Reviewer's report

Title: Depression and Decision-making Capacity: A Systematic Review

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Reviewer: SY Kim

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The authors reviewed published clinical ethical analyses and empirical studies of DMC and depression. This is a useful review because there has not been a systematic review of this topic, and it does come up frequently in variety of discussions about DMC. Also, it is quite difficult to do a systematic search of such studies because there is not a uniform categorization scheme in the bibliographic databases. So this would be a valuable contribution.

The authors reviewed two types of literature: ‘clinical ethical accounts’ and more systematic empirical papers that attempted to measure the impact of depression on capacity.

I enjoyed reading this summary, as it nicely puts key papers into one discussion. I tend to agree with the authors that many of the ‘objections’ to appreciation standard as ‘too cognitive’ are probably not accurate and that the appreciation standard can reasonably be interpreted to capture many of the arguments to the effect that the current standards are too cognitive.

This paper is likely to acceptable for publication but I do think that some corrections need to be made, clarifications added, and some points addressed. I have tried to explain each point below.

1. In regard to the first type of papers, the list did seem fairly complete but I did wonder how reproducible the search for those papers would be. How does one decide something has “substantial ethical analysis”? For instance, there were a number of articles in 1990s or so on ‘rational suicide’ focusing on suboptimal choices made by patients due to influence of depression (similar in spirit to the Leeman, Halpern etc papers cited in this review), except those papers in general did not discuss the phenomena under the rubric of ‘capacity’ and thus are not included in this review. I couldn’t help wishing for a more “operational” definition of procedures used to arrive at their list of articles of “clinical ethical analyses.” (Also, it is not clear to me that given the type of content they are seeking, why it should be limited to articles—I’d imagine there are chapters in ethics books that provide rich and useful discussions.)

2. In regard to the list of empirical studies:

   a. First, do the Stacey et al and the Simon et al studies conform to the authors’ definitions in the methods section? It appears that no “DMC assessment tools” are used in those studies, nor are there “performance measures” of DMC in
those studies. They do have something to do with the depressed patients’ opinions about medical decision-making but that is distinct from assessing their abilities. I would recommend against including them in the review. (In fact, a better case can be made to include studies by Ganzini and Lee on severely depressed elderly who change their minds on treatment preferences after treatment of depression, as being more relevant than these two articles… although I don’t think the G&L study fits into this review either since it is not about DMC specifically… my point is that comparatively, they would be more informative than the Simon and Stacey studies).

b. Second, the authors should double check their review details. For example, the Appelbaum MacCAT-CR study of 1999 involved moderately depressed outpatients in a psychotherapy trial, not severely depressed inpatients.

Another example: the 1995 Grisso-Appelbaum paper did not use MacCAT-T as the MS text suggests (although, inconsistently but correctly, in table 2, it is said that precursors to MacCAT-T are used). Also, I’m not sure if you can make the assertion as is done in Table 2 that appreciation is most impaired. In a sample of 92, it’s a difference between, for example, 8% with impaired reasoning and 12% with impairment in appreciation, which is not significantly different.

These two articles I am very familiar with, so I happened to see these discrepancies. I would suggest double checking the summaries of the other articles also.

c. Third, perhaps the studies should be summarized with a bit more detail—quantitative details when available, and providing key methodological details when relevant. This seems necessary given the diversity of methods used by these studies, and given that interpretation will depend on patient characteristics, methods of measurement used, and methods of categorizing incapacity. Where ratings were done to measure severity of depression, the summary statistics should be given. The actual frequencies of impaired capacity should be given as well (rather than mere qualitative summaries when in fact summary numbers are available). Also, it is important for the readers to know how the papers categorized their subjects—e.g., the 1995 Grisso study used a statistical cutoff to determine impaired capacity status, and this has an impact on how to interpret the results. Another important factor is actually whether studies like Bean et al measure appreciation at all, given the format of their questions in the instrument. This is important because, as the authors note, methods varied and given the importance that Grisso/Appelbaum have placed on first person versus third person formulations of interview questions for distinguishing between understanding something intellectually versus applying it to oneself, it may be worth noting that not all instruments follow that convention.

3. Some comments on interpretation of studies reviewed and conclusions drawn.

a. Judgments of incapacity are meant to justify seeking decisional authority in a surrogate. One could have impaired abilities for decision-making but still be capable. This distinction is not made anywhere in the paper, leaving the
impression that any time depression affects decision-making, this implies incapacity.

b. The authors assert that measurements of appreciation are deficient bc it is said to be based on detecting incapacity in psychotic patients and not in depressed patients (i.e., MS states, “The law has not articulated its perspective on appreciation…” But law is pretty silent on details of all of these standards.) I’m not so sure about this as a matter of legal history as the authors argue. Perhaps it is, but I think more evidence needs to be provided in support.

Also, an alternative explanation could be that perhaps appreciation standard is by design not meant to be overly sensitive, in the interests of patient autonomy? In the clinic and in the hospital, we often deal with poor choices of patients, but we deal with it clinically rather than resorting to questioning their decisional authority every time.

c. From an empirical point of view, I think it is difficult to assert based on current evidence that depression per se has a strong impact on capacity (in the sense of justifying depriving the patient of decisional authority). I worry that a very general statement like “DMC may be impaired in depressive illness” gives the wrong impression that DMC is routinely impaired in depression, when in fact evidence is to the contrary (indeed, most studies of even severely depressed patients show relatively weak impact).

Of course, the common concern that depression can make people’s decisions worse in some measurable sense is probably true. Severe depression, especially, likely has an effect. However, it is a normative question whether society should deprive a person’s right to make decisions based on the fear that they are not at their best. I get the feeling that the authors may be in favor of lowering the threshold for incapacity based on the appreciation standard (or rather, parts of the paper read in that direction). But it may be that the studies tend to show low rates of incapacity because they operationalize appreciation in a way that reflects the high regard put on autonomy.

Overall, I think this paper would make a useful contribution to the literature. I hope the above suggestions will help improve it.

**Level of interest:** An article of importance in its field

**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’