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## Panel Discussion: Responsibility in Driving Safety - The Registry and the Driver. The Guild of St. Luke of Boston, Meeting-May14, 1967

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# THE GUILD of ST. LUKE of BOSTON

Meeting—May 24, 1967

## **Panel Discussion**

### RESPONSIBILITY IN DRIVING SAFETY— THE REGISTRY and the DRIVER

Panel members were:

Reverend Robert F. Drinan, S.J., *Dean*, Boston College Law School

Richard J. McLaughlin, *Registrar of Motor Vehicles*

Richard D. Mulroy, M.D., *Chief of Orthopedic Surgery*, Waltham Hospital and member of the Mass. Medical Committee on Driving Safety

Joseph R. Stanton, M.D., *Assistant Clinical Professor of Medicine*, Tufts University School of Medicine, the Moderator of the Panel

The remarks of the Panel Members follow:

*Dr. Stanton:*

This panel will concern itself with the driver and the automobile. It will focus upon the driver's legal, moral, and medical responsibilities and the problems related thereto from the standpoint of the Registry, the clergyman, who is also a distinguished lawyer, and the physician.

The phrase, *driver responsibility*, is appropriate because so often we think of driving as a privilege or a right and seldom is emphasis put upon the concomitant responsibilities. One out of every eight deaths in males in this country is accidental in origin and the majority of these are automobile fatalities. It is stated that one million five hundred thousand people have been killed in automobile accidents since the invention of the car of which fifty-two thousand occurred in the United States last year.

It is obvious from reading any of the highway statistics after one of our long weekends, or even an average one, that there is a tremendous problem of death here. When one's attention shifts from those who have died and whose suffering has ended and consider those who live to suffer after injuries, the figures either in monetary terms or suffering are startling. For many reasons, the problem of the automobile fatality has never really been studied in depth as a public health problem, and yet its mortality is worse than the mortality of tuberculosis or a host of infectious diseases. It is the commonest killer up to the age of 35 in this country and ranks close behind cardio-vascular disease in those over the age of 35. Dr. Robert Hess of the Michigan Highway Safety Institute points out that forty billion dollars are currently being spent on highway programs but that the hazards of the highway are not scientifically known.

*Registrar Richard McLaughlin:*

We tend in our country, in our society to compartmentalize things, A,B,C, and so forth; and here we have today the automobile being discussed. The automobile does not lend itself realistically to that kind of compartmentalization because this vehicle, in a short span of one man's lifetime, from the year 1900 to date, has become about the most pervasive instrument that we have in our civilization. It is that important. It is that omnipresent. It is a part of everyone's life. It is a part of everyone's livelihood. It is the second factor in the economy—second only to housing and construction. It accounts for 1/7 of all the jobs in America; 1/7 of all the dollars invested in our economy, and it has taken a fearful toll.

It has certainly re-made the face of the country. It has destroyed the central cities. It has exploded the population out to areas that just a few years ago were thought rural—today they are suburban or exurban—and the central cities are dying in consequence. We are carving up the countryside to try to provide the highways, the channels of movement for this mode of transportation, and frankly I think it is beyond our capability to go very much further than we have gone.

In this Commonwealth alone, the vehicles now on the highways here, if parked bumper to bumper, would extend somewhere between nine and ten thousand miles of

solid automotive metal and there are only about 27,000 miles of highway in Massachusetts.

For this we have paid a frightful toll. Last month in Washington, it was presented to us that the insurance company figures were not accurate: that far from merely two million persons being injured in 1966, accurate figures would be twice that. The actual number of fatalities was about 54,000 last year. We don't argue much about fatalities and that's why, I suppose, we use these as the rubric to discuss the problem. However, we do not have figures on the number of people who are completely incapacitated for the rest of their lives in institutions—and these, of course, represent a tremendous cost both in dollars and in human suffering. All of the statistics become rather meaningless when you reckon in the millions. You cannot grasp its import. The human mind can't encompass it. And then, when one of these statistics is a personal tragedy, that is beyond measure.

Last year President Johnson described automobile safety as the principle domestic problem of America, and he launched a tremendous highway program in 1966 to try to do something about it. We are moving in the areas of highway design; in the area of vehicle design and construction; in the areas of all of the subsisting environmental factors including the law, its enforcement and the medical aspects of highway safety.

One of the areas where the medical profession can contribute to highway safety a great deal is in identifying the driver who is an unsafe operator by reason of a physical affliction or even a psychiatric problem. We are moving on this and I have been working with the Massachusetts Medical Society on this problem to pass new laws which will make this more effective.

Now this would, on the one hand, create a Medical Advisory Board for the Registry of Motor Vehicles. It would formalize what has been in effect for about 50 years in cases where the Registry has called upon leading members of the profession to advise us in their areas of specialty to establish guidelines, policies and procedures. These are fairly effective in controlling the known problems of a potential incompetency to operate. Beyond that, we are asking the legislature to pass a law whereby physicians would be required to report—not to the Registry but to the Commissioner of Public Health—encounters in their professional ministrations, that in their judgment are an impairment to operate a motor vehicle safely.

Here we touch upon the area of professional ethics—the relationship and confidentiality between the patient and his physician. This Bill is now pending. It is now in the Ways and Means Committee of the House. It has been given a favorable report from the Committee on Highways and Motor Vehicles. How far should the law

compel the physician to go in revealing for the public good something that has become known to him in his professional ministrations? We have this requirement in the case of gunshot wounds, in the case of narcotics addiction, in the case of child abuse and there is this very delicate question—this line of demarcation. Does the public safety and the public welfare outweigh the sanctity of the professional obligation to secrecy in regard to the patient?

From the point of view of government and public safety with the problems we have today, we have reached the point where public safety might well outweigh professional ethics or secrecy. 912 people died last year in Massachusetts in auto accidents. Our evidence indicates that well over two-thirds—in excess of 600 people—died by reason of drunken driving. More studies are being done in this area. There is a public belief that the drunken driver is just the fellow next door who has had one too many drinks. Studies are now demonstrating, however, that the arrested and convicted drunken driver is a very, very different person from the driver who has had just one drink too many. He is just about a confirmed alcoholic. His behavior attracted police attention and the evidence was such as to convict him, which is not too easy to do on this kind of charge. The drunken drivers tend to have a higher rate of other offenses ranging from sex crimes to robberies, and many more alcohol-related of-

fenses. They are established as an anti-social group. They have bad job records, bad family records. They are the products of bad family or are themselves involved in divorce at a rate of 5 to 9 times that of the rest of the population. These are not social drinkers. They are an identifiable type. Then, it is in this area, too, I think that the physician is more apt to identify in his practice the alcoholic who is a potential problem on the highway. Here again it becomes a question of professional ethics. I do not propose to make a judgment on this myself but I am inclined to the belief that when you are talking of this potential threat of life and limb to the public safety there is a responsibility here, as in epilepsy or in any type of cardiac or vascular disease where safe operation of a motor vehicle is impaired. Here again there is a responsibility on the part of the physician to render this information to the government so that protective measures can be taken.

What corrective measures do we take? We can revoke his license, but the evidence from very, very large surveys today indicates that some 85% of the drinking drivers just mail in the license and keep right on driving—keep right on drinking!

Do you imprison these people? Do you tattoo these members on the forehead to identify them? I do not really know the answer. Perhaps the other members of the panel can contribute some help.

*Fr. Robert F. Drinan, S.J.*

Before casting any stones at doctors, let me say first that lawyers have not done enough to remove dangerous drivers from the road.

Both the AMA and the ABA agree there is a need for a standard definition of alcoholism. There is a need to identify the alcoholic. The points I'd like to discuss are:

1. What is the physician-client relationship?
2. What are some of the moral dilemmas of the doctors?
3. Proposed legislation.

On the first point Hippocrates said—and the doctor takes this oath—"Whatsoever things I see or hear in my attendance on the sick which ought not to be noised abroad I will keep silence thereon, counting such things to be sacred secrets." There are two basic purposes for this confidentiality. One is to encourage the patient to communicate without being inhibited; the second is to protect the patient against defamation.

However, it is a qualified privilege. Doctors should not reveal that which is confidential, even though Massachusetts law does not legally give the physician this privilege. Doctors must, however, reveal some kinds of diseases and must state the cause of death on a death certificate. The holder of the privilege is the patient. The moral mandate is clear; the doctor should not reveal.

Now the second point—what are the unsolved dilemmas of the doctor? The clear alcoholic is easy to identify, but what about the borderline person whom you know every Friday night drinks and thereafter may drive so as to endanger. What is your obligation? How can you curb him? Should there be a law requiring doctors to report him? I am reluctant to endorse such a law for a variety of reasons. First, this would possibly deter said individuals from coming to doctors and, too, I'm not certain that it is the doctors' responsibility to be law enforcement officials, although they would want to collaborate and cooperate. Moreover this individual has not committed any overt act. In cases of narcotics, gunshot wounds, and child abuse, an overt act has occurred. What is being asked is that doctors make judgments in medical conditions where there has been no overt act. Nothing has happened yet. How predictable is an overt act?

Doctors, if they are going to be required to report, should have a very clear standard as to what is reportable. The difficulty with the presently proposed legislation is that the standards are less than clear.

The third point — corrective measures: In 1965 there were 1,004 deaths in the Commonwealth and 263, more than ¼ of those deaths, were caused by people between the ages of 17 and 21—where alcohol may or may not have been involved. What can doctors or lawyers do about the teenager?

What is physical or mental disability to drive? A clearer standard is required and perhaps the doctors could develop such a standard.

I'm delighted that the doctors are taking the initiative in this and it is heartening particularly to see St. Luke's Guild involved. It is good to see that doctors could and should and are developing standards by which people should be disqualified from driving. They should make them as specific and as categorical as is possible. They should then educate people that it is dangerous and immoral to drive when certain, specific medical conditions are present.

*Dr. Richard D. Mulroy:*

The role of the physician in driving safety is an important one. The physician is by nature interested in the prevention of all disease. Certainly, at this time traffic accidents have reached the nature of a highway epidemic. Historically and traditionally, physicians, while devoting a full measure to the treatment of disease, are primarily interested in the prevention of disease. In this way, physicians have become involved in the field of traffic safety and many interesting and important papers have been published as far back as 1955 dealing with the problems we are confronting today. Unfortunately, the time was not ripe for suggestions from the medical profession and the automobile industry certainly was not receptive. However, things have changed and now we have a National Traffic Safety agency headed by a physician so

that the future appears bright. Those of us who are engaged in the surgery of trauma have asked ourselves why certain dangerous features of the automobile have been allowed to persist; features that to us, as non-engineers, certainly did not seem safe. It would appear that now we are going to get some progress in the field of packaging of the occupant and, certainly, physicians as a group are very happy at the prospect of this movement.

It is the province and responsibility of a physician to identify those diseases and disorders which constitute driver limitation. Whether or not a driver license agency will issue a license remains with the agency. Doctors welcome the opportunity to work closely with the Registrar to serve on a Medical Advisory Panel to assist him in the judgments on special medical cases as to whether there is driver limitation.

This advisory panel would assist the Registrar in the initial license examination, in periodic renewal, and at renewal examinations for older drivers. Once, a license is granted, under an ideal plan, this driver should come up for re-examination at a specified interval; such as four to five years and also when there appears to be indication for medical examination. The indications as proposed by the American Medical Association in their report "Medical Aspects for Driver Limitation" are quite satisfactory. In addition to the physician's responsibility to a medical advisory panel,

he also should accept the responsibility to volunteer to a patient that he is suffering from a condition that definitely limits his driving safety and advise him whether or not he should drive.

At the present time we are conducting a continuing survey with the Boston University Law and Medicine Institute on Automobile Fatalities. There is no question that advanced age and medical problems do account for some automobile accidents but certainly it appears that alcohol and lack of mature judgment in the young driver are two of the major causes of automobile accidents. We physicians certainly agree that there should be an implied consent law to help police control the driver under the influence of alcohol and also that the level should be reduced from the present .15 to .10.

As physicians we would certainly like to contribute to the improvement in the emergency medical service that is rendered to the victim of a highway accident. There is no doubt that we can create a much better system than we now have for extricating the victims and getting them from the scene of the accident to the Emergency Ward of the hospital for early definitive treatment.

There is no doubt that in cooperation with the police and state authorities we can achieve this through better communications, transportation and trained paramedical personnel at all levels.