Author's response to reviews

Title: Treating frailty. A practical guide.

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Author's response to reviews: see over
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Dr Lin Lee
The BioMed Central Editorial Team

Dear Dr Lee

Thank you for the second review of the manuscript ‘Treating frailty. A practical guide’.

We have addressed the reviewer’s comments below. The revised version of the manuscript has been uploaded.

Please do not hesitate to contact me for further information or clarification.

Yours sincerely,

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Reviewer: Calvin Hirsch

Minor essential revisions

1. P 9, para 1, line 2 (“Application of the principles of behavior change to frail individuals involves acknowledging frailty can be a reversible, treatable condition....”) To be consistent with their adoption of the Fried and Walston frailty phenotype to anchor their approach to frailty management, it might be more appropriate to refer to improving components (or contributors) to frailty, eg, “acknowledging that components of frailty can be treated.” The notion that frailty can be reversed (a la Thomas Gill’s article on transitions in and out of the frailty state) is not really a fair assertion, as only components making up a definition can be treated, causing the patient to no longer meet the definition. Reversal also implies cure, which is not likely to occur. “Treated” seems like a more honest and appropriate term.

The text was amended as follows:

Application of the principles of behaviour change [33] to frail individuals involves acknowledging that components of frailty can be treated frailty can be a reversible, treatable condition and specifying the link between the intervention and outcome.
2. p 9 para 1, last sentence: Although I suspect it’s implied, it is important to state explicitly the need to engage family members. The wording, “recognition of their environmental and personal contexts” seems too vague and unhelpful. What I suspect you’re driving at is the adequacy of social support systems and potential barriers to interventions, which are important to assess and address.

The text was amended as follows:

Individuals should be supported, motivated, and empowered, with recognition of their environmental and personal contexts, and given assistance to develop both goals and the strategies to achieve them. Potential barriers to adherence should be assessed and addressed, with particular reference to engagement of social support systems.

3. p 9, para 2 (“In our experience, a geriatrician is also necessary.”) There simply aren’t enough geriatricians to go around, and internists and family physicians certainly can learn important geriatric concepts and approaches to care. I recommend changing “also” to “often” or “generally.”

The text was amended as follows:

In our experience, a geriatrician / rehabilitation physician is also generally necessary.

SUGGESTED BUT DISCRETIONARY REVISIONS

P 9, para 2, “The Team:” There simply aren’t enough geriatricians or interdisciplinary care teams (certainly in the States and throughout much of Europe and Canada) to take on the role of treating all patients with frailty, so implying that all frail patients should be referred to interdisciplinary geriatric healthcare teams is unrealistic. While there may not have been studies of GEM performed by non-geriatrician providers, “community GEM” has to happen, and it will be incumbent on geriatric experts to help train internists and family physicians in core geriatric principles, incorporating lessons learned from the frailty intervention trials. This manuscript tends to use a great deal of generalities in its discussions, which do not provide the reader with much tangible guidance. Mitigating this is the recognition that there isn’t space to incorporate all the desired detail. An example of a well-written but minimally helpful generality is the sentence (p 9, paragraph 1), “Individuals should be supported...with recognition of their environmental and personal contexts...” This is pretty obvious stuff. It would be great if the authors could edit out generalities and replace them with somewhat more concrete recommendations without expanding the overall word length.

We appreciate the reviewer’s comments regarding the lack of availability of interdisciplinary care teams and geriatricians in many countries. We have addressed
the reviewer’s suggestion by replacing generalisations with more concrete recommendations in the following sentences:

1. Known characteristics of effective teams should be incorporated in the team structure, for example there is consensus that inter-professional collaboration should be promoted [37]. through policies and systems that facilitate communication, common goals and a shared decision-making process. Strategies include employing policies and systems that facilitate a shared decision-making process, encourage communication regarding patient care and reduce duplication of patient information and testing.

2. A recent review of case management for long-term conditions found case management is more effective if the interventions and procedures are well-defined, and are followed, the service is structured and resourced to allow appropriate caseload size is appropriate (for example there is adequate time for patient monitoring and review), and case-management practice allows for continuity and scope of care in terms of assessment, monitoring, review and as well as management of resources [42].

3. In addition, targeting those patients with identified problems that require intervention suitable patients may increase the effectiveness of the intervention [39].

4. Also, the amendment in response to Minor Essential Revision 2: Individuals should be supported, motivated, and empowered, with recognition of their environmental and personal contexts, and given assistance to develop both goals and the strategies to achieve them. Potential barriers to adherence should be assessed and addressed, with particular reference to engagement of social support systems.