Author's response to reviews

Title: Depression and Decision-making Capacity for Treatment and Research: A Systematic Review

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Author's response to reviews: see over
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Version: 3 Date: August 2013 Author's response to reviews: see over
The Editor BMC Medical Ethics
Dear Mr Adrian Aldcroft,

August 2013

Re. Depression and Decision-making Capacity for Treatment and Research: A Systematic Review. Hindmarch et al. MS: 128779502843042
Many thanks for your response to this submission and for further reviewer comments that we found very helpful in fine-tuning the manuscript. We have again made every effort to respond to the criticisms in a point-by-point manner and have revised the paper. We think the paper is now improved and suitable for publication in BMC Medical Ethics. Please find our responses below.

Yours sincerely

Thomas Hindmarch and Gareth Owen

Reviewer's report Title: Depression and Decision-making Capacity for Treatment and Research: A Systematic Review
Reviewer's report:

Major compulsory revision: This MS is much improved. The authors have either made changes or have thoughtfully responded to the comments.

Minor essential revisions:

1. The title and the abstract do not give an indication of the fact that the concept of appreciation is a major focus of this paper. Would mention it in title, or perhaps better, in the abstract, or both.

   We decided against altering the title as we fear it may become excessively long. We have therefore attempted to highlight the major role appreciation plays in the manuscript by italicizing the term in the abstract and further emphasizing our focus on the appreciation ability in the conclusion. Additionally, we further contextualize this in the background with a short introduction to the four abilities model.

2. In the first section in their exposition of four abilities model, the assertion that loss of any of the four abilities is sufficient to make someone unable to make autonomous decisions is not exactly true. Grisso/Appelbaum note that reasoning is not used as sole basis for incapacity by courts (see Berg et al 1996); also, they note that loss of appreciation in some states do not constitute incapacity (see their 1998 book).

   Thank you. We have added a sentence to page 4 paragraph 3 to emphasize the role of the four abilities model as guiding rather than decisive. Additionally, we’ve placed an endnote clarifying your point for the reader. Hopefully this make clear that the four abilities model exists to aid physicians and courts in making a standardized assessment of abilities, but that not all of these abilities may pertinent to local jurisdiction.

Discretionary:

1. In regard to their Discussion section, I wonder if both Halpern’s and Sullivan/Younger views can also be interpreted to address lack of appreciation of future possibilities, not just Meynen’s views.

   We agree that drawing this into the discussion is useful. See page 13 paragraph 2:

   Clinical ethical analysis stresses appreciative ability as site of impairment. Different formulations of this inability exist in the literature and each is relatively unspecified. Two concepts seem to offer useful leads: Meynen (2010), Halpern (2010), and Sullivan & Youngner (1994) highlight an inability to appreciate future possibilities and Elliott (1997) highlights an inability to
maintain a minimal concern for self. Both are viewed as normative inabilities that may threaten DMC. The affective symptoms of depression can theoretically distort [15] or blind [13] an individuals’ perception of the future, but as Meynen remarks, the ability to appreciate future possibilities needs, further specification and empirical testing [12]. Elliot presents the minimal concern for self concept as distinct from appreciation but this distinction depends upon the boundaries one places around the appreciation ability which seems sufficiently broadly defined to encompass minimal concern for self. It is also unclear how minimal concern for self differs from the trait of low self-esteem, which is common and is not diagnostic [26], and does not automatically confer lack of DMC.

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Declaration of competing interests:

: I receive royalty income from Oxford U Press for my book on decision-making capacity (Evaluation of Capacity to Consent to Treatment and Research, OUP, 2010).

Reviewer's report Title: Depression and Decision-making Capacity for Treatment and Research: A Systematic Review

Version: 2 Date: 3 July 2013

Reviewer: Bettina von Helversen
Reviewer's report:

I reviewed a prior version of the article. The additional information added in the revision (and being more familiar with the topic after reading it again) helped me understand the paper and the goals of the authors better. I think the article is now more accessible for readers outside of the field and close to acceptance. Although (or maybe because) I had fewer problems with understanding the article, I still had trouble with some parts. In addition, I'm not quite satisfied with the authors’ responses to one of my concerns.

Major Compulsory revisions

1) In my first review I complained the appreciation ability was not sufficiently defined. I can see that the authors use the standard formulation to define it and I appreciate the additional information, but it still remains unclear how appreciation is operationalized in the MacCat. Adding this information would make it easier to follow the discussion regarding appreciation and potential measurement problems in the MacCat, in particular if there are problems how appreciation can be operationalized for patients with depression. I don’t think simply citing references for the MacCat is sufficient, as it is an important part of the article.

The difficulties faced in the way appreciation ability is operationalized as part of the MacCAT is explored as part of the discussion (p14). However, as you point out, detail is lacking as to the practical operationalization and how this contributes to measurement problems. Thus an endnote has been added as follows:

'b When assessing appreciation, the patient is asked whether they think the treatment may benefit them. The patient’s “yes” or “no” response is not important at this point. Instead, the assessor is seeking to establish whether the patients’ explanation regarding their beliefs about treatment/(research) is based on a delusional premise or a serious distortion of reality. However, in recognition of the difficulty faced in the operationalization of appreciation for affective disorder, the MacCAT-T scoring rules for appreciation have an additional note: “failures to acknowledge the potential benefit of treatment may obtain a 0 rating not only if they are based on delusional belief systems, but also if they are strongly influenced by extremes in affective symptoms: e.g. mania, severe depression.” (bold added). ([1] p106 and p187).'

2) I like that the model by Grisso and Appelbaum is introduced in the beginning to help understanding the abilities necessary to make treatment decisions. I was surprised, however, that the discussion only considered the appreciation ability. Reasoning abilities are frequently mentioned in the summaries of the empirical studies and seem to be impaired to a similar if somewhat lower degree than appreciation abilities. Thus I think it should be discussed to what degree reasoning abilities are impaired in depression and why they are not mentioned in the clinical ethical analyses. They do seem to play a part in the legal considerations (i.e. use or weigh ability).
A new paragraph has been written and included as we agree that consideration of reasoning ability is necessary. It reads as follows:

‘Deficits in appreciation ability are reported in both empirical and clinical ethical literature. Some empirical studies additionally report deficits in understanding and reasoning ability. Appelbaum & Grisso (1995 & 1999), Cohen, and Vollman, all identify understanding and reasoning deficits, with the latter two studies indicating reasoning as the most impaired ability amongst their depressed cohort [17-19, 21]. Despite these findings, consideration of reasoning ability in relation to DMC is absent from clinical ethical analyses. This may reflect ethical concern that the four abilities model remains too cognitive [4], and that appreciation is the only ability seemingly broad enough to accommodate affective status when judging DMC. Whilst the clinical ethical analyses are well positioned to interpret complex interplay between affect and decision-making abilities it may be that in emphasizing “non-cognitive” abilities in depression, e.g. appreciation they neglect the impact affect can have on abilities to recall accurately and manipulate information logically. However, the empirical studies that report reasoning impairments more than appreciation impairments are limited by difficulties in the operationalizing of MacCAT-T appreciation (see below). Together these factors could explain why the clinical ethical data and the empirical data show some divergence.’

Minor essential revisions

3) “understandable quality”: I did not quite understand what “understandable quality” means: Does it mean that patients are able to rationalize their choices and thus convince others that they are not impaired even though they lack appreciation abilities? It would help to explain this in more detail.

Yes. You’re interpretation is correct, but we recognize the need for more clarity here and throughout. We have altered the relevant sentences. See below.

Depression is significant in relation to these debates because of its high prevalence in health settings; its emotional nature; its dimensionality; and the often “understandable” quality of patient decision-making, which is perhaps best characterized by Appelbaum & Roth. [9]:

“Of all the psychopathological processes associated with refusal [of treatment], depression is the most difficult to recognize, because it masquerades as, ‘Just the way I would think if it happened to me’ … The depressed patient is frequently able to offer ‘rational’ explanations for the choices that are made.”

4) In the discussion some references are missing. For instance in the second paragraph several papers are mentioned to but the references are not included. In addition the following claims about self esteem should be supported by references: “... low self-esteem, which is common in the general
population, can be secondary to any illness involving stigma and which ordinarily would not be seen as resulting in a lack of DMC”

The paper has been reviewed with references made more uniform and missing references added. (see below)

Added referencing:

Discussion

Paragraph 2
The affective symptoms of depression can theoretically distort [15] or blind [13] an individuals’ perception of the future, but as Meynen remarks, the ability to appreciate future possibilities needs, further specification and empirical testing [12].

It is also unclear how minimal concern for self differs from the trait of low self-esteem, which is common and is not diagnostic [26], and does not automatically confer lack of DMC.

Paragraph 7
One may also draw attention to the importance of supported decision-making in which the doctor seeks to enable rather than formally substitute for a depressed patients’ decision–making [20, 28, 29].

Discretionary revisions

6) I’m not a native English speaker, thus I may not be the best to judge language quality, but I found a few sentences rather convoluted. In the following I listed a few examples of sentences that I think should be reworded. Overall, I think checking for readability and clarity would not hurt.

Thank you for your input. We want the review to be accessible to all readers world-wide and on the basis of your comments, we’ve spent some time improving the clarity and readability of the manuscript throughout. Changes to specific sentences you highlighted as problematic are below:

p4. “There is also the question of how much ability a patient requires to yield a categorical judgment and the reliability of physician judgments” (it is somewhat unclear if ability refers to the ability of the patient or the doctor)

p6. “and where relevant, studies were read in through to determine eligibility”

p7. “The heterogeneous methods used within the 17 included papers made systematic quality assessment of the papers unsuitable for the review but all studies were found to relate to the legal standards pertinent to the review."

p12. “to assess the prevalence of impaired DMC using the MacCat-T to structure a clinical judgment:” should this not be “the prevalence of impaired
p 14. "Sullivan & Youngner (1994) highlight the demands in assessing appreciative ability; when asking a patient to describe the clinical facts presented, grappling with the pro’s and cons to his or her own life may pose no problem, but when evaluating the patient’s answers to these questions, an assessor may need considerable contextual information and interpretive ability."

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