

## Knowledge Translation for Severe Frailty

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### Introduction

He was not an unusual patient; the treatment he received met the standard of care and his outcome was not unusual either. Even so, Mr. Smith's last year of life was far from ideal, and it was very costly.

At 93 years of age, Mr. Smith was admitted to our Geriatric Medicine inpatient ward due to profound fatigue. When I first interviewed him, I was struck by the effort it took him to sit up in bed and his extremely thin body habitus. His past medical history included the usual suspects: multi-vessel coronary artery disease, moderate aortic stenosis, hypertension, benign prostatic hypertrophy, polymyalgia rheumatic, and osteoporosis. Over the last four months, he'd been having increasing difficulty doing basic self-care, was falling frequently, lost 20 pounds, and had new urinary incontinence. His rheumatologist had begun a steroid taper a few months ago. We returned his prednisone to its previous dose, focused on exercise and diet and he began to improve [1].

It is well known that frailty alone is associated with a limited prognosis and that the degree of frailty correlates with life expectancy. However, this understanding is seldom used in clinical practice. The important features of frailty, including impairments in mobility, functional status, cognition and social support, are undervalued as prognostic indicators, and without a careful history, the trajectory of decline may not be apparent. Instead, the patient's story is lost and he becomes a collection of medical diagnoses, where each diagnosis is treated without regard for the overall picture. As a result, patients are subjected to needless and often risky investigations and treatments. Without identifying frailty, we are unlikely to recognize when our patients are nearing the end of life.

Based on Mr. Smith's limited mobility and functional dependence at his baseline, he was severely frail (Clinical Frailty Scale Score = 7). While he was not imminently dying, his life-expectancy was clearly

limited. When I spoke to Mr. Smith about his prognosis, he was surprised; this was not something that had been discussed before. But now he was able to say, "I want to go home as soon as possible and focus on enjoying whatever time I have left. I don't want any more tests" [2].

Unfortunately, despite Mr. Smith's clearly stated preference, in the four months that followed, he returned to the hospital three times and underwent innumerable blood tests, multiple radiographs, EKGs, a few CT Scans, a Doppler ultrasound, and an echocardiogram. He was treated with intravenous fluids, a blood transfusion, and intravenous antibiotics right up to the day of his death. He died in hospital, alone.

We've all encountered Mr. Smith in our daily practice. What will it take for us to collectively recognize and respond to his frailty, and become comfortable with the limits of curative medicine?

We can do better for our frail older patients. It is time to translate our knowledge of the prognostic significance of frailty into clinical practice. When we do, we will gain the opportunity to help the Mr. Smiths actualize their priorities for life's close [3].

To achieve this goal, we will need to support novel care models, such as the Palliative and Therapeutic Harmonization (PATH) model, whose primary focus is to help patients, families and health teams consider frailty when making medical decisions.

### References

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