Reviewer's report

Title: Assessment of the capacity to consent to treatment in patients admitted to acute medical wards

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Reviewer: James Wilson

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GENERAL COMMENTS ON MANUSCRIPT
The authors of the study pose themselves two research questions: “to identify the prevalence of patients lacking the capacity to consent to treatment within the first 72 hours of admission to a general internal medicine ward of a university hospital and (ii) to compare a standardized assessment by means of the Silberfeld questionnaire with the assessment by a multidisciplinary medical team or by a senior psychiatrist.”

Both are good questions, but as far as I can see, these are separate questions and would perhaps benefit from separate treatment. The fact that they are not separated in this way means that the article as it stands is a little unsatisfying, as neither question gets quite the detailed treatment is deserves.

Given this caveat, the paper is of a publishable quality: the methods are appropriate and accurately described; the data are sound, and the manuscript adheres to the relevant standards for reporting and data description. The discussion is well-balanced and adequately supported by the data, but for one case which I shall detail later. The limitations of the work are clearly stated, and the title and abstract adequately convey what has been found. The article is well-written and easy to follow.

SPECIFIC COMMENTS

(1) p. 3, paragraph 1. “Providing treatment against the wishes of a patient capable to consent to treatment violates the principle of patient autonomy and of physician beneficence.”

DISCRETIONARY REVISION: It would be better to say that it *can often* violate physician beneficence. For there will be cases where the patient wants to refuse a treatment that would be in his best interests: in this type of case respect for autonomy and physician beneficence can come into conflict.

(2) p. 3, paragraph 1. “In busy clinical practice, however, capacity to consent is
often presumed unless the patient refuses treatment or shows obvious signs of cognitive failure or mental disorder.”

DISCRETIONARY REVISION: The discussion here comes across as a little one-sided. One thing that might be worth mentioning is that there may be good ethical reasons to adopt this policy, given that many adults will find it insulting to have their mental capacity explicitly tested before they are allowed to decide what happens to their own body. (Hence there are arguably reasons stemming from respect for autonomy for not testing for capacity in adults unless there is at least a prima facie reason for thinking that capacity is impaired.)

(3) p.3 paragraph 2. “The capacity to consent to treatment requires the ability to understand and retain information, to use it as part of the decision-making process and to make free choices.”

MAJOR COMPULSORY REVISION: There is an important ambiguity here which vitiates much of the rest of the discussion. We can talk about the capacity to consent to treatment in general (with the assumption being that a patient either has, or lacks overall capacity), or we can talk about the capacity to consent to a particular treatment. If we are talking about the capacity to consent to a particular treatment then it does not necessarily follow that if a patient lacks capacity to consent to treatment X, she will also lack capacity to consent to treatment Y. Over the last twenty years there has been a movement, both in the ethics and the legal literature towards specific measures of capacity, rather than general ones, as this is generally thought to be required by respect for autonomy, given that general measures of capacity will tend to deprive the patient of the chance to make some decisions that she would be competent to make.

For example, In English law, there have been two important cases which turned on the realisation that capacity is decision-relative rather than an all-or-nothing affair. In Re MB (An Adult: Medical Treatment) [1997] 2 FCR 54), it was determined that the woman’s severe phobia of needles amounted to an involuntary compulsion which rendered her unable to weigh the relevant information and deprived her of capacity with regard to the question of whether or nor to have a caesarean section, even though she was otherwise competent. In Re C 1 All ER 819; [1994] 1 WLR 290, a schizophrenic who had many delusional beliefs, but who was able to understand that if he did not have his leg amputated he would very likely die of gangrene, was found to have capacity to refuse this particular treatment.

I would like the authors to acknowledge the distinction between global and decision-specific accounts of capacity, and to explain in more detail which they took themselves to be testing. (It it important to ensure that all the various tests are testing the same thing: it would clearly be problematic if some of the tests were testing capacity in a global sense, whilst others were testing capacity to consent to a particular intervention).

(4) p. 3 “Capacity to consent to treatment depends on the above mentioned patient factors but also on physician factors, such as skills in explaining relevant medical facts adapted to the patient’s educational and cultural background.”
Advisory comment: I think this is false: the *capacity* to consent does not depend on these factors, though it is true that the ability to realise this capacity in a meaningful way does.

(5) p. 4, bottom line. Two typing errors (1) “no sever cognitive impairment”. Should read “no severe cognitive impairment”. (2) “The MMSE is a brief, easily test”. Should read “The MMSE is a brief, easily administered test”.

(6) p.9, paragraph 1. “In addition to the 38 patients having evident incapacity to consent, the psychiatrist found sufficient evidence consider an additional 14 patients to lack capacity to consent to treatment; this represents 26.7% of the included patients and confirms the need for a careful evaluation of the patient.”

MAJOR COMPULSORY REVISION: I don’t think that the evidence provided warrants the second half of the sentence. Out of the 195 patients in the study, 38 (19.5%) were said to *evidently lack capacity*. I am assuming that by definition if someone evidently lacks capacity, they do not require careful evaluation to determine whether or not they have capacity. Of the remaining 157 patients, a further 14 (9%) were determined by the psychiatrist to lack capacity – not nearly such a large figure. In short, the authors want to claim that one of their main findings is that “Prevalence of incapacity to consent to treatment of patients admitted to an acute internal ward is high”, however its status as a new finding is somewhat compromised by the fact that 38 out of the 52 patients deemed to lack capacity were evidently lacking in capacity, and so the overall level of incapacity should scarcely come as a surprise.

(7) DISCRETIONARY REVISION: General point on the discussion. The discussion as it stands largely takes for granted the claim that we can take the psychiatrist’s determination of capacity to consent to be the ‘gold standard’, and use this to measure the sensitivity and specificity of other ways of measuring capacity. However it is well known that determination of capacity to consent is by no means an exact science; and there is little reason to think that the psychiatrist chosen will herself have a high level of agreement with other psychiatrists. (In particular, is there any reason to think that a second psychiatrist would show a greater degree of agreement in judgements with the first psychiatrist than would the inter-disciplinary medical team?)

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.
Declaration of competing interests:

I declare that I have no competing interests