Driving and Epilepsy: Ethical, Legal, and Health Care Policy Challenges

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ABSTRACT
Although the principle of autonomy allows patients to refuse interventions their physicians recommend, patients are not free to ignore legally mandated restrictions on driving, and physicians are ethically justified in constraining their patients’ driving rights in compliance with state law. Furthermore, the standard of care for treatment of patients with epilepsy includes counseling about lifestyle modifications that promote patient safety and compliance with the law. Neurologists should not only counsel their patients with epilepsy about legally mandated driving restrictions but also document this counseling in the medical record. Failure to counsel and to document may result in legal liability if patients experience seizures while driving and injure either themselves or third parties. The neurologist’s duty of care may be limited to the patient in some jurisdictions but may be extended to injured third parties in others. Furthermore, a patient’s own contributory negligence may limit or completely foreclose recovery against the physician to varying degrees, depending on the state in which the injury occurred.

CASE
Note: This is a hypothetical case.
A 27-year-old man diagnosed with juvenile myoclonic epilepsy at age 15 was seizure free on valproic acid until he began his work as a management consultant, which required many late nights of work and frequent international travel. Because of his work schedule and frequent crossing of time zones, the man occasionally missed doses of valproic acid. He therefore experienced breakthrough generalized tonic-clonic seizures. However, he commuted to his office by car and did not wish to stop driving because of the inconvenience of having to rely on taxis and ride-sharing services. At his last visit with his neurologist, the patient’s valproic acid level was found to be subtherapeutic, and he admitted to occasionally missing doses of his medication and to having experienced a breakthrough seizure 2 months earlier. The neurologist counseled the patient about the importance of medication compliance and lifestyle modification but either forgot to discuss driving restrictions or discussed restrictions but failed to document the details of the counseling in the electronic health record. Two weeks after the appointment, the patient experienced a generalized tonic-clonic seizure while driving to work, striking...
an oncoming vehicle, seriously injuring both himself and the other driver, and completely wrecking both cars.

**DISCUSSION**

In all but a few cities that have outstanding public transportation systems, living an independent, socially and financially productive life in the United States depends heavily on an adult’s ability to drive. Although most adults take the right to drive for granted, people with epilepsy face considerable driving restrictions, with each state establishing its own laws. Most states use an inflexible interval of seizure freedom before legal driving privileges can be reinstated, ranging from 3 to 12 months, but several states do allow individualization of restrictions based on features of a driver’s epilepsy that mitigate the risk of seizures with driving. Whereas the majority of states do not compel medical providers to report drivers who experience seizures to the state department of motor vehicles, six states do impose such a restriction. In this issue of *Continuum*, the article “Counseling and Management of the Risks of Living With Epilepsy” by Katherine Noe, MD, PhD, FAAN, reviews in detail the impact driving restrictions have on people with epilepsy, including data about the impact of seizures on the risk of motor vehicle collisions and the impact of shortening the duration of driving restrictions to 3 months of seizure freedom. Noe’s article concludes with data indicating that many, if not most, adults with epilepsy do not recall being counseled about driving restrictions and then explains that “[p]roviders may be challenged to balance advocating for the needs of an individual patient with promoting the safety of the individual and the public. . .” This call for improved counseling and the important insight about providers experiencing conflict in their dual roles as advocates for the individual patient and the public interest are two starting points for this article on the ethical, legal, and health care policy challenges of driving and epilepsy.

This article first explores the ethical issues arising from the physician’s role in managing driving restrictions in patients with epilepsy, and then, using the case above, it explores the legal liability physicians may face for the actions of their patients who cause motor vehicle collisions because they experienced a seizure while driving. This article then discusses ways physicians can discharge their ethical duty to their patients and simultaneously mitigate legal risk through adequate patient counseling and documentation of that counseling in the medical record.

**Ethical Conflicts Arising From Driving Restrictions**

“It is the responsibility of the state, not the physician, to determine who should or should not drive an automobile.” However, state authorities often rely on physicians’ medical assessments of patients in rendering their decisions, and physicians have a legal and ethical obligation to comply with the law. When recommending that a patient who recently experienced a seizure cease driving in compliance with state law, neurologists may feel conflicted as they shift their focus of concern from patient to public. Typically, physicians consider the impact of their clinical recommendations on the patient they are treating and leave explicit societal considerations out of the examination room. Furthermore, in the United States, medical practice promotes patient autonomy through the informed consent process and, therefore, does not restrict adults with
decision-making capacity from refusing medical interventions, even when a medical provider believes that the informed refusal is potentially harmful to the patient. Therefore, a shift from a patient-centric, autonomy-promoting approach to a public-centric, communitarian approach changes the power balance and risks threatening the therapeutic alliance, an uneasy situation for physician and patient alike. Although both parties understand that uncontrolled seizures are dangerous not only to others on the road but also to the patient and the patient’s passengers, driving restrictions still impose serious, uncompensated socioeconomic burdens on those prevented from driving. Driving restrictions, however, do align with the principles of beneficence and nonmaleficence, requiring providers to maximize patient benefit while minimizing patient harm. Preventing serious bodily harm and economic damage fulfills both ethical imperatives. However, patients and physicians alike understand that the costs of driving restrictions represent a tremendous, very tangible harm to the patient, weighed (from the patient’s perspective) against the merely theoretical risk of experiencing a seizure while driving. Therefore, physicians need to muster the virtues of courage, honesty, and even self-sacrifice (because of the risk of angering and even losing a patient) to discuss restrictions on driving, even more so in states that mandate physician reporting to state authorities.

Counseling and Documenting: Ethical Obligations and Legal Risk Mitigation
Because neurologic diseases render patients particularly vulnerable to harm, lifestyle counseling and anticipatory guidance are critical components of the neurologist’s therapeutic armamentarium. Therefore, the standard of care for the treatment of a patient with epilepsy involves not merely prescribing medication but also counseling the patient about lifestyle choices that may reduce the risk of recurrent seizures (eg, obtaining adequate sleep) and of harm during a seizure (eg, not swimming alone). Counseling about driving restrictions, including the requirement that the patient self-report to the state authority regulating driving, falls into the latter category because it reduces the risk of harm and promotes compliance with the law. Thus, failing to counsel patients appropriately about driving restrictions may open a clinician up to legal liability.

CASE CONTINUED
In the case presented, the victim sued both the patient and the neurologist for negligence.

DISCUSSION CONTINUED
The victim’s suit against the patient is rather straightforward. “Under the common law, a cause of action for negligence has three elements: (1) a legal duty; (2) a breach of that duty; and (3) damages proximately resulting from the breach.”3 The reasonable-person standard is generally used to judge whether the defendant breached a legal duty. The patient has a duty to others sharing the roads to drive safely and in compliance with the law. The patient in this case breached that duty when he chose to operate his automobile under conditions that were both illegal (given the recent seizure) and of particularly high risk of breakthrough seizures (history of inconsistent medication adherence and poor sleep hygiene). “But for” the patient’s negligence, the victim would not have
suffered physical, psychological, and financial injuries, making the patient’s negligent action both the direct and the “proximate” cause of the victim’s injuries.

The less predictable part of the victim’s lawsuit relates to the allegation of negligence against the neurologist. According to the victim, had the neurologist warned the patient not to drive, the motor vehicle collision may not have occurred. Therefore, the victim alleges that the neurologist owed a duty to third parties who are not her patients to mitigate the risk of her patient’s unlawful driving, and she acted negligently by not counseling the patient about the legal restrictions on driving and the safety risks of driving under the extant conditions.

The threshold legal question in the victim’s lawsuit against the neurologist is whether the neurologist owes the victim, a complete stranger, a duty of care. The answer to this question is not uniform among the states. In no jurisdiction would the neurologist be found to have acted negligently vis-à-vis the victim on the basis of malpractice. Although an allegation of medical malpractice is a type of negligence case, the victim’s lawsuit against the neurologist does not meet the requirements for a malpractice case in any jurisdiction because of the lack of a physician-patient relationship between the neurologist and the victim.

Some courts have decided that a physician does not owe “a duty to third parties to warn an epileptic patient not to drive or to report the patient’s condition to state authorities that govern the issuance of drivers’ licenses.”

For example, in *Praesel v Johnson*, the Texas Supreme Court found that “[b]alancing both the need for and the effectiveness of a warning to a patient who already knows that he or she suffers from seizures against the burden of liability to third parties … the benefit of warning an epileptic not to drive is incremental [because a doctor’s warning may have little effect on the patient’s behavior] but that the consequences of imposing a duty are great.” The Court found that drivers carry the responsibility for safely operating their vehicles and declined to impose on physicians a duty to third parties to warn a patient with epilepsy not to drive.

Other courts have reached quite a different conclusion. Cases like the California Supreme Court decision *Tarasoff v Regents of University of California* influenced a number of jurisdictions to impose duties of care beyond the patient-physician dyad. *Tarasoff* imposed on mental health providers a duty to protect from harm a patient’s intended victim. Cases such as *Duvall v Goldin*, in which the Michigan Supreme Court, influenced by *Tarasoff* among other cases, found that a physician’s failure to properly treat a patient with epilepsy with antiepileptic drugs resulted in a breach of a duty of care to third-party drivers, expanded the duty of care beyond a specific intended victim to all drivers at large. Although recognizing that at common law, “no one has a duty to protect an individual who is endangered by the conduct of another,” the *Duvall* Court concluded that “[w]here the actor stands in a special relationship with either the third-party victim or the person causing the injury, a duty of reasonable care may arise.”

Having found that the physician, by virtue of his special relationship with the patient, did have a duty to third-party drivers to treat the patient’s seizures appropriately, the *Duvall* Court next considered whether it was foreseeable that the patient’s conduct would harm the victim. The *Duvall* Court cited *Gooden v Tips*, a case in which a physician failed to warn a patient about the sedating nature of a medication, resulting in the patient crashing and injuring another party. The foreseeability of this consequence led the *Gooden* Court to conclude
that “under proper facts, a physician can owe a duty to use reasonable care to protect the driving public where the physician’s negligence in diagnosis or treatment of his patient contributes to plaintiff’s injuries.”7 The Duvall Court concurred, finding that “it is foreseeable that a doctor’s failure to diagnose or properly treat an epileptic condition may create a risk of harm to a third party.”86 Thus, depending on the jurisdiction in which the injury occurs, the victim’s negligence case against the neurologist would be either dismissed or allowed to proceed.

CASE CONTINUED
Finding himself the defendant in a negligence lawsuit, the patient sued the neurologist for malpractice, alleging that the neurologist’s treatment did not meet the standard of care because the neurologist failed to warn the patient not to drive until he was seizure free for at least 3 months, the legal requirement in the state in which the parties of the case reside.

DISCUSSION CONTINUED
To prevail in a malpractice lawsuit against the neurologist, the patient will have to prove that a physician-patient relationship existed between patient and neurologist and that the neurologist breached her duty to provide care at the nationally accepted standard for neurologists, resulting in harm to the patient. The outcome of the lawsuit will hinge on the jury’s decision about two issues: (1) the neurologist failed in her duty to her patient by failing to warn the patient not to drive, and (2) the neurologist’s breach of the standard of care harmed the patient, resulting in damages. After hearing from expert witnesses in neurology on both sides of the case, the jury may find that the lack of documentation about driving restrictions supports the allegation that the neurologist did breach the standard of care. The neurologist may claim that, regardless of her documentation in this case, her standard practice is always to counsel about driving restrictions. Yet the jury may find this argument unconvincing and indicative of sloppy practice. However, even if it does conclude that the physician breached the standard of care, the jury may also find that the patient contributed to his own injury through his personal negligence. Depending on how the state assigns damages, a finding that the patient’s behavior was also negligent may have a profound impact on how much in damages the patient can recover from the neurologist.

Every US jurisdiction uses one of four basic systems for allocating fault and damages: (1) pure contributory negligence, (2) pure comparative fault, (3) modified comparative fault, or (4) slight or gross negligence comparative fault.8 Four states and the District of Columbia (the District of Columbia uses a different standard for pedestrians and bicyclists) operate under a pure contributory negligence regime, in which plaintiffs cannot recover if they are even 1% at fault. In the 12 states with a pure comparative fault regime, fault is apportioned proportionately, and the plaintiff’s damages are reduced by the percentage of fault assigned to the plaintiff. In a modified comparative fault jurisdiction, “each party is held responsible for damages in proportion to their own percentage of fault, unless the plaintiff’s negligence reaches a certain designated percentage.”88 In 10 states, plaintiffs cannot recover any damages if
they are 50% or more at fault, whereas in 23 states plaintiffs cannot recover any damages if they are 51% or more at fault. Finally, only South Dakota uses the slight or gross negligence comparative fault rule, under which a “plaintiff is barred from any recovery for anything other than slight negligence.”

Mitigation of Risk
How could the neurologist have avoided both lawsuits in the first place? The best way for neurologists treating patients with epilepsy to mitigate risk is to standardize both counseling about driving as well as documentation of this counseling. In many electronic health records, providers can create standardized templates to document their discussion with the patient. Standardized documentation ensures that the neurologist has communicated all relevant points and documents the details of the conversation relatively easily. In addition to reviewing the state’s driving laws and reporting requirements, the neurologist should remind the patient about the physical, financial, and legal (both civil and criminal) risks of driving when state law forbids driving. Patients should also be encouraged to follow the law by self-reporting and should be informed if the physician will be reporting them to the state licensing authority. Even states without mandatory physician reporting generally allow reporting but only at the physician’s discretion. Physicians are ethically justified to report patients who insist on driving illegally because they pose a heightened risk to themselves and others.

Each state has its own process for self-reporting, and many states rely on the patient’s own physician’s assessment to determine if a patient is safe to drive. Other states use independent medical advisors. Some states offer statutory immunity from lawsuits to physicians who render opinions about driver safety in good faith, whereas others do not offer such protections. Physicians are encouraged to search the Epilepsy Society’s State Driving Law Database9 for more information about the relevant driving laws and reporting procedures in every state and the District of Columbia.

REFERENCES


5 Tarasoff v Regents of University of California, vi7 Cal 3d 425; 131 Cal Rptr 14; 551 P2d 354 (1976).


7 Gooden v Tips, 651 SW2d 364 (Tex App, 1983).
