Commentary

Family medicine in an aging society

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All industrialized societies have populations that are aging rapidly. Aging is associated with rising levels of dependency and comorbidity, and the older population accounts for most costs in health services. Health and social care costs are increasing everywhere, prompting third-party payers to want reduced hospital admission and readmission rates for older people, shorter lengths of stay, and postponement of admission to nursing homes. This pressure to reduce the costs of health and social services for the aging population is causing problems for practitioners across disciplines and sectors. Some of the articles in this issue of *Canadian Family Physician* demonstrate this well, showing how attempts to make generalists into mini-specialists in the service of cost-containment fail to achieve their objectives.

For example, specialist training in medicine for the elderly equips family physicians for work in an aging population, but it might also mean that they move away from comprehensive generalist roles toward subspecialist work outside family practice, adding to the drift away from family medicine. Similarly, guidelines intended to move the boundary between generalist and specialist practice deeper into the specialist zone fail to meet the needs of family physicians and have little effect.

Generalist perspective

In my view family physicians must define what knowledge and skills they need to acquire in order to cope with demographic change. This will be difficult for a number of reasons. First, primary care services are often reactive, fragmented, and poorly adapted to the management of older patients with high levels of dependency and comorbidity, leading to enthusiasm among managers for "case management" methods in primary care. This enthusiasm is powerful and has the ear of funders. The proposals that flow from it are plausible to those who do not work in and with communities, structured as they are by specialist perceptions of the problem. Second, family physicians are trained in organ- and disease-based approaches and might lack knowledge about the concepts, tools, and instruments needed to manage complex health problems in an aging population. There is a very definite knowledge gap that needs to be closed. Third, the evidence-base that supports the recently or currently fashionable approaches to coping with an aging population is weak and getting weaker, as one negative trial follows another. For example, the case for routine comprehensive screening for unmet health needs in the older population has collapsed following the UK Medical Research Council trial's demonstration that there is little or no benefit of such screening to quality of life or health outcomes for older people.[1] It is no surprise that the obligation of British family doctors to offer annual "75 and over checks" disappeared quietly from the new general practitioner contract in 2004. More targeted approaches (such as using senior nurses as "community matrons" [in effect, case managers] to work intensely with older people who have histories of repeated hospital admissions or who have multiple comorbidities and polypharmacy) have also failed to show much reduction in emergency admissions. Policy and practice in the medical management of an aging population are now paralyzed. Although the policy objectives are clear, the means to achieve them are not.

We are in this dilemma because the increased demand for health services in an aging population is being seen from managerial and specialist viewpoints, rather than clinical and generalist perspectives. These managerial and specialist perspectives work on easily measured proxies for illness and disability, like polypharmacy or multiple comorbidities, instead of working with clinical paradigms. Targeted efforts to enhance health status and reduce service use are focused on older people with combinations of diseases (typically heart disease and diabetes), symptoms (like memory loss or leg ulcers), or repeat prescription of multiple medications, forgetting that the success of medical care lies in its stabilization of disease processes. Having several medical problems does not mean that you are a problem. When functioning at its best, family medicine acts as a containing mechanism that reduces risks of clinical destabilization and decompensation. Similarly, recurrent hospital admission is seen as a risk for future admission rather than an outcome of potentially tractable clinical conditions like gait instability, bone fragility, or multisystem failure.

Frailty

The concept that is missing from the policy debate in primary care, and that provides both clinical and generalist perspectives on aging, is that of *frailty*. Frailty appeared in specialist clinical discourse more than 20 years ago as one of the core issues in caring for older patients. Debates about its definition, diagnosis, status as a syndrome, independence from disability, measurement, and consequences have left us with a rich concept ideally suited to guide the development of primary care.

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On the basis of US studies, it appears that frailty affects about 7% of people aged 65 years or older and about 25% to 40% of those aged 80 or older.[2] As frailty leads to recurrent hospitalization, institutionalization, and death, prevention and, where possible, treatment of frailty should be high on the medical agenda. Because frailty appears to be a dynamic—and also potentially reversible—process, early recognition of frailty and early interventions should be important issues for family medicine.

Frailty is a state of increased vulnerability to adverse outcomes. It is a syndrome that results from a multisystem reduction in reserve capacity to the extent that a number of physiological systems approach or cross the threshold of symptomatic clinical failure. The frail older patient has a declining reserve capacity for dealing with stressors.

Frailty has multiple possible manifestations. No single manifestation, by itself, is sufficient or essential in the presentation, but there is a discernible phenotype with 3 or more core elements. These are weakness, tiredness, poor endurance, weight loss, low levels of physical activity, and slow gait speed.[3] In this heuristic, 3 or more of these features denote frailty, 1 or 2 denote prefrailty, and none denotes no frailty. These states are related to one another, and to death, in complex ways, but an important aspect of this model is that both frailty and its precursor state are potentially reversible.

Because we are still organ- or disease-focused, both frailty as a syndrome and the vulnerability that underpins it can easily be overlooked. Frailty does not fit into an organ- or disease-focused understanding of patients, because there is almost never a chief complaint, and the features of frailty occur in combination.

Change over time

Frailty provides a conceptual basis for moving away from organ- and disease-based medical approaches toward a health-based, integrative approach, and therefore fits the biopsychosocial model of generalism very well. Because frailty is a dynamic process involving change over time, repeated assessments of the different components are often necessary, and the continuity of contact that family medicine offers provides the framework for this. We are already familiar with the idea of frailty, even if we do not make it the central feature of our practice with older people. Family physicians already use the concept of frailty to aid clinical decision making, assess risk factors and complications, evaluate interventions, and predict outcomes, because it is a better measure than chronological age. For example, using clinical judgment alone, British general practitioners are able to identify older people who would benefit from multidisciplinary interventions[4] and those on the boundary of frailty who could benefit from exercise therapy.[5]

The addition of a more formal assessment of frailty, perhaps using Fried and colleague's heuristic,[3] could potentially strengthen case-finding strategies in primary care. This might provide new opportunities for prevention, diagnosis, and care planning for older people with complex problems, and warrants further study. We need to know how the assessment of frailty can be most effectively undertaken in primary care. We also need to know the value of such assessment for frail, community-dwelling older people and their families. There is an important research agenda here, but it is time to measure things that matter to us and to our patients.

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Competing interests
None declared

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