Analysis

Does frailty need a new name?

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KEY MESSAGES

- Frailty is an important and useful construct but there are significant differences between clinical and lay understandings of the term.
- Some older people may resist the label frailty, which makes it a potential barrier to accessing medical care.
- A new term could lose many of the pejorative connotations that frailty carries, helping people make better sense of their situation and maintain their well-being. This possibility for active benefit has been largely unrecognised to date.
- We call for greater collaboration with older people to co-develop ways of talking about frailty; and discuss the attributes of a successful term.

Contributors and sources

SAH is a geriatric medicine registrar undertaking a Joint The Dunhill Medical Trust and British Geriatrics Society doctoral fellowship. SEH is a medical sociologist. LP is a GP and medical sociologist. RL is an older person herself, and also has experience of caring for older relatives. RS is a Community Geriatrics Consultant. JKC is a Geriatric Medicine Consultant and ageing researcher. MPK is a Professor of Public Health and previous Director of Public Health for NICE. SB is a GP and Professor of Palliative and End of Life Care. RHH is a Geriatric Medicine Consultant and Professor of Palliative and End of Life Care.

SAH, SEH, LP and MPK devised the idea for this article and refined it with input from RL, RS, SB and RHH. SAH, SEH, LP, RL, RS, MPK, SB and RHH contributed to developing the first draft and all authors contributed to editing and writing of subsequent versions. SAH is the guarantor.

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Patient involvement

The concept for this article built on discussions with PPI colleagues about use of the term frailty. RL, herself an older person, has been involved in planning and writing this article.

Conflicts of Interest

We have read and understood BMJ policy on declaration of interests and declare no competing interests.

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Does frailty need a new name?

In the UK, new national policy incentivises hospitals to identify patients with frailty, yet being labelled frail may be problematic. Geriatrician Sarah Hopkins and colleagues discuss why a new term could help patients to maintain their well-being, and help their clinicians care for them.

The biomedical concept of frailty has been a significant advance in how we approach the care of older people: it is central to better evidenced medicine and policy.(1) In some settings, up to 80% of patients with unplanned hospital admissions are living with moderate or severe frailty.(2) Identifying frailty can help clinicians best care for such patients, keeping people living at home,(3) helping avoid iatrogenic harm,(4) and potentially reversing some aspects of frailty itself.(5)

Reflecting this, identifying and acting on frailty is the aim of recent financially incentivised NHS “Commissioning for Quality and Innovation” (CQUIN) guidance that affects all acute care providers in England.(6) Globally, national guidelines recommend using frailty to guide patient care, and service design.(7)

Meanwhile, frailty is the subject of ongoing research, with debate about its nature, underlying mechanisms, measurement and reversibility.(1,5,8,9) Here we focus on the term itself. We identify problems with it, and highlight the limited involvement of older people themselves in addressing these. We consider pros and cons of renaming frailty, and suggest a new term might help older people make sense of their experiences and sustain their well-being. Aligning with the UN’s Plan of Action for a Decade of Healthy Ageing, we recommend greater collaboration with older people to co-develop improved ways of talking about frailty.(10)

Differences between clinical and lay understandings of the term frailty

Synthesising research on public perceptions of frailty, two scoping reviews found that older people commonly understand frailty to be a state of physical, psychological, and social decline, linked to dependency, loss of identity, social exclusion and stigma.(11,12) It is associated with negative age-related stereotypes. “Frail” is thus often understood as a pejorative term, and has been suggested to have connotations of a weak incapable person who is “failing” (Box 1).(11,13)
Box 1: Dictionary definition of frailty(14)

Frailty
- noun -

Meaning & use
1.a. The quality of being physically weak or fragile, or vulnerable to damage; the state of being mortal. Also: an instance of this. c1384–
In later use chiefly with reference to physical weakness or infirmity as a result of old age.

1.b. Weakness in an abstract or immaterial sense; the state of being transient, subject to change, or vulnerable to harm. Also: an instance of this. c1450–

2.a. A moral failing; a particular weakness or character flaw. c1390–

2.b. Moral weakness; sinfulness; propensity to give in to temptation, esp. of a sexual nature. a1400–

In contrast, geriatricians and researchers use frailty to describe (i) a reduction in biological reserves across multiple body systems (ii) that reduces the body’s capacity to respond to stressors (iii) resulting in increased vulnerability to adverse health outcomes (iv) associated with the ageing process (Table 1).(1,15,16) Frailty explains why “an apparently small insult (e.g. a new drug; “minor” infection; or “minor” surgery) results in a dramatic and [otherwise] disproportionate change in health state” such as from independent to dependent, or lucid to delirious.(16)

Table 1 - Key differences in biomedical and lay understandings of the term frailty

<table>
<thead>
<tr>
<th>Biomedical</th>
<th>Lay</th>
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<tr>
<td>A specific term, meaning reduced biological reserves across multiple body systems leading to reduced capacity to respond to stressors with increased risk of adverse health outcomes.(1,15)</td>
<td>An overarching statement about a person as whole, suggesting they are physically and psychologically weak, fragile, and with physical and psychological impairments.(11)</td>
</tr>
<tr>
<td>Usually conceptualised as a physical state.(16)</td>
<td>A multidimensional state that includes physical, psychological and social aspects, and possibly even a moral or normative component.(11,13,14,17)</td>
</tr>
<tr>
<td>Generally acknowledged to range in severity e.g. the Clinical Frailty Scale classifies frailty severity as very mild/mild/moderate/severe/very severe frailty.(18)</td>
<td>A binary state: frail or not.(17)</td>
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</table>
Something that can be objectively measured and screened for, albeit with ongoing debate about the best way of doing this. (1,8,16)

A state that may be to some extent preventable. (1)

Includes an element of possible reversibility. (5)

A clinical term that does not imply criticism.

Something that can be identified subjectively, without the need for an objective measure. (19)

An inevitable part of the ageing process. (11,20)

An irreversible state, meaning the person is close to the end-of-life. (17,21)

A pejorative term that is offensive. (11,13,20)

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Studies in Europe, North America and Australia have all found similar conceptual differences between lay and biomedical understandings of frailty. (11,12,17,20–24) While research from non-English-speaking countries is limited, there are similar findings among Dutch and French older adults. (22,24) We are not aware of any research in low-income or middle-income countries, despite the high prevalence of frailty. (25)

Studies in English primary, secondary and emergency care have explored clinicians’ concepts of frailty. These have found a range of views, with some healthcare professionals who are not geriatricians sharing the lay understanding of frailty as an irreversible, end-of-life state, although this maybe changing. (17,26,27) This has implications for how these clinicians care for those identified as frail. (26,27)

Many older people resist identifying as frail

Given the lay meaning of frailty, it is unsurprising that older people have an aversion to the term, with some describing finding it offensive and problematic. (11,12) Older people often do not self-identify as frail, despite meeting biomedical criteria to be categorised as such. (11,12,20,23)

The effects on older people of a frailty label are hard to measure, but a growing body of qualitative evidence suggests detrimental consequences. The scoping reviews of qualitative research found that older people emphasise the potential negative impacts of frailty language, with some believing that identifying as frail leads to reduced self-esteem, disengagement, and exclusion. (11,12) Being labelled frail was seen as “damaging to health” because it may lead to feeling and acting frail, reducing healthy behaviours. (11,19,20)

Although further research is needed, a small US study suggested that some people (in a group of those classed as non-frail and “pre-frail”) may reject healthcare professionals who discuss frailty. (28)
By using the term frailty, with its connotations of personal weakness, the medical profession may inadvertently contribute to negative societal perceptions of ageing, and focus responsibility for poor health onto individuals rather than structural inequalities. At an individual level, negative perceptions of ageing have been linked to lower quality of life and poor health outcomes, including disability, hospitalisations and frailty itself.

Addressing the problems associated with the term frailty

Various strategies have been proposed to address the problems associated with the term frailty (Table 2). These are based on research into older people’s views on the label frailty but, to our knowledge, older people themselves have had limited involvement in co-producing the recommendations. We suggest greater involvement of older people in developing approaches to talking about frailty, including discussing whether a new term would be helpful.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Examples</th>
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<tr>
<td>1. Avoid using the terms frail or frailty when talking to older people.</td>
<td>● Ask individuals for their own language preferences e.g. “what words do you use to talk about your health?”</td>
</tr>
<tr>
<td>2. Encourage older people to identify with the concept of frailty.</td>
<td>● Rather than using the term frailty, use examples individuals might identify with (such as finding it more difficult to do everyday tasks). (17) ● Use “language that resonates with older people’s desire to maintain or return to a level of independent living” (17) ● Be clear that that identifying frailty is the “best way to get solutions in place to help older people to achieve their goals” (17)</td>
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<td>3. Educate older adults about the concept of frailty.</td>
<td>● Promote understanding that frailty is “a dynamic, reversible, and avoidable state”. (11) ● Emphasise frailty is a “medical diagnosis”. (28) ● Share examples of persons living with frailty to “promote acceptance of the term”, and reduce stigma. (11) ● “Build on existing awareness of the risk factors for frailty, [and] raise awareness of lesser-known risk factors” (17) ● “Build on existing beliefs that ‘living with frailty’ is not an inevitable or irreversible part of getting older and emphasise that it is possible to maintain independence by engaging with strategies and services” (17)</td>
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Table 2 – Current recommendations to address the problems associated with the biomedical term ‘frailty’
4. Use a strengths-based/assets-based approach that focuses on what individuals can do. (11,13)

- Focus on what older individuals can do, what strategies they have deployed to deal with their situation, what their priorities are for services and care. (13) This is reflected in the concept of “intrinsic capacity” outlined in the World Health Organisation (WHO) World report on ageing and health. (15)
- "Validate strengths by stating, “you have a very strong mind, family, support system, faith or physique. Let’s focus together on using your many strengths to manage the health changes you are experiencing.”" (11)
- Talk more about independence, enablement and resilience. (13,17) Resilience can be understood as "the capability of an individual to adapt and bounce back following a stressor". (33)

5. Focus on the prevention, treatment and management of frailty. (20)

- Emphasise what can be achieved through healthcare. (17)
- Help promote understanding of comprehensive geriatric assessment (CGA) and how it can help identify and address a wide range of issues. (17)
- Raise awareness of the variety of services that are available, including smaller scale services that show that “getting ‘support’ doesn’t mean going into a care home”. (17)
- Encourage older people to ask their healthcare professionals about what services they are entitled to, and require healthcare professionals to raise this with older people and help put services in place. (17)

**Arguments for a new term**

By clearly positioning “biomedical frailty” as a separate concept, a new term could lose many of the pejorative connotations that “frailty” carries. It is likely to remain an unwelcome diagnosis, but renaming frailty would mean it is no longer conflated with personal weakness. A new less stigmatising term could help older people make sense of their situation and discuss it with their clinicians.

Helping people make sense of their situation is an important goal in itself. Those living with “biomedical frailty” often struggle to make sense of what is happening to them, feeling that old age does not offer an adequate explanation and there is no clear medical illness to blame. (34) This perplexity over the cause of their circumstances is associated with reduced well-being. (35) People living with frailty note that ‘who they are’ does not fit with ‘how they are’, a distressing mismatch that undermines their sense of self and their meaning and purpose in life. (35) For such people, offering a biomedical explanation for their situation may help. While this is something clinicians already try to do, their efforts are hampered by the term frailty, which is liable to be misconstrued and resisted. Yet if the clinician tries to explain
the situation without naming it, they lose an important therapeutic benefit: naming one’s condition is important in providing an explanation both to oneself and to others. Such explanations help align “who one is” with “how one is”, and thus help sustain well-being. A new, widely-acceptable name could be of active benefit, a possibility that has gone unrecognised.

The recommendation (Table 2, strategy 1) that clinicians avoid using the term frailty with patients is problematic unless clinicians also avoid using the term among themselves. In a study of non-specialist clinicians from 2015, participants felt they should not describe patients in language they would not use with the patient themselves. In another study clinicians describe finding it “hard to negotiate the tension between the clinical use of the term frailty and the translation of this to the patient”, and believe a different term would help. This is supported by research in other conditions: although real-world effects are difficult to evaluate, terminology can influence perceived disease severity, management preferences and anxiety. Recently, ‘monkeypox’ was renamed ‘mpox’ because of concerns about stigma and its effect on people’s willingness to present themselves for diagnosis and treatment.

Arguments against a new term

An important argument against renaming biomedical frailty is the clinical usefulness of a widely accepted term: a new term risks confusion in the transition period. However, confusion about frailty is already widespread among patients, and there is also some evidence of misunderstanding amongst non-specialist clinicians, albeit to a lesser extent. This existing confusion reflects the differing lay and biomedical meanings of frailty and is a key reason to look for a new term.

Frailty has a robust evidence base giving the term validity, and measuring frailty is important for both research and clinical practice. Some believe that debating alternative names for frailty will divert attention away from more important clinical, policy and research work, but this seems a false dichotomy. Moreover such a debate may bolster public and professional awareness.

Changing terms is not easy. A new term would require not just wide acceptance of the term itself but also development and validation of measurement instruments, and assessment of clinical and research utility. While this represents a significant task, it is worth noting that
there is presently no consensus on how to measure frailty, with over 50 different instruments available, in part reflecting debate over the nature of the condition.\(^8,9\)

A final consideration is that any term that replaces frailty might itself become stigmatising, potentially reflecting societal ageism. While this is possible, the biomedical label frailty is stigmatising in part because of the pre-existing pejorative lay meaning. Renaming biomedical frailty would help position it as a separate concept from the lay definition.

**How to choose a new term**

If the term for frailty were to be changed, how should we decide what to replace it with? Here we outline some considerations that might guide such a choice. To elucidate these, we look for parallels with the word “neurodiversity” – the idea that people experience and interact with the world in a range of ways and that these differences are not necessarily pathological.\(^41\) Neurodiversity has been credited as ‘a term that changed the world for the better’,\(^42\) so we consider what makes it a success (Box 2).

First, neurodiversity originated within the community it describes.\(^41\) Second, it refers to a spectrum – recognising that we all lie somewhere on this spectrum is less othering than, for example, “special needs” which can be a binary distinction between “pathological” and “normal”.\(^41\) By referring to a spectrum, neurodiversity does not automatically pathologise difference.\(^41\) Third, it does not have a pre-existing lay meaning, and certainly not a pejorative one. Finally, it imparts a sense of biomedical gravitas that helps with providing an explanation to self and others.

There are, however, concerns about the term, especially that it calls for acceptance of things that some would wish to be treated.\(^43\) Like neurodiversity, a new term for frailty has to steer a tricky course that minimises negative connotations but still denotes a condition that may be both challenging and amenable to medical help.

**Box 2: Suggested attributes of a helpful term**

- Selected with input from the population to whom it applies
- Acceptable to all parties who will use it
- Does not already have an existing meaning, especially one with negative connotations
- Refers to a spectrum rather than a binary state
- Does not over pathologise
- Possesses biomedical gravitas
Drawing on these attributes, the most important consideration is that diverse older people, including those living with “biomedical frailty”, are involved in the process of finding the new term. In addition, the new term should highlight that there is a range of biological reserve across the whole population. We suggest avoiding words that already have negative connotations, such as vulnerability, and constructs that imply personal responsibility which may engender shame and impede access to healthcare. The new term should have biomedical gravitas, as this is likely to give it greater explanatory power, helping individuals make sense of their circumstances. Finally, as per WHO, the selected term should recognise that what an individual can do (their functional ability) is a combination of personal and environmental factors.

WHO recommends “intrinsic capacity”

WHO advocates using the different but overlapping constructs of “intrinsic capacity” and “functional ability” (Box 3) instead of “frailty”. The term intrinsic capacity possesses several of the attributes we have highlighted as important: it has biomedical gravitas, and refers to a spectrum across the whole population. It takes a lifecourse, assets-based approach which has positive implications for societal perceptions of ageing. This framework also emphasises the importance of environment on an individual’s capabilities.

**Box 3: WHO definitions**

Intrinsic capacity: the composite of all the physical and mental capacities that an individual can draw on.

Functional ability: the health related attributes that enable people to be and to do what they have reason to value. It is made up of the intrinsic capacity of the individual, relevant environmental characteristics and the interactions between the individual and these characteristics.

As these terms are not yet much used in clinical practice, (in part because their evidence-base is not as strong as frailty’s) this is a good time to explore public perceptions, for example asking how it would feel to be given a label of ‘low intrinsic capacity’. In addition, we should seek views on the constructs themselves: unlike biomedical frailty, intrinsic capacity encompasses all attributes of an individual, including aspects like ‘sociality’, not just biological reserve. This breadth highlights that someone may use psychological strength
to compensate for reduced physical capacity. Conversely, however, it means that “low
intrinsic capacity” risks implying psychological weakness.

Looking to the future

“Changing how we think, feel and act towards age and ageing” is a top research priority of
older people themselves, according to the WHO, and the UN identifies it as a key area for
action.(10,46) Reconsidering how we think and talk about frailty aligns closely with this
broader aim. Working collaboratively with older people, we should aim to co-develop ways of
talking about frailty that help biomedically “frail” individuals to make sense of their
experiences and maintain their well-being, and that are not a barrier to accessing care.

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