Reviewer's report

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

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Reviewer: Stuart M White

Reviewer's report:

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Reviewer's report
Fassassi et al. Assessment of the capacity to consent to treatment in patients admitted to acute medical wards.
BMC Medical Ethics ref.: 9581560062414974

Dear Daniel,

Generally:
• An interesting paper
• It needs an extensive rewrite and resubmission, but I would encourage the authors to do so
• It would be a much stronger paper if so many potential subjects had not been excluded initially. There are an awful lot of ‘soft’ exclusions, which could skew the results: if, for example, all the initial 70 exclusions/265 patients were in fact competent, the prevalence of incompetence may have been lower, at 20%. Had the temporarily incompetent regained competence, this figure might be even lower. Is 25% high – this is typical for a geriatric IM ward
• Needs anglicising and spell-checking by editor or authors.
• Needs statement about comparative jurisdiction.
• Assumes senior psychiatrist is gold standard – which they may not be, when determining consent for a procedure about which they know little.

Specifically:
Introduction
• l.1 omit ‘medical’
• Para 2 l.1 – no it doesn’t (in England and Wales, anyway): purely a legal entity, although I can see what they’re saying. Rephrase.

Methods
• Effectuated?
• Were any attempts made to include patients with major haemodynamic instability once they’d improved?
• Did the patients who refused to participate have the capacity to do so? Or did they refuse because they were all confused – in which case, prevalence of incapacity might have been even higher. Prevalence of incapacity then is only 74% among responders. Furthermore, how did the 25% without capacity give their consent to take part in the study? Is the written consent of relatives valid?
• Does anyone have an ‘obvious’ lack of capacity? Out of the 38 obviously incompetent, who was unconscious, who was obviously severely impaired? Were any attempts made to see if capacity returned later within the 72 hours after admission?
• Capacity to consent to treatment is only of importance if there is a treatment proposed? Was there a standard treatment proposed in this research for which the patients’ capacities were being assessed by the senior psychiatrist?
• I prefer that the text is not referenced in the methods section
• More discussion of the Silberfeld questionnaire is required in the Discussion
• I don’t understand the blinding process. Please elaborate.
• Or the statistical analysis. Please elaborate.
• What charts?

Results
• Either figure 1 or text, not both
• Table 1 not needed. Restrict sociodemographics to age (give mean, SD and range) and sex only.
• Opinions of medical team. Was this a unanimous, majority or individuals’ decision that was correlated?

Discussion
• Needs discussion about linear and relative nature of capacity.
• Para 3 – several studies, or just the two quoted?
• What were the specificities claimed by Silberfield in the original paper? Who did Silberfield recommend the test be administered to?
• GPs – this may be a country-specific problem. Is there an equivalent to the Mental Capacity Act 2005 in Switzerland? – this Act has had the effect of raising
awareness about mental capacity in the UK …

• Were the French speakers stratified according to French as first language/second language? Was any assessment made for specific communication problems in elderly French speakers (the deaf, expressive dysphasia, the blind etc etc)

• The concluding paragraph is weak

I would be happy to review this paper again,

yours sincerely,

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

**Quality of written English:** Needs some language corrections before being published

**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