

AGING, DRIVING, AND PUBLIC HEALTH: A THERAPEUTIC JURISPRUDENCE APPROACH[†]

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I. INTRODUCTION

An important and increasing public health problem is presented by elders who are losing their ability to drive safely.¹ The problem was dramatically revealed when eighty-six-year-old George R. Weller, likely mistaking his car accelerator for the brake, crashed into the Santa Monica farmer's market in 2003, tragically killing ten people and injuring more than fifty others.² In 2008, twenty-eight million baby boomers over the age of sixty-five were still driving, and the projection for 2030 is that forty-six million drivers will be over the age of sixty-five, representing twenty-five percent of the total driving population.³ More-

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¹ See J. Peter Kissinger, *Foreword* to AM. AUTO. ASS'N FOUND. FOR TRAFFIC SAFETY, 2008 NORTH AMERICAN LICENSE POLICIES WORKSHOP PROCEEDINGS 2 (2008) [hereinafter AAA WORKSHOP PROCEEDINGS], available at <http://www.aaafoundation.org/pdf/LPWorkshopProceedings.pdf>; ROBIN OLSON, INT'L RISK MGMT. INST., INC., SENIOR DRIVER ISSUES: UPCOMING CHALLENGES AND SOLUTIONS 2 (2004) [hereinafter SENIOR DRIVER ISSUES], available at <http://www.irmi.com/expert/articles/2004/images/olson10.pdf>.

² Henry Weinstein et al., *Santa Monica Crash: A 2-Car Crash May Have Started it All*, L.A. TIMES, July 18, 2003, available at 2003 WLNR 15137443.

³ David B. Carr, *Current Knowledge on Medical Fitness-to-Drive: The Role of the Clinician*, in AAA WORKSHOP PROCEEDINGS, *supra* note 1, at 39, 40; see Insurance Information Institute, Older Drivers, <http://www.iii.org/media/hottopics/insurance/olderdrivers/> (last visited April 7, 2010) [hereinafter Older Drivers].

over, drivers over the age of seventy are driving more miles than before.⁴

Automobile accidents involving the elderly are more likely to result in more injuries and fatalities.⁵ One factor associated with the increased number of fatalities is that older drivers are more fragile than young drivers, which can result in older drivers being up to four times more likely to die in a crash than those who are younger.⁶ As the population ages and more people continue driving well into their eighties and nineties, the expectation is the number of fatal crashes involving elder drivers will also increase.⁷

⁴ See *Older Drivers up Close: They Aren't Dangerous Except Maybe to Themselves*, STATUS REP. (Ins. Inst. for Highway Safety, Arlington, Va.), Sept. 8, 2001, at 1, 2 [hereinafter *Drivers up Close*], available at <http://www.iihs.org/externaldata/srdata/docs/sr3608.pdf>; Governor's Office of Highway Safety, Elderly Drivers, <http://www.azgohs.gov/transportation-safety/default.asp?ID=19> (last visited April 7, 2010) ("In 1990, elderly drivers accounted for 6.7 percent of all miles driven. By 2030, according to our conservative estimate, elderly drivers will account for 18.9 percent of all vehicle miles driven, almost triple the 1990 figure. Based on current rates, the number of elderly traffic fatalities will more than triple by the year 2030.").

⁵ See Centers for Disease Control and Prevention, Research Update: Motor Vehicle-Related Injuries Among Older Adults: A Growing Public Health Concern, http://www.cdc.gov/MotorVehicleSafety/Older_Adult_Drivers/motorolder.html (last visited April 7, 2010); U.S. GOV'T ACCOUNTABILITY OFFICE, REPORT TO THE SPECIAL COMMITTEE ON AGING, U.S. SENATE, OLDER DRIVER SAFETY: KNOWLEDGE SHARING SHOULD HELP STATES PREPARE FOR INCREASE IN OLDER DRIVER POPULATION 1 (2007) [hereinafter GAO REPORT], available at <http://www.gao.gov/new.items/d07413.pdf>; *Drivers up Close*, supra note 4, at 2.

⁶ NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP'T OF TRANSP., TURNING THE CORNER . . . AND STILL DRIVING: A REVIEW OF LAW ENFORCEMENT PROGRAMS INVOLVING OLDER DRIVER SAFETY 7 (2005) [hereinafter TURNING THE CORNER], available at <http://www.nhtsa.dot.gov/people/injury/olddrive/TurnThecornerWeb/images/TurningtheCorner.pdf>; Fatality Analysis Reporting System Encyclopedia, People, All Victims, <http://www-fars.nhtsa.dot.gov/People/PeopleAllVictims.aspx> (last visited April 7, 2010) (reporting that in 2008 people over sixty-five accounted for 14.8% of all traffic fatalities); Governors Highway Safety Association Issues, Mature Drivers, <http://www.ghsa.org/html/issues/olderdriver.html> (last visited April 7, 2010).

⁷ See PATRICIA S. HU ET AL., OAK RIDGE NAT'L LAB., PROJECTING FATALITIES IN CRASHES INVOLVING OLDER DRIVERS, 2000-2025, at 3-34 to 3-35 (2000), available at http://cta.ornl.gov/cta/Publications/Older_Drivers/index.html; Luci Andres, *Motor Vehicle Crashes Among the Elderly: Advocates Cite the Need for Mandatory Retesting of Elderly Drivers*, 30 J. EMERGENCY NURSING 509, 509 (2004). See generally S. Lyman et al., *Older Driver Involvements in Police Reported Crashes and*

Aging alone has not been found to be a reliable predictor of motor vehicle accidents in the elderly population.⁸ However, several factors associated with aging are correlated with higher risk of automobile accidents.⁹ These include a decline in motor, sensory, and cognitive abilities that accompany the normal aging process,¹⁰ an increase of chronic diseases,¹¹ increased use of medications,¹² increased frailty,¹³ and inadequate compensatory behaviors.¹⁴

Fatal Crashes: Trends and Projections, 8 INJ. PREVENTION 116 (2002), available at <http://injuryprevention.bmj.com/cgi/content/abstract/8/2/116>. But see Alan Mozes, *Elderly Car Crash Deaths Down in Last Decade*, HEALTHDAY REP., Jan. 23, 2009, available at <http://www.washingtonpost.com/wp-dyn/content/article/2009/01/23/AR2009012303478.html> (finding reduction in automobile accidents among the elderly).

⁸ See Andres, *supra* note 7.

⁹ See generally DAVID W. EBY ET AL., UNIV OF MICH. TRANSP. RESEARCH INST., THE ASSESSMENT OF OLDER DRIVERS' CAPABILITIES: A REVIEW OF THE LITERATURE (1998); NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP'T OF TRANSP., MEDICAL CONDITIONS AND DRIVING: A REVIEW OF THE SCIENTIFIC LITERATURE (1960-2000) (2005), available at http://www.nhtsa.dot.gov/people/injury/research/medical_condition_driving/Medical%20Cond%20809%20690-8-04_Medical%20Cond%20809%20690-8-04.pdf; Carr, *supra* note 3, at 41-53.

¹⁰ See Carr, *supra* note 3, at 41-53; Older Drivers, *supra* note 3.

¹¹ See Richard A. Marottoli et al., *Predictors of Automobile Crashes and Moving Violations Among Elderly Drivers*, 121 ANNALS INTERNAL MED. 842, 843 (1994); Older Drivers, *supra* note 3. See generally Miriam K. Campbell et al., *Medical Conditions Associated With Driving Cessation in Community-Dwelling, Ambulatory Elders*, 48 J. GERONTOLOGY: SOC. SCI. S230 (1993); Gerald McGwin, Jr., et al., *Relations Among Chronic Medical Conditions, Medications, and Automobile Crashes in the Elderly: A Population-based Case-Control Study*, 152 AM. J. EPIDEMIOLOGY 424, 427 (2000) (“[O]lder drivers with heart disease or stroke were more likely to be involved in . . . automobile crashes and that these associations appear to be independent of the medications used to treat these diseases.”).

¹² Carr, *supra* note 3, at 48-50; Suzanne G. Leveille et al., *Psychoactive Medications and Injurious Motor Vehicle Collisions Involving Older Drivers*, 5 EPIDEMIOLOGY 591, 591 (1994).

¹³ Guohua Li et al., *Fragility Versus Excessive Crash Involvement as Determinants of High Death Rates Per Vehicle-mile of Travel Among Older Drivers*, 35 ACCIDENT ANALYSIS & PREVENTION 227, 233 (2003).

¹⁴ Some seniors may not be able to compensate for deteriorating skills for which they are not aware. Inadequate compensatory behavior could potentially create or promote unsafe practices by the driver if not properly understood. See Germaine L. Odenheimer, *Driver Safety in Older Adults: The Physician's Role in Assessing Driving Skills of Older Patients*, GERIATRICS, Oct. 2006, at 14, 17, available at <http://>

Notwithstanding this serious public health problem, state practices dealing with the issue vary widely and are inadequate at several levels. Part III of this Article describes state practices for identifying and dealing with the problem and critically evaluates these practices. One serious defect in these practices is the failure to address the psychological and social consequences to the elderly of restricting or terminating their driving privileges. Indeed, such practices often produce serious psychological consequences for the elderly and their families. This Article uses the therapeutic jurisprudence approach to analyze these antitherapeutic consequences and to suggest ways of minimizing or avoiding them. Part II of this Article describes the therapeutic jurisprudence approach and explores its relationship to public health. Part IV analyzes the antitherapeutic consequences of existing practices. Part V proposes solutions that seek to achieve a better balance between the public health of the community and the emotional well-being of elder drivers.

II. THE RELATIONSHIP BETWEEN THERAPEUTIC JURISPRUDENCE AND PUBLIC HEALTH

Therapeutic jurisprudence can be employed as a public health approach that focuses on using the legal system to increase community and individual health and well-being.¹⁵ Legal rules and procedures and the way legal actors perform their roles are social forces that impact psychological well-being.¹⁶ The public health approach uses the behavioral sciences to assess the function of the law in this context, and this approach seeks to reshape law as well as how the law applies “to mini-

geriatrics.modernmedicine.com/geriatrics/data/articlestandard/geriatrics/422006/379233/article.pdf.

¹⁵ JUDGING IN A THERAPEUTIC KEY: THERAPEUTIC JURISPRUDENCE AND THE COURTS 7 (Bruce J. Winick & David B. Wexler eds., 2003) [hereinafter JUDGING IN A THERAPEUTIC KEY] (discussing the implementation of problem-solving courts as a public health approach to the judicial system using principles of therapeutic jurisprudence); Nadav Davidovitch & Michal Alberstein, *Therapeutic Jurisprudence and Public Health: A Broad Perspective on Dialogue*, 30 T. JEFFERSON L. REV. 507, 523 (2008).

¹⁶ David B. Wexler, *Justice, Mental Health, and Therapeutic Jurisprudence*, in LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE 713, 714 (David B. Wexler & Bruce J. Winick eds., 1996) [hereinafter LAW IN A THERAPEUTIC KEY].

mize its anti-therapeutic effects and maximize its therapeutic potential.”¹⁷ The mission of public health is defined as “fulfilling society’s interest in assuring conditions in which people can be healthy”¹⁸ through three core functions: assessment, policy development, and assurance.¹⁹ Assessment involves monitoring, diagnosing, and investigating community health problems.²⁰ Public health agencies then seek to develop policy designed to inform, educate, and empower the public about health problems in order to mobilize community organizations to work together to identify and solve these problems.²¹ Assurance includes making resources available to those in need, enforcing laws designed to promote and protect health, maintaining the quality of service delivery, and researching new solutions to health problems.²² An important focus of public health is assuring the public understands the conditions that promote community health, which can be achieved through prevention and education.²³

Therapeutic jurisprudence has much to contribute to public health, and public health has much to contribute to therapeutic jurisprudence.²⁴ Public health’s focus and methodologies can improve therapeutic jurisprudence’s ability to identify and evaluate the effectiveness of legal interventions.²⁵ Conversely, therapeutic jurisprudence can help public health to understand how the legal system can achieve the goals of public health as well as increase compliance with legal rules that seek to promote health through “emphasis on the interpersonal and psychological well-being of the subjects”²⁶ Applied in the context of

¹⁷ Bruce J. Winick, in 9 *LAW AND PSYCHOLOGY: CURRENT LEGAL ISSUES* 30, 32-36 (Belinda Brooks-Gordon & Michael Freeman eds., 2006); see *LAW IN A THERAPEUTIC KEY*, *supra* note 16.

¹⁸ COMM. FOR THE STUDY OF THE FUTURE OF PUB. HEALTH, INST. OF MED., *THE FUTURE OF PUBLIC HEALTH* 7 (1988), available at <http://www.nap.edu/openbook.php?isbn=0309038308&page=7>.

¹⁹ *Id.* at 7-8.

²⁰ *Id.* at 7.

²¹ *See id.* at 8.

²² *Id.*

²³ *See id.* at 7; INST. OF MEDICINE, *THE FUTURE OF THE PUBLIC’S HEALTH IN THE 21ST CENTURY* 6 (2003).

²⁴ Davidovitch & Alberstein, *supra* note 15, at 508.

²⁵ *Id.* at 518.

²⁶ *Id.* at 523.

elderly drivers, therapeutic jurisprudence seeks to understand how laws and legal practices can be reformed to prevent risky driving behaviors without unduly diminishing the psychological well-being of at-risk drivers and their families.

III. CURRENT STATE PRACTICES FOR DEALING WITH THE PROBLEM OF ELDER DRIVERS

A. *Triggering Mechanisms for Reevaluation of Elder Drivers' Fitness to Drive*

Driving is regulated at the state level. State practices vary widely in dealing with age-related licensure requirements and renewals.²⁷ In almost all states, age alone is not a disqualifying factor.²⁸ Several occurrences will trigger the reevaluation of the elder driver's continued fitness to drive. States differ concerning the criteria for invoking the assessment process and the tools or tests used to measure the skills needed for safe driving.²⁹

Incidents that trigger review can be grouped into four general categories:

²⁷ See AAA, Senior Licensing Laws, <http://www.aaapublicaffairs.com/Assets/Files/2010331532430.SeniorLicensing.doc> (last visited April 7, 2010); Governors Highway Safety Association, Mature Driver Laws, http://www.ghsa.org/html/stateinfo/laws/olderdriver_laws.html (last visited April 7, 2010) [hereinafter Mature Driver Laws]; U.S. Driver Licensing Procedures for Older Drivers, Special Provisions for Older Drivers, <http://www.hldi.org/laws/OlderDrivers.aspx> (last visited April 7, 2010).

²⁸ See Mature Driver Laws, *supra* note 27 (noting some states require an in-person renewal process, more frequent renewals, and vision tests for older drivers); see also TRANSANALYTICS, LLC, SUMMARY OF MEDICAL ADVISORY BOARD PRACTICES IN THE UNITED STATES (2003), available at <http://www.mdsupport.org/drivingsummary.pdf> [hereinafter MAB PRACTICES].

²⁹ There is no consensus as to which tests best determine at-risk driving. See KATHY H. LOCOCO & LOREN STAPLIN, U.S. DEP'T OF TRANSP., REPORT NO. DOT HS 809 874, STRATEGIES FOR MEDICAL ADVISORY BOARDS AND LICENSING REVIEW 15-44 (2005) [hereinafter STRATEGIES FOR MABs], <http://www.nhtsa.dot.gov/people/injury/research/MedicalAdvisory/pages/Job%201602%20-%20final%20new.pdf>; AM. MED. ASS'N, AMA PHYSICIAN'S GUIDE TO ASSESSING AND COUNSELING OLDER DRIVERS 24-41 (2003), available at <http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/geriatric-health/older-driver-safety/assessing-counseling-older-drivers.shtml> [hereinafter AMA PHYSICIAN'S GUIDE] (summarizing fitness-to-drive tests used in each state).

1. Attainment of a Particular Age

Few jurisdictions require evaluation based on age alone.³⁰ Among these, only three jurisdictions require a physical examination based on the driver being older than sixty or seventy at the time of initial licensure.³¹

Only one jurisdiction requires a driver older than seventy-years-old to submit a physician's report along with his renewal by mail.³² Other jurisdictions impose shorter renewal periods after a certain age³³ or require the driver to come in person for renewal³⁴ and/or to perform additional tests.³⁵

2. Occurrence of Certain Adverse Driving Events

These adverse events may include involvement in a certain number of accidents, involvement in a crash resulting in a fatality, or accumulation of points on the license.³⁶ In about half the jurisdictions, involvement in a fatal crash will require evaluation of an individual's ability to continue driving.³⁷ Other jurisdictions condition reevaluation

³⁰ Carl A. Soderstrom, *Licensing Agency Options for Interventions*, in AAA WORKSHOP PROCEEDINGS, *supra* note 1, at 123, 124; *see* Mature Driver Laws, *supra* note 27.

³¹ Soderstrom, *supra* note 30, at 124 (noting that the three jurisdictions that require age-based examinations for an initial license are Louisiana, Maryland, and the District of Columbia).

³² *Id.* (referring to Nevada's requirement).

³³ Sherrilene Classen & Kezia Awadzi, *Model State Programs on Licensing Older Drivers*, in AAA WORKSHOP PROCEEDINGS, *supra* note 1, at 140, 144-45. Sixteen states impose age-based shorter renewal periods. *Id.*

³⁴ *Id.* at 145. Five states require in-person renewals starting at various ages ranging from sixty-one to seventy. *Id.*

³⁵ STRATEGIES FOR MABS, *supra* note 29, at 8. Two jurisdictions require drivers older than seventy-five to pass a road test on renewal. *Id.* Nine states and the District of Columbia require vision tests after a certain age. Classen & Awadzi, *supra* note 33, at 144.

³⁶ *See* STRATEGIES FOR MABS, *supra* note 29, at 10-11 (discussing how certain driving events can trigger reevaluation); MAB PRACTICES, *supra* note 28, at 402-08 tbl.C-5.

³⁷ Soderstrom, *supra* note 30.

on the occurrence of a given number of crashes within a specified period of time.³⁸

3. Reports Concerning Driving Irregularities or Diminished Capacity

Police,³⁹ courts,⁴⁰ physicians,⁴¹ or family members⁴² can make reports on driving irregularities or diminished capacity of elderly drivers. Whether initiated by the police when the elderly driver is stopped for a traffic infraction or involved in an accident, initiated by a traffic court upon a hearing, or initiated by a physician pursuant to his or her duty to report impaired drivers,⁴³ reporting triggers a process in which the elderly driver is required to produce supporting documentation of his ability to drive, subject himself to a variety of tests, or both.⁴⁴ In some states, a report also triggers an in person or video evaluation of the elderly driver by the state's medical advisory board (MAB).⁴⁵ Many

³⁸ STRATEGIES FOR MABS, *supra* note 29, at 11. Although renewal of licenses by mail is typical, an increasing number of states require renewal in person for drivers after a certain age. *Id.* at 13. In some jurisdictions, the accumulation of points on the license and/or the accumulation of crashes, paired with age, will trigger reevaluation. *Id.* at 11. In twenty-five of the fifty states, a crash with a fatality could trigger reevaluation of the driver. *Id.*

³⁹ See AMA PHYSICIAN'S GUIDE, *supra* note 29, at 75-146 (outlining the reporting laws and procedures of all fifty-one jurisdictions); MAB PRACTICES, *supra* note 28, at 398-401 tbl.C-4; STRATEGIES FOR MABS, *supra* note 29, at 13. All fifty-one jurisdictions allow law enforcement to report potentially impaired drivers. *Id.*

⁴⁰ See MAB PRACTICES, *supra* note 28, at 398-401 tbl.C-4. In forty-nine jurisdictions, courts can trigger reevaluation of the license of a potentially impaired driver. *Id.* at 401.

⁴¹ *Id.* at 390-97. Only six jurisdictions require physicians to file a report with the DMV office upon a finding of impairment of a patient. *Id.* at 397. Reportable conditions are defined narrowly in some statutes (e.g., epilepsy) but broader in others (e.g., "[a]ny condition likely to impair the ability to control and safely operate a motor vehicle"). *Id.* at 394-95.

⁴² *Id.* at 398-401. Some jurisdictions limit reporting to only family members, while others allow any concerned citizen to file reports whether or not they are related to the impaired driver. *See id.* at 401.

⁴³ *See id.* at 402-08 (describing state by state, the instances when reports are initiated and by what authority they are referred by).

⁴⁴ STRATEGIES FOR MABS, *supra* note 29, at 9.

⁴⁵ MAB PRACTICES, *supra* note 28, at 433 tbl.D-5; STRATEGIES FOR MABS, *supra* note 29, at 11. Thirty-seven jurisdictions have medical advisory boards. STRATEGIES

jurisdictions allow reporting by friends and family members of the elderly driver, although requirements and designation of the persons permitted to report vary.⁴⁶

4. Disclosure by the Driver at the Time of Renewal in Response to Questions Concerning the Existence of Conditions that May Impair Driving Ability

The majority of jurisdictions require drivers to answer questions regarding certain medical conditions at the time of license renewal.⁴⁷ The types of questions asked vary among the states.⁴⁸ Some jurisdictions only require the driver to answer a simple question such as “Do you have any medical conditions that may affect your ability to drive safely?”⁴⁹ Other jurisdictions, however, require very detailed answers regarding specific health conditions.⁵⁰ A response from the elderly driver identifying an infirmity that may impair driving will trigger review.

FOR MABS, *supra* note 29, at 11. Activities of the MABs may include conducting reviews of medical reports (thirty-three states), interviewing referred drivers and impaired drivers in person or by video (five states), and conducting hands-on screening and assessment of the drivers (three states). *Id.*

⁴⁶ STRATEGIES FOR MABS, *supra* note 29, at 13. Forty-eight jurisdictions will consider reports from family members, although some only accept reports from specific family members (e.g., wife or siblings). *Id.*; MAB PRACTICES, *supra* note 28, at 398-401 tbl.C-4. In thirty-nine jurisdictions, reports from friends and other citizens could also trigger reevaluation of the driver. MAB PRACTICES, *supra* note 28, at 401 tbl.C-4.

⁴⁷ MAB PRACTICES, *supra* note 28, at 388-89 tbl.C-2; STRATEGIES FOR MABS, *supra* note 29, at 8. All states except Arkansas and New Hampshire require drivers to answer questions about medical conditions either initially or upon renewal. STRATEGIES FOR MABS, *supra* note 29, at 8. In four jurisdictions, only first time applicants are required to disclose the existence of health conditions that may impair driving. *Id.*

⁴⁸ STRATEGIES FOR MABS, *supra* note 29, at 8.

⁴⁹ *Id.*

⁵⁰ *Id.* (noting that Utah and Maryland both require such questioning).

B. License Reevaluation Outcomes and How They Are Communicated

State practices vary widely concerning the methods of reviewing continued licensure. In the majority of jurisdictions, a state MAB performs a review.⁵¹ Sometimes the individual is required to appear for testing or evaluation in person or by video before the board or before a member or physician designated by the board.⁵² Sometimes the board conducts its own evaluation of the driver's ability by simply reviewing the written file, which contains any evidence or allegations of impairments or negative tests results.⁵³ In states without a MAB, the Division of Motor Vehicle's (DMV) examiner makes the decision regarding continued licensure.⁵⁴ Sometimes the examiner or the MAB will refer the individual for remediation, further tests, or require the individual to submit a letter from his physician.⁵⁵

After conducting an evaluation, the licensing agency or MAB notifies the individual of its determination to continue, restrict, or terminate his driving privileges.⁵⁶ This may be done by letter.⁵⁷ Sometimes the individual's license has been suspended beforehand, confiscated by a police officer at the scene of an accident or driving incident, or suspended by an examiner at the DMV office.⁵⁸

C. Hearings

Although driving was once considered a privilege outside the ambit of due process protection, the Supreme Court has held that the ability to drive is a property interest within the meaning of the Due

⁵¹ See MAB PRACTICES, *supra* note 28, at 386-87 tbl.C-1.

⁵² See *id.* at 431-33.

⁵³ See *id.*

⁵⁴ See *id.* at 386-87.

⁵⁵ See *id.* at 436-37.

⁵⁶ See STRATEGIES FOR MABs, *supra* note 29, at 9.

⁵⁷ See MAB PRACTICES, *supra* note 28, at 65.

⁵⁸ See Kim Snook, *Roles and Responsibilities of Licensing Agencies*, in AAA WORKSHOP PROCEEDINGS, *supra* note 1, at 37, 38.

Process Clause.⁵⁹ Notice and hearing are therefore required before or soon after the right to drive is taken away.⁶⁰ Such a hearing does not require a formal adversarial judicial determination.⁶¹ Informal administrative hearing procedures are permissible.⁶² Moreover, because driving by an incapacitated driver poses serious risks to public safety, a postdeprivation procedure is adequate to meet the requirements of due process.⁶³

All states provide presuspension or postsuspension hearings where elderly drivers can present written or oral evidence, including documents provided by the driver's physician, to refute immediate concerns about continued driving ability.⁶⁴ Following the hearing, the licensing agency or MAB may restore or continue driving privileges, revoke the license, or suspend it for a period of time.⁶⁵ License suspension allows the individual time to submit additional information or testing, or to remedy the condition that justified the suspension, such as by obtaining corrective lenses or other adaptive equipment. Another option is for the agency or MAB to permit continued driving subject to restrictions.⁶⁶

These restrictions may include the mandatory use of prosthetics or vehicles with special adaptive devices.⁶⁷ They may also limit the driving area to the driver's home and surrounding radius or to specific destinations with which the driver is familiar.⁶⁸ In addition, they may

⁵⁹ *Bell v. Burson*, 402 U.S. 535, 539 (1971) (reasoning that “[o]nce licenses are issued, . . . their continued possession may become essential in the pursuit of a livelihood”).

⁶⁰ *Mullane v. Cent. Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950) (“An elementary and fundamental requirement of due process in any proceeding which is to be accorded finality is notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections.” (citations omitted)).

⁶¹ *Mackey v. Montrym*, 443 U.S. 1, 13 (1979); *Dixon v. Love*, 431 U.S. 105, 113-14 (1977) (upholding the constitutionality of a postrevocation hearing).

⁶² *Love*, 431 U.S. at 115.

⁶³ *Id.* at 114-15.

⁶⁴ *See MAB PRACTICES*, *supra* note 28, at 412-13 tbl.C-8.

⁶⁵ *See id.* at 436-37.

⁶⁶ *See id.*

⁶⁷ *See id.*

⁶⁸ *STRATEGIES FOR MABs*, *supra* note 29, at 40.

limit driving to daytime hours or to roads with lower speed limits.⁶⁹ Some jurisdictions make driving privileges conditional on the individual's attendance of remedial, counseling, or educational programs.⁷⁰

IV. THE ANTITHERAPEUTIC CONSEQUENCES OF CURRENT STATE PRACTICES

Current methods of regulating the driving privileges of the elderly, although necessary for community protection, often impose a variety of negative consequences on the elder driver. These include social, economic, health, and psychological consequences, as well as potentially disruptive effects on the driver's relationship with his family and physician. Part IV explores these negative effects in detail. Part V proposes solutions designed to minimize these negative consequences, while continuing to fulfill the public health mission of protecting community health and safety.

A. *Negative Social, Economic, and Health Consequences*

Driving in the United States is a symbol of status, independence, and autonomy.⁷¹ Since Henry Ford's invention of the automobile and

⁶⁹ *Id.* at 40-41.

⁷⁰ See MARY K. JANKE, CAL. DEP'T OF MOTOR VEHICLES, RSS-94-156, AGE-RELATED DISABILITIES THAT MAY IMPAIR DRIVING AND THEIR ASSESSMENT: LITERATURE REVIEW 236-37 (1994), available at http://www.dmv.ca.gov/about/profile/rd/r_d_report/Section%206/156-Age-Related%20Disability.pdf; STRATEGIES FOR MABS, *supra* note 29, at 13. Thirteen jurisdictions provide older drivers with educational programs designed to keep them driving safely longer. STRATEGIES FOR MABS, *supra* note 29, at 13. These programs vary in methods of delivery and availability, but each assists the elderly to develop an awareness of their limitations and to seek remediation of their problems. *Id.* In addition, counseling to impaired drivers (provided in ten jurisdictions) helps them cope with changes and develop new habits to adjust to driving restrictions or cessation. *Id.*

⁷¹ Roxanna M. Bendixen et al., *The Relationship of Home Range to Functional Status and Cognitive Status of Frail Elders*, in COMMUNITY MOBILITY: DRIVING AND TRANSPORTATION ALTERNATIVES FOR OLDER PERSONS 43, 44 (William Mann ed., 2005), available at <http://driving.php.ufl.edu/publications/232343622005.pdf>; LISA J. MOLNAR ET AL., UNIV. OF MICH. TRANSP. RESEARCH INST., PROMISING APPROACHES FOR PROMOTING LIFELONG COMMUNITY MOBILITY 2 (2007) [hereinafter PROMISING APPROACHES], available at <http://deepblue.lib.umich.edu/bitstream/2027.42/60921/1/101054.pdf>; NAT'L ETHICS COMM. OF THE VETERANS HEALTH ADMIN., DEP'T OF

the development of the interstate highway system, driving has played a unique role in American life. Indeed, the car has emerged as a central icon of individual identity. Driving is an essential part of daily living.⁷² For many seniors, it is also the only means to connect to the outside world, maintain social integration,⁷³ and access needed resources. The elderly community in Australia rated driving as the second most important activity of daily living, second only to the use of a telephone.⁷⁴

As a result, the deprivation of the right to drive strikes a devastating blow to an elderly individual's lifestyle, autonomy, ability to undertake the everyday tasks of life,⁷⁵ and sense of self-identity.⁷⁶ Studies confirm that driving cessation, whether forced or voluntary, produces

VETERANS AFFAIRS, *IMPAIRED DRIVING IN OLDER ADULTS: ETHICAL CHALLENGES FOR HEALTH CARE PROFESSIONALS* 3-4 (2007), available at http://www.ethics.va.gov/docs/necrpts/NEC_Report_20070930_Impaired_Driving_in_Older_Adults.pdf

[hereinafter *IMPAIRED DRIVING IN OLDER ADULTS*]; TURNING THE CORNER, *supra* note 6, at 3; Geri Adler & Susan Rottunda, *Older Adults' Perspectives on Driving Cessation*, 20 J. AGING STUD. 227, 227 (2006); June M. Sullivan, *Physicians as Gatekeepers for Society: Confidentiality of Protected Health Information Versus Duty to Disclose At-Risk Drivers*, HEALTH LAW., Nov. 2003, at 20, 20; Monica S. Yassuda et al., *Driving Cessation: The Perspective of Senior Drivers*, 23 EDUC. GERONTOLOGY 525, 525-26 (1997).

⁷² See AMA PHYSICIAN'S GUIDE, *supra* note 29, at 18; Nahid Azad et al., *A Survey of the Impact of Driving Cessation on Older Drivers*, 5 GERIATRICS TODAY: J. CANADIAN GERIATRICS SOC'Y 170, 170 (2002); Richard Marottoli et al., *Consequences of Driving Cessation: Decreased Out-of-Home Activity Levels*, 55B J. GERONTOLOGY: SOC. SCI. S334, S334 (2000); Sandra Rosenbloom, *Transportation Needs of the Elderly Population*, 9 CLINICS GERIATRIC MED. 297, 297-98 (1993).

⁷³ See Loren Staplin, *Driver Screening and Assessment in the 21st Century*, in AAA WORKSHOP PROCEEDINGS, *supra* note 1, at 86, 87; Marottoli et al., *supra* note 72 (noting that more social integration has been related to a lower mortality risk); Sullivan, *supra* note 71.

⁷⁴ Janet Fricke & Carolyn Unsworth, *Time Use and Importance of Instrumental Activities of Daily Living*, 48 AUSTRALIAN OCCUPATIONAL THERAPY J. 118, 118, 124 (2001); see Marottoli et al., *supra* note 72; Staplin, *supra* note 73; Azad et al., *supra* note 72, at 170; Sullivan, *supra* note 71.

⁷⁵ See Jeffrey T. Berger et al., *Reporting by Physicians of Impaired Drivers and Potentially Impaired Drivers*, 15 J. GEN. INTERNAL MED. 667, 667 (2000).

⁷⁶ See AMA PHYSICIAN'S GUIDE, *supra* note 29, at 18.

profound consequences on the life of the elderly; including highly negative social,⁷⁷ health,⁷⁸ and psychological⁷⁹ consequences.

The social consequences are evident. Cessation of driving is associated with decreased self-perceived roles in family and society.⁸⁰ It reduces or eliminates employment opportunities and participation in religious, family, and volunteer activities, thus increasing social isolation.⁸¹ It reduces options, spontaneity, and comfort. Male drivers, in particular, may perceive their inability to continue driving as a threat to their status as head of the family.⁸²

⁷⁷ See Briana Mezuk & George W. Rebok, *Social Integration and Social Support Among Older Adults Following Driving Cessation*, 63B J. GERONTOLOGY: SOC. SCI. S298, S298 (2008) (citations omitted) (discussing negative impact of driving cessation on social networks and social integration); Anne E. Dickerson et al., *Transportation and Aging: A Research Agenda for Advancing Safe Mobility*, 47 GERONTOLOGIST 578, 578-79 (2007) (discussing mobility of elders as critical to maintaining their quality of life).

⁷⁸ See Azad et al., *supra* note 72 (stating that factors associated with driving cessation have been linked to the development of medical conditions such as stroke and Alzheimer's).

⁷⁹ See Julie E. Johnson, *Urban Older Adults and the Forfeiture of a Driver's License*, J. GERONTOLOGICAL NURSING, Dec. 1999, at 12, 16 (noting that driving cessation can be associated with regret and loneliness). See generally Stephanie J. Fonda et al., *Changes in Driving Patterns and Worsening Depressive Symptoms Among Older Adults*, 56B J. GERONTOLOGY: SOC. SCI. S343 (2001); Richard A. Marottoli, et al., *Driving Cessation and Increased Depressive Symptoms: Prospective Evidence from the New Heaven EPESE*, 45 J. AM. GERIATRICS SOC'Y 202 (1997); David R. Ragland et al., *Driving Cessation and Increased Depressive Symptoms*, 60A J. GERONTOLOGY: MED. SCI. 399 (2005).

⁸⁰ See Azad et al., *supra* note 72, at 171-72.

⁸¹ See Marottoli et al., *supra* note 72; Stephen J. Cutler, *The Effects of Transportation and Distance on Voluntary Association Participation Among the Aged*, 5 INT'L J. AGING & HUM. DEV. 81, 83 (1974).

⁸² HU ET AL., *supra* note 7, at 3-21 (explaining that men are not only reluctant to give up driving even when they are aware of impairments, but they are also more reluctant than women to ask for help from others); LIDIA P. KOSTYNIUK ET AL., UNIV. OF MICH. TRANSP. RESEARCH INST., REPORT NO. UMTRI-98-23, THE PROCESS OF REDUCTION AND CESSATION OF DRIVING AMONG OLDER DRIVERS: A REVIEW OF THE LITERATURE 27 (1998); Kate Davidson, *Declining Health and Competence: Men Facing Choices About Driving Cessation*, GENERATIONS, Spring 2008, at 44, 46-47; Lidia P. Kostyniuk & Jean T. Shope, *Driving and Alternatives: Older Drivers in Michigan*, 34 J. SAFETY RES. 407, 409 (2003); Desmond O'Neill, *Predicting and Coping with the*

The impact of driving cessation on health, although less evident, is similarly devastating. Driving cessation is associated with a general decline in function that further negatively affects quality of life. The inability to drive may diminish the individual's access to health care.⁸³ It is also associated with decline in cognitive functions and memory.⁸⁴ The psychological consequences contribute significantly to decreased health and quality of life.⁸⁵

B. Negative Psychological Effects to the Elderly Driver

Existing state practices for dealing with elderly drivers only serve to exacerbate the negative psychological consequences instead of alleviating them. For example, if an elderly driver is involved in a car accident, the police or the examiner at the Driver's License Office may immediately confiscate their license.⁸⁶ If the confiscation occurs in public, this can cause intense embarrassment.⁸⁷ Indeed, when unexpectedly stripped of a driver's license, the individual may be required to ask friends or family for a ride home or for help relocating a vehicle, triggering unwanted feelings of dependency.⁸⁸ The elder driver may lose their driving privileges suddenly, without any previous warning.⁸⁹ The examiner or police officer usually informs the individual of their loss of driving privileges in person, either during the visit to the DMV or during the incident in question.⁹⁰ In most instances, the actor is insensitive to the psychological impact of the revocation and has no training in the

Consequences of Stopping Driving, 11 ALZHEIMER DISEASE & ASSOCIATED DISORDERS 70, 71 (1997).

⁸³ See Hyungsoo Kim & Virginia E. Richardson, *Driving Cessation and Consumption Expenses in the Later Years*, 61B J. GERONTOLOGY: SOC. SCI. S347, S347 (2006).

⁸⁴ Kaarin J. Anstey et al., *Predicting Driving Cessation Over 5 Years in Older Adults: Psychological Well-Being and Cognitive Competence are Stronger Predictors than Physical Health*, 54 J. AM. GERIATRICS SOC'Y 121, 124 (2006).

⁸⁵ See *infra* Part IV.B.

⁸⁶ MAB PRACTICES, *supra* note 28, at 25.

⁸⁷ See Johnson, *supra* note 79 (recounting the experience of an elderly woman whose license was confiscated).

⁸⁸ Kostyniuk & Shope, *supra* note 82, at 407.

⁸⁹ See MAB PRACTICES, *supra* note 28, at 25.

⁹⁰ See *id.*

interpersonal skills needed to cushion the blow.⁹¹ Embarrassment, despair, and a sense of helplessness may result from this sudden and unforeseen loss of privileges.⁹²

Therapeutic jurisprudence is particularly concerned with the psychological consequences of legal practices.⁹³ The psychological effects of the deprivation of driving privileges may be somewhat less evident than the economic, social, and general health consequences, but they are more serious in many ways. When a police officer or the DMV confiscates an elderly person's license after a traffic violation or after receiving negative test results, many psychological mechanisms are likely to be triggered that negatively affect the person's emotional well-being.

Confiscation of a driver's license, particularly when it occurs in public, is a form of labeling.⁹⁴ It signifies the individual is incompetent to drive, and the person may experience many of the negative effects associated with that label. When the law applies an incompetency label to individuals, it effectually brands them, often imposing serious psychosocial disadvantages which adversely affect the ways others view and treat them.⁹⁵ An incompetent-to-drive label stigmatizes and discredits the elder driver in the eyes of family members, friends, and others learning of the determination. This reaction is a form of deviance labeling that marginalizes the elder driver, causing the internalization of a deviant self-image.⁹⁶ It also negatively impacts the driver's

⁹¹ See PROMISING APPROACHES, *supra* note 71, at 38 (describing a program designed to train law enforcement officers to identify at-risk drivers and communicate effectively with them).

⁹² In such instances, the elderly driver may find himself deprived of his mobility and means to provide for himself. Not only was he exposed to the embarrassment of being publicly identified by the police or the DMV examiner as a bad driver, but he may be devastated by the need to contact family members or friends to provide a ride home.

⁹³ See generally *supra* note 16, and accompanying text.

⁹⁴ See Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, in LAW IN A THERAPEUTIC KEY, *supra* note 16, at 17, 19-20.

⁹⁵ See *id.* at 20-23.

⁹⁶ Jeannine Coreil, *Social Reactions to Disease*, in SOCIAL AND BEHAVIORAL FOUNDATIONS OF PUBLIC HEALTH 133-34 (Jeannine Coreil ed., 2d ed. 2010) [hereinafter Coreil I]; Douglas Raybeck, *Anthropology and Labeling Theory: A Constructive Critique*, 16 ETHOS 371, 372 (1988); Winick, *supra* note 94, at 20-21.

self-esteem and self-concept in ways that can have a major impact on motivation and ability to function.⁹⁷ In addition, the incompetent-to-drive label may diminish the elder driver's sense of well-being and lead to depression.⁹⁸

This form of incompetency labeling produces a lasting stigma that strongly affects the way others regard and interact with labeled individuals and the way labeled individuals perceive themselves.⁹⁹ Stigma is "an attribute that is deeply discrediting"¹⁰⁰ The application of a stigmatizing label often causes others to view the labeled individual as "unable to participate in life normally."¹⁰¹ The classification as deviant causes others to perceive the labeled individual "through a lens colored by the stereotype associated with the deviant characteristic."¹⁰² The individual "'become[s] the label,' and society treats the person accordingly."¹⁰³ The stigmatizing label often functions to exclude former drivers from social activities and opportunities. Family members and social acquaintances may be discouraged from including these individuals in dinners, parties, and other social occasions due to concerns that the individual may no longer act appropriately and imposes the burden of requiring transportation. Similarly, others may become reluctant to extend opportunities for employment and participation in community volunteer efforts upon learning an individual has had their driving privileges revoked. This differential treatment is an example of the self-fulfilling prophecy effect.¹⁰⁴ Under the self-fulfilling prophecy concept, those learning of a stigmatizing label act in a manner that serves to induce behavior in the stigmatized individual

⁹⁷ Winick, *supra* note 94, at 33-35.

⁹⁸ *Id.* at 36.

⁹⁹ *Id.* at 35-36.

¹⁰⁰ ERVING GOFFMAN, *STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY* 3 (1963).

¹⁰¹ Winick, *supra* note 94, at 22.

¹⁰² Coreil I, *supra* note 96, at 133.

¹⁰³ *Id.*

¹⁰⁴ See EDWARD E. JONES ET AL., *SOCIAL STIGMA: THE PSYCHOLOGY OF MARKED RELATIONSHIPS* 177-78 (1984); Mark Snyder, *On the Self-Perpetuating Nature of Social Stereotypes*, in *COGNITIVE PROCESSES IN STEREOTYPING AND INTERGROUP BEHAVIOR* 183, 184 (David L. Hamilton ed., 1981).

that tends to confirm the “initially false belief[s]” or prophecy associated with the label.¹⁰⁵

Not only does the stigmatizing label affect how others treat the individual, but it also has a significant impact on the stigmatized individual’s self-perception, self-attribution, and sense of self-efficacy.¹⁰⁶ Self-efficacy theory shows how an individual’s perceptions concerning their skills and abilities influence their behavior.¹⁰⁷ Stigmatized individuals may internalize the label and discredit themselves.¹⁰⁸ Those labeled as incompetent drivers may begin to question their competency in other areas and perceive events in their life as outside of their control. The consequences this perceived lack of control has on an individual’s emotional well-being, motivation, and ability to function depends on how the individual defines their identity.¹⁰⁹ Whether a stigmatizing label will damage the individual’s self-concept will depend on the importance he or she places on the quality or trait in question.¹¹⁰ If the individual links the label to a central aspect of their identity, the negative self-attributional effects of stigma will occur.¹¹¹ Stripping an individual’s ability to drive is likely to have strong negative effects on their self-concept and subsequent behavior, given the societal importance attached to driving, the role of the automobile in American life, and the common conception of driving as a symbol of independence and autonomy.

Therefore, labeling an individual as an incompetent driver may produce a number of adverse psychological effects, particularly as it is

¹⁰⁵ JONES ET AL., *supra* note 104, at 176-77; *see* Winick, *supra* note 94, at 22-23.

¹⁰⁶ *See* Albert Bandura, *Recycling Misconceptions of Perceived Self-Efficacy*, 8 COGNITIVE THERAPY & RES. 231, 242 (1984). *See generally* ATTRIBUTION: BASIC ISSUES AND APPLICATIONS (John H. Harvey & Gifford Weary eds., 1985) [hereinafter ATTRIBUTION]; ALBERT BANDURA, SELF-EFFICACY: THE EXERCISE OF CONTROL (1997).

¹⁰⁷ *See* Sandra Graham, *A Review of Attribution Theory in Achievement Context*, 3 EDUC. PSYCHOL. REV. 5, 30 (1991).

¹⁰⁸ JONES ET AL., *supra* note 104.

¹⁰⁹ *See* Winick, *supra* note 94, at 33 (discussing the difference between individuals who are motivated internally, externally, or by nothing).

¹¹⁰ *See* JONES ET AL., *supra* note 104, at 116-18.

¹¹¹ *Id.*; *see, e.g.*, MARCIA MILLMAN, SUCH A PRETTY FACE: BEING FAT IN AMERICA, at x (1980) (describing how self-concept regarding appearance determines the individual’s reaction to being labeled as obese).

also a loss of control over an important aspect of everyday life. It may produce what psychologist Martin Seligman termed *learned helplessness*.¹¹² Under Seligman's theory, "subjecting individuals to noncontingent negative (or even positive) consequences can produce generalized feelings of helplessness and hopelessness."¹¹³ Studies with animal and human subjects demonstrate organisms quickly learn to generalize feelings of powerlessness in one context and bring these feelings into other contexts, developing a global sense of powerlessness that debilitates functioning.¹¹⁴ Thus, when an authority figure tells an elder, many of whom are already aware their capacities are diminishing, that they are an incompetent driver, the elder may quickly come to see themselves as incompetent in other walks of life.¹¹⁵ Their fragile sense of identity may be shattered, and they may quickly spiral downward as they further deteriorate mentally and physically.¹¹⁶

Seligman showed that the symptoms produced by this feeling of noncontrollability mirror those of major affective depression. Individuals display retarded initiation of response that parallels the passivity, psychomotor retardation, and social impairment found in depression. They acquire a generalized belief that their actions are doomed to failure. Their self-attribution of failure produces such

¹¹² See Winick, *supra* note 94, at 27-30 (discussing learned helplessness) (citing HUMAN HELPLESSNESS: THEORY AND APPLICATIONS 3-4 (Judy Garber & Martin E.P. Seligman eds., 1980)); Christopher Peterson & Lisa M. Bossio, *Learned Helplessness*, in SELF-DEFEATING BEHAVIORS: EXPERIMENTAL RESEARCH, CLINICAL IMPRESSIONS, AND PRACTICAL IMPLICATIONS 235-52 (Rebecca C. Curtis ed., 1989).

¹¹³ Winick, *supra* note 94, at 28.

¹¹⁴ See, e.g., Martin E.P. Seligman et al., *Learned Helplessness in the Rat: Time Course, Immunization, and Reversibility*, 88 J. COMP. & PHYSIOLOGICAL PSYCHOL. 542, 542 (1975).

¹¹⁵ This generalization effect is compounded by the psychological effect of self-handicapping, under which people tend to inhibit performance to avoid what they perceive as an expected failure resulting from their internal deficits. Robert M. Arkin & Ann H. Baumgardner, *Self-Handicapping*, in ATTRIBUTION, *supra* note 106, at 169, 170-71; Edward E. Jones & Steven Berglas, *Control of Attributions About the Self Through Self-Handicapping Strategies: The Appeal of Alcohol and the Role of Underachievement*, 4 PERSONALITY & SOC. PSYCHOL. BULL. 200, 202 (1978). The application of an incompetent-to-drive label thus may cause people to exaggerate their lack of abilities and reduce future attempted performance.

¹¹⁶ See *supra* notes 75-85 and accompanying text.

negative effects as self-blame, guilt, feelings of incompetence, and lowered self-esteem. They develop a generalized apathy, resignation, and lowered intrinsic motivation. Their ability to solve problems is diminished, and their mood is depressed. In summary, they experience the symptoms of clinical depression and a loss of self-confidence that is itself debilitating.¹¹⁷

The need to be self-determining is a basic human need.¹¹⁸ “[T]he need for feeling competent and self-determining motivates two kinds of behavior: behavior which ‘seeks’ optimal challenge and behavior which ‘conquers’ challenge.”¹¹⁹ “This [need] relates to needs of the central nervous system”¹²⁰ An incompetent-to-drive label denies the individual the ability to be self-determining in important aspects of life. It communicates to the individual they are globally impaired, the impairment is unlikely to change but will probably increase over time, and the deficit is internally caused. As a result, depression is likely to occur.

Older drivers forced to stop driving may experience accelerated dependency, depression, and decline in physical functioning and social interaction.¹²¹ These factors have been associated with an increase in suicidality.¹²² Based on Aaron Beck’s cognitive model of depression, stressful events may trigger depression through the activation of negative schemata, leading individuals to perceive occurrences in their lives negatively.¹²³ When the elderly driver experiences the stressful event of being stripped of his driver’s license, and labeled incompetent as a result, it can activate the downward spiral of negative perceptions and feelings that may lead the elderly driver to depression. In addition, the

¹¹⁷ Winick *supra* note 94, at 28-29 (citations omitted).

¹¹⁸ EDWARD L. DECI, *INTRINSIC MOTIVATION* 61-62 (1975).

¹¹⁹ *Id.* at 57.

¹²⁰ *Id.* at 62.

¹²¹ See *supra* notes 74-85 and accompanying text (for the consequences of driving cessation).

¹²² See STEPHEN J. MOREWITZ & MARK L. GOLDSTEIN, *AGING AND CHRONIC DISORDERS* 35-37 (2007).

¹²³ See AARON T. BECK, *COGNITIVE THERAPY AND THE EMOTIONAL DISORDERS* 107-10 (1976); AARON T. BECK & BRAD A. ALFORD, *DEPRESSION: CAUSES AND TREATMENT* 24-25 (2d ed. 2009).

elderly driver's lack of participation in social activities, due to his or her own depression or lack of transportation, may contribute to increased suicidality. According to Emile Durkheim's theory of suicide,¹²⁴ lack of integration with, and disengagement of, the individual from his or her social environment may strongly contribute to depressed feelings and increased suicidality.¹²⁵

Moreover, when the police or DMV officer confiscates the license without prior notice, the driver may not only need to make last-minute arrangements for transportation, but may have no time to prepare or adjust psychologically to the severe blow of losing their license. This may create feelings of helplessness and lack of control, as well as fear of becoming a burden on family and friends now responsible for their transportation needs.¹²⁶ Furthermore, feelings of hopelessness and helplessness resulting from depression may further alienate friends and family trying to help with transportation.

C. *Procedural Justice Effects*

The manner in which the older driver's license is taken away can be an important factor bearing on the impact to the individual's psychological well-being. Although state practices vary widely, frequently the critical event occurs when a police officer at the scene of an incident or an examiner at the motor vehicle department confiscates the individual's driver's license.¹²⁷ This occurs suddenly, often not allowing the individual to prepare emotionally for the devastating conse-

¹²⁴ EMILE DURKHEIM, *SUICIDE* (1897), reprinted in EMILE DURKHEIM, *SUICIDE: A STUDY IN SOCIOLOGY* (George Simpson ed., John A. Spaulding & George Simpson trans., 1951). Durkheim proposed suicide resulted from too little social integration. *See id.* at 58. Individuals that were not sufficiently bound to social groups had little or no social support. *See id.* at 299. Individuals left without support or guidance were therefore more likely to commit suicide. *See id.* This theory seems to support some of the current literature on social networks and social interventions, which have found a strong link between the existence of social support and positive health outcomes. Jeannine Coreil, *The Social Environment and Health*, in *SOCIAL AND BEHAVIORAL FOUNDATIONS OF PUBLIC HEALTH*, *supra* note 96, at 109, 110-12 [hereinafter Coreil II].

¹²⁵ *See* MOREWITZ & GOLDSTEIN, *supra* note 122, at 36-37.

¹²⁶ *See* HU ET AL., *supra* note 7, at 3-21.

¹²⁷ *See* STRATEGIES FOR MABs, *supra* note 29, at 35; *supra* notes 56-58 and accompanying text.

quences. The police officer or examiner may simply confiscate the license with minimal or no explanation. Sometimes the confiscation is accompanied by verbal or body language that communicates disdain to the individual for driving, disrespect, and even ageism.¹²⁸ Such ageism reflects America is a youth culture that, unlike other societies, does not venerate its elders—but rather, marginalizes and socially ostracizes them. Officers or examiners may be acting upon stereotyped assumptions about older people, sometimes exacerbated by a negative transference reaction relating to their attitudes about their own parents.¹²⁹ The attitude conveyed, whether explicitly expressed or not, may be the equivalent of “Grandpa, you should have not been driving, you are a menace to the public.”

The driver may have a right to a hearing or to an appeal.¹³⁰ However, few elder drivers assert their rights in this regard, perhaps as a result of a lack of awareness concerning their rights, difficulty in understanding and pursuing them, or a sense of futility concerning the ability of a hearing or appeal to restore their licenses. Therefore, for many elder drivers, the moment of confiscation is itself the final and most critical event triggering whatever psychological consequences they will suffer as a result of their forced cessation of driving.

The literature on the psychology of procedural justice helps to understand these psychological reactions.¹³¹ This literature suggests

¹²⁸ Ageism has been defined as “any attitude, action or institutional structure which subordinates a person or group because of age or any assignment of roles in society purely on the basis of age.” Anthony J. Traxler, *Let's Get Gerontologized: Developing a Sensitivity to Aging*, in THE MULTI-PURPOSE SENIOR CENTER CONCEPT: A TRAINING MANUAL FOR PRACTITIONERS WORKING WITH THE AGING 4-5 (1980). See generally AGEISM: STEREOTYPING AND PREJUDICE AGAINST OLDER PERSONS (Todd D. Nelson ed., 2004).

¹²⁹ Cf. Marjorie A. Silver, *Love, Hate, and Other Emotional Interference in the Lawyer/Client Relationship*, 6 CLINICAL L. REV. 259, 262-65 (1999) (describing negative effects of transference in the lawyer/client relationship).

¹³⁰ See *supra* Part III.C.

¹³¹ See generally E. ALLAN LIND & TOM R. TYLER, THE SOCIAL PSYCHOLOGY OF PROCEDURAL JUSTICE (Melvin J. Lerner ed., Plenum Press 1988) (1948) [hereinafter SOCIAL PSYCHOLOGY]; TOM R. TYLER, WHY PEOPLE OBEY THE LAW 115-24 (2006) [hereinafter OBEY]; E. Allan Lind et al., *Voice, Control, and Procedural Justice: Instrumental and Noninstrumental Concerns in Fairness Judgments*, 59 J. PERSONALITY & SOC. PSYCHOL. 952 (1990); Norman G. Poythress, *Procedural*

people are more satisfied with and more likely to comply with the outcome of legal proceedings or interactions when they perceive them to be fair and when they have an opportunity to participate in them.¹³² Such feelings of fairness and participation are dependent on whether the individual feels he or she has been treated with dignity and respect, has been given *voice* (“the extent to which [he or she] was afforded an opportunity to express his or her opinion”), and *validation* (“the extent to which what [he or she] had to say was taken seriously”).¹³³ When individuals feel they have been treated with dignity, respect, in good faith, and have been afforded voice and validation, individuals are more satisfied with the legal interaction and more willing to accept the result and comply with it.¹³⁴ Conversely, when these conditions are not met, individuals are less likely to be satisfied or to accept and comply with the outcome. Moreover, they are more likely to experience the result as coercive;¹³⁵ whereas, if accorded procedural justice, they are less likely to feel they have been coerced and more likely to accept the result as morally legitimate.¹³⁶

When legal authorities treat people with dignity and respect and give them a sense of meaningful participation, this confirms their status

Preferences, Perceptions of Fairness, and Compliance with Outcomes: A Study of Alternatives to the Standard Adversary Trial Procedure, 18 L. & HUM. BEHAV. 361 (1994); John Thibaut & Laurens Walker, *A Theory of Procedure*, 66 CAL. L. REV. 541 (1978).

¹³² See OBEY, *supra* note 131, at 163-64; SOCIAL PSYCHOLOGY, *supra* note 131, at 64.

¹³³ BRUCE J. WINICK, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL 25 (2005) [hereinafter CIVIL COMMITMENT].

¹³⁴ See *id.* at 145-49.

¹³⁵ See John Monahan et al., *Coercion to Inpatient Treatment: Initial Results and Implications for Assertive Treatment in the Community*, in COERCION AND AGGRESSIVE COMMUNITY TREATMENT: A NEW FRONTIER IN MENTAL HEALTH LAW, 13, 14 (Deborah L. Dennis & John Monahan eds., 1996) [hereinafter A NEW FRONTIER] (discussing positive and negative consequences of coercion for individuals with mental illness); CIVIL COMMITMENT, *supra* note 133, at 24-26 (discussing factors associated with perceived coercion in patients).

¹³⁶ See CIVIL COMMITMENT, *supra* note 133, at 24-26; Nancy S. Bennett et al., *Inclusion, Motivation, and Good Faith: The Morality of Coercion in Mental Hospital Admission*, 11 BEHAV. SCI. & L. 295, 305 (1993); Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, 443-44 (1992) [hereinafter *Psychological Consequences*].

as competent equal citizens and human beings.¹³⁷ When elders are not treated this way, their status as a competent citizen is threatened and they feel devalued as members of society.¹³⁸ This treatment diminishes their perceptions of self-esteem, self-worth, and personal responsibility.¹³⁹ Elders beginning to lose their faculties have already been marginalized by a variety of other social mechanisms. Self-respect and their sense of value as members of society, therefore, are of special importance. Because such elders may be particularly sensitive to issues of participation, dignity, and trust, the psychological effects posited by the literature on the psychology of procedural justice are especially applicable in this context.

When police officers or DMV examiners strip elders of their licenses in ways that violate their sense of procedural justice, they are likely to feel disrespected and treated unfairly in ways that may trigger the negative psychological effects described in Part IV, section B. Moreover, they are less likely to accept and comply with such an outcome. Older drivers who have lost their licenses, like many drivers generally in this situation, may simply continue to drive without a license, with potentially devastating personal and social consequences. Therefore, compliance with this issue is especially important, and the likelihood of compliance will increase if the process of license removal satisfies conditions of procedural justice.

D. Impact on the Family

Sudden deprivation of elderly drivers' ability to drive affects not only their psychological well-being, but also their existing family dynamics.¹⁴⁰ Especially for male drivers, the blow can be particularly devastating. Not surprisingly, studies find men more reluctant to relinquish their driver's licenses than women.¹⁴¹ "The love affair with men

¹³⁷ See generally TOM R. TYLER & YUEN J. HUO, TRUST IN THE LAW: ENCOURAGING PUBLIC COOPERATION WITH THE POLICE AND COURTS 49-57 (Russell Sage Found. Series on Trust Vol. V, 2002). See also *Psychological Consequences*, *supra* note 136, at 440-41.

¹³⁸ See Winick, *supra* note 94, at 25-26.

¹³⁹ See *Psychological Consequences*, *supra* note 136, at 443.

¹⁴⁰ See Adler & Rottunda, *supra* note 71, at 232-33 (emphasizing the reluctance of nondriving elders to ask family for transportation unless it was absolutely necessary).

¹⁴¹ See *supra* note 82 and accompanying text.

and their cars is legend.”¹⁴² For men, the ability to drive a car is associated with the traditional social role of being a provider for the family.¹⁴³ Inability to provide for the needs of a wife or dependent family members can impose not only a devastating blow to the male’s self-esteem and sense of self-worth, but also predictably, will alter the existing family power dynamic. As a provider who can no longer meet the needs of his wife and loved ones, the elderly driver may feel a sense of uselessness and lack of purpose. A recent study on successful aging showed that older adults who did not frequently feel useful to others or valued as members of their social networks experienced an increase in disability or death over a follow-up period of seven years.¹⁴⁴

For a spouse and other family members dependent upon the driver’s care, the sudden loss of the driver’s privileges can have devastating consequences for their ability to meet many of their basic needs.¹⁴⁵ In addition, the spouse or family members might be forced to assume the role of primary caregiver, a role for which they may be unprepared or unable to assume.¹⁴⁶ They may experience feelings of resentment for having to assume this new role, triggering many of the negative psychological mechanisms associated with role reversal and role strain.¹⁴⁷ This disruption of the role relationships within the family can place stress on the new caregiver, put the caregiver at an increased risk for health problems, and result in role overload, particularly if the new caregiver is a spouse.¹⁴⁸ In extreme cases, it may significantly di-

¹⁴² TURNING THE CORNER, *supra* note 6, at 3; Davidson, *supra* note 82, at 45.

¹⁴³ See Davidson, *supra* note 82, at 46.

¹⁴⁴ See generally Tara L. Gruenewald et al., *Feelings of Usefulness to Others, Disability, and Mortality in Older Adults: The MacArthur Study of Successful Aging*, 62B J. GERONTOLOGY: PSYCHOL. SCI. P28 (2007).

¹⁴⁵ See Berger et al., *supra* note 75; Jacki Liddle & Kryss McKenna, *Older Drivers and Driver Cessation*, 66 BRIT. J. OCCUPATIONAL THERAPY 125, 130 (2003).

¹⁴⁶ See generally Dorothy A. Miller, *The ‘Sandwich’ Generation: Adult Children of the Aging*, 26 SOC. WORK 419 (1981) (describing middle age individuals who have become not only responsible for their grown children, but also their aging parents); S. Wallace Williams et al., *Caregiver Role Strain: The Contribution of Multiple Roles and Available Resources in African-American Women*, 7 AGING & MENTAL HEALTH 103 (2003).

¹⁴⁷ See Miller, *supra* note 146, at 421.

¹⁴⁸ See Carla L. Barnes et al., *Caregivers of Elderly Relatives: Spouses and Adult Children*, 17 HEALTH & SOC. WORK 282, 287 (1992) (comparing the effects of role

minish the quality of the relationship, the couple's quality of life, and may even lead to separation or divorce.

These devastating alterations in family dynamics may extend to children and other family members as well.¹⁴⁹ Older former drivers rely heavily on family and friends for their continued mobility. For middle age children, caught in what has been called "the sandwich generation," the additional responsibility of suddenly having to provide transportation for an aging parent may produce conflicts with other commitments and role obligations.¹⁵⁰ This may be true as well for teenage children who in many states are able to drive at age sixteen or seventeen. Caregiving tasks often increase and become permanent, making it difficult for family members to fulfill their other roles in society as employees, friends, students, mothers, and fathers.¹⁵¹ The added commitment of driving the former driver to appointments, work, or social activities may lead to difficulty in meeting role demands causing role strain.¹⁵² Role strain has been associated with higher levels of depression, comorbidities, and mortality for the caregiver,¹⁵³ and increased rates of institutionalization for the elderly.¹⁵⁴ Adult-child caregivers with siblings are the most at risk for feeling overburdened at the initial period of their caregiving activities.¹⁵⁵ Those without siblings experience increased feelings of abandonment and lack of effective support, and over time become the most vulnerable to risks of health problems.¹⁵⁶

strain and role overload on spouse caregivers and adult-child caregivers); Williams et al., *supra* note 146, at 104-05.

¹⁴⁹ See Barnes et al., *supra* note 148 (explaining that adult-child caregivers experience more feelings of abandonment than spouse caregivers, although less overall health problems).

¹⁵⁰ See generally Miller, *supra* note 146.

¹⁵¹ See generally Maaik G.H. Dautzenberg et al., *The Competing Demands of Paid Work and Parent Care: Middle-Aged Daughters Providing Assistance to Elderly Parents*, 22 RES. ON AGING 165 (2000).

¹⁵² See Jerold Heiss, *Social Roles*, in SOCIAL PSYCHOLOGY: SOCIOLOGICAL PERSPECTIVES 94, 123-26 (Morris Rosenberg & Ralph H. Turner eds., Am. Sociological Ass'n 1990) (1981).

¹⁵³ Carole Cox & Abraham Monk, *Strain Among Caregivers: Comparing the Experiences of African American and Hispanic Caregivers of Alzheimer's Relatives*, 43 INT'L J. AGING & HUM. DEV. 93, 93-103 (1996).

¹⁵⁴ See Miller, *supra* note 146, at 421.

¹⁵⁵ Barnes et al., *supra* note 148.

¹⁵⁶ *Id.* at 288.

Often, the family will perceive the elder driver's inabilities before they come to the attention of the legal system. This perception itself may impose a dilemma for the family. Suggesting to the elder driver that he stop driving may provoke intense resentment and oppositional behavior from the driver.¹⁵⁷ However, opting not to discuss the issue with the driver may cause rising anxiety within the family and fear of the consequences which might ensue. When increased family efforts to restrict the elder driver's activities do not succeed in altering his behavior, family members may feel compelled to report him to the DMV.

When a report from a family member triggers license reevaluation, suspension, or revocation,¹⁵⁸ social, economic, and psychological consequences may result for the family. Because only a limited number of states assure confidentiality of the identity of the reporter,¹⁵⁹ the driver is confronted with the reality that a family member questioned his ability to drive and deprived him of everything driving means to him. Family disharmony, resentment, and feelings of betrayal may intensify the driver's feelings of depression as the result of losing driving privileges.¹⁶⁰ Losing the right to drive may also deprive the elder driver of his needed social network support.¹⁶¹ The literature strongly links the existence of positive social support networks to beneficial health outcomes.¹⁶²

Existing legal practices ignore these effects on the family. The focus is exclusively on protecting the public from an impaired elder driver. Little attempt is made to provide social service support or counseling to the family, or to bolster its ability to deal with the problem of the older driver before it gets out of hand.

¹⁵⁷ See Fauzia Gardezi et al., *Qualitative Research on Older Drivers*, 30 *CLINICAL GERONTOLOGIST* 5 (2006).

¹⁵⁸ See *supra* note 42 and accompanying text.

¹⁵⁹ See *infra* note 167 and accompanying text.

¹⁶⁰ Berger et al., *supra* note 75, at 667, 669.

¹⁶¹ *Id.* at 667.

¹⁶² Coreil II, *supra* note 124, at 114. Although there are still questions regarding the sociobiological processes that serve as mediators in this association, studies confirm that mortality and morbidity are enhanced for those with adequate social support networks although the strength of this relationship seems to vary across communities and between genders. See *id.* at 104, 110-11, 114.

E. Impact of the Physician-Patient Relationship

The elderly driver's physician may play a key role in the license revocation or restriction process.¹⁶³ Six states require physicians to report to the DMV when their patients suffer from specified conditions that may impair driving.¹⁶⁴ The remaining forty-four states and the District of Columbia make such reporting discretionary.¹⁶⁵ In addition, whether or not he filed such a report, a physician may be requested to provide medical information to the DMV concerning the driver's condition.¹⁶⁶ In only a minority of jurisdictions is such a report confidential without exception, thus drivers will often learn the physician played a role in the license revocation or restriction process.¹⁶⁷ This reporting requirement may pose tensions with the physician's duty to his patient, and may produce feelings on the part of the patient that interfere with the professional relationship.¹⁶⁸

A physician has a fiduciary duty to the patient.¹⁶⁹ He must act in the patient's best interest, and must *do no harm*.¹⁷⁰ Moreover, the physician has a duty of confidentiality under which, absent patient authorization, information gained in the professional relationship should not be

¹⁶³ Berger et al., *supra* note 75.

¹⁶⁴ AMA PHYSICIAN'S GUIDE, *supra* note 29, at 83, 88, 117, 119, 127, 129; MAB PRACTICES, *supra* note 28, at 24, 57, 203, 212, 258, 266 (stating that California, Delaware, Nevada, New Jersey, Oregon, and Pennsylvania have mandatory physician reporting policies or regulations).

¹⁶⁵ See AMA PHYSICIAN'S GUIDE, *supra* note 29, at 79-146. See generally MAB PRACTICES, *supra* note 28.

¹⁶⁶ STRATEGIES FOR MABS, *supra* note 29, at 32.

¹⁶⁷ See MAB PRACTICES, *supra* note 28, at 71, 109, 143, 181, 217, 325. Although all fifty-one jurisdictions allow physicians to report, not all assure confidentiality. See generally *id.* This may have an impact on the willingness of the physician to report. AMA PHYSICIAN'S GUIDE, *supra* note 29, at 69-70.

¹⁶⁸ See *infra* notes 169-80 and accompanying text.

¹⁶⁹ IMPAIRED DRIVING IN OLDER ADULTS, *supra* note 71, at 4; AMA, Principles of Medical Ethics, at II, VIII, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics_print.html; The Hippocratic Oath, <http://nktiuro.tripod.com/hippocra.htm> (last visited April 7, 2010) [hereinafter Hippocratic Oath].

¹⁷⁰ IMPAIRED DRIVING IN OLDER ADULTS, *supra* note 71, at 4; Hippocratic Oath, *supra* note 169.

disclosed to third parties.¹⁷¹ Indeed, confidentiality has been described as “the foundation of the patient-physician relationship”¹⁷² because it facilitates open and frank discussion with the physician, which is necessary to the administration of appropriate medical care.¹⁷³ The physician, therefore, may feel conflicted when asked to disclose to the DMV information that might jeopardize the patient’s driving privileges. This reporting requirement cuts against the grain of the physician’s professional duty to the patient.¹⁷⁴ Yet, there are exceptional circumstances when the public interest requires such reporting.¹⁷⁵ Such circumstances include when the patient’s behavior poses a threat to the community’s safety or health.¹⁷⁶ Although the physician may legally and ethically breach confidentiality in these situations, the reporting requirement likely produces feelings of anxiety and distress on the part of the physician.¹⁷⁷ These strong feelings may undermine the reporting requirement, making the physician reluctant to report all but the most serious potential problems. These feelings may also produce cognitive distortions that may cause the physician to minimize, rationalize, or even deny the patient’s problem and its impact on his driving ability.¹⁷⁸ This tendency is further exacerbated by the uncertainty many physicians experience concerning whether they need to report and which conditions are the subject of mandatory reporting, as well as the fear of litigation

¹⁷¹ AMA, Principles of Medical Ethics, *supra*, note 169, at IV. The duty of confidentiality is also enforced by licensing statutes in many states. See generally MAB PRACTICES, *supra* note 28.

¹⁷² Sullivan, *supra* note 71, at 25.

¹⁷³ *Id.*; AMA PHYSICIANS’ GUIDE, *supra* note 29, at 69.

¹⁷⁴ Berger et al., *supra* note 75.

¹⁷⁵ *Id.*

¹⁷⁶ 45 C.F.R. § 164.512(j) (2009); IMPAIRED DRIVING IN OLDER ADULTS, *supra* note 71, at 4; Berger et al., *supra* note 75, at 669.

¹⁷⁷ See Brian R. Ott & Stephen T. Mernoff, *Driving Policy Issues and the Physician*, 82 MED. & HEALTH 428, 428 (1999). Many physicians today have little or no training in determining driving risk. See *id.* Often, they feel inadequate in diagnosing a driver’s impairment due to inaccurate risk predictability of the many existing safe driving assessment tools available and the lack of consensus on what constitutes reportable impairments. See *id.* See generally Sullivan, *supra* note 71.

¹⁷⁸ See generally LEON FESTINGER, A THEORY OF COGNITIVE DISSONANCE (1957).

due to the failure of many jurisdictions to grant the physician immunity for reporting.¹⁷⁹

Patient recognition that the physician disclosed medical information that led to a restriction or revocation of driving privileges may seriously undermine the effectiveness of the doctor-patient relationship.¹⁸⁰ The concept of the therapeutic alliance originated in the context of the psychotherapist-patient relationship,¹⁸¹ but now is recognized to apply more generally to the physician-patient relationship.¹⁸² “[T]he actual caring, human relationship between therapist and patient is transformative or curative[,]” and therefore the therapeutic relationship itself can be regarded as a therapeutic agent.¹⁸³ “To reach its therapeutic potential, the therapist must establish an environment of safety and trust.”¹⁸⁴ A real and open patient-physician dialogue concerning treatment, planning, and decision making is necessary to bolster the patient’s faith in the physician and in the physician’s dedication to the patient’s best interest.

Mandatory reporting laws can interfere with the professional relationship “by motivating patients to withhold information that is cru-

¹⁷⁹ See generally MAB PRACTICES, *supra* note 28. Only thirty states provide immunity for civil liability to physicians who report potentially impaired drivers. See *id.*

¹⁸⁰ See Gregory L. Krauss et al., *Individual State Driving Restrictions for People With Epilepsy in the U.S.*, 57 NEUROLOGY 1780, 1785 (2001) (stating patients are often not forthcoming about their ailments for fear of losing their driving privileges); M.C. Salinsky et al., *Epilepsy, Driving Laws, and Patient Disclosure to Physicians*, 33 EPILEPSIA 469, 469 (1992).

¹⁸¹ See Gerald Adler, *Transference, Real Relationship and Alliance*, 61 INT’L J. PSYCHOANALYSIS 547, 547-48 (1980); Ralph R. Greenson, *The Working Alliance and the Transference Neurosis*, 34 PSYCHOANALYTIC Q. 155, 157 (1965).

¹⁸² See Edward S. Bordin, *The Generalizability of the Psychoanalytic Concept of the Working Alliance*, 16 PSYCHOTHERAPY: THEORY, RES. & PRAC. 252, 252 (1979) (claiming a working alliance can be applicable in many other relationships outside of psychotherapy); Jairo N. Fuertes et al., *The Physician-Patient Working Alliance*, 66 PATIENT EDUC. & COUNSELING 29, 30 (2007); Nicola Mead & Peter Bower, *Patient-Centered Consultations and Outcomes in Primary Care: A Review of the Literature*, 48 PATIENT EDUC. & COUNSELING 51, 51 (2002).

¹⁸³ BRUCE J. WINICK, *THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT* 340 (1997).

¹⁸⁴ *Id.*

cial to diagnosis and treatment.”¹⁸⁵ These laws may make the patient reluctant to disclose signs and symptoms of medical conditions to the physician or to minimize their severity out of fear that his driving privileges will be taken away.¹⁸⁶ Many elderly patients, especially those in rural areas or small cities where the doctor-patient relationship tends to be more consistent and long lasting, view their physicians as a trusting source of information and guidance.¹⁸⁷ Reporting laws can shatter patients’ sense of trust and confidence in the physician, eroding the effectiveness of the doctor-patient relationship.

In extreme cases, the patient may experience a sense of anger or betrayal, and as a result, sever the relationship with the physician or utilize it much less frequently. An analogous situation is mandatory child abuse reporting requirements.¹⁸⁸ When a patient in therapy reveals an act of child abuse to the therapist, the therapist typically is required to report this to the child protective agency.¹⁸⁹ This triggers an investigation and sometimes a temporary suspension or permanent termination of parental rights.¹⁹⁰ Empirical work in this context reveals the deleterious effects of such reporting on the therapeutic relationship.¹⁹¹ Indeed, approximately twenty-five percent of such patients drop out of treatment after such a report has been made.¹⁹² Even in

¹⁸⁵ Sullivan, *supra* note 71, at 25.

¹⁸⁶ See Salinsky et al., *supra* note 180.

¹⁸⁷ Katrina E. Donahue et al., *Length of Patient-Physician Relationship and Patients’ Satisfaction and Preventive Service Use in the Rural South: A Cross-Sectional Telephone Study*, 6 BMC FAM. PRAC. 40, 46 (2005), available at <http://www.biomedcentral.com/content/pdf/1471-2296-6-40.pdf>.

¹⁸⁸ See MURRAY LEVINE & HOWARD J. DOUECK, THE IMPACT OF MANDATED REPORTING ON THE THERAPEUTIC PROCESS: PICKING UP THE PIECES 78 (1995); Murray Levine, *A Therapeutic Jurisprudence Analysis of Mandated Reporting of Child Maltreatment by Psychotherapists*, in LAW IN A THERAPEUTIC KEY, *supra* note 16, at 323, 336-37; Holly Watson & Murray Levine, *Psychotherapy and Mandated Reporting of Child Abuse*, 59 AM. J. ORTHOPSYCHIATRY 246, 252-53 (1989).

¹⁸⁹ FLA. STAT. § 39.201(1)(a) (2009).

¹⁹⁰ FLA. STAT. § 39.301(1), (9)(b).

¹⁹¹ Watson & Levine, *supra* note 188, at 252.

¹⁹² *Id.* at 253.

cases where the patient does not discontinue treatment, many drop out mentally.¹⁹³

At present, only six states require physician reporting.¹⁹⁴ In view of the negative effects of reporting on the physician-patient relationship, less reliance should be placed on mandatory reporting as a means of detecting unusual problems. Other approaches of discovering driver infirmities should be creatively sought. The absence of a reporting requirement by the physician could facilitate open and honest discussions within the physician-patient relationship of potential infirmities affecting driving free of the concern these problems must be revealed to the authorities. This would increase the chance that such professional dialogue could help the patient voluntarily choose to reduce or eliminate his driving when necessary. When the physician is required to report, confidentiality should be provided—although only a minority of jurisdictions require confidentiality now. Such confidentiality prevents the patient from learning the physician was responsible for the termination of his driving privileges. This could ameliorate some of the previously discussed negative effects on the professional relationship.

V. A PROPOSED SAFE DRIVING CENTER

Therapeutic jurisprudence seeks not only to assess the therapeutic consequences of law and legal practices, but also to reshape legal practices to diminish antitherapeutic effects and maximize emotional well-being.¹⁹⁵ Viewing elderly drivers as a therapeutic jurisprudence and a public health issue requires that we consider both the psychological well-being of the individual and the goal of increasing the community's health and safety.¹⁹⁶ A therapeutic jurisprudence approach enriched by a broader public health focus¹⁹⁷ can help to achieve these goals. Both therapeutic jurisprudence and public health embrace princi-

¹⁹³ Levine, *supra* note 188, at 336; see Watson & Levine, *supra* note 188, at 254 (indicating negative outcomes of reporting can be underrepresented due to the study's reliance on the therapists' notes, which can differ greatly in style).

¹⁹⁴ MAB PRACTICES, *supra* note 28, at 24, 57, 203, 212, 258, 266.

¹⁹⁵ LAW IN A THERAPEUTIC KEY, *supra* note 16, at xvii.

¹⁹⁶ See *supra* Part II.

¹⁹⁷ See *supra* note 15 and accompanying text.

ples from ecological systems theory to analyze problems and find adequate solutions, considering both the physical and social environments in which the individual exists.¹⁹⁸ They also both emphasize preventive approaches.¹⁹⁹

Our proposed solutions use the social ecology of health model as a framework.²⁰⁰ When designing, implementing, or critically evaluating interventions, this model focuses on the context in which behavior occurs.²⁰¹ The social ecology of health model posits multiple levels of influence that interact with one another.²⁰² These levels include intrapersonal (the psychological and biological factors of the individual), interpersonal (the individual's immediate social networks), institutional (the structure and functioning of relevant institutions and organizations), community (the physical environment), and public policy.²⁰³ The different components of the model, consistent with systems theory, are interrelated and affect each other as changes are introduced at any level.²⁰⁴ The social ecology of health model has been used to analyze

¹⁹⁸ See Jeannine Coreil, *Why Study Social and Behavioral Factors in Public Health?*, in SOCIAL AND BEHAVIORAL FOUNDATIONS OF PUBLIC HEALTH, *supra* note 96, at 14, 14-16 [hereinafter Coreil III]; Barbara A. Babb, *An Interdisciplinary Approach to Family Law Jurisprudence: Application of an Ecological and Therapeutic Perspective*, 72 IND. L.J. 775, 788 (1997); Susan L. Brooks & Robert G. Madden, *Relationship-Centered Lawyering: Social Science Theory for Transforming Legal Practice*, 78 REV. JUR. U.P.R. 23, 34 (2009).

¹⁹⁹ JUDGING IN A THERAPEUTIC KEY, *supra* note 15, at 8-9; Dennis P. Stolle et al., *Integrating Preventive Law and Therapeutic Jurisprudence: A Law and Psychology Based Approach to Lawyering*, 34 CAL. W. L. REV. 15, 18-20 (1997).

²⁰⁰ See Coreil III, *supra* note 198.

²⁰¹ See *id.*; Joseph G. Grzywacz & Juliana Fuqua, *The Social Ecology of Health: Leverage Points and Linkages*, 26 BEHAV. MED. 101, 101-02 (2000); Gerjo Kok et al., *The Ecological Approach in Health Promotion Programs: A Decade Later*, 22 AM. J. HEALTH PROMOTION 437, 437-38 (2008); Daniel Stokols, *Translating Social Ecological Theory into Guidelines for Community Health Promotion*, 10 AM. J. HEALTH PROMOTION 282, 282-83 (1996).

²⁰² Coreil III, *supra* note 198, at 14-15.

²⁰³ *Id.*

²⁰⁴ See *id.* An application of this approach that has been used in therapeutic jurisprudence contexts is family systems theory. See, e.g., Brooks & Madden, *supra* note 198, at 37-38; Susan L. Brooks, *Therapeutic Jurisprudence and Preventive Law in Child Welfare Proceedings: A Family Systems Approach*, 5 PSYCHOL. PUB. POL'Y & L. 951, 960 (1999); Susan L. Brooks, *A Family Systems Paradigm for Legal*

and address current public health problems such as eating disorders, obesity, and HIV/AIDS.²⁰⁵

In the context of elderly driving, an important goal of our proposed solutions is to reduce the negative psychological effects described in Part IV that are likely to occur when elderly drivers are stripped of driving privileges. Solutions should embrace a multilevel approach guided by the social ecology of health model framework. Based on this framework, these solutions must include interventions designed to (a) reduce the risky behavior of elderly drivers; (b) restructure the relationship between elderly drivers' families and support networks; (c) improve drivers' relationships with health providers; (d) involve institutions, organizations, and the community; and (e) alter legal, social, and cultural policies. Therapeutic jurisprudence's particular focus is on how laws and legal practices can be redesigned to achieve this mission.

To achieve the goal of reducing the risk to community safety and health while minimizing antitherapeutic effects to the elder driver, we have proposed a new model—the Safe Driver Center.²⁰⁶ This model can achieve many public health objectives in this area while cushioning the psychological blow to those individuals who are deprived of driving privileges. This center would serve primarily a preventative function—

Decision Making Affecting Child Custody, 6 CORNELL J.L. & PUB. POL'Y 1, 4-5 (1996) [hereinafter Brooks II].

²⁰⁵ Coreill III, *supra* note 198, at 16-17.

²⁰⁶ This proposal does not address how the Center will be funded. We describe a center with broad scope, and funding constraints may require a narrower scope with fewer components. Funding could be sought from various agencies to cover these different components of the Center. In addition, grants could be sought to cover the different services offered at the Center. Needless to say, we do not propose that the Center model be implemented generally, rather, we would like to see a pilot program that receives thorough evaluation to determine whether benefits achieved are commensurate with cost. We are committed to an evidence-based approach, and this model builds on various existing approaches in the states that use some of the components of the more comprehensive model proposed. *See generally* PROMISING APPROACHES, *supra* note 71 (describing currently used models and best practices). A California program called "Getting Around" combines several of the components of the Safe Driving Center model that we propose. *See* Getting Around: Alternatives for Seniors Who No Longer Drive, <http://www.getting-around.org/home/documentary.cfm> (last visited April 7, 2010).

identifying, assessing, and providing solutions before the elderly driver becomes a problem on the road. The aim is to provide the necessary tools, means, and skills to keep elderly drivers driving longer and safer, and when this is no longer possible, to transition them successfully into their postdriving years.

The proposed Safe Driver Center would apply the *one-stop shop* concept, a business model²⁰⁷ that efficiently provides access to the multilevel interventions discussed above. Referrals to the center may come from a variety of sources which, upon interacting with a driver, perceive the existence of a present or potential problem. These would include law enforcement, the courts, the DMV, healthcare professionals, insurance companies, and family and other members of the individual's support network. The individual driver could also self-refer, and would be incentivized to do so.

The center's design is evidence based and incorporates existing interventions that have been shown to be effective in dealing with problems of the elderly. Multilevel interventions offered by the center would include: (a) driver screening and assessment, (b) driver rehabilitation and remediation, (c) education and training, and (d) counseling. Community participation would exist at each of these levels. As a result, all of these services would be provided through a community-based approach. In addition, the center will seek to influence public policy concerning safe driving practices and change community attitudes on these issues.²⁰⁸

A. *Driver Screening and Assessment*

Many elderly drivers fail to recognize or hesitate to admit they may be having problems driving.²⁰⁹ This is especially likely to occur before their problems materialize—for example, when a driver is reported by physicians, family members, or social service agencies, or by involvement in repeated traffic infractions or accidents. An essential

²⁰⁷ Rene T. Domingo, *Future Proof with One-Stop-Shop Business Model*, RTDONLINE.COM, <http://www.rtdonline.com/BMA/CSM/15.html> (last visited April 7, 2010).

²⁰⁸ See *supra* note 21 and accompanying text.

²⁰⁹ See KOSTYNIUK ET AL., *supra* note 82, at 1.

component of any intervention designed to improve elderly driving is the assessment and evaluation of the limitations health and other age-related problems may impose on the driver.²¹⁰

A police officer or a traffic judge encountering a motorist displaying signs of impairment may perform the initial assessment or screening. An agency employee at a DMV field office may also employ the initial screening. The need for evaluation may be triggered by an informal screening occurring in a clinical setting where the driver's deficits are noticed by a physician, nurse, rehabilitation specialist, or other healthcare professional.²¹¹ Such screening may also occur at a community day-care center or senior center when a staff member, peer volunteer, or driving skills educator notices an individual's deficits.²¹² Finally, such an informal screening can occur at the driver's home, where such deficits come to the attention of a spouse or other family member, friend, or geriatric caseworker.²¹³ This initial screening assessment does not generally involve specialized equipment or lengthy procedures, but consists of quick identification of drivers who display the most serious mental or physical limitations.²¹⁴ Some drivers, once made aware of their limitations, will stop driving at this point, but many will not.

Once a driver's limitations are brought to the attention of the DMV by one or more of these sources, the DMV will likely require the driver to undergo a more formal assessment.²¹⁵ This may involve specialized diagnostic testing such as an on-road exam and/or a written or oral test of the driver's knowledge about road signs and the rules of the road.²¹⁶ It also may include clinical testing of vision, hearing, reaction time, attention span, or for the existence of symptoms of dementia.²¹⁷

²¹⁰ See PROMISING APPROACHES, *supra* note 71, at 6.

²¹¹ NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP'T OF TRANSP., DOT HS 808 853, SAFE MOBILITY FOR OLDER PEOPLE: NOTEBOOK (1999), available at <http://www.nhtsa.dot.gov/people/injury/olddrive/safe/> (emphasizing the importance of early screening in settings outside the DMV).

²¹² *Id.* at I.C.1(c)iii.

²¹³ See *id.* at I.C.1(b)i.

²¹⁴ *Id.* at I.B.1.

²¹⁵ *Id.*

²¹⁶ *Id.*

²¹⁷ *Id.*

Those who perform such assessments and screenings frequently require training in these techniques. In addition, law enforcement and DMV officials should receive training to use visual and verbal cues to evaluate older motorists' fitness to drive.²¹⁸ The Safe Driving Center would provide such training.

The Safe Driving Center would provide these assessments, performed by trained personnel. These individuals either would be present on-site at all times, if the volume of referrals warrants, or a screening could be performed to first identify particular assessment needs and individuals would be scheduled for future assessment by personnel with appropriate skills. Center staff would also conduct training on-site for police, court personnel, and DMV employees to improve their assessment skills.

Trained personnel at the Safe Driving Center can conduct these screenings of elder drivers who visit the center or are referred there in order to ascertain whether a more formal assessment is necessary. Center staff also can make appointments for such testing with clinical experts, either on-site or in the community. In addition, DMV officials may be given space within the Safe Driving Center to conduct official assessments. Those drivers who are identified as possessing remediable deficits can receive such services on-site or by appointment in the community.²¹⁹

B. Remedial/Rehabilitation Programs

Elderly drivers often experience reduced vision, hearing, flexibility, or dexterity as a result of chronic illnesses like diabetes, arthritis, atherosclerosis, or the normal aging process. Such deficits can include reduced vision, auditory acuity, and peripheral vision, as well as limitations of range of motion in the limbs, and difficulty assessing distances. Elderly drivers may also have difficulty operating control knobs and buttons on the dashboard of a vehicle.²²⁰ The Safe Driving Center will

²¹⁸ See PROMISING APPROACHES, *supra* note 71, at 23 (describing a program focused on training law enforcement officers to make fitness to drive determinations).

²¹⁹ See *infra* Part V.B.

²²⁰ See PROMISING APPROACHES, *supra* note 71, at 29-30; Elin Schold-Davis, *Remediation from the Occupational Therapist's Perspective*, in AAA WORKSHOP

offer remedial/rehabilitation programs on-site and by appointment in the community. These include optical and ophthalmological services to provide vision training and corrective lenses to enhance visual ability. They may also include ear specialist care which can fit individuals with appropriate hearing aids. In addition, they can include occupational and physical therapy to help the elder driver maintain his driving skills and improve and maintain mobility needed for safe driving, such as improving strength and flexibility in lower limbs, and increasing neck and back flexibility to facilitate observation of traffic challenges and hazards. Therapists can provide adaptive equipment and prosthetics to allow drivers to compensate for physical deficits.

In addition, the center could offer vocational counseling to help elderly drivers find volunteer or work opportunities closer to their homes or jobs that would not require driving at night. Vocational counselors can also help the elderly driver to find alternative transportation services. Such services may be provided by local private and public programs, and may include public, individual, and group transportation, sometimes free of charge or at a reduced cost.²²¹ Counselors may also provide information and training about the use of public transportation. In addition, where a voucher system has been established to allow free or reduced cost taxi rides, such services also can include information about how the system will operate.²²² All of these services, when feasible, could be provided at the center, which may include a store that sells adaptive equipment at a discount. In the alternative, drivers could be referred to appropriate facilities in the community and given discount coupons.

C. *Education and Training*

Important additional services that will be provided at the Safe Driving Center are education and training. Education programs vary in

PROCEEDINGS, *supra* note 1, at 127, 129 (discussing vehicle adaptations that may assist older drivers in compensating for their declines).

²²¹ See PROMISING APPROACHES, *supra* note 71, at 70 (explaining a program operated by nonprofit and government sectors that assists individuals in locating and paying for volunteers to drive them).

²²² See *id.*

purpose, content, length, and target audience.²²³ Some can address elderly drivers' deficiencies directly in the form of on-road training. Others can address knowledge deficiencies by offering in-class refresher courses on the rules of the road and automobile safety. In addition, other classes can reinforce drivers' existing skills while teaching them new requirements and evolving practices for defensive driving. These educational programs would use methods and techniques tailored to the elderly driving population.²²⁴ Participants should be made to feel they have control over their learning, and information should be presented in a variety of ways to increase understanding and retention.²²⁵

Other educational programs can target family members, professionals who work with the elderly, and the public in general.²²⁶ These groups can be taught to identify deficits in older drivers, discuss the issue of driving cessation with elder drivers, and educate drivers about remedial possibilities and alternative transportation options. Public education can alter perceptions about elder drivers and influence cultural values concerning rights and responsibilities in the driving context. In addition, the center can offer education and training to DMV officials concerning appropriate behavior when dealing with elder drivers. These officials can be sensitized to the psychological dimensions of such interactions. In the way they interact with elder drivers, they function as therapeutic agents, sometimes producing devastating psychological consequences in those drivers.²²⁷ These officials need to be aware of their role as therapeutic agents, and this insight should motivate them to make a conscious effort to minimize the imposition of antitherapeutic effects. They need to be taught appropriate listening and interviewing skills, how to convey empathy, and how to display greater sensitivity in

²²³ See *id.* at 31-33. For examples of educational programs, see *id.* at 34-42.

²²⁴ See *id.* at 32. Consideration can be given to the production and use of videos or films designed to depict seniors discussing amongst themselves the problems they are encountering with driving. Such visual depictions, which often are quite powerful, can include an account by one of the elder drivers of a tragic accident in which another elder driver was killed or seriously harmed along with minor grandchildren who were in the car with them. Whether these techniques will be effective calls for empirical research.

²²⁵ *Id.*

²²⁶ See generally *id.* at 34-42.

²²⁷ See *supra* Part IV.C.

order to cushion the negative psychological blow their words and actions may cause. They need to understand the insights of the psychology of procedural justice, and the value of providing voice and validation, treating the elderly driver with dignity and respect, and conveying the message they are acting in good faith to protect the public as well as the driver.²²⁸ These approaches can avoid the sense of powerlessness and diminished self-esteem that can be psychologically devastating to elderly drivers, and can facilitate acceptance of the need to reduce their driving privileges and their willingness to comply with any imposed restrictions.

D. Counseling: Individual, Family, and Group

While studies show that many elderly drivers self-limit or cease to drive on their own,²²⁹ many others continue to put themselves and others in danger. They may continue driving because they psychologically minimize their limitations, or simply are unaware they exist. They may feel pressured to continue driving because of a perceived or real duty to others.²³⁰ They may continue driving because they do not understand they have any real option not to do so without significantly limiting their life options.²³¹ They believe giving up driving will mean they can no longer go to work, to the store to buy groceries, to the doctor, to visit family and friends, or otherwise to continue the full range of their present activities. Many simply love to drive and feel that without it, their life will be over. Many of these assumptions are unrealistic or reflect cognitive distortions. Education and counseling can help the individual to realize that he has other options and need not continue to drive.

For those who are aware of their limitations but continue to drive, their beliefs, attitudes, and perceptions regarding driving cessa-

²²⁸ See *supra* Part IV.C.

²²⁹ DAVID S. LOUGHRAN ET AL., INST. FOR CIVIL JUSTICE, REGULATING OLDER DRIVERS: ARE NEW POLICIES NEEDED? 12 (2007), available at http://www.rand.org/pubs/occasional_papers/OP189/. Some stop because of awareness of their own limitations, others due to pressure from friends and family. Many of them would start avoiding risky road conditions or would adjust their driving as their impairments worsen. *Id.* at 12-13.

²³⁰ KOSTYNIUK ET AL., *supra* note 82, at 6-7.

²³¹ *Id.* at 4-5.

tion and/or its consequences are the main obstacles that perpetuate such risky behavior.²³² Because driving is such an important component of who a person is, the thought of giving it up is so distressful that it can produce denial, minimization, rationalization, and cognitive dissonance.

Because many elderly drivers regard driving as the cornerstone of their autonomy, mobility, and independence, driving cessation has been associated with feelings of diminished self-worth and self-esteem as well as depression.²³³ The center would address these negative psychological consequences through individual and group counseling, family counseling, and family group conferencing. These forms of counseling would extend to elderly drivers whose licenses have been suspended, restricted, or revoked, as well as to those who are considering voluntarily relinquishing their driving privileges.

Several counseling techniques could be useful in addressing the particular psychological issues involved in driving cessation. A one-to-one client-centered approach tailored to the specific needs of the individual would allow flexibility to incorporate the wide diversity of psychological needs existing among the elderly population. At an interpersonal level, social cognitive theory²³⁴ calls for the inclusion of the spouse, adult children, and other caregivers in the counseling process. As discussed in Part IV, section B, one of the most significant effects of driving cessation is the negative impact on the elderly driver's feelings of self-efficacy. Social cognitive theory describes how social relationships influence cognitions and behaviors through reciprocal interactions.²³⁵ Counseling using social cognitive theory can increase knowledge about transportation options alternative to self-driving. For example, drivers can be offered vouchers redeemable for taxi rides or public transportation. In areas where special transportation services exist for disabled individuals, the center can inform drivers about these

²³² Holly A. Tuokko et al., *Perception, Attitudes and Beliefs, and Openness to Change: Implications for Older Driver Education*, 39 ACCIDENT ANALYSIS & PREVENTION 812, 812-13 (2007).

²³³ See *supra* notes 75-85 and accompanying text.

²³⁴ See Albert Bandura, *Social Cognitive Theory: An Agentic Perspective*, 52 ANN. REV. PSYCHOL. 1, 4 (2001).

²³⁵ *Id.* at 14-15.

services and provide opportunities to try them out.²³⁶ In addition, the center may be able to arrange a network of community volunteers offering to provide transportation for elderly individuals, and organize a telephone hotline to link the elderly to this service. Moreover, the center may facilitate family assumption of some or all of the elderly driver's transportation needs. By teaching the individual about these options, facilitating his use of them, and teaching him the skills needed to utilize them, the center can do much to avoid the diminished self-efficacy that often accompanies driving cessation. This in turn could help to alter driving behavior to encourage voluntary cessation or limitation, when appropriate, and to comply with any legally imposed restrictions.²³⁷

In addition to developing new alternatives to driving, effective counseling also should open new opportunities for social support while encouraging the elderly to stay connected with their communities. In the area of interpersonal interventions, the center would use group counseling and social groups. A review of qualitative studies on driving cessation in the elderly shows that “[o]lder drivers often prefer to discuss driving with friends who are their peers and can identify with the problems they are experiencing.”²³⁸ Friends and family members have been found to be significant factors in individuals voluntarily relinquishing their driving privileges.²³⁹ Through the provision of family counseling to the elder driver and his family and support group, the center can facilitate supportive, compassionate communication for those involved, making it easier for the individual to come to terms with and adjust to this difficult decision. Family counseling also would address the negative consequences to families discussed in Part IV, section D involving emotional responses, guilt, role reversal, role strain, and ways of coping with the new situation and the feelings it engenders. Family counseling could also give consideration to residential relocation of the elderly driver, family assumption of the elder's transportation needs,

²³⁶ See generally *State-by-State Guide to Transportation Assistance*, AARP BULLETIN TODAY, http://bulletin.aarp.org/yourworld/gettingaround/articles/state-by-state_guide.html (last visited April 7, 2010).

²³⁷ Timothy D. Windsor & Kaarin J. Anstey, *Interventions to Reduce the Adverse Psychosocial Impact of Driving Cessation on Older Adults*, 1 CLINICAL INTERVENTIONS IN AGING 205, 205-06 (2006).

²³⁸ Gardezi et al., *supra* note 157, at 14.

²³⁹ *Id.*

and encouragement of visitation and telephoning to prevent loneliness and isolation.

All of these counseling approaches would seek to empower the elder driver to make an informed, voluntary decision to give up or reduce driving or to continue driving with newly acquired skills and resources. If the individual can decide this important question for himself, rather than having it determined coercively by the DMV stripping him of his license, he would feel better about it and avoid many of the negative psychological effects described in Part IV, section B. People function better through voluntary choice than they do through government coercion,²⁴⁰ and such choice can avoid the lowered self-esteem, labeling effects, learned helplessness, and depression that may otherwise occur. Through the provision of information about alternative transportation options and by bolstering family and community support, the center's counseling program can help the individual to realize he may choose to cease or reduce driving without the devastating effects he supposed may occur.

The benefits of this voluntary approach are illustrated by the experiences of one of the authors of this Article—Bruce Winick—who suffers from a congenital visual deficit that has progressed over time. A little over twenty years ago, Mr. Winick began to reduce his driving and avoided driving at night as a result of the increasing visual deficits he was experiencing. At the time, Florida required drivers to renew their licenses every six years by appearing in person at the DMV and receiving a vision test. Mr. Winick barely passed his previous vision test, and realized the chance he would fail the next one was high. As the time for renewal approached, he thought about the consequences of failing the test and having his license taken away. He believed having his license involuntarily taken away could have extremely negative psychological effects, including resentment, anger, lowered self-esteem, and depression. He decided it would be better for him to avoid these negative effects by deciding for himself to relinquish his license. Having done so, he felt good about this exercise of choice and was more able to accept the end of his driving than if it had been imposed upon him involuntarily.

²⁴⁰ See CIVIL COMMITMENT, *supra* note 133, at 17-21.

The center would also utilize family group conferencing to assess the family's strength and harness its abilities to cope with the problem of the impaired driver.²⁴¹ Family group conferencing is grounded in restorative justice.²⁴² Unlike the American criminal justice system's focus on retribution, restorative justice seeks to understand crime as upsetting the equilibrium of the community and to provide a remedy that restores this equilibrium through an intervention with the perpetrator,

²⁴¹ See, e.g., FAMILY GROUP CONFERENCES: PERSPECTIVES ON POLICY & PRACTICE (Joe Hudson et al. eds., 1996) [hereinafter FAMILY GROUP CONFERENCES] (examining the practice of family group conferencing in child protection and juvenile justice systems); Brooks II, *supra* note 204, at 5-6; Murray Levine, *The Family Group Conference in the New Zealand Children, Young Persons, and Their Families Act of 1989 (CYP&F): Review and Evaluation*, 18 BEHAV. SCI. & L. 517, 517-18 (2000) [hereinafter Levine II].

²⁴² RESTORATIVE COMMUNITY JUSTICE: REPAIRING HARM AND TRANSFORMING COMMUNITIES 7-8 (Gordon Bazemore & Mara Schiff eds., 2001) [hereinafter RESTORATIVE COMMUNITY JUSTICE]; see JOHN BRAITHWAITE, CRIME, SHAME AND REINTEGRATION 56-57 (1989); John Braithwaite, *Restorative Justice and Therapeutic Jurisprudence*, 38 CRIM. L. BULL. 244, 246-47 (2002) [hereinafter *Restorative Justice*]. The victim, offender, and their respective families and support groups are brought together in a conference room for a discussion moderated by a trained facilitator. See *Restorative Justice*, *supra* note 242, at 246-47. The victim is asked to describe the crime and its repercussions for him and his emotional response to it. See *id.* Upon hearing this, the perpetrator may respond emotionally. See *id.* at 252. This may prompt an apology, which if accepted by the victim, can bring about healing for these individuals in the community. See *id.* The presence of their family members may facilitate this reaction. See *id.* at 248. The group then discusses an appropriate plan, which may include restitution, counseling, and punishment, and the recommendations are reported to the court. Restorative justice grows out of indigenous tribal practices among the Maori in New Zealand, the aborigine in Australia, and Indian tribes in Canada and the United States. See FAMILY GROUP CONFERENCES, *supra* note 241, at 140-42, 167-68; Levine II, *supra* note 241, at 517-20. Although rarely used in the American criminal justice system, restorative justice is increasingly used in New Zealand, Australia, Canada, in United States tribal practices in Indian reservations, and in the United Kingdom. See generally MARK S. UMBREIT ET AL., UNIV. OF MINN. CTR. FOR RESTORATIVE JUSTICE & PEACEMAKING, THE IMPACT OF RESTORATIVE JUSTICE CONFERENCING: A REVIEW OF 63 EMPIRICAL STUDIES IN 5 COUNTRIES (2002), http://www.cehd.umn.edu/ssw/rjp/Resources/RJ_Dialogue_Resources/Restorative_Group_Conferencing/Impact_RJC_Review_63_Studies.pdf.

the victim, and their respective family and support networks.²⁴³ It frequently uses victim-offender conferencing to accomplish this end.²⁴⁴

This model has also been applied to deal with problems of juvenile delinquency, child abuse, and neglect.²⁴⁵ In child abuse and neglect contexts, the family group conference seeks to empower the family, including the child's extended family system, which "creates the conditions in which children can recover from adverse circumstances" and "allows and encourages families to grow and thrive[.]"²⁴⁶ The family is viewed as having unique strengths and the best information concerning ways of dealing with the child's well-being.²⁴⁷

This family group conferencing model can easily be adapted to deal with the problem of the elder driver. When the driver is losing his abilities, and the family or physician's attempt to persuade him to limit driving has failed, they and other members of the driver's support network can be called together under the auspices of the Safe Driving Center to discuss the problem and potential solutions. A trained facilitator at the center can probe the family's resources and strength. The group can acquaint the driver with the existence of transportation possibilities not previously considered by him, and attempt to persuade him to reduce or eliminate driving and to substitute these other methods. In this way, the group can confront the individual with the problems he has been avoiding, expressing concern for his well-being and that of family and friends who may be endangered by his driving behavior. They can express their love and affection for the driver and their willingness to assist in providing alternative ways of meeting his transportation needs. They can assure him they will gladly assume these added responsibilities and do not view them as a burden, but rather, as an act of love and family duty. This group conference is likely to produce emotional expressions on the part of members of the group that have the

²⁴³ See *Restorative Justice*, *supra* note 242, at 246.

²⁴⁴ *Id.*; RESTORATIVE COMMUNITY JUSTICE, *supra* note 242.

²⁴⁵ GORDON BAZEMORE & MARK UMBREIT, BALANCED & RESTORATIVE JUSTICE PROJECT, CONFERENCES, CIRCLES, BOARDS, AND MEDIATIONS: RESTORATIVE JUSTICE AND CITIZEN INVOLVEMENT IN THE RESPONSE TO YOUTH CRIME, at ii (1999); FAMILY GROUP CONFERENCES, *supra* note 241, at 1; see JUDGING IN A THERAPEUTIC KEY, *supra* note 15, at 3; Brooks II, *supra* note 204, at 17.

²⁴⁶ FAMILY GROUP CONFERENCES, *supra* note 241, at 3.

²⁴⁷ See *id.* at 2-3.

potential to touch the driver and produce an emotional response that may allow him to pierce through the denial and rationalization that have prevented him from confronting his problem and dealing with it. The goal will be to get the driver to deal voluntarily with the problem, rather than having the legal system restrict his driving coercively. Incentives and creative alternative transportation options can allow the individual to understand a voluntary cessation or restriction of driving will not produce the disastrous results he might have imagined. If he can come to this conclusion on his own, the negative psychological effects driving cessation can produce will be considerably limited.

E. A Community-Based Approach

An important public health initiative involves community participation in the achievement of public health goals.²⁴⁸ Community participation is a “process by which individuals and families take an active part in discussions and activities to improve community life, services, or resources.”²⁴⁹ A community-based approach calls for public health professionals to collaborate with community members.²⁵⁰ These may include “community professionals, lay leaders, activists, representatives of local businesses, members of the religious community, volunteers, and other citizens.”²⁵¹ Under a community-based approach, “[w]ork is conducted using existing community organizations and members as a means to strengthen their capacity and promote social justice.”²⁵²

Community involvement should be an integral part of any organized efforts to provide sensible solutions to the problem of impaired elderly drivers. The Safe Driving Center proposed here would accordingly include participation of all the stakeholders involved in dealing with the problem of elder drivers. Achievement of the center’s purposes, therefore, would require a partnership of interdisciplinary service

²⁴⁸ See Carol A. Bryant, *Community-Based Approaches to Health Promotion*, in SOCIAL AND BEHAVIORAL FOUNDATIONS OF PUBLIC HEALTH, *supra* note 96, at 273, 273-76.

²⁴⁹ *Id.* at 275.

²⁵⁰ *Id.*

²⁵¹ *Id.*

²⁵² *Id.* at 276.

providers,²⁵³ professional organizations,²⁵⁴ community institutions,²⁵⁵ local and state agencies,²⁵⁶ and private entities.²⁵⁷ The center can serve as a convener and facilitator of this partnership. This partnership is fundamental for the provision of many of the services the center will offer, as well as for the incentives the center will provide to induce the participation of elder drivers and their families.

Through the provision of vouchers and services offered for free or at a reduced cost, elder drivers can be incentivized to participate in and realize the benefits of the interventions offered at the center. In addition, to induce elder drivers to participate in the center, they can be offered discounts on their auto insurance and license and vehicle registration fees.

VI. CONCLUSION

The problem of elder drivers experiencing impairments that diminish their driving abilities raises serious concerns for public health and safety. Although this is a significant public health problem, existing state practices are inadequate in several respects and impose unnecessary negative social, economic, health, and psychological consequences for many of the elder drivers whose driving privileges are restricted or terminated.

This Article suggests the therapeutic jurisprudence approach to examine these issues by focusing attention on the antitherapeutic consequences of legal rules and practices. Therapeutic jurisprudence pro-

²⁵³ See Getting Around: Alternatives for Seniors Who No Longer Drive, *supra* note 206. These professionals should include physicians, occupational therapists, social workers and case managers. A Compendium of Law Enforcement Older Driver Programs: California, <http://www.nhtsa.dot.gov/PEOPLE/INJURY/olddrive/LawEnforcementOlderDriver03/california.htm> (last visited April 7, 2010).

²⁵⁴ Examples include American Medical Association (AMA), American Osteopathic Association (AOA), and American Public Health Association (APHA).

²⁵⁵ Examples include churches, counseling and family services organizations, senior centers, and foundations.

²⁵⁶ See, for example, city and county area agencies on aging, police departments, DMVs, the court system, and Adult Protective Services.

²⁵⁷ See, for example, American Association for Retired Persons (AARP), Gray Panthers, Mothers Against Drunk Drivers (MADD), and American Automobile Association (AAA).

vides a useful complement to public health strategies for dealing with these issues. We seek to balance the public health needs of the community with the desire to minimize the negative consequences existing practices pose on the psychological well-being of elder drivers and their families. We propose a comprehensive solution based on the social ecology of health model augmented by principles and approaches of therapeutic jurisprudence. This model, the Safe Driving Center, combines screening and assessment, remedial/rehabilitation interventions, education and training, individual and family counseling, and a comprehensive community-based approach for dealing with the problem preventatively. Whenever possible, the center will seek to persuade impaired elder drivers to voluntarily cease or restrict their driving by offering inducements and alternative transportation solutions.