CHAPTER 7 ETHICAL AND LEGAL ISSUES

KEY POINTS

- Laws, regulations, and policies vary not only by state but also by local jurisdiction and are subject to change. Healthcare professionals should seek legal advice on specific issues or questions.[1,2]
- It is important to know and comply with state requirements to avoid being subject to a third-party lawsuit.
- Some states (CA, DE, NJ, NV, OR, PA) have mandatory reporting requirements that may give rise to liability for failure to report.
- The ethical responsibility to maintain patient confidentiality as well as the ethical responsibility to public safety is not limited to physicians; all healthcare professionals have the same obligation.
- Patient permission should be obtained before contacting caregivers, and this should be documented in the patient's health record. If the patient maintains decisional capacity and denies permission, his or her wishes must be respected.

Mrs. Allen, *a 78-year-old woman, is accompanied by her daughter, who reports that her mother lives alone, has become increasing forgetful, repeats herself within minutes, and has difficulty dressing herself, performing personal hygiene tasks, and completing household chores. She is particularly concerned about her mother's daily trips to the grocery store two miles away. Mrs. Allen has become lost while on these trips and, according to the store manager, has handled money incorrectly. Dents and scratches have appeared on the car without explanation. Mrs. Allen's daughter has asked her mother to stop driving and tried to take the car keys, but Mrs. Allen responds with anger and resistance. On previous visits, you have recommended that she consider alternatives to driving. The daughter would like to know how to manage her mother's long-term safety and health, and especially how to address the driving issue.*

This chapter provides a general overview to assist clinicians to understand the process, including their ethical and legal responsibilities, for reporting unsafe drivers to their state licensing agency. Although some of the issues addressed are inherently ethical and/or legal, this chapter is not to be construed as providing legal advice. The views, discussion, conclusions, and legal analysis are those of the authors and do not represent the opinions, policies, or official positions of the National Highway Traffic Safety Administration or the American Geriatrics Society and do not replace local legal advice and review of state laws and local statutes. It is important for physicians and other healthcare providers to seek legal advice in their state on specific issues or questions that may arise with an individual patient.

Older adults receive services in multiple settings from all types of professionals, including all members of the clinical team (medicine, nursing, pharmacy, social work, occupational therapy,

psychology, etc.). Most existing legal guidance for older adult drivers refers specifically to physicians, although all clinical professionals have similar ethical duties and obligations. The following discussion therefore specifically cites physicians in most instances, but the principles discussed should be adopted by the entire clinical team.

Clinician: **Mrs. Allen**, *I understand you drove yourself to the appointment today. This worries me. At our last visit, I recommended you retire from driving. Please share the reason you drove here today.*

Mrs. Allen: Well, I don't understand why you're so concerned. I've never gotten into a car crash. My driving is fine and, frankly, I don't think you have any right to tell me not to drive.

Clinician: It sounds like you are frustrated, and I can't imagine how difficult it must be for you to adjust to a life without driving. It's not an easy choice to make; however, it's the best choice for your health and safety, and as your healthcare provider, that is my primary concern. I want to help make this easier for you. Your Rapid Pace Walk (15 seconds) and MoCA test results (score 18/30) show that your responses are not as sharp as they need to be for you to drive safely. Let's talk about some of your concerns regarding retiring from driving.

Laws, regulations, and policies vary not only by state but also by local jurisdiction. They are also subject to change, and the state licensing agency should be contacted for the most up-to-date information. For a state-by-state list of licensing agency contact information and additional resources for locating licensing requirements and renewal criteria, reporting procedures, etc, see Chapter 8.

Clinician: **Mrs. Allen**, *when do you think it's an appropriate time for a person to stop driving?*

Mrs. Allen: I suppose when they drive unsafely or are a threat to others on the road.

Clinician: That is an excellent observation, and I would agree with you.

Mrs. Allen: Well, a friend of mine doesn't drive very well. He drives all over the road and runs red lights. I won't get in the car with him anymore because I worry about what may happen.

Clinician: That is indeed a scary situation for your friend and others on the road, too. It's great that you're aware of the potential danger and know how to ensure your own safety. I'm wondering if there's someone you trust who would tell you when they thought it was unsafe for you to continue driving?

The case studies in this chapter serve to illustrate the range of opinions in attempting to fairly define the scope of the clinician's responsibility to report age impaired drivers. In addition, they consider society's efforts to provide a safe environment for its citizens.

On further evaluation, you diagnose **Mrs. Allen** *with Alzheimer disease. It is readily apparent that her condition has progressed to the extent that she can no longer drive safely and that rehabilitation is not likely to improve her driving. You tell Mrs. Allen that she must stop driving for her own safety and that of others on the road. You also explain that the state reporting laws instruct physicians to notify the licensing agency of medically unsafe drivers. Initially, Mrs. Allen does not understand but when you specifically tell her that she can no longer*

drive herself to the grocery store every day, she becomes agitated and abusive, screaming, "I hate you!" and "I'm going to sue you!" Her daughter understands your decision to report Mrs. Allen to the state licensing agency but is now concerned that her mother will encounter problems if she attempts to drive without a license. Mrs. Allen's daughter asks if it is absolutely necessary for you to report her mother. What do you say?

Many physicians are uncertain of their legal responsibility, if any, to report unsafe drivers to their state licensing agency.[3,4] A survey of geriatric physicians in the United states, discovered 31.8% were ignorant of state guidelines regarding reporting at-risk drivers.[5] The situation is further complicated by the risks of damaging the clinician-patient relationship, violating patient confidentiality, and potentially losing patients.[4,6] As a result, clinicians are often faced with a dilemma: should they report the unsafe driver, or should they forego reporting and risk being liable for any potential patient or third-party injuries for failing to report? Furthermore, how should clinicians engage caregivers to lessen the burden of a driving restriction or cessation?

ETHICAL DUTIES

Current legal and ethical debates highlight duties of the physician that are relevant to the issue of driving. These include the duties to protect patient health as well as maintain patient confidentiality.

Duty to Protect

The Patient: Protecting the patient's physical and mental health is considered the clinician's primary responsibility. This includes not only treatment and prevention of illness but also caring for the patient's safety. Clinicians should advise and counsel patients about medical conditions and possible adverse effects from medication that may impair the ability to drive safely and document this discussion in the medical record. Some states have mandatory reporting requirements that may give rise to both civil and criminal liability for failure to report.[7] For example, wording in the Pennsylvania law has led the Pennsylvania state licensing agency to conclude that physicians who do not report "could be held responsible as a proximate cause of an accident resulting in death, injury or property loss caused by your patient; the Pennsylvania statute further states that providers who do not comply with their legal requirement to report may be convicted of a summary criminal offense."[8] Case law illustrates that failure to advise patients about such medical conditions and adverse effects of medication can be considered negligent behavior, making the physician liable for monetary damages.[9]

The Public: In addition to caring for their patients' health, physicians may, in certain circumstances and jurisdictions, have some responsibility for protecting the safety of the public.[10,11] This is termed third-party liability. In certain states, physicians have been found liable for third-party injuries because they failed to advise their patients about medical conditions, adverse effects of medication, or medical devices that may impair driving performance.[12–14]

Generally, American civil law does not impose liability on parties for failing to aid or rescue other parties. According to The Restatement (Second) of Torts § 314 (1965): "The fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action."[15] However, physicians have had an ethical mandate to protect the public from dangerous patients for

decades. In the case of Tarasoff v. Regents,[16] the California Supreme Court recognized the right of a third party to sue if a health professional did not warn of an imminent threat. The ruling applies only in California but has been cited across the nation. The Tarasoff doctrine states that the most important consideration is the existence of a foreseeable threat. So if a physician believes or predicts that a person in treatment is likely to inflict serious bodily harm on a third party who can be reasonably identified, then he or she has a duty to warn or protect that potential victim.[17]

Maintain Patient Confidentiality

Patient confidentiality is the right of an individual to have personal, identifiable medical information kept private. These protections are found in the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).[18] All healthcare professionals have a legal duty to protect private patient information from disclosure to anyone, including the patient's family, attorney, or the government, without authorization from the patient.[19-21]

HIPAA encourages the free exchange of information between the healthcare professional and the patient, allowing the patient to describe symptoms for diagnosis and treatment. Individuals may be less likely to seek treatment, disclose information for effective treatment,[22] or trust the healthcare professional unless confidentiality is ensured.[19]

However, nondisclosure requirements are not absolute. There may be public policy reasons to breach confidentiality, such as removing unsafe drivers from the road.[4,23] Thus, patient confidentiality may not necessarily protect the physician from a third-party legal action in the impaired driver situation.[23,24]

Some states do not provide immunity for physicians who warn a government agency about an individual who has become an unsafe driver. In those states, it is important to document the following:[25]

- An assessment regarding the ability of the patient to drive a motor vehicle.
- An assessment of the specific danger posed by the patient's driving to other individuals on the highway.
- Attempts made to contact patient's family members[26] or guardian, including the content of the conversation and the means used to make contact.

Other Healthcare Professionals: The ethical responsibility to maintain patient confidentiality is not limited to physicians; all health care professionals have the same obligation.[27,28] Patient confidentiality is crucial within the health care professional–patient relationship, because it encourages the free exchange of information allowing the patient to describe symptoms for diagnosis and treatment.[19] Without belief that their care is confidential, patients may not trust their health care professional and, thus, be less likely to disclose information for effective treatment.[19] However, just as with physicians, this responsibility, is not absolute.[20,29] A good example of health care professional standards for the treatment of older adult patients can be found on the website of the American Society of Consultant Pharmacists (https://cdn.ymaws.com/www.ascp.com/resource/collection/28D69F2D-18D9-4EF8-A086-675AB7E4ECD8/Quality_Standards_and_Practice_Principles_for_Senior_Care_Pharmacists.pdf) [20]

CONCERNS ABOUT REPORTING

A Canadian study explored physicians' attitudes on medical fitness to drive and found that although most medical professionals would report unfit drivers, they believed such action could adversely affect the confidentiality expectations within the

physician-patient relationship.[24,30] Physicians have raised concerns about mandatory reporting, stating it can violate privacy, compromise the ability to counsel patients, and negatively impact the physician-patient relationship.[24,31] Some physicians have suggested that mandatory reporting has the potential to discourage patients from seeking health care.[3,32]

In the six states that have mandatory reporting requirements (California, Delaware, Nevada, New Jersey, Oregon, and Pennsylvania), studies show physicians are more likely to report.[33] Unless required by law to report, clinicians may choose not to do so.

Immunity and Confidentiality

NHTSA's Highway Safety Program Guideline No.13 - Older Driver Safety[35] recommends that states enact policies or regulations that protect clinicians. The AAA Foundation for Traffic Safety report Driver Licensing Policies and Practices provides a list of states that currently have laws in this area which medical providers can use to look up their own state regulations.[36]

Adherence to State Reporting Laws

Each state has its own reporting laws. For a state-by-state listing of licensing agency contact information and other resources for licensing requirements, see Chapter 8. Note that information may change over time, and the state licensing agency should always be contacted for the most up-to-date information.

In states without laws mandating physicians to report patients to the state licensing agency, physicians should have written patient releases that comply with HIPAA before disclosing medical information. In these states, physicians who disclose medical information without patient authorization may be liable for breach of confidentiality. However, failure to disclose may make the physician liable to third parties who are injured by the patient.[13] This presents a "take it or leave it" Hobson's choice,* but ultimately safety of the patient and the public should come first.

BALANCING ETHICAL AND LEGAL RESPONSIBILITIES

Balancing competing ethical and legal duties can be problematic. The following strategies may be helpful.

Counsel Patients and Caregivers

Patients should be advised of medical conditions, medications, medical devices, and procedures that may affect driving performance. (For a reference table of such medical conditions and medications, with recommendations for each, see Chapter 9.) If the patient gives permission, his or her caregivers should be involved in the counseling process whenever appropriate. Caregivers included in the process are more likely to assist the patient with the changes a loss of license will bring. Losing one's driver's license has significant psychological consequences, because the ability to drive is inexorably intertwined with the sense of independence.

Driving cessation has other major consequences besides loss of autonomy. The older adult's ability to conduct the business of daily living is impaired, as is his or her ability to participate in social activities or volunteering. Therefore, social isolation is likely. Caregivers are also negatively impacted, because they are expected to fill in many of the gaps that

*Thomas Hobson (circa 1544–1630) kept a stable and required every customer to take either the horse nearest the stable door or take no horse at all.[37] Thus, a "Hobson's Choice" is given to one asked to choose between two undesirable alternatives.

will inevitably arise as a result of the older adult's driving cessation. These risks need to be recognized and weighed versus the concerns of public safety.

If the older adult does not have decision-making capacity (e.g., due to Alzheimer disease), this information should be given to a surrogate decision-maker.

Recommend Driving Cessation

As discussed in previous chapters, clinicians should recommend driving cessation for patients believed to be unsafe drivers who have a condition(s) likely to affect driving safety but unlikely to improve with available medical treatment or with an adaptive device or technique. As always, clinical judgment should be based on the older adult's driving abilities and not on age per se. This recommendation should be documented in the patient's health record, and the clinician's office should have a system to check on compliance with recommendations.

Know and Comply with State Reporting Laws

Clinicians must know and comply with their state's reporting laws (see Chapter 8). Clinicians who fail to follow these laws may be liable for patient and third-party injuries and could face civil or criminal charges as well.

In states that have a mandatory medical reporting law, the state licensing agency's official form should be used to report the required medical conditions. In states that have a voluntary medical reporting law, the state licensing agency's official form can be used or other similar forms. Some states provide civil immunity if professionals report in good faith. Patient consent, if any, should be documented. If the state licensing agency's guidelines do not indicate what patient information must be reported, only the minimum information necessary to show that the patient may be an unsafe driver should be provided.

Reduce the Impact of Breaching Patient Confidentiality

In adhering to state reporting laws, clinicians may need to breach patient confidentiality, as is true for several other medical conditions commonly reported to state and local health departments. However, several measures can be taken to reduce the impact on the clinician-patient relationship.

Inform the Patient of Notice to the State Licensing Agency: Before reporting a patient to the state licensing agency, clinicians should inform the patient of their intent and explain that it is the ethical, and in some cases, legal responsibility of the clinician to make the report. Describing the kind of follow-up that can be expected from the state licensing agency is also advised. The patient should be assured that out of respect for his or her privacy, only the minimum information required will be disclosed and that all other information will remain confidential. When submitting a report to the state licensing agency, only the minimum information necessary (or required by the reporting guidelines) should be provided to establish that the patient may be unsafe to drive.

Even in states that offer anonymous reporting or reporter confidentiality, being open and honest with patients is a good idea. It may help to remind patients that the physician does not determine whether they are licensed to drive and that this decision is ultimately made by the state.

Providing patients with as much information as possible, perhaps including a copy of the state licensing agency report, can involve them in the process and give them a greater sense of control. In addition, patient permission should be obtained

before contacting caregivers, and this should be documented in the patient's health record. If the patient maintains decisional capacity and denies permission, their wishes must be respected.

Document Diligently: All efforts to assess and maintain the patient's safety and that of the public should be documented in the patient's health record. In the event of a patient or third-party crash injury, good documentation may protect the clinician from civil liability.

Clinicians should protect themselves legally by documenting their efforts, discussions, recommendations, and any referrals for further testing in the patient's health record.[38] In other words, all the steps performed in the Plan for Older Drivers' Safety (PODS) (see Chapter 1) should be documented, including:

- Any direct observations of the patient's functional status or red flags as described in PODS. Driving history that leads the clinician to believe that the patient may be at risk of unsafe driving should also be documented.
- Any counseling specific to driving (e.g., documenting that the patient is aware of the warning signs of hypoglycemia and its effects on driving performance).
- Formal assessment of the patient's driving-related functions (e.g., documenting that the patient has undergone the Clinical Assessment of Driving Related Skills (CADReS); include the CADReS scoring sheet in the patient's health record).
- Any medical interventions and referrals that have been made to improve the patient's function, as well as any repeat testing to measure improvement.
- A copy of the driver rehabilitation specialist (DRS) report if the patient has undergone driver assessment and/or rehabilitation.
- The clinician's recommendation on whether the patient should continue driving or cease driving. In the case of a cease driving recommendation, a summary of interventions (e.g., "sent letter to patient to reinforce recommendation," "discussed transportation options and gave copy of 'Patient Resource Sheet'," "contacted family members with patient's permission," "reported patient to state licensing agency with patient's knowledge") should be included. Copies of any written correspondence should also be included in the patient's health record.
- Follow-up for degree of success in using alternative transportation options and any signs of social isolation and depression, including any further interventions, such as referral to a social worker, geriatric care manager, or mental health professional.

ADDITIONAL LEGAL AND ETHICAL CONCERNS

Other particularly challenging situations may arise. The following examples provide some possible actions that may be used as a guide.

Situation 1: The patient threatens to sue if he or she is reported to the state licensing agency.

- A patient's threat to sue should not deter the clinician from complying with state reporting laws. If a patient threatens to sue, clinicians can take several steps to protect themselves in the event of a lawsuit:
  - Know if your state has passed legislation specifically protecting healthcare professionals against liability for reporting unsafe drivers in good faith (see Chapter 8).[28]
  - Understand that even in the absence of such

legislation, physicians generally run little risk of liability for following mandatory reporting statutes in good faith. Consult your attorney or malpractice insurance carrier to determine your degree of risk.

- Make certain the reasons for believing that the patient is an unsafe driver have been clearly documented.

■ Be aware that clinician-patient privilege does not preclude the clinician from reporting the patient to the state licensing agency. Physician-patient privilege, which is defined as the patient's right to prevent disclosure by the physician of any communication between the physician and patient, does not apply in cases of mandatory reporting. Patients can be reminded that clinicians do not determine licensing. Ultimately, this is the responsibility of the state, and thus the state makes the final decision on determining whether the patient can continue to drive.

Situation 2: The patient is an unsafe driver in a state without state reporting laws.

In this situation, the clinician's priority is to ensure that the unsafe driver does not drive. If this can be accomplished without having the patient's license revoked, then there may be no need to report the patient to the state licensing agency. Before reporting a patient, clinicians may address the risk of liability for breaching patient confidentiality by following the steps listed under Situation 1.

However, if the patient continues to refuse to stop driving, then clinicians must consider which is more likely to cause the greatest amount of harm: breaching the patient's confidentiality versus allowing the patient to potentially injure himself or herself or third parties in a motor vehicle crash.

Situation 3: The patient's license has been suspended by the state licensing agency for unsafe driving, but the clinician is aware that he or she continues to drive.

This patient is violating the law, and several questions are raised: Is the clinician responsible for upholding the law at the expense of breaching patient confidentiality? Because the license has been revoked by the state licensing agency, is the driving safety of the patient now the responsibility of the state, the clinician, or both?

Several steps can be taken in this situation:

■ Ask the patient why he or she continues to drive. Address the specific causes brought up by the patient (see Chapter 6 for recommendations). With the patient's permission, caregivers should be involved in finding solutions such as alternative methods of transportation.

■ Ask the patient if he or she understands that continuing to drive is breaking the law. Reiterate concerns about the patient's safety and ask how he or she would feel about causing a crash and potentially being injured or injuring someone else. Discuss the emotional burden a car crash would cause the patient, his or her family, and all others involved.

■ Discuss the financial and legal consequences of being involved in a crash without a license or auto insurance. Many clinicians remind patients and families/caregivers of the possibility of their financial liability for any injuries caused by driving.

■ If the patient is cognitively impaired and lacks insight into this problem, the issue must be discussed with the individual who holds decision-making authority for the patient, if the patient has a designated decision-maker. If not, the patient and caregiver(s) should pursue the process of appointing one. These parties should understand

their responsibility to prevent the patient from driving.

- If the patient continues to drive and the state has a mandatory reporting law, clinicians must adhere to the law by reporting patients who are unsafe drivers (even if the patient has been reported previously). If the state does not have a mandatory reporting law, the clinician should base the decision to report as in Situation 2 (see above). The state licensing agency, as the agency that grants and revokes the driver's license, will follow up as it deems appropriate.

Situation 4: The patient threatens to find a new clinician if reported to the state licensing agency.

Although unfortunate, this situation should not prevent clinicians from caring for the patient's health and safety. In addition, physicians must adhere to state reporting laws, regardless of such threats.

Several strategies may help diffuse this situation:

- Reiterate the process and information used to support the recommendation that the patient stop driving.
- Reiterate concern for the safety of the patient, any passengers, and others on the road.
- Remind the patient that providing him or her with the best possible health care includes safety measures of all types. State that driving safety is as much a part of patient care as encouraging patients to keep smoke detectors in the house and have regular physical check-ups.
- Encourage patients to seek a second opinion, if appropriate. A DRS may evaluate the patient if this has not already been done, or the patient may consult another clinician.
- If the state licensing agency follows up on clinician reports by requiring the patient to be retested, inform the patient that just as it is the clinician's responsibility to report the patient to the agency, it is the patient's responsibility to prove his or her driving safety to the agency. Emphasize that the state licensing agency makes the final decision, and that only the state can legally revoke a driver's license. Remind the patient that everything medically possible has been done to help him or her pass the driver test.
- As always, maintain professional behavior by remaining matter-of-fact and not expressing hostility toward the patient, even if he or she ultimately makes the decision to seek a new clinician.

PATIENT RESOURCES

The following online patient/caregiver resources are available from the National Highway Traffic Safety Administration (NHTSA). Clinicians may wish to download these materials and are free to put their personalized information/logo on the materials.

Driving Safely While Aging Gracefully,[39] is guidance available on the National Highway Traffic Safety Administration Older Driver website and can help older adults assess whether they should still be driving.

Getting Around: Other Ways to Get Around[40] is a brochure from AAA designed to help families cope with an older adult who should not be driving. Clinicians may wish to keep a supply of these documents on hand. Additional resources are discussed in Chapter 6 and listed in Appendix B.

GLOSSARY OF TERMS[42–45]

Before consulting the reference list in Chapter 8, it will be helpful to be familiar with the following terms and concepts (Table 7.1).

Table 7.1 Glossary of Terms

Anonymity and legal protection	Several states offer anonymous reporting and/or immunity for reporting in good faith. More than half of all states will maintain the confidentiality of the reporter, unless otherwise required to disclose by a court order.[41]
Driver rehabilitation programs	These programs, run by DRSs, help identify at-risk drivers and improve driver safety through adaptive devices and compensatory techniques. Drivers typically receive a clinical evaluation, on-road assessment, and, if necessary, vehicle modifications and training. (For more information on driver assessment and rehabilitation, see Chapter 5.)
Duty to protect	In certain jurisdictions, physicians have a legal duty to warn the public of danger their patients may cause, especially in the case of identifiable third parties.6 With respect to driving, mandatory reporting laws and physician reporting laws provide physicians with guidance on their duty to protect.
Good faith	Honesty and respect in all professional interactions[42]
Immunity for reporting	Many states exempt physicians from liability for civil damages brought by the patient if the physician previously reported the patient to the state licensing agency.
Medically impaired driver	A driver who is suffering from cognitive and/or functional impairments likely to affect the ability to safely operate a motor vehicle.
Mandatory medical reporting laws	In some states, physicians are required to report patients who have specific medical conditions (e.g., epilepsy, dementia) to their state licensing agency. These states provide specific guidelines and forms that can be obtained through the state licensing agency.
Medical Advisory Boards (MABs)	MABs generally consist of local or consultant physicians who work in conjunction with the state licensing agency to determine whether mental or physical conditions may impair an individual's ability to drive. Some MABs specify mitigation that would permit continued licensure. MABs vary among states in size, role, and level of involvement.

Table 7.1 Glossary of Terms/cont.

Patient confidentiality	The right of an individual to have personal, identifiable medical information kept private.
Physician reporting laws	Some states require physicians to report "unsafe" drivers to the state licensing agency, with varying guidelines for defining "unsafe." The physician may need to provide the patient's diagnosis and any evidence of a functional impairment that can affect driving (e.g., results of neurologic testing) to prove that the patient is an unsafe driver.[43]
Physician liability	Refers to the legal duty of the physician to report his or her patient's status as an at-risk driver to the state licensing agency. Failure to report (negligence) can result in the physician being held liable (responsible) for civil damages caused by the patient's car crash.[44]
Renewal procedures	License renewal procedures vary by state. Some states have age-based renewal procedures, i.e., at a given age, the state may reduce the time interval between license renewal, restrict the ability to obtain license renewal by mail, require specific vision ability and knowledge of traffic laws and signs, and/or require on-road testing. Very few states require a medical report for license renewal.[45]
Restricted driver's license	Some states offer a restricted license as an alternative to revoking a driver's license. Typical restrictions include prohibiting night driving, limiting driving to a certain distance from home, requiring adaptive devices, and shortening the renewal interval. The efficacy of these types of restrictions has not been studied.
Third party	The generic legal term for any individual who does not have a direct connection with the clinician but who might be affected by him or her, e.g., anyone injured other than the patient.

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8. Title 75 PA. CODE § 1518(b) The Vehicle Code (stating physicians are immune from any civil or criminal liability if they report patients 15 years old or older who have been diagnosed as having a condition that could impair their ability to safely operate a motor vehicle; but, if the physician does not report could, then, possibly be held responsible as a proximate cause of an accident resulting in death, injury, or property loss caused by the physician's patient. Also, physicians who do not comply with their legal requirement to report may be convicted of a summary criminal offense).

9. Gooden v. Tips, 651 S.W.2d 364, 1983 Tex. App., 43 A.L.R.4th 139 (Tex. App. Tyler 1983) (case stating that physicians have a duty to warn patients that medications may impair driving but that physicians do not have a duty to control a patient's behavior). However, the Supreme Court of Texas significantly narrowed physicians' duties to third parties. In Praesel v. Johnson, 967 S.W.2d 391, 396 (Tex. 1998), the court noted that it had "generally limited the scope of the duty owed by physicians in providing medical care to their patients." The court "declined to impose on physicians a duty to third parties to warn an epileptic patient not to drive." Somewhat similarly that court "weighed the risk, foreseeability, and likelihood of injury against the social utility of the actor's conduct, the magnitude of the burden of guarding against the injury, and the consequences of placing the burden on the defendant," and also considered "whether one party would generally have superior knowledge of the risk or a right to control the actor who caused the harm." 967 S.W.2d at 397-98. For a general discussion on this topic, see 43 A.L.R. 4th 153; 35 U. Mem. L.Rev. 173; See Comment: Driving on the center line: Missouri physician's potential liability to third persons for failing to warn of medication side effects (46 St. Louis L.J. 873); Wilschinsky v. Medina, 1989- NMSC-047, 108 N.M. 511, 775 P.2d 713, (N.M. 1989). (New Mexico case stating that the physician owed a duty of care to an individual harmed by the physician's patient, that the patient's duty specifically extended to persons the patient injured by driving a car from the doctor's office after being injected with drugs that were known to affect judgment and driving ability; the medical standards for administering drugs had to define the physician's duties of care). Limited by Lester by & Through Mavrogenis v. Hall, 1998-NMSC-047, 126 N.M. 404, 970 P.2d 590, 38 N.M. B. Bull. 2, 38 N.M. B. Bull. 11 2 (1998) (This Court did not extend the duty articulated in Wilschinsky to prescription cases under the case fact pattern.) See also Brown v. Kellogg, 2015-NMCA-006, 340 P.3d 1274 (N.M. Ct. App. 2014).

10. Tarasoff v. Regents of University of California, 17 Cal. 3d 425; 551 P.2d 334; 131 Cal. Rptr. 14 (Cal. 1976 Cal.); 83 A.L.R.3d 1166, 1976 (rehearing to the California Supreme Court upheld on the duty to warn and protect). In Tarasoff, the California Supreme Court held that, under certain circumstances, a therapist had a duty to warn others that a patient under the therapist's care was likely to cause personal injury to a third party. There the court said, "Although . . . under the common law, as a general rule, one person owed no duty to control the conduct of another, nor to warn those endangered by such conduct, the courts have carved out an exception to this rule in cases in which the defendant stands in some special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct." (P. 435.) Applying that exception to the facts of Tarasoff, the court held that where a therapist knows that his patient is likely to injure another and where the identity of the likely victim is known or readily discoverable by the therapist, he must use reasonable care to prevent his patient from causing the intended injury. Such care includes, at the least, informing the proper authorities and warning the likely victim. However, the court did not hold that such disclosure was required where the danger presented was that of self-inflicted harm or suicide or where the danger consisted of a likelihood of property damage. Instead, the court recognized the importance of the confidential relationship which ordinarily obtains between a therapist and his patient, holding that ". . . the therapist's obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others . . . ." (Tarasoff, supra, p. 441; italics added). The holding in Tarasoff was questioned in Mason v. IHS Cedars Treatment Ctr. of Desoto Tex., Inc. (Tex. App. Dallas Aug. 15, 2001); criticized in Gregory v. Kilbride, 150 N.C. App. 601, 565 S.E.2d 685 (N.C. App. 2002) and Tedrick v. Cmty. Res. Ctr., Inc., 235 Ill. 2d 155, 920 N.E.2d 220 (Ill. 2009); and superseded in part by Nebraska State statue in Munstermann v. Alegent Health - Immanuel Med. Ctr., 271 Neb. 834, 716 N.W.2d 73, (Neb.2006). It should be noted that the Tarasoff ruling per se, upon which the principles of "Duty to Warn" and "Duty to Protect" are based, originally applied only in the State of California and now applies only in certain jurisdictions. The U.S. Supreme Court has not heard a case involving these principles. Many states have adopted statutes to help clarify steps that are considered reasonable when a physician is pre-sentenced with someone making a threat of harm to a third party. Tasman, A., Kay, J., Lieberman, J. A., & Fletcher, J. (eds). Psychiatry, 1st ed. Philadelphia: W.B. Saunders Company; 1997, p. 1815.

11. Brisbane v. Outside in Sch. of Experiential Educ., Inc., 799 A.2d 89 (Pa. Super. Ct. 2002) (defining factors in a Pennsylvania case to determine the existence of a duty: (1) the relationship between the parties, (2) the social utility of the actor's conduct, (3) the nature of the risk imposed and foreseeability of the harm incurred, (4) the consequences of imposing a duty upon the actor, (5) the overall public interest in the proposed solution). Pennsylvania did not expand the duty of a parent to encompass supervision of adult children, see Kazlauskas v. Verrochio (M.D. Pa. Oct. 27, 2014). Case questioned by Bellah v. Greenson, 81 Cal. App. 3d 614, 146 Cal. Rpt., 535, 1978, 17 A.L.R. 4th 1118 (Cal. App. 1st Dist. 1978). Explained by Felty v. Lawton, 1977 OK 109, 578 P.2d 757 (Okla. 1977). For a general discussion on this topic, see A.L.R. 3d 1201; 46 Ca. Jur., Negligence Sections 10 and 212.

12. Gooden v. Tips, supra at FN 5; Kaiser v. Suburban Transp. System, 65 Wn.2d 461, 398 P.2d 14 (Wash.1965) (Washington case stating that a physician could be held liable due to the fact that a patient took medication completely unaware that it would have any adverse effect on him because the physician failed to warn his patient, whom he knew to be a bus driver, of the dangerous side effects of drowsiness or lassitude that may be caused by taking this particular medication). Superseded on other grounds by statute State v. Fisher (Wash. Ct. App. May 29, 2012).

13. Calwell v. Hassan, 260 Kan. 769, 925 P.2d 422 (Kan. 1996) (Kansas case stating that the doctor had no duty to protect bicyclists - a third party from his patient's actions because the patient who had a sleep disorder was aware of the problem and admitted to knowing that she should have stopped driving). Adams v. Bd. of Sedgwick County Comm'rs, 289 Kan. 577, 214 P.3d 1173 (Kan. 2009); Wilson v. McDaniel, 327 P.3d 1052, 2014 Kan. App. Unpub. (Kan. Ct. App. 2014) (cited in dissenting opinion). Duvall v.Goldin, 139 Mich. App. 342, 362 N.W.2d 275, (Mich. App. 1984) (Michigan case stating the physician was liable to third persons injured as it was foreseeable that a doctor's failure to diagnose or properly treat an epileptic condition could have created a risk of harm to a third party and that as a result of the patient's medical condition, caused an automobile accident involving the third persons). Dawe v. Dr. Reuven Bar-Levav & Assocs., P.C., 485 Mich. 20, 780 N.W.2d 272 (Mich. 2010). Distinguished in Singleton v.United States Dep't of Veterans Affairs, 2013 U.S. Dist. (E.D. Mich. Aug. 15, 2013). Myers v. Quesenberry, 144 Cal. App. 3d 888, 193 Cal. Rptr. 733 (Cal. App. 4th Dist. 1983) (California case stating that if a physician knows or should know a patient's condition will impair the patient's mental faculties and motor coordination, a comparable warning is appropriate). Distinguished in Greenberg v. Superior Court, 172 Cal. App. 4th 1339, 92 Cal. Rptr. 3d 96 (Cal. App. 4th Dist.2009) Schuster v. Altenberg, 144 Wis. 2d 223, 424 N.W.2d 159 (Wis. 1988) (Wisconsin case stating that if it was ultimately proven that it could have been foreseeable to a psychiatrist, exercising due care, that by failing to warn a third person or failing to take action to institute detention or commitment proceedings someone would be harmed, negligence could be established). Distinguished by Milwaukee Deputy Sheriff's Association v. City of Wauwatosa, 2010 WI App 95, 327 Wis. 2d 206, 787 N.W.2d438 (Wisc. App.2010) and Hornback v.Archdiocese of Milwaukee, 2008 WI 98, 313 Wis. 2d 294, 752 N.W.2d 862(Wisc. 2008)

14. Joy v. Eastern Maine Medical Center, 581 A.2d 418 (Me. 1990) (appeal after remand affirmed) (Maine case stating that when the doctor knew, or reasonably should have known that his patient's ability to drive has been affected by treatment that the doctor provided, he had a duty to the driving public as well as to the patient to warn his patient of that fact). Distinguished by Flanders v. Cooper, 1998 ME 28, 706 A.2d 589 (Me. 1998).

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