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Reply

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We thank Drs. Ely and Jackson for their comments and for complementing our review [1] by providing further helpful references on the Confusion Assessment Method for the Intensive Care Unit. In both the additional reports from Intensive Care Units (ICU) [2, 3] the reported κ is substantial (between 0.81 and 1.0). These reports usefully show that a high level of agreement can be obtained in that setting, but two issues suggest that the generalizability to usual care outside ICUs might be suspect. Especially in the setting of a clinical diagnosis, where the line between reliability of expert clinical raters and convergent validity becomes blurred, the usefulness of testing inter-rater reliability is the measure of the discriminatory ability of the instrument under study. Each study [2, 3] excluded people with severe cognitive dysfunction, and while this removes confounders, it also diminishes our understanding of the discriminatory ability of the tool in cognitively im-

paired elderly people. A second issue is the context of evaluation; even though the studies estimated reliability from the 'first alert or lethargic' evaluation, both the studies had multiple evaluations – in the study by Ely et al. [2] 38 patients had 293 evaluations, and in the study by Lin et al. [3] an attempt was made to study all 102 patients every day for the first 5 days of their ICU stay. While this is certainly necessary and feasible in an ICU, it is different from a typical medical, surgical or geriatric ward. This strategy does, however, help to define the acuity of onset with greater clarity and it is this feature (along with fluctuation in consciousness) that is common to both the Confusion Assessment Method [4] and the Delirium Rating Scale [5]. Thus these additional delirium inter-rater reliability studies help elaborate points from our review, especially that core features of delirium need re-examination.

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