



DOCTORS



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A Letter from the Chair of the Board

Dear Colleague:

We would like to alert you to what we believe are hidden liability issues in your practice that you need to be acutely aware of. The news is full of incidents where older drivers have been involved in serious accidents, many of which could have been avoided. The following is one example. Last year a car driven by an older driver went through a crowd of people at a California farmer's market usually closed to traffic. The accident took the lives of ten people and injured scores of others. Prior to this incident, the American Medical Association (AMA) had approved recommendations aimed at helping you gain a greater awareness of factors that may impair the driving skills of your older patients.

This issue of the newsletter will look not only at the older patient, but will help you assess and counsel those patients who, for a variety of reasons, may be at an increased risk to themselves and others when they get behind the wheel.

This newsletter also provides important information for surgeons regarding the new Protocol required by JCAHO for the prevention of wrong-site surgery.

D. Ted Levers, M.D.
Chair of the Board

Medical Mutual Liability Insurance Society of Maryland

Spotting the Impaired Driver: A Roadmap for Physicians

The daughter of one of your patients comes to you and tells you that her mother has had a number of "spells" recently. She is afraid that one of these spells may occur when her mother is driving and asks that you speak to mom about this. The daughter believes that her mother would handle it better if this discussion came from you. What do you do?

You prescribe anti-depressant medication to a patient who is experiencing work-related stress anxiety. You warn the patient not to drive while taking the drugs in question. He drives anyway and is involved in a motor vehicle accident and is injured. Are you at fault?

Depending on your patient base, questions similar to the one described above may arise with increasing frequency. Many physicians are at a loss as to how to respond because they are unclear as to their responsibilities to the patient and are doubly unsure as to what their legal responsibilities might be. They are concerned that by reporting a patient to the state motor vehicle administration, they run the risk of alienating the patient, being accused of breaching patient confidentiality or losing patients from their practice altogether. On the other hand, physicians may be generally aware that the state where they practice may have laws requiring them to report patients that the physician deems to be unsafe behind the wheel and failure to report may put them at increased risk from a legal standpoint.

Part of the dilemma that physicians face is the question of determining who is at increased risk. Driving a motor vehicle is an activity that requires a number of important cognitive skills such as memory, judgment and attention. This does not mean that physicians make the decisions as to who should lose their license, but rather should look at

Continued on next page

their patient base and determine if medical conditions, medications or other functional impairments are negatively impacting a patient's driving abilities.

In order to answer these questions, we must first look to what the physician's responsibilities are to their patients. The relationship between a doctor and a patient is at the very heart of medicine. Most physicians would say that their primary responsibility is to care for the physical and mental health of their patients. An integral part of this is caring for the patient's safety. When the physician is dealing with a patient who drives, it becomes an added responsibility to inform the patient about medical conditions and medications that could alter their ability to drive safely.

Even the best of drivers can become unsafe when their abilities are reduced by certain medical conditions. The effects of different medical conditions on driving ability are many and varied. Some conditions, such as Alzheimer's disease, Parkinson's, dementia, stroke, musculoskeletal disorders, psychiatric disorders, sleep apnea and drug and alcohol abuse are easy to relate to reductions in driving ability. However, less obvious conditions such as heart disease, diabetes, pulmonary dysfunction, renal disease, kidney failure or sclerosis may also contribute significantly to the reduction of a patient's abilities of judgment, memory or attention. The detection, diagnosis and treatment of illnesses in these categories may help in reducing the risk of an automobile accident and maintaining the driving skills of your patients. Sometimes, a particular disease may be so severe and irreversible that a recommendation to stop driving is obvious. Often, however, an increased risk for an accident may not be so clear. In these patients, referral to other professionals or organizations may be useful in the evaluation and rehabilitation process.

As the second example illustrates, some cases of physician liability that involve driving are related to medications. Physicians should warn a patient if a particular medication may affect them adversely while they are driving or operating machinery and should document that conversation in the medical records to avoid the issue of "if it wasn't documented, it wasn't done." If medications are an issue, an attempt

should be made to discontinue any drugs that could impair driving (if medically feasible) or alternative drugs such as non-sedating antihistamines or non-sedating antidepressants be substituted. Physicians and pharmacists should be consulted before any new medications are started to determine whether the drug can affect the ability to drive. Since side effects are often more pronounced during the first few days of a new prescription, patients should be instructed to avoid driving until they can see what effect the new medication is having on them. The risk of traffic injuries among older patients is further heightened by the varieties of medications they may be on at any one time. Updated medication lists are a necessity to prevent serious medication interactions that may cause problems on the road.

According to the American Medical Association's report "Impaired Drivers and Their Physicians", Physicians should "use their best judgment when determining when to report impairments that could limit a patient's ability to drive safely. 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 the Department of Motor Vehicles." (E.2.24)

What does state law have to say? **Maryland's** Motor Vehicle Administration (MVA) requires that application for and renewal of a Maryland driver's license include visual acuity and visual field testing in-person at a state mandated site. Additionally, a medical report is required of new drivers age 70 and older. Application and renewal for commercial drivers includes a color vision requirement.

Maryland law provides for the discretionary reporting to the MVA of persons who have "disorders characterized by lapses of consciousness." The law goes on to state that a civil or criminal action may not be brought against any person who makes a report/referral to the Medical Advisory Board (MAB) (an arm of the MVA) and who does not violate any confidential or privileged relationship conferred by law. The Medical Advisory Board is comprised of 16 physicians specializing in various areas of medicine. They work in concert with the MVA to ensure that a driver is capable of safely operating a motor

Doctors RX

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vehicle. The MAB will accept information from courts, other DMVs, police, family members, and other sources (i.e., complaints). The MAB can also provide guidance to physicians wondering whether they should report a patient. They can be reached at (410) 768-7513 for information and assistance. Generally speaking, approval to drive by the Board is required for any of the following conditions:

- Cerebral palsy
- Diabetes
- Epilepsy
- Multiple Sclerosis
- Muscular dystrophy
- Heart condition
- Stroke
- Alcoholism, or alcohol abuse
- Drug addiction
- Loss of limb or limbs
- Organic brain syndrome
- Manic depressive disorders (major affective disorders)
- Schizophrenic disorders
- Severe anxiety disorders



Other illness in which there are lapses of consciousness, blackout, seizure or Disorders that prevent a corrected minimum visual acuity of 20/70 in each eye and a field of vision of at least 110 degrees.

If a patient is referred, the MVA's Driver Wellness and Safety Division will send that individual a packet of information indicating if any additional information is required. The DW&S may then decide to refer the patient to the MAB for an evaluation.

The physicians on the MAB do not perform medical examinations themselves. The physical evaluation part of the process primarily depends upon reports from the patient's physician or other treatment sources. Members of the MAB (not the full Board) do meet with the affected driver, either in person or via teleconference. After a review of the information, the Board will return a recommendation to the DW&S for final action. The MVA may take a variety of actions, from allowing the patient to continue to drive to suspending their driving privileges. All medical records obtained by the MAB are confidential and not open for public disclosure. These records may only be revealed by a court order.

If the MVA decides to suspend an individual's driving privileges, and they disagree with that ruling, there is a mechanism for appeal. The individual may contact the DW&S and request an administrative hearing on the matter.

Similar requirements can be found in the motor vehicle administration regulations of **Virginia**. Virginia's licensing requirements also require visual acuity and visual field testing. Restrictions on an individual's license to drive may be based on road test performance, medical conditions, violation of probation, or court convictions. Conditions may include mandatory corrective lenses, hand controls, radius limitations, daylight driving only, mandatory ignition interlock device, and driving only to and from work/school.

Physicians are not required to report medically unsafe drivers. However, for physicians who do report these, laws have been enacted to prohibit release of the physician's name as the source of the report. Va. Code section 54.1-2966.1 states that if a physician reports a patient to the DMV, it shall not constitute a violation of the doctor-patient relationship unless the physician has acted in bad faith or with malicious intent.

The DMV also relies upon information from courts, other DMVs, law enforcement officers, physicians, and other medical professionals, relatives, and concerned citizens to help identify drivers who may be impaired. At the present time, Virginia law provides confidentiality for family members who report impaired drivers. Drivers are notified in writing that the DMV has initiated a medical review and they are advised of the medical review requirements. Drivers are also advised of any restrictions of suspension imposed as a result of the review.

Virginia's Medical Advisory Board enables the DMV to monitor drivers throughout the state who may have physical or mental problems. The MAB assists the Commissioner with the development of medical and health standards for use in the issuance of driver's licenses. The MAB helps the DMV in denying issuance of licenses to per-



sons suffering from any physical or mental disability or disease that will prevent their exercising reasonable and ordinary control over a motor vehicle while driving it on highways. Virginia's MAB reviews the more complex cases, including those referred for administrative hearings, and provides recommendations for medical review action.

The main difference in the licensing requirements of the **District of Columbia** is that they do not maintain a medical advisory board as part of their Department of Motor Vehicles. They do require visual acuity and visual field testing and there is a color vision requirement for new drivers only. As for licensure renewal, drivers with physical disabilities may require a road test at the time of their renewal. Additionally, senior citizens may be required to take the road test on an observational basis. Drivers reaching age 70 must submit a letter from their physician stating that they are medically fit to drive based on physical and mental capabilities.

As in the other two states, DC does not require that physicians report medically impaired drivers but, if they choose to do so, they are allowed to remain anonymous.

Where does HIPAA fit in? The *HIPAA Standards for Privacy of Individually Identifiable Health Information* (Privacy Rule) permits health care providers to disclose protected health information (PHI) without individual authorization *as required by law*. It also permits

health care providers to disclose PHI to authorities authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability.

As mentioned previously, it is not always easy for a physician to make the determination as to whether a patient can continue to drive. Driver rehabilitation specialists (DRS) can be an additional resource to help with this assessment. A DRS can perform a more in-depth functional determination and evaluate a patient's performance in the actual task of driving. Based on how the patient performs, the DRS may recommend that the patient continue driving with or without restrictions; advise the use of adaptive techniques and devices to overcome certain functional deficits; or recommend that the patient discontinue driving altogether. If a determination is made that the patient should "retire" from driving, the DRS can assist the patient with alternative transportation suggestions.

Driver rehabilitation programs are often associated with hospitals (occupational therapy departments), rehabilitation centers, driving schools and state licensing agencies. You can also contact the Association for Driver Rehabilitation Specialists at www.driver-ed.org for additional information on the driver rehabilitation specialists in your particular area.

New Wrong Site Surgery Protocol

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently approved the Universal Protocol for preventing wrong-site, wrong-procedure and wrong-person surgery. Statistics indicate that Orthopaedic Surgery accounts for 40% of all wrong-site surgery incidents, with Neurosurgery at 14% and Urologic Surgery at 11%. The largest percentage of reported incidents involves operating on the wrong body part.

Compliance with the Protocol by all accredited organizations that provide surgical services is required beginning July 1, 2004. The required steps in the JCAHO Universal Protocol are as follows:

Preoperative verification process

Purpose: To ensure that all of the relevant documents and studies are available prior to the start of the procedure and that they have been reviewed and are consistent with each other and with the patient's expectations and with the team's understanding of the intended patient, procedure, site and, as applicable, any implants.

Missing information or discrepancies must be addressed before starting the procedure.

Process: An ongoing process of information gathering and verification, beginning with the determination to do the procedure, continuing through all settings and interventions involved in the preoperative preparation of the patient, up to and including the "time out" just before the start of the procedure.

Marking the operative site

Purpose: To identify unambiguously the intended site of incision or insertion.

Process: For procedures involving right/left distinction, multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures), the intended site should be marked such that the mark will be visible after the patient has been prepped and draped.

"Time out" immediately before starting the procedure

Purpose: To conduct a final verification of the correct patient, procedure, site and, as applicable, implants.

Process: Active communication among all members of the surgical/procedure team, consistently initiated by a designated member of the team, conducted in a "fail-safe" mode, i.e., the procedure is not started until any questions or concerns are resolved.

We strongly encourage you to work closely with your hospital and the members of your surgical team to implement these procedures as soon as possible. This is a **preventable** problem.



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Make sure you get the best possible opportunity to attend the program, date and location of your choice by registering now for one of our 2004 Risk Management educational seminars. Physicians in Maryland can choose from "Communication-Plus," "Mock Deposition" and "Specialty Specifics." Physicians in Virginia and Washington, D.C. can take "Medical Matters," a seminar focused on actual closed medical malpractice cases. Participating Physicians earn CME Credits and a 5% premium discount on their 2005 MEDICAL MUTUAL or Professionals Advocate renewal policies. Visit our web site at www.weinsuredocs.com for complete seminar information or for convenient online registration.



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CME Test Questions

Instructions for CME Participation

CME Accreditation Statement — MEDICAL MUTUAL Liability Insurance Society, which is affiliated with Professionals Advocate, is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. MEDICAL MUTUAL designates this educational activity for a maximum of one hour in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Instructions — to receive credit, please follow these instructions:

1. Read the articles contained in the newsletter and then answer the test questions.
2. Mail or fax your completed answers for grading to the address or fax number provided below:
Med•Lantic Management Services, Inc.
225 International Circle
P.O. Box 8016
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Attention: Risk Management Services Dept.
3. One of our goals is to assess the continuing educational needs of our readers so we may enhance the educational effectiveness of the Doctors RX. To achieve this goal, we need your help. You must complete the CME evaluation form to receive credit.
4. Completion Deadline: July 31, 2004
5. Upon completion of the test and evaluation form, a certificate of credit will be mailed to you. Please allow three weeks to receive your certificate.

1. Physicians should only worry about their older patients when looking at the issue of impaired driving ability.
A. True B. False
2. Approval by Maryland's Medical Advisory Board is required for patients who suffer from diabetes before they can get operate a motor vehicle.
A. True B. False
3. A patient's treating physician must make the final determination as to whether a patient can keep their license.
A. True B. False
4. The State of Virginia requires treating physicians to report all unsafe drivers to the state motor vehicle administration.
A. True B. False
5. Virginia law allows physicians to report patients to the DMV who don't pay their bills in a timely manner without fear of retribution from the patient.
A. True B. False
6. In discussing your recommendations to the patient regarding conditions that might affect their driving ability, always make sure you document the conversation/suggestions in the medical record.
A. True B. False
7. Driver rehabilitation specialists can assist physicians and family members in assessing a patient's driving abilities.
A. True B. False
8. Operating on the wrong patient has the highest percentage of reported incidents that the Joint Commission is trying to prevent.
A. True B. False
9. The new JCAHO Protocol on Wrong -Site Surgery will go into effect July 1, 2005.
A. True B. False
10. The JCAHO Protocol requires that the surgical team take a "time out" prior to the procedure to verify that they have the correct patient, procedure, site, etc.
A. True B. False



CME Evaluation Form

Statement of Educational Purpose

"Doctors RX" is a newsletter sent three times each year to the insured physicians of MEDICAL MUTUAL/Professionals Advocate. Its mission and educational purpose is to identify current health care related risk management issues and provide physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:

- 1) gain information on topics of particular importance to them as physicians,
- 2) assess the newsletter's value to them as practicing physicians, and
- 3) assess how this information may influence their own practices.

CME Objectives for Spotting the Impaired Driver

Educational Objective: To gain an understanding of how to assess and counsel patients on medical fitness to drive.

To gain an awareness of specific state reporting laws regarding impaired drivers

To become familiar with JCAHO's new Protocol on Wrong-Site Surgery

Strongly Agree	Strongly Disagree
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Part I. Educational Value:

5 4 3 2 1

I learned something new that was important.

I verified some important information.

I plan to seek more information on this topic.

This information is likely to have an impact on my practice.

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature: _____ Date: _____

Part 4. Identifying Information: Please PRINT legibly or type the following:

Name: _____ Telephone Number: _____

Address: _____
