



The Most Primary of Care — Talking about Driving and Distraction

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Imagine the scene: three young women are traveling in a car. It is a sunny morning, traffic is light, and all are wearing their seat belts and are not intoxicated. They are talking about a friend —

“You like him, don’t you?” It is happy, benign teenager chatter. Then the driver decides to include that other friend in the conversation. While steering, she sends him a short text message on her cell phone.

Suddenly, the car swerves into oncoming traffic and metal hits metal at high speed. Bodies are thrown. Glass breaks. Blood splatters. When the car finally comes to a stop, only the driver is conscious. Her screams speak of not only the agony of her injuries but also the realization that she has just killed her two friends — by texting.

This scene appears in a British public service announcement. The video (www.youtube.com/watch?v=R0LCmStIw9E) is

horrifying to watch, but although it is obviously staged, the scenario is hardly a fiction: driving while distracted — by talking or texting — increases the likelihood of accident and injury. And some of these accidents kill people.

Although it is difficult to assess the absolute increase in the risk of collision attributable to driver distraction, one study showed that talking on a cell phone while driving posed a risk four times that faced by undistracted drivers and on a par with that of driving while intoxicated.¹ Another study showed that texting while driving might confer a risk of collision 23 times that of driving while undistracted.² Al-

though there are many possible distractions for drivers, more than 275 million Americans own cell phones, and 81% of them talk on those phones while driving.³ The adverse consequences have reached epidemic proportions. Current data suggest that each year, at least 1.6 million traffic accidents (28% of all crashes) in the United States are caused by drivers talking on cell phones or texting.⁴ Talking on the phone causes many more accidents than texting, simply because millions more drivers talk than text; moreover, using a hands-free device does not make talking on the phone any safer.

Acknowledging these risks, all but 11 states have passed laws regarding cell-phone use while driving. And the U.S. government is concerned: in January 2010, the secretary of transportation and the National Safety Council announced the creation



of FocusDriven, an organization devoted to reducing the prevalence of distracted driving. The Department of Transportation has also launched a Web site, www.distraction.gov.

At the medical school and academic practice where I teach, students and residents routinely query patients about habits associated with harm, asking about the use of helmets, seat belts, condoms, cigarettes, alcohol, and drugs. There is little solid evidence that asking these screening questions has any benefit. But we continue to ask them — as I believe we should. And as technology evolves, our questions must be updated in keeping with the risks: it's time for us to ask patients about driving and distraction.

Although no direct correlation can be made, we know that counseling patients about dangerous behaviors can have powerful consequences. According to the U.S.

Preventive Services Task Force, even 3 minutes spent discussing the risks of tobacco use increases the likelihood that a patient will quit smoking. Context matters. When a doctor raises an issue while providing overall preventive care, the message is different from that conveyed by a public service announcement nestled between ads for chips and beer or a printed warning on a product box.

Recently, I have added a question about driving and distraction to my annual patient review of health and safety. I begin with the customary seat-belt question. Then I ask, "Do you text while you drive?" Although I'm concerned about both texting and talking, most people are aware of the risks associated with texting, and many judge it more harshly. If a patient admits to texting while driving, I share my knowledge and concerns. Many patients who do not text while driving voice opinions about its dangers, giving me an opening to note that talking on the phone while driving actually causes more accidents than texting. Although I can share published data and often recommend that patients view the video described above, I find it more powerful simply to say that driving while distracted is roughly equivalent to driving drunk — a statement that captures both the inherent risks and the implied immorality.

I ask patients whether they could reduce or abstain from cell-phone use while driving. As with any plan for behavior modification, we need to understand the circumstances surrounding the activity. Many people have become accustomed to the diversion of talking on the phone while driving, and we're all susceptible to the allure of a new message or

call. If patients tell me that occasionally they receive "important" phone calls they don't want to miss, we discuss what that means in the context of the risks. We talk about alternatives, including pulling over to make or take calls. I remind them that we all managed without mobile phones until recently and encourage them to return to the practices of the pre-cell-phone era. What can drivers do if they want to fill the resulting void? They can listen to the radio or a CD. They can pay attention to what they're doing and their surroundings, rather than attempt to multitask. We talk about practical solutions. I tell them about a driver who killed a woman while talking on his phone but couldn't restrain himself even after that horror. He now puts his phone in the trunk of his car before he gets behind the wheel. I talk about creating such a system for eliminating the risk.

Although I've encountered less resistance from patients than I'd anticipated, many do have questions. Most commonly, they ask why talking on the phone, even with a hands-free device, is more dangerous than talking to a passenger in their car. There are several reasons: first is the obvious risk associated with trying to maneuver a phone, but cognitive studies have also shown that we are unable to multitask and that neurons are diverted differently depending on whether we are talking on the phone or talking to a passenger.⁵ When patients aren't convinced, I ask them, "How would you feel if the surgeon removing your appendix talked on the phone — hands free, of course — while operating?" This hypothetical captures the essence of the problem — the

challenge of concentrating fully on the task at hand while engaged in a phone conversation.

Another frequent question is whether talking on the phone is really any more dangerous than putting on mascara, shaving, or reading a map while driving — all things we've seen drivers do. I reply that indeed, any activity that distracts a driver visually or cognitively increases the risk of an accident. (And for clinicians, that includes dictating.) It's just that cell-phone use is far more widespread than these other activities. But none of them is safe.

In 1959, before seat belts were standard equipment in cars, my father — a surgeon who was an active member of Physicians for Automotive Safety in its infancy and had seen the terrible consequences of motor vehicle accidents — had airplane seat belts

installed in our family Studebaker. Vehicular safety was thus part of my education before I was in grade school. Fifty-plus years later, laws enforce seat-belt use in nearly every state, and deaths from motor vehicle accidents have decreased markedly. Just as we've moved beyond Studebakers, it's time for us to update our model of preventive care. Primary care doctors are uniquely positioned to teach and influence patients; we should not squander that power. A question about driving and distraction is as central to the preventive care we provide as the other questions we ask. Not to ask — and not to educate our patients and reduce their risk — is to place in harm's way those we hope to heal.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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Health Insurance Exchanges — Key Link in a Better-Value Chain

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The focus on health insurance exchanges in the Patient Protection and Affordable Care Act (ACA) is one sign of just how politically mainstream the new law is. Not only are exchanges market-based, but also the ACA decentralizes them, delegating primary responsibility to the states. The states are eligible for federal financial support for developing statewide or multiple substate exchanges or forming multistate, regional exchanges. A state may even contract with a private, non-profit entity to operate its exchange. Only if a state failed to act or to meet minimum standards would a federal exchange operate within its boundaries.

Exchanges have been an important element of almost every recent proposal for national health care reform.¹ One of the political virtues of the concept is its flexibility: reformers spanning a fairly broad ideological range have been free to imagine various versions, even as they nod in agreement over the value of exchanges. So how does the ACA envision the function and mission of exchanges, and how do exchanges affect the organization of care?

Simply put, an exchange sells insurance. If it does not enroll many people, it has failed at its core mission. Under the ACA, the administrative budgets for state exchanges will be covered through

surcharges on transactions, so both margin and mission depend on sales.

The ACA models exchanges on Massachusetts' Commonwealth Health Insurance Connector Authority. Like a regulated stock exchange, the Health Connector runs a market that makes the purchasing transaction relatively easy and inexpensive, offers trustworthy choices, and is transparent about the value of its offerings. Like any good market, the Health Connector tries to stock its shelves with high-value offerings. Unlike most commercial enterprises, it also exercises a fourth public policy function: to seek out the uninsured and encourage,