Over the last 25 years we have seen a substantial rise in the number of publications in the area of falls in older people (Figure 1). It is 10 years since the publication of Tinetti’s seminal paper showing that it is possible to prevent falls in an at-risk population [1]. The recent release of UK NICE guidelines ‘Falls: the assessment and prevention of falls in older people’ summarise the available evidence up until the end of 2003 and give simple guidance on intervention was diluted. As with PROFET [6], Davison et al. report trends towards reduction in subsequent bed day utilisation and serious injury in the intervention group.

In the trial, all consenting participants in the intervention group underwent detailed cardiovascular assessment including carotid sinus massage irrespective of the nature of the falls. For many service providers in the UK and across the world, this is potentially resource intense in terms of finance and manpower, notwithstanding the risk to the individual patient of a 1:1000 chance of a neurological event [7].

Whilst successful in a cognitively intact Emergency Department population, this multifaceted approach, when applied with the same rigour, has not been shown to have the same impact on cognitively impaired individuals [8], leaving us with a gap in our current knowledge base as to how we prevent falls in cognitively impaired older people.

There is little doubt that prevention of falls is a complex area given the methods by which we identify and define risk, the heterogeneity of the population at risk and the modes of intervention on offer. Are all falls of equal impact and are all interventions of equal value within and between different at-risk populations? Should the aim of intervention strategies be to prevent all falls or prevent ones which impact on

Prevention of falls—a time to translate evidence into practice

the function of the older individual? Can we extrapolate data from one population and apply it to another—will the effect of the intervention be the same? We know from the Dunedin work that strength and balance training is of benefit to women aged 80 years identified by general practitioner registers [9] but not to a younger cohort of at-risk people on centrally acting medications [10]. Davison et al. highlight the need to prioritise interventions based on individualised assessment and suggest the development of evidence-based stratified care pathways for the management of fallers to ensure efficient use of resources.

In a health service with limited resources, most would agree that investment should be in services for which we have sound evidence of effectiveness and which stand up to the external rigours of the peer review process. Using binomial regression, a favoured method of analysis for recurrent events [11], the authors report a 36% reduction in falls which is comparable to other RCTs looking at high-risk populations [1, 6, 9, 12]. However, the reported benefit is dwarfed when compared to the 60% reduction in falls reported by the National Falls Collaborative in its 'Sloppy Slipper Campaign' [13] whereby older people 'exchange their old, potentially dangerous slippers for a newer safer pair'. In a similar vein, this collaborative reports 60% reductions in falls for single interventions such as battery-operated lights and light exercise [14]. A friend and colleague recently reminded me of Mencken’s law—‘to every complex problem, there is a simple, easy to understand, wrong answer’.

Whilst we may seek to challenge the evidence base of the specific interventions on offer in these non-peer-reviewed articles and request clarification as to the methods of data analysis, we should also acknowledge that there is evidence to support the collaborative methodology in terms of being able to effect change. In a recent BMJ article, Horbar et al. successfully used a collaborative methodological approach in an RCT to promote evidence-based use of surfactant treatment in pre-term babies [15]. The real challenge for the scientific community is to use proven improvement methodologies to ensure that clinical trial data can be successfully translated and applied to the populations who stand to benefit most from the intervention.

Davison et al. allude to the requirement within the National Service Framework to set up specialised Falls Clinics. However, there is often an apparent disconnect between the academic world and those with a responsibility for commissioning and providing services for older people. It would be naïve to believe that commissioners of services regularly read journals which often influence how we, as clinicians, practise, and it is therefore imperative that strong strategic links with commissioners are in place to ensure that resources are channelled effectively in the future. Equally, commissioners of services should be answerable and subject to formalised challenge through channels within health and social care networks as to the justification of their decisions as to what, where and how services are set up and delivered. Investment in non-evidence-based services...
where there is an existing evidence base amounts to a waste of NHS resource and taxpayers' money.

There are undoubtedly remaining gaps in the falls literature which require further scientific scrutiny and experimentation. However, 10 years after the publication of Tinetti's successful paper on the prevention of falls in community-dwelling older people with pre-determined risk factors for falls, I wonder what percentage of an equivalent population now receive this care as standard everyday practice. How long will it be before Davison et al. can say that assessment and access to a specialist falls service for older people presenting to the Emergency Department with a fall is routine clinical practice?

**Jacqueline C. T. Close**
Department of Health Care of the Elderly
King's College Hospital, London
Email: Jacqueline.close@kcl.ac.uk

**References**


