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Portsmouth NHS Trust v Wyatt

[2006] 1 FLR 652

21/10/2005

Barristers
Barbara Mills KC

Court
Family Division

Facts
The child, Charlotte, was born at 26 weeks' gestation, with a number of serious medical problems. She had not left hospital since birth. She had chronic respiratory and kidney problems, coupled with profound brain damage. The parents believed that the child should receive intensive ventilation if that were necessary to keep her alive; the medical team considered that artificial ventilation would not be in the child's best interests. In declarations unlimited in time, the court had authorised the medical authorities, in the event of continued disagreement between the parents and the doctors, not to send the child for artificial ventilation or similar aggressive treatment. The parents' application to have the declarations discharged, following some improvements in the child's condition, was dismissed, and so was their subsequent appeal, but an accelerated review of the continuation of the declarations was thought appropriate. The evidence showed that although the child still had significantly damaged kidney function, gross irreversible brain damage and chronic lung disease, there had been some slight growth, some weight gain and discernible progress in the condition of her lungs. Because her need for oxygen had reduced, she was now able to receive it via nasal cannulae, a development which would enable her to leave the hospital, albeit briefly. While her life expectancy remained very severely impaired, she had a real prospect of surviving the forthcoming winter. The parents were hoping that the child would be discharged in early spring, but this would depend on a complex care package being put in place and on the child's dependency on oxygen being reduced to at least a stable 30%. Because of these developments the doctors were now able to envisage circumstances in which they would be prepared to ventilate the child in the event of an infection, or of a reversible decline causing the child respiratory distress, but still felt that in the event of a catastrophic event, such as cardiac arrest or respiratory collapse, or in the event of a gradual deterioration in her lung function, it would be wrong to ventilate. The medical evidence was that it was quite impossible to define in advance the circumstances in which ventilation would be justified, and wrong to prescribe a pre-determined length of time for which it would be right to ventilate. The hospital trust now sought a declaration which would have the effect of giving the doctor the last word in the event of irreconcilable disagreement between medical staff and the parents. The doctors remained very concerned that the parents would try to insist on a course of treatment, notwithstanding the medical team's view that such a course was not in the child's best interests. The parents had, since the child's birth, been very vocal in their complaints against the medical team, including a formal complaint to the police about the care being given to the child; none of these

complaints had ever been substantiated and were now explained by the parents as the result of stress.

Held

Held – refusing any further declaration –

(1) The duty of a clinician was towards the patient and where the patient was not competent to make her own decisions, to act in the patient's best interests. The clinician treating a child did not take orders from the family any more than he gave them; he acted in what he saw as the best interests of the child, no more and no less. In acting in the best interests of the child, parental wishes should be accommodated as far as professional judgment and conscience would permit, but no further. A dispute that encroached on conscience would be rare indeed, but was possible (see paras [29], [41]).

(2) A doctor could not be required to act contrary to his conscience. Conscience was not a wholly rational sense, being more in the nature of intuition or hunch as to whether something was right or wrong, albeit honed by experience of patients, exposure to the practice of colleagues and the ethos of work. Where a clinician concluded that a requested treatment was inimical to the best interests of the patient, and his professional conscience, intuition or hunch, confirmed that view, he might refuse to act and could not be compelled to do so, though he should not prevent another from so acting, should another clinician feel able to do so (see paras [32], [34], [36]).

(3) Given the unanimous medical evidence, it was not possible to frame a conventional declaration to deal with the problems in the case; any declaration which might have been granted would have had to take the wholly novel form of committing a treatment veto to the treating clinician. While it might be right in certain circumstances to make such an order, the court should hesitate long before so doing (see para [40]).

(4) At present, no further declaratory relief was required, not least because even the grant of a declaration would not preclude future litigation (see para [42]).

Permission