Frailty and the geriatrician

Frailty is the special mandate of the geriatrician, or ought to be. The essence of management in frailty is to embrace the complexity of the patients and their needs for care. When we do our jobs well, this is what geriatricians do. We have complex patients (i.e. those with multiple needs, and a multifactorially determined state) on whom we apply a complex intervention (Comprehensive Geriatric Assessment and multidisciplinary care) to achieve a variety of ends. Although these ends roughly can be summarised as lessening pain, improving function and delaying death, they have many manifestations, which arguably also require a complex measurement tool (e.g. Goal Attainment Scaling) or in any case, something more sophisticated than knowing their length of stay in hospital.

There is good reason for geriatricians to focus on the frail. In business parlance, it is our chief ‘value added’. Specialised geriatric medicine with multidisciplinary care can prevent functional decline and reduce nursing home utilisation for frail older patients in their own homes [1, 2] and in the acute hospital setting [3].

There is another good reason for us to care for older people who are frail. There are a lot of them about and they consume a great deal of health care; indeed, for many services, frail elderly people are the majority users of care. It is a pity, therefore, that we do not organise ourselves better to care for them. There is a mismatch between the patients for whom clinical trials are designed and highly expensive interventional facilities are built, and the patients who actually use these drugs and services. We have largely designed a system to care for people who have only one thing wrong at once, but which is chiefly subscribed by people who have many things wrong.

How we react to this mismatch between who the services are designed for and who shows up to use them is telling. It might be argued that if you set up a service for people who have only one thing wrong at once (a diabetic clinic, for example, or a coronary artery bypass graft service) but people with many things wrong turn out to be its major users, the fault lies not with the users, but with the service and its design. In modern health care, however, this appears to be a minority view, and one which is trumped by the notion that the people with many things wrong at once are at fault – that they are ‘inappropriate’.

Modern health care needs to reconcile itself to complex patients. There are many wrong ways to address this, each of which has the following in common: instead of getting to grips with how service is provided, they want the frail old people to go away, to some more appropriate place. This appears to be an important motivator in the current UK political agenda of promoting intermediate and community care. A similar desire apparently underlies an important Canadian recommendation for more home care [4], a point which otherwise would be inarguable. If such initiatives are a substitute for acute care of elderly people who are not just frail, but who are frail and acutely ill, such steps will be retrograde.

More sensible approaches focus more on the goals of care, and do not simply assume that if processes work efficiently, then patient care is being enhanced. For example, people with broken hips would like to achieve maximum mobility after having their hips repaired, and not just be discharged within 5 days without infection. People having bypass graft surgery will be glad for less chest pain, but not at the cost of dementia. People with diabetes are glad to have normal glucose values, but people in nursing homes who have dementia and diabetes are unlikely to prioritise four times a day finger pricks as being the first thing to do to enhance their quality of life. Under current methods of evaluation, there is much less accounting for patient preferences than there is rhetoric about patient-centredness and nowhere is this more true than for the people most at risk for adverse health outcomes.

An evidence base needs to be developed that better conforms to the sorts of patients who are likely to be considered for care than those who are typically enrolled in clinical trials. Is drug X still likely to be better than placebo if it is the ninth and not the third drug to be added to a patient’s regimen? Adverse drug reactions are more frequent in older people [5, 6], whose involvement in research studies and clinical trials has been limited [7]. This has made rational prescribing both to maximise benefit and reduce risk problematic.

As important as advocacy is, there are other things that we must do if we are not to be irrelevant to those with the greatest need and the greatest likelihood of benefiting from our skills. We must pay attention to what we teach. For example, many standard textbooks of geriatric medicine have only an introductory chapter on managing patients with multiply problems, followed by many dozens more on individual problems, presented in a ‘one-thing-at-once’ fashion (and often authored by people with little actual expertise in ageing). A more integrated approach to patients, based on their individual problems and their own priorities, has recently been advocated in preference to the current disease-oriented management model [8]. Though this is not without controversy [9], it merits consideration as a way to address the complex needs of older patients.

We also need to get to grips with frailty. While there are many and divergent views on what frailty is [10–13], we need to move beyond viewing frailty, like beauty, as a subjective and imprecise concept, and understand frailty as a quantifiable entity [14, 15]. Frailty is a failure to integrate responses in the face of stress. This is why diseases manifest...
as the ‘geriatric giants’: functions that require integration of higher order cortical processing, such as staying upright, maintaining balance and walking, are more likely to fail, resulting in falls or delirium. It therefore seems particularly worthwhile to measure mobility and balance as a means of knowing whether acutely ill older people who are frail are recovering from their illness or becoming more ill.

Finally, we must do our field justice. This comes from understanding our speciality as the intellectually challenging and personally rewarding field of human endeavour that it is.

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Not because they are old—revisited

‘Not because they are old’, an independent enquiry by the Health Advisory Service (HAS 2000) into the care of older people on acute wards in general hospitals was published in 1998, following a series of critical articles entitled ‘Dignity on the Ward’ in the Observer newspaper during autumn 1997 [1]. The independent report confirmed the picture painted in the original Observer articles. The main areas of concern, which detracted from the quality of care, included [2]: insufficient staff with relevant skills in the care of older people; lack of leadership, both professional and managerial, particularly at ward level; poor communication; lack of attention to nutritional needs and help with eating and drinking; low morale among staff who are aware that competing pressures on their time have a negative impact on their ability to care; inadequate supplies of essential equipment; and poor standards of decoration and repair.

Shortly after the report was published, Frank Dobson announced the setting up of the review group that eventually produced the National Service Framework for Older People in 2001. It is widely believed that the Health Advisory Service report persuaded Frank Dobson, the then Secretary of State for Health, that older people’s services should become the next National Service Framework, rather than paediatrics.

Six years on from the Health Advisory Service Report, and 3 years on from the publication of the National Service Framework, what progress is being made with day-to-day care on acute wards?