Analyses compared exclusively heterosexual women with all other women. Data were weighted to correct for over-sampling in non-metropolitan areas. Odds ratios were adjusted for age, region of residence, and father's occupation (as a measure of social class).

Younger women were significantly more likely to report risky drinking and illicit drug use. Women from urban areas were significantly more likely to be non-heterosexual and to use illicit drugs, but less likely to report risky levels of alcohol consumption. Women whose fathers were professionals or managers were significantly more likely to be non-heterosexual and more likely to use illicit drugs, but less likely to smoke or report risky drinking. Details are available from the authors.

Non-heterosexual women were significantly more likely than heterosexual women to have ever smoked, to be current smokers, to report risky levels of alcohol consumption, to have used marijuana and other illicit drugs in the last year, and to have ever injected drugs (Box). Although these relative differences are important, so too are the absolute values — 45.6% of non-heterosexual women were smokers, and 45.6% reported alcohol consumption of concern. In the last year, 58.2% used marijuana and 40.7% used other illicit drugs. One in 10 had ever injected illicit drugs.

Although women are generally less likely than men to use drugs, and may not be a high-priority target for drug education, non-heterosexual young women's rates of illicit drug use are at least as high as those of young men.[4] Higher levels of drug use among young non-heterosexual women may be the result of individual experiences of homophobic discrimination, where drugs are used as an — albeit, short lived — panacea.[1] Greater drug use may also be the result of normalisation of recreational drug use within lesbian communities.[5] There is a need for specific interventions in young non-heterosexual women, and for further research to determine the reasons for their high levels of recreational drug use.

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Frequencies and adjusted odds ratios for drug use among 9260 heterosexual and non-heterosexual Australian women aged 22–27 years, 2000

Drug use	Exclusively heterosexual	Bisexual and lesbian	Adjusted odds ratio* (95% CI)
Smoking status	(*n* = 8284)	(*n* = 755)	
Never smoked	60.8%	37.0%	1.00
Former smoker	14.2%	17.4%	2.15 (1.65–2.79)
Current smoker	25.0%	45.6%	3.18 (2.61 - 3.89)
Alcohol consumption†	(*n* = 8419)	(*n* = 796)	
No risk	36.7%	23.9%	1.00
Low risk (no bingeing)	31.5%	30.6%	1.33 (1.05–1.69)
Low risk (with bingeing)	27.9%	38.6%	2.01 (1.60–2.52)
Risky	3.9%	7.0%	2.50 (1.68–3.72)
Illicit drugs	(*n* = 8409)	(*n* = 797)	
Marijuana (in the last year)	21.5%	58.2%	4.68 (3.91–5.61)
Other illicit drugs‡ (in the last year)	10.2%	40.7%	5.50 (4.51–6.71)
Injected drugs (ever)	1.2%	10.8%	12.26 (8.53–17.63)

* Adjusted for age, region of residence, and father's occupation.
† According to National Health and Medical Research Council guidelines.[3]
‡ Amphetamines, LSD (D-lysergic acid diethylamide), ecstasy/designer drugs, tranquillisers, natural hallucinogens, cocaine, inhalants, heroin, barbiturates.

New driving guidelines: ethical and legal uncertainties

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TO THE EDITOR: Seizure disorders are often the most scrutinised medical conditions in relation to road accidents.[1] Epileptologists internationally have reached some consensus on the role best played by treating doctors:

- ensuring patients receive proper medical care;
- advising on assessed risk and its minimisation; and
- reporting (if necessary, without patient consent) when a patient becomes a risk yet continues to drive.[2]

In a recent editorial on sleep disorders and driving,[3] McEvoy also emphasises the essential role of first establishing the therapeutic relationship, and refers to the impending release by the National Road Transport Commission of new medical standards for all vehicle types.[4]

Australian neurologists and the Epilepsy Society of Australia find that the new guidelines are imprecise in defining the role played by doctors and Driver Licensing Authorities (DLAs), and are excessively detailed with cumbersome processes that are open to confusion. The instructions for using four separate forms (3.3) are complex and imprecise, giving no indication about discretion in their use or non-use. Moreover, it is not the role of doctors to define specific restrictions for holders of conditional licences (3.3.1), but that of the DLA. Demands on doctors for surveillance and enforcement are excessive, and by interfering with the maintenance of proper rapport may prove counter-productive. The roles for consultants are not clearly defined.

A more desirable model is one in which the DLA takes responsibility for

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.

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Recommended therapeutic digoxin blood levels: a cause for concern

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TO THE EDITOR: The recent review of digoxin by Campbell and MacDonald[1] pointed out that a serum digoxin level of over 1.0 ng/mL is associated with excess mortality. Indeed, higher blood levels ($\geq$ 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 trial[2] 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.

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