Summary of submissions

Amendments to *Medical aspects of fitness to drive: a guide for health practitioners* based on feedback

Copyright information

Copyright ©. This copyright work is licensed under the Creative Commons Attribution 4.0 International licence. In essence, you are free to copy, distribute and adapt the work, as long as you attribute the work to NZ Transport Agency Waka Kotahi (NZTA) and abide by the other licence terms. To view a copy of this licence, visit http://creativecommons.org/licenses/by/4.0/

Disclaimer

NZTA has endeavoured to ensure material in this document is technically accurate and reflects legal requirements. However, the document doesn't override governing legislation. NZTA doesn't accept liability for any consequences arising from the use of this document. If the user of this document is unsure whether the material is correct, they should refer directly to the relevant legislation and contact NZTA.

Summary

Between July and September 2024, NZ Transport Agency Waka Kotahi (NZTA) consulted on the proposed amendments to the *Medical aspects of fitness to drive: a guide for health practitioners* (MAFTD) to help inform the final content of the guide. This consultation period was made up of two separate rounds, departmental consultation (with government departments) and formal consultation with health practitioners, impacted industry organisations and interest groups.

This document outlines our responses to the formal consultation period only.

The consultation documents (Summary of proposed changes and Draft Medical aspects of fitness to drive) are available on our website:

Consultation on Medical aspects of fitness to drive

We received 88 responses during the formal consultation phases, the majority from health professionals. The consultation asked:

1. Do you have any comments to the reviewed *Medical aspects of fitness to drive*? If so, please select which chapter you want to comment on and provide evidence such as data, research or documentation, and source. If applicable, also provide a proposed solution such as corrective wording.

   Contributors could then select to comment on entire guide, one or multiple chapters or something else.

2. If you're a health practitioner, do you have suggestions on what support could be provided to increase the ease of use and knowledge of the guide?

Purpose and structure

The purpose of this document is to summarise and respond to the main themes in the submissions received, and to provide further reasoning and justification for the changes we have made or not made since consultation. Some responses are based on the common themes raised across all submissions and some are in response to a specific submission.

The structure of this document has been arranged in the following order:

1. General responses received regarding the entire guide.
2. Specific issues that relate to the proposed new or amended medical content of the guide.

Acknowledgement to contributors

NZTA would like to thank everyone who has made a submission and provided feedback. We appreciate the careful consideration given to our proposed additions and amendments to the guide.

Response to submissions

Introductory note

Reviewing the MAFTD guide contributes to NZTA's objective of creating an effective, efficient, and safe land transport system in the public interest. It also ensures that the guidelines remain up to date with medical advances and to ensure we're not under- or over-regulating. Aligning the content with Austroads *Assessing fitness to drive for commercial and private vehicle drivers* guide, where appropriate, has been one way of achieving that.

This is because the Austroads guide was developed from medical and fitness to drive studies, medical guidelines and expert medical opinion. The guidance in MAFTD was also developed with input from the medical community in New Zealand who have supported the alignment of our content with the Austroads guidance where appropriate to do so.

Proposed amendments have also considered, and addressed where appropriate, the findings from coroner reports provided to NZTA by the Office of the Chief Coroner that relate to road deaths linked to medical conditions and other factors outlined in MAFTD.

Other considerations included:

- ensuring content is clear, in an easily accessible format and tailored to the intended primary audience (health practitioners)
- ensuring alignment with the NZTA's regulatory strategies.

The summary of feedback and our responses focus on the main themes received during consultation. Any submissions not directly addressed here have been considered as well and addressed as appropriate.

Feedback received – whole of guide

SUPPORT FOR THE UPDATED GUIDE

We received several submissions that expressed support for the updated version of the guide and didn't provide any further feedback for NZTA to consider. Broadly summarised, this feedback included:

- Confidence that the guide provides a useful evidence base and review of relevant matters to assist assessments.
- Support for the transparency and ease of understanding for health practitioners and drivers achieved by the review.
- Appreciation for the application of plain language throughout the guide.
- Support for the updated guidance for specific conditions where a reduction in standdown times has been implemented, such as strokes and traumatic brain injuries, especially for commercial drivers.

REQUEST FOR STANDARDISED MEDICAL EXAMINATION TEMPLATE

One submission proposed including a standardised medical examination template in the guide that could then be used as part of a health practitioner's paperwork or incorporated into the Medical certificate for driver licence (DL9 medical certificate) so that all patients are subject to the same standardised examination.

Response:

We don't propose to standardise medical examinations or include a standardised examination template in the guide as it's up to the health practitioner to determine the appropriate medical tests that are required for a patient, depending on their situation. The DL9 already provides a broad guideline for most medical conditions, and we don't believe that there'd be any additional value in making this form more prescriptive.

REQUEST TO REMOVE USE OF GUIDANCE NOTES

Several submissions didn't support the use of guidance notes throughout the guide. Concerns were expressed that these were not applied correctly or consistently, and that this content could be more useful being incorporated into the introductory paragraphs at the start of each section.

Response:

We reviewed the content and application of guidance notes across the whole guide and removed these. Where relevant and appropriate, we have incorporated the information that was contained in a particular guidance note into the introductory part of the section of the guide that the guidance note was related to.

Feedback received – specific medical sections

General matters

PRACTICAL DRIVING ASSESSMENTS

From the submissions that we received, it's unclear whether the existing guidance provides health practitioners with sufficient clarity as to the differences between an occupational therapy driving assessment (OTDA) and an on-road safety test (ORST), and which situations call for which driving assessment to be used.

Response:

We've added a table to this part of General matters which outlines the key differences and benefits of each type of driving assessment for further clarity. Additional wording has also been included below the table to highlight that some tests may not be available or accessible in some parts of the country, and that patients should be aware that completing a driving assessment will come at additional time and cost to them.

Neurological conditions

FORMATTING CHANGES RECOMMENDED

A submission recommended that the neurology content should be reordered so that the subsection on structural intracranial lesions comes after the subsection on subdural haematomas. The feedback advised this would make more sense, as the introduction for structural intracranial lesions mentions head injuries and TBIs, and making the recommended reordering change would mean that the relevant subsections that address these conditions would immediately follow this introduction.

Response:

We agree with this submission and have reordered the subsections under the 2.10 structural intracranial lesions section. The numbers of the subheadings have been amended accordingly.

BLACKOUTS OF UNKNOWN CAUSE STANDDOWN TIMES FOR COMMERCIAL DRIVERS

We received a submission which disagreed with the proposed standdown period of 5 years for commercial drivers who have experienced blackouts of unknown cause. The submission outlined a specific case where they believed having a 5-year standdown period would have ended this person's working life.

Response:

For the specific case mentioned in the submission it was suggested that a known cause for the blackout was identified, and therefore for that person the unknown cause standdown period doesn't and wouldn't apply.

The updating of the standdown time for commercial drivers to 5 years for blackouts of unknown cause was based on the Austroads guidance, and supported by the neurologists that we consulted with in reviewing this section of our guide. We therefore consider a standdown time of 5 years to be the appropriate standard for those holding or seeking a commercial driver licence. However, in all scenarios health practitioners are still able to refer a patient for special consideration via the NZTA review process.

REQUEST FOR BETTER CLARITY OF STANDDOWN TIMES FOR 'SAFE SEIZURES' AND THE REMOVAL OF WITNESS TESTING

One submission called out that the guidance regarding 'safe seizures' did not clearly define how long a patient must have only experienced safe seizures before they can drive. It also questioned the practice of assessing normal responsiveness through a 'reliable witness' noting that this often can be a family member, whose judgement may be compromised or biased due to their relationship to the patient.

Response:

We have updated the wording in this guidance note box to provide clarity, aligning with the standdown times outlined in the Austroads guide. This standdown time is 2 years provided no seizures of any other type have occurred. The reference to testing normal awareness through reliable witnesses has also been removed from this guidance.

REQUEST TO IMPROVE WORDING AND TERMINOLOGY REGARDING CEREBROVASCULAR DISEASE

Submissions for cerebrovascular disease focussed on wording amendments and some reordering of the guidance to provide more accurate advice and better clarity around the fitness to drive requirements for patients with these conditions.

Response:

We agree with the amendments proposed to the cardiovascular disease guidance and have updated this part of the neurology section with the recommended changes.

REQUEST TO UPDATE STANDDOWN PERIODS FOR COMMERCIAL DRIVERS AND STROKES

A recommendation was made that NZTA update the standdown times for commercial drivers based on the type of stroke they have experienced, ischaemic or haemorrhagic. The expert opinion provided in this submission outlined that research has shown that there is a risk of post traumatic epilepsy in the 2 year period following a stroke for a portion of people who experience a haemorrhagic stroke as opposed to those that experience an ischaemic stroke, and that therefore the broad 3-month standdown time for any type of stroke that was originally proposed in the guide would be inappropriate for haemorrhagic strokes.

Response:

We agree with the amendments proposed to have separate standdown periods for ischaemic and haemorrhagic strokes in relation to commercial drivers. We have updated the commercial classes information with the recommended changes.

REQUEST TO INCLUDE TE REO MĀORI TERM FOR DEMENTIA THROUGHOUT GUIDE

This submission proposed that NZTA include the Māori term for dementia 'mate wareware' wherever dementia is mentioned in the guide. Their view was that this would assist Māori patients with understanding of dementia and also ensure that NZTA was in alignment with other government agencies that use this terminology.

Response:

We agree that it is beneficial and appropriate to include the Māori term 'mate wareware' in the title of the dementia section. This has also prompted NZTA to include a Māori translation of all the section headings in the guide for consistency and to align with the change made to the dementia title.

REQUEST FOR FURTHER AMENDMENTS TO GUIDANCE ON COGNITIVE IMPAIRMENTS, INCLUDING DEMENTIA

Two submissions were received advocating for changes to be made to the section on cognitive impairments, including dementia. One submission advised that focusing on alcohol and solvent abuse as causes of dementia detracts from many other causes which are also relevant. The other submission outlined that the specific considerations for private class licence contained some incorrect or imprecise wording that could cause confusion, and which were not necessarily relevant to include.

Response:

We agree that the feedback above warrants further revision of this section. The paragraph on alcohol and solvent abuse has been reworded to indicate that these are factors to consider but that assessment of any suspected impairment is ultimately most important, as there are many other possible causes of cognitive impairment. For the guidance for private licence classes, we have updated the wording as recommended to achieve the necessary clarity around assessing the fitness to drive for patients with these conditions.

REQUEST TO REMOVE WESTMEAD TESTING AS THE RECOMMENDED METHOD FOR ASSESSING THE SEVERITY OF HEAD INJURIES

Several submissions questioned the proposed addition of the Westmead post-traumatic amnesia memory testing to section 2.10. These submissions advised that some health practitioners had not heard of Westmead testing, and requested further information on it be included should the testing method remain in the guide. Further feedback indicated that Westmead testing isn't commonly conducted at a general health practitioner level, and if used, is done so predominately by specialist neurosurgeons.

Others didn't believe that this was a particularly relevant or accurate methodology for assessing the severity of traumatic brain injuries and were advocates for all references to Westmead testing to be removed from the guidance in this section.

Response:

After careful consideration of the submissions that touched on Westmead testing, we removed references to Westmead from the guide. Given that this guide is principally targeted at general health practitioners, it wouldn't be appropriate to reference Westmead testing if this isn't something that they would normally use to assess traumatic brain injury severity. We therefore trust and rely on health practitioners to exercise appropriate judgement in assessing the severity of head injuries in determining whether a patient is fit to drive or not.

Cardiovascular conditions

GENERAL LANGUAGE AND WORDING UPDATES REQUESTED

Submissions received have recommended small language and wording updates throughout this section of the guide to assist with the clarity of the cardiovascular guidance.

Response:

We have made minor amendments throughout this section to address these recommended changes.

REQUEST TO REMOVE REFERENCE FOR HEALTH PRACTITIONERS TO CONSIDER POTENTIAL OCCUPATIONAL-RELATED EFFECTS FROM ASSESSMENT OF COMMERCIAL DRIVERS

One submission expressed concern that the guide is asking health practitioners to conduct an overall occupational assessment for patients with cardiovascular conditions who hold a commercial class of licence. They believe that asking health practitioners to consider potential effects of duties associated with a person's role is inappropriate for a driving assessment.

Response:

NZTA disagrees in part with this submission. We would like to make clear that we don't require, or expect, health practitioners to be conducting an overall occupational assessment of their patients. However, we do believe that it could be relevant to a driving assessment to consider if work-related physical tasks have the potential to exacerbate or otherwise impact the patient's cardiovascular condition when driving. We have therefore elected to retain this guidance.

REQUEST FOR CLARITY AROUND WHICH PATIENTS REQUIRE A NEW ECG WHEN PROVIDING A MEDICAL CERTIFICATE

This submission requested that we add guidance around which patients require a new ECG when providing a DL9 medical certificate, specifically which pre-existing conditions and whether patients without a history of cardiac conditions require an ECG screening for private and commercial licences.

Response:

We don't consider this guidance needs to be included in the guide. NZTA doesn't require people without cardiac conditions to have an ECG for any class of licence as part of obtaining a DL9 medical certificate.

REQUEST TO REMOVE SPECIALIST ASSESSMENT REQUIREMENT FROM GUIDANCE ON ACUTE MYOCARDIAL INFARCTIONS AND CORONARY ARTERY BYPASS SURGERY

Submissions on these conditions advised that the existing guidance that private class licence holders require specialist assessment before being deemed fit to drive is inappropriate for these drivers, and that the health system in New Zealand wouldn't have the capacity to provide these assessments if this requirement was implemented.

Response:

As these submissions have been provided by health practitioners familiar with these conditions, we accept this recommendation. We have removed the requirement for private class drivers to get a supporting specialist assessment before having their fitness to drive considered by a health practitioner for both acute myocardial infractions and coronary artery bypass surgery based on expert opinion.

REQUEST TO REVIEW AND AMEND THE STANDDOWN TIME FOR PRIVATE CLASS DRIVERS WITH SYNCOPE OR PRESYNCOPE

It was noted in submissions that the standdown time from driving for private classes, proposed to be 3 months, seemed overly harsh and would disadvantage many drivers. The submissions proposed a timeframe of 4 weeks as more appropriate for this group of drivers.

Response:

This was an error. The standdown time in the guide should have originally been proposed to be 4 weeks, as the submissions have correctly pointed out. We have amended the standdown time for private class drivers from 3 months to 4 months accordingly.

REQUEST TO INCLUDE POSTURAL DIZZINESS DUE TO POSTURAL HYPOTENSION

One submission called for postural dizziness due to postural hypotension to be mentioned in the cardiovascular conditions section.

Response:

Inclusion of postural dizziness due to postural hypotension is too prescriptive in this instance and therefore we haven't included it.

REQUEST TO UPDATE OUTCOME FOR CARDIAC FAILURE

A submission believed that the outcome of unfit to drive for cardiac failure proposed by the guide is incorrect. The submission stated that in some instances, patients with cardiac failure should be declared unfit to drive but that many other patients experience minimal symptoms and should be permitted to continue driving.

Response:

The existing guidance is that patients with cardiac failure are generally unfit to drive is correct, and the inclusion of 'generally' is intended to signal that this is not a blanket outcome across the board. Additionally, for both private and commercial classes, there are clear criteria which can be met to allow a patient to return to driving, meaning that a diagnosis of cardiac failure doesn't necessarily mean that a person will lose their licence long-term.

Diabetes

GENERAL LANGUAGE AND WORDING UPDATES REQUESTED

Feedback was received regarding the use of 'diabetics' as a term to describe patients with diabetes, and the potential for this term to be perceived as derogatory language. Submissions also advised minor word changes such as 'satisfactory glucose control' instead of 'hypoglycaemic control' as these are more accurate and commonly used terms.

Response:

We agree that a terminology update in relation to patients with these conditions would be beneficial to apply throughout this section of the guide. 'Patients with diabetes' has replaced the term 'diabetic' in the context of referring to an individual. However, the use of 'diabetic' in the context of specific medical terminology such as diabetic retinopathy or diabetic coma has been retained as these are correct medical terms.

We have also further updated this section with several additional minor terminology and language amendments as recommended in the submissions received. A definition of 'severe hypoglycaemia' has

been added as recommended . The introduction to Type 2 diabetes partly or solely controlled by insulin has also been updated based on expert feedback.

REQUEST TO UPDATE LIST OF NON-INSULIN GLUCOSE LOWERING TREAMENTS

Submissions recommended a small update to the list of non-insulin glucose lowering treatment drugs and medications.

Response:

We have updated this list based on the expert advice in the submissions.

REQUEST TO PROVIDE A BETTER LINK BETWEEN DIABETES AND COGNITIVE DECLINE

One submission recommended to add cognitive decline as another example in the list of other health conditions that can be linked to diabetes.

Response:

A link between diabetes and cognitive decline is useful to outline in the guide. We have included 'higher instance of cognitive decline' as an additional example in the list of other health conditions on page 62.

REQUEST TO INCLUDE GUIDANCE ON MANAGING HYPOGLYCAEMIA

Submissions pointed out that while managing hypoglycaemia was addressed in the guide, management of hyperglycaemia wasn't.

Response:

While we understand that hyperglycaemia doesn't pose as much of a risk to safety when driving as hypoglycaemia, we agree that it would be useful for health practitioners to have some guidance on this condition. A brief paragraph on managing hyperglycaemia has been added.

REQUEST TO INCLUDE REFERENCE TO HEALTH PATHWAYS

For managing hypoglycaemia, a submission recommended that adding a reference to Health Pathways for possible use of Continuous Glucose Monitoring systems somewhere in the guide would be useful to health practitioners.

Response:

We have added guidance to refer to Health Pathways around the use of Continuous Glucose Monitoring to the 'Managing hypoglycaemia' section.

Musculoskeletal conditions

No submissions were received regarding the proposed changes to this section.

Visual standards

USE OF TITMAS MACHINES FOR EYESIGHT SCREENING AT DRIVER LICENSING AGENTS

We received a submission expressing concerns with the current eyesight testing regime for driver licensing and the Titmas machines used at the agents to screen a person's vision.

Response:

The recommendations from this submission are out of scope of the work to update the guide. Therefore this feedback has been noted and forwarded to the appropriate parties within NZTA for their consideration should the legislated eyesight standards be reviewed in future.

CONCERNS OF IMPACT OF PROPOSED CHANGES ON COMMERCIAL DRIVERS WITH MONOCULAR VISION

Submissions highlighted that it was unclear what the impact of the proposed changes would be for existing commercial drivers who have monocular vision, and whether this would result in them now losing their licence.

Response:

We acknowledge that the proposed guidance for commercial drivers with monocular vision was confusing We have now amended the wording to indicate that while the legislated standard is that a commercial diver is generally considered unfit to drive, NZTA will continue to consider granting licences to existing commercial licence holders provided there're sound reasons to do so.

Hearing

GENERAL LANGUAGE AND WORDING UPDATES REQUESTED

Feedback indicated that the proposed wording of 'deaf or profound hearing loss' was inaccurate terminology to describe patients with hearing conditions. A submission also pointed out that 'hearing weakness' as a term could be viewed as discriminatory language.

Response:

We have reverted to the original wording in the previous version of the guide of 'hearing loss or impairment'. We have also replaced 'hearing weakness' with 'hearing difficulties.'

REQUEST TO CHANGE UNIT OF MEASURE FOR FORMAL HEARING TESTS TO dBHL

One submission advised that for formal audiometric hearing tests, the scale dBHL (decibel hearing level) is used and that therefore this is not the same as dBA currently used in the guide. The recommendation from this submission is that we update references to dBA with dBHL.

Response:

We have replaced the references to 40dBA hearing with 40dBHL in respect to hearing tests based on expert recommendations in this submission.

Mental health

REQUEST TO INCLUDE EATING DISORDERS IN MENTAL HEALTH SECTION

Submissions were received requesting that NZTA include fitness to drive guidance for severe eating disorders in the guide, specifically under the mental health section. One submission was seeking a BMI or weight 'cut off' for not being fit to drive.

Response: We don't consider it's appropriate to include guidance on eating disorders. An eating disorder, in itself, doesn't prevent a person from being able to drive. Instead, it is the various side-effects or symptoms (such as cardiovascular conditions, dizziness, hypoglycaemia) that can develop from an

eating disorder that can affect a person's fitness to drive. These symptoms are addressed elsewhere in the guide, and it is these symptoms that should be assessed when considering fitness to drive, not the person's weight or BMI. We also note that the Austroads guide which we're seeking to align with doesn't address eating disorders.

Sleep conditions

REQUEST TO ALIGN CONTENT AND STANDARDS FOR EXCESSIVE DAYTIME SLEEPINESS AND OBSTRUCTIVE SLEEP APNOEA WITH AUSTROADS GUIDANCE

One submission outlined that despite previous recommendations being made to NZTA, the guidance around excessive daytime sleepiness and OSA had not been brought into line with the guidance in Austroads, including standardising the definition of CPAP, or update it with a focus on more clinical assessment. This submission urged revision of these parts of the sleep condition section to align with the standards in Austroads, emphasising that failure to do so could result in drivers being inappropriately and erroneously stood down from driving.

Response:

We apologise that the previous recommendations that were made prior to consultation were missed when originally updating the sleep condition section of the guide. We recognise the importance of having accurate guidance on sleep conditions to ensure fitness to drive is being assessed consistently. We have reviewed the guidance in Austroads and believe this information is relevant and appropriate to incorporate into our own guide. The excessive daytime sleepiness and OSA parts of the sleep conditions section have been revised to bring our content into alignment with Austroads and the expert recommendations made in the submission.

Increasing age

REQUEST TO STANDARDISE COGNITIVE TESTING FOR OLDER DRIVERS

We received several submissions outlining concerns with current cognitive screening tests such as the SIMARD test used by health practitioners in assessing older drivers' fitness to drive. These submissions also requested NZTA to stipulate which specific tests should be used or to introduce a standard cognitive test for older drivers to provide more firm and fair guidance on this matter.

Response:

We acknowledge the concerns and requests made in these submissions. However, it should be noted that it isn't within NZTA's remit to determine or recommend what specific tests are appropriate for use in cognitive screening. Unless the Ministry of Health mandates the use of a specific test or tests for older drivers, health practitioners have the discretion to use the test or tests that they think are appropriate to determine the patient's fitness to drive, if the test is fit for purpose. We have updated the wording in this section to signal that in some cases a single test may not be appropriate, and to encourage health practitioners to use of a range of testing methods as they see fit.

NZTA HAS MADE CHANGES TO CONTENT ON MEDICAL ASSESSMENT OF THE OLDER DRIVER

Many submissions referenced the existence of inequities and other perceived disadvantaging of older drivers within the New Zealand licensing system and during assessment of their medical fitness to drive.

Response:

Based on submissions, we feel it would be more appropriate and seen as less discriminatory to older drivers if we did not continue with the proposal to separate fitness to drive conditions into private and commercial classes and endorsements, but make these the same for all drivers. We have therefore

removed the private class and commercial classes boxes and collated the content under a new subheading: ‘Guidance for all licence classes and endorsements.’

After additional internal review, we also made changes to the order of the list of factors that health practitioners should consider when conducting a medical assessment of fitness to drive for an older driver. We have reordered the list to reflect the format that medical conditions are presented on the DL9 medical certificate, to ensure that the same broad criteria are considered by health practitioners when assessing an older driver as for drivers of any other age.

We have also included a link to the ORST and OTDA information contained in the General matters section of the guide to assist health practitioner in determining if one, and if so which one, of these tests is appropriate to refer the patient to complete.

Miscellaneous conditions

GENERAL FEEDBACK

Two submissions with limited information were received in relation to Miscellaneous conditions. One was in relation to increasing age and cognitive testing, and the other in relation to respiratory conditions querying the selective removal of references to dyspnoea and requesting guidance on patients using intermittent oxygen therapy.

Response:

We consider the existing content under respiratory conditions appropriate. The four references to dyspnoea appear in the guide because the absence of dyspnoea is a prerequisite for fitness to drive for specific cardiovascular conditions, and as such we don’t consider it’s appropriate to remove these references from that section. For patients on oxygen therapy, the guidance is that those on continuous oxygen therapy are unfit to drive. The implication is that any other form of oxygen therapy, provided it is not continuous, wouldn't generally make a patient unfit to drive. We don’t believe adding specific guidance regarding intermittent oxygen therapy would add value in this instance.

Effects of medication, drugs, and abuse of substances

REQUEST TO ADVISE HEALTH PRACTITIONERS AND PATIENTS OF VEHICLE INSURANCE IMPLICATIONS OF DRIVING UNDER THE INFLUENCE.

One submission requested that health practitioners and substance abuse support groups raise insurance coverage implications of driving under the influence of alcohol or illicit drugs with patients and their families. It was also suggested that more awareness about the risks of certain prescription medications being mixed with alcohol or illicit drugs should be included in the guide and communicated by health practitioners to patients.

Response:

This request falls outside of the scope of what is appropriate for a health practitioner to discuss with their patient, and therefore outside of the scope of what the review of the guide has intended to achieve. In terms of increasing awareness around the risks of drug driving and mixing medications with other substances, there already is relevant information in this section of the guide.

REQUEST FOR FURTHER GUIDANCE REGARDING DRUG DRIVING LAW CHANGES AND THE USE OF MEDICINAL CANNABIS

Some submissions requested NZTA to include additional guidance for health practitioners of the estimated doses and timeframes after administration that would be expected to be above or below the blood

concentration thresholds outlined in the 2023 Drug Driving Amendment Bill. Requests were also made to consider including guidance on the use of medicinal cannabis by patients.

Response:

We don't have this information and are not the appropriate agency to conduct the relevant research or investigation into this matter. We recommend that these submitters contact the Ministry of Health for further information and assistance.

Driving after surgery

No submissions were received regarding the proposed changes to this section.

Helmet and safety belt exemptions

SEAT BELT EXECEPTION LETTER TEMPLATE

The single submission received for this section of the guide advised that the example certificate template that health practitioners can use to confirm a child restraint or seatbelt exception could place an unnecessary administrative burden on the health practitioner as they typically issue a medical certificate that excepts the patient from wearing a seatbelt rather than a letter.

Response:

We aren't removing this template from the guide. The template contains all details that must be included on an exception certificate under legislation, particularly the issue and expiry dates. However, we understand that health practitioners can also meet the legislative requirements by issuing a medical certificate and therefore the guide advises that the use of the example certificate template is a recommended option.

Temporary driving impairments

No submissions were received regarding the proposed changes to this section..

Suggestions for what support could be provided to increase knowledge and use of the guide

Physical copy of the guide

One submission suggested that NZTA produce a paper or hardcopy version of the guide, as well as an online version with easy directions to look up as they noted it can be difficult during a consult to remember everything or locate information in a timely manner.

Response:

NZTA will not be producing a hardcopy version of the MAFTD guide. Having an online, digital version of the guide makes the document easier to maintain and update should further amendments be required in future. The digital version of the guide is to be provided to health practitioners in PDF format and they have discretion to print this off themselves if they want to have a hardcopy of the guide available to them. However, if choosing to print the PDF they must ensure that they are referring to the most up-to-date version of the document.

Have an online refresher course on how to use the guide

A suggestion was received that it would be helpful for NZTA to have an online refresher course available to health practitioners that provided an overview of how to use the guide when assessing a patient's fitness to drive.

Response:

NZTA will conduct a webinar to this effect following publication of the updated guide.