Ethical Dilemmas in Driver Reeducation

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This article illustrates ethical dilemmas faced by therapists who provide driver reeducation. The dilemmas discussed are (a) accepting a wide range of referral sources and client disabilities versus the inability to know enough to anticipate all driver performance errors, (b) the client's safety versus the client's right to independence, (c) financial constraints versus advantages of technology, and (d) the reporting of poor driving risk versus client confidentiality. A method for determining one's pattern of resolving ethical dilemmas is discussed.

Driving is so important to our society that it may be regarded as an activity of daily living (van Zomeren, Brouwer, & Minderhoud, 1987). Occupational therapists provide driver reeducation to adults with brain injuries or physical challenges and may also provide driver instruction and adaptation to adults with developmental disabilities. Therapists who provide driver reeducation and recommend adaptive driving equipment must often make critical safety and ethical decisions. Lives may be at stake, and there is a potential for lawsuits.

The purpose of this article is to discuss some of the ethical dilemmas faced by therapists who provide driver education, to offer suggestions to resolve some of these dilemmas, and to point out the need for efficacy studies in the area of specialized driver education. An ethical dilemma is defined as a difficult problem that has no clear resolution, that is, one in which we are quite sure that we will be making a big mistake regardless of the path we choose (Hundert, 1987). By discussing ethical dilemmas rather than just relating success stories, we hope to alleviate some of the problems faced by therapists who provide driver reeducation.

Literature Review

In discussing ethical problem solving in medicine, Hundert (1987) applied the term incommensurable to those decisions that make it impossible to quantify the worth of one value, such as truthfulness, to another value, such as relief from suffering. He noted that the balancing of values offered by our conscience are our moral principles, and these are usually more complicated than the moral actions that we take. He illustrated this by stating that first-year medical students articulate their moral principles with simplicity, for example, by saying, “Always do everything you can to save your patient’s life.” This contrasts with their viewpoints after they have had clinical experience. Another complication to balancing our own values is that we are operating simultaneously within institutions, cultures, or laws that have a different pattern of balancing values.

A library reference search did not reveal driver reeducation publications dealing specifically with ethical dilemmas, but background information on driver reeducation can be obtained from Bartlow (1983); Galski, Ehle, and Bruno (1990); Golper, Rau, and Marshall (1980); Gurgold and Harden (1978); Johnson and Keltner (1983); Jones, Giddens, and Croft (1985); Katz et al. (1990); Keltner and Johnson (1987); Kewman, Seigerman, Kintner, and Chu (1985); Lippmann (1979); Peck (1988); Quigley and Delisa (1983); Shaffron and McPherson (1989); Sivak, Hill, Henson, Butler, and Silber (1984); Sivak, Olson, Kewman, Won, and Henson (1981); Strano (1987); and van Zomeren et al. (1987).

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Ethical Dilemmas in the Clinical Setting

The occupational therapist who provides driver education and reeducation evaluates the client's strengths and weaknesses as related to driving. This evaluation may include visual and perceptual testing as well as judgment, reaction time, coordination, endurance, and strength assessment. Positioning is also assessed and modified, as indicated. Adaptive equipment is provided, evaluated, and prescribed along with training in its use. Driver reeducation may involve the use of compensatory tactics, such as increased following distance when reaction time is slow or increased visual scanning when the visual field is decreased. Finally, the transfer of evaluated and trained abilities to the actual driving situation is assessed.

This process of driver assessment and reeducation involves multiple ethical issues that require a balance between the beliefs of the client, the family, the occupational therapist, and society as a whole. Occupational therapy as a profession is not value-neutral. Some of its purported tenets are that clients should be encouraged to become as independent as possible; that they should be empowered or encouraged to make choices, because autonomy promotes well-being; that activities should be purposeful; and that a return to work is important for workers with disabilities. Therapists pride themselves on the use of innovation and adaptation in facilitating independence. When applied to driver reeducation, however, these tenets may conflict with the therapist's and society's values. Some ethical concerns regarding driver reeducation are discussed below.

Who Should Refer Driver Reeducation Candidates to the Therapist?

Driver reeducation programs may accept referrals from diverse sources, such as state rehabilitation commissions, rehabilitation counselors, neurologists, ophthalmologists, physiatrists, psychologists, families, and potential clients themselves. This diversity of referral sources results in clients with an enormous variance in abilities. More importantly, however, it presents the therapist with varying availability of amounts and types of information and assessments regarding the client. For example, professionals making referrals may note only those problems pertinent to their expertise and may forget to mention other factors, such as that the client has an uncontrolled seizure disorder, is antisocial, or is suicidal. Evaluations to obtain further information, such as an ophthalmologic examination of visual fields or a neuropsychiatric evaluation, may be prohibitively expensive for the person referred. Should the therapist refuse the referral on the basis of insufficient information?

The expectations of and follow-up by the referring sources also may vary, but the therapist may not have the time to investigate each referrer's expectations and follow-up procedures. This could lead to litigation if follow-up is inappropriately managed or if the client is involved in an accident. Driving is often thought of as the last consideration in a client's rehabilitation. The referral is usually made at or just before discharge, which places the burden of managing the driving issue on the therapist.

An example of incomplete information from a referrer can be seen in the case of a 60-year-old man who sustained a brain injury in a fall at work. He was referred by a neuropsychologist for driver reeducation assessment. The referral report indicated that the man's cognitive processing was slowed, that he might have some inattention on the left side of his visual field, and that he had been treated with biofeedback for tension headaches. During his driving evaluation, the client needed frequent reminding to slow down and remain within the speed limit, but he repeatedly increased his speed. When the therapist indicated that the client may need to return again the next day, the client expressed inappropriate anger and verbal abuse, which distracted his attention from driving. A subsequent telephone call to the neuropsychologist indicated that the neuropsychologist knew that this client had been concerned about his own driving safety when he found himself driving over 80 mph in a 40 mph zone and was unable to stop himself. This threat to the safety of the therapist and client could have been avoided if the neuropsychologist had indicated the client's emotional instability. The therapist could have deferred the evaluation until the client had more self-control; planned a driving route that would allow an immediate exit from the route; employed some of the techniques the neuropsychologist was using to assist the man in maintaining emotional control; or planned to make the driving evaluation short, within the limits of the driver's frustration tolerance.

This example suggests that referrers do not necessarily refer for driver's assessments only those clients that they themselves would be willing to be behind the wheel with, yet they expect the therapist to ride with these clients. Clearly, behind the wheel is not the safest place to determine how far a client's self-control has progressed.

What Type of Clients Should be Accepted Into the Program?

Driver reeducation programs may value the goal of driving so highly that the therapist must try to provide driver training to clients with such diverse disorders as drug addiction, alcohol addiction, psychiatric problems, visual field deficits, head injuries, cerebral palsy, spinal cord injuries, degenerative diseases, and a history of risky driving behaviors. The therapist is thus expected to have the skills to assess the relevant driving behaviors of multiple disorders. Should the therapist reject a client simply because he or she has never worked with someone having a particular disorder or limitation? A client may try driving...
on his or her own if the formal evaluation is not done. Also, the therapist may not be able to find driving skills information regarding a particular disorder in the literature because articles on the subject are scarce.

An example of a lack of knowledge of the literature is illustrated in the case of a therapist’s early experience with a client with T-4 paraplegia. On evaluation, the client appeared to have appropriate upper extremity strength and coordination, trunk balance, and cognitive skills. She had had several hours of driving experience when, one day, she panicked at a left turn and overaccelerated. She was thrown into the therapist’s lap and, in her distress, pulled down on the hand-controlled throttle in an effort to regain her balance. The therapist was almost unable to override the throttle with the brake. Had there been anyone in the intersection or crosswalk, there would have been a disaster. If the therapist had known of Hymen’s (1982) review of two studies that delineated the effects of emergency situations such as sudden stops or turns in drivers with paraplegia, she could have ensured that the driver have sufficient trunk-support straps.

Another example of lack of knowledge of the available literature is illustrated in the case of a man 1 year after a bilateral cerebrovascular accident whose year-old neuropsychological evaluation had predicted that he would probably never able to work again. When he met with the examiner, he had successfully returned to work, had made gains in speech and strength, and wished to resume driving in order to get himself to work. Because he was doing so well and the referring agency was reluctant to invest in another neuropsychological examination, the therapist decided to proceed with a driving evaluation. The client passed the clinical evaluation, which consisted of driving simulation, eye-foot reaction time, perceptual testing, visual screening, and an interview, and was taken for a driving assessment. He drove adequately in the parking lot and adjacent area. The evaluation progressed to driving in light city traffic, where the therapist noted that the client would attempt to signal with his right hand and alternated his feet to depress the brake. It was unclear whether this behavior was manifestation of a prior driving habit, lack of recent practice, or a neurological deficit. The neurological nature of these symptoms of foot confusion and hand-signal confusion became readily apparent in a more complex traffic situation—the juncture of a multiple-lane road and a one-way street. The client was told to slow down, but he instead pushed both the accelerator and the brake, causing a high-speed skid. Luckily, no collision resulted. Had the therapist been given a recent neuropsychological report at the time of referral, she might have known about his motor behavior under duress. Had she been aware of the subtle functional manifestations of unilateral neglect and faulty motor programming, she would have curtailed the evaluation. Even after such a blatant loss of control, the client’s perception of the situation was that “it was a close call, that’s all.” This classic denial of symptoms was further strengthened by the client’s perception that he must be able to drive if he was referred for an evaluation and that he performed well. He did not agree with the therapist’s opinion that he should not drive.

What Type of Preliminary Assessments Should be Performed?

Ideally, one would like to know as much as possible about the client, but it is not feasible to assess every skill relevant to driving. Standardized tests such as intelligence and motor performance do not indicate how the person will function in a driving situation. The person may have a normal IQ but engage in risk-taking behaviors, or an ophthalmologic examination may indicate visual-field deficits that do not appear to interfere with performance in the actual driving test. A driving simulation may be safer for the driver and the therapist but will not duplicate the movement and control of a moving object that occurs in a real driving situation. The route used for driving instruction may not adequately reveal how the person would react without an accompanying driver and in a stressful situation. Road and weather conditions, familiarity with the route, and compliance with road signs and speed limits cannot be controlled sufficiently. The cost of extensive testing by the therapist and other disciplines before an actual driving evaluation may be prohibitive, so the therapist may have only a minimal amount of information with which to decide whether to approve the client for driving reeducation.

Should the Therapist Have Primary Responsibility for Determining Whether the Client Should Drive?

Unofficially, the therapist may be expected to be the professional primarily responsible for determining if a client should receive driving instruction in preparation for a driving examination. The client and family may have high expectations that the therapist will make the client capable of driving. Independence in driving has tremendous implications for self-care, family functioning, and employment potential. The client is no longer seen as a burden to society, because the ability to drive facilitates employment potential, thus contributing to self-support rather than dependence on funds from public agencies or private insurers. Conversely, the therapist is obligated to ensure clients’ and others’ safety by ensuring that an incompetent driver not be placed on the road. No matter what the decision regarding recommendation of driver training, the therapist may be viewed as the bad guy.

A related ethical issue is whether an injured driver should be made aware that some states do not have laws requiring medical clearance after injury, thus allowing him or her to legally continue driving until the regular expiration date of his or her license. In the absence of
such a law, is it ethical to strongly imply that the client does need driver assessment?

To illustrate the ethical dilemma of whether adapted driver education should be available for new drivers (i.e., those who did not drive before injury), we offer the case of a young man with a longstanding head injury who insisted on driving lessons even after the neuropsychologist told him that he did not have the requisite skills to drive. The neuropsychologist asked the therapist to perform a driving evaluation to demonstrate to the client that he could not drive because he did not understand explanations, only concrete examples. Further, the client showed poor time-sharing ability (i.e., the ability to concentrate on more than one thing at a time). The neuropsychologist assured the therapist that the client’s reaction time would be slow enough to indicate that the driving evaluation should terminate early. Reluctantly, the therapist accepted the client. To the therapist’s dismay, the client performed well on all of the clinical evaluations and demonstrated an aptitude for learning behind the wheel. The client was instructed in driving and advised of appropriate adaptive driving equipment. He took the driver’s license test on his own before completing the driving training program. The therapist observed that the client’s skills declined under time constraints as well as when driving in time-pressured or complex situations; unfortunately, this became apparent only after the client had learned to drive. The driving evaluation had been undertaken as a way to communicate to this client that he could not drive safely, but it only facilitated his driving. A comprehensive road test performed by the state’s Department of Public Safety did not stop this client either. The therapist was left with the task of convincing the client that he should not drive. The client, however, was enabled by the therapist and by the accepted standards of the Department of Public Safety, which proved he could indeed drive. He was able to adequately master the operation of a car in a simple driving test but was extremely dangerous behind the wheel due to his inability to handle complex traffic situations that are not evaluated on the Department of Public Safety examination.

This example raises the question of whether the official driving examination is sufficient to evaluate clients with disabilities. It also indicates what can happen when a limited number of assessments as well as fewer professionals are used in order to contain driver training costs within the client’s financial capabilities.

Should Technology and Car Adaptations Be Used Fully?

Technology and vehicle adaptations are becoming increasingly sophisticated and are allowing persons to drive who previously could not. With technology comes additional ethical dilemmas. Should the therapist suggest modifications and equipment that are extremely expensive if the client does not have sufficient financial resources? Who should be given the limited public funding available? Should specialized driving equipment be suggested as a possibility if that equipment is not available for trial? For example, one client was told that he might benefit from a steering wheel modification, but he could not try it first because the equipment was unavailable. He did not follow up on the suggestion by scheduling an assessment at an institution that had the actual equipment. Later, the therapist learned that the client’s funding source had approved vehicle modifications amounting to thousands of dollars, only to find that the client still could not drive because of insufficient strength to use the modified steering wheel. Ironically, the therapist had been expected to train the client to use the equipment.

With the availability of rehabilitation engineering and custom modifications of equipment, the dilemma is whether to offer these modifications or other nonresearched modifications to a client or to place the therapist’s needs for protection from liability in the event of equipment failure above the client’s needs for independence. Systematic crash testing and security evaluation of modifications and new equipment for all customized equipment is not financially feasible, which places the equipment vendor in a position of liability as well. Foremost is the dilemma of balancing the client’s needs for safety with his or her need for independence.

Who Should Receive a Copy of the Therapist’s Report?

Client confidentiality is a concern and a legal responsibility of the therapist, as is public safety. These two concerns, however, can represent opposing forces. Depending on state laws, some clients may be able to refuse to share negative information about their driving abilities with their physician or with the state’s licensing agency or Department of Public Safety. Who is ultimately liable if the therapist indicates that driving training is not recommended but this information is not shared appropriately?

Suggestions to Help Resolve the Ethical Dilemma

To solve ethical problems, Hundert (1987) suggested that a list be made of the conflicting values in each case. Such a list in driver reeducation might include the following:

- The client’s independence versus potential danger to self and others.
- The client’s safety versus the client’s right to self-determination.
- The public’s safety versus the client’s right to confidentiality and independence.
- Financial constraints versus advantages offered by technology, extended evaluations, and training.
- The client’s time constraints (e.g., needing to drive before being able to work, needing the evalu-
This list should be updated as new information is learned.

- Recommendation to drive versus a potential lawsuit.

Hundert indicated that, by saving the lists, one could observe the relative weight one attaches to a given value over time. It could also delineate the patterns of value balancing employed by various professionals.

Careful planning and collaboration with other professionals can clarify procedures for handling many driver reeducation concerns, such as finding alternative forms of transportation or assisting with obtaining equipment funding. The suggestions that follow were developed from the first author's own value balancing and might help other therapists who are just beginning to address the issues of driver reeducation programs.

Written procedures can provide a safety net for liability issues. For example, referral guidelines should be clearly specified, including who can make referrals, what background information is required, what types of clients will be considered, and the usual amount of time from referral until the client is seen by the therapist. Alternative means of reimbursement should be provided for those unable to pay for services, such as driver's training not covered by insurance, otherwise the client may decide to drive without the benefit of postinjury training. The therapist may know of some sources of alternative funding or may refer the client to another discipline or group that addresses funding.

A list of assessments should be made, and the minimum information required for each should be specified. This list should be updated as new information is learnt.

Professionals should specify in writing who is ultimately responsible for decisions regarding fitness for driving. Ideally, this should be a team decision with several levels of screening finalized by a well-informed local licensing agency. The therapist may also put in writing that the driver reeducation program does not guarantee that the client will receive a driver's license. It is advisable to have the client sign a release granting permission to send copies of the driving evaluation results to the appropriate Department of Public Safety and to the client's personal physician. In some states, the therapist can report directly to a medical advisory board without receiving the client's permission, if the client is considered to be incompetent to drive. This can be determined by contacting a particular state's licensing agency, Department of Public Safety, Department of Public Health, or medical association.

Policies for technology recommendations should be established. If there are state guidelines for technology in accordance with the Technology Related Assistance for Individuals With Disabilities Act of 1988 (Public Law 100-407), the therapist can act in accordance with the guidelines. The therapist should make every effort to access available resources to try adaptations before recommending that the adaptation be made to the client's vehicle. If the adaptation is not readily available, the therapist's report can indicate that the modification is not recommended until its efficacy has been verified with the client. Referral to a facility that has the equipment is crucial. This will avoid the funding of adaptations that are only theoretically effective. If equipment is recommend-

ed, the therapist may stipulate that the client must also receive training on the use of the equipment. Allocation of financial resources should be determined according to certain priorities, such as ability to return to employment, rather than changing the rules for each client. This can better ensure a fair policy for limited resources while providing some protection from liability. Exceptions to the policy should be noted. If too many exceptions occur, this may indicate a need to change the policy.

The efficacy of driver reeducation programs should be evaluated. Two important outcomes to follow are the number of traffic violations and the number of accidents incurred by clients who have completed the program. We tell clients that program evaluation is essential, that they will be contacted at a specified time, that driving is a privilege, and that a car is a lethal weapon.

Finally, we recommend that the therapist have sufficient malpractice insurance and have an attorney review client protocols and releases prior to their use.

**Research Needs**

The ability to make ethical decisions regarding driver training may be enhanced by appropriate research. Areas for study include: (a) whether prior training with powered mobility, such as scooters and wheelchairs, enables persons with perceptual and motor deficits to more effectively learn to drive; (b) which impairments tend to result in certain deficits and to what degree or how are they compensated for in training and performance; (c) an examination of individual tasks to determine which are necessary and sufficient for driving; (d) a determination of the correlation between standardized and functional test results, with follow-up driving records on tickets and accidents or on which factors are the best predictors of subsequent poor driving records; and (e) a determination of the effects of recommendations not to drive on the client and family. The number of accidents of driver reeducation clients can be compared with local or state statistics on accidents to determine if the driver reeducation program is doing an adequate job of client selection and training.

Specific concerns scarcely addressed in the literature are (a) How effective are restrictions, such as allowing the driver to drive only during daylight hours and on familiar roads? (b) Do clients comply with the restrictions? (c) Do the restrictions help ensure the client's safety? and (d) How effective are compensatory techniques?
Summary and Conclusion

Provision of driver reeducation is fraught with ethical dilemmas and safety decisions for the client, the therapist, and the public. To ensure safety and wise decision making, we encourage the occupational therapist to become aware of his or her pattern of making ethical decisions and to establish clear policies, procedures, and role responsibilities. Program evaluation should be a continuous part of the driver reeducation program to ensure appropriate updating of the program. Safety must be a priority. The therapist may judge a client’s fitness to drive but cannot guarantee that the client will always exercise his or her best skills while driving. Further, when a client, family member, or other professional is disappointed in the therapist’s decision or suggests that the therapist is uncaring, the therapist must remember that the pains taken to make ethical decisions reflect the importance attached to those decisions (Hundert, 1987).

References


