To submit a case that has been reviewed by an ethics committee or to submit papers on related topics in clinical ethics, readers are invited to contact section editor Ruchika Mishra at ruchika.mishra@gmail.com.

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The Case

"Only a Spider Bite"

RUCHIKA MISHRA

Ann is a 58-year-old woman who was admitted to the hospital after an episode of temporary unconsciousness secondary to poorly controlled diabetes. She also has cardiac issues and uses a walker due to rheumatoid arthritis complicated by obesity. Ann is extremely guarded, possibly paranoid, though this is difficult to determine simply because she *is* so guarded. She has been assessed by a psychiatrist as lacking decisional capacity for most medical decisions. Ann lives alone and has three daughters. She gets along with all of them but is closest to the middle daughter, Jayne. With the agreement of her sisters, Jayne is willing to act as surrogate and seems to have her mother's best interests in mind. Discharge is planned for an extended stay facility. Although she is not enthusiastic, Ann agrees to go.

During her stay in the facility, Ann is found to have a mass in her breast that looks like it could be cancer. However, she denies that she has cancer, and even the possibility that she *could* have cancer, and is not receptive to discussing any diagnostic procedures. The oncologist who examined her believes the mass is most likely a hormone-receptive breast cancer. If so, without treatment, Ann will likely die within a year. However, with oral chemotherapy, such as tamoxifen, Ann could have 10 years or more. Without confirmation that it is cancer, and without identifying the type, initiating a course of treatment would not be safe. The possibility of treating her for paranoia with psychotropics was considered but was rejected when it was discovered that Ann's cardiac condition contraindicates these medications.

When asked, Ann says that if she ever has a life-threatening illness but one from which she could recover by taking medication, she would want treatment rather than "letting nature take its course." Ann explains, "I know people who think differently and don't like hospitals, but I want treatment. That's why I'm here." She affirms enjoying life and wanting to continue living. At the same time, she adamantly refuses to allow a tissue sample to be taken for

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examination, stating, "I already know what that is; I was bitten by a spider years ago, and it never healed." When neither family members nor members of the healthcare team could persuade Ann to change her mind, an ethics consult was called.

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Commentary: Denial or Delusion?

Karen Smith

Ann's situation is understandably troubling to both her family and her caregivers. Although she has agreed to hospital treatment to control her diabetes and to go to an extended care facility, she has repeatedly refused to allow diagnostics to confirm or deny a potentially cancerous mass in her breast. Her capacity to make this decision is the ethical question at hand, which focuses the dilemma on the choice between respecting her autonomy and promoting her medical well-being or the value of beneficence. One might understandably guess that the patient is in denial. Perhaps she merely requires further reasoning to allow her to reach the conclusion that biopsy testing is required to allow her to obtain an accurate diagnosis so that she can move forward with her treatment and life plans.

Several clues make me less than willing to believe that this may be so. First, for reasons not provided in the case, Ann has already been deemed by a psychiatrist as lacking in decisional capacity for "most medical decisions." This assessment is especially troubling, as it is not specified as to which ones Ann is capable of deciding. Is it merely the ones to which she agrees—thereby making her unable to decide on the ones with which she disagrees, such as the biopsy? We are not given a psychiatric diagnosis of any mental health disorder; we are merely told that she is guarded, possibly paranoid, but no signs of psychosis are indicated. The concept of capacity to make autonomous decisions remains one of the most difficult-to-assess issues in daily hospital practice and is often done inconsistently. It is difficult to respect a patient's right to make decisions (especially in the case of patients whose abilities vary) without violating another basic principle: the promotion of his or her well-being. This difficult balance was navigated by J. F. Drane in 1984 in developing his three standards for competency.[1] It seems that Ann's situation is well suited for his particular model of evaluation, given her ability to make some—but not all—decisions. It must be noted that the term "competence" is a legal term, and in the field of clinical ethics and medical practice now, the term that is most often used is "decisional capacity."

In this model, the standard for granting decisionmaking capacity goes up as the danger to the patient if he or she were to refuse treatment goes up. This means that for a simple treatment or procedure with clear patient benefit, such as obtaining a temperature, one need only grant *assent* to proceed.[2] There is little harm in refusing, and it is a quick and harmless procedure that requires little thought for consequences. The second level is for chronic conditions (such as Ann's diabetes), when diagnosis is unclear (such as Ann's breast mass), and when treatments are dangerous or uncertain or when alternatives exist for treatments. Then the patient must be able to *understand the alternatives* and make a reasoned choice.[3] The third standard is for when the diagnosis is