Legal standard of care: a shift from the traditional *Bolam* test

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ABSTRACT – An essential component of an action in negligence against a doctor is proof that the doctor failed to provide the required standard of care under the circumstances. Traditionally the standard of care in law has been determined according to the *Bolam* test. This is based on the principle that a doctor does not breach the legal standard of care, and is therefore not negligent, if the practice is supported by a responsible body of similar professionals. The *Bolam* principle, however, has been perceived as being excessively reliant upon medical testimony supporting the defendant. The judgment given by the House of Lords in the recent case of *Bolitho* imposes a requirement that the standard proclaimed must be justified on a logical basis and must have considered the risks and benefits of competing options. The effect of *Bolitho* is that the court will take a more enquiring stance to test the medical evidence offered by both parties in litigation, in order to reach its own conclusions. Recent case law shows how the court has applied the *Bolitho* approach in determining the standard of care in cases of clinical negligence. An understanding of this approach and of the shift from the traditional *Bolam* test is relevant to all medical practitioners, particularly in a climate that is increasingly litigious.

KEY WORDS: *Bolam* test, *Bolitho*, clinical negligence, legal standard of care, medical litigation

In medical litigation, the central question that arises is whether or not a doctor has attained the standard of care that is required by law. The standard expected is one of 'reasonable care'. This needs to be judged by taking into account all the circumstances surrounding a particular situation, and by balancing the diversity inherent in medical practice against the interests of the patient. In determining the standard, the court uses the *Bolam* test.[1]

This article explores the limits of the *Bolam* test, and examines the recent shift in the way the legal standard should be determined in medical litigation. The implications of this are relevant to all medical practitioners, particularly in a climate that is increasingly litigious.

Bolam – the traditional view

In 1954, John Hector Bolam underwent electroconvulsive therapy (ECT) for clinical depression. At that time, medical opinion differed on how best to minimise the risk of injuries possible from convulsions induced by ECT. In Mr Bolam's case, the technique of manual restraint was ineffective and as a result he fractured his pelvis. He subsequently argued that the doctor had been in breach of the standard of care in providing treatment, and that the hospital had been negligent.

The *locus classicus* of the test for the standard of care in law, required of a doctor, developed from this landmark case. Mr Justice McNair, in his direction to the jury, said:

> [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 skilled in that particular art …Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.*

It follows that if a medical practice is supported by a responsible body of peers, then the *Bolam* test is satisfied and the practitioner has met the required standard of care in law. This test has been applied on numerous occasions in cases of medical litigation.

A strong endorsement of this test was provided in the House of Lords by Lord Scarman in the case of *Maynard*.[2] His Lordship stated:

> *I have to say that a judge's 'preference' for one body of distinguished professional 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 and honestly held, were not preferred. …For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another.*[2]

The reason for his Lordship taking such a view is that there are, and always will be, differences of opinion and practice within the medical profession. One answer exclusive of all others is seldom the solution to a problem that requires professional

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judgement. A court may prefer one body of medical opinion to another, but that does not amount to a conclusion of clinical negligence.

In practical terms, the effect of the *Bolam* test is that a finding of negligence is not made where the defendant doctor has acted in accordance with a responsible body of medical opinion. This test has been repeatedly approved at appellate level and is enshrined in law.

Criticisms of the *Bolam* test

The principal criticism of the *Bolam* test is that it fails to draw a distinction between 'what is done' and 'what ought to be done'. Whether an action is negligent or not should be judged against a standard of what ought to be done.[3] Something which is done, even if by most people, could still be negligent if it falls below the standard of what ought to be done. The *Bolam* test is seen as stating the standard of care as dependent upon what is done, thereby allowing medical practitioners to set for themselves the legal standard by eliciting the support of 'a responsible body of medical men'. Should this be allowed in medicine when this is clearly not the case in other areas of professional liability, where the expected standard of the defendant is a matter that is set by the court?[4]

The approval of practice by responsible medical peers may be the only way to set the standard in matters requiring technical knowledge and expertise. The *Bolam* test has been justifiably applied to cases of medical litigation involving diagnosis[2] and treatment.[5] However, is this the correct test for information disclosure to patients, or for all matters pertaining to medical intervention in persons unable to give valid consent? These are issues involving ethics and the fundamental rights of individuals. Critics have argued that the court should set the standard in such cases, rather than a body of medical opinion, no matter how responsible or authoritative.[6]

In *Sidaway*,[7] a case concerning the level of information that should have been disclosed to a patient, the speech of Lord Bridge in the House of Lords is particularly apposite:

> *Whether non disclosure in a particular case should be condemned as a breach of the doctor's duty of care is an issue to be decided primarily on the basis of expert medical evidence, applying the* Bolam *test.*[7]

This approach has been criticised as being excessively deferential to medical opinion when balanced against the rights of a patient to be told about the risks and benefits of medical intervention.[6] This criticism has been vindicated in retrospect. The doctrine of consent has now evolved in favour of warning the patient of all material risks inherent in the proposed treatment.[8] In modern medical practice, obtaining consent requires not only giving a patient information, but also ensuring that the patient gives consent with understanding.[9]

The *Bolam* principle has also been applied to the ethical issues inherent in medical interventions performed on mentally incapacitated patients unable to give valid consent. In *Re F*, the question that arose was whether sterilisation should be performed in a 36-year-old patient who had a mental age of five.[10] A body of medical opinion supported this as being in the 'best interests' of the patient. In an ethical matter such as this, should it not be the court that decides what is in the patient's best interests? However, in *Re F*, the decision was left to medical professionals:

> [A] *doctor can lawfully operate on, or give other treatment to, adult patients who are incapable, for one reason or another, of consenting…provided that the operation or other treatment concerned is in the best interests of such patients.*[10]

The *Bolam* test would appear to have crossed the boundaries of diagnosis and treatment, as well as the limits of medicine, thereby enlarging the role of the doctor to that of a moral arbiter.[6]

The ubiquitous application of the *Bolam* principle has made this the litmus test for the standard of care in every issue surrounding medical litigation, including ethical issues. Some legal academics perceive this as an undue reliance on medical testimony and an insufficient focus on the interests of the patient. The mere invocation of *Bolam* could be enough to defeat claims sufficiently contestable to reach the courts.[11] Should this be the case when clearly the standard of care is a question of reasonableness? Should it not be left to the court to appraise what would be reasonable under the circumstances, and to state the expected standard, thus defining the boundaries of reasonable conduct?

It is unlikely that in *Bolam* the judge meant that compliance with a body of medical practice was *conclusive* in terms of escaping liability for negligence. In his summing up, he stated:

> *If the result of the evidence is that you are satisfied that his practice is better than the practice spoken of on the other side, then it is really the stronger case.*[1]

This seems to leave open the possibility of the court having a more active role in setting the standard of care by objectively evaluating the practice proffered by each of the parties.

Bolitho: the dawn of a new era

Bolitho was a clinical negligence case that reached the House of Lords. The central legal issue was whether or not non-intervention by a doctor caused the plaintiff's injury. The speech by Lord Browne-Wilkinson, in the leading judgment, has potential implications for the way in which the *Bolam* test might be interpreted in the future.

The facts of the case were that Patrick Bolitho, a two-year-old child, suffered catastrophic brain damage as a result of cardiac arrest due to respiratory failure. The senior paediatric registrar did not attend the child, as she ascribed to a school of thought that medical intervention, under those particular circumstances, would have made no difference to the end result. Liability was denied on the grounds that even if she had attended, she would not have done anything that would have materially affected the outcome. This view was supported by an impressive and responsible body of medical opinion. In giving judgment, Lord Browne-Wilkinson said:

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. In particular, in cases involving, as they so often do, the weighing of risks against benefits, 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 on the matter.[12]

Here is an explicit assertion from the highest judicature in the land that the court may want to look beyond *Bolam* and actively assess the calibre and merit of the basis on which the standard is proclaimed.

The key manner by which the judgment in *Bolitho* might impact upon the principle in *Bolam* is that the court is likely to take a much more interventionist stand in appraising the professed standard of care. In practical terms, the first stage would be for the court to assess whether the decision had responsible peer support, based on an approach that was structured, reasoned and defensible. The professed opinion must withstand 'logical analysis'. This broadly reflects the *Bolam* test as it is known. The second stage, and this is where *Bolitho* might really take effect, is to assess on a 'risk analysis' basis the validity of accepting the treatment or course of action offered by the defendant and, more importantly, the validity of rejecting competing decisions. In undertaking such an analysis, the court may look at a number of factors, including the magnitude of the risk, the comparative risks of alternative interventions and treatments, the seriousness of the consequences, the ease by which the risk might be avoided, and the implications of such avoidance in terms of finances and resources of healthcare.

Bolitho applied

In determining the legal standard of care, the court has shown a definite movement towards applying the principle enunciated in *Bolitho* in recent cases. In *Penney*,[13] three women developed cervical cancer, although cyto-screeners had previously reported their cervical smears as being negative. In preferring the evidence provided by experts for the plaintiff, the judge said he did not consider the evidence provided by the defendant experts as standing up to logical analysis because:

[t]*here were admitted abnormalities which, to put it most favourably to the cyto-screener, he could not positively have said they were not pre-cancerous …* [Having] *regard to the potentially disastrous consequences of a mistaken identification, a reasonably competent cyto-screener would have classified the smear as borderline.*[13]

This decision was upheld in the Court of Appeal and, in giving judgment, Lord Woolf said:

In resolving conflicts of expert evidence, the judge remains the judge; he is not obliged to accept evidence simply because it comes from an illustrious source; he can take account of demonstrated partisanship and lack of objectivity.

This demonstrates that a coherent and reasoned opinion of a suitably qualified expert will be weighed and considered against a coherent reasoned rebuttal. By comparing the evidence in such a way, the court would determine what is the appropriate standard of care, using a 'logical analysis' approach.

Marriott further demonstrates how the Court of Appeal took a 'risk analysis' approach in determining the legal standard.[14] The plaintiff suffered head injuries after a fall and was taken to hospital for investigations, and discharged the next day. At home his condition worsened. His GP did not appreciate the seriousness of his condition (the plaintiff had suffered an intracranial bleed) which finally led to residual paralysis and a speech disorder. The defendant's experts argued that the decision to leave the plaintiff at home could be supported on the grounds that the risk of an intracranial lesion was very small. The trial judge, finding for the plaintiff, said that although the risk was very small,

the consequences of things going wrong are disastrous to the patient. In such circumstances, it is my view that the only reasonably prudent course … [would be] *to readmit for further testing and observation.*[14]

The judge added that readmission of the patient would have been particularly appropriate as facilities for further investigation were relatively easily available. The Court of Appeal approved of this decision on the basis of an appropriate judicial exercise in determining the required standard of care by using the 'risk analysis' approach of *Bolitho*.

In Pearce,[15] the issue before the court was whether or not a doctor ought to have informed a pregnant woman at 42 weeks of gestation of the additional risk of stillbirth which was inherent in allowing the pregnancy to continue, thus enabling her to make a fully informed choice. Lord Woolf, in the Court of Appeal, said:

[if] *there is a significant risk which would affect the judgement of a reasonable patient, then in the normal case it is the responsibility of the*

Key Points

In law, the standard of care in medical litigation is determined by the *Bolam* test: a practitioner does not breach the standard if the practice in question is supported by a responsible body of similar medical peers

The court has applied the *Bolam* test to a wide range of medical issues, including diagnosis, treatment, information disclosure and ethics in medicine

The principal criticism of the *Bolam* test is that it has extended beyond its intended limits, and allows the standard in law to be set subjectively by doctors

The case of *Bolitho* imposes a requirement for an explanation of the 'logical basis' underlying the standard of care that is proclaimed

The effect of *Bolitho* is that the court will enquire more closely into the justification of a defendant doctor's practice, based on a logical analysis of why such an opinion was formed, as well as a risk analysis against competing options

doctor to inform that patient of that significant risk, if the information is needed so that the patient can determine for himself or herself as to the course he or she should adopt.[15]

The Court went on to say:

[t]*he doctor, in determining what to tell a patient, has to take into account all the relevant considerations, which include the ability of the patient to comprehend what he has to say to him or her.*

This pronouncement reinforces the contention that peer approval of medical practice alone would not be sufficient to satisfy the standard in law. Furthermore, it places the patient's right to self-determination as foremost, and it is likely that the Human Rights Act 1998 will require judges to pay even more attention to the rights of claimants.

Conclusion

In medical litigation, the test for the standard of care in law expected of doctors is based on the principle enunciated in *Bolam*. Put at its simplest, the test is that a medical practitioner does not fail to reach the standard of care if a responsible body of similar medical peers supports the action in question. The judgment in *Bolitho*, however, suggests a judicial move at the highest level to shift the balance from an excessive reliance on medical testimony supporting a defendant doctor, to a more enquiring approach to be taken by the court. In order to reach its own conclusion on the reasonableness of clinical conduct, the court will arbitrate on the standard in each case. This would operate within the framework of normative values held by society. Patient empowerment is a strong theme in the new health service. This is likely to act as a conjunctive force in shifting the traditional 'accepted practice' approach to one whereby the standard of care is set by the court, on the basis of 'expected practice'. This would be determined by evaluating the reasonableness of competing options.

In practical terms, the court would scrutinise more intensely the basis on which defendant doctors proclaim the standard of care. There would be a requirement to justify this on a 'logical basis'. The court would look for 'logical analysis', and the opinion expressed would have to be coherent, reasoned and evidence-based. The court would also apply a 'risk analysis' approach by seeking justification of the medical decision taken against competing alternatives. The emergence of independent guidance on good practice would enable the court to utilise the *Bolitho* principle more proactively in setting the expected standard of care required of doctors, in cases of medical litigation. In other words, it may no longer be sufficient for a practitioner's actions to be *Bolam*-defensible. The court would seek to determine whether such action is *Bolitho*-justifiable.

The traditional *Bolam* test is unlikely to survive in its basic form. Medical practitioners should recognise that the time has come to say 'byebye to *Bolam*',[11] and to take account of the new requirements created by *Bolitho*.

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