Frailty

Predicts death, delirium and surgical complications better than age · and takes ten seconds to screen for

Watch them walk
then prescribe resistance training

⚠ WHAT IT IS, AND THE THREE THINGS IT IS NOT

THE DEFINITION THAT MATTERS

Reduced physiologic reserve across multiple systems, so a stressor a robust person absorbs -a UTI, a new drug, a night in an unfamiliar ward- produces a **disproportionate, cascading decline**. The clinical signature is exactly that: the patient who becomes delirious from a UTI, deconditions irreversibly over three days, or never returns to baseline after a minor operation **is showing you their reserve**.

⚠ NOT AGE · NOT MULTIMORBIDITY · NOT DISABILITY

Not age -plenty of 85-year-olds are robust and some 65-year-olds are frail. **Not multimorbidity** -a patient can carry five diagnoses with substantial reserve, or one with none. **Not disability** -disability is established functional loss; frailty is the **vulnerability that predicts it**. They overlap, but **treating them as synonyms is exactly what leads to decisions made on the birth date**.

WHY IT BELONGS IN GENERAL MEDICINE

It predicts **mortality, delirium, falls, length of stay, institutionalization and postoperative complications more accurately than chronological age**, and should change intensity of investigation, threshold for surgery, glycemic and BP targets, and which preventive drugs still make sense. **It is the concept that turns "he's 88" from a prejudice into a measurement.**

MEASURING IT

Tool	How it works
⚠ Gait speed fastest useful screen	**≤ 0.8 m/s** at usual pace over 4 meters -no equipment, seconds to do. Against the frailty phenotype it is **~99% SENSITIVE but only ~68% SPECIFIC**. **Read that properly: a NORMAL speed effectively rules frailty OUT** (the useful direction), while a slow one is a **prompt for fuller assessment, not a diagnosis** -plenty of slow walkers are slow for orthopedic, neurologic or pain reasons
Fried phenotype	Five criteria: **unintentional weight loss, exhaustion, weakness (grip strength), slow gait, low physical activity**. Score by how many are present: **0 robust · 1-2 PRE-FRAIL · 3+ frail. ⚠ The pre-frail group is the point of the whole exercise** -most reversible, and nobody is currently looking for it
Clinical Frailty Scale deficit accumulation	Judgment-based **1 to 9** from illness, function and cognition: **1 very fit · 4 living with very mild frailty · 7 severely frail · 9 terminally ill**. Fast, widely adopted, and easy to hand over between teams
⚠ Score the BASELINE	**Do NOT score during acute illness or delirium** -that measures the illness, not the reserve. Use function from about **two weeks before admission**, with a **collateral history** if the patient cannot say. Grip strength with a dynamometer tracks change over time better than most clinic measures

ANCHORING THE CLINICAL FRAILTY SCALE *it is judgment-based, so people score it inconsistently without anchors*

Level	What it looks like in practice
1-3 very fit → managing well	**Robust, active, energetic**, exercising regularly or at least walking without help. Medical problems may exist but are **well controlled and not limiting**. **These patients are not frail and should not be treated as though they are**
4 very mild frailty	**Not dependent on others day to day, but symptoms limit activities** -"slowed up", tired during the day. **This is the group closest to the pre-frail phenotype and the one where intervention pays best**
5-6 mild → moderate	**5:** needs help with the higher-order tasks -finances, transport, heavy housework, medications. **6:** needs help with **outside activities and keeping house**, often with bathing and dressing. **The transition point where hospital risk climbs steeply**
7-9 severe → terminally ill	**7:** completely dependent for personal care, though stable. **8:** completely dependent and approaching end of life, not recovering even from minor illness. **9:** terminally ill, life expectancy under about 6 months without otherwise being frail. **At these levels the goals-of-care conversation is overdue, not premature**

⚠ IT IS DYNAMIC -AND THAT CHANGES EVERYTHING

⚠ NOT ONE-WAY, NOT A TERMINAL LABEL

People move between robust, pre-frail and frail **in both directions**, and the pre-frail are the most reversible of all. **Treating a frailty score as a prognosis to document, rather than a target to treat, is the commonest misuse of these tools** -and using it to justify **WITHHOLDING** care rather than tailoring it is a misuse with real consequences.

INTERVENTIONS, BY EVIDENCE

1. PROGRESSIVE RESISTANCE TRAINING within a multicomponent program (balance, gait, aerobic) -best evidence by a clear margin, and it **works in the very old and already frail**, precisely the group told to take it easy. **Prescribe it specifically**: what, how often, supervised where possible. **"Stay active" reliably achieves nothing. 2. Protein** -needs are higher in older adults and intake is commonly inadequate; **protein plus resistance beats either alone**. **3. Deprescribing** -cutting anticholinergics, sedatives and drugs causing orthostasis directly improves cognition, balance and energy. **4. Vitamin D only if deficient** (not a general anti-frailty supplement; high intermittent dosing has been linked to MORE falls). **5. Comprehensive geriatric assessment**, which is where a positive screen should lead.

LETTING IT CHANGE DECISIONS -WITHOUT RATIONING CARE

Setting	What to do
Perioperative	**Frailty beats age** for predicting complications, delirium, length of stay and mortality -use it for consent and procedure choice. **PREHABILITATION before elective surgery is one of the few chances to intervene in advance, and it is routinely wasted**
Treatment targets	**Relax targets whose benefit takes years** (tight A1c, intensive BP) while protecting what affects the patient this month. This is time-to-benefit reasoning applied to a **measured** horizon rather than a guess
⚠ But do NOT withhold	Frail patients still benefit from **anticoagulation in atrial fibrillation, treatment of infection, and appropriate surgery**. They need the decision made deliberately and the risks discussed honestly. **Frailty MODIFIES the plan; it does not cancel it**
In hospital	Anticipate **delirium, deconditioning, falls, pressure injury and adverse drug events**. **Mobilize early and protect the day-night structure** -a frail patient loses function over days that takes months to rebuild
Reversible contributors	Screen while you are there: **depression, undiagnosed cognitive impairment, hearing and vision loss, dentition, anemia, thyroid disease, vitamin D, undernutrition, and MEDICATIONS** -several look exactly like frailty and are fixable
Severe and advancing	A legitimate prompt for **goals-of-care discussion and advance care planning, held early rather than in a crisis**

References: Fried et al., frailty phenotype criteria · Rockwood Clinical Frailty Scale (9-point version) and the deficit-accumulation frailty index · published test characteristics of gait speed against the physical frailty phenotype · evidence reviews on resistance and multicomponent exercise, protein supplementation and comprehensive geriatric assessment in frailty.

Educational aid; verify against current guidance and patient factors.