Chapter Ten

Driving and Other Transportation Issues

A. Background

AD "presents a significant challenge to driving safety. With progressive dementia, patients ultimately lose the ability to drive safely and the ability to be aware of this.... It becomes the responsibility of family members and other care givers to protect the safety of these patients by enforcing driving cessation" (American Medical Association and National Highway Traffic Safety Administration 2003). Yet, dissension over continued driving can disrupt family relations. One commentator describes the tension when, for example, a spouse or child thinks that a loved one with AD should no longer drive, but the driver resists that decision:

> The paternalistic interventions of caregivers increase, sometimes to the dismay of the patient and often to the dismay of the caregivers as well. Personal tensions increase in the household; stress builds up on top of on-going grief over loss, guilt over forgoing other life activities in favor of caregiving, and physical and emotional fatigue. When this moment arrives in the course of the disease, it is not a happy time.

(Jennings 2001, at 596.)

Although the Maryland Motor Vehicle Law is premised on the principle of safety, it does not presume that a person with AD is an "unsafe" driver. Instead, the law looks at the facts of a person's driving record and the driver's physical and mental competence.

Identifying the right time for intervention is no easy matter. There is unsurprising evidence that, in general, the driving performance of people with AD declines over time, even when the disease is relatively mild (Duchek, Carr, Hunt et al. 2003). Those who continue to drive despite serious impairment of the attributes that are essential for safe driving pose a serious risk to personal and public safety and need to be gotten off the roads. Others with AD, however, are functioning well and can still drive safely, at least under some conditions.

Distinguishing between the two groups is an important task of government, for it requires attention not only to the obvious safety issues but also to the real impact that loss of mobility can have: declining self-esteem, social isolation, neglect of proper nutrition or medical care (Coughlin 2001). As a recent federal report observed, "functional screening to assure the 'driving health' of older persons is rightfully viewed in the context of injury prevention. As such, its potential benefits to individuals and society are profound, *if* integrated with education and counseling to improve awareness about the risks associated with functional loss, referrals for remediation of functional loss whenever possible, and connection to alternative transportation resources to preserve – instead of penalizing – the independent mobility of affected drivers" (National Highway Traffic Safety Administration 2003a).

B. Current Law

Although the Maryland Motor Vehicle Law is premised on the principle of safety, it does not presume that every person with AD is an "unsafe" driver. Instead, the law looks at the facts of a person's driving record and the driver's physical and mental competence. Specifically, the Motor Vehicle Administration (MVA) may suspend, revoke, or refuse

to renew a license if there is sufficient evidence that the licensee is unfit or unsafe.[1] Usually, notice and hearing are required before this action may be taken, but suspension can be immediate if the MVA determines that there is a likelihood of substantial and immediate danger and harm to the licensee or others.[2]

The Vehicle Law contains several provisions specific to older drivers. For example, when an individual who is 70 years or older applies for a new license, he or she must provide the MVA with proof of previous satisfactory driving experience or a written certification from a doctor attesting to the individual's physical and mental qualifications.[3] The MVA, however, may not use the age of an individual as the sole criterion for requiring a licensee to submit to a reexamination. To require a reexamination of any licensee, old or young, the MVA must have good cause to believe that the licensee is unfit or unsafe.[4]

Reporting of medical conditions that pose a significant risk to safe driving is permissible under health information privacy laws and is encouraged as a matter of medical ethics.

Under the Vehicle Law, physicians and other diagnosticians are authorized (although not mandated) to report certain disorders, including those "characterized by lapses of consciousness."[5] A "lapse of consciousness" is defined in the pertinent regulation as a "failure to be oriented to time, place, person, [or] situation"; "confusion" is listed as an example of lapse of consciousness.[6] AD, as it progresses, presents these characteristics.

Reporting of medical conditions that pose a significant risk to safe driving is permissible under health information privacy laws and is encouraged as a matter of medical ethics. Federal privacy regulations allow disclosure of protected health information without patient authorization to a public health authority legally authorized to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability.[7] The MVA serves this public health function with respect to prevention of vehicle accidents. In addition, Maryland law governing

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the confidentiality of medical records permits health care providers to disclose a medical record without patient authorization "to a government agency performing its lawful duties ...."[8] With regard to the ethical issue, the American Medical Association's opinion on the subject affirms that, "In situations where clear evidence of substantial driving impairment implies a strong threat to patient and public safety, and where the physician's advice to discontinue driving privileges is ignored, it is desirable and ethical to notify [state licensing authorities]" (Council on Judicial and Ethical Affairs 2002, at E-2.24).

To deal with medical issues that may cause unsafe driving, the General Assembly has authorized the MVA's Administrator to appoint a Medical Advisory Board.[9] This Board may be asked by family members, physicians, the police, or other concerned persons to consider the case of any licensee or applicant who, because of a suspected mental or physical disability, could be an unsafe driver. The name of the person making the request is kept confidential. The Board then provides the Administrator with an advisory opinion on the case.[10]

Hence, the law is designed to provide a process to remove unsafe drivers from the road, and there can be no doubt that some people with AD are unsafe drivers. Data from one recent study, for example, suggest that even some drivers with mild AD suffer a decline in driving performance over time (Ducheck, Carr, Hunt et al. 2003). The formidable public policy objective is to design a system that effectively differentiates between safe and unsafe drivers and that maintains the goal of promoting autonomy without sacrificing safety. The MVA, through its Medical Advisory Board and an impressive and innovative research program, is actively pursuing this objective.

C. MVA's Assessment and Remediation Strategies

In a brochure entitled *Is It Time To Stop Driving?*, issued in conjunction with local chapters of the Alzheimer's Association, the MVA states clearly that it is "committed to helping people drive as long as they can do so safely." The MVA, through its Driver Safety Research Program, seeks to develop a methodologically sound and feasible strategy to carry out this commitment. The MVA and its Medical Advisory Board, under the leadership of Dr. Robert L. Raleigh, Chief of the Board and Director of the Office of Driver Safety Research, are to be commended for their foresight and skill in dealing with the issues associated with driving privileges for persons with AD.

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One major component of the Program is outreach and education of the public through self-awareness driving checklists, tips on overcoming impairments, and guide books and handbooks for use in locating assistance, resources, and additional information. In conjunction with the Maryland Research and Development Consortium, a multidisciplinary group of over 35 government and private organizations, the Program plans research and development projects to support its outreach efforts. Some of these include:

> Safe Mobility for Older Persons Notebooks, a reference document providing the "why" and the "how to" for the various components of the Program;
>
> Self-Assessment for Seniors: Testing Your Own Abilities to Drive Safely, a guidebook for seniors to recognize and accept responsibility for driving limitations;

Concerned About an Older Driver? - What to Look For In Observing Driving Difficulties by Seniors, a guidebook for family members, friends, and others, including law enforcement officers; and

Handbook of Recommended Procedures for Driver Functional Screening, a guidebook presenting protocols for quick tests of core abilities, tailored to application by MVA personnel, health professionals, and other professionals in the community.

The MVA has tested the efficacy and practicability of a variety of assessment tools **(National Highway Traffic Safety Administration 2003b)**. *The goal of this effort is to fairly and accurately identify high-risk older drivers.*

A second component of the Program looks to opportunities for greater physician involvement in assessing driving capacity. The Program has recognized that physicians need to be educated, sensitized, and trained to identify driving impairment problems and to know when to refer patients to the Medical Advisory Board. Ideally, assessment instruments used in clinical practice might be shown to be a valid predictor of driving risk.

Under the auspices of a multidisciplinary research consortium, the MVA has tested the efficacy and practicability of a variety of assessment tools (National Highway Traffic Safety Administration 2003b). The goal of this effort is to fairly and accurately identify high-risk older drivers. Some of the assessment tools have particular pertinence for drivers with AD. For example, a trail-making test, “Trails B,” is used by clinicians to measure deficits in an individual’s ability to perform a visual search and to divide attention effectively.[11] Relatively poor performance on this test has been validated by MVA’s research as having highly significant predictive value for risk of crash involvement (National Highway Traffic Safety Administration 2003b). Thus, this test can serve as an objective basis for a physician to act, including making a referral to the Medical Advisory Board.[12]

A third component of the MVA Program is assessment and evaluation. The Program will conduct an intensive, individual assessment using face-to-face interviews with the driver and family members, review of medical records, and sequential driving skills assessments. The assessments focus on the driver's ability to make judgments, estimate distances accurately, and remember routes and destinations. Because driving skills are based on long- term imbedded memories, which may at times mask an impairment of tactical driving skills, several driving skills assessments may occur over a two- to three-week period, with follow up as necessary. Depending on the results of the assessment, a person with very mild or mild AD may continue to drive on a unrestricted license, be issued a geographically restricted license, or have driving privileges revoked.

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Sometimes an assessment may indicate that a person with AD needs remediation as a condition of driving. For example, someone with some physical weakness or impairment in movement may need physical therapy to remediate the problem or occupational therapy to practice driving techniques that would compensate for the problem. Unfortunately, the evaluation and remediation services needed to keep a person "on the road" may not generally be covered by health insurance. Lack of insurance coverage for such services creates a barrier to continued driving.

RECOMMENDATION 10-1: The MVA should continue developing its model assessment program, especially its effort to encourage physicians to make the link between specific assessment tools and reporting to MVA.

RECOMMENDATION 10-2: Med Chi, the State medical society, should encourage its members to participate in the MVA's program.

RECOMMENDATION 10-3: The General Assembly should base any new legislation concerning the licensing of older drivers on the data and research findings that will derive from the Driver Safety Research Program.

RECOMMENDATION 10-4: The Maryland Insurance Administration should gather information about health insurance coverage of physical or occupational therapy or similar health care services needed for purposes of continued driving and, if its inquiry suggests that coverage is commonly denied, consider an appropriate response to the problem.

D. Transportation Alternatives

Accessible public transportation can significantly minimize the negative effects of loss of driving privileges. The State has long recognized that "The public interest requires the development of an effective and efficient transit service to meet the special needs of the elderly and handicapped person." **(Transportation Article, §7-201.1(e).)**

Losing one's privilege to drive can have a devastating impact. Previously routine tasks, performed independently, become problems requiring assistance. Getting to the grocery store, the hairdresser, or the doctor's office often becomes possible only when the schedules of family or friends permit. Greater dependency is almost inevitable; social isolation becomes a risk.

Accessible public transportation can significantly minimize the negative effects of loss of driving privileges. The State has long recognized that "[t]he public interest requires the development of an effective and efficient transit service to meet the special needs of the elderly and handicapped person."[13] One currently available option for persons with AD is Paratransit, established by the Maryland Transit Administration (MTA) to comply with the Americans with Disabilities Act.[14] The Paratransit system was designed to address discriminatory access practices that precluded disabled persons from using the existing public transportation system.[15] Paratransit is a shared-ride, curb-to-curb service for people with disabilities.[16] A trip by Paratransit can be for any

purpose. The one-way, heavily subsidized fare on a Paratransit van is $1.85.[17]

For persons with mild AD who, for example, may be able to travel from home to the grocery store without assistance, Paratransit can provide some measure of independence. Even for persons who are more functionally impaired and who cannot travel independently, the service can be useful, because a personal care aide may accompany the person on the van.

The restrictions built into the Paratransit service, however, may limit its usefulness as an alternative to driving. For example, it is not an on-call system, but instead requires reservations. Moreover, there are geographic limitations on the areas it serves; the Paratransit service area consists of locations within Baltimore City, Baltimore County, or Anne Arundel County within three-quarters of a mile of an MTA fixed-route service. Hence, some suburban and most rural residents cannot benefit from Paratransit.

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RECOMMENDATION 10-5: The MTA should continue its ongoing effort to adapt the current public transportation system to the transportation needs of those whose health precludes their driving and that it work closely with the Alzheimer's Association and other groups to assess in particular the demands for alternative transportation that the increased incidence of AD over the next two decades will generate.

References

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Endnotes

1. Transportation Article, § 16-206(a)(1)(ii).

2. Transportation Article, § 16-206(d).

3. Transportation Article, § 16-103.1(9).

4. Transportation Article, § 16-207(a)(2).

5. Transportation Article, § 16-119(a). We note that, under §16-119(b)(2), a physician is not to report (without patient consent) "information derived from the diagnosis or treatment of any individual on whom a confidential or privileged relationship is conferred by law." The extent to which this provision is a barrier to reporting is not clear.

6. Code of Maryland Regulations, 11.17.03.02B.

7. 45 C.F.R. § 164.512(b).

8. Health-General Article, § 4-305(a)(3).

9. Transportation Article, § 16-118.

10. Transportation Article, § 16-118(c).

11. The Trails B test involves drawing a line to connect, in proper sequence, numbers and letters scattered on a page. Those with memory or attention problems will likely require more than average time to complete the test.

12. The results of other assessments performed for clinical purposes may also be telling. For example, the Clinical Dementia Rating scale (CDR), currently used by physicians to determine the level and severity of AD, may also serve as an indicator of when a referral to MVA for further assessment may be necessary. The CDR assigns a rating from zero (no AD) to 3 (severe AD) in six functional categories – memory, orientation, judgment/problem solving, community affairs, home and hobbies, and personal care. If a person's CDR is a 2 (moderate AD) or 3 (severe AD), it is clear that the person should not be driving. If he or she has not stopped driving voluntarily, the Program would educate physicians that a referral to the Medical Advisory Board for license revocation would be necessary. A CDR of 1 (mild AD) might also require a referral, depending on the person's abilities and impairments (Dubinsky, Stein, and Lyons 2000). This brief account is not intended as a comprehensive description of the circumstances under which physician referral is indicated.

13. Transportation Article, § 7-201.1(e).

14. 42 U.S.C. § 12132 *et seq.*

15. 49 C.F.R. §§ 37.5 and 37.121.

16. More detailed information about Paratransit is available at the following web page: http://www.mtamaryland.com/disability/para/index.cfm (accessed September 3, 2003).

17. The actual cost per ride is approximately $25.00.