Surgical practice is besieged by traditional methods, which, although they may have been intuitively sound, have not necessarily withstood critical analysis. Many of the surgical doctrines have failed the test of randomised clinical trials. Some of us will remember working as the junior doctor on a surgical attachment and knowing that patients needed to be nil by mouth from midnight for the following morning’s list, even if they were last on that list. The ramifications of patients being cancelled the next day because they had eaten were often profound and not an experience to be repeated! This surgical practice was “set in stone” and there was no reason to doubt it. It made sense. Brady et al\(^1\) challenged this concept and conducted a systematic review evaluating the effects of different preoperative fasting protocols. They concluded that there was no evidence that this practice was helpful in eliminating the risk of aspiration pneumonitis and that regular sips of clear fluid in fact reduced gastric volumes while improving the patient’s hydration.

Enhanced Recovery After Surgery (ERAS) is an evidence-based strategy involving a paradigm shift in perioperative care. It involves preoperative education, enhanced nutrition, avoidance of fasting, restricted use of opioid analgesia, minimally invasive surgery and rapid postoperative mobilisation. This multimodal, multidisciplinary approach has resulted in reducing hospital stays by up to 50% with a similar reduction in complications and fewer readmissions.\(^2\) Apart from the obvious advantage to the patient, this also results in reduced costs to the funder. Several branches of surgery have been active in adopting this practice, in particular colorectal surgery, but its translation to other branches of surgery has been slow.

There are many reasons for the delay in translating evidence-based medicine into surgical practice, but a major one is likely to be the lack of coordinated knowledge translation to the relevant interested providers. Barriers to this knowledge transfer are often centred on a lack of resource, in particular designated staff to ensure that the translation into practice occurs. Proudfoot et al\(^3\) in “Implementation and effects of Enhanced Recovery After Surgery for hip and knee replacements and fractured neck of femur in New Zealand orthopaedic services” have been successful in engaging 18 out of 20 of our district health boards (DHBs) to implement this perioperative process to improve outcomes and reduce the length of stay in hospital for some orthopaedic procedures. This has been supported by both the Ministry of Health and the National Orthopaedic ERAS Collaborative. They show, that for total hip and knee replacement, the average length of stay in hospital can be reduced by almost one day by implementing ERAS strategies alone. Last year, approximately 11,000 joints were replaced in public hospitals throughout New Zealand. The national ERAS programme would have saved almost 11,000 hospital bed days with the potential to allow a further 2,444 hips and knees to be replaced; a major saving in a health system under significant pressure. We have seen the projected increase in demand for joint replacement in the next 20 years,\(^4\) which is going to put even more stress on health care providers and hospitals, so any efficiency in the provision of this care needs to be carefully assessed and implemented. This initiative between the Ministry of Health and other health care organisations is to be applauded and should be the catalyst for future collaborations to translate evidence-based medicine into surgical and medical practice.

Unfortunately the same was not true of fracture neck of femur where their hospital stay was unchanged. This is likely to be due to several factors, including the unpredictability of acute injuries and the difficulty to...
weight bear these patients early, which is often a prerequisite for early discharge. Our ageing population means that fragility fractures in the elderly will require increasing health resource, and we need to continue to develop strategies to improve the efficiency of this management. Involving multiple provider groups combined with funding agencies (Ministry of Health, ACC) and a collective approach across all DHBs appears to be the best approach for the future. The recent development of a hip fracture registry across New Zealand and Australia is an important initiative to provide patient and treatment data, which can then be used to improve outcomes. Like the successful and world renowned New Zealand Joint Registry, we are likely to see this combined database provide the evidence base required to improve outcomes for hip fractures. As Proudfoot et al have shown, the implementation of change within major organisations, such as DHBs, is reliant on having adequately resourced and designated personnel to monitor, educate and manage improvement programmes. This ultimately means employing nationally based staff to coordinate such activities across all DHBs. We look forward to the future development of such initiatives to improve the care of these vulnerable patients.

**Competing interests:**
Nil.

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