ADVANCE DECISIONS

Introduction

1. This paper sets out the Department's rationale for not codifying the current common law rules relating to advance decisions to refuse treatment in the Mental Capacity Bill (the Bill).

Background

2. Advance decisions to refuse treatment can currently be made in Northern Ireland. Legal provision exists within English common law dating back to the 1990s[1]. Departmental guidance issued in 2003 states that failure to respect an advance decision to refuse treatment can result in legal action being taken against the medical practitioner[2]. Reference is also made in that guidance to the different considerations that may apply in the case of a person who is detained under the Mental Health (NI) Order 1986.

Current provision in Bill

3. The Bill gives statutory recognition to advance decisions to refuse treatment in clause 11[3].

4. The effect of clause 11 is that any act to treat a person that conflicts with an effective advance decision to refuse treatment will not attract the defence provided for in clause 9.[4] The only exception to this is where a court decision is being sought and the act either involves life-sustaining treatment or is necessary to prevent a serious deterioration in the person's condition (subsection (4)).

5. The meaning of "an effective advance decision to refuse treatment" is to continue to be determined in accordance with the common law

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[1] See statement at paragraph 19 by Munby J in *HE v A Hospital NHS Trust, AE (by her litigation friend the Official Solicitor)* [2003] EWHC *1017 (FAM)*
[2] DHSSPS Reference Guide to Consent for Examination, Treatment or Care (2003) page 13
[3]Consequential provision is made in clauses 96, 97 and 135.
[4] Advance decisions to refuse medical treatment that are not effective under the common law could constitute a written statement. These are recognised in clause 7(6)(a).

(subsection (2)). The Bill does not, therefore, codify the current common law rules relating to advance decisions to refuse treatment.

Common law v codification

6. The Department's main reason for adopting this approach is flexibility: the common law can continue to evolve as the provisions are not set in stone. If, conversely, the current common law were to be codified in the Bill, similar to sections 24 to 26 of the Mental Capacity Act 2005 (the MCA), the rules would be fixed and subsequent changes to the common law would require amendments to be made to the Bill via future primary legislation.

7. Flexibility in the Bill is considered particularly important for two key reasons. Unlike the MCA, the Bill will fuse mental health legislation and mental capacity legislation. As a result, it will create a radically different legal framework to that in which the common law rules were codified in England and Wales in 2005: a framework that will apply to a wider range of treatment decisions than those falling within the scope of the MCA. In other words, the position in England and Wales is not directly comparable.

8. Flexibility in the Bill will also help to mitigate any potential unintended consequences of adopting a more fixed approach. The Department did not consider it prudent to ignore, for example, the tragic case that came to light not long after the enactment of the MCA in England and Wales (the *Kerrie Wooltorton* case). This case was referenced by one of the stakeholders during one of the recent evidence sessions. Further information about this case is provided at **Annex 1**.

Conclusion

9. The Department has adopted the position outlined above following careful consideration of all the arguments for and against codification put forward during the policy development and consultation phases of

the Bill[5]. It also reflects the need to maintain the balance in the Bill between two often conflicting aims: the protection of autonomy and the protection of self and others.

10. Finally, the Department's position allows for wider public debate around advance decisions to take place as the Bill itself beds in and for the law to develop in light of that debate. The Code of Practice can be updated to take account of developments which can ultimately inform future legislation on the matter if desired.

Department of Health, Social Services and Public Safety
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[5] See paragraphs 3.14 to 3.19 of the consultation summary report.

Annex 1

“Doctors allowed a young woman, Kerrie Wooltorton, to kill herself because she had signed a “living will” that meant they could have been prosecuted if they intervened to save her life.

By Rebecca Smith, Aislinn Laing and Kate Devlin 10:33PM BST 30 Sep 2009

Comments

Miss Wooltorton, 26, who was suffering depression over her inability to have a child, drank poison at home and called an ambulance. However, she remained conscious and handed doctors a letter saying she wanted medical staff only to make her comfortable and not to try to save her life.

Doctors said her wishes were “abundantly clear” and although it was a “horrible thing” there had been no alternative but to let her die.

They feared they would be charged with assault if they treated her because they believed she understood what she was doing and was mentally capable of refusing treatment.

It is thought to be the first time someone has used a living will to commit suicide. The documents are more commonly associated with patients who are terminally ill and want to refuse treatment.

Miss Wooltorton’s family have since criticised the doctors, saying they should have intervened to save her.

The case will revive the “right to die” debate days after new guidelines on assisted suicide were published, saying those who help terminally ill patients to die are unlikely to face prosecution unless they stand to gain financially.

So-called living wills – or advance directives – allow patients to set out what treatment they do not want should they become seriously ill. They were introduced following the 2005 Mental Capacity Act.

The General Medical Council has told doctors that failure to comply with the directives could lead to them being struck off.

Experts said that before the new laws came in, doctors faced with a similar case to Miss Wooltorton’s would have been likely to insist the patient be treated.

Doctors debating the case online said her history of mental illness could cast doubt on her ability to refuse treatment. Some argued it was not uncommon for people who attempt suicide to refuse treatment, only to change their minds later.

Campaigners gave warning that living wills were not designed for patients who wanted to commit suicide and questioned whether someone who had repeatedly tried to kill themselves had the capacity to refuse treatment.

The inquest into Miss Wooltorton’s death heard that she had drunk the poison up to nine times in the year before her death and each time doctors had flushed the toxins from her system.

She drew up her directive on Sept 15, 2007, stating in the document that she was “100 per cent aware of the consequences” of her actions and did not want to be treated.

Three days later she called an ambulance after drinking the poison at her flat in Norwich.

She was taken to the accident and emergency department of Norfolk and Norwich Hospital and handed over her letter and also made her wishes clear verbally, the inquest was told.

The letter said that if she called for an ambulance it was not a plea for treatment, but because she did not want to die alone and in pain. She lapsed into unconsciousness and died in hospital the next day. William Armstrong, the Norfolk coroner, recorded a narrative verdict that did not blame the hospital for her death. He stated: “She had capacity to consent to treatment which, it is more likely than not, would have prevented her death. She refused such treatment in full knowledge of the consequences and died as a result.”

But asked about the consequences had he intervened, Dr Alexander Heaton, the hospital’s consultant renal physician, said: “I would’ve been breaking the law and I wasn’t worried about her suing me, but I think she would have asked, 'What do I have to do to tell you what my wishes…”