EDITORIAL

Identifying the frail patient in the emergency department: an urgent and necessary effort

Identificar al paciente frágil en un servicio de urgencias: un esfuerzo urgente y necesario

Sira Aguiló Mir

In 2020, the number of people over 60 years of age will surpass the number of children under 5 years of age according to the World Health Organization (WHO) report on aging and health. The rate of population aging is much faster than in the past. These figures, together with the increased need for medical care in these age groups, pose a challenge for today's health and social care system.

The WHO has defined the period 2020-2030 as the decade of healthy aging,[1] understood as well-being in old age, maintaining the functional capacity to be and do what is important to us. It seems simple, even poetic; but reality is imposed, and it is not always possible to maintain the cognitive capacity to make decisions or to maintain functionality and autonomy in old age. Just by opening your eyes for a second, anyone working in an emergency department (ED) can see more than one elderly person with unhealthy aging waiting to be attended. In most Spanish EDs, the care of these patients does not meet the recommended quality standards.[2,3] The geriatric patient is the paradigm of the complex patient, and this paradigm shift brings with it new challenges as healthcare professionals, as society as a whole and as a global healthcare system.

Aging is a biological process, gradual and irreversible due to the action of time on the organism. Perhaps overwhelmed by the medical advances of the last decades, we wanted to believe that we could ignore it and that immortality was just around the corner. Changes in the immune system, loss of muscle mass, increased risk of falls, brain changes that affect cognitive capacity and coordinated responses, increased arterial stiffness, and decreased adaptation of the response of the hypothalamic-pituitary-adrenal axis[4] are some of the physiological changes characteristic of aging that cause a different manifestation of the disease and the possibilities of coping with it and responding to established treatments.

As healthcare professionals, we are aware of this because it is imposed on us daily by reality, but it is not uncommon to confuse aging with disease. We medicalize aging, treating it as a disease, and we try to evaluate the response to treatment according to standardized dose-response processes. If we continue to follow the model of diagnosis by disease, and do not consider aging as a stage with specific differential characteristics, we will continue to fail to detect the frail elderly and to propose treatments that are not adjusted to this patient and, therefore, not appropriate.

The first step would be to determine the patient's biological age, his or her state of aging, and act accordingly. The term fragility would best define this biological age. It is defined as the capacity of a material to fracture. We thus refer to the elderly person we must take care of so that he/she does not fracture either physically or mentally, working on the prevention, maintenance and even improvement of this fragility.

We can define frailty as the tangible response to multiple changes, a characteristic of aging that led to a decrease in functional reserve with a worse response to any stress.[5] A geriatric syndrome, conditioned by the limitation of compensatory mechanisms that place the individual in a vulnerable situation. It is an independent risk factor for mortality and adverse health outcomes with a higher strength of association than chronicity and comorbidity.[6,7] Frailty measures this physiological response and the sum of these changes that mark biological age and, together with the comprehensive geriatric assessment (CGA), goes beyond and encompasses the cognitive and psychosocial sphere of the individual.

Although the ED is not the most suitable place for comprehensive assessment of complex patients, the elderly and frail patient is becoming increasingly frequent. Currently, we do not have a universal frailty scale[8] and it is necessary to develop a standardized measurement tool that allows its quantification as objectively as possible to facilitate its systematic identification in the ED and its incorporation as an essential item in decision-making.

In this regard, the present issue of EMERGENCIAS publishes the article "Performance of three frailty scales to predict adverse 30-day outcomes in elderly patients discharged from the emergency department" in which Fernández Alonso et al. compare one of the most widely used frailty scales, the Clinical Frailty Scale (CFS), the Identification Senior at Risk (ISAR) which, although not

Author Affiliations: Emergency Department, Hospital Clínic, Barcelona, Spain.
Author Contributions: The author has confirmed her authorship in the document of author responsibilities, publication agreement and assignment of rights to EMERGENCIAS.
Corresponding Author: Sira Aguiló Mir. Emergency Department. Hospital Clínic. Villarroel 170. 08036 Barcelona, Spain.
Email: siraaguilo@gmail.com
Article information: Received: 11-4-2023. Accepted: 13-4-2023. *Online:* 25-4-2023.
Editor in charge: Òscar Miró.

strictly a frailty scale, is capable of predicting safety at discharge from an ED in elderly patients, and the eMErgency Index (FIM), which is much simpler and in this sense more suited to ED time and space. The FIM shows a good correlation, especially with CFS. It is likely that incorporating the FIM into daily ED practice[9] as a screening tool would allow the elderly patient to be categorized as frail or non-frail in a rapid manner and could be standardized as a starting point to alert the need for a more detailed estimation.

As Hippocrates postulated, we should never forget the principle of do no harm, Primum non nocere. Detect the frail patient to prevent them from breaking down. Frailty is a chronic but dynamic condition that, with the right measures, can even be reversed. But to do so, it is necessary to detect it and to be able to measure and standardize it. EDs, as an integral part of the healthcare system, must adapt to the frail patient with a comprehensive approach, establishing personalized care plans that not only comprise the specific treatment of the disease, but are aimed at maintaining functionality, autonomy, and maximum quality of life, in accordance with the patient's real possibilities, preferences and ethical-moral beliefs. This paradigm shift will not be possible if we do not incorporate bioethics to adequately address the challenges that arise. Only in this way will we achieve the medicine that many of us believe should be the future. Precision medicine, with the patient as its focus, with therapeutic proposals that provide real value, offering the necessary resources in an efficient healthcare system. Only in this way will we be able to avoid burnt-out professionals, social-health centers full of people with no real capacity for rehabilitation and nursing homes with people without functional or cognitive autonomy, but with highly complex treatments. In this medicine of the future, we must put the patient at the center and establish real and honest doctor-patient-caregiver communication and a bioethical and multidisciplinary approach, with the participation of social workers, nurses, physiotherapists, psychologists, and nutritionists.

Conflict of interests Disclosure: None reported.

Funding/Support: The author declares no funding in relation to the present article.

Ethical responsibilities: The author has confirmed the maintenance of confidentiality and respect for patients' rights in the document of author responsibilities, publication agreement and assignment of rights to EMERGENCIAS.

Article commissioned and reviewed internally by the Editorial Committee.

References

1 https://www.who.int/es/initiatives/decade-of-healthy-ageing
2 Age-Friendly Health Systems: Guide to Recognition for Geriatric Emergency Department Accredited Sites. April 2022.
3 Martín-Sánchez FJ, Bermejo Boixareu C. EDEN: una oportunidad para conocer y mejorar la atención integral de las personas mayores en los servicios de urgencias españoles. Emergencias. 2022;34:409-10.
4 Clegg A, Young J, Iliff S, Olde Rikkert M, Rockwood K. Frailty in elderly people. Lancet. 2013;381:752-62.
5 Frailty and the management of patients with acute cardiovascular disease: A position paper from the Acute Cardiovascular Care Association. European Heart Journal: Acute Cardiovascular Care 1-18. 2018.
6 Martín-Sánchez FJ, Parra Esquivel P, Llopis García G, González Del Castillo J, Rodríguez Andrada E, Espinosa B, et al. Resultados a 30 días en los pacientes mayores frágiles con insuficiencia cardiaca aguda dados de alta desde urgencias o sus unidades vinculadas que cumplen los criterios de alto riesgo del estudio DEED FRAIL-AHF. Emergencias. 2021;33:165-73.
7 Amblàs-Novellasa J, Espaulella-Panicot J, Inzitari M, Rexachf L, Fontechag B, Romero- Ortunoh R. En busca de respuestas al reto de la complejidad clínica en el siglo xxi: a propósito de los índices de fragilidad. Rev Esp Geriatr Gerontol. 2017;52:159-166.
8 Fernández Alonso C. Sobre los mayores que viven en residencias y su atención en los servicios de urgencias. Emergencias. 2022;34:411-2.
9 Fernández Alonso C, Del Arco Galán C, Torres Garate R, Madrigal Valdés JF, Romero Pareja R, Bibiano Guillén C, et al.Rendimiento de tres escalas de fragilidad para predecir resultados adversos a 30 días en los pacientes mayores dados de alta en los servicios de urgencias. Emergencias. 2023;35:195-204.