3. Hypoactive or quiet delirium:
   a is frequently missed in clinical practice
   b has a better prognosis than agitated or hyperactive delirium
   c does not respond to antipsychotic agents
   d frequently makes patients unrousable
   e rarely includes delusions or hallucinations.

4. In the management of patients with delirium:
   a iatrogenic causes of delirium are common
   b involvement of relatives is generally discouraged
   c risk factor reduction allows episode prevention
   d delirious patients should not contribute to treatment decisions
   e the effectiveness of antipsychotics is principally due to sedative actions.

5. In delirium assessment:
   a delirium rating scales allow distinction of delirium from dementia
   b delirium cannot be accurately assessed in mute patients
   c the CAM has good coverage of delirium symptoms
   d the DRS has good coverage of delirium symptoms
   e the MMSE has good coverage of delirium symptoms.

MCQ answers

1	2	3	4	5
a T	a F	a T	a T	a T
b T	b T	b F	b F	b F
c F	c T	c F	c T	c F
d F	d F	d F	d F	d T
e F	e F	e F	e F	e F

Commentary

Alastair Macdonald

Dr Meagher's measured account of delirium, and his proposal for a greater role for psychiatry, brings to mind Jim Birley's extension, when President of the Royal College of Psychiatrists, of Desmond Curran's "Psychiatry Ltd" (Curran, 1952). This tried to redress the overweening presumption that psychiatrists should not only opine on every aspect of medical, social and political life, but also demand hegemony over them. Sadly, for instance, in the case of violent behaviour by people with mental illness, his caution went unheeded, and the results are there for all to see. It is against his injunction that I test the role of psychiatry in delirium.

A distinction must be made between a description (what is the current role of psychiatry – service, research and teaching – in delirium?) and prescription (what should be the role of psychiatry?). Another point is that 'psychiatry' cannot have a role – only psychiatrists can, and then only in a particular, local matrix of service organisation and delivery. I take this matrix from the UK, at this juncture, although of course we arrogate evidence where we will. I will also say nothing further about delirium in childhood; a fascinating yet grossly underresearched topic.

First, description. In terms of service, we need to know where delirious people are, who is dealing

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with them and how psychiatrists are involved. It is likely that most delirious adults are older people, but probably the older you are, the more likely your delirium is to occur outside hospital, since delirium in younger patients is more likely to associated with severe systematic or cerebral disease. But there is next to no evidence from the UK on the topic of delirium in the community, and, although there are American and Scandinavian studies, we do know that, in general, rates of disorder in community settings differ across countries because of the different ways services are organised, so extrapolation is difficult. It would probably be safe to say that most delirium in the community does not involve psychiatrists, even in older people. In hospital, rates of delirium from UK studies in psychiatric and old age psychiatry wards, and in referred liaison samples, are generally lower than those in general medical and surgical wards, for all adults. So it is in general hospitals that psychiatrists may be playing a role. Dr Meagher describes a 'classical' model of involvement of psychiatrists with medical teams including significant educational elements, but it is by no means clear that this is common, let alone universal. It is probably be the case that most clinical involvement of psychiatrists with delirium is after a specific referral for an opinion, whether or not the delirium is recognised by the referrer. Often, this opinion would be sought because of management problems, rather than because of the syndrome itself. The role of psychiatrists is to confirm the presence of the syndrome, and to suggest behavioural interventions or advise about capacity to consent to some intervention. Many cases of delirium in the UK are probably not dealt with by a team in which a psychiatrist is playing an integrated role. The proportion of research carried out with significant psychiatric involvement remains constant, but small – Dr Meagher is an exception. Most is carried out by physicians and neurologists. The position in relation to teaching is unclear. In some medical schools, undergraduate delirium teaching is jointly carried out by physicians and psychiatrists, but the frequency of this model is not known, nor is the frequency with which psychiatrists are involved in general nursing or postgraduate general medical or surgical education. In summary, then, the present position is that psychiatrists are probably involved in only a small minority of patients with delirium, are not particularly prominent in research, and may be involved in teaching but possibly not teaching the right people.

When it comes to prescription rather than description, Dr Meagher's figure points to various ways in which psychiatrists might contribute to the care and treatment of people with delirium, directly and indirectly. Psychiatrists might improve the detection of delirium. Teams with psychiatric involvement might be better able to distinguish delirium from other psychiatric syndromes than non-psychiatrists, and better able to assess risk, contribution of medication and legal capacity. Management of delirium with psychiatric involvement might be better than without it, perhaps because of psychiatrists' skill in multi-disciplinary working. Dr Meagher's prescription for research involvement of psychiatrists leans heavily on our phenomenological, psychopharmacological and methodological expertise. All these may be reasonable suggestions, but the evidence on which to base them is mostly simply absent. This is not surprising, as he correctly says – psychiatrists are busy enough dealing with the syndromes in patients referred to them without having to consider the large number of patients with delirium, many of whom are quietly distressed rather than causing a nuisance. We can point to evidence that delirium identification, assessment, management and research is inadequate; what we have less grounds for is an assertion that psychiatrists can rectify all these inadequacies.

The big issue here – of the respective role of psychiatrists and other disciplines – is of course a very general one, and it is important that psychiatrists do not casually offend other professionals by questionable claims to supremacy in any area. (Unquestionable claims are, of course, legitimate.) Delirium is, par excellence, the disorder in which the distinction between physical and the psychological or emotional aspects of patient assessment and management dissolves, and interest in delirium brings UK psychiatrists into contact with organisations or parts of organisations with a very different style of service – one that might be regarded as not only unhelpful to people with delirium, but frankly deliriogenic. If we want a role in this fascinating area, we need to work out when to involve ourselves in a helpful and educational way, and when we need to stand back and offer a clear, dispassionate critique in a way that will lead to change. However tempting, the urge to take over must be resisted.

Reference

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