Has Bolitho affected assessment of the appropriate standard of medical care?

The courts' use of the Bolam test has been criticized for giving the medical profession deferential treatment and making it easier to defend a minority opinion. This article asks whether the shift to the Bolitho principle has gone too far or not far enough.

Clinical negligence claims often hinge on whether the 'standard of care' (the minimum level of treatment that patients should expect) was met, yet this can be extremely difficult for litigants to prove. Generally providers have to meet the standard of an average and 'reasonable' person [*Alderson B Blyth v Birmingham Waterworks* 1856]. As such it considers that an average person is not flawless and does not foresee every risk and so does not require perfection. However, in a field of expertise such as medicine the Bolam test [*Bolam v Friern Hospital Management Committee* 1957] is traditionally applied. This means that a doctor has to act in a way that a responsible body of other doctors would have done. Many, including the Lord Chief Justice (Woolf, 2001), feel that this shows doctors excessive deference, effectively allowing them to set their own standards, unfairly stacking the odds against the claimant (McHale, 2003).

In a time when society questions the medical profession more and more beneficence is not automatically assumed and this has been reflected in the courts. Less deference is shown and a greater scrutiny of the medical evidence using the Bolitho test [*Bolitho v City and Hackney Health Authority* 1997] is used to determine the appropriate standard. This historical evolution will be discussed and the significance of these changes will be assessed in terms of the shift in balance from medicalism to legalism in determining the standards that doctors should provide.

The Bolam test

The traditional *Bolam v Friern Hospital Management Committee* [1957] approach states: 'a doctor is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men.' Crucially it also recommends: 'A man is not negligent... merely because there is a body of opinion who would take a contrary view.' This takes into account the diversity of approaches inherent in medical practice [*Hunter v Hanley* 1955], the courts relying upon medical experts to determine when a responsible body concurred.

This approach has been criticized for making it too easy to defend a minority view. Seemingly all that is required for a successful defence is to find one or two doctors who are prepared to state under oath that the doctor's actions were acceptable (Lewis, 2007), something not afforded to other professions (Brazier and Miola, 2000).

Pre-Bolitho developments

In other areas of the law the courts were already reaching their own opinion regarding standards, for instance in matters of failure to disclose sufficient information such as *Rogers v Whitaker* [1992], and the shift towards greater scrutiny of the medical profession was already underway. The year before Bolitho Lord Justice Roch said that if opinion was not analysed decisions on negligence would be in the hands of doctors [*Joyce v Merton Sutton and Wandsworth Health Authority* 1996]. There are earlier examples of this such as *Edward Wong Finance Co Ltd v Johnson Stokes and Master* [1984] and *Hucks v Cole* [1968] where the judge felt that the reasoning of the four experts did not stand up to analysis and so discounted it.

Generally, however, attempts to override the medical evidence on the basis of 'unreasonable risk' were unsuccessful. This was strengthened by Lord Scarman's judgement that:

> **'a judge's "preference" for one body of medical opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred… negligence is not established by preferring one respectable body of professional opinion to another.' [*Maynard v West Midlands Regional Health Authority* 1984]**

In *Hughes v Waltham Forest HA* [1991] the trial judge's own risk analysis showed that the surgical management did not stand up to logical analysis, but his decision to override the medical evidence was overturned at appeal. This reluctance to ignore professional opinion was shown in *Defreitas v O'Brien CA* [1995], where the judge stated that the courts do not abdicate their powers to the medical profession and that it was incumbent on them to assess the evidence and make their own decisions. Despite this comment he actually relaxed the interpretation of Bolam further by deeming that as few as eleven surgeons out of a possible thousand could constitute a substantial body.

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The Bolitho test

The facts and the appeal

Patrick Bolitho suffered two respiratory attacks from which he appeared to recover. Each time a doctor had been called but had failed to attend. He then suffered a third episode resulting in a cardiac arrest. It was asserted that the doctors had been negligent for failing to attend the patient and provide the appropriate treatment (in this case intubation) and that if they had the situation could have been averted [*Bolitho and others v City and Hackney Health Authority* 1993].

The case focussed on one doctor who admitted negligence in failing to attend but said that had she done so she would not have intubated the patient and thus the course of the events would be unaltered. The judge held that applying the standard of the ordinary skilled doctor with the special medical skills in question, not all doctors would have intubated the deceased and thus found for the doctor on the basis that the failure to attend did not affect the course of events.

At appeal the patient's family were asked to prove that if he had been intubated he would have survived and thus that the failure to do so was negligent. However, there was strong medical opinion for both sides and so despite the death of the 2-year-old boy the majority of judges felt compelled to find that the doctor had not acted negligently. But dissatisfaction with this result was expressed:

> **'Expert opinion should only be rejected on the grounds that the reasons of the group of doctors does not stand up to analysis if the court, fully conscious of its own lack of medical knowledge and clinical experience, was nonetheless clearly satisfied the views of that group of doctors were Wednesbury unreasonable. That was an impossible thing to say of the honest views of experts of the distinction of those called by the defendant.'**

The Wednesbury test [*Associated Picture Houses Ltd v Wednesbury Corporation* 1948] asks whether a decision or reasoning is so unreasonable that no reasonable person acting reasonably could have made it. This allows considerable leeway to variation in medical practice but requires the reliability of the experts themselves to be questioned in order to have rejected all three experts supporting the doctor. Furthermore with no unanimity in what was actually wrong with the child the judge would have been required to sort through the conflicting and complex medical evidence in order to be able to make that decision.

The patient's family argued that even if a doctor meets the standard of a competent doctor the courts should still assess whether that standard is appropriate or not. They asserted that it was inconceivable that intubation was inappropriate thus challenging the defence expert, a consultant in paediatric respiratory medicine at Great Ormond Street Hospital. Judge Harrison had some sympathy with this argument, stating: 'As a layman… the views of the defendants' experts simply were not logical or sensible.' However, he felt it would be inappropriate for him to: 'substitute my own views for those of the medical experts.' Thus applying Lord Scarman's test from *Maynard v West Midlands Regional Health Authority* [1984] he found the doctor not guilty.

House of Lords

The appeal was dismissed, with all three judges agreeing that Judge Harrison had directed himself correctly as there had been good reason for accepting the expert's opinion [*Bolitho v City and Hackney Health Authority* 1997]. Ordinarily the test for causation is the 'but for' test [*Wilsher v Essex Health Authority* 1988], but when an issue of deviation from standard practice is in question the patient has to establish that there is a normal practice and that to deviate from this was wrong, thereby introducing the Bolam test as the determinant of breach.

The patient's family again argued that this standard should nonetheless be able to stand up to analysis and that it was illogical to fail to intubate a child in respiratory distress. This argument met with considerable sympathy, but it was felt that the experts had demonstrated that they had directed their minds to the question of comparative risks and benefits even though the conclusion seemed illogical. They also met the *Bolam v Friern Hospital Management Committee* [1957] standard of being reasonable and responsible and the *Maynard v West Midlands Regional Health Authority* [1984] standard of being respectable. By doing so the experts were able to establish that their views were representative and reached in a logical manner.

Post-Bolitho: how has it been applied?

While the Bolitho approach was not new it helped to crystalize the shifting attitudes and effected a change in the way that standard of care is assessed. One year later the Court of Appeal [*Marriott v West Midlands RHA* 1999] confirmed that a judge is: 'entitled to carry out [their] own assessment of risk… and not bound to follow the opinions of a body of experts' and is therefore entitled to find that this opinion is not logical.

The most dramatic example is in the ongoing case of *Burne v A* [2006]. A GP appealed a finding of negligence on the grounds that he had carried out the standard medical practice. Both sets of experts agreed with this (although the patient's expert felt he had been negligent in his management). However, the trial judge rejected this expert opinion and his approach was supported at appeal where it was felt he was right to exercise his judgment even when medical opinion was undivided.

While these cases suggest a dramatic change in approach academic reviews of case law do not feel that this is so (Maclean, 2002). In *Wisniewski v Central Manchester HA* [1998] the trial judge's findings were that the doctor's actions were illogical. However, at appeal there was doubt cast on the validity of this on the basis that the judges were not prepared to hold that the views of eminent experts 'cannot be logically supported at all'.

A case heard in the Court of Appeal [*Sutcliffe v BMI Healthcare Ltd* 2007] demonstrated that the courts can still be reticent to strictly apply Bolitho. A patient claimed against a hospital citing negligence occurring at two separate points where nurses had an opportunity to identify and treat his complications. Unfortunately on both occasions the correct observations or practices were not done. It was recognized by the courts that the nurses had both acted inappropriately and negligently but that they had done so in a manner that was acceptable practice to a reasonable body of nurses.

The judge felt that they were entitled to exercise their clinical judgement and furthermore that their actions stood up to logical analysis. At appeal Lord Justice May referred to the locus classicus of Bolitho which stated that it would be seldom right for a judge to consider the genuine views of a competent expert unreasonable. He also referred to Scarman in Maynard that it was not for a judge to choose a preferred expert if both stand up to logical analysis. Significantly he also made the point that the claimant had not tried to argue on the grounds of Bolitho, implicitly recognizing that it was 'unpersuasive'.

How much has really changed?

So have the courts got it right at last? According to Brazier and Miola (2000) Bolitho is much less pioneering than hoped and may even just serve to reiterate Bolam for:

> **'While the medical experts are to be required, in rare cases to justify their opinions on logical grounds, there still appears to be a prima facie presumption that non-doctors will not be able fully to comprehend the evidence. This leads inexorably to a conclusion that the evidence cannot after all be critically evaluated by a judge.'**

So while determination of standard of care is in theory in the hands of the judiciary we are not yet in an age of legalism of negligence, as the following points demonstrate.

Overturning medical opinion is still very difficult

The problem with Bolitho is that the bar for overturning the expert's opinion was set very high. Lord Justice Mustill [*Bolitho and others v City and Hackney Health Authority* 1993] said that it would be an 'impossibly strong thing' to override experts of distinction (see earlier). The court was not swayed by the fact that the defence found three experts to concur with the doctor (they were in fact in the minority), rather it was the weight attached to those opinions by the judge that ensured they prevailed.

Does this therefore really herald an era of legalism? The key defence expert was singled out for his extensive knowledge and genuineness, making it very difficult for a court to disregard his evidence even in the face of a majority view to the contrary. If a knowledgeable specialist is impartial, genuine and felt to be representative then he/she still carries great weight. While the courts have to evaluate the experts they still need to rely on them for the medical standard of care. This must then be appraised for its reasonableness and logic but is likely to be accepted as the case of *Nidri v Moorfields Eye Hospital NHS Trust* [2007] shows. In this case the practices in a London hospital, although somewhat outdated and phased out throughout much of the world, were found to have met the standard of care. This was in no small part because: 'The expert for N was not a reliable witness, having expressed dogmatic views and having couched parts of his report in emotive terms. The experts for M were, on the other hand, balanced, fair and consistent.'

What is 'logical analysis'?

There are no criteria for measuring logic although we are provided with this guidance from Lord Browne-Wilkinson: 'the judge before accepting a body of opinion as being responsible, reasonable or respectable, 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' [*Bolitho v City and Hackney Health Authority* 1998]. Despite this, in *Bolitho v City and Hackney Health Authority* [1997] the Lords were of the opinion that the mere fact that experts were distinguished demonstrated the reasonableness of their opinion:

> **'It will very seldom be right for a Judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a Judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the Judge to prefer one of two views both of which are capable of being logically supported. It is only where a Judge can be satisfied that the body of expert opinion cannot be logically supported at all.'**

While expressing sympathy with the family and even some dissatisfaction with the end result, the Lords felt unable to disregard the defence experts' views as illogical and dismissed the appeal. In fact there is no evidence that the Lords themselves undertook any logical analysis of the decision not to intubate.

Teff (1998) felt that the test of 'logic' may be too narrow and 'reasonableness' is more appropriate. Another approach is that of Lord Justice Sachs who considered 'unreasonable risk', a view supported in *Joyce v Merton Sutton and Wandsworth Health Authority* [1996] when the Court of Appeal approved Bolitho but rejected Wednesbury as the sole basis for analysis of the standard of care. Lord Justice Roch felt that negligence was a matter for the courts.

Can the courts choose between two conflicting medical opinions?

There are many issues in medicine that have vexed researchers for many years and it would be unreasonable

to expect the issue to be dealt with in court by a judge. Furthermore the correct application of Maynard prevents the judge from doing so unless there is an issue of credibility or logic. It must be remembered that in Bolitho itself the conflicting opinions were not analysed to see which one was most appropriate.

Conclusions

There are many who feel that it is essential that we still rely on clinical experts to provide their experience and peer-reviewed evidence in order to determine the standard of care. Baroness Findlay defended the Bolam test, stating:

'Medicine is so specialised that without reference to expert opinion… the very foundation on which a judgment is made will be flawed… We are not talking about the lowest common denominator, but about a standard which is accepted as good. A different robust standard to the Bolam principle has not been found. (Findlay, 2005)'

Traditionally the courts deferred to medical opinion and the Bolam test meant that a doctor could put up a strong defence by finding experts willing to state under oath that his/her actions were acceptable. This approach was demonstrated by Lord Scarman [*Sidaway v Board of Governors of Bethlem Royal Hospital and the Maudsley Hospital* 1985] who stated that: '…the law imposes the duty of care: but the standard of care is a matter of medical judgment.'

Judge Sopinka [*ter Neuzen v Korn* 1995] explains that this is because: '... the medical profession ...is assumed to have adopted procedures which are in the best interests of patients and are not inherently negligent.'

It has long been felt that where there is little or no active scrutiny, partisan evidence for the defence has a disproportionate impact on outcomes (Teff, 1998). After Bolitho the courts have greater power to scrutinize the evidence but the assessment of reasonableness and logic is still evolving and it is not clear how far it will yet go.

The courts are taking note of Bolitho and at least considering it, but there is little evidence that a powerful change has occurred. Maclean (2002), in a review of medical negligence cases, found that Bolitho was widely referred to but liability is more often than not determined on the factual evidence or an assessment of the credibility of the witness rather than a true assessment of common practice. This is perhaps because the principle itself was tempered by the qualifying comments from Lord Browne-Wilkinson and the actual decision which exonerated the doctor despite circumstances that the judges felt sympathy with. This reticence to override the expert's evidence is compounded by the adversarial system providing two sets of conflicting medical opinion that are difficult to ignore. In order to make the most of the impetus Bolitho provided it is felt that the courts should interpret it in terms of exposure to unreasonable risk rather than logic in order to afford the patient the correct level of protection.

Nonetheless there has been a shift from the deferential approach of the courts. Other factors such as the recent spate of high profile scandals involving doctors and changes in society such as the increasingly rights-focussed culture and perhaps human rights have also played a major part in this shift.

McHale (2003) summed the situation up:

'Bolitho has to date not proved as revolutionary as it might have, as first suggested and indeed as some clinicians feared. The real revolution in clinical standards scrutiny and mechanisms for accountability is being instead developed outside the courtroom walls.' BJHM

KEY POINTS

- The Bolam test was the traditional way to determine whether a doctor's actions were negligent or not and relied heavily on medical expert opinion.
- The more recent Bolitho principle requires that this medical evidence has to stand up to logical analysis by the judge and that it can be rejected if it does not.
- There is undoubtedly a shift towards greater scrutiny of medical expert opinion evidence of acceptable practice. Doctors need to ensure therefore that their day-to-day practice takes into account all available options and appropriately balances risk and benefit.

Conflict of interest: Mr Perera acts a medical expert in clinical negligence cases.

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