COMMENTARY ON PAPER BY CONROY ET AL.

Clinician’s view

Comprehensive geriatric assessment (CGA) is one of the key health technologies in geriatric medical practice, which has been shown to be beneficial in a number of settings, particularly in inpatient care [1–3]. It is important that we understand the environments and conditions in which CGA is most beneficial. One way in which our understanding will be expanded is through careful observation of service developments which bring CGA to places where it has not previously been delivered.

The authors describe the implementation of a form of CGA in the acute care setting, at the front door of the hospital, in the emergency department (ED), which suggests that this model of delivery of CGA is feasible. They also report a controlled evaluation which shows improvement across the range of adult age groups, in conversion (hospital admission from the ED) and re-admission rates during the period of observation.

Unfortunately, the study design does not allow the authors to distinguish between secular trend(s) affecting all age groups, and a causal relationship between the introduction of CGA and the improvements in operational outcomes that were observed. So the question of whether CGA in the ED brings specific benefits to those who receive it remains open, and further research will be required before the effectiveness and importantly, the cost-effectiveness of CGA in the ED is demonstrated.

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References

Statistician’s view

The authors implemented an intervention (comprehensive geriatric assessment) designed to reduce the conversion rate among older people. Unfortunately, as their Table 1 makes clear the reduction in conversion rate for older people was paralleled by a reduction in the rate among younger people. The evidence for this from Table 1 seems apparent even visually but various statistical models could have been fitted and a formal test for interaction carried out. The authors themselves quote a risk ratio further from unity for the youngest age group (0.76) than for the three older age groups which have very similar risk ratios (0.90, 0.88 and 0.88). To place so much stress in the discussion and the abstract on the 85+ age group is an example of the very common practice which has become known in the evidence synthesis literature as outcome reporting bias [1, 2].

The conclusion I draw from this paper is that on the evidence presented here any commissioner who spends public money on an emergency frailty unit is wasting it.

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References