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Older people's perspectives on frailty screening in primary care settings – a citizens' jury study

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Abstract

Background As the world's population ages, there is a growing concern with frailty, marked by reduced strength and greater vulnerability to stress. Overcoming obstacles like reluctance towards screening methods in this process is crucial for identifying and addressing frailty at an early stage. Understanding older people's perspectives can help adapt screening procedures in primary healthcare settings.

Methods A citizens' jury, comprising 14 purposively selected members reflecting community diversity, was conducted in South Australia to explore older adults' opinions on how and when frailty screenings occur within primary care settings. Participants engaged in discussions and deliberations informed by expert testimonies and evidence-based resources. This deliberative inclusive research method supported jurors to understand the evidence and contribute informed insights into health policy.

Results The jury systematically addressed several key concerns, including the major issues surrounding frailty screening, its benefits and potential harms, and measures to prevent screening bias and misdiagnosis. The outcome was 17 recommendations within the themes of screening age and frequency, consent, access and setting, communication and public awareness, and resources and cost.

Conclusions The study highlights the value of including older adults in the decision-making about health interventions aimed at them. The method proved effective in capturing a spectrum of community values and preferences, offering actionable recommendations for refining health screening policies to better address the needs and expectations of older adults.

Keywords Citizens' jury, Frailty screening, Older adults, Preventative health services, Primary care

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Background

The world's population is ageing. By 2050, it is projected that 2.1 billion people will be aged 60 years and over [1]. To improve the lives of older adults, the United Nations Decade of Healthy Ageing (2021-2030) has been implemented globally, a core goal of which is to maintain an individual's functional independence into older age [2]. A major challenge to achieving this goal is the high prevalence of frailty among older adults [3-5]. The clinical condition is characterised by a decreased homeostatic ability of multiple physiological systems, and a resultant increased susceptibility to stressors [4, 5]. Older adults living with frailty have a greater likelihood of poorer quality of life [6], a high need for health services support [7] and early mortality [8]. Various factors influence the development of frailty, including age, genetic background, sex (females are more likely to be frail), malnutrition, and chronic disease [5, 9]. Importantly, frailty can, and often does, develop without the presence of chronic disease [4, 9].

Early identification of older adults at risk of frailty or living with frailty, paired with implementation of appropriate interventions, is central to slowing or even potentially reversing the condition's development and progression [4, 10]. Thus, early case finding for frailty is paramount [10, 11]. However, the case for screening, in the sense of case-finding in symptom-free populations, is less clear [10]. Recent literature has highlighted that there exist many barriers to implementation of screening [12] and screening tools for frailty are often implemented in clinical settings without co-designed research involving older adults and adequate understanding of the specific context [10]. Indeed, very little research has been conducted on the perceptions, priorities, and opinions of older adults themselves regarding screening for frailty and the barriers and facilitators affecting their screening practice [13]. Such information is urgently needed to reevaluate current screening practices for frailty in older populations [12]. Given the complexity of the issues surrounding screening in general practice, one novel method to obtain informed public views is via citizens' juries.

Citizens' juries are an established methodology for including public values and preferences in research to inform health policy and decision making [14, 15]. As a deliberative method, citizens' juries bring together a diverse group of community members to engage with evidence, build understanding, deliberate and make recommendations on a topic of public concern [14]. Citizens' juries typically include members of the public, purposively selected to represent their community, who are tasked collectively with deliberating on a jury charge (research question) [15]. Jurors are provided with access to supporting evidence-based resources and expert witness testimonies to support their deliberations and are asked to deliver a verdict or make recommendations at the end of the jury [15, 16].

The use of citizens' juries in research can enhance older adults' participation in healthcare decision making to ensure that their needs and perspectives are adequately represented in translation of practices into health policy [17]. Engaging healthcare providers, older people, and policymakers in evidence-informed discussions [18] about screening and treatment can help older people receive timely advice on screening for common health conditions. Further, these methods can have a transformative effect on jurors, potentially shifting deeply held beliefs and attitudes [15].

Few citizens' juries to date have addressed the views of older people on screening for common health conditions [19, 20], and none related to screening for frailty. Our study aimed to address this gap by canvassing the evidence-informed views of older people (50+years), including under-represented sub-groups, about the circumstances under which health service providers should perform screening of older people for frailty within the primary care context.

Methods

The citizens' jury was set within the state of South Australia. South Australia offers particular advantages for a study seeking to maximise diversity among its participants, as it is a state characterised by significant heterogeneity with respect to population density, diversity, accessibility/remoteness, and health service distribution [13].

This citizens' jury on frailty screening is reported in accordance with the CJ Checklist (Table S1) [18]. It was the first of four citizens' juries analysing screening of older people for common health-related conditions within general practice (frailty, dementia, cardiovascular disease and diabetes) (Table S2). Jury charge questions considered by the jury were developed with reference to other citizens' juries conducted within Australia [21, 22]. The Human Research Ethics Committee of Torrens University Australia approved the study (#0206). Research was conducted in accordance with the Declaration of Helsinki and the Australian Code for the Responsible Conduct of Research.

Participants

The study aimed to recruit between 12 and 20 participants per jury [23]. Participants were purposively recruited to encourage maximum diversity [14], including representation from: Culturally and Linguistically Diverse (CALD) individuals, people identifying as gender and/or sexually diverse (GSD), persons living in rural/ remote regions and areas of high socio-economic disadvantage, and persons with varying numbers of chronic conditions. The Healthy Ageing/Vulnerable ENvironment (HAVEN) Index [24] was used to target recruitment to areas ranking in the lowest quartile of the index [24]. Lastly, it should be noted that, in accordance with the principles of ethical conduct in research with Aboriginal and Torres Strait Islander Peoples [25], we did not specifically seek representation from these communities with the intent of formulating recommendations specific to them; it was decided that this would be better addressed by a separate process, in full consultation with these communities. However, First Nations peoples self-selecting into the jury as part of standard recruiting processes were welcome to participate.

Inclusion criteria

For inclusion, participants needed to be aged 50+years, residents of South Australia, able to provide fully informed consent and effectively conduct a conversation in English. The 50+years and over age limit (as opposed to 65+years) for the older population was selected due to the project emphasis on early screening.

Exclusion criteria

Exclusion criteria were having previously been diagnosed with frailty or having worked as a general practitioner (GP) or nurse in a primary care clinic.

Recruitment process

To meet the participant criteria described above, a hybrid passive and active recruitment strategy was used. Passive recruitment was via publication in an electronic newsletter (Seniors' Card electronic subscribers) and social media posts targeting subscribers aged 50+years in South Australia with active recruitment via direct approach to local community groups such as the Country Women's Association and Returned and Services League of Australia, among others. In addition, approaches

Table 1 Jury charge: citizens' jury on Frailty Screening in Primary

 Care settings

The jury examined the charge: "Under what circumstances should screening be provided for frailty within general practice?".

Guiding questions included:

What are the most important issues that you have heard about during the expert sessions and your discussions?

How important are the potential benefits of screening for frailty in general practice, and which potential benefits seem most important?

How important are potential harms or dangers of screening for frailty in general practice, and which harms or dangers seem most important? What should be done about the potential for screening bias and misdiagnosis?

If we do introduce screening for frailty in general practice, which health professionals should conduct the screening? At what age should patients start being screened? How should people be approached with the offer of a screening test?

were made to representatives of a number of Culturally and Linguistically Diverse community groups operating within the study area, both through industry and consumer contacts known to the research team as well as listed contacts sourced through an internet search.

Interested individuals self-selected by contacting the research team. Participants gave verbal consent before their demographic data was collected during the screening telephone call to determine eligibility for participation. To provide demographically diverse juries, participants who met inclusion criteria were allocated to a jury based on responses to demographic and health status screening questions and availability. Participants completed a Participant Information and Consent Form (PICF) prior to the jury. Participants received a \$500 honorarium and reimbursement of travel costs.

Jury process

A week prior to the jury, participants were sent an information booklet and a hard-copy pre-jury survey (Table S3), to collect further demographic information (i.e., age, gender, postcode, language spoken at home, cultural identification, income, level of education, employment status, health status). The Participant Information Booklet (Table S2) provided preliminary information about the jury proceedings, background information on frailty, screening and general practice and event logistics.

The jury was convened in the capital city centre, between 9am and 5pm each day over two consecutive days. An external facilitator with experience in community engagement facilitated proceedings. Participants gave written informed consent.

Participants were asked to consider the 'jury charge' (Table 1) and make recommendations based on the evidence presented to them throughout the proceedings, their own experience, their interactions with experts and their responses to the views of other jurors which they encountered in the deliberative process. To reduce the risk of bias, research team members attending the jury were instructed to support the jurors in a practical sense with their deliberations by providing instruction, small group moderation and/or clarifying points of fact when requested, but to avoid influencing jurors directly through expressing personal or professional opinions about the jury charge.

On Day One of the jury, a panel of expert and lived experience witnesses (Table S2) presented evidence to the jury. Experts presented information on frailty, screening, the Australian general practice landscape, ethical implications of screening and the experience of living with frailty. Participants could question the expert panel and participated in small group and whole group discussions. On Day Two, jurors convened to draft, debate, refine and vote on recommendations developed in relation to the jury charge, led by the facilitator. Jurors used coloured voting cards in an open voting manner to signify agreement (green), disagreement (red) or uncertainty (orange) with each recommendation. Researcher contributions on Day Two of the jury included providing feedback from the expert witnesses regarding questions the jurors had asked overnight, providing further clarification of facts in response to juror questions (where the researchers were also subject matter experts), acting as moderators during small group discussions among jurors, counting juror votes and live drafting and refinement of recommendations in real time. At the conclusion of the jury, participants completed a hard copy evaluation form (Table S4).

Data collection and analysis

Jury proceedings were recorded using a combination of court stenographers and hand-held audio recorders. Audio recordings not transcribed by stenographers were transcribed using online software (Otter.ai) [26]. Each participant was assigned a unique alpha-numeric identifier which was used in all transcriptions and when completing hard copy surveys. Hard copy surveys were scanned and uploaded into a central repository. Data was then entered manually into secure online platform, Qualtrics [27], for extraction to SPSS [28] for quantitative analysis. Participant postcodes were used to allocate several area-based indicators, including areas falling within the lowest quartile of the HAVEN index [24] and the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) [29], along with rural/remoteness status. A qualitative descriptive approach was used to analyse transcripts with the aim of understanding the key justifications for the recommendations put forward by jurors [30]. Two analysts (RA, CR) jointly coded the transcripts within the Microsoft Word software platform, meeting to compare, refine and rationalise codes. The unit of analysis was the whole of jury level.

Results

Participant characteristics

Fourteen jurors participated in the jury over both days (Table 2), with one attending for only the first day (their participant data has been excluded to protect their anonymity). The jury comprised a diverse group of citizens across age groups, with a greater proportion of individuals aged between 70 and 74 years. Gender representation was skewed, with the majority being female. The cohort predominantly identified as heterosexual/straight, and the overwhelming majority were born in Australia, with a smaller representation from the UK, South Africa, and predominantly non-English speaking countries. In terms of educational background, most jurors held a university or higher degree. Most participants were retired, reflective of the study's focus on older age groups. The jurors mostly resided in metropolitan areas and reported a range of health statuses, with many indicating the presence of chronic conditions. Regular visits to GPs were common, although screening for conditions varied, with none having been screened for frailty prior to the study.

Recommendations

The jury broadly supported screening for frailty in general practice and made a range of recommendations related to screening age and frequency, consent, access and setting, communication and public awareness, and resources and costs. They also submitted an overarching statement directed particularly at health professionals (see Table 3).

Screening age and frequency

The jury recommended that screening should commence at age 70 and be offered every 12 months. The jurors debated the case for a lower age limit, weighing up the possibility of identifying frailty earlier against the reduced likelihood of successfully returning a true positive screening result at younger ages, and associated increased expenses for the health system.

Consent

Jurors weighed the advantages and disadvantages of making screening mandatory. They drew on examples of mandatory national programs such as driver's license testing in considering whether mandating screening would work for frailty. However, they were also concerned that patients would acquire a frailty "label" that might be hard to shift. They therefore decided that screening should be optional following fully informed consent.

Obtaining informed consent from patients was considered an essential step before providers commenced screening. To jurors, 'being fully informed' signified that providers would be responsible for providing a full explanation of the potential harms and benefits of screening, and for ensuring that patients had understood this explanation, prior to seeking consent. The jury were very concerned about the negative consequences of being given a potentially permanent 'frailty label' in the absence of any prior explanation. One juror cited an experience of having been given a cognitive screen by a GP without permission or explanation when attending for a lung function test as a comparable exemplar:

"Sometimes I think you can be doing something not really aware of what's happening. I mean, I will give you a personal example. Earlier this year I turned 70 and I went - I was having a lung function assessment and the doctor said, just before he started, "I would just like to ask you a question. Can you start counting back from 100 in multiples of 7?" I said,

Table 2 Jury characteristics

Characteristics	No. of jurors (<i>N</i> = 14)
Age Group (in years)	
50–54	1 (7%)
55–59	1 (7%)
60–64	1 (7%)
65–69	4 (29%)
70–74	5 (36%)
75–79	2 (14%)
Gender	
Female	11 (79%)
Male	3 (21%)
Sexual Orientation	
Heterosexual/Straight	11 (79%)
Lesbian	3 (21%)
Country of Birth	
Australia	11 (79%)
UK and South Africa	2 (14%)
Predominantly non-English speaking countries	1 (7%)
Highest level of education	
Yr10/11/School certificate	1 (7%)
Yr12/Leaving certificate	0
Trade/apprenticeship	0
Other TAFE / Certificate / Diploma	3 (21%)
University / Higher degree	10 (72%)
Employment	
Full time employed	0
Part time employed	2 (14%)
Unemployed/student	0
Retired	12 (86%)
Suburb	
Metro	13 (93%)
Non-metro	1 (7%
HAVEN area	
Yes	3 (21%)
No	11 (79%)
SEIFA/IRSAD area	
Yes	2 (14%)
No	12 (86%)
Self-rated health	
Poor	0
Fair	3 (21%)
Good	6 (44%)
Very good	3 (21%)
Excellent	2 (14%)
Chronic condition	
0	4 (29%)
1–2	8 (57%)
3+	2 (14%)
GP visits (in the year)	2 (11/0)
1–3 times	9 (64%)
4–12 times	4 (29%)
13+times	1 (7%)
Conditions screened for	. (770)

Table 2 (continued)

Characteristics	No. of jurors (N=14)
CVD	2 (14%)
Dementia	1 (7%)
Diabetes	5 (36%)
Frailty	0
Other (i.e., breast cancer, osteoporosis)	2 (14%)
Unsure	1 (7%)
None	4 (29%)

Table 3 Jury Recommendations

Recommendation number	Order of recommen- dation development	Recommendation
SCREENING AGE AND FREQUENCY		
1	1	Screening for frailty should be available for everyone at 70 + years of age
2	17	Patients should be offered frailty screening as part of a comprehensive health assess- ment every 12 months
CONSENT		
3	4	Screening should be optional
4	16	Patients should be fully informed before consenting to frailty screening
5	3	Screening results can only be shared with the permission of the patient
ACCESS AND SETTING		
6	7	Screening should be part of a comprehensive health assessment
7	6	Screening should be conducted by a GP, allied health professional or practice nurse (12 yes, 2 uncertain)
8	5	The Department of Health and Aged Care should notify people before 70 years of age to contact their health professional for their screening
COMMUNICATION AND PUBLIC AW	/ARENESS	
10	9	Health professionals should communicate with patients in terms that encourage participation and empowerment
12	8	Health practitioners conducting frailty screening should avoid the terms 'frail' and 'frailty'
9	10	The government should conduct a public health campaign to encourage people 70 years and over to have a health assessment that includes frailty screening
11	15	Public health communications about frailty should be appropriate for culturally and linguistically diverse communities
RESOURCES AND COSTS		
13	2	Screening should be free for people at 70 + years of age
16	13	Resources should be provided to treat frailty identified through screening
14	12	Sufficient resources should be provided to ensure a successful screening program
15	14	If a person tests positive for frailty, a follow-up assessment should be done in a timely manner
17	11	In the event of a positive screening result, the GP team should offer appropriate educa- tion and other support to empower the patient to be actively involved in their health plan
Overarching statement	We would also like to bring the following to the attention of health professionals: A preventive approach should be prioritised in the general practice team . A preventive approach should be emphasised in medical education and professional development. Health professionals should recognize that functional disability is not the same as frailty.	

Unless otherwise noted, recommendations were unanimous

'Excuse me?'... I did reasonably well, but I thought, what is going on? This has got nothing to do with my lungs." (F02).

and therefore they required that screening results only be shared with the permission of the patient.

Access and setting

The jurors were also concerned to ensure that patients would remain in control of information about themselves,

Jurors were unanimous in proposing that screening should occur within the context of a comprehensive

health assessment as is currently available in Australia to those aged 75 years and over [31]. In placing the screening within the context of the pre-existing 75+Health Assessment, jurors reasoned that GPs may be more likely to implement this since it would be a simple extension of a familiar program. As one juror noted:

"I think the one big advantage we've got here is that we've already got Medicare paying for 75 plus. So the mindset from the GP practice point of view including the nurses, everyone else is for 75 plus test. All we ask, I think it would be simpler to say let's bring that back to 65 so that we can pick up pre-frail, Medicare pays for it, you get your five free treatments offered out of that test." (F11).

They complemented this recommendation with a proposal that the Department of Health and Aged Care (Australian Government) should provide alerts to encourage uptake of screening.

Jurors agreed that health professionals should conduct frailty screening, but they were divided on which specific disciplines should be responsible. GPs were viewed as a natural choice given the trust that many older people place in their doctors, as one juror noted:

"...people respect their doctor in general, don't they, more than any other health clinician. You can have your social workers, OTs and physios and whoever else, but it's the GP is probably the one that people listen to the most." (F11).

In addition, in rural or remote areas GPs might be the only point of contact. However, the jurors also recognised that GPs are extremely time-poor and adding frailty screening to an already busy schedule might not be feasible. Health professionals other than GPs were also thought to be more cost effective to use and/or have skill sets (care planning, holistic assessment) that would more readily align with frailty identification and treatment. Dissenting jurors felt that non-GPs should be preferred over GPs in the recommendation, because of their greater availability, greater cost-effectiveness and specialist skillsets.

Communication and public awareness

Effective communication was viewed as pivotal to the quality of the frailty screening experience for patients. Providers were seen to have a responsibility to encourage and motivate patients to take action on frailty. Disclosure of a positive frailty screening result was considered to be a potentially threatening and disempowering experience for older people, and jurors felt that health professionals would need to be proactive in terms of how they dealt with this, along with any formal frailty diagnosis and treatment that followed.

Stigma, and the potential to be given a 'frailty label', were enduring concerns the jury held regarding the potential harms of frailty screening. Jurors generally viewed the term 'frailty' as a negative one, aligning it with notions of vulnerability, weakness, incapacitation and loss of freedom.

"I think a lot of us feel as non-medical practitioners the word "frailty" is difficult. My understanding, and I might be wrong, but I think that it is already a technical clinical term for doctors. So the word exists for doctors in their vocabulary, for clinical staff, and so it's a question of they have got that word but perhaps the general public or the patients can have a different terminology ...perhaps that would be useful." (F14).

The solution put forward by the jury was for screening providers to judiciously avoid using frailty-related terminology, although no specific alternative was proposed in its stead.

Similarly, public education was seen as critical to ensuring success of the screening program. In particular, jurors felt it was important to educate the public about the rationale for screening, including the consequences of untreated frailty, and the potential benefits of treatment, so that more people would opt for screening. Cultural sensitivity within the frailty screening process was also important. Central to these recommendations was the idea that people should assume individual responsibility for their own health, and that educating people about frailty screening might equip and empower them with the necessary information to proactively seek screening from their providers:

"...education for the public so the public know what is available, what's out there, how they can deal with it and also for them, for the public to take some responsibility for their own wellbeing too. I don't think there's enough of that happening. So not just for the government to be providing all of these assessments all the time, but I do think go back to the question of how many people take responsibility for their own health."(F04).

Resources and costs

The jurors highlighted that the Australian model of general practice as privately-run businesses affects access to healthcare. In particular, they pointed to many people's inability to pay for screening or ensuing treatment, due to both rising cost of living increases and the need to pay the 'gap' (the difference between the fees charged by practices and the amount funded by the Australian government under the Medicare system). These factors were key reasons in explaining the recommendation to make screening freely available to eligible groups.

Screening (and for that matter, diagnosis) without follow-up treatment was viewed as a pointless, and potentially harmful, exercise. For example, costs relating to accessing allied health professionals such as podiatrists and physiotherapists were cited as a potential barrier, along with the costs of special diets if required. The jurors recommended an expansion of government funding to effectively provide treatment for identified frailty.

Moreover, there was an expectation that this treatment would be provided by the GP team to enable the patient to participate as an active partner in their care. Although jurors continually emphasised the personal responsibility of the individual patient to take care of their own health, there was still a strong feeling that health care providers should take the lead in motivating and supporting their patients to be able to do so.

"I think one of the risks or barriers is that if something like this isn't implemented as a complete package, and by that I mean you've got to have education, you have to have the correct tools, you then have to have the support network in terms of doctors, physios, occupational therapists, whatever it might be. If you don't have all of those then it becomes a much more difficult program to sell because we go back to what we said earlier, that if there's no point in identifying an issue if you can't have a resolution to that issue." (F12).

Jurors were also aware that a positive screening result for frailty might not automatically be followed by further assessment conducted within a reasonable timeframe. As the exchange below reflects, the jurors were concerned about the potential lasting impacts of a frailty label following a positive screening result, especially in situations where no follow up was offered:

F13: "So to me a negative too is if you are just relying on this test with no other... it's a triage system, and the test is an initial trying to allocate you. If you are just going to keep the allocation based on that one test, that's bad. So there needs to be something that comes in after that that can be more nuanced and can weed out those people that are false positives." F08: "Before it becomes an issue in their lives." F13: "If it's just a test that's not good."

Overarching statement

In addition to the recommendations supported by the jury, several jurors felt strongly that there should be a general focus on prevention and on differentiating between disability and frailty. However, most of the jurors considered these aspects outside the scope of the jury charge, as they related to primary care practice more generally and not to frailty screening specifically. Following consultation with the research team, the jury opted to include a statement as an addendum to the recommendations as follows:

We would also like to bring the following to the attention of health professionals:

- Health professionals should recognise that functional disability is not the same as frailty.
- A preventive approach should be prioritised in the general practice team; AND.
- A preventive approach should be emphasised in medical education and professional development.

Discussion

Although our study is the first we are aware of to address frailty screening via the novel methodology of using a citizens' jury, our findings are largely consistent with prior studies exploring this theme via other methods [32, 33]. Firstly, the jury's selection of the 70+-year age group as a target population for screening accords directly with the age group identified in a previous expert consensus paper on this topic [34, 35]. Given that the evidence on agerelated prevalence rates and associated age-specific positive/negative predictive values for screening instruments at least in part informs both viewpoints, this is a promising indicator of jurors' critical engagement with the evidence presented, as does the fact that it refutes the 'status quo' of existing age limits for free assessment in Australia. Secondly, participants viewed frailty overwhelmingly as a negative term and concept, consistent with previous qualitative research conducted with consumers [12], generally within non-deliberative focus groups and individual interviews [32, 36]. However, in contrast to these studies, jurors were more aware and hopeful about the prospect of being able to address frailty through timely intervention. This may be due to the increasing awareness in the community about frailty. Thirdly, the jury placed a great deal of emphasis on the need for expanded public and provider awareness on frailty and the benefits of early identification, comprehensive assessment and treatment, echoing calls from the broader community of experts for the same [34, 37, 38].

Despite this alignment with the previous body of work on frailty, our findings also raise questions about the practicalities of frailty screening. While most jurors felt very strongly that GPs had a key role to play in screening, there was explicit recognition that time and cost pressures within the Australian general practice context made it very difficult for GPs to fulfil this role. Consequently, the possibility that providers other than GPs might deliver the screening was explored, although jurors did not address workforce implications in depth.

Further, jurors assigned significant responsibility to healthcare providers with respect to guiding the patient through the screening experience, including initiating discussions about frailty. However, this assignment reflected an assumption that providers would have both the skills and knowledge to confidently conduct conversations about frailty, which our prior research has shown is not necessarily the case [39, 40]. This underscores the importance of current recommendations for training healthcare professionals in effective communication and shared decision-making about frailty with older adults [41]. These recommendations advocate for several components, including establishing a knowledge base regarding frailty and screening pathways, offering 'hands-on' practical training to clinicians in effective communication skills, identifying suitable discussion partners (such as family members, friends, paid carers, or interpreters), actively involving patients in decision-making processes, and promoting interprofessional collaboration.

Finally, jurors placed value on obtaining fully informed consent, but also wished for healthcare providers to avoid using the terms 'frail' and 'frailty'. This aligns with prior research indicating how the negative associations, fears, and societal stigmatisation surrounding ageing and frailty can affect communication during healthcare interactions [42, 43]. Furthermore, it supports qualitative findings suggesting that older adults would rather initiate discussions about frailty themselves and focus on strategies to prevent or manage frailty (e.g., exercise), than simply be labelled with a potentially stigmatising term [12, 42, 44]. Although placing frailty screening within the context of a broader comprehensive health assessment would reduce the emphasis on frailty as a standalone concept to some extent, it is questionable as to whether the consent process for assessment would then inform patients as thoroughly as jurors required. Potentially, emerging concepts such as 'intrinsic capacity' that emphasise capability rather than deficit [13], may represent a step towards resolving the jury's concerns, although to our knowledge, there have been no studies exploring the acceptability of this term to older people.

Strengths and limitations

Our study was characterised by a number of strengths. To our knowledge, this was the first citizens' jury to be held on frailty screening for older adults. Although several previous studies have explored consumer perceptions of frailty through methodologies such as focus groups [32, 36, 43, 45], none to date have been deliberative – that is, none have involved consumers in a structured process that encourages critical thinking and engagement with the evidence to develop recommendations. Such an approach is an advantage because it ensures that participants can critically engage with accurate and relevant information, which underpin the robustness of the recommendations [34, 46]. Evaluations indicated that jurors found their experience to be very positive, with the majority indicating that participating in the jury had increased their awareness of different perspectives on frailty screening, and most feeling that there would be a positive policy/governance outcome relating to their recommendations (Tables S5 and S6).

There were also some limitations of our study. Jurors were recruited from a single Australian state (South Australia) and formulated recommendations within the context of the Australian health care system, which makes care available at free or low cost to citizens via a taxpayer-funded platform (Medicare). Further, despite efforts to encourage representation from diverse groups, the relatively small sample, recruitment via social media/ email, difficulties in recruiting from some groups (e.g. rural/remote) and late notice withdrawals from the jury due to illness resulted in a relatively well-educated, technologically-savvy, predominantly female and largely Australian-born jury. However, it should be noted that the issue of 'representativeness' within citizens' juries remains a somewhat contested concept. As Huitema and colleagues note [46], jury participants are encouraged to develop their recommendations on the principle of the common good, rather than to deliberate on the basis of their individual experience alone. Consequently, they go on to argue, if one is adhering strictly to the principles of deliberative democracy, it should not matter who is selected to attend the jury. In practice, they advocate aiming for inclusivity, as we have also attempted to do, while acknowledging that true inclusivity can be difficult to achieve, for a whole range of practical reasons. Additionally, participants self-selected into our study, and therefore may represent a cohort with pre-existing interest/knowledge in screening and/or health policy more generally. Consequently, our results may not be generalisable to other contexts. Lastly, we cannot rule out the possibility of bias introduced through the jury process itself, although a number of safeguards were put in place throughout the jury to reduce the impact of research team influence on juror deliberations.

Conclusion

This citizens' jury of older South Australians aged 50+years supported government-funded, free frailty screening for all Australians aged 70 years and over, provided by GPs, Practice Nurses and/or allied health professionals within the context of an annual comprehensive health assessment program. Screening was contingent on a number of conditions being met, including:

(1) screening be optional; (2) patients be fully informed before consenting; (3) results be shared only with permission; (4) communication about frailty be culturally/ linguistically appropriate; (5) follow-up be timely, and; (6) patients be empowered to actively engage in care planning. Despite the strong emphasis on proactive communication by patients with healthcare providers, the jury desired that health professionals avoid explicitly mentioning the term 'frailty', because of perceived stigma with identification as a frail person. The jury emphasised a strong role for Government, including: (1) adequately resourcing frailty screening and treatment; (2) an awareness campaign to educate the public about frailty; and (3) a notification system to remind eligible Australians approaching 70 years to seek an assessment. Juror recommendations aligned with several previous studies regarding recommended age of screening, negative consumer perceptions of frailty and the need for greater public and provider awareness on frailty. Policy makers and practitioners should bear our findings in mind when formulating health policy on frailty screening for older adults.

Supplementary Information

The online version contains supplementary material available at https://doi.or g/10.1186/s12875-024-02626-8.

Supplementary Material 1	
Supplementary Material 2	
Supplementary Material 3	
Supplementary Material 4	
Supplementary Material 5	
Supplementary Material 6	

Author contributions

ABM, ED, AC, RV, JB, ML and RA conceptualised the initial study design. ABM, JS, BF, and RA designed and conducted the jury. RA, ABM, RV and JB presented as expert witnesses in the jury. RA, CR, LOB, ABM, JS and BF analysed and interpreted the data. RA, ED, CR, and LOB drafted the initial version of the manuscript. All authors contributed to manuscript revisions. All authors reviewed and approved the final version of the manuscript.

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Data availability

Data availability: The datasets generated and/or analysed during the current study are not publicly available but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Ethics approval granted by the Torrens University Australia Human Research Ethics Committee (#0206). All participants gave written, informed consent to participate.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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