Collaboration with Orthopaedic Surgeons

Sir—P. D. Gibson disagrees with the statement ‘there is good evidence that collaboration between orthopaedic surgeon and physician in geriatric medicine is of benefit’ [1].

We have examined the effects of regular input by a geriatrician to one acute orthopaedic ward while using the adjacent orthopaedic ward as a control, looking at main outcome measures of length of stay, cost and discharge destination. Patients from both acute wards were transferred to an Orthogeriatric Rehabilitation Ward. In the year prior to the study, patients in both wards had a mean total stay (acute and rehabilitation) of 28 days. On the intervention ward, the mean total stay was reduced to 20.7 days and on the control ward to 27 days. The benefit was seen on both the acute wards (12 vs. 16 days) and the rehabilitation ward (13 vs. 19 days), p = 0.05.

Total cost on the intervention ward was $NZ9400.00 per case, compared with $NZ11 500.00 per case on the non-intervention ward (p = 0.05). In contrast, the percentage of patients discharged to a higher level of residential care (home to rest home or rest home to hospital) was 11% from the intervention ward, compared with 23% from the non-intervention ward (p = 0.05).

We conclude that a geriatrician input on a twice weekly basis to all patients over 65 years of age on an acute orthopaedic ward, saves bed days, reduces costs and produces an improved outcome.

The added benefit to patients’ medical care from a specialist physician input early in their hospital stay has impact by pre-empting medical complications and by co-ordinating rehabilitation and discharge planning from the day of admission. Management of these elderly patients with fractured neck of femur, with often multiple medical problems, is better suited to the skills of the geriatrician than the orthopaedic surgeon or junior house surgeon [2].

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