Studying delirium

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We have a number of concerns regarding the recent study by Martin G. Cole and associates[1] of multidisciplinary care in patients with delirium.

Delirium represents a change in cognition or the development of a perceptual disturbance that is not better accounted for by a pre-existing, established or evolving dementia.[2] However, given that between 60% and 70% of the patients in both the intervention and usual care groups had suspected dementia, it is difficult to interpret the results of the study. It is also unclear why improvement was measured in terms of Mini-Mental Status Exam (MMSE) scores. The MMSE was not developed as a means of rating delirium; a more appropriate scale for this purpose would be the Delirium Rating Scale.[3] The authors indicated that the rates of compliance with the recommendations of a geriatric specialist were "relatively high," but Rockwood,[4] commenting on this study in the same issue of *CMAJ*, noted that "27% of recommendations on medication and 31% of recommendations on investigations were not followed." This is particularly disconcerting given that delirium in the medically ill is associated with higher mortality rates.[5] Also, patients with an untreated medical disorder (e.g., a urinary tract infection) remain delirious despite receiving a "nursing intervention."

The primary treatment for the symptoms of delirium is pharmacologic, including neuroleptic medication.[6] Evidence for the efficacy of antipsychotic medication has been shown in a randomized, double-blind, comparison trial.[7] However, Cole and associates did not indicate what medications were given to either the intervention group or the usual care group.

The results of this study should not alter the current management of delirium, which includes reversing the underlying cause and treating agitation, psychosis and insomnia with appropriate medication.[8,9]

References

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[Two of the authors respond:]

Stephen Anderson and Robert Hewko have raised 5 important issues, to which we have the following responses.

First, in our study[1] we included patients with delirium superimposed on dementia because dementia is the most common risk factor for delirium in elderly hospital patients[2] and because most elderly hospital patients with delirium also have dementia.[3] In our subgroup analysis, patients with delirium alone appeared to benefit more from the intervention, although this effect was not statistically significant.

Second, we used the change in the MMSE score as our primary outcome measure because it is a reliable, valid, reasonably responsive and widely used measure of cognitive impairment, a core feature of delirium. Analysis of our secondary outcome measures (reported on page 757 of the article), the Delirium Index score (a measure of the severity of 7 delirium symptoms)[4] and the Barthel Index score (a measure of basic self-care activities),[5] yielded similar results.

Third, we reported the results of our process of care analysis on the *CMAJ* Web site (as noted on page 755). Of course we are concerned that compliance with recommendations was not 100%. However, the rate of compliance with the consultants' recommendations in our study (about 70% for recommendations related to medications and investigations) was much higher than corresponding rates of compliance reported elsewhere.[6,7] We attribute this modest success to the work of the intervention nurse, who encouraged compliance.

Fourth, the pharmacologic treatment of symptoms of hyperactive delirium may involve the use of antipsychotic medication.[8] However, there is no evidence that antipsychotics are useful in patients with hypoactive delirium.[8] Our geriatric specialist consultants made a mean of 6 management recommendations per patient, including the appropriate use of medication. Antipsychotic medication was prescribed for 47% of patients in the intervention group and only 24% of those in the control group.

Finally, we agree with Anderson and Hewko that our results should not alter current best management of delirium in elderly medical inpatients.[8] Unfortunately, current best management means that in most elderly patients with delirium the condition goes undetected, and only half recover.[8,9] Surely there should be continuing efforts to improve the treatment and outcomes of these patients.[10]

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Medical women in academia: silenced by the system

Anita Palepu and Carol Herbert are to be commended for their thoughtful analysis of the issues facing women in academic medicine.[1] While there is acknowledgement that domestic responsibilities are a major contributor to the career obstacles many women face, there also exists a gender issue at the systems level. Because the academic structure developed at a time when men were its only members, it tends to value stereotypically male characteristics such as autonomy, assertiveness and decisiveness.[2,3] In such a structure, "women are perceived as having less leadership ability and less competence, and when women exercise assertiveness or try to assume leadership they have to work harder to get attention and they receive more negative reactions."[2]

Perhaps women could develop a different type of organizational structure. A survey of faculty at a single US academic institution found that, relative to their male counterparts, women faculty placed less value on accomplishments such as leadership, scholarship and national recognition and more value on recognition of their work by patients, students and local peers.[4]

This analysis by no means presumes that men intentionally perpetuate the system, nor does it imply that all men benefit from the current structure.[3] New strategies must address ways of changing the academic system to best accommodate the strengths of both women and men, rather than trying to mould women to fit an organizational structure that was never designed for them. This goal can be accomplished by a willingness on the part of academia to understand and root out the cultural biases that lead to discrimination. We would all be well served by institutional approaches that address "discrimination by fixing the organization, not the women who work for it."[3]

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Early in my career I was blessed with 4 children. Needless to say, this forced me to make major decisions about how I would conduct my medical practice. Although my doctor-husband became involved in hospital and committee work, teaching and a full range of family medicine activities, I decided that I wanted to spend more time with my children while they were young; therefore, I had an exclusively office-based practice.

Now all 4 children are off to university. I have no regrets about how my career evolved. I continued to practise medicine while many of my female colleagues fell by the wayside because they could not balance career and family. My only regrets echo those expressed in the article by Anita Palepu and Carol Herbert[1] — I "regret the time [I] did not have for [my family] rather than the time that [I] did not have for work."

There are some things that I would have done differently, but in the end I think things turned out well for all of us. Proof of this was a recent family discussion during which we talked about which was our favourite weekday. My eldest, without hesitation, declared Thursday to be his favourite weekday because, as a little guy growing up, he knew that I was always home on Thursdays and we would spend time together and do things. The tears in my eyes confirmed that I made the right decisions.

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I commend Anita Palepu and Carol Herbert[1] for challenging us to rethink the orthodoxy that characterizes medical academia. It is through the work of pioneers such as these that not only women, but also visible minorities and other previously restricted demographic groups have entered and succeeded in the academic realm.

Perhaps one of the most critical elements in this transition is the social awareness within student populations at Canadian medical schools. At the University of Western Ontario, I witnessed the development and expansion of several initiatives related to gender, culture and socioeconomics, and from my vantage point as a student leader, I observed this trend at other Canadian medical schools as well.

Central to the success of these projects was the support, both moral and financial, of faculty and administrators. Palepu and Herbert recommend mentorship and innovative administrative portfolios as ways to encourage women to advance their academic careers. Such initiatives send a strong message about the priorities and social conscience of an