> gained the status of a "justified belief," although being unjustifiable (and non-falsifiable) in discourse. According to the German tradition of phenomenological psychopathology two criteria can be named for delusional convictions: a) the extraordinary degree of conviction concerning particular ideas; and b) the outright rejection of alternative explanations, the so called *Unkorrigierbvarkeit* (incorrigibility) of these convictions (ideas).[8]

Although we do not have a psychiatric evaluation to confirm, it appears that Ann may be suffering from a delusion that she merely has a spider bite. If this is the case, per Schlimme, "the deluded person is ('*per definitionem*') ineffective and helpless with respect to altering these convictions."[9] If Ann has such a specific delusion, it would then significantly hamper her ability to pursue her stated goals of "enjoying life and wanting to continue living." The confirmation of wanting and pursuing treatment for her diabetes seems to be an autonomous (self-directed and chosen) true value, wherein the refusal of the biopsy is a specific aberration. Furthermore, if this is correctly a delusion, then she is not acting with true autonomy in refusing the biopsy, because she is unable to rationally review the conviction that she has a spider bite and to consider that not allowing the biopsy may cause her harm. Therefore, her autonomy to make this decision is impaired and a surrogate is required.

In this situation, her daughter Jayne is the appropriate decisionmaker to consent or deny the biopsy. It ought to be explained to the patient that the only way to confirm or deny if the mass is a spider bite is to complete the biopsy and that the healthcare team will use all medications required to minimize her discomfort during the procedure. Ann both fails to meet Drane's evaluation of capacity to refuse treatment and, more specifically, may have her autonomy impaired by the delusion of a spider bite. Overall, the psychological discomfort of going against a patient's autonomy may be mitigated by the knowledge that her capacity to make a choice, in this decision, is lacking due to a delusion, and overall beneficence will be greater once the results of the biopsy are known and once appropriate treatment may be started (or not, if the biopsy is negative).

Notes

1. Drane JF. Competency to give an informed consent: A model for making clinical decisions. *JAMA* 1984 Aug 17;252(7):925–7.
2. See note 1, Drane 1984.
3. See note 1, Drane 1984.
4. See note 1, Drane 1984.
5. *Northern v. Tennessee Department of Human Services*, 435 U.S. 950 (1978); available at http://law.justia.com/cases/tennessee/court-of-appeals/1978/563-s-w-2d-197-1.html (last accessed 14 February 2013).
6. See note 5, *Northern v. Tennessee Department of Human Services* 1978.
7. Schlimme JE. Is acting on delusions autonomous? *Philosophy, Ethics, and Humanities in Medicine* 2013;8(14); available at http://www.peh-med.com/content/8/1/14 (last accessed 3 Apr 2014).
8. See note 7, Schlimme 2013.
9. See note 7, Schlimme 2013.

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Commentary: What Does Ann Really Want?

Jens Clausen

Ann's "only a spider bite" case presents a challenging situation for clinical decisionmaking. In order to provide advice in an ethics consultation, the first step after summarizing the facts about Ann's medical condition would be determining possible alternatives of action. Because no safe treatment is possible without a prior diagnosis, a prophylactic treatment of the possible cancer is not recommended. So, if Ann does not change her mind and refuses to allow a diagnosis, what alternatives remain?

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Five Scenarios

One alternative would be not to seek a diagnosis; the other would be to try to coerce Ann into undergoing a diagnosis. In either case, Ann may, or may not, have cancer. So if we consider possible treatment options after a coerced diagnosis, we are left with five possible scenarios.

Scenario 1: No Diagnostics and No Cancer

In the case that the mass found in Ann's breast is not a cancer, failing to pursue a diagnosis will have no negative consequences. It is important to take into account that without a proper diagnosis, the oncologist who examined Ann could have erred, and it is still possible that the mass found in her breast is not a cancer.

Scenario 2: No Diagnostics and Cancer

If the mass is in fact a cancer, not diagnosing it inevitably leads to a situation without treatment, and, consequently, Ann is estimated to die probably within the next 12 months. Although it poses a threat to her life, her current situation is not an emergency requiring immediate action.

Scenario 3: Coerced Diagnostics and No Cancer

If Ann is forced to undergo diagnostics and no cancer is found, the situation, with respect to life expectancy, is the same as in scenario 1. However, coercion—although done with the best intentions—may result in harm by undermining Ann's confidence and putting a strain on the relationship between the patient and the physician.

Scenario 4: Coerced Diagnostics, Cancer, and Treatment

If a coerced diagnosis identifies the mass in Ann's breast as a hormone-receptive breast cancer, it could be treated accordingly; and if Ann agrees to the possible therapy, her life expectancy could be expanded by 10 years or more.

Scenario 5: Coerced Diagnostics, Cancer, and No Treatment

If a coerced diagnosis identifies the mass in Ann's breast as the suspected hormone-receptive cancer, and if she refuses the possible therapy, her life expectancy is still about 12 months.

Discussion

With respect to the patient's benefit, the most preferable alternative surely would be to take a tissue sample for examination and thereby provide evidence as to which treatment of the possible cancer—if any—might be best (scenarios 3–5). This would open the way to well-founded therapeutic decisions. However, in this case, Ann refuses to allow the sample to be taken.

Because she lacks decisional capacity for most medical decisions, her refusal to undergo a diagnosis is most likely not legally binding. When a patient lacks decisionmaking capacity, proxy consent is required. However, Ann's assent would still be needed. For the sake of argument, let's assume that taking the tissue sample for a diagnosis is in Ann's best interest and that her daughter Jayne is willing to consent to this procedure.

Of course, before considering coercion, the action of choice would be to talk with Ann and try to convince her to assent to the requested diagnostics. If Ann agrees, her mass should be diagnosed, with Jayne consenting. More challenging is the situation in which Ann remains unwilling to undergo the necessary diagnostics. If this is the case, is there a justification to override the missing assent and coerce a diagnosis?

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What at first might seem as a conflict between the patient's benefit and her autonomy turns out to be the question, *What does Ann really want?*

Ann's stated preference for treatment in case of a life-threatening illness from which she could recover seems to support taking the tissue sample, because an accurate diagnosis is a prerequisite for the right treatment. However, this preferred course is in direct conflict with Ann's adamant refusal to undergo diagnosis. Because we have no way to judge whether her interest in treatment or her refusal to undergo a diagnosis best expresses her true will, we are left with a dilemma. There is no unqualified argument for the right course of action in this situation. Nevertheless, with her reference to a previously unhealed spider bite, Ann is obviously grounding her refusal to allow a diagnosis on false beliefs. This irrationality could be seen as a weak justification for not taking her refusal too seriously. Together, Ann's interest in treating a possible life-threatening illness and the opportunity to treat the possible hormone-receptive breast cancer with oral chemotherapy might justify acting according to the principle *in dubio pro vita*: when in doubt, favor life. The opportunity to extend her life-span from 12 months to 10 years through diagnosing and, if necessary, treating a possible cancer might outweigh the possible harm caused by a coerced diagnosis. All these aspects could justify diagnosing Ann without her agreement. However, because a change in German law significantly restricts coerced treatment against even the "natural will" of a patient lacking decisional capacity, as long as Ann refuses to assent, the strong recommendation in our German context would be to seek a legal guardianship through the courts before coercing diagnosis.

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Commentary: Ethically Important Moments

Clare Delany

One way of approaching this case would be for the ethicist to consider the overriding ethical question of whether Ann is sufficiently competent to refuse to have a tissue sample taken to examine a mass in her breast. The consequences of her refusal are that potentially life-saving treatment may be denied, resulting in her likely death within one year. Reduced to its fundamentals, the ethical conflict concerns a clash between the offer of likely beneficial treatment and respect for Ann's autonomous wishes and choices about her own healthcare. This ethical issue arises from Ann's adamant refusal to undergo testing.

However, I suggest, in this case analysis, that Ann's case raises not just one overriding or fundamental ethical issue on which a decision can be made but rather a number of ethically important moments. Guillemin and Gillam[1,2] define ethically important moments as occurring when an approach to care or decisionmaking appears mundane or uncontentious but nevertheless has important ethical ramifications for a patient or health clinician. In this case commentary, I identify and discuss these ethically important moments to provide a map of moral issues that need to be considered by the ethicist called to consult. This is a deliberate analytic process designed to demonstrate an inclusive process of ethics consultation in which the goals are "to facilitate communication, clarify moral positions and arrange a safe moral space within which differences can be aired, understood and resolved."[3] Such a process is not predictive of the outcome but is designed to generate its own outcome, which emerges from the process itself.

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