

Episode: *Author Interview: "Why We Must Prevent and Appropriately Manage Delirium"*

Guest: Jo Ellen Wilson, MD, PhD, MPH

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Transcript by: Cheryl Green

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[bright theme music]

[00:00:04] TIM HOFF: Welcome to another episode of the Author Interview series from the *American Medical Association Journal of Ethics*. I'm your host, Tim Hoff. This series provides an alternative way to access the interesting and important work being done by Journal contributors each month. Joining me on this episode is Dr Jo Ellen Wilson, an assistant professor of psychiatry and behavioral sciences at Vanderbilt University Medical Center in Nashville and a physician-scientist at the US Department of Veterans Affairs Geriatric Research, Education, and Clinical Center. She's here to discuss her article, coauthored with Drs Jennifer Connell and Maria Duggan, "*Why We Must Prevent and Appropriately Manage Delirium*," in the October 2023 issue of the Journal, [Geriatric Psychiatry](#). Dr Wilson, thank you so much for being on the podcast. [music fades]

DR JO ELLEN WILSON: Thank you so much for having me.

[00:00:55] HOFF: So, to begin with, what is the main ethics point that you and your coauthors are making in your article?

WILSON: So, before we can talk about the key ethics point, I think it's really important that everyone understands what delirium is. Delirium is a form of acute brain dysfunction. It's characterized by changes in attention, orientation, awareness, and in some cases can be associated with the development of delusional thoughts as well as hallucinations, and can be quite distressing both for the patient and for the caregivers who help manage these patients. Delirium is very common, unfortunately, and its prevalence increases amongst certain patient populations, particularly older adults, those with existing cognitive impairments such as preexisting dementia, and in some patient populations with a history of prior anxiety and/or depression, for example. Delirium is felt to be not only highly prevalent but highly preventable. And in some cases, delirium's prevalence has been considered to be a form of a nosocomial or an iatrogenic phenomenon, meaning that there's things that we do in the hospital that have been associated with the prevalence of delirium.

And so, I think the key ethics point here is that there is a major ethics practice gap, or some people have termed this the "no do gap," meaning that we as a healthcare system have invested incredible resources to conduct research into the risk factors for the development of delirium amongst different patient populations, we've developed screening tools to help us recognize delirium amongst a number of different patient populations, and we understand how we should best prevent and manage delirium. Yet we don't do it consistently across the board.

[00:02:58] So, in terms of just understanding a little bit more about what is the evidence, or what do we know about how to prevent and manage delirium, for over two decades now, there have been a number of different cognitive-friendly policies that have been researched, developed, and formatted into consensus guidelines for preventing and managing delirium. A good example of that would be the clinical practice guidelines for the management of pain, agitation, and delirium in adult patients in the intensive care unit.

This care bundle has been highly recommended by the Society of Critical Care Medicine to prevent and reduce delirium prevalence amongst adults in the intensive care unit. And they found that even in these sickest of patients, by strict adherence to this care bundle, you can reduce delirium prevalence on the next day by up to 40 percent. Additionally, that's been associated with a number of other beneficial outcomes in terms of reducing length of time on mechanical ventilation, etc.

There's other great examples of cognitive-friendly policies that've been shown to reduce delirium as well. For example, the Hospital Elder Life Program or HELP program is a multi-component strategy to prevent the functional and cognitive decline in hospitalized older adults. And this HELP program has been associated with the reduction of delirium by 50 percent amongst older hospitalized adults. So, we know a lot of the things that we should be doing, yet for many reasons, these policies are not implemented across the board. Hospitals are also not financially incentivized to adhere to these care bundles that we know help improve outcomes.

[00:04:52] HOFF: And so, what would you say is the most important thing for health professions students and trainees specifically to take from this article?

WILSON: I think it's actually really simple. So, we've talked about some of these care bundles that we know help improve outcomes for our patients. You can do something. So, this isn't something that we just have to kind of sit back and observe and say, "Well, geez. This is really sad that this affects our patients in this way." You can do something. You can look at these guidelines. You can look at the literature. You can encourage the teams that you're on and question. Be inquisitive. "Hey, are we mobilizing our patients early? Are we," for example, with intensive care unit patients, "are we doing spontaneous awakening trials, spontaneous breathing trials? Are we engaging the family in the care of this patient and in advocacy for this patient? Are we perhaps using too many deliriogenic medications such as benzodiazepines, to manage distress? Are there other things that we could think about doing? Are we trying to normalize the environment for the patient as much as possible?" Bringing in pictures of their loved ones, frequently orienting them, using music to comfort and soothe. And then, being inquisitive and asking the family, "Hey, does your loved one typically use glasses or hearing aids at home?" and encouraging the use of that.

Frequently, one of the things that I encourage students that rotate with me—I'm a consultation-liaison psychiatrist, and so students that rotate with me or trainees that rotate with me—is empowering them to use some of these cognitive-friendly policies that've been built into these care guidelines. You can do that. You can implement portions of the care guideline even if you're not the main person managing their care.

[00:07:01] HOFF: And finally, if you could add a point to your article that you didn't have the time or the space to fully explore, what would that be?

WILSON: I think just helping the reader to understand the real human toll of delirium. Delirium is a very real form of human suffering. And so, I think that most of us who go into a health profession field enter it because we want to prevent human suffering, treat human suffering, and connect with our patients, and make a difference in their lives. Delirium is a very real form of human suffering, not only for the patient. We know that suffering is real, but also for the families and those that love and support that patient. We know that delirium is associated with significant morbidity and mortality. That evidence is clear. Delirium is well associated with the development of new-onset depression, PTSD, cognitive impairment akin to a new-onset dementia, institutionalization. I mean, these patients more frequently are not able to return home, and oftentimes their new cognitive

and functional disabilities impair them from being able to engage in life in the same way that they used to, such as being able to return to work and support their families. [theme music returns] So, the suffering from delirium is very real, and we want to do everything in our power to prevent it, if at all possible.

[00:08:37] HOFF: Dr Wilson, thank you so much for your time on the podcast today, and thanks to you and your coauthors for your contribution to the Journal this month.

WILSON: Thank you.

HOFF: To read the full article, as well as the rest of this month's issue for free, visit our site, [journalofethics.org](http://journalofethics.org). We'll be back soon with more *Ethics Talk* from the *American Medical Association Journal of Ethics*.