From *Bolam* to *Bolitho*: unravelling medical protectionism

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Introduction

In 1990/91 the cost of clinical negligence claims to the NHS was estimated at around £52 million[1]. Twenty years later, by 2009/10, the NHS Litigation Authority (NHSLA) received a record 6,652 negligence claims, a 10% increase on the previous year, and paid almost £800 million in damages[2].

This seemingly inexorable rise in the cost of clinical negligence litigation poses a limitless drain upon the finite health service purse. Contrary to the principles of beneficence, in which resources are equitably distributed for the maximum benefit of the maximum number of patients, large sums of money are diverted away from the wider patient population through the restriction of clinical services and approved treatments to a small number of successful claimants.

Notwithstanding the spiralling cost of clinical negligence claims, fuelled partly by contingency fee arrangements and after the event insurance, the potential number of claimants extends far beyond that which is currently forthcoming. Holding back the tide of litigation remains the hurdle faced in proving liability, a hurdle embodied by the *Bolam* defence.

However, with the courts moving steadily towards a lower, more measurable, standard of proof of liability, stripping away the layer of protection afforded to doctors by *Bolam*, the need for an alternative mechanism for controlling the cost of litigation is easy to understand. The new NHS Redress Act, which returns an element of beneficence to the compensation equation, appears to be a natural and logical response, but it is a gamble as yet untested.

This discussion concerns breach of duty and the *Bolam* defence. It will assess the validity of the assertion that the *Bolam* test unfairly favours doctors at the expense patients who bring claims in clinical negligence against them, and will investigate the effect of the ruling in the *Bolitho* case upon that perceived imbalance.

Firstly, the facts of the *Bolam* case will be outlined, and the importance of the precedent it established will be examined through an analysis of subsequent clinical negligence case law. The problems inherent within the *Bolam* liability test will then be considered to contextualise the judgement in the *Bolitho* case.

Finally, the post-*Bolitho* case law will be analysed to determine not only the extent to which the law has distanced itself from *Bolam* but also to predict where deficiencies

[1] Fenn P, Diacon S, Gray A, Hodges R, Rickman N. Current cost of medical negligence in NHS hospitals: analysis of claims database. BMJ 2000;320:1567–71.
[2] The NHSLA Report and Accounts 2010 available at www.nhsla.com.

remain and the likely trajectory of a more patient-centred judicial approach to medical negligence claims.

The *Bolam* Case[3] - the product of a bygone era?

The 1950s were a 'golden' era for the fledgling NHS. The medical profession was both paternalistic and largely unregulated. Medical professionals enjoyed unquestioning compliance from patients and were treated with great deference by society in general, including the judiciary. Hospital consultants were not accountable to hospital managers as they are today and clinical negligence litigation was in its infancy.

It is important to understand this backdrop, for herein lies the reasoning behind the High Court judgement in *Bolam* v *Friern Hospital Management Committee*, and a legal precedent that, with the passage of time, is feeling its age.

In 1954, John Hector Bolam, a patient suffering from depression, was voluntarily admitted to the Friern Hospital to undergo Electroconvulsive Therapy (ECT), a recognised treatment for intractable depression. The ECT was delivered 'unmodified', that is to say no muscle relaxing drugs were administered. He was unrestrained during treatment apart from the presence of nursing staff at the side of the bed to prevent him from falling. During the course of his treatment Mr Bolam sustained such violent muscles spasms as to cause fractures of both hips. He pursued a claim in negligence, firstly on the grounds that had he been warned of this risk he would not have undergone treatment, and secondly that had he received a muscle relaxant drug his injuries would not have occurred.

Expert evidence revealed a range of professional opinion as to whether or not ECT should be undertaken unmodified, and if no muscle relaxant was used whether or not there was a need for manual restraint to reduce the potential for bone fractures. On the disclosure of risk, the defence maintained that there was no requirement to explain the risks of treatment unless asked specifically to do so by the patient.

McNair J reflected upon the competing testimony of experts, whose opinions he respected equally, in his direction to the jury, and referred to the test of negligence applied by Lord President Clyde in the earlier Scottish case of *Hunter* v *Hanley*[4]:

> '*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.*'

To this McNair J added his own interpretation, contending that a doctor is:

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[3] *Bolam* v *Friern Hospital Management Committee* [1957] 1 W.L.R. 582
[4] *Hunter* v *Hanley* 1955 S.C. 200

> '*…not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. 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.*'

This interpretation prevailed in the minds of the jury who found for the defendant on both issues of consent and treatment. In so doing, the *Bolam* test emerged as a legal benchmark, placing the burden of proof upon claimants to demonstrate that no responsible body of professional opinion would have endorsed a particular course of action, be it the disclosure of risk or the method of treatment.

Protection for doctors under *Bolam*

For many years doctors have enjoyed the protection in law that *Bolam* has brought and it is important to consider some of those cases that best illustrate the scope of its effect upon clinical negligence litigation.

In *Whitehouse* v *Jordan*[5] the Court of Appeal reversed a trial judge's decision that found for the claimant who alleged negligence in the performance of an attempted trial of forceps delivery which left him permanently brain damaged. The case was heard on appeal to the House of Lords which wrestled with the concept of the non-negligent error of judgment, and with Lord Denning's sweeping statement that '*in a professional man, an error of judgment is not negligent*'[6]. Lord Fraser of Tullybeaton effectively re-set the position in law in alignment with *Bolam*:

> '*If* (the error) *is 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.*'

Hence doctors are allowed to make mistakes, so long as they are mistakes that might be made by a responsible body of doctors with equivalent skills and experience, exercising a reasonable standard of care. In *Maynard* v *West Midlands Health Authority*[7] it was established that doctors also benefit from protection under *Bolam* for decisions that flow from a clinical error. In this case the decision to undertake an exploratory mediastinoscopy was based upon a mis-diagnosis of possible Hodgkin's disease, but it was a decision which, under the circumstances, was supported by medical evidence. Lord Scarman confirmed that the law holds no licence to prefer one expert's opinion over another:

> '*…a judge's "preference" for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not*

[5] *Whitehouse* v *Jordan* [1981] 1 W.L.R. 246
[6] *Whitehouse* v *Jordan* [1980] 1 All E.R. 650
[7] *Maynard* v *West Midlands Regional Health Authority* [1984] 1 W.L.R. 634

> *preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his judgment he stated the law correctly. For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate speciality, if he be a specialist) is necessary.*'

What is not clear is what McNair J meant in his *Bolam dicta* by 'responsible' for the word itself, contrary to how it has been interpreted in law, does not quite conjure up the notion of 'majority', or indeed 'significant minority'. It would appear that no matter how small a minority adopt a particular opinion, if that opinion is 'responsibly' held it confers a valid defence to liability.

This was explored further in *De Freitas* v *O'Brien*[8]. The claimant in this case underwent orthopaedic surgery to fuse two lumbar vertebrae, and a second operation to correct the resultant complication of nerve root compression. It was the performance of the second operation that was at issue, an operation which led to leakage of cerebrospinal fluid, infection and chronic disabling pain. The defendant surgeon called upon expert opinion that existed within a small body of only eleven so-called 'spinal' surgeons practising in the UK at that time; opinion within this group of specialists was always likely to differ from the larger body of over a thousand orthopaedic or neurosurgical non-specialists. Although a responsible body of opinion does not have to be substantial one, Otton LJ recognised the potential inequity in attaching disproportionate weight to the opinion of a very small minority and a defence in *Bolam* to which it thereby gives effect:

> '*It was submitted that the Bolam test was not designed to enable small numbers of medical practitioners, intent on carrying out otherwise unjustified exploratory surgery, to assert that their practices are reasonable because they are accepted by more than one doctor. If it appears from the evidence that the body of medical opinion relied upon by the defendant is both very small and diametrically opposed in its views to the conventional views of the vast majority of medical practitioners, the court should be vigilant in carrying out its duty to test whether the body of medical opinion relied upon by the defendant is a "responsible" body.*'

Notwithstanding the apparent anomaly that in civil cases the standard of proof is the balance of probabilities while the *Bolam* test permits a minority view to be determinative, Otton LJ was reluctant to dismantle *Bolam* further for fear that it would degenerate into a 'head count' of opinion:

> '*The issue whether or not to operate could not be determined by counting heads. It was open to him to find as a fact that a small number of specialists constituted a responsible body and that the body would have considered the first defendant's decision justified*'

[8] *De Freitas* v *O'Brien* [1995] P.I.Q.R. P281

Nevertheless, the effect of *De Freitas* was to restore some measure of judicial discretion in the interpretation of witness testimony in cases where it is the minority view that holds sway.

The problem with *Bolam*

There are a number of difficulties with the *Bolam* test which still apply asymmetrically in negligence cases, mainly to the advantage of the defendant doctor or health authority; it is often simply too easy to invoke *Bolam* on the basis of a single expert's opinion and conversely, too difficult for the claimant to show that no other doctor would have acted similarly.

As a measure of liability, *Bolam* gives weight to what medical practice *is* (or what contemporary practice *was*) rather than what practice *should be*. So instead of upholding a standard of care that is good, *Bolam* defaults to a standard of care that can be supported, even if it falls below what is objectively acceptable. Consequently, the court has little discretion to decide what the standard of care should have been considering all the circumstances of a particular case; there is no option to prefer one expert's opinion over another, the choice is all or nothing - can the action be supported or can it not?

Bolam therefore, is a clumsy tool, born out of medical nepotism and implemented through a system of peer review, where doctors set the standards required of them and give testimony in each other's defence. Under *Bolam*, doctors and defence organisations enjoy a degree of protection that validates and perpetuates outdated medical practice simply because that practice remains entrenched in some doctors.

The fault lines in *Bolam* as applied to consent to treatment and the disclosure of risk, have been exposed through a series of cases that have moved the law step-wise to a position more in alignment with that of North American jurisdictions[9,10,11]. Where liability for diagnosis and treatment is concerned, however, *Bolitho* pointed to a palpable indication of judicial dissatisfaction with *Bolam*, and a shift towards redressing of the balance in favour of claimants.

A logical defence: *Bolitho* v *City and Hackney Health Authority*[12]

At the age of two years Patrick Bolitho was diagnosed with a patent ductus arteriosus, a condition that prolongs the foetal circulation after birth to the detriment of the normal oxygenation of the blood. An operation to correct the anomaly had been undertaken in 1983 from which he made a good recovery. A year later he was admitted to St Bartholomew's Hospital with croup. During the course of his admission he experienced a precipitous deterioration in his breathing on several occasions, a sequence of events which culminated in a respiratory collapse and cardiac arrest from which Patrick emerged with severe brain damage and subsequently died.

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[9] *Pearce* v *United Bristol Healthcare NHS Trust* [1999] E.C.C. 167
[10] *Sarah Wyatt* v *Dr Anne Curtis, Central Nottinghamshire Health Authority* [2003] EWCA Civ 1779
[11] *Birch* v *UCL Hospital NHS Foundation Trust* [2008] EWHC 2237 (QB)
[12] *Bolitho (Deceased)* v *City and Hackney HA* [1993] P.I.Q.R. P334

The hospital admitted breach of duty for the failure of the paediatric senior registrar, Dr Horne, to attend when she was called on account of being detained in the out-patient clinic. Experts for the claimant asserted that endo-tracheal intubation would have been the correct course of action under the circumstances, but Dr Horne maintained that even had she attended she would not have attempted intubation and cited *Bolam* to demonstrate that a responsible body of opinion would have endorsed her decision. Therefore, the failure to attend was not causally linked with the respiratory arrest since, hypothetically, had she attended the outcome would have been the same.

It was debated, however, whether or not the *Bolam* test could be properly applied to the chain of causation in this way. The questions for the court were firstly whether or not the hypothetical act of omission would have represented a breach of duty and secondly whether or not intubation would have prevented the injuries that were sustained. The Court of Appeal felt compelled to rely upon expert evidence to answer the first question and found for the defence in determining that had she failed to intubate she would have been acting in accordance with a responsible body of medical opinion. Farquaharson LJ, however, indicated that the *Bolam* test could not be used to justify actions that place a patient at risk:

> '*It is not enough for a defendant to call a number of doctors to say that what he had done or not done was in accord with accepted clinical practice. It is necessary for the judge to consider that evidence and decide whether that clinical practice puts the patient unnecessarily at risk.*'

The subsequent appeal to the House of Lords five years later was dismissed on similar grounds[13] but it provided an opportunity for Lord Brown-Wilkinson to clip the wings of the *Bolam* test by viewing it through the prism of reasonableness:

> '*The effect of the Bolam test is that the defendant must live up to the standard of the ordinary skilled man exercising and professing to have special skill. The existence of the practice is not of itself determinative of the issue of breach of duty. The court has to subject the expert medical evidence to scrutiny and to decide whether the practice is reasonable. The issue of reasonableness is for the court and not for the medical profession.*'

Two caveats to the *Bolam* test emerged. According to Lord Brown-Wilkinson, the reasonableness of professional opinion depends firstly upon careful consideration of the risks and benefits of a particular course of action, and secondly the logic upon which it is founded:

> '*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 in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding*

[13] *Bolitho (Deceased)* v *City and Hackney HA* [1997] 3 W.L.R. 1151

logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

Redressing the balance? *Bolitho* applied

Bolitho therefore, built upon *De Freitas* to require that a defence in *Bolam* must be reasonable both in terms of its logic and in demonstrating that the risks and benefits of a particular course of action have been properly considered.

There was some initial reticence on the part of the judiciary to implement *Bolitho* as illustrated by *Wisniewski* v *Central Manchester Health Authority*[14]. *Wisniewski* closely resembled *Bolitho* in that it also dealt with an act of omission, in this case the failure of a doctor to act upon an abnormal cardiotocograph (CTG) which led to birth asphyxia and cerebral palsy. It was suggested that either the doctor negligently failed to attend when summoned by the midwife, or that the midwife negligently failed to inform him of the abnormality. The trial judge, without the benefit of *Bolitho*, considered what the defendant doctor would have done had he attended and, in finding for the claimant and contrary to some expert opinion, concluded that the abnormal CTG would have alerted him to the need to rupture the foetal membranes and proceed to a caesarean section.

The Court of Appeal however, post-*Bolitho*, concluded that the trial judge was not entitled to substitute his own opinion for that of the defendant's experts and overturned the decision with the comment '*it is quite impossible for a court to hold that the views sincerely held by Mr Macdonald ("an eminent consultant and an impressive witness") and Professor Thomas cannot logically be supported at all*.' Were this degree of deference to medical opinion to have prevailed, then *Bolitho* may never have succeeded in law at all[15].

However, a typical example of *Bolitho* 'in action' arose in 2002 with *Reynolds* v *North Tyneside Health Authority*[16]. Here the court held that the defendant midwife negligently failed to perform a vaginal examination at an appropriate time and, in so doing, missed a foot breach presentation that resulted in cord prolapse, birth asphyxia and cerebral palsy. Gross J dismissed argument on behalf of the defence in classic *Bolitho* style:

> '*Where the sole reason relied upon in support of a practice is untenable, it follows (at least absent very special circumstances) that the practice itself is not defensible and lacks a logical basis. That is the case here. The suggested contrary practice (or body of opinion) is neither defensible nor logical. Having carefully examined the evidence, this is one of those rare cases where it is appropriate to conclude that there is a lacuna in the practice for which there is no proper basis.*'

[14] *Wisniewski* v *Central Manchester Health Authority* [1998] P.I.Q.R. P324
[15] Rachael Mulheron. Trumping Bolam: a critical legal analysis of Bolitho's "gloss" (2010) 69 Cambridge Law Journal 609
[16] *Reynolds* v *North Tyneside Health Authority* [2002] Lloyd's Rep. Med. 459

The issue of benefit versus risk resurfaced as the focus of *Marriott* v *West Midlands Regional Health Authority*[17] concerning a GP who, having attended a patient who had fallen, failed to request tests to exclude an extra-dural haemorrhage. The court heard that the risk of intracranial bleeding after a fall was extremely low, but determined that while a responsible body of opinion would have acted similarly, the seriousness of the complication was sufficient to make a defence in *Bolam* unreasonable.

In *Marriott*, therefore, the approach by the court was to question whether the action taken was *Bolitho* justifiable rather than *Bolam* defensible, a significant step towards redressing the balance in negligence cases in favour of the claimant. However, in considering what might or might not be *Bolitho* justifiable, the court must be careful to avoid undue haste in reaching a conclusion without assimilating the entirety of expert opinion.

It was on these grounds that the Court of Appeal, in favour of the defendant doctor, ordered a retrial following the trial judge's ruling in *Burne* v *A*[18] for failing to allow medical experts to fully explain common practice in the defence of a General Practitioner accused of negligence. Furthermore, where a judge, in weighing the medical evidence, rejects the opinion of the defendant expert, a full explanation of the reasoning behind that decision must be given. In *Glicksman* v *Redbridge Healthcare NHS Trust*[19] the Court of Appeal reversed the trial judge's findings in favour of the claimant, since she had failed to provide a reasoned explanation for her rebuttal of the defendant expert evidence. Henry LJ observed that:

> '*... no reasoned rebuttal of any expert's view was attempted by the judge: her conclusions alone were stated in circumstances which called out for definition of the issues, for marshalling of the evidence, and for reasons to be given.*'

Similar circumstances arose in *Smith* v *Southampton University Hospitals NHS Trust*[20] where complex issues were debated in relation to complications following pelvic cancer surgery. In this case the Court of Appeal found for the claimant, and reversed in part the trial judge's decision since no adequate explanation had been given for preferring a defence in *Bolam* over other medical opinion. Wall LJ re-iterated the view that:

> '*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.*'

Consequently, where a case is determined on the basis of either *Bolam* or *Bolitho*, the judge's decision must be supported by a reasoned explanation having properly considered the full the range of professional opinion. In redressing the balance, therefore, the claimant's case is strengthened by the fact that if a judge is to accept a defence in *Bolam* it becomes incumbent upon them, as well as the defendant, to demonstrate the logic underpinning that defence making it *Bolitho* justifiable.

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[17] *Marriott* v *West Midlands Regional Health Authority* [1999] Lloyd's Rep. Med. 23
[18] *Burne* v *A* [2006] EWCA Civ 24
[19] *Glicksman* v *Redbridge Healthcare NHS Trust* [2001] EWCA Civ 1097
[20] *Smith* v *Southampton University Hospitals NHS Trust* [2007] EWCA Civ 387

Where a case for the defence is made out in *Bolam*, it is also important to separate out findings of fact, upon which a judge is entitled to decide on the balance of probabilities, from a division of medical opinion upon which the judge may adjudicate in accordance with *Bolitho* case law. In *Penney* v *East Kent Health Authority*[21] the cervical smears of four patients were reported by cyto-screeners as negative for early cancerous changes, but all four patients went on to develop invasive cervical cancer. Reviewing the original slides there was a division of expert cytopathologist opinion on what the slides showed.

The defendant health authority submitted a defence in *Bolam*, maintaining that the screeners exercised ordinary skill and judgement; the Court of Appeal, however, supported the trial judge's findings on the basis of fact that the smears *did* demonstrate abnormalities and that those abnormalities should have raised suspicion in the mind of any reasonably competent screener. In reaching his judgement, Lord Woolf MR referred to the earlier *dicta* of Bingham LJ[22], advising caution in the interpretation of some expert evidence:

> '*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.*'

In a later case of missed diagnosis, the defendant obstetrician was put to proof under the maxim of *res ipsa loquitur* to demonstrate how it was that he missed the intra-uterine brain defect of holoprosencephaly[23]. The trial judge considered precedent set by *Bolitho, Maynard* and *Penny* and held that the claimant had failed to establish negligence. However, the Court of Appeal[24] overturned the trial judge's decision. Although it was agreed that *res ipsa loquitur* could not be properly applied to the facts of a complicated case where medical evidence on both sides was forthcoming[25], it was still incumbent upon the defence to provide an explanation for the error; it was not sufficient simply to demonstrate that other practitioners would have erred similarly.

The enduring effect of *Bolitho* was evident in *Oakes* v *Neininger*[26] concerning the failure of an ambulance crew and a general practitioner to diagnose the early stages of cauda equine syndrome and to deliver the claimant patient expediently to hospital for surgery. Akenhead J made a finding of fact in favour of the claimant as to which symptoms, indicative of the condition, were reported by the patient and in referring to the '*arguably culpable omission*' in *Bolitho* held that, but for the negligence, the resultant disability would have been less.

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[21] *Penney* v *East Kent Health Authority* [2000] P.N.L.R. 323
[22] *Eckersley* v *Binnie* [1955–95] P.N.L.R. 348
[23] *Celia Ann Lillywhite, Peter George Lillywhite* v *University College London Hospitals NHS Trust* [2004] EWHC 2452 (QB)
[24] *Lillywhite & Anor* v *University College London Hospitals' NHS Trust* [2005] EWCA Civ 1466
[25] Latham LJ relied upon *obiter* of Hobhouse LJ in *Ratcliffe* v *Plymouth and Torbay Health Authority* [1998] P.I.Q.R. P170: "*Res ipsa loquitur* is not a principle of law and it does not relate to or raise any presumption. It is merely a guide to help identify when a prima facie case is being made out. Where expert and factual evidence is being called on both sides at trial its usefulness will normally have been long since exhausted."
[26] *Oakes* v *Neininger* [2008] EWHC 548 (QB)

Guidelines and the NHS Redress Act: objectivity and pragmatism?

Since *Bolam*, the law has gradually moved from a position where the support of one's peers alone provides an effective defence in negligence, to one where that defence must be reasonable in terms of its logic and regard to risk, where the judge must provide reasons for rejecting medical opinion and where expert evidence is under greater scrutiny for bias.

Bolam, however, still remains the cornerstone of breach of duty, but with the passage of time medical practice is becoming more protocol-driven with guidelines emerging as the new standard of care. Hence a position adopted in *Bolam* must be increasingly qualified by adherence to those objective professional standards, and any departure from clinical guidelines, endorsed by the Royal Colleges, NICE or other bodies, can be easily exposed.

Where a doctor deviates from clinical guidelines the balance of favour shifts further in the direction of the claimant; in such cases the burden of proof falls upon the *doctor* (rather than the claimant) to demonstrate that they were not negligent. In *Clark* v *MacLennan*[27] guidelines existed to prevent haemorrhage following surgery for post-partum stress incontinence. In breach of those guidelines, surgery was undertaken within one month of giving birth; the risk of bleeding eventuated and resulted in permanent and disabling incontinence. Other examples in case law have illustrated the persuasiveness of clinical guidelines in benchmarking the standard of medical care[28,29].

For the doctor, therefore, guidelines are a double-edged sword; on the one hand obedient adherence to guidelines (relevant at least to the time of their writing) confers an objective, evidenced-based confirmation of best practice, while on the other hand doctors remain vulnerable to close scrutiny of their management of any given patient and the potential to unmask inconsistencies with one guideline or another.

Guidelines are fluid and subject to updates and reviews, shifting the medico-legal goal posts at regular intervals. Moreover, reliance upon clinical guidelines as the lowest common denominator of best practice removes independent clinical decision making, arguably contrary to the best interests of patients. Laudably, therefore, the Supreme Court of Western Australia has ruled that lawful practice can indeed exist outside of established clinical guidance[30] while in the United States guidelines informed by unproven scientific methodology, in failing to meet the *Daubert* standard[31], are of little or no evidential value.

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[27] *Clark* v *MacLennan* [1983] 1 All E.R. 416
[28] *Early* v *Newham Health Authority* [1994] 5 Med. L.R. 214
[29] *Fotedar* v *St George's Healthcare NHS Trust* [2005] EWHC 1327 (QB)
[30] *Albrighton* v *Royal Prince Alfred Hospital* [1980] 2 NSWLR 542(CA), 562
[31] *Daubert* v *Merrill Dow Pharmaceuticals Inc*. 509 US 579 (1993)

Nevertheless, studies indicate that lawyers at home[32] and abroad[33] are likely to continue to make use of clinical guidelines, but for now, according to Brian Hurwitz[34], guidelines are simply a starting point representing:

> '*...justified, advocated medical standards—from which to make an assessment of questionable conduct, and this represents quite a departure for the process of adjudication hitherto adopted by the courts, which has relied almost exclusively on expert witnesses setting normative boundaries.*'

In the aftermath of *Bolitho* clinical negligence claims have become more difficult to defend. The pragmatic response by policy-makers has been the NHS Redress Act[35], designed to facilitate the expedient compensation of increasing numbers of claimants, while limiting legal costs and as damages in return. No doubt it is hoped that unworthy cases will cease to be litigated and that the net result will be to limit the overall financial burden of medical litigation to the NHS. This aspiration accords with the principles of beneficence and distributive justice, even though it is one that is denied as the motivating force behind the Act[36].

Conclusion

The *Bolam* test may well be an anachronistic throwback to 1950s medical paternalism but it remains an enduring comparator in medical negligence litigation. Modern day values, however, pay less heed to the pedestal upon which doctors have hitherto been placed, while the internet revolution has created a new generation of well informed patients, fully acquainted with the intricacies of medical treatments as well as the objective care standards established in clinical guidelines.

Undeniably, *Bolitho* marked the beginning of the protracted erosion of medical protectionism enshrined in *Bolam* and a process that gives greater effect to judicial discretion when determining liability in negligence. Lord Woolf summarises the still current position in law, such that '*when interference is justified* (the courts) *must not be deterred from doing so by any principle such as the fact that what has been done is in accord with a practice approved of by a respectable body of medical opinion*.'[37]

While the direction of travel does not appear as yet to have over-compensated for previous inequalities, it certainly seems to have created more favourable conditions for bringing claims. The NHS Redress Act may yet prove effective in creating an alternative and fairer system for compensating the victims of medical accidents but it could equally be forgiven for appearing to represent an exercise in damage limitation.

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[32] Ash Samanta, Michelle M. Mello, Charles Foster, John Tingle, Jo Samanta. The Role Of Clinical Guidelines In Medical Negligence Litigation: A Shift From The Bolam Standard? (2006) 14 Med Law Rev 321

[33] Hyams AL, Brandenburg JA, Lipsitz SR, Shapiro DW, Brennan TA. Practice guidelines and malpractice litigation: a two way street. Ann Intern Med1995; 122: 450-5.

[34] How Does Evidence Based Guidance Influence Determinations of Medical Negligence? Hurwitz, B. BMJ 2004; 329: 1024-8.

[35] NHS Redress Act 2006 c. 44

[36] Lord Warner, Minister of State, Department of Health. Hansard, HL Vol.675, col.207. November 2, 2005.

[37] Lord Woolf. Are The Courts Excessively Deferential To The Medical Profession? (2001) 9 Med Law Rev 1

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