

Refusing medical treatment after attempted suicide: Rethinking capacity and coercive treatment in light of the Kerrie Woollorton case

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The inquest into the death of Kerrie Woollorton in Norfolk, England, ignited extensive public debate on the scope of the common law right to refuse medical treatment where a patient is distressed, depressed or actively suicidal. In Australia, a patient's wishes need not be honoured if the patient is not legally competent, if he or she falls within the ambit of the compulsory treatment provisions in the mental health legislation, and possibly also if there is a recognised public interest in preventing suicide which is sufficient to override the patient's choice. This article argues that decisions about whether to give medical treatment despite an apparent refusal should be based solely on a determination of the patient's competence to make their own choice. However, the test for legal competence must take into account the person's agency in making the decision, and decisions which will effectively end the person's life must be shown to be thought through.

INTRODUCTION

On 17 September 2007, a 26-year-old woman named Kerrie Woollorton consumed several glasses of antifreeze in a suicide attempt and called an ambulance. She carried a letter informing doctors that she knew the consequences of her actions, wanted no life-saving treatment, and had come to hospital only so that she could be made comfortable and because she did not want to die alone. The letter is set out in full below.

To whom this may concern, if I come into hospital regarding taking an overdose or any attempt of my life, I would like for NO lifesaving treatment to be given. I would appreciate if you could continue to give medicines to help relieve my discomfort, painkillers, oxygen etc. I would hope these wishes will be carried out without loads of questioning.

Please be assured that I am 100% aware of the consequences of this and the probable outcome of drinking anti-freeze, eg death in 95-99% of cases and if I survive then kidney failure, I understand and accept them and will take 100% responsibility for this decision.

I am aware that you may think that because I call the ambulance I therefore want treatment. THIS IS NOT THE CASE! I do however want to be comfortable as nobody want to die alone and scared and without going into details there are loads of reasons I do not want to die at home which I realise that you will not understand and I apologise for this.

Please understand that I definitely don't want any form of Ventilation, resuscitation or dialysis, these are my wishes, please respect and carry them out.

When questioned by doctors following her admission, Kerrie said simply: "It's in the letter, it says what I want."

The treating doctors consulted widely and sought legal advice. They took the view that Kerrie was competent to refuse treatment and, on this basis, believed they were obliged to act in accordance

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with her wishes. She died in hospital two days later.¹ Late in 2009, the Norfolk coroner endorsed the doctors' decision, prompting widespread comment in the media and calls for a review of English law.²

The outcome of the Woollorton case reflects the well-established principle that lawful medical treatment requires patient consent, and that medical treatment may be refused by a competent person even where, without treatment, the person will likely die.³ However, the common law right to autonomy in making medical decisions is not unassailable, and in Australia, competent people who refuse medical treatment may be coercively treated in one of two ways.

First, competent patients who nonetheless fall within the terms of Australia's mental health legislation may be involuntarily treated once that person is deemed to be mentally ill and at risk of serious physical harm. It is likely that should Kerrie Woollorton have presented to an Australian hospital in the same circumstances as she did in Norfolk, she could have been involuntarily treated under Australian mental health laws.⁴

Secondly, there is a recognised public interest in preserving life and preventing suicide at common law, which might also operate to override a competent refusal of medical treatment in some circumstances.

A commonly expressed view in the wake of the Woollorton inquest is that the ability to coercively treat some competent patients is a good thing, and that mental health legislation, in particular, provides an important humanitarian safeguard against the self-harming actions of depressed people, competent or otherwise. However, if personal autonomy remains a fundamental and long-held right in relation to the provision of medical treatment, the rationale for any involuntary medical intervention deserves careful scrutiny.

These two ethical imperatives – the right of patients to autonomous choice and the need to protect vulnerable people – often pull in opposite directions. This article argues that, when considering whether to give effect to refusal of medical treatment after a suicide attempt, the way the law currently balances these competing pressures is inadequate, often leading to unpredictable and discriminatory outcomes. It suggests both that patients' rights to autonomy and the need to protect vulnerable people will best be served by a renewed focus on competence, but that, in addition to the usual rules for assessing competence, treating clinicians must be satisfied that patients' refusals of life-saving treatment are well considered and that attention should be given to the extent to which the decision is consistent with the patient's sustained values and desires. The authors argue that this approach is both fairer and more effective than the current legal approaches that either rely on a diagnosis of mental illness or disorder regardless of competence, or require problematic distinctions to be drawn between refusals of medical treatment which might be "suicidal" and those which are not.

AUTONOMY, COMPETENCE AND REFUSALS OF TREATMENT

It is broadly accepted that people should be allowed to make decisions about their lives based on their own beliefs and values, provided that those decisions do not significantly disadvantage others. In the ethics literature this is known as the principle of "respect for autonomy".⁵

¹ *Inquest into the Death of Kerrie Woollorton* (unrep, Norfolk County Coroner's Court, Armstrong J, 28 September 2009).

² Gabbatt A, "Doctors Acted Legally in 'Living Will' Suicide Case", *The Guardian* (1 October 2009), <http://www.guardian.co.uk/society/2009/oct/01/living-will-suicide-legal> viewed 14 December 2010; Bingham J, "Bishops: Legal Rules Could Prevent Repeat of Kerrie Woollorton 'Living Will' Suicide", *The Telegraph* (6 October 2009), <http://www.telegraph.co.uk/news/newstoppers/religion/6265722/Bishops-legal-rules-could-prevent-repeat-of-Kerrie-Woollorton-living-will-suicide.html> viewed 14 December 2010; Smith R, Laing A and Devlin K, "Doctors Feared Saving Suicidal Young Woman", *Sydney Morning Herald* (2 October 2009).

³ See Freckelton I, "Patients' Decisions to Die: The Emerging Australian Jurisprudence" (2011) 18 JLM 427.

⁴ For example, Ryan C and Callaghan S, "Legal and Ethical Aspects of Refusing Medical Treatment After a Suicide Attempt: The Woollorton Case in the Australian Context" (2010) 193 MJA 239; Storm V, "Despair Is Not the End of the Road but the Beginning", *Sydney Morning Herald* (5 October 2009), <http://www.smh.com.au/opinion/contributors/despair-is-not-the-end-of-the-road-but-the-beginning-20091004-ghu5.html> viewed 14 December 2010.

⁵ Beauchamp T and Childress J, *Principles of Biomedical Ethics* (6th ed, Oxford University Press, New York, 2009) p 99.

The work of John Stuart Mill had a major influence on the development of this principle in liberal political theory, and on English common law in relation to a patient's right to refuse medical treatment. Mill's "liberty principle" states:

[T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good ... is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right ... In the part [of a person's conduct] which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.⁶

This principle is directly reflected in a well-established line of legal authority which provides that a competent person may refuse medical treatment for any reason, even if it will likely lead to the person's own death or serious injury.⁷ Providing medical treatment without consent, or despite a competent refusal, is a trespass at common law.⁸

In order to make an autonomous decision, an individual must have capacity – that is, the person's ability to make a decision must meet a certain minimum standard. If a person lacks capacity, their decision may be overridden as it will not be taken to reflect a genuine free choice. A person who lacks capacity may be treated by doctors according to a clinical assessment of the person's best interests, notwithstanding the stated refusal of medical treatment.⁹ Guardianship laws provide for consent to be given by a substitute decision-maker in the same circumstances.

There are many ways in which a person's capacity might be assessed and many standards of competence to which a person might be held. The prevailing common law test takes a "functional" approach to competence, in that it focuses on whether a person can demonstrate threshold decision-making ability, rather than the content of the decision (an "outcomes" approach) or whether the decision-maker is one of a class of persons who are deemed to be incompetent (a "status" approach).¹⁰ Functional tests for capacity are often regarded as fairer and more supportive of patient autonomy than outcomes or status-based methods, which involve an objective evaluation of the content of the patient's decision or the characteristics of the decision-maker rather than permitting all persons who are *able* to make decisions to do so according to their own values.¹¹ While the common law test has been expressed in various ways, generally speaking a person will be taken to be competent to refuse medical treatment if the person is able to

- understand and retain treatment information;

⁶ Mill JS, "On Liberty" in Ryan A (ed), *On Liberty and the Subjugation of Women* (Penguin, London, 2006) p 16.

⁷ That principle has been established by decisions in each of the major common law jurisdictions, including the United States (*Schloendorff v Society of New York Hospital* 105 NE 92 at 93 (1914); *Bowvia v Superior Court* 179 Cal App 3d 1127 at 1137, 1139-1141 (1986)); Canada (*Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR (4th) 385; *Malette v Shulman* (1990) 67 DLR (4th) 321 at 328); the United Kingdom (*Airedale NHS Trust v Bland* [1993] AC 789 at 857 (Lord Keith), at 864 (Lord Goff)); *B v An NHS Hospital Trust* [2002] 2 All ER 449 at [16]-[21]); New Zealand (*Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 at 245); and Australia (*Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88; [2009] NSWSC 761 at [9]-[15]; *Brightwater Care Group v Rossiter* [2009] WASC 229 at [26]; *H Ltd v J* (2010) 107 SASR 352; [2010] SASC 176 at [33]-[46]).

⁸ *Malette v Shulman* (1990) 67 DLR (4th) 321 at 328; *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's Case)* (1992) 175 CLR 218; *Hunter and New England Area Health Service v A* [2009] NSWSC 761 at [9]-[15].

⁹ *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95 at 103 (Donaldson LJ) cited with approval in *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88; [2009] NSWSC 761 at [31]-[34].

¹⁰ Stewart C and Biegler P, "A Primer on the Law of Competence to Refuse Medical Treatment" (2004) 78 ALJ 325.

¹¹ See eg Stewart and Biegler, n 10 at 326; New South Wales Parliament, Legislative Council, Standing Committee on Social Issues, "Substitute Decision-making for People Lacking Capacity", *Report 43* (February 2010) pp 30-32. [http://www.parliament.nsw.gov.au/Prod/parliament/committee.nsf/0/e00602d3c8f39ca5ca2576d500184231/\\$FILE/100225%20SDM%20Final%20Report.pdf](http://www.parliament.nsw.gov.au/Prod/parliament/committee.nsf/0/e00602d3c8f39ca5ca2576d500184231/$FILE/100225%20SDM%20Final%20Report.pdf) viewed 14 December 2010.

- use and weigh the information among other factors and reach a decision;¹² and
- communicate that decision by some means.

A competent decision to refuse medical treatment does not have to be sensible or well considered in the opinion of others.¹³ A valid refusal may be thought to be foolish or mistaken¹⁴ and the reasons given by a competent person may be rational or irrational, unknown or even non-existent.¹⁵ Having an active mental illness will not necessarily preclude a finding of competence, provided the effects of the illness do not directly impact the person's ability to make the decision in question.¹⁶

The outcome of a decision does not, in itself, preclude a finding of competence and is relevant only as evidence as to whether the person meets the requirements of the functional test. Consequently, a competent refusal of medical treatment will be valid even if it will likely lead to the person's own death or serious injury.¹⁷

Kerrie Woollorton was found by her treating doctors, and later by the coroner, to be competent to refuse life-saving treatment. However, if she had been found to lack capacity to make her decision, in Norfolk Hospital, or any hospital in Australia, she could lawfully have been treated back to health.

IRRATIONALITY AND DISTRESS: COERCIVE TREATMENT UNDER THE MENTAL HEALTH ACTS

Despite the common law's insistence on the rights of competent people, in Australia a person who falls within the terms of the applicable mental health legislation¹⁸ (referred to here as the "Mental Health Acts") may be given treatment without consent if the person is mentally unwell as defined by the Act, if the person is considered likely to come to some harm as a result of her or his condition, and if the treatment is "the least restrictive" option. In each jurisdiction, definitions of mental unwellness – variously termed mental "illness" or "disorder" or "disturbance" or "dysfunction" – differ slightly, but all would be likely to cover a person presenting with a clinical diagnosis of reactive depression or adjustment disorder as well as a more serious major depression or psychosis. The issue is not per se whether a depressed, distressed or suicidal person like Kerrie Woollorton is competent in common law terms to refuse medical treatment – and it is possible that they will be – as the person's competence is not a factor to be taken into account in determining whether involuntary treatment should be given. As a consequence, some people will be detained and treated notwithstanding what has the potential to be a competent refusal of medical care.

¹² *Re MB (Adult: Medical Treatment)* [1997] 2 FCR 541 at 553-554 (Butler-Sloss LJ), cited with approval in *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88; [2009] NSWSC 761 at [25]; *Brightwater Care Group v Rossiter* [2009] WASC 229 at [13].

¹³ *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95 at 116 (Butler-Sloss LJ), cited with approval in *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88; [2009] NSWSC 761 at [10].

¹⁴ In *Malette v Shulman* (1990) 67 DLR (4th) 321 at 328 (Robins JA), cited with approval in *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88; [2009] NSWSC 761 at [14].

¹⁵ *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95 at 113 (Butler-Sloss LJ), cited with approval in *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88; [2009] NSWSC 761 at [15] and *Brightwater Care Group v Rossiter* [2009] WASC 229 at [27]. However, in *Hunter*, McDougall J noted (at [15]) that "the lack of any discernible basis for a decision to refuse treatment may be something to take into account in assessing the competence or validity of the decision".

¹⁶ *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819.

¹⁷ See n 7.

¹⁸ *Mental Health (Treatment and Care) Act 1994* (ACT); *Mental Health Act 2007* (NSW); *Mental Health and Related Services Act* (NT); *Mental Health Act 2000* (Qld); *Mental Health Act 2009* (SA); *Mental Health Act 1996* (Tas); *Mental Health Act 1986* (Vic); *Mental Health Act 1996* (WA).

A person like Kerrie Woollorton, who had a history of depression and suicide attempts,¹⁹ would probably have met the criteria for coercive treatment under all of the Australian Mental Health Acts.²⁰ However, if autonomy is an important right for all citizens, and people are generally permitted to refuse medical treatment – even if to do so would allow their inevitable death – there is reason to consider whether the operation of the Acts in this way really represents good public policy. The concern is that, by determining whether to honour a patient’s wishes on the basis of the person’s mental health status rather than on whether they are *able* to make a true decision for themselves, the Mental Health Acts may represent unjustified discrimination against a class of competent people who happen to receive a diagnosis of mental illness. The authors return to this issue, and a possible alternative approach, later in the article.

LIMITS TO AUTONOMY: PUBLIC INTERESTS IN THE PREVENTION OF SUICIDE?

There is also an argument that, competence aside, there may be limits to the principle of autonomy, even where it is restricted to what Mill called “the part [of a person’s conduct] which merely concerns himself”.²¹ In other words, there may be some types of decisions to die that should simply not be allowed under any circumstances. It has already been established that there is a right to succumb to illness or injury without medical treatment, no matter how dire the patient’s condition. But is there a discernible difference between “succumbing” and the wilful infliction of injury on one’s self, which is sufficient to exclude an enforceable right to the latter – even where people are competent?

As it stands, the law in relation to self-harm depends a lot on context. While suicide itself is not illegal, the common law recognises a public interest in preserving life and preventing suicide²² which may, on occasion, need to be weighed against the right to autonomy in making medical decisions. If the balance is tipped in favour of preserving life, a competent person who does not fall within the ambit of the Mental Health Acts may, at least in theory, be treated against their will at common law. Assisting suicide also remains a criminal offence in all Australian jurisdictions,²³ and some jurisdictions offer a statutory defence for any person who uses force to prevent a suicide.²⁴

In medical treatment cases, however, this type of “outcomes” approach is problematic because it is not always easy to explain the difference between what should count as “suicide” – which must be

¹⁹ Kerrie Woollorton’s depression and extensive history of self-harming behaviour is detailed in David A, Hotopf M, Moran P, Owen G, Szmukler G and Richardson G, “Mentally Disordered or Lacking Capacity? Lessons for Management of Serious Deliberate Self Harm” (2010) 241 *BMJ* c4489.

²⁰ The degree of certainty with which non-psychiatric treatment can be given without consent to patients who are admitted to hospital under the involuntary treatment provisions of the Mental Health Acts (see n 18), varies in each jurisdiction. Victoria (*Mental Health Act 1986* (Vic), s 84(3)), the Australian Capital Territory (*Mental Health (Treatment and Care) Act 1994* (ACT), s 44(1)(c)), South Australia (*Mental Health Act 1993* (SA), s 18(1)), Western Australia (*Mental Health Act 1996* (WA), s 110) and the Northern Territory (*Mental Health and Related Services Act 1988* (NT), s 63) expressly permit urgent life-saving treatment. In New South Wales the law is not explicit but an authorised medical officer is permitted to give “any treatment (including any medication) the officer thinks fit” to an involuntary patient (s 84). Section 18(2) also states that a person may be detained and treated under the Act for “a condition or illness other than a mental illness or other mental condition”. The warrant for non-psychiatric treatment is even less clear in Queensland, although urgent life-saving treatment is not one of the specially regulated treatments in the *Mental Health Act 2000* (Qld) which require patient consent. It would be reasonable to conclude that provisions in Queensland which permit non-voluntary treatment for mental illness or disorder would include treatment of the physical consequences of self-harm which arise from the illness or disorder. This was the conclusion reached in relation to similar provisions in the *Mental Health Act 1983* (UK) in *B v Croydon Health Authority* [1995] 2 *WLR* 294.

²¹ Mill, n 6, p 16.

²² For example, “the interest of the state in ... preventing suicide” was acknowledged but excluded from consideration in *Re T (Adult: Refusal of Medical Treatment)* [1993] *Fam* 95 at 117 (Butler-Sloss LJ). For further discussion, see Stewart C, “Public Interests and the Right to Die: Compelling Reasons for Overriding the Right to Refuse Treatment” (2001) 14 *Australian Institute of Health Law and Ethics Issues Papers* 1.

²³ *Crimes Act 1900* (ACT), s 17; *Crimes Act 1900* (NSW), s 31C; *Criminal Code* (NT), s 168; *Criminal Code* (Qld), s 311; *Criminal Law Consolidation Act 1935* (SA), s 13A(5); *Criminal Code* (Tas), s 163; *Crimes Act 1958* (Vic), s 6B(2); *Criminal Code* (WA), s 288.

²⁴ *Crimes Act 1900* (ACT), s 18; *Crimes Act 1900* (NSW), s 574B; *Criminal Law Consolidation Act 1935* (SA), s 13; *Crimes Act 1958* (Vic), s 463B.

prevented – and what is merely a lawful refusal of treatment, albeit one which will inevitably lead to the patient’s death, which must be upheld. Certainly, each of the two legal approaches to this question – ascertaining whether patient has a suicidal motive,²⁵ and determining whether the cause of death is “natural”²⁶ – has been heavily criticised,²⁷ and has generated haphazard and unpredictable results.

For example, in most medical treatment cases which have considered the question of “suicidal motive” – that is, whether the patient has an active wish to die which should be honoured – the court has determined that a patient who accepts death as the preferable alternative to the continuation of overly burdensome medical treatment, at least where there is no hope of cure, cannot be said to want to die. Rather, these people are taken to just *really* not want medical treatment – and that death is merely the necessary and preferable alternative to continuing with it.²⁸

Conversely, in at least one case from the United States, a 28-year-old quadriplegic patient who *was* found to have “formed an intent to die” was denied an application to refuse medical treatment.²⁹ This can be contrasted with the recent Western Australian case of *Brightwater Care Group v Rossiter* [2009] WASC 229, where a hospital sought orders as to whether a patient’s direction to withdraw artificial feeding and hydration was lawful. The court acknowledged that the patient was not terminally ill or dying but that he “wish[ed] to die ... However, because of the physical limitation upon his movements [due to his quadriplegia] he lack[ed] the physical capacity to bring about his own death” (at [11]). Notwithstanding the acknowledged suicidal motive, however, the court held that a competent direction by Mr Rossiter to refuse treatment would be lawful and the hospital would be legally required to cease treatment.

The second approach to distinguishing treatment refusals from suicide involves the frequently criticised³⁰ legal distinction between acts and omissions. This approach maintains that a person who refuses medical treatment, or who dies after life-saving treatment is withdrawn, does not die from an *act* of suicide but rather from the underlying medical condition which has been permitted to take its natural course (by the omission to provide medical treatment).³¹ It is difficult to say, however, without direct precedent, how this reasoning would be applied to a case where the fatal underlying condition was self-inflicted – such as kidney failure after drinking poison.

None of these issues was considered by the coroner in the Woollorton case. However, on balance, it appears that the lawfulness of a refusal of medical treatment may be in doubt where, without treatment, the patient will die from the effects of a deliberate, self-inflicted injury, but probably not if

²⁵ For discussion of suicidal motive in a medical treatment case, see *Bouvia v Superior Court* 179 Cal App 3d 1127 (1986). Also, regarding intention to suicide generally, see *Schneidas v Corrective Services Commission* (unrep, Sup Ct, NSW, 8 April 1983) where force feeding of a hunger-striking prisoner was permitted on the basis that his refusal of food amounted to attempted suicide. Also see *Re Caulk* 480 A 2d 93 at 96-97 (1984).

²⁶ See eg *Re Conroy* 486 A 2d 1209 (1985); *Superintendent of Belchertown State School v Saikewicz* 370 NE 2d 417 (1977).

²⁷ Stewart, n 22; Price D, “Assisted Suicide and Refusing Medical Treatment: Linguistics, Morals and Legal Contortions” (1996) 4 Med L Rev 270; Lanham D, *Taming Death by Law* (Longman Cheshire, Melbourne, 1993).

²⁸ For example, *Superintendent of Belchertown State School v Saikewicz* 370 NE 2d 417 (1977); *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95 at 102 (Donaldson LJ): “This appeal is not in truth about the ‘right to die’. There is no suggestion that Miss T wants to die. I do not doubt that she wants to live and we all hope that she will. This appeal is about the ‘right to choose how to live’. This is quite different, even if the choice, when made, may make an early death more likely.”

²⁹ This was the finding at trial; however, on appeal, it was determined that motive was not relevant to the question of whether the patient had validly refused medical treatment: *Bouvia v Superior Court* 179 Cal App 3d 1127 (1986).

³⁰ For example, concerns about the distinction between acts and omissions were discussed in detail in *Airedale NHS Trust v Bland* [1993] AC 789 in relation to whether withdrawal of treatment leading to death could be said to “cause” death. Browne-Wilkinson LJ acknowledged (at 885) that the acts/omissions distinction in relation to killing/letting die “will appear to some to be almost irrational ... [b]ut it is undoubtedly the law”. Mustill LJ was also highly critical, commenting (at 893) that “the current state of the law is unsatisfactory both morally and intellectually ... We cannot however try to put it in order here. For the time being all are agreed that the distinction between acts and omissions exists, and that we must give effect to it.”

³¹ The acts/omissions distinction in withdrawal of medical treatment is discussed in detail in *Airedale NHS Trust v Bland* [1993] AC 789; see eg Goff LJ (at 866): “[T]he doctor, in discontinuing life support, is simply allowing his patient to die of his pre-existing condition.” For discussion, see Williams G, *Intention and Causation in Medical Non-killing* (Routledge Cavendish, Abingdon, 2007).

a competent person (who is not subject to a regime of involuntary treatment) refuses medical treatment for any other type of illness or injury. It may also be in doubt if the person appears to be suicidal, but not if he or she is suicidal and suffering from a debilitating and incurable condition.

The reason for the apparent inconsistency and, some would say, unfairness in the case law on refusal of medical treatment seems to be that the law is really interested in preventing what some authors have called “irrational”³² or “unjustifiable”³³ self-destruction, but the strictures of common law principle prevent this from being clearly articulated, and prevent the dividing line between acceptable refusals of medical treatment and unacceptable “suicides” from being clearly drawn. Without addressing head-on the issue of exactly which refusals of treatment should be rejected, and why, results will continue to be unpredictable and the rights of patients and the role of doctors will remain in doubt in refusal of treatment cases.

COMPETENCE AND AGENCY: A BETTER ALTERNATIVE?

If it seems arbitrary to override the right to self-determination based on the cause of the presenting injury; inconsistent to consider patients’ “motives” in some cases but not in others; and discriminatory to override competent decisions on the basis of a person’s mental health status, the authors suggest that the better approach is to reconsider the capacity requirements for a refusal of medical treatment – and to permit autonomous choices where a person, self-harming or succumbing, mentally ill or otherwise, fulfils these capacity criteria and makes a clear choice. The authors believe that this approach preserves the well-established right to self-determination in decisions about medical treatment, while adequately serving legitimate policy goals that require vulnerable people in the community to be protected.

In particular, it is suggested that a refusal of medical treatment, where the refusal will lead to the patient’s death, should be considered valid and enforceable if it satisfies the following criteria:

- the decision-maker must be competent according to the usual function-based rules applying to refusals of medical treatment;
- the degree to which the person’s decision is consistent with their stable and enduring desires must be considered when determining whether the person is able to “use and weigh information” about the consequences of a treatment decision; and
- the person must demonstrate that their decision is well considered.³⁴

The “agency” requirement

The requirement that, in assessing competence, consideration should be given to the degree to which the person’s expressed desire is consistent with stable and enduring desires, underlines the notion that, generally speaking, a person will tend to make decisions that are consistent over time. It also accords with the notion of agency, a crucial component of autonomy, which refers to a person’s awareness of their goals.³⁵ When a person makes an important decision (such as the refusal of life-saving treatment) that is radically at odds with her or his previously held views, there is reason to suspect that the person may temporarily lack the capacity to make that decision and may come to regret that decision within a short period of time. While this requirement does mean that the outcome of a decision – that is, whether the decision is consistent with the person’s usual life views – is relevant in determining competence, it is limited to being an indicator of functional competence rather than being

³² Otowski M, *Voluntary Euthanasia and the Common Law* (Oxford University Press, Oxford, 1997) p 74.

³³ Price, n 27 at 289-292.

³⁴ Stewart C, Peisah C and Draper B, “A Test for Mental Capacity to Request Assisted Suicide” (2010) *J Med Ethics*, <http://www.jme.bmj.com/content/early/2010/11/21/jme.2010.037564.full> viewed 14 December 2010. Stewart et al argue that a legal test for competence to request assisted suicide should require that patients be able to demonstrate an ability to understand detailed information about their illness and the consequences of treatment or withdrawal of treatment intended to cause death. It is not clear whether the authors believe that patients should demonstrate that they have actually understood this information, but in practical terms, an ability to understand would presumably be best demonstrated by actual understanding. The authors also say that “the decision should be consistent over time with past expressed wishes and beliefs”.

³⁵ Richardson G, “Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions” (2002) 65 *Mod L Rev* 702.

determinative of it. This means that a person may be found to have competently changed their mind from their “usual views”, but acknowledges, quite properly, that people who make decisions in situations of high emotional stress that are inconsistent with their usual life views are often, on closer inspection, functionally incompetent to make the decision in question. Medical professionals have a responsibility to identify these individuals and to treat them in their best interests should they be found to lack capacity to decide for themselves.

Why should “decisions to die” be well considered?

At common law, a refusal of medical treatment by a competent person need not, strictly speaking, be well considered. It has been said that a decision to refuse medical treatment, even one leading to the patient’s death, will be valid even if the reasons given are “irrational, unknown or even non-existent”³⁶ and, while courts have acknowledged that “the lack of any discernible basis for a decision to refuse treatment may be something to take into account in assessing the competence or validity of the decision”,³⁷ there has been no clear insistence that competence in life-and-death decisions requires a deal of thinking through. Indeed, approaches to competence which focus on the nature and quality of a decision, which might include whether the decision is well made by objective standards, have been criticised as unfairly limiting the established right at common law for competent people to make any type of decision they wish.³⁸

However, there are good policy reasons why hospitals and treating clinicians should take reasonable steps to assure themselves that a patient’s decision to die has been thought through before acting on it. Not least of these is that the decision to die is drastic and fundamentally irrevocable. Those with the ability, and perhaps the duty, to prevent a person’s death should be confident that a person is sure about what they want before withholding or withdrawing critical assistance. A requirement that a person who has capacity should have demonstrably applied their reasoning ability to the question at hand, is not an unfairly limiting requirement when balanced against the public interest in preventing death – at least in circumstances where a decision to die may not be a genuine choice made with the fully engaged decision-making capacity of a competent person.

WHAT MIGHT THIS HAVE MEANT FOR KERRIE WOOLTORTON?

Kerrie Woollorton did not usually want to die. She had attempted suicide before, but after her previous suicide attempts she had received treatment and had apparently decided, at least for a time, to get on with life. A thorough consideration of whether Kerrie Woollorton’s agency was fully engaged may have raised doubts about her competence.³⁹

Just this sort of concern has troubled judges in other cases. For example, in the leading judgment in *B v Croydon Health Authority* [1995] 2 WLR 294 Hoffmann LJ noted his discomfort with the trial judge’s finding that a young woman with borderline personality disorder, whose symptoms included a chronic compulsion to self-harm, had capacity at common law to refuse artificial feeding during a life-threatening period of anorexia. Referring to the young woman’s testimony, Hoffmann LJ said (at 300):

I find it hard to accept that someone who acknowledges that in refusing food at the critical time she did not appreciate the extent to which she was hazarding her life, was crying inside for help but unable to break out of the routine of punishing herself, could be said to be capable of making a true choice as to whether or not to eat.

At the time of her review, Kerrie Woollorton was not asked, and possibly was unable to answer, the sorts of questions that might have allowed assessment of whether she had the capacity required to

³⁶ *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95 at 103 (Donaldson LJ).

³⁷ *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88; [2009] NSWSC 761 at [15].

³⁸ See eg New South Wales Parliament, Legislative Council, Standing Committee on Social Issues, n 11, pp 30-32. The Standing Committee endorsed a “functional approach” over a “status” or an “outcomes” approach to capacity testing which, according to a submission by Blake Dawson Lawyers (quoted at [4.41]), “considers the result or quality of a decision rather than the person’s capacity to make the decision”.

³⁹ David et al, n 19, also raise questions about the limitations of the capacity assessment made in relation to Kerrie Woollorton.

make a decision both with serious consequences and apparently counter to her usual desires. Were things different this time? Why? How long had things been different? Why had she called the ambulance, presumably knowing that in all likelihood she would be treated against her will? Why was it so important that she not die alone that she would risk almost certainly not dying at all?

It is possible to imagine a range of answers that Kerrie might have given to these questions that would have reassured her doctors that her decision to die was truly autonomous. Unfortunately though, the law has not been articulated so as to clearly require her to be asked those kinds of questions, so one cannot know what impact her answers may have had on the assessment of her competence.

CONCLUSION

Most people who present in a manner similar to that of Kerrie Woollerton will not have made a considered decision to die that carries forward their agency. For most, the attempt will be impulsive and a suicide note, including one refusing treatment, will be written in the context of that impulsive decision. In such cases, unless the person can clearly demonstrate functional competence and that their decision has been thought through, they deserve treatment in their best interests – as is the right of all people who lack capacity to make their own medical decisions.

However, where a person is found to be competent, and to have arrived at a critical decision to refuse life-saving treatment after genuine consideration, the person's decision should be honoured, whether or not the person has a mental illness, or whether the decision can be characterised as "suicide" or the process of allowing one's self to die from other causes.