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Trumping Bolam: a critical legal analysis of Bolitho's "gloss"

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Case: Bolitho (Deceased) v City and Hackney HA [1998] A.C. 232 (HL)

*C.L.J. 609 I. INTRODUCTION

THE *Bolam* test of breach - that classic and well-known statement of the law, with its genesis being a defendant's reliance upon a body of responsible peer professional opinion - is the "universal test"¹ of professional (and, in some contexts, non-professional²) negligence. It is qualified, however, by the "gloss"³ that was applied, courtesy of the House of Lords' 1997 decision in *Bolitho v. City and Hackney H.A.*⁴ By virtue of that decision, peer professional opinion which purportedly represents evidence of responsible medical practice can be departed from, if that opinion is determined by the court to be "not capable of withstanding logical analysis", or is otherwise "unreasonable" or "irresponsible".⁵

As has been judicially pointed out, *Bolitho* turned *Bolam* on its axis, in that the court, and not the medical profession, became the final arbiter of medical breach.⁶ Since then, however, it has become a challenging legal question as to *what features* particularly characterise a peer professional opinion as one that is "illogical", "irresponsible", and "indefensible". Such labels are difficult to understand or to apply, unless fleshed out with content. As other academic commentary has rightly noted, although "lower courts are taking notice of [*Bolitho*]", it is *C.L.J. 610 how they apply it that may be causing the trouble".⁷ A precise legal analysis of *Bolitho's* gloss is the focus of this article.

Section II of the article sets the context, by briefly discussing the reasons that *Bolitho's* qualification upon *Bolam* was judicially considered to be necessary insofar as medical diagnosis and treatment by a healthcare professional are concerned⁸ (disclosure of inherent risks is treated differently at law,⁹ and does not form the subject of discussion in this article), and by examining some matters which do not comprise *Bolitho* factors in English law. Then, in light of a close analysis of post-*Bolitho* case law, Section III elucidates and categorises the factors that have indicated, expressly or impliedly, that the requisite logical basis for a defendant doctor's expert medical opinion was absent. The results of that analytical review are surprising in two respects. For one thing, the number of cases in which *Bolitho's* gloss has been invoked (in this article, over 20 such decisions are discussed) is not quite so low as to be labelled "rare"; and for another, the scenarios in which courts have considered *Bolam* evidence to be lacking logical analysis, whilst sufficiently repetitive to comprise recognisable categories, have been reasonably varied too. Section IV concludes.

It is suggested that a close consideration of the *Bolam/Bolitho* framework, of the type undertaken in this article, is timely and important for three reasons. First, "labels" may be signposts for lawyers, but without proper delineation, they are not particularly illuminating (on that point, Lord Bridge's reference to the "convenient labels" of proximity and fairness, in the context of proving a duty of care, also spring to mind¹⁰). How oft-cited labels actually apply in factual situations is crucial for legal clarity, particularly where these labels have been in place now for over a decade, allowing a reasonable body of jurisprudence to develop on the subject. Certainly, *Bolitho* itself does not give much guidance, and no case since has undertaken that analytical exercise either. Secondly, categorisation of the *Bolitho* factors is important to prevent the impression that courts may simply prefer the patient's expert to the doctor's (an approach which is stringently *C.L.J. 611 disallowed¹¹), but in circumstances where some unexpressed *Bolitho* factor has seemingly been responsible for that preference. In several cases since *Bolitho* was handed down, that case has not been explicitly referred to, but the relevant *Bolam* evidence has been discounted, for reasons which suggest that the doctor's expert opinion was not perceived to be defensible. In that regard, unarticulated *Bolitho* factors do not enhance the transparency of the law. Thirdly, given the reminders issued by the Court of Appeal¹² that reasons are to be given for a court's stating that the one side's expert opinion should not be followed, where a

conflict in the expert opinion exists, an articulation of the *Bolitho* factors has a much-heightened importance for courts too.

The law must be much clearer in delineating the correct ambit of the *Bolam/Bolitho* framework than is presently the case. In any dispute involving clinical professional judgment to which *Bolam* properly applies, and in which the court nevertheless prefers the patient's expert evidence to that of the doctor's, there must be a clear articulation as to why that was permissible, if the framework governing medical breach is to retain cogency and consistency.¹³ It is the specific purpose of this article to contribute to that articulation.

II. THE EMERGENCE OF *BOLITHO*

A. The Perceived "Deficiencies" of *Bolam*

To reiterate, if a doctor¹⁴ who is accused of negligence presents expert opinion to the effect that he "has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art",¹⁵ that will absolve the doctor of negligence. Even though it is possible that, upon a close reading of *Bolam*, McNair J. **C.L.J. 612* himself did not intend the doctor's expert's evidence to be *conclusive* of the question of breach,¹⁶ that is certainly how it came to be interpreted - and, on that basis, it was judicially criticised on several counts.

It was said to be "over protective and deferential" toward doctors.¹⁷ It had the potential to be satisfied "by the production of a dubious expert whose professional views existed at the fringe of medical consciousness".¹⁸ There was a perception that the medical profession was "above the law", that the *Bolam* test deprived courts of the opportunity of "precipitating changes where required in professional standards",¹⁹ and that the courts were being "dictated to" rather than exercising their judgment.²⁰ It was said that "professions may adopt unreasonable practices. Practices may develop in professions... not because they serve the interest of the clients, but because they protect the interests or convenience of members of the profession".²¹ More dramatically, there was a view that *Bolam* did not necessarily protect the community against unsafe medical practices, and that more judicial safeguards for the public were required.²² It was contrary to the increasingly "rights-based society" to dismiss patients' concerns as obviously as the *Bolam* test countenanced.²³ Further, it was contended that a judicial scrutiny of medical expert opinion was no different from the type of careful analysis that a judge must make in respect of other professional evidence, be it "a judgment by an accountant, lawyer, underwriter or other professional" - if the court was the final arbiter in respect of these professionals, then so too should it be with the medical profession.²⁴

**C.L.J. 613* In *Bolitho v. City and Hackney H.A.*,²⁵ these numerous concerns were explicitly addressed. Lord Browne-Wilkinson (with whom the other members of the House agreed) stated that:

in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence ... that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts informing their opinions. But 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.²⁶

As a result of this pronouncement, a two-step procedure came to be recognised in English law as being necessary to determine the question of alleged medical breach: first, whether the doctor acted in accordance with a practice accepted as proper for an ordinarily competent doctor by a responsible body of medical opinion; and secondly, if "yes", whether the practice survived *Bolitho* judicial scrutiny as being "reasonable" or "logical". That two-step analysis was explicitly confirmed as being the appropriate one, for example, in *French v. Thames Valley Strategic H.A.*,²⁷ and has been described in other English medical cases, too, as "uncontroversial"²⁸ and as the "correct approach".²⁹ It has also been said to have "considerable force" in the non-medical professional context.³⁰

Perhaps most importantly, where two schools of *Bolam* -reasonable thought have been put forward as explanations of what occurred during the course of medical diagnosis or treatment, courts have not

***C.L.J. 614** been prepared (and nor have they regarded themselves as permitted) to undertake a third stage, viz, a superiority analysis.³¹ This point is briefly explored in the following section.

B. Other Qualifications upon Bolam: When a Patient's Expert Opinion can be Preferred

In one recent medical negligence case, Mackay J. candidly admitted that the task of applying the two-step *Bolam* / *Bolitho* framework can be very difficult for a trial judge: “[a]lthough the test for clinical negligence is well established, it is easy after five days spent listening to extensive evidence, in which such phrases as competent care or sub-standard care are freely used, to forget the test to be applied in these cases and to be drawn into the error of deciding which side has presented the better case for a given course of action.”³²

Nevertheless, as the House of Lords has frequently reiterated,³³ it is *not* for the court to venture into a consideration of two contrary bodies of opinion and to decide a case on the basis of which, of the patient's and the doctor's expert medical opinion, it prefers. If the scenario *is one that involves clinical judgment* to which the *Bolam* test applies, and if the doctor does produce evidence that his practice was supported by such opinion, then, in the words of Sedley L.J., “the judge or jury *have* to accept the opinion of a body of responsible practitioners, unless it is unreasonable [in the *Bolitho* sense]”.³⁴ Once *Bolam* applies, the mere fact of differences in expert opinion cannot lead to a rejection of *Bolam* evidence, as *Bolam* itself acknowledged (“a man is not negligent, if he is acting in accordance with such a practice, merely because there is a ***C.L.J. 615** body of opinion who would take a contrary view”³⁵); and the *Bolitho* test is only to be applied to those circumstances in which a body of medical opinion “cannot be logically supported at all”.³⁶

This point continues to resonate in medico-legal jurisprudence. In a recent 2010 decision,³⁷ the Court of Appeal overturned a finding of negligence against a GP, on the basis that the trial judge had “steer[ed] a course between the two experts”, and had “impose[d] his own opinion, regardless of the practice of the medical profession”,³⁸ in circumstances where the expert opinion called on behalf of the defendant GP could not be faulted under the *Bolitho* test. Leveson L.J. remarked that the trial judge “comes nowhere close to concluding that the view expressed by [the GP's expert] was not a view held by an expert in the field, still less that it was one that was not capable of withstanding logical analysis (as required by the test in *Bolitho*)”, and that it must follow that “unless the judge concluded that [the GP's expert's] genuinely held view could not withstand logical analysis and was thus unreasonable, [the patient] could not succeed.”³⁹ There were no grounds for invoking *Bolitho* in this case, and preferring the patient's expert opinion (*i.e.*, that the patient should have been referred for further investigations on a routine basis, given her repeated complaints of a breast lump) was not a course that was available.

It is worth reiterating at the outset that, apart from *Bolitho*'s operation, there are *three* other scenarios in which *Bolam* evidence will *not* absolve a doctor.⁴⁰ In each of these, it is not a question of merely determining whether there was a respectable body of medical opinion to support the doctor's (non-negligent) version of events. Rather, it is for the court to weigh up the evidence on both sides, and it may properly prefer the evidence of the patient's expert witness to that of the doctor's.

In the first of these scenarios, the *Bolam* test only applies to matters of clinical or professional judgment, or to tasks that require the exercise of special skill and knowledge. *Bolam* itself refers to a doctor acting in “a situation which involves the issue of some *special skill or competence*”,⁴¹ and in *Penney v. East Kent H.A.*, the Court of Appeal reiterated that the defendant cytoscanners there “were exercising skill and judgment in determining what report they should make and, in *that* respect, the *Bolam* test was generally applicable”.⁴² Clearly, clinical judgment on the part of a defendant doctor is frequently manifested - from ***C.L.J. 616** providing contraceptive advice⁴³ to deciding what physical precautions ought to be taken to prevent a suicidal patient from self-harming,⁴⁴ and from determining whether to carry out a further diagnostic procedure upon an already unwell patient⁴⁵ to deciding whether to intervene to deliver a distressed baby via a forceps delivery.⁴⁶ The aforementioned 2010 case of *Ministry of Justice v. Carter* also concerned the exercise of the GP's clinical judgment (*i.e.*, whether a female prisoner ought to have been referred to a breast clinic, following her complaint of a lump in her right breast), and hence (said the Court of Appeal⁴⁷), it properly attracted the operation of the *Bolam* / *Bolitho* framework - albeit that this framework had been applied incorrectly by the trial judge. Obversely, Lloyd L.J. commented in *Gold v. Haringey H.A.* that if the doctor's impugned conduct required no clinical judgment or special skill to be applied, then he “could see an argument that the *Bolam* test should not apply” at all.⁴⁸ This qualification upon *Bolam*'s application has since been applied by the Court of Appeal in the non-medical context,⁴⁹ has been emphasised in academic

medico-legal commentary,⁵⁰ and was the subject of a notable special leave application to the House of Lords in a medical negligence case relatively recently⁵¹ (ultimately refused⁵²). Interestingly, however, some courts have been willing to invoke a *Bolam* assessment in medical scenarios where the judgment under challenge did not appear to be particularly *clinical* at all - involving matters such as hospital staffing levels,⁵³ the nature of questions asked during a medical triage,⁵⁴ and what communications should occur between nursing and medical staff when discharging a patient⁵⁵ - while other courts have been frustratingly unclear about the issue, by **C.L.J. 617* stating that the situation was probably one that did not attract *Bolam*'s operation - but then proceeding to apply the *Bolam/Bolitho* framework, just in case!⁵⁶

As a second qualification, the *Bolam* test only pertains to questions requiring expert opinion, and not to disputes about mere questions of fact.⁵⁷ This is another issue upon which courts have occasionally struggled to articulate the dividing line - for example, questions of fact have included: whether or not a cervical smear slide showed a significant number of abnormal (pre-cancerous) cells,⁵⁸ and whether a patient was displaying sufficient symptoms of infection such that the defendant registrar should have considered treatment by antibiotics earlier than he did.⁵⁹ As Steele points out, the more willing that courts are to classify issues as questions of fact rather than of opinion, the less scope there is for *Bolam* to apply.⁶⁰

In the third of the exceptional scenarios, *Bolam* does not apply where the doctor's expert opinion does not represent the views of a responsible *body* of doctors nor a recognised *practice* within the medical profession.⁶¹

Hence, the *Bolam* test is "universal"⁶² *only* in the sense that it applies well beyond the medical (psychiatric treatment) setting in which it was first articulated in McNair J.'s direction to the jury. However, it is certainly *not* a universal test of medical breach, nor is its ambit of application particularly straightforward in some medical mishaps. It is the qualification which *Bolitho* places upon *Bolam* evidence, however, which is the most legally difficult of them all.

C. Some Preliminary Comments about *Bolitho*'s Gloss

The *Bolitho* test has been intriguing in a number of respects. For one thing, English courts have practically never relied upon precedent to **C.L.J. 618* identify a *Bolitho* -type situation. Cases have been determined very much on a singular, fact-by-fact, basis. Ancillary to that, perhaps, more than a decade after *Bolitho* was handed down, there has been no judicial (or academic⁶³) undertaking of the type of close analytical exercise - of identifying "*Bolitho* factors" - that follows in Section III. It is also striking that some courts have preferred a patient's expert testimony, and have been critical of that provided by the defendant doctor's expert, but have explained their preference in circumstances where *Bolitho* was not referred to at all. In some of these cases, however, *Bolitho* has clearly been "the phantom in the courtroom". Notwithstanding some academic commentary⁶⁴ which suggested that the lack of judicial reference to *Bolitho* meant that "courts might not regard *Bolitho* as having made a change of any great significance", it is contended by this author that *Bolitho* has had a tangible impact on medical jurisprudence, and that the unexpressed instances of its application unfortunately conceal the effect of the "brake" which it is applying to *Bolam*.

Another intriguing aspect of *Bolitho* is that its operation is generally regarded as a "rare" occurrence,⁶⁵ only to apply in exceptional circumstances where "the evidence shows that a lacuna in professional practice exists",⁶⁶ and "extreme".⁶⁷ It has variously been said that peer professional opinion "should not lightly be set aside",⁶⁸ and that it would have to display a degree of "*Wednesbury* unreasonableness" in order for *Bolitho* to be triggered.⁶⁹ However, as stated in the Introduction, the *Bolitho* test, while not *commonly* trumping *Bolam*, has certainly changed the outcome of medical negligence lawsuits in more cases than perhaps the label of "rarity" would suggest.

**C.L.J. 619* Moreover, the *Bolitho* test introduced a notable asymmetry into the litigious challenges facing the adversely-affected patient and the accused doctor. As Tugendhat J. remarked in *Zarb v. Odetoyinbo*⁷⁰ (a case in which Mrs Zarb unsuccessfully sued her GP for failing to refer her to an orthopaedic surgeon before she developed the rare condition of *causa equina* syndrome), suppose that both experts claim that the other side's expert testimony is indefensible and illogical. The doctor's expert only has to persuade the court that his views are capable of withstanding logical analysis, but he does not have to satisfy the court that the views of the patient's expert are *not* capable of withstanding logical analysis. Obversely, however, the patient's expert has to do both, if *Bolitho* is to be applied.⁷¹

It is also worth debunking two matters that are *not Bolitho* factors. First, in *Bolitho*, Lord Browne-Wilkinson's actual terminology was that the doctor's expert medical testimony may be rejected as being "unreasonable". That term, however, must be construed as meaning something other than "merits-based" - for otherwise, a superiority analysis of the merits of conflicting expert opinion would be implicitly condoned. In *Khoo v. Gunapathy d/o Muniandy*,⁷² the Singapore Court of Appeal was particularly alive to this issue, and remarked that the *Bolitho* exception must be *narrowly* construed, if the various House of Lords' statements on the matter were to be honoured:

Interpreted liberally, *Bolitho* could unwittingly herald invasive inquiry into the merits of medical opinion. For if "defensible" were to be given a meaning akin to "reasonable", the *Bolam* test would only be honoured in lip service. A doctor would then be liable when his view, as represented by the defence experts, was found by the court to be unreasonable. We do not think this was the intention of House of Lords in *Bolitho*.⁷³

In fact, there was an earlier suggestion by the English Court of Appeal, in *Joyce v. Wandsworth H.A.*,⁷⁴ that a comparative assessment of reasonableness by the trial judge was permitted (because the Court of Appeal described the judge's role in these terms: "[there is no negligence] [p]rovided that clinical practice stood up to analysis and was not unreasonable in the light of the state of the medical knowledge at the time"⁷⁵). However, as discussed above,⁷⁶ that is clearly *not* the way **C.L.J. 620* in which *Bolitho* has been applied since. Something more than a superiority-of-merits assessment is required, to displace the doctor's *Bolam* evidence.

Secondly, a body of responsible medical opinion which endorses the defendant doctor's conduct may be in the minority⁷⁷ - but still sufficient to satisfy the *Bolam* test. Merely being a minority view of accepted medical practice does not, of itself, render that view "illogical" or "irrational" in the *Bolitho* sense.

III. THE POST-BOLITHO ANALYTICAL REVIEW

A. The *Bolitho* Factors

A detailed scrutiny and analysis of the post-*Bolitho* case law indicates that seven (7) different scenarios have attracted judicial consideration in English law, as to whether the peer opinion adduced by the defendant doctor was illogical, indefensible, etc. Some of these are subject to notable exceptions and caveats, however. Dealing with each in turn:

1. The peer professional opinion has overlooked that a "clear precaution" to avoid the adverse outcome for the patient was available

If the risk of an adverse outcome for the patient could have been easily and inexpensively avoided by *an alternative course* of medical treatment or diagnosis, then the doctor's conduct will be held to be negligent, even if a body of medical opinion did endorse that conduct.

To constitute a *clear* precaution, this *Bolitho* factor contemplates that the precaution should have been obvious as a matter of lay common sense, invoking no particular medical knowledge. In *French v. Thames Valley Strategic H.A.*,⁷⁸ Beatson J. remarked that *Bolitho*'s gloss was more likely to be activated "where a case does not involve difficult or uncertain questions of medical treatment or complex, scientific or highly technical matters, but turns on failure to take a simple precaution the need for which is obvious to *the ordinary person considering the matter*".

That point had already been demonstrated pre-*Bolitho*. In the 1968 case of *Hucks v. Cole*,⁷⁹ the defendant GP (with a diploma in obstetrics) **C.L.J. 621* prescribed a five-day course of tetracycline antibiotics for a new mother, to treat various sores and yellow spots on her fingers and toes, but stopped the treatment when the sores appeared to be improving - notwithstanding that the defendant knew that the septic spots contained streptococcal infection, capable of leading to puerperal fever. The following day, the patient did indeed contract puerperal fever. Negligence was found, on the basis that penicillin ought to have been prescribed. A number of distinguished doctors with obstetric experience gave evidence that they would have followed the GP's practice and would not, in the circumstances, have treated the mother with penicillin (which was capable of killing streptococcal infection). However, Sachs L.J., writing for the Court of Appeal, considered that the GP had not taken "every precaution" to prevent the outbreak of puerperal fever, given the advances in medical science which penicillin represented at the time, and that the views of the GP's expert witness showed "a

residual adherence to out-of-date ideas” which “on examination do not really stand up to analysis”.⁸⁰ The case may have been pre-*Bolitho*, but the philosophy was very much *Bolitho* in action.⁸¹

Post-*Bolitho*, several examples of peer professional opinion understating a “clear precaution” have occurred - where that missed precaution amounted to, say, failing to consult with more experienced specialists about a patient's condition;⁸² failing to ask a series of leading questions, over the telephone, of a mother whose child was ill;⁸³ failing to maintain “good lines of communication” between hospital and cytogenetic laboratory re the genetic testing of a sample;⁸⁴ and failing to assign a negative status to slides unless the “absolute confidence” threshold could be met.⁸⁵ In *Lowe v. Haverling Hospitals N.H.S. Trust*,⁸⁶ *C.L.J. 622 the “clear precaution” was as simple as a more rigorously-arranged series of medical appointments for the patient. The defendant specialist physician arranged for an 8-week gap between two consultations for a patient who had dangerously high and uncontrolled blood pressure (and who then suffered a major disabling stroke). That practice of such widely-spaced appointments was held to be negligent, in that it had failed to take into sufficient account matters such as the patient's unstable and very high blood pressure, “suspicions” that the patient was not diligently taking his prescribed medication, and that the patient was a relatively young man who had a wife and a dependent family, and for whom a disabling stroke would be devastating (a social, rather than a medical, consideration, but one which a reasonable physician ought to have taken into account, said the court). A body of expert medical opinion had supported the conduct of the physician as being acceptable medical practice, but that opinion was explicitly rejected under *Bolitho*.

There is an important caveat to this factor, however. Suppose that there was a precaution open to the defendant doctor, but the patient's and the doctor's experts differ as to how *risky* that precaution would have been - precedent then suggests that the court will be unwilling to interfere with the doctor's judgment. In that event, there will be no “clear precaution”, for both sets of peer opinion withstand logical analysis. For one set of peer opinion, the risk of an adverse outcome should have been prevented by taking the precaution. For the other body of peer opinion, that precaution may have posed an unacceptable risk. This is merely a different weighing of risk.

Hence, in *Macey v. Warwickshire H.A.*,⁸⁷ where a baby was brain-damaged as a result of his negligently-handled birth, and where it was alleged that he ought to have been intubated and ventilated when his respiratory difficulties were noticed, there was a breach for the delay of 45 minutes before medical attention was drawn to his respiratory distress, but there was no breach in failing to intubate and ventilate either before or during his transfer by ambulance to a special baby care unit at a specialist maternity hospital. The obstetrician's peer professional opinion said that intubation would have been a risky and potentially dangerous procedure, particularly during an ambulance journey of some 20 minutes, whilst the patient's peer professional opinion was that it would have been unreasonable not to intubate in these circumstances. The court concluded that “[b]oth points of view are logical and rational; they differ because of different views of the balance of risks” *C.L.J. 623 one way and the other.”⁸⁸ On balance, the obstetrician's expert opinion prevailed on that point. In the same vein, in the aforementioned *French* decision itself⁸⁹ reasonable differences in medical opinion occurred as to how to safely handle the pre-eclampsia from which the patient's mother was suffering. The area was complicated and technical, contemporary literature advised that handling pre-eclampsia was “a matter of opinion and judgment, with few facts or absolute guidelines”, and another source considered that there was “probably no disorder in which the pathological findings are so controversial and contradictory”. These matters meant that the scenario definitely did *not* fall within the “simple precaution” category. The *Bolam* evidence prevailed, and the brain-damaged patient failed to prove any breach of duty. More recently still, *Bolitho* was not applied in a case⁹⁰ where the depressed patient took unescorted leave from a psychiatric facility and threw herself in front of a train at Northwick Park tube station. Given that “[p]sychiatry - perhaps more than any other branch of medicine - is not an exact science”, and that psychiatrists have to make “difficult decisions” about the management, treatment and rehabilitation of patients suffering from a range of mental illnesses and distress, the court expressly rejected an invitation by the claimant to invoke *Bolitho*, and her claim in negligence failed.⁹¹

Thus, to summarise: if the accused doctor's peer professional opinion has overlooked that a “clear precaution” to avoid the adverse outcome was available, *Bolitho* will be invoked - but that outcome is unlikely to occur, to the patient's advantage, if the medical conduct in question involved a high level of complexity and/or uncertainty.

2. A question of resources and conflicts of duty

Whether the body of medical opinion is logical and rational will depend, in part, upon the reality that

doctors owe co-existing duties to other patients, and that hospitals owe co-existing duties to all their employees. Scarcity of resources requires that these conflicting interests are balanced. Where this tension impacts directly upon an adverse outcome for the patient, then no matter how illogical the medical practice may appear on its face, successful reliance by the patient on the *Bolitho* test is unlikely.

In *Garcia v. St Mary's N.H.S. Trust*,⁹² the court considered whether *Bolitho* should be applied, notwithstanding that medical opinion called by *both* sides of the litigation attested that the medical conduct in the **C.L.J. 624* circumstances was reasonable and defensible. The conduct in this case concerned timing and on-call procedures. Mr Garcia (G) underwent heart by-pass surgery, which was completed by 7.00 pm. At 11:53 pm, G coughed to clear secretions, at which point he suddenly lost consciousness, having suffered an acute post-operative bleed into the chest area, a recognised complication to this type of surgery. A "crash call" was placed at 11:54 pm. The anaesthetic team arrived at 11:56 pm. At 11:58 pm, the on-call specialist cardiothoracic registrar was notified at his home. He arrived in the recovery room at 00.25 am. He re-opened the chest at 00:30, and by 00:40 am the bleeding was under control. During that period, and as a result of the haemorrhage, there was hypotension and hypoperfusion of the brain, and G was left brain-damaged. The neurological experts agreed that the length and severity of the hypotension/hypoperfusion determined the neurological outcome, and that, at 15 minutes, there would be no or only slight injury; at 20 minutes, there would probably be significant neurological damage; and that, at 30 minutes or longer, there would be severe neurological damage, as in this case. Hence, G argued that, unless there was an on-call registrar staying at the hospital overnight to deal with such emergencies, then the inevitable delay whilst the registrar made his way to the hospital condemned any patient in his position to severe and irreversible brain damage, and that this was an instance in which the court should invoke the *Bolitho* principle and declare the body of medical opinion to be flawed.⁹³ In response, the court recognised that it was a potential *Bolitho* scenario⁹⁴ - but decided that the body of peer medical opinion was defensible. True it was that to have a surgical registrar on site was likely to have cut the time between crash call and control of the bleeding by almost half⁹⁵ - but even had that been the case:

[it] does not necessarily mean he would be available for Mr Garcia. He might be engaged with another patient in the fast track. He might be engaged with a medical emergency. If an accident came into Accident and Emergency requiring the care of a chest surgeon he might be required for that. Having the surgeon on site does not necessarily signify that he would be available for Mr Garcia. ... I bear in mind that the Trust, operated under the provisions of the National Health Service, has a duty to Mr Garcia to take reasonable care of him and that that duty co-exists together with the duty which is owed to other patients, and also the duty as employers to its own staff.⁹⁶

**C.L.J. 625* All in all, the practice of having no specialist registrar on site was a defensible position, "conform[ing] to that which is reasonable, catering for all to whom the duties are owed".⁹⁷

Other case law also confirms that where the accused doctor has to balance the risks and benefits of treatment to persons *other than the directly-injured patient* - scenarios involving mother and brain-damaged baby,⁹⁸ or as between various mothers in hospital to give birth⁹⁹ - the court will be reluctant to interfere and overturn the doctor's expert medical opinion (that the practice followed by the doctor was defensible) on *Bolitho* grounds.

3. Failure to weigh the comparative risks and benefits of the chosen course of conduct

It is plain from Lord Browne-Wilkinson's judgment in *Bolitho* itself that the principal way in which the defendant doctor's peer medical opinion will be rejected is where that peer opinion failed to take into account the risks and benefits of the doctor's conduct and of the conduct which the patient alleges *ought* to have been practised:

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.¹⁰⁰

Although related to scenario 1. above, this factor entails a more explicit attention to whether the doctor's expert testimony properly assessed the *comparative* risks/benefits. As Cranston J. noted in *Birch v. University College London Hospital N.H.S. Foundation Trust*, the fact **C.L.J. 626* that two bodies of medical opinion weigh benefits and risks differently does not impute negligence - but if there

is a *failure* to weigh those risks and benefits by the experts who are sanctioning the doctor's conduct, that will invoke *Bolitho's* application.¹⁰¹ The Singapore Court of Appeal put it like this: it is the *process*, rather than the result, that brings down the expert evidence, if that expert has not considered and weighed all the countervailing factors relevant to the issue.¹⁰²

A significant number of decisions now demonstrate this *Bolitho* factor in practice.¹⁰³ For example, in *Kingsberry v. Greater Manchester Strategic H.A.*,¹⁰⁴ where a cardiotocograph (CTG) trace¹⁰⁵ indicated the presence of complicated tachycardia and foetal distress, the proper risk/benefit analysis indicated that a trial of forceps should have been carried out in theatre to deliver a baby (who was ultimately severely brain damaged), rather than attempting to deliver the baby by manual rotation and forceps delivery. This was notwithstanding that peer professional opinion was given, on behalf of the defendant obstetrician, that there was a practice, in 1985, *not* to perform a trial of forceps in these circumstances. That expert opinion did not carry the day: "it does not withstand logical analysis".¹⁰⁶

***C.L.J. 627** This *Bolitho* factor has an important caveat, however. Typically, the peer opinion adduced by the patient, as to what the doctor ought to have done according to accepted medical practice, seeks to advocate a course of action that would have minimised or eliminated the risk altogether. It is not, however, the standard of perfection, but of *reasonableness*, which is required by law. Hence, if the patient's argument is that the doctor should have done x, with very small to nil risk to the patient, but such practice would lead to *unworkable* systems of medical practice, then that is not a *Bolitho* scenario. It will not be irrational or illogical for the doctor to have declined to practise what the patient advocated, because the reasonable exercise of clinical judgment does not require reducing risk to zero or close to it. In *Garcia's* case,¹⁰⁷ for example, the risk of post-operative bleeding into the chest area following heart by-pass surgery was 1 in 1,000. Was it worth having a specialist registrar on site for such an event, one who could arrive in the operating theatre much more quickly than an on-call but offsite registrar could manage? The court held not, because "[s]ystems and resources obviously have to be designed in order to accommodate what is reasonably to be foreseen, always bearing in mind that the unexpected sometimes occurs, and, therefore, should come within the range of the foreseeable." It followed that "the whole system obviously has to be framed to deal with that which is reasonably foreseeable ... [and not] framed to deal with the possibility that a rare occurrence will happen".¹⁰⁸ For the same reasons, some courts have held that the situation surrounding a difficult birth, leading to catastrophic injuries to the newborn, may have been far-from-perfect, but nevertheless peer support for the obstetricians' conduct could not be attacked on a *Bolitho* basis.¹⁰⁹

It is also important to appreciate that there is a subtle difference between what *Bolam* expects of the defendant doctor, and what *Bolitho* expects of the expert "responsible body of medical opinion". Certainly, the expert opinion will not be sanctioned as being responsible and defensible unless that opinion has weighed the comparative risks and benefits of the doctor's conduct and what alternatives may have been available to avoid the adverse medical outcome. By contrast, however, it is not required, under the *Bolam* test, that a doctor should explicitly consider, reflect upon, and then reject, all other avenues of medical treatment open to the patient. The English High Court dealt with the point explicitly in *Smith v. West Yorkshire H.A. (t/a Leeds H.A.)*,¹¹⁰ and ***C.L.J. 628** held that the *Bolam* test does *not* require the doctor to "second-guess" what other peer professionals may think, and then conduct himself so as to make a conscious choice between the opinions, in order to preclude a finding of negligence. It is sufficient that the doctor acts according to a practice that was accepted as proper by a reasonable body of persons who practiced the same art. In *Smith* itself, at issue was how medical staff should have interpreted CTG readings during the mother's labour (the baby boy suffered from quadriplegic cerebral palsy, allegedly as a result of the negligently-handled birth). The patient's case¹¹¹ was that a responsible body of professional opinion took the view that the CTG trace was of a baby who was unwell; but another body of professional opinion (in support of the defendant obstetrician) considered that the trace was of a baby who was well; and hence, if there were different bodies holding respectable, but significantly different, opinions on CTG trace interpretation, the obstetrician's conduct was compromised by the fact that he failed to take into account that other respectable opinion could reasonably take a different view. The court considered this submission untenable, as an unacceptable re-writing of *Bolam*: "[t]he claimant's submission, if correct, would drastically alter the law of negligence".¹¹²

Indeed, in a non-medical case,¹¹³ the English Court of Appeal had, by majority, earlier concluded that there was no difference between a doctor who decided to follow a particular practice because, on the basis of his experience, it was a reasonable and accepted medical practice, and one who sat down in a chair and mused upon *all* the alternative practices open to him and then consciously selected the one to follow. If sued for alleged negligence, both defendants would escape a finding of breach if their

conduct accorded with accepted medical practice. (By contrast, the dissenter, Sedley L.J., considered it to be a “requirement of the *Bolam* test” that the defendant doctor consider and evaluate the alternatives.) Hence, it is something of an oddity in medical negligence jurisprudence (but probably reflective of “practical medicine”) that the doctor's expert must have directed his attention to the alternative courses of clinical judgment that could have been exercised to avoid the adverse outcome for the patient before his support for the doctor's conduct is *Bolitho* -defensible, whereas the doctor himself, when acting “at the coalface”, can afford to be less considered.

To summarise this factor, the *Bolitho* exception will be invoked to overrule *Bolam* evidence where the defendant doctor's expert evidence did not undertake a comparative risk/benefit analysis of that doctor's **C.L.J. 629* conduct and of any alternative course that would probably have avoided the adverse outcome. However, the law will not insist upon a course of conduct (via *Bolitho*) that completely eliminates the risks of an adverse outcome; and nor does the law require the doctor himself to have considered, and rejected, all alternative diagnoses or treatments, in order to rely successfully upon *Bolam*.

4. Where the accepted medical practice contravenes widespread public opinion

It will be recalled¹¹⁴ that one of the reasons advocated for judicial scrutiny of *Bolam* peer opinion was to safeguard community expectations of acceptable medical practice. Hence, expert testimony which fails to meet such expectations (as the court perceives these to be) will invoke a *Bolitho* overrule.

In the case of organ retention that had occurred in hospitals in Leeds and elsewhere, and which culminated in the *Nationwide Organ Retention Group Litigation*,¹¹⁵ the issue was whether pathologists were negligent in failing to inform the relatives (mainly parents of children who had died either at, or shortly after, birth) that, at post-mortem examinations of their children, some organs might be removed and retained for later scientific study. A national outcry arose when this practice of harvesting and retaining hearts and brains came to light, and where the parents had been deprived of an opportunity to object or to refuse. The jointly-agreed expert evidence was that, when this happened in 1992, the practice was “not to be explicit with parents about the details of the post-mortem examination”, and that this was “in keeping with the accepted practice of the day”.¹¹⁶ Furthermore, according to one expert called by the defendants, no parent ever raised any questions about the process of a post-mortem; it had “never struck the profession that people were concerned about whether the heart or brain was actually with the rest of the body”; and pathologists involved in the post-mortems “genuinely believed that they were acting in the best interests of these parents”.¹¹⁷ However, the court accepted the parents' claim that *Bolam* could not operate to defend this medical practice. Even if universally accepted, the “blanket practice” was unreasonable, especially given that it was applied without any case-by-case therapeutic judgment as to each parent's ability to cope with any organ-retention proposal put to them by the relevant doctors.¹¹⁸ **C.L.J. 630* The parents had called the medical practice “irresponsible conservatism” on the part of the medical profession, but notably, Gage J. expressly disagreed, remarking that the defendant doctors in this case were “conscientious and careful practitioners who at all times sought to act in the best interests of their patients” and that “much of the care provided was in the vanguard of best practice in respect of bereaved parents”.¹¹⁹ Nevertheless, the very fact of the national scandal that gave rise to the group litigation in the first place was probably an indicator as to how indefensible the practice was, in the public's eyes.¹²⁰

Thus, it is apparent that the *Bolitho* exception permits the community's expectations to be taken into account where the question of medical breach is concerned. Perhaps more than any other *Bolitho* factor, this one aptly demonstrates Lord Tomlin's oft-cited caution that “[n]eglect of duty does not cease by repetition to be neglect of duty.”¹²¹

5. Where the doctor's peer medical opinion cannot be correct when taken in the context of the whole factual evidence

Lord Woolf MR has noted extra-curially that the phrase, “Doctor knows best”, should now be followed by the qualifying words “if he acts reasonably and logically and gets his facts right”.¹²² The same caveat applies to the peer professional opinion adduced in a medical trial. In some instances in which such opinion has been rejected by the courts and breach found, the *Bolitho* “found-to-be-wanting-in-logicalanalysis” reasoning has been expressly or implicitly applied, when the factual context was considered as a whole.

As explained earlier in the article,¹²³ disputes between conflicting expert testimony on questions of

fact should not attract the *Bolam/Bolitho* framework at all. This *Bolitho* factor is different, however, in that it applies where the defendant doctor misinterprets the facts (and the expert testimony supports the doctor in circumstances where the court considers that to have been illogical) or where the doctor's expert proceeds to support the defendant doctor's conduct in circumstances where that expert himself has proceeded upon a mistaken fact. In either case, the expert testimony cannot be logically sustainable or defensible.

The case of *Lillywhite v. University College London Hospitals' N.H.S. Trust*¹²⁴ is arguably an example of the first type of "mistake" in expert **C.L.J. 631* testimony (although the *Bolitho* test was not expressly cited to discount the evidence adduced on behalf of the defendant specialist sonologist here). The patient, baby Alice, was born with a severe malformation of her brain, caused by the failure of her fore-brain to divide into two, early in her foetal development. As a result, she was severely brain-damaged, quadriplegic, and unable to use her limbs or to talk. The trial judge held that there had been no negligence on the sonologist's part in failing to identify that three parts of the brain - the cavum septum (CSP), the anterior horns from the lateral ventricles, and the falx - were absent. Peer medical opinion adduced at trial on the defendant's behalf (which the trial judge accepted), was that the sonologist must have identified echoes mimicking the brain structures that he was seeking to find. The Court of Appeal overturned this finding (by majority¹²⁵), holding that these explanations "were neither possible nor plausible ... In the case of the falx and the CSP the explanations were not possible when looked at in the context of the evidence as a whole".¹²⁶ Other cases where a defendant doctor proceeded upon a mis-diagnosis of the facts have expressly attracted the application of *Bolitho*, rejection of that doctor's expert testimony, and liability on the part of the defendant.¹²⁷

An example of the second type of mistake - and where the court took a fairly dim view of *Bolam* evidence where it was based upon an incorrect factual premise as to what, precisely, happened during surgery - occurred in *Tagg v. Countess of Chester Hospital Foundation Trust*,¹²⁸ where the patient suffered a bowel injury during a gynaecological operation. Not only was the defendant surgeon's expert testimony "neutralised by the unreliability of the factual evidence about what happened ... at the operation on 13 March 1999", but also the surgical expert had assumed that the surgeon had performed a certain procedure for purpose X (placing a patch over a thinned area of bowel to strengthen the bowel wall), whereas it had come to light at trial that it was done for purpose Y (to prevent further adhesions).¹²⁹ Although *Bolitho* was not expressly referred to, these misunderstood facts and misplaced assumptions meant that the expert's opinion did not exculpate the surgeon, and breach of duty was found. Similarly, if an expert assumes that the defendant obstetrician was present at the time that a patient was discharged into the care of a community mid-wife, and **C.L.J. 632* the defendant was not, then any assessment by the expert that what occurred was responsible obstetric practice can be *Bolitho* -flawed.¹³⁰

Hence (and as the Singapore Court of Appeal has articulated too in *Khoo v. Gunapathy d/o Muniandy*¹³¹), where peer professional opinion ignores or controverts known medical facts or extrinsic facts, *Bolitho* will be activated.

6. Where the doctor's expert medical opinion is not internally consistent

In *Khoo*, the Singapore Court of Appeal helpfully sought to flesh out the meaning of the *Bolitho* gloss, and in so doing, it further observed that:

the medical opinion must be internally consistent on its face. It must make cogent sense as a whole, such that no part of the opinion contradicts with another. A doctor cannot say, for example, that he supports a certain approach and attest that in that very situation, he would nevertheless have done quite the opposite.¹³²

This result had earlier been illustrated in the English case of *Hunt v. N.H.S. Litigation Authority*,¹³³ a case of a difficult birth, where the question was whether a forceps delivery should have been proceeded with, when the CTG was showing signs of foetal distress. The expert called for the defendant obstetrician gave evidence that, were a forceps delivery to be regarded as appropriate in this type of case (as the patient had contended), then "untold damage would be caused to the maternal population" - but then conceded that a forceps delivery could have been carried out without difficulty, and that 10% of cases involving this type of scenario did proceed by forceps delivery. The court regarded the evidence as lacking a logical basis, and "extreme", and rejected it, explicitly relying on *Bolitho*.

The same rationale applies where, say, the defendant's expert says, "I wouldn't do it the way [the

defendant surgeon] did it ... [but] I don't think he was remiss in doing it that way";¹³⁴ or where the court was satisfied that the expert "lost sight of his overriding duty to the court in the heat of the forensic moment and allowed himself to be an advocate of a position which he did not really believe";¹³⁵ or where the court's **C.L.J. 633* view of the defendant's expert evidence amounted to this: "though what the team did was plainly contrary to established 'as taught' practice, and was illogical and useless in physiological terms, most or many other doctors would do the same in an emergency ... I cannot accept this proposition".¹³⁶ In none of these cases did *Bolam* evidence carry the day.

Some internal inconsistency was also evident in the *Organ Retention Litigation* ¹³⁷ - if the jointly-prepared expert opinion agreed that parents were entitled to have their wishes about their deceased children's bodies respected and complied with, Gage J. could not perceive how that was possible, without the parents being told of the fact that their children's brains and hearts might be retained post-mortem.¹³⁸

A further type of inconsistency may occur where the doctor's expert agrees with broad areas of the patient's expert, and yet *still* concludes that the doctor's conduct represented acceptable medical practice. This type of problem was particularly evident in *Smith v. Southampton University Hospital N.H.S. Trust*.¹³⁹ Ms Terrosina Smith underwent a radical hysterectomy and the associated removal of potentially cancerous pelvic lymph nodes, during which one of the defendant surgeons accidentally cut or tore the right obturator nerve, which controls the adductor muscles of the right leg. Together with other (non-negligent) injuries sustained in the operation, Ms Smith was left with significant disabilities. In relation to the obturator nerve incident, the trial judge found¹⁴⁰ that the surgeon had not been negligent, but on appeal, this finding was reversed.¹⁴¹ The allegation turned on the question of whether the surgeon had been parting tissue using closed scissors, or whether he had slightly opened the scissors at a time when he could not see their tips and the extremely sharp tips of the open scissors had come into contact with Ms Smith's right obturator nerve, severing it. Ms Smith's expert gave evidence that the points of a surgeon's scissors in this operation should have been kept closed when not in view, and that damage to the right obturator nerve from partially opened scissors was sub-standard surgery. The surgeon's expert agreed: "exposed scissor blades are a common part of our surgical practice and they really should be only exposed when fully visible to the operating surgeon" and "the commonest reason why the obturator nerve is damaged is that it does come into contact with an incompletely closed pair of **C.L.J. 634* scissors".¹⁴² However, that latter expert then concluded that to have the scissors partially opened (if that is what occurred) was not sub-standard surgical practice. The trial judge accepted the evidence of the surgeon's expert on this point. She agreed with the view that damage to the obturator nerve "is a recognised complication of a radical hysterectomy", and explicitly relied on the *Bolam* test to exculpate the surgeon from negligence, stating that his expert was "knowledgeable, skilled and experienced in the field of gynaecology. His opinion was based upon experience of this procedure and the difficulties encountered by surgeons. ...No one has suggested that [the expert] does not represent the view of a responsible body of gyn-oncological surgeons. Accordingly the claimant has failed to satisfy the test for negligence in respect of damage to the right obturator nerve."¹⁴³

However, the Court of Appeal disagreed with this analysis, held the surgeon to be negligent, and rejected that defendant's *Bolam* evidence. According to Wall L.J. (with whom the other judges agreed):

[The trial judge] appears to rely exclusively on the *Bolam* test. Thus, she merely says that [the surgeon's expert] is highly reputable and that it had not been suggested that he did not represent the view of a responsible body of gyn-oncological surgeons. With great respect to the deputy judge, I do not think this is good enough. *Where there is a clear conflict of medical opinion, the court's duty is not merely to say which view it prefers, but to explain why it prefers one to the other.* This, in my judgment, is all the more so when the expert whose view is preferred accepts a substantial element of what the less favoured expert describes as basic good practice - in this case, keeping your scissors shut unless you can see what you are doing. In such circumstances, it is not sufficient, in my view, simply to say that [the expert] is representative of a responsible body of medical opinion and that, as a consequence, the surgeon was not negligent."¹⁴⁴

With respect, this passage is somewhat confusing. In cases to which *Bolam* applies (and this aspect of Ms Smith's operation was explicitly described as involving medical "practice", within the ambit of *Bolam*), the court is **not** permitted to prefer the patient's body of opinion over the defendant doctor's and conclude negligence on that basis - *Maynard*, *Bolitho* and *Sidaway* explicitly prohibit that course.¹⁴⁵ However, although *Bolitho* was not referred to, the inconsistency in the testimony of the surgeon's expert meant, in effect, that it could not be determinative of the question of negligence. Once that

expert had conceded that a surgeon's scissors ought to have been kept shut if they were out ***C.L.J. 635** of sight and the surgeon could not see what he was doing, and given that the damage to the obturator nerve was more likely than not caused by their being apart/open, then it was presumably illogical and indefensible to opine that the practice of holding the scissors slightly open was acceptable medical practice. It is a marked pity that the Court of Appeal was not clearer in its reasoning in respect of this part of the case.

Although often not attributed to the *Bolitho* judgment, it is submitted that the Singapore Court of Appeal is correct when it suggests that a body of medical opinion adduced on behalf of the defendant doctor cannot withstand logical analysis when it is internally inconsistent on its face. The clarity of English judgments would benefit from a more explicit recognition of this *Bolitho* factor.

7. The peer professional opinion has adhered to the wrong legal test

If the peer medical opinion called by the defendant doctor applies the wrong legal test, so that the expert asks himself whether the defendant achieved, say, a lower-than-reasonable standard of care (i.e., the expert peer opinion has referred to the wrong standard of care, when contending that the doctor's conduct met that standard), then the expert has not adhered to the *Bolam* test at all. In that event, the evidence given by the expert will fail as indefensible, and *Bolitho* will be activated.

Although this may be regarded as an almost unthinkable error, it has indeed occurred in English medico-legal jurisprudence. For example, in the case of *Hutchinson v. Leeds H.A.*,¹⁴⁶ the court had to consider whether the defendant surgeon had allowed faecal impaction to cause the disintegration of the patient's posterior-rectal wall, thereby requiring the patient, a young woman who was being treated for acute myeloblastic leukaemia, to undergo surgery and to have a colostomy. The peer opinion adduced on behalf of the surgeon was not accepted, because "[i]n my judgment, [the expert] was adopting a standard... that is not the standard adopted by the law. To say that before a doctor is guilty of a breach of his duty of care he has to be found to have committed an error so gross and/or so crass that no reasonably competent doctor would ever have committed, is not the standard adopted by the law as set out in *Bolam*, *Maynard* or *Bolitho*."¹⁴⁷ A breach was found, and the *Bolam* evidence was rejected, principally because the expert "set a yardstick" by which to assess the acts or omissions of the surgeon and the surgical team, which was incorrect.

***C.L.J. 636 B. More than a Matter of Credibility**

As a final point, some real inconsistency has emerged in English judgments about the assertion, "the doctor's expert is very eminent in his field, and therefore, how could he not represent the views of a responsible body of medical opinion?". After all, in *Bolitho* itself, Lord Browne-Wilkinson suggested that it would "very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable",¹⁴⁸ such that the defendant's expert opinion triggered the operation of the *Bolitho* trump card.

Typical of the issue is the decision in *Wiszniewski v. Central Manchester H.A.*,¹⁴⁹ a birth-related negligence suit, in which the defendant obstetrician's expert evidence was that a respectable school of obstetricians would not have conducted further investigations and moved immediately to intervene in the birth by means of a Caesarean section, at signs of possible trouble with the foetal heartbeat. The trial judge preferred the patient's expert testimony that investigations and earlier intervention should have occurred, and found the obstetrician negligent, explicitly on the basis that the obstetrician's expert evidence lacked logical analysis: "[t]he risks of not acting were too great and the downside very small." Hence, the trial judge performed the very type of comparative risk/benefit analysis which Lord Browne-Wilkinson advocated in *Bolitho* itself (and which was handed down just after the trial judge's decision). However, the trial judge's findings on this point were overturned on appeal, partly on the basis that the very eminence of the defendant's experts rendered the *Bolitho* test difficult to satisfy. Brooke L.J. (writing for the Court of Appeal) considered that the case "falls unquestionably on the other side of the line" from the type of expert testimony that lacks a logical basis, referred to the fact that the relevant expert was "an eminent consultant and an impressive witness", and noted that it was wrong and "quite impossible" to have concluded that the defendant's expert's views as to how the birth should have been managed could not be logically supported by responsible doctors.¹⁵⁰ (Ultimately, though, breach was upheld on a different basis.)

Of course, if this type of deferential attitude towards the defendant's experts were to prevail (and other judges continue to remark that it will be very difficult to apply *Bolitho* where a distinguished expert in the field considered the accused doctor's treatment or diagnosis to be a reasonable one¹⁵¹), then

there would be very little scope for *Bolitho's* *C.L.J. 637 application at all. In that regard, some commentators have considered the *Bolitho* test as going to the heart of the credibility of an expert witness, that "[o]nce the credibility of that expert has been tested, there is a more limited scope for rejecting professional opinion",¹⁵² and that *Bolitho* -type cases pertain more to "an assessment of the credibility of the witness rather than a true assessment of common practice".¹⁵³

However, as seen by the foregoing analysis in this Section, the categorisation of *Bolitho* factors covers a range of scenarios in which the expert evidence was not defensible, and while some of those factors (e.g. , where the expert endorses a practice that he or she personally would "never practise") do pertain to credibility, others require a close examination of the reasons as to why experts (however eminent they might be) advocated certain medical diagnosis or treatment for that patient which have nothing whatsoever to do with credibility (e.g. , the comparative weighing of risks and benefits).

IV. CONCLUSION

It has often been said that the temptation to treat a grievously-injured patient with sympathy and hindsight must be sternly resisted¹⁵⁴ - and so too, these must not trump a consistent exposition of legal principle. In that regard, the precise meaning to be attributed to *Bolitho's* labels - in circumstances where there is a conflict of expert medical opinions, and the court is being asked to prefer that of the patient's - requires close analysis, if the law's assessment of medical breach is to retain cogency and clarity.

In totality, seven factors have emerged, post-*Bolitho*, by which to test whether Lord Browne-Wilkinson's labels - "illogical" and "irrational" - can be made out, so as to overrule approved medical practice under the *Bolam* test. In short, the court must consider whether the doctor's expert testimony:

- took account of a clear and simple precaution which was not followed but which, more probably than not, would have avoided the adverse outcome;
- considered conflicts of duties among patients, and resource limitations governing the medical practice;
- *C.L.J. 638 weighed the comparative risks/benefits of the medical practice, as opposed to other course(s) of conduct;
- took account of public/community expectations of acceptable medical practice;
- was correct in light of the factual context as a whole;
- was internally consistent;
- adhered to the correct legal test governing the requisite standard of care.

If the answers to any of these is "no", then a "red flag" should arise, because it then constitutes a ground upon which English courts, over the past decade, have been prepared to reject peer medical opinion as being indefensible.

The stated purpose of this article has been to flesh out the *Bolitho* "labels" of "irresponsible", "irrational", or "lacking a logical basis" with recognisable scenarios by which to identify when *Bolam* evidence may be attacked and, ultimately, disregarded. In circumstances of clinical judgment to which *Bolam* properly applies, where the court is faced with two bodies of peer professional medical opinion, and prefers the patient's, then explaining that preference on the basis that the defendant's expert opinion lacks a logical basis (and why it does) should be judicially articulated, to avoid any potential confusion between exhibiting a preference for the patient's case (impermissible) and the invocation of *Bolitho* (permissible). Moreover, the application of *Bolam* beyond the bounds of medical negligence¹⁵⁵ renders the clarification of *Bolitho's* gloss of wider moment for professional negligence law as a whole.

In an age when patient-based rights seem to be in the ascendancy, it is worthwhile emphasising that the medical profession has "rights" too - one of which is a clear exposition and application of legal principle as to when, and why, *Bolam* evidence will not "carry the day" and absolve a defendant doctor of breach.

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C.L.J. 2010, 69(3), 609-638

1. *Williams & Co. Ltd. v. Michael Hyde & Ass. Ltd.* [2000] Lloyd's Rep. P.N. 823, 830, referring to: *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 583, 587. The *Bolam* test now applies to any profession which requires special skill, knowledge or experience: *Gold v. Haringey H.A.* [1988] Q.B. 481, 489; *Edward Wong Finance Co. Ltd. v. Johnson Stokes & Master (a firm)* [1984] A.C. 296.
2. *Adams v. Rhymney Valley DC* [2000] Lloyd's Rep. P.N. 777, at [42] (Sir Christopher Staughton and Morritt L.J., Sedley L.J. dissenting) (re window design and fire escape). *Cf.* : *Buck v. Nottinghamshire Healthcare N.H.S. Trust* [2006] EWCA Civ 1576, at [36] (*Bolam* does not determine question of breach of hospital towards staff).
3. The terminology used, *e.g.* , in: *Joyce v. Merton Sutton and Wandsworth H.A.* (1995) 27 B.M.L.R. 124, 137; *Rampling v. Haringey H.A.* (Q.B., 30 July 1996); *Birch v University College London Hospital N.H.S. Foundation Trust* [2008] EWHC 2237 (Q.B.), at [54].
4. [1998] A.C. 232 (Lord Browne-Wilkinson delivered the judgment of the House, on behalf of Lords Slynn, Nolan, Hoffmann and Clyde, on 13 November 1997).
5. These phrases are to be variously found in the judgment, *ibid.* , at 238, 241 and 243. The phrase, "respectable body of professional opinion", was also cited by Lord Browne-Wilkinson, at 241, with reference to Lord Scarman's terminology in the earlier decision, *Maynard v. West Midlands Regional H.A.* [1984] 1 W.L.R. 634, 639.
6. *Kingsberry v. Greater Manchester Strategic H.A.* [2005] EWHC 2253, 87 B.M.L.R. 73, at [11].
7. R. Heywood, "The Logic of *Bolitho*" (2006) 22 Professional Negligence 225, at 234.
8. In *Maynard v. West Midlands Regional H.A.* , Lord Scarman paraphrased the *Bolam* test as applying "in the realm of diagnosis and treatment" [1984] 1 W.L.R. 634, 638 (emphasis added); and in *Bolitho*, Lord Browne-Wilkinson referred to *Bolam*'s test as a question of whether "the defendants' treatment or diagnosis accorded with sound medical practice": [1998] A.C. 232, 241 (emphasis added), and at 242.
9. For recent discussion of *Bolam* in failure-to-disclose-inherent-risks litigation, see: *Birch v. University College Hosp. N.H.S. Trust* [2008] EWHC 2237, 104 B.M.L.R. 16, and earlier: *Pearce v. United Bristol Healthcare N.H.S. Trust* (1998) 48 B.M.L.R. 118; *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] A.C. 871. For commentary on *Birch*, see, *e.g.* : R. Heywood, "Medical Disclosure of Alternative Treatments" [2009] C.L.J. 30.
10. *Caparo Industries plc v. Dickman* [1990] 2 A.C. 605, 618. See too, Lord Bingham's statement about labels in *Commrs of Customs and Excise v. Barclays Bank plc* [2006] UKHL 28, [2007] 1 A.C. 181, at [6].
11. Per the authorities cited at note 33 below.
12. *English v. Emery Reimbold & Strick Ltd.*; *D.J. & C. Withers v. Ambic Equipment Ltd.*; *Verrechia v. Commr of Police of the Metropolis (Practice Note)* [2002] EWCA Civ 605, [2002] 1 W.L.R. 2409, and see, too: *Flannery v. Halifax Estate Agencies Ltd.* [2000] 1 W.L.R. 377 ("the judge must enter into the issues canvassed before him and explain why he prefers one case over the other. This is likely to apply particularly in litigation where ... there is disputed expert evidence"), cited in *Withers*, at [6]; *St George v. Home Office* [2008] EWCA Civ 1068, [2009] 1 W.L.R. 1670. In the medical context, see: *Glicksman v. Redbridge Healthcare N.H.S. Trust* [2001] EWCA Civ 1097, 63 B.M.L.R. 109, at [10]-[11], for a discussion of the importance of due judicial process, and the safeguards which careful judicial rebuttal of experts' views provide. See too: B. Moxon Browne QC, "Butterfingers and the *Bolam* Test: Can *Bolam* Apply to Simple Clumsiness by the Doctor?" [2008] Injury Times (2 Temple Gardens).
13. Albeit that there is no property in a witness, and under the Civil Procedure Rules, r. 35.3(1) and (2), the role of the expert is now "to help the court on the matters within his expertise", so that this "duty overrides any obligation to the person from whom he has received instructions or by whom he is paid". See, further, on this point: *Royal Brompton Hosp N.H.S. Trust v. Hammond (No 2)* [2002] All E.R. (D) 189 (T.C.C.), at [22]; and Moxon Browne QC, *ibid.*
14. Throughout this article, references to the masculine gender import references to the feminine gender, unless otherwise indicated by the context.
15. *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 583, 587 ("*Bolam*"). The test was derived from McNair J.'s direction to the jury.

16. This point was alluded to, e.g., by Warner J. in *Taylor v Warners* (Ch.D., 21 July 1987), citing that part of McNair J.'s judgment in *Bolam* which states: "it is not essential for you to decide which of two practices is the better practice, as long as you accept that what the defendants did was in accordance with a practice accepted by responsible persons; 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 a stronger case": [1957] 1 W.L.R. 583, 587-588. See too: I. Kennedy and A. Grubb, *Medical Law*, 3rd ed., (London 2000), p. 427.
17. *Foo Fio Na v. Dr. Soo Fook Mun* [2007] 1 M.L.J. 593, [2006] M.L.J.U. 518 (Fed. Ct. of App., 29 December 2006), at [26]. This view was also posed by J. Fleming, *The Law of Torts*, 9th ed., (Sydney 1997), p. 121.
18. *Khoo v. Gunapathy d/o Muniandy* [2002] 2 S.L.R. 414, at [63].
19. *Hajgato v. London Health Assn* (1982), 36 O.R. (2d) 669, 693.
20. *Burne v. A* [2006] EWCA Civ 24, at [10].
21. *F v. R* [1983] 33 S.A.S.R. 189 (Full Ct.) 191, per King C.J. (this was also a disclosure, not a treatment, case). Also: *Scott v. Lothian University Hospitals N.H.S. Trust* [2006] Scot. C.S. (O.H.), at [33], [36] ("Professional practice is not conclusive evidence of the prudence of a course of action where that practice, which a profession has adopted as a matter of its own convenience, involves risks that are foreseeable and readily avoided").
22. See, e.g.: *Shakoor v. Situ* (2000) 57 B.M.L.R. 178, 184 (using a hypothetical example only of prescribing arsenic). See too: Ipp Committee, *Review of the Law of Negligence: Final Report* (2002), at [3.10] and [3.24], citing cervical smear results and subsequent cancer treatment in New Zealand: *Committee of Enquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters* (1988).
23. Lord Woolf, "Are the Courts Excessively Deferential to the Medical Profession?" (2001) 9 Med L. Rev. 1, at 3.
24. *Wisniewski v. Central Manchester H.A.* [1998] EWCA Civ 596. [no pp]; *Kamalam a/p Raman v. Eastern Plantation Agency (Johore)* [1996] 4 M.L.J. 674. See too: I. Kennedy and A. Grubb, *Medical Law*, 3rd ed., (London 2000), p. 425 (*Bolam* gave "exceptional prominence to expert evidence"); E. Jackson, *Medical Law: Text, Cases and Materials* 2nd ed., (London 2010), p. 120 (Some post-*Bolam* cases showed "excessive deference").
25. [1998] A.C. 232. For a previous similar reasoning, see: *Hills v. Potter* [1985] 1 All E.R. 643, 728.
26. *Ibid.*, at 243. For academic commentary at the time, either emphasising or debunking the effect that *Bolitho* would have on the law of professional breach, see, e.g.: H. Teff, "The Standard of Care in Medical Negligence: Moving on from *Bolam*" (1998) 18 O.J.L.S. 473; A. Grubb, "Negligence: Causation and *Bolam*" (1998) 6 Med. L. Rev. 378; M. Brazier and J. Miola, "Bye-Bye *Bolam*: A Medical Litigation Revolution?" (2000) 8 Med. L. Rev. 85; J. Keown, "Reining in the *Bolam* Test" (1998) 57 C.L.J. 248; N. Castle, "Applying *Bolitho*" [1998] J. of Personal Injury Law 278; M. Jones, "The *Bolam* Test and the Reasonable Expert" (1999) 7 Tort L. Rev. 226; N. Glover, "*Bolam* in the House of Lords" (1995) 15 Professional Negligence 42.
27. [2005] EWHC 459 (Q.B.), at [9]-[10].
28. *Kingsberry v. Greater Manchester Strategic H.A.* [2005] EWHC 2253, 87 B.M.L.R. 73, at [11].
29. *M v. Blackpool Victoria Hospital N.H.S. Trust* [2003] EWHC 1744, at [24]; *Marriott v. West Midlands Regional H.A.* [1999] 1 Lloyd's Rep. Med. 23, 35; *Ball v. Wirral H.A.* (2003) 73 B.M.L.R. 31, 43.
30. *J.D. Williams & Co. Ltd. v. Michael Hyde & Ass. Ltd.* [2000] Lloyd's Rep. P.N. 823.
31. e.g.: *Bellarby v. Worthing and Southlands Hospitals N.H.S. Trust* [2005] EWHC 2089, 86 B.M.L.R. 1, at [112]; *Tuke v. Mid Essex Hospital Services N.H.S. Trust* (Q.B., 1 May 2003), at [32]; *Manning v. King's College Hospital N.H.S. Trust* [2008] EWHC 1838 (Q.B.), at [140]; *Cowley v. Cheshire and Merseyside Strategic H.A.* [2007] EWHC 48 (Q.B.), 94 B.M.L.R. 29, at [53]-[55]; *O'Loughlin v. Greig* (Q.B., 5 November 1999); *Rampling v. Haringey H.A.* (Q.B., 30 July 1996), [no pp]; *Nash v. Kingston and Richmond H.A.* (1996) 36 B.M.L.R. 123; *Newbury v. Bath District H.A.* (1998) 47 B.M.L.R. 138, 143; *Brooks v. Home Office* (1999) 48 B.M.L.R. 109, 116; *Joyce v. Merton Sutton and Wandsworth H.A.* (1995) 27 B.M.L.R. 124, citing trial judge Overend J.'s earlier statement with approval; *Adderley v. North Manchester H.A.* (1995) 25 B.M.L.R. 42, [no pp]; *Neilson v. Basildon of Thurrock H.A.* (Q.B., 15 February 1991); *Marriott v. West Midlands Regional H.A.* [1999] 1 Lloyd's Rep. Med. 23 ("the judge... correctly directed herself that it was not open to her simply to prefer the expert evidence of one body of competent professional opinion over that of another where there was a conflict between the experts called by the parties").
32. *B v. North West Strategic H.A. (City Maternity Hospital Carlisle)* [2008] EWHC 2375, at [9].
33. *Maynard v. West Midlands Regional H.A.* [1984] 1 W.L.R. 634, 638, 648, per Lord Scarman ("[a] court may prefer one body of opinion to another, but that is no basis for a conclusion of negligence"); *Sidaway v. Governors of Bethlem Royal Hospital* [1985] A.C. 871, 895, per

Lord Diplock ("[the court] has to rely upon and evaluate expert evidence, remembering that it is no part of its task of evaluation to give effect to any preference it may have for one responsible body of professional opinion over another, provided it is satisfied by the expert evidence that both qualify as responsible bodies of medical opinion"); *Bolitho v. City and Hackney H.A.* [1998] A.C. 232, 243, *per* Lord Browne-Wilkinson ("it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported").

34. *Adams v. Rhymney Valley DC* [2000] Lloyd's Rep. P.N. 777, at [41] (emphasis added).
35. *Bolam*, at 587.
36. *Bolitho* [1998] A.C. 232, 243.
37. *Ministry of Justice v. Carter* [2010] EWCA Civ 694 (a unanimous judgment delivered 18 June 2010).
38. *Ibid.*, at [28] and [29], *per* Sir Scott Baker.
39. *Ibid.*, at [22].
40. See, generally: *Williams & Co. Ltd. v Michael Hyde & Ass. Ltd.* [2000] Lloyd's Rep. P.N. 823.
41. [1957] 1 W.L.R. 583, 587 (emphasis added).
42. (2000) 55 B.M.L.R. 63, at [26] (emphasis added).
43. *Gold v. Haringey H.A.* [1988] Q.B. 481.
44. *Savage v. South Essex Partnership N.H.S. Foundation Trust* [2008] UKHL 74, at [50].
45. *Bailey v. MOD* [2008] EWCA Civ 883.
46. *L v. West Midlands Strategic H.A.* [2009] EWHC 259.
47. [2010] EWCA Civ 694, at [23] ("That clinical judgment takes the case back to an analysis as described in *Bolam* and *Bolitho*", *per* Leveson L.J.).
48. *Ibid.*, at 490.
49. *J.D. Williams & Co. Ltd. v. Michael Hyde & Ass. Ltd.* [2000] Lloyd's Rep. P.N. 823. Also: *Royal Brompton Hosp N.H.S. Trust v. Hammond (No 2)* [2002] All E.R. (D) 189 (T.C.C.), at [17].
50. A. Dugdale *et al.* (eds.), *Clerk and Lindsell on Torts*, 19th ed., (London 2009), at [10.63] (*Bolam* "only to professional decisions whether or not to use a certain form of treatment [and diagnosis], and not to simple cases of carelessness"; and see, too: M. Jones, *Medical Negligence*, 4th ed., (London 2008), p. 255.
51. *Smith v. Southampton University Hospital N.H.S. Trust* [2007] EWCA Civ 387, and discussed further in: B. Moxon Browne QC, "Butterfingers and the *Bolam* Test: Can *Bolam* Apply to Simple Clumsiness by the Doctor?" [2008] Injury Times (2 Temple Gardens).
52. Report from the Appeal Committee of the House of Lords (dated 16 October 2007) (on the grounds that the case did not raise an arguable point of law of general public importance).
53. *Garcia v. St Mary's N.H.S. Trust* [2006] EWHC 2314 (Q.B.), at [88] ("[o]bviously this issue does not relate to medical or surgical diagnosis or treatment. What it relates to is staffing levels. But it has been argued before me on the footing that the *Bolam/Bolitho* principles apply to that question as well. I, therefore, deal with the case on that basis").
54. *Burne v. A* [2006] EWCA Civ 24, at [13] (the point, "while an important aspect of clinical practice, sits at the threshold rather than at the centre of it").
55. *Rehman v. University College London* [2004] EWHC 1361 (Q.B.).

56. *Mellor v. Sheffield Teaching Hospitals N.H.S. Trust* [2004] EWHC 780 (re the medical decision to discharge a patient who was unable to tolerate an exercise test and who complained of chest pain, without conducting further coronary investigation and treatment; patient suffered cardiac arrest shortly after, and died; negligence held, on the basis that either this was not a *Bolam* matter, or "even if *Bolam* is applicable to this issue", the expert evidence which supported the defendant cardiologist's decision to discharge "would not be logically sustainable": at [245]. The same either/or analysis was evident in, e.g. *Sutcliffe v. BMI Healthcare Ltd.* [2007] EWHC Civ 476, 98 B.M.L.R. 211, at [33], on which, for criticism, see: P. Case, "Applications of *Bolitho* to Standard of Care and Causation" (2007) 23 Professional Negligence 193.
57. *Fallows v. Randle* (C.A., 7 May 1996) (accessed via Lexisnexis, no pagination available).
58. *Penney v. East Kent H.A.* (2000) 55 B.M.L.R. 63, and applied, in a similar type of case of what was visible to the cytoscreeners, in: *Conway v. Cardiff and Vale N.H.S. Trust* [2004] EWHC 1841 (Q.B.).
59. *Colwill v. Oxford Radcliffe Hospitals N.H.S. Trust* [2007] EWHC 2881 (Q.B.).
60. J. Steele, *Tort Law: Text, Cases and Materials* (Oxford 2007), p. 128.
61. See, e.g. : *Marriott v. West Midlands Regional H.A.* [1999] Lloyd's Rep. Med. 23, per Bedlam L.J.; and see, more recently: *A v. Croydon Social Services* [2009] EWHC 939 (Admin), at [79]-[80]. For a non-medical application, see, e.g. : *Nye Saunders & Partners (a firm) v. Alan E. Bristow* (1987) 37 B.L.R. 97, 103.
62. See n 1 above.
63. Other interesting post-*Bolitho* reviews have concentrated on different aspects, e.g. : R. Heywood, "The Logic of *Bolitho* " (2006) 22 Professional Negligence 225; A. Maclean, "Beyond *Bolam* and *Bolitho* " (2002) 5 Med. Law Intl. 205.
64. J. Herring, *Medical Law and Ethics*, 3rd ed., (Oxford 2010), p. 108.
65. Noted, e.g. , in: *In Re B (A Child)* [2000] 1 W.L.R. 790 (Fam. Ct.), at 796, per Otter L.J.; *E v. Castro* [2003] EWHC 2066, 80 B.M.L.R. 14, at [99]. In *Bolitho* itself [1998] A.C. 232, 243, Lord Browne-Wilkinson referred to the occasion for the court's contrary decision as "very seldom" occurring. Reiterated in: *M v. Blackpool Victoria Hospital N.H.S. Trust* [2003] EWHC 1744 (Q.B.), at [42]. Academic commentary has also suggested that the application of *Bolitho* would occur in "the very rare case": W. Rogers, *Winfield and Jolowicz on Tort*, 17th ed., (London 2008), at [5.56], or "may not advance the law very much": S. Deakin, A. Johnston and B. Markesinis, *Markesinis and Deakin's Tort Law*, 6th ed., (Oxford 2008), p. 234.
66. *French v. Thames Valley Strategic H.A.* [2005] EWHC 459 (Q.B.), at [112]; *Hucks v. Cole* [1993] 4 Med. L.R. 393, 397 (Sachs L.J.).
67. *Calver v. Westwood Veterinary Group* (2000) 58 B.M.L.R. 194, at [31], [34] (Simon Brown L.J.).
68. *AB v. Leeds Teaching Hospital N.H.S. Trust* [2004] EWHC 644 (Q.B.), 77 B.M.L.R. 145, at [226].
69. See, e.g. : *Kushnir v. Camden & Islington H.A.* (Q.B., 16 June 1995), citing: *Bolitho v. City and Hackney H.A.* [1993] 4 Med. L.R. 381, 392 (Dillon L.J.). Note, however, the disapproval in: *Joyce v. Merton Sutton and Wandsworth H.A.* (1995) 27 B.M.L.R. 124, [no pp available] ("it does not assist to introduce concepts from administrative law such as the *Wednesbury* test; such tests are directed to very different problems and their use, even by analogy, in negligence cases can ...only serve to confuse"), and the criticism by noted commentators such as: I. Kennedy and A. Grubb, *Medical Law*, 3rd ed., (London 2000), p. 442.
70. [2006] EWHC 2880 (Q.B.), (2007) 93 B.M.L.R. 166. A point also noted in, e.g. : M. Jones, *Medical Negligence*, 4th ed., (London 2008), p. 241, fn. 65.
71. *Ibid.* , at [33]. The expert opinion given by the neurosurgeon called on behalf of the defendant GP was in accordance with *Bolam*, and the court expressly disavowed *Bolitho* from applying: at [105]-[106].
72. [2002] 2 S.L.R. 414.
73. *Ibid.* , at [65].
74. (1996) 27 B.M.L.R. 124. Also pointed out in, e.g.: J. Montgomery, *Health Care Law*, 2nd ed., (Oxford 2003), p. 176.
75. *Ibid.* , at p. 144.
- 76.

See Section IIB.

77. *McCallister v. Lewisham and North Southwark H.A.* (Q.B., 15 December 1993), [no pp] ("This was, in my judgment, a borderline case, and although ...[the defendant senior neurosurgeon] can immerse himself in a school of thought which would have condoned intervention here, I am bound to say that I think that school was very much in the minority"; no breach on the basis of negligent treatment; there was, however, a failure to disclose risks). See, too, *e.g.* : *De Freitas v. O'Brien* (1995) 25 B.M.L.R. 51 (only 11 specialist spinal surgeons in England could constitute a body of peer opinion as to whether surgery on the patient was accepted medical practice).
78. [2005] EWHC 459 (Q.B.), at [112] (emphasis added).
79. [1993] 4 Med. L.R. 393, and hence, a "long overlooked" decision: M. Lunney and K. Oliphant, *Tort Law: Text and Materials*, 4th ed., (Oxford 2010), p. 2020.
80. *Ibid.* , at 399.
81. A point also made recently in: *Ministry of Justice v. Carter* [2010] EWCA Civ 694, at [22], *per* Leveson L.J., referring to *Hucks v. Cole* as exemplifying the "group" of *Bolitho* cases.
82. *Gascoine v. Ian Sheridan and Co.* (Q.B., 9 September 1994) (legal negligence case for allowing action in medical negligence to be struck out for want of prosecution; clear precaution, when confronted with an invasive malignancy in a patient, was to consult others with wider experience, instead of proceeding to radical treatment by external pelvic irradiation; "some prospect" of showing negligence).
83. *Burne v. A* [2006] EWCA Civ 24 (child A born with a hydrocephalic condition that required him to be fitted with a ventriculo-peritoneal shunt, which continuously drained excess fluid from the brain cavity, and of which any blockage was potentially critical; clear precaution was for the defendant GP to ask a series of "closed" or leading questions (*e.g.* , was A vomiting, or experiencing headaches?), rather than asking open questions that lead to an incorrect diagnosis of upper respiratory infection; shunt was blocked, and A suffered heart attack and brain damage). A retrial was ordered, on the basis that the medical experts had not been asked to address the *Bolitho* point; this was necessary before a court could apply *Bolitho* and reject the GP's expert evidence.
84. *Farraj v. King's Healthcare N.H.S. Trust* [2008] EWHC 2468 (Q.B.).
85. *Penney v. East Kent H.A.* [2000] Lloyd's Med. L.R. 41 (where cervical smear slides demonstrated observable abnormalities, clear precaution was not to designate the slide as "negative", but to only assign negative status to a slide if there could be "absolute confidence" that it had no abnormalities; failure by cytoscreeners to adopt that clear precaution rendered their practice of assigning negative status illogical).
86. (2001) 62 B.M.L.R. 69.
87. [2004] EWHC 1198 (Q.B.). See too: *Calver v. Westwood Veterinary Group* [2001] Lloyd's Rep. Med. 20, at [34] (noting that one expert "clearly treats animals more defensively" than the other; "Both opinions, however, seem to me clearly capable of logical support and in that situation there is no room for a finding of negligence"; no breach found on appeal).
88. *Ibid.* , at [65].
89. [2005] EWHC 459 (Q.B.), at [113].
90. *G v. Central and North West London Mental Health N.H.S. Trust* [2007] EWHC 3068 (Q.B.).
91. *Ibid.* , at [152].
92. [2006] EWHC 2314 (Q.B.).
93. *Ibid.* , at [88].
94. *Ibid.* , at [91].
95. *Ibid.* , at [92]-[93].
96. *Ibid.* , at [94]-[95], *per* Judge Shaun Spencer Q.C., citing: *Arthur J.S. Hall & Co. (a firm) v. Simons* [2002] 1 A.C. 615, 690, *per* Lord Hoffmann.

97. *Ibid.*, at [96].
98. *French v. Thames Valley Strategic H.A.* [2005] EWHC 459 (Q.B.), at [113] ("Mrs French's doctors had to balance her interests and those of the Claimant [newly born daughter], but the balancing is to some extent skewed in favour of the mother"; no breach of duty found).
99. Competing obstetric emergencies meant that one mother/baby was not attended to in time to prevent brain damage to the baby in, e.g. : *DA v. North East London Strategic H.A.* [2005] EWHC 950 (Q.B.), at [95] (no breach; court satisfied that conduct of attendant obstetrician "represent a sensible and realistic approach"). Also: *Smithers v. Taunton and Somerset N.H.S. Trust* [2004] EWHC 1179 (Q.B.) (no breach).
100. *Bolitho v. City and Hackney H.A.* [1998] A.C. 232, 241-42. A direct finding that a comparison was undertaken, and no breach found, occurred, e.g. , in: *Sutcliffe v. BMI Healthcare Ltd.* [2007] EWCA Civ 476, 98 B.M.L.R. 211; *Zarb v. Odetoyinbo* [2006] EWHC 2880, 93 B.M.L.R. 166 (Q.B.), at [84], [100], [106]; *French v. Thames Valley Strategic H.A.* [2005] EWHC 459 (Q.B.), at [113]; *Ju v. See Tho Kai Yin* [2005] SGHC 140, [2005] 4 S.L.R. 96, at [65]; *Burke v. Gillard* [2003] EWHC 2362 (Q.B.), at [84]; *E v. Castro* [2003] EWHC 2066 (Q.B.), 80 B.M.L.R. 14, at [186]; *Ocloo v. Royal Brompton and Harefield N.H.S. Trust* (2001) 68 B.M.L.R. 89, at [62]; *Mirza v. Birmingham H.A.* (Q.B., 31 July 2001), at [71]; *Zinzuwadia v. Home Office* [2001] EWCA Civ 842, at [11]; *Julien v. East London and City H.A.* (Q.B., 10 November 2000); *Brown v. Lewisham and North Southwark H.A.* (Q.B., 6 March 1998); *Hallatt v. North West Anglia H.A.* (C.A., 8 April 1998); *Ashard v. Cambridge H.A.* (Q.B., 26 November 1999); *Brooks v. Home Office* [1999] 2 F.L.R. 33, 48 B.M.L.R. 109.
101. [2008] EWHC 2237 (Q.B.), at [55].
102. *Khoo v. Gunapathy d/o Muniandy* [2002] 2 S.L.R. 414, at [64].
103. e.g. : *Mellor v. Sheffield Teaching Hospitals N.H.S. Trust* [2004] EWHC 780 (Q.B.), at [244]-[245] (decision to discharge patient, with multiple risk factors for coronary disease and low tolerance for exercise, not logically sustainable; risk/benefit calculation pointed "overwhelmingly" in favour of proceeding to a thallium scan); *Reynolds v. North Tyneside H.A.* (Q.B., 30 May 2002), at [47] (for reasons of risk of infection, no vaginal examination performed upon pregnant woman who presented with complications; child asphyxiated during birth; failure to examine did not withstand logical analysis, given extremely minimal risk of such infection); *Marriott v. West Midlands H.A.* [1999] Lloyd's Rep. Med. 23, 26-27 (patient suffered head injury in fall; GP failed to refer patient for further neurological tests when, 8 days later, he was presenting with headaches, lethargy and lack of appetite; patient suffered paralysis from intracranial lesion; GP's expert evidence said it was reasonable to leave patient at home, with instructions to wife to telephone if husband's condition worsened; this lacked logical analysis, and patient should have been admitted to hospital for neurological testing and observation, especially when risks of not doing so were so catastrophic, and when facilities for performing scans, etc, were so readily available); *Purver v. Winchester and Eastleigh Healthcare N.H.S. Trust* [2007] EWHC 34 (Q.B.), at [64] (re the so-called "ten-minute-rule", whereby at onset of significant foetal bradycardia, baby must be delivered within ten minutes, failing which risk of irreversible brain damage; newborn suffered brain damage due to oxygen deprivation during birth; obstetrician's expert evidence was that it was acceptable medical practice to have proceeded to further traction rather than perform a caesarean section; but any suggestion that longer than 10 minutes was an appropriate objective was "incapable of withstanding logical analysis"); *Bouchta v. Swindon* [1996] 7 Med. L.R. 62 (County Court (Wandsworth)) (following routine hysterectomy, patient's ureter blocked and damaged; explanation for that damage provided by surgeon's expert testimony not a "good and sufficient explanation", despite complexities of operation; negligence found); *Hanson v. Airedale Hospital N.H.S. Trust* [2003] C.L.Y. 2989 (Q.B.) (patient sustained severe brain injury after suffering cardiac arrest at A&E department while unmonitored; hospital failed to urgently request results of blood sample for CPK enzyme; CPK results would have resolved any difficulty with diagnosis; no logical reason why CPK result could not have been expedited).
104. [2005] EWHC 2253 (Q.B.), 87 B.M.L.R. 73. Cited and applied in part in: *Purver, ibid.*
105. An electronic device attached to a mother's abdomen during labour, which simultaneously records the rate of the foetal heartbeat and the rate of maternal contractions.
106. *Kingsberry, ibid.*, at [45].
107. [2006] EWHC 2314 (Q.B.).
108. *Ibid.*, at [95]-[96].
109. See, e.g.: *Smithers v. Taunton and Somerset N.H.S. Trust* [2004] EWHC 1179 (Q.B.), at [53(vi)] (no breach); *DA v. North East London Strategic H.A.* [2005] EWHC 950 (Q.B.), at [95] (no breach).
110. Q.B., 27 May 2004.
111. *Ibid.*, at [27]-[28].
112. *Ibid.*, at [30].
113. *Adams v. Rhymney Valley DC* [2000] Lloyd's Rep. P.N. 777, at [43], with Sedley L.J.'s dissenting opinion at [19].

114. See n 22 above.
115. See Group Litigation Order No. 9, at: <<http://www.hmcourts-service.gov.uk/cms/150.htm>>. The title of the litigation was: *AB v. Leeds Teaching Hospital N.H.S. Trust* [2004] EWHC 644 (Q.B.), 77 B.M.L.R. 145.
116. *Ibid.* , at [213].
117. *Ibid.* , at [215], [217].
118. *Ibid.* , at [237].
119. *Ibid.* , at [240].
120. *Ibid.* , at [220] (a point made during the course of the claimants' submissions).
121. *Bank of Montreal v. Dominion Gresham Guarantee and Casualty Co. (Canada) Ltd.* [1930] Q.C. 659 (P.C.) 666.
122. Lord Woolf, "Are the Courts Excessively Deferential to the Medical Profession?" (2001) 9 Med. L. Rev. 1, at 1 (emphasis added).
123. Section IIB.
124. [2005] EWCA Civ 1466.
125. Latham and Buxton L.JJ.; Arden L.J. dissenting.
126. *Ibid.* , at [106] (Buxton L.J.).
127. *Drake v. Pontefract H.A.* [1998] Lloyd's Rep. Med. 425 (Q.B.) (mis-diagnosis of serious suicide risk); *Mellor v. Sheffield Teaching Hospitals N.H.S. Trust* [2004] EWHC 780 (Q.B.) (mis-diagnosis of serious cardiac disease).
128. [2007] EWHC 509 (Q.B.), at [64].
129. *Ibid.* , at [75].
130. *Ogwang v. Redbridge Healthcare N.H.S. Trust* (Q.B., 4 July 2003) (pregnant woman discharged from hospital into care of community midwife; sent back to hospital and readmitted the following day; breach of duty).
131. [2002] 2 S.L.R. 414, at [65]-[66].
132. *Ibid.* , at [65].
133. [1998] Lloyd's Rep. Med. 425, at [34].
134. *Glicksman v. Redbridge Health Care N.H.S. Trust* (Q.B., 23 June 2000), at [14], [24]. The trial judge rejected the defendant surgeon's expert evidence, and found breach; but liability was set aside on appeal, because of a lack of reasoned rebuttal of the experts' views in the trial judge's decision: [2001] EWCA Civ 1097, 63 B.M.L.R. 109.
135. *Ogwang v. Redbridge Healthcare N.H.S. Trust* (Q.B., 4 July 2003), at [39].
136. *Antoniades v. East Sussex Hospitals N.H.S. Trust* [2007] EWHC 517 (Q.B.), at [73].
137. *AB v. Leeds Teaching Hospital N.H.S. Trust* [2004] EWHC 644 (Q.B.), 77 B.M.L.R. 145.
138. *Ibid.* , at [235].

- [139.](#) [2007] EWCA Civ 387.
- [140.](#) (2006) 150 S.J.L.B. 1114 (Q.B.).
- [141.](#) Another surgeon was absolved from negligence with respect to a perforation of the left external iliac vein during the surgery, and special leave to appeal against that finding was refused: see note [52](#) above.
- [142.](#) (2006) 150 S.J.L.B. 1114 (Q.B.), at [35].
- [143.](#) [2007] EWCA Civ 387, at [41], and see too, (2006) 150 S.J.L.B. 1114 (Q.B.), at [60]-[62] for the trial judgment.
- [144.](#) *Ibid.*, at [44] (emphasis added).
- [145.](#) See note [33](#) above.
- [146.](#) Q.B., 6 November 2000.
- [147.](#) *Ibid.*, at [78]. See also the criticism of the expert's use of the wrong standard in: *Ng Yuk Ha v. Yip Siu Keung* (H.K.C.F.I., 19 July 2005).
- [148.](#) [1998] A.C. 232, 243.
- [149.](#) [1998] EWCA Civ 596, [1998] P.I.Q.R. P324.
- [150.](#) *Ibid.*, at 336.
- [151.](#) See, e.g.: *Cowley v. Cheshire and Merseyside Strategic H.A.* [2007] EWHC 48 (Q.B.), 94 B.M.L.R. 29, at [55] (no *Bolitho* application; no breach); *Ndri v. Moorfields Eye Hospital N.H.S. Trust* [2006] EWHC 3652 (Q.B.), at [35]; *Sellers v. Cooke* (Q.B., 4 April 1989) ("Honest and brilliant gynaecologists called in this case have given different opinions. One group exculpates, one group exculpates Mr Cooke"; no breach on main allegation); *Zarb v. Odetoyinbo* [2006] EWHC 2880 (Q.B.), at [34] ("The challenge facing the Claimant is a high one, given the qualifications of [the neurosurgeon called to give evidence on behalf of the defendant GP]").
- [152.](#) J. Montgomery, *Health Care Law*, 2nd ed., (Oxford 2003), p. 176.
- [153.](#) A. Maclean, "Beyond *Bolam* and *Bolitho*" (2002) 5 Med. Law Intl. 205, at 222.
- [154.](#) e.g., *Townsend v. Worcester and District H.A.* (1994) 23 B.M.L.R. 31, 45; *Nawoor v. Barking Havering and Brentwood H.A.* [1998] Lloyd's Rep. Med. 313 (Q.B.), at [last para]; *Goby v. Ferguson* [2009] EWHC 92 (Q.B.), at [103].
- [155.](#) Note [1](#) above.