Reviewer’s report

Title: Conceptions of decision-making capacity in psychiatry: interviews with Swedish psychiatrists

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Reviewer: Gareth Owen

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This is an interesting study that uses some in depth interviews with Swedish psychiatrists and an analysis of Swedish Mental Health Law to probe the concept of decision-making capacity (DMC).

Overall, I think the study has the potential to add to the literature. It conveys nicely how the folk psychological notion of DMC (which the law and medical ethics tends to operate) is quite close to the one that psychiatrists tend to extract from their experience. Some areas where psychiatrists tend to push beyond the standard models, or interpret them more finely, are alluded to. The paper also conveys some of the ambiguities surrounding the concept of DMC, their deep sources in philosophical disputes about the nature of rationality and how these ambiguities express themselves both in legal practice and in the attitudes of psychiatrists. Some of the points made about discrimination and a sort of double bookkeeping are well made.

I offer some comments to aid the revision process

General

1) The paper could be clearer in setting out its aims earlier. I had to go back and forth in the manuscript to get them. They seem to be: a) to explore psychiatrist’s concepts of DMC and b) to explore, with psychiatrists, the uncertain legal and practical role given to DMC in Sweden.

2) A little more description about the methods used rather than reference to things like “theoretical saturation” might helpful. 8 interviews with psychiatrists on 2 complex topics is very likely to have left matters uncovered. The interviews are a start and the research field is overall quite new so exploratory studies like this are justified. A limitation of the study, which I think merits some consideration is that, given the nature the topics, the interviewees may be unclear about what they are being asked. And given the emotive nature of treatment without consent interviewees may adopt defensive postures. Both semantic ambiguity over what is being asked and defensiveness about the area in general may cloud the data and reduce its interpretability.

3) Relating the data to the debate (raised in the background section) about adding a 5th “authenticity” category to DMC could be clearer in the discussion. Do the authors think their data supports psychiatrists wanting it or not? Overall, on my reading of the data presented, I didn’t think that what the psychiatrists

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reported gives strong evidence for a wish for such a 5th category.

Specific

1) Background. – p3

line 91 - The authors write that DMC has been conceptualized as a compound of “intellectual abilities”. I would doubt that law has committed itself to the abilities all being “intellectual”. It has simply committed to “abilities”.

Line 98 – the authors write there is a “clinical consensus on the standard [DMC] conception”. It is more accurate to say this is a “legal and ethical” consensus as the origins of the construct are legal/ethical. Here Grisso and Appelbaum’s 4 abilities model is seminal and needs a reference.

Line 99-101 – reliability of DMC judgements. This needs modifying. In some clinical settings rates of agreement have been shown to be excellent (see ref 11 for details on these studies).

2) Legal situation in Sweden, p 4.

This section was very interesting for me to read as a UK based researcher/practitioner. It shows that, like the UK, there is a basic ambiguity about right to refuse for psychiatric patients. There were a few points where I thought some more information would be helpful:

a) Might the authors give more detail on what they say is the “basic legal right to reject care and treatment”. It would be interesting to know how Sweden has interpreted its obligations under the European Convention on Human Rights here and how that relates to long-standing medical law in Sweden on right to refuse surgery, etc..

b) With the LPT the authors elaborate on some of the criteria for involuntary psychiatric treatment, e.g. serious psychiatric disorder, but not others. A criterion that will do a lot of work is number 2 “imperative need of psychiatric care”. It would help to have a sense of how Swedish law interprets that criterion.

3) Results – p 5 -10

The category of “appreciation” is curiously absent here. Insight into one’s illness is put under an “understanding” category. But this seems strange given the appreciation category in the standard 4 abilities model of DMC (Grisso and Appelbaum 1998) is the ability to apply information abstractly understood to oneself. What the psychiatrists are reporting about insight, but also about motivation (e.g. lines 299-306), could be argued to be within the category of appreciation. If not then I think the authors need to argue why not?

In the section on volition I wondered whether what psychiatrists are describing is really going outside the 4 abilities model - which does not include a separate volition category. The case described by a psychiatrist in lines 294-296 - the depressed patient -needs some interpretation. Is the patient unable to decide between options (literally “stuck”) or is it that they are not experiencing options as meaningfully different (a kind of appreciation inability). And if we really believe
that the depressed case is quite literally stuck in relation to resolving a decision then that would be an inability to express a choice. Both appreciation and expressing a choice are in the 4 abilities model. Similarly, in the impulse section. The psychiatrist in lines 314-15 is describing an inability of some patients to “evaluate” sudden impulses. The psychiatrist in lines 317-19 is expressing an inability of some patients to “see the consequences of... “ because of impulses. Does that imply a separate volition category additional to the standard understanding and appreciating/evaluating categories? As the paper stands, I wasn’t convinced.

It wasn’t clear to me why the “making a medically sound decision” was a subcategory of volition. As the authors rightly point out this category is in real tension with the standard DMC concept because it has the function to protect right to refuse.

4) Discussion – p 10 onwards
Line 456-458 – seemingly pathological values. The authors report that this topic was addressed by the respondents. I couldn’t see that the data was clear on that.

Line 442 – I worry a bit about the proliferation of terms in the literature on DMC. “internal vs external rationality”. Do these terms help add to the basic distinction between a “functional” model of DMC and an “outcome” model of DMC –terms already used and understood in the DMC literature? As I say, it’s a worry...

Lines 459-62 – I agree that “making a medically sound decision” is hard to square with the paradigm of respect for personal autonomy but the other components of “volition” discussed – motivation and ability to control impulses – are not obviously hard to square with respect for personal autonomy. Personal autonomy will require some minimal motivational and impulse control abilities.

Lines 476 – I doubt that the psychiatrists really view somatic care patients who refuse treatment as necessarily having DMC (it would contract too much of the experience they are likely to have). I think that is likely to be an artifact of the data and relate to the limitations mentioned above and the influence of the dual legal frameworks on respondents’ expressions about DMC (right to refuse vs. LPT).

Is the “disguised paternalism” (line 501) that the authors refer to really disguised? It is pretty clear and undisguised in law. Lack of DMC is not a necessarily criterion for treatment over refusal in the LPT and that mirrors laws for psychiatric patients in all jurisdictions I know of that have mental health laws. Exceptionalism regarding psychiatric patients would seem clearly reinforced by the legal framework rather than possibly reinforced. This exceptionalism may not be debated/researched sufficiently – “disguised” in that sense – and I would agree with that - but in written law it seems undisguised.

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