A District Health Board

A Report by the Health and Disability Commissioner

(Case 05HDC09043)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Ms B	Complainant
Mrs C	Complainant's mother (deceased)
Dr D	Consultant psychiatrist
Ms E	Case Manager
Dr F	Clinician
Ms G	Case Manager
Dr H	Clinician
Ms I	Clinician
A District Health Board	Provider / District Health Board

Complaint

On 2 December 2004, the Commissioner received a complaint from Ms B about the services provided to Mr A by a District Health Board's Alcohol and Other Drug Service. The following issues were identified for investigation:

- *The adequacy and appropriateness of the care and treatment provided to Mr A from 29 February 2004 to 12 May 2004 by staff at the District Health Board Alcohol and Other Drug Service.*

- *The adequacy and appropriateness of the care and treatment provided to Mr A from 13 May 2004 to 27 August 2004 by staff at the District Health Board Alcohol and Other Drug Service.*

An investigation was commenced on 24 June 2005.

Information reviewed

Information from:
- The District Health Board
- Ms B
- Land Transport Safety Agency
- New Zealand Police.

Independent expert advice was obtained from Dr Geoffrey Robinson, specialist physician in drug and alcohol medicine.

Introduction

This report concerns the obligations of medical practitioners in managing patients who may be unfit to drive a motor vehicle by reason of known drug abuse.

A man on a methadone programme, who was known to often combine his methadone with illicit drugs, was advised not to drive by his treatment team, because of the potential effects of his drug-taking behaviour on his ability to drive safely. The man's treatment team did not witness him driving while intoxicated. However, they were aware that he continued to abuse drugs. This report considers whether the man was appropriately managed by his treatment team, particularly in the light of their knowledge of his continued illicit drug abuse and consequent driving risk.

The issue of when, if ever, practitioners should take steps to address a patient's potential driving risk is difficult. This case illustrates that practitioners need to make a balanced judgement on all the available information as to whether to involve other agencies with any concerns about a patient's driving. If a practitioner has any doubt as to the ability of a patient to drive safely, the practitioner should take steps to reduce that risk. This should include strongly advising the patient (and possibly telling their family members and support persons) not to drive and, if there is concern that that advice is not being followed, considering notification to the Director of Land Transport Safety. Any immediate risk should be notified to the Police.

Information gathered during investigation

Background
Mr A first entered the District Health Board Alcohol and Other Drug Service (the Service) in August 2002. At that time, Mr A was under the formal management of a methadone programme in another city, and Dr D was his consultant psychiatrist. Due to Mr A moving to the region, the Service agreed to be responsible for his ongoing monitoring. Mr A was then aged 27 years.

A case manager at the methadone programme in the other city, wrote to the Service on 4 September 2002, formally requesting transfer of Mr A's management. In January 2003, Mr A was accepted by the Service as a patient on the methadone programme. His primary case manager was Ms E and his prescribing clinician was Dr F. Mr A was later transferred on 5 August 2003 to a second methadone programme, where his primary case manager was Ms G and his prescribing clinician was Dr H.

Names have been removed to protect privacy. Identifying letters have been signed in alphabetical order and bear no relationship to the person's actual name.

Treatment protocols
At the time of Mr A's acceptance as a client of the Service, the Service operated in accordance with its Methadone Programme Policy (May 1998). The policy set out requirements of the Service with regard to staffing, commencing and maintaining clients on the methadone programme, documentation and audit.

The policy requires that during intake onto the methadone programme, clients are to be in weekly contact with the medical officer, counsellor or nurse counsellor. Stable clients are to be seen at least once a month by their counsellor, with the option of more regular counselling if requested. Stable clients are also to be reviewed by the medical officer at least once every three months, as resources allow. The policy requires weekly methadone programme team meetings with a minimum of three members to discuss the status of clients in treatment. During the meeting, every client's current treatment plan, stability, drug use, and general welfare are to be discussed and recorded.

With regards to client review, the policy requires the treatment team, consisting of at least the medical officer and two counsellors, to review every client on methadone every six months. The review process is aimed at looking at:

1) treatment progress from the client's perspective;

2) treatment progress from the Service's perspective;

3) outstanding issues from the client's perspective;

4) outstanding issues from the Service's perspective;

5) future directions for the client as negotiated with the team.

The policy requires that the results of the review are documented and placed in the client's file.

The Service protocol of 2004 includes information given to patients who enter the programme. The protocol advises clients not to drive if they have combined methadone and other opioids with other substances (including alcohol). Clients are also advised that, once they are on a stable dose, use of other drugs will result in their treatment plan being reviewed.

Mr A's care and treatment at the Service
On 9 January 2003, following his admission to the Service, Mr A underwent a comprehensive drug and alcohol assessment by Ms I.

Ms I summarised her assessment in this way:

> "[Mr A] showed good insight into his need for the process of the assessment, and was open with the questions asked of him. He believes his problems to be

> stemmed at present from being unstable on the methadone, and he is committed to having this corrected.
>
> He has good support from his partner, and shows good commitment to … getting 'on track'.
>
> He has future goals of receiving his Drivers License back at the end of the month, so as to [find] full time work, and furthermore, a two year goal of abstinence, once he has stabilised himself."

Mr A commenced treatment on 21 January 2003. He was assessed by Dr F, who recommended a gradual dose increase over the following week. Dr F noted that once Mr A was stable on the increased dose of methadone, his dependency on benzodiazepines would be reviewed. A week later Mr A's dose of methadone was 80mg per day, and was subsequently increased to 100mg in mid-February. He collected his methadone from the pharmacy on a daily basis.[1]

Mr A continued to receive treatment throughout 2003 and 2004. There is no documented treatment plan for Mr A's care and treatment over this time, and no documented information regarding Mr A's reviews as required by the Methadone Programme Policy. The progress notes record outpatient contact on 9 and 16 April 2003, 28 May 2003, 23 July 2003, 6 and 20 August 2003, 3, 4 and 24 September 2003, 1 and 9 October 2003, 8 December 2003, and 9 February 2004. Mr A's drug abuse and concerns regarding "dirty" urine are documented, as are negotiations around his use of take-away methadone.

Mr A's urine was screened for drugs 16 times during 2003. On 21 January, the test was positive for benzodiazepine; on 4 July, the test was positive for opiates; on 14 July, the test was positive for opiates and amphetamines; on 21 July, the test was positive for opiates; on 29 July, the test was positive for benzodiazepine and opiates; and on 28 August and 16 October, the test was positive for amphetamines. No other such drugs were detected in any other test in 2003.[2] Mr A's first two drug-screen urines in 2004 (on 29 January and 29 February) were clear.

Driving concerns and management in 2004

At the time of Mr A's transfer to the Service, Dr D had advised the Service of Mr A's driving risk (this was documented in Mr A's discharge summary, dated 11 March 2003). He noted that Mr A had arrived intoxicated at the surgery for his methadone dose on "more than one occasion. Mr A's methadone dose was reduced to 30mg dose due to safety concerns of continuing to prescribe to Mr A whilst out of area." As documented in Ms I's assessment report, Mr A did not have a valid licence at the time

[1] From February 2003 until August 2004, Mr A was on a daily dose of 100mg of methadone, consumed at the pharmacy under the supervision of the pharmacist. On a few occasions, Mr A was allowed to take his methadone off-site, for example, when working outside the area.

[2] See Appendix 1 for a comprehensive table of the results of Mr A's drug screen urines from 9 October 2002 to 27 August 2004.

of his transfer to the Service, having had it revoked following a conviction for careless driving.

It is unclear when Mr A was given back his driver's licence, but it appears that it was during 2003. On 29 February 2004, Mr A was involved in a collision while driving his car. He was taken to the hospital Emergency Department and a urine sample was taken for the purposes of a urine drug test. It was later established that this was likely to be a false sample.

On 1 and 10 March 2004, Mr A's drug-screen urine returned traces of amphetamines.

On 10 March, a meeting was held between Mr A, his partner and members of the Service, precipitated by the motor vehicle crash. At the meeting, there was a discussion about alternative transport, and Mr A was advised that if he took other drugs in addition to the methadone he must take responsibility for not driving. (This advice was not noted in the minutes of the meeting, although the meeting minutes do note that there was a general discussion around Mr A's urine results and "chaotic behaviour (for example car accident)".)

The minutes of the meeting held on 10 March also state, "[Mr A] [was] given another chance — this means that [he is] to abstain from benzodiazepine and amphetamine use."[3] It was documented that Mr A would be subject to regular urinary drug-screening, and daily onsite dispensing. While no other plan was documented, the DHB advised that the plan was that if Mr A did not comply his treatment plan would be reviewed.

The Service stated that Mr A was not referred to the Land Transport Safety Authority in accordance with section 18 of the Land Transport Act 1998[4] because, although his urine tests indicated his use of drugs other than methadone, he did not show signs of intoxication when methadone was dispensed. The Service also stated that the "regular assessment of driving risk is not a core function". The DHB submitted that knowledge that a person may be intoxicated in the future is not a ground to invoke section 18; if the Service had witnessed Mr A driving while intoxicated, staff would have informed the Police of the immediate risk he posed.

On 3 March 2004, Mr A was placed on a restriction notice under section 25 of the Misuse of Drugs Act 1975 and section 49(2) of the Medicines Act 1981, in an attempt to prevent him obtaining benzodiazepines from other general practitioners.

Mr A underwent further urine tests on 23 March (positive for benzodiazepine, opiates and amphetamines) and 29 March (positive for amphetamines).

[3] The four urine tests subsequent to the 10 March meeting (on 23 and 29 March, 30 April and 26 May) were positive for amphetamines.

[4] Section 18 of the Land Transport Act 1998 sets out the obligation of medical practitioners to report to the Director of Land Transport Safety if they assess a patient as unfit to drive due to a mental or physical condition and as likely to drive (see page 14, below).

Mr A met with Ms E on 6 April. He was advised that if he continued to use amphetamines, then the Service "will look at the suitability of him being on the programme". The documented plan was for a review appointment in three weeks' time. On 30 April, a drug-screen urine returned a positive result for amphetamines.

On 12 May, Mr A presented at the Emergency Department with drug-induced psychosis. At a meeting between Mr A and Ms E on the same date, Mr A stated that he had been using methamphetamine two days earlier, and so there was no point in him giving a urine test, as it would be positive. The plan at the end of the meeting was that Mr A was told that he had a month to "clean his act up", and that if this did not occur "his place on the programme would be reviewed". Mr A's driving risk was not raised during this meeting. However, the DHB advised that Mr A's counsellor presented him with an option to work towards compliance with the methadone programme and reduction of other drug use, to be evaluated after a month. This was evaluated in a meeting with the counsellor and medical officer after two weeks. At this interview, Mr A reported that his other drug use had reduced, and was adamant that he had abstained from methamphetamine since 8 May. However, a urine test on 26 May was positive for amphetamines. Tests on 11 and 15 June, and 1 and 28 July, were negative for amphetamines.[5]

Mr A had an appointment with Ms E on 13 July, and further contact with the Service on 19 July regarding take-away methadone.

Ms E recorded on 23 July a meeting with Mr A:

> "Talked about present issue and future plan. [Mr A] will see […] and needs to have up to date bloods at next meeting. Still very defensive about dirty urine and lack of trust. Plan:
>
> 1) Further [appointment] with […]
>
> 2) Continue random urine
>
> 3) If he has confirmed employment we will look at [take-away doses]."

An unsigned entry in the clinical notes on 5 August states:

> "Are urine [samples] being faked? Possible referral to […] for … assessment as staff have difficulty making [Mr A] understand requirements of being on the programme."

On 17 August, Ms E wrote that Mr A had called in sick for an arranged appointment, and Mr A requested to take his methadone off-site. This request was refused, and Ms E wrote that Mr A "felt I wasn't understanding or caring. Again looking back on his lack of stability I have concerns as the last [appointment] he tried to cancel then tried

[5] Mr A had refused to provide a urine sample on 22 July.

to get [a take-away dose of methadone] from Pharmacy." Ms E recorded that she would request the team give him no take-aways until he managed to keep three appointments in a row. This decision was confirmed in a letter to Mr A dated 18 August 2004.

On 26 August, Mr A was the driver of a car involved in a collision, injuring himself and his passengers and killing the driver of another car, Mrs C. The urine test taken in a public hospital on 27 August was positive to opiates, benzodiazepines, cannabinoids, methadone and amphetamines. The plasma methadone level was 720nmol/L.[6]

Mrs C's daughter, Ms B, complained to the Commissioner, claiming that the Service had not provided Mr A with appropriate care.

Summary of DHB response

On 8 September 2004, in a letter to the Police, the Service advised that they had been concerned about Mr A's continued drug use over the previous year. The DHB advised this Office that Mr A's treatment was discussed at weekly team meetings held every Wednesday, where all staff present discuss the treatment. Staff regularly considered the option of notifying the Land Transport Safety Authority, as well as the Police. However, the Service took the view that if any person chooses to become intoxicated and drive, they must suffer the legal consequences of their actions. Where a patient presents at the Service and is assessed as being intoxicated, they are not allowed to drive away. While the Service may appropriately advise a client not to drive while intoxicated, a patient's decision to become intoxicated unobserved by Service staff and to subsequently drive is outside the Service's control. The DHB advised:

> "At this service we see over 2000 clients annually with alcohol and/or drug problems. Our interpretation of the recommendation that persons with alcohol and drug problems be notified to Land Transport New Zealand is that alcohol and drug problems can, through intoxication, cause impairment of driving but this impairment is of a variable nature. For most clients either the choice to become intoxicated or the choice to drive is under conscious control. When we have evidence that the client is choosing to drive while intoxicated notification to Land Transport New Zealand is contemplated. With respect to this case consideration of notification of Land Transport New Zealand did happen on a regular basis, however [Mr A] was being seen daily by the pharmacists dispensing methadone and regularly by clinic staff. He was consistently observed not to be intoxicated. In fact, he was never observed to be intoxicated at this clinic in any appointment since starting here in 2003. This is a strong indication that despite having a substance use disorder, he has sufficient choice over when to use drugs, to be capable of making the choice not to drive when intoxicated."

[6] Methadone therapeutic range: 650–1950nmol/L.

The DHB submitted that the option of removing Mr A from the methadone programme was discussed given his lack of co-operation with staff and ongoing use of other drugs. However, at the time they did not consider it a viable option. Mr A was maintained on methadone on the basis that taking him off methadone would have made him more unstable. The DHB advised: "The advantage of continuing treatment, which in this situation is done with daily dispensing of methadone ... is that the unstable patient has daily contact with a health professional. … The withdrawal process from 100–130mgs of methadone … would take 3 to 4 months."

Subsequent decisions and notification to the Land Transport Safety Authority
On 1 December 2004, the Service met with Mr A and a decision was made to reduce his methadone by 10mg. The decision was a result of Mr A's latest drug screen, which had returned positive for amphetamine and opiates. Mr A was advised that his methadone dose, and place on the programme, would be reviewed weekly.

The Service (Dr H) reported Mr A to the LTSA on 18 March 2005. The notification was based on factors, including Mr A's two motor vehicle crashes, and his own admission and his partner's report that he continued to drive while intoxicated. The DHB advised that this information was not available before the fatality of 26 August 2004.

Independent advice to Commissioner

The following expert advice was obtained from Dr Geoffrey Robinson, specialist physician:

> "Thank you for seeking 'independent medical expert advice' over this investigation.
>
> I have previously signed a confidentiality agreement which arrived prior to any detail of the case.
>
> I have read the HDC Guidelines for advisors and agree to follow them. …
>
> My qualifications are MB ChB (1972), Fellow of the Royal Australasian College of Physicians FRACP (1979), and Fellow of the Australasian Chapter of Addiction Medicine FAChAM (2002).
>
> I originally trained at the Addiction Research Foundation (Toronto) and completed the residency programme in Addiction Medicine there (1978–1980).

Thereafter I was appointed as the Specialist Physician at the Wellington Alcohol & Drug Service (Wellington Hospital Board and subsequently Capital & Coast District Health Board).

This was 50% of my employment and was from 1981 to mid-2003. I have considerable experience with patients on methadone maintenance treatment through this period of time. For the rest of my employment during this period I was a Consultant Physician at Kenepuru Hospital in General Medicine and also running the inpatient Medical Detoxification Unit, the latter of which continues to the current time.

Since returning from Canada, I have also been the Senior Clinical Lecturer in the Department of Medicine at the Wellington School of Medicine, and have been regularly involved with undergraduate and postgraduate teaching in alcohol and drug medicine.

Since 1 May 2005, I have been Chief Medical Officer at Capital & Coast District Health Board. I attach a copy of my CV in the University of Otago format.

EXPERT ADVICE REQUIRED:

1. *Please comment generally on the care provided to [Mr A] by the Service.*

   If not answered above, please answer the following queries, giving reasons for your view:
2. *Was the frequency of drug screening urine tests appropriate during the period 29 February to 27 August 2004?*
3. *Were the appropriate actions taken by the Service following the results of the urine tests?*
4. *At any stage prior to 27 August 2004 would it have been appropriate to refer [Mr A] to the LTSA or any other organisation/service? If so, at what stage, and for what reasons?*
5. *Was the appropriate guidance given to [Mr A] on 10 March 2004 in relation to driving?*
6. *Was the standard of documentation satisfactory?*
7. *Are there any aspects of the care provided by the Service that you consider warrant additional comment?*

If, in answering any of the above questions, you believe that the Service did not provide an appropriate standard of care, please indicate the severity of its departure from that standard.

To assist you on this last point, I note that some experts approach the question by considering whether the providers' peers would view the conduct with mild, moderate, or severe disapproval.

You should be aware that some of the clinicians attending [Mr A] are known to me, these being [Ms E], [Dr F], [Dr H], and [Ms I], but I am not of a view that this provides personal or professional conflict in attempting to be objective about approaching the questions proposed.

You have already provided a background summary of the case. You cite the meeting on 10 March 2004 between members of the Service [and] [Mr A] … following a motor vehicle accident. I note that you say [Mr A] was advised that he must take responsibility not to drive, but this was not specifically addressed in the minutes of that meeting. As far as I can gather there was no medical practitioner present at that meeting, although a medical practitioner might have been appraised of that advice by the team members present. I should say that I am not aware of the onus on non-medical practitioners (if any) to report to the Land Transport Safety Authority. I am aware of Section 18 of the Land Transport Act 1998 as it applies to medical practitioners.

I am aware that [Dr H] did notify the Land Transport Safety Authority on 11 March 2005, subsequent to the motor vehicle accident of 26 August 2004 which precipitated this enquiry. I understand there were ongoing reported concerns about [Mr A's] driving in early 2005 which precipitated this notification.

Regarding legal obligations on medical practitioners I refer to 'Medical Aspects of Fitness to Drive — A Guide for Medical Practitioners, May 2002' by the Land Transport Safety Authority. The usual interpretation is on page 12 of this book; it requires medical practitioners to advise the Director of the Land Transport Safety to notify any individual who poses a danger to public safety by continuing to drive when advised not to. I have interpreted this as being when advised not to by that particular medical practitioner. Secondly that practitioner needs to be made aware that the individual is continuing to drive having been advised not to.

Page 140 and 141 of this booklet refer to medications of concern with regards to the ability to drive which includes benzodiazepines, amphetamines (chronic use), cannabis, and opiates. Page 141 refers to methadone with the implication that chronic methadone treatment *per se* is unlikely to affect the ability to drive safely, with which I concur. The reason for this is patients on methadone or other prescribed long-term opioids develop considerable tolerance to the effects of these drugs. This assertion is broadly supported by the enclosed review *Opioid Dependence and Driving Ability: A Review in the Context of Proposed Legislative Change in Victoria by Lenne M G, et al in Drug and Alcohol Review 2000, Volume 19, pages 427–439.*

Page 141 also refers to obligations to advise patients who are taking 'illegal drugs' whilst on methadone treatment.

The wider issues of drugs of abuse and driving were addressed in a coronial decision by Mr G L Evans, the Wellington Coroner, on 18 April 2005.

Also, a wider note, having been a General Physician for 25 years, I suspect there [are] difficulties and probable widespread under-compliance with a very large number of medical conditions addressed in the 'Medical Aspects of Fitness to Drive' booklet. Audits may have been undertaken by the LTSA Medical Section.

Returning to [Mr A], I believe there are limitations to my being able to answer the expert advice questions that have been put forward based just on the perusal of the service records which you have provided, and without the opportunity to interview staff or clinicians involved which would ordinarily be the process in a DHB investigation for example.

One of the difficulties I have is identifying medical practitioner contact with this patient by perusal of the case notes. I am not able to discern [Dr H's] clinical contact, but am able to recognize medical entries by [Dr F] on 16 April 2003 and 6 August 2003. Many case entries are signed, but not further designated as to the name or status of the clinician.

I am not able to see documentation of driving advice, although this may have followed the team meeting of 10 March 2004.

I have seen the service's individual policies which will complement the National Methadone Guidelines. I note the pharmacy policy whereby 'the pharmacy will inform the Alcohol and Other Drug Service of any concerns they may have at any time'. This is important from the point of view of observed drug intoxication. Having said this, most patients pick up methadone as early as possible in the morning, and the pharmacist would not observe intoxication which occurred subsequently during the day. I note the Clinic has a policy on abusive other drug dependencies which addresses benzodiazepines, alcohol and cannabis.

I note the referral information from [the city methadone programme], and the [case manager] of 4 September 2002 mentions that [Mr A] had lost his motor vehicle licence, and it would be interesting to know whether and when this was regained.

Secondly, the referral letter from [Dr D] of 11 March 2003 refers specifically to driving concerns 'arrived intoxicated at [the] pharmacy on more than one occasion and … had driven in this state …', and [Mr A's] methadone dose had been reduced.

Thus, clearly the Clinic were faced with a challenging therapeutic situation, and it appears that [Mr A] would be at the more difficult end of an already difficult spectrum regarding treatment. …

I note that there was a comprehensive assessment by [Ms I] on 9 January 2003, at which time [Mr A] was 'looking forward to getting his driver's licence back' (to facilitate work), and in the past he had received sentence of periodic detention following some motor vehicle involvement. However, there was no clearly documented treatment plan. I now see there was medical assessment on 21 January 2003 by [Dr F] who fairly rapidly increased [Mr A's] methadone upwards from the 30 mg dose which would have been inadequate, but as above had been reduced by the [city clinic] because of a period of benzodiazepine misuse.
…
I note also that a methadone blood level taken at 4:00 p.m. on 26 August 2004 (the date of the fatal accident) found a methadone level at the lower limit of the therapeutic range 720 nmol/L (650–1950).

I would say that the frequency of urine drug screening over the 18 months in question was appropriate, particularly given the compliance issues that would likely have occurred.

It was quite clear that [Mr A] had continuing problems with polydrug abuse, with ongoing use of cannabis and intermittent use of benzodiazepines and methamphetamine. It is worth remembering that methadone prescription is primarily a treatment of opioid dependence which was proving reasonably effective. It is not in itself a treatment of other polydrug abuse which is frequently a management issue for methadone patients. I note the comment to [the Police] by [Ms E], 8 September 2004, explaining the difficulties of enlisting [Mr A's] co-operation, ongoing use of other drugs and the debate as to whether he should be taken off the methadone programme. It is true that to do so would have likely made him more unstable, and the great majority of patients involuntarily taken off methadone maintenance quickly relapse into street opiate abuse and/or increased polydrug use. However, some patients are taken off methadone programmes because of persisting polydrug use or alcohol use when there is ongoing observation of intoxication from these whilst these are on the methadone programme.

Whilst positive urine tests for other drugs will alert clinicians to such use, it needs to be noted that these tests are extremely sensitive, and it is difficult to make extrapolations about dosage of polydrug use or impairments.

Thus it is the observation of clinical intoxication rather than urine drug tests per se which usually generate clinical action by clinicians and these include changes to the methadone dose or dispensing conditions, or stronger consideration of taking patients off the programme (a last resort) with abuse of

drugs which are known to interact with methadone, particularly alcohol or benzodiazepines (sedatives).

I am not aware from the notes provided that there were frequent reports of observed intoxication (by pharmacists, clinicians or others).

A majority of these issues had been covered in correspondence from [the Chief Medical Advisor of the District Health Board] in his letters of 29 September 2005 and 12 January 2005, … which I have re-read and [with which I] am in agreement.

I would also like it noted that it remains relatively uncommon for patients on methadone maintenance with significant polydrug use to be reported to the LTSA, and that when it does occur this will be after serial observations of clinical intoxication.

It also needs to be said that clear evidence of intoxication with cannabis or methamphetamine may be difficult to discern as tolerance to these drugs and benzodiazepines are also developed similar to the situation described above with methadone.

From my reading of the notes, although there was awareness of the polydrug use there appeared to be deficiency of documented treatment plans or latter medical involvement (this may be due to my difficulty in interpretation of notes or signatures).

I also note the detailed questions in the Commissioner's letter of 24 June 2005 and the responses from [the Chief Medical Advisor] and presumably the Service. I hope my remarks have gone some way in verifying or broadening perspectives.

I was interested in the response to question 5C in that the 'assessment of driving risk is not a core function of the Service' which may be so, but nevertheless is a legislative issue for at least medical practitioners involved. Driving is not specifically mentioned in the National Opioid Substitution Guidelines (2002), but 'Medical Aspects of Fitness to Drive' are referred to on (page 59).

In summary, I would say that the answers to question 1, 2 and 3 was that adequate care was provided to [Mr A]. With regard to question 4, it was probably arguable not to have notified him despite the prior accident, but at that point appropriate driving advice should have been and was given by the Service. My interpretation is that notification to the LTSA should be given by a doctor who has advised the patient not to drive and continues to do so, in the knowledge of ongoing known intoxication.

As above, I have some concerns about the standard of documentation relating to greater medical assessment and documentation of treatment plans and options (mild-moderate disapproval level)."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

Other standards

Land Transport Act
Section 18 of the Land Transport Act 1998:

"(1) This section applies if a registered medical practitioner … who has attended or been consulted in respect of a driver licence holder, considers that —

(a) The mental or physical condition of the licence holder is such that, in the interests of public safety, the licence holder —
(i) Should not be permitted to drive motor vehicles of a specified class or classes;
… and
(b) The licence holder is likely to drive a motor vehicle.
(2) If this section applies, the registered medical practitioner … must as soon as practicable give the Director written notice of the opinion under subsection (1)(a) and the grounds on which it is based."

Land Transport Safety Authority, "Medical Aspects of Fitness to Drive — A Guide for Medical Practitioners" (2002):

"…
11.2 Alcohol and/or drug addiction and dependency
…
Individuals with symptoms or effects of alcohol and/or drug dependency or abuse that may impair their ability to drive safely, should be advised not to

drive until effective treatment has been established. For example, where the effects of the individual's dependency impair their driving skills, perceptions, cognitive abilities, or other factors necessary for safe driving.

11.3 Methadone

…

When driving may resume or may occur

An individual on an oral methadone treatment programme may continue to drive if the individual is stable on the programme and their methadone treatment is unlikely to affect their ability to drive safely.

Medical practitioners should be aware of the effects of oral methadone and a combination of any illegal drugs on driving, and where appropriate advise patients that they should not drive when taking oral methadone and illegal drugs."

Documentation standards

The Medical Council guidelines "The Maintenance and Retention of Patient Records" (August 2001) state:

"(a) Records must be legible and should contain all information that is relevant to the patient's care.

(b) Information should be accurate and updated at each consultation. Patient records are essential to guide future management, and invaluable in the uncommon occasions when the outcome is unsatisfactory."

The Medical Council publication "Good Medical Practice — A Guide for Doctors" (2003) states that doctors must:

"keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed."

Response to provisional opinion

The Chief Medical Advisor of the District Health Board (the Board) responded:

"[The Board accepts] there were deficiencies in the treatment reviews and documentation provided for [Mr A]. The Board accepts its obligations to improve these aspects across the Service. It also intends to carry out the development of guidelines for the ongoing assessment of risk of clients who continue to drive.

However, we request that you review your decision to find the Board in breach [of the Code]. We consider this decision does not give sufficient emphasis to the

difficulty posed to practitioners working in this area. You have stated that practitioners should make a balanced judgement on all available information as to whether to involve other agencies with concerns about a patient continuing to drive. Yet you say they should maintain a low threshold for intervention.

If practitioners exercise a low threshold for intervention (in relation to driving and other risks), this will dissuade patients from seeking assistance from the service. Furthermore, revoking the ability to drive would deprive many patients of transport in order to attend clinics. The effect would be that more patients would end up outside legitimate programmes with an inevitable increase in risk to patients and the general public as a result.

The Board understands that the judgement about this threshold is particularly difficult to make by those providing these services. The risks of a patient driving whilst affected by drugs and alcohol are accepted. However we understand the research supports the view that maintaining patients on a methadone programme significantly reduces the overall risks to society from those same patients. It also understands that many patients provide some level of non-compliance.

Many patients on the methadone programme have an Anti Social Personality Disorder and the rate of non-compliance with advice (including driving advice) is high. … Given the predictably low level of compliance, we submit that if a low threshold for intervention is to be applied, we may be obliged to report about half of all patients on the methadone programme to the LTSA.

…

The Board [accepts] the need for it to make improvements. It will review the documentation and develop the guidelines suggested. It considers it important to support this process by using external expertise to provide the necessary training and guidance required. It also intends to consult the National Association of Opiate Treatment Providers."

Opinion: Breach — The District Health Board

Mr A's needs were clearly very difficult for the methadone programme to manage. The Service had ongoing concerns about his management, and discussed his place on the programme on several occasions. The issue is whether, in light of their concerns, the Service appropriately managed Mr A's care. There were shortcomings in the Service's management of Mr A in relation to treatment planning and documentation, and the assessment of, and response to, his escalating driving risk given his ongoing drug abuse. In my view these shortcomings amount to a breach of the Code of Health and Disability Services Consumers' Rights (the Code). The reasons for my decision are set out below.

Treatment planning and documentation
The requirement that health care professionals keep accurate and clear patient records is fundamental. Accurate and clear records assist by confirming the key details of a patient's care and treatment, including follow-up actions and treatment plans. For doctors, the Medical Council of New Zealand guidelines "The Maintenance and Retention of Patient Records" note that "patient records are essential to guide future management, and invaluable in the uncommon occasions when the outcome is unsatisfactory". The Council's publication "Good Medical Practice — A Guide for Doctors" states that records should be "clear, accurate and contemporaneous" and should "report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed". The guidelines also state that "records must be legible and should contain all information that is relevant to the patient's care" and that "information should be accurate and updated at each consultation". Furthermore, as noted in *Cole's Medical Practice in New Zealand* (2004),[7] keeping a proper medical record is "a tool for management, for communicating with other doctors and health professionals, and has become the primary tool for continuity of care". The medical record contains vital information relevant to a patient's history, care and treatment, which may be needed if the patient receives subsequent care from other health professionals.

Although the staff involved in Mr A's care and treatment were not all doctors to whom these professional standards apply, the Nursing Council and the New Zealand Association of Counsellors have similar standards for the maintenance of adequate records and documentation.

The documentation of Mr A's care and treatment at the Service was substandard. It does not meet professional standards or the standard set by the Service's internal policy. The lack of documentation creates doubt as to whether the Service managed Mr A in accordance with its policy. In particular, the Service's internal policy sets out strict requirements with regards to the review and assessment of patients on the methadone programme, and the documentation of those reviews. The policy requires regular patient review, which includes, for stable patients, counselling every month,

[7] Edited by Dr Ian St George, and published by the Medical Council of New Zealand.

medical officer review at least once every three months, client review by the treatment team every six months, and weekly methadone programme team meetings. The policy requires all such discussions and reviews be recorded and/or documented in the client's file. I cannot identify any such reviews from the clinical record.

Of particular concern is the lack of documented medical review. Dr H was identified as the clinician responsible for Mr A's management, yet no contact between Mr A and Dr H is detailed in the clinical record. Dr F made entries on 21 January, 16 April and 6 August 2003, but there is no evidence of a further review by a medical practitioner thereafter.

When Mr A was first assessed on 9 January 2003, there was no resulting treatment plan, even though a history of illegal drug use was identified. The clinical record of Mr A's contact with the Service contains an account of his contacts with staff. Apart from Ms E's record of 23 July 2003, there is no document that is identifiable as a plan. Mr A was a complex and high-risk patient. I am concerned that no treatment plans were formulated, to ensure clear direction in his ongoing care and management, and documented in his records, to ensure continuity of care.

It is often stated by medical defence lawyers that "If it isn't documented, it didn't happen." Baragwanath J made comments to similar effect in his recent decision in *Patient A v Nelson-Marlborough District Health Board*.[8] Justice Baragwanath noted that it is through the medical record that doctors have the power to produce definitive proof of a particular matter (in that case, that a patient had been specifically informed of a particular risk). Doctors whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted. Given the lack of documentation, I conclude that Mr A's reviews fell short of that required by the Methadone Programme Policy. Accordingly, the Service breached Right 4(1) of the Code in failing to adequately manage Mr A.

It is essential that all relevant information, including appointments, examinations, test requests and results, are accurately recorded to guide future management, ensure continuity of care, and enable audit and review. The documentation in this case was substandard. Some of the entries in the clinical record are unsigned, and most do not have the staff designation, nor a printed name. It is important that clinical records are legible, and the name and designation of the member of staff making the entry are present and legible. The critical advice given to Mr A during the meeting on 10 March 2004 — that he should not drive if he used drugs other than methadone — was not recorded in the minutes of the meeting. Such important information should have been recorded. In my view, the Service's record-keeping was significantly below professional standards and amounted to a breach of Right 4(2) of the Code.

[8] *Patient A v Nelson-Marlborough District Health Board* (unrep, HC Blenheim, CIV-2003-204-14, 15 March 2005).

Assessment of driving risk

The legal obligations of medical practitioners relating to a patient's fitness to drive are set out in section 18 of the Land Transport Act 1998, and are summarised clearly in the Land Transport Safety Authority's document "Medical Aspects of Fitness to Drive — A Guide for Medical Practitioners". Section 18 requires medical practitioners to advise the Director of Land Transport Safety in cases where the mental or physical condition of the licence holder is such that, in the interests of public safety, the person should not be permitted to drive or be permitted to drive only subject to limitations and conditions — and it is considered that the person is likely to drive against medical advice. A practitioner who notifies the Director in good faith will not be subject to any civil or professional liability because of any disclosure of personal medical information in that notice.

The District Health Board submitted that section 18 of the Land Transport Act did not apply in this case. The Board's submission was that section 18 refers to mental or physical conditions that impair driving ability, which does not cover potential future intoxication. The Land Transport Safety Authority's document "Medical Aspects of Fitness to Drive — A Guide for Medical Practitioners" clearly anticipates that section 18 applies in respect of medications, drugs and abuse of substances. With reference to section 18 of the Land Transport Act 1998, chapter 11 notes that when assessing an individual for fitness to drive, practitioners should consider whether the individual has a known history of use of illicit drugs and medications. The document goes on to state:

> "[M]edical practitioners should discuss with patients seeking treatment for drug problems, whether hard line drugs such as heroin or so-called 'soft drugs' such as cannabis, the potential implications of driving under the influence of drugs. …
>
> Individuals with symptoms or effects of alcohol and/or drug dependency or abuse that may impair their ability to drive safely, should be advised not to drive until effective treatment has been established. For example, where the effects of the individual's dependency impair their motor skills, perceptions, cognitive abilities, or other factors necessary for safe driving. …
>
> An individual on an oral methadone treatment programme may continue to drive if the individual is stable on the programme and their methadone treatment is unlikely to affect their ability to drive safety.
>
> Medical practitioners should be aware of the effects of oral methadone and a combination of any illegal drugs on driving, and where appropriate advise patients that they should not drive when taking oral methadone and illegal drugs."

The LTSA Guidelines state at section 1.1 that medical practitioners should inform the LTSA of "any individual who poses a danger to public safety by continuing to drive when advised not to".

On 10 March 2004, Mr A was advised that "in the event [he] uses other drugs then he must take responsibility to not drive". It was appropriate that staff took this step at this time. However, results from four consecutive urine tests subsequent to this meeting[9] show that his urine was positive to amphetamines; it is therefore clear that the Service was aware that Mr A was continuing to use drugs in addition to methadone. The question is whether the Service adequately managed Mr A's driving risk in light of its knowledge of his ongoing drug abuse.

My expert, Dr Geoffrey Robinson, advised that it is uncommon for a referral to the Director of Land Transport Safety to take place, and even then it is only made after "serial observations of clinical intoxication". Staff at the Service did not witness Mr A intoxicated, or intoxicated while driving. Accordingly, it was submitted that in advising Mr A not to drive the staff had fulfilled their legal obligation in respect of his driving risk, and no further action was required. It was further submitted that the "regular assessment of driving risk is not a core function" of the Service.

Staff of the Service were aware from the car crash that precipitated the 10 March 2004 meeting that Mr A's driving was a concern. He was specifically advised not to drive and "use" other drugs. Accordingly, the Service was aware that Mr A was a driving risk. The knowledge of Mr A's driving risk was compounded by the Service's awareness of his previous drug-driving and the loss of his licence following a careless driving conviction in 2002. Although staff did not witness Mr A driving intoxicated, they were aware of the escalating risk by his continued drug abuse (evident in his presentation to the Emergency Department with drug-induced psychosis on 12 May 2004), and his historical tendency to drive whilst intoxicated. In my view, a responsible provider with such knowledge would take action in response to that risk. This would include, for example, close monitoring, reassessment of management plans, and considering notification to the Director of Land Transport Safety or the Police. The Board submitted that "[t]he system of notifying the LTSA, as well as the Police … and other agencies was considered throughout Mr A's treatment". Yet, apart from threats to withdraw Mr A from the methadone programme, there is no evidence that the Service appreciated or responded to the risk that Mr A would drive while intoxicated.

I note that despite its submission that assessment of driving risk is not a core function of the Service, Dr H notified the Director of Land Transport Safety that Mr A was a driving risk on 18 March 2005. The Board advised that the notification was based on information previously unavailable to the Service, including Mr A's two car crashes, and information from Mr A and his partner that he was continuing to drive while intoxicated.

In response to the provisional opinion, the Board stated that if it referred to the LTSA all patients who did not take the Service's advice not to drive, then up to half of the clients on the methadone programme would require referral. I accept the Board's

[9] Urine tests on 23 and 29 March, 30 April and 26 May 2004, all positive to amphetamines, and the clinical record noted that on 12 May 2004 Mr A stated that he had used amphetamines two days earlier, and his urine test would be positive.

submissions, and appreciate that by depriving clients of the ability to drive to the Service some may end up "outside legitimate programmes with an inevitable increase in risk to patients and the general public as a result".

In light of Dr Robinson's advice about how section 18 is applied in practice, it is difficult to criticise the Service for failing to refer Mr A to the LTSA at an earlier stage. However, as noted above, I have some concerns about the Service's failure to appreciate and respond to the risk that Mr A would drive while intoxicated.

In my opinion, the Service should have taken steps to reduce that risk, following the meeting on 10 March.

Summary
I note Dr Robinson's description of Mr A as being at the "difficult end of an already difficult spectrum regarding treatment". It is clear that clinical staff recognised Mr A to be a challenging client. In those circumstances, it was important that there was a clearly defined and structured management plan for Mr A. Although Dr Robinson advised that, overall, "adequate" care was provided, he criticised "the standard of documentation relating to greater medical assessment and [the] documentation of treatment plans and options". By its lack of treatment planning and review, apparent lack of medical review, and poor documentation, the DHB breached Rights 4(1) and 4(2) of the Code.

Recommendation

I recommend that, by 1 July 2006, the District Health Board provide a copy of its guidelines for the ongoing assessment of risk of clients of the methadone programme who continue to drive when advised not to.

Follow-up actions

An edited copy of this report, with details identifying the parties removed, will be sent to the Royal New Zealand College of General Practitioners, Royal Australasian College of Physicians, the Australasian Chapter of Addiction Medicine, the Land Transport Safety Authority, and all District Health Boards, and will be placed on the Health and Disability Commissioner's website, www.hdc.org.nz.

Appendix 1

Mr A's urine drug tests. 'n/d' – not detected.

	Cannabinoids	Benzodiazepine	Opiates	Methadone	Amphetamines
9-Oct-02	**164**	n/d	n/d	**pos**	n/d
21-Jan-03	**3110**	**pos**	n/d	**pos**	n/d
7-Apr-03	**900**	n/d	n/d	**pos**	n/d
16-Apr-03	**1580**	n/d	n/d	**pos**	n/d
4-Jul-03	**1000**	n/d	**pos**	**pos**	n/d
14-Jul-03	**2980**	n/d	**pos**	**pos**	**pos**
21-Jul-03	**1860**	n/d	**pos**	**pos**	n/d
29-Jul-03	**3450**	**pos**	**pos**	**pos**	n/d
6-Aug-03	**1060**	n/d	n/d	**pos**	
28-Aug-03	**340**	n/d	n/d	**pos**	**pos**
4-Sep-03	**1060**	n/d	n/d	**pos**	
17-Sep-03	**1120**	n/d	n/d	**pos**	n/d
16-Oct-03	**360**	n/d	n/d	**pos**	**pos**
6-Nov-03	**171**	n/d	n/d	**pos**	n/d
27-Nov-03	**300**	n/d	n/d	**pos**	n/d
10-Dec-03	**186**	n/d	n/d	**pos**	n/d
18-Dec-03	**380**	n/d	n/d	**pos**	n/d
29-Jan-04	n/d	n/d	n/d	**pos**	n/d
29-Feb-04	n/d	n/d	n/d	n/d	n/d
1-Mar-04	**980**	n/d	n/d	**pos**	**pos**
10-Mar-04	**270**	n/d	n/d	**pos**	**pos**
23-Mar-04	**410**	**pos**	**pos**	**pos**	**pos**
29-Mar-04	**760**	n/d	n/d	**pos**	**pos**
30-Apr-04	**450**	n/d	n/d	**pos**	**pos**
26-May-04	**420**	n/d	n/d	**pos**	**pos**
11-Jun-04	**310**	n/d	n/d	**pos**	n/d
15-Jun-04	**770**	n/d	n/d	**pos**	n/d
1-Jul-04	**183**	n/d	n/d	**pos**	n/d
28-Jul-04	**162**	n/d	n/d	**pos**	n/d
27-Aug-04	**167**	**pos**	**pos**	**pos**	**pos**

Names have been removed to protect privacy. Identifying letters have been signed in alphabetical order and bear no relationship to the person's actual name.