Guest Editorial

Delirium and Dying

KEYWORDS: Delirium; diagnosis; palliative care

A parted ev’n just between twelve and one,
ev’n at the turning o’ th’ tide— for after I saw
him fumble with the sheets, and play with
flowers, and smile upon his finger ends, I
knew there was but one way; for his nose
was as sharp as a pen, and ’a babbled of
green fields . . . A bade me lay more clothes
on his feet. I put my hand onto the bed and
felt them, and they were cold as any stone.

William Shakespeare, Henry V

There is a terrible poignancy to the
delirium experienced by a person who is
dying. For those who love that person,
and likely for the dying individuals
themselves, there can be a sense of
opportunity lost, of having left too soon.
This is not an isolated phenomenon:
Case series show that many, even most,
patients who die of advanced cancer
experience delirium (Gagnon et al.,
2000; Jenkins et al., 2000; Lawlor et al.,
2000; Massie et al., 1983; Pereira et al.,
1997; Power et al., 1993). In this obser-
vation lie conceptual and practical prob-
lems. Conceptually, it is not clear how
those whose chief focus is the advance-
ment of research and practice on deliri-
um should view decreased attention and
concentration and arousal (and from
this, impairment in higher aspects of
cognition) in a person who is dying. If
this is largely an inevitable and untreat-
able aspect of the last several hours of
the lives of terminally ill patients,
should it be conceptualized differently
from the onset of these symptoms over
a few hours in a person who has other-
wise been well? Or should these situa-
tions be seen as being at opposite poles
of an approach to the management of a
condition that is nevertheless a unified
entity? There is currently no phenome-
nological or pathophysiological evi-
dence that might help us on this issue.
Might the best analogy here be to view
delirium as if it were, say, a myocardial
infarction? “Heart attack” has continuity
as a concept despite diverse instantia-
tion, and we readily accept that the
diverse circumstances result in diverse
management. Even if we accept the
assumptions inherent in the inevitability
and naturalness of delirium as part of
the dying process, how are we to count
it? Where does delirium in a terminally
ill patient count in the statistics reckon-
ing the prevalence and incidence of
delirium, or more importantly in the
impact of delirium on survival? Have
some of the accounts of the poor prog-
nosis of delirium overstated its impact
by not taking into account delirium
among the dying?
Delirium among the terminally ill is also of interest, of course, to those whose focus is the advancement of research and practice in the care of the dying. While recognizing that delirium can sometimes be a relatively brief and natural part of the dying process, it is difficult to read a recent Consensus Panel statement of end-of-life care without feeling some of the poignancy of the cases that must have motivated this effort. The statement, by a panel of the American College of Physicians and the American Society of Internal Medicine, challenges health care providers to face head-on some of the practical dilemmas of potentially reversible delirium among patients who are nevertheless terminally ill (Casaret & Inouye, 2001). Usefully, these dilemmas are dealt with by working through a difficult but exemplary case. Patients' and families' goals are rightly accorded center stage, exhaustive laboratory and imaging studies are not undertaken, and scrupulous attention is paid to medications and to the patient's environment. A role for family members in diagnosis and management, though not spelled out, is at least envisioned.

But to return to our original focus—on delirium—what are we to make of this as delirium researchers? Perhaps an analogy is useful here. Patients with dementia often demonstrate behavioral and psychological symptoms that are akin, for example, to depression or to anxiety but which nevertheless fall short of meeting relevant diagnostic criteria. In such cases, it is useful to think of these diagnoses as metaphors for how the behaviors and symptoms have occurred and how they might be treated (Tariot, 1999). Similarly, among those patients with known terminal illness, the metaphor of delirium might be employed as an aid to diagnosis and to management, while keeping it distinct from the delirium encountered among those not recognized at the outset as terminally ill.

What are the consequences of understanding delirium as a metaphor for what is sometimes called the “terminal drop” among those who are dying? For those caring for the dying, it allows insights into the potential for reversal of the delirious symptoms, insights which, with judicious application, can help relieve suffering. For those whose interest is delirium, there is a need to estimate the impact of unrecognized “terminal drop” on our understanding of the outcomes of delirium. We need to separate from the notion of delirium the idea of terminal decline as an event heralding death, which requires not the application of delirium diagnostic schedules but the thoughtful institution of palliative care (Bruera et al., 1992). Perhaps some part of the persisting difficulty in communicating delirium management techniques to practicing clinicians (Rockwood, 1999) has been our failure to disentangle this aspect of delirium, as heralding the final act in the play of death, from the delirium as the villain to be vanquished.

The distinction, of course, can be tricky, and it is easy to think of cases—for example, of a depressed patient with lymphoma who poisons himself with methanol but presents with delirium—that blur distinctions of “terminal illness,” incidental delirium, and disease presentation. But let us not be dissuaded by this. Delirium is a truly clinical research phenomenon, and as such requires systematic clinical observa-
tion of large numbers of patients. Such study will unravel many unique threads in the rich tapestry of altered cognition in the face of illness, and we must allow these to be properly described, and not precluded by premature specification of models of disease.

Such a study will also highlight areas in which the interest of palliative care researchers and delirium researchers coincides. The role of analgesia in causing delirium, or, by combating delirio-genic pain, in relieving it; the question of whether delirious patients who are dying can competently change their wills during apparently lucid periods; the limitations that cognitive impairment, including delirium, has on the perception, recognition, or management of pain; or how to think of dementia as a terminal illness when making decisions about superimposed acute illness (Morrison & Siu, 2000): these are all important clinical questions that are likely to need the combined expertise of researchers from both backgrounds. Questions like these, by dwarfing our current abilities, can unite us in our enquiries.

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REFERENCES


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