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With a growing burden of surgical procedures and very large numbers of patients, Chinese surgeons should have an important role in seeking consensus on global strategies through participation in international collaboration.[1] However, many obstacles are hindering their enthusiasm for joint studies, including considerable extra workload in clinical research besides a heavy clinical burden, difficulties in participant enrolment due to the deteriorated doctor–patient relationship, language barriers, and limited opportunities to communicate and cooperate with international colleagues.

We appeal to health administrators in China for an increased awareness of the importance of collaborative research and for supportive policies. For instance, appropriate assessment of the achievement of these research collaborations is an important issue. The present academic evaluation system in China recognises and rewards the position of first and corresponding authors for published studies, and the contributions of other participants tend to be neglected. Hence, how to encourage the active participation of more surgeons in future international research collaboration is an issue worthy of discussion for health policy makers in China and worldwide.

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Surgical clinical trials—need for quantity and quality

The implementation of a nationwide surgical trials programme in the UK was the response to the overall need for more clinical trials in surgery.[1] Randomised controlled trials (RCTs) represent the gold standard in evaluating effectiveness of novel interventions, hence establishing such a programme is welcomed. However, increasing the number of trials evaluating surgical interventions is necessary but not sufficient. We argue that quality must also be a prerequisite.

Indeed, surgical trials with poor methodological quality, principally scarce use of intention-to-treat analysis and allocation concealment, is an area of concern.[2] Furthermore, surgical trials associated with poor reporting quality can generate bias when evaluating intervention effectiveness and subsequent suboptimal patient outcomes.[3]

Along with the challenges described by Becky McCall,[1] surgical trials pose further difficulties with respect to blinding, intervention complexity, inconsistent expertise of care providers, and centres' volume.[4] The Consolidated Standards of Reporting Trials checklist for non-pharmacological interventions (CONSORT NPT)[4] was developed to aid reporting of these features, but it has not been enforced by journals.

All journals enforcing the mandatory completion of a CONSORT NPT checklist for all RCTs submitted could improve trial reporting, in turn enhancing trial quality. Collaboration between the Royal College of Surgeons and clinical trial units aims to focus on trial methodology, hypothesis development, and mentorship for surgeons.[1] Encouraging education about CONSORT might foster a better trial reporting culture, which could improve trial quality, enabling authentication of best practice.

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Care for patients with grave alcohol use disorders

Ryan McCormack and colleagues (Sept 14, p 995)[1] pledged that "laws governing involuntary commitment should consider disability associated with grave alcohol use disorders in the same way as other mental illnesses" and urged "to develop and test innovative policies and practices".[1] This deserves a comment.

First, the term "involuntary commitment for patients" seems a voluntary misleading understatement. In fact, involuntary treatment, or assisted treatment, refers to a forced medical treatment undertaken without a person's consent.

Second, this is not "innovative", but inappropriate policy. Patients gravely disabled by alcohol use disorders reached this advanced state after many years of an evolution characterised by a lack of comprehensive community services and support (as evidenced by the association between forced admissions and poor economic conditions)[2] and by inappropriate care. In the USA, among 30 acute and chronic conditions, alcohol dependence ranked the worst for quality of care,

recommended care being provided for only 10·5% of the patients.[3]

Last, the level of agreement between emergency physicians and consulting psychiatrists in their diagnosis and disposition of emergency department patients with behavioural emergencies is poor.[4]

Forced treatment is a very dangerous slippery slope.[5]

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Authors' reply

We agree that involuntary treatment for any clinical purpose should not be taken lightly. We explicitly advocate for strong safeguards to protect the rights of the vulnerable individuals for whom it might be appropriate.[1] Past misuses of involuntary treatment make legal protections and frequent oversight essential. But the past ought not blind us to the needs of individuals today.

Civil commitment should be considered selectively and only for high-risk individuals with grave disability only after less restrictive measures have failed. The individuals we describe having grave alcohol use disorders also have considerable disability and risk, as evidenced by their high rates of mortality, disabling injuries, psychosocial instability, and underlying undiagnosed medical and psychiatric comorbidities.[1,2] If the temporary, legally sanctioned restriction of autonomy can ensure their safety and restore their dignity and autonomy, then we propose that this option be available as it has been in many countries.[3] We also recognise the need for rigorous studies to ensure that measurable treatment outcomes are achieved, to determine best practices, and answer remaining questions such as determining appropriate admission and discharge criteria, treatment duration, and aftercare.

We agree that inadequate social support and ineffective communication and coordination contribute to the overall poor quality of care that fails these individuals. While the USA has poor health outcomes in relation to its health-care expenditures, and this discordance might be attributed to the limited allocation of funding for social services,[4] the ineffective care for individuals with advanced alcoholism remains a global problem. Our concerns about the failure of the existing standard of care is why we believe it is ethical to "develop and test innovative policies and practices".[1] In addition to civil commitment when necessary, these would include multidisciplinary and institutional partnerships that align medical and public health services to deliver multimodal intervention (including behavioural and pharmacological therapy, supportive housing, and intensive care management) in line with the Principles of Effective Treatment of Addiction.[5] However, the availability of services is often not adequate to foster the motivation necessary to accept assistance and change outcomes.[1] In selected cases, limited civil commitment should be considered in the spirit of beneficence with the goal of ultimately empowering individuals to choose whether to participate in their own recovery, however defined.

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Mental illness and crime in Brazil


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A recent *Lancet* Editorial (Oct 19, p 1309)[1] invited the readers to rethink the risks associated with people with mental health disorders. "The stigmatisation is alive and well" states the Editorial, while referring to the situation in the UK. We would like to add a Brazilian's perspective to this debate.

3989 persons with mental disorders live in forensic hospitals in Brazil.[2] The first forensic hospital opened in 1921, and today there are 23 forensic hospitals and three psychiatric wards in prisons. There is no life sentence in Brazil, and individuals should not be incarcerated for more than 30 years. Offenders with mental disorders do not receive a sentence, but a 1–3 year compulsory