Classic cases revisited: The suicide of Kerrie Wooltorton 1F05 2C06

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This article reviews the case of a patient who ingested ethylene glycol and who presented to hospital but refused treatment while she was assessed as having capacity. The author reviews issues surrounding the Mental Capacity Act 2005, assessment of capacity and a way forward when confronting this difficult situation.

Keywords: *ethical issues; autonomy; advance directives; suicide*

Introduction

Attempted suicide is not uncommon. The act is commonly a compulsive one and most patients accept an offer of treatment. Occasionally, however, a person may present at hospital having undertaken a potentially lethal course of action and refusing a lifesaving intervention. The decision not to treat stands starkly in conflict with the ethos of modern medicine. However, any treatment against the will of a competent individual constitutes an assault. Recently, Ms Kerrie Wooltorton, who refused treatment after the ingestion of a lethal dose of ethylene glycol, presented clinicians with this problem. In the eyes of the media, both medicine and the law failed the patient. The aim of this paper is to provide a sketch of the legal and ethical landscape that may inform more pragmatic clinical decision-making in similar cases and perhaps question our understanding of patient autonomy and its limits.

The case

On the 18th September 2007, Kerrie Wooltorton, a 26-year-old charity shop worker, called an ambulance and came to hospital following the ingestion of a lethal dose of ethylene glycol with suicidal intent. In the previous 12 months, she had attended the hospital several times in similar circumstances, and on each occasion had accepted treatment. This time, however, Miss Wooltorton declined all treatment with the exception of comfort measures and, to emphasise that, handed an 'advance directive' to the clinical team. This she had prepared three days prior to the admission. She was conscious, alert, able to communicate at the time of admission and she persisted with her decision. While the patient had been known to psychiatric services with a history of self-harm, depression and untreatable personality disorder, and had required a previous admission under the Mental Health Act, on this occasion she was judged to have capacity. The clinician in charge sought a second opinion and legal advice, and felt obliged to comply with Ms Wooltorton's wishes. The patient did not receive any treatment, deteriorated and died the following day. At the inquest, the Coroner, Mr William Armstrong, confirmed that the patient had capacity to refuse treatment and noted that 'any treatment to save Kerrie's life in these circumstances would have been unlawful.' The ethical dissonance caused by the case has been noted by the media[1-3] and the medical press, with articles published in the *BMJ*[4,5] and elsewhere[6]. The media's focus has mostly been on the 'advance directive,' which in fact played little role in the case.

The question of capacity

The prevalence of the lack of capacity among acutely unwell, older medical in-patients has been estimated at 31%.[7] When considering patients with mental health issues admitted to psychiatric hospitals, this may reach 60%.[8] It can be difficult to ascertain the prevalence of capacity among those actually detained under the Mental Health Act,[9] but even in patients with schizophrenia, capacity to consent was present on and during trial recruitment.[10] It follows that, even if mental health is an issue, absence of capacity should not be presumed. When assessing capacity using the Mental Capacity Act 2005,[11] the first step in its assessment is to identify 'an impairment of or disturbance in the functioning of the brain or mind.' This can be an organic pathology or mental illness. Whether the personality disorder from which Kerrie Wooltorton suffered can be viewed as a disturbance of the mind can be debated, as it may be considered as one of the extreme range of possible personalities. If it is felt that there is a lack of capacity, an individual's decision-making ability should be assessed by ascertaining whether he or she is able to understand the information provided, retain it and use it to make a choice about treatment. The individual is expected to weigh up the pros and cons of making that decision and be able to communicate the decision. It is not explicit in the assessment that the weighing up needs to be articulated. The law permits irrational (from the clinician's perspective) decisions.

The Mental Capacity Act of 2005 safeguards the autonomy of individuals. The presence of capacity should always be presumed and, if any doubt exists, the Act details how it may be tested. In the case of Kerrie Wooltorton, the treating doctors went to great lengths to assess her capacity and the inquest following her death has confirmed that. As her actions were autonomous, to treat her would have constituted an assault on

her person. The case law instructs us that a competent person may refuse lifesaving treatment[12] and that the individual does not have to stipulate reason for the refusal.[13] We also know that the presence of mental illness does not preclude the presence of capacity to refuse lifesaving treatment.[14] Given the irreversibility of the course of action taken, there is always an obligation to ensure that no ambiguities exist in the patient's expressed values and that the mental state does not interfere with decision-making. The capacity to make a particular decision may fluctuate, as demonstrated in re: MB,[15] where the patient refused treatment in a state of panic and was judged not competent at the time of refusal. The consistency and lack of ambivalence with regards to the course of action that would result in death were also examined in detail in the case of Ms B.[12]

An alternative legal approach to the above case has been proposed by AS David and colleagues.[4] The Mental Health Act 1983 allows professionals to 'section' individuals that are a threat to themselves. Specifically, the Act allows detention in hospital if a patient has a mental disorder of a nature or degree that warrants such detention, and if it is in the interest of safety of the person and others. The detention may be for assessment or treatment. Undoubtedly, Kerrie Wooltorton had significant mental health issues. The authors were guardedly critical of the existence of two separate legislative Acts that can give rise to dichotomous outcomes. They emphasise that a careful assessment of the scope of the terms 'use' and 'weigh' when deciding whether the patient can truly use provided information and weigh it in the balance when making a decision. They have also pointed out the discrepancy between the patient's actions and her previous acceptance of treatment.

What do we understand by autonomy?

Bruce Jennings, in a rather voluminous handbook of bioethics writes 'It is important to note that autonomy is not a single idea but a cluster of closely related, overlapping ideas. And it is not only a philosophical or theoretical construct. The idea, if not the actual term, is part and parcel of contemporary culture and everyday self-consciousness in the West.'[16] A concise and clear, although by no means complete, overview of the concept of autonomy is provided by Gracia.[17] He proposes to view autonomy in four different ways. The term autonomy originates in ancient Greece meaning 'self rule' with respect to the state. As such, autonomy initially had a purely political dimension. It implied sovereignty. It was not until the eighteenth century that Immanuel Kant gave autonomy a metaphysical dimension, linking it inexorably with the concept of the person as a rational being. In that context, we speak of autonomous persons. Kantian moral theory attributes intrinsic worth to human beings. This moral value stems from human beings acting as rational agents capable of moral choices – or being able to attribute value to things. Because of that, they deserve the utmost respect. Kant's categorical imperative in one of its versions says 'we should never act in such a way that we treat Humanity, whether in ourselves or in others, as a means only but always as an end in itself.'[18] The philosopher James Rachels remarked about Kantian morality 'We should not force adults to do things against their will; instead, we should let them make their own decisions. We should therefore be wary of laws that aim to protect people from themselves.'[19] In accordance with Kantian views, doctors who treated Ms Wooltorton should perhaps be commended for respecting her as a human being rather than a potential subject of a therapeutic intervention.

The third way of viewing autonomy, according to Gracia, is within the legal dimension. Here, we speak of autonomous acts rather than persons. An autonomous act is one which is performed by a competent individual (ie, one who has capacity), who is suitably informed (informed consent or refusal) in the absence of any coercion. The legal dimension of autonomy is adopted by bioethicists. We may note here that in the light of the law, Kerrie Wooltorton acted autonomously, as she passed a test of competency, did not appear to be coerced and was aware of the outcome. But the philosophical question may still exist as to whether, given her circumstances, she was an autonomous person. Gracia distinguishes a fourth possible way of considering autonomy, and that is in a moral sense. He proposes that autonomy is equivalent to responsibility. The mind experiment he employs is to consider acts of obedience (eg, people compelled by religion to a particular course of action). These may well fulfil the legal criteria for autonomous action, yet there is a transfer of responsibility for that action, and thus a person cannot be considered truly autonomous. Bruce Jennings articulates this very well speaking about consent 'The moral life of the individual is made up of relationships, commitments, and obligations that the individual has freely chosen, not those into which she was born or that were imposed upon her. Rather, autonomy means living in accordance with rules that one gives to oneself. If an autonomous person does her duty, it is because she has freely and rationally chosen to do so. Autonomy gives an inward turn to moral duty, obligation, or responsibility, grounding them not in nature or history, but in the domain of will and rational choice.'[16] This way of thinking is rooted very much in the Western philosophical tradition. We can also appreciate here the subtle difference between this view of autonomy and the one that a lawyer may have. In practice however, while individualistic, we may find it hard to dissociate ourselves from the demands of the society that we live in.

There is an alternative to viewing autonomy from the perspective of reason, duty or responsibility. The alternative is to view it as freedom of choice. This is a view expounded by thinkers such as John Stuart Mill or Isaiah Berlin, where autonomy is often termed liberty. Conceptually, it can be viewed as freedom from constraints and freedom to self-direction and it underpins such important statements as the Declaration of Human Rights or the Helsinki Declaration. As such, autonomy would legitimately prevent any unwanted intervention, occasionally bringing about a moral problem as seen in the case of Kerrie Wooltorton.

Is there a role for authenticity?

As indicated above, autonomy has many shades. When it is applied in the clinical context, it is primarily viewed within its legal dimension. Law demands that a patient, when making a decision about treatment, is under no duress, is sufficiently

informed and has capacity. However, case law, as for example in re: Ms B[12] suggests that capacity may not be enough to warrant immediate compliance with the patient's wish to forgo a life saving treatment. Any ambiguities or 'out-of-character' decisions need to be clarified prior to taking what may be an irreversible course of action. The theoretical construct used here is that of authenticity.[20] Autonomy viewed in this way has two components – agency (or capacity) and authenticity. The former refers to the ability to process information and make decisions (as may be tested in accordance with the Mental Capacity Act 2005). The latter concept refers to a set of values acquired over the years that defines the moral identity of the individual and the values they live by. Where capacity allows individuals to make choices, authenticity provides the foundation on which those choices are based. It is a reflection of self. Authenticity allows us to lead a distinctive life. It allows us to say 'it's me; it's my way of life,' while capacity does not. This concept provides a fabric to the self over time. It is a sustained achievement. And if autonomy is associated with persons as rational agents, we can see yet another parallel when considering John Locke's definition of a person as 'a thinking intelligent being, that has reason and reflection and can consider itself as itself, the same thinking thing in different times and places.'[21] Authenticity exists not for an instant but over time. It provides continuity. It opens the door to precedent autonomy and advance directives, which are now codified in English Law. In their discussion about authenticity, Brudney and Lantos go as far as to say: 'we believe that the value of agency alone, that is, not conjoined with the value of authenticity, is insufficient to justify the refusal of lifesaving treatment.'[20] Questioning the authenticity of one's wish to die has led clinicians in the past to go against advance directives and treat the patient.[22] In the case of Kerrie Wooltorton, an advance directive did not play any role as the patient was able to assert her will, but if she presented in an unconscious state, the course of action taken might have been completely different.

A wish to hasten death

For every completed suicide, there are 200 attempts. As many as 24% of individuals attempting suicide give the idea less than five minutes' consideration.[23] Clearly, such an act is an impulsive one rather than premeditated. In many cases, the action is a 'cry for help' rather than a genuine wish to hasten death, and treatment is offered and often accepted. In Ms Wooltorton's case, we may note a degree of premeditation. The statement she provided the doctors with, although not legally valid, was nevertheless a succinct outline of her wishes that had been maintained for at least three days (if one does not count the suicide attempts over the previous year). Patients who commonly have reason and time to think about death are the elderly and those suffering from a terminal illness. A systematic review and meta-ethnography of qualitative studies by Monforte-Royo and colleagues examined the question of reasons behind a wish to hasten death.[24] Some of the themes identified included:

- a response to suffering
- loss of self
- the desire to live, but on different terms
- a way to end suffering
- a means of control over one's life.

The authors' conclusion was that the wish to hasten death is often a reactive phenomenon, a response to overwhelming emotions and 'does not necessarily imply a genuine wish to hasten one's death.'[24] They highlighted the need to analyse patients' wishes and the vulnerability of individuals desiring death. Was Kerrie Wooltorton's wish to die a genuine one? Was it a response to suffering, or a perceived lack of control associated with her mental health problems? Would she have accepted an offer of treatment if it came together with options for an alternative future? By attending the hospital, she may have wanted that discussion but in truth, we shall never know. She appears to have exercised her autonomy and succeeded in achieving her apparent goal.

Other notable cases

Mr Galanas was an 86-year-old man who presented to hospital having shot himself in the abdomen and chest with the intention of committing suicide.[25] He was responsive, but his decision-making capacity was in doubt. He accepted pain relief, but refused all other treatment. He had a valid 'living will,' which gave his wife the power of attorney and expressed the wish to refuse medical intervention in case of an end-stage condition. The commentators on the case emphasised the need to ensure that the patient's decision was informed, voluntary and deliberate or simply authentic. An important question was 'Why now?' Indeed, that question is pertinent to Kerrie Wooltorton's case. She attended hospital on numerous occasions and accepted treatment for self-poisoning. What had changed? Why did she decide to act differently on that occasion? Was her wish to die genuine? Mr Galanas was briefly extubated after initial resuscitation. He promptly deteriorated and a decision had to be made on whether to continue with therapeutic efforts. He gave a 'thumbs-up' when asked whether to proceed to save his life. The majority of psychiatric patients who lose capacity and are treated 'against their will' indicates retrospective approval upon the return of capacity.[26]

In another case in the UK, a 62-year-old woman who was severely disabled with arthritis, presented to an emergency department having taken a drug overdose with suicidal intent.[22] The patient left a suicide note and her husband presented clinicians with an advance directive stating that she did not want life-sustaining treatment. The advance directive was made five years prior, after the patient's parents died in an intensive care unit. The suicide attempt appeared to be precipitated by a recent acute deterioration of her arthritis. The advance directive was deemed valid and consistent with the patient's beliefs and values. The clinical team, however, decided to intervene. The reasons for the decision were five-fold:

- A delay in treatment regardless of the ultimate decision would prejudice the outcome.
- The advance directive did not specifically address the present situation.
- There was uncertainty about the patient's state of mind at the time of her taking the overdose
- Her condition was likely to respond to treatment.

- It was felt that the risk of adverse consequences resulting from treatment was small.

At the six-month follow-up after discharge, the patient was grateful that the staff had acted in her best interests, but maintained that in view of her poor future prospects, she would rather have had her wishes respected.

Conclusions

While the lack of time is a limiting factor in an emergency, an assessment of capacity in combination with a thorough exploration of the patient's background to establish the authenticity of the decision concerning refusal of treatment, are crucial to ensuring the validity of that decision. The presence of mental illness does not preclude capacity, but careful consideration should be given as to whether the patient is able to 'weigh in the balance' the information provided. If a patient has capacity, any treatment that is instituted against the patient's wishes constitutes an assault. While the Mental Capacity Act 2005 may prevent an offer of intervention, an alternative legal avenue is to explore the possibility of admission for treatment under the section of the Mental Health Act with the psychiatrist. While the patient is conscious, in possession of her faculties and able to state her preferences, any existing advance directive does not apply. If a patient lacks capacity and the advance directive is available, careful examination of its validity and applicability is warranted. A second opinion and legal counsel are recommended.

Conflict of interest

None declared.

References

1. **Gabbatt A**. Doctors acted legally in 'living will' suicide case. *Guardian* 1 October 2009. http://www.guardian.co.uk/society/2009/oct/01/living-will-suicide-legal. Accessed 16.11.2012.
2. **Pitcher G**. Kerrie Wooltorton's death shows how we lost respect for life. *The Telegraph* 2 October 2009. http://www.telegraph.co.uk/comment/columnists/georgepitcher/6253306/Kerrie-Wooltortons-death-shows-how-we-have-lost-respect-for-life.html#. Accessed 16.11.2012.
3. **BBC**. Doctors 'forced' to allow suicide. *BBC*. 1 October 2009. http://news.bbc.co.uk/1/hi/england/norfolk/8284728.stm. Accessed 16.11.2012.
4. **David AS, Hotopf M, Moran P *et al***. Mentally disordered or lacking capacity? Lessons for managing serious deliberate self harm. *BMJ* 2010;341:c4489.
5. **Kapur N, Clements C, Bateman N *et al***. Advance directives and suicidal behaviour. *BMJ* 2010;341:c4557.
6. **Muzaffar S**. 'To treat or not to treat' Kerrie Wooltorton, lessons to learn. *Emerg Med J* 2011;28:741-44.
7. **Raymont V, Bingley W, Buchanan A *et al***. Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study. *Lancet* 2004;364:1421-27.
8. **Owen GS, Richardson G, David AS *et al***. Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study. *BMJ* 2008;337;448.
9. **Owen GS, Szmukler G, Richardson G *et al***. Mental capacity and psychiatric in-patients: implications for the new mental health law in England and Wales. *Br J Psychiatry* 2009;195:257-63.
10. **Stroup TS, Appelbaum PS, Gu H *et al***. Longitudinal consent-related abilities among research participants with schizophrenia: results from the CATIE study. *Schizophr Res* 2011;130:47-52.
11. Mental Capacity Act 2005. http://www.legislation.gov.uk/ukpga/2005/9/contents. Accessed 16.11.2012.
12. Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam).
13. Re T [1993] Fam. 95.
14. Re C [1994] 1 All ER 819.
15. Re MB [1997] 38 BMLR 175 CA.
16. **Jennings B**. Autonomy. In: *Oxford Handbook of Bioethics*. Oxford University Press. 2007.http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199562411.001.0001/oxfordhb-9780199562411-e-004 Accessed March 2013.
17. **Gracia D**. The many faces of autonomy. *Theor Med Bioeth* 2012;33:57-64.
18. Johnson R, Kant's Moral Philosophy, *The Stanford Encyclopedia of Philosophy* (Summer 2012 Edition), Edward N. Zalta (ed.), http://plato.stanford.edu/archives/sum2012/entries/kant-moral/ Accessed March 2013.
19. Rachels J, Rachels S. *The Elements of Moral Philosophy*. 6th edition. McGraw Hill. 2010.
20. **Brudney D, Lantos J**. Agency and authenticity: which value grounds patient choice? *Theor Med Bioeth* 2011;32:217-27.
21. **Locke J**. An essay concerning human understanding. *Book II: Ideas*. 1689. http://www.earlymoderntexts.com/pdfbits/lo24.pdf. accessed 22.11.2012
22. **Bonner S, Tremlett M, Bell D**. Are advance directives legally binding or simply the starting point for a discussion on patients' best interests. *BMJ* 2009;339:b4667.
23. **Simon TR, Swann AC, Powell KE *et al***. Characteristics of impulsive suicide attempts and attempters. *Suicide Life Threat Behav* 2001;32(1 Suppl):49-59.
24. **Monforte-Royo C Villavincencio-Chavez C, Tomás-Sábado J *et al***. What lies behind the wish to hasten death? A systematic review and meta-ethnography from the perspective of patients. *PLoS One* 2012;7:e37117.
25. **Volpe RL, Levi BH, Blackall GF, Green MJ**. *Exploring Limits of Autonomy*. Hastings Center Report 2012.
26. **Owen G, David AS, Hayward P *et al***. Retrospective views of psychiatric in-patients regaining mental capacity. *Br J Psychiatry* 2009;195:403-07.

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