'To treat or not to treat'. Kerrie Wooltorton, lessons to learn

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ABSTRACT

One of the main reasons for contact of psychiatric patients with Accident and Emergency (A&E) departments is deliberate self-harm. The situation is often complicated by the patient's ambivalence about treatment. Kerrie Wooltorton was one such patient who presented to an A&E department after having self-harmed by taking a fatal dose of antifreeze. She had an Advance Decision forbidding any treatment for her overdose, and continued to refuse the treatment. Her wishes were honoured and she died 3 days later. The case raises many ethical and practice issues, and this review aims to clarify the medico legal position in such a situation. It draws on the Mental Capacity Act and case law, which clearly favour preservation of life, to argue that there are many lessons to learn from this case. There are enough safeguards for treating clinicians if they are not satisfied of the validity and applicability of the Advance Decision and decide to override it. Alternatively, any decision to follow the Advance Decision has to be objectively supported by evidence. The Mental Capacity Act itself allows for overriding the patient's wishes if certain criteria under the Mental Health Act are met. This route was not explored in the Wooltorton case and this is the main lesson to learn.

INTRODUCTION

Kerrie Wooltorton, a 26-year-old woman with a history of mental illness and a history of anti-freeze overdose on up to nine previous occasions, presented to the Accident and Emergency department of Norfolk and Norwich University Hospital on 18 September 2007 after having taken a toxic amount of antifreeze, with a copy of her Advance Decision. She had drafted the Advance Decision on 15 September 2007, indicating that she did not wish to be treated if she took an overdose, even if she called an ambulance. Rather than being treated, she wanted to die in a situation where she was not alone and comfort and care was available. She continued to refuse the treatment while in hospital and died a few days later.

Was the hospital right in honouring her refusal of treatment, and did the hospital explore all the avenues before allowing Miss Wooltorton to die? The coroner, William Armstrong, recorded a narrative verdict that did not blame the hospital for her death.

The balance between best interests and patient autonomy is at the heart of the issue. Kerrie Wooltorton was judged to retain her capacity and thereby her Advance Decision was not relevant.[1] The relevance of her Advance Decision was that it added weight to her contemporaneous refusal of treatment. Despite the fact that the decision to withhold her treatment was not a direct result of her Advance Decision, this case does highlight issues regarding Advance Decisions, which this review will explore in some detail before going on to explore the powers to treat such patients under the Mental Health Act.

SELF-DETERMINATION

The principles of self-determination and patient autonomy are well established in English law. Capacitated adults have a right to give or withhold consent to medical treatment, even though their decision may be seen as being irrational and harmful.[2] Any attempt to treat or even touch a patient without consent may amount to civil battery in tort law, a criminal offence and may breach the person's rights under the European Convention of Human Rights.

In the absence of capacity, the alternatives are to allow the treating clinician to make decisions on a patient's behalf in his/her best interests, to have a system of surrogate decision-makers or to have a system where persons can make decisions about their future medical situations while they retain capacity. All of these measures are recognised by the law to various degrees.

The ability of a person to make decisions about future medical questions while he still retains the capacity has been given various names like an Advance Directive, a Living Will or, as the Mental Capacity Act 2005 calls it, an Advance Decision. The idea of the Living Will was first suggested in the late 1960s by Kutner[3] and became a part of Legislation in California in the form of the California Natural Death Act. Despite concerns that the incompetent future self lacks the requisite psychological relationship with a competent present self,[4] Advance Directives have become an accepted part of many legal systems across the world.

COURTS' APPROACH TO ADVANCE DECISIONS

In England the Courts considered the validity of an Advance Decision for the first time in *Re C*.[5] This ruling made a capacitous Advanced Refusal of treatment as binding. There was no requirement for formal documentation.

The propositions that can be derived from case law include: there is no requirement for a written Directive and the Directive is binding following a subsequent incapacity (*Re AK (medical treatment: consent)*),[6] the level of evidence must be scrutinised with special care where life is at risk and any doubt should be resolved in favour of preservation of life

(*HE v A Hospital NHS Trust, Para 43*),[7] and there is no formality for making or revoking Advance Directives and all Advance Directives are inherently revocable (*HE v A Hospital NHS Trust, Para 37*).

In his analysis of case law, Mclean[8] suggests that the Courts assess competence of patients on the basis of outcome of the choice. What makes an outcome of choice irrational is that a worthwhile life will be lost that could otherwise have been preserved. Although this may be dismissed as a cynical view, the case law on advanced refusals, when an individual has already lost capacity, suggests reluctance to favour Advance Decisions where this would result in a preventable death and where, with the treatment, the patient is likely to recover.

MENTAL CAPACITY ACT 2005

Advance Decisions to refuse treatment: general: Section 24 Mental Capacity Act

Capacity

There is nothing in the Mental Capacity Act that requires a formal assessment of capacity prior to making an Advance Decision, and capacity is presumed unless there are reasons to doubt it.

Doubts about capacity to make a contemporaneous decision can be resolved by the functional test described in Section 3 of the MCA. As the Advance Decision becomes operational only when the person loses capacity, such a formal assessment is not possible. In the absence of a functional test, the retrospective assessment of capacity, necessary to prove legality of an Advance Decision, would be heavily influenced by the apparent rationality of the decision. In other words, capacity will be determined by the 'reasonable outcome of choice test'[9] or, in cases where the reasons for the Advance Decision are known, by the 'rational reasons approach'.[10] Such tests are less respectful of individual autonomy than a functional test.

Specified circumstances and specified treatment

There is no requirement in the Mental Capacity Act or in common law to seek professional guidance prior to making an Advance Decision. Without good information it is hard to foresee future medical state. This contrasts with the process of contemporaneous decision-making, where the decision is made in consultation with a medical professional and where the patient, being in a particular situation, has a better understanding and better appreciation of the circumstances. The person making an Advance Decision would lack the personal experience of the circumstances and, in the absence of discussion with professionals, is likely to lack the benefit of expert opinion, thereby making the prediction of circumstances more difficult and open to challenge.

Oral Advance Decisions

Allowing the freedom to make oral Advance Decisions would facilitate more people to make such decisions and it could be argued that this supports the principles of individual autonomy, but in the long run such decisions are inherently more prone to challenge.

It is hard for the clinician to be convinced that an oral decision was made by a person who had capacity, had enough information and had indeed intended the statement made during a conversation to be a binding directive, rather than an opinion on a hypothetical situation. It is even harder to establish that the person was not under undue influence at the time and that he did not make a statement revoking the oral Decision at a later time during a separate conversation. Indeed, it would be difficult to establish that such a conversation even took place. In the context of Government evidence that, '…where there is any doubt (about oral Advance Decisions) the clinician can safely treat someone and receive protection from liability…',[11] it is easy to appreciate the vulnerability of such Advance Decisions.

Validity and applicability of Advance Decisions: Section 25 Mental Capacity Act

One of the major problems with drafting Advance Decisions is difficulty in drafting a sufficiently specific decision that anticipates future circumstances. This may have more to do with the inherent weakness of any system based on future prediction, but, as discussed above, such an inherent weakness could have been partly remedied by making the system more formal.

The Mental Capacity Act, by allowing the change of circumstances to be considered when determining the applicability of Advance Decisions, allows the incompetent patient to have benefits of new treatments. It invites the clinicians to make a substituted judgement on behalf of the patient in such situations. The onset of illness itself is an important change of circumstance and research has shown that the onset of illness changes one's perception of the illness and often changes one's views of the treatments.[12] It is hard to quantify such a change of view while making the substituted judgement, but it may tilt the balance against withholding treatment in finely balanced cases.

The Mental Capacity Act places no time limit on the validity and applicability of an Advance Decision. The Code of Practice states that decisions made a long time ago are more likely to raise doubts about validity and applicability.[13] Such decisions would be subject to more rigorous scrutiny. It is possible that a decision made decades ago represents the patient's wishes at the time of incapacity, but it is equally possible that the person's wishes had changed but he procrastinated making changes to his Advance Decision or that he simply forgot the Decision existed. This may inadvertently result in withholding appropriate treatment from a person just because he never got round to updating the Decision. On the contrary, the Advance Decision may be wrongly rejected. The only way to resolve this is to require regular reviews.

Effect of Advance Decisions: Section 26 Mental Capacity Act

The test for following the Advance Decision (reasonable belief) is more stringent than the test for rejecting it (satisfaction). This difference helps to protect the vulnerable and understandably requires a higher degree of proof for stopping the treatment than for continuing it.

The decision to follow an Advance Decision must be supported by objective evidence of reasonability. On the contrary, the decision to reject the Advance Decision is based on the clinician being satisfied that the decision was made by a competent person, with reasonable information, without any undue influence, is specific enough, applies to the current situation, has never been overruled, that the person has not done anything contrary to the decision since and the circumstances have not greatly changed. The clinician may reject the Advance Decision if he is not satisfied on any of these criteria and there is no statutory requirement for the satisfaction to be objectively reasonable. Such a subjective test gives the clinician a wide discretion and makes the Advance Decision more vulnerable, and, possibly from a clinician's point of view, easier to reject

than to accept. Only the most well drafted and most certain of the directives may survive such a scrutiny. A recent case demonstrating the vulnerability of Advance Decisions is described by Bonner *et al.*[14] The Advance Decision was rejected on the basis that it was not specific enough for the situation in question and that it was not regularly reviewed. This case demonstrates the difficulty in formulating a specific enough Advance Decision and the dilemmas that the treating teams face in such situations.

Did the Wooltorton case meet all these criteria? It appears reasonable to think that Kerrie Wooltorton's Advance Decision would pass most of these tests. It could be argued that her call for an ambulance was an action contrary to her Advance Decision, but she had preempted this argument and made it clear that this must not be construed as an action contrary to her Advance Decision. This, however, does not put her Advance Decision beyond reproach. There is another test to pass, one formulated in Section 28 of the Mental Capacity Act (box 1).

Mental Health Act (MHA) matters: Section 28 Mental Capacity Act

Patients detained under the Mental Health Act and being treated under part 4 of the Act can be treated against their concurrent wishes (Section 63 MHA) and against their Advance Decisions (Section 28 MCA), with the exception of electroconvulsive therapy.

The treatments allowed by the part 4 of the Mental Health Act cover the medical treatment for mental disorders. There was enough evidence to suggest that Kerrie Wooltorton suffered from a personality disorder, which would qualify as a mental disorder under the Mental Health Act. Whether her mental disorder was of such a nature or degree as to warrant a detention, was never tested. Assuming that a Mental Health Act assessment had been called and she was detained, would it be possible to treat her overdose under the Mental Health Act? Existing case law would suggest yes.

Box 1 Summary

Questions to ask about an Advance Decision:

- Is the Advance Decision still valid or has it been overruled by another decision or by an Enduring Power of Attorney?
- Was the patient competent when making the Advance Decision?
- Did the patient have a reasonable amount of information on which to base the Advance Decision?
- Are you satisfied that there was no undue influence in making the Advance Decision?
- Is the Advance Decision specific about the situation you are dealing with?
- Has the patient done anything contrary to the Advance Decision since it was made?
- Have the circumstances changed since the decision was made?
- Is there any reason to suspect that the patient suffers from a Mental Disorder?
- Does the patient meet the criteria for detention under the Mental Health Act?
- Would the treatment for the patient's illness constitute a treatment under the Mental Health Act? In other words is it a treatment that is a part of, or ancillary to, treatment for mental disorder?

Medical treatment under the Mental Health Act

Can we treat physical health problems under Section 63 MHA?

The answer to this question was provided by Wall J in *Tameside and Glossop Acute Services Trust v CH*[15] in 1996. The patient was detained while she was pregnant under the s.3 MHA. She was suffering from paranoid schizophrenia. Tests carried out at the 38th week of her pregnancy indicated that unless labour was induced very shortly the fetus was likely to die in utero. The patient was wavering in her consent to the medical procedures. Her doctor's opinion was that it was in her interests to give her a live baby, but the patient was delusional and believed that the medical staff were a threat to her child.

The Court granted a declaration that it was lawful to carry a treatment that included induction of labour, and, if necessary, a caesarean section. The reason given by the Court was that the Mental Health Act allows a treatment ancillary to the main treatment of a mental illness. The Judge ruled that a successful outcome of pregnancy fell under ancillary treatments of a mental illness as it would prevent deterioration of the patient's mental state. Also, it was ruled that, in order for treatment of her schizophrenia to be effective, it would be necessary for her to give birth to a live baby, and that the pregnancy was interrupting the patient's antipsychotic medication and could not be resumed until after the child was born. The decision concluded that achievement of a successful outcome of this patient's pregnancy was a necessary part of overall treatment of her mental disorder.

The Mental Health Act clarifies the meaning of medical treatment allowed under the Mental Health Act. Section 145(4) states that a medical treatment for a mental disorder is 'a medical treatment the purpose of which is to alleviate, or prevent worsening of, the disorder or one or more of its symptoms and manifestations'. One could argue that overdose was a possible manifestation of Kerrie Wooltorton's mental disorder and therefore could be treated under the Mental Health Act. The Code of Practice for the Mental Health Act states that 'the meaning of medical treatment under the Mental Health Act includes the treatment of physical health problems only to the extent that such treatment is part of, or ancillary to, treatment for mental disorder (e.g. treating wounds self-inflicted as a result of mental disorder').[16]

The meaning of the word ancillary treatment was clarified by the court of appeal in *B v. Croydon Health Authority.*[17] The court stated that 'treatment is capable of being ancillary to core treatment if it is care concurrent to core treatment or as a necessary prerequisite to such treatment or to prevent a patient from causing harm to himself or to alleviate the consequences of the disorder. Relieving the symptoms is as much a part of treatment as relieving the underlying cause'.

Another case where the Courts have allowed treatment of self-harm under the Mental Health Act is *A NHS Trust v T (adult patient: refusal of medical treatment).*[18] T, a patient with personality disorder, was admitted to the hospital after having cut herself and losing a substantial amount of blood. She refused a blood transfusion and her condition was deteriorating. The hospital sought a declaration to treat her with a blood transfusion, which was granted by the duty Judge.

These cases make it clear that overdoses and other acts of deliberate self-harm as a result of a mental disorder (which includes personality disorders) can be treated under the Mental Health Act. A refusal of treatment for non-self-induced

conditions, eg diabetic ketoacidosis, could potentially be a means of deliberate self-harm. In such cases, treatment under the Mental Health Act would require much clearer demonstration of a link between refusal of treatment and mental disorder.

It is easy to see how treating Kerrie Wooltorton's overdose would be a treatment concurrent to treatment of her mental illness, a treatment to prevent the patient from harming herself and also a treatment of the symptoms of the mental disorder (overdose being a manifestation and a symptom of her personality disorder). The question in Kerrie Wooltorton's case was not whether her overdose could be treated under the Mental Health Act, but whether she met the criteria for detention under the Mental Health Act. If she met the criteria, she could be detained and treated. Unfortunately, this route was not explored.

CONCLUSION

The provisions of the Mental Capacity Act surrounding the Advance Decisions provide robust safeguards for incompetent patients' welfare and against exploitation. They establish clear rules for the clinicians to follow when deciding the applicability and validity of Advance Decisions. The application of an Advance Decision becomes much harder if the patient has a mental disorder. In such cases, after satisfying themselves that the Advance Decision is fully applicable and valid, the next question should be: Is the patient showing any evidence of a mental disorder? If the answer is yes, advice must be sought from those with relevant mental health expertise, for example a Consultant Psychiatrist.

For Kerrie Wooltorton, the Advance Decision was not directly applicable, but even her competent contemporaneous wishes would not have precluded her from treatment under Part 4 of the Mental Health Act, provided she met the relevant criteria for detention. This would have been tested by an assessment under the Mental Health Act, which was never called. If there is any reason to suspect a mental disorder, the treating team needs to be satisfied that the patient cannot be detained and treated under the Mental Health Act, before a decision to withhold treatment is taken.

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