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Fitness to drive

Dear Editor

Two recent papers discussed the difficult problem of assessing patients with early Alzheimer disease regarding safety for driving and refer to the value of an occupational therapist in assessing a patient's fitness to drive (*AFP* April 2012).^{1,2} Carmody et al¹ quote the Australian New Zealand Society of Geriatric Medicine position statement which regards such assessments as the 'gold standard' for assessing risk. However, the basis for this statement is questionable on reading the supporting references.^{3,4} Both papers report studies of patients with early Alzheimer disease compared to controls who were assessed clinically and on-road when it was found patients had less safe driving patterns and errors were better detected by an on-road assessor. But neither study showed it was possible to clearly discriminate those who would be a risk on the road in terms of crashes from those who would not; a controlled trial would be necessary to show this.

A randomised controlled trial to assess this may be ethically problematic. But providentially a controlled study is possible between states such as New South Wales that require medical examinations plus an on-road driving assessment at age 80 years and over, and states such as Victoria that do not. Langford et al⁵ have compared several aspects of fatal crashes involving senior drivers in these states and found no significant differences. This does not support the usefulness of on-road assessments.

The recent addition of *Assessing Fitness to Drive* is cautious regarding the use of driving assessments for unstable conditions such as Alzheimer disease.⁶ Patients' conditions wax and wane and emergency situations such as a child running out onto the road cannot be assessed. As in ordering any test to assist

clinical judgement, the limitations of the test, including driving assessments, should be recognised.

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Dr Hocking was the principal medical consultant to the National Transport Commission in developing the 2012 edition of *Assessing Fitness to Drive*.

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Reply

Dear Editor

We thank Dr Hocking for his comments on our paper.¹ We agree that reliance upon on-road assessments alone is inappropriate when determining driving safety.

Although the Australian New Zealand Society of Geriatric Medicine position paper² states that 'performance on a standardised occupational therapist assessed on road driving test is accepted as a gold standard assessment', the claim is later qualified: 'However, there are potential problems with safety, the liability of assessors, and the reluctance of older people with dementia to participate because of fears

of licence cancellation. Moreover, while a given driving assessment can be standardised and validated, this is difficult to do across different locations'.

It is hoped that our paper highlighted the complex nature of assessing drivers with dementia. To this end we (i), quoted an American Academy of Neurology practice parameter:³ 'unfortunately, there is neither a test nor a historical feature that accurately quantifies driving risk, clinicians can only make qualitative estimates of driving risk' and (ii), described a 14-point management strategy for GPs. We proposed that GPs could 'consider an occupational therapist driver assessment referral (limited by availability and cost) which can be repeated'.

The New South Wales driver licensing authority requires all drivers to undergo an annual medical review from the age of 75 years.⁴ From the age of 85, drivers must undergo an on-road assessment every 2 years. However, drivers may waive this on-road assessment by accepting a modified licence.

Thus far, much of the transport safety literature concentrates on how best we can identify unsafe older drivers. Perhaps the time has come for researchers and policy makers to focus their efforts on how we, as a society, can provide user friendly alternative transport options for our senior citizens.⁵ Our research group is currently developing a client centred booklet which could enable people with dementia to consider early retirement from driving.

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COPD and pulmonary rehabilitation

Dear Editor

Chronic obstructive pulmonary disease (COPD) is increasingly common, putting it in the top four leading causes of mortality in Australia and the third leading burden of disease, affecting 12.4% of patients aged 45–70 years.¹ The burden of COPD on global health is steadily increasing with the ageing population and it is important to utilise all available assets in its management.

COPD can significantly decrease a patient's quality of life. Its management is mostly symptomatic, thus quality of life is considered an important outcome.² Pulmonary rehabilitation, as an adjunct to current COPD management, is an underutilised intervention that targets morbidity, as opposed to mortality. Programs vary in design, but the fundamental elements of exercise, education and psychological support still remain. It is a multidisciplinary treatment that focuses on patient centred care and is flexible in its application, having potential applications in home or hospital environments.

Pulmonary rehabilitation is proven to have marked benefits on quality of life for COPD patients. A Cochrane review stated that programs 'lead to large and clinically relevant improvements in health related quality of life and exercise capacity'.³ The programs also work to decrease hospital admissions, thus reducing the associated health service costs.³ Anything that works to reduce the burden on the healthcare budget while also reducing the personal and emotional burden on a patient must be a viable asset for future management regimens.

However, pulmonary rehabilitation is often unavailable, which is the main obstacle to the widespread utilisation of this effective intervention.² Reducing this barrier is pivotal to its extensive application in Australian healthcare. The Australian Lung Foundation estimates that as little as 1% of COPD patients that could benefit actually have access to pulmonary rehabilitation.⁴ In 2009, a large multidisciplinary, nationwide committee worked together for the Australian Lung Foundation to design a supportive guide, or toolkit, to assist with the implementation of pulmonary rehabilitation in various rural or urban areas of Australia.⁵ Thus, if availability of programs or resources is a problem, particularly in rural areas of Australia, this toolkit is a valuable starting point.

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Meeting RACGP QI&CPD requirements for CPR

Dear Editor

I sympathise with the frustrations of Dr Chee Koh (Letter to the Editor, *AFP* May 2012) regarding The Royal Australian College of General Practitioners censor's inability to accept his ALS, PALS, and ATLS/EMST certificates toward the RACGP basic life support mandatory requirement.

I would point out that the advanced certificates do not just 'require a prerequisite knowledge of BLS', but that basic life support is an integral component of most of the courses, with programmed time and teaching devoted to it.

Perhaps the censor's office should refresh its knowledge of up-to-date advanced life support programs?

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