The changing face of medical negligence law: from Bolam to Bolitho

The Bolam test was the standard by which medical negligence cases were judged. However, recently, the Bolitho case has resulted in a shift away from Bolam, with significant effects for all future negligence suits. Doctors need to have a thorough understanding of these issues in order to practice successfully in the current litiginous climate.

Negligence is concerned with compensating people who have suffered some kind of damage as a result of the actions or inactions of others. It is, therefore, part of tort law except in exceptional circumstances where gross negligence is said to have occurred, in which case a criminal offence charge may also be available. It is clear from the trial judge at *R v Adomako* [1991] that 'you should only convict a doctor of causing death by negligence if you think he did something which no reasonably skilled doctor should have done'. This sets a very strict bar for medical negligence cases in the criminal domain, and therefore the rest of this review will be dedicated to civil law cases.

Three essential components need to be proven in a successful negligence claim (Mason and Laurie, 2006):

1. A duty of care existed between defendant and claimant
2. There was a breach in this duty of care by the defendant
3. This breach caused, or at least materially contributed to, the damages incurred to the claimant on a balance of probabilities.

Except in emergency situations where there is no legal compulsion for a doctor to perform 'good samaritan' acts, there is a valid assumption that a duty of care exists between doctor and patient, and thus the vast majority of negligence suits get beyond this first point (C Gavaghan, personal communication, 2005). Moving on to causation (point 3), it is often very difficult for the claimant to prove that the resulting damages were at least materially the result of the doctor's actions, rather than the natural history of the disease or some other factor (the 'but for' test) (Mason and Laurie, 2006). However, the issue doctors are most concerned with is that of the second point, that of a breach in the duty of care. This will thus be discussed for the remainder of this review.

Breaches in the duty of care

In order to discuss what constitutes a breach in the duty of medical care, it is necessary to first examine what is the acceptable standard of care below which a breach can be said to have occurred. The standard of care set by law is normally the objective test of a reasonable and prudent man (Maughan, 2001). In *Muir v Glasgow Corporation* [1943] it was stated that 'the reasonable man is presumed to be free from both over-apprehension and over-confidence'. While this applies to doctors, the caveat of the reasonable man test is that it refers to the reasonable doctor in the same specialty, professing an ordinary level of skill and competence, so the obstetrician will be judged against the ordinary obstetrician, the urologist against the ordinary urologist, and so on. This was alluded to originally by Tindall in *Lanphier v Phipos* [1838] and again in *R v Bateman* [1925] where it was said that a doctor cannot be found negligent if he is following approved practice.

The standard of care in negligence suit was developed further by McNair in *Bolam v Friern Hospital Management Committee* [1957]:

> **'the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is… sufficient if he exercises the ordinary skill of an ordinary man exercising that particular art'.**

This has become known as the Bolam test. In Scotland, a very similar view was taken by Lord President Clyde in *Hunter v Hanley* [1955a]:

> **'To establish liability… it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care. There is clearly a heavy onus on the pursuer to establish [this]'.**

Therefore, it appears that to establish liability the claimant must prove not only that the doctor adopted a course of action that resulted in harm (causation), but also that no other reasonable doctor in his position would have adopted the same course of action. Hence, it appears from *Bolam v Friern Hospital Management Committee* [1957], *Hunter v Hanley* [1955a], and the earlier cases that a doctor accused of negligence need only find other doctors in similar positions who hold his actions to be correct in order to be cleared of the charge. This is true even if a substantial body of expert medical opinion states that the doctor's actions were incorrect: '… one man clearly is not negligent merely because his conclusion differs from that

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of other professional men, nor because he has displayed less skill or knowledge' [*Hunter v Hanley* 1955b]; '… a man is not negligent… merely because there is a body of opinion who would take a contrary view' [*Bolam v Friern Hospital Management Committee* 1957].

Outside the sphere of medical negligence, the courts have had no difficulty in finding certain commonly adopted practices as negligent [*Edward Wong Finance Company Ltd v Johnson Stokes and Masters* 1984]. However, what is exceptional about medical cases is that judges in the main did not feel able to choose between two schools of expert medical opinion; Lord Scarman said in *Maynard v West Midlands RHA* [1985]:

'..a judge's preference for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence… negligence is not established by preferring one respectable body of professional opinion to another'.

This was stated in the highest civil court in the UK, the House of Lords, and has been upheld repeatedly at this appellate level.

More cases after Bolam

In *Gordon v Wilson* [1992] a GP was cleared of negligence in failing to diagnose a brain tumour and refer the claimant at an early stage because there was a responsible body of medical opinion that would not have referred the claimant any earlier than when the defendant actually did. In *Whiteford v Hunter* [1950] the defendant was cleared of negligence in failing to diagnose a bladder tumour by not using a cystoscope because it was shown that other urologists at the time did not use such a diagnostic tool. In *Sidaway v Board of Governors, Bethlem Royal Hospital* [1985a] the surgeon who failed to warn his patient of a risk of spinal cord injury of 1–2% for the proposed operation was cleared of negligence as the judge found that the surgeon had followed an accepted practice in not warning the patient of such a risk. An anaesthetist was cleared of negligence in *Crawford v Board of Governors, Charing Cross Hospital* [1953] when he caused a brachial plexus palsy in the claimant by keeping his arm in a certain position during surgery, even though that position had been shown to confer a risk of that very complication in an article in the *Lancet* 6 months previously. The judge stated that it was not possible for a doctor to read every published article in his specialty and be expected to adopt practices that are not yet widely established.

A further illustration of how the law is tilted in favour of the medical defendant is the case of *Whitehouse v Jordan* [1980] in which an obstetrician who admittedly made an error of judgment in pulling too hard, and possibly too often, on a fetus during attempted forceps delivery was not found negligent despite causation being undisputed. It was felt that such an error of judgment could '… have been made by a reasonably competent professional man' [*Whitehouse v Jordan* 1981], and was within the bounds of acceptable human fallibility and therefore did not warrant liability.

There is, however, one notable exception to this trend for an abdication of responsibility by the law allowing expert medical opinion to determine the outcome. In *Hucks v Cole* [1993] a GP with a diploma in obstetrics saw a near-term pregnant woman who had a septic spot on her finger. At that time the GP did not institute any management. Four days later, the GP sent a swab for pathological assessment and prescribed a 5-day course of tetracycline as the infection had worsened. After the 5-day course had finished, the GP discharged the patient despite the infection not having cleared and the pathology report stating that the infection was sensitive to penicillin. The patient then developed fulminating septicaemia, a life-threatening condition. In this case, the court found that the GP was negligent to not prescribe penicillin after he had seen the pathology report and known the patient was still suffering from the infection. Although, in this instance the court was willing to scrutinize medical expert witnesses and reject their evidence, it is interesting to note that this case took place in 1968 but was not widely reported until the 1990s, hence representing a blip in the overwhelming trend of deference to any body of medical opinion that agrees with the defendant.

The Bolitho redress

In more recent times, however, there are signs that the judiciary are willing to scrutinize medical opinion more closely. In the *Sidaway* case, although the decision was made in favour of the defendant, Bridge asserted:

'Even in a case where… no expert medical witness in the relevant medical field condemns the non-disclosure as being in conflict with accepted and responsible medical practice, I am of the opinion that the judge might... come to the conclusion that disclosure of a particular risk was so necessary…' [*Sidaway v Board of Governors, Bethlem Royal Hospital* 1985b].

At around the same time Hirst said in *Hills v Potter* [1983]:

'I do not accept… that by adopting the *Bolam* principle, the court in effect abdicates its power of decision to the doctors. In every case the court must be satisfied that the standard contended for on [the defendant's] behalf accords with that upheld by a substantial body of medical opinion, and that this body of medical opinion is both respectable and responsible, and experienced in this particular field of medicine'.

While these words are, strictly speaking, in keeping with *Bolam*, it is clear that Hirst is stating that the courts should exert their right to scrutinize the medical opinion favouring the defendant's actions, that they retain the ability to judge whether such opinion is substantial and not merely exerted by a few adherents, and whether such opinion is credible in their own judgment.

A seminal case that furthered the views of Hirst and Bridge in the above cases then resulted. A 2-year-old boy named Patrick Bolitho was admitted to St Bartholomew's Hospital under the paediatricians. He was diagnosed with croup and was being treated medically. On a ward round the boy appeared to be recovering well, but shortly afterwards the nurse bleeped the senior registrar as she felt the boy had deteriorated. The doctor did not attend, but Patrick recovered spontaneously. After a second similar episode, the same doctor was bleeped and again she failed to attend, being stuck in clinic. Patrick suffered a third episode and went into cardiac arrest. After 32 minutes of arrest he was successfully resuscitated but had sustained brain damage. In this case, *Bolitho v City and Hackney Health Authority* [1993], the senior registrar, Dr Horn, was deemed to have breached her duty by non-attendance. It was claimed by the plaintiff's lawyers that had Patrick been intubated the cardiac arrest would not have occurred. This was not disputed by Dr Horn but she claimed that she would not have intubated even if she had attended and thus Patrick would have suffered the same outcome regardless. The judge accepted that Dr Horn would not have intubated, and thus the crux of the case centred on whether it would have been negligent of her not to do so had she attended Patrick after the second episode.

Although there were disagreements between judges at different levels of court as to whether *Bolam* applied in this hypothetical situation, it was finally ruled that it did. Also, because there was a reasonable body of distinguished medical opinion stating that it was proper not to have intubated at that time, most notably that of Dr Dinwiddie, a consultant paediatric respiratory physician from Great Ormond Street Hospital, the House of Lords ruled that the defendant could not be found negligent.

However, reference was made to the words of Sachs in the Court of Appeal of the *Hucks v Cole* case [1993]:

'When the evidence shows that a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then, however small the risk, the court must anxiously examine that lacuna… If the court finds… there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact and where necessary to state that it constitutes negligence… the fact that other practitioners would have done the same thing as the defendant practitioner is a very weighty matter to put on the scales on his behalf, but it is not… conclusive. The court must be vigilant to see whether the reasons given for putting a patient at risk are valid… or whether they stem from a residual adherence to out-of-date ideas'.

Furthermore, Lord Browne-Wilkinson stated:

'In the *Bolam* case itself, McNair stated that a defendant had to have acted in accordance with a practice accepted as proper by a responsible body of medical men. Later he referred to a standard of practice recognized as proper by a competent reasonable body of opinion. Again, in a passage cited from *Maynard*'s case, Lord Scarman refers to a respectable body of professional opinion. The use of these adjectives – responsible, reasonable, and respectable – all show that a court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular… the judge will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits, and have reached a defensible conclusion on the matter' [*Bolitho v City and Hackney Health Authority* 1998].

All this illustrates a change in the mindset of the judiciary in their role as arbiters of medical experts.

More cases after Bolitho

In *Penney, Palmer, and Canon v East Kent Health Authority* [2000] three women whose cervical smears were reported as negative went on to develop cervical cancer. The judge preferred the evidence from the claimants' experts and was prepared to deem that the testimony from the defendant's experts did not stand up to logical analysis, stating:

'There were admitted abnormalities which, to put it most favourably to the cyto-screener, he could not have positively said were not pre-cancerous… a reasonably competent cyto-screener would have classified the smear as borderline'.

Lord Woolf upheld this decision in the Court of Appeal and said:

'In resolving conflicts of expert evidence, the judge remains the judge; he is not obliged to accept evidence simply because it comes from an illustrious source…' [*Penney v East Kent Health Authority* 2000].

This case illustrates well that *Bolitho* has ushered in a new dawn, with judges preparing to consider suitably qualified expert testimony and weigh it up logically against a reasoned rebuttal, to determine what is for themselves the appropriate standard of care.

In Marriott v West Midlands Health Authority [1999] the claimant had suffered a head injury for which he had been in hospital and discharged. While at home his condition deteriorated and the GP did not send the patient back to hospital for further investigations. The patient had suffered an intracranial haemorrhage and had a residual paralysis because of the delay in treatment. The defendant's experts argued that it was justified to leave the claimant at home because the risk of haemorrhage was minimal, but the judge found this unacceptable: '… the consequences of things going wrong are disastrous for the patient… it is my view that the only reasonably prudent course… [would be] to readmit for further testing and observation'.

This decision was also upheld in the Court of Appeal, and provides further evidence that courts are beginning to use the risk analysis approach of *Bolitho*.

In *Glicksman v Redbridge Healthcare NHS Trust* [2000] the court found in favour of the claimant and deemed that the surgeon, Mr Abbas, was not justified in his surgical approach for hernia repair despite evidence from a respected surgical expert, Mr Foley, who said: '… I don't think [Mr Abbas] was remiss in doing it that way'. *Bolitho* was again cited in this judgment. Although the finding in *Morris v Blackpool Victoria Hospital NHS Trust* [2003] was in favour of the defendant, much of the judges' statements in both the original case and its appeal referred to the *Bolitho* clarification of *Bolam*, with both sides of the argument being taken into account, rather than the predominant approach pre-*Bolitho* of simply not wishing to make such a judgment.

The impact of *Bolitho* has also extended to information disclosure, and in *Pearce v United Bristol Healthcare NHS Trust* [1998] Lord Woolf said:

> **'… (if) there is a significant risk which would affect the judgment of a reasonable patient, then… it is the responsibility of the doctor to inform the patient of that significant risk…'.**

The case of *Chester v Afshar* [2004] illustrated that negligence could apply to information disclosure with regard to informed consent. In it, a surgeon was deemed negligent not because of the manner in which he performed the operation on the claimant, but rather because it was felt that he did not provide the patient with sufficient information regarding the risks of surgery. The test of causation was satisfied as it was deemed that Ms Chester would not have undergone surgery and consequently suffered the complication if she had been warned of the risks. This case emphasized the importance of patient autonomy, choice, and redefined the law on causation.

All the more recent cases discussed above reinforce the contention that peer-accepted medical practice is no longer sufficient in itself to satisfy the standard in law. The Human Rights Act 1998 has furthered the rights of claimants in this regard, and introduced the concept of 'expected practice' rather than 'accepted practice' as the potential new standard of care (Samanta and Samanta, 2003).

KEY POINTS

- The Bolam test is the standard of the ordinary skilled man exercising and professing to have that special skill.
- The Bolam test became the standard by which medical negligence cases were judged.
- The Bolam test often resulted in acquittal for the defendant who could show that others in his position would have acted in a similar vein.
- The Bolitho case ushered in a new dawn of medical negligence cases in which judges could find negligent even accepted medical practices.
- The bar has been raised and doctors need to be aware that simply stating that others would have acted similarly is no longer acceptable, and their actions must be considered reasonable by a scrutinizing judiciary.

Conclusions

In the past UK courts approached the issue of medical negligence with an exaggerated level of deference to expert medical opinion. They did not want to choose between conflicting opinions, finding in the vast majority of cases for the defendant so long as he could show others in his position would have acted similarly. This judicial practice has halted somewhat after the judgments in *Sidaway*, *Hills* and, most notably, *Bolitho*. *Bolitho* reminded judges that the courts reserve the right to decide that even accepted medical practice may be negligent, and allowed them to scrutinize what constituted 'reasonable' in the *Bolam* test.

There are significant indications that *Bolitho* is being applied, as illustrated by the cases of *Penney*, *Marriott*, *Glicksman*, *Morris*, and *Pearce*. The Human Rights Act 1998 will enforce an even higher standard than either *Bolam* or *Bolitho* – that of best or expected practice (Maughan, 2001). The development of clinical guidelines, by the National Institute for Health and Clinical Excellence among others, will only serve to promote this higher standard being applied as courts will rely less on expert testimony and more on these guidelines of best or expected practice to judge allegedly negligent doctors against (Tingle, 2002). Doctors can no longer hide behind the backup of their colleagues as a defence for negligent behaviour. **BJHM**

Conflict of interest: none.

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