

all legally enforceable decisions and does not expect treating doctors to decide on fitness-to-drive. A treating doctor may provide factual information, but is not expected to give an opinion on licensing questions. This model, used in the United Kingdom,⁵ is simple, well understood and respected. The DLA there obtains independent medical advice in deciding borderline cases, an optional mechanism given little attention in the Australian review. Doctors in the UK are well aware of their common law duty to report patients if their actions are endangering.

We are drifting away from this simpler and ethically and medicolegally more satisfactory model at our peril. We should re-engage our DLA colleagues to establish a more effective relationship, in which they ensure their licence holders are well informed of their obligations, while we provide the expert care and management of our patients which will best encourage a safer driving environment.

1. Black AB, Lai N. Epilepsy and driving in South Australia: an assessment of compulsory notification. *Med Law* 1997; 17: 253-267.
2. Fisher RS, et al. Epilepsy and driving. An international perspective. *Epilepsia* 1994; 25: 675-684.
3. McEvoy RD. Asleep at the wheel: who's at risk? *Med J Aust* 2003; 178: 365-366.
4. Assessing Fitness to Drive for Commercial and Private Vehicle Drivers. Australian Transport Council 2003. (Final Draft dated 3 September 2002.)
5. Taylor JF, editor. Medical aspects of fitness to drive. 5th ed. London: Medical Commission on Accident Prevention, 1995. □

Recommended therapeutic digoxin blood levels: a cause for concern

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TO THE EDITOR: The recent review of digoxin by Campbell and MacDonald¹ pointed out that a serum digoxin level of over 1.0 ng/mL is associated with excess mortality. Indeed, higher blood levels (≥ 1.2 ng/mL) are associated with higher crude rates for all-cause hospitalisation, and for increased hospitalisation for worsening heart failure or suspected digoxin toxicity.²

The post hoc analysis of the DIG trial² suggests that the optimal range is 0.5–0.8 ng/mL.

I recently surveyed 31 private pathology laboratories across Australia to determine their recommendations about the therapeutic range of serum levels of digoxin. In summary, their recommendations ranged from a lower limit between 0.5 ng/mL and 1.0 ng/mL, and an upper limit between 1.6 ng/mL and 2.1 ng/mL. Twenty-six of the 31 suggested that values below 0.8 ng/mL were subtherapeutic. It is likely that many doctors will heed such advice and inappropriately increase the dose of digoxin in patients being treated for heart failure.

It is possible that adverse effects will flow from current laboratory industry recommendations, and these should be revised.

1. Campbell TJ, MacDonald PS. Digoxin in heart failure and cardiac arrhythmias. *Med J Aust* 2003; 179: 98-102.
2. Rathore SS, Curtis JP, Wang Y, et al. Association of serum digoxin concentration and outcomes in patients with heart failure. *JAMA* 2003; 289: 871-878. □

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