The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

50 years

27 September 2024

NZ Transport Agency | Waka Kotahi
Submitted via online portal

Tēnā koe

Medical aspects of fitness to drive: a guide for health practitioners (MAFTD)

Thank you for the opportunity to provide a submission on the updated version of medical aspects of fitness to drive guide for health practitioners.

The Royal New Zealand College of General Practitioners (the College) is the largest medical college in New Zealand. Our membership of over 6,000 general practitioners and rural hospital doctors makes up 40 percent of New Zealand's specialist medical workforce. The Medical Council of New Zealand accredits the College to deliver vocational training to the specialist General Practitioner and Rural Hospital Doctor workforce. Our kaupapa aspires to improve equity by upholding principles of Te Tiriti o Waitangi and supporting members to be culturally safe and competent through the General Practice Education Programme, and the Division of Rural Hospital Medicine Training Programme.

The College's Practice Quality Programme plays a crucial role in assuring standards of care across 1,077 general practices, including rural areas, throughout New Zealand. Achieving accreditation against the College Foundation Standard reflects a commitment to meeting standards of care and achieving equitable patient health outcomes.

Our submission

The College acknowledges the NZ Transport Agency | Waka Kotahi (NZTA) proposed amendments that were developed with input from the medical community, including the College. We recognise significant advances in medical knowledge, practice, treatments, and other new areas, since the last review of Medical Aspects of Fitness to Drive. This consultation aims to refine advice to ensure it is relevant for medical practitioners.

Our submission includes feedback from specialist GPs on the consultation document.

Summary of changes

Clarification of roles and responsibilities

The College supports clarifying roles and responsibilities in assessing fitness to drive. Specialist GPs have two main legal obligations under transport legislation[1]:

1. Advise the Transport Agency (via the Chief Medical Adviser) of any individual who poses a danger to public safety by continuing to drive when advised not to (Section 18 of the Land Transport Act 1998 – Section 1.4)
2. Consider Medical aspects of fitness to drive during medical examinations.

The College upholds these obligations, emphasising the importance of driving for quality of life. Driving involves complex skills and can be influenced by various factors, making the assessment of fitness to drive complicated. None of these factors is straightforward and impairment can vary or be absent.

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Judgement on ability to drive

Driving is crucial for independence and mobility but holding a driver's licence is not a right. The balance between quality of life and road safety must be considered. Specialist GPs play a vital role in assessing fitness to drive based on medical examinations and patient records.

Scope of assessments:

- Driving is a complex activity bringing together a wide range of skills, abilities and behaviours involving physical, cognitive, and perceptual skills including the ability to respond to the external environment.
- Driving performance is influenced by a person's experience, personality, mental health, medication affecting their ability to drive, or other conditions.
- Making a final decision is complex and determining a person's fitness to drive depends on an assessment of their medical condition and the likelihood of causing an accident.

Specialist GP feedback

1. General matters

- **Specialist GPs – specialists**
  To avoid confusion, it would be helpful to clarity whether issues are allocated to specialist GPs or other specialists.

- **Notification of licence renewal**
  Send age-based licence renewal forms 3 months before the expiry date to allow for timely input.

- **Cost of assessments**
  DL medical examinations are not covered by government funding to primary care, and therefore will (at most practices) be at a higher charge (i.e. non capitated rate). Patients need to be aware that when booking this appointment with their GP, they should state that it is for a DL medical in case extra time needs to be allocated for the appointment, If this is included in the letter, along with an explanation as to why, then it may prevent some of the anger directed at primary care (particularly reception staff) when patients are charged a higher fee for their DL medical.

- **Clarification sought**
  Specify who considers fitness to drive – specialist GP, another relevant specialist, or the NZTA after receiving written advice.

- **Physical examinations**
  To reduce variability, provide examples of typical physical examinations for private and commercial classes.

- **Reaction times**
  Clarify tests and specify appropriate cut off for reaction times.

- **Restricted driving areas or range**
  Some patients have been given a restricted license to drive within a 10k/20km radius from where they live. Provide clarity and guidance on restricted licences and driving within a specific radius.

- **Assessment requirements**
  Clarify expectations for full and partial examinations, and implications, e.g., some GPs are not aware that medical information is forwarded to a Medical Officer for review and would like the option to be contacted to discuss a medical issue of concern and/or obtain a second opinion about risks identified, e.g., reaction times in relation to driving risks.

- **Rural**
  Access to public specialist review is increasingly difficult within the current health system and even more of a barrier for those living rurally, where being deemed unfit to drive has a much more significant impact when there is limited or no public transport service.

- **Return to driving following a medical event**
  For medical conditions that enable a patient to return to driving e.g., the stand down period following seizure, the specified length of driving may be shortened following a specialist review. This would require an addendum to support specialist GP authorisation on behalf of the specialist following a phone consultation.

2. Neurological conditions

2.2.3 Unknown causes and vicarious liability

- Address concerns about consequences for health practitioners if an incident occurs after certifying a patient as fit to drive, e.g. What are the consequences for a health practitioner if the Coroner, courts or police find fault in the assessment.

2.5.1 Strokes

- Clarify the section on ‘No evidence of cognitive defects’ in the context of fitness to drive, to reduce variation and align with the thresholds for dementia.

2.8 Cognitive impairments, including dementia

- Align expectations with dementia thresholds to reduce variation. Our members expressed a need for advice about which cognitive screening tests are more appropriate for medical assessments in elderly patients with no suspicion of cognitive impairment.
- Determine if the Roadsign Screening Test (Appendix 9) on its own is sufficient for patients with mild dementia or no suspicion of dementia.

2.10.3 Serious or significant head injuries (Including TBI)

- Specialist GPs already use the mini-ACE and SIMARD tests and both are easy to administer, but the MOCA is not used by some due to licensing costs. The Abbreviated Westmead PTA Scale, is considered too complex for patients with Traumatic Brain Injuries (TBI) (Appendix 1) and declining cognitive impairment. If the Westmead Test is to be used, we suggest there should be a test site and link to guidance.

  Key points raised:
  - Specialist GPs find the Westmead system unfamiliar and time-consuming to use.
  - Adding complex tests burdens already stretched practices.
  - Nurse assessments are possible, but GP follow-up is still needed.
  - The Westmead is better suited for the concussion service with ACC care. Patients have free ACC team care, and results are sent to the specialist GP doing the DL9 assessment.

3. Cardiovascular conditions

General points

- Clarify which patients need a new ECG for DL9 Certificates, e.g., which pre-existing conditions, and whether patients without history of cardiac conditions require screening, or ECG for private or commercial licences.
- Loading and unloading duties that are not relevant for driving assessments.
- Patients with cardiovascular disease should generally be reviewed by a consultant cardiologist or cardiothoracic surgeon, especially for commercial licenses.

3.3.2 Syncope and presyncope

- The six-month standdown period after a syncope and presyncope lacks context and seems unenforceable.

3 Diabetes

- Pharmac[1] updates and changes to educational resources, including Health Pathways, will support primary care professionals and patients with access to continuous glucose monitors CGM and Insulin Pump Funding.

12. Effects of medication, drugs, and substance abuse

12.1 Drug Driving and impairment

The laws on impairment are confusing. Comprehensive drug driving assessment guidelines that are regularly updated would clarify levels and types of impairment. Guidance should clarify the law on substances that impair driving and how to assess impairment before imposing penalties.

- **Roadside testing and impairment**
  The introduction of a random roadside oral fluid testing regime to test drivers for the presence of high-risk illicit and prescription drugs that impair driving is likely to unfairly penalise patients on prescription medications. [1]

  - NZTA provide guidance[2] on substances that carry risk and provide specialist GPs with information about how to assess whether impairment is present before fitness to drive is assessed, or penalties imposed.
  - Saliva testing will not detect all prescribed medications that can potentially impair driving, or cognitive function.
  - Assessments should focus on the reason for cognitive impairment to address uncertainty.
  - Clarify the role of cannabis clinics and drugs that contain THC.

- **Medication - impairment and testing**
  - The NZ Police website advises drivers to check with their doctor about being safe to drive with medications.
  - Medsafe guidance suggests the NZ Police only perform blood testing for drug levels if an individual fails a roadside impairment test. Guidance identifies 15 medications and sets tolerable limits and high-risk blood levels for each. A level above those deemed high-risk is a criminal offence.
  - If an individual has a drug level above the tolerable level but below high-risk then an infringement notice and/or fine may be issued.

- **Advising patients**
  The law changes are confusing for practitioners. Specialist GPs need more specific information and training to inform best practice. Most questions from related to what to advise patients, e.g. ‘Should I continue with the previous advice of relating to physical symptoms of impairment?’, ‘Should I consider anyone prescribed a medication from this list (p.112) unfit to drive?’, ‘If a patient is involved in a road traffic incident and is found to have a higher than tolerable level of one of the listed medications which I have prescribed - can I be found liable for my actions?’.

  It is difficult to accurately assess blood levels from the dose in the prescribed medications from the list of 15. Local blood services do not offer quantitative blood drug testing, and even if a blood test is available

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[1] Pharmac. Educational Resources to Support Upcoming Changes to CGM and Insulin Pump Funding. Communication 24.9.24. Available at https://pharmac.govt.nz/news-and-resources/cgms-and-insulin-pumps/resources-for-health-care-professionals

to assess levels, it still does not account for significant variability in patients on a day-to-day basis. While Medsafe does offer some guidance on these new changes.

- **Emerging issue**
  Some GPs report receiving letters from cannabis clinics seeking information about 8 THC containing drugs that patients may be taking, and question their legal responsibility for commercial interests, e.g., The cannabis clinic provides patients with a letter to give to their employer regarding access to OT assessments, these are expensive for patients who pay for the service, in spite of the NZTA website promoting on road testing as free.

13. Seat belt exceptions

13.1 Letter template (p.132)

- The letter template confirming a child restraint or seat belt is an unnecessary administrative burden as a medical certificate is issued to give the patient an exemption from wearing a seatbelt. The legal requirement is for the driver issued with a medical certificate, to carry that certificate when driving (7.11 of the Road User Rule 2004).

Occupational therapist driving assessments (OTDA)

- Include optimal wait times for occupational therapy assessments.

Summary

Specialist GPs do not assess the technical aspects of driving, highlighting the need for more research and improved evidence to clarify assessment and judgement of fitness-to-drive. They play a crucial role in recognising when a patient needs an assessment, but the lack of sufficient evidence, national standards or standardised tools complicates decision-making. The risks of allowing an unsafe driver to continue driving are balanced against their quality of life and safety and the decision to revoke a driving licence is not considered lightly as it limits independence.

The College supports incremental system improvements to ensure that a person's fitness to drive is accurately determined based on the best available evidence, and we recommend the introduction of a minimum standard to reduce variation[2] in the assessment process, across GPs, patients, and practices.

If you require further clarification, please contact Maureen Gillon, Manager Policy, Advocacy, Insights – Maureen.Gillon@rnzcgp.org.nz.

Nāku noa, nā

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Medical aspects of fitness to drive – A guide for health practitioners (version 4) (nzta.govt.nz)
Medical aspects of fitness to drive a guide for health practitioners summary of proposed changes (nzta.govt.nz)

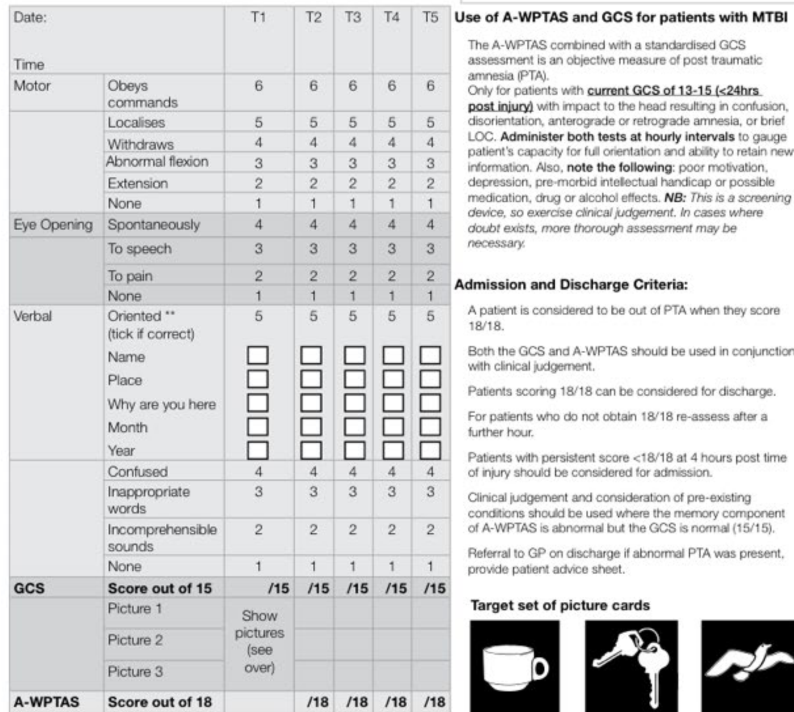
[2] Variation was also highlighted as a problem in the NZTA Webinar on September 10, 2024.

Appendix 1

ABBREVIATED WESTMEAD PTA SCALE (A-WPTAS)
GCS & PTA testing of patients with MTBI following mild head injury

Abbreviated Westmead PTA Scale (A-WPTAS) incorporating Glasgow Coma Scale (GCS)

MRN sticker here



Date: Time		T1	T2	T3	T4	T5
Motor	Obeys commands	6	6	6	6	6
	Localises	5	5	5	5	5
	Withdraws	4	4	4	4	4
	Abnormal flexion	3	3	3	3	3
	Extension	2	2	2	2	2
	None	1	1	1	1	1
Eye Opening	Spontaneously	4	4	4	4	4
	To speech	3	3	3	3	3
	To pain	2	2	2	2	2
	None	1	1	1	1	1
Verbal	Oriented ** (tick if correct)	5	5	5	5	5
	Name	☐	☐	☐	☐	☐
	Place	☐	☐	☐	☐	☐
	Why are you here	☐	☐	☐	☐	☐
	Month	☐	☐	☐	☐	☐
	Year	☐	☐	☐	☐	☐
	Confused	4	4	4	4	4
	Inappropriate words	3	3	3	3	3
	Incomprehensible sounds	2	2	2	2	2
	None	1	1	1	1	1
GCS	**Score out of 15**	**/15**	**/15**	**/15**	**/15**	**/15**
	Picture 1	Show pictures (see over)				
	Picture 2					
	Picture 3					
A-WPTAS	**Score out of 18**		**/18**	**/18**	**/18**	**/18**

** must have all 5 orientation questions correct to score 5 on verbal score for GCS, otherwise the score is 4 (or less).

Use of A-WPTAS and GCS for patients with MTBI

The A-WPTAS combined with a standardised GCS assessment is an objective measure of post traumatic amnesia (PTA).
Only for patients with **current GCS of 13-15 (<24hrs post injury)** with impact to the head resulting in confusion, disorientation, anterograde or retrograde amnesia, or brief LOC. **Administer both tests at hourly intervals** to gauge patient's capacity for full orientation and ability to retain new information. Also, **note the following**: poor motivation, depression, pre-morbid intellectual handicap or possible medication, drug or alcohol effects. ***NB:*** *This is a screening device, so exercise clinical judgement. In cases where doubt exists, more thorough assessment may be necessary.*

Admission and Discharge Criteria:

A patient is considered to be out of PTA when they score 18/18.

Both the GCS and A-WPTAS should be used in conjunction with clinical judgement.

Patients scoring 18/18 can be considered for discharge.

For patients who do not obtain 18/18 re-assess after a further hour.

Patients with persistent score <18/18 at 4 hours post time of injury should be considered for admission.

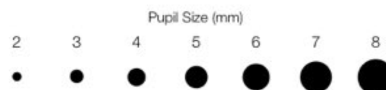
Clinical judgement and consideration of pre-existing conditions should be used where the memory component of A-WPTAS is abnormal but the GCS is normal (15/15).

Referral to GP on discharge if abnormal PTA was present, provide patient advice sheet.

Target set of picture cards

PUPIL ASSESSMENT	T1		T2		T3		T4		T5					
	R	L	R	L	R	L	R	L	R	L		+	=	REACTS BRISKLY
												SL	=	SLUGGISH
Size												C	=	CLOSED
Reaction												-	=	NIL

Comments



Shores & Lammel (2007) - further copies of this score sheet can be downloaded from http://www.psy.mq.edu.au/GCS

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[1] The Royal New Zealand College of General Practitioners. Submission to the Transport and Infrastructure Committee. Land Transport (Drug Driving) Amendment Bill. September 2024. Available at:

[2] New Zealand Transport Authority. Safety – What waka Kotahi is doing. Education initiatives. Available at: https://nzta.govt.nz/safety/what-waka-kotahi-is-doing/education-initiatives/medication/doctors-pharmacists-and-nurses/