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ABCDE-Frailty for critical presentations: summary of the 2025 ESICM expert consensus recommendations

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The European Society for Intensive Care Medicine (ESICM) has endorsed critical care recommendations for people aged over 80 years [1]. These 48 statements and 2 checklists were developed using a Delphi study which achieved consensus among multi-national experts from intensive care, emergency, and geriatric medicine.

Like emergency departments (ED), intensive care units (ICU) are observing that 'very old patients' (defined by these 131 experts as being aged 80+) represent their fastest growing cohort [2, 3]. As is now well known in emergency medicine, this group are more likely to be living with frailty [4], which carries inherent risks of poorer healthcare outcomes including longer stays, increased complications such as falls, and higher mortality up to one year after ED presentation [5, 6, 7]. It is perhaps this fragility of health that leads people living with frailty to consider meaningful those aspects of emergency care beyond simply providing timely and efficient treatment for the acute condition, namely feeling safe and supported, and feeling holistically involved and empowered [8]. These differences in perspective, goals, and outcomes pose complexity when decisions are required, often requiring clinicians to step away from unrepresentative evidence and guidance and instead employ person-centredness and pragmatism. That proves just as difficult in the ICU as in the ED, probably because research and training have generally focussed on single problem presentations rather than the inherent multiple problems occurring in people living with frailty [9, 10].

The recommendations prompt us to consider quality of life goals and individual perspectives on intervention options. As emergency physicians, we note the need to hone and improve our ability to tread the fine line of shared decision-making between imparting our own ideas on patients and asking them to make under-informed choices.

In addition, the statements emphasise the importance of recognising and attending to the significance of delirium, care transitions and transfers, and multi-disciplinary working with other relevant specialties and professions. We too in the ED can learn from these recommendations, and we are reminded of the European Taskforce on Geriatric Emergency Medicine's (ETGEM) own guidelines and the necessity to implement such core principles in our emergency care delivery [11].

The ESICM critical care recommendations for very old patients provide similarities with ETGEM approaches. Strong ESICM recommendations are that decisions about life-sustaining treatment should be made within the context of both the likely outcomes and the time-dependent burden of interventions in intensive care, so chronological age should not be used alone as a criterion for admission to the ICU or to limit life-sustaining therapy. This is in line with ETGEM recommendations. Importantly, both the

ETGEM and now ESICM strongly promote person-centeredness. This does not necessarily mean that older patients cannot receive critical care but indicates that it should be clear for both patient and physician what matters most to that individual and whether those goals can be achieved in the ICU.

Time pressures combined with prognostic uncertainty sometimes limit confidence in decisions concerning older people with critical illness in the ED. An important and strong ESICM recommendation is the consideration of a time-limited trial. This provides capacity for emergency and intensive care physicians to collect information and manage uncertainty, but also for the patient to reflect upon and define their goals. This is especially important for the complex older person for whom intensive care treatment is desired and delivered, whose situation ultimately proves reversible.

Therefore, in the older person it is essential to avoid both overtreatment and undertreatment. Wrangling this dilemma is core business for all emergency and intensive care physicians who care for older people, and these new guidelines confirm that person-centredness as a potential solution transcends inter-specialty boundaries when those with potential frailty are concerned. The concept of frailty as a syndrome provides us with a common frame on which to build and inform our approach, with simple measures such as the Clinical Frailty Scale giving a lens through which to begin to appreciate a person's potential trajectory during and following care [12]. Perhaps considering frailty as early as the primary survey ("ABCDE-F": airway, breathing, circulation, disability, exposure, frailty) would arm the clinician with information on which to base subsequent interventions and decisions. One could even argue ascribing precedent priority ("F-ABCDE" akin to trauma assessment or F-CAB for cardiopulmonary resuscitation) so that the context is understood before critical interventions are performed.

ESICM calls for the implementation of frailty-attuned care across European ICUs and these principles are just as critical for implementation in our EDs. Many of these recommendations for intensive care are in fact also core competences in geriatric emergency medicine, and the advocated statements are of relevance to all older people living with frailty attending the emergency department – not just those using the resuscitation room.

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