New Zealand Society of Anaesthetists
(Incorporated)

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Sharon Woollaston
Sector & Services Policy
Policy Business Unit
Ministry of Health
PO Box 5013
WELLINGTON 6145

By email: sharon_woollston@moh.govt.nz

Proposed Amendments to Midwives’ and Nurse Practitioners’ prescribing of Controlled Drugs, April 2014

The New Zealand Society of Anaesthetists (NZSA) welcomes the opportunity to provide feedback to the Ministry of Health on Amendments to the Misuse of Drugs Regulations 1977.

The New Zealand Society of Anaesthetists Inc., (NZSA) is a professional medical education society established in 1948. It represents 430 medical anaesthetists in New Zealand and works to foster education and research into anaesthesia and support the professional interests of its members. Members include specialist anaesthetists in public and private practice, and trainee anaesthetists. NZSA is a member society of the World Federation of Societies of Anaesthesiologists (WFSA) and is represented at Executive level of the WFSA.

The NZSA respects the professionalism and patient care that both midwives and nurses bring to their patients and we are supportive of midwifery and nursing developing their roles further.

We are happy to provide advice on proposals such as the above amendments. The NZSA is available for further formal or informal discussions on these amendments and we would welcome the opportunity to discuss our submission further.

Nurse Practitioners prescribing of controlled drugs

The NZSA does not support an easing of the current restrictions on Nurse Practitioners’ (NPs) prescribing of controlled drugs. We support the current restrictions remaining in place.

We believe supervision is required with regard to prescribing narcotic drugs and we would not support independent NP prescribing of up to one month’s supply of these drugs.

Controlled drugs are categorised as such in part because they have a high propensity for misuse and development of addiction. The misuse of controlled prescription drugs is a serious and escalating problem in New Zealand. We believe that widening the number of people who can prescribe these drugs will inevitably lead to a higher circulation of them, with the likely consequence being increased numbers of patients addicted to or dependent on prescription drugs.

We acknowledge that there are rural and remote areas of New Zealand experiencing a GP shortage, leaving NPs as the main local health practitioner. We believe Nurse Practitioners could in these instances endorse repeat prescriptions for narcotics, provided all the other rules around prescribing are followed. The prescriber needs access to the patient history to lessen the potential for abuse of these drugs and the ensuing social consequences.
NZSA recommendations

Proposal to remove the current restrictions on NP prescribing of controlled drugs

We support:

1. The current restrictions on nurse practitioner prescribing of controlled drugs in the Misuse of Drugs Act being retained as they currently stand at three day's supply.

We do not support

1. Nurses prescribing without having had NP training.

2. Short-courses for nurses to allow them to prescribe a wider range of medications - we prefer the NP model because of the length and complexities involved in the training.

3. Nurse Practitioners being allowed to prescribe neuromuscular blocking drugs. These drugs are specific to anaesthesia, intensive care, and emergency departments.

4. Nurse Practitioners being allowed to prescribe drugs which obtund consciousness (drugs for the induction or maintenance of general anaesthesia).

Allowing midwives to prescribe morphine and fentanyl

NZSA believes the scope of midwives' prescribing could be widened to include morphine and fentanyl, but only with further training and in the case of fentanyl, we recommend that midwives use this only in public hospital situations. Our submission outlines the effects, uses and risks of these drugs in support of our recommendations below.

Pethidine

This drug has been in use for at least 50 years and midwives are very experienced and skilled in using pethidine in labour. Anaesthetists frequently use pethidine via an epidural catheter to manage pain following caesarean section. When used with care and respect by experienced practitioners, pethidine has a good safety record.

We recommend that pethidine continue to be used by midwives as a drug for pain relief in labouring women, and that the intravenous route is the preferred route of administration for pethidine. The risks involved in using pethidine and morphine are similar, so our view is that these two drugs might be considered interchangeable for use by midwives.

Morphine

All opioid analgesic drugs work in similar fashion, the major differences between them being time-course and metabolism. Morphine has slower onset than pethidine, and longer duration of action. Its metabolites are active though not toxic, whereas those of pethidine might be toxic.

We believe that midwives will still need more training in order to administer morphine safely and effectively.
Fentanyl

With any opioid analgesic drug, along with analgesia comes respiratory depression and sedation.

Fentanyl is a rapidly-acting, potent, and relatively short-acting opioid analgesic. Its effects are also somewhat unpredictable. These factors make fentanyl both very effective, dangerous, and more difficult to use than morphine or pethidine.

We are aware that experienced anaesthetists may inadvertently overdose a patient with fentanyl, and cause profound respiratory depression (i.e. stop their patient breathing). Fentanyl is best given intravenously (due to its rapid metabolism, if given via the intramuscular route, it is far less effective or predictable). Its rapid onset of action and potency - for both pain relief and respiratory depression, make it a drug to be used with caution and respect.

We would prefer midwives to administer morphine rather than fentanyl.

Fentanyl is widely used in hospital surgical wards for post-operative pain control. In these situations it is almost always used via a Patient Controlled Analgesia (PCA) device – where the patient self-administers small doses of drug, with a set “lock-out” interval following each dose. PCA devices tend not to be used in delivery units, and opioid analgesics are usually given by bolus dosing – intramuscular or intravenous.

Fentanyl brings higher risks during childbirth. Pregnant women have less physiological reserve to cope with respiratory depression and apnoea, and these are more likely with fentanyl given intravenously than with either morphine or pethidine. Fentanyl may also interact with Entonox gas to cause respiratory depression at the end of a contraction.

Toxicity due to fentanyl is easily corrected by administering naloxone intravenously but there may be a delay in using it by which time maternal apnoea and hypoxia may have become very dangerous.

We would suggest that naloxone injection be immediately available wherever intravenous fentanyl is used in labouring women.

We would encourage midwives using fentanyl to develop further skills in airway management in adults to complement their airway skills in neonates. One route might be to Level 6 or 7 NZRC ACLS training.

Fentanyl is most effective when used intravenously. We believe it must be used with care and respect, in locations staffed and equipped appropriately. We do not support this drug being used intravenously in primary care situations. We recommend midwives only use this drug after being given training on how to use it in a secondary or tertiary care environment.

Another risk with fentanyl is that because of its short duration of action compared to morphine or pethidine, there is a risk of multiple small doses accumulating in the baby who cannot metabolise it as quickly as the mother. This carries the risk of causing respiratory depression in the new-born, which will need to be recognised and managed by midwifery staff. There are many causes of respiratory depression in neonates, and apnoea of the new-born will need to be distinguished from fentanyl- induced apnoea at birth if prolonged neonatal resuscitation is to be avoided.

Because of its potency, rapid onset, and short duration of action, fentanyl is also highly addictive so we discourage the wider use of this drug for the general population.

In summary: The major risk with anyone using fentanyl is the occurrence and unpredictably of respiratory depression, apnoea, and loss of consciousness.
To mitigate the risks with the use of intravenous fentanyl for labouring mothers, we recommend that fentanyl only be used in a public hospital environment by well trained and supported midwives, specifically trained in the use of this drug. We believe that oxygen saturation should be monitored continuously while this drug is being administered, and for one hour post-administration, and oxygen be available. We believe intravenous naloxone should be immediately available, and a "crash" trolley with airway equipment, and a cardiac arrest, ICU or ED team with trained staff skilled in airway management should be immediately available should issues arise from its use.

NZSA recommendations

Proposal to allow midwives to prescribe morphine and fentanyl, in addition to pethidine

1. We recommend that pethidine continue to be used as a drug of choice for midwives, and that midwives are given the authority to prescribe morphine independently and while a patient is on transfer.

2. We recommend that midwives be given authority to administer fentanyl, but only after being given training on how to use it in an appropriately equipped secondary or tertiary care environment. We do not support this drug being used intravenously in primary care situations.

3. There will be a steep learning curve for midwives using intravenous fentanyl. We suggest that extreme care is taken in the implementation of fentanyl protocols, and that the introduction of fentanyl to different units includes input from anaesthesia, obstetrics, and neonatal paediatrics.

4. Due to the risks of the drug and extensive training required, midwives should not be allowed to administer fentanyl in primary care, home births or on transfer.

Thank you for the opportunity to provide input into these proposed legislation amendments.

Yours faithfully,

[Signature]

Dr Ted Hughes
President