia does not automatically mean that the patient is not fit to drive.⁸³ Instead, the question is at what point in the progression of the illness does driving really become impaired.⁸⁴ The tests that physicians can provide do not correlate with driving skills.⁸⁵ Most often, physicians need to conduct a wide range of tests and assessments to determine a patient's potential risk for unsafe driving.⁸⁶ Clinician predictions on driving ability have very little correlation to identifying an unsafe driver.⁸⁷

77. Black, *supra* note 55, at 393.

78. *See id.*

79. *See generally* U.S. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., *supra* note 72, at 3.

80. Rottenda, *supra* note 47.

81. *Id.*

82. U.S. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., *supra* note 72, at 7-8.

83. *Id.* at 2.

84. Ott & Daiello, *supra* note 12, at 4.

85. D.J. Iverson et al., *Practice Parameter Update: Evaluation and Management of Driving Risk in Dementia*, 74 NEUROLOGY 1316, 1316 (2010).

86. AM. ACAD. OF NEUROLOGY, DRIVING WITH DEMENTIA: UNDERSTANDING THE SAFETY RISKS (2010), <https://www.aan.com/Guidelines/home/GetGuidelineContent/398>.

87. Iverson, *supra* note 85.

A. The Weaknesses in Current Laws

The biggest weaknesses of the current systems are: 1) vagueness in the statutes; 2) confidentiality and liability concerns; and 3) lack of uniformity among the states in both reporting and evaluation. A 2004 National Transportation Safety Board (NTSB) Special Investigation Report also noted that a lack of liability clarity, and immunity, causes doctors to underreport.⁸⁸

Only one of the thirteen states that have mandatory reporting requirements specifically mentions dementia or Alzheimer's disease.⁸⁹ The other twelve states make ambiguous statements about lapses of consciousness, loss of awareness or functional impairments.⁹⁰ The difficulty doctors face is determining whether they are in a position to report, or if they are required to do so. Some dementia patients may experience lapses in consciousness, but others may only exhibit symptoms such as disorientation, memory loss, and confusion,⁹¹ which undoubtedly make driving more dangerous, but are unlikely to fit neatly into the state reporting requirement category. Even in Pennsylvania, a state that requires physician reporting of loss of awareness,⁹² it took a Commonwealth Court case to determine that a probable diagnosis of Alzheimer's disease satisfied the DOT's burden of proof for revocation of a driver's license.⁹³ If physicians cannot determine whether a report is required, and thus protected, they are unlikely to make the report at all. Enacting such vague laws where physicians cannot fulfill their purpose (i.e. keeping dangerous drivers off of the road) does not benefit society and will not ensure the safety of the individual or of the public.

Physicians face a very serious confidentiality problem when determining when to report. Most states offer criminal and civil liability protection for physicians when they report a dangerous driver in

88. *Medical Oversight of Noncommercial Drivers, Highway Special Investigation Report*, NAT'L TRANSP. SAFETY BOARD 20 (2004).

89. California is the only state to specifically mention dementia as a condition which triggers a physician to mandatorily report. Rapoport et al., *supra* note 48, at 600.

90. Rapport et al., *supra* note 48, at 600.

91. *What is Dementia?*, *supra* note 13; *Stages of Dementia*, *supra* note 15.

92. PA. DEP'T OF TRANSP., MEDICAL CRITERIA AND REGULATIONS, <http://www.dmv.pa.gov/Information-Centers/Medical-Reporting/Pages/Medical-Criteria.aspx#.ViMVodaDKEA>.

93. *Reynolds v. DOT, Bureau of Driver Licensing*, 694 A.2d 321 (Pa. Commw. Ct. 1997).

good faith,⁹⁴ but doctors can still face sanctions from local medical boards for breaching confidentiality⁹⁵ and risk losing patients if their involvement becomes known. Even in states in which reporting is mandatory and there is protection from liability and breaches of confidentiality,⁹⁶ doctors can still face potential lawsuits for their failure to report.⁹⁷ In 2010, an eighty-five-year-old driver in California turned her car into oncoming traffic and caused an accident that resulted in the death of her long-time boyfriend, age ninety.⁹⁸ The children of the deceased filed a wrongful death suit in an Orange County court against the doctor of the driver for not reporting her dementia to the state and for failing to begin the process of revoking her license.⁹⁹ Shortly thereafter, a California jury declined to find the doctor liable for the accident.¹⁰⁰ The jury decided that, despite the fact that California has a mandatory physician reporting law, the doctor did not violate it, or the standard of care, when he did not report his patient's dementia.¹⁰¹ As demonstrated by the lawsuit, even states with reporting laws leave much of the decision-making up to the doctor's medical judgment.¹⁰²

The lack of uniformity of reporting laws is apparent just from examining those states that do require reporting;¹⁰³ there is a wide range of conditions and severities that mandate reporting and interpreting those differences can be difficult. Another significant problem is the fact that health care at the federal level, most notably the VA system, must defer to state rules and regulations.¹⁰⁴ Therefore, pa-

94. See generally IND. CODE 9-24-10-7.5 (2014) (physicians are not civilly or criminally liable for a report made in good faith given to 1) the bureau, 2) the commission, 3) the driver licensing medical advisory board when they have examined a patient "not more than thirty (30) days before making the report"); CAL. HEALTH AND SAFETY CODE § 103900 (West 2014) (physicians are allowed to make reports that may not be required under law if they hold a good faith belief that it is in the public interest to make the report and physicians are also not criminally or civilly liable for any report of a diagnosis of lapses of consciousness if they are required by the law).

95. Black, *supra* note 55, at 393-94.

96. Jessica Garrison & Alan Zarembo, *Doctor sued over fatal crash by patient with dementia*, L.A. TIMES (Sept. 7, 2012), <http://articles.latimes.com/2012/sep/07/local/la-me-elderly-drivers-20120907>; see generally Zarembo, *supra* note 8.

97. Garrison & Zarembo, *supra* note 96.

98. *Id.*

99. *Id.*

100. Zarembo, *supra* note 8.

101. *Id.*

102. *Id.*

103. Rapoport et al., *supra* note 48, at 600.

104. Rottenda, *supra* note 47.

tients receiving healthcare in what should be a uniform system will have their care determined by the state in which they happen to seek medical attention. In addition, the process that follows a physician report is varied and complex.¹⁰⁵ The lack of uniformity in evaluation and procedures put drivers across the country at risk because when states do not use the same criteria for evaluating driving abilities and many drivers who are unfit to drive will be left on the roads. Access to driving rehabilitation specialists varies among the states, as does training for DMV employees to recognize cognitive impairments that may indicate an unfitness to drive.¹⁰⁶ The disparities in access to treatment and training for drivers and training and resources for the states lean heavily in favor of standardizing the evaluation and examination process across the country.

105. See generally IND. CODE 9-24-10-7.5 (2014) (in which the bureau may request medical information of both the driver and from his physician, require the driver to submit to an examination and investigation and then determine whether to suspend, revoke, or restrict driving privileges); *Physical and Mental Evaluation Guidelines*, CAL. DEP'T OF MOTOR VEHICLES, https://www.dmv.ca.gov/portal/dmv/?1dmy&urile=wcm:path:/dmv_content_en/dmv/dl/driversafety/pm_guidelines (last visited Feb. 29, 2016) (detailing the investigation/reexamination process which is followed by the determination of the connection between a condition and driving, and then a review of factors that may mitigate the condition, an evaluation of the driver's understanding and awareness, and finally a decision on licensing renewal).

106. *DriveWell: Promoting Older Driver Safety and Mobility in Your Community*, AM. SOC'Y ON AGING 1, 32 (2007), <http://www.trafficsafetymarketing.gov/newtsm/SeniorDrivers/DriveWellTK.pdf>; Sean Connolly, Kristopher Jorgenson & Nicholas Shallow, *Medically At-Risk Drivers: A Review of Research and Policies*, NELSON A. ROCKEFELLER CTR. AT DARTMOUTH C. 1, 7 (2014).

B. Arguments Against a Mandatory Reporting and Evaluation Scheme

Competing interests also pose a challenge to developing uniform reporting and licensing laws. There is a significant societal interest in keeping the patient and the public safe that must be balanced against the physician's legal and ethical obligation for confidentiality.¹⁰⁷ Doctors have an obligation to provide care that is in the best interest of their patients.¹⁰⁸ In order to provide this level of care, physicians must establish relationships of trust with their patients that facilitate honest discussion and better treatment.¹⁰⁹ Patients have their own interests in maintaining their ability to be mobile and live on their own such as continued interaction in their community, less reliance on children or friends for transportation, and the lack of public transportation available to substitute for driving privileges.¹¹⁰ When deciding whether to report an at-risk driver, the doctor must also consider the greater impact it will have on the patient. Loss of driving ability is associated with depressive symptoms and decreased participation with out-of-home activities.¹¹¹ For example, a Canadian study found that just over twenty-seven percent of physicians would hesitate to report a potentially unsafe driver, even when legislation was in place for mandatory reporting.¹¹² Another study in Canada analyzed 1605 drivers involved in dangerous vehicle accidents and discovered one-third of these drivers had a pre-existing medical condition that was "potentially reportable" but that very few of the patients (28 of 1605) were actually reported.¹¹³ Physicians fear that their patients will see the revocation of their license as a punishment for seeking treatment and will terminate the relationship with their physician.¹¹⁴ The difficulty of these decisions and the individual analysis that accompanies each one weighs against a one-size-fits-all system of reporting.

Additionally, when mandating that physicians report certain symptoms to the licensing authorities, the liability for accidents is

107. Black, *supra* note 55, at 393.

108. AMA Code of Medical Ethics, Opinion 10.01, *supra* note 47.

109. *Opinion 10.015-The Patient-Physician Relationship*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.page?> (last visited Feb. 29, 2016).

110. Marottoli, *supra* note 23, at 373.

111. *Id.*

112. Rapoport et al., *supra* note 48, at 599.

113. Donald A. Redelmeier et al., *Mandatory Reporting by Physicians of Patients Potentially Unfit to Drive*, 2(1) OPEN MED. E8 (2008).

114. Rapoport et al., *supra* note 48, at 599.

placed on doctors, the medical system, and monetarily-stressed state systems. Government-funded hospitals are already overcrowded and financially burdened;¹¹⁵ forcing them to take on a more active role in elderly patient care and evaluation could stress the system even further.¹¹⁶ The state's ability to regulate private physicians and hospitals is extremely limited.¹¹⁷ Writing and passing legislation that will set clear guidelines within the state's power to regulate private business is potentially very difficult.

Concern about a decrease in the communication and honesty between doctor and patient is also a concern for mandatory reporting laws. Physicians express concern that mandatory reporting laws will cause patients to underreport the extent of their illness or not seek treatment at all.¹¹⁸ A study conducted in an Oregon seizure clinic found that twenty-eight percent of patients said they would not report a seizure if there was a mandatory reporting law in place.¹¹⁹

A final obstacle to enacting uniform legislation regarding mandatory reporting is that each state administers its own DMV.¹²⁰ Consequently, each state will have different rules and guidelines for licensing, retesting, and even administering different tests for driving evaluation. States also have a wide range of resources available to DMVs.¹²¹ Much like the impact increased reporting will have on public hospitals and resources, the transportation budget of each state will have to be stretched even further to accommodate for increased testing and evaluations.

115. See generally Joseph Abrams, *VA Medical System in Shambles, Veterans Groups Say*, FOXNEWS.COM (June 24, 2009), <http://www.foxnews.com/politics/2009/06/24/va-medical-shambles-veterans-groups-say/>.

116. Abrams, *supra* note 115 (arguing that "complacency, poor funding and little oversight" have created a failing VA system along with too few physicians); *Public Hospitals Decline Swiftly*, WASH. TIMES (Aug. 16, 2005), <http://www.washingtontimes.com/news/2005/aug/16/20050816-102614-7824r/?page=all#pagebreak> (reporting on the decline in the number of public hospitals nationwide and attributing most of the closures to financial strain from under- and uninsured patients).

117. Rottenda, *supra* note 47.

118. *Medical Oversight of Noncommercial Drivers, Special Investigation Report*, *supra* note 88, at 17.

119. M.C. Salinsky, K. Wegener & F. Sinnema, *Epilepsy, Driving Laws, and Patient Disclosure to Physicians*, 33 *EPILEPSIA* 469, 470 (1992).

120. Black, *supra* note 55, at 393.

121. See generally *Licensing Procedures for Older Drivers*, NAT'L HIGHWAY SAFETY BOARD (Sept. 2013), <http://www.nhtsa.gov> (type in "Safety Outcomes of Licensing Procedures for Older Drivers").

C. Arguments in Favor of a Uniform Mandatory Reporting Scheme

For caregivers and patients alike, the stress and uncertainty involved with diminishing cognitive abilities brought on by old age can be very burdensome for families.¹²² The families and caregivers of elderly patients are not always equipped to determine when it is time to take the keys away.¹²³ The National Highway Traffic Safety Administration conducted a study in which they found that caregivers of elderly drivers want authority figures to assist them in taking the keys away from a loved one.¹²⁴ Physicians can also be reluctant to make this determination because of the severe repercussions to their relationship with their patients and the impact it will have on the patient's lifestyle.¹²⁵ Physicians are also not the most qualified to make the necessary determination about driving skills. Their expertise is in making an initial diagnosis or noting symptoms,¹²⁶ not in how that diagnosis affects actual driving ability.

According to the National Highway Safety Board (NHSB), one of the main concerns that affect the likelihood that a doctor will report a potentially unsafe driver is knowledge of reporting laws.¹²⁷ The report issued by the NHSB noted that twenty-eight percent of "geriatricians in the United States were unaware of the procedures for reporting drivers with . . . dementia."¹²⁸ The AMA and other organizations implemented programs for informing doctors about reporting laws and practices,¹²⁹ but a more uniform system would decrease confusion

122. Doug Russell et al., *Dementia and Alzheimer's Care*, HELPGUIDE.ORG (Nov. 2014), <http://www.helpguide.org/articles/alzheimers-dementia/dementia-and-alzheimers-care.htm> (last updated Aug. 2015).

123. *Driving Assessment*, ALZHEIMER'S ASS'N, http://www.alz.org/georgia/in_my_community_16195.asp (last visited Feb. 29, 2016).

124. *Impaired Drivers the Physician's Dilemma*, THE MED. SOC'Y OF THE STATE OF N.Y. 4 (2003), https://www.mssny.org/App_Themes/MSSNY/pdf/Public_Health-Public_Health_Concerns_Ongoing_Health_Concerns_Impaired_Drivers_White_Paper_on_Impaired_Drivers.pdf.

125. Rapoport et al., *supra* note 48, at 599.

126. *Id.*

127. *Medical Oversight of Noncommercial Drivers, Highway Special Investigation Report*, *supra* note 88, at 17.

128. *Medical Oversight of Noncommercial Drivers, Highway Special Investigation Report*, *supra* note 88, at 17; *Impaired Drivers the Physician's Dilemma*, *supra* note 124, at 9 (stating that physicians may not even know what their state reporting laws are and how to go about making a report of a driver with a condition that could potentially put himself or the public at risk).

129. *Medical Oversight of Noncommercial Drivers, Highway Special Investigation Report*, *supra* note 88, at 118; *Impaired Drivers the Physician's Dilemma*, *supra* note 124, at 9.

overall and promote more reporting when it is necessary.¹³⁰ Uniform laws will also address the difficulties of interpreting the laws by determining under what circumstances symptoms and diagnoses need to be reported.¹³¹

This Note has addressed the issues with mandatory reporting laws and the problems that physicians raise with them, but one of the strongest arguments in favor of mandatory reporting laws is the very real risk that doctors will not report patients if they are not required to.¹³² Additionally, in jurisdictions that do have mandatory reporting laws, there has been a marked increase in the number of reports made for unsafe drivers.¹³³ Pennsylvania has seen an increase of almost four times in the number of reports made to the DMV following a publicity campaign highlighting its mandatory reporting law in 1992.¹³⁴

Uniform reporting laws that make requirements for how authorities handle patients that pose a potential risk to themselves or others would incorporate the already established, unofficial guidelines adopted by federal agencies and the AMA.¹³⁵ One such requirement, which could be easy to implement, is the recommendation that patients with Alzheimer's disease have their driving reevaluated every six months due to rapid decline in abilities, especially those patients with mild Alzheimer's.¹³⁶

Similarly, in the NHSB Special Investigation Report of 2010, the Board recommended that for assessing chronic conditions, such as dementia, licensing agencies must "measure performance related to driving, determine a threshold that can be used to screen drivers, and follow up periodically to gauge changes in performance."¹³⁷ This recommendation serves the patient and public safety needs by consider-

130. *Medical Oversight of Noncommercial Drivers, Highway Special Investigation Report*, *supra* note 88, at 18.

131. *See generally* Reynolds, 694 A.2d at 364 (in which court interpreted 75 Pa.C.S. § 1518(b) to determine whether medical testimony was required at a hearing to revoke a license or if the report submitted by the physician would be sufficient for the Department of Transportation to carry its burden).

132. *Medical Oversight of Noncommercial Drivers, Highway Special Investigation Report*, *supra* note 88, at 19.

133. *Id.* ("[I]n the five Canadian provinces with mandatory reporting laws, eighty-four percent of physicians reported patients with seizures, as compared to nineteen percent in the five provinces with discretionary laws.").

134. Kane, *supra* note 38, at 73.

135. AMA Code of Medical Ethics, Opinion 2.24(4), *supra* note 67.

136. Erten-Lyons, *supra* note 35, at e45.

137. *Medical Oversight of Noncommercial Drivers, Highway Special Investigation Report*, *supra* note 88, at 15.

ing patients on a case-by-case basis and allowing for rehabilitation training to improve skill as well as monitor potentially degenerative conditions to determine when driving ability has been impaired. Since physicians do not have the skills to determine the actual driving ability of their patient,¹³⁸ it is important that the states adopt a uniform system in which driving specialists and state agents are trained to recognize cognitive impairments and are aware that simply because a driver has a diagnosis, this does not mean that he or she is automatically unfit to drive.

Physicians and medical professionals have always struggled to determine if they should report dangerous or unhealthy behavior involving their patients.¹³⁹ Mandatory reporting laws simply take the discretion of *when* to report away from the physicians.¹⁴⁰ It is then usually up to another government agency to determine whether the report has any merit and what steps need to be taken.¹⁴¹ One popular example of a comparable system is the mandatory reporting laws for child abuse and neglect. In most, if not all, states physicians are required to make a report of any child they have “reasonable cause to believe” is abused or neglected.¹⁴² Once that report is filed, the state agency responsible for child welfare takes over the case to make a determination about what steps need to be taken.¹⁴³ Doctors then do not have to grapple with deciding whether or not to report a possible incident of abuse or neglect because they are required to do so by law.¹⁴⁴ There is less of a risk to the relationship with the patient because the doctor can put the “blame” for reporting on the government and the

138. *See id.*

139. *See Medical Oversight of Noncommercial Drivers, Highway Special Investigation Report, supra* note 88, at 19 (showing that doctors are more likely to report when it is mandatory).

140. *See id.*

141. Redelmeier et al., *supra* note 113.

142. *See Mandatory Reporters of Child Abuse and Neglect*, CHILD WELFARE INFO. GATEWAY (Nov. 2013), <https://www.childwelfare.gov/pubPDFs/manda.pdf#page=5&view=Summaries of State Laws> (giving an overall summary and specific summaries of the mandatory reporting laws in each state).

143. *See, e.g.*, 325 ILCS 5/7.3 (2014) (describing the duty of the Department of Children and Families to be the “sole agency responsible for receiving and investigating reports of child abuse or neglect . . .”).

144. *See generally Making and Screening Reports of Child Abuse and Neglect*, CHILD WELFARE INFO. GATEWAY (Nov. 2013), <https://www.childwelfare.gov/pubPDFs/repproc.pdf>.

statute.¹⁴⁵ There is no real determination that the physician must make, other than that there is a reasonable belief of abuse or neglect.¹⁴⁶ Notably, unlike mandatory laws for disabled drivers, mandatory child abuse laws often carry a penalty for *failing* to report¹⁴⁷ even charging doctors or other mandatory reporters with a crime.¹⁴⁸

Modeling the system for reporting at-risk elderly drivers after the child abuse and neglect statutes would be the most efficient and would provide much needed guidance to the process of developing a regulatory scheme. The reporting system for elderly drivers would require the doctor to make a determination that there is a reasonable basis to believe that the driver has cognitive impairments that could affect the ability to drive. A report would be made to the DMV (or equivalent) who then would conduct an investigation to determine whether the driver poses a risk to himself or herself and the public. The investigation would include meeting with the patient and discussing health concerns and talking to family and friends who interact with the patient on a regular basis to determine abilities and general functionality of the patient. If the investigator believes there is a possibility that the patient could pose a risk, both a written and field driving test would be administered to the patient. Passing the tests would allow the driver to retain his license; failing would result in the state agency revoking the driver's license. At the time that determination is made, the state can issue an identification card to the driver to replace the lost license. The state can also make recommendations of services to drivers who failed (or almost failed) to improve their skill and regain the license. Such services could include the driving rehabilitation

145. See generally *Penalties for Failure to Report and False Reporting of Child Abuse and Neglect*, CHILD WELFARE INFO. GATEWAY (Nov. 2013), <https://www.childwelfare.gov/pubPDFs/report.pdf#page=2&view=PenaltiesforFailuretoReport>.

146. *Id.*

147. See, e.g., 325 ILCS 5/4.02 (2014) ("Any physician who willfully fails to report suspected child abuse or neglect as required by this Act shall be referred to the Illinois State Medical Disciplinary Board . . .").

148. CHILD WELFARE INFO. GATEWAY, *supra* note 145. All states statutes for mandatory reporting of child abuse or neglect cases carry some penalty for failing to make a mandated report of suspected child abuse or neglect for those that fall within the designated class of mandatory reporters. This class can include doctors, teachers, counselors, and others who may regularly interact with children. The state of Florida makes failure to report a felony and in thirty-nine other states, failure to report is a misdemeanor. These charges can carry a jail sentence or a fine. Additionally, in seven states reporters who failed to make the mandatory report can be held civilly liable (on top of any criminal charges) for any damage caused by their failure. And finally, reporting professionals who are mandated to the state review or disciplinary board commonly accompanies any failure of reporting.

therapy discussed above. Physicians would also be protected from liability for good faith reports.

The proposed system above is similar to the mandatory reporting laws adopted by California in Section 103900 of the California Health and Safety Code.¹⁴⁹ Doctors are required to report to the “local health officer” anyone whom the doctor has “diagnosed as having a case of a disorder characterized by lapses in consciousness.”¹⁵⁰ The local health officer in turn reports the diagnosis to the DMV.¹⁵¹ The DMV will then examine the driver’s record and send the driver a medical evaluation form which the driver will have to fill out to authorize the primary physician to give the DMV information about the patient’s health.¹⁵² If the driver has a diagnosis of moderate to severe dementia, the DMV will revoke the license because the driver is no longer safe to drive.¹⁵³ Patients diagnosed with mild dementia are then reexamined by the DMV in a three-part test to determine driving ability.¹⁵⁴ First, the driver will have an in-person contact, or interview, during which he will be expected to answer general questions about health and driving needs and skills.¹⁵⁵ The interview is designed to test awareness, language deterioration, perception, and cognitive abilities.¹⁵⁶ Next, a driver will have to take a written knowledge test on the rules of the road;¹⁵⁷ however, the DMV states that the primary function of the written exam is to test cognitive and language skills.¹⁵⁸ When determining the outcome of the exam, the DMV considers the speed in which the driver could complete the exam, how many questions were missed, if the driver could answer the questions verbally when asked in a different way, and if the knowledge could be improved by studying.¹⁵⁹ If the driver fails the written portion and interview, the DMV determines whether the reason for failure is a medical

149. CAL. HEALTH & SAFETY CODE § 103900 (2014).

150. CAL. HEALTH & SAFETY CODE § 103900(a) (2014).

151. CAL. HEALTH & SAFETY CODE § 103900(b) (2014).

152. *Dementia, Driving and California State Law*, FAM. CAREGIVER ALLIANCE, <https://caregiver.org/dementia-driving-and-california-state-law> (last visited Feb. 29, 2016).

153. *Dementia*, CAL. DEP’T OF MOTOR VEHICLES, <https://www.dmv.ca.gov/portal/dmv/detail/dl/driversafety/dementia> (last visited Feb. 29, 2016).

154. *Id.*

155. *Id.*

156. *Id.*

157. *Id.*

158. *Id.*

159. *Id.*

condition which results in the suspension of the driver's license.¹⁶⁰ However, if the driver passes both exams, they will then move on to the Special Driving Test which, if passed, results in the driver maintaining his license.¹⁶¹ The Special Driving Test focuses on areas affected by dementia, like the ability to find the car, remember a series of driving commands, and whether driving for a longer period of time affects the driver's abilities.¹⁶² The California DMV will also continue to monitor drivers who have been reported with dementia but passed the driving examination and were allowed to continue driving.¹⁶³ Importantly, the California model does revoke driving privileges without further evaluation based on a diagnosis of moderate to severe dementia.¹⁶⁴ However, it does take into account the individual nature of each patient and focuses on training evaluators to look for specific impairments of driving associated with aging and dementia separately from the actual mechanics and overall driving ability.¹⁶⁵ This approach recognizes that physicians themselves are not able to properly predict driving ability based on a diagnosis and therefore, trained evaluators are necessary to make the final determinations regarding fitness to drive.

D. Addressing All Areas Collectively

Individually modifying the areas of mandatory reporting, evaluation and examination, and the physician liability laws independently will not effectuate the change necessary to fully address the problems of dementia patients behind the wheel. Tying physician liability to dangerous patients, without authorizing their disclosure of potentially dangerous medical conditions, will only confuse the system even more. Improving evaluation procedures, availability of rehabilitation specialists, and standardizing tests will do little if physicians do not feel compelled to report, and therefore, patients do not partake in the required evaluations. Writing mandatory reporting laws alone will put stress on the system without much effect on the safety of the public if tests are not standardized and evaluations are done improperly.

160. *Id.*

161. *Id.*

162. *Dementia, Driving and California State Law, supra* note 152.

163. David B. Reuben & Peggy St. George, *Driving and Dementia: California's Approach to a Medical and Policy Dilemma*, 164(2) WEST J. MED. 111, 120 (Feb. 1996).

164. *Dementia, supra* note 153.

165. Reuben, *supra* note 163, at 118.

There will also continue to be a difference between the requirements of public and private hospitals so patients will receive different care and experience different outcomes after a dementia diagnosis depending on where they can afford to receive treatment.

Physicians also need to have some faith in the system if they are to participate and comply with mandatory reporting laws. They must know and believe that after they report a condition to the licensing authorities, the case will be handled professionally and responsibly and that a true evaluation of their patients' driving abilities will be conducted. If this is not the case, the pressure to maintain the doctor-patient relationship and the unfairness of having a license revoked for simply consulting a doctor about dementia symptoms will undermine the system and decrease physician compliance.

Finally, simply because a physician can recognize symptoms that may impair driving, or even make a diagnosis of dementia, does not mean that they are in a position to determine whether a patient is fit to drive or not.¹⁶⁶ There is no standardized evaluation that doctors can give patients that can determine their abilities to drive.¹⁶⁷ This task is better suited for driving rehabilitation specialists and licensing authorities with the knowledge, skill, and equipment to properly test a driver's ability in real-world conditions.¹⁶⁸ This is why simply enacting mandatory reporting regulation is not enough; what happens to the patient after the condition is reported?

Much like the California model, the system needs to recognize the limitations of the independent parties at play. Patients have an interest in continuing to drive and maintaining their independence. The families and caregivers want to protect their loved ones from danger and harm, but also recognize the burden they would have to carry if the patient ceased driving. Physicians are able to recognize and diagnose cognitive limitations that can potentially lead to unsafe driving, but they cannot evaluate actual driving ability.¹⁶⁹ Doctors also have an interest in maintaining a relationship with their patients and encouraging them to be forthcoming with concerns and symptoms. States have an interest in protecting the citizens from unsafe drivers, but also need to take into account the realities of cost, time, and com-

166. Rapoport et al., *supra* note 48, at 599.

167. *Id.*

168. *Learn About: CDRS, ASS'N FOR DRIVER REHABILITATION SPECIALISTS*, <http://www.adednet/?page=210> (last visited Feb. 29, 2016).

169. Rapoport et al., *supra* note 48, at 599.

plexity of any changes to the current evaluation systems. To best balance and address the many competing interests at stake both locally and nationally, the states and the driving specialists should have mandatory and uniform procedures for evaluating drivers diagnosed with dementia and determining the risk they pose to themselves and others.

E. Difficulties in Enacting such Legislation

The federalist system in the United States poses significant hurdles to enacting the kind of broad regulatory scheme necessary to address the issue of elderly drivers with dementia. The federal government is limited to its spending and commerce clause powers; it does not have power to generally require the states to adopt legislation that deals with issues not specifically granted to the federal government.¹⁷⁰

However, much like the federal government compelled the states to adopt uniform drinking age laws,¹⁷¹ the federal government can also compel the states to adopt legislation by tying the reception of federal transportation funds to the adoption of legislation.¹⁷² Through the federal government's spending power, found in Article I, Section VIII, Clause III of the Constitution, the federal government is allowed to allocate funds to the several states.¹⁷³ As long as the federal government does not apply coercive pressure to the states, they can condition the receipt of federal money on adopting certain provisions.¹⁷⁴ This is the strategy that will be the most effective in implementing the necessary regulatory scheme.

There is a significant cost to implementing such a system including, but not limited to, the training of state DMV employees to be able to effectively administer an evaluation system that identifies cognitive impairments associated with dementia that can reduce driving ability. However, the failure to implement such a system now will only result in greater costs in the coming years as more and more drivers become susceptible to the diseases and degenerations of aging. California has

170. U.S. CONST. amend. X.

171. National Minimum Drinking Age Act, 23 U.S.C. § 158 (2012).

172. *South Dakota v. Dole*, 483 U.S. 203, 212 (1987).

173. U.S. CONST. art. I, § 8, cl. 3.

174. *Dole*, 483 U.S. at 211 (holding that tying a "relatively small percentage" of federal funds to raising the drinking age was not so coercive as to become compulsive).

successfully implemented such a program¹⁷⁵ and the availability of driving rehabilitation specialists throughout the country that can transition into state work (through direct hire or contracts with the state) will alleviate some of the financial pressures the states will feel.¹⁷⁶

IV. Recommendation

The federal government should adopt a comprehensive legislative scheme that includes mandatory reporting laws for all physicians along with uniform evaluation systems and techniques that include both written and on-road driving tests. Mandatory reporting laws reduce the tension on the physician between the confidentiality owed to the patient and the duty to report a potentially unsafe driver.¹⁷⁷ Mandatory reporting alone will not fully address the risk that drivers with dementia pose to the public, a standardized evaluation process is also necessary.

The evaluation programs for states would need to be expanded for training of employees to recognize signs of cognitive impairment when issuing written and on-road tests. Utilizing restrictions on licenses instead of suspensions or revocations allows for further testing and increasing the use of driving rehabilitation specialists. Standardized tests also ensure that all drivers, across the country are subject to the same determinations of ability, thus protecting the borders between states where drivers from one state frequently pass over into another. The uniformity of the system is important to ensure that physicians comply with the regulations, and that patients, regardless of where they live or what hospital they attend, receive the same evaluation of driving skills and potential risks posed.

Liability for physicians both for breaching confidentiality and for failing to report a driver who is then involved in an accident needs to be uniform as well, for the same reasons. Physicians cannot protect the safety of society if they will be faced with loss of license or AMA repercussions, not to mention civil and criminal liability, for breaching doctor-patient confidentiality.¹⁷⁸ Requiring the reporting of certain impairments to licensing authorities removes the responsibility from

175. *Dementia*, *supra* note 153.

176. *Learn About: CDRS*, *supra* note 168.

177. Rapoport et al., *supra* note 48, at 599.

178. See generally Michael H. Kottow, *Medical Confidentiality: An Intransigent and Absolute Obligation*, 12 J. MED. ETHICS 117 (1986), <http://jme.bmj.com/content/12/3/117.short>.

the physician to make a determination of when and whether to report for evaluation. This will ease the tension placed on the relationship between doctors and patients because essentially, the decision-making of whether to report a dangerous condition is taken out of the doctor's hands so the patient has no reason to resent his physician personally. Mandatory reporting will also alleviate pressure on caregivers. Often, as cognitive conditions worsen, more and more decision-making is left up to the caregiver, even if the patient is still functional.¹⁷⁹ If there is no plan in place for the stage at which the patient will cease driving (often decided shortly after diagnosis), caregivers are left to make that determination without guidance or support from the patient. Under the mandatory reporting system, caregivers and family members will only be responsible for reporting changes in symptoms and possible deteriorations in health, instead of needing to decide whether or not to bring up the issue of driving and license revocation. This issue will be left to the doctor to determine if the patient's condition has deteriorated to the point at which reporting is mandatory, and then the final decision will ultimately be in the hands of the state.

In order to ensure compliance with the mandatory reporting scheme, liability would have to focus not on breaches of confidentiality, but instead on when physicians fail to report. Instead of increasing liability for third-party accidents, similar to wrongful death suits in which physicians are responsible for patients who drive with conditions that impair cognitive ability,¹⁸⁰ liability should be modeled after failure to report standards.¹⁸¹ This would include civil liability and possible sanctions from the state medical board.

The complexity of the issue of elderly drivers with dementia mandates congressional guidance and motivation. Public interest in the topic is often sparked by reports of tragic accidents¹⁸² and consequently, few states have taken the initiative on their own to address the issues.¹⁸³ Additionally, because of the great cost associated with implementing improved evaluation programs, federal funding will

179. Russell, *supra* note 122.

180. Jeffrey Berger et al., *Reporting by Physicians of Impaired Drivers and Potentially Impaired Drivers*, 15 J. GEN. INTERNAL MED. 667, 669 (2000).

181. See generally *id.*

182. See generally *Retest Elderly Drivers in the State of New York!*, *supra* note 10.

183. See generally *Behind the Wheel: Occupational Therapy and Older Drivers*, AM. OCCUPATIONAL THERAPY ASS'N, INC., <http://www.aota.org/about-occupational-therapy/professionals/rdp/articles/older-drivers.aspx> (last visited Feb. 29, 2016).

likely be required.¹⁸⁴ The complexity of the issue, competing interests, and high costs mandate a comprehensive federal scheme. The scheme proposed balances the competing interests and motivates action before the problem becomes more dangerous.

A. Criticisms and Answers

As compelling as a comprehensive scheme sounds, it is important to note that sweeping federal regulations of complex issues are not without their hurdles.¹⁸⁵ One-size-fits-all legislation cannot account for all of the nuances that states must address in the actual implementation and day-to-day workings of the scheme. States should be the laboratories of the government, implementing different strategies to find ones that work for individual state needs, not the other way around.¹⁸⁶ States have different resources and needs that cannot be addressed by a large, overreaching, legislative scheme. To combat this perceived flaw of the recommendation, the legislation would have to be tailored loosely enough to be compatible with the different forms of DMVs and licensing agencies in each state.

Additionally, states have already achieved similar uniformity in several other areas of law traditionally left to state control, such as the legal drinking age,¹⁸⁷ health insurance schemes,¹⁸⁸ and laws designating mandatory reporting of child abuse and neglect.¹⁸⁹ Often, these systems require congressional impetus with the use of threats to

184. Robert I. Field, *Why Is Health Care Regulation So Complex?*, HEALTH CARE & L. (Oct. 2008), http://www.ncbi.nlm.gov/pmc/articles/PMC2730786/pdf/ptj33_10p607.pdf.

185. Regulations such as the one proposed in this note face real monetary challenges and also concerns about the separations of powers between the states and the federal government. See, e.g., Avik Roy, *7 Reasons Why Obamacare 'Federalism' Won't Lead Anthony Kennedy to Join the Supreme Court's Left In King v. Burwell*, FORBES (Mar. 4, 2015), <http://www.forbes.com/sites/theapothecary/2015/03/04/7-reasons-why-obamacare-federalism-wont-lead-anthony-kennedy-to-join-the-supreme-courts-left-in-king-v-burwell/> (summarizing the federalism and coercion arguments opposing the Affordable Care Act highlighted in the Supreme Court case, *King v. Burwell*, argued in 2015).

186. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932).

187. National Minimum Drinking Age Act, 23 U.S.C. §158 (2014).

188. See generally *Affordable Care Act*, <http://medicaid.gov/affordablecare-act/affordable-care-act.html> (last visited Feb. 29, 2016) (discussing how the federal and state governments have worked together to implement the Affordable Care Act and set up enrollment policies across the nation); *Mandated Health Insurance Benefits and State Laws*, NAT'L CONF. OF STATE LEGS. (Jan. 2014), <http://www.ncsl.org/research/health/mandated-health-insurance-benefits-and-state-laws.aspx>.

189. *Mandatory Reporters of Child Abuse and Neglect*, *supra* note 142.

withhold money or requiring a federal government agency to intervene.¹⁹⁰ Despite the need for some variation in details, overall, the states have reached a relatively uniform (and in the case of the drinking age, completely uniform) regulatory scheme.¹⁹¹ There is no reason that states could not achieve similar success with a reporting scheme for drivers that pose a safety risk due to dementia.

A comprehensive system such as the one proposed would require significant resources, especially to establish availability of driving rehabilitation specialists and increased screening, including administering written and on-road tests as patients age. While this is a valid concern, there is no real alternative if the issue of driver ability is to be properly addressed. The problem of unfit drivers suffering from cognitive impairments will only increase in the next few years as the baby-boomer generation ages and the elderly driving population increases. Establishing proper protocol, infrastructure, and facilities now is the best way to address the issues of the future before they become too numerous and dangerous to deal with. Additionally, all states already have DMVs equipped to administer written and on-road driving tests.¹⁹² The employees will have to be trained to watch for signs of cognitive impairment in elderly drivers, tests will need to be administered more often as drivers age in line with the AMA's recommendation that patients suffering with Alzheimer's are assessed every six months to monitor progression of the disease,¹⁹³ and physicians will have to become actively involved in reporting potentially dangerous symptoms to the proper authorities.

190. See, e.g., National Minimum Drinking Age Act, 23 U.S.C. § 158; *South Dakota v. Dole*, 483 U.S. 203 (1987) (in which the federal government tied the reception of federal highway funds to an increase in the legal drinking age in the state to twenty-one years); *Key Features of the Affordable Care Act By Year*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html> (last visited Feb. 29, 2016). To implement the Affordable Health Care Act, states are given the choice to create and run their own health care exchange system or the Department of Health and Human Services will develop and implement a plan for the state.

191. National Minimum Drinking Age Act, 23 U.S.C. § 158.

192. See *50 State DMV Links*, DEP'T OF MOTOR VEHICLES, OFFICIAL WEBSITE OF THE ST. OF NEV., http://www.dmvnv.com/50_state_dmv_list.html (last visited Feb. 29, 2016).

193. Erten-Lyons, *supra* note 35.

V. Conclusion

The rapidly growing elder population poses many challenges that will need to be addressed in the coming years, including the dangers associated with elderly drivers. A comprehensive mandatory reporting and evaluation scheme for at-risk drivers is the best way to effectively address the competing interests of safety, confidentiality, proper evaluation, and liability in reporting schemes. Uniformity is necessary to ensure that all drivers get the same evaluations and are subjected to the same standards in determining whether they possess the cognitive abilities associated with driving.

Legislatures are struggling to find adequate solutions to the issue of elderly drivers.¹⁹⁴ Courts are at a loss as to how to reconcile vague statutes that allow for exceptions to confidentiality laws with the strict standards of doctor-patient confidentiality that our society has come to expect.¹⁹⁵ A national reporting scheme would resolve these issues by providing clarity and direction to physicians, patients, their caregivers, and the courts. This approach will effectively balance all of the competing interests and produce the best possible outcome of ensuring that public safety is protected by keeping dangerous drivers off the road, while still providing enough individual assessment to ensure that licenses are not needlessly revoked or suspended. This comprehensive scheme requires adaptations and changes to multiple areas of law, but that is the best way to address all concerns associated with elderly driving regulation.

194. See generally Garrick F.D. Aplin, *Elderly Drivers: Balancing Public Safety with Permanent Personal Mobility*, 87 WASH. L. REV. 378 (Jan. 2009), http://open-scholarship.wustl.edu/cgi/viewcontent.cgi?article=1085&context=law_lawreview.

195. See Joy L. Pritts, *Altered States: State health Privacy Laws and the Impact of the Federal Health Privacy Rule*, 2 YALE J. OF HEALTH POL'Y L. & ETHICS 327, 329 (Oct. 2008).

