BYE-BYE BOLAM: A MEDICAL LITIGATION REVOLUTION?

MARGARET BRAZIER* AND JOSÉ MIOLA**

I. INTRODUCTION

When McNair J. delivered his direction to the jury in Bolam v. Friern Hospital Management Committee1 just over forty years ago, it can only be a matter of speculation whether he ever appreciated how famous, or infamous, the Bolam test would become. For defendants in medical malpractice claims, and for health professionals generally, Bolam may be viewed as no more than simple justice requiring that they, like other professionals, be judged by their peers. Many academic commentators2 and organisations campaigning for victims of medical accidents perceive the Bolam test very differently. Bolam, in their judgment, has been used by the courts to abdicate responsibility for defining and enforcing patients’ rights. In its original context, actions for medical negligence, Bolam ran out of control. The test became no more than a requirement to find some other expert(s) who would declare that they would have done as the defendant did. More disturbingly, Bolam infiltrated all sorts of other areas of medical law, being utilised to prevent development of any doctrine of informed consent this side of the Atlantic, and allowed to become the standard for judging the welfare interests of patients lacking the requisite mental capacity to make their own treatment decisions. Bolam, out of control and out of context, came close to acquiring demonic status in some quarters.

Late in 1997, Lord Browne-Wilkinson in Bolitho v. City & Hackney Health Authority3 sought to correct what he believed had been a misinterpretation of Bolam. His Lordship reiterated that ultimately the courts, and only the courts, are the arbiters of what constitutes reasonable care. Doctors cannot be judges in their own cause. Bolitho struck

---

* Professor of Law, Institute of Medicine, Law and Bioethics, University of Manchester.
** Lecturer in Law, Faculty of Law, University of Leicester. We would like to thank Jean McHale, Giorgio Monti and Sara Fovargue for their helpful comments on earlier drafts of this paper.
1 [1957] 1 W.L.R. 582.
fear into medical hearts. The past twenty years has seen numbers of claims for medical malpractice rise dramatically,\(^4\) levels of damages have rocketed; yet the proportion of successful claims remains low. Undermining judgment by their peers might remove even this latter crumb of comfort. Does *Bolitho* herald a medical litigation revolution at which health professionals should tremble?

Lord Browne-Wilkinson’s speech and the decision in *Bolitho* have now been elegantly analysed by a number of medical lawyers.\(^5\) This paper attempts a rather broader view of the potential impact of a series of developments, including the decision in *Bolitho*, which we argue are likely to change the face of health care law in this country. *Bolitho*, recent case-law on informed consent, the establishment of the National Institute of Clinical Excellence and the Law Commission’s proposals relating to treatment of mentally incapacitated patients are just some of the factors which we contend will in many cases ensure that the courts no longer blindly accept assertions of good medical practice, but evaluate that practice. Substance will be given to patients’ interests in welfare and autonomy. However, we shall also seek to demonstrate that such developments should not cause doctors or other health professionals to fear for their professional integrity or independence. Returning the *Bolam* test to its proper limits and appropriate context will be beneficial, rather than detrimental, to medicine and to medical litigation. The revolution, if it can be so styled, will be a velvet revolution, not a bloodbath.

II. BOLAM REVISITED

We need first to revisit *Bolam* itself. The facts are well-known so we rehearse them only briefly. The plaintiff had undergone electro-convulsive therapy (ECT). No relaxant drug was administered to him nor was any restraint used to control the convulsive movements which happen during ECT. He suffered a fractured hip. At that time professional practice varied widely about the use of drugs and physical restraint, and in relation to whether patients should be warned of the

\(^4\) Accurate figures are difficult to find. Answers to parliamentary questions suggests that payments in medical negligence claims cost the NHS £179 million in 1993–4; £160 million in 1994–5; £149.1 million in 1995–6; see V. Harpwood, *Medical Negligence and Clinical Risk: Trends and Developments 1998* (Monitor Press, 1998) at vii. The Secretary of State for Health claimed that in 1996–7 the cost of litigation approached £300 million yet only 17 per cent of claims succeeded; see *Hansard* (H.C.) 24.3.98, Cols. 165–6.

risk of fractures. Experts disagreed. McNair J. saw the issue as quite simply one of professional negligence. He formulated what might be described as a two-part test. Part I may be seen as uncontroversial: ‘The test is the standard of the ordinary skilled man exercising and professing to have that special skill.’ The defendant need not attain the ‘highest expert skill’ but must achieve the ordinary level of competence expected of a person in his profession and practising in a particular specialty of that profession.

Part II is more problematic and the source of later misunderstanding of Bolam itself. The core dispute in professional negligence cases which are defended often centres on just what does constitute ‘proper practice’ or ‘ordinary competence’ in relation to the procedure in dispute. The profession itself cannot agree whether or not a particular practice amounts to adequate care of the patient’s, or client’s, interests. In such cases, McNair J. held:

A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular act . . . a doctor is not if he is acting in accordance with such a practice, merely because there is a body of opinion taking a contrary view.7

Once again, in context, Bolam Part II is unexceptionable and governs all forms of professional liability. It is not special pleading for doctors. The very nature of professional services involves the exercise of skills, and the possession of a body of knowledge, not shared by the public at large. Judges are not qualified to make professional judgments on the practices of other learned professions. If, in a claim against an architect, the dispute concerns either whether her original design plans recognised and dealt with risks posed by subsidence, or whether, in delegating certain responsibilities to a quantity surveyor she acted properly, only her peers can identify to the judge what amounts to appropriate and safe practice. When those peers disagree and the disagreement illustrates genuine and well founded debate within a profession on good practice, judges are not generally equipped to adjudicate in such a dispute. A professional should not be penalised, and be held to be incompetent, just because a judge fancies ‘playing’ at being architect, solicitor or doctor.

In particular, judges will have difficulty in dealing with cases of disputed practice in the following instances: where practice is evolving rapidly in a new specialty or sub-specialty of a profession, identifying responsible practice will be demanding. Where exceptionally complex scientific or technical issues are moot, the lawyer-judge may be some-

---

7 Ibid. at 587.
what out of his or her depth. When either evolving practice or highly technical issues, or both, pose delicate questions of risk assessment, judges may quite properly be hesitant to intervene to second-guess the opinion held, and reasonably held, by one body of opinion within a profession. All these considerations apply (or should apply) to all professions. Yet only in relation to medicine has the Bolam test of professional negligence been so excoriated.

III. BOLAM OUT OF CONTROL

What distinguishes medical litigation from other areas of professional liability is in part that a series of judgments (or maybe a gloss on those judgments) have given rise to a perception that all Bolam requires is that the defendant fields experts from his or her medical specialty prepared to testify that they would have followed the same course of management of the patient-plaintiff as did the defendant. If such experts can be identified, are patently honest and stand by their testimony vigorously, neither they nor the defendant will be asked to justify their practice. The judge will play no role in evaluating that expert evidence. As Michael Jones notes, it may be that judges find it difficult to find against members of the medical profession on questions of negligence, or, doctors’ lawyers may just be better players of the litigation game.8 The result however, as Jones points out, is that out of six medical negligence claims before the House of Lords in 16 years the ‘score’ was Plaintiffs 0; Defendants 6! Yet in other professional negligence claims, time after time, judges have made it clear that expert opinion must be demonstrably responsible and reasonable.

In Edward Wong Finance Co. Ltd. v. Johnson Stokes and Master9 a practice nearly universally endorsed by solicitors in Hong Kong was nonetheless found to be negligent. Hong Kong practice on mortgage completion provided for the money to be handed over to the borrowers on receipt of an undertaking from the borrowers’ solicitors to hand over the requisite deeds. A dishonest solicitor absconded with the money never having provided the documents which constituted security to the loans. The lenders sued their own solicitors. The Privy Council held that the solicitors were negligent despite having conformed to the general practice of the profession in Hong Kong. The risk of fraud was obvious and inherent in the practice. It could have been prevented with ease. Evidence that other respected professionals followed the same ‘unsafe’ practice was not sufficient to amount to conclusive evidence

---

9 [1984] A.C. 296, P.C.
that that practice was responsible. It self-evidently was not. In relation to many professions, other than medicine, the courts have on a number of occasions adopted an equally robust approach to ensure that peer evidence cannot be used simply to sanction negligence. Judges have declared that the principles governing medical negligence are no different from those applying to other professions, that doctors and surgeons fall into no special category, but reality has not met the rhetoric.

In Maynard v. West Midlands Regional Health Authority the trial judge who heard and evaluated the expert evidence found for the plaintiff declaring honestly that he had weighed the evidence and ‘preferred’ the opinion of the plaintiff’s expert. The House of Lords in no uncertain terms declared that ‘a judge’s preference for one body of distinguished professional opinion to another is not sufficient to establish negligence in a practitioner whose actions have received the approval of those whose opinions, truthfully held, honestly expressed, were not preferred’. Lord Scarman continued ‘in the realm of diagnoses and treatment negligence is not established by preferring one respectable body of professional opinion to another’. In similar vein, it mattered not in De Freitas v. O’Brien that the disputed procedure was one only a tiny minority of neurosurgeons (four or five out of two hundred and fifty consultants) would consider safe. The ethos of medical litigation came to be seen as sanctioning a modern form of trial by battle. Line up your champion expert in sober garb and with letters after his name and the defendant could not fail. In its most grisly form, the trial by expert reached its nadir in Whitehouse v. Jordan where it appeared that obstetricians had unbridgeable divisions on relatively simple issues of management of trial of labour.

If our attack on Bolam out of control seems too highly coloured, consider the argument advanced by counsel for the defendant in Bolitho itself and (to a limited extent) conceded by the trial judge. If the evidence advanced by expert witnesses is truthful the judge cannot question its logical force. Bolam, in suits for medical malpractice, was interpreted, whatever the judges might say, to allow judgment by colleagues to substitute for judgment by the courts.

---


12 At 639.

13 Ibid.


IV. BOLAM OUT OF CONTEXT

However unsatisfactory Bolam may have become in its original context, what is much more disturbing is that the Bolam test has been allowed to become the litmus test not just of clinical practice but of medical ethics. Davies eloquently argues that the dominant judicial approach in medical law has become ‘[w]hen in doubt “Bolamise”’.16 Three key areas of ethical judgment have in turn effectively been ‘Bolamised’. ‘Informed consent’ was hustled into a Bolam straight-jacket. The criteria for determining the legality of the treatment of mentally incapacitated patients, even whether such patients live or die, was subjected to Bolam. In both of the above areas the Bolam test is invoked overtly. In our third example the Gillick, and post-Gillick, debacle, we contend that Bolam crept in by the back door.

A. Overt Bolamisation

Lord Scarman, that stalwart defender of Bolam in Maynard v. West Midlands Regional Health Authority, took a different view in Sidaway v. Royal Bethlem Hospital.17 Addressing the doctor’s duty to disclose information about the risks of proposed treatment he adopted the ‘prudent patient’ standard. The majority voted for Bolam. A patient was prima facie entitled to be told only so much as a responsible body of medical opinion judged prudent. Lord Bridge did declare that there might be circumstances where a judge would come to the conclusion ‘ . . . that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it’.18 He appeared to re-enforce the words of Sir John Donaldson M.R. in the Court of Appeal who had said:

[The courts] cannot stand idly by if the profession, by an excess of paternalism, denies its patients real choice. In a word, the law will not allow the medical profession to play God . . . I think that, in an appropriate case, a judge would be entitled to reject a unanimous medical view if he were satisfied that it was manifestly wrong and that the doctors must have been misdirecting themselves as to their duty in law.19

18 Ibid. at 663.
19 [1984] 1 All E.R. 1018 at 1028.
Yet subsequent judgments of the Court of Appeal in Blyth v. Bloomsbury Health Authority\textsuperscript{20} and Gold v. Haringey Health Authority\textsuperscript{21} effectively limited patient choices to what their doctor thinks good for them. The Court of Appeal in Blyth and Gold operated on a strong preference for Lord Diplock’s approach in Sidaway. Failure to give a patient adequate advice on the merits and demerits of proposed treatment was simply an issue relating to breach of duty of care to be judged identically (i.e. in conformity to Bolam) to any other alleged breach of duty.\textsuperscript{22}

**B. Widening the Bolamite Spectrum**

*In re F (Mental Patient: Sterilisation)*\textsuperscript{23} marked yet a further step in the process of Bolamisation. *Re F* addressed the lawfulness of medical treatment of adults incapable of consenting to on their own behalf. F was a 36-year-old woman, an informal patient in a mental hospital, who was believed to have entered into a sexual relationship with a male patient. She was said to have a mental age of five and the verbal capacity of a two-year-old. The House of Lords concurred in the findings of the trial judge and the Court of Appeal that the common law neither provided for any form of proxy consent on behalf of mentally incapacitated adults nor did the *parens patriae* power of the courts survive to sanction treatment.\textsuperscript{24} Given the lacuna in the law, all the judges involved in *Re F* agreed on the following principle: treatment of a person unable to consent to treatment (temporarily or permanently) was justified on a principle of necessity:

\begin{quote}
[A] doctor can lawfully operate on, or give other treatment to, adult patients who are incapable, for one reason or another, of consenting to his going so, provided that operation or other treatment concerned is in the best interests of such patients.\textsuperscript{25}
\end{quote}

Where the Law Lords disagreed with the Court of Appeal, however, was as to how ‘best interests’ might be judged. All three judges in the Court of Appeal argued that Bolam was insufficiently stringent to determine whether proposed treatment was in the patient’s best interests.

\textsuperscript{22} See Kerr L.J.’s judgment in Blyth, op. cit., n. 20, particularly at 155.
\textsuperscript{25} At 55 per Lord Brandon.
The Court of Appeal had rejected Scott Baker J.’s view that the test of what was in the interests of an incapacitated patient was little different from that for negligence. Neill L.J. said of Bolam in this context:

But to say that it is not negligent to carry out a particular form of treatment does not mean that that treatment is necessary. I would define necessary in this context as that which the general body of medical opinion in the particular speciality would consider to be in the best interests of the patient in order to maintain the health and service the well-being of the patient26 (our emphasis).

The House of Lords rejected any suggestion that a Bolam-plus test was called for. Conformity to a reasonable and responsible body of medical opinion sufficed.27 Lord Goff acknowledged that decisions about the welfare of a mentally incapacitated person are not exclusively within medical expertise. He declared:

No doubt, in practice, a decision may involve others besides the doctor. It must surely be good practice to consult relatives and others who are concerned with the care of the patient. Sometimes, of course, consultation with a specialist or specialists will be required; and in others, especially where the decision involves more than purely medical opinion, an inter-disciplinary team will in practice participate in the decision.28

Note that his words are permissive. The decision may involve others. Good practice would entail consultation with relatives. The ultimate arbiter remains the doctor. Best interests is judged by Bolam alone. That the pros and cons of sterilising women unable to consent themselves to loss of their reproductive capacity ‘. . . involved principles of law, ethics and medical practice’ had been openly acknowledged in Re B (A Minor) (Wardship: Sterilisation)29 when the Law Lords had two years earlier considered the sterilisation of minors. The pervading influence of Bolam granted medical practitioners control not just of their own practice but of matters of medical ethics and law as well,30 extending in Airedale N.H.S. Trust v. Bland31 to the ethics of withdrawal of life-sustaining treatment.

26 At 32; and see per Lord Donaldson M.R. at 18.
27 At 560 per Lord Brandon; at 567 per Lord Goff.
28 Ibid. at 567.
31 [1993] 1 All E.R. 821 (H.L.) at 861 per Lord Keith; 871 per Lord Goff.
In cases which have followed Bland, judges have on several occasions simply deferred to the doctors. In Frenchay N.H.S. Trust v. S, Sir Thomas Bingham M.R. first said that it would be wrong to assume that ‘... what the doctor says is the patient’s best interest is the patient’s best interest’. However, he continued by noting that to question such a medical opinion would leave the doctor in an extremely difficult and unsatisfactory position, into which ‘one should be reluctant to lead doctors’. It seems that a court will only depart from the medical practitioner’s definition of the patient’s best interests in rare cases. Perhaps unsurprisingly, there is little evidence of such questioning of medical authority. In Re G, Sir Stephen Brown P. was faced with a conflict where the doctors and the patient’s wife supported the withdrawal of treatment, but G’s mother did not. He stated that while the views of relatives should be considered, they were not determinative, and the views of the doctors should be followed.

C. Covert Bolamisation

In the context of informed consent and treatment of mentally incapacitated patients, Bolam appears centre stage. In Gillick v. West Norfolk and Wisbech Area Health Authority, Bolam is never expressly invoked, or even cited in any of their Lordships’ speeches. Yet a similar judicial policy of handing over sensitive issues of ethics to the doctors surfaces again. Girls under 16 can be prescribed ‘the Pill’ if judged to be ‘Gillick competent’ by a doctor and his clinical judgment endorses such treatment as in their interests. Lord Fraser is quite open about this process of ‘medicalising’ ethics:

The medical profession have in modern times become entrusted with very wide discretionary powers going beyond the strict limits of clinical judgments and, in my opinion, there is nothing strange about entrusting them with this further responsibility which they alone are in a position to discharge satisfactorily (our emphasis).

If Gillick may be understood as covertly applying the Bolam test to mature minors, just as F openly applies it to mentally incapacitated

[33] Ibid. at 411.
[34] Ibid. at 411–2.
[37] [1985] 3 All E.R. 402 (H.L.).
adults, the subsequent judgments on minors’ incapacity to refuse treatment become more comprehensible. The Court of Appeal in Re R (A Minor) (Wardship Medical Treatment)40 and Re W (A Minor) (Wardship: Medical Treatment)41 effectively denies either parents or older children decision-making powers. The ‘reasonable doctor’ determines whether or not to override the adolescent’s refusal of treatment, regardless of whether or not the young person is Gillick-competent. The doctor is free to act on consent to treat granted by either parent or by the minor. Lord Donaldson in Re W describes consent as a flak-jacket. Where the patient is a mentally competent adult, only the patient can provide the doctor with a flak-jacket to protect her doctor from the fire of litigation. When the patient is a minor, that patient and her parents are all empowered to proffer the requisite protection to the doctor.42 And if no flak-jacket is forthcoming from the parents or the minor, the doctor can apply to the court to sanction treatment which responsible medical practice judges necessary to protect the minor’s welfare.43

In Re R, Lord Donaldson had used a different, if equally colourful, metaphor. He likened consent to a key. A Gillick-competent minor acquired a key to consent to treatment, but his parents retained all their separate rights as keyholders, as did the court. His Lordship abandoned ‘keys’ for ‘flak-jackets’ in Re W because, he acknowledged, keys can lock, as well as unlock doors. The impact of Re W is to grant the power to decide disputes about the treatment of a minor to the medical profession. Bolam may not be cited in either Gillick itself or the hotly disputed judgments which came later and abrogated any substantive claim to adolescent autonomy,44 nonetheless a Bolamite philosophy prevails. A body of responsible medical opinion is presumed to be the best arbiter of disagreements about treatment, whether those disagreements be between doctors and young patients, doctors and the patient’s parents, or amongst doctors themselves.

Where the Bolam philosophy enters the legal arena surreptitiously, it may be disguised by the use of terms such as ‘clinical judgment’ or ‘best

44 Ian Kennedy, e.g. sees Lord Donaldson as ‘Driving a coach and horses through Gillick’: I. Kennedy, ‘Consent to Treatment: The Capable Person’ in C. Dyer (ed.), Doctors, Patients and the Law (Blackwell 1992) at 60.
interests’, as in Re F. In Re W, ‘medical ethics’ is the chosen disguise. Lord Donaldson accepts that doctors must take account of a minor’s objections to treatment. He says:

... [m]edical ethics also enter into the question. The doctor has a professional duty to act in the best interests of his patient and advise accordingly ... [and in the event of disagreement] he will need to seek the opinion of other doctors and may well be advised to apply to the court for guidance.

The wise doctor will heed his Lordship’s words. Assuming he does so, is it likely that a court will reject the body of opinion advanced by the doctor and his colleagues? Is the outcome not all too often Bolam under another name? The extension of a Bolamite philosophy, way beyond the original context of Bolam, has led many commentators to charge that the courts (and the legislature) have allowed social and moral questions surrounding individual rights to become “medicalised”. Human rights have been squeezed out of health care law. What we must now address is whether the process of Bolamisation may be about to be reversed.

V. BOLITHO: NEW DAWN OR FALSE DAWN?

The medical malpractice claim brought on behalf of Patrick Bolitho, which culminated in the judgment of the House of Lords in Bolitho v. City & Hackney Health Authority, is at first glance an unlikely candidate to become a landmark case in medical litigation. The central issue in dispute is a problem of causation rather than breach of duty. Our focus is on the potential impact of Lord Browne-Wilkinson’s

---

45 Re W, op. cit., n. 41 at 635.
46 Sally Sheldon, e.g. highlights the way in which the issue of abortion has been medicalised: S. Sheldon, ‘Subject only to the Attitude of the Surgeon Concerned: The Judicial Protection of Medical Discretion’, (1996) 5 Social and Legal Studies 95. For a more general discussion of this point, see E. Ginzberg (ed.), Medicine and Society—Clinical Decisions and Societal Values (Westview 1987); or, for a highly polemic and extreme view, T. Szasz, The Theology of Medicine (Oxford University Press 1979). Szasz argues that we have allowed the medical profession to become as much a force for social control as the church in previous centuries, and attributes this to our human desire to abrogate responsibility to others. Although controversial, this view may explain, for some, the Bolam explosion. The introductory chapter of the book sets out his position.
47 See I. Kennedy, ‘Consent to Treatment: The Capable Person’ in C. Dyer (ed.), Doctors, Patients and the Law, op. cit., n. 44.
review of the Bolam test so we explore the facts of the case itself and the intricacies of the causation debate only briefly.  

Patrick Bolitho, aged two-years-old, was admitted to the defendants’ hospital suffering from respiratory difficulties. A couple of days earlier he had been treated in the same hospital for croup. The day after his readmission to hospital, Patrick’s breathing deteriorated and a nurse summoned the paediatric registrar, Dr Horn. The registrar said that she would attend as soon as possible, but did not do so. Patrick, however, recovered, quickly regaining his colour and energy. At 2.00 pm Patrick suffered a second episode of breathing difficulties. The doctor was again summoned and failed to attend. Patrick recovered briefly. Unhappily at 2.30 pm he collapsed, his respiratory system failed, and he suffered a cardiac arrest resulting in catastrophic brain damage. Patrick subsequently died and the proceedings were continued by the administrator of his estate. The essence of the claim was whether the defendants were responsible for the brain damage caused by the cardiac arrest. The hospital admitted negligence on the part of Dr Horn in failing either to attend Patrick or arrange for a suitable deputy to examine the child. They denied liability on the grounds that, even had she attended Patrick, Dr Horn would not have intubated him. To prevent the cardiac arrest which caused his brain damage, Patrick would have to have been intubated prior to 2.30 pm.

The trial judge accepted Dr Horn’s evidence that she would not have intubated Patrick before 2.30 pm. He went on to examine expert evidence as to whether or not a competent doctor who had attended Patrick should have intubated the child. The plaintiffs’ five experts all testified that the evidence of respiratory distress was such that a respiratory collapse should have been contemplated and Patrick should have been intubated immediately to prevent such a catastrophe. The defendants’ three experts contended that the evidence suggested that, apart from the two acute episodes of breathing problems, Patrick seemed quite well, and intubation itself was not a risk free process in such a young child. A responsible doctor would not have intubated before 2.30 pm. The trial judge found that the views of the two leading experts, Dr Heaf for the plaintiff, and Dr Dinwiddie for the defendants, were diametrically opposed. Dr Dinwiddie was an especially impressive


50 The judge found as a fact that she would have made preparations for speedy intubation if later required but that such preparations would have made no difference to the ultimate outcome.
witness. Both represented a responsible body of professional opinion, espoused by distinguished and truthful experts. Accordingly, applying the Bolam test, as he interpreted it, the judge was obliged to conclude that Patrick’s injury did not result from the defendants’ admitted negligence. The judge placed great weight on Lord Scarman’s speech in Maynard v. West Midlands Regional Health Authority\textsuperscript{51} stressing it was not for him to prefer one respectable body of professional opinion to another. The Court of Appeal upheld the first instance judgment.\textsuperscript{52}

Two questions were central to the appeal before the Law Lords. (1) Did the Bolam test have any application at all in deciding issues of causation? (2) Does the Bolam test require a judge to accept without question truthful evidence from eminent experts? The House of Lords answered the first question in the affirmative. Generally where the only question relevant to causation is simply ‘what would have happened but for the defendants’ negligence?’ the Bolam test has no part to play in causation. Exceptionally, as on the facts of this case, an answer to the question ‘what would have happened if . . . ?’ simply prompts the further question of ‘what should have happened?’ Having found as a fact that Dr Horn would not have intubated Patrick, whether or not her negligence caused his injury depended on what she should have done—what the competent doctor attending the child would have done. Hence the Bolam test was inevitably central to that second question of causation.\textsuperscript{53}

As to the second issue before their Lordships, does Bolam require that a judge accept the views of one truthful body or experts, even if unpersuaded of its logical force, Lord Browne-Wilkinson (with whom his brethren agreed) forcefully rejected any such proposition. The court is not bound to find for a defendant simply because he leads evidence from a body of experts who genuinely believe that the defendant’s practice conformed to sound medical practice. As McNair J. had stressed in Bolam itself the practice must be one endorsed by responsible opinion, ‘a standard of practice recognised as proper by a reasonably competent body of opinion’.\textsuperscript{54} These adjectives, Lord Browne-Wilkinson ruled, ‘ . . . all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis’.\textsuperscript{55} Analysing earlier case-law on professional negligence, especially the opinion of the Privy Council in Edward Wong Finance

\textsuperscript{51} [1984] 1 W.L.R. 634, (H.L.) discussed supra at Section III.
\textsuperscript{52} [1994] 1 Med. L.R. 381; note the dissenting judgment of Simon Brown L.J.
\textsuperscript{54} Op. cit., n. 1 at 586.
Co. Ltd. v. Johnson Stokes & Master,\textsuperscript{56} he went on to declare that in the vast majority of cases the fact that distinguished experts hold a particular opinion will demonstrate the responsibility of that opinion. Nonetheless ‘. . . if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.’\textsuperscript{57}

Doctors, like all other professionals, cannot be judges in their own cause. The judge in a malpractice claim is free to, must be ready to, scrutinise the basis of opinion professed to him as representing responsible practice. Bolitho must not be oversold. Lord Browne-Wilkinson speaks of rare cases and emphasises later in his judgment that it will ‘very seldom’ be right for a judge to reach a conclusion that views genuinely held by competent experts are unreasonable. On the facts of the claim before him he concluded that there was no basis for dismissing the defendants’ expert evidence (especially that of Dr Dinwiddie) as illogical. There were sound reasons not to intubate. Lord Browne-Wilkinson does no more than seek to restore Bolam to its original limits. McNair J.’s full judgment is crystal clear that he did not intend to give doctors carte blanche to clothe inadequate practice with some sort of official blessing, thereby effectively sanctioning negligent practice. McNair J. makes it clear that negligence is not proven merely because a doctor conforms to one school of thought and practice rather than another but says forcefully that:

\[
\ldots \text{that does not mean a medical man can obstinately and pigheadedly carry on with some old technique if it has been proved contrary to what is really substantially the whole of informed medical opinion.}\]

Before looking at what restoring Bolam to its original limits might mean in practice, we need first to consider whether the attempt to do so in Bolitho will actually take root. For Bolitho is not the first judgment which seeks to correct misperceptions of the Bolam test. In Hucks v. Cole,\textsuperscript{59} decided in 1968, albeit not reported until 1993, Sachs L.J. used language almost identical to that of Lord Browne-Wilkinson in Bolitho.

\begin{itemize}
\item \textsuperscript{56} [1984] A.C. 296; discussed supra in section III.
\item \textsuperscript{57} Ibid. at 243.
\item \textsuperscript{58} [1957] 1 W.L.R. 582 at 587. It would appear, therefore, that Bolamisation for over 40 years has been based on an erroneous interpretation of the case. As Grubb exclaims in his casenote on Bolitho: ‘Eureka! The courts have got it at last. Expert evidence, whether of professional practice or otherwise, is not conclusive in a medical negligence case that the defendant has not been careless.’ A. Grubb, ‘Negligence: Causation and Bolam’, op. cit. at 380.
\item \textsuperscript{59} [1993] 4 Med. L.R. 393, (C.A.).
\end{itemize}
In *Joyce v. Merton, Sutton & Wandsworth Health Authority*, the Court of Appeal had asserted an authority to scrutinise expert evidence to determine whether that evidence represented a responsible judgment of good practice. Yet none of these judgments were hailed as reining in *Bolam* or altering the face of malpractice litigation. Will *Bolitho* really make a difference? We believe it will.

Self-evidently, *Bolitho* is a decision from the House of Lords, the highest court in the land. Lord Browne-Wilkinson’s words carry ultimate authority. *Bolitho* has already made a difference. *Bolitho* has been applied by the Court of Appeal to uphold a judgment against a defendant general practitioner. In *Marriott v. West Midlands Health Authority* the judges concluded that the expert opinion advanced in the doctor’s favour was not defensible. Most importantly *Bolitho* has been decided at a time when other developments also point to a revolution in the way medical malpractice is judged. Medicine itself is changing with practitioners increasingly evaluating their own practice and seeking to develop evidence-based medicine. The traditional guardians of clinical standards, the Royal Colleges of Medicine, have over the last decade become more and more proactive, issuing guidelines about good practice with reference to treatment and procedures. The government in its White Paper, *The New NHS*, stated its intention to establish national standards and guidelines for services and treatments. To give substance to that intention, the National Institute of Clinical Excellence (NICE) has been established to develop guidelines for good practice, not just in the context of new drug treatments, but in a much wider sphere of reviewing all forms of therapies and procedures. The Commission for Health Improvement will oversee clinical services and tackle shortcomings. The day of the unfettered autonomy of the individual consultant is over. The profession in partnership with govern-

---


65 See, *A First Class Service: Quality in the New NHS* (DoH 1999) which states at para. 2.27 that NICE will provide ‘[c]lear, authoritative, guidance on clinical and cost effectiveness . . . to front line clinicians’ (our emphasis). Similarly, in a speech on 31 March 1999, the Secretary of State for Health said that ‘NICE will give advice on the clinical and cost effectiveness of both new and existing technologies’. The full text of this speech can be found in the NICE website at http://www.nice.org.uk.

ment\textsuperscript{67} is moving to set transparent standards for increasing numbers of treatment. The judge confronted by individual experts who disagree about good practice will in certain cases be able to refer to something approaching a ‘gold standard’.

One other factor combines with Bolitho to make it more likely that Bolam in the context of malpractice litigation can be returned to its original limits. Doctors have (rightly or wrongly) had a ‘bad press’ lately,\textsuperscript{68} so that in June 1998, The Guardian\textsuperscript{69} declared ‘... secrecy and clubbiness are still the prevailing attitudes at the top of a profession, where the main concern often seems to be protect doctors, not patients’. The events in Bristol,\textsuperscript{70} which resulted in Professor Ian Kennedy being asked to review circumstances surrounding the deaths of several infants after cardiac surgery, are perhaps the worst of a number of tragic cases where gross medical error has had disastrous results. Moreover, the effect of the trial of the GP, Harold Shipman, on the public’s automatic presumption of beneficence on the part of the medical practitioner is likely to be severe and long lasting. Blind acquiescence on the part of the judiciary to any plausible opinion expressed by an apparently exalted medical practitioner no longer looks like a viable policy.

VI. HOW WILL BOLITHO WORK THEN?

If Bolitho is to make a difference to medical litigation, some clear view on how Lord Browne-Wilkinson’s revision of Bolam will work is needed. He declares that the court must be satisfied that expert opinion has ‘logical force’; that it is capable of withstanding ‘logical analysis’. Yet later he acknowledges that 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. Nor may a judge simply operate on his ‘preference’ for one set of opinion over another. We almost seem to come full circle. 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. Put another

\textsuperscript{67} Or even, on occasion in partnership with lawyers? The BMA and Law Society produced a joint document regarding capacity to consent in 1996: Assessment of Mental Capacity: Guidance for Doctors and Lawyers (BMA and Law Society 1996).


\textsuperscript{69} The Guardian, 25.6.98, at 12.

way, the difficulty in establishing the logic or otherwise of medical evidence lies in an argument that laypersons may not be capable of understanding the merits of such logic. It becomes easier to see how the Bolam has metamorphosed in the way it did, appearing to grant doctors something close to immunity from suit.

The judgment of Hucks v. Cole,\textsuperscript{71} cited with unqualified approval in Bolitho, may assist in breaking the circle. In Hucks v. Cole the facts were as follows. Dr Cole, a general practitioner, was treating a woman in the final weeks of her pregnancy for a septic finger. He was well aware that the area was infected with \textit{streptococcus pyrogenes} capable of developing into puerperal (childbirth) fever. Yet he continued to prescribe tetracycline rather than penicillin. After giving birth Mrs Hucks succumbed to puerperal fever. All the medical experts acknowledged that penicillin would have prevented the puerperal fever. Four defence experts nonetheless testified that they, like Dr Cole, would not have prescribed penicillin. Tetracycline was a slightly cheaper drug and they would have regarded the risk of puerperal fever as low. By 1968 cases of puerperal fever were rarely seen in the United Kingdom. The Court of Appeal upheld the trial judge’s findings of negligence. Sachs L.J. said:

> When the evidence shows that a lacuna in professional practice exists by which risks of grave danger are \textit{knowingly} taken, however small the risk, the court must anxiously examine the lacuna—particularly if the risk can be \textit{easily} and \textit{inexpensively} avoided.\textsuperscript{72}

Sachs L.J. acknowledged that the evidence indicated that other doctors would have done as the defendant did was ‘a very weighty matter’. But such evidence could not be conclusive. The experts agreed about the risk of harm to the patient. They agreed that there was an obvious means of eliminating risk. The defendants’ experts failed to provide any convincing explanation for rejecting that obvious means of protecting the patient. Hucks v. Cole required that experts explain the grounds for adopting a course of treatment clearly contrary to at least a significant body of opinion among their peers. In Bolitho itself, Lord Browne-Wilkinson says that in weighing risks and benefits the judge must assure himself that ‘. . . experts have directed their minds to the question of comparative risks and benefits and have reached a defendable conclusion on the matter’.\textsuperscript{73}

That approach is exactly the approach taken by the Court of Appeal

\textsuperscript{72} Ibid. at 397.
\textsuperscript{73} Op. cit., n. 3 at 243.
in Marriott v. West Midlands Health Authority\textsuperscript{74} in finding against the defendant doctor. The plaintiff fell and suffered head injuries. He was unconscious for about half an hour. He was taken to hospital for X-rays and investigation but discharged the next day. Once home, he remained unwell. He had headaches. He was lethargic and had no appetite. Eight days after his fall he was visited by his general practitioner, the second defendant. The defendant carried out certain neurological tests at the plaintiff’s home. He found no abnormalities on the basis of those tests. He advised the plaintiff’s wife to telephone him again if her husband’s condition deteriorated and suggested painkillers. Four days later the plaintiff’s condition worsened. He was re-admitted to hospital and a large extradural haematoma was operated on. The surgery revealed a skull fracture and internal bleeding. The plaintiff was left paralysed and suffering from a speech disorder.

The plaintiff claimed both that the hospital was negligent in discharging him prematurely on the first occasion, and that his general practitioner was negligent in not referring him back to hospital when he visited him at home. It is this latter claim against the general practitioner with which we are concerned. The plaintiff alleged that his general practitioner should have perceived the seriousness of his injury and subsequent symptoms, and that further investigation at that stage would have prevented the catastrophic deterioration in this condition. The key question was whether a responsible general practitioner should have judged that a full neurological investigation was necessary. Should he have done more than the simple tests he carried out at the plaintiff’s home? Such tests, all agreed, were insufficient to exclude an intracranial lesion.

The plaintiff’s experts testified that, given the patient’s history (in particular that he had been unconscious for a period of time after the fall), and in the light of his symptoms and failure to improve after coming home, the doctor ought to have sent him back to hospital. The defendant’s expert argued that she would support a decision to leave the plaintiff at home as the risk of an intracranial lesion causing a sudden collapse was very small. The trial judge held first that the defendant’s expert’s view of the plaintiff’s condition was over-optimistic being based largely on the defendant’s witness statement. She went on to say that, although the risk of an intracranial lesion was very small, ‘. . . the consequences, if things go wrong, are disastrous to the patient. In such circumstances, it is my view that the only reasonably prudent course . . . is to re-admit for further testing and observation’.\textsuperscript{75}


\textsuperscript{75} Ibid. at 27.
In the appeal court, the judge’s exercise in risk assessment was upheld at least by Beldam L.J. She was entitled to weigh the admittedly small risk of something going wrong against the seriousness of the consequences. Facilities to carry out a comprehensive neurological examination were readily available in local hospitals. Given the devastating nature of the consequences of the risk of an intracranial lesion, no reasonable or responsible general practitioner would have exposed the plaintiff to that risk.

_Marriott_ is no doubt an extreme case and one where the defendant’s own expert witness offered him less than whole-hearted support. Beldam L.J. noted that to some extent both parties’ experts tended to focus on what their individual approach might have been, rather than what would have constituted responsible practice. It is a judgment which provoked from Michael Jones the following pertinent question:

In five or ten years time will _Marriott_ mark the beginning of a sea-change in judicial attitudes to medical negligence actions, or will it stand out as an isolated, and comparatively rare, example of a case in which logical analysis ruled?

We hope and believe that the former is the case, that _Marriott_ will mark the beginning of a revolution in judicial attitudes to medical negligence claims.

_Bolitho_ has set in train a process whereby judges scrutinise medical evidence, using the same mixture of common sense and logical analysis that they use to scrutinise other expert evidence in negligence claims against professionals such as architects and accountants. That process of scrutiny will be aided and enhanced by the revolution within medicine itself. Where clinical guidelines have been developed in relation to a disputed treatment, the judge will be enabled to judge the individual expert testimony in context of the profession’s considered judgment.

A simple example can be drawn from claims relating to failure to warn patients of the risks that both male and female sterilisation occasionally fail. Nature triumphs over medical science and the relevant ‘tubes’ reconnect themselves. A spate of cases on failed sterilisation surfaced from the 1970’s onwards. Practice clearly varied widely as to whether patients were warned of the risk of failure. The outcome of consequent medical negligence claims also varied widely. That outcome depended on the skill of the defendants’ lawyers in finding eminent

---

76 With whom Swinton Thomas L.J. agreed; Pill L.J. considered it unnecessary to resort to _Bolitho_.
77 Op. cit., n. 74 at 120.
doctors to testify that they did not consider that proper practice required them to warn of the risk of failure. Today the position different. In the context of female sterilisation, the Royal College of Obstetricians and Gynaecologists advises on a practice of full and frank disclosure. Department of Health guidelines, supported by a special consent form, require disclosure. Any doctors still not warning their patients of the risks of failed sterilisation will be hard pressed to establish the logic of rejecting a case endorsed by the leaders of the profession. Failure to warn of the risk of sterilisation failing will be condemned as neither reasonable nor responsible. Ironically, a defendant who fails to warn a patient of the risk of sterilisation reversing itself may still escape any substantial liability. For while he or she is unlikely to avoid a finding of negligence, the House of Lords in McFarlane v. Tayside Health Board controversially ruled that damages may not be awarded in respect of the costs of caring for and bringing up a healthy child. The House of Lords upheld an award of £10,000 damages for the mother in compensation for the pain and discomfort of pregnancy and childbirth, but rejected the much larger claim of £100,000 in relation to the costs of the child’s upbringing as irrecoverable economic loss.

Failed sterilisation is an exceptionally easy target. The profession and the Department of Health have promulgated clear guidance in a case where the possibility of arguing justification for departing from that guidance looks remote. However a commitment has been made to develop similar sorts of guidelines over a wide spectrum of medicine, especially through the National Institute of Clinical Excellence. The Institute’s central purpose is to rationalise and co-ordinate clinical guidance on effective treatment, in appropriate cases developing something close to protocols on disease-management. Presumably such guidance will be written lucidly, in terms intelligible to judges in medical malpractice claims. The judge will have access to material, independent of the particular dispute before him, enabling him to assess the logic of the parties’ cases. Bolitho, plus more ready access to clinical guidelines, suggests a more proactive role for judges assessing expert evidence. Nor will clinical guidelines necessarily be the only source of judicial guidance on the logic of the evidence presented by the parties. The burgeoning literature on medical developments, often presented in a style

---

79 See, e.g. Gold. The case concerned a failed sterilisation carried out in 1979. The Court of Appeal held that as at the time of the procedure there was a responsible body of medical opinion that would not have given such a warning, then the plaintiff’s case must fail.


81 Note Lord Millett’s dissent denying damages to the mother too.

82 See Harpwood op. cit., n. 4 at 100–21; and see V. Harpwood, ‘NHS Reform, Audit, Protocol and Standards of Care’, (1994) 1 Med. L. Int. 241.
comprehensible to lay people, may also be resorted to much more frequently in litigation.\textsuperscript{83} \textit{Bolitho} demands that doctors explain their practice. Doctors themselves are developing tools which will enable judges to review those explanations.

There will be those who have doubts whether judges will be ready to use those tools. Reluctance to engage in an exercise some judges perceive as ‘meddling’ in clinical autonomy is starkly demonstrated in \textit{R. v. Cambridge Health Authority ex parte B}\textsuperscript{84} where Sir Thomas Bingham M.R. declared that:

\begin{quote}
the courts are not, contrary to what is sometimes believed, arbiters as to the merits of cases . . . Were we to express opinions as to the likelihood of the effectiveness of medical treatment, or as to the merits of medical judgment, then we should be straying far from the sphere which under our constitution is accorded to us. We have one function only, which is to rule upon the lawfulness of decisions. That is a function to which we should strictly confine ourselves.
\end{quote}

In the Court of Appeal\textsuperscript{85} in \textit{Bolitho} itself, Dillon L.J., while affirming that expert evidence was not immune from judicial scrutiny, set the burden of proof to justify rejection of such evidence at an almost impossibly high level. To question the defendant’s evidence a court must be ‘. . . clearly satisfied that the views of that group of doctors were \textit{Wednesbury} reasonable i.e. views such as no reasonable doctor could have held’. He went on to say ‘. . . that would be an impossibly strong thing to say of the honest views of experts’.\textsuperscript{86} Were Lord Browne-Wilkinson’s ‘rare’ cases to be judged by this ‘Dillon’ benchmark, they may prove to be so rare as to be almost invisible. The opportunity to develop what Harpwood\textsuperscript{87} describes as ‘a more objective approach to the standard of care required of doctors’ would have been squandered.

There are those who view the development of guidelines and their use as dire for both patients and doctors. They argue that centrally directed standards will undermine the \textit{art} of medicine, especially if courts judging malpractice claims do treat such standards as a gold standard. The distinguished physician, Sir Douglas Black,\textsuperscript{88} has said of guidelines

\begin{itemize}
\item \textsuperscript{83}See \textit{e.g.} J. Collier (ed.), \textit{Guidelines for Management of Common Medical Emergencies}.
\item \textsuperscript{84}[1995] 2 All E.R. 129 at 136.
\item \textsuperscript{85}[1993] 4 Med. L.R. 381.
\item \textsuperscript{86}Ibid. at 392.
\item \textsuperscript{87}\textit{Op. cit.}, n. 4 at 107.
\end{itemize}
they can become ossified and too rigid for the flexibility required in the heterogeneous circumstances of clinical practice’. Commentators, such as Sir Douglas Black, fear that doctors, to avoid litigation, will cease to treat the individual and concentrate on ticking the relevant boxes. We argue that such an outcome should not result from either the process of setting standards or the use of standards in litigation.

We attempt an example to illustrate our optimism, acknowledging that our knowledge of obstetrics may well be flawed. Obstetricians hold radically different opinions on good practice in relation to delivery of a premature breech baby. A number strongly argue that such an infant should be delivered by caesarean section. Others allow labour to proceed. Assume that after clinical trials and reviews of the evidence, NICE issued guidance recommending delivery by caesarean. Does it follow that any obstetrician who nonetheless allows trial of labour will inevitably be found liable in negligence? Not at all. Several factors might logically justify departing from that guidance. First, the patient’s own wishes and feelings must be taken into account. Second, her circumstances will be relevant. It may be that for most women the ratio of risk to benefit of a caesarean delivery points in favour of such surgery. But were the woman likely to return to a part of the world where in a subsequent pregnancy she would be at risk of a ruptured uterus or if she planned a large family that ratio would itself alter radically. Even her own size and obstetric history could alter advice designed for the generality of labouring women. All the guidance would require is that once again the defendant justifies, and explains, the management of the particular case.

Doctors may also fear that Bolitho will have adverse effects on the litigation process itself. The pessimistic medical observer of malpractice litigation may reason as follows: More claimants will now try it on. Even when confronted by substantial evidence of a body of expert opinion supporting the defendant, claimants will play the Bolitho card. They, and their lawyers, will contend that that opinion lacks any logical basis. Cases will be dragged out for even longer periods of time. Further expert evidence will be required to counter allegations of illogicality. Costs will spiral. The bitterness of litigation will increase when the defendant is attacked, not just as a doctor who has made a mistake, but as one whose practice lacks any rational basis.

Such a catastrophic scenario ignores several factors. Bolitho speaks of rare cases. One would at least wish to assume that most practice does have a rational basis? Perhaps it may be the case that there are medical

---

90 In his speech launching NICE (op. cit., n. 65), the Secretary of State assured doctors that clinical judgment in relation to individual patients would continue to be respected.
experts a little too willing to testify in support of practices any of their peers no longer consider sound. *Bolitho* may simply result in cases which should not be contested being settled more swiftly and economically. Moreover, contemporaneously with the advent of a post-*Bolitho* era, the civil justice system is undergoing radical change as a result of Lord Woolf’s review. The full extent of Woolf’s proposals and their implementation in the new Civil Procedure Rules is beyond the scope of this paper. However, some points are worthy of note here. Case-management is designed to restrain the worst excesses of adversarial litigation. Most importantly, reforms relating to expert evidence ought to reduce both delay and confrontation in the system. Judges are empowered to appoint a single expert in straightforward cases. When each party continues to call their own experts, the judge can require the use of experts’ meetings. The experts will be directed to ascertain which matters they can agree together and submit a joint report where possible. Better training for experts is urged by Woolf and the creation of a pool of experts was recommended in his Interim Report. The aim of reforming the civil justice system is to achieve easier access to, and a higher quality of, expert evidence. Misuse of expert evidence which renders litigation akin to trial by battle should become much rarer, countering fears that *Bolitho* itself will become a new battleground for experts. Woolf appears to emphasise conciliation and common ground among, rather than confrontation between, the experts in trials.

**VII. INFORMATION DISCLOSURE—BOLAM RESTRAINED**

In the context of straightforward claims for medical negligence, *Bolitho* simply restores *Bolam* to its proper limits and treats claims for medical negligence like other claims for professional negligence. *Bolitho* does not undermine either the role of clinical judgment or peer review of professional practice. Medical competence remains for the most part a medical matter. De-Bolamisation is not in this context *de-medicalisation*. As Teff has noted, ‘[judicial] involvement is not the same as encroachment, or even engagement’ in clinical freedom. It is in other sorts of dispute between patients and their doctors that the *Bolam* test may well either be substantially diluted or abandoned altogether.

We would suggest that information disclosure and the supremacy of

---

92 Para. 35.7.
93 Para. 35.12.
94 See Harpwood’s reference about how effective reforms in relation to expert evidence will be; *op. cit.*, n. 4 at 96–100.
the ‘reasonable doctor test’ may be the first Bolitho casualty. The nature
of the issue before the court in claims that the defendant doctor failed to
give her patient sufficient information about the risks and side-effects,
and alternatives to the treatment proposed, involve questions which
judges can much more easily assess than the issues arising in claims
relating to, say, diagnoses or modes of treatment. Attempting to analyse
whether or not the doctors’ justification for non-disclosure is logical
and rational will not be a task bedevilled by too much technical or
scientific detail.

However, one reading of Bolitho might suggest that Lord Browne-Williamson excluded information disclosure from his efforts to restore Bolam to its proper context. His Lordship declares that ‘in cases of
diagnoses and treatment there are cases where, despite a body of pro-
fessional opinion sanctioning the defendant’s conduct, the defendant
can properly be held liable in negligence’. Then appears in brackets the
following cryptic phrase: ‘(I am not here considering questions of
disclosure of risk).’ An interpretation of that throwaway phrase as
meaning that information disclosure disputes were to be judged on the
basis of what his Lordship had declared to be a misinterpretation of
Bolam would be itself illogical and irrational. Either, his Lordship was
simply and correctly flagging up the fact that questions of information
disclosure were simply not relevant on the facts of Bolitho, or, more
probably, Lord Browne-Wilkinson considered that restraining Bolam in
the context of information disclosure had already been achieved.

In Sidaway itself, we have already noted that Lord Bridge made it
clear that there might be cases where ‘. . . disclosure of a particular risk
was so obviously necessary to an informed choice on the part of the
patient that no reasonably prudent medical man would fail to make
it’. Many years in advance of Bolitho, Lord Bridge had sought to
clarify the point that expert opinion to negate negligence must be
responsible. Again as we have seen earlier, subsequent judgments in
Blyth v. Bloomsbury Health Authority and Gold v. Haringey Health
Authority appeared to endorse an unrestrained Bolamite interpretation
of Sidaway. Other more recent case-law breathes new life into Lord
Bridge’s words.

Prior to Bolitho in the House of Lords, in Smith v. Tunbridge Wells
Health Authority, Morland J. condemned the expert evidence offered
on behalf of the defendant as ‘neither reasonable nor responsible’.

97 Ibid.
98 Op. cit., n. 17 at 663. Lord Templeman’s speech can also be interpreted in this way (see
A. Grubb, ‘Negligence: Causation and Bolam’, (op. cit., n. 5) at 382–3).
Failure to warn a young man of the risk of impotence inherent in rectal surgery deprived the plaintiff of an informed choice in relation to that surgery. In finding the defendants negligent, Morland J. described himself as ‘... applying the Bolam test as elucidated in Sidaway’. That Bolam was already restrained in the context of information disclosure is an opinion re-enforced by the judgment of the Court of Appeal in Pearce v. United Bristol Healthcare N.H.S. Trust, a case decided subsequent to the decision of the House of Lords in Bolitho. Lord Woolf M.R. had no doubts that Bolitho applied to claims concerning information disclosure and appeared to perceive Lord Browne-Wilkinson’s general approach in Bolitho as essentially in the same vein as Lord Bridge’s more restricted qualification of the Bolam test in Sidaway.

The facts of the case, briefly, are as follows. Mrs Pearce was pregnant with her sixth child. The child was two weeks overdue. She was seen by her obstetrician who told her that medical intervention (in the form of an induction or a caesarean), was inappropriate. He warned her of the risks to the foetus of an induction, and the inherent risks to herself of a caesarean, but did not tell her of the increased risk of stillbirth associated with non-intervention, estimated at 0.1–0.2 per cent. Reluctantly, she agreed to non-intervention. Sadly the child was stillborn. Mrs Pearce alleged that failure to advise her of the risk of stillbirth was negligent.

Lord Woolf’s judgment concludes in the defendant’s favour. In the circumstances of the case, the ‘very, very small additional risk’ to the child was not a sufficiently ‘significant risk’ to render the doctor negligent in failing to advise Mrs Pearce of that risk, especially given her distressed condition at the time of the consultation. His reasoning, however, departs significantly from an unrestrained application of the Bolam test. He cites both Lord Bridge in Sidaway, and Lord Browne-Wilkinson in Bolitho, to support a proposition capable of effecting a radical departure from a ‘reasonable doctor’ test. Lord Woolf declares that the law requires that ‘... if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course she should adopt’ (our emphases).

The cynic will of course respond that whatever his Lordship’s language, the Court of Appeal rejected Mrs Pearce’s claim finding it not to ‘... be proper for the courts to interfere with the clinical opinion of the

---

100 Ibid. at 339.
102 Ibid. at 59.
medical man responsible for treating Mrs Pearce’. Even the cynic must concede that, whatever the outcome on the facts, the ‘reasonable doctor’ test received a body blow in *Pearce*. It survives only if the ‘reasonable doctor’ understands that he must offer the patient what the ‘reasonable patient’ would be likely to need to exercise his right to make informed decisions about his care. The recent guidance to doctors from the General Medical Council re-enforces that message. Patients must be given the information they want or ought to know. Judges evaluating information disclosure practices will be encouraged to take a more pro-patient stance not just by the higher courts but by the medical profession itself.

VIII. THE LAW COMMISSION—*BOLAM* ABANDONED?

In the context of claims for medical negligence, including claims relating to information disclosure, all that can be said at this stage is that the courts appear to be prepared to reign in the worst excesses of the *Bolam* test. It is in relation to the principles governing the treatment of mentally incapacitated adults that *Bolam* may literally be abandoned. Nearly five years after the Law Commission published its report on reforming the law relating to decision-making on behalf of mentally incapacitated persons, the government announced its intention to implement a number of those proposals. Among the proposals to be included in legislation is the Law Commission’s recommendation that while a “best interests” test should continue to govern what treatment be provided for those unable to consent to treatment on their own behalf, statutory guidance should define ‘best interests’. The Law Commission vigorously condemned resort to *Bolam* to define the “best interests” of a vulnerable patient. Its Report declares:

[I]t should be made clear beyond any shadow of a doubt that acting in a person’s best interests amount to something more than

---

103 *Ibid.* at 60.
104 Grubb (‘Negligence: Causation and *Bolam*’), e.g. argues that in *Pearce* the Court of Appeal has ‘shown a renewed appetite to set the standard of disclosure’ (at 384).
105 *Seeking Patients’ Consent: The Ethical Considerations* (GMC 1999).
108 No timetable for introducing such legislation into Parliament has been set.
not treating a person in a negligent manner. Decisions taken on behalf of a person lacking capacity require a careful, focused consideration of that person as an individual. Judgments as to whether a professional has acted negligently, on the other hand, require a careful, focused consideration of how that particular professional acted as compared with the way which other reasonable professionals would have acted.\(^{109}\)

Judgments about the welfare of mentally incapacitated patients are no longer to be classified as primarily clinical judgments. The spotlight shifts from the doctor to the patient. In its original proposals the Law Commission suggested that regard must be had to the following four matters in assessing a patient’s best interests:\(^{110}\)

1. The ascertainable past and present wishes and feelings of the person concerned, and the factors that person would consider it able to do so;
2. the need to permit and encourage the person to participate, or improve his or her ability to participate, as fully as possible in anything done for and any decision affecting him or her;
3. the views of other people whom it is appropriate and practicable to consult about the person’s wishes and feelings and what would be in his or her best interests;
4. whether the purpose for which any action or decision is required can be as effectively achieved in a manner less restrictive of the person’s freedom of action.

Subsequent consultation led the government to propose a further two factors to be included in legislation:\(^{111}\)

5. whether there is a reasonable expectation of the person recovering capacity to make the decision in the reasonably foreseeable future;
6. the need to be satisfied that the wishes of the person without capacity were not the result of under influence.

The Law Commission’s approach demands a focus on the patient as an individual and rejects the notion that doctors should be able to hide behind some cloak of professional opinion. The doctor caring for a

\(^{109}\) Law Commission Report No.231, op. cit., n. 106 at para. 3.27.

\(^{110}\) See paras. 3.26–3.37.

\(^{111}\) Making Decisions, supra, n. 107 at para. 1.12. The following paragraph sensibly provides that that the statutory list of factors to be taken into account in assessing best interests ‘... should not be applied too rigidly’ and should not exclude consideration of any relevant factor in a particular case.
mentally incapacitated person will be required to exercise her judgment to meet the needs of that person. In determining what the person’s medical needs might be, the opinion of other doctors may well be relevant, but the doctor must give equal weight to her patient’s social needs and individual characteristics. Assessing which treatment options meet the patient’s overall welfare, professional opinion takes a back seat. Such an approach does more than simply reject the *Bolam* test as the arbiter of patients’ best interests. It rejects a Bolamite philosophy. In the opening paragraph of its Report, the Law Commission notes\(^\text{112}\) that the law is out of date, and does not rest on clear or modern foundations of principle. It has failed to keep up with social changes. It has also failed to keep up with developments in our understanding of the rights and needs of those with mental disability.

The whole tenor of the Law Commission Report, in so far as it concerns medical decision-making, reflects a change of emphasis from professional responsibilities to patients’ rights. The Law Commission explicitly recognises that the medical profession has failed certain groups of patients, that there has been unacceptable discrimination against people with ‘. . . mental disabilities (and especially mental illness) in the past by *medical practitioners*; the law and society as a whole’.\(^\text{113}\) They highlight the growth of a ‘rights culture’ and the proliferation of documents emphasising the ‘obligation of providers to consumers of services’.\(^\text{114}\) Such language is inconsistent with a philosophy which allows the providers, the doctors, to dictate what those services will comprise. Rather, the law, in whatever context, must seek to ascertain what the patient is entitled to and what her needs demand.

Legislation effectively overruling that part of the judgment in *Re F*, which applied the *Bolam* test to determine ‘best interests’, will constitute only a relatively minor exercise in *de*Bolamisation. What will be of equal interest will be whether legislative reform in one area of health care law will prompt the judiciary too to embark on a retreat from *Bolam* more generally. We sought to argue earlier that even in judgments which do not overtly invoke the *Bolam* test, a Bolamite philosophy prevailed. In *Gillick*, and subsequent cases concerning disputes about the treatment of minors, the judiciary once again regarded professional opinion as the best arbiter of any dispute and showed reluctance to investigate the validity of such professional judgments. Rooting out *covert*, possibly unintentional, resort to *Bolam* will not be an easy process. It will take place if, and only if, the courts acknowledge that past deference to medical opinion has been somewhat misguided and


\(^{113}\) At para. 2.40, emphasis added.

\(^{114}\) *Ibid.*
are prepared to struggle to give substance to rhetoric surrounding patients’ rights, whatever their age or mental capacity. Predicting which way the courts will jump is nigh on impossible.

IX. BOLAM—IN RETREAT

If the judgment in Bolitho stood alone, as the only indicator of a medical litigation revolution, we would have had substantial doubts whether any change, even change well short of revolution, might be expected in health care law. Lord Browne-Wilkinson’s words might go as much unheeded as those of Sachs L.J.’s in Hucks v. Cole. However, we have sought to demonstrate that the timing of the decision, amidst a host of other relevant developments affecting the provision of health care, suggests that in several contexts medical professional opinion will be subjected to rigorous scrutiny. An expert opinion, be it one on allegations of professional negligence, disclosure of risks, or the appropriate care of certain groups of patients, will no longer be determinative of professional obligations.

In claims for medical negligence the emergence of sources of neutral and independent guidance on good practice will empower judges to utilise Bolitho and assess whether the opinion advanced by each party’s experts is logical and defensible. No flood of judgments ruling expert evidence to be illogical and indefensible should be expected. Nonetheless the swift resort to Bolitho in Marriott show that courts may now be ready to restore Bolam to its original limits.

The Court of Appeal in Pearce applied Bolitho in the context of an information disclosure claim. Read together with the first instance judgment in Smith v. Tunbridge Wells Health Authority, Pearce signals that announcements of the stillbirth of ‘informed consent’ in England were premature. The era of unquestioning acceptance of Lord Diplock’s application of the Bolam test expressed as by him in Sidaway is over. Lord Scarman’s extra-judicial injunction115 to ‘ignore Lord Diplock’s opinion’ may be (belatedly) about to enter into force. An obligation to disclose any significant risk which would affect the judgment of a reasonable patient can never be defined by reference to a body of professional opinion alone. In an era when the General Medical Council directs clinicians that they ‘. . . must take appropriate steps to find out what patients want to know and ought to know about their condition and its treatment’116 blind adherence to Bolam in its unrestrained, and much misunderstood, form should no longer be possible.

116 Seeking Patients’ Consent: The Ethical Considerations, op. cit., n. 105.
Returning Bolam to its original limits does not exclude expert medical opinion about what should have been done for, or said to, the patient. It simply treats that opinion as evidence, whose weight will depend on the circumstances of particular cases. Professional opinion advanced by doctors will be evaluated on a par with professional opinion advanced by other kinds of professionals. In many instances, professional opinion will remain highly, and rightly, influential.

The prospect of the English courts suddenly revising the tradition of decades and actively seeking to arrogate to themselves the making of clinical judgments is remote. Neither the decision in Bolitho nor the other developments outlined in our paper threaten the proper boundaries of medical judgment. Doctors themselves are now partners in a process which should strive to ensure that medical practice is soundly based on evidence and reason. The leaders of the profession have moved to acknowledge the importance of working in partnership with patients. Bolitho is a decision delivered in the midst of an era when the common law itself is immersed in change. The entry into force of the Human Rights Act 1998, in October 2000, will require that judges pay much more attention generally to claimants’ rights. The Law Commission’s emphasis on identifying the rights of mentally incapacitated patients and defining the obligations of doctors in the context of those rights will have relevance to all patients.

If there is to be a ‘revolution’ in health care law, as with all revolutions, it will have many causes and Bolitho may prove to be of less significance than others. The decision does, however, signal judicial will, at the highest level, to return Bolam to its proper context. Together with the many other factors prompting change, inappropriate deference to medical opinion should be replaced by legal principles which recognise the imperative to listen to both doctors and patients and which acknowledge that the medical professional is just as much required to justify his or her practice as the architect or solicitor.