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Editor's view

The main purpose of the 'Editor's view' is to draw attention of the reader to the journal content; hopefully it provides enough of a 'hook' to encourage the inquisitive mind to look at published articles more deeply, and consider the implications for their practice (including clinical geriatrics, research and teaching). There is also a role of placing the content of the journal in the wider context of existing literature, clinical realities, and the 'political' environment. The views expressed are personal, and hopefully readers will understand that and forgive any idiosyncrasies.

The publications in this issue of Age and Ageing include a wide range of highly relevant and topical material. Within a selection of top ten 'highlights' I have tried to identify and rank what lessons I have taken from the content of the journal, noting what is 'going up' and what is 'going down' in medicine of older age.

Going up ….

1) Orthogeriatrics.
   Aw and Sahota's review of the development of the subspeciality of orthogeriatrics shows a particular success story for geriatric medicine. It seems only relatively recently that medical and rehabilitation needs of older people undergoing orthopaedic surgery were ignored. Orthogeriatric services are now well established in most regions of the UK, and there is a thriving program of academic research, seeking to further improve clinical outcomes. Onwards and upwards!
2) Research methods.
   Access to authoritative information on good research methods used to be a major challenge for researchers. Now there is no excuse! Cheek and Rajkumar summarise the key resources freely available on the web to guide the conduct and assessment of medical research.
3) Two eyes are better than one.
   Removing one cataract may in some patients have unintended adverse consequences in terms of increased falls risk. Meuleners *et al.* present an argument that for subjects with bilateral cataract that both eyes should be done - in quick succession [further discussed in Harwood and Foss's editorial (pp. 310–312)] (pp. 341–346). Note to self – wonder if this principle extends to trend seen recently to correct refractive error with a single contact lens for sports?
4) Look after your parents.
   Brain ageing is strongly influenced by parental longevity [Murabito *et al.*, (pp. 358–363)]. Note to self, must make more effort to look after and support my mother – don't want her to die prematurely.
5) Retirement and physical activity.
   It is encouraging to see that physical activity levels generally go up after retirement [Godfrey *et al.*, (pp. 386–393)]. The editor wonders with all the extra golf practice he will get whether this will allow him to get his handicap down.

Going down ….

1) Telemedicine.
   This technology has been widely touted as a solution to the problems of the health service, a key 'plank' of anticipatory care that might reduce demands on the acute care sector and free up scarce resources. However, as shown in an excellent pragmatic interventional study by Hirani *et al.*, the reality is benefits are modest; they found only a minor improvement in mental health and mood with the intervention. Hopefully politicians and health care providers will become more realistic about what can be achieved with such technology (pp. 334–341).
2) Predictive scoring.
   Predictive scoring remains a blunt tool that has not as yet translated well into clinical practice. Identification of statistically significant predictors of bad (or good) outcomes does not automatically lead to improvement in treatment or clinical decision making. The big challenge for researchers is to take this a step further, integrating prediction into clinically meaningful interventions that lead to improved patient outcome. Perhaps from Suman *et al.*'s systematic review of predictors of delirium the main clinical intervention that could be easily implemented and evaluated is avoiding urinary catheterisation? (pp. 326–333)
3) Ageism and age discrimination.
   As Rippon *et al.* point out ageism remains rife in the modern world (pp. 379–386). Clinical research reflects this societal reality, in many domains not including appropriate representation of older people – and particularly those with disabilities, cognitive impairment and / or multi-morbidity. That this is the case in stroke rehabilitation research does not surprise but is important depressing news [Gaynor *et al.* (pp. 429–431)]. We must keep the pressure up on funders, ethics committees and researchers to try and overcome this persisting failure.
4) Visiting the dentist.
   In the experience of the editor dentists are generally caring lovely people. However visiting the dentist still can engender a sense of terror! Muirhead *et al.* explore the effect of the older patient-dentist relationship on uptake of dental care using a related but slightly different paradigm, trust and confidence (pp. 399–405). Note to self – need to arrange that 6 month check-up, although I'm not confident that the experience will be enjoyable.
5) Job strain.
   Job strain in middle age has adverse health consequences well into retirement [von Bonsdorff (pp. 393–399)]. The editor wonders if this information will help in negotiations over his job planning.