**To What Extent are Healthcare Professionals Immune from Professional Negligence: A
review of the Bolam and Bolitho Cases**

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Introduction

This paper reviewed the extent to which Bolam provided healthcare professionals with immunity from claims based in negligence in the past, and whether Bolitho was able to resolve that issue.

During the early 1950s, when the NHS was in its golden era, the medical profession was still “unregulated and paternalistic” in approach. Consequently, the medical profession had enjoyed an unreserved obedience from patients, and treated with great reverence by the society. John Hector Bolam¹ was a patient who sustained fractures because the defendants applied unmodified electro-convulsive therapy on him. So, his suit for negligence provided the much needed opportunity for grounding the principles of medical negligence which was still in its early stage of development.²

The issue was unprecedented, and therefore the dictum of Lord President Clyde in the Scottish case of *Hunter and Hanley*³ became handy. The ruling gave doctors the latitude to set standard of care and justify their action by simply having their peer to support them. It placed the onus of proving “Wednesbury unreasonableness”⁴ on the patients in order to succeed in medical negligence litigation against a doctor. That was very difficult to prove. This attracted criticisms against Bolam that it provided excessive immunity to doctors, and difficulties to the patients. Several cases had been decided in favor of the doctors and allied healthcare professionals.

¹ Bolam V. Friern Hospital Management Committee [1956 B. No. 507.

² Christopher Stone (2011), From Bolam to Bolitho, unraveling medical protectionism p2

³ (1955) S.L.T. 213, 217

⁴ i.e. a view such as no reasonable doctor could have held. Lord Green's much quoted test

Similar opportunity arose in 1984 when the *Bolitho*⁵ rule was propounded which empowered the courts to intervene and determine if a body of medical opinion is indeed responsible, by subjecting their evidence to the logicity and risk/benefit analysis tests.

Issues for consideration include, to what extent did *Bolam* provide immunity to healthcare professionals and, post *Bolitho*, if the issues have now been resolved. To accomplish that, the author will examine the various court decisions pre- and post- *Bolitho* with a view to coming up with answer(s) to the issues raised.

The Extent to which Bolam provided Immunity to Healthcare Professionals

John Hector Bolam, the plaintiff in this case⁶ was voluntarily admitted in the defendant's hospital for electro convulsive therapy (ECT). ECT consisted of passing an electric current through the patient's brain causing violent muscular spasms unless relaxant medication is administered prior to that.⁷ It is associated with small risk of bone fractures. As in practice, the defendant doctor did not administer any relaxant medication, nor applied any form of manual restraint other than to support the plaintiff's chin and hold his shoulders. Consequently, the plaintiff "sustained bilateral "stove-in" fractures of the acetabula.⁸

The plaintiff, therefore, claimed damages in negligence on the following grounds:

(1) failure to administer any relaxant drug prior to administering the electro convulsive therapy, (2) failure to provide at least some form of manual restraint or control beyond that given; and (3) failure to warn him of the risks involved in the treatment.

Both parties invited experts who gave evidence on their behalves as to the different techniques adopted when giving E.C.T. Consequently, there was no unanimity of professional opinion as to the need for muscle relaxants, and/or manual restraint to reduce the risk for fractures. Defendant's expert claimed that manual restraint increases the risk of fracture. It was the practice of the defendants' doctors not to warn patients of the risks unless asked for. The plaintiff's witness was of the opinion that it would be

⁵ [1998] A.C. 232 (HL)

⁶ No.1 supra

⁷ No. 2 supra, p2

⁸ Todd NV (2010) Medical Negligence: Legal theory And Surgical Practice Orthopaedics and Trauma 25:1

wrong not to warn a patient of the risks involved. On the question of warning, the plaintiff's witness averred that it would "fool-hardy" not to warn a patient of the risk of fracture while the defendants took the view that it was not desirable to warn patients of the risk unless they asked about it.

The court held, inter alia, that a doctor who had acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion skilled in the particular form of treatment in question was not guilty of negligence merely because there was a body of competent professional opinion which might adopt a different technique. McNair J, while reflecting on what he considered the respected competing expert medical opinions, referred the jury to the dictum of Lord President Clyde in the case of **Hunter v Hanley** as follows:

"In the realm of "diagnosis and treatment there is ample scope for genuine " difference of opinion and one man clearly is not negligent merely "because his conclusion differs from that of other professional" men, nor because he has displayed less skill or knowledge than " others would have shown. The true test for establishing" negligence in diagnosis or treatment on the part of a doctor is "whether he has been proved to be guilty of such failure as no "doctor of ordinary skill would be guilty of, if acting with" ordinary care." ⁹

McNair J went further on:

"Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view..." ¹⁰

This seemingly convinced the jury who found for the defendant on both issues of consent and treatment. Bolam therefore became a new legal bench mark in medical negligence. It placed the burden of proving negligence upon claimants to demonstrate that no responsible body of professional opinion would have endorsed a particular course of action.¹¹

⁹ No. 3 supra p 217

¹⁰ [1957] 1 W.L.E., p587

¹¹ No. 2 supra, p3

Bolam is regarded as the primary test for the breach of duty of care,¹² and a starting point for all professional negligence^{13, 14}. In the field of medical negligence, it applied to both treatment and clinical judgment¹⁵ which includes diagnosis, treatment and advice.^{16,17} but Bolam should not be allowed to inhibit medical progress.^{18,19} Additionally, it applies only where experts fail to agree on an aspect of professional conduct.²⁰

Bolam assumes that a judge, who is unschooled and unskilled in the art of medicine, has no business adjudicating on matters over which medical experts themselves cannot come to an agreement. This is especially so where complex medical disputes are resolvable by empirical observation and long-term research.²¹ McNair J himself had reasoned, in his sum-up, that we have to try to strike a balance between compensating the injured and service to the community. Taking any contrary decision could lead doctors becoming conscious more of their own safety than the patient's safety.²²

Note that during the 1950s, or the “golden era” of the NHS,²³ the medical profession was both paternalistic and largely unregulated²⁴. They enjoyed unalloyed loyalty from their patients and were treated with great deference by the society in general, including the judiciary.²⁵

Consequently, criticisms arose against the *Bolam* test for the apparent undue deference shown to doctors in medical negligence,²⁶ with the result that it provided immunity to the

¹² No. 8 p64

¹³ Catherine Tay Swee Kian () Interpretation of the *Bolam* Test in the Standard of Medical Care: Impact of the *Gunapathy* case and Beyond (draft) Accessed 12/5/2013 p389

¹⁴ *Greaves & co Ltd v Baynham Meille & Partners* (1995) 1 WLR 1095 CA- duty of reasonable care and skill applied doctors, lawyers, accountants, architect or engineers, to the extent of the Bolam rule.

¹⁵ No. 8 p65,

¹⁶ Michael Kirby (1995) Patients' rights - why the Australian courts have rejected 'Bolam' *J*ournal of medical ethics 1995; 21: 5-8

¹⁷ B6P4

¹⁸ *JS v An AHS trust; JA v NHS Trust* (2002) EWHL 2734

¹⁹ (1955) SC 200 at 206.

²⁰ *Penney v East Kent HA QBD* (1999) Lloyd LR Med. 123

²¹ No. 13, p 393

²² No. 1 p594

²³ No. 2 p2 intro

²⁴ Matthew Hartwell (2005) Medical negligence: Can doctors and nurses still rely on the doctrine that they know best? *Legal Medicine* 7 (2005) 293–298

²⁵ No. 8 p64

²⁶ Alasdair MacClean (2002) Beyond Bolam and Bolitho *Medical Law International* 2002 5: 205

medical profession.²⁷ This perception was further fortified by Lord Denning's dictum: '*in a professional man, an error of judgment is not negligent.*'²⁸ Lord Fraser only had to bring it to align with Bolam when he said:

*"...a judge's "preference" for one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that such a man, acting with ordinary care, might have made, then it is not negligent."*²⁹

Therefore, doctors were allowed to make mistakes as long as they can satisfy the requirement of the *Bolam* test.³⁰

How did the *Bolam* test gave immunity to doctors? Perhaps because, if a doctor, who is accused of negligence, presents an 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", that absolves him from negligence. This is more so as the judge is disallowed from making preference for any one opinion. McNair J had said:

*"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; ..."*³¹

Similarly, the court in **Woolley**³² an anesthetist was found not negligent in failing to appreciate that phenol would enter the ampoule. Also an ambulance crew was found not negligent for the death of a heavily pregnant and hypertensive woman who had collapsed. They followed an accepted practice of keeping her on her back, rather than tilting her on her side for the fear of spinal injury.³³ In **Nicholas v Imperial College**

²⁷ Racheal Mulheron (2010) Trumping Bolam: a critical legal analysis of Bolitho's "gloss" Cambridge Law Journal p 609

²⁸ Whitehouse v Jordan (1980) 1 ALL ER 650

²⁹ Whitehouse v Jordan (1981) 1 W.L.R 246

³⁰ Maynard v West Midlands Regional H.A (1984) 1 WLR 634

³¹ [1957] 1 W.L.R. 583, 587-588

³² Woolley v Min of Health (1954) 1 LR 128

³³ Moied v South Central Ambulance Service NHS Trust QBD (unreported) 30/5/2012

Healthcare Trust ³⁴ the consultant vascular surgeon's decision and advice which resulted in stroke was held not negligent as it was a practice accepted by his peers.

The courts had no discretion to decide on the standard of care required to be satisfied,³⁵ and is inhibited from exercising their restraining influence,³⁶ doctors dictate to the courts.³⁷ The *Bolam* test allows doctors to set for themselves the standard of care, unlike other areas of professional liability where the expected standard of the care is a matter that is set by the court³⁸.

In the *Sidaway*³⁹ Lord Bridge of the House of Lords had this to say regarding the level of information disclosure to patients:

"Whether non-disclosure in a particular case should be condemned as a breach of the doctor's duty of care is an issue to be decided primarily on the basis of expert medical evidence, applying the Bolam test." ⁴⁰

A good instance of the courts providing immunity to doctors even when such is balanced against the patient's right to be informed of the attendant risks and benefits of his/her care.⁴¹

Similarly, in *Re F*⁴², in deciding whether sterilization should be performed on a 36-year-old patient who had a mental age of five, the court agreed with a body of medical opinion which supported the defendant's action as being in the 'best interests' of the patient:

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

³⁴ (2012) EWHC 591 (QBD)

³⁵ No. 2 p5

³⁶ No. 24 p297

³⁷ *Burne v. A* [2006] EWCA Civ 24, at [10].

³⁸ Ash Samanta and Jo Samanta (2003) Legal standard of care: a shift from the traditional *Bolam* test, *Clin Med* 2003;3:443–6

³⁹ *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 AllER 643

⁴⁰ No. 38 supra at p 643

⁴¹ Teff H. The standard of care in medical negligence – moving on from Bolam? *Oxford J Legal Studies* 1998;18:473–84.

⁴² *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1

The Bolam test is satisfied if the standard can be supported, even though it is not necessarily a good standard.⁴³ It places on the plaintiff, the burden of proving “Wednesbury unreasonableness”⁴⁴ for securing a successful litigation, which is too difficult to prove.⁴⁵

Ultimately, Bolam became a clumsy tool for medical repression and peer review⁴⁶ that perpetuated outdated practices, just because some other doctors could simply support their practices.⁴⁷ Therefore, the test was no more than a perfunctory requirement to exculpate doctors from liability.⁴⁸ Consequently, it became prone to abuse by dubious experts “whose professional views existed at the fringe of medical consciousness.”⁴⁹ As a result, practices that develop may be tailored not to protect the patients, but the doctors against liabilities.⁵⁰

Finally, *Bolam* may have encouraged medical professionals to adopt unreasonable practices⁵¹, and dismissed patients’ cause so obviously⁵² that the test could not have protected the community against unsafe medical practices.⁵³ The *Bolam* test would appear to have enlarged the spectrum of medical practice to include the role of a moral arbiter.⁵⁴ This could have resulted in a shift of focus from the patient’s interests to reliance on medical testimony.⁵⁵ All a doctor needed to do was to invoke *Bolam* to defeat a highly contestable claim⁵⁶

It seems unclear, though, if McNair J meant that compliance with a body of medical practice was *conclusive* in terms of escaping liability for negligence. He had said:

⁴³ Re v Ministry of Health (1954) 2 ALL EP 131

⁴⁴ Associated Provincial Picture Houses Limited v Wednesbury Corporation (1948) per Lord Green

⁴⁵ J. Warren Jones (2000) *The healthcare professional and the Bolam test* British Dental Journal, Volume 188, No. 5, March 11 2000 p240

⁴⁶ No. 38

⁴⁷ No. 13 p388

⁴⁸ No. 25 p205

⁴⁹ *Khoo v. Gunapathy d/o Muniandy* [2002] 2 S.L.R. 414

⁵⁰ No. 21 609

⁵¹ No. 37 p10 Brazier M, Miola J. Bye-bye Bolam: a medical litigation revolution. *Med LR* 2000;8:85–114.

⁵² Lord Woolf, (2001) Are the Courts Excessively Deferential to the Medical Profession? 9, *Med L.Rev.* 1 at 3

⁵³ See *Shakoor v Situ* (2000) 57, B.M.L.R. 178 at 184

⁵⁴ 38 *supra*

⁵⁵ Brazier M, Miola J. Bye-bye Bolam: a medical litigation revolution. *Med LR* 2000;8:85–114.

⁵⁶ B2P5

*“If the result of the evidence is that you are satisfied that his practice is better than the practice spoken of on the other side, then it is really the stronger case.”*⁵⁷

Although it is possible that, upon a closer reading of *the dictum*, McNair J. himself did not intend the doctor's expert's evidence to be *conclusive* of the question of breach,⁵⁸ that is certainly how it came to be interpreted.⁵⁹ It is submitted that, this was a window of opportunity for the courts to revisit the Bolam test. Doing so might enable them to evolve a role for the courts in the determination of the standard of care that is just and fair to all parties.

The Emergence of Bolitho: An anticlimax of the Impunity?

Additionally, other factors may have prepared the stage for the emergence of the *Bolitho* test. Time has changed, and the reasons for the changes are easy enough to see. They include the general advance of education of the population at large, the decline of the undue reverence of professionals, the cessation of unquestioning approval of professional judgment, health issues became a common subject of public discourse, and doctors nowadays embrace holistic approach to patient treatment rather than just simply treating a body part.⁶⁰ Also, the society was fast becoming more conscious of right of individuals.⁶¹ Consequently, patient's right to life and to terminate life⁶² or to refuse treatment,⁶³ and the professional duty to treat⁶⁴ became focal point for the determination of medical negligence.⁶⁵

⁵⁷ No. 1 *supra*

⁵⁸ I. Kennedy and A. Grubb, *Medical Law*, 3rd ed., (London 2000), p. 427.

⁵⁹ E.g., Warner J. in *Taylor v Warners* (Ch.D., 21 July 1987), citing that part of McNair J.'s judgment in *Bolam*

⁶⁰ No. 6 *supra*

⁶¹ No. 2 *supra*

⁶² RE A (Children) (Conjoined Twins Surgical separation) (2000) 4 All ER 961 Court of Appeal

⁶³ Georges Healthcare NHS Trust V S (1999) Fam 26 (Court of Appeal)

⁶⁴ R V Portsmouth Hospital NHS Trust Ex Parte Glass (1999) 50 Butterworth's Medico-Legal Reports 269 (CA).

⁶⁵ No. 24 *supra*, at 294

At the confluence of all these factors, *Patrick Bolitho*, a two-year-old child, was admitted in 1984 to defendant's hospital with croup. He was subsequently discharged but re-admitted because of further breathing difficulties. Patrick's breathing difficulties deteriorated while in hospital and died from cardiac arrest and severe brain damage. The defense accepted that there had been a breach of duty in failing to attend to him, but contended that had she attended Patrick she would not have intubated him because the procedure itself carries a certain degree of mortality and morbidity. The plaintiff's expert medical witnesses contended that intubation would have protected his airway and thus saved his life.

At the Court of Appeal, counsel for the plaintiff argued that it was for the court to decide on the appropriate standard of care, and to accept the views of expert medical witnesses only if they were logical; a move away from *Bolam*. The House of Lords partly accepted this argument and held that a defendant doctor is not bound to escape liability for his actions merely on the basis of a supporting opinion provided by his peers.⁶⁶ Lord Browne-Wilkinson said:

*"The court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter"*⁶⁷

This was a complete departure from the Bolam test with the logicality and risk/benefit analysis test.⁶⁸ Under *Bolitho*, the courts would no longer blindly rely on the doctors to set out the standard of care, but can intervene to assess and determine the standard of care.⁶⁹ Practically, the court would have to determine, first, if the course of action undertaken by the defendant is accepted by a body of medical opinion that stands the test of logical analysis - *Bolam* defensible. And secondly, determine if, the

⁶⁶ No. 45 supra

⁶⁷ No. 5 supra

⁶⁸ 24 supra

⁶⁹ 24 supra

action/decision was founded on risk/benefit analysis – *Bolitho justifiable*. Such an analysis depends on such factors as “the magnitude of the risk, the comparative risks of alternative interventions and treatments, the seriousness of its consequences, the ease by which the risk might be avoided or, the implications of such avoidance in terms of finances and resources of healthcare”.⁷⁰

Paradoxically, even post *Bolitho* there were relatively lesser precedents from *Bolitho* than those that relied on *Bolam*.⁷¹ In *Penney*⁷², the judge preferred the plaintiffs’ evidence because, defendant expert’s evidence did not stand up to “**logical analysis**”. Affirming the decision, the Court of Appeal per Lord Woolf said:

*“In resolving conflicts of expert evidence, the judge remains the judge; he is not obliged to accept evidence simply because it comes from an illustrious source; he can take account of demonstrated partisanship and lack of objectivity.”*⁷³

The court weighs the evidence of one party against the rebuttal of the other, and determines, by logical analysis, the appropriate standard of care.⁷⁴

But, in *Marriott*⁷⁵ the Court of Appeal took a different approach; the “**risk analysis**”⁷⁶ approach for determining the standard of care. The plaintiff was brought to the defendant hospital for investigation for head injuries after a fall but was discharged the next day. At home his condition worsened, leading to an intracranial bleed which further resulted in residual paralysis and a speech disorder. The defendant’s experts argued that the decision could be supported on the grounds that the risk of an intracranial lesion was very small. The Court of Appeal approved⁷⁷ the trial judge’s decision that, although the risk was very small, “*the consequences of things going wrong are disastrous to the patient. ... the only reasonably prudent course ... [would be] to readmit for further testing and observation.*”⁷⁸

⁷⁰ 24 supra

⁷¹ No. 27

⁷² *Penney, Palmer and Canon v East Kent Health Authority* [2000] Lloyds Rep Med 41

⁷³ No. 72

⁷⁴ No. 38 supra

⁷⁵ *Marriott v West Midlands Health Authority* [1999] Lloyds Rep Med 23

⁷⁶ See also, *Brown v Scarborough & North East Yorkshire Health NHS Trust* (2009) EWCH 3103 (QBD)

⁷⁷ No. 75

⁷⁸ No. 38 supra p445

The “**significant risk**” approach was introduced in **Pearce**.⁷⁹ In deciding whether a doctor ought to have informed a pregnant woman at 42 weeks of gestation of the additional risk of stillbirth inherent in allowing the pregnancy to proceed, thus enabling her to make a fully informed choice,⁸⁰ Lord Woolf said:

“[if] there is a significant risk which would affect the judgment of a reasonable patient, then in the normal case it is the responsibility of the doctor to inform that patient of that significant risk, “if the information is needed so that the patient can determine for himself or herself as to the course he or she should adopt....”

The result is that the Bolam requirement of peer approval alone is no longer sufficient, and the patient’s right to self-determination takes precedent.⁸¹ It was submitted that the case of **Pearce** shifted from the “reasonable doctor” test, to “reasonable patient” for the court to decide the standard of disclosure.⁸²

Has Bolitho, in any way, impacted on Bolam?

What, if any, was the impact of *Bolitho* on *Bolam*? Lord Browne-Wilkinson propounded some caveats for determining if a body of medical opinion is to be considered “responsible, respectable or reasonable”, i.e., the logicity and risk/benefit analysis tests.⁸³

Ironically, Lord Browne-Wilkinson, however, indicated that it is seldom for medical experts to give opinions which would be considered unreasonable.⁸⁴ But, it also means that, though rarely, the court may “reject expert evidence if it is illogical and, may, theoretically, hold an accepted practice to be unreasonable.”⁸⁵ Per Lord Browne-Wilkinson:

⁷⁹ *Pearce v United Bristol Healthcare NHS Trust* [1998] 48 BMLR 118

⁸⁰ No. 38 p447

⁸¹ No. 38 p446

⁸² No. 24, p297

⁸³ No. 45 p239

⁸⁴ No 1 supra

⁸⁵ No. 25 p221

*'It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed.'*⁸⁶

This seems to be a significant step forward from the "Wednesbury unreasonableness" approach where expert opinion could only be rejected on the basis that no reasonable expert could have taken such an approach or held such a view.⁸⁷

Unfortunately, opinions have been varied as to whether *Bolitho* had any impact on *Bolam*, and to what extent? Some observed that *Bolam* remained the universal test of professional negligence, or "cornerstone" of the test of breach of duty⁸⁸ until "gloss" arrived with *Bolitho*.⁸⁹ Brazier and Miola (2000) have submitted that *Bolitho*, rather than creating a new rule, has only restored *Bolam* to its proper and original limits.⁹⁰ *Bolitho* began the process for eventual banishment of the "protracted erosion of medical protectionism enshrined in *Bolam*" and therefore seems to have paved way more favorable way of bringing claims.⁹¹ To that extent, the *Bolitho* ruling was considered a "timely addendum" or "supplement"⁹² to *Bolam*, giving it a "common sense understanding" which was hitherto unexpressed.⁹³ They conclude that "the court's role as final arbiter has been reasserted,"⁹⁴

Others are less enthusiastic about the impact of *Bolitho* on *Bolam*.⁹⁵ In their view, the House of Lords did not abandon *Bolam*, but merely qualified its use. It is unlikely that *Bolitho* will make a significant difference, as it is rare for expert medical opinion to be considered illogical by the courts.⁹⁶ Therefore, *Bolitho* has done little to counteract the pitfalls of *Bolam*, but conceded, however, that *Bolitho* has confirmed the courts' authority to decide between expert medical witness testimony, and not only on the basis

⁸⁶ No. 4 supra

⁸⁷ No.45 p239

⁸⁸ No.2, p10

⁸⁹ No.25 p 205

⁹⁰ No. 56 p85.

⁹¹ No.2, p10

⁹² B3 391

⁹³ No. 13 p392

⁹⁴ No. 58

⁹⁵ No. 27

⁹⁶ *Wisniewski v Central Manchester HA* (1998) *Lloyd's L.R. Med.* 223

of being ‘Wednesbury unreasonable.’⁹⁷ The pessimists are of the view that Bolam is “neither down nor out.”⁹⁸

Numerous practical problems have affected the application of Bolitho in subsequent cases, perhaps because *Bolitho* gave no clear guidance on its application as a precedent,⁹⁹ and that creates the tendency for confusion over what test to apply.¹⁰⁰ Often, the courts did not rely upon precedent to identify a *Bolitho*-type situation,¹⁰¹ and cases are determined on case to case basis. *Bolitho*, also called the “phantom in the court”¹⁰² is applied only where a body of expert opinion cannot be logically supported at all,¹⁰³ or in some rare circumstances that manifests lacunae in clinical practice.¹⁰⁴ In several cases, there was no explicit reference to *Bolitho* even though its principles were applied.¹⁰⁵ Even as at January 2013, the Court of Session, has held in *M’s Guardian*¹⁰⁶ that a consultant obstetrician was not required to inform the patient of a very small risk of shoulder dystocia since it is a practice accepted by a body of medical men, and being not illogical. Reference was made only to *Bolam*, but not to *Bolitho*.

This, therefore, necessitated a proper categorization of the so called “*Bolitho* factors” to prevent the courts from drawing preference for one expert, which is disallowed.¹⁰⁷ Rachael Mulheron identified some “*Bolitho* factors” or scenarios where Bolitho test could be applied.¹⁰⁸ They include failure to observe a simple, clear precaution to prevent an adverse outcome to the patient.¹⁰⁹ The precaution must be simple and obvious to the ordinary person using common sense.¹¹⁰ Other examples are, failure to

⁹⁷ Check source

⁹⁸ (97)

⁹⁹ (126)

¹⁰⁰ (141)

¹⁰¹ (149)

¹⁰² (151)

¹⁰³ (143)

¹⁰⁴ (153)--66

¹⁰⁵ (128)

¹⁰⁶ (2013) CSIH 3

¹⁰⁷ No. 27 p622

¹⁰⁸ No. 27 p621

¹⁰⁹ No. 27 p621

¹¹⁰ *French v Valley Thames Strategic HA (2005) EWHC459 QBD p 112 (168-78)*

prevent a foreseeable outbreak of puerperal fever,¹¹¹ to consult more experienced specialist,¹¹² or to assign negative status on specimen slides.¹¹³

Also, questions of resources and conflicts of duty could trigger off Bolitho application. Whether a decision was rational or logical depends on other conflicting or co-existing duties to other patients.¹¹⁴ A failure by the doctor to weigh comparative risks and benefits of a chosen course of action could trigger Bolitho application.¹¹⁵ Similarly, where the accepted medical practice contravenes widespread public opinion¹¹⁶ or where the peer medical opinion cannot be correct within the context of the whole factual evidence.¹¹⁷ Additionally, if the course of action is not internally consistent, it could be a good ground for Bolitho application¹¹⁸

Conclusion: *Has Bolitho resolved the Bolam anomalies?*

The *Bolam* test was handed down in 1950s to the effect that a doctor is not negligent if his decision could be supported by a body of medical expert opinion. This was laid down during the “golden era” of the NHS when, due to its paternalistic and unregulated natures of the medical practice, doctors were seen as “knowing best” and therefore enjoyed unquestioned loyalty from the society, including the judiciary.

Bolam, the “bench mark in medical negligence”, attracted lots of criticisms, mainly that it provided immunity to the doctors against medical negligence. The criticisms apparently culminated in the emergence of the *Bolitho* test in 1984. It was found that the courts have ruled many cases in favor of doctors under *Bolam*.

Now, post *Bolitho* has the issue of immunity to healthcare professionals been resolved? *Bolitho* itself was considered vague, and therefore could not provide a clear definition of

¹¹¹ *Hucks v Cole* (1993)4, Med. L.R. 393

¹¹² *AB v Leeds Teaching Hospital NHS Trust* (2004), EWCH 644 QBD 77

¹¹³ No. 72, p4

¹¹⁴ *Garcia v St. Mary's NHS* (2006) EWHC 2314 QBD

¹¹⁵ *Birch v UCLH* (2008) EWCH 2237 QBD p55

¹¹⁶ *Nationwide Organ Retention Group Litigation* under No. 112 supra

¹¹⁷ *Lillywhite v UCL Hospitals; Trust* (2005) EWCA Civ 1466

¹¹⁸ *Hunt v NHS Litigation Authority* (1998) Lloyd's Rep. Med. 425 p34

those factors that would trigger off its application, or explicit precedents to guide the courts in its applications. Precedents arising from *Bolitho* were relatively fewer than the number of cases in which *Bolam* continued to generate precedents. In many cases, *Bolitho* was not explicitly referred to, even though its principles were applied.

Despite the problems enumerated above, *Bolitho* has introduced a “notable symmetry” into the challenges facing patients in medical negligence cases.¹¹⁹ And, even though its impact is sometimes concealed by the implicit instances of its application, *Bolitho* has made a tangible impact on medical jurisprudence by trumping on *Bolam*.¹²⁰ It explicitly empowered the courts to determine the standard of care through the two-steps test. Healthcare professionals can no longer base their action even on beneficence, non-maleficence or therapeutic privileges; they have to defend their actions by *Bolitho* test.¹²¹ A standard must not only be *Bolam* defensible, but it must also be *Bolitho* justifiable. It is still unclear if the courts have really waved “bye-bye *Bolam*.”¹²²

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