The future of orthogeriatrics

Orthogeriatrics finally came of age last year—21 years after the first randomised controlled trials suggesting its effectiveness [1, 2]. This anniversary offered the chance to celebrate success in at last confirming the benefits of orthogeriatric rehabilitation [3] and in our having finally gained real acceptance by orthopaedic surgeons [4].

This progress combined with the heightened political profile generated by the new National Hip Fracture Database (NHFD) [5], the Royal College of Physicians’ audit of Falls and Bone Health [6], the Department of Health’s ‘commissioning tool-kit’ [7] and the start of work on the National Institute for Health and Clinical Excellence’s hip fracture guideline [8]. In addition, hip fracture’s inclusion in the roll out of ‘Best Practice Tariff’ [9] will (at least in England) financially reward units which include an orthogeriatrician in leading patient care, offering an unprecedented opportunity for hospitals to buy into the support we can offer.

This political and clinical impetus behind hip fracture and orthogeriatrics is to be applauded and reflects numerous geriatricians’ work in collaboration with clinical colleagues, specialist societies, colleges and government agencies.

It is tempting to consider the future by predicting which models of orthogeriatrics will be most widely adopted (perhaps a continued growth of orthogeriatrician-led acute trauma wards?) but local pressures and local enthusiasm will always generate new and innovative models of care. The benefits of orthogeriatrics have long been obscured by the wide variety of models employed in different studies [3], and the label given to any particular approach should not distract us from its key element—the personal relationship between the orthogeriatrician and their individual patient, as together they face the complexities of the modern health service.

Hip fractures tend to affect the oldest, frailest patients, so that inpatient care is often prolonged, and significant inpatient mortality perhaps inevitable [10]. As we make high-quality data on operative delay, length of stay and mortality more readily available [5, 9], we risk tempting health service managers into creating targets around simplistic views of outcome. Orthogeriatricians must try to ensure that outcome models do not neglect the individual patient perspective with which our daily work is concerned [11].

- It is right that hospitals are held to account for nonclinical delays in addressing the pain and indignity of an unrepaired fracture; early surgery is clearly a humane response to a patient’s distress, and a mass of research has shown the importance of avoiding pre-operative delay for this population [12, 13]. However, we still lack a coherent means of judging whether early surgery will be to the advantage of an individual patient. Inadequate pre-operative medical attention carries real risks, but identification of those who ‘can quickly be made fitter’ is difficult and too important to be left to orthopaedic departments driven by a focus on the urgency of surgery.
- Similarly, studies of hip fracture patients were in the vanguard of the development of Intermediate Care services [14], and so helped to reduce the length of stay for many older hospital inpatients. However, it remains difficult to identify which older trauma patients would benefit from additional time in hospital, and which of them could be more completely and happily rehabilitated in their own home or care home.

The NHFD and Best Practice Tariff recognise these issues and seek to monitor delivery of surgery and rehabilitation in a way which allows orthogeriatricians to identify which patients are not suited to a simple emphasis on pre-operative and inpatient length of stay. We need to develop tools for comprehensive orthogeriatric assessment that identify patients who need specific medical or multidisciplinary attention, at the same time as providing an individual perspective to performance and outcome monitoring.

The new political momentum behind orthogeriatrics also risks being dominated by issues that are important to others: provision of thromboprophylaxis, prevention of surgical site and hospital acquired infection, osteoporosis assessment and secondary prevention of falls. These areas are all important, but we need to ensure that they are complemented by attention to more subtle aspects of our patients’ priorities and needs.

Any geriatrician preparing a grand round will experience a temptation to pitch the presentation to their audience’s interests; to make it ‘more interesting’ by choosing a case at the interface between our own work and that of others. However, this can be at the expense of trying to demonstrate the subtle psychological, medical and social triumphs that contribute so much to the joy of our daily work, and which so often prove crucial to a patient’s recovery.

We need to address the more intangible elements of the quality of orthogeriatric care—issues that are difficult to measure, and thus easy to neglect, amidst the competing pressures of an efficient but potentially arid modern health service:

- How should we approach the needs of a population in which the majority has some degree of cognitive impairment [15] and has often therefore been excluded from the evidence base underlying the care and procedures they are being offered?
- How do we prevent such people being provided with inadequate or inappropriate food, drink, analgesia, pressure and continence care—simply because it is difficult for them to communicate their needs?
How do we ensure that they are given the opportunity to learn to walk again, even though their engagement with therapy is more challenging, and less immediately rewarding than that of younger or fitter patients on the same unit?

How do we measure the quality of care among people who cannot contribute to the simplistic questionnaire approaches that are often relied on by hospital management?

These are huge challenges, but cognitively impaired patients do respond to high-quality orthogeriatric care [16, 17]. Uncertainties reflect weaknesses of the published literature and of our ability to demonstrate the impact of orthogeriatric assessment and multidisciplinary care. We are improving the care provided to many patients but must pay particular attention if people with cognitive impairment and other psychological problems are not to be left behind.

‘Orthogeriatrics’ broadly translates as ‘straight medicine for the elderly’. Orthogeriatricians may work in a peculiar setting and have to deal with additional clinical complexities, but the philosophy underpinning our practice is no different from that of other geriatricians; we must champion the delivery of individualised care to people whose heterogeneity of medical, psychological and social comorbidity fits them poorly to the rigours of an increasingly protocol- and pathway-driven health service.

The highly specialist nature of orthopaedic surgery has always highlighted a skills gap, and it was this that initially attracted and accommodated geriatricians’ complementary expertise. Increasingly focused medical training and early specialisation across all clinical specialties suggest that geriatricians should anticipate the need to extend similar approaches to new areas, as is already happening in respect of elective surgery [18]. Our involvement with such services is the best way to ensure that our frailest patients continue to have access to them.

Hip fracture has long provided a clinical and research model of the needs of the frailest older hospital inpatients patients. The new national audit profile of hip fracture [5, 6] means that this condition can continue helping us to challenge how services view and respond to the needs of such individuals as they negotiate the complexities of modern health care.

Conflicts of interest

None declared.

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References


