EDITORIAL

Fitness and frailty: opposite ends of a challenging continuum! Will the end of age discrimination make frailty assessments an imperative?

In Europe, those over 65 years of age will increase to 30% of the population over the next 30 years [1]. Those over 75 and especially 85 years of age concentrate the highest proportions of poor health and disability. At the same time, even at the oldest ages, the majority live in non-institutionalised settings [2]. Increasingly, the ‘demographic time bomb’ concept is being replaced by a more constructive discourse based on the realisation that population ageing is diverse and the association between chronological age and health status is extremely variable [3, 4].

Consequently, the efficient delivery of health and social care services to older people requires a specific focus, for doctors and allied professionals, in responding to this combination of diversity and complexity. The intuitive concepts of ‘fitness’ and ‘resilience’ often underpin decisions on the escalation of medical therapy, as they safeguard against iatrogenesis [5]. On the other hand, those presenting to the acute hospital for medical admission are more likely to suffer from multiple chronic illnesses, polypharmacy, cognitive and functional decline and other geriatric syndromes driven by accumulation of deficits and dysregulation in multiple biological systems.

‘Frail’ individuals are vulnerable and therefore at an increased risk of adverse outcomes (e.g. iatrogenesis, functional decline and death), but also benefit from specialist multidisciplinary care and interventions [6]. However, the identification of those most likely to benefit (and least likely to be harmed) from an intervention remains a challenge: where are they along the fitness-frailty spectrum? In answering the question, chronological age is of little help. Indeed, decisions for clinical treatment based primarily on age are not best suited to the complexity of the human body, especially the complexity of older humans [7].

In the UK, from 1 October 2012, older people will have the right to sue if they have been denied health and/or social care based on age alone [8]. The Department of Health is committed to rooting out age discrimination and, as far as health or social care services are concerned, there will be no exceptions to the implementation of the Equality Act 2010 [9]. Indeed, any age-based practices by the NHS and social care organisations will need to be objectively justified, if challenged [10]. Therefore, it is likely that the assessment of older people’s ‘fitness level’ will become desirable (if not necessary) in routine health and social care practice. The problem is how to objectively grade ‘fitness level’ in every specific clinical or social care scenario.

‘Fitness’ and ‘frailty’ are opposite ends of a challenging continuum. While experienced practitioners can (and often do) intuitively place their patients along that imaginary spectrum, that subjective ‘clinical impression’ of vulnerability may not be sufficient in the eyes of the Equality Act 2010. Therefore, formal frailty metrics will be required in health and social care, for various purposes including documentation. However, the objective measurement of frailty has limitations (e.g. some physical performance measures are unfeasible in the very frail [11]). As yet, there is no consensus (nor any official guidance) on which measures may be appropriate for the explicit documentation of frailty status in older people. Recently, the NHS Evidence Adoption Centre published a review of the methods and instruments for identifying frailty, including risk stratification models, performance assessment and self reports [12]. Efforts like the latter will likely be of help to practitioners; however, despite ongoing research efforts, the development and validation of frailty metrics is currently underdeveloped, compared with the clarity of concept and implementation speed of the Equality legislation. Some mismatch may be felt on the ground after 1 October.

Overall, the full implementation of the Equality Act 2010 in health and social care is to be welcomed. It will minimise instances of ageism and age discrimination at a time when European populations are getting older in chronological, but not necessarily biological, terms. Developments occur on a background of heightened public expectations and aggressive cost-containment measures, adding to the complexity known to geriatric practitioners. Unintended consequences may or may not ensue, but good documentation will always be good practice, good advocacy and good defence.

In the UK, the selection and adoption of appropriate frailty metrics for health and social care will likely become a matter of some urgency as a result of the implementation of this pioneering piece of legislation. In other European countries, geriatric practitioners ‘cannot wait’ to implement...
frailty in clinical practice [13], but in their case the main drivers of change are practitioners themselves, not the Law. Similarly, in the Republic of Ireland, the adoption of the frailty paradigm in health and social care has led to the development of a new Model of Care for Specialist Geriatric Services, which is a joint initiative between the Directorate of Clinical Strategy and Programmes of the Health Service Executive and the Royal College of Physicians of Ireland [14]. The new Model of Care will include suggestions on existing assessment tools that are brief, user friendly, economical and efficient in detecting frail older patients in need of specialised assessment, treatment and referral.

The care of the older frail patient is complex and comes within the responsibility of many different professional bodies, governmental agencies and society as a whole. Being able to place a person along the fitness-frailty spectrum independently of age will become crucially important in the years ahead, both to advocate for resource and to target specialist care appropriately. The new Model of Care is our health services response to the increasing numbers of older people in our community who present to acute hospitals. It behoves us all to plan services and systems to meet this predicted demand.

Health and social care practitioners are in urgent need of easy and valid instruments for frailty assessment and now is the time for professional consensus on this complex matter.

**Key points**

- ‘Fit’ people are resilient; ‘frail’ people are vulnerable.
- Age alone cannot tell where a person is along the ‘fitness-frailty’ spectrum.
- Subjective impressions of ‘fitness-frailty’ may not be sufficient in the eyes of the Equality Act 2010.
- Objective ‘fitness-frailty’ metrics will be required in health and social care.
- Now is the time for professional consensus on this complex matter.

**References**