‘A BRAVE NEW BOLAM?’

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SCHOOL OF LAW
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ABSTRACT

This thesis will argue that it is crucial for the courts in clinical negligence claims to play a proactive role in ensuring effective standards in medicine and to provide adequate redress if these standards are not met. I will argue that the courts are, and always have been, the ultimate arbiters of the standard of care in clinical negligence and that it is only right and proper for this to be so. There was a considerable period when the English courts seemingly abdicated responsibility to the clinicians, and failed in carrying out even the most rudimentary checks as to the credibility of expert witnesses. Many commentators blamed the direction to the jury given by McNair J in *Bolam*. Yet *Bolam* of itself did not offer any sort of privilege to doctors. Other powerful factors were acting on the judiciary of this period, skewing the way in which the courts set the standard of legally acceptable medical care. The fear of defensive medicine, the special status ascribed to clinical knowledge and the presumed particularly altruistic nature of its proponents.

That the courts now have the authority to set the appropriate standard of care in clinical negligence is not a particularly contentious claim. But the *Bolitho* decision, in and of itself, will not be sufficient impetus to ensure that such unjustified weight is not accorded to the profession's own views again. *Bolitho* does no more than restore the true meaning of *Bolam*.

There have also in the past decade been changes to clinical professional practice largely led by the medical profession themselves. An increase in evidence based medicine including the usage of clinical guidelines provides a framework for a more assertive judiciary less likely to fall back into deference. In order to provide comprehensive and effective redress within the modern NHS the existence and extent of various institutional primary direct duties of care must be determined. In the increasingly complex healthcare system both commissioners and providers of healthcare must owe a duty to ensure care is taken. The courts must not compromise from an irreducible standard of reasonable care, despite the resource issues facing institutions. A distorted interpretation of *Bolam* must not be permitted to be revived when the institutional duty is invoked.
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Dedication and Acknowledgments

For my Mother, Father, Husband Chris, Son Edward and the late great Maxwell the horse.

This thesis could not have been completed without the support, encouragement and patience of my supervisor Professor Margot Brazier.
INTRODUCTION

The central argument of this thesis is that the courts both could, and should be the ultimate arbiters of what constitutes appropriate medical professional practice, and that medical clinicians should not be treated differently than any other professional group. One of the principal means for controlling the medical profession and demarcating acceptable professional practice has historically been the tort of negligence. Clinical negligence need not be seen as conceptually distinct from the wider tort. Tortious accountability is of symbolic importance, not least because it is the one procedure which injured persons begin themselves. The deterrent effect of accountability via negligence should not be dismissed particularly when considering institutional liability. Healthcare providers anxious to offer the lowest cost procedure may cut costs at the expense of safety.

There was much vocal criticism of the law’s attempt to regulate this area; the Bolam test was found by many to be the culprit. It became synonymous with automatic unthinking deference to medical opinion. While there is no doubt that there was a period when the courts seemingly abdicated responsibility to the clinicians, and failed in carrying out even the most rudimentary checks as to the credibility of expert witnesses, this thesis will contend that period did not inevitably result from the Bolam test. Other powerful factors were acting on the judiciary of this period skewing the way in which the courts set the standard of legally acceptable medical care. Moreover, if McNair J’s oft quoted passage is examined it is plain to see that the courts did (theoretically) have the authority to reject expert medical evidence if after scrutiny it did not meet the appropriate standard of care, that of reasonable care as determined by the court. That the courts now have the authority to set the appropriate standard of care in clinical negligence is not a particularly contentious claim. There have been a

1 Though not the only regulatory mechanism, others being the GMC and CQC there are already concerns about the effectiveness of these bodies as independent regulators, some of which are beyond the scope of this thesis. The coalition governments intended retrenchment of national regulation shows why tort standards via Bolam are important if regulation of clinical practice is too be prescriptive and effective.


3 Some evidence of this might be asserted to exist in the case of secondary care by the fact an ISTCs was less safe than a traditional trust in the treatment of John Hubley and the fact that certain undesirable market forces act on some providers of out of hours care to prioritise economy at the expense of safety.
wealth of commentaries proclaiming the birth of a new Bolam. However commentators do literally mean a new Bolam and point to the decision in Bolitho particularly the only substantive judgment given in the House of Lords that of Lord Browne-Wilkinson. His Lordship proclaimed that in order to be acceptable to the courts, clinical judgment had to be logical. The usage of this adjective was held to have created a new Bolam. This thesis will contend that this variation in the use of the adjective has not and will not on its own produce a new Bolam. If Bolam was applied as interpreted by some commentators, common practice could be determinative of the standard required by law; this would be preposterous. The interpretation of Bolam needs to be right. It will be asserted, we do not need a ‘new Bolam’ as, if the past and to some extent current dichotomy between the theoretical and practical impact of the Bolam test were overcome and the test plainly and confidently applied respecting the spirit of McNair J’s words, this would in practice unleash a ‘brave new Bolam.’ A number of developments the influence of which have intensified in the last decade could combine with this confident interpretation of McNair J’s words to impact on this area meaning that the practical ‘new’ operation of Bolam would remain very much of current concern. The courts’ increased reference to evidence based material may help to close the gap which admittedly has existed between the theoretical Bolam standard and its operation in practice. It will achieve this in a number of ways; firstly, it will make the courts more confident that they can refer to more easily determined standards independent of the vagaries of expert witnesses. Secondly, the changes to medical professional practice e.g. the trend for evidence based practice and the profession’s utilisation of such tools does dispel the mystique of the art of medicine, again making judges more confident to assert the court’s authority. The possibility of the growing importance of direct institutional responsibility will be examined. Although much case law has proceeded against individuals, not all instances of negligence which cause harm fit within this framework. It will be

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4 Ian Kennedy and Andrew Grubb, Medical Law, (2nd edition Butterworths 2000) 3rd edition by Andrew Grubb where it was stated at page 441 “Suddenly in 1993 the Court of Appeal in Bolitho reinterpreted Bolam leaving the Court the final say…subsequently the Court of Appeal approved this ‘new Bolam’ approach.”

5 Bolitho v Hackney HA [1997] All ER 771.


7 With resources under increasing pressure institutional practices are likely to become stretched, for example only having an ‘on duty’ anesthetist during weekdays.
argued that if the law is to provide an effective means of redress for patients who have suffered harm, and retain its prescriptive ability on standards of medical care a direct institutional duty should be extended not just to hospital trusts but to those bodies who are responsible for arranging both primary and secondary care currently Primary Care Trusts. This would ensure effective institutional accountability and an irreducible minimum standard of care, notwithstanding tight resources.

This thesis will examine these arguments in the following chapters. Chapter 1 will examine; the role of common practice in general negligence, medical negligence before Bolam, how Bolam operates in professional negligence other than claims concerning the medical profession and finally the tests operation in certain other jurisdictions in the Commonwealth in relation to clinical negligence.

Chapter 2 will examine why Bolam went awry; including the use of expert witnesses before the Woolf reforms, the impact of the spectre of defensive medicine and the perceptions of medical practice including the special status accorded to physicians in society.

Chapter 3 will develop the argument that the misdirection of Bolam was not inevitable, that what I have termed the “conventional” view of Bolam was not the only interpretation which could be given to McNair J’s words. The chapter will then proceed to outline an “alternative view” to that “conventional” (and much maligned) view. The alternative view contends Bolam needs no theoretical modification in order to permit critical analysis of medical professional conduct and therefore judicial decisions which recognise this should not be properly referred to as ‘new’ Bolam from a substantive perspective, even if they appear new in their application.

Chapter 4 will examine developments within the medical profession’s practice, including evidence based medical practice and question how the principle’s greater utilisation through various mechanisms, for example; clinical guidelines might provide a framework for a more assertive judiciary.

Chapter 5 will examine government policy most particularly the introduction of the National Institute for Health and Clinical Excellence and the Care Quality Commission and how these bodies and their utilisation of the tools discussed in

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8 The Commissioning role will remain, but PCTs are set to be replaced by Commissioning Consortia according to the Health Bill 2011. As methods of delivery change, opportunities for redress become more complex, arguments of liability move to commissioners and providers.

9 *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.
the previous chapter might impact on the determination of the appropriate standard of care. The discussion will be separated in this way in an attempt to gauge the impact of the government endorsed initiatives separately from other sources. Both chapters 4 and 5 will concentrate on the potential of the reforms on the classical liability of the individual medical practitioner.

Chapter 6 will move on to consider institutional liability for clinical negligence particularly the direct primary duty of hospital trusts and commissioners of healthcare. There are a number of reasons why this will be considered; firstly, the present agenda of this government could result in fewer NHS employees providing care to patients. Secondly although such questions might appear to concern the duty of care rather than addressing the standard of care that should be achieved, if there is no direct institutional duty placed on an NHS body, the standard of care owed could conceivably vary with the identity of the body which actually treats the patient.

Chapter 7 will focus on how questions of breach of duty in instances of institutional liability will be determined. The utilisation of *Bolam* in this context and the determination of the appropriate standard of care, given the circumstances of the case, could be politically sensitive. The circumstances of the case become sensitive when harm is caused by less than optimum treatment and particularly so when the notion that care need not even be of a reasonable standard due to NHS resource constraints is postulated to be acceptable.

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10 As the diversity of those providing healthcare under the auspices of the National Health Service increases, the employment status of the individual becomes important, if the vicarious responsibility of NHS bodies were exclusively focused on.

11 Although the distinctive elements of the tort of negligence might be argued to be artificial constructs.
CHAPTER ONE

Bolam: How Deference Seized the Courts

Introduction

This chapter will argue that it was not the intrinsic nature of the Bolam test itself that led to the perceived judicial abdication of control of clinical negligence. It will be argued; the perception of the appropriate standard of care owed in clinical negligence under Bolam, having been inevitably a matter of medical opinion, rather than of law is incorrect. It is contended that just as compliance with common practice in the wider tort of negligence is not determinative of the legal standard of care, nor is it seen as determinative through the operation of Bolam in cases of professional negligence by other groups, common medical practice need not be perceived as determinative in clinical negligence.

The Role of Common Practice in the Tort of Negligence

This thesis is concerned primarily with claims in clinical negligence. However, it is necessary to examine, how the courts ascertain the appropriate standard of care in general negligence litigation, if the assertion, that clinical, or any species of professional negligence, should be seen for what it is, a claim in the tort of negligence, is to be substantiated. When ascertaining the standard of care in general negligence cases it is clear that it is an issue of law and not fact to decide the rules which are to be applied in ascertaining whether or not the defendant has breached their duty. When looking at general cases of negligence it is clear that the standard required is that of the reasonable man, a man of ordinary prudence, a man using ordinary skill and care, it is a

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1 This view will be examined in more depth later on page 6 and 7 of this chapter where it is described as the ‘conventional’ interpretation as in the years where Bolam went awry the approach did appear to become the conventional one.

2 Glasgow Corporation v Mair [1943] AC 448 HL Lord Thankerton explained after deciding that the appellants owed a duty to take reasonable care for the safety of the children on the premises that a further question had to be settled, namely, ‘the test by which…the standard of care is to be judged.’

3 John Murphy, Street on Torts (12th Edition Butterworths 2007) p98.

4 Blyth v Birmingham Waterworks Co. (1856) 11 Exch 781.

5 Vaughan v Menlove (1837) 3 Bing NC 468.

6 Heaven v Pender (1883) 11 QBD 503.
standard set by law. The standard of care that will be required is reached by
consideration of three categories of criteria: objectivity, balancing cost and
benefit and a consideration of community values, common practice is an
important consideration forming part of community values. As Dugdale pointed
out each category contains tensions and requires a balancing exercise. Common practice will not be conclusive, but regarded as a strong indication
that to follow the practice satisfies the exercise of reasonable care, providing of
course there is evidence to show that the practice was followed for some period
without untoward results. Common practice is merely a useful indication as to
the appropriate standard of care, as the practice itself may include an inherent
danger that should not be encouraged. It is clear that the court remains the
ultimate arbiter of the standard of care, contrary to the position in clinical
negligence if the ‘conventional’ view of Bolam is favoured. The court does not
have to wait until an accident occurs, to demonstrate that the practice does not
satisfy the criteria of reasonable care, ‘a neglect of duty does not cease by
repetition to be a neglect of duty.’ It is always open to the court to hold that
common practice does not adequately address a known risk. Furthermore,
condemning accepted practice as not the appropriate standard in law, does not
depend on risks being known, but extends to those risks which ought
reasonably to have been known, but were ignored by the profession or public as
a whole. An example can be found in Re: The Herald of Free Enterprise where Hirst J held that:

Although the practice adopted by Captain Lewry was the same
as that adopted by all the masters of “Spirit” class vessels…
The system that was in operation in all other “Spirit” class ships
was defective. The practice of the other HERALD masters does
not evidence the standard of reasonable care. It evidences a
general and culpable complacency, born perhaps of a repetitive
routine and fostered by shortcomings on the owners and
managers…The standard to which Captain Lewry conformed,
that of his fellow captains fell below the standard of the
reasonably prudent cross-channel ferry Master.

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9 See Gray v Stead [1999] 2 Lloyd's Rep. 559 C.A.
10 Blenkiron v Great Central Gas Consumers Co. Ltd [1948] 1 KB 542.
11 See Slesser J in Carpenters’ Co v Mutual Banking Co. Ltd. [1937] 3 All ER 811.
14 Ibid.
Essentially the test for breach of duty asks, was the defendant's conduct reasonable in all the circumstances of the case, this leaves the court the power to decide what is reasonable and which circumstances of the case have to be considered. Thus, in *Paris v Stepney Borough Council*\(^{15}\) although there was evidence that the general practice of employers was not to provide goggles for certain kinds of work, all of the judges found the employers to be negligent as Lord Simonds made clear;

> It is possible that the practice, however widespread is carried on in disregard of risks that are obvious.

**Medical Negligence before Bolam**

The notion that medical professionals should be answerable for their careless actions pre-dates the conception of the modern tort of negligence. A large variety of situations in which negligence was the common element became subsumed under the action on the case. It was not until 1825 onwards, there was an emergence of negligence as a separate tort. It is notable that the accountability of the medical profession for their conduct predated the modern tort of negligence as well as the *Bolam* test.\(^{16}\) From very early times the medical man has been regarded by the law as answerable for want of care and skill in the exercise of his profession. The profession of surgeon\(^{17}\) was regarded a "common calling", the exercise of which imposed on its practitioners a duty to use proper care and skill “it is the duty of every artificer to use proper skill and care”.\(^{18}\) In 1957 Nathan declared “in modern law the liability of the medical man is only a particular instance of the general liability of the tort of negligence”\(^{19}\) Fifoot\(^{20}\) referred to *The Surgeons Case*\(^{21}\) as probably the first significant malpractice case in English law. In the aforementioned case an analogy is drawn with a horse doctor who escapes liability if 'he does all he can and

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16 The main milestones were *Vaughan v Menlove* (1837) 3 Bing NC 468, *Winterbottom v Wright* (1842) 10 M & W 109, *Heaven v Pender* (1883) 11 QBD 503 Extracted from Murphy John, n3. A comprehensive examination of this area is beyond the scope of this thesis.
17 Like the profession of apothecary.
19 Ibid p 7 although here Nathan n18 was referring to the origin of the duty of care in the broad sense it illustrates that medical negligence did not necessarily evolve as a substantively distinct area of law.
20 Fifoot *C, History and Sources of the Common Law: Tort and Contract* ( Steven's and Sons 1949).
21 *Stratton v Swanland* Y B Hill 48 Edw III, f. 6, pl. 11 (1374).
applies himself with due diligence to the cure’. Teff\(^ {22} \) noted that down the centuries the case law ‘continued to identify the required standard of performance with the public nature of the activity. Lord Loughborough stated ‘if a man gratuitously undertakes to do a thing to the best of his skill, where the situation or the profession is such as to imply skill, an omission of that skill is imputable to him as negligence’.\(^ {23} \) Nathan\(^ {24} \) explained where a person represents he is possessed of special skill or knowledge in the conduct of a profession or calling, the law demands of him that he in fact possesses that skill and knowledge.\(^ {25} \) There is a duty on the medical man to use proper care and skill.\(^ {26} \) These pre-twentieth century cases, display a tension as to how influential professional standards should be judged as the present day decisions do.\(^ {27} \)

\textit{The Distortion of Bolam}

The first point of reference when examining the way in which the law judges what is the appropriate standard of care in professional negligence actions, is the direction which McNair J gave to the jury in the first instance case of \textit{Bolam v Friern Hospital Management Committee}\(^ {28} \) where the plaintiff Mr John Bolam suffered fractures as a result of the administration of electro-convulsive therapy without anaesthetic. At the time, there were in existence two schools of thought.

\begin{itemize}
  \item Harvey Teff, \textit{Reasonable Care} (1\textsuperscript{st} Edition Clarendon Press 1994) p 176.
  \item \textit{Shiells v Harmer} (1789) I Hy Bl 158.
  \item Nathan, n18 p 20.
  \item Ibid. Where he cites \textit{Shiells v Harmer} (1789) I Hy Bl 158 per Heath J at p162 and \textit{Harmer v Cornelious} (1858) 5 CB (NS) 236 “The public profession of an art is a representation and undertaking to all the world that the professor possess the requisite ability and skill. An express promise or express representation in the particular case is not necessary.” per Willes J at p 246.
  \item \textit{Sere v Prentice} (1807) 8 East 347 A twentieth century pre Bolam case which requires ‘the standard of the ordinary careful and competent practitioner of that class’ is \textit{R v Bateman} (1925) 94 KB 791 where at p 794 Lord Hewart C.J. said “The jury should not exact the highest, or a very high, standard, nor should they be content with a very low standard. The law requires a fair and reasonable standard of care and competence.” Also see \textit{Hunter v Hanley} [1955] SLT 213 where Lord President Clyde stated “The true test for establishing negligence in diagnosis or treatment on the part of the doctor is whether he has been proved to be guilty of such a failure as no reasonable doctor of ordinary skill would be guilty of if acting with reasonable care.” Michael Jones with Muiris Lyons, \textit{Medical Negligence} (4\textsuperscript{th} edition Sweet and Maxwell 2008) note that this statement of the law has been approved by the House of Lords \textit{Sidaway v Bethlem Royal Hospital Governors} [1985] AC 871 at 897 per Lord Bridge. But they note that it has been argued that there is a difference between this formulation and the \textit{Bolam} test by Howie [1983] JR 193 c.f. Norrie [1985] JR 145. Also \textit{Mahon v Osbourne} [1939] 1 All ER 535 [1939] 2 KB 14 “the standard of the care which the law requires... is such a degree of care as a normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances of the case in question.” Per Scott LJ at 31.
  \item Teff n 22. Or to put it another way, to illustrate how the debate as to the weight which should be accorded to what is actually done, when determining what ought to have been done, is not a new phenomenon.
  \item \textit{Bolam v Friern Hospital Management Committee} [1957] 2 All ER 118.
\end{itemize}
on the administration of anaesthetic before such treatment, one holding the view relaxant drugs should be used before such treatment, the other held their use only increased the risk. Divergence of professional opinion also existed on the questions of whether Mr Bolam should have been restrained and whether he should have been warned of the risks. McNair J explained:

Where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

He went on;

A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art… Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice merely because there is a body that takes a contrary view.

However, he added,

That does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to the contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying "I don't believe in antiseptics I am going to continue to do my surgery the way that it was done in the Eighteenth century." That would clearly be wrong.

It is not essential for you to decide which of the two practices is the better practice as long as you accept that Dr. Allfrey did was in accordance with a practice accepted by reasonable persons.

The Bolam test was not expressly approved by the House of Lords until the case of Whitehouse v Jordan when the era of deference began in earnest. It was subsequently approved by their Lordships in Maynard v West Midlands Health Authority in cases involving diagnosis, and Sidaway v Bethlem where

30 Maynard v West Midlands Regional Health Authority [1984] 1 WLR 634 [1985] 1 All ER 650.
31 Sidaway v Board of Governors of the Bethlem Royal and Maudsley Hospital [1985] 1 All ER 635.
their Lordships held that *Bolam* was applicable to all aspects of the medical practitioners work including what information the patient should be told. The Court of Appeal reiterated their support for the 'professional' standard, and rejected any distinction between therapeutic and non-therapeutic treatment in *Gold v Haringey HA*.\textsuperscript{32} They held that as the provision of any health care advice or treatment required the exercise of professional skill, the *Bolam* test must apply which they proceeded to apply in a very pro doctor way.\textsuperscript{33} The following decades witnessed an almost total abdication by the judiciary of responsibility for ensuring responsible medical practice. Doctors not judges became arbiters of professional negligence. It might even be said the medical profession moved beyond the law’s remit.

*The ‘Conventional’ View of Bolam*

There is a line of authority that seems to suggest that the judiciary might indeed accord undue deference to the weight of the testimony from medical expert witnesses. For example, in *Maynard v West Midlands RHA*\textsuperscript{34} Lord Scarman, delivering judgment for their Lordships stated:

> A case which is based on the allegation that a fully considered decision of two consultants in the field of their special skill was negligent certainly presents certain difficulties of proof. It is not enough to show that there is a body of competent professional opinion which considers theirs was a wrong decision, if there also exists a body of professional opinion, equally competent which supports their decision as reasonable in the circumstances… Differences of professional practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment.

As Jones contended\textsuperscript{35} the above statement alone is unexceptional enough. However, in the passage below Lord Scarman appeared to adopt the view that compliance with accepted practice will, without more absolve the doctor from liability:

\textsuperscript{32} *Gold v Haringey Health Authority* [1987] 2 All ER 888.
\textsuperscript{33} Ibid.
\textsuperscript{34} *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634 [1985] 1 All ER 635.
\textsuperscript{35} Jones with Lyons n26 p233.
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 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.

Here Lord Scarman, appeared to equate a body of medical opinion with a body of professional opinion which is responsible in fact. Jones argued that he thus conflated accepted medical practice with the absence of negligence. Thus the 'conventional' view of the Bolam test is once the doctor established that his conduct was in accordance with a body of medical professional opinion, he cannot be found in breach of that duty, even though another body of medical opinion takes another view. It could be contended at its crudest that the defendant doctor’s counsel could call together a group of his/her peers to assert that they represent a responsible body of professional opinion, thereby preventing the plaintiff/claimant succeeding. It is after all for the plaintiff/claimant to prove that the doctor failed to act in accordance with a responsible body.

Equally, where there is more than one common practice it would appear compliance with one will usually excuse the defendant. If this view is accepted, if only prima facie, this would mean that expert medical evidence is admissible not only to illustrate what standard practice is, but to actually determine the standard of care required by the law. Judicial support for this view can be found in Lord Scarman's dissenting judgement in Sidaway, where he stated:

The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at that time as proper by a responsible body of medical opinion.

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36 Ibid.
37 There are a number of other cases which have taken a similar view to that of Lord Scarman, Pargeter v Kensington and Chelsea and Westminster Area Health Authority (1979) 2 Lancet 1030, Taylor v Worcester Health Authority [1991] 2 Med LR 215 Burgess v Newcastle Health Authority [1992] 3 Med LR 224 and Ratty v Haringey Health Authority [1994] 5 Med LR 413 at 416 Kennedy LJ said that it was important once it was accepted that [the defendant’s expert witnesses] represented a responsible and reasonable body of colo-rectal opinion, to accept without qualification their [evidence] when evaluating the conduct of the second defendant. Jones, and Lyons n 26 p 232 point out ‘where there has not been a considered clinical judgement, but rather a catalogue of errors, the approach in Maynard to competing professional opinion is not relevant: Le Page v Kingston v Richmond Health Authority [1997] 8 Med LR 229 at 240.
39 Sidaway v Board of Governors of Bethlem Royal and Maudsley Hospital [1985] 1 All ER 365.
even though other doctors adopt a different practice\(^{40}\). In short, the law imposes the duty of care, but the standard of care is a matter for medical judgement.

Kennedy and Grubb\(^{41}\) question whether there is a fundamental problem with the approach of McNair J, in the *Bolam* test, in that his formulation is descriptive rather than prescriptive, as the question of standard of care should be. They contend that it is unusual for the courts to allow a professional group to prescribe what the law is. They appeared to base this argument on that advanced by Montrose\(^{42}\) that the view of McNair J in *Bolam* meant conformity with a professional practice cannot be negligent. Although Montrose did acknowledge later, that ‘it is perhaps going too far to say that McNair J had entirely omitted the possibility of consideration of a recognised practice as negligence’.\(^{43}\) I shall return to this issue, after I have discussed the *Bolitho* decision, in Chapter Three and the plethora of debate that their Lordships sparked as to whether or not what they held amounted to a New *Bolam*.

**Implications of the ‘Conventional View’ of the Bolam test\(^{44}\)**

The problem with such an approach was noted by Teff\(^{45}\) certain judicial applications of the *Bolam* test can convey the appearance of automatically equating professional practice with expertise and identifying the reasonable doctor with the ordinary doctor. If the courts defer too readily to expert evidence

\(^{40}\) It is argued that the presence of the adjective responsible could be interpreted as a way in which the courts would remain the ultimate arbiters of the standard of care and that a way of understanding Lord Scarman’s dicta would be to emphasise that where medical opinion satisfied the objective legal criteria of reasonable or responsible it was not negligent. The closing sentence could be seen as evidence of the ‘conventional’ interpretation of *Bolam* as an abdication of responsibility and *prima facie* difficult to reconcile with the assertion of the possibility of the condemnation of common practice found in *Re The Herald of Free Enterprise: Appeal by Captain Lewry* (1987) *Independent* 18 Dec Div Ct. However even that case while recognising this theory in practice found against Captain Lewry on the basis that while his conduct was in accordance with other HERALD masters it was not in accordance with the standard of the hypothetical reasonably prudent cross channel ferry master. Taken one way (and if the court had not found as they did) this could be interpreted as a number of the ‘conventional’ *Bolam* cases are, as evidence of an abdication of responsibility, as equating the common practice of the profession, other than herald captains, automatically with the standard required by the law. It is suggested that the case should not be viewed in this way but rather seen as an acknowledgment by the court that reasonable care in law will correlate with actual professional practice assuming such practice is objectively reasonable.


\(^{43}\) Ibid.

\(^{44}\) The cases which did not fit within this trend such as *Hucks v Cole* [1993] 4 Med LR 393 are considered in chapter three of this thesis.

the standard of medical care may decline. Kennedy and Grubb\textsuperscript{46} contended it is only if the court sets the standard of care which should be achieved, that the law retains its prescriptive power and does not reduce the conduct expected to the lowest common denominator. Also, Jones\textsuperscript{47} argued that where there are competing views in the medical profession \textit{Bolam} opts for the lowest common denominator.

If it is not ultimately for the court to determine whether any practice is legally acceptable, the medical profession could effectively place itself outside the remit of the law, free to set its own standards according to its own perceptions of what is acceptable. It is contended that the interpretation of the \textit{Bolam} test exemplified by Lord Scarman’s judgment in \textit{Maynard}, with whom the other four Law Lords agreed, obscured the difference between standards and practices which are in fact adopted by the medical profession itself and those which are acceptable in law.\textsuperscript{48} Jackson and Powell\textsuperscript{49} were not alone when they stated that it cannot be right that the court is obliged to give its 'unreserved and universal' approval to all the practices of the medical profession, whatever those practices may be.

\textbf{BOLAM OUTSIDE MEDICINE}

Outside the area of medical practice, the courts had little difficulty in grasping that they themselves remain the ultimate arbiters of the standard of care and whilst common practice is persuasive, it is not conclusive. The corollary of this being the court's willingness to impose its own view of what was reasonable in

\textsuperscript{46} Grubb n 41.
\textsuperscript{47} Jones and Lyons n 26.
\textsuperscript{48} He conflated accepted practice with the absence of negligence. Jones and Lyons n26 p 233 contend that this interpretation is supported by Lord Scarman’s speech in \textit{Sidaway v Bethlem Royal Hospital Governors} [1985] AC 871 at 881 “In short the law imposes the duty of care; but he standard of care is a matter of medical judgement.” Jones and Lyons contend that earlier passages of his judgment illustrate that he considered the \textit{Bolam} test to require the determination of a doctor’s duty of care to be conducted ‘exclusively by reference to the current state of responsible and competent professional opinion and practice at the time’. As he himself recognised “the implications of this view of the law are disturbing. It leaves the determination of the legal duty to the judgment of doctors.” Cf Sir John Donaldson in the Court of Appeal [1984] 1 All ER 1018 at 1028 “The definition of the duty of care is a matter for the law and the courts. They cannot stand idly by if the profession, by an excess of paternalism, denies its patients a real choice. In a word, the law will not permit the medical profession to play God.” Lord Scarman’s interpretation of the \textit{Bolam} test was not supported by Lord Bridge in \textit{Sidaway} who said “…the issue 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 \textit{Bolam} test [1985] AC 871 at 900.
\textsuperscript{49} Jackson R and Powell JL \textit{Professional Liability} (Sixth edition Thomson 2007) p919 where they state that the practice of defending a negligence action by calling an expert to say he would have done as the defendant was held impermissible by the House of Lords in \textit{Bolitho}. 

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the circumstances of the case. It would be odd if the rule on compliance with common practice differed in relation to the medical profession, particularly as the Court of Appeal\(^50\) emphasised that the *Bolam* test applies to all professions equally. They emphasised that as far as they were aware McNair J’s direction had always been treated as being applicable whenever the defendant possessed a special skill. However, as Brazier,\(^51\) pointed out, although the judge is no more expert in carpentry or accountancy practice than he is in medicine, the courts are, more ready to challenge accepted practice as unsatisfactory when considering the practices of professional groups other than the medical profession.

Notwithstanding this, Lloyd LJ commented:

> I can see no possible grounds for distinguishing between doctors and any other profession or calling which requires special skill, knowledge or experience.\(^52\)

This was reinforced by the speech of Lord Diplock in *Sidaway*\(^53\) where he made it clear the *Bolam* test was rooted in an ancient rule of common law applicable to all artificers.

This is not to say the courts should not listen to expert witnesses from the relevant profession in order to gain a factual picture, as to what constitutes common practice. Nor that professionals should be constrained to necessarily follow time honoured procedures at the expense of stifling innovation and growth. As Brazier and Miola\(^54\) contended when peers disagree, and the disagreement illustrates well-founded (therefore reasonable) debate within the profession, the professional should not be penalised. However, this should not license any profession to decide what the appropriate legal standard should be.

When examining the case law in relation to professions other than medicine, it appears that the judiciary take a different line when interpreting the impact the *Bolam* test has on their deliberations as to what amounts to the appropriate standard of care. The line taken with other professional groups does appear

\(^50\) *Gold v Haringey* [1988] QB 481.
\(^52\) *Gold v Haringey* [1988] QB 481 at 489. In *Whitehouse v Jordan* [1981] 1 All ER 267 at 276 Lord Edmund-Davies reinforced his restatement of the *Bolam* with the comment that “doctors and surgeons fall into no special category”.
\(^53\) *Sidaway v Board of Governors of the Bethlem Royal and Maudsley Hospital* [1985] AC 871 [1985] 2 WLR 480 [1985] 1 All ER 643 HL.
more attuned to the approach which is taken towards common practice in non-
professional cases.
In *Lloyds Bank v Savory & Co.* Lord Wright firmly rejected the proposition that
a bank is not negligent if it takes all the precautions usually taken by bankers at
least in cases where:

> The ordinary practice of bankers fails in making due provision
> for a risk known to those experienced in the business of
> banking.

Clearly in the above case, the fact the bank had followed the practice used by
other members of the banking profession, did not absolve them from liability nor
prevent the courts from acting as the ultimate arbiters of the appropriate
standard of care. More modern examples of the courts assertion of ultimate authority in
determining the standard of care in cases of professional negligence can be
found in the following. In *Roberge v Bolduc*, a notary was liable in negligence
despite following a practice which was generally accepted by other notaries
because it was held by the court that the practice simply was not reasonable.
This decision highlights the fact that a practice is generally accepted by a
particular profession, does not automatically make it reasonable in legal terms.
It is this very point some judges appear loath to assert in relation to clinical
negligence.
Also in *Edward Wong Finance Co. Ltd v Johnson, Stokes and Masters* the
court utilised a traditional risk/benefit analysis. They held that the conveyancing
practice adopted by the defendant solicitors, commonly used in Hong Kong,
was negligent because the practice had an inherent risk which would have been
foreseen by a person of reasonable prudence and that there was no need to
take this risk (my emphasis). They emphasised the fact that virtually all other
solicitors adopted this practice was not conclusive evidence that it was prudent.
In *G. & K. Ladenbau Ltd. v Crawley and de Reya* the alleged negligence lay
in the failure of the defendant solicitors when carrying out a conveyance to

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56 This case was decided before McNair J gave his direction in *Bolam* and whilst it is asserted that *Bolam*
was merely a restatement of existing law and therefore such a decision would be perfectly proper after
1957.
59 *G. & K. Ladenbau Ltd. v Crawley and de Reya* [1978] 1 WLR 266.
check the register of common land. The case for the defendants was that conveyancing was an art and it was therefore necessary to allow a solicitor considerable discretion in deciding what searches and enquiries to make.\textsuperscript{60} In \textit{Brown v Gould and Swayne}\textsuperscript{61} where Millett LJ suggested that today questions of acceptable conveyancing practice should be regarded as largely questions of law.

In \textit{Greaves v Baynham}\textsuperscript{62} the fact the defendant would have done the same as Mr Baynham did not excuse him because other designers may too have fallen short of the appropriate standard of care. This is illustrative of the notion while common, perhaps even universal practice is a useful indicator for the courts it is not prescriptive of the standard of care. The Court of Appeal\textsuperscript{63} considered the weight to be accorded to the common practice of surveyors the case centred on the weight that the trial judge had placed on the testimony of the plaintiff’s expert witness. At appeal it was contended that the expert witness had erred in his evidence, as the logical consequence of his view was that the majority of mortgage valuations given on that same estate would have been negligent. This line of argument failed to impress the court as they unanimously agreed that the defendant had been negligent. Ward LJ stated:

\begin{quote}
It is obvious to me that the judge had the standard well in mind. The literature of which a competent surveyor ought to have been aware pointed ineluctably at the risks. The incompetent do not set the standards. Neither do the experts. Nothing in the judgement suggests to me that the judge failed to address himself to the correct standard, which is reasonable competence.\textsuperscript{64}
\end{quote}

The above extract is noteworthy as the plaintiffs included in evidence at first instance a number of books, articles and information papers published well before the valuation and which it was held would have been readily available to surveyors.

\textsuperscript{60} Notwithstanding this, judgment was given for the plaintiff.
\textsuperscript{61} \textit{Brown v Gould & Swayne} [1996] PNLR 130.
\textsuperscript{62} \textit{Greaves &Co (Contractors) Ltd. v Baynham Meikle and Partners} [1975] 1 WLR 1095.
\textsuperscript{63} \textit{Field Palmer & Ors v Izzard & Anor} (1999) unreported Lawtel L1500326.
\textsuperscript{64} Estates Gazette EG No. 0009 Page 178 4/3/2000.
BOLAM IN CANADA, IRELAND AND AUSTRALIA

This is not intended to be an exhaustive comparative examination of the way in which every jurisdiction ascertains the standard of care in clinical negligence actions. However it would seem that, in the jurisdictions used as exemplars, the courts have been at times more confident of the notion that it is the law and not the professions themselves who set the appropriate standard of care in clinical negligence cases.\(^{65}\) They have also been more aware of the dangers of the courts not being the ultimate arbiters. The abdication of responsibility has not occurred to the same extent even where the Bolam test is utilised, although there remains confusion about what the test actually means. This confusion over the application/interpretation of Bolam can be viewed as uncertainty over the correct place and weight to be accorded to common medical practice. It is speculative, how if at all the socio-legal factors such as concerns over defensive medical practices have varied between jurisdictions and whether any variations of sufficient significance can be found to explain the prima facie differences in attitudes.

Canada

In Vancouver General Hospital v McDermid\(^{66}\) Lord Alness said that a defendant charged with negligence can “clear his feet” if he shows that he has acted in accordance with general and approved practice.\(^{67}\) This view of the relevance of actual practice was repeated by Maugham J in Marshall v Lindsey County Council.\(^{68}\)

An act cannot in my opinion, be held to be to a want of reasonable care if it is in accordance with the general practice of mankind. What is reasonable in a world not wholly composed

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\(^{65}\) In a number of cases that are examined from these jurisdictions the area of duty under consideration has been information disclosure. A comprehensive analysis of so called ‘informed consent’ is beyond the scope of this work. It is noteworthy that this might go some way to explain the courts apparent increased confidence in asserting their authority, although the very application of Bolam on a ‘conventional’ interpretation could be perceived as an affront to patient autonomy. However, if applied in accordance with an ‘alternative’ interpretation as outlined in chapter three, and teamed with developments discussed in chapter four, Bolam could as postulated by Jose Miola, ‘On the Materiality of Risk: Paper Tigers and Panaceas’ (2009) 17 Medical Law Review 76 be extremely supportive to patient autonomy.

\(^{66}\) Vancouver General Hospital v McDermid (1934) 152 LT 56.

\(^{67}\) Jones and Lyons n 26 p195.

\(^{68}\) Marshall v Lindsey County Council [1935] 1 KB 516.
of wise men and women must depend on what people presumed to be reasonable constantly do.

Yet even in 1949 the Manitoba Court of Appeal in *Anderson v Chasney*\(^{69}\) recognised that if the doctors plea that he had acted in conformity with general practice was to serve as a complete defence to a claim against him,

A group of operators by adopting some practice could legislate themselves out of liability for negligence to the public by adopting or continuing what was obviously negligent practice, even though a simple precaution, plainly capable of obviating danger which sometimes might result in death was well known.\(^{70}\)

This was one reason why expert evidence from doctors could not be conclusive on the issue of negligence. As Jones\(^{71}\) contended this is ‘especially so where the conduct in question did not involve a matter of technical skill and experience.’ This later qualification could be extremely limiting and it is suggested is unnecessary.\(^{72}\)

Similarly in *Crits v Sylvester*\(^{73}\) Schroeder JA commented that:

Even if it had been established that what was done by the anaesthetist was in accordance with ‘standard practice’, such evidence is not necessarily taken as conclusive on an issue of negligence, particularly where the so-called standard practice related to something which was not essentially conduct requiring medical skill and training either for its performance or a proper understanding of it...If it was standard practice, it was not a safe practice and should not have been followed.\(^{74}\)

In *Hajgato v London Health Association*\(^{75}\) where the prescriptive role was also emphasised and upheld “the courts have a right to strike down substandard approved practice when common sense dictates such a result. No profession is above the law and the courts on the part of the public have a crucial role to play in monitoring and precipitating changes where required in professional standards.”

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\(^{69}\) *Anderson v Chasney* [1949] 4 DLR 71.

\(^{70}\) Per Coyne JA.

\(^{71}\) Jones and Lyons n 26 p199.

\(^{72}\) It is suggested that Jones et al n 26 did not intend to limit the court’s authority, but sought to emphasise that the rejection of common practice as decisive was most notable in information disclosure cases.

\(^{73}\) *Crits v Sylvester* (1956) 1 DLR (2d) 502 affirmed (1956) 5 DLR (2d) 601.

\(^{74}\) *Crits v Sylvester* (1956) 1 DLR (2d) 502 at 541.

\(^{75}\) *Hajgato v London Health Association* (1982) 36 OR (2d) 669 at 693 per Callaghan J.
This principle was echoed in *Roberge v Bolduc*\(^{76}\) by L’Heureux-Dube:\(^{77}\)

The fact that a professional has followed the practice of his peers is strong evidence of reasonable and diligent conduct, but it is not determinative. If the practice is not in accordance with general standards of liability, i.e. that one must act in a reasonable manner, and then the professional who adheres to such a practice can be found liable depending on the facts of each case.\(^{78}\)

**Ireland**

In *O'Donovan v The County Council of the County of Cork*,\(^ {79}\) Lavery J declared the principle for ascertaining the appropriate standard of care was well settled and the same as the courts in England, Ireland, and Scotland. He went on to state:

There is no real difference between the law of negligence to be applied in such a case (i.e. medical) and the general law that requires that a person… Shall discharge that duty with reasonable care, and if he is a person claiming a special knowledge or skill, he shall possess such knowledge or skill in a reasonable degree and will use it.

In *Dunne v National Maternity Hospital*\(^ {80}\) the Supreme Court of Ireland said although a medical practitioner may rely on a general and approved practice of the profession, this will not exculpate him if the claimant establishes that the practice has “inherent defects which ought to be obvious to any person giving the matter due consideration…and an allegation that, although generally adopted they were unsafe”.\(^ {81}\) Yet *Collins v Mid-Western*\(^ {82}\) highlighted the tension felt by the courts when dismissing common practice within a profession

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\(^ {78}\) For an example Jones n26 p 236 points to the case *Comeau v Saint John Regional Hospital* [2001] NBCA 113 where doctors were held liable despite following “accepted” practice, which was inconsistent with measures that a reasonable practitioner would take in such circumstances.

\(^ {79}\) *O'Donovan v The County Council of the County of Cork* [1967] IR 173.

\(^ {80}\) *Dunne v National Maternity Hospital* [1989] IR 91.

\(^ {81}\) *Walsh v Family Planning Services Limited* [1992] 1 IR 496 the patient had been informed of the risk of discomfort in the immediate aftermath of the operation and how in about one in forty case more severe swelling might result involving time off work. He was not warned of orchialgia, an extremely rare and not properly understood consequence of the operation. The surgery went ahead and orchialgia resulted. Expert evidence at the trial established that there had been no general or approved medical practice on warning of the incidence of orchialgia. Chief Justice Finlay held that if in failing to disclose a risk, the medical practitioner was following a general practice prevailing among medical practitioners, and approved of by his colleagues of similar specialisation and skill, he could still be found liable if the plaintiff could satisfy the court that such practice had inherent defects, which ought to have been obvious to any person giving the matter due consideration. Chief Justice Finlay appeared to believe that the court
...a lay tribunal will be reluctant to condemn as unsafe a practice which has been universally approved in a particular profession. The defects in a practice universally followed by specialists in a field are unlikely to be as obvious as the test requires: if they were, it is a reasonable assumption that it would not have been so followed. But the principle, which was first stated by the court in O’Donovan v Cork County Council, is an important reminder that, ultimately, the courts must reserve the power to find as unsafe practices which have been generally followed in a profession. 83

In Geoghegan v Harris84 where although the evidence failed to disclose any other instances of chronic neuropathic pain having arisen as a result of the procedure undergone by the plaintiff, and none of the experts called from either side believed that a warning would have been necessary, the court found for the plaintiff. The duty to warn had been breached by the defendant. They held that the requirements of Walsh had been satisfied, and accordingly there had been a duty to warn which had been breached by the defendant.85

Australia

The weight to be accorded to common professional practice did not appear to trouble Reynolds JA in Albrighton v Royal Prince Alfred Hospital86 when he stated:

…it is not the law that, if all or most of the medical practitioners in Sydney habitually fail to take an available precaution to avoid foreseeable risk of injury to their patients, then none can be found guilty of negligence.

The case F v R87, the facts of which are neatly summarised by Miola88 concerned “a married woman who had already had three children and did not want any

82 Collins v Mid-Western Health Board [2000] 2 IR154.
83 Collins v Mid-Western Health Board [2000] 2 IR154 per Keane J at 156.
84 Geoghegan v Harris [2000] 3 IR 536 the plaintiff underwent a dental implant procedure and was left with chronic neuropathic pain in his chin.
85 Trainor n81 p8.
86 Albrighton v Royal Prince Alfred Hospital [1980] 2 NSWLR 542 at 562.
88 Miola n 65 p85.
more children and was advised by her doctor to undergo a sterilisation by tubal ligation. She consented to the procedure, which was carried out properly, but was not warned of the risk (assessed as being less than one per cent), that the operation might reverse itself. The plaintiff’s claim was unanimously dismissed”. As Miola\(^{89}\) contended the method by which the decision was reached is as important as the result. He explained\(^{90}\) “King CJ used Bolam to determine materiality\(^{91}\) but did not interpret it in the way that the English courts were doing at that time, but instead in the way that Bolitho was later to do. So, when answering the question regarding the adequacy of the warning about risks”, King CJ emphasised “much assistance will be derived from evidence as to the practice prevailing in the medical profession. I am unable to accept, however, that such evidence can be decisive in all circumstances”.\(^{92}\) He continued by explaining the justification for the courts being the ultimate arbiters of the standard of care:

...professions may adopt unreasonable practices. Practices may develop in professions...not because they serve the interests of clients, but because they protect the interests or convenience of members of the profession. The court has an obligation to scrutinize professional practices to ensure that they accord with the standards of reasonableness imposed by the law. A practice... approved and adopted by a profession or a section of it may be in many cases the determining consideration as to what is reasonable... The ultimate question, however, is not whether the defendant's conduct accords with the practice of his profession or some part it, but whether it conforms to the standard of reasonable care demanded by law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community.

In this, King CJ was supported by Bollen J who stated

Nothing in Bolam ...justifies any suggestion that evidence of the practice of the medical profession is automatically decisive of any issue in an action...for negligence.

He similarly concluded that ‘[t]he court will be guided and assisted by the expert evidence. It will not produce an answer merely at the dictation of the expert

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\(^{89}\) Miola n 65 p100.
\(^{90}\) Miola n 65 p87-88.
\(^{91}\) Ibid he refers to the materiality of risk, F v R being an ‘informed consent’ case.
\(^{92}\) F v R (1982) 33 SASR 189 at 19 King CJ as discussed by Miola n 65 p87-88.
evidence’. King CJ as Miola pointed out cited several cases in Australia, New Zealand, Canada and England that he claimed supported his opinion regarding the inconclusiveness of medical expert evidence, including Bolam itself. Miola concluded that the case does not reject Bolam. Although it is difficult to reconcile this assertion with the ‘conventional’ view of Bolam as espoused in England, it is not contentious given an ‘alternative view’.

The next noteworthy Australian case was Rogers v Whitaker, the Australian High Court accepted that there was a single comprehensive duty of care which covered diagnosis, treatment and the provision of information to the patient. However Grubb explained the High Court made clear that the content of the duty varies depending on the activity that the doctor is engaged in. He contended even as regards diagnosis and treatment, the Court was reluctant to endorse the Bolam approach, holding only that medical evidence ‘will have an influential, often decisive role to play.’ The High Courts decision regarding the doctor’s duty of information disclosure could be viewed as an abandonment of Bolam. The question of whether a patient has received sufficient information to allow them to make a decision to consent to treatment ‘is not a question the answer to which depends on medical standards or practices’. Yet the court went on to state that the content of this aspect of a doctor’s duty was ‘a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is or should reasonably be aware

93 Ibid p201. He held “but the court does not merely follow expert evidence slavishly to a decision. The court considers and weighs up all admissible evidence which it has received. If the court did merely follow the path apparently pointed out by expert evidence with no critical consideration of it and the other evidence, it would abdicate its duty to decide on the evidence, whether in law a duty existed and had not been discharged.” Per Bollen J.
94 Miola n 65.
96 Miola n 65 p107.
97 Rogers v Whitaker (1992) 67 AJLR 47.
99 Grubb n 99 p170.
100 Miola n 65. It is only in light of the decisions and interpretations at the height of deference in England termed the ‘conventional view’ of Bolam that such a statement necessarily need to be seen as contradictory or restrictive of the principle in Bolam.
101 Grubb n 99.
that the particular patient if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege’. It is contended while the approach in the first part of this quote of removing this question from the medical practitioners remit is understandable when considering patient autonomy the latter part of the quote shows how the same result could have been achieved without the distancing from the Bolam test at all. Particularly when the facts of the case, as neatly summarised by Miola are reviewed; “Maree Whitaker had for many years been blind in one eye. She consulted an ophthalmic surgeon, who advised her he could offer an operation that would not only improve the appearance of her 'bad' eye, but also potentially restore some sight to it. Mrs Whitaker consented to the operation, which was performed. Unfortunately, not only did her eyesight in her 'bad' eye not improve, but her other eye developed an inflammation that led to the loss of all sight in that eye, due to sympathetic ophthalmia, which the court assessed as having a likelihood of 1 in 14,000 of occurring. Mrs Whitaker sued on the basis that the failure of the doctor to warn her of the risk constituted negligence”. As Miola outlined the submissions to the court by the opposing barristers provide a snapshot of the approaches the judges had to decide between. The appellant submitted that '[h]aving found that there were two responsible bodies of medical opinion on the issue [of whether to warn of the risk], it was not open to the judge to choose between them'. Moreover, a reference to 'professional expertise' with regard to warning of risks only serves to strengthen the idea the appellant was arguing that these were his decisions to make as a doctor. The respondent, meanwhile, submitted Bolam 'does not establish that simply because there is a body of reasonable medical opinion a practitioner who follows that opinion cannot be guilty of negligence'. The question said the Court, was not whether the defendant’s conduct accorded with the practice of the medical profession or some part of it, but whether it conformed to the standard of reasonable care.

102 Grubb n 99 where he contended that this broke the link between Bolam and the duty to inform. Whether such a break is necessary or desirable from an ideological perspective is not a question that will be addressed here as the focus for present purposes is the level of control which the Bolam test gives the court when reviewing medical practice.

103 Miola n 65.

104 She won damages at first instance, and the defendant’s appeal was dismissed. He made the further appeal to the High Court of Australia who found lack of disclosure was negligent. The High Court took the opportunity provided by this appeal to state the law for Australia not only in relation to what the medical practitioner must tell the patient concerning the risks of the proposed treatment but also in relation to the question whether a court can, in appropriate circumstances, demand a standard of care which is at variance with the practices of the medical profession or some part of it.

That was a question for the court, and the duty of deciding it could not be
deprecated to any profession or group within the community. Jones agreed
the standard required here was reasonable care and the duty of deciding this
standard could not be delegated to the medical profession. This approach was
reiterated in Naxakis v Western General which interpreted Rogers as having
rejected the Bolam test. Amirthalingam asserted there is a retreat in
Rosenberg v Percival from the position that had been adopted in Rogers. In
Rosenberg v Percival Gleeson CJ commented that Rogers v Whitaker makes
it clear that professional practice and opinion was relevant, but what the case
denied was its conclusiveness. He took the view that, while the standard of care
in medical negligence cases was a matter for the judges to decide, “in many
cases, professional practice and opinion will be the primary, and in some cases
it may be the only, basis upon which a court may reasonably act.”

Conclusion

This chapter has shown if the role of common practice was accorded the same
weight in clinical negligence as in other professions negligence, the courts
would remain the ultimate arbiters of the standard of care which should be
achieved. In the years which Bolam might have been said to have gone awry,
when deference towards common medical practice seized the courts, this
deference was not adopted toward other groups of professionals when
determining the standards which they should achieve. The courts in Ireland,
Australia and New Zealand also appear to have been less afflicted with this
deference to clinical opinion while applying Bolam than their English
counterparts. This serves to illustrate it was not the adoption and application of
Bolam which led to the period of undue deference.

SASR 524 Ellis v Wallsend District Hospital (1989) 17 NSWLR 553. The High Court specifically
disapproved Bolam v Friern Hospital Management Committee (1957) 1 WLR 582 and Sidaway v Board
of Governors of the Bethlem Royal Hospital (1985) AC 871.
107 Jones and Lyons n 26 p 201.
108 Naxakis v Western General Hospital [1999] HCA (1999) 162 ALR 540 the interpretation they took of
Bolam was that it involved treating what other doctors say they would do in the same or similar
circumstances as decisive. This would appear to be in accordance with a ‘conventional’ interpretation of
the Bolam test. It is submitted that the High Court were correct in their rejection of the decisiveness of
medical practice on the standard of care but that they incorrectly blamed Bolam for conflating the two
standards.
532.
112 Where the Bolam test is also utilised.
CHAPTER TWO

Why Bolam went Awry

Introduction

The prima facie conclusion which was drawn in Chapter 1 that medical doctors had, over the years when Bolam went awry, received more favourable treatment from the courts than other professional groups appears inescapable. This chapter will seek to examine some of the reasons for this differential treatment; including the underlying rationales which might have contributed to the more favourable treatment of medical professionals and distorted the operation of the Bolam test, giving rise to what is termed in this thesis as the ‘conventional view’ of Bolam. The first part of the chapter will begin by looking at the pre Woolf Report position, in relation to the utilisation and treatment of expert witnesses in both medical and non-medical case law. It will question whether or not medical evidence really is more complex and difficult to understand for the judiciary than evidence about any other profession, or even a technical occupation that one may require specialist training for. This quasi-legal section will conclude with an examination of the notion of defensive medicine. It might be that the judiciary’s fear of such a spectre appearing on the English horizon, could go some way to explaining why the medical doctor is treated more favourably than other professional groups. The chapter will then go on to examine other possible explanations for the apparent judicial deference from a wider socio-political perspective. This chapter will conclude by postulating the idea that if we are to see ‘a brave new Bolam’ it will take more than the Bolitho judgment. As judicial policy influences the interpretation of

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1 The view that compliance with accepted practice will, without more absolve the doctor from liability: the ‘conventional’ view of the Bolam test is once the doctor established that his conduct was in accordance with a body of medical professional opinion, he cannot be found in breach of that duty, even though another body of medical opinion takes another view as discussed more fully in chapter one of this thesis, see page 23.


3 The question of whether this assertion should be in the past or present tense has been reflected on and I have decided to continue to use the present tense as I consider that the medical doctor is still today treated more favourably.
black letter law, and it is the amalgam of social influences discussed within this chapter which in turn informs judicial policy.

*The role of experts before the Woolf reforms*

Within the tort of negligence the court determines certain benchmarks; for example if A owes B a duty of care, A must attain the standard of the ‘reasonable’ person.\(^4\) The standard of the reasonable person is a legal construct,\(^5\) although the facts of the case will be considered by the courts in determining this standard. Commonly, a defendant will support his claim to have shown due care by showing that he conformed to the common practice of those engaged in the activity in question.\(^6\) Such evidence will only support the claim, as the determination of the standard of care is a matter for the courts.\(^7\) Courts’ cannot decide whether a doctor has been negligent without expert evidence\(^8\) of ‘accepted medical practice’.\(^9\) In claims against other professionals the courts for many years scrutinized such claims to ensure that evidence of professional opinion could be demonstrated as reasonable and responsible.\(^10\) In claims against doctors, it appeared as long as suitably qualified expert witnesses endorsed the defendant’s conduct, English judges nearly always\(^11\) deferred to the doctors.\(^12\) The courts appeared to conflate truthful expert testimony with reasonable and responsible practice. It has been argued\(^13\) the key to successfully defending a claim in negligence was to find expert witnesses who would be impressive in the witness box. In *Whitehouse v Jordan*; Mr Jordan was referred to as ‘very able and promising’,\(^14\) as a young obstetrician of ‘highest skill and repute’\(^15\) and it was noted that the specialist unit where he worked was ‘held in the highest regard by the medical profession.’\(^16\) Mr Ross,  

\(^5\) Ibid.  
\(^6\) Murphy n 4 p106.  
\(^7\) *Glasgow Corporation v Muir* [1943] AC 448.  
\(^8\) Margaret Brazier and Emma Cave *Medicine, Patients and the Law* (5th edition, Penguin, 2011) p162.  
\(^10\) Brazier and Cave n8 p162.  
\(^11\) Chapter Three will argue that a few pre-*Bolitho* cases clearly recognised that the courts were the ultimate arbiters of the standard of care. The most notable of these efforts was probably *Hucks v Cole* (1968) [1993] 4 Med LR 393.  
\(^12\) Ibid.  
\(^13\) Ibid.  
\(^14\) *Whitehouse v Jordan* [1980] 1 All ER 650 at 653.  
\(^15\) Ibid 662.  
\(^16\) Ibid 656.
one of the surgeons in *Maynard*, was described as ‘a careful, skilful, highly experienced consultant with a cautious approach’. The approach by the courts that evidence of medical practice was somehow more complex and beyond their comprehension has been another closely related reason for the medical profession’s favourable treatment in tort. An example of the judiciary’s belief in the mysterious quality of clinical judgment can be found in the following extract of a judgment from Denning LJ. Here Denning LJ quoted from the expert’s report adduced for Mr Whitehouse:

> How hard one should pull with forceps and how many times one should pull in this kind of case is a matter of clinical judgment based on experience…I can see nothing improper in this course of action nor in the manner of implementing it. One cannot argue that because the child probably suffered some intracranial damage (although even this is uncertain) he pulled too hard.

The ‘virtual immunity’ offered to the medical profession for errors of clinical judgement was firmly condemned by Lord Edmund Davies sitting in the House of Lords in *Whitehouse*;¹⁸

> The test of negligence is the ordinary skilled man exercising or professing to have that special skill. If a surgeon fails to measure up to that standard in any respect (‘clinical judgment’) or otherwise he has been negligent.

Yet the courts have been reticent in finding that clinical judgment has not achieved this standard of reasonable care. Maclean¹⁹ contended because in cases of clinical negligence, the doctors and the courts recognise the concept of clinical judgment, it allows the doctor a certain security in his decision making. She contended that the concept of clinical judgment places a barrier in front of the claimant.²⁰ Presumably Maclean is referring to the extent to which the clinician is permitted to depart from the evidence base,²¹ without advancing an explanation other than a bald assertion of their clinical judgment.

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¹⁷ at 657.
¹⁸ [1981] 1 WLR 246 at 258, HL.
²⁰ Ibid.
²¹ Even if the evidence base in question is extremely restricted. If it is limited to partisan witness testimony it clearly interacts with the previous concern that truthful testimony might be conflated with reasonable practice.
This notion of the clinical judgment of the doctor has been of pivotal importance and has been further exacerbated by the fact that medicine has not by any means always been evidence based. In 1993 Roy Griffiths,\textsuperscript{22} wrote about practices within the NHS, "clinical evaluation of particular practices is by no means common". It seems that in some instances there have been long delays in implementing the results of clinical findings within clinical practice. For example: in 1601 lemon juice was shown to be effective in the prevention of scurvy by James Lancaster. The experiment was repeated nearly 150 years later, with the British Navy eventually adopting the prophylactic at the beginning of the Nineteenth Century.\textsuperscript{23} More recently Haines and Jones\textsuperscript{24} noted that thrombolytic treatment for myocardial infarction was shown to be clinically effective more than a decade before it was widely advocated. They\textsuperscript{25} also questioned how given in their view after dilation and curettage had been shown to be "therapeutically useless and diagnostically inaccurate"; it was in 1992/93 still the fourth most commonly performed surgery in the NHS.\textsuperscript{26} The NHS Executive's commitment\textsuperscript{27} to improving clinical effectiveness and moving towards evidence based medicine first became explicit in 1993.\textsuperscript{28} It stressed (with an audience of chief executives in mind) the growing body of information which they could use to improve the effectiveness of their services and drew their attention to guidelines available. By the 1994/95 contracting round, purchasing authorities were asked to provide summaries of the action that they were taking to use these guidelines.\textsuperscript{29} A more in-depth examination of the impact of evidence based medicine will be carried out in Chapter 4.

\textit{The Spectre of Defensive Medicine}

The fear of defensive medicine has certainly been a cause for concern among elements of the judiciary notwithstanding a lack of evidence for such a

\textsuperscript{23} A. Haines and R. Jones, 'Implementing the Findings of Research' (1994) 308 \textit{British Medical Journal} 1488.
\textsuperscript{24} Ibid.
\textsuperscript{25} Ibid.
\textsuperscript{26} Ibid.
\textsuperscript{27} EL (93)115 issued in December 1993 was the first executive letter to make this commitment explicit.
\textsuperscript{28} Acting on the Evidence - A review of clinical effectiveness: sources of information, dissemination and implementation, National Association of Health Authorities and Trusts Research paper 17.
\textsuperscript{29} Ibid.
phenomenon.\textsuperscript{30} This has been part of a wider fear over the last twenty years, most evident in the medical literature and popular press that the UK is in the grip of a malpractice crisis. They feared that the increased likelihood of litigation would lead to defensive medical practices. Lawton LJ in \textit{Whitehouse v Jordan} said “defensive medicine consists of adopting procedures which are not for the benefit of the patient but safeguards against the possibility of a patient making a claim in negligence”.\textsuperscript{31}

The consequences of which would include \textit{inter alia}; a waste of resources, and the possibility certain areas of medical practice would become less attractive to new members of the profession and perhaps even avoided. Ham et al, identified several ‘high risk’ specialities as being obstetrics and gynaecology, anaesthetics, accident and emergency, orthopaedics and neurosurgery\textsuperscript{32} Ham, Dingwall, Fenn and Harris reported in 1988, they referred to Lord Pitt’s definition of the phenomenon:

\begin{quote}
If doctors are to face these awards of severe damages they have to make sure of their defence. You are always better off in the witness box if you can say that you have done all the tests that are considered necessary...This means that one is wasting resources. We must therefore face the fact that if we are going to pursue the course that we are now pursuing we shall find an increase in defensive medicine with an alarming waste of resources.\textsuperscript{33}
\end{quote}

It is notable how Lord Pitt appeared to equate the ability of the clinician in the witness box to say that they had done all the tests they considered necessary with a waste of resources. Is this not rather a contradiction in terms? Is the assertion that to proceed with medical treatment without conducting all the diagnostic tests the clinician considers necessary is acceptable practice?\textsuperscript{34} Jones and Lyons discuss the lack of agreement about the meaning of the term ‘defensive medicine’ and how some doctors use the term defensive simply to mean treating the patient conservatively or even “more carefully” and how what

\textsuperscript{30}Michael Jones with Muiris Lyons \textit{Medical Negligence} (4th edition Sweet and Maxwell 2008) p 295 where they noted judicial acceptance of the phenomenon.
\textsuperscript{31} \textit{Whitehouse v Jordan} [1980] 1 All ER 650 (CA) at 659.
\textsuperscript{32} C. Ham, R. Dingwall, P. Fenn, and D. Harris \textit{Medical Negligence: Compensation and Accountability} (London Kings Fund Institute 1988).
\textsuperscript{33} Hansard HL debate, 10 November 1987, columns1350-51.
\textsuperscript{34} Jones with Lyons n 30 p 21. Also M J Powers in R V Clements (ed) \textit{Safe Practice in Obstetrics and Gynaecology} (1994 Churchill, Livingstone) p15 comments that “Often what is regarded as defensive medicine is simply the prevailing view of safe and prudent practice.”
to one doctor may seem defensive may to another appear good practice.

McQuade\textsuperscript{35} defined defensive medicine as

The ordering of treatments, tests and procedures for the purpose of protecting the doctor from criticism rather than diagnosing or treating the patient.

The definitions given by Lord Pitt and McQuade are examples of the fear that such practice would appear and act as a potentially alarming drain on resources. The difficulty remains in deciding when further tests and cross-checks cease to be sensible precautions in the interests of the patient and become a waste of resources.\textsuperscript{36}

Lord Denning, in particular was most vocal in his warnings of defensive medicine.\textsuperscript{37} He warned in \textit{Whitehouse v Jordan}:\textsuperscript{38}

\begin{quote}
Take heed of what is happening in the United States 'Medical 'Malpractice' cases there are very worrying... Experienced practitioners are known to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved. In the interests of all we must avoid such consequences in England.
\end{quote}

Lord Denning illustrated the notion that the threat of litigation will prevent doctors from taking on the treatment of certain 'high risk patients' at all, and the perceived risk that the profession may end up being seriously depleted as young men (\textit{sic}) are deterred from entering the profession. Of course if these threats were to be proven by objective evidence the implications for society could be very worrying.\textsuperscript{39}

Much earlier in \textit{Roe v Minister of Health}\textsuperscript{40} he had stated:

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{35}JS McQuade, ‘The medical malpractice crisis-reflections on the alleged causes and proposed cures: Discussion paper’ (1991) 84 \textit{Journal of the Royal Society of Medicine} 408.
\item \textsuperscript{36}Brazier and Cave n8 p238.
\item \textsuperscript{37}Jones with Lyons n 30 p 295.
\item \textsuperscript{38}\textit{Whitehouse v Jordan} [1981] 1 All ER 267.
\item \textsuperscript{39}There is very little evidence to support the existence of this phenomenon in England. Ham et al noted that a commonly cited example of such defensive practice was the increased rate in caesarean section deliveries. However caesarean rates have been increasing in many other developed countries with different systems of healthcare provision and different litigation practices. They therefore conclude this increase can be explained by factors which have little to do with litigation. Jones with Lyons n 30 p 21 are critical of the assumption of the phenomenon’s existence without empirical evidence to support its existence in the NHS.
\item \textsuperscript{40}\textit{Roe v Minister of Health} [1954] 2 QB 66 at 86-87.
\end{itemize}
\end{footnotesize}
We should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think of more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken.

He explained in *Hatcher v Black*\textsuperscript{41}

...a doctor examining a patient, or surgeon operating at his table, instead of getting on with his work, would be forever looking over his shoulder to see if someone was coming up with a dagger - for an action in negligence against a doctor is for him like unto a dagger.\textsuperscript{42}

Judicial concern over the cost of litigation to the NHS has been expressed, by Stuart-Smith LJ in *AB v John Wyeth & Brother Ltd*\textsuperscript{43} where he stated:

The National Health Service has better things to spend its money on than lawyer’s fees and the cost...is a matter of public concern.

However, it cannot be stated that the whole of the judiciary has fallen prey to the fear of defensive medicine and the potential consequences of such practice. Some judgments have actually acknowledged that making special allowances for the medical profession in order to avoid such fears may lead to more negative consequences. For example:

Rougier J\textsuperscript{44} in *Barker v Nugent*

I can only think of one thing more disastrous than the escalation of defensive medicine and that is the engendering of a belief in the medical profession that certain acts or omissions which would otherwise be classed as negligence can, in a sense, be exonerated.

Also, Mustill LJ in *Wilsher*\textsuperscript{45}

...the proper response can not be to temper the wind of the professional man. If he assumes to perform a task, he must bring to it the appropriate care and skill.

\textsuperscript{41} *Hatcher v Black* (1954) The Times 2\textsuperscript{nd} July.
\textsuperscript{42} *Hatcher v Black* (1954) The Times 2\textsuperscript{nd} July.
\textsuperscript{43} *AB v John Wyeth & Brother Ltd* [1994] 5 Med LR 149 at 153.
\textsuperscript{44} *Barker v Nugent* Unreported, Extracted from Jones with Lyons n 30.
\textsuperscript{45} [1986] 3 All ER 801 CA.
At least one senior member of the judiciary has noted, extra judicially:

It is unwise to place any profession or other public body providing services to the public on a pedestal where their activities cannot be subject to close scrutiny. The greater the power the body has, the more important the need.\(^46\)

The idea that a differential approach was required toward clinical negligence was evident in Lord Hoffman’s judgment in *Fairchild v Glenhaven Funeral Services Ltd*\(^47\) where he endorsed the narrow application of *McGhee*\(^48\) which had been adopted by their Lordships in *Wilsher*.\(^49\) He opined:

\[\text{...the political and economic arguments involved in the massive increase in the liability of the National Health Service which would have been a consequence of the broad rule favoured by the Court of Appeal in *Wilsher’s* case are far more complicated than the reasons...for imposing liability upon an employer who has failed to take simple precautions.}\(^50\)

This differential treatment of clinical negligence continued in *Gregg v Scott*\(^51\) the facts of which are neatly summarised by Brazier and Cave “in November 1994 his GP (the defendant) wrongly diagnosed a lump under Mr Gregg’s arm as a benign lipoma. The following August a different doctor referred him to a consultant and, a biopsy revealed a malignant lymphoma. The delay in diagnosis reduced Mr Gregg’s chance of a cure from 42 to 25 per cent.” By a majority of 3:2 the House of Lords rejected the claim, though given the disparities in their Lordships’ speeches no clear principle has emerged.\(^52\) Baroness Hale noted an anomaly in the outcome:

\[\text{So why should my solicitor be liable for negligently depriving me of the chance of winning my action, even if I never had a better than evens chance of success, when my doctor, is not liable for negligently depriving me of my chance of getting better, even if I never had a better than evens chance of getting better? Is this another example of the law being kinder to the medical profession than to other professions?}\(^53\)

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\(^{47}\) *Fairchild v Glenhaven Funeral Services Ltd* [2002] UKHL 22 [2002] 3 All ER 305.

\(^{48}\) *McGhee v National Coal Board* [1972] 3 All ER 1008 HL.

\(^{49}\) *Wilsher v Essex Area Health Authority* [1988] AC 1074 HL.

\(^{50}\) *Fairchild v Glenhaven Funeral Services Ltd* [2002] UKHL 22 at par 69.

\(^{51}\) *Gregg v Scott* [2005] UKHL 2; [2005] 2 A.C. 176.

\(^{52}\) Jones with Lyons n 30 p 504.

\(^{53}\) *Gregg v Scott* [2005] UKHL 2 at 218.
Yet she declined to answer her own question. The fear of both cost and defensive practices might have influenced these later developments. Yet Lord Nicholls was dismissive of the defensive medicine argument in *Gregg v Scott*.\(^{54}\)

This argument is not impressive. Every doctor is fully aware he may be sued if he is negligent. There is no reason to believe that adopting the approach set out...will affect the practices followed by doctors.

Furthermore as Lord Bingham\(^{55}\) noted:

To describe awareness of a legal duty as having an ‘insidious effect’ on the mind of a potential defendant is to undermine the foundation of the law of professional negligence.

The idea of the unique nature of medical practice was evidenced by Dunn LJ in *Sidaway*\(^{56}\) which discussed the differences between the disclosure of risks\(^{57}\) by a consulting engineer and a medical doctor:

In my judgment therefore the justification for treating a doctor as being under a duty to disclose different from that applicable in other cases can not be simply in the fact that in relation to diagnosis and treatment of patients he is exercising a professional skill. The justification, if any, must be found in factors peculiar to the medical profession which demonstrates the general rule applicable to other professions is inappropriate in that case. Are there any such factors?

He went on:

There are a number of factors which undoubtedly distinguish the doctor's position from that of any other professional man in relation to the disclosure of unusual but material risks. First, in general terms the patient goes to the doctor to be cured and the overriding concern of the doctor is to use his professional skill to effect a cure. Second, the process of treatment depends to a substantial extent on the relationship between the patient and the doctor, in particular the confidence of the patient in the doctor, the existence of a duty to disclose such risks would positively militate against

\(^{54}\) *Gregg v Scott* [2005] UKHL 2 where he was in favour of imposing liability on a doctor in respect of the lost opportunity of successful treatment for cancer.

\(^{55}\) *JD v East Berkshire Community Health NHS Trust* [2005] UKHL 23 at 33.

\(^{56}\) *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1984] 1 All ER 1018 at 1032.

\(^{57}\) This thesis is not concerned with information disclosure per se but the above extract is useful as it illustrates the differential approach of the courts to the medical as opposed to other professions. This reinforces the more colloquial evidence that the medical profession is viewed differently to others.
the main purpose of the relationship, a factor not present in relation to disclosure of risks by any other professional advisor.

It might be questioned whether the attitude of the court in *Chester v Afshar* illustrates a shift in the attitudes of certain members of the judiciary and the significance of such a change.

*Perceptions of Medicine - The special status of physicians*

This section will set out and examine the social context of the judgments which have ignited much of the criticism of the *Bolam* test, in relation to clinical negligence. This social context will go some way to explain the deference shown by the courts to the medical profession. This section will examine the nature and practice of the profession of medicine and the nature of the relationship between doctors and patients. It will investigate the perceived 'special' motivation of the medical professional. Moving on to examine the perceptions and images of the medical profession in popular culture, drawing on examples from the arts and quantifiable expressions of public opinion using the legal profession as a comparison, it will question how these images reinforce the special status attributed to the medical profession and the doctor/patient relationship. How despite a number of high profile incidents which suggest that medical professionals can be subject to the same failings and weaknesses as other groups their special status continues, if not completely unabashed. The material in these sections will go some way to explain why there has been such a conservative interpretation of McNair J's direction. Sheldon contended the choice the judiciary makes as to which policy arguments to give precedence to is best understood in the context of class, race

59 Where a patient was not told of an inherent risk and the risk materialised (and according to JK Mason and G Laurie, *Mason and McCull Smith’s Law and Medical Ethics* (Eighth Edition Oxford University Press 2011) p 158 the law of causation dictated that she had to prove that she would never have had the operation. All five of their Lordships agreed she would fail on a strict application of the law, but the majority could not accept this outcome and argued the patient’s right to self-determination demanded a remedy. As Lord Hope put it “the function of the law is to protect the patient’s right to choose. If it is to fulfil that function it must ensure that the duty to inform is respected by the doctor. It will fail to do this if an appropriate remedy cannot be given if the duty is breached and the very risk that the patient should have been told about occurs and she suffers injury” at para 56.
60 Is it now that the distinctions between the disclosure of risk by other professionals and the medical profession are no longer seen as persuasive? If that is the case it raises the question of whether the perceived distinctions between the medical and other professions in other respects are still seen as persuasive.
and gender. She argued that the judiciary identifies with doctors as fellow professionals, they share the same socio-economic space in society, with similar career aspirations and that they are also likely to have family and friends who are doctors and thus have a clear understanding of their concerns. Teff observed that medicine is generally considered supreme among the professions and how it is one of the few occupations where people are routinely addressed by their professional title, both in and out of their working environment.

The idea that the relationship between doctors and patients is of a special nature and the impact which this view could have had on the judiciary’s view of the medical profession will now be examined. There was a time not all that long ago when it was a central presupposition of medical practice that the doctor was in charge and that the patient did what s/he was told. Whilst this situation has evolved in some-ways, the basic presupposition seems the doctor possesses the knowledge of the patient’s condition and its causes that is professional expertise, through the application of their professional expertise the doctor has the ability to end pain and disease and restore to good health by virtue of their power. Society tends to view the doctors knowledge as total, and their power to control events complete. Ozar contended although, both doctors and patients realise that medicine as a whole is limited, this does not actively permeate either parties’ presuppositions about medical practice.

Ozar reviewed some reasons which have led to the adoption and proliferation of such a view. He noted that patients do not usually want to die, that they are fearful at the loss of control that illness brings with it, and that the desire to ascribe someone complete control over such matters is a powerful motivation. He contends that from the doctors’ perspective it is a powerful notion to be thought of as capable and that his ordinary human need for commendation has led through a long cultural process to the presupposition of total knowledge and control.

The possibility that it is the perceived particularly altruistic and sensitive nature of the medical profession which explains the judicial approach in clinical

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62 Ibid.
63 Exact data as to commonality of factors such as school background and private clubs is difficult to collect and to interpret.
64 Harvey Teff Reasonable Care (First edition Clarendon Press 1994).
66 Ibid.
67 Ibid.
68 Ibid.
negligence will now be examined. The courts appear to subscribe to certain
assumptions that doctors are motivated by altruistic reasons and because of
this it would be unjust each time they made an error to find them liable

Medical science has conferred great benefits on mankind,
but those benefits are attended by considerable risks...We
cannot take the benefits without taking the risks... Doctors
like the rest of us have to learn by experience; and
experience often teaches the hard way.\footnote{69}

Lord Woolf pointed out that until comparatively recently the practice of medicine
gave rise to little controversy and what has been described as the 'presumption
of beneficence'.\footnote{70} Sheldon\footnote{71} contended a jurisprudential analysis of the policy
arguments advanced by the courts reveals that they are based on a
stereotypical idealised vision of the medical relationship. The court's belief in
the special altruistic nature of the medical professional is also evident in the
following extract:

Here we have a medical unit that would not have existed but
for the energy and public spirit of Dr Hardy. If the unit had not
been there, the plaintiff would probably have died. The
doctors and nurses worked all kinds of hours to look after the
baby. They safely brought it through the perilous shoals of its
early life. For all that we know they far surpassed on
numerous occasions the standard of reasonable care. Yet it
is said that that for one lapse they and not just their
employers are to found to have committed a breach of
duty...but has the law not taken a wrong turning if an action
of this type is to succeed?\footnote{72}

That the judiciary could perceive the medical profession as somehow more
vulnerable to the effects of an action in negligence may be reinforced by this
quote from Lord Denning:

A charge of professional negligence against a medical man
was serious. It stood on a different footing to the charge of
negligence against the driver of a motor car. The
consequences were far more serious. \textit{It affected his
professional status and reputation}\footnote{73} (my emphasis)

\footnote{69} \textit{Roe v Minister of Health} [1954] 2 QB 66 at 83.
\footnote{70} Woolf n 46.
\footnote{71} Sheldon and Thomson n 61 p23.
\footnote{72} \textit{Wilsher v Essex AHA} [1986] 3 All ER at 810. Although the court held the doctor negligent, they
adopted an almost apologetic tone.
\footnote{73} \textit{Hucks v Cole} [1993] 4 Med LR 281 CA.
This illustrates his view of the threat of litigation on the particular sensibilities of the medical professional.

This would appear to be reflected in the way at least some healthcare professionals view the threat of litigation, one obstetric specialist in the USA opined:

In the malpractice situation, you no longer see yourself as an important professional, working for the community. You see yourself as a villain. I mean you'd be surprised how many times the lawyer is indirectly calling you a liar, a murderer, a criminal, and things of that nature. I think that's really devastating to the ego.  

This is far removed from an informed view of the ideological underpinning of any negligence action. Equally it is doubtful any defendant, professional person or not, enjoys being party to a claim in negligence but that it hardly the point. Lord Denning appeared to completely ignore the fact that clinicians receive relatively attractive remuneration for their practice.  

The impact of representations of different professions in popular culture might inform and mould the way these professions are perceived socially and in turn perhaps judicially. In order to illustrate this without an exhaustive number of comparisons the medical profession will be compared with the legal profession. As far back as the Eighteenth Century, Benjamin Franklin in Poor Richard's Almanack exclaimed "God works wonders now and then: Behold, a lawyer an honest man!" Or a Danish proverb, of the time "Lawyers and painters can soon change black to white." More recently, it is interesting to note the largely more flattering image created by the media of both film and television of medical doctors. This can be contrasted with some images of lawyers in film, for example; Sean Penn in Carlito's Way where he plays a lawyer who is "an utter scumbag" and Al Pacino in The Devil's Advocate portraying the world as one

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75 Was Dr Hardy entirely motivated by energy and public spirit?
76 Editorial ‘A Case of Truly Lawful Humour’ The Herald (Glasgow 19 November 1999).
77 Ibid.
78 The phrase “Trust me I’m a doctor” appears to have permeated language although its roots are unclear. It inspired a BBC 2 TV series of the same name which ran from 1997-1999 and prompted a book of the same name by Dr Phil Hammond and Michael Moseley.
79 Andrew Drought ‘Why does the courtroom set the scene for so many movie dramas?’ The Herald (Glasgow 19th November 2001).
in which a powerful lawyer is Satan.\textsuperscript{80} One commentator has suggested\textsuperscript{81} whilst television drama is just fictional entertainment it does impact on public attitudes. Note, the cosy, caring portrayal of GP’s in Peak Practice.\textsuperscript{82}

Up to ten million viewers are paraded a world where the patient does not need to request a home visit but the GP instead readily offers to pop in during those spare hours in a day, for that long living room consultation over a fresh cuppa.\textsuperscript{83}

The journalist concerned reported that representatives at the BMA’s annual conference\textsuperscript{84} were concerned such portrayals impacted negatively on the doctor/ patient relationship (as they led to unrealistic expectations). Whilst such a consequence may occur, there must undoubtedly be some positive impact which such a view of the medical profession engenders in the collective public conscience.

Statistical interpretations of public opinion in polls would seem to further reinforce the favourable opinion/image of the medical profession and suggest notwithstanding negative press coverage, life does indeed imitate art.

In a survey carried out by \textit{The Independent}, of a representative sample of 167 MP’s of where professions should appear in an ‘integrity league’, doctors came out top.\textsuperscript{85} Another example of parliamentary feeling may be implicit in a statement made by Frank Dobson:\textsuperscript{86} “As far as I am concerned, the best place for lawyers in the NHS is on the operating table, not sliding around causing trouble for other people”.

Another poll on public attitudes to different professional groups, conducted by MORI asked people to name the profession they respected the most, ten per cent mentioned solicitors whilst seventy nine per cent said doctors.\textsuperscript{87} In a \textit{Telegraph} poll\textsuperscript{88} it was shown that the public perceived a career in medicine as more glamorous than being a film star or Prime Minister. Notwithstanding, the

\textsuperscript{80} Ibid.
\textsuperscript{81} Maxine Frith ‘TV Drama’s Adding to Pressure on Gp’s’ \textit{Western Daily Press} (Bristol 8\textsuperscript{th} July 1999).
\textsuperscript{82} A popular ITV drama series which ran from 10\textsuperscript{th} May 1993 to 30\textsuperscript{th} January 2002.
\textsuperscript{83} Frith n 81.
\textsuperscript{84} Belfast conference.
\textsuperscript{85} Editorial \textit{The Independent} (London May 1 1995).
\textsuperscript{86} Mark Sutters and Carol Sutters ‘A New Way is Needed for Medical Negligence’ \textit{The Times} (London 12\textsuperscript{th} June 2001).
\textsuperscript{87} Virginia Matthews ‘Solicitors Have Sunk in the Public’s Eyes, Poll Finds’ \textit{The Daily Telegraph} (London 21\textsuperscript{st} September 1989).
\textsuperscript{88} ‘Film Star? I’d Rather be a GP’ CMP Information Ltd. actually obtained through \url{http://web.lexis-nexis.com/}.
adverse publicity discussed below, in the first opinion poll that was carried out afterwards, the public have rated doctors the most trustworthy of a number of occupations. In that same poll 89 per cent of those polled when asked how well they thought that doctors were doing their jobs said that doctors were doing very or fairly well. However, more than one in five people believe ‘that solicitors are not as honest as they could be.’

Some developments which might indicate a shift in perceptions of and public attitudes towards the medical profession include the establishment of the pressure group Action for the Victims of Medical Accidents, founded in 1982. Teff points out that their work has been influential in prompting reform. He cited their involvement in the case Naylor v Preston AHA and the consequential reform on the rules of disclosure. The Association of Personal Injury Lawyers was founded in 1990 there have been many other reforms since then not least the Pre-Action Protocol for the Resolution of Clinical Disputes. Additionally there have also been a number of well publicised medical scandals: the Bristol heart surgery; the retention of organs at Alder Hey; the conviction for murder of Harold Shipman; the disgraced gynaecologists Dr Ledward and Dr Neale and finally the case of Dr Robertson who stole an elderly patients’ savings. Between 2002 and 2005, staff cuts and poor communication led to the deaths of new mothers in London maternity hospitals.

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90 Ibid.
91 Matthews n 87.
92 Teff n 64 p 20.
93 Naylor v Preston AHA [1987] 1 WLR 938.
94 Civil Procedure, Volume 1, 2008, Sweet and Maxwell (The White Book Service 1008) As Jones with Lyons n 30 p1085 explained these protocols were designed to ensure if litigation could not be avoided to at least help ensure claims have been prepared in a way that will facilitate and expedite any litigation. CPR r 35.3(1) provides “it is the duty of the expert to help the court…”CPR r35.3(2) continues “This duty overrides any obligation to the person from whom he receives instructions or by whom he is paid”.
97 see http://www.theshipman-inquiry.org.uk.
98 Widower settles in Ledward Case, BBC News 12th February 2002. Mr Ledward was struck off the medical register by the GMC in 1998 while a formal inquiry chaired by Jean Ritchie found that ‘there was something slapdash and unmethodical in his character, an element of seeing what he could get away with.’
100 Healthcare Commission, Investigation into 10 Maternal Deaths at, or following delivery at the Northwick Park Hospital, North West London Hospitals NHS Trust Between April 2002 and April 2005 (August 2006).
Chief Justice\(^\text{101}\) has pointed out that the judges were not oblivious to these scandals. Although, it is suspected these scandals may not have affected the general public perception of the medical profession as much as one may have thought. Particularly as not all the publicity over this period has been negative. As Brazier\(^\text{102}\) noted, albeit over a decade ago, thus, predating some of the events above, both the investment into high technology medicine and the resulting publicity of this may reinforce the established perception of the medical doctor as a miracle worker. She\(^\text{103}\) noted "the medical marvels which the public are bombarded reinforce the image of the doctor as superman." It is concluded that if we are to see a ‘brave new Bolam’ it will take more than the Bolitho decision alone. It is suggested that the developments considered in chapters 4 and 5 of this thesis might provide the impetus needed to counter the influences examined in this chapter on judicial policy.\(^\text{104}\)

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\(^{101}\)Woolf n46.

\(^{102}\)Margaret Brazier, *Medicine, Patients and the Law* (1st edition Penguin 1992) p7. These observations have not been repeated in the latest edition of this work.

\(^{103}\)Ibid.

\(^{104}\)The influences in this chapter encourage a less assertive judiciary.
CHAPTER THREE

New Bolam or Old?

Introduction

This chapter will develop the argument that the approach I have termed the “conventional” view of Bolam, was not the only plausible interpretation of the test. There is little doubt the medical professionals sued for negligence fared better before the courts than other professionals did,¹ it was not that English law did not permit the judiciary to scrutinise medical professional practice, it was rather that they were reticent to do so.² This chapter will examine an ‘alternative view’ of Bolam arguing the courts have always been the ultimate arbiters of the standard of care. It will reinforce the contention in Chapter 2 that the social and political explanations examined there, are a better explanation of the apparent judicial deference towards the medical profession.³

This ‘alternative view’ of Bolam is merely an accurate reflection of McNair J’s original test. It is not dependent on any subsequent case law to modify it, or to introduce a ‘new Bolam’. Especial attention will be paid to Bolitho in each of its stages, as this case more than any other has produced a number of assertions that Bolam has been modified in some way, permitting critical analysis of medical professional practice where previously such an examination was impossible. A question for this chapter is did Bolitho alter the substance or the application of Bolam? Was there a change to the substance of the law modifying Bolam, or rather a change of judicial policy, not altering the law, just the trend of interpretation?

The major contention of this chapter is that the Bolam test as espoused by McNair J needed no adaptation in order to permit critical analysis of medical professional conduct. The following chapters of this thesis will concentrate on extra judicial developments which might help to translate the courts’ theoretical power under Bolam, into a strong independent assessment of the

¹ In terms of the court assertively determining what constituted responsible professional practice.
² For a full discussion of the other factors which may explain this judicial reticence see the previous chapter.
³ During the period in which Bolam might be said to have gone particularly awry.
reasonableness of common practice that would be unremarkable outside the sphere of clinical negligence.\footnote{See chapter one of this thesis for an examination of common practice in general negligence actions.}

This would counter two common criticisms levelled at Bolam. It would reinforce the notion that the appropriate standard of care has always been a question of law and not fact; and counter the contention that Bolam reduces the standard of care owed to the lowest common denominator by 'rubber stamping' existing medical practice. This ‘alternative’ view of Bolam need not be perceived as threatening to the medical profession it would be capable of not stifling medical advances by confining doctors into a 'straight jacket' of methods.\footnote{Judicial assessment of appropriate common practice could be quite dynamic.}

\textit{Pre-Bolitho - Examples of the Courts as the Ultimate Arbiters of the Standard of Care}

It had at times seemed as though all that was required for a successful defence to clinical negligence was for another doctor to give evidence to the court that they found the defendants’ actions acceptable. For example the judge at first instance in Bolitho\footnote{Judgment of Hutchinson J given on February 15\textsuperscript{th} 1991 where he dismissed a claim for damages.} where he had declared “It is not for me to make a choice between Dr Heaf and Dr Dinwiddie, one of whom is convinced that any competent doctor would, the other that she would not have undertaken the procedure. Plainly in my view this is one of those areas in which there is a difference of opinion between two distinguished and convincing medical witnesses as to what as a matter of clinical judgment proper medical treatment requires.” The trial judge did not prefer one body of medical opinion to another. This is a too simplistic approach, and is by no-means the necessary outcome of the application of Bolam. This can be reinforced by an examination of the application of Bolam in relation to other professional groups.\footnote{See chapter one of this thesis.}

A number of decisions before Bolitho also highlight the fact that it is not Bolam, per se, that prevented the judiciary from scrutinising medical expert opinion. In Hucks v Cole\footnote{Hucks v Cole [1993] 4 Med LR 393 was not an information disclosure case.} decided in 1968 but not reported until 1993, the defendant doctor failed to treat a new mother with an infected finger with penicillin, known to be a bacteriocidal, rather than tetracycline which was not. The patient subsequently suffered puerperal septicaemia and brought proceedings in
negligence.\textsuperscript{9} Notwithstanding that the expert witness for the defence gave evidence he would have acted in the same way as Dr Cole the Court of Appeal refused to accept the testimony as the end of the matter.

Two of the judges held Dr Cole was negligent, but neglected to explain how this could be when he had expert testimony to support him.\textsuperscript{10} Sachs LJ was satisfied that if penicillin had been administered the infection would not have occurred and the patient would have avoided serious injury. He said unless there was a good cause for not administering it:

\begin{quote}
the onset was due to a lacuna between what could easily have been done and what was in fact done. According to the defence, that lacuna was consistent with and accorded with the reasonable practice of others with obstetric experience. When the evidence shows that a lacuna in professional practice exists by which risks of great danger are knowingly taken, then, however small the risks, the courts must anxiously examine that lacuna-particularly if the risks can be easily and inexpensively avoided. If the Court finds on analysis of the reasons given for not taking those precautions that, in the light of current professional knowledge, there is no proper basis for the lacuna, and it is definitely not reasonable that those risks should have been taken, its function is to state the fact and where necessary to state that it constitutes negligence... On such occasions the fact that other practitioners would have done the same thing as the defendant practitioner is a very weighty matter to be put on the scales on his behalf; but it is not...conclusive. The Court must be vigilant to see whether the reasons given for putting a patient at risk are valid.
\end{quote}

\textit{Hucks v Cole} was an example of the Courts asserting their authority as the ultimate arbiters of the standard of care in clinical negligence. But did \textit{Hucks v Cole} permit critical analysis of medical professional opinion where previously there had been none, thus making it an early progenitor of a ‘New Bolam’ test?

It is submitted on its facts the decision was unremarkable and accurately

\textsuperscript{9} Penicillin was capable of killing streptococcal infection which led to puerperal fever. Sachs LJ considered that the GP had not taken “every precaution” to prevent the outbreak of puerperal fever, given the advance which penicillin represented at the time, and that the views of the GP’s expert showed “a residual adherence to out-of-date ideas” which “on examination do not really stand up to analysis”.

\textsuperscript{10} It is suggested that the Court did not go to great pains to justify their decision, preferring one body of expert evidence to another, as the decision predated the era where \textit{Bolam} went awry most notably following it’s ‘conventional’ interpretation in \textit{Maynard v West Midlands Regional Health Authority} [1985] 1 All ER 635 discussed in chapter one of this thesis. Therefore the Court of Appeal did not feel obligated to justify their decision, in light of the operation of \textit{Bolam}, reinforcing the viability of the ‘alternative’ view of \textit{Bolam}. It is noteworthy another case from a similar era \textit{Coles v Reading District Management Committee} (1963) 107 SJ 115 Found it to be negligent not to have given a patient an anti-tetanus injection, since it was a simple precaution, and the consequence of the infection are serious.
reflected the true nature of *Bolam*. Goldrein\(^\text{11}\) analysed *Hucks v Cole* in what he termed 'the tort matrix', the model applied to general negligence. The court considered the magnitude of the risk, the seriousness of the risk which as Sachs had noted was death, the likelihood of death occurring, and the foreseeability of that risk,\(^\text{12}\) the medical experts advised on the practicability of prevention, namely: what safety measures were feasible, in this case it was penicillin and that such safety measures did not prejudice the health of the patient and that there was no realistic effort or expense involved in taking such safety measures.\(^\text{13}\) The decision is an example of a clinical negligence claim being treated akin to general negligence litigation. Teff\(^\text{14}\) noted that Sachs LJ employed a straightforward negligence analysis: if the court finds 'that it is definitely not reasonable those risks should have been taken, it's function is to state that fact and where necessary to state that it constitutes negligence.'\(^\text{15}\)

There are those who interpreted the decision differently, Grubb\(^\text{16}\) cited Fleming’s\(^\text{17}\) analysis of *Bolam* to support his contention that *Hucks v Cole* represented a challenge to *Bolam*. Fleming’s\(^\text{18}\) analysis of *Bolam* was the effect of the test ‘is to remove from the judge or jury the possibility of finding a standard medical practice to be negligent, thus conferring on the medical profession a special privilege which it denies accountants, lawyers and others practising special skills’. This analysis ignored the adjectives reasonable, responsible and respectable, which imply the court has the final decision on the standard of care, and a number of judgments which have declared *Bolam* to be applicable to all professions equally.

Another example of the Courts asserting their authority as the ultimate arbiters of the standard of care can be found in the judgment of Hirst J in *Hills v Potter*,\(^\text{19}\) where he stated:

\[\text{I do not accept the argument of counsel... that, by adopting the } \text{Bolam principle, the Court in effect abdicates its power of decision to the doctors. In every case the court must be...}\]

\(^{11}\) Iain Goldrein, ‘Exploding the *Bolam* Myth, Part Two’ (1994)144 NL J 1283.
\(^{12}\) Ibid.
\(^{13}\) Ibid. An analogy can be drawn between the reasoning in *Hucks* and the so-called new *Bolam* decision in *Marriot*, discussed more fully later in this chapter.
\(^{15}\) Per Sachs at 397.
\(^{18}\) Ibid.
\(^{19}\) *Hills v Potter* [1984] 1 WLR 641.
satisfied that the standard contended for on their behalf accords with that upheld by a substantial body of medical opinion, and that this body of medical opinion is both respectable and responsible, and experienced in this particular field of medicine.

The above excerpt of Hirst J’s judgment would support what in this thesis is termed the ‘alternative view’ of Bolam. The use of the adjectives respectable and responsible make it clear common practice is not determinative and is merely persuasive of the appropriate standard of care in a given situation, even in the sphere of clinical negligence.\(^{20}\)

It is instructive to examine the judgments of the Sidaway litigation in detail, in order to discover the nature of the Bolam test. Lord Bridge said:

> The issue whether non disclosure …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. But I do not see that this approach involves the necessity to hand over to the medical profession the entire scope of the duty…including the question whether there has been a breach of duty…Even in a case where, as here, no expert witness in the relevant medical field condemns the non disclosure as being in conflict with accepted and responsible medical practice, I am of the opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed decision on the part of the patient that no reasonably prudent medical man would fail to make it.

Lord Keith’s judgment was limited to agreeing with Lord Bridge. Lord Diplock was the most protective of the health care professional, he said:

> The court has to rely on and evaluate expert evidence…it is no part of its task… To give effect to any preference it may have for one body of opinion over another, provided it is satisfied by the expert evidence that both qualify as responsible bodies of opinion.\(^{21}\)

Even this more restrictive view does not abdicate responsibility to the medical profession: note the use of the adjectives evaluate and responsible, along with the caveat 'provided that it is satisfied'. Lord Bridge was clear the court could

\(^{20}\) It is only conduct that on the courts assessment is respectable and/or responsible that is not negligent. It is noteworthy that many of the instances of judicial assertiveness are found in litigation concerning appropriate information disclosure.

\(^{21}\) My emphasis.
condemn medical practice as negligent.\footnote{22} Although \textit{Sidaway} was concerned with the disclosure of risks, there is no reason to confine the interpretation of \textit{Bolam}, as the majority of their Lordships said \textit{Bolam} applied to all aspects of a doctor's duty. However, it is noteworthy courts both domestic and in certain other jurisdictions\footnote{23} have appeared more confident in setting standards when dealing with information disclosure cases than in other allegations of clinical negligence.

If the 'alternative view' of \textit{Bolam} is correct; and the courts have always had the power to scrutinise and adjudicate on what amounts to responsible medical practice, and act as the ultimate arbiters of the standard of care as one would expect in any action for negligence; why is it that the medical profession have been treated differently in comparison with other professions?\footnote{24} Why was it that plaintiffs fared so poorly?\footnote{25} \textit{Hucks v Cole}\footnote{26} had little impact on medical jurisprudence until its significance was re-emphasised.\footnote{27} The possible social and political explanations for this have been contemplated in chapter two. This chapter will now move on to examine whether \textit{Bolitho} and judicial reactions to that litigation have substantially impacted on the nature of \textit{Bolam} itself or the judicial trend for its interpretation. Later chapters of this thesis\footnote{28} will examine and assess various developments and their impact on \textit{Bolam} both in theory and in application. These developments might have more of an impact on how \textit{Bolam} is applied in practice, through demystifying medical practice and increasing judicial confidence in their setting of the legal standard of care, bringing clinical negligence cases more in line with other cases of professional negligence and general negligence actions.

\footnote{22}{Not even Lord Diplock envisaged professional opinion as determinative of the legal standard of care, shutting out the courts.}
\footnote{23}{As examined in chapter one.}
\footnote{24}{For a fuller examination of this point see chapter two of this thesis.}
\footnote{25}{Michael Jones expressed the state of play as a football score. In medical negligence claims before the House of Lords between 1980 and 1999, the score stood at Plaintiffs 0 Defendants 6: see M Jones ‘The \textit{Bolam} Test and the Responsible Expert’ [1999] \textit{Tort Law Review} 226.}
\footnote{26}{\textit{Hucks v Cole} [1993] 4 Med LR 393 (decided in 1968).}
\footnote{27}{Re-emphasised by Grubb n 16 and Christopher Newdick, \textit{Who Should We Treat?: Rights, Rationing and Resources in the NHS} (Second edition, Oxford University Press, 2005) p140 noted while there have always been sporadic assertions of New \textit{Bolam}, little may be said to have changed in practice.}
\footnote{28}{particularly 4, 5.}
THE BOLITHO LITIGATION

Facts

A two-year-old boy, Patrick Bolitho, admitted to hospital for treatment of croup subsequently suffered two episodes of acute shortness of breath. The case involved a paediatric registrar’s failure to attend, in either instance or send an appropriate deputy to him having been summoned by a nurse. The first request to attend was made at approximately 12.40pm by Sister Sallabank who had been so concerned that instead of following the usual chain of command, she elected to immediately contact the senior paediatric registrar Dr Horn. Patrick subsequently appeared to recover. The second episode of breathing difficulties occurred at approximately 2.00pm. Dr Horn was summoned and again failed to attend, although she asked Dr Rodgers to examine Patrick, Dr Rodgers did not attend either. Although he appeared to recover briefly, Patrick suffered a cardiac arrest caused by obstruction of the bronchial air passages which resulted in severe brain damage. Although the hospital admitted negligence in the registrar’s failure to attend, and it was accepted that intubation would have prevented his injuries, the registrar claimed that even if she had attended she would not have intubated before 2pm. The plaintiff’s experts testified that Patrick should have been intubated immediately on suffering respiratory distress, while the defendant’s experts testified that given that intubation was not a risk free procedure a responsible doctor would not have intubated until 2.30pm.

The court of first instance held the views of the experts, as to what a reasonable doctor would have done were diametrically opposed, but both represented a responsible body of professional opinion. The trial judge applied the Bolam test, holding if Dr Horn had attended, she would not have intubated, and therefore it had not been proven that the admitted breach of duty by the defendant’s had caused Patrick’s injuries. The judge accepted the testimony

29 It was accepted by the court that if his injuries were to have been prevented Patrick would have required intubation before 2pm.
30 Placing great emphasis on Lord Scarman’s speech in Maynard ‘a judge’s preference for one body of distinguished professional opinion over another is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions were not preferred’.
31 In Maynard’s case Lord Scarman when advancing the test of ‘responsible medical opinion’ was dealing with breach of duty, he was not dealing with causation. Accordingly, it was argued that causation was a matter for the judge to decide in the normal way and on ordinary common law principles. However the majority of the Court of Appeal implied the use of Bolam into the test of causation; as the alleged breach
of the defendant's experts as to the acceptability of (non) intubation as satisfying Bolam's requirements. 32

The Court of Appeal 33

Two of the three judges considered the meaning of the Bolam test. Farquharson LJ stated:

It is not enough for the defendant to call a number of doctors to say what he has done is in accordance with clinical practice. It is necessary for the judge to consider the evidence and decide whether the practice puts the patient unnecessarily at risk.

Moreover, according to Dillon LJ, the court would be entitled to:

Reject [one body] of medical opinion on the ground that...the court fully conscious of its own lack of medical knowledge and clinical experience was nonetheless clearly satisfied that the views of the doctor were Wednesbury unreasonable.

Whilst recognising the authority of Hucks v Cole both Dillon and Farquharson LJJ asserted the importance of interpreting Hucks v Cole in the light of the higher authority of Maynard. Farquharson LJ stated that he saw no conflict between the two cases; he did not explain this view. Dillon LJ seemed to envisage a probable tension between the two earlier decisions and this might explain why he took the more restrictive view he did of when the court might reject medical practice. One way of reconciling the two authorities could be as follows; the Maynard rule "a judges preference for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence", is not it is contended saying anything different to McNair J in Bolam where he stated "a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art".

32 That the body of professional opinion relied on was reasonable and responsible in law.
33 Bolitho (Deceased) v City and Hackney Health Authority [1993] 4 Med LR 381, 13 BMLR 111.
Both of the above excerpts could be understood as recognising the legitimacy of divergent schools of thought within a profession, allowing the profession to evolve practice. This is by no means to ignore the possibility that unless the courts are the ultimate arbiters of the standard of care, any divergence of opinion could serve as a *de facto* defence in an action in clinical negligence. This was recognised and guarded against even in *Maynard*, it is clear opinion must be distinguished and respectable,\(^{34}\) similarly reasonable and responsible in *Bolam*. This should ensure professional accountability, although with the varying adjectives, there might be a danger of conflating reasonable and respectable with a witness rather than the practice they advocate. The courts should not automatically assume that any practice carried out by a professional is reasonable, but should remain astute in examining the evidence and utilising the tools they have at their disposal. The judgment of Sachs in *Hucks v Cole* showed that the courts understand this obligation. Since 1957 McNair J had spotted “medical men were not entitled to obstinately and pigheadedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion.” Therefore, there is not any particular tension between the judgments in *Maynard* and *Hucks*. This analysis supports the contention that the above cases were not any sort of 'new *Bolam*', but accepts they show a possible change in tenor of judicial interpretation. In reaction to the Court of Appeal judgment in *Bolitho*: Grubb\(^{35}\) suggested that the views expressed, albeit *dicta* permitted a number of first instance judges to express a new scepticism at the 'conventional' understanding of *Bolam*. Kennedy and Grubb\(^{36}\) announced the Court of Appeal judgment in *Bolitho* reinterpreted *Bolam*, leaving the courts with the final say on whether or not a doctor had been negligent. They contended that this 'New *Bolam*' had been approved by a number of judges. It is argued the Court of Appeal rather than creating a 'new *Bolam*' were merely stating the true nature of *Bolam*. Given the odd adoption of the public law concept *Wednesbury* unreasonableness the Court of Appeal's view might have restricted analysis. This chapter will now move on to examine the judgments\(^{37}\) decided in the time between the Court of Appeal's consideration of *Bolitho* and its consideration in their Lordships House.

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\(^{34}\) The variation in the adjectives used moved clinical negligence away from the wider tort and could be said to highlight the problem of conflating descriptive and prescriptive. This is only true if a view expressed by a medical practitioner is *ipso facto* seen as satisfactory in law.


\(^{36}\) Grubb n16 p441.

\(^{37}\) Those at least which have prompted declarations of a new *Bolam* test.
This approach is adopted due to the lapse of six years between the two courts considering the case, and also to distinguish between ‘new Bolam’ cases, decided before Lord Browne-Wilkinson’s pronouncements of logic, and those which followed the introduction of this adjective.

Supposed ‘new’ Bolam cases that followed Bolitho in the Court of Appeal.

In Bowers v Harrow Health Authority the judge at first instance held the registrar’s treatment was negligent he should have realised at the time of the vaginal examination, if not all along, that he was dealing with a transverse lie; and that attempting a breech extraction when the lie is in transverse is not a practice that would be accepted a proper by a reasonable body of medical practitioners.

Expert evidence in Defreitas v O’Brien established only a small minority of neurosurgeons endorsed the defendants’ practice. According to Grubb it was an instance where the Court of Appeal approved the ‘new Bolam’ approach put forward in Bolitho. Khan and Robson were concerned it would license a small fringe group practising experimental techniques as a responsible body of medical opinion. Brazier and Cave argued the perception arose that English judges would not cross swords with the doctors, however thin the evidence advanced in defence of a claim. Defreitas need not necessarily have worrying consequences, it might only illustrate that a robust interpretation of Bolam where the courts are the ultimate arbiters need not risk stifling the innovation of the medical profession. It confirmed the requirement is reasonable on the courts assessment, that numbers alone do not count.

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38 Bowes v Harrow Health Authority [1995] 6 Med LR 16.
40 Four surgeons out of two hundred and fifty.
41 Grubb n15 p441.
42 Although Bolitho itself was not referred to in the judgement, other supposed ‘new Bolam’ decisions were relied on such as Hills v Potter [1983] 3 All ER 716 [1984] 1 WLR 641 and Sidaway v Board of Governors Bethlem Royal Hospital and Maudsley Hospital [1985] 1 All ER 643.
45 Margaret Brazier, Emma Cave, Medicine, Patients and the Law (5th edition Penguin 2011) p 163.
46 This is of course presupposing that the court did subject the view of the experts to a ‘hard look’ and determine after this process that the practice was in accordance with reasonable care in law.
47 JK Mason and G Laurie, Mason and McCall Smith’s Law and Medical Ethics (8th edition Oxford University Press 2010) p140 also recognised the case need not interpreted as bolstering a ‘conservative’ approach in assessing the acceptability of medical practice.
In *Smith v Tunbridge Wells* 48 a 28-year-old man brought an action claiming the surgeon failed to inform him of inherent risks including impotence and bladder dysfunction attached to his surgery, which did materialise. The High Court held that *Bolam* applied. To expect such a warning to be given was reasonable, notwithstanding the fact the leading textbook of the day did not specifically refer to the risks, as data was available from analogous operations from which surgeons could extrapolate information such information. It was also held the fact that there may have been a body of surgeons who did not warn, did not render such an omission as reasonable. Grubb49 stated so far as he was aware *Smith* was the first reported case where a doctor had been held to have breached his duty by failing to warn a patient of a risk, notwithstanding that the omission to warn was a practice accepted by doctors at that time. Montgomery50 contended it was arguable that the decision in *Smith* was inconsistent with *Maynard*, although on the interpretation of *Maynard* advanced previously in this chapter it is argued this was not so. Morland J was not prepared to hold the surgeons, who relied upon, the information in the leading textbook of the day on this issue constituted a reasonable and responsible body of opinion from a legal perspective, as there were those within the profession who were aware of the risk. *Smith* was a case considering disclosure of information, and it does appear that the judiciary are more proactive when interpreting the confines of *Bolam* in cases which concern risk disclosure. The fact remains, if *Bolam* were a defence, as some assert the decision in *Smith* would have been different.

Importantly, *Joyce v Merton Sutton and Wandsworth* 51 did not concern information disclosure. Mr Joyce underwent brachial cardiac catheterisation on 4 March 1987 as a day patient. He returned to the hospital on 11, 19 and 24 March, during which visits he complained of pain and numbness. He was referred to a vascular surgeon on 9 April a reconstruction of the artery was advised which took place on 22 April. The operation was not a success and on 29 April there was a further procedure. The surgery of 29 April was not

48 *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR 334.
49 Grubb n35.
51 *Joyce v Merton, Sutton and Wandsworth Health Authority* [1996] 7 Med LR 1. The allegations of negligence relating to 4 March were: the occluding of the artery with the suture, the failure to observe that the artery had been occluded; failing to obtain the opinion or assistance of a vascular surgeon; failing to warn the appellant to return to hospital if he were to suffer problems with his right arm; failing to require the appellant to return for review prior to 24 March.
successful either and on 22 June, an arch aortogram was performed. Thrombus dislodged in the course of the procedure causing upper brain stem infarction leaving Mr Joyce with ‘locked-in’ syndrome.

The Court of Appeal approved the judge’s direction to himself that:

> a defendant is not guilty of negligence if his acts or omissions were in accordance with accepted clinical practice, provided that clinical practice stood up to analysis and was not unreasonable in the light of the state of medical knowledge at the time.

Roch LJ, in the Court of Appeal, stated that Overend’s direction would have been misdirection if he had not added ‘provided that clinical practice stood up to analysis.’ As without that addition his direction would leave the question of determining liability squarely in the hands of the medical profession. This would reinforce that *Bolam* itself allowed the Courts to act as the ultimate arbiters of the standard of care. Hobhouse LJ agreed with Roch, but crucially went on to reject the statement of Dillion LJ, in *Bolitho* that a court could only reject a practice as unreasonable by use of the public law test of *Wednesbury* unreasonableness.

In the first instance judgment in *Wiszniewski v Central Manchester*, the law as outlined in *Joyce* was used alongside the *Maynard* decision, without any apparent concern of conflict between the approaches. If there was no conflict,

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52 Roch LJ noted “The only ground on which it could be said that the judge's acceptance that the evidence of the respondent’s experts represented a responsible body of medical opinion skilled in the particular form of treatment in question was mistaken, is the accepted absence in the medical literature of any reference to the practice of waiting and seeing after a BCC in cases where the radial pulse is markedly reduced in following the procedure volume. The judge gave careful consideration to this point and examined the medical literature with great care. This court was taken to the medical literature and in my judgment the judge’s view that the medical literature was not as strongly supportive of the views of the appellant’s cardiologist as might appear at first glance was a proper view for the judge to take.”

53 *Bolitho v City & Hackney Health Authority* [1993] 4 Med LR 381 Court of Appeal Judgment Hobhouse LJ noted “The criticism that I would make of the judgment is that the judge was too impressed by the reputation, at the time of the trial, of Dr Stewart and Nurse Eugene and placed inappropriate weight on it in the face of the documentary evidence which could not be gainsaid and the evidence of the appellant’s witnesses which, whilst in certain respects understandably confused or overlaid by the tragic situation of Mr Joyce, nevertheless included evidence which was corroborated and not seriously contradicted.”

54 *Wiszniewski v Central Manchester Health Authority* [1996] 7 Med LR 248 Mrs Wiszniewski was admitted and taken to the pre-delivery room and a cardiocograph trace applied, there were two decelerations although they both recovered. The CTG was disconnected, upon reconnection the CTG showed that the fetal heart baseline had deteriorated. Sister Brockbank carried out another examination and noted weak to moderate contractions and no descent of the fetal head. Sister Brockbank performed an artificial rupture of membranes which released thick meconium stained liquor. Dr Renninson was called and he attended. Subsequently, the contractions had rapidly increased and labour progressed quickly. Phillip was born at 05.40 hours his head had descended rapidly, tightening the cord around his neck depriving him of oxygen.
this reinforces the notion that the substantive legal test of how the standard of care is to be determined in a clinical negligence action has not altered thereby producing a 'new Bolam' test. Thomas J said:

In my judgment it is clearly necessary for me to analyse whether the course of treatment put forward [by the defendant's expert witness] put the patient unnecessarily at risk and was not one that a competent doctor acting with ordinary skill and care or a responsible body of medical opinion would have followed.

He went on:

I reject the submission that such an analysis takes the trial judge into the medical arena; such an analysis of medical evidence given by experts to see if a view put forward is in fact one that a responsible body of medical practitioners could hold about a clinical judgment on an individual patient is no different in this respect to a similar analysis of judgment by an accountant, lawyer, underwriter or other professional. A judge has to be conscious of his own lack knowledge and of the fact that clinical decisions are often difficult to make. However, where an analysis of the expert evidence on the facts relating to a particular case shows that a decision made by a doctor supported by the experts cannot be justified as one that a responsible medical practitioner would have taken, then a judge should not preclude himself from reaching that conclusion just because clinical judgment is involved.

Thomas J recognised clinical negligence as no different from any other branch of professional negligence, reinforcing the argument advanced in chapter one. These views were to be echoed to some extent by Lord Browne-Wilkinson.

*Bolitho*- *House of Lords*

There was only one substantive speech, that of Lord Browne-Wilkinson, with whom the other four Law Lords agreed.\(^{55}\) It was this judgment that prompted the largest number of academic commentaries in this area, of any to date. This section will begin by examining the judgment itself and move on to examine the commentaries it provoked. Counsel for the appellant argued, *Bolam* had been wrongly interpreted, as requiring acceptance without question the views of one

\(^{55}\) *Bolitho (administratrix of the estate of Bolitho (deceased) v City and Hackney Health Authority* [1997] 4 All ER 771.
truthful body of expert professional evidence. Lord Browne- Wilkinson considered this submission and replied:

My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis, just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In Bolam's case McNair J stated that the defendant had to have acted in accordance with a practice accepted as proper by a responsible body of medical men. Later he referred to a standard of practice recognised as proper by a competent responsible body of opinion. From Maynard's case Lord Scarman refers to a respectable body of professional opinion. The use of these adjectives; respectable, reasonable and responsible—all show that the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis.

This passage demonstrated that the courts, theoretically at least, are the ultimate arbiters of the standard of care in clinical negligence. He went on to explain:

In particular, in cases involving, as they often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being reasonable, responsible or respectable, will need to be satisfied that, in forming their views the experts have directed their minds to the question of comprehensive risks and benefits and have reached a decision a defensible conclusion on the matter.

This passage appeared to recognise the utilisation of the general approach to ascertaining appropriate standards of care in negligence actions. He went on;

In cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the, defendant's conduct, the defendant can be properly held liable in negligence. (I am not here considering questions of disclosure of risks.) In my judgment that is because in some cases it cannot be demonstrated to the judges satisfaction that the body of opinion relied on is reasonable and responsible.

The question as to when his Lordship envisaged that it would be appropriate to intervene would seem to be partially answered in the following section of the judgment. He said:
In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of the opinion...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 opinion is neither reasonable or responsible.

I emphasise that in my view, it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence.

Lord Browne-Wilkinson's judgment left a number of questions open. Firstly, why did he distinguish information disclosure cases from those involving other elements of a clinician’s duty of care? Secondly, did he envisage his judgment as a revision or clarification of *Bolam*?

Brazier and Miola\(^{56}\) contended that what appeared to be Lord Browne-Wilkinson's exclusion of information disclosure, could be explained as him noting no such issues arose in the case before him, or more likely that he considered 'the restraining of *Bolam*' had already been achieved in the context of information disclosure.\(^{57}\) On that issue *Pearce v United Bristol Healthcare Trust*\(^{58}\) might be said to extend *Bolitho*, as Lord Woolf had no doubt that the *Bolitho* judgment applied to information disclosure.\(^{59}\) Consideration of judgments supports the contention that courts are more assertive in this area for the reasons discussed in chapter one of this thesis i.e. decisions less technical *ergo* court more confident.\(^{60}\)


\(^{57}\)There appears to be a tendency of increased assertiveness in information disclosure cases, in both this and certain other jurisdictions.


\(^{59}\)This thesis is not concerned with the issue of informed consent *per se*, it is inevitable that such cases will be considered as the courts have repeatedly held that information disclosure is as much an element of the doctor's duty of care as anything else. It has been asserted that Lord Woolf used ‘politically correct’ language to conceal continued deference see A McLean, ‘The Doctrine of Informed Consent: Does it Exist and Has it Crossed the Atlantic?’(2004) 24 *Legal Studies* 386.

\(^{60}\)As Brazier and Miola n56 contended “attempting to analyse whether or not the doctor’s justification for non-disclosure is logical or rational will not be a task bedevilled by too much technical or scientific detail.” It is noted in chapter one of this thesis that a similar point can be made regarding many medical interventions. The fact that material is scientific or technical, does not prevent the courts from intervening in the practice of other professions. This reinforces the notion of the different status in society of clinicians, in comparison with other professional groups.
Did *Bolitho*, particularly the reference to logic impact on the form of *Bolam* creating something which could properly be termed a ‘new’ test, or did it signify a change in judicial assertiveness in this area? Will the use of the particular adjective 'logical' precipitate change? Lord Woolf argued the *Bolitho* decision would enable a court to distinguish between two sets of medical opinion, with the caveat that future cases would clarify exactly what Lord Browne-Wilkinson intended by the use of the term logical analysis. A straightforward semantic analysis of the terminology is circular. Definitions of logical include; “in accordance with the principles of logic, conformable to the laws of correct reasoning; characterised by reason, rational, reasonable.” It is argued this new adjective does not impact substantively on *Bolam*. The use of this adjective could reinforce the demystification of medicine, allowing judges in light of other developments to independently examine medical practice, in a manner similar to the Court of Appeal’s analysis in *Field Palmer & ors. v Izzard & another*. This analogy with the surveyor’s case would have to be considered in light of the cautious tone towards criticising medical professional practice evidenced in *Bolitho*.

Academic reaction, to both the theoretical significance and likely practical impact of the *Bolitho* decision has been decidedly mixed, ranging from the distinctly cautious to the bolder. Brazier and Miola viewed the decision as a return of *Bolam* to its original position. Kennedy and Grubb commented ‘the defences of *Bolam* have been breached.’ Keown contended *Bolitho*, a step in the right direction, did not go far enough. It has been asserted that the rhetoric of *Bolitho* did not match the outcome.

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62 Does his Lordship make it clear whether this is limited to preferring one set of medical evidence or does it go further and reserve the courts authority to pronounce that the evidence of common practice is not conclusive?
63 Oxford English Dictionary, Volume k-m page 402.
64 Discussed more fully in chapters 4 and 5 of this thesis.
65 Discussed fully in chapter one of this thesis.
67 Brazier and Miola n56. They assert it is imperative if we are to assess the impact of Lord Browne-Wilkinson’s judgment on clinical negligence litigation that we understand how what they call his ‘revision of *Bolam*’ will work. They commented that some clinicians could perceive what they viewed as this return of *Bolam* to its original position as the judiciary meddling in clinical judgment.
69 However, note the title of their paper referring to just one area of application of the *Bolam* test.
71 Rob Heywood, ‘The Logic of *Bolitho*’ (2006) Professional Negligence 225 where he invited examination of the two treatment options available; to intubate or not to. He asserted “something does not
In the most recent consideration of Bolitho, Mulheron\textsuperscript{72} described a gloss to Bolam as being the outcome of Bolitho.\textsuperscript{73} She contended “Bolitho turned Bolam on its axis, in that the court and not the medical profession became the final arbiter of breach.”\textsuperscript{74} She identified seven factors as Bolitho factors, circumstances in which the courts have asserted their authority as the ultimate arbiters of the standard of care and rejected peer opinion adduced by the defendant. The ‘Bolitho factors’ are: (i) peer professional opinion overlooked a clear precaution to avoid the adverse outcome; (ii) the question of resources and conflicts of duty; (iii) failure to weigh the comparative risks and benefits of the course of conduct; (iv) where medical practice contravenes widespread public opinion; (v) where the peer evidence cannot be correct when taken in the context of the whole factual evidence; (vi) where the expert medical opinion is not internally consistent; (vii) peer professional opinion has adhered to the wrong legal test.\textsuperscript{75} It is contended Bolitho confirmed\textsuperscript{76} the courts are the ultimate arbiters of the standard of care in medical malpractice they could impugn accepted medical practice. It is argued there is not a ‘new Bolam’ the law remains as McNair J intended, although it is conceded the Bolitho decision indicated a change in the judicial policy approach to clinical negligence. If the courts have always had the authority to act as the ultimate arbiters of the standard of care in clinical negligence; this calls into question the impact these quite add up”. Intubation is a procedure which undoubtedly carries risks, but it confers the benefit of preventing the greatest catastrophe of all, death. Any analysis of the two options must lead to the conclusion that the decision not to intubate was ‘illogical’ in the circumstances. The judges did not accept this and the Health Authority avoided liability. Jones 24 concluded ‘notwithstanding the very clear statements of principle in Bolitho, there is no evidence that their Lordships undertook an analysis of the balance of risk nor is it apparent why that balance came down against the plaintiff’s claim.’\textsuperscript{72} Rachael Mulheron, ‘Trumping Bolam: A Critical Legal Analysis of Bolitho’s Gloss’ (2010) 69 Cambridge Law Journal 609.

\textsuperscript{73} Mulheron n 72 interpreted the outcome of Bolitho as being the recognition of a ‘two-stage procedure’ to determine the question of alleged breach of duty in clinical negligence: 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 responsible or logical.” She viewed an important limitation on this new tier of scrutiny as being “where two schools of Bolam reasonable thought have been put forward as explanations, courts have not been prepared (nor have they regarded themselves as permitted) to undertake a third stage or superiority analysis.” It is argued, the confusion as to what would amount to a ‘superiority analysis’ is what has driven much misinterpretation of the courts role in clinical negligence since Maynard. It is not that the court’s cannot prefer one body of expert opinion over another, in any circumstance, but rather all that is required to avoid liability in negligence is a finding of reasonable care in the circumstances of the case, and sometimes there will be more than one course of action permissible as reasonable care.

\textsuperscript{74} Mulheron n72 lists another three scenarios where apart from Bolitho’s operation “Bolam evidence will not absolve a doctor” these are for Bolam to be applicable. There must be (i) a matter of clinical or professional judgment that requires special skill (ii) a question requiring expert opinion and (iii) a responsible body of recognised practice.

\textsuperscript{75} Not all of her seven Bolitho categories evidence instances of the courts being assertive.

\textsuperscript{76} In that they certified that this was already the case.
more recent pronouncements recognising this authority will have in practice, for example; will more claimants succeed? Will clinicians be treated like other professional groups? The courts had this power since 1957, and before, but had distorted the law of negligence by treating clinical negligence as a distinct genre, have the reasons for such distortion changed?

The possibility the judgment will bring the treatment of the medical profession, in line with other professional groups will be assessed. The tone of Lord Browne-Wilkinson’s judgment appeared to reflect the particular and familiar deference of tone reserved for the discussion of medical practitioners. Teff detected the deference to clinicians which was still discernible and contended if this persisted the court may only reject an expert’s opinion if they doubted his credibility. It did appear from the general tone of the judgment; that certain factors might be influencing Lord Browne-Wilkinson. One facet of this deference is the belief that medical evidence is somehow more complex to evaluate. Brazier and Miola suggested there existed a prima facie presumption, those outside the medical profession cannot understand the evidence, much less evaluate it. They contend it was a similar presumption which led to the way Bolam developed its tarnished image. Maclean agreed the problem with Bolam lay ‘in its interpretation and deferential application’ rather than with the test itself. The final question is when are the courts likely to feel that it is appropriate to intervene? Brazier and Miola contended if Lord Browne-Wilkinson’s rare cases were to be interpreted by the Dillon benchmark, they might prove to be so rare as to be almost non-existent.

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77 As discussed in chapter one of this thesis.
78 Teff n 14.
79 Ibid p 481 He contends that Lord Browne- Wilkinson was ‘undeniably impressed by the distinction of the defendant’s witnesses.’
80 The talk of ‘rare cases’ and ‘how it will very seldom be right for the judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable’.
81 The special status accorded to clinicians discussed in chapter two of this thesis.
82 Brazier and Miola n56.
83 This idea of medical evidence being more complex and unsuitable for non-medical comprehension may be influenced by social factors.
84 Brazier and Miola n56.
85 MacLean n65.
86 Ibid.
87 See judgment of Dillon, Court of Appeal and his use of the public law concept of Wednesbury unreasonableness.
88 Will they be as sporadic as the pre-Bolitho examples of the courts exercising such authority? Mulheron n72 p610 contended that on her analysis Bolitho’s ‘gloss’ had been invoked in over 20 decisions, and that was not such a low view as to the termed ‘rare’.
An examination of post *Bolitho* judgments and publications will be carried out with a number of aims. Firstly, to return to the question of the root of the courts' ability to determine the standard of care in clinical negligence as debate is still lively as to the aetiology of this power. Mulheron blamed *Bolam* for the special treatment afforded to the medical profession and that the courts were being dictated to rather than exercising their own judgment. She used the phrase ‘*Bolam* evidence’ to describe a view of an expert witness introduced to the court, and appeared to elevate the importance of this to a *quasi*-defence. She acknowledged the existence of the view, that judicial scrutiny of medical expert opinion was no different from the legal analysis a judge must make in respect of other professional evidence, and how McNair J did not intend the doctor’s expert evidence to be conclusive, yet she felt no compunction in blaming *Bolam* for the period when the courts went awry in their deference. It is contended *Bolitho* could go awry in the same way *Bolam* did. The adjective ‘logical’ does not prevent, prescriptive and descriptive standards becoming confused. Mulheron acknowledged it has already been judicially recognised it will be difficult to apply *Bolitho* where a distinguished expert in the field considered the accused doctor’s treatment or diagnosis to be a reasonable one. Mulheron’s other preferred *Bolitho* adjective ‘irrational’ raises particular concern, especially if she is intending the meaning given to this in the opinion of Dillion LJ in the Court of Appeal consideration of *Bolitho* where he applied the public law test of *Wednesbury*. The second aim is to examine the possibility whilst the substantive law has not changed; we might since *Bolitho* be entering a judicial renaissance in the application of the law, where the courts have become more assertive in setting the standard of care required in clinical negligence. Brazier and Miola contended *Bolitho* had been decided at a unique time, given its synthesis with

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89 Does it date back many decades, as is suggested in the earlier part of this chapter when pre-*Bolitho* cases are discussed, and in chapter one of this thesis with its best known enunciation being *Bolam* or is it merely traceable to *Bolitho*?
90 Mulheron n72.
91 As explored in the previous chapter of this thesis.
92 My emphasis.
93 *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223.
94 Brazier & Miola n56 p99.
other developments.\(^95\) Mulheron\(^96\) conceded “it is 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 has not been referred to at all.” Maclean\(^97\) carried out an early study on the impact of Bolitho on a claimant’s chance of success.\(^98\) One of his conclusions was over all the post-Bolitho litigation suggested a less deferential attitude towards medical practitioners, but that this trend was by no means universal. He\(^99\) contended the trend towards a less deferential approach was less noticeable in the Court of Appeal.\(^100\) Only time will tell if there is any sustainable trend and one can only speculate as to its occurrence without the impetus of the Bolitho decision.\(^101\)

The post-Bolitho case law does provide examples of the courts behaving assertively, when setting the standard of care in clinical negligence. However, while less numerous, there are also decisions which deliver a more explicitly cautious message as to the approach which will be taken. The concern raised by this later group of cases being Bolitho has done little to counter the most fundamental prohibitive influences which act on the judicial consciousness i.e. concern as to resource implications for the NHS, the entrenched ‘special’ respect for medical professionals, the persistence of viewing clinical negligence as ideologically distinct from other forms of the tort including erroneous treatment of common practice via misrepresentation of Bolam. Throughout both of these sections Mulheron’s ‘Bolitho factors’ will be considered, as it will be argued these instances where the courts have exerted their authority as the ultimate arbiters of the standard of care in clinical negligence existed pre-Bolitho.

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95 These other developments will be considered in chapters four and five of this thesis. It is argued such developments could impact more on the future of clinical negligence than the Bolitho judgment itself.
96 Mulheron n72 p 619 and p614 where she stated “Once Bolam applies, the mere fact of differences in expert opinion cannot lead to a rejection of Bolam evidence, as Bolam itself acknowledged. She quoted (a man is not negligent… merely because there is a body of opinion that takes a contrary view) without noting the limiting qualification placed upon this assertion by the previous sentence of McNair J “A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of men skilled in that particular art.” It is only where this precondition has been met that the proposition she cited is engaged.
97 MacLean n66.
98 Based on post Bolitho cases heard in England and Wales up until 13\(^{th}\) November 2001.
99 MacLean n66.
100 In the cases he considered nine of eighteen cases before the Court of Appeal and sixteen of the Forty-Five first instance cases ended with the defendant held to liable in negligence. MacLean n65 further breaks down this statistical approach by contending that in the Court of Appeal 75% of the Bolitho judgments resulted in liability, compared to 38% of the Bolam group and 50% of the neither category.
101 Although that impetus might be due to change of application rather than substance.
An Assertive Era? A Braver (if reluctant) Judiciary?

It is argued Marriott v West Midlands HA\textsuperscript{102} signified the court utilising a less deferential approach. The patient had been admitted to hospital following an injury to his head, after X-rays and neurological observations he was discharged the following day. He continued with head aches, lethargy and loss of appetite, his GP visited and advised the claimant’s wife to telephone him if the claimant deteriorated and suggested analgesics for the headaches. Four days later the claimant’s condition deteriorated, and following emergency surgery to repair a skull fracture he was left paralysed with a speech disorder. Judge Alton found:

: …a court must clearly be reluctant to depart from the view of an apparently careful and prudent general practitioner, I have concluded that, if there was a body of professional opinion which supports the course of leaving the patient who has some seven days previously sustained a head injury at home in circumstances where he continues to complain of headaches, drowsiness, etc, and where there continues to be a risk of the existence of an intracranial lesion which could cause a sudden and disastrous collapse, then such a view is not reasonably prudent.

Although the risk was slight in probability, this had to be balanced against the most grave of consequences.\textsuperscript{103} Samanta\textsuperscript{104} et al explained although ‘a wealth of expert opinion’ supported the notion a referral to hospital for neurological assessment was not indicated at an earlier point, in the light of the plaintiff’s symptoms a weighing of the risks suggested otherwise. The Court of Appeal dismissed the appeal on the basis the judge was entitled to find that it could not be a reasonable exercise of a GP’s discretion to leave the patient at home rather than readmit to hospital. Beldam LJ\textsuperscript{105} quoted from Bolitho where Lord Browne-Wilkinson noted the use of such adjectives as reasonable, responsible

\textsuperscript{102} Ian Leslie Marriott by his next friend Gillian Patricia Marriott) v (1) West midlands Health Authority (2) South east Staffordshire Area Health Authority (3) Surrendra Purshottam Patel [1999] Lloyd's LR Med 23.
\textsuperscript{103} In general negligence, it is recognised that ‘the degree of care which that duty involves must be proportioned to the degree of risk involved if the duty of care should not be fulfilled’ Northwestern Utilities Ltd v London Guarantee and Accident Co [1936] AC 108 PC approved by Lord Normand in Paris v Stepney Borough Council [1951] AC 361 at 381 HL. The amount of caution required tends to increase with the likelihood the defendant’s conduct will cause harm and vice versa Bolton v Stone [1951] AC 850 HL.
\textsuperscript{105} The leading judgment in the Court of Appeal Beldam LJ with whom Swinton Thomas LJ agreed.
and respectable showed the court had to be satisfied that the "exponents of a body of opinion relied upon can demonstrate that such opinion has a logical basis." Beldam LJ asserted having re-examined the evidence he was not convinced the evidence of Dr Fell or Dr La Frenais amounted to a responsible body of professional opinion shared by others in their profession. Maclean emphasised as the experts only provided evidence as to their own practice and not a reasonable or responsible body of opinion, the judge was required to approach the circumstances from first principle. However Maclean contended Marriott was probably the case claimed most strongly by what he termed the Bolitho camp. Is the conclusion Marriott could not have been decided the way it was, if it had not been preceded by Bolitho inevitable? Although Brazier and Miola stated Marriott proved that Bolitho had already made a difference, they noted the defendant’s own expert offered ‘less than whole-hearted support’. They contended that Marriott will mark the beginning of a revolution in judicial attitudes to medical negligence but not a ‘new Bolam’. It is argued Marriott could be viewed as similar to Hucks v Cole. It showed the worst excesses of ‘conventional’ Bolam, envisaged from a conservative interpretation of Maynard and De Frietas, were not inevitable. This interpretation offers support to the idea advanced in chapter one that factors outside the law brought Bolam into disrepute. Mason and Laurie adopted the language of ‘new Bolam’ post Bolitho yet contended prima facie, Marriott moved Bolitho from logic to reasonableness, opening an alternative route to a ‘new Bolam.’ This return of terminology to pre-Bolitho adjectives is perceived by Mason and Laurie to move the test for the appropriate standard of care to one more akin to the

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106 Does this reference to Bolitho logical after discussing the adjectives reasonable etc reinforce the contention that in substance at least the Bolitho judgment is nothing new?
107 Ibid. It is suggested that really all any expert witness can do is ‘provide evidence as to their own practice’ as it is for the court to decide whether it amounts to legally reasonable or responsible, so Marriott need not be viewed as not being subject to the operation of the Bolam test for this reason.
108 Maclean n65.
109 Brazier and Miola n56 p99.
110 Ibid p103.
111 Brazier and Miola n56.
112 Whilst the outcome and broad reaction to Marriott is that it signified the courts assertiveness the Court of Appeal opined “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.” It is argued that the undertone to this sentiment might be indicative of the predilection to conflate professional opinion with reasonable in law which contributed to the Bolam awry era.
113 It was a reticence to apply ordinary tortious principles to clinical negligence that led to criticism of the test.
114 Mason and Laurie n47 p141.
115 Ibid.
reasoning applied in other, non-medical standard of care cases. It is argued that their view supports the contention that the adjective logical does not substantively alter *Bolam* and adds credence to ‘alternative’ *Bolam*. Mulheron discussed *Marriott* as an example of her third *Bolitho* factor ‘failure to weigh the comparative risks’. It is suggested her view is merely illustrative of the approach taken to establishing breach in any negligence action.

The courts were also assertive in their rejection of expert opinion in *Lowe v. Havering Hospitals N.H.S. Trust* the facts of which were neatly summarised by Mulheron. “The defendant arranged for an 8-week gap between consultations for a patient who had high and uncontrolled blood pressure who then suffered a major disabling stroke. The practice of such widely-spaced appointments was held to be negligent, it had failed to take into sufficient account matters such as the patient's unstable and very high blood pressure. A body of expert medical opinion had supported the conduct of the physician as being acceptable, but that opinion was rejected”. It is argued pre-*Bolitho* a suitably willing court could have held the same way.

The basis for decisions, and their impact on the questions posed in the introduction to the analysis of the post *Bolitho* position, is not always clear. Mulheron categorised *Penney, Palmer and Cannon v E. Kent HA* as an example of a clear precaution being overlooked. The three claimants each brought an action against the defendant health authority, arising out of cervical

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116 Mulheron n72.
117 She n72 acknowledged the relation of this to her first *Bolitho* category. She attributed such assessment to *Bolitho* where it is stated “in cases involving,... the weighing of risks against benefits, the judge before accepting a body of opinion as 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.”
118 *Lowe v Havering Hospitals N.H.S. Trust* (2001) 62 BMLR 69. The “clear precaution” (Mulheron’s n72 first *Bolitho* category) was as simple as a more rigorously-arranged series of medical appointments for the patient.
119 Mulheron n 72.
120 Mulheron n72 asserted the decision was rejected ‘under Bolitho.’ This would prima facie appear contradictory given that *Hucks* predated *Bolitho* (HL) by thirty years, unless *Bolitho* is taken as convenient shorthand for an assertive court, actively determining the appropriate standard of care.
121 For example Mulheron n72 p.617 “*Bolam* only pertains to questions requiring expert opinion, and not to disputes about mere questions of fact.” She emphasised the variety of situations in which clinical judgment could be said to be manifest and how “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.” This is significant as on her view; “Once *Bolam* applies, the fact of differences in expert opinion cannot lead to a rejection of *Bolam* evidence”. She does not recognise the potential for the court to assertively examine expert opinion and to only be constrained in the manner described above where both bodies of opinion are legally reasonable and responsible on the court’s own assessment.
122 *Penney, Palmer and Cannon v East Kent health Authority* [2000] Lloyd’s LR Med 4. *Penney* was considered and applied in *Manning v King’s College Hospital NHS Trust* [2008] EWHC 1838 aff’d [2009] 110 BMLR 175 the essence of which was that a case of a doubtful malignancy should not be reported as negative.
smears taken from them. Each of the smears was reported by the primary screener as being negative, the consequence of which was no follow up or diagnostic or therapeutic intervention. Each of the claimants went on to develop invasive adenocarcinoma, and had to undergo surgery. The judge at first instance[^123] had found for the claimants. As Mulheron[^124] explained “he applied the standard of a reasonably competent screener exercising reasonable care at the time when the screening took place and found, preferring the evidence of the claimants’ experts, the slides contained abnormalities which meant it was not possible for the reasonably competent screener to have passed the slides as negative”.[^125] The health authority appeal was dismissed. According to Montgomery[^126] the Court of Appeal approached the issue from the perspective that the disagreement was due not to the standard of professional practice to be expected but the actual appearance of specimens.[^127] Montgomery[^128] contended the Court of Appeal were on this basis able to uphold liability without departing from the peer review standard of care in clinical negligence.[^129] He[^130] contended even if Bolitho represented a stronger affirmation of the judicial right to set standards in medicine, they preferred to avoid doing so.[^131] However the Court of Appeal reiterated that the defendant cytoscreeners “were exercising skill and judgment in determining what report they should make and, in that respect, the Bolam test was generally applicable.”[^132]

[^123]: Where both Bolam and Bolitho were referred to and it appeared Bolitho’s requirement of logical analysis was used as an explanation of reasonable and responsible.

[^124]: Mulheron n 72.

[^125]: Peppitt J stated “I do not consider the evidence of Drs Hudson and Boon (defence experts) stands up to logical analysis as the phrase was used by Lord Browne-Wilkinson in Bolitho…This is not to disparage the evidence of either.”


[^127]: On appeal it was explained Bolam had no application where there were findings of fact, even where the findings of fact are subject to conflicting expert evidence. There was substantial but not total agreement between the experts, the evidence having been given the judge had to make his own finding on the balance of probabilities as to what could be seen on the slides. The question of breach of duty, involved on the training and amount of knowledge a screener should have had at that time and what the judge found there to be on the slide, mixed fact and opinion as to the standard of care that should have been exercised.

[^128]: Ibid.

[^129]: Ibid.

[^130]: Ibid.

[^131]: Ibid.

[^132]: Mulheron n 72 p615 conceded that clinical judgment is frequently manifested in a wide variety of situations but noted that Bolam did not apply to simple cases of carelessness. B.Moxon Browne QC ‘Butterfingers and the Bolam Test: Can Bolam Apply to Simple Cases of Clumsiness by the Doctor?’(2008) Injury Times argued the Court of Appeal were wrong to apply Bolam in Smith v Southampton University Hospital NHS Trust [2007] EWCA Civ where the allegation was the surgeon had been clumsy. I do not argue with his assertion “the issue of whether or not the physical performance of the surgery is of an appropriate standard ought to be resolved by the court”. However exception is taken to his assertion that Bolam’s operation would mean “the mere fact of disagreement between the experts
A number of cases show the courts behaving assertively in their role as the ultimate arbiters of the standard of care in situations where there was a failure to weigh the comparative risks and benefits of the chosen course of conduct.\textsuperscript{133} Purver v Winchester & Eastleigh Healthcare NHS Trust\textsuperscript{34} Mr Moors, had tried four times to deliver P using forceps the decision was taken to proceed to caesarean section. The interval of time between this decision and delivery exceeded ten minutes,\textsuperscript{135} as a result of which the claimant suffered irreversible brain damage. The judge lamented;

\begin{quote}
In my judgement...the logic suggests that the objective of the reasonably competent and well informed obstetrician would be to deliver the child well within the period of ten minutes.
\end{quote}

Of the defendant’s expert he said:

Miss Penn… an experienced and distinguished (my emphasis) obstetrician, would support Mr Moors decision… for the reasons I have endeavoured to set out I do not think that the position is defensible within what is known as the second limb in Bolitho…I should, say that I reach this conclusion with reluctance.

The terminology of Bolitho does appear to have permeated judicial consciousness. However, it is argued Purver could have been decided by utilising Bolam and risk/benefit analysis. It is noted deferential undertones are still discernible in the excerpt above.

The defendant’s argument it was reasonable to ignore a small risk of catastrophic consequences, when the burden of precautions was minimal, was rejected as indefensible in Reynolds v North Tyneside Health Authority\textsuperscript{136} Gross J was not convinced, on the evidence there was a responsible body of medical opinion. But in any event:

\begin{quote}
would suffice to ground a decision in favour of the defendant.” It is correct that the physical competence of a surgeon is a matter for the court, the standard required is unexceptionally reasonable care in the circumstances of the case. It is argued that Bolam would not constrain the court.\textsuperscript{133} Mulheron’s third category of where trumping Bolam might occur.\textsuperscript{134} [2007] All ER 89.
\textsuperscript{135} Contravening the so-called “ten minute rule” whereby at the outset of foetal bradycardia the baby must be delivered within ten-minutes.\textsuperscript{136} Reynolds v North Tyneside Health Authority [2002] Lloyd’s Rep Med. 459 Set against the low risk of cord prolapse were (i) the gravity of the consequences should the risk materialise and (ii) the ease and economy of undertaking an immediate vaginal examination.
\end{quote}
Even if there was any such contrary practice, or body of opinion, then the only reason articulated for its support …does not withstand scrutiny. Having carefully examined the evidence, this is one of those rare cases where it is appropriate to conclude that there is a lacuna in practice for which there is no proper basis…

This could be seen as an application of the principle enunciated in Hucks v Cole\textsuperscript{137} due to the explicit reference of the existence of a lacuna and illustrative of risk/benefit analysis.

In a similar vein Mellor v Sheffield Teaching Hospitals\textsuperscript{138} Gross J said discharging from hospital a patient who was at high risk of a coronary event without undertaking further investigations “would not be logically sustainable” given the serious consequences should the event occur.\textsuperscript{139} Also Brown v Scarborough & North East Yorkshire Healthcare NHS Trust\textsuperscript{140} B had undergone a hysterectomy, post operatively she suffered constant pain\textsuperscript{141} the issue was whether the length and shape of the incision constituted a breach of the trust’s duty.\textsuperscript{142} Evidence showed the link between incision extension and risk of damage to the adjacent nerves was known, the surgeon’s starting point was illogical and unsupported by evidence\textsuperscript{143} the trust had breached their duty. On this issue of risk/benefit analysis, Mulheron\textsuperscript{144} limited its impact, she pointed to

\textsuperscript{137} (1968) [1993] 4 Med LR 393.
\textsuperscript{138} Mellor v Sheffield Teaching Hospitals[2004] EWHC 780.
\textsuperscript{139} Also Kingsberry v Greater Manchester Strategic Health Authority [2005] EWHC 2253 there were signs of foetal distress, the court held that the proper risk/benefit analysis indicated a trial of forceps should have been carried out in theatre rather than attempting manual rotation and forceps. As Mulheron n72 noted this was notwithstanding peer professional opinion, on behalf of the defendant obstetrician that was supportive of his practice. It was held that expert opinion “did not withstand logical analysis”.\textsuperscript{140} [2009] EWHC 3103 (QB).
\textsuperscript{141} She was diagnosed with ilio-inguinal neuralgic pain. It was accepted the nerve was damaged by the procedure.
\textsuperscript{142} Both parties’ experts agreed that the length of the incision was a matter of clinical judgment.
\textsuperscript{143} Notwithstanding that the trust had put forward evidence that other surgeons frequently used incision lengths over 15 cms. Held even if that were so, that might have been justified by the circumstances of the particular patient and would have been preceded by the appropriate risk assessment.
\textsuperscript{144} Ibid p 627. She n71 opined “it is 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 opinion.” She contended expert opinion will not be what Bolitho expects of the expert unless it has weighed the comparative risks and benefits. By contrast she contended such a ‘weighing up’ is not required under Bolam She referred to Birch v University College London Hospital NHS Foundation Trust [2008] EWHC 2237 (QB) at 55 at p 625 “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”. This applied Pearce v United Bristol and Healthcare Trust (1999) 48 BMLR 118 and could be perceived as an assertive use of ‘alternative’ Bolam given that Mason and Laurie n 44 p 117 described the language in Pearce “as suggestive of a movement away from precedents of the past, yet the outcome and reasoning may simply locate the decision within the existing paradigm- namely the Bolam test.” They perceive an exception as existing where there is a significant risk, which no reasonable person would find it acceptable to withhold. It is argued this assertion need not be perceived as a departure, or exception from the Bolam test but rather a recognition of its true criterion that what amounts to reasonable care is ultimately for the court to decide after weighing up the circumstances of the case.
Smith v West Yorkshire H.A. she asserted Bolam does not require the doctor to “second-guess” what peers may think, and make a choice in order to preclude a finding of negligence. The court considered and rejected the patient’s submission “if there were different bodies holding respectable, but significantly different, opinions of the CTG trace, the obstetricians conduct was compromised by the fact he failed to take into account that other respectable opinion could reasonably take another view.” It is argued ‘alternative Bolam’ could have been used to require consideration of the possibility of different interpretations of the trace.

Mulheron’s fourth Bolitho category “where Bolam would be trumped” was illustrated she contended by Nationwide Organ Retention Group Litigation where complaints came to light about the retention of organs from deceased children without parental consent, as a result of which parents suffered psychiatric injury. The practice universally adopted by clinicians for many years of not informing the parent’s of deceased children that at post-mortem their child’s organs might be removed or retained was not considered as evidencing appropriate care.

Gage J stated:

The argument of the defendants, based on evidence of a practice universally adopted by clinicians over the years, is a strong one. Yet having carefully considered the evidence…I find myself unable to accept it.

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145 Smith v West Yorkshire Health Authority [2004] EWHC 1592.
146 It is sufficient if the doctor acts in accordance with a practice accepted as proper by a reasonable body of persons who practised the same art. However it is contended that a body of opinion in order to constitute ‘reasonable’ would need to be aware ‘of the state of knowledge’ or particular evidence base, including that alternative interpretations were possible and thus perform an appropriate risk/benefit analysis. It is conceded the same course might have been taken, so no change in the outcome, it is recognised a limitation on this could be that the law only requires reasonable care in the circumstances of the case.
147 In a non-medical case Adams v Rhymney Valley DC [2000] Lloyd’s Rep PN 777 the dissenting judge Sedley LJ considered it to be a “requirement of Bolam that the defendant doctor consider and evaluate the alternatives.”
148 Where the accepted medical practice contravenes widespread public opinion.
149 See Group Litigation Order No 9 at http://www.hmcourts-service.gov.uk/cms/150.htm AB v Leeds Teaching Hospital NHS Trust [2004] EWHC 644 para 30 where a practice universally adopted by clinicians was rejected by the court.
150 The court reasoned that although the expert evidence was that doctor’s were taught to respect a dead body, and that the parents’ wishes with respect to a deceased child were respected and complied with, these views did not fit with a failure to explain to parents that a post-mortem might well involve the removal and retention of an organ, particularly a heart or brain.[2004] EWHC 644 [2005]QB 506 [2005] Lloyd’s Rep Med 1.
Mulheron\textsuperscript{151} asserted the courts accepted the parents’ claim that Bolam could not operate to defend (my emphasis) this medical practice. This is not because it invoked a “Bolitho overrule” but rather even if universally accepted this practice was unreasonable, especially as it was carried out without any case-by-case therapeutic judgment and therefore pre- Bolitho the court could have rejected such practice.\textsuperscript{152}

Lord Woolf MR noted\textsuperscript{153} the phrase “Doctor knows best”, should now be followed by the qualifying words “if he acts reasonably and gets his facts right,”.\textsuperscript{154} Mulheron contended the same caveat applies to peer professional opinion.\textsuperscript{155} Lillywhite v University College London Hospitals NHS Trust\textsuperscript{156} Alice was born with a severe malformation of her brain. Her clinical negligence claim relied upon the failure of Professor Rodeck,\textsuperscript{157} to diagnose brain abnormality when he carried out an ultrasound at 19 weeks gestation.\textsuperscript{158} At trial there was a division of expert opinion.\textsuperscript{159} The claimant failed as three experienced scanners reached the same conclusion as Professor Rodeck had. The Court of Appeal by a majority\textsuperscript{160} overturned the decision. Latham LJ noted the fact three expert scanners reached the same conclusion was a ‘powerful

\textsuperscript{151} Mulheron n72 p 629.
\textsuperscript{152} Mulheron n72 p30 suggested this ‘Bolitho factor’ illustrated Lord Tomlin’s caution “that neglect of duty does not cease by repetition to be neglect of duty” Bank of Montreal v Dominion Gresham Guarantee and Casualty Co (Canada) Ltd [1930] QC 659 (PC) 666 where he noted there could be many reasons, such as convenience or cost, or habit, why a particular practice is commonly followed, which have nothing to do with exercising reasonable care to avoid harming others. It is contended this decision illustrated the proper approach to common practice and one reason why it could not be permitted to be determinative. It is further suggested there was no reason for not extending this same caution to medical professional practice.
\textsuperscript{154} Mulheron distinguished this, her fifth Bolitho factor from disputes concerning expert testimony on questions of fact, by contending it applied where the defendant doctor misinterpreted the facts or where the doctor’s expert supported the defendant’s conduct where the expert had proceeded on a mistaken fact. In either case the expert testimony cannot be logically defensible. Similarly, her sixth Bolitho category that the doctor’s expert medical opinion is not internally consistent.
\textsuperscript{155} Mulheron n72 asserted “in some instances in which such opinion has been rejected by the courts and breach found, the Bolitho found to be wanting in logical analysis reasoning, has been expressly or implicitly applied”.
\textsuperscript{157} Chair and Head of Department of Obstetrics and Gynaecology at the University College London Hospital.
\textsuperscript{158} Prior to her referral to Professor Rodeck, Mrs Lillywhite had had a routine scan at 18 weeks gestation; two of the three brain structures were not located. Mrs Lillywhite was referred to Professor Rodeck.
\textsuperscript{159} The claimant called two experts who expressed the view that upon a tertiary referral, an experienced sonologist must have failed to exercise an appropriate degree of care if he concluded there was no evidence of abnormality when three critical brain structures were not present. The two experts called by the defence expressed the opinion the failure to diagnose this rare condition which had an atypical presentation in this case, could not justify a finding that there had been a failure of adequate care on the part of Professor Rodeck.
\textsuperscript{160} The majority were Latham and Buxton LJJ, Arden LJ dissented.
consideration but could not of itself be sufficient.’ This asserted that the law, and not common medical practice determines the appropriate standard of care in clinical negligence.\(^{161}\) Mason and Laurie\(^{162}\) considered the main lesson to the adduced was evidence to refute an allegation of negligence must be more convincing when a specific diagnostic question has been posed. Jones\(^{163}\) said Lillywhite showed the obligation on a hospital dealing with a tertiary referral was a high one as it “was a scan with a focus”.

Mulheron cited Tagg v Countess of Chester Hospital Foundation Trust\(^{164}\) where a patient suffered a bowel injury during a gynaecological operation, as an example of a case where the court took a fairly dim view of ‘Bolam evidence’. Misunderstood facts and misplaced assumptions meant that the expert opinion did not exculpate the surgeon.\(^{165}\) It is argued it is inappropriate to term such evidence as ‘Bolam evidence’. An expert’s views which are based on a mistaken diagnosis are also likely to be condemned as illogical, Drake v Pontefract Community NHS Trust.\(^{166}\)

Mulheron’s sixth Bolitho category is related to the fifth, it is where the doctor’s expert medical opinion is not internally consistent. Hunt v NHS Litigation Authority\(^{167}\) which involved a difficult birth, the question was whether a forceps delivery should have been preceded with in the circumstances? The Claimant succeeded as the expert evidence as to appropriateness of forceps delivery was rejected\(^{168}\) as lacking a “logical basis”. It is argued such a view could also have been rejected as neither reasonable nor responsible. Mulheron contended Smith v Southampton\(^{169}\) was an example of another situation where ‘Bolam evidence’ would not absolve the doctor, “where it may properly prefer the

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\(^{161}\) Latham LJ concluded with the observation “the result is an extremely distinguished doctor has been found to have fallen below the appropriate standard of care and skill in what was undoubtedly a difficult case where he showed great compassion and gave considerable assistance once he knew what the position was. But those considerations do not deflect me from concluding that this appeal should be allowed.”

\(^{162}\) Mason and Laurie n47 p 142.


\(^{164}\) [2007] EWHC 509 (QB).

\(^{165}\) The defendant’s surgical expert had assumed that the surgeon had performed a procedure for purpose X (placing a patch to strengthen the bowel wall), whereas it came to light it was done for purpose Y (to prevent further adhesions). Bolitho was not expressly referred to.


\(^{168}\) The expert witness for the defence opined were a forceps delivery considered appropriate in this type of case “untold damage would be caused to the maternal population” but then he conceded that a forceps delivery could have been carried out without difficulty.

\(^{169}\) Smith v Southampton University Hospital NHS Trust [2007] EWCA Civ 387.
evidence of the patient’s expert witness to that of the doctor’s.” The issue centred on the acceptability of having surgical scissors open rather than closed when not in the surgeon’s view. The claimant failed at first instance but partially succeeded on appeal as the Court of Appeal overturned the finding that Mr Nielto could be absolved of negligence in relation to the damage done to the obturator nerve. Jones explained the Court of Appeal were critical of the trial judge for “relying exclusively on the Bolam test” in the sense the judge had accepted the evidence of expert witnesses for the defendant on the basis the witness was “highly reputable” in his field. This conflated status with reasonableness and left the court unable to make their own assessment. Mulheron credited Bolitho, although it was not referred to, with allowing the court to reject the evidence of the expert witness. It is argued Smith v Southampton could be explained as the court asserting their authority as the ultimate arbiters of the standard of care, rejecting contradictory asserted practice, as not reasonable in law. In Antoniades v East Sussex Hospitals where Jacob sought damages for alleged breach of duty by clinicians attending after his birth which caused him to sustain irreversible brain damage, the experts agreed the reason for the harm was an obstruction of the airway. Two experts defended the team’s actions Mackay J concluded:

170 Smith v Southampton University Hospital NHS Trust [2007] EWCA Civ 387 was subject of a notable special leave application to the House of Lords which was refused on the grounds that the case did not raise an arguable point of law of general public importance. See Report from the Appeal Committee of the House of Lords (dated 16 October 2007).
171 The expert for Ms Smith said points of the scissors should be kept closed during this procedure. The surgeon’s expert agreed “exposed scissors blades… really should be only exposed when fully visible to the operating surgeon” and “the commonest reason why the obturator nerve is damaged is it does come into contact with an incompletely closed pair of scissors. Yet the defence expert then concluded that to have the scissors partially opened, when not in sight was not substandard practice.
172 Mulheron, n72 said in rejecting the trial judges analysis the Court of Appeal rejected that defendants Bolam evidence. It would appear what she means by this is expert evidence on behalf of the defendant.
173 Jones with Lyons n163 p243.
174 Mulheron n72 p 634.
175 Unlike Mulheron the view is not taken here that Maynard, Bolitho and Sidaway would prohibit the court from preferring the patient’s body of opinion over the defendant doctor’s on the basis that the defendant’s was unreasonable. Mulheron concluded that English judgments would benefit from a more explicit recognition of the fact that a body of medical opinion cannot withstand analysis when it is internally inconsistent. Unfortunately she viewed this as a Bolitho factor.
177 The experts agreed that there was no ante-natal brain damage and that hypoxic ischaemia began at about 19.18 hrs with the cardiac collapse. That damage did not become irreversible until 19.30.
178 Professor Weindling accepted all resuscitation teaching drove home the A-B-C algorithm, yet he defended the team’s actions in attending to B and C even if they knew A had not been established. Dr Ogilvie also was of this view, saying that even though it was not logical, ‘few practitioners’ would not do so, and that it would be ‘very difficult’ not to start on C even when A was not completed, although he conceded it would be pointless to do so.
It amounts to saying this, though what the team did was plainly contrary to established ‘as taught’ practice, and was illogical and useless, most or many other doctors would do the same in an emergency. Given the concessions about standard practice I cannot accept this proposition.

In *Hutchinson v Leeds Health Authority*179 Bennett J held an expert’s evidence to be “less than helpful (putting it tactfully) and illogical.”180

**A More Explicitly Cautious Message? A Passive Judiciary?**

Consideration of Mulheron’s second *Bolitho* factor has been reserved until this point as it will be argued it might be an area where the courts are especially cautious. Mulheron recognised scarcity of resources required conflicting interests be balanced. She noted where this tension impacted directly upon an adverse outcome for the patient, no matter how illogical the medical practice might appear on its face, successful reliance by the patient on the *Bolitho* test was unlikely.181 *Garcia v St Mary’s N.H.S. Trust*182 the judge dealt with the question of the appropriateness of the hospital’s staffing levels using the *Bolam/Bolitho* principles.183 The Court accepted expert evidence as to the divergence of practice in other hospital trusts at this time. Counsel for Mr Garcia urged despite a system being accepted by the expert witnesses, it should be rejected as a proper system evidencing appropriate care by virtue of *Bolitho*.184

Case law has also confirmed that the doctor has to balance the risks and benefits of treatment to persons other than the directly affected patient.185

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179 *Hutchinson v Leeds Health Authority*, QB 6 November 2000.

180 “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 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.*” Ibid at [78] Mulheron categorised this as her seventh Bolitho exception “that peer professional opinion had adhered to the wrong legal test” and explained ‘*Bolam* evidence’ was rejected as “the expert had set a yardstick by which to assess the acts or omissions of the surgeon… which was incorrect.” The courts disproval of such a standard is welcomed as ‘conventional’ *Bolam* view pushed to its logical conclusion might accord more closely with such a view than is desirable.

181 Mulheron n 72.

182 *Garcia v St Mary’s NHS Trust* [2007] EWHC 3068.

183 As discussed in my own previously published work; Joanne Beswick ‘A First Class Service? Setting the Standard of Care for the Contemporary NHS?’ (2007) 15 *Medical Law Review* 245. The question of the existence of such an institutional duty will be addressed more thoroughly in chapter six of this thesis. Chapter seven will then go on to question how breach of such an institutional duty might be determined.

184 Beswick n 183.

185 *Smithers v Taunton and Somerset NHS Trust* [2004] EWHC 1179 no breach of duty, as while the situation involving a difficult birth, leading to catastrophic injuries to a newborn, may have been far from
Mulheron did not categorise Wisniewski\textsuperscript{186} within her scheme she dealt with it as an example of the difficulty of overcoming the assumption “the doctor’s expert is very eminent in this field, therefore, how could they not represent the views of a responsible body of medical opinion?” She noted the chilling effect Lord Browne-Wilkinson’s view\textsuperscript{187} could have. This more openly deferential stance can be detected in the appeal by the defendants Wisniewski v Central Manchester Health Authority.\textsuperscript{188} Brooke LJ\textsuperscript{189} held the appeal would be allowed because it was wrong for the court to hold that the views sincerely held by the defendants’ experts could not logically be supported and held by responsible doctors.\textsuperscript{190} The Court of Appeal accepted the defence’s submission that the judge had erred, and that ‘a view sincerely held by the defendant expert’ must equate to a reasonable and responsible one. Brook LJ stated “it is quite impossible for a court to hold that the views sincerely held by Mr Macdonald\textsuperscript{191} and Professor Thomas cannot be logically supported by responsible doctors at all.” He went on:

It is therefore said that the judge did what the House of Lords in Bolitho has again very recently confirmed that he must not do, which was to substitute his own assessment of what would have been the appropriate standard of care for the standard considered appropriate by a responsible body of medical opinion.

Maclean\textsuperscript{192} submitted ‘the Court of Appeal’s approach in Wisniewski was to equate an honest view of an eminent specialist with a view that must have some logical basis’, which he contended suggested that Bolitho had done little to counteract the pitfalls of the ‘conventional’ Bolam.

Mulheron noted that other judges have continued to remark that it would be difficult to apply Bolitho where a distinguished expert in the field considered the accused doctor’s treatment or diagnosis to be reasonable. Cowley v Cheshire perfect, peer support for the obstetricians conduct could not be attacked.

\textsuperscript{186} Wisniewski v Central Manchester Health Authority [1998] Lloyd's Rep Med 223 CA.
\textsuperscript{187} [1998] AC 232.
\textsuperscript{188} Wisniewski v Central Manchester Health Authority [1998] Lloyd's Rep Med 223 CA where the trial judge’s findings were overturned partly on the basis that the very eminence of the defendant’s experts. rendered the Bolitho test difficult to satisfy.
\textsuperscript{189} Aldous and Roch LJJ agreeing.
\textsuperscript{190} Ultimately breach was upheld on a different basis.
\textsuperscript{191} Described as “an eminent consultant and impressive witness”.
\textsuperscript{192} MacLean n66.
and Merseyside Strategic Heath Authority\textsuperscript{193} and Zarb \textit{v} Odetoyinbo\textsuperscript{194} Mrs Zarb unsuccessfully sued her GP for failing to refer her to a surgeon before she developed a rare condition after the court reflected “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].” Moreover, it is unlikely to just be the eminence of particular medical experts, which the courts remain loath to challenge as the Court of Appeal’s reaction to the following decision showed. \textit{Ministry of Justice \textit{v} Carter}\textsuperscript{195} the claim centred on Dr Premaratne’s failure to make a non-urgent referral for Ms Carter to a breast clinic, notwithstanding the fact it was her third consultation for the same condition of a reported breast lump. At first instance Holland J had held:

\begin{quote}
I am steering a course between two experts...It is here that I heed the submission of Miss Sparks for [Ms Carter], drawing attention on the one hand to the potential significance of a breast lump if there, and on the other hand to the relative ease with which a routine referral could be arranged and carried out- a balance of factors that has parallels elsewhere in the common law.\textsuperscript{196}
\end{quote}

Holland J held the Ministry of Justice were in breach of their duty to Ms Carter. The primary ground for appeal was the judge had failed to apply the correct test for breach of duty in clinical negligence cases.\textsuperscript{197} Leveson LJ held “the effect of his finding is he comes nowhere close to concluding that the view expressed by Dr Cheng\textsuperscript{198} 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.” Neither did he consider that it would have been open to Holland J on the evidence to do so.\textsuperscript{199}

\textsuperscript{193} [2007] EWHC 48 QB.
\textsuperscript{194} Zarb \textit{v} Odetoyinbo [2006] EWHC 2880 QB.
\textsuperscript{196} See Morris \textit{v} West Hartlepool Steam Navigation [1956] AC 552 which concerned the failure to fence an unprotected hold in accordance with a general practice in relation to grain ships in ballast while at sea. It was held that the risk to the deck hand who fell into the hold were serious; negligence was thus established.
\textsuperscript{197} It was contended far from relying on \textit{Bolam} he had reached a conclusion based upon the unresolved concern of the claimant and the relative ease of referral.
\textsuperscript{198} Dr Cheng’s view was some GP’s would have referred but referral was not mandatory. Dr Cheng noted neither NICE guidelines nor the Kent and Medway Cancer Network Guidelines made referral in such a case mandatory, but leave it to the discretion of the GP. The expert for Ms Carter, Dr Ross took a different view of the NICE guidance and maintained, if a patient complained of the presence of a lump, even if no such lump was found, by the second visit to the GP, there was an ‘unresolved diagnostic problem’ which had to be referred for further investigation.
\textsuperscript{199} Sir Scott Baker (agreeing with Leveson) held “the judge was not entitled to impose his own opinion, regardless of the practice of the medical profession. The test he should have applied is that explained in
Leveson LJ agreed with the defence's submission that unlike employment cases where the court is able to impose safety precautions, a referral to a specialist in cases such as this had implications in relation to the pressure of work on this service and, as the judge found, a clinical judgment will always be required before such a step is taken... clinical judgment takes the case back to an analysis as described in Bolam and Bolitho.\(^{200}\) It is unclear if this sought to limit the court’s ability to set the appropriate standard of care or whether the Court of Appeal were requiring judges be more explicit in rejecting professional standards as (in)appropriate if that were their finding.

The decision from the Singapore Court of Appeal Khoo Gunapathy d/o Muniandy\(^{201}\) was worrying as it appeared to suggest that erroneous ‘conventional’ interpretation of Bolam persisted. It proceeded on the basis there had been a substantive change to the law following Bolitho, but was not a decision where the court asserted their authority as the ultimate arbiters of the standard of care. This could point to Bolitho’s logic as being as impotent as ‘conventional’ Bolam if the courts consider they need to defer to medical experts. It was held the Bolitho exception must be narrowly construed, if the various House of Lords statements on the matter were to be honoured.\(^{202}\)

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 found liable when his view, as represented by the defence experts was found by the court to be unreasonable.

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200 Roger Harris, ‘Personal Injury: Taking the blame’ (2010) 160 NLJ 110. In light of these authorities governing allegations of clinical negligence Holland J’s decision that referral was not mandated was fatal to the claim.

201 Khoo v Gunapathy d/o Muniandy [2002] 2 SLR 414. In October 1995 Mrs Ghoo was diagnosed with a brain tumour. She consulted the first appellant, J, who performed a craniotomy. From December 1995 to January 1996 G was referred to the second appellant, H, and underwent radiotherapy treatment. In February 1996 an MRI scan revealed a lesion in the same region from where the tumour had been removed. J was unsure whether the lesion represented scar tissue or a tumour and advised G to wait. Ten months later G had another scan. In the opinion of the radiologist, the lesion seemed to be scar tissue. J disagreed and recommended radiosurgery on what he considered to be a tumour. G sought a second opinion from P, who also considered the lesion to be a tumour. In January 1997 J, H and a radiation physicist performed the radiosurgery procedure which led to radionecrosis of surrounding brain tissue. G consulted a further neurosurgeon, P, who considered a second craniotomy in order to halt the radionecrosis. The procedures left G with permanent disabilities. G sued J, H and J’s clinic, alleging negligence. She claimed the doctors had unnecessarily advised her to undergo treatment which had resulted in serious disabilities. The judge considered the question of whether the lesion was scar tissue or a tumour to be a finding of fact which he was entitled to arrive at by weighing the soundness and credibility of the expert testimony. He found the lesion was scar tissue and held the doctors were liable with respect to their diagnosis, reasoning that no responsible medical expert could have recommended radiosurgery for a non-existent tumour. The appellant healthcare professionals appealed. The Appeal was allowed.

202 Mulheron n72 p 619.
We do not think this was the intention of the House of Lords in *Bolitho*.

It is asserted this is just what was intended in *Bolitho* and it is submitted the Singapore Court misrepresented *Bolam*.\(^\text{203}\) Mulheron\(^\text{204}\) argued that Lord Browne-Wilkinson’s terminology of rejecting expert testimony where it was unreasonable must be construed as meaning something other than “merits based- for otherwise, a superiority analysis of the merits of conflicting expert testimony would be explicitly condoned.” She contended the Singapore Court of Appeal were particularly alive to this issue and that is why they interpreted *Bolitho* as they did. She pointed to the following judicial pronouncements to support the contention that this was impermissible *Bellarby v Worthing and Southlands Hospitals NHS Trust*\(^\text{205}\) and *Marriot v West Midlands Regional H.A*\(^\text{206}\) where the Court of Appeal noted “the judge…correctly directed herself it would not be open to her to simply prefer the expert evidence of one body of competent professional opinion over that of another where there was a conflict between the experts.” Mulheron contended the House of Lords had reiterated it was not “for the court to venture into consideration of two contrary bodies to decide which it preferred.” She cited *Maynard, Sidaway* and *Bolitho* in support of this assertion, her interpretation ignored the fact it was only when both bodies of opinion satisfied the court (on their assessment) as being reasonable and responsible in law that the court would not choose between them.

**Conclusion**

What Mulheron termed *Bolitho* factors could just as easily have been explained

\(^{203}\) It is argued that *Khoo* illustrated the confusion between the prescriptive and descriptive, the standard which care should be rather than the standard it is in fact. It is true that the courts should not reject after their own assessment, legally reasonable medical opinion, as negligence generally only requires ‘reasonable care in the circumstances of the case and does not demand perfection.’ This has long been recognised as a problem, see A Montrose, ‘Is Negligence an Ethical or Sociological Concept’ (1958) 21 MLR 259.

\(^{204}\) Mulheron n72 p 619 contended the interpretation of reasonableness given in Joyce “is clearly not the way in which *Bolitho* has been applied since.” It is argued this is a matter of opinion, and it is also suggested that such an interpretation of *Bolitho* could be more limited than the propounded ‘alternative’ *Bolam*.

\(^{205}\) *Bellarby v Worthing and Southlands Hospitals NHS Trust* [2005] EWHC 2089.

by an ‘alternative’ view of Bolam.\textsuperscript{207} It has been suggested that the lack of judicial reference to \textit{Bolitho} meant that “courts might not regard \textit{Bolitho} as having made a change of any great significance.”\textsuperscript{208} Furthermore it is argued it is not an inevitable pitfall of \textit{Bolam} which would lead the court to conflate status with logic, or reasonable and responsible, but rather social and policy factors.\textsuperscript{209} Moreover, Mason and Laurie\textsuperscript{210} contended “logic is an unusual criterion on which to assess questions based on clinical judgement”, they considered it unlikely the courts would be able to regain control over health care standards if logic were the sole criterion.\textsuperscript{211} They\textsuperscript{212} contended \textit{Jones v Conway and Denbighshire}\textsuperscript{213} encapsulated the tenor of the emerging jurisprudence ‘by collapsing the distinction between logicality and reasonableness.\textsuperscript{214} It is argued if the tests of logic and reasonableness are so easily collapsed and assimilated; the preoccupation with analysing the change in terminology post \textit{Bolitho} may be counterintuitive. This could reinforce the assertion that \textit{Bolitho} did not substantively alter \textit{Bolam}. Furthermore Teff\textsuperscript{215} warned the term logic ran the risk of focussing too much on the internal consistency of the expert’s testimony, rather than a more extensive assessment of what the court deems reasonable. Heywood\textsuperscript{216} contended that the Scottish case of \textit{Montgomery}\textsuperscript{217} demonstrated

\textsuperscript{207} The test as espoused by McNair J never excluded the possibility that a recognised professional practice could amount to a breach of duty by not achieving the relevant standard of care, reasonable care in the circumstances of the case. This position is explored in more depth in chapter one of this thesis. Also \textit{Taylor v Warners} (Ch D 21 July 1987) extracted from Mulheron n72 where Warner J cited McNair J’s test “it is not essential for you to decide which of the two practices is the better practice, as long as you accept that what the defendant’s did was in accordance with a practice accepted by responsible persons.”

\textsuperscript{208} J Herring, \textit{Medical Law and Ethics} (3rd Edition Oxford University Press 2010) p 108 Mulheron contended n72 “\textit{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 \textit{Bolam}.”

\textsuperscript{209} As discussed in chapter two of this thesis.

\textsuperscript{210} Mason and Laurie n47 p 141.

\textsuperscript{211} Mason and Laurie n47 cite Rob Heywood ‘The Logic of Bolitho’ (2006) \textit{Professional Negligence} 225 for a discussion on logical and an alternative of unreasonable risk.

\textsuperscript{212} Mason and Laurie n47 p141.

\textsuperscript{213} \textit{Jones v Conway and Denbighshire} [2008] EWHC 3172.

\textsuperscript{214} In holding that in the absence of a clear bright-line rule about how to proceed in a given set of clinical circumstances it was neither illogical nor unreasonable to delay the procedure. The decision here was whether or not to order an immediate CT scan.

\textsuperscript{215} Teff n13.

\textsuperscript{216} Rob Heywood ‘Negligent antenatal disclosure and management of labour’ (2011) 19 \textit{Medical Law Review} 140.

\textsuperscript{217} \textit{Montgomery v Lanarkshire Health Board} [2010] CSOH 104 Alleged negligence against an obstetrician there was a delay in delivery which caused acute hypoxia which left Sam seriously disabled. It was claimed no ordinary competent obstetrician acting with reasonable skill and care would have: (a) attempted a vaginal delivery; (b) failed to recommend delivery by caesarean section between 08:10 and 17:00 h on the 1st October at the latest; and (c) failed to take foetal blood samples (FBS) between 08:10 and 17:00 h on the same day. These arguments hinged on an interpretation of a CTG trace. The pursuer’s expert witnesses claimed the CTG trace was pathological, and as such, either a foetal blood sample or caesarean was necessary. The defendant’s position was it never became necessary to intervene. Two
It is argued the Bolitho ‘gloss’ could go awry in the same way as a ‘conventional’ interpretation of Bolam did. Elements of the judiciary appear too easily prone to conflate an impressive expert view of proper professional practice with one acceptable to the law, namely reasonable care. This would support the idea that if medical negligence litigation is going to change to any significant extent, more than pronouncements from their Lordships House will be required. It is argued the developments discussed in the following two chapters of this thesis could impact here making the traditional risk/benefit analysis used in general negligence more of a realistic possibility. Brazier and Miola contended that if we are to see ‘a revolution’ in clinical negligence litigation, Bolitho may prove to be of less significance than these other factors, such as the changes in practice in medicine e.g. clinical guidelines. It is asserted that these developments occurring beyond the courts, could help to address one of the oft-cited practical difficulties in the courts being the ultimate arbiters of the appropriate standard of care. The problem illustrated by Badenoch who contended “it is inappropriate to ask judges to arbitrate between insoluble medical problems which great experts on each side say with equal force should be dealt with in different ways.” Two things are evident from his view; the reality that certain areas of medical science are uncertain and ever evolving and the perceived necessity to note the ‘greatness’ of the experts. Heywood concluded:

bodies of expert opinion supported the defendant’s interpretation of the CTG trace; two bodies of expert opinion disagreed, suggesting the interpretation of the CTG was negligent because it was clear that either a FBS sample or a caesarean section was mandatory.

218 As Heywood contended, Lord Bannatyne became too preoccupied with assessing the credibility of the defendant expert testimony and overlooked the question that is central to the negligence action; “What the defendant did in the case and what her experts said in her support undoubtedly seemed logical to both of them, and indeed the court, at least in a medical and scientific sense, but that is different from saying that it was reasonable.” There was little evidence, of judicial scrutiny of the two treatment options including risk-benefit analysis. He concluded; “Putting it another way, did the defendant’s interpretation of the CTG, coupled with her knowledge of the patient, expose the patient to an unnecessary and unreasonable risk in the circumstances? Reviewing the evidence in its entirety, the answer to this question could well be yes.”

219 Brazier and Miola n56 their talk of revolution encompasses the much wider ‘Bolamised’ spectrum of health care law than this thesis considers.


221 Ibid.

222 In an action in negligence, the defendant will always be judged in the light of the state of scientific and technical knowledge at the time of the alleged breach.

223 The point being there needs to be an active assessment of the situation by the courts themselves, or we are simply returned to confusing the difference between the prescriptive and the descriptive. As Teff n13 noted, ‘where there is little or no active scrutiny, partisan evidence for the defence has a disproportionate impact on outcomes.’
where the courts are faced with two contrasting medical opinions, and one of these opinions exposes the patient to an unreasonable risk which is disproportionate to the benefit conferred, or where there are relatively few benefits at all, then the courts should be entitled to reject this evidence by saying ‘this particular practice is not what we consider reasonable in the circumstances and thus the evidence does not pass the threshold test for becoming responsible.’

He opined\textsuperscript{225} had this test been applied in \textit{Bolitho} the outcome would have been different. It is contended this would place clinical negligence within the reasoning of general negligence, the threshold requirement simply being reasonable care in the circumstances of the case.

\textsuperscript{224} Heywood n71.
\textsuperscript{225} Ibid.
CHAPTER FOUR

Empowering the Judiciary without Unduly Fettering Clinical Freedom

Introduction

One concern evident in the last two chapters was that the operation of *Bolam* necessarily entailed a deferential court, where the medical profession and not the law set the appropriate standard of care for clinical negligence with all the consequent dangers of this, allowing the standard of medical care to be reduced to the lowest common denominator of actual practice. There was undoubtedly a period where the courts went awry in their interpretation of *Bolam*¹ and instances of these concerns could be detected. The period was not the inevitable outcome of the operation of *Bolam*, an ‘alternative’ interpretation of *Bolam* was available, which would have left the courts in control of setting the appropriate standard of care in clinical negligence just as in any other instance of negligence.² Yet despite this ‘alternative’ view of *Bolam* long being possible and further bolstered by the House of Lords’ decision in *Bolitho*³ the courts remain reluctant to reject the standard, detailed by medical expert witnesses as not appropriate as reasonable care required by the law. Judges have appeared⁴ to be too readily swayed by the post, credentials and demeanour of experts in this area.

It will be argued in this chapter that certain changes which have been occurring within medical professional practice could also be utilised by the courts and the legal profession. The principal changes within medical professional practice focussed on are; the growth of evidence based medicine and the proliferation of clinical guidelines.⁵ This chapter will discuss these developments and analyse their likely impact both individually and cumulatively on the way in which the

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¹ As examined in chapter two of this thesis where it is termed a ‘conventional’ view of *Bolam*.
² With evidence of common clinical practice no more persuasive than common practice elsewhere. In clinical negligence expert witnesses detail common practice and the real crux of the matter is providing a means by which the court can meaningfully assess those expert views independently so they do act as the ultimate arbiters of the standard of care.
³ Leading some commentators to conclude a new *Bolam* had been introduced an argument which was examined and dismissed in the previous chapter of this thesis, chapter three.
⁴ In both the past and the present.
⁵ Clinical audit and clinical governance will be touched upon but only in so far as they impact on clinical guidelines.
appropriate standard of care in clinical negligence is determined. It is argued these developments could assist the courts to take the hard look necessary in determining the appropriate standard of care in law\textsuperscript{6} impacting on the operation of Bolam in practice. They could encourage the courts to assert more readily their authority as the ultimate arbiters of the standard of care, by providing concrete ways in which this more interventionist stance could be implemented, such documents providing a framework for the courts to use in determining the appropriate standard of care.\textsuperscript{7} The clinicians’ own perceptions of these developments will be examined, as will the fact that these developments are not without critics who assert the changes could bring deleterious effects on the practice of medicine.

This chapter will then move on to conduct an examination of the utilisation of professional guidelines by the courts to date, in order to establish if their potential is being recognised by the judiciary.\textsuperscript{8} Finally indications of lawyers’ perceptions of guidelines will be examined, as it might be that their use of them as resources could be important in assessing there future impact in clinical negligence. The introduction of clinical guidelines and evidence based medicine are not developments which have occurred in isolation, accompanying and complementary developments have occurred, under the remit of clinical governance.\textsuperscript{9}

\textsuperscript{6} In a manner that neither Bolitho logic nor the mere usage of other different adjectives could. They will have more impact on the test for ascertaining the appropriate standard of care, what is reasonable in law as they will aid the courts in their consideration of many of the factors which are relevant in the determination of the standard of care in all negligence actions. Namely the likelihood of harm, the magnitude of harm, the social utility of the defendant’s act, acts undertaken in an emergency, the relative cost of avoiding the harm and finally common practice.

\textsuperscript{7} As Christopher Newdick Who Should We Treat? Rights, Rationing, and Resources in the NHS (Second Edition Oxford University Press 2005) p 19 pointed out medicine has “moved away from a model of the Hippocratic Oath largely based on personal clinical instinct” to requiring doctors to adjust their practice according to reliable clinical evidence. Similar control of unfettered clinical discretion could be adopted by the courts in the determination of reasonable care in law.

\textsuperscript{8} Their usage in clinical negligence cases will be examined, as will their utilisation in allegations of negligence in relation to other professional groups. Finally an examination of how medical professional guidelines impact on the legal regulation of medical practice beyond clinical negligence will be carried out.

\textsuperscript{9} The main catalyst being Learning from Bristol: The Report of the Public Inquiry into Children’s Heart Surgery at the Bristol Royal Infirmary 1984-95, CM 52071 (2001) where it was observed “We cannot say that the external system for assuring and monitoring, the quality of care was inadequate. There was, in truth, no such system.” para 30 and 192. The most direct legacies of the Bristol Inquiry and other events will be examined in chapter five.
EVIDENCE BASED MEDICINE

In the past, when there was less clinical evidence of the treatments which worked (and those which did not), doctors were necessarily obliged to make judgments based on clinical instinct. Today, however, as Newdick\(^\text{10}\) pointed out large quantities of clinical research are available to guide doctors. It is argued this change could enable the courts to meaningfully engage with professional opinion and clinical judgment in two ways; as a source of information to inform their own opinion of reasonableness, and as a measuring tool of the credibility of witness testimony and clinical guidelines in order to assess whether reasonable care has been achieved in a given scenario.

Evidence based medicine is defined as the 'conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.'\(^\text{11}\) It involves evaluating rigorously the effectiveness of healthcare interventions, disseminating the results of evaluations and using these findings to influence clinical practice.\(^\text{12}\)

Evidence based medicine has four distinct steps.\(^\text{13}\) The reluctance of some medical professionals to accept evidence based practice was noted in chapter one\(^\text{14}\) and still appears to be present. Dr Iain Chalmers\(^\text{15}\) cited how the Royal College of Obstetricians and Gynaecologists did not officially recommend the use of prophylactic steroids for pregnant women who were likely to deliver premature babies with immature lungs, until many years after the practice's efficacy had been scientifically\(^\text{16}\) established. The impact of evidence based practice in light of recent government policies will be examined in the next chapter. O'Rourke\(^\text{17}\) contended the term evidence based medicine is misleading.

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\(^\text{10}\) Newdick n7 p 19.
\(^\text{11}\) David Sackett, William Rosenberg, J. Muirgray, R. Haynes, W. Richardson ‘Evidence based medicine: What it is and what it isn’t’ from [http://cebm.jr.2.ox.ac.uk/ebmisint.html](http://cebm.jr.2.ox.ac.uk/ebmisint.html). This article is based on an editorial from (1996) 312 British Medical Journal 71.
\(^\text{13}\) DL Sackett W Richardson WMC Rosenberg RB Haynes Evidence based medicine. How to practice and how to teach EBM, (Churchill Livingstone 2000) To begin with, formulate clear clinical questions from a patient's problem; search the literature for relevant articles; evaluate the evidence for its validity and usefulness; and finally, apply useful findings in clinical practice extracted from Wai-Chi Leung and Paula Whitty ‘Is Evidence Based Medicine Neglected by the Royal College Examinations?’ (2000) 321 British Medical Journal 603.
\(^\text{14}\) Chapter One of this thesis.
\(^\text{15}\) The Director of the UK Cochrane Centre.
as the practice of medicine has always been based on some sort of evidence, “even if that evidence was little more than a concoction of inaccurate cribs of ancient texts and anecdotal observations”. He contended it would have been better to call it research based medicine. A dissemination body with a very particular aim is the Cochrane Collaboration it publishes a database of systematic reviews on all clinical areas via the Cochrane Library, and a quarterly CD-ROM that aims to provide the best single source of reliable evidence about the effects of healthcare.

Neville Goodman was at pains to distinguish ‘evidence based medicine’ from ‘medicine based on evidence.’ He asserted the latter ‘medicine based on evidence’ was the only medicine that was worthy of being practised. He recognised the valuable things EBM had done for medicine:

not least ensuring there is no longer any place for physicians who rely completely on what they learned in medical school many years before, and whose sole authority was themselves and their experience, and whose only explanation for choice of treatment was “clinical freedom.”

Writing some fifteen years after he had written an obituary for clinical freedom, Professor Hampton reviewed the situation in light of the growing importance of evidence based medicine:

When a patient falls neatly into a disease category covered by a trial, the results of the trial can be applied and supervised by a

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18 Ibid.
19 “The Cochrane Collaboration was founded in 1993 under the leadership of Iain Chalmers. It was developed in response to Archie Cochrane's call for up-to-date, systematic reviews of all relevant randomized controlled trials of health care. Cochrane's suggestion that the methods used to prepare and maintain reviews of controlled trials in pregnancy and childbirth should be applied more widely was taken up by the Research and Development Programme, initiated to support the United Kingdom's National Health Service. Funds were provided to establish a 'Cochrane Centre', to collaborate with others, in the UK and elsewhere, to facilitate systematic reviews of randomized controlled trials across all areas of health care.” Extracted from http://www.cochrane.org/about-us/history Accessed on 4/3/2011.
20 Ibid. “The Collaboration is a not-for-profit organisation based in the UK. To carry out its mission of producing systematic reviews, a central administration supports disease and health condition-based groups (Cochrane Review Groups) who work with authors and editors to develop systematic reviews. The Review Groups are spread across the world, generally based at universities and teaching hospitals. The Cochrane Collaboration involves more than 10,000 people, worldwide”. Extracted from http://consumers.cochrane.org/about-cochrane-collaboration accessed on 4/3/2011.
22 Goodman n21 where he asserted “EBM has made the idea of appraising evidence more familiar to clinicians; and it has enabled easier access to research findings.” He also recognised “that EBM is also good at showing up gaps in medical knowledge;” and “also for showing where selective reviewing of research has obscured the uncomfortable truth that a particular clinical question does not actually have a simple, single answer.” Goodman n21
general practitioner, a nurse or even a computer. There are, however, many patients who do not fit neatly into the inclusion/exclusion criteria of the published trials, and many more who have complications of their disease or treatment for whom there can never be proper trial evidence on which to base management. In all such patients the doctor has to do the best he can, and needs freedom to treat the patient as an individual in whatever way seems the best way.

This shows the limitations of evidence based practice, if the evidence base is taken narrowly, as results of a relevant randomised controlled trial but also serves to highlight resentment that clinical judgment should be in anyway constrained. The move towards evidence based practice could be viewed more widely. Evidence based practice could be approached as involving a whole range of issues with different levels and types of evidence. For the medical profession it could mean instilling reflective practice or be epitomised through continuing professional development. For the judiciary it is not only a method of reinforcing this effectively, the ethos of evidence based practice is reflected in oft-neglected aspects of Bolam where McNair J noted at the outset “counsel for the plaintiff was also right, in my judgment, in saying that a mere personal belief that a particular technique is best is no defence unless that belief is based on reasonable grounds.” He continued after the locus classicus of his judgment;

…that does not mean that a medical man can obstinately and pig-headedly carry on with the same old technique, if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying ‘I don’t believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century.’ That clearly would be wrong.

McNair J envisaged an assessment of medical professional practice by independent criteria.
Hurwitz, noted that until relatively recently in historical terms, variability between doctors in their clinical judgement was viewed as a natural expression of the differing personal doctoring qualities of clinicians. Hippocrates had observed:

24JR Hampton ‘Evidence-Based Medicine, Practice Variations and Clinical Freedom’ (1997) 3 Evaluation of Clinical Practice 123.
25Further examples of difficulties which doctors faced when applying evidence based data to individual treatment decisions were heard by The House of Lords’ Select Committee on Science and Technology.
26Hurwitz n16 p82.
...as in all other arts, those who practice them differ much one from the other in dexterity and knowledge, so it is in like manner with medicine.27

As Newdick28 contended the amount of clinical research available has meant medicine has moved away from the model based largely on personal instinct and doctors are now required to adjust their practice according to reliable clinical evidence. There remain areas in which the evidence is ambiguous, incomplete and inconsistent and there will often be scope for differences of opinion in matters of diagnoses, prognosis or clinical management, some inherent due to the state of clinical knowledge. Although evidence suggests, wide differences of practice do exist both without compelling scientific support29 and due to non-clinical reasons. Newdick30 argued there is a legitimate interest in reappraising the value of clinical freedom. Unfettered clinical freedom based on little more than whimsy should not be occurring. Doctors should be versed in ‘the state of the art’ in their given field and be prepared to give a reasoned justification for departing from the norm rather than merely claiming clinical judgment.31

CLINICAL GUIDELINES

What are Clinical Guidelines?

Clinical practice guidelines offer a framework which can be utilised by the courts in order to assess the reasonableness, or otherwise, of medical decisions in the arena of clinical negligence.32 Therefore it is important that the guidelines

27 Hippocrates extracted from Ibid.
28 Newdick n7 p 19.
29 Newdick n7 p 20 where he pointed out a range of factors might be responsible: Medical “fashion”, diagnoses made for the patient’s peace of mind (such as prescribing antibiotics for viral infections), and how the method of remuneration might also impact on treatment decisions. The last factor was found to be an influence in systems which remunerate doctors according to a “fee for service” system as found in France and Germany.
30 Ibid. Where he asserts that it is for this reason that pressure is being exerted on doctors to comply with clinical practice guidelines, and to undertake audit of their procedures and be able to justify substantial differences between them.
31 If the concept is not to be abused, even to conceal substandard care.
32 Ash Samanta, Michelle Mello, Charles Foster, John Tingle and Jo Samanta, ‘The Role of Clinical Guidelines in Medical Negligence Litigation: A Shift from the Bolam Standard?’ (2006) 14 Medical Law Review 321. Samanta et al suggested “guidelines may serve to inform the standard of care, thereby providing an added dimension to the evaluation of the legal standard of care and promoting a move away from a hard-line Bolam approach”. They appeared to perceive the utilisation of professional guidelines as
creation procedure is transparent.\textsuperscript{33} It is noteworthy such collective statements can pool ignorance as well as wisdom. Therefore, the link between evidence based practice in medicine and clinical guidelines will be pertinent when looking at the diversity of guidelines and assessing the likely impact on ascertaining the standard of reasonable care.\textsuperscript{34}

Hurwitz\textsuperscript{35} contended that lawyers do not generally distinguish between guidelines, protocols or codes of practice. He recognised although such distinctions may be important in medicine, in the context of legal proceedings all tend to share similar significance, as they advise doctors to practise in one way rather than another.\textsuperscript{36} Hurwitz explained the term guideline is of modern coinage and in his opinion there is `no single definitive encapsulation of the notion.\textsuperscript{37} In this chapter, the definition will be applied in the broadest possible sense as all `declarations’ of professional practice could potentially be utilised by the legal system. The question of the production and proliferation of clinical guidelines will be examined.\textsuperscript{38}

Over the past decade, clinical guidelines have increasingly become a familiar part of clinical practice.\textsuperscript{39} Clinicians and policy makers perceive guidelines as a tool for making care more efficient and consistent\textsuperscript{40} one outcome of which could be error reduction.\textsuperscript{41} Although as Tuffnell\textsuperscript{42} pointed out one of the most important benefits of clinical guidelines, consistency of care, is dependent on the guidelines being developed, presented and implemented in an appropriate

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\textsuperscript{33} That is whether it was developed by predominantly opinion based or evidence based processes. Furthermore, if guideline authors did not specify how the evidence was reviewed, or explain the steps taken to ensure that relevant scientific reports were not missed, or explain how disagreements within the group were resolved then the resulting guidelines are said to be based on an informal consensus.

\textsuperscript{34} The stronger the methodology of guidelines the more certain they pool the latter quality rather than the former. This could possibly result in greater weight being attached by the courts to such documents.

\textsuperscript{35} Hurwitz n16.

\textsuperscript{36} This approach of not distinguishing will be followed in this chapter.

\textsuperscript{37} Hurwitz n16. Although the Institute of Medicine defined guidelines as `systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances from MJ Field and KN Lohr (eds) Guidelines for Clinical practice. From Development to Use (1st edition National Academy Press 1992).

\textsuperscript{38} This area will also be affected by the Government initiatives which are discussed in chapter five. Some of these new bodies will produce and disseminate their own guidelines, the specific impact of the guidelines produced by these bodies will be examined in chapter 5.


\textsuperscript{40} Ibid.

\textsuperscript{41} CNST Risk Management Standards ( NHSLALondon 2000).

\textsuperscript{42} DJ Tuffnell Why Clinical guidelines? A Medical Perspective from Tingle and Foster (editors) n17.
Evidence based practice is likely to effect consistency, but undoubtedly there will be debate as to whether its influence will be negative or positive. As Samanta et al contended the credibility of guidelines used by the court would therefore need to be determined on the basis of pre-determined standards. They suggested that a number of key attributes; such as authorship by esteemed professional bodies, and guidelines being systematically developed on the basis of evidence, bolster the authority of guidelines.

Where are guidelines from?

Informal Guideline Creation

In Early v Newham (considered later in this chapter) the judge accepted the validity of a local guideline. Tuffnell contended the majority of clinical guidelines are produced at local level and take into consideration local circumstances. These localised guidelines have both strengths: as authorship is local compliance with such guidelines is likely to be high, they can deal with a wider range of problems than national guidelines, and they can be both developed and implemented more quickly, Tuffnell cited the example of the publication of The Term Breech Trial which showed that planned vaginal breech delivery was associated with a significant statistical increase in the risk of foetal death and how local guidelines were changed in days, whereas the national guidelines from the Royal College of Obstetricians and Gynaecologists were unchanged several months later. However, he conceded that this fast incorporation was entirely dependent on local clinician’s knowledge of these trials, which he acknowledged would by no means always the case. The major

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43 Ibid.
44 Samanta et al n32.
45 Ibid.
47 Tuffnell n42.
48 Ibid.
49 Ibid.
50 ME Hannah ‘A multi-centre randomised controlled trial of planned caesarean sections versus planned vaginal birth for breech presentation at term’ (2000) 356 The Lancet 1375. The Term Breech Trial’s findings have been influential for health professionals’ attitudes to breech births. And they have imposed a new standard of care for the management of breech deliveries around the world. The study concluded that, for breech presentations, “the results were clearly in favour of planned caesarean section” over planned vaginal delivery. Remarkably, the follow-up study two years later, did not show any difference in the long-term outcomes. These findings could challenge the practices put in place after the original study.
weakness in local production of guidelines might be; the clarity of the evidence used and the potential for increasing the likelihood of contradictory guidance.

**The Royal Colleges**

Mason and Laurie explained one of the most important features of ‘modern’ medicine is the importance attached to experimentation and research. They contended that one of the first practical effects of this was to convince doctors that they had an expertise worth preserving. This gave rise to the establishment of the Royal Colleges. The nine specialities represented are varied in their production of clinical guidelines. The Royal College of Anaesthetists have produced extensive guidelines on the provision of anaesthetic and critical care services. They introduce their published collection with a statement of intent:

This document should be considered to contain guidance only. It is not intended to replace the clinical judgment of the individual anaesthetist; the freedom to determine the most appropriate treatment for individual patients in a particular place at a specific moment should not be constrained by a rigid application of this guidance.

51 Tuffnell n42.
52 JK Mason and GT Laurie *Mason and McCall Smith’s Law and Medical Ethics* (Eighth Edition Oxford University Press 2011) p12.
53 The establishment of the Royal College of Physicians can be traced back to the sixteenth century. The Royal Colleges now represent nine specialities: Anaesthetists, General Practitioners, Obstetricians and Gynaecologists, Ophthalmologists, Paediatric and Child health, Pathologists, Physicians, Psychiatrists, Radiologists and Surgeons and additional faculties. Fellowship of a Royal College indicates competence in a field, registration as a specialist demands a Certificate of Completion of Specialist Training.
54 The Royal College of Surgeons established an audit unit in 1990. It now functions as a Clinical Effectiveness Unit which receives funding from NICE. The Royal College of Paediatrics “committed to publishing evidence based guidelines to members”, initially by identifying appropriate guidelines produced by other groups. Their Quality Practice Committee wished to become involved in the development of evidence based clinical practice guidelines. The Royal College of Physicians London undertakes clinical effectiveness work rather than original clinical studies. The web-site lists thirty-five guidelines, audit proforma and supporting papers produced since 1992. The Royal College of General Practitioners webpage has one guideline on back pain. It is developing national evidence based guidelines on depression and type II diabetes which will be endorsed by NICE. Information extracted from AJ O’Rourke ‘The Role of Clinical Institutions and Central Government in Guideline Creation and Development’ from Tingle and Foster (editors) n17. The Royal College of Radiologists produced six sets of guidelines which they detail on their website although all have now been withdrawn from www.rcr.ac.uk accessed on 1/3/2011. NB The Clinical Oncology Information Network (COIN) Project:background, purposes and products *Journal of Evaluation in Clinical Practice*, 5,2,179-87 accessed via website. The Royal College of Psychiatrists has links to NICE guidance on a wide variety of mental illness from www.rcpath.org accessed on 1/3/2011 The Royal College of Ophthalmologists has 30 sets of guidelines accessible from its website dating from 2001 to present. The Royal College of Pathologists, no sets of guidelines are mentioned on its homepage though the College does issue guidance on clinical audit http://www.rcpath.org accessed on 1/3/2011.
Hurwitz\textsuperscript{56} contended that a guideline created by a Royal College, or sponsored by a specialist medical association ‘will appear to carry greater face credibility than one developed by an unknown group of doctors in a clinical area.’ Although an accusation of partisanship (in one sense at least)\textsuperscript{57} might be levelled at guidelines produced by the Colleges they undoubtedly carry a degree of \textit{gravitas} and should counter the worst suspicions levelled at some guidelines.\textsuperscript{58}

\textit{Other Bodies Producing National Guidelines}

There are three confidential enquiries: the Confidential Enquiry into Patient Outcome and Death; the Confidential Enquiry into Maternal and Child Health and the Confidential Enquiry into Suicide and Homicide by People with Mental Illness.\textsuperscript{59} Each produces recommendations which might require clinicians to establish guidelines in particular areas.\textsuperscript{60} They often contain an outline guideline. Tuffnell and Wright\textsuperscript{61} cited the CEMD guidance for the management of pregnant women who have refused blood transfusions. These confidential enquiries are important as they are evidence based and monitor the utilisation of guidelines.

\textit{Possible disadvantages of the usage of clinical guidelines (including evidence based ones)}

There are concerns that clinical guidelines might damage clinical care. There are a number of different strands to this viewpoint. Firstly, concern that bad guidelines could further ingrain bad practice, recommendations which do not

\begin{footnotesize}
\textsuperscript{56} Hurwitz n16.
\textsuperscript{57} As they are guidelines controlling clinical practice which are written by clinicians themselves, thus, possibly falling prey to the assertion that they can be prone to being descriptive rather than prescriptive. Although lay participation is provided for in certain instances.
\textsuperscript{58} The worst case scenario with local guidelines without a clear evidence base is the legitimisation of ‘most untenable views’ via their endorsement with the title guidelines. It is plausible that the worst Pre-Woolf Reform excesses, of selection of expert witnesses for trial could be replaced with the concern that individuals might be willing to produce guidelines to order.
\textsuperscript{59} Each organisation disseminates it’s own findings and recommendations with the aim of preventing or reducing future harm they work independently from NPSA, the Department of health and other organisations. From http://www.nhs.uk/corporate/confidentialenquiries.
\textsuperscript{60} J Tuffnell and J Wright ‘Designing Clinical Guidelines: Steps and Procedures’ from Tingle and Foster n17.
\textsuperscript{61} Ibid. At the time of Tuffnell and Wright’s work there were four confidential enquiries. CEMD referred to Confidential Enquiry into Maternal Death.
\end{footnotesize}
take into account the evidence can result in suboptimal even harmful practices. There is also concern that the increased presence of clinical guidelines could act so as to unjustifiably fetter clinical judgment, this argument has several discrete strands. There is a concern that guidelines might have a deleterious impact on clinical practice leading to what could be termed 'cookbook medicine'. Some contend guidelines ignore the notion of how the art of medicine is needed to take into account the individual variation of patients. This concern is also evidenced by Woolf et al:

Algorithms that reduce patient care into a sequence of binary (yes/no) decisions often do injustice to the complexity of medicine and the parallel and iterative thought processes inherent in clinical judgement.

Over a century ago the surgeon, Wilhem Billroth, whilst celebrating the growth of what he termed scientific medicine opined:

To render medical ability independent from personal tradition, to establish the art of medicine for all time so firmly in writing that it will be independent from the talent of individuals, and to transform it wholly into a science is the ideal goal of all our efforts… I doubt that this goal will ever be reached: it will at least not be reached by the art of medicine any sooner that the art of poetry will be dissolved into metrics, painting into colour therapy or music into harmony.

Such arguments ignore the fact that clinical guidelines should include enough flexibility to take account of the factors that may alter the treatment or investigation required in a specific circumstance. Although similar concerns have been in existence for some time, Carter pointed to Plato’s notion of codifying the majority decisions of panels, then officially publishing the results in order to dictate the way in which treatment of the sick

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62 Woolf, Grol, Hutchinson, Eccles and Grimshaw n39.
63 Ibid.
64 Tuffnell n42 p19.
65 Ibid.
66 Woolf, Grol, Hutchinson, Eccles, and Grimshaw n39. There could be concern that the negative outcomes of guidelines could have an undesirable impact on the legal standard of care. However guidelines simply provide a tool for the courts they are not determinative of the legal standard a “brave new Bolam” would not be dictated to.
was practised. This did appear to share certain parallels with the introduction of clinical guidelines. However, although Plato was prepared to concede the potential, in such moves, no matter how successful, they remained in his view a debased form of practice. Plato thought the ‘imposition of guidelines upon an educated medical professional would threaten the intellectual autonomy of the profession.

This latter concern, evidenced something rather different from holding back the progress of medical science, and is an early example of the perceived ‘special status’ of the medical profession and medical knowledge. Tuffnell, himself a medical practitioner, contended not only did these arguments ignore all the positive benefits that can come from guideline utilisation, they also ignored the notion that a guideline should not be followed slavishly but should provide a framework in which the health care professional can work. He continued all clinicians have to pass examinations before being allowed to practice and a guideline should be considered as the perfect examination answer.

Foster noted some clinicians were concerned that failure to follow a clinical guideline would necessarily connote negligence. However, he pointed out that the Bolam test does not cease to apply simply because a protocol has been drafted. It is argued here, that common practice, however evidenced, should never be determinative of the standard of care owed in law. The court must consider the defendant’s compliance/non-compliance to follow a clinical practice guideline and their reasons for choosing their course in the circumstances of the case. As Hurwitz rightly pointed out;

Whilst accepting that variation in clinical practice may be justifiable in the face of scientific uncertainty and differences in values, the US Institute of Medicine rightly asserted variability to be unacceptable where it: stems from poor practitioner skills, poor management of delivery systems, ignorance or deliberate disregard of well documented preferable practices. It should not be tolerated when it is a self serving disguise for bad practices that harm people and waste resources.

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68 Hurwitz n16 p75.
69 Ibid.
70 Ibid.
71 Ibid.
72 Ibid.
73 Hurwitz n16 p80.
74 Charles Foster ‘Civil Procedure, Trial Issues and Clinical Guidelines’ from Tingle and Foster (Editors) n17.
75 Ibid.
The courts as the ultimate arbiters utilising an ‘alternative’ Bolam could ensure that variations in practice were due to acceptable reasons and not driven by inappropriate concerns.

*Imparting evidence based practice and guideline usage within the Medical profession (Informing Reasonable clinical practice?)*.

There is some empirical research which sought to ascertain, the extent of use and attitudes towards both evidence based medicine and clinical guidelines by clinicians. The study\(^{76}\) posted a questionnaire to a random sample of 190 practitioners in obstetric practice between March and May 1996.\(^{77}\) The response rate of family physicians and obstetricians was the same at seventy-eight per cent. The findings of this study included; over three-quarters of respondents were aware of evidence based medicine,\(^{78}\) while slightly over half\(^{79}\) would consult a respected clinical authority\(^{80}\) when faced with a difficult clinical problem. Olatunbosun et al found that 27 per cent felt they were familiar with critical appraisal of medical literature, 21 per cent with the use of computers in scientific enquiry, while only 9 per cent indicated that they had access to the Cochrane Pregnancy and Childbirth Database. This research was not carried out in this jurisdiction, but is a gauge to physician responses both to evidence based practice and guideline usage.\(^{81}\) Only 40 per cent considered evidence based medicine to be very applicable to obstetric practice, although another 38 per cent thought it was somewhat applicable. 88 per cent expressed interest in learning more about it. The clinicians in the study expressed the following concerns about evidence based medicine: “erosion of physician autonomy”, “obstetrics requires more manual dexterity than science”, and “evidence based medicine ignores clinical experience”. The physicians concerns appeared to

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\(^{77}\) There does not appear to have been a more recent empirical study on this. It is open to speculation if things have changed.

\(^{78}\) 76 per cent of the 148 respondents were aware of evidence based medicine.

\(^{79}\) 51 per cent indicated that when faced with a difficult clinical problem they consulted a respected authority.

\(^{80}\) 37 per cent of these referring to a text book or clinical practice guidelines with only 8 per cent conducting medline searches.

\(^{81}\) It is noted that this study is now some years old.
centre broadly on the art or science debate which has already been alluded to in this chapter.

Wright and Tuffnell, both consultants, contended guidelines are not self implementing and “most clinicians recognise that they usually end up in the bin, or being added to the guideline mountain in the corner of the clinic room.” They explained how in their view there is pretty good evidence about what works in changing professional practice, that the traditional methods of professional development i.e. posting guidelines out, publishing them in journals and giving didactic lectures does not. They only rate the use of clinical audit as being of variable effectiveness.

In 1997 The Chief Medical Officer drew attention to the fact that quality of care did not seem to be as high on the agenda of the NHS as financial and workload targets. As will be examined fully in the next chapter, the Government had become unsympathetic to the latitude of discretion enjoyed by clinicians and less likely to accept without question the inevitability of the fact of clinical practice variations. The remit of Clinical governance is broad and encompasses several key processes; ensuring a comprehensive programme of quality improvement (including clinical audit, supporting and applying evidence based practice, implementing clinical standards and guidelines), and providing integrated procedures for all professional groups to identify and remedy poor performance. The government’s commitment to clinical governance reinforces the developments in evidence based medicine and usage of clinical guidelines.

Guidelines mesh with this goal because the systematic use of high-end empirical evidence will facilitate best practice. Consequently there has been a strong political drive to promote the use of guidelines. The GMC and Royal Colleges concurred that good practice should be measured against established guidelines and stressed the importance of robust mechanisms to identify and

82 John Wright, DJ Tuffnell, ‘Implementing Clinical Guidelines’ from Tingle and Foster n 17 (editors) p 54.
83 If audit examines the implementation rate of new practices the inter-relationship with clinical guidelines can be seen.
84 ‘Clinical Governance -Introduction from the Chief Medical Officer’ from http://www.doh.gov.uk/progress/clingov/index.htm accessed on 4/12/02.
85 Clearly the underlying notion of clinical governance is fundamental to the implications of the other developments discussed in this chapter.
86 Extracted from Clinical Governance at http://www.doh.gov.uk/progress/clingov/index.htm accessed on 4/12/02. Also see Department of Health, A First Class Service (HMSO) para 6.12.
87 Samanta et al n.32 p 323.
88 Ibid. Samanta et al contend “the responsibility and accountability underlying integrated governance could both advance and monitor the use of evidence based guidelines in routine practice.”
maintain high standards in medical care. As Samanta explained there is an expectation that in the process of quality improvement, clinical teams will normally use recommended guidelines. One method of monitoring compliance with practice guidelines and exercising governance is by the implementation of clinical audit. Clinical audit has been defined as the systematic, critical analysis of the quality of care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcomes for the patient. A new audit strategy was introduced by the Government in 1991. It was contended that the government's prescriptions for the introduction of audit contrasted significantly with their prior requirements for the quality assessment of medical care. Hurwitz quoted from a study that concluded when: audit shows a gap between protocol and practice then either the guidelines or the practice or both should change. Wilson noted the symbiosis of audit and clinical guidelines is an important element in the delivery of high quality care. However, the efficacy of the clinical audit was seriously called into question by the tragedy at the Bristol Royal Infirmary, where they did in fact undertake a monthly audit.

“The 2007 White Paper ‘Trust, Assurance and Safety’ called for the revitalisation of clinical audit in order to deliver its full potential. The subsequent strategy embodied in the Next Stage Review, ‘High Quality Care For All’, in 2008, stressed more broadly that quality and quality improvement, including clinical audit, was the centre of improving the NHS. The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. HQIP is currently contracted...
by the Department of Health to deliver a programme of activity to reinvigorate clinical audit.\textsuperscript{99}

\textbf{THE COURTS’ UTILISATION OF PROFESSIONAL PRACTICE GUIDELINES}

\textit{Clinical Negligence Cases which referred to clinical guidelines in England and Wales}

There are a number of different medical negligence cases in this jurisdiction which have examined the issue of adherence or otherwise to clinical guidelines in the past. However, the courts’ past reaction to such arguments may not be an accurate gauge of their future reactions given the developments which have occurred in medicine, information technology and politics in more recent years. Changes to the law of evidence have also impacted here. The 1995 Civil Evidence Act effected a fundamental change in the civil law of evidence by providing for the general admissibility of hearsay evidence. It was the classification of guidelines and the like as hearsay which limited their utilisation.\textsuperscript{100}

In 1953, \textit{Crawford v Board of Governors of the Charing Cross Hospital}\textsuperscript{[101]} considered the impact of learned medical publications on the standard of care owed in law. The judge at first instance had found the defendant liable in negligence as the plaintiff had developed brachial palsy after surgery where the arm had been kept in the extended position on the operating table. An article in \textit{The Lancet} had appeared six months earlier warning of the dangers of this. However, the Court of Appeal disagreed. Lord Denning held:

\begin{quote}
...it would I think be putting too high a burden on the medical man to say that he has to read every article appearing in the current medical press; and it would be quite wrong to suggest that the medical man is negligent because he did not immediately put into operation the suggestions which some contributor or other might make in a medical journal. The time may come in a particular case when a new recommendation
\end{quote}

\textsuperscript{99} The work focuses on the following key strategic areas: managing and improving the national clinical audit programme, improving clinical audit expertise through training and resources, building clinical audit into commissioning, regulation and revalidation processes.

\textsuperscript{100} \textit{Loveday v Renton} [1990] 1 Med LR 117 where Stuart Smith LJ speaking about published contraindications to pertussis vaccine said “… so far as the plaintiff seeks to rely on the contraindications as evidence of the opinions of experts not called as witnesses…this evidence is inadmissible in law.

\textsuperscript{101} \textit{Crawford v Board of Governors of the Charring Cross Hospital} (1953) The Times, 8th December.
may be so well proved and so well known, and so well accepted that it should be adopted, but that was not so in this case.

As Tingle\textsuperscript{102} pointed out \textit{Crawford} predated the revolution in information technology and the approach taken may need to be reconsidered in light of such developments. Although, he\textsuperscript{103} recognised that this increased ease of access needed to be weighed against the increased proliferation of such information. A more recent case to examine the issue in 1994 was \textit{Gascoine v Ian Sheridan and CO and Latham}\textsuperscript{104} where Mitchell J clearly attempted a balancing exercise of the issues. He said that the consultant in question was a very busy man:

\begin{quote}
...who clearly had a responsibility to keep himself generally informed on the mainstream changes in diagnosis, treatment and practice through the mainstream literature such as the leading textbooks and The Journal of Obstetrics and Gynaecology. Equally clearly it would be unreasonable to suppose that [he] had the opportunity to acquaint himself with the content of the more obscure journals.
\end{quote}

Mitchell J held the ‘shop floor gynaecologist’\textsuperscript{105} had a responsibility to keep himself generally informed within the constraints noted above. It is suggested that this could signal a change in judicial attitude from \textit{Crawford}, as the court in \textit{Gascoine} was willing to demand that practitioners keep themselves apprised of developments in mainstream literature at least. Such a requirement was not as evident in \textit{Crawford}. It is noted there are two separate strands to this decision; the failure to implement the findings and actual knowledge of the article. It is unclear which strand Denning LJ found most persuasive. It is noteworthy the journal in question in \textit{Crawford} was \textit{The Lancet}\textsuperscript{106} which it is contended is ‘not a more obscure journal’ but well within the mainstream literature. There is also some evidence that the courts are willing to accept locally produced guidelines, which might not have such a clear underpinning rationale as published works. Also in 1994 \textit{Early v Newham Health Authority}\textsuperscript{107} where

\textsuperscript{102} John Tingle ‘The Developing Role of Clinical Guidelines’ Tingle and Foster n17 p99.
\textsuperscript{103} Ibid.
\textsuperscript{105} By which expression it is assumed he meant the ‘ordinary’ gynaecologist in specialist practice.
\textsuperscript{106} In the 2009 Journal Citation Reports The Lancet’s impact was ranked second for medical journals at (30.8) after \textit{The New England Journal of Medicine} (47.1) Journal Citation Report Science Edition, Thompson Reuters, 2009.
\textsuperscript{107} \textit{Early v Newham Health Authority} [1994] 5 Med LR 214.
the procedure used for intubation, which in fact failed, was at the time of the procedure an orally stated clinical guideline and by the time of the trial it was committed to writing. Deputy Judge Patrick Bennett QC considered this and stated:

having heard Dr McAteer describing how in relation to this procedure, it was put before the division of anaesthesia in the hospital… there are about ten of them there, seven of eight of whom were consultants, who then decided that this was the proper procedure to follow and minutes of the discussion were kept. I find it somewhat unfortunate that Professor Robinson should suggest that those consultants and the drill that they adopted was nevertheless such that no reasonably competent medical authority could have adopted it. I am quite satisfied from what I have heard… that I am dealing with a competent medical authority who applied its mind to the problem and came up with a reasonable solution.

It is argued the overall tone of Early was subservient towards the medical profession and that the ready endorsement of such informal, local guidelines makes little difference to the courts’ overly deferential reliance on expert witnesses. The danger of conflating actual practice with reasonable practice, and deferring too readily to expert opinion remains present, despite the utilisation of guidelines, particularly if the provenance of such missives is not examined and they are too readily endorsed by the court.

A more proactive use of clinical standards was apparent by 2000 in Penney, Palmer and Cannon v East Kent Health Authority\(^{108}\) in which the standards of the Cervical Screening Programme had not been complied with. The judge at first instance had relied on the national clinical guideline known as the 'absolute confidence test' which was endorsed by all the experts in the case. The trial judge later approved by the Court of Appeal used this test of 'absolute confidence' in order to determine if the appropriate standard of care had been met. It was held that the health authority’s expert’s assertions that the slides could have been reported as negative were inconsistent with the accepted principle of absolute confidence.

Ratty v Haringey HA\(^{109}\) showed that the courts utilisation of standard practice guidance need not stifle all individual clinical discretion, the claimant relied on 'Marnham's rule' a medical rule of thumb that asserted there should be no


\(^{109}\) Ratty v Haringey Health Authority [1994] 5 Med LR 413.
resection without histological proof of cancer. In this instance the claimant had a lesion of the colon with no histological evidence it was malignant. Notwithstanding ‘Marnham’s rule’ the defendant surgeon performed a resection which later histology proved to be non-malignant. The Court of Appeal held although Marnham’s rule was a useful guideline it was no more than this, there was evidence the surgeon had deviated from it for sensible clinical reasons, he was not negligent. This highlighted how practice need not be overly constrained, although it illustrated how a careful balance needed to be struck, between not overly constraining medical practice, and the courts too readily endorsing medical expert witnesses, the courts need to take a ‘hard look’ before endorsing deviation from standard professional practice as reasonable in law. The standard practice laid down in guidelines was departed from yet the deviation endorsed by the court as reasonable care in law in Vernon v Bloomsbury Health Authority. The plaintiff received doses of a drug higher than those recommended by the Product Datasheet, the British National Formulary, the Monthly Index of Medical Specialities, and Martingale’s Extra Pharmacopoeia. The periods of administration also exceeded that recommended in MIMS and Martingale’s. She suffered bilateral vestibular damage and loss of balance as a result. Judge Tucker heard the evidence of several expert witnesses, all but one agreeing that they would have prescribed at the same dose as the defendant. It was held:

...the dosage was a proper one. The doctors were not negligent in prescribing it. I agree with the defendant’s experts that the guidelines laid down by the manufacturers and, for example, MIMS, are too conservative and that they err on the side of caution. I accept the views expressed by Dr Sowton, Dr Reeves, and Dr Cooke, all of whom have had great practical experience of prescribing this drug. In particular, I rely on the views of Dr. Reeves. He has consistently prescribed higher doses than those recommended by the manufacturers and has advised others to do the same.

It might be argued manufacturer’s guidelines or dosages indicated in MIMS might err on the side of caution for partisan reasons.

100 Vernon v Bloomsbury Health Authority (1995) 6 Med LR 297.

111 Such recommendations might be made with a view to limiting their potential liability. After all the manufacturers guidance on dosage addressed to the doctor will normally discharge their duty of care to the patient in the case of prescription drugs. It was significant that expert witnesses were prepared to endorse the actual prescribing practice, although it is difficult to determine retrospectively, whether the judge merely deferred to such luminaries or whether the court on their own assessment determined reasonable care would require this.
No reasons for failing to follow practice guidelines were offered in *Sutton v Population Services Family Planning Programme*112 where a nurse employed by a well-woman clinic failed to follow the prescribed procedure for referring a patient with a breast lump. McCowan J held the first defendants were liable due to Nurse Hancock’s failure to obey ‘their sensible rules’ that ‘their well woman centres in matters of breast screening must act as a referral source and not take on the role of diagnostician.’

By 2005 a failure to follow authoritative guidelines supported a finding for the claimant *DF (by her litigation friend and mother CF) v St Georges’s Healthcare NHS Trust*.113 “An obstetrics senior registrar performed an instrumental delivery at a time when guidance from the Royal College of Gynaecologists and Obstetricians stipulated that it was not acceptable practice to do so.”114

The relative weight which will be accorded to evidence contained in clinical guidelines remains to be determined, it might be the following view of Stuart Smith LJ is now outdated:

…the evidence contained in the contraindications against pertussis vaccination published from time to time in this country by the DHSS and similar bodies in other countries cannot be relied upon as though it was evidence of qualified experts not called as witnesses, that the vaccine in fact causes permanent brain damage.115

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**The Utilisation of Medical Guidelines in Cases other than Clinical Negligence**

An examination of the way in which the courts have utilised clinical practice guidelines in areas other than clinical negligence is pertinent, it may serve as an indicator of how proactive the courts are, and are likely to be in the future, both in utilising the initial consideration of such materials and in independently determining the propriety of particular medical conduct.

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113 *DF (by her litigation friend and mother CF) v St Georges’s Healthcare NHS Trust* [2005] EWHC 1327.

114 Gray J held as Samanta et al n 32 p 336 noted ‘those guidelines would have been circulated to medical staff prior to the incident, gave clear and authoritative indication that to attempt instrumental delivery at the time prior to full dilation of the cervix was not acceptable practice’. It is noteworthy that the status of the guidelines, their clear dissemination and their clear prohibition on instrumental delivery were all factors which influenced the court.

Re F\textsuperscript{16} a decision concerning an incompetent adult, Lord Donaldson MR in the Court of Appeal commented on the role of professional guidelines:

consultation with other doctors and those in the caring disciplines may be necessary if the doctor...is to be able to satisfy himself, and it may be subsequently a court, that he is performing his duty under the law and so is immune from suit. The difficulty of this decision cannot ever be removed, but it would undoubtedly be much lessened if the medical profession were able to produce ethical and professional guidelines for the treatment of incompetent adults.

Hurwitz\textsuperscript{17} contended that this decision outlined one of the roles for guidelines was to provide doctors with a degree of legal protection. Equally though, it could be taken as an indication of the court's recognition, that evidence of endorsed professional practice could be a useful resource for the courts to use, in their determination of matters.

In determining the most difficult questions of the withdrawal of life-prolonging treatment, it had appeared to be envisaged by the courts’ that there would exist some collective professional consideration of the issue. For example, Lord Goff in \textit{Bland} noted:\textsuperscript{18}

\begin{quote}
It is expected that guidance will be provided to the profession; and, on the evidence of the present case, such guidance is for a case such as the present to be found in a discussion paper on Treatment of Patients in Persistent Vegetative State, issued in September 1992 by the Medical Ethics Committee of the British Medical Association.
\end{quote}

He went on to explain:

Study of this document left me in no doubt that if a doctor treating a PVS patient acts in accordance with the medical practice now being evolved by the medical ethics committee he will be acting with the benefit of guidance from a responsible and competent and relevant body of professional opinion as required by the \textit{Bolam} test.

As Foster\textsuperscript{19} contended such guidelines were only held to constitute \textit{Bolam} compliant practice, as reaching the appropriate standard of care after judicial study of the document, their Lordships did not simply assume that the fact of

\textsuperscript{16} Re F (Mental patient: sterilization) (1989) 2 WLR 1025.
\textsuperscript{17} Hurwitz n16 p 97.
\textsuperscript{18} Airedale NHS Trust v Bland [1993] 1 All ER 821.
\textsuperscript{19} Charles Foster ‘Civil Procedure, Trial Issues and Clinical Guidelines’ from Tingle and Foster n17.
authorship by an authoritative professional body necessarily equated to acceptable practice. Furthermore, they did not consider that guidelines themselves should be the arbiter of professional rectitude. Foster contended that this had more to do with the nature of the case and the impact on public policy of withdrawal of nutrition and hydration rather than the way the courts would consider the relevance of guidelines in professional negligence actions.

A similar decision was reached by the Court of Appeal in Burke regarding GMC guidance on decision-making in respect of life-prolonging treatment. Samanta explained “the claimant expressed his wish to be given ANH during the final stages of life and that he did not want this either withdrawn or withheld on the basis of a decision taken by doctors that his life was no longer worth living which he contended was incompatible with his human rights”. At first instance, Munby J held that the GMC guidance was incompatible with the rights under the Convention. The Court of Appeal reversed the decision thereby implying “that in the context of withholding or withdrawing life-supporting treatment in the incompetent patient, a doctor’s practice in acting in conformity with guidance from a responsible professional body would be in keeping with reasonable practice.” Samanta et. al. contended ‘it is arguable that in the context of such decisions, the courts would be more willing to give greater weight to guidance endorsed by relevant clinical opinion on the basis that the principle determinative in such cases is the medical prognosis of the patient’.

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120 However they did note the source of the guidelines and appeared satisfied at their provenance. This could be taken in two ways; the fear of de facto guidelines being produced and endorsed simply by virtue of there being given the tag of ‘guidelines’ might be diminished, but the suspicion might remain that the courts will too easily give credence to the views to authoritative bodies, that status will be conflated with reasonableness.
121 Foster n119.
122 Foster n119.
123 The choice of particular noun rectitude is worthy of examination. It has three definitions i) moral uprightness ii) righteousness and iii) correctness. The Concise Oxford Dictionary (eighth edition) (Oxford, London, 1993). Did the usage indicate the courts greater willingness to assert authority in non-technical clinical areas or was a wider interrogative role suggested by the third definition.
124 Burke v General Medical Council (defendant) and Disability Rights Commission (interested party) and the Official Solicitor (intervenor) [2005] EWCA 103.
125 General Medical Council, Withholding and Withdrawing Life Prolonging Treatments: Good Practice in Decision Making (2002).
126 Samanta et al n 32 p 335.
127 Such a decision by doctors would be supported by, and in accordance with GMC guidance.
128 Samanta et al n32 p 335 it is argued that this need not be seen as an indication that the courts will blindly endorse such clinical practice as reasonable in law it need not prevent them from taking a ‘hard look’. Conformity with guidance endorsed by a responsible (on the courts assessment) professional body is simply a useful indicator for the courts as to the discharge of the duty of care.
They contended this may not necessarily reflect the view taken in relation to guidelines representing a purported standard of care.

More recent decisions in the area could suggest that the courts understand the correct balance with the courts as the ultimate arbiters. *Re Z* Bennett J relying on Lord Goff in *Re F* clarified the position of experts vis-à-vis the court:

> Experts are what they are - experts. They must be listened to with respect, but their opinions must be weighed and judged by the courts.

Best interests have also had a crucial role in end of life decisions relating to the very young. The High Court in *Re C* as Samanta explained “commented on guidance from the Royal College of Paediatrics and Child Health. In approving the guidance, the court stated what had been proposed by the attending doctors with regard to the withdrawal of treatment had the support of reliable opinion from the College and was therefore justified”. This was not to abdicate their control, the Court of Appeal in *Wyatt* stated “any criteria which seek to circumscribe best interests are, we think, to be avoided”. This approach was expanded upon in *NHS Trust v MB* where Holman J noted at the outset how the court must arbitrate on treatment decisions and exercise its own independent and objective judgement.

Beyond the consideration of medical opinion in relation to the best interests of those unable to decide for themselves medical guidelines were also referred to in *W v Egdell*. W’s solicitors commenced an action for breach of confidence against Dr Egdell. The Court of Appeal found the court must reach its own decision on the balance. However in doing so it is legitimate for the court to

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129 Ibid. Does this assertion ignore the fact that medical prognosis of the patient will also often be a consideration in treatment decisions which involve clinical negligence.
131 A relatively recent case which considered the issue from a human rights perspective was *A National Health Service v D* [2000] FLR 67 (2000) BMLR 19 where it was made clear as Mason and Laurie n52 p 484 note “the courts and not any other party, lay or professional, are the ultimate arbiters in these cases.”
133 Samanta et al n 32 p 336.
135 *Portsmouth NHS Trust v Wyatt* [2005] 1WLR 3995.
136 At para 88.
138 Mason and Laurie n52 p486-7 where they noted that medical evidence has never been seriously challenged by the amicus curiae in the reported cases.
139 *W v Egdell* [1990] 2 WLR 471.
‘give such weight to the considered judgment of a professional man as seems in all the circumstances to be appropriate.’

Utilisation of Guidelines in negligence claims pertaining to other Professional groups

A brief examination of the utilisation of guidelines in professional negligence cases, other than those involving clinical negligence, will be made in order to assess the impact of the further utilisation of guidelines in clinical negligence cases. It must be remembered, when attempting to draw any conclusions from this comparison, the operation of Bolam and the courts willingness to actively assess common practice in relation to other professional groups, has varied to the approach taken to the medical profession. Guideline usage is one way in which it is possible the differential treatment of the professions may diminish, meaning that the medical profession are treated the same way as other professional groups. Although given the deep seated reasons for their differential treatment guidelines utilisation per se might not immediately offer perfect parity. Codified standards of professional conduct might constitute significant evidence of what constitutes reasonable care in a given situation. Woolf J said of accounting and auditing standards in Lloyd Cheynham v Littlejohn & Co.

While they are not conclusive, so that a departure from their terms necessarily involves a breach of duty of care, and they are not... rigid rules, they should be strong evidence as to what the proper standard which should be adopted is and unless

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140 The disclosure in Egdoll was justified on the basis by reference to the public interest in order to avert a ‘real risk of consequent danger to the public’ ibid 493 per Bingham LJ. Note Guidance from the General Medical Council on Confidentiality also recognised that “where necessary to prevent the risk of serious harm to the patient or others, disclosure to an appropriate person or authority will not be regarded as professional impropriety”.
141 The differences in the approach of professional negligence and clinical negligence case law are discussed more fully in chapter one of this thesis. It is markedly in relation to the medical profession that Bolam went awry.
142 Such equalisation could be informed by a number of developments; not least increasing the courts confidence in asserting their authority as the ultimate arbiters of the standard of care and de-bunking notions of ‘conventional Bolam’ but also by challenging notions of the ‘special status’ of the medical profession, exemplified by the mysterious notion of ‘clinical judgment’. This later consideration could be directly influenced by the changes in medical professional practice.
143 The social and non legal reasons behind this differential treatment of the medical profession qua profession are discussed more fully in chapter two of this thesis.
there is some justification, a departure from this will be regarded as constituting a breach of duty.

Therefore, it is not contended they will be automatically determinative, for example *Johnson v Bingley*\(^{146}\) where it was held that a solicitor’s breach of the Guide to Professional Conduct was not *ipso facto* negligence as the guide was not mandatory.

As Jackson and Powell\(^{147}\) pointed out a particular feature of the construction profession is the large number of codes of practice and published standards relating to the manner of construction. They\(^{148}\) contended that the purpose of such codes was to provide for standards of safety and good building practice. In *Ward v Ritz Hotel (London)*\(^{149}\) it was said of British Standards Institute recommendations:

> British Standards Codes of Practice are not legal documents binding upon engineers or anyone else, but they reflect the knowledge and expertise of the profession at the date when they were issued. They are guides to the engineer and in my view also provide very strong evidence as to the standard of the competent engineer on the date when they were issued.

An architect’s, compliance with relevant codes of practice will be an indication that they have not been negligent it will not be conclusive *I.B.A v E.M.I*\(^{150}\) where Lord Fraser stated:\(^{151}\)

> I have reached the firm conclusion that B.I.C.C. failed in their duty of care when they applied the code of practice that had been found to be appropriate for lattice masts to the new cylindrical mast at Emley Moor without noticing that the reason for disregarding ice on the stays was not applicable to a cylindrical mast. They were therefore negligent in their design.\(^{152}\)

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\(^{146}\) *Johnson v Bingley* [1997] PNLR 392. Nor is it suggested they should be determinative, whether mandatory or otherwise. It is for the courts to act as the ultimate arbiters anything else risks the well rehearsed weaknesses under ‘conventional *Bolam*’.

\(^{147}\) R Jackson and JL Powell *Professional Liability* (Sixth edition Thomson 2007).

\(^{148}\) Ibid.

\(^{149}\) *Ward v Ritz Hotel (London)* [1992] PIQR 315 where the court agreed with the words of HHJ Newey in *The Board of Governors for the Hospital for Sick Children v McLaughlin and Harvey* 19 Con LR 25 extracted from Foster n117.


\(^{152}\) It is noteworthy that this showed an instance of where either; a guideline had been followed inappropriately by the professionals concerned, or they had utilised an inappropriate guideline. Moreover, it illustrated the courts effectively utilising guidelines for their own determination of the appropriate standard of care.
This view was followed in *Kaliszewska v John Clague & Partners*\(^{153}\) where the defendant architect was found to have been negligent in his design of foundations as he failed:

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\text{to call evidence or to show by rational analysis that although the defendant's design did not comply with the current Codes of Practice and did not appear to be within the mainstream of knowledge, it was nevertheless as a result of local conditions adequate…}
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The effect of non-compliance was further considered in a claim against an engineer for negligent design in *Bevan Investments Ltd v Blackhall and Struthers (No 2)*\(^{154}\) where Beattie J held, notwithstanding expert evidence that rigid application of codes of practice would stifle progressive innovations:

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\text{Bearing in mind the function of codes, a design which departs substantially from them is } \textit{prima facie} \text{ a faulty design, unless it can be demonstrated that it conforms to accepted engineering practice by rational analysis. If I am correct in this appreciation, and if on the evidence it is established that the design in several material respects fails to comply with the relevant codes, then [the defendant engineer] and his experts must show that the design is capable of rational analysis and is adequate and is safe.}
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These cases concerning construction professionals do show how professional guidelines can be utilised by a pro-active judiciary as a tool in their determination of the appropriate standard of care. There is no reason why clinical practice could not be subjected to similar review.

**GUIDELINES IN THE USA**

To inform the debate, about the effect the increased use of clinical guidelines could have on clinical negligence in England, it may be illuminating to examine developments in the USA. Solomon noted the development of clinical practice guidelines in the United States of America had proliferated.\(^{155}\) He\(^{156}\) explained that in the US, there were two legislative projects which defined the precise

\[^{153}\text{Kaliszewska v John Clague & Partners (1984) 5 Con LR 62.}\]
\[^{154}\text{Bevan Investments v Blackhall and Struthers [1973] 2 NZLR 45.}\]
\[^{155}\text{RP Solomon, 'Clinical Guidelines in the United States: Perspectives on Law and Litigation' From Tingle and Foster n17 p137.}\]
\[^{156}\text{Ibid.}\]
effect of compliance, or non-compliance, with defined acceptable standards of clinical care.\textsuperscript{157}

\textit{The Legislative projects}

Maine and Florida developed, implemented and completed demonstration projects, these initiatives had particular objectives. The aim of the Maine project\textsuperscript{158} was to reduce the practice of defensive medicine. Under the Maine scheme a doctor's compliance with the state established guidelines represented a rebuttable presumption that the doctor had met the appropriate standards of care.\textsuperscript{159} In Florida the aim of the state legislature\textsuperscript{160} was to increase the defensibility of claims, thereby reducing the need for defensive medicine. However, the Florida statute did not prevent the claimant from introducing the clinical practice guidelines into evidence, but such use did not automatically establish the standard of care.

\textit{The Courts' Utilisation of Clinical Practice Guidelines in the US}

US courts have also utilised guidelines beyond these schemes, notably those produced by the medical speciality societies and physician organisations, which have been admitted at trial as evidence of the appropriate standard of care. Solomon\textsuperscript{161} noted their overall impact on medical malpractice had been greater than the projects such as Maine. This utilisation is closer to what could happen in this country; guidelines being considered by the court in order to help inform the judiciary with their determination of the appropriate standards of care. The utilisation of clinical guidelines other than within the state led projects was restricted by the operation of the hearsay rule, US courts were in the past reluctant to allow exceptions, therefore clinical guidelines were not readily admitted into evidence in tort or medical malpractice litigation.\textsuperscript{162} More recently

\textsuperscript{157} Two states, Florida and Maine, enshrined in legislation these acceptable practice guidelines.
\textsuperscript{158} The Maine Liability Demonstration Project, Maine Public Law 1990, Chapter 931 subsequently amended on 17 June 1991 at Maine Public law 1991, Chapter 319. The project was not extended beyond it’s scheduled termination date in 2000. The project only applied to four specialities; anaesthesiology, emergency medicine, radiology and obstetrics and gynaecology.
\textsuperscript{159} Solomon n151 pointed out that the scheme in Maine was notable as it permitted the exculpatory use of guidelines by defendants but prohibited their inculpatory use by claimants.
\textsuperscript{160} Florida statutes title XXIX (1992) Chapter 408.02(9).
\textsuperscript{161} Solomon n151.
\textsuperscript{162} Ibid.
the courts have developed exceptions to the hearsay rule which have allowed them to make reference to clinical guidelines and other learned treatises. In *Frakes v Cardiology Consultants* the court required an expert witness to testify as to the authority of the guidelines, in this instance the American College of Cardiology's guidelines on 'Exercise test parameters associated with poor prognosis and/or severity of CAD'. However, as Solomon noted others have allowed guidelines use without expert witnesses.

US Courts have recognised the relevancy of guidelines in judging whether or not a breach of duty has occurred, they are just one of a variety of sources of information. In *Lowry v Henry Mayo Newhall Memorial Hospital* the claimant argued that the doctor had deviated from the American Heart Association's Guidelines for cardiac life support by administering the drug atropine rather than epinephrine. The judge at first instance (upheld on appeal) held in favour of the defendant, the AHA guidelines were no more significant or persuasive than the general facts of the case. The courts in a more assertive mood could be seen in their rejection of a hospital's assertion that the practice guidelines propounded by the American Society for Anaesthesiologists were emerging and not mandatory. The claim had arisen when the hospital had failed to provide a carbon dioxide monitor in 1987 to a patient undergoing general anaesthesia for an elective procedure. Rejecting the argument, of the non-mandatory nature of the guidelines and the hospital's assertion of the relevance of locality, the court firmly stated that a national standard was proper when it came to the provision of medical treatment.

In *Daubert v Merrell Dow Pharmaceuticals Inc.* the Supreme Court created strict standards for the judicial evaluation of the reliability and authoritativeness of scientific evidence. Solomon speculated that this might encourage the judiciary to scrutinise the process behind the development of guidelines and both the credentials and motivations of their producers. He further contended that the NGC inclusion criteria might provide an example of the minimum

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163 Ibid.
165 Solomon n151.
169 Solomon n151.
170 Ibid.
171 The NGC was launched by the US government in 1998. It is a website (www.guideline.gov) intended to make evidence based clinical practice guidelines widely available. It is operated by the US Department
credentialing criteria that should be required in order for the guideline to be admissible. The NGC project highlighted the importance and place of evidence based medicine.

The US jurisprudence also offers an example, of a standard set down in clinical guidelines being a minimal standard, and not a sufficient determinant of reasonable care under the circumstances and also an instance of conflicting sets of professional guidelines.

**Empirical Indications as to Guidelines Impact on Litigation Practice in Clinical Negligence**

Another way which clinical guidelines might impact on clinical negligence is by virtue of their utilisation, in a variety of ways, by legal practitioners. Their utilisation of guidelines will impact on the decision to begin an action and how the claim is argued. There are two important studies which sought to examine this area.

**USA**

Hyams and colleagues carried out two studies that examined the frequency and use of guidelines in litigation, and their impact on the pre-trial stage and the outcome of litigation. The study reviewed 259 claims received by professional liability insurance companies. The researchers requested a large sample of anaesthesia and obstetrics claims as they felt the use of guidelines in these

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of Health, The Agency for Health Care Research and Quality, the American Medical Association and the American Association of health Plans. The NGC has adopted minimum criteria for inclusion on their website.

172 Jewett v Our Lady of Mercy Hospital (1992) 82 Ohio App 3D 428 612 NE 2d 724 where as Samanta n32 p 344 explained “it was argued that although the standard of care complied with that of the American College of Obstetricians and Gynaecologists, nonetheless there was actionable negligence as those standard were the minimum expected standard and more should have been done by the defendant”.

173 Levine v Rosen (1992) 616 A 2d 623 (Pa) where as Samanta n32 p 344 explained: “the claimant’s experts raised the recommendations of the American Cancer Society whereas the defendant’s experts raised those of the American College of Obstetricians and Gynaecologists. The court acknowledged that there were two competent bodies of medical authority that may differ and permitted the use of the guidelines raised by the defendant on the basis that the defendant’s conduct was strongly supported by respected professionals”. As Samanta et al n32 contend p 344 expert opinion will always be required in such cases and possibly in assisting the court in assessing Daubert validity for the admissibility of guidelines.

specialities would play an especially important role. A claim was classified as involving the use of a guideline if in the view of the research team it was both relevant and played a pivotal role in the proof of negligence. The findings were; seventeen cases out of their sample involved guidelines, in twelve of the cases there use was inculpatory, in four exculpatory and there was one case which the researchers termed indeterminate.

A further sample was taken of attorneys working in the medical malpractice field in order to assess practitioner’s opinions on the use of guidelines. Forty-eight per cent of respondents had one case a year in which a clinical guideline played a role with thirty-six per cent saying that a clinical guideline had played an important role. More than twenty-seven per cent of respondents reported a guideline had influenced their decision to settle a case, with twenty-two per cent stating that a guideline had influenced a judge or jury in the previous year. Additionally, twenty-six per cent of attorneys responded that clinical guidelines influenced their decision to reject a case, whereas thirty-one per cent were influenced as whether to accept and file a suit. The authors themselves noted that their study might underestimate the influence of guidelines as the claims they had studied pertained to care provided in the mid-1980’s which preceded the issuance of many newly formulated guidelines and the establishment of the National Guidelines Clearing House.

**England- Empirical indications**

Samanta et al embarked on a study to determine practising lawyers’ perceptions of the use of guidelines in medical negligence litigation in England and Wales. They developed a questionnaire, specific enquiries were made about four types of guidelines:

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175 The research examined a variety of legal documents; briefs, interrogatories, depositions amongst other materials.
176 A questionnaire was sent to 980 attorneys drawn from all fifty states. 399 of those approached responded.
177 Solomon n151.
178 Samanta et al n32 noted there is no UK equivalent body, although they suggested the performance framework for the NHS driven by ‘Standard for Better Health Department for Health on http://www.dh.gov.uk/assessRoot/ which they accessed on 11 April 2006.
179 Samanta et al n32.
180 Based on their knowledge of guidelines currently in use in clinical medicine in the UK and previous literature regarding the use of guidelines in medical litigation.
181 Samanta et al n32 p328.
those emanating from the Royal Colleges, the National Societies, NICE and the Scottish Intercollegiate Guidelines Network (SIGN). The principal solicitors and barristers practising in clinical negligence in England and Wales were identified. A total of 110 completed the survey (71 solicitors and 39 barristers). A high percentage of respondents reported that they were somewhat familiar with each of several major guidelines, although a relatively small proportion described themselves as being very familiar with them. Overall, 80 per cent of respondents were either very familiar or somewhat familiar with guidelines from various Royal Colleges, 75 per cent were familiar with NICE guidelines and 46 per cent were familiar with guidelines from learned national societies.

Eighty-nine per cent of respondents reported that they or someone in their team had used guidelines in clinical negligence cases that they had handled in the past three years (17 per cent often or very often and 72 per cent sometimes) a similar proportion had seen guidelines used in a case by the opposing side during the past three years. Lawyers were somewhat more likely to report having seen guidelines used for inculpatory purposes (87 per cent) than for exculpatory purposes (79 per cent). The most prevalent specific use of guidelines was citation in medical expert reports (25 per cent very often/often and 69 per cent sometimes). About half of the respondents reported having seen guidelines used in each of the following ways: by a witness during his or her testimony, by a lawyer in direct examination of a witness and by a lawyer during cross-examination.

Just over 40 per cent of respondents believed the use of guidelines had been influential in the court's decision in clinical negligence cases. Forty-four per cent believed the guidelines had influenced the court to decide in favour of the claimant (5 per cent often and 39 per cent sometimes) and 48 per cent felt they had influenced the court in favour of the defendant (4 per cent very often/often and 44 per cent sometimes). Of those who reported seeing guidelines used for inculpatory purposes, 48 per cent believed that the guidelines had swayed the court toward the claimant at least sometimes. Of those who had seen guidelines introduced for exculpatory purposes, 55 per cent believed that they had influenced the court to decide in favour of the defendant at least sometimes.

The Royal Colleges' guidelines were reported to be used most often in clinical negligence litigation. Eighty-three per cent of respondents had seen them used at least sometimes during the past three years; reported use of other guidelines was substantially lower. However the majority of respondents stated that in their experience guidelines had not played a role in determining liability.

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182 From the Chambers UK Guide to the Legal Profession 2004 and the Legal 500 Directory 2004. The questionnaire and a cover letter were mailed to 372 lawyers (220 solicitors and 152 barristers).
183 Samanta et al n32 at p329.
184 Ibid at p331.
185 Ibid at p331.
186 Ibid at 333.
187 Samanta et al n32 fifty-six per cent of respondents stated guidelines had never played a key role in determining liability in favour of the claimant and 52 per cent stated the same for the defendant. They
Samanta et al concluded that the reported prevalence of the use of guidelines in their study was considerably higher than that reported by Hyams et al. They concluded “their study provided suggestive evidence that the current use of guidelines in England might be higher than in the USA a decade earlier”\textsuperscript{188}. In speculating as to the future use of clinical guidelines, Samanta\textsuperscript{189} et al questioned their respondents, as to their perceptions on this; “over four-fifths of respondents felt that the use of guidelines in medical litigation would increase in the future; the principal reasons for this increased usage were considered to be clinical governance and associated agendas”.\textsuperscript{190}

Conclusion

It is contended that the developments within the medical profession which have been examined in this chapter impact on how the appropriate standard of care is determined in clinical negligence actions. Jones\textsuperscript{191} claimed codified standards of professional conduct constitute significant evidence of reasonable care. This could go someway to address the worst excesses experienced in the years when Bolam went awry. However it leaves open the point, the standard of care should be prescriptive rather than descriptive. The courts need to be prepared to take a hard look at guidelines rather than ‘rubber stamping’ documents as definitive as to reasonable care. This need not be unduly problematic as common practice, however evidenced is not determinative in other areas of negligence. However, the utilisation of sources, other than expert testimony is noted the difficulty of their respondents accurately predicting the factors which persuade judges’ decisions but they contended that it was suggestive evidence that a degree of judicial scepticism about the weight of guidelines in determining the legal standard. It is suggested that the judicial feeling ascertained by Samanta that ‘guidelines are for guidance rather than prescription in this determination’ is just as it should be, the courts should be the final arbiters of appropriate standards of care.

\textsuperscript{188} Samanta et al n 32 p 338 explained: “There is, no up to date evidence from the USA to make a contemporaneous comparison. Furthermore, data from the National Audit Office indicates a steep rise in both clinical negligence claims and settlements which might be an additional factor for the higher use of guidelines observed in this study”.

\textsuperscript{189} Ibid.

\textsuperscript{190} Samanta et al n32 p 346 and p 346 where they explain how: “Guidelines engage as part of the risk management strategies. The Clinical Negligence Scheme for Trusts is a collective scheme with the remit of assisting Trusts to meet the costs of defending clinical negligence actions and promotes the use of guidelines as a means of reducing medical error. National Health Service Litigation Authority, ‘General Clinical Negligence Scheme for Trusts. Clinical Risk Management Standards.’ (HMSO 2005)”.

\textsuperscript{191} Jones and Lyons n144 p251 and 252 where he points to \textit{Zarb v Odetoyinbo} [2006] EWHC 2880 where Tugendhat commented “It is is principle possible that the Guidelines of the Royal colleges might fail the Bolam test. But it is difficult to envisage the circumstances where the judge would be bound to reach that conclusion.”
not entirely without problem. Edmond\textsuperscript{192} warned that judges, especially judges in the United States, have tended to rely upon the fact of publication of information, as a reliability filter to inform their assessments of proffered evidence.\textsuperscript{193} He warned peer review is neither uniform nor totally reliable nor intended as a fraud detection mechanism. Furthermore, he contended judges might not be sufficiently appraised as to the origins of research.\textsuperscript{194} The issue of commissioned research will be revisited in the next chapter of this thesis, when the guidelines produced by the government bodies largely emanating from the Health Act 1999\textsuperscript{195} will be examined. If Edmond’s major concern is unbiased objectivity, a similar point can be levelled at traditional witness testimony. It is not the aim of this chapter to argue for trial (or treatment) by guideline, but rather to reassert the court’s authority as the ultimate arbiters of the standard of care and to allow best use to be made of developments in medical professional practice, as a means of examining the circumstances of the case, including the full remit of common practice. This is not to constrain the courts within common practice, not to confuse the descriptive with the prescriptive but to arm the judges in their determination of the prescriptive standard of care which is always reasonable in the circumstances of the case.


\textsuperscript{193} Daubert v Merrell Dow Pharmaceuticals, Inc. 509 US 579, 593 (1993) Presenting criteria for the admissibility of scientific evidence, the majority explained that: “Ordinarily, a key question to be answered in determining whether a theory or technique is scientific knowledge that will assist the trier of fact will be whether it can be (and has been) tested…. Another pertinent consideration is whether the theory or technique has been subjected to peer review and publication.”

\textsuperscript{194} They may be ignorant as to sponsorship arrangements, financial relations with authors, or even the identity of the actual authors. He also contended how peer review has generally failed to identify flaws or limitations within favourable studies and even that adverse research findings could be suppressed or delayed (by sponsors).

\textsuperscript{195} As amended most recently by the changes proposed by the Health and Social Care Bill 2011.
CHAPTER FIVE

New NHS Regulators and New Bolam

INTRODUCTION

An underlying premise of this thesis is there should exist an impartial system of effective monitoring of all professions, including the medical profession, in order to ensure appropriate standards. Such standards should be set by the law and be prescriptive not merely descriptive. One way of achieving this is through the tort of negligence with its requirement for ‘reasonable care’. However, as has been seen earlier in this thesis; during the era in which Bolam went awry, a perverted\(^1\) version of Bolam developed in relation to the medical profession. There was no substantive legal reason for this deference and the failure to achieve the above objectives. There were even strands of case law which pointed towards an ‘alternative’\(^2\) operation of Bolam, which would have achieved the objectives above. The previous chapter of this thesis, examined how using the medical profession’s own tools, a ‘brave new\(^3\) Bolam’ could be confidently utilised by the courts. This chapter will examine a number of government driven initiatives regarding healthcare provision and regulation which would also appear to point towards a more prescriptive, interventionist approach. These developments are occurring in parallel to the reminder provided by the Bolitho decision, that the courts are the ultimate arbiters of the standard of care in clinical negligence and could serve to increase judicial confidence in so acting, both through the further provision of measuring tools and the reassurance of the existence of a wider movement towards assertive clinical regulation.

As was noted in chapter 4, a new era of clinical governance had entered the policy arena, with the government becoming increasingly unsympathetic to the latitude of discretion accorded to clinicians; and dissatisfied with the fact that quality of care, did not appear to be as high profile in the NHS as other targets.

\(^1\) Although somewhat ironically, this interpretation of Bolam became the ‘conventional’ one and was the reason the Bolam test was much maligned. It is contended, the interpretation given to Bolam in Bolitho was the true test which McNair J envisaged.

\(^2\) As examined fully in chapter three of this thesis.

\(^3\) This is not to concede it would require substantive alteration, an argument more fully examined in chapter 3. Merely that it would require the courts to apply McNair J’s test with new rigour.
A number of the government initiatives were pre-empted by the medical world itself, for example, clinical practice guidelines. The question will be posed whether the government initiatives will have an impact on the use made of these tools by the courts when ascertaining the appropriate standard of care.\(^4\)

Before this time “the culture of the NHS was still largely dominated by local clinical forces which were subject to relatively little central supervision.”\(^5\)

Newdick\(^6\) contended during the time clinical regulation was dominated by a ‘letting go’ of direct control, when policy makers were satisfied to fall back on the professional view of how quality should be assessed, the courts were similarly behaving passively and with deference towards the medical profession giving rise to the most vociferous criticisms of Bolam.\(^7\) It is noteworthy that the more interventionist regulatory era post 1999, some of the particulars of which will be outlined in this chapter, was introduced at a time post Bolitho when there was a renewed focus on the courts as the ultimate arbiters of the standard of care. However the Health and Social Care Bill 2011 might suggest a retrenchment of government intervention it is hoped that the courts will not follow.

Governance along with the wider tenor of the government initiatives, explicitly recognised, although clinical negligence might be the responsibility of an individual or team, it might also be due to a systems failure\(^8\) within the institution itself. This move towards recognising institutional responsibility reinforces the argument for a meaningful institutional duty to be required by the law, via a direct duty of care being placed on NHS bodies.\(^9\) The likely impact of the initiatives on classic clinical negligence will be considered in this chapter, after a critical appraisal of these reforms.

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\(^4\) Chapter four examined these topics independently from government initiatives.


\(^6\) Ibid.

\(^7\) Discussed in detail in chapter one of this thesis as the era in which the deference seized the courts and which led to what can only be termed a perverted interpretation of Bolam.

\(^8\) Learning From Bristol, The Report of the Public Inquiry into Children’s Heart Surgery at the Bristol Royal Infirmary 1984-1995 Cm. 5207(2001) The Bristol Inquiry found that many of the shortcomings identified in Bristol existed through the NHS.

\(^9\) The existence and extent of an institutional direct duty will be considered in the next two chapters of this thesis.
THE GOVERNMENT INITIATIVES- A NEW ETHOS TOWARDS INTERVENTION

This chapter argues one factor which may impact on how the courts set standards in clinical negligence claims is the more general move to set national standards for medical care. The era of the wholly autonomous clinician and predominantly local regulation came to an end. Fourteen years ago, *The New NHS: Modern and Dependable* explicitly acknowledged the importance of national standards and guidelines and first mentioned the National Institute for Clinical Excellence, and National Service Frameworks. Since that time the speed of government initiatives has been bewildering. As Davies pointed out the regulatory regime introduced by the Health Act 1999 differed from the previous regime in two important ways. Firstly, the source of much of the regulation is governmental rather than professional. Secondly, the style of regulation is interventionist in contrast to the light touch of the previous regime.

Previous systems of regulation had been largely based on the professionals’ views of what services were needed and how quality of care should be assessed. Regulation was heavily dependent on the judgment of the clinicians; deferred to as ‘experts’ in this arena as much as in the courts, Klein had suggested the size and complexity of the NHS, and the lack of accepted means by which targets could be measured had led to this. A catalyst for the changes, were the problems highlighted with this type of NHS governance after a number of high profile scandals in the NHS. One example is to be found in *The Inquiry into Quality and Practice within the NHS Arising from the Actions of Rodney Ledward*. A surgeon was found to have continued in obstetric practice despite a well-known poor record of clinical success. The Inquiry considered the

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11 AJ O’Rourke ‘The Role of Clinical Institutions and Central Government’ from John Tingle.
13 Davies n12. She contended that both the Act and related policies were ‘remarkable’ for the amount of direct intervention particularly as this direct intervention is aimed at clinical care. The ethos of this interventionist approach first heralded in statutory form in the 1999 Act has been followed in subsequent legislative developments to date.
14 Newdick n 5.
16 Department of Health (2000) paragraph 25.1-2. arguably, such a state of affairs, in which the risk of damage was foreseen but not responded to, would amount to ‘system’, or ‘managerial’ negligence. See *Bull v Devon H.A.* [1993] 4 Med LR 117.
failure of hospital managers to identify and deal with the poor standards of practice of the consultant gynaecologist. It said:

We accept that certain individuals tried to take steps to deal with a number of problems but our strong impression is that there was no concerted effort, no one took charge of the problem and each concern was dealt with on an ad hoc basis. [The District General Manager] told us that he was unaware of any concerns about Rodney Ledward’s clinical practice. If that is so then he should have been. [He] told us that in his view there was no system in place to identify and deal with problems involving a consultant.

The events and findings recounted in *Learning from Bristol*, the report from a Public Inquiry conducted between October 1998 and July 2001, provide further impetus for reform. The remit of the Inquiry was to examine the management of paediatric cardiac surgery at the Bristol Royal Infirmary between 1984 and 1995, and to make findings as to the adequacy of the services. The aim was to make recommendations which could help to secure high-quality care across the NHS. The final report noted the problems in Bristol owed as much to general failings in the NHS at the time as to any individual failing. The report noted how it was an account of a time when there were no agreed means of assessing the quality of care. There was confusion throughout the NHS as to who was responsible for monitoring the quality of care. The clinicians in Bristol had no one to satisfy but themselves that the service which they provided was of appropriate quality. The report remarked that:

In the decades after the establishment of the NHS (in fact right up until the late 1980’s) Quality was regarded by government as a matter for individual healthcare professionals. For their part, healthcare professionals, particularly hospital doctors, had deeply embedded in their culture the notion of professional autonomy, often expressed in the form of clinical freedom.

In 2007, the then Chairman of the Healthcare Commission, Sir Ian Kennedy felt the lessons from Bristol had still not been learned. As Newdick contended the

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17 *Learning from Bristol* n8.
18 Ibid.
19 Ibid.
20 Ibid para 2.
21 Editorial “Passionate over patient safety” *The Times* (London June 26 2007). Where he was quoted as stating “Bristol was an opportunity to say something about how children were looked after, but also offer more general lessons about safety. In the foreword to the report I said I could not say that this sort of thing couldn’t be happening again, somewhere else, and it remains the case.”
government carries ultimate responsibility for the stewardship of the NHS.\textsuperscript{22} Therefore the government was constrained to do something about the lack of effective systems for identifying, quantifying and responding to failure. The latest raft of reforms planned by the coalition government\textsuperscript{23} might suggest a retrenchment from national state intervention.\textsuperscript{24}

\textit{Clinical Governance}

Clinical governance is the regulatory framework through which NHS organisations are accountable for safeguarding the standard of clinical care.\textsuperscript{25} Newdick\textsuperscript{26} contended, governance at its worst could, “risk relying too heavily on an industry of empty comfort certificates and shallow rituals of verification at the expense of other forms of organisational intelligence.”\textsuperscript{27} Concerns about excessive governance are not restricted to healthcare they have also been voiced in other sectors, for example the Chief Inspector of Schools said:

\begin{quote}
\ldots an excessive or myopic focus on targets can actually reduce achievement. The innovation and reform that we need to see \ldots may be inhibited by an over- concentration on targets \ldots there is a crucial balance to be struck between government initiative and legitimate power of intervention on the one hand, and the professional responsibility of individuals making decisions in the best interests of their pupils.\textsuperscript{28}
\end{quote}

Another possible danger, of an over concentration on performance targets in the NHS was observed by Dr Richard Harrad:\textsuperscript{29}

The waiting time targets for new outpatient appointments at the Bristol Eye Hospital have been achieved at the expense of cancellation and delay of follow-up appointments. At present we

\begin{flushright}
\textsuperscript{22} Newdick n5 and as is clear from the NHS Acts. Ultimately it is the Minister who may be required to answer for shortcomings within the system.
\textsuperscript{23} \textit{Enabling Excellence Autonomy and Accountability for Healthcare workers, Social workers and Social care Workers} Cm 8008 (2011).
\textsuperscript{24} It might be that such a retrenchment would be followed by a similarly cautious phase from the courts. Although it is hoped this will not prove to be the case.
\textsuperscript{25} A precise definition of clinical governance is difficult, essentially the concept appear to involve two key concepts (i) measurable standards or benchmarks of performance (ii) which can be applied and monitored externally as well as internally.
\textsuperscript{26} Christopher Newdick \textit{Who Shall We Treat} (Second Edition Oxford University Press 2005) p196.
\textsuperscript{27} M Power \textit{The Audit Society- Rituals of Verification} (1\textsuperscript{st} edition Oxford University Press 1999) p 123.
\textsuperscript{28} David Bell Chief Inspector of Schools speech to the City of York annual education conference on 28 February 2003, www.education.guardian.co.uk/ofsted/story extracted from Newdick n26 p197.
\textsuperscript{29} Dr Richard Harrad, Clinical Director of the Bristol Eye Hospital, in evidence to the House of Commons Public Administration Committee. See \textit{On Target? Government by Measurement} (HC 62-12003) paras 52 and 53 extracted from Newdick p 198.
\end{flushright}
cancel over 1,000 appointments per month...We have clinical incident forms for all patients, mostly those with glaucoma or diabetes, who have lost vision as a result of delayed follow up; there have been 25 in the past 2 years...

Clinical performance management can bring about both advantages and disadvantages, the proper balance is not easy to find, particularly when performance data is published. It is made difficult by the sensitivity of the subject and the presentation of information in a meaningful and non-sensational manner, such headlines can alarm both surgeons and patients, but this does not necessarily imply that performance publication should be abandoned. The American experience as evidenced in the Dranova et al research concluded:

For sicker patients, doctors and hospitals avoided performing cardiac surgical treatments of all types. These changes were particularly harmful, leading to sicker patients to have substantially higher frequencies of heart failure and repeated [heart attacks], and ultimately higher costs of care.

It is uncertain how far these results are likely to be replicated in England given the fundamental difference in healthcare provision. The Bristol Eye Hospital experience, as to how targets are actually achieved, might be another worrying indication of future developments. In a recent report Ben Bridgewater a cardiac surgeon contended: “The political and media scrutiny of cardiac surgery after Bristol meant we were held to account in a way almost no other

30 Newdick n26 p198.
31 Newdick n26 p199 where he illustrated the point by reference to the following headline Editorial ‘Heart surgeons’ death figures to be published.’ The Times (London 18 January 2002) on rates of clinical success amongst cardiolgists. This headline illustrated the danger that surgeons subject to such publicity might ‘cherry pick’ less ill patients with a better prognosis than the extremely sick. This concern was explored by the National Bureau of Economic Research into cardiac surgery in New York and Pennsylvania. It found that performance data did lead to substantial patient selection and a decline in the severity of the illness of patients receiving CABG by comparison with hospitals where such data was published. D.Dranove, D.Kressler, M.McClenann and M. Satterthwaite “Is More Information Better? The Effects of Report Cards on Health Care Providers” National Bureau of Economic Research Paper 8697(2002) 18.
32 Ibid.
33 Ibid Executive summary entitled as Newdick points out “Health Care Report Cards May Fail Patients”.
34 Dr Richard Harrad, Clinical Director of the Bristol Eye Hospital, in evidence to the House of Commons Public Administration Committee. See On Target? Government by Measurement (HC 62-1,2003) paras 52 and 53. extracted from Newdick p 198.
36 Jeremy Laurance ‘Doctors Warn that ‘club culture’ among surgeons is costing lives’ The Independent (London March 21st 2011).
specialty was.” Mr Bridgewater\textsuperscript{37} noted there was still dispute about whether cardiac surgeons were being deterred from operating on sicker, riskier patients. However he noted the average age of patients having surgery had increased, indicating that surgeons were in fact accepting riskier patients. Alleviating another possible fear, Mr Bridgewater contended monitoring of cardiac surgeons is estimated to cost £1.5m a year,\textsuperscript{38} but the improved performance it has delivered means patients spend less time in hospital saving over £5m a year.\textsuperscript{39} This research would suggest that increased regulation from external sources whether governmental or judicial need not necessarily lead to feared detrimental consequences.\textsuperscript{40} This could reassure the judiciary and make them more inclined to apply a ‘brave new Bolam.’\textsuperscript{41}

THE PROMULGATION OF GOVERNMENT GUIDANCE

This section will move on to examine if government endorsed practice may have a more powerful impact on clinical practice than guidance from other sources.\textsuperscript{42}

\textit{The National Institute for Health and Clinical Excellence}\textsuperscript{43}

NICE was created by the National Institute for Clinical Excellence Regulations 1999.\textsuperscript{44} As noted in chapter four there has been a proliferation of clinical guidelines in recent years. One of the very reasons that NICE were asked to

\begin{footnotesize}
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\item \textsuperscript{37}Ibid.
\item \textsuperscript{38}Less than 1 per cent of the total NHS spend on cardiac surgery.
\item \textsuperscript{39}This suggests requiring high standards of care through prescriptive means as a ‘brave new Bolam’ would, is not necessarily too expensive for the system to bear.
\item \textsuperscript{40}Such fears are: that the most sick patients would not be treated for fear of the increased likelihood of a poor outcome, and the possible costs involved in such monitoring of professional’s practices.
\item \textsuperscript{41}A good example of a case where the courts have been overprotective of the NHS in the past is Lord Hoffman’s comments in \textit{Fairchild v Glenhaven Funeral Services Ltd} [2005] 1 AC 134 where at para 69 he referred to the seemingly unique position of the NHS when he stated the political and economic arguments applicable to the NHS were “far more complicated than the reasons stated by Lord Wilberforce for imposing liability upon an employer who has failed to take simple precautions.”
\item \textsuperscript{42}Particular attention will paid to the guidance provided by clinical guidelines.
\item \textsuperscript{43}NICE originated in Department of Health \textit{A First Class Service: Quality in the New NHS} (HMSO 1998).
\item \textsuperscript{44}As amended by the National Institute for Clinical Excellence (Establishment and Constitution) Amendment Order 2002. This just increases the numbers of members of the institute who are not officers of the institute from seven to eight. In 2005 the Health Development Agency joined the Institute and it is now called National Institute for Health and Clinical Excellence. The acronym remains as NICE. Further name changes are proposed in the Health and Social Care Bill 2011, clause 229 proposes the creation of a body known as the National Institute for Health and Care Excellence with s 245 of the same Bill providing the special health authority known as the National Institute for Health and Clinical Excellence is to be abolished.
\end{itemize}
\end{footnotesize}
develop guidelines in the first place was to help to counter problems and concerns about certain clinical guidelines as discussed in the previous chapter.\footnote{Expressed in the previous chapter of this thesis from URL http://www.nice.org.uk/cat.asp?c=57704 accessed on 13/3/03.} NICE worked from the premise that: published guidelines can vary a great deal in quality; clinical guidelines in the same fields can sometimes contradict each other and guidelines are not at hand at the time they are needed most. The question is will NICE guidelines counter these problems?\footnote{Particularly as the ethos underpinning the recommendations made by NICE is debatable, the basic tension appears to be between quality and resource allocation. Similar tensions beset the formulation of NPF’s and NSF’s, therefore the consideration of the question of the ethos of reform; whether standard setting or rationing will be reserved until page 12 when those other initiatives have been introduced. From http://www.nice.org.uk/aboutnice/howwework/developingclinicalguidelines/guideline_review_panels.jsp accessed 18/04/2011 page last updated 28th June 2010. Guideline Review Panels replaced Guidelines Advisory Committees one of the roles of which was to assess whether individual guidelines had successfully completed the quality assurance system established by the institute and whether to recommend the guideline to the institute for dissemination in the NHS.} The Institute has moved from having seven guideline review panels to four.\footnote{Particularly given the special status accorded to the medical profession (as discussed in chapter two of this thesis) combined with the traditional dynamic of the doctor/patient relationship.} The panels incorporate a non medical member variously labelled. The rationale behind the non medical member of the panels was to counter the assertion that the production of the guidelines was left entirely to the medical professionals. It is questionable how the fact that some of the ‘lay members’ have been patients of the speciality, alters their interaction with the group, particularly with clinical members? It would not seem an unreasonable suspicion to suppose that some will be automatically deferential to the medical members;\footnote{PR Advisor to The MS Society in telephone conversation on 16th of June 2004.} however, this is not a view that is universally shared. David Harrison\footnote{MS Society involved with NICE on the formation of NICE guidelines on MS and the appeals made re the NICE recommendations on Beta interferon.} stated that in the case of the Multiple Sclerosis Society, they did not ‘feel uncomfortable when working with the medical fraternity; either generally or specifically in their encounters with NICE.’\footnote{There are currently 43,000 members. He estimated that two thirds of members actually suffer with MS.} However, he did point out that the MS Society was a ‘mature patient group’ and that it had a large membership.\footnote{The active involvement of lay members helps to counter the concerns; that guidelines formation and development are skewed for the convenience of the medical profession and that expert opinion continues to dominate the determination of standards of care, but via the medium of guidelines rather than directly through the courts.}
How NICE guidelines differ from guidelines from other sources?

The objective of the section is to examine both if and how government produced guidelines differ from those emanating other sources. Guidelines from governmental sources have some added value as they overcome the worst problems associated with ‘bad’ guidelines. The involvement of a single national government organisation could also help to counter proliferation or contradiction in guidelines, as theoretically the crème de la crème could be condensed into the guidelines. It could be argued that organisations such as the Royal Colleges already did this, the problem with such guidelines being they are both produced and written, largely by the doctors themselves, although the NICE Guideline Review Panels are also largely comprised of medical professionals. It might also be contended that given the organisational basis of NICE the affordability issue of recommended treatment could serve to distort guidelines recommendations. However, it would seem to be likely, that the courts might place particular reliance on such guidelines as they will have been endorsed by a body created by the government.

Dissemination techniques

It was noted in chapter four that one possible problem with the use of guidelines was the dissemination of such material and it actually being followed in practice. It is contended that the reasonable and responsible doctor should be expected to have accessed such guidance. Every NICE guideline is posted to a core

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52 Guidelines from other sources were discussed in the previous chapter, chapter four.
53 For example, the concern that a number of colleagues could insist compliance with their own internal guidelines, based on no evidence whatsoever, except an informal meeting could be seen to add 'extra value' to their assertions of reasonableness having been satisfied.
54 The question of the likelihood of this is addressed when looking at the likelihood of a gold standard emerging.
55 Davies’ argument considered later in this chapter that guidelines produced in this way will be manipulated away from important clinical issues towards the periphery of medical practice.
56 This issue will be examined more fully later in this chapter in the section titled “The ethos of reform”.
57 Not only will they have been ‘officially’ validated, but by bodies whose stated purpose was to create national standards. Although it is asserted that as ever, the courts will remain the ultimate arbiters of what amounts to reasonable care in the tort of negligence. A useful comparison to support the contention of ‘added value’ might be found with the British Standards Codes of Practice. British standards are “collective works with committees working to produce publications that meet the demands of society at large” extracted from www.standardsuk.com/bsi/british-standardspublications accessed on 10th June 2011. The judicial attitude to such standards and the construction industry was briefly touched upon in chapter three of this thesis.
58 Although it is recognised that effective dissemination may be quite distinct from guidelines being utilised in practice.
number of people in the NHS.\textsuperscript{59} All guidance is published on NICE’s website www.nice.org as it is released, both health professionals and members of the public can register for emails informing them of when new guidance is produced. Every six months a compilation of NICE’s guidance is published and circulated to health professionals. It is also available from NHS Evidence\textsuperscript{60} via the health information resources, formerly the national electronic library. The dissemination strategy of NICE guidelines raises a number of issues.\textsuperscript{61} It has been acknowledged, that many departments are overflowing with guidelines which hard-pressed practitioners may have little chance to read. One immediate advantage of an organisation such as NICE is that it could cut down and consolidate the sheer number of sources of guidelines.

\textit{NHS Evidence}\textsuperscript{62}

The National Institute for Health and Clinical Excellence launched NHS Evidence, an online source of “fast, free, relevant and trustworthy” information for health and social care staff.\textsuperscript{63} Speaking at the launch in 2009, Lord Darzi said:

\begin{quote}
NHS Evidence will ensure that whatever you do within the NHS you will always have access to the best information you need to deliver the highest quality care to your patients.
\end{quote}

From May 2011, NICE (NHS Evidence) launched a new specialist evidence service to replace the existing model of specialist collections.\textsuperscript{64} The relevance of this service for this thesis, is it provides a credible information source for both

\textsuperscript{59} Copies are sent to chief executives and to clinicians working in the clinical area affected by the guideline.

\textsuperscript{60} NHS Evidence was launched in 2009 as a web-based service allowing healthcare professionals to find the latest healthcare information and advice.

\textsuperscript{61} Not only those considered below but questions raised in chapters three and four e.g. what is the reasonable doctor expected to read and in what sort of timeframe? Will the fact that information it is issued by a government backed body make a difference? E.g. is it reasonable to ignore a lone article by a singular clinician until more evidence available but should NICE guidance/guidelines should be acted on immediately? The individual clinician’s autonomy is formally preserved even in relation to NICE guidance (discussed below). However NICE’s view on an appropriate treatment could inform what the court considers reasonable care in the circumstances of the case.

\textsuperscript{62} The new service was first promised in the final report of Lord Darzi’s Next Stage Review of the NHS, High Quality Care for All and is being promoted as a way to spread innovation across the health service.\textsuperscript{63} from \url{http://www.ehi.co.uk/news/ehi/4806} accessed on 11/1/2011.

\textsuperscript{64} "All information submitted for accreditation will be assessed by an independent advisory committee and guidance producers must show they meet a pre-defined set of criteria indicating that their product has been developed using rigorous processes.” Therefore the forensic process behind guidelines formulation should become more uniform and transparent. This resource could be utilised by the courts in determining the standard of care. It could also impact on the question of how up to date clinicians are expected to be, examined later in this chapter.
the courts and litigants to refer to, it could shape what is considered reasonable and responsible medical practice. It is also illustrative of the changing ethos, from the unparelled autonomy of the individual clinician towards evidence based professional practice.

The Introduction of NICE Guidance

Newdick noted that before 2002 NICE had limited impact on health authorities, because they were not bound to adopt its recommendations. As part of a policy to reduce differential access to NHS care, from 2002, NICE guidance has assumed the status of Directions. This means,

...a Primary Care Trust shall, unless directed otherwise by the Secretary of State...apply such amounts of the sums paid to it...as may be required to ensure that a health intervention that is recommended by [NICE] in a Technology Appraisal Guidance is, from a date not later than three months from the date of the Technology Appraisal Guidance, normally available (a) to be prescribed for a patient on a prescription form for the purposes of his NHS treatment, or (b) to be prescribed or administered to any patient for the purpose of his NHS treatment.

65 It is important to note there are two manifestations of NICE wisdom, guidance based on technology appraisals have a different standing to guidelines affecting treatments in other ways. There are 224 published NICE technology appraisals from http://guidance.nice.org.uk/ page last updated 9th June 2011. Newdick n26 p206 such guidance had to be considered in the decision making process, but as he explained PCT’s were free to depart from it in ‘their own reasonable discretion.’

67 Newdick n26 p 206 and p207.

68 Newdick n26 raised the issue of why if guidance is supposed to be mandatory the word normally appears? He explained that this question was raised by the House of Commons Health Committee and the Government responded that “the word normally was included... to cover unusual circumstances outside the control of PCT’s such as disruption in supply of a medicine...Scarce resources is not a good reason for failure to implement NICE guidance...PCTs are expected to manage their budgets so that patients can be guaranteed that if a treatment recommended by NICE is appropriate for them they will receive it.” Government’s Response to the Health Committee’s Second Report of Session 2002-02 on the National Institute for Clinical Excellence Cm. 5611,2002) 8.

69 Secretary of State’s Directions (undated) of 2003 the Secretary of States directions consolidated and revised which confirmed no change to the policy that funding should be available can be found on the Department of Health Website on a page last updated 17th March 2010. As Previously noted NICE will be subject to change through the Health and Social Care Act 2011. Part 8 clause 235 Establishment and general duties of The National Institute for Health and Care Excellence clause 240 Advice, guidance, information and recommendations (1) Regulations may confer functions on NICE in relation to the giving of advice or guidance, provision of information or making of recommendations about any matter concerning or connected with the provision of (a) NHS services,(b) public health services, or(c) social care in England. 8) The regulations may make provision requiring specified health or social care bodies, or health or social care bodies of a specified description, to (a) have regard to specified advice or guidance, or advice or guidance of a specified description, given by NICE pursuant to the regulations; (b) comply with specified recommendations, or recommendations of a specified description, made by NICE pursuant to the regulations. This suggests that ‘guidance’ will continue to exist and the above terminology ‘to have regard’ might suggest mandatory status.
The Government provided no guidance on how resources should be found, and Newdick\textsuperscript{70} argued if funding came from existing budgets this would necessarily lead to disinvestment elsewhere. It was suggested that in the absence of any central guidance this could result in local responses which were even more varied and inconsistent than before.\textsuperscript{71} However, money is now available from central sources by which to achieve the aim that the NHS in England will provide any treatment endorsed by NICE within three months unless exception is made.\textsuperscript{72} It is reiterated that NICE guidance is binding on NHS institutions not on individual doctors.\textsuperscript{73}

Although NICE guidelines do not have mandatory force and remain discretionary, Newdick cautioned against under-estimating the political pressure to implement them. The greatest significance of clinical guidelines might be, the political mileage to be gained in announcing to the public the introduction of such standards even if there is an awareness that these standards might not be achieved by many actual providers.\textsuperscript{74}

\textit{National Performance Frameworks}

National Performance Frameworks measure how local services are progressing against their targets. The utilisation of these frameworks is intended to make it clear to the public, and those working in the NHS where performance needs to be improved, by using greater benchmarking of performance in different areas and the publication of comparative information, allowing both the comparison of performances and the sharing of best practices.\textsuperscript{75} They are another example of the changing ethos referred to in this chapter. They are also another potential tool which could be utilised by the courts in examining the standard of care. It is intended that coupled with the introduction of National Service Frameworks unacceptable variations in practice across the NHS will be reduced and eliminated.

\textsuperscript{70} Newdick n26 p 208.
\textsuperscript{71} R. Cookson, D. McDaid and A. Maynard, ‘Wrong SIGN, NICE mess: is national guidance distorting allocation of resources?’ (2001) 323 \textit{British Medical Journal} 743.
\textsuperscript{72} Further Directions to Primary Care Trusts in England Concerning Arrangements for the Funding of Technology Appraisal Guidance from the National Institute for Health and Clinical Excellence (NICE, 20 May 2007).
\textsuperscript{73} The position regarding individual clinicians will be examined more fully later in this chapter.
\textsuperscript{74} It is argued such documents might go towards the reasonable public expectation of services which is important re institutional liability.
\textsuperscript{75} This would also provide a set of benchmarks which could be utilised by the judiciary.
National Service Frameworks are developed by the Department of Health in England. They set “national standards for a defined service or care group; put in place strategies to support the implementation of these standards; establish milestones against which progress can be measured and form one of a range of measures to raise quality and decrease variations in quality”. Each NSF is developed with the assistance of an external reference group. There are currently 10 National Service Frameworks and Strategies on: Cancer, Children, Coronary heart Disease, Diabetes, COPD, Long term conditions, Mental health, Older People, Renal Services and Stroke. The NSF on CHD launched in 2000, had a 10-year strategy to reduce CHD and stroke-related deaths by 40% by March 2010. This target was met five years ahead of schedule. It is stated the NSF is based on clear evidence, it sets out formal standards of care that local health communities are expected to achieve. The aim of NSF’s is to disseminate standards and aspirations for best practice across the country and to introduce a greater degree of national uniformity in the care available. Therefore, they could potentially be of great use in the court’s determination of the appropriate standard of care relating to particular conditions. Although how brave a Bolam, in terms of the exactingness of standards they might require, does depend on the ethos underlying the development of these frameworks. NSF’s are ‘brave’ in the sense they are an external standard imposed on clinical care.

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76 NSF’s were first mentioned in A First Class Service.
77 From http://www.nhs.uk/nhsengland/NSF/pages/Nationalserviceframeworks.aspx accessed on the 24th May 2011 page states it was last reviewed 01/02/2010.
78 That will bring together health professionals, service users and carers, health service managers, partner agencies and other advocates with the Department of Health managing the whole process.
79 From http://www.nhs.uk/nhsengland/NSF/pages/Nationalserviceframeworks.aspx Where it states the page was last reviewed: 01/02/2010 the page states, one of the main strengths of each strategy is that it is inclusive, having been developed in partnership with health professionals, patients, carers, health service managers and voluntary agencies.
81 My emphasis.
82 Noted by Davies n12. Again an illustration may be provided by the NSF on CHD where the Secretary of State contended “It then sets out the standards and care which those people who do become ill should have: early diagnosis, prompt and effective ambulance and emergency services, high quality medical, surgical and nursing care.” Indeed para 1.16 NSF CHD (ibid) states that the effect of the NSF will be to reduce undesirable variations and inconsistencies in service delivery and access, improving overall quality of care for CHD.
83 However if the ethos underlying such missives is cost cutting, it could be contended that the standards which they advocate are rather basic and easy to satisfy and so not brave in that sense.
With the emphasis in this chapter being on the possible consequences of compliance with government endorsed guidance, it is necessary to examine the likely rationale behind the inception of the organisations issuing such guidance. This section will examine arguments which were raised with the inception of NICE and the introduction of NSF’s in turn. There do appear to be common threads to the points raised in relation to both initiatives; particularly that they might be more concerned with economy than efficiency and standard setting. There is some cynicism about the basic rationale of NICE, and thus presumably the guidelines that it produces, is NICE primarily cost or quality driven? One view is that the basic rationale for NICE:

_Came from political disapproval of “postcode prescribing”:_
patients from opposite sides of the same street may receive or be denied treatment because they fall under different health authorities, each with different policies on what they will fund._

This quote would seem to suggest that a primary purpose of NICE was uniformity in policy. But uniformity of policy alone does not address the question as to whether NICE is primarily about standard setting or rationing. Smith contended that “the impression that if the evidence supports a treatment then it is made available and if it does not it is not, is a lie which corrupts the notion of evidence based medicine.” If this were true, it would impact on the speculation over NICE’s function and its credibility as a standard setting organisation. There are contradictory pictures of both the basis of NICE and its effect on the standards of patient care. For example; guidance from NICE which recommended the more widespread use of atypical antipsychotic drugs for

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84 This term is intended to cover NICE guidance, NICE guidelines and NSF’s.
86 This would be good in one way as if there was a clear uniform policy on which drugs/treatment to prescribe and when would be very useful in clinical negligence litigation. However, questions would remain to be determined on the particular facts of the case.
87 Smith n85.
patients with schizophrenia on the grounds they have fewer side effects, was greeted enthusiastically by the National Schizophrenia Fellowship\textsuperscript{88} who stated:

\begin{quote}
The guidance was a real victory for people with a severe mental condition in the ten year battle to end rationing of medicines for schizophrenia.
\end{quote}

Vass\textsuperscript{89} pointed out, the NICE guidance came after a year long review of over 200 trials. The argument of Vass that the guidance provided medicine of a ‘gold standard’\textsuperscript{90} could support the credibility of NICE as an efficient standard setting organisation and be developed to contend that it’s role in cost control was not so much rationing as efficient deployment of available resources, to put it another way that the two hypothetical roles of NICE do not have to be seen as mutually exclusive, even contradictory but rather could be viewed as complementary.\textsuperscript{91} A further positive example of NICE may be the decision to recommend that anyone with chronic myeloid leukaemia who has failed first line therapy or is in the accelerated and blast phase of the disease should have access to imatinib.\textsuperscript{92}

However, some evidence of NICE being an agency of rationing concerned primarily in the cost of treatment may be found in\textsuperscript{93} the following critique of the NICE guidance on prescribing for patients with multiple sclerosis: “I can only conclude that the institute’s true purpose is to deprive patients of treatment by delay”.\textsuperscript{94} Or as \textit{The Times} put it “The National Institute of Clinical Excellence is rationing made plain”.\textsuperscript{95}

\begin{flushright}
\textsuperscript{88} Alex Vass ‘NICE Guidance a Real Victory for People with Schizophrenia’ (2002) 324 \textit{British Medical Journal} 1413.
\textsuperscript{89} Ibid.
\textsuperscript{90} His phrase my emphasis.
\textsuperscript{91} This would depend on the viability of the argument that patients suffering from schizophrenia receive “better” treatment through the use of atypical drugs and outpatient care than by typical drugs and inpatient care. This is difficult to prove as different patients will have different views, but as the National Schizophrenia Society were impressed this would appear to be a good indication.
\textsuperscript{92} Zosia Kmietowicz, ‘NICE widens patient group for leukaemia drug’ (2002) 325 \textit{British Medical Journal} 852. When it first issued its consultation document NICE considered that there was insufficient evidence to recommend the drug for treatment of the chronic or blast phase of the disease. However, after considering further submissions from patients, professionals, and manufacturers the institute revised its analysis. It raises the question of whether this was an example of NICE’s revised appraisal process in action perpetually reviewing best practice or the result of lobbying.
\textsuperscript{93} Simon Ellis ‘The Failings of NICE. Doctors treating patients with multiple sclerosis will lose confidence in NICE’ (2001) 322 \textit{British Medical Journal} 491.
\textsuperscript{94} Ibid. Ellis details how in 1993 Beta interferon was found to be efficacious for relapsing/remitting MS and how in 2001, patients in the UK with clear indications for interferon beta were still being deprived of it seven years after it was shown to be clinically effective.
\textsuperscript{95} Editorial ‘Not a NICE habit’ \textit{The Times} (London 12 April 2002). For a recent attack on the organisation, one which JK Mason and G Laurie Mason and McCall Smith’s \textit{Law and Medical Ethics}
Similarly, the ethos behind the introduction of NSFs raised many of the same issues, for consideration, which were raised above with regard to NICE guidelines. Davies\textsuperscript{96} said generally of the 1999 reforms “they introduced a system of rationing, under which doctors will be expected to conform to guidelines as to the availability and use of certain treatments”. The NSF on CHD for example has a caveat; the standards of care are standards the NHS will aim\textsuperscript{97} (presumably so can they assert the do not have resources) for in relation to heart attack: acute myocardial infarction and other acute coronary syndromes.\textsuperscript{98} The aim of the NSF on CHD to reduce delay in the delivery of thrombolysis for acute myocardial infarction, did not appear to have been achieved in practice, according to a survey of all 201 acute hospitals in England that routinely admit patients with acute myocardial infarction.\textsuperscript{99} Also, there were criticisms of the standards advocated in this NSF, one group of researchers pointed out, in the case of cholesterol more efficacious methods of diagnosis were available. Wilson et al\textsuperscript{100} carried out a study to evaluate the guidelines on the measurement of cholesterol in the NSF for CHD in comparison to alternative strategies as a means for identifying people at risk of coronary heart disease in the general population. They contended the NSF guidelines identified 81.2 of those at 15% or greater risk, with other methods; the Sheffield table and a selection by age alone (over 50) identifying 99.91 and 92.8 respectively. As both of the methods advocated by Wilson et al were more efficient than the NSF criterion the likelihood of NSF guidelines leading to the creation of gold standards might not appear promising.\textsuperscript{101} The phrase ‘gold standard’ itself is not unproblematic, in everyday parlance it would suggest a standard equated with excellence.\textsuperscript{102}

\textsuperscript{96} Davie s n12 p 447.
\textsuperscript{97} My emphasis.
\textsuperscript{98} It includes standards such as the acceptable time lapse in receiving defibrillator treatment.
\textsuperscript{100} S Wilson, A Johnston, J Robson, N Poulter, D Collier, G Feder and M Caulfield, ‘Comparison of Methods to Identify Individuals at Risk of Coronary Heart Disease from the General Population’ (2003) 326 British Medical Journal 1436.
\textsuperscript{101} Will this make it more unlikely that counsel for the claimant will utilise such guides?
\textsuperscript{102} If initiatives are indeed discrete rationing mechanisms guidance will always be skewed towards economy; and introducing ‘gold standards’ in medicine is the last thing that they are likely to do.
Impact on how the standard of care is set in clinical negligence actions

The government initiatives could be utilised by the legal system, particularly an active judiciary, as a possible tool in determining the appropriate standard of care in clinical negligence litigation with implications for the operation of the Bolam test. They could impact on the ‘state of scientific knowledge at the time.’ NICE guidance is binding on NHS institutions, but it is not binding on individual doctors. The decision whether to use the treatment remains a matter for their own reasonable clinical discretion. Doctors must consider the impact of NICE guidance, and bear it in mind, in deciding what is best for individual patients. It could be negligent to use it just because it emanates from NICE.

Many years ago now, Kennedy and Grubb contended that NICE guidelines along with the National Service Frameworks would increasingly be taken to set the standard and quality of care that a patient is entitled to expect, and were likely to be seen by the courts as indicative of the expected level of care, such that a departure would require some demonstrable justification relating to the individual patient’s particular circumstances. The dissemination techniques of NICE and NSFs could impact on how up to date doctors are expected to be. By earmarking, some developments as so important, a government agency has deemed it necessary to issue guidelines that are easily and quickly obtainable. This could impact on the question of how up-to-date doctors are expected to be, as Crawford v Board of Governors of Charing Cross Hospital decreed that the reasonable doctor has a duty to keep himself informed of major developments.

103 As in Roe v Minister of Health [1954] 2 All ER 574 where it was held that there was no negligence as the defendant’s conduct had to be judged by the standard of the reasonable person with the knowledge available at the time.
104 The position after the Health and Social Care Bill 2011 is not certain. It has been suggested that clause 240 might point towards this status continuing.
105 Christopher Newdick n26 p 211 where he cited “The institute has always indicated that health professionals, when exercising their clinical judgment should take its guidance fully into account; but that does not override their responsibility for making appropriate decisions in the circumstances of the individual. This principle is important because even the best clinical guideline is unlikely to be able to accommodate more than around 80% of patients for whom it has been developed.” Response to the Report of the Bristol Royal Infirmary Inquiry (NICE 2001).
107 Ibid p125.
108 This would perhaps be where the scenario of a pregnant women returning to a country where a safe repeat caesarean would not be available may constitute a demonstrable justification for departure from the treatment e.g. where caesarean section was otherwise recommended by the guideline for the factual situation.
109 Crawford v Board of Governors of the Charring Cross Hospital (1953) The Times 8th December.
The more indirect effect of the government initiatives; is they may influence medical practice to the extent that the ordinary doctor changes their practice, with a consequential effect on the ordinary skill of a man practising that particular art.\textsuperscript{110} Nevertheless, as was noted earlier in this thesis, common practice is merely one aspect that the court considers, and is by no means determinative of the legal standard of care. If the courts were to follow government endorsed guidance, this would impact on the clinical autonomy of the individual physician. This would be beneficial when imagining the worst displays of such deference to individual clinical judgment,\textsuperscript{111} but more difficult instances could arise, where the clinician gives what they consider to be the best treatment, contrary to the government view. Whether such a departure would be viewed as negligent would seem to depend on whether or not ‘there is demonstrable justification’ for departure from the guidance. \textit{Bolam} has in the past shown itself to be capable of incorporating ‘ultra specialisms’,\textsuperscript{112} and although such flexibility has lead to negative comments it could be important in this context.

The assertion that standards could be raised does require faith in the integrity of the contents of the guidelines. As discussed earlier in this chapter, it is debatable, whether NICE’s views,\textsuperscript{113} will contain solely either state of the art medical knowledge, or gold standards for treatment. Thus the court’s willingness to review would become important. The court could consider such matters proactively, utilising risk/benefit analysis as the theoretical limits of \textit{Bolam} would allow. The alternative approach would be for the court to sit back and rubber stamp government standards.\textsuperscript{114} If they took the proactive path, there may be a danger particularly if NICE guidelines or NSFs were found to be wanting, possibly due to lack of resources, that difficult questions would arise.\textsuperscript{115} This does assume the judiciary are going to be galvanised into action. The possibility of continued deference could even be exacerbated by the

\textsuperscript{110} While at one stage in medical practice it was perfectly acceptable common practice not to use antiseptic no one could really assert that it was common practice now. This whole premise rests on the assumption that that NICE guidelines and NSFS would improve standards in clinical care.

\textsuperscript{111} Cases such as \textit{Whitehouse v Jordan} [1981] 1 All ER 267 immediately spring to mind.


\textsuperscript{113} And other government endorsed guidance.

\textsuperscript{114} Which it is contended by some is flawed out of budgetary concerns.

\textsuperscript{115} When the statutory powers of a public authority are in issue the initial question for the court is whether the alleged negligent act or omission is even justiciable. The fact that a public body has exercised a discretionary power conferred by statute does not necessarily preclude the courts from finding that there has been actionable negligence. A thorough examination of this issue can be found in John Murphy \textit{Street on Torts} (12th Edition Oxford University Press 2007) p 49-54.
government endorsed guidelines, for example, if they were viewed as having added value and *prima facie* being correct. The assertions of government backed ‘gold standards’\(^\text{116}\) could again bring *Bolam* into disrepute, as impotent other than to endorse existing practice. Notwithstanding, these reservations, it is contended, considerable progress would have been made, from the worst examples of cases appearing to be decided entirely on the reputation of the expert witnesses. Brazier and Miola\(^\text{117}\) contended, the establishment of this era of regulation showed how the medical profession in partnership with government, is moving to set transparent standards for an increasing range of treatments. Standards which could provide an ascertainable reference point independent of the vagaries of individual experts.\(^\text{118}\) The situation for the claimant would be preferable to that which has existed in the past, as an objective standard would be committed to writing and would be available for reference. However, the problem of bad\(^\text{119}\) guidelines cannot be ignored, particularly if they had a defensive capacity, as they may make it virtually impossible for even a deserving claimant to succeed. Although, it must be remembered as per *Bolam* and *Bolitho* the courts would be the final arbiters of the standard of care and they could refuse to be constrained by the guidelines, as nowhere in statute does it state that compliance with NICE guidelines constitutes a complete defence to allegations of clinical negligence.

*The Reaction of the Medical Profession*

Davies\(^\text{120}\) noted the 1999 reforms were greeted with a largely constructive response by the medical profession. However she\(^\text{121}\) contended that this does not mean they will not be subverted by the doctors they affect. She explained that empirical studies carried out at the time of the NHS reforms in 1990 suggested if the regulatory strategy chosen was not one of ‘negotiated

\(^\text{116}\) The term gold standard will be used as an expression indicating a standard endorsed by the government. Whether this will be accurate terminology in practice is a major question. However, the language of the government initiatives does tend to impute something equating to a gold standard e.g. We have the National Institute for Clinical Excellence, The consultation paper ‘A First Class Service’ and more recently Enabling Excellence.


\(^\text{118}\) Ibid.

\(^\text{119}\) The most extreme manifestation of this phenomenon should be prevented by the involvement of these government initiatives. However issues do remain with NICE guidelines and NSF’s.

\(^\text{120}\) Davies n12.

\(^\text{121}\) Ibid.
compliance’ problems may ensue. Therefore the involvement of the Royal Colleges in the creation of NICE guidelines is a good thing, as professionals will see the legitimacy of such guidelines.

According to McBarnett if a strategy of negotiated compliance is not pursued, an agency is likely to lose the co-operation of those it regulates; who may decide to ignore the standards, or cheat, or use ‘creative compliance’. Davies pointed out that following the 1990 reforms of the Patients Charter, some Accident and Emergency departments found the standard too difficult to achieve in local conditions. Dyke noted as hospitals found the charter standard of a patient being given a bed in under two hours difficult, they disregarded it altogether. Davies contended that this problem, of setting standards that do not fit with local circumstances, was likely to be exacerbated by the 1999 regime. She contended there was a real danger some national standards would be ignored because they did not chime with local conditions. Davies explained human ingenuity is such that however carefully the standards are drafted, and however closely they are monitored opportunities to cheat can never be eliminated completely. She referred to research carried out by McBarnett and Whelan of accountancy regulation which argued that detailed standards offer more opportunities for ‘creative interpretation’ and evasion. Davies further contended, not only might national standards be ignored, the very creation and production may be flawed or corrupted. She argued that as doctors are involved in the drafting of NSF’s, NICE guidelines and audits this presents the opportunity to ‘deflect standard setting onto issues which are peripheral to the practice being regulated’. She was sceptical that the lay

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122 Davies n12 contended that some elements of the 1999 reforms continue to ignore what she termed ‘negotiated compliance’.
123 This may be questionable if taking the same line as Davies, who asserts the possibility of the Royal Colleges subverting guideline formation.
125 Which he explained as interpreting the standard in a way that makes it easier to comply with: meeting the letter but not the spirit, of the standard.
127 Davies n12.
128 Ibid.
130 Davies n12.
131 Ibid.
132 Both through the involvement of professional associations and as individual experts.
133 Davies argued for example standards might be set about procedural aspects of providing care, to the neglect of substantive clinical judgements. It also provides doctors the opportunity to ensure that audit
involvement provided for by both NSF’s and NICE guidelines would guard against this ‘neutralisation’. She referred to empirical research that suggested lay people place heavy reliance on expert judgement, when it formed part of the material on which they must base their decision.\textsuperscript{135} This is pertinent when reconsidering the material discussed in chapter one of this thesis, which appeared to show an unusual deference to the medical profession. If the guidelines are ‘neutralized’, in the way Davies suggested, they might remain on the periphery of medical negligence litigation, as they will have been purposefully manipulated away from crucial issues; therefore making it unlikely that they would be either introduced by counsel or utilised by the judiciary when ascertaining the appropriate standard of care.\textsuperscript{136}

Smith\textsuperscript{137} demonstrated how data on performance can mislead. Berwick curious as to how the radiology department in his hospital\textsuperscript{138} had such spectacular results, approached the director of the department, when asked how she got such good results the reply was, “we make them up”. Also, it appeared according to an empirical survey\textsuperscript{139} that during a monitoring week,\textsuperscript{140} two-thirds of A&E departments in England put in place temporary measures to meet government targets. The idea that sub-optimal care would be reduced by the government initiatives alone might appear weakened in light of this, as might the notion of greater \textit{meaningful} regulation of clinical standards. This reinforces the contention, that it is essential to have a judiciary who are not unduly deferential so that prescriptive standards which cannot be subverted can be applied.\textsuperscript{141}

\textsuperscript{134} Davies n12.
\textsuperscript{135} For empirical evidence on the power of professionals over lay tribunal members in the mental health context, she referred to J.Peay, \textit{Tribunals on Trial: A Study of Decision Making Power under the Mental Health Act 1983} (1989).
\textsuperscript{136} Moreover, we might travel full circle, from the days were it could be said that all the defendant had to do to avoid liability in negligence was to produce one witness, never censured by the GMC in order to avoid liability, to the situation where all the defendant doctor has to do, is comply with flawed guidelines, particularly where those guidelines have been produced by bodies created by the government. However, it must be remembered that the courts remain the ultimate arbiters of the standard of care in clinical negligence.
\textsuperscript{138} Don Berwick extracted from Smith n137.
\textsuperscript{139} Susan Mayor ‘Hospitals take short term measures to meet targets’ (2003) 326 British Medical Journal 1054.
\textsuperscript{140} A&E departments were given warning of the Department of Health monitoring exercise to monitor waiting times, which took place in the week commencing 24 March 2003.
\textsuperscript{141} The standard of care might still be raised by the consideration of such missives, assuming the issues they cover have not been deflected too much. Particularly if research shows that such standards are being meet as this will impact on common practice. Also as CQC will carry out a number of random,
THE NHS REGULATORS

The new breed of NHS regulators discussed in this section, with particular emphasis on the Care Quality Commission, provide central control or supervision of clinical behaviour which utilises prescriptive benchmarking of standards, involving what Newdick might call a ‘holding on’. The Council for Healthcare Regulatory Excellence reiterated an awareness that complete self regulation by professional groups could become dangerously flawed, a manifestation of the ‘holding on’ ethos. The theoretical interrelationship of these bodies with a ‘brave new Bolam’ is; both strands of development are potentially prescriptive and not merely descriptive influences on medical professional practice. The second and more practical way, in which these new regulators might impact on Bolam is through the data which they collect being utilised by claimants in litigation. The third correlation is the move towards recognising systems failures via institutional responsibility. The final point of interaction might be rather different, in as much as it might be the fitness for purpose, (or lack of) these NHS regulators which could bolster the argument that an assertive judiciary is required to ensure that justice is done in these areas.

The Care Quality Commission

The various incarnations of this organisation serve as an exemplar of the dynamic changes which have been taking place in this area. The organisation

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142 Benchmarking is also an important theme underlying the NPSA.
143 Newdick n5.
144 With the ‘holding on’ approach equating to policy makers prescribing independent prescriptive standards with the ‘letting go’ approach adopting standards already utilised by the profession itself so more descriptive in nature.
145 Providing a brake on unfettered clinical discretion.
146 I am grateful to Professor Brazier for providing the following suggestions of the use of a CQC report about an institution, (particularly a negative one). It could be introduced in evidence in a subsequent action for the neglect of an elderly relative, via the tort of negligence. Alternatively it could mean that more cases are settled without protracted litigation.
147 This area of institutional responsibility will be examined in depth in the following two chapters of this thesis. It is argued that tort law via a ‘brave new Bolam’ must adapt to ensure this.
148 There have been many suggestions in the press that the CQC might not be up to the job of assertive prescriptive regulation of medical care, if this is the case, it is important that tort law and a ‘brave new Bolam’ be adopted to ensure effective accountability of the area is maintained.
149 The basic ideology behind the various organisations appears to be and have been responsibility for quality in the NHS via independent investigations into actual healthcare provision.
was formerly known as, The Commission for Health Improvement. Section 41 of the Health and Social Care (Community and Health Standards) Act 2003 provided that the Commission for Health Improvement would be abolished, and replaced by a new regulatory body, the Commission for Healthcare Audit and Inspection (CHAI), popularly known as the Healthcare Commission. The Healthcare Commission ceased to exist on the 31st March 2009. The Health and Social Care Act 2008 provided the Care Quality Commission is now the new health and social care regulator.

The Healthcare Commission conducted reviews and inspections, the reviews and investigations were carried out in order to ensure NHS bodies complied with their duty to continually monitor the quality of healthcare they provide. Commenting on the practical impact of the prospect of a CHI investigation Davies contended that it was likely to act as a spur to action with trusts wishing to avoid the stigma of a poor assessment outcome. In place of the annual reviews conducted by CHAI, the CQC will carry out periodic reviews under section 46 of Primary Care Trusts, NHS providers in England and local authorities in England. The Health and Social Care Act 2008

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150 As per section 19 & 20 of the Health Act 1999. The Health Act 1999 stipulated that the functions of CHI were numerous, with the aim of producing benchmarks. Any attempt at benchmarking standards might have implications for the way in which the standard of care in clinical negligence claims is judged.

151 Received its first reading on the 12th of March 2003, came into force 1/4/04.

152 CHAI- The Commission for Healthcare Audit and Inspection was its statutory name but it preferred to be known as The Healthcare Commission. The efficiency of this body as an independent regulator which could increase standards of care achieved might have been called into question. See for example the Mid Staffordshire NHS Foundation Trust Inquiry Chaired By Robert Francis QC. Mr Lansley announced the Public Inquiry on the 9th June 2010 into the role of commissioning, supervisory and regulatory bodies in the monitoring of the particular trust see http://www.midstaffspublicinquiry.com/.

153 From the 1st October 2010 CQC will register, and license services if they meet essential standards and monitor them to make sure they continue to do so.

154 Newdick n26 p 221 and 2003 Act s 45.

155 Davies n12.

156 She likens this to schools eagerness to avoid being labelled failing by the Office for Standards in Education.

157 Health and Social Care Act 2008 under Section 57(1) Health and Social Care Act 2008 the Care Quality Commission may also review— (a) studies and research undertaken by others, or the quality of data obtained by others, in relation to the provision of NHS care or adult social services or the carrying on of regulated activities,(b) the methods used in undertaking such studies and research or in collecting and analysing such data, and (c) the validity of conclusions drawn from such studies and research or from such data.(2) The Commission must conduct a review under subsection (1) if the Secretary of State so requests.

158 CQC will carry out certain routine and also extraordinary inspections. Earlier this year CQC publicly reprimanded a trust (Plymouth hospital NHS Trust) ahead of the official report. CQC threatened prosecution if they failed to tighten implementation of their surgical checklist. Jeremy Laurence ‘NHS watchdog orders crackdown on basic safety checks by surgeons: Trust faces prosecution after series of preventable errors in operating theatres, including surgery on the wrong body part and swabs being left inside patient’ The Independent on Sunday (London February 27 2011). Another example of CQC in action can be found in Chris Smyth ‘Warning for maternity unit where five mothers died’ The Times (London April 28 2011) where Croydon University Hospital was condemned by inspectors from the Care Quality Commission, who said that its maternity unit was short on midwives and equipment, while
allows the Secretary of State to issue statements of standards for the provision of care in the National Health Service. PCTs will be required to have regard to these standards, in discharging their duty under the new section 23A of the NHS Act 2006 (see section 139) to secure continuous improvement in the quality of health care provided or commissioned by them.  

Further changes introduced by the coalition government are currently before Parliament in the form of the Health and Social Care Bill 2011 Mr Lansley announced a review of what he termed ‘arm’s length bodies’. CQC will be retained as quality inspectorate across health and social care, operating a joint licensing regime with Monitor, NICE will be retained, and put on a firmer statutory footing by establishing it in primary legislation its scope will be expanded to include social care standards.

The National Patient Safety Agency

The NPSA was created after An Organisation with a Memory observed how much can be learned from the trends and patterns in which adverse events occur. The idea was that local systems of reporting would ultimately lead to a national database which would reveal previously unrecognised risks and allow principles of best practice to be identified and disseminated. The NPSA expects that like the practice of air safety reporting as risks are better managed; the number of accidents will fall. There are three divisions of the NPSA; the National Reporting and Learning Service who manage national safety warning that women giving birth "may not receive treatment from competent staff" as training was not up to date. A report into the first three deaths at the hospital found that one was avoidable and all involved poor care.

As made explicit by the Health and Social Care Act 2008 (Explanatory Notes).

Press Release 26th June 2010. Hereafter ALB as shorthand for arms length bodies. In line with the wider reforms set out in the White Paper, Equity and Excellence: Liberating the NHS.

Although given the controversy of the Health and Social Care Bill 2011 it is impossible at this time to know for certain what will eventually happen. An overhaul in the way hospitals are inspected was demanded, as a report from the Dr Foster organisation revealed that nine trusts rated excellent or good by the official health regulator CQC were failing when it came to patient safety from Terri Judd ‘Demand for overhaul in wake of hospital report’ The Independent (London November 30 2009).

Created by the National Patient Safety Agency (Establishment and Constitution) Order 2001(SI 2001 No 1743). Further information can be found on their website www.npsa.nhs.uk.

Building a Safer NHS for Patients- Implementing An Organisation with a Memory (Department of Health 2001) 10.

Newdick n26 p222.

Newdick n26 p 223 where he cited as an example, how the NPSA issued a “patient safety alert” on administering vincristine the dangers of which were well understood but which continued to be misused and kill patients. It is possible the courts could require an explanation as to why, if patient safety alerts were ignored.
the National Clinical Assessment Service\textsuperscript{167} previously the National Clinical Assessment Authority,\textsuperscript{168} the third division of NPSA is the national research ethics service. Practitioners are required to co-operate with an assessment when required to by the PCT.\textsuperscript{169} It is proposed that NPSA will be abolished as an ALB. Its safety functions are to be retained and transferred to the National Commissioning Board. The National Research and Ethics Service functions are to be transferred to a single research regulator. The National Clinical Assessment Service is to become self-funding over the next two to three years. It is unclear exactly what impact this repackaging of functions might have, although as it is the institutions rather than their functions which are going much of the commentary on the exercise of the current bodies’ functions would appear to remain pertinent.\textsuperscript{170}

\textit{Council for Healthcare Regulatory Excellence}\textsuperscript{171}

Following the Bristol Inquiry there was a concern that the interests of the professionals, were sometimes put before the public interest, by the professionals’ own regulatory bodies, for example the GMC.\textsuperscript{172} The CHRE was created to regulate those professional bodies and to formulate principles of

\begin{itemize}
\item \textsuperscript{166} www.nrls.npsa.nhs.uk/ Again this provides a form of benchmarking and a potential source of data which \textit{Bolam} could utilise.
\item \textsuperscript{167} www.ncas.npsa.nhs.uk/ An example of an interventionist strategy towards professional self regulation which could be matched through an assertive use of \textit{Bolam}.
\item \textsuperscript{168} NCAS, previously the National Clinical Assessment Authority (NCAA), was established as a special health authority in April 2001, following recommendations made in the Chief Medical Officer for England’s report, Supporting Doctors, Protecting Patients (November 1999), and Assuring the Quality of Medical Practice: Implementing Supporting Doctors, Protecting Patients (January 2001). In April 2005, the National Clinical Assessment Authority became the National Clinical Assessment Service, an operating division of the National Patient Safety Agency (NPSA) historic review as can be found at http://www.ncas.npsa.nhs.uk.
\item \textsuperscript{169} National Health Service (General Medical Services Contracts) Regulations 2004 (SI 2004 No. 291), Schedule 6, para 68 (1)(b).
\item \textsuperscript{170} THE NPSA also impacts, as in addition to the issue of “patient safety alerts” above, it is another example of external governance acting upon medical practice and this is one way in which it might contribute to a ‘brave new \textit{Bolam}’. Moreover, in likening its data collection to air safety, it might signify a move towards treating clinical practice more in line with other forms of professional conduct and risk management and less as a special category.
\item \textsuperscript{171} The Health and Social Care Bill 2011 proposes to rename the council, the Professional Standards Authority for Health and Social Care. Harry Clayton, Chief Executive of CHRE stated on the 16\textsuperscript{th} May 2011 “We do not now expect the proposed Professional Standards Authority for Health and Social Care to come into being until at least July 2012” extracted from http://www.chre.org.uk/media/18/398/. The closure of the Office of the Health Professionals Adjudicator programme, was announced on 2\textsuperscript{nd} December 2010 and the proposals for them to take over the disciplinary role of the GMC were dropped.
\item \textsuperscript{172} Newdick n26 p226.
\end{itemize}
good professional self regulation.\textsuperscript{173} Each of the professional regulatory bodies must co-operate with the CHRE, which has the power to give directions that require that the body introduce new rules to amend its procedures.\textsuperscript{174} The CHRE can also refer to the High Court any adjudication by a professional body which it considers unduly lenient,\textsuperscript{175} whether as to the finding, or any penalty imposed or both. The High Court will hear the matter as though it were an appeal against the regulatory body by the CHRE.\textsuperscript{176} Newdick explained, how the creation of this new regulatory body reflected the extent to which self-regulation alone is no longer considered a sufficient mechanism for regulating the health care professions.\textsuperscript{177} This might be significant, for clinical negligence, as highlighting a more interventionist approach when considering the regulation of the health care professions. However, as Newdick contended that some of the early decisions of the courts suggest that the traditional deference to professional disciplinary tribunals will not be wholly changed.\textsuperscript{178}

Furthermore it was announced:\textsuperscript{179}

> the Coalition Agreement signalled an end to the assumption that national statutory action should be the first resort in dealing with risks arising from professional activities or concerns that happen locally. It is not necessarily the case that the state should automatically take responsibility for managing risks which arise from the activities of healthcare workers… or assume that national legislation is the most effective vehicle for doing so. The health and social care systems in the United Kingdom therefore need a new approach to risk that is more effective and more responsive to local and individual needs.\textsuperscript{180}

These latest moves might point towards a return to the older approach with less prescriptive external regulation.

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\textsuperscript{173} Originally established as the Council for the Regulation of Health Care Professionals but renamed by National Health Service Reform and Health Care Professions Act 2002, s 25 and the Health and Social Care Act 2008 s 113.

\textsuperscript{174} Ibid s 27.

\textsuperscript{175} The court must consider the sanction unduly lenient, lenient is not sufficient.

\textsuperscript{176} Ibid s. 29.

\textsuperscript{177} Newdick n26 p229.

\textsuperscript{178} Ibid p 229.

\textsuperscript{179} Para 1.8 Enabling Excellence Autonomy and Accountability for Healthcare workers, Social workers and Social care Workers Cm 8008, February 2011.

\textsuperscript{180} Justified at para 3.1 of Enabling Excellence by the decline in the percentage of fitness to practice decisions which required referral to the High Court for undue leniency. Acknowledged at para 1.4 ibid “while the current system is working reasonably well, and while regulation sometimes is the only way to mitigate against risk, there are nonetheless significant costs associated with statutory professional regulation.”
Conclusion

The healthcare system is currently facing yet another statutory reformulation in the form of the Health and Social Care Bill 2011. The continued commitment to CQC and NICE appears clear, although their exact function and the future of other ALBs is more uncertain. However, certain of the Coalition’s statements, not least the very title of its White Paper *Enabling Excellence Autonomy and Accountability for Healthcare workers*,\(^\text{181}\) might suggest a move back towards a period of ‘letting go’, a retrenchment of national prescriptive control, to some extent at least, with policy makers content to return to reliance on the professions own views of how quality should be assessed. If this is the case, it is imperative that the reminder provided by *Bolitho*, that the judiciary are the ultimate arbiters of the standard of care is not unheeded. Particularly as the last time when healthcare regulation went through such a phase the courts were similarly passive and deferential. It becomes all the more important that the courts do assert their authority as the ultimate arbiters of the standard of care, if we are not to see a return to increased, unchecked autonomy of clinicians.

The significance of the governmental lead developments which have been examined in this chapter is primarily that they are determined externally and are *prima facie* prescriptive. Prior to these developments heralded by the Health Act 1999 government regulation of the medical profession was descriptive, assessing standards by the benchmarks determined by the medical professionals themselves. This relates to *Bolam/Bolitho* in two ways. As Brazier and Miola\(^\text{182}\) suggested it might provide a synergy of relevance, a two fold increase in the prescriptive regulation of the medical profession, by both the general mood and the availability of sources which could be utilised in determining the question of reasonable care in the circumstances of the case. Although questions remain about both the basis of the government backed guidelines and the efficiency of clinical governance\(^\text{183}\) in addition to the possible chilling effect on judicial assertiveness which their government endorsement could have, it is contended the developments are progressive. They provide an external reference point independent of individual expert witnesses, this teamed

\(^{181}\) *Enabling Excellence Autonomy and Accountability for Healthcare workers, Social workers and Social care Workers* Cm 8008, February 2011.

\(^{182}\) Brazier and Miola note 117.

\(^{183}\) Concerns about the efficiency of clinical governance as discussed on page 129 of this thesis.
with the possible utilization of CQC data by claimants and courts could help to make Bolam brave.

There are indications that government policy might be changing which could cause concern if the courts followed this and became similarly content to return to merely endorsing common medical practice as legally acceptable. Such a change would compound the concerns about both how exacting such standards are, and the impact of governmental approval on the courts willingness to meaningfully assess standards rather than merely rubber stamping them.

Bolitho will not prevent another era of the determination of the standard of care going awry; over relevance on its terminology could even make it more likely to occur than an’ alternative’ view of Bolam would do.\textsuperscript{184} There is no certainty that the judiciary will be content to return to such a state of affairs and there is independent research evidence suggesting that meaningful external regulation need not lead to the feared detrimental consequences.\textsuperscript{185}

\textsuperscript{184} An alternative view as described on pages 58-59 of this thesis.

\textsuperscript{185} See the experience referred to at note 35 of this chapter. That the judiciary have or do still fear the existence of defensive medicine is discussed in chapter two of this thesis. The uncertainty of tense used is deliberate as there is much uncertainty over the phenomenon without empirical proof as discussed in chapter 2 of this thesis.
CHAPTER SIX

The Impact of NHS Reforms and Bolam; ‘From Individual to Institutional Liability’?

Introduction

The first three chapters of this thesis focused on the classic negligence liability of the individual clinician. The immediately previous two chapters, focused on changes which have occurred within the medical profession’s own practices, and the governmental attitudes towards the regulation of clinical practice including clinical governance. This last move, in particular, has led to awareness that not all instances of clinical negligence can be neatly attributed to an individual, that failures of institutions1 are as likely to cause harm. This chapter2 will argue that if the main focus of clinical negligence litigation should shift to institutional liability, from the classic focus of the negligence of the individual practitioner, then the question of liability could move from the vicarious duty of NHS bodies to their primary duty of care to their patients.3 Such duties whether labelled primary, direct or as some would prefer non-delegable duties are not without their difficulties.4 Both the best terminology and the boundaries of such duties have perplexed the courts.5 The NHS is changing

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1 Institutions to include both commissioners and providers of healthcare. That such a change could occur for reasons discussed in earlier chapters of this thesis at a time when less of our healthcare will be provided by employees for whom the various NHS bodies would be vicariously liable could create a synergy of relevance.
2 A large part of this chapter draws on previously published work, a jointly authored work with Professor Margot Brazier, M Brazier and J Beswick, ‘Who’s Caring for Me?’ (2006) 7 Medical Law International 183.
3 This species of responsibility being the direct duty of the institution as opposed to the secondary or vicarious one. In addressing institutional liability this chapter will be examining a number of different potential duties (in terms of their extent) of different NHS providers. The different providers of NHS care grow increasingly complex, the consistent actor at present appears to be the Commissioner.
4 Andrew Grubb Principles of Medical Law (2nd edition Oxford University Press 2003) p460 where he contended that to suggest that a hospital within the NHS owed a ‘non- delegable’ duty to ensure that reasonable care was taken of its patients was controversial. Also see Michael Jones with Muiris Lyons Medical Negligence (4th edition Sweet and Maxwell 2008) where they state p 605 “The circumstances in which a non-delegable duty will be imposed are relatively fixed, but there is no guiding principle which determines precisely how and when such a duty arises.” The term non delegable duty is not adopted to describe; the primary direct duty of institutions, the idea that in appropriate circumstances the institution should owe a duty to ensure that care is taken. Such a term is considered misleading as is imagined that an institutions duty might be properly altered over time in appropriate circumstances.
in both substance and form, new facets of the institution are functioning and their significance is only just being questioned. Currently the Primary Care Trust is fundamental to the institutional structure of the NHS. It is through PCTs that NHS patients obtain access to both primary and secondary care. It is through the PCT that patients gain access to a general practitioner and provision is made for primary care out of hours. Secondary care is commissioned by the PCT with local NHS hospital trust being just one of the possible providers. PCTs can also choose to devolve some of their responsibilities. Commissioners might be the one constant in a system that promotes wider diversity of providers in both primary and secondary care it is at least the hope of Brazier and Beswick that this will prove to be the case. The Health and Social Care Bill 2011 already indicates the end of PCTs in name if not in substance. The Bill originally signalled a transfer of power to GP consortia by 2013. After the Bill's 'pause' it appears the Government will take heed of the NHS future forum's recommendations that clinical senates be set up to oversee consortia. The National Commissioning Board will expand if there are a number of consortia not ready by 2013 until Consortia are "able and willing" to take over. At the time of writing it is impossible to be sure of the exact shape of the future NHS, although it appears there will be bodies; either a National Commissioning board, individual consortia or clinical senates which will act as gatekeepers to care (both primary and secondary) which is free at the point of delivery. At present it appears likely that the diversity of providers will only increase from the position outlined in this chapter. This chapter will aim to argue that as a matter of principle commissioners and/or providers of NHS care should owe a direct duty of care to patients for the treatment they arrange/commission/facilitate/provide. The excess of verbs used is intentional, to highlight the firm belief that legal responsibility for NHS treatment should not hinge on fine semantic distinctions. It will be asserted that the extent of the direct duty placed upon the provider or commissioner should be a duty to ensure reasonable care is provided to the patient. Given that a patient might unknowingly move from one of the longer established providers to the new

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6 As professionals from all disciplines are still familiarising themselves with the current scheme further changes to the healthcare system are proposed. Within the current system the Primary Care Trust is the pivotal actor. The principal legislation in respect of the NHS in England is currently the National Health Service Act 2006 section 18 of which confirmed that Primary Care Trusts were to continue in existence although the Primary Care Trusts (Establishment and Dissolution)(England) Order SI 2006/2072 meant the names and boundaries of PCTs changed Halsbury's Laws of England .  
7 Brazier and Beswick n 2.
breed of private providers without ever knowing, if we do not want situations where patients are left with little satisfactory accountability and redress we shall see why the argument for a convincing direct duty of care to be placed on providers and commissioners is compelling, for both practical and ideological purposes. Given the lack of cases which have arisen around this type of scenario such concern might be viewed as theoretical, but it is believed that the number of such cases will rise due to NHS reforms. The primary duty of longer established NHS institutions will be examined first, as direct duties appear to have already been placed on certain NHS institutions by the courts and this might help to allay many objections to the notion of direct duties on Commissioners, as the road to acceptance of direct duties has not always been an easy one in modern litigation at least.

**Origins of Institutional Duty in hospitals**

Historically hospitals did not owe a secondary duty, namely vicarious responsibility, for the clinical performance of their medical staff. A century ago, patients injured by medical negligence might have found that their only remedy lay against the doctor identifiable as the causal agent of their injury. In *Hillyer v St Bartholomews Hospital* the Court of Appeal endorsed the doctrine that a hospital's duty was limited to selecting competent staff and ensuring adequate facilities. A hospital's vicarious responsibility was limited to liability for medical professionals' ministerial or administrative duties and not for any negligent exercise of clinical professional practice, as doctors were considered too skilled to be subject to the usual norms of vicarious responsibility. This decision was based on the no longer tenable view that a person could not be an employee (for whom the institution would be vicariously liable) unless the institution had control over the performance of an individual's duties with doctors clinical decisions and practice not seen as subject to control. However it was

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8 It will be argued that the decision considered shortly *M v Calderdale & Kirklees Health Authority* [1998] Lloyd's Rep Med 157 was correct in basic principle and its end result and that the Court of Appeal's criticism of it in *Child A, Child A v Ministry of Defence* [2004] EWCA Civ 641 was misplaced. It is a source of concern that if the factual scenario were to be repeated again Miss M could be left with no effective redress, that NHS treatment would not be accompanied by NHS accountability.

9 Chapter 7 will examine how the standard of care of this institutional duty would be set particularly the operation of *Bolam* in this context.

10 This departure from ordinary principles originated in *Evans v Liverpool Corporation* [1906] 1 KB 160. *Evans v Liverpool Corporation* [1906] 1 KB 160 and see Brazier and Beswick n 2 p184.

12 [1909] 2 KB 820.
recognised that there were two types of duty by which an institution might be accountable.\textsuperscript{13} The development of the case law discussed in this section illustrates how ideas of both control and responsibility can change over time in response to changing social conditions.\textsuperscript{14}

The \textit{Hillyer} doctrine survived until \textit{Gold v Essex County Council}\textsuperscript{15} where the specific issue was whether a local authority were liable for the negligent acts or omissions of a professional radiographer employed in a hospital. The Court of Appeal held that it was, reversing the earlier decision of \textit{Hillyer}.\textsuperscript{16} Lord Greene, MR described the approach that should be adopted by the court as follows:

\begin{quote}
Apart from any express term governing the relationship of the parties, the extent of the obligation which one person assumes towards another is to be inferred from the circumstances of the case. …in each case the first task is to discover the extent of the obligation assumed by the person whom it is sought to make liable. Once this is discovered … the person accused of a breach of the obligation cannot escape liability because he has employed another person, whether a servant or agent, to discharge it on his behalf, and this is equally true whether or not the obligation involves the use of skill.\textsuperscript{17}
\end{quote}

He reasoned:

\begin{quote}
It is clear, therefore, that the powers of the defendants include the power of treating patients… If they exercise that power, the obligation which they undertake is an obligation to
\end{quote}

\textsuperscript{13} It was first suggested that a hospital might owe a primary direct duty where the patient is admitted to hospital in \textit{Gold v Essex County Council} [1942] 2 All ER 237 per Lord Greene MR at 240, \textit{Jones v Manchester Corporation} [1952] QB 852,867 per Denning LJ and \textit{Cassidy v Minister of Health} [1951] 2 KB 343 per Denning LJ 360 or where he presents himself at the open casualty department seeking medical attention \textit{Barnett v Chelsea and Kensington HMC} [1969] 1 QB 428[1968] 1 All ER 1068 As Nathan, \textit{Medical Negligence} ( First edition Butterworths 1957) p12 recognised “the obligations which are thus imposed upon a hospital or other institution are direct or personal obligations for a breach of which the institution is personally liable.” This illustrates that the notion of requiring institutional primary responsibility is not new. Post \textit{Hillyer} where neither surgeons nor anaesthetists were servants of the defendant hospital so as to make the latter vicariously responsible for their negligence, this was all that was left; although nurses were said to be servants of the hospital for general purposes.

\textsuperscript{14} The National Health Service Act 1946 came into effect on the 5\textsuperscript{th} July 1948. Before this and subject to notable exceptions (charity hospitals and local authorities who took over poor law hospitals under the Local Government Act 1929) patients were generally required to pay for their care. It is beyond the scope of this work to provide an in-depth review of the history of the health service in England. It is discussed here, as it is contended that the changing role of hospitals and relationship between doctors and patients influenced the courts development of the law. The changes which took place in the first half of the twentieth century regarding the legal duty of hospitals referred to in footnotes 9-20 of this chapter mirrored those changes taking effect in the system for the provision of healthcare.

\textsuperscript{15} [1942] 2 KB 293 [1942] 2 All ER 237.

\textsuperscript{16} \textit{Hillyer v St Bartholomews Hospital} [1909] 2 KB 820.

\textsuperscript{17} \textit{Gold v Essex County Council} [1942] 2 KB 293 at 301.
treat, and they are liable if the persons employed by them to perform the obligation on their behalf act without due care.\(^\text{18}\)

Crucially he concluded:

> I am unable to see how a body invested with such a power and to all appearance exercising it, can be said to be assuming no greater obligation than to provide a skilled person and proper appliances.\(^\text{19}\)

In *Cassidy v Ministry of Health*\(^\text{20}\) the plaintiff, was suffering from a contraction of the third and fourth fingers of his left hand, diagnosed as Dupuytren's contraction. The doctor sent the plaintiff to Walton Hospital, Liverpool, where he was seen by a Dr. Fahrni, who was a whole-time assistant medical officer of the hospital. He confirmed the diagnosis and recommended an operation, which he personally performed on April 8, 1948. Following surgery the patient's hand and lower arm had to be kept rigid in a splint for eight to fourteen days. While the plaintiff was undergoing this treatment he was under the care of Dr. Fahrni, Dr. Ronaldson, and the hospital's nursing staff. After fourteen days the plaintiff's hand was released from the splint, when it was found that both fingers which had been operated on were bent and stiff and the trouble had affected the two good fingers. After two unsuccessful manipulative operations attempts to remedy the condition were abandoned. The plaintiff alleged that he had been negligently treated after the operation. The Ministry\(^\text{21}\) denied Dr. Fahrni or any

\(^{18}\) Per Lord Greene in *Gold v Essex County Council* [1942] 2 KB 293 at p 304 rejected the *Hillyer* doctrine. As Nathan in 13 p 127 explained unfortunately the court of Appeal did not make clear the principles which they thought should be substituted for *Hillyer*, he went on “all members of the court evidently felt that there was no justification for drawing any distinction between the vicarious liability of a hospital and any other corporate entity.” He suggested that Goddard LJ expressed the ‘conventional’ view that this rested on the hospital being vicariously responsible for the acts of a person whom it employed under a contract of service but not for the acts of an independent contractor employed under a contract of services. Mackinnon LJ appeared to have approached the case on the same basis. Nathan, ibid, then went on to examine Greene MR’s approach “which was entirely different”. He said the primary task was to discover the extent of the obligation undertaken by the hospital towards its patients; such an approach would make it unnecessary to inquire as to whether the relationship of master and servant existed. Nathan, ibid, submitted that Lord Greene’s approach to hospital liability was the proper one for just as the assumption of responsibility by a doctor for the care of the patient imposes upon the doctor a personal or primary duty of care, so by receiving a patient for treatment a hospital undertakes a personal or primary duty of care towards the patient.

\(^{19}\) At p 304 rejecting the idea that responsibility was limited to ‘no greater obligation than to provide a skilled person or proper appliances’. The last sentence of his Lordships observation would appear to be particularly pertinent when considering the extent of liability of a Commissioner for treatment it elects to remove from the NHS.

\(^{20}\) *Cassidy v Ministry of Health* [1951] 2 KB 343.

\(^{21}\) The action had originally been brought against the Liverpool Corporation as owning and controlling the hospital, but later by virtue of s. 6 of the National Health Service Act, 1946, the Ministry of Health were substituted as defendants.
of the staff were guilty of negligence and denied that they were responsible for any negligence on the part of Dr. Fahrni, but brought him in as third party. The third party denied negligence. At first instance, Streatfeild J gave judgment for the defendants on the ground that the plaintiff had failed to prove negligence on the part of any of the hospital staff. He gave no decision on the question whether Dr. Fahrni was a servant of the Ministry, or whether, if he were, the Ministry would be liable for his negligence. The plaintiff appealed.

The appeal was unanimously allowed. The case is often summarised as Denning LJ applying a ‘non delegable duty’ with the other judges resting the defendants’ liability on vicarious liability. Although Somervell LJ stressed that the principle respondeat superior is not ousted by the fact that a "servant" has to do work of a skilful or technical character, for which the servant has special qualifications and held on the facts that both Dr. Fahrni and Dr. Ronaldson had contracts of service. They were employed, like the nurses as part of the permanent staff of the hospital. He went on to approve Lord Greene’s assertion in Gold, when considering what a patient is entitled to expect when he knocks at the door of the hospital "that he is entitled to expect nursing, and therefore the hospital is liable if a nurse is negligent."

He asserted in his view the same must apply in the case of the permanent medical staff:

> It seems to me that the patient is as much entitled to expect medical treatment as nursing from those who are the servants of the hospital.

Singleton LJ distinguished the case from Hillyer he held Dr. Fahrni was a full-time employee of Liverpool Corporation. He had no doubt the corporation could not interfere with him in the operating theatre even if they had wished to do so, but recognised that ultimately everything was under the control of the hospital authority and therefore responsibility lay with them. He further recognised that harm might be due to a failure in the system for providing care:

> It is not possible for the plaintiff to say that the negligence

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22 Andrew Grubb n4 page 461.
was the negligence of any particular individual: it may be that a number of people were at fault, or that lack of system was the cause. Everything was under the control of the hospital authorities, and those immediately concerned were in the employ of the corporation. Responsibility lies upon the defendants.

Crucially Denning LJ recognised the pivotal role played by the institution:

... whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves: they have no ears to listen through the stethoscope, and no hands to hold the surgeon’s knife.23

He went on:

He had no say in their selection at all. If those surgeons and nurses did not treat him with proper care and skill, then the hospital authorities must answer for it, for it means that they did not perform their duty to him.24

**Primary direct duty of Hospital Trusts confirmed**

As Jones contended25 Lord Denning’s approach appeared to be confirmed in *X (minors) v Bedfordshire County Council*26 where Lord Browne-Wilkinson stated:

It is established that those conducting a hospital are under a direct duty of care to those admitted as patients to the hospital (I express no view on the extent of that duty).27

This tantalising statement raised as many questions as it answered. It might be asserted that it clearly raised the possibility of a direct duty.28 Despite Lord Browne-Wilkinson’s *prima facie* clear words, he himself was cautious to clarify the extent of the duty. It might be contended; that it is only the duty to ensure

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23 [1951] 2 KB 343 at 360 Denning LJ identified responsibility as falling on the institution, where on the most literal interpretation it might have been contended that the hospital authority did not actually provide the care directly. He clearly identified the impossibility of the institution doing so in this literal sense and instead advanced a more realistic portrayal of providing healthcare. It is argued this approach could be extended to reflect the more complex healthcare provision of the twenty-first century.

24 [1951] 2 KB 343 at 365 per Denning LJ.

25 Jones with Lyons n4 p793.

26 *X v Bedfordshire County Council* [1995] 2 AC 633.

27 Ibid.

28 It is noted that the specific scenario in *X* was where a patient was admitted to hospital for treatment.
that care is taken which provides a comprehensive direct duty of care, in the sense that if a patient suffers any negligent harm in (virtually) any circumstances that the institution will be accountable to answer for that harm.

One of the reasons, why direct institutional responsibility is important, even when care is provided directly by a NHS hospital trust, is illustrated in *Robertson v Nottingham Health Authority*. The alleged failure concerned a breakdown in communications between the medical and nursing staff during the confinement of the pregnant patient, the alleged result of which was that the plaintiff was born with severe disabilities. The Court of Appeal confirmed that a hospital:

> Has a non-delegable duty of care to establish a proper system of care just as much as it has a duty to engage competent staff and a duty to provide proper and safe equipment…if a patient is injured by reason of negligent breakdown in the systems for communicating material information to the clinicians responsible for her care, *she is not to be denied redress merely because no identifiable person or persons are to blame for the deficiencies in setting up and monitoring the effectiveness of the relevant communications systems.*

Brooke LJ sought to distinguish the boundaries between the vicarious liability of the hospital for the negligence of its employees and its primary direct liability for institutional failings:

> If effective systems had been in place at this hospital for ensuring that so far as is reasonably practicable communications breakdowns did not occur in connection with such a significant area of a patient’s treatment then the health authority would be vicariously liable for any negligence of those of its servants or agents who did not take proper care to ensure, so far as is reasonably practicable, that the communications systems worked efficiently. If, on the other hand, no effective systems were in place at all…then the authority would be directly liable in negligence for this lacuna.

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30 Grubb n4 p 435.
31 The fact the institution was a hospital was key to this decision.
32 Ibid my emphasis.
33 As Christopher Newdick *Who Should We Treat? Rights, Rationing and Resources in the NHS* (Second edition Oxford University Press 2005) p 175 noted that on the facts of the case liability was denied
According to Grubb, the judgment of Brooke LJ seemingly illustrated that an organisational duty is at the heart of an institution’s direct liability to the patient. The judgment of Brooke LJ was predicated on the assumption that where an improper communications breakdown, a breach of duty, had caused actionable harm to a patient who was owed a duty, the hospital would be liable either primarily or vicariously. In this instance whether the duty was judged to be a vicarious or primary one in essence made little practical difference to the claimant, the damages were to be paid from the same ‘person’. However with the diverse new ways of providing services, including NHS services, less people will be employed staff, classic vicarious liability will be of less relevance. Commissioner and actual operators might each blame the other and the loser will be the claimant who faces a stalemate situation between the two potential defendants each blaming the other. The judgment of Brooke LJ shows that clinical negligence can evolve to solve problems, for example, if a patient is injured by reason of negligent breakdown in the systems for communicating material information to the clinicians responsible for her care, she is not to be denied redress merely because no identifiable person or persons are to blame for the deficiencies in setting up and monitoring the effectiveness of the relevant communications systems. The imposition of a wider organisational duty where all care is no longer predominately provided by employees need only be viewed as another instance of this flexibility of the common law.

Another example of why direct institutional liability is important can be found in Bull v Devon Health Authority where the defendants operated a ‘split site’ hospital. The plaintiff was in one of its hospitals expecting twins. The first twin was born without complication, but the second twin could not be delivered without expert assistance. The obstetrician responsible was on duty at the other hospital site and was unable to deliver the second child for over an hour, by which time the twin had suffered asphyxia and brain damage. The defendant explained the delay by saying the hospital operated over two sites and that there would inevitably be times when senior staff were required in both places at once. They went on to explain that such a system was “par for the course” by

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because it could not be shown that the negligence caused the baby’s damage, which would probably have occurred in any event.

34 Grubb n4 p458.

35 Bull v Devon Area Health Authority (1989) 4 Med LR 117.

36 Newdick n 33 p174.
comparison with other NHS hospitals and therefore it had not fallen below the standard of care that could reasonably be expected of the NHS. Nevertheless Mustill LJ held:

I see nothing ideal about a system which would give the mother and child the protection against emergencies when it was needed …the system should be set up so as to produce a registrar or consultant on the spot within twenty minutes, subject to some unforeseeable contingency. In the present case there was an interval of about an hour during which the mother and child were at risk, with nobody present who could do anything if an emergency were to develop. The trend of the evidence seems to me to be manifestly that this interval was too long. Either there was a failure in the system, or it was too sensitive to hitches which fell short of the major kind from which no system is invulnerable.

The defendants were held liable for failing to implement a system capable of providing the patient with an acceptable standard of care. Garcia v St Mary’s NHS raised the question of the duty owed by a hospital trust to its NHS patients, including whether an NHS Hospital Trust owed an institutional, primary (as opposed to a vicarious) duty to a patient admitted to its care and what the extent of that duty might be. Unfortunately full answers do not emerge from this case. That Spencer J proceeded on the basis that St Mary’s owed an institutional duty to take care cannot be doubted, as he states “I bear in mind that the Trust has a duty to Mr Garcia to take reasonable care of him.” That he found any institutional duty at all is highly significant; as cases decided on the basis of a hospital’s institutional duty rather than its vicarious liability remain relatively few in number.

37 Ibid.
38 Bull v Devon Area Health Authority (1989) 4 Med LR 117 at 141.
39 Newdick n 33 p 175.
40 [2006] EWHC 2314 (QBD) A case that will be discussed in depth in the next chapter of this thesis which examines breach of the institutional duty of care, where the full facts of the case will also be outlined.
41 This material draws heavily from my previously published work Joanne Beswick, ‘A First Class Service? Setting the Standard of Care in the Contemporary NHS’ (2007) 15 Medical Law Review 245.
42 [2006] EWHC 2314 at para 95.
43 Beswick n41 Also see Naver, Ravi ‘Outsourcing genetic and diagnostic services: a consideration of the principles for establishing a hospital’s non-delegable duty and why it matters’ (2011) Journal of Personal Injury Law 61 who asserted that Lord Phillips’ reference to strong arguments of policy in Child A (a child) means there will come a time in the near future where a the imposition of a non-delegable duty (my emphasis) on a hospital will form the ratio of one of the higher courts judgments in England. Presumably by the particular phrasing of this statement he is referring to an institutional primary duty of the third extent contemplated by Lord Phillips, a duty to ensure that treatment administered is administered with due care.
The reason for the slow development of the notion of primary direct duty within hospital trusts.

After the rejection of the Hillyer doctrine\textsuperscript{44} most cases proceeded on the basis of the vicarious liability of the hospital as most people working and providing care in NHS hospitals were employees. Bettle\textsuperscript{45} suggested that this change in approach combined with the change in perception of hospitals (from seeing them as places offering equipment and facilities for physicians and surgeons, to seeing them as providing medical services to the public) resulted in the courts increasing willingness to find them vicariously liable for negligence on the part of their staff.\textsuperscript{46} Although this change in perception described by Bettle was said to have increased the courts willingness toward the development of hospitals vicarious responsibility, it is argued the changing perception of hospitals also underpins a strong justification for their primary direct duty.

Until Margaret Thatcher’s accession to power, it was rare for patients in NHS hospitals to be treated other than by NHS employees,\textsuperscript{47} and even in cases where the exact status of an individual had been in doubt, often vicarious liability has been assumed by the hospital.\textsuperscript{48} This might explain why the distinction between the two species of a hospital trusts liability primary/direct and vicarious/secondary was not one that has received more consideration by the courts, in this jurisdiction. Furthermore, the agreement reached between the Government and the medical defence organisations\textsuperscript{49} on the apportionment of damages between the defence organisations and the institution meant that the fact that the patient’s injuries might be attributable to both the doctor’s negligence and the hospital’s breach of duty to provide, for example, sufficient staff was hardly ever litigated.\textsuperscript{50} NHS indemnity replaced this system from the

\textsuperscript{44} As discussed on pages 4-7 of this chapter a trend which continued until 1954 where Lord Denning in Razell \textit{v} Snowball [1954] 3 All ER 429 could confidently state that the title of consultant did not prevent a clinician from being a member of staff. Most staff were employees from the 1950’s until Mrs Thatcher’s government when the use of agency staff was introduced.


\textsuperscript{46} Radiographers, assistant medical officers, anaesthetists, house surgeons and special consultants.

\textsuperscript{47} Brazier and Beswick n 2 p 186.

\textsuperscript{48} Jones with Lyons n4 p780 where he stated the fact that hospital authorities accept vicarious responsibility for consultants and agency staff removed much of the practical importance of the arguments about whether a hospital is under a non delegable duty to patients.

\textsuperscript{49} Grubb n4 p 457 referring to Circular HM (54)32.

\textsuperscript{50} Ibid.
1\textsuperscript{st} January 1990.\textsuperscript{51} The reality that most patients will not enquire as to the employment status of their doctors has been a fact recognised by the judiciary for over half a century.\textsuperscript{52} Whilst subsequent changes make it even more likely that care will not be provided by an NHS employee,\textsuperscript{53} the beginnings of changes in this area were first evidenced in hospital care with the use of agency staff and contracting out certain procedures.

**GP practices**

*Holt v Edge*\textsuperscript{54} appeared to confirm, albeit never expressly articulated, that a GP practice owes a direct common law duty of care to their patients. As Brazier and Cave\textsuperscript{55} explain a GP’s terms of service, the doctor’s obligation to the health service, can be found to derive from statute,\textsuperscript{56} these terms of service provide that he must provide medical care during core hours to all his patients. The terms of service provide that his patients are those accepted on to his list.\textsuperscript{57} A GP’s patients also include persons accepted as ‘temporary residents’ and ‘persons to whom he may be requested to give treatment which is immediately required owing to an accident or other emergency in his practice area’.\textsuperscript{58} As Brazier and Cave\textsuperscript{59} point out, breach of their terms of service, could lead to disciplinary sanctions, but that would not offer the aggrieved patient any redress as the conditions of such terms of service are not determinative of a common law duty. Kennedy and Grubb also contend that just because the regulations\textsuperscript{60} impose a duty on the GP it does not necessarily follow that a duty will exist at

\textsuperscript{51} See Claims of Medical Negligence Against NHS Hospital and Community Doctors and Dentists HC (89) 34, it covered staff provided by external agencies, irrespective of legal relationship with hospital. NHS indemnity does not apply to General Practitioners except where the GP has a contract of employment with a health authority or NHS Trust.

\textsuperscript{52} Lord Denning in *Cassidy*. As Jones with Lyons n5 p 795 explain in their judgment in *Child A* Lord Phillips appeared to accept that the hospital could owe a duty in respect of the treatment that it provided in the hospital itself, so that it would be irrelevant whether the professional who was negligent was engaged as an employee or independent contractor.

\textsuperscript{53} For example; in the realm of secondary care provided by a larger range of possible providers including foreign hospitals.

\textsuperscript{54} [2007] EWCA Civ 602.

\textsuperscript{55} Margaret Brazier and Emma Cave, *Medicine, Patients and the Law* (5\textsuperscript{th} edition Penguin 2011) p 174.

\textsuperscript{56} See the National Health Service Act 2006, ss 83-95; the National Health Service (General Medical Services Contracts) Regulations 2004, SI 2004/291; the National Health Service (Primary Care) Act 1997.

\textsuperscript{57} National Health Service (General Medical Services Contracts) Regulations 2004, reg 15.

\textsuperscript{58} National Health Service (General Medical Services Contracts) Regulations 2004, reg 15(6).

\textsuperscript{59} Brazier and Cave n55 p 174.

\textsuperscript{60} At the time of their writing they were referring to the terms of service contained in Schedule 2 of the National Health Service (General Medical Services) Regulations 1992.
common law. They state a GP only owes his patient a duty of care at common law when he has knowledge either actual or constructive of circumstances which trigger his obligations, for example a direct or indirect request for care from the patient. The extent of the common law duty is unclear. This has been the case for many years probably since the inception of the NHS. Brazier and Cave contend that as regards patients on his list a GP has a continuing duty to them. Until relatively recently primary medical care was provided on the same basis throughout the country. It was provided principally by GP’s, acting as independent contractors, in agreement with their health authorities under the same terms throughout the NHS. Prior to the 1990 reforms, at home in the community, the patient’s GP was responsible for his primary care twenty-four hours a day, seven days a week.

“She might not deliver all his care, but she was legally responsible for that care. If a locum GP was negligent...legal responsibility continued to rest with the patient’s GP. The law matched common sense expectations.”

WHY INSTITUTIONAL DUTY MATTERS NOW

A practical examination of the changing methods of provision of NHS care

This section will examine the practical differences in the provision of NHS care which came about in both the last raft and the current round of changes in the way NHS care, both primary and secondary, is provided to patients. As already explained the commissioners are the central institution that provides all care within the current system of provision. Their legal responsibility and accountability for that care will be examined. As was noted in the introduction of this chapter the days of the PCT are numbered if the Health and Social Care Bill 2011 becomes law. The precise name and format of their replacement is at the time of writing uncertain though Mr Lansley said “ministers hoped new clinical commissioning groups would exist across England by April 2013”. However, it

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61 Grubb n4 p 295.
62 Ibid the scope of which is uncertain see Kavanagh v Abrahamson (1964) 108 SJ 320, and Edler v Greenwich and Deptford HMC (1953) Times 7 March.
63 Newdick n 33 p86.
64 Ibid.
65 Ibid.
66 Ibid.
67 From http://www.guardian.co.uk accessed on 1st June 2011.
is contended that the direct institutional duty of any replacement will be as crucial and involve the same considerations as those pertaining to the PCT perhaps even more crucial given concerns about the Health Bill 2011. For a pertinent example, Lord Owen has warned “the aim in this Bill is explicit the NHS will become a state insurance provider not a state deliverer.”68 This section is intended to illustrate how the existence of a primary direct duty of care on NHS commissioners and providers to ensure care is taken is of practical significance and how a lack of such institutional accountability could impact both on individual patients and the institutional credibility of the NHS.

Changes in the provision of secondary care

Treatment in private hospitals and independent sector treatment centres

This policy became ingrained with the Labour parties long-term concordat with the private sector because it was asserted “there should be no organisational or ideological barriers to the delivery of high quality healthcare free at the point of delivery to those who need it.” Independent Sector Treatment Centres (ISTCs) service agreements declare:

that Independent Sector services are delivered in accordance with the founding NHS principle of treatment free at the point of delivery and available according to clinical need, rather than ability to pay.69 Independent Sector healthcare organisations provide greater scope to introduce new and innovative ways of delivering healthcare to NHS patients by adapting the traditional NHS model to suit local healthcare needs.70 Some Centres are refurbished sections of existing hospitals, or new buildings and some are mobile units that travel around the country.71

The impact of reforms on patients should not be doubted. One patient on whom the consequences were fatal was Dr John Hubley.72 In evidence to the House of

70 Ibid.
71 Ibid.
72 As revealed in Panorama: Dying to be Treated?, BBC One, Wednesday, 30 September 2009 at 2000BST In January 2007, Dr Hubley underwent surgery at a private clinic contracted by the NHS to carry out routine, low-risk procedures. The centre lacked some of the basic equipment to help stem the bleeding. The surgeon performing the operation did not have access to a phone in the operating theatre to call for help when it became clear that he was losing his patient. There was a delay in obtaining blood as the ISTC did not (unlike a district general hospital) stock blood. The method for obtaining blood was to
Commons select committee, the Secretary of State suggested “somewhere between 50-60,000 operations a year are funded by the NHS in private sector facilities. The Independent Healthcare Association maintained that it was reasonable to expect a possible annual total of 200,000 [patients per year].” The question of legal liability and the consequential accountability to patients is a complex one and *prima facie* could vary depending on how the patient had found their way to the alternative provider. Although it might well be contended that any possible differences in referral were not important as it was the commissioner who ultimately had allowed the referral to the alternate provider.

*Treatment abroad*

Yet the most dramatic incarnation of new policy is seen in *Treating More Patients and Extending Choice: Overseas Treatment for NHS Patients*. This guidance from the Department of Health provides that the maximum wait for NHS patients in 2005 should be set at 6 months for in-patients and 3 months for out-patients. PCTs are exhorted to consider other options including ‘more effective use of the independent sector’ and ‘innovative use of NHS capacity’. PCTs in exercising their powers to meet their responsibilities to local patients may elect to send patients abroad. It is envisaged that treatment abroad ‘…will potentially become an option available to patients from the point at which they are first assessed as needing the relevant procedure’.

Send a porter in their own car, when it did arrive it was too cold to use and the clinic did not have the equipment to warm it, the theatre staff resorted to using bowls of hot water. Dr Hubley died of multi-organ failure the next day. At the inquest, the coroner ruled that the death was due to misadventure, aggravated by neglect and said that on the balance of probabilities, had the surgery been conducted at the nearby hospital, he would have survived. In his summation, the coroner was scathing, stating: “Surgery is about safety, not what can be got away with.”


74 Intriguingly http://www.dh.gov.uk/en/Healthcare/Primarycare/Treatmentcentres/DH_083041 declares that ‘patients treated at any NHS Treatment Centre that is managed by an independent healthcare company are still NHS patients.’ The question remains to be decided whether this will be matched by a legal duty of care.

75 This draft guidance for primary care and acute trusts was a consultation document published 19/7/2002. It is para 6.1 of this guidance which is extracted here url http://www.dh.gov.uk/Consultations/ClosedConsultationsArticle/fs/en/.

76 Since December 2005 the following have been in place for NHS waiting times. A maximum of 26 weeks for inpatient care and 13 weeks for the first outpatient appointment following GP referral. *NHS Inpatient and Outpatient Waiting Times*, Department of Health News Release, COI News Distribution Service 28\(^{th}\) February 2009 accessed via Lexis Nexis on 22\(^{th}\) May 2009. The NHS Constitution introduced an 18 week maximum wait. It would appear that things are changing; reports suggest that more people are actually waiting over 18 weeks in May 2011 than in May 2010. The number of areas where targets are not met has doubled in the past year. See ‘Hospital waits going up’ dated 16\(^{th}\) June 2011 from www.bbc.co.uk/news/health.

77 Brazier and Beswick n2.
The guidance spells out the procedure for referral abroad. It also addresses liability questions. In paragraph 6.1, the Guidance states:

The law on the commissioner’s liability for clinical issues is not wholly clear. However, should a patient sent abroad for treatment wish to raise an issue of medical negligence, the courts may regard NHS bodies as having a duty of care that cannot be delegated, despite the fact that treatment was being provided by a non-UK provider. Patients would therefore be able to sue the NHS in the English courts, rather than having to take a case through foreign courts. This approach is in line with the Government’s policy preference, which states that patients traveling abroad for treatment should have the same rights and remedies as patients receiving treatment in the UK.

The Guidance thus suggests (1) that PCTs referring patients abroad owe a non-delegable duty of care to all their ‘medical tourist’ patients and (2) that PCTs owe a duty of care in respect of care commissioned on behalf of their patients anywhere. Seemingly the guidance promises redress in England. Note what is said is that ‘patients travelling abroad for treatment should have the same rights and remedies as patients receiving treatment in the UK’. Thus the medical tourists’ fate is only assured if the commissioners are held responsible for all their patients who are treated by alternative providers. There is more recent guidance where overseas medical treatment is requested by the patient it states:

the responsibility for ensuring the quality of care that the patient receives is that of the health system in the country of treatment... [authorization] will not make the NHS liable for clinical negligence and...any liability of the provider would have to be established in accordance with the host state.

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78 Brazier and Beswick n 2.
79 Brazier and Beswick n 2.
80 Such responsibility extending to the third type of duty outlined by Lord Phillips in Child A, a duty to ensure care is taken. Such a duty would only be akin to the most constrained view of a hospital trusts primary direct duty teamed with the secondary vicarious duty which they would also owe as employers. The imposition of such a direct duty would further reflect the spirit of the Lord Greene’s judgment in Gold of the proper extent of a direct primary institutional duty as outlined on page 11 of this chapter.
81 Otherwise as Cara Guthrie and Hannah Volpe, ‘Overseas Treatment for NHS Patients’ (2006) Journal of Personal Injury Law 12 describe the patients options would be to; “to sue the overseas hospital in that country under the law of that country, to sue the overseas hospital in England and contend that the applicable law should be English law, to sue the overseas hospital in England with the applicable law being the law of the country where the treatment took place”.
82 Department of Health, Patient Mobility: Advice to Local Commissioners on Handling Requests for Hospital Care in Other European Countries following the ECJ’s Judgment in the Watts Case (London 2007).
It is argued here that this guidance should be interpreted narrowly to situations where overseas healthcare is explicitly requested by the patient.  

Changes to provision of primary care including out of hours services

Until April 2004, GPs were responsible for all out of hours care. This covered evenings and nights, plus weekends and bank holidays. Now primary care trusts are responsible for around nine million patients receiving care out of hours in England each year. Since GPs handed over responsibility for out of hours services to primary care trusts in April 2004 only one in 50 services has met performance targets. Out of hours services provided to patients in England have been condemned as difficult to access slow to respond and their overall performance as not good enough. The Public Accounts Committee stated the only people to benefit from GPs shedding their 24-hour responsibility in return for giving up £6,000 in pay, were the doctors themselves. The amount they gave up was not enough to fund the new service, run by primary care trusts using a mix of private companies and GP co-operatives, which cost £70m a year more than had been foreseen. Concerns with such provision were also raised by The Royal College of General Practitioners who admitted services had become "confusing, fragmented, and highly variable". The BMA also said many out of hours services "left a lot to be desired." If changes in the way services are provided raise questions about efficiency, particularly the standard of treatment actually provided, it is imperative that the NHS be accountable on such matters. It is contended that this highlights both the need and the justification for the commissioner to owe a patient a direct duty of care, so that

83 Mrs. Watts was the protagonist in receiving her hip transplant abroad, by her expressly applying to have the operation in France under the E112 scheme, without the prior authorisation of her PCT. It is argued this is quite different from the type of situation which arose in M v Calderdale & Kirklees Health Authority [1998] Lloyd’s Rep Med 157 but with the patient being sent abroad rather than to a private clinic. This replaces the earlier guidance for patients who request treatment abroad. It is argued that the concept of ‘requesting treatment abroad’ should be confined to the facts of the case of Mrs. Watts of R (Watts) v Bedford PCT and the Department of Health [2004] EWCA Civ 166 CA and not extended to the situation where a patient selects a foreign provider through the policy of allowing greater choice for NHS patients, where the patient regards their treatment as being provided under the auspices of the NHS.

84 Editorial ‘Out of Hours Services Send Nurses Not Doctors as the Trusts Cut Back’ The Daily Mail (London April 12 2007).
85 Editorial ‘Don’t you Dare Be Ill Out of Hours!’ Daily Mail (London March 14 2007).
87 Jeremy Laurance ‘Out of hours GP service ‘good news for doctors and no one else’ The Independent (London March 14 2007).
88 Ibid.
89 Ibid.
the commissioner is accountable to the public for the quality of care which they actually receive. It is noteworthy that in the instances of personal tragedy which will be examined, those left behind believed the legal system could be trusted to offer an impartial assessment of the situation including if appropriate some sort of redress, yet if a primary direct duty of care to ensure reasonable care for patients is not placed on commissioners the legal system will be misleading the public as much as certain politicians, as it might not be the NHS that will answer for such shortcomings within the national health service, but rather one of the new breed of care providers placing NHS accountability beyond the laws remit.

The latest tragedy in out of hours provision concerned a foreign doctor Dr Ubani who administered 10 times the normal maximum dose of diamorphine to a patient David Gray. The German doctor who flew into the UK having carried out his normal shifts and having enjoyed only three hours sleep admitted he was "too tired" to concentrate and under tremendous stress before he even administered the drug. The case, raises fundamental questions for the NHS, not least because a third of primary care trusts rely on GPs from European countries such as Lithuania, Poland and Hungary, for their out of hours care. The incident occurred after Mr. Gray's partner asked Suffolk Doctors On Call, a company which supplies doctors for Take Care Now, to send a doctor.

This highlights the problem of accountability, namely who will answer for such lapses in care if and when they occur. Dr Ubani was not engaged on a contract of service, but rather a contract for services for which neither TCN nor

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90 Previously Gordon Brown stated that the National Health Service needed to improve night and weekend GP cover after the system was heavily criticised over the death of Penny Campbell. He spoke after investigators said Miss Campbell was let down by "serious flaws" in the out of hours GP service. Editorial ‘Brown admits NHS needs better out-of-hours care’ The Daily Telegraph (London May 26 2007). Another death which raised concerns about the efficacy of out of hours care provision was that of Alison Christian a coroner said Miss Christian was a victim of ‘gross failings’ in the NHS n86.

91 Dr Ubani was sent to visit David Gray, who suffered from kidney stones and renal colic. Within hours the patient was dead, but it was the following day before the severity of the incident was clear to health managers and Ubani was suspended from his second shift.


93 Meikle n92.

94 Editorial ‘Foreign GP’s give cover for a third of trusts’ The Daily Telegraph (London August 25th 2009). Ubani specialises in cosmetic surgery and anti-ageing medicine, has since admitted that he administered the overdose of morphine because he could not understand the patient.

95 “Family accept payout over overdose from locum doctor” from www.independent.co.uk/life-style/healthandfamily Where a spokesman for Anthony Collins solicitors stated although negotiations over costs continued the family (of David Gray) have accepted the compensation figure of £40,000. Intriguingly it was added the compensation came from sources which must remain confidential as a term of the settlement accessed on 24th May 2011.
Cimarron Locum Agency nor any NHS institutions were vicariously responsible. In order to pursue anyone other than Dr Ubani himself a direct duty of care would need to be asserted. If such a duty were to be argued for it could be asserted against either TCN or the PCT who had arranged the out of hours service. As Brazier and Alghrani\textsuperscript{96} contend the degree of negligence in the Ubani case is high on any scale of poor practice.\textsuperscript{97} Equally “any ‘system’ that permitted an exhausted doctor with poor English and a lack of familiarity with medical practice in the UK to treat patients looks defective.” This of course is most pertinent when considering the direct duty owed by the PCT to patients requiring primary care. Gooderham\textsuperscript{98} was pessimistic of the likelihood of a PCT owing a civil duty of care in these circumstances following the cases of Child A\textsuperscript{99} and Farraj.\textsuperscript{100} It is argued these cases have to be viewed on their own very particular facts.\textsuperscript{101} Before examining these decisions, the changing climate in which care is provided will be examined below.\textsuperscript{102}

\textit{Is the ethos of care changing?}

As alternative providers from the commercial sphere are used to provide NHS care it would appear that some of the less desirable characteristics of the market place are influencing the way in which out of hours primary care is offered. If this is the case the tort of negligence should not be too fainthearted to insist that reasonable care be provided for patients. Evidence that the ethos of care is changing for the worse in this manner provides cause for concern. In an email leaked to Pulse,\textsuperscript{103} Dr Mark Reynolds “the medical director of On Call Care, which provides out-of-hours medical services in Kent, told staff that the firm was introducing a five per cent reduction in doctors’ hours. He also implied that some doctors spent too long talking to patients and referred too many

\textsuperscript{96} Brazier and Alghrani n92 p53.
\textsuperscript{97} It is assumed that the reference they make here is linked to the classic negligence liability of the individual practitioner.
\textsuperscript{98} Peter Gooderham “‘No-one fully responsible’: a ‘collusion of anonymity’ protecting healthcare bodies from manslaughter charges?” (2011) 6 Clinical Ethics 68.
\textsuperscript{100} Farraj v Kings Healthcare NHS Trust [2009] EWCA 1203.
\textsuperscript{101} Brazier and Cave n55 p221 where they contend although Farraj might be interpreted as indicating an unwillingness to extend direct liability it does leave the question open in relation to NHS patients. The impact of Farraj on the imposition of a duty of care on commissioners to ensure care is taken is discussed further at footnotes 157 and 199 of this chapter.
\textsuperscript{102} Primary care provision is focused on, although there is little doubt similar changes to the ethos of care in relation to secondary care are also occurring.
\textsuperscript{103} See Pulse magazine at http://www.pulsetoday.co.uk/home.
patients to hospital." It went on, that “from now on the company would monitor how many home visits doctors made, the number of referrals and how long they spent on the phone with patients”. In the email, Dr Reynolds said:

We have to make this reduction to balance our budget, but also to try to get the most cost-effective use of our valuable doctors. I hope everyone can understand why we are adopting this approach. ‘Dr Anxious’ can produce more than twice as much work for the system as ‘Dr Perfect’, and ‘Dr Refer-a-lot’ can send four times the average to 999 or to hospital.

The leaked email also warned GPs they will be taken off the rota if they do not hit targets. It detailed that around 50 per cent of calls should be resolved over the telephone, with patients invited to the surgery or walk-in centre in 39 per cent of cases.

Other medical care providers have also begun to monitor doctors to ensure that their performances are cost-effective. Urgent 24 in Liverpool, Harmoni in central and southern England and Seldoc in south London have all introduced performance management criteria. “One company has told its GPs they should aim to visit patients at home in just 11 per cent of cases. Doctors are also under pressure to refer fewer patients to hospitals at night or over the weekend.”

This climate is someway removed from the idyll we have of primary care providers, the Dr Finlay type of clinician at the heart of a community which they served. Even if this idyll was little more than that, patients had the assurance that they would be treated with reasonable care or “their” GP would answer why not.

Even further changes are expected in primary care provision the government intends to expand the number of independent sector treatment centres. It is opening expensive polyclinics, operating seven days a week, which will be run by multinational companies. The Primary Care Trust in Birmingham is to be allowed to shut the city’s surgeries and replace them with primary care units.

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104 Gary Cleland, ‘Out of hours doctors told to reduce home visits to save cash’ The Daily Telegraph (London April 16 2008).
105 Cleland n104 p2
106 Ibid.
107 Ibid.
108 Ibid.
109 Ibid.
110 Daniel Martin ‘Out of hours firms use nurses not doctors to save money’ The Daily Mail (London April 16 2008).
franchised to corporations.\textsuperscript{111} It is transferring GPs' surgeries to supermarkets.\textsuperscript{112}

Michael Ingram warns:

\textit{... Waiting in the wings is the privatisation of general practice and its metamorphosis from a personal, long-term relationship of care that is valued in this country and admired abroad into a private production line system, where the concept of “your” family doctor is just a distant memory.} \textsuperscript{113}

\textit{Conflicting Precedents M and Child A}

The exact parameters of institutional primary responsibility the direct duty of care, on commissioners and providers is uncertain. Two conflicting judgments are \textit{M v Calderdale and Kirklees Health Authority}\textsuperscript{114} and \textit{A (A Child) v Ministry of Defence}.\textsuperscript{115} Despite the views expressed in \textit{Child A} this chapter will argue that it is the decision of \textit{M} which should be followed. Miss M sought a termination of pregnancy under the auspices of the National Health Service, she consulted her general practitioner. She was referred to a private hospital as an NHS patient. The termination was negligently performed and M sued the health authority, the private hospital, and the surgeon who failed to terminate the pregnancy. At the relevant time, Calderdale and Kirklees Health Authority had chosen to contract out all abortion services, as they were entitled to do. The Health Authority argued that the extent of their duty of care to Miss M was to use reasonable care in selecting the clinics to which they contracted out services.\textsuperscript{116} Judge Garner disagreed, but did not accept that the defendant health authority had even discharged its lesser duty to exercise reasonable care in the choice of service provider.\textsuperscript{117} It failed to check on the indemnity arrangements in place in the private hospital. It had ‘no up-to-date information about competence’.

\textsuperscript{111} Editorial \textit{The Guardian} (London March 11 2008) the promoter of this scheme happily admits to modelling it on McDonald's. These moves are even more worrying when the fragmented nature of the corporate NHS shown in the Ubani case makes it more difficult to establish corporate criminal responsibility for the worst mistakes under the Manslaughter and Corporate Homicide Act 2007 Gooderham n98 for thorough consideration of the criminal position.
\textsuperscript{112} Ibid.
\textsuperscript{113} Michael Ingram, ‘A bizarre plan to abolish family doctors’ \textit{The Daily Telegraph} (London February 5 2008).
\textsuperscript{115} \textit{A (A Child) v Ministry of Defence} [2004] EWCA 641[2004] 3 WLR 469.
\textsuperscript{116} Brazier and Beswick n2.
\textsuperscript{117} Brazier and Beswick n2 p188.
Judge Garner found for the plaintiff Miss M (applying a variety of different reasoning) the most expansive ground for the decision was based on the notion that the defendant health authority, owed a primary *non-delegable duty*\textsuperscript{118} to Miss M.

He put it thus:

The plaintiff never left the care of the first defendant. She was its patient. She never had an opportunity to divert from the route of treatment arranged on her behalf. In those circumstances she is entitled in my view to remain in the same position as a patient who remains in house relying upon the expectation of an effective provision of services. There will be all the backing of the authority if things go wrong. There is no need to make enquiries about competence: about standards; about insurance because the umbrella of the authority remains above. The patient who is sent elsewhere, without having intervened in the choice of destination will have that provided. In the event of it being ineffectively provided or secured, the patient’s rights and remedies will remain the same.

If there was no remedy against the defendant NHS authority, Miss M’s other remedies could be worthless. The private hospital might be uninsured or insolvent. The surgeon might not belong to a medical defence organisation. Even without such problems, as medical staff are rarely employed by private hospitals, litigation would become more complex than in a NHS Hospital Trust setting as doctor and hospital might both blame the other for the relevant error.\textsuperscript{119}

As Judge Garner’s decision was only in the County Court and has not been affirmed by a higher court its status is uncertain. It was referred to dismissively in *Child A*\textsuperscript{120} by the Court of Appeal stating that the decision ‘does not represent the current state of English law’. It will however be argued that to hold otherwise than Judge Garner did, under the wider duty above could have left the already vulnerable Miss M with no effective remedy in law, and all without her ever

\textsuperscript{118} My emphasis.
\textsuperscript{119} Ibid.
\textsuperscript{120} *Child A v Ministry of Defence* is dismissive of M [2004] EWCA Civ 641 at para 52.
realising that she was leaving the protection of the NHS. It would damage the very essence of the National Health Service if it became just an intermediary in the provision of care in certain instances.\textsuperscript{121} Miss M did not question the legal niceties of her treatment. She was satisfied that the NHS had organised a termination of her pregnancy. Today most patients including those treated by alternate providers will not question who in law is responsible and accountable for their treatment. That patients do not consider questions of the legal technicalities of how their treatment is provided, that they trust the NHS has been commented on judicially, for one example of such recognition see Denning LJ in \textit{Cassidy v Ministry of Health}:\textsuperscript{122}

\begin{quote}
The plaintiff knew nothing of the terms... all he knew was that he was treated in the hospital by people whom the hospital authorities appointed; and the hospital authorities must be answerable for the way in which he was treated.
\end{quote}

A closely related strand of reasoning that supports the imposition of a wider duty, which will be examined, is that of reasonable expectation.\textsuperscript{123} It is argued that Miss M’s reasonable expectation was that the NHS would provide her with a competent termination of her pregnancy or at least answer for why it was not competently performed. \textit{A (Child A) v Ministry of Defence} considered the scope of a duty of care in the context of a radically changed system of providing healthcare within the armed forces. Changes in ways of providing care in the NHS e.g. commissioners using non standard providers of secondary care rather than NHS Hospital Trusts might be likened as factually similar to the changes introduced by the Ministry. The argument will be advanced that there are considerable ideological and practical differences to drawing such a parallel.

A was born in 1998 in a German hospital while his father a British soldier was serving in Germany. The child suffered serious and irreversible brain damage in

\textsuperscript{121} Brazier and Beswick n2 p188. Although it might be contended, that alas that is just what the Health and Social Care Bill 2011 aims to do. It is argued that the government has not done enough to achieve this; the provisions of the Bill have not changed people’s \textit{reasonable} expectations of the NHS. It can be distinguished from the trouble taken by the MOD in explaining the changes to British forces care in Germany.

\textsuperscript{122} \textit{Cassidy v Ministry of Health} [1951] 2 KB 343 at 366 It is contended, that this statement would have been applicable to Miss M’s situation, the only difference being that at the time of \textit{Cassidy} NHS secondary care was only provided in NHS hospitals.

\textsuperscript{123} A strand of judicial reasoning that figured in the Australian authorities and one explanation of the decision in \textit{Child A} was that on the facts of the case and the evidence before the court the ‘reasonable expectations’ of b and c were met by the service provided.
the course of his delivery. The fact that A’s injury was caused by the negligence of the German hospital was not disputed. A’s mother contended that the Ministry of Defence owed A a non-delegable duty to provide treatment delivered with reasonable skill and care. To understand the judgment and context of the claim, the history relating to the provision of health care for service personnel and their families stationed abroad must be outlined.124 Until 1996, the Ministry of Defence had provided secondary care in British military hospitals staffed by doctors, nurses and midwives employed by the Ministry, a situation that could be likened to the traditional provision of our NHS secondary care provision since the scheme’s inception. So, had A been born in 1995, and delivered in such a hospital, the Ministry of Defence would simply have been vicariously liable for any negligence in the course of A’s birth. Some commentators125 might argue that the changes in the military healthcare system mirror those the NHS has implemented and that the decision should not be confined to its own particular facts but could indicate a template to be applied with our domestic health service changes. Knowledge or reasonable expectation of the patient influenced the decision in Child A, and is one of the reasons the terminology of non-delegable duty is not preferred in this chapter as a way of describing the third duty. In 1996, the Ministry altered its arrangements, no longer providing such care itself. Instead, the Ministry contracted out primary and secondary care to German hospitals. This change formed part of a more general policy to limit government agencies to their ‘core functions.’126 The contractual arrangements were complex. A group styled The Health Alliance (THA) was chosen to take the lead. THA arranged a number of ‘contracts’. In relation to obstetric care they contracted with Guy’s and St Thomas’s Hospital NHS Trust (GST) to procure obstetric care from chosen German Hospitals. The object of the contract with GST was that GST would ensure a comprehensive service in Germany. They would not manage that service of the German hospitals. These

124 Brazier and Beswick n2 p 189.
125 Guthrie and Volpe n81 who argue it is in their view entirely possible following the decision in Child A that a court would decide that the NHS Trust does not owe the third type of duty, even in Overseas Commissioning Scheme cases with the courts being even more likely to limit liability of the referring trust (to duty two) in this way where it had been explained to the patient “considering whether elect to undergo treatment abroad that, in the event of clinical negligence, the patient would have to sue the overseas hospital rather than the local NHS trust.”
126 Ibid. This being one of the first fundamental differences between the provision of healthcare to military personnel and their families and the provision of healthcare within the NHS. The core function of the Ministry of Defence is not to provide healthcare it is to defend. However the core function of the NHS is to provide healthcare.
changes were implemented unilaterally by the Ministry. The Ministry ‘distanced’ itself from secondary care for service personnel and their families and closed its own hospitals. They had no direct contractual relationship with the German hospitals. They did in co-operation with GST seek to monitor the quality of the service. A’s father had joined the Army in 1988 and married A’s mother in 1991 before these new arrangements for health care came into effect. When she was expecting A, his mother had the option of returning to the UK to give birth. Counsel argued on A’s behalf (1) that the (new) arrangements current in 1998 imposed a non-delegable duty on the Ministry (2) that A’s parents had a reasonable expectation that such a duty prevailed and (3) that the Ministry could not unilaterally free itself of the non-delegable duty existing prior to 1996. All their arguments failed. There was only one substantive judgment on behalf of the court that of Lord Phillips MR. He conceded that:

Those responsible for the operation of a hospital offer a medical service to those whom they accept for treatment.

This apparently simple statement then begs the question of just what sort of personal positive duties ‘which cannot be discharged by delegation’ are then incumbent on the hospital? The Master of the Rolls distinguished between four types of duty:

1. A duty to use reasonable care to provide access to hospital care.
2. A duty to use reasonable care to ensure that the hospital staff, facilities and organisation provided are those appropriate to provide a safe and satisfactory medical service for the patient. This is an organisational duty.
3. A duty to ensure that the treatment administered by the hospital to the patient is administered with reasonable skill and care. This duty will be broken if one of the hospital staff, however competent, commits an isolated act of negligence in the treatment of the patient.
4. A duty to ensure that the patient comes to no harm while in the hospital. This is a duty that amounts to a guarantee that the patient will receive the appropriate treatment. It will be broken if there is a failure to administer the appropriate treatment, even if this does not involve negligence on the part of anyone.

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127 Ibid.
128 Ibid.
129 At para 32.
130 Brazier and Beswick n2 p190 or any commissioner or provider of NHS care.
The first duty the Ministry conceded but rightly argued that it had fulfilled. The second duty, Lord Phillips MR spoke of which might be described as an ‘organisational duty’, a duty to use reasonable care to ensure that hospital staff, facilities and organisation are appropriate to provide a safe and satisfactory service. The Ministry has a responsibility to act reasonably to ensure adequate systems were in place. This again the Ministry argued it had done. The case centred on the third type of duty described by Lord Phillips:

A duty to ensure that the treatment administered by the hospital to the patient is administered with reasonable skill and care. This duty will be broken if one of the hospital staff, however competent, commits an isolated act of negligence in the treatment of the patient.

In essence this was the type of duty Judge Garner found under his wider reasoning to be incumbent on the Calderdale and Kirklees Health Authority. The Court of Appeal found no such duty incumbent on the Ministry of Defence. It will be argued that due to the functioning of vicarious responsibility for employees in the case of hospital trusts there will be little practical difference between duties two and three, except where the Trust ‘contracts out’ treatment although it is crucial when considering commissioners. Furthermore the Court of Appeal in Child A were considering an institution that had always been further removed from directly providing care than a hospital trust or even a PCT or other commissioner. The Ministry had provided care through military hospitals. It is debatable whether the closest analogy within the NHS would be drawn to a hospital trust, commissioner or the Department of Health itself. Child A should not be considered conclusive as to the extent of the direct duty owed by any NHS organisation; it was a case decided on its own particular facts; the performance of core functions of the institutions and the reasonable

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132 Para 32(2).
133 Para 32(3).
134 This is the type of duty with which this chapter is really concerned. If patients like Miss M receiving NHS funded secondary services, beyond the environment an NHS hospital trust are not to be left without the protective assurance of an NHS institution being answerable for their care.
135 Possibly not even then if X and Garcia are applied but it is crucial when examining the position of PCTs.
136 It will be argued that the Ministry of Defence was further removed than even the PCT, if for no other reason than the idea of institutional core functions. Providing healthcare was never a core function of the Ministry of Defence.
137 The idea being that institutions have core functions on which they should concentrate their efforts, being free to use alternate providers for non core functions. The institution examined in Child A was the Ministry of Defence whose core function was certainly not to provide healthcare. It is contended that such reasoning should not be extended to PCTs as their core function is to provide healthcare.
expectations of particular institutions being two key factors in the judgment. The culmination of these factors led Bell J\textsuperscript{138} to conclude that there was no obvious policy reason for the MoD to retain ‘direct personal responsibility for treating soldiers and their families.’\textsuperscript{139} Reasonable expectations are presumably as informed by information disseminated by the institution in question, in \textit{Child A} the MOD. It is due to this criterion that the term non-delegable duty is found to be problematic. If the argument is to be advanced that, institutions like everything must evolve and that as they do so their duty of care might also change. Yet there must be some sort of check on this or it could be cynically exploited by institutions seeking to limit their potential liability. One such key check will be \textit{reasonable expectation} as determined by the court.\textsuperscript{140} It was integral to the outcome in \textit{Child A} that both Bell J and Lord Phillips MR concurred that limiting the Ministry’s responsibility and duty of care to providing access to appropriate care ‘met the reasonable expectations of service personnel and their families.’\textsuperscript{141} Lord Phillips also suggested that there must be convincing grounds of policy to impose the more exacting duty required by his third category, to take reasonable care to ensure the safety of the claimant.\textsuperscript{142} He referred to Samuels JA imposing a non-delegable duty on a hospital in \textit{Ellis v Wallsend District Hospital}:\textsuperscript{143}

The basis of the duty is, more persuasively, the satisfaction of expectations about where liability ought to be. In essence the question became whether convincing policy reasons demanded the imposition of a non-delegable duty on the Ministry of Defence. The Master of the Rolls found that the Ministry’s duty required them to provide access to health care in Germany. The MoD’s obligations were limited to exercising reasonable care in selecting and putting in place appropriate providers of hospital care. It discharged that obligation by contracting with the Trust to

\begin{itemize}
  \item \textsuperscript{138} \textit{A v Ministry of Defence and Guy’s and St Thomas’s Hospital NHS Trust} [2003] EWHC 849 (QB)
  \item \textsuperscript{139} Ibid at para 100.
  \item \textsuperscript{140} Otherwise ‘actual’ NHS care could be curtailed by government stealth allowing extravagant claims as to the public provision of health care with no meaningful accountability.
  \item \textsuperscript{141} Ibid p 629-631.
  \item \textsuperscript{142} To ensure the safety of the claimant would seem to go beyond a duty to ensure that the claimant was not injured by actionable negligence. As is suggested in Brazier and Beswick n2, p191, some confusion of the third and fourth duties does cloud the decision of the Court of Appeal. “The fourth type of duty outlined by Lord Phillips would involve the imposition of strict liability. It goes well beyond any ‘non-delegable’ duty of care and not (in our judgement) any part of the claimant’s case”.
  \item \textsuperscript{143} (1989) 17 NSWLR 553.
\end{itemize}
procure and manage the arrangements with German Hospitals. Thus as Grubb\textsuperscript{144} acknowledged there is no necessary inconsistency between \textit{M v Calderdale} and \textit{A v Ministry of Defence}. Although Bell J was less than complementary about the reasoning used by Judge Garner in the former case,\textsuperscript{145} the real difference between the two cases lies in the assumption of responsibility by the defendant.\textsuperscript{146} Assumption of responsibility, being evidenced by both a consideration of the core function of the institution and the reasonable expectations which persons have of the institution in \textit{M} the claimant was and remained a NHS patient. In \textit{A}, the claimant was never a MoD or Trust patient. Grubb suggests that a careful reading of Bell J’s judgment might lead the reader to conclude that he actually agreed with at least the result in \textit{M}.\textsuperscript{147} Naver\textsuperscript{148} contended regarding the \textit{Farraj}\textsuperscript{149} decision, that the policy decision of whether or not to impose a duty, in the context of NHS contracting out certain processes, should be by reference of the vulnerability of the patient. He argued that each NHS service user should have a reasonable expectation that the NHS is carrying out those procedures.\textsuperscript{150}

**IDEOLOGICAL GROUNDING FOR PRIMARY DUTY**

Sharing the spirit of \textit{M v Calderdale} by requiring the imposition of the more exacting duty on providers and commissioners of healthcare, a duty to ensure reasonable care, is not without precedent in the wider area of general negligence. Markensis and Deakin\textsuperscript{151} argue that vicarious liability has never been an entirely satisfactory solution to the need to fashion a set of principles for determining the liability of the enterprise for the risks it creates. For example the more exacting duty placed on employers in \textit{McDermid v Nash Dredging}.

\textsuperscript{144} Grubb n4 p 522.
\textsuperscript{145} A v Ministry of Defence and Guy’s and St Thomas’s Hospital NHS Trust [2003] EWHC 849 (QB) at para 53 where it would appear his principal difficulty was the reference made by Garner J to the possibility of breach of statutory duty. It is noteworthy that this was only one of several bases for his decision.
\textsuperscript{146} Grubb n4 p 522.
\textsuperscript{147} Ibid.
\textsuperscript{148} Ravi Naver ‘Outsourcing Genetic and Diagnostic Services: A Consideration of the Principles for Establishing a Hospital’s Non-Delegable Duty and Why it Matters’ (2011) \textit{Journal of Personal Injury Law} 61 where it is argued that it appears undeniable, as Dyson LJ noted in \textit{Farraj}, that the question of whether to impose a non-delegable duty (my emphasis) is one of policy.
\textsuperscript{149} Farraj v Kings Healthcare NHS Trust [2008] EWHC 2468 [2009] EWCA 1203. Discussed more fully later in this chapter.
\textsuperscript{150} Ibid.
Company was hard to distinguish in terms of its effects, from holding that the employer was vicariously responsible for the tort of an independent contractor. The raison d'etre of an employer’s responsibility in so far as one can be discerned is a policy decision as to where liability should rest. A similar ideological justification would seem apt when considering responsibility for healthcare. The courts in Australia have accepted that a hospital may come under a ‘non-delegable’ duty to its patients, albeit there is a difference of opinion as to precisely when the duty arises. On the other hand the majority in the Canadian case, Yepremian v Scarborough General Hospital held that a Canadian hospital ‘does not undertake a non-delegable duty to its patients.’ Jones contends that the under-lying justification for imposing a non-delegable duty on hospital authorities rests on patient expectations. Jones explains that when Arnup J in Yepremian was critical of the notion of non-delegable duties, as they seemed to him to be a way of saying that: “In all the circumstances of the case the hospital should be liable” that Arnup J was missing the very point of such a duty, and that the same could be said to be true of the principle of vicarious liability and most tort duties. Grubb finds both the approach and the conclusion of the minority in Yepremian attractive. It is contended that it would not be inappropriate to argue for a primary direct duty to be placed on all NHS commissioners for the same reason(s). Lord Phillips in Child A even referred to Samuels JA’s assertion:

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153 Deakin et al n137.
154 The essential characteristic of the duty ‘is, that if it not performed, it is no defence for the employers to show that he delegated it’s performance …despite such delegation the employers remain liable for the non-performance of the duty’. Per Lord Brandon McDermid v Nash Dredging Company.
155 Jones and Lyons n4 p 796.
156 (1980) 110 DLR (3d) 513 the plaintiff attended the emergency department of the hospital. His symptoms were hyperventilating, vomiting and increased frequency of urinating and drinking. The doctor failed to diagnose that he was suffering from diabetes. He was subsequently admitted to hospital but suffered a cardiac arrest and brain damage. He sued the defendant for the negligence of the doctor. The court determined that the doctor was not an employee of the hospital that he had admission privileges. Therefore the majority held that the defendant hospital was not liable on the basis that it did not owe a ‘non-delegable’ duty of care to exercise reasonable care. The majority determined that the extent of the hospitals duty of care was to exercise reasonable care in picking their staff and there was no suggestion that this had been negligent or that the doctor was unqualified or incompetent (at para 522).
157 Jones and Lyons n4 p796.
158 Jones and Lyons n4 p797.
159 Ibid.
160 Yepremian v Scarborough General Hospital (1980) 110 DLR (3d) 513.
161 Grubb n4 p 463. The dissenting judges (Blair and Houlden) held that a hospital could owe a non-delegable duty to patients and whether it did depended on ‘whether and to what extent a hospital assumes a direct duty’ which in turn ‘depends upon the circumstances of the particular case’ para 579 Blair extracted from Grubb n5 p 463.
162 What duty has the defendant assumed or undertaken expressly or impliedly p463.
The basis of the duty is, more persuasively, the satisfaction of expectations about where liability ought to be.

The reasonable expectation of patients is also pertinent and in combination is able to justify this further departure from the strict fault principle.\textsuperscript{164}

\textit{Theoretical Underpinnings}

The basis of non-delegable duties in tort generally is unclear; Murphy\textsuperscript{165} contended that a study of the Commonwealth case law on non-delegable duty reveals two key characteristics. These are:

First that the defendant’s enterprise carried with it a substantial risk; and second, that the defendant assumed a particular responsibility to the claimant...these justifications seem to emerge quite independently of one another in the classic non-delegable duty cases. Accordingly, they tend to create the impression that they are alternative theoretical bases for the imposition of a duty.

Murphy\textsuperscript{166} contended “that both features can be collapsed into one central concern the assumption of responsibility”. He noted that vulnerability had also been invoked as a possible ground for the imposition of a non-delegable duty. This is in accordance with the idea of the liability in Lord Denning’s judgments and \textit{M v Calderdale}. Murphy\textsuperscript{167} contended “non-delegable duties are increasingly called upon to plug the gaps left by vicarious liability doctrine, a doctrine which only applies in those (dwindling) instances in which there is a formal employee/employer relationship.” These dwindling relationships that

\textsuperscript{164} Lord Phillips was after all open to the idea that convincing policy reasons could demand the imposition of what he termed a ‘non-delegable’ duty or the third type of duty that he outlined. In \textit{Farraj v Kings Healthcare NHS Trust} [2008] EWHC 2468 [2009] EWCA 1203, it was actually argued that the basis of the ‘non-delegable’ duty is founded upon satisfying the expectations about where liability should lie. The argument was that the claimants in \textit{Farraj} had an expectation that the hospital to which they submitted their sample, should be fixed with a non-delegable duty. This was rejected as the key determining factor but was not based on expectations, but on whether or not the creation of the non-delegable duty was fair, just and reasonable [at 91]. It is suggested that \textit{Farraj} should be viewed as decided on its particular facts and that a foreign national’s relationship with the hospital is different to a patient treated under the auspices of the NHS.


\textsuperscript{166} Ibid.

\textsuperscript{167} Murphy n163 p370.
Murphy commented on generally are reflected in the changes to healthcare provision.

If assumption of responsibility and vulnerability are the grounds for imposing a more exacting institutional duty, one which would correlate with the third category of duty examined in Child A, it is contended it is a duty which should be owed to all NHS patients as it is only going to have a significant impact on the NHS liability, where the significant changes to NHS care outlined above impact. Therefore it need not be viewed as increasing NHS liabilities but is rather safeguarding NHS legal responsibility to patients.

One aspect of the Court of Appeal’s reasoning that was important in denying liability in Child A was the ‘reasonable expectation’ of service users. An example from decided case law that should be considered is Rogers v Night Riders. The defendants operated a minicab service. The mini cabs themselves were owned by the driver who was an independent contractor. The plaintiff had telephoned the defendants for a cab and was simply told that one would be available. The plaintiff was injured as a result of the driver’s negligent maintenance of the vehicle. The Court of Appeal held that, as the defendants had held themselves out to the general public as a hire firm, and had undertaken to provide a mini-cab for the plaintiff they owed her a non-delegable duty to ensure that the vehicle provided was well maintained. Dunn LJ made it clear that if the plaintiff had known that Night-Rider Cars was just a booking agency the result would have been different. While the NHS through PCTs or other commissioners holds itself out as the provider of healthcare free at the point of treatment the reasoning in the above case should be followed.

The terminology of non-delegable duty was preferred by the courts in these cases to describe the extent of the institutional duty. It is contended that they might adopt this label in order to explain how the primary duty can extend to accountability for the actions of independent contractors, thus contrary to basic rule of vicarious liability, and yet such reasoning would seem to confuse the primary and secondary liability of organisations. The term non-delegable is also

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168 Reference was made to the effort that the Ministry had gone to, in order to disseminate information that British Service Hospitals would no longer be providing treatment and to inform parties of the changes.


170 Rather like Night riders held themselves out as being providers of the minicab, except even more so, as possibly even less is understood by the public about the provision of care in the modern NHS than the fact that some mini-cab drivers will be self-employed. Equally the rhetoric about service provision, which will feed reasonable expectations, is more persuasive in the case of NHS institutions including PCTS.
not preferred in this chapter to convey the idea of robust institutional accountability, as it is felt to be misleading, as like Dunn LJ above it is imagined that an institution’s duty might be altered over time,\textsuperscript{171} that reasonable expectation and assumption of responsibility are interrelated.

\textit{Institutional Duty of Primary Care Trusts and Liability of the new Commissioners}

The essential question is the precise extent of the duty of care owed by the commissioners to the patient? Does the law effectively impose responsibility for the quality of care they arrange? These are questions of academic complexity but also of crucial practical importance to patients who wish to know exactly “Who’s Caring for me?” A commissioner may argue that NHS and private sector providers are responsible for provision and that their responsibility is solely to arrange that they are akin to a dating service.\textsuperscript{172} This is scarcely an attractive analogy for the NHS.\textsuperscript{173} If an institutional duty within the modern NHS is to give peace of mind to patients\textsuperscript{174} and place a meaningful duty of care on the commissioners to answer for the quality of care provided by them, if there is to be any sort of authentic organisational responsibility for the care received by NHS patients commissioners must answer for the care that they provide.\textsuperscript{175}

\textit{The extent of legal responsibility for provision of Primary Care}

The question needs to be answered as to whether or not a patient injured as a result of the negligence of ‘their’ GP practice, or out of hours provider\textsuperscript{176} might pursue a remedy against their commissioner. Currently PCT’s determine the shape of all primary care, the form and quality of that service rests largely in

\textsuperscript{171} That is why the MOD were only fixed with duty two in \textit{Child A} they had been open and gone to some considerable trouble in informing about the changes.
\textsuperscript{172} Brazier and Beswick n2 p194.
\textsuperscript{173} Ibid.
\textsuperscript{174} Even if they do not necessarily direct their minds to the question (at the moment) until something goes wrong.
\textsuperscript{175} It is recognized that they do not provide care directly for patients in a physical sense and consequentially it might be said to not directly provide care in a legal sense. Yet if the spirit of Lord Denning’s words when considering the institutional duty on hospitals is remembered “The hospital authorities cannot, of course, do it by themselves: they have no ears to listen through the stethoscope, and no hands to hold the surgeon’s knife. They must do it by the…” and applied to the modern NHS where means of delivery have changed it is perhaps not beyond imagination that PCT’s are held accountable for the care which they provide to patients.
\textsuperscript{176} Where that service is not provided by employees of the PCT, some out-of-hours services are provided by employees of the PCT where of course the PCT will be vicariously responsible.
their hands. Fixing the PCT with responsibility for any negligent delivery of a primary care service would be one solution to concerns over the organisational changes in the way that primary care is delivered. One of the arguments against this duty being imposed in this way might be that the changes introduced in primary care are somehow less fundamental than secondary as primary care has since the inception of the NHS been provided by independent contractors, the traditional GP. It is suggested that GP’s status was rooted in the way in which doctors were persuaded to provide services for the NHS rather than any deliberate policy limitation on NHS institutional liability. Furthermore this did not mean that commissioners were in no way accountable for GP conduct.

*Godden v Kent & Medway Strategic Health Authority* raised the issue of the extent of the Strategic Health Authority’s responsibility for a GP within its area. Thirty-one former patients allegedly indecently assaulted by Dr Clifford Ayling claimed damages from Kent and Medway Strategic Health Authority. The claimants contended, at all material times Kent and Medway and/or its predecessors in title were responsible for arranging with practitioners the provision of general medical services in the Kent region. Moreover, that Kent and Medway were under a duty owed to all patients of all GPs in its area which they had breached. The claimants also advanced a claim against the first defendants based upon its alleged vicarious liability for its employees. Ayling had worked at hospitals and clinics which were at least partly staffed by employees of bodies that Kent and Medway were successors in title to. The

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177 Brazier and Beswick n2 p196.
179 Named as the first defendant and the GP’s who were formerly in partnership with Ayling as second defendant. The second defendant was not involved in this application.
180 The defendant Strategic Health Authority had succeeded to the liabilities of the Kent Family Health Service Authority. FHSA’s used to be responsible for contracting for GP Services just as PCTs are now Brazier and Beswick n2 p196.
181 A primary duty to (a) monitor adequately all contracted general practitioners;(b) take all reasonable steps to ensure that all contracted general practitioners within their area provided a safe and/or competent medical service for patients;(c) act upon any complaints made and/or concerns raised in respect of a contracted general practitioner within its area and to take all reasonable and/or necessary steps to investigate;(d) take all reasonable steps to act upon any complaints made and/or concerns raised including but not exclusively a duty to discipline and/or regulate the practice of general practitioners within its area where such investigations revealed and/or ought to have revealed that such discipline and/or regulation was required to ensure patients’ safety and/or that a competent health service was provided;(e) instruct all contracted general practitioners within its area to take all reasonable and/or necessary steps to ensure that patients being treated were reasonably safe and/or were provided with competent medical care;(f) take all reasonable steps to ensure that all contracted general practitioners within its area reported all matters of concern and/or complaints made; (g) take all reasonable steps to ensure that general practitioners in its area provided a safe and/or competent medical service for patients whom they examined.
claim rested on the basis that Kent and Medway were vicariously liable not for any tort committed by Dr Ayling, but for the negligence by its own employees in failing to protect patients from Dr Ayling. The defendants sought to have the claim struck out on the basis that the FHSA owed Dr Ayling’s patients no duty of care. Gray J refused to strike out the claim, he explained the existence and nature of a public bodies duty of care, had to be considered. Gray J stated that it seemed clear from Gorringe and Stovin v Wise that liability at common law against a body such as the first defendant can arise from statute. He stated that the real question was whether the 1977 Act provided the particular claimants in this case with an argument, or whether the claim under that head should be struck out. He held that insofar as the claim in this case was based on a statutory duty arising out of the 1977 Act it should be struck out as disclosing no reasonable grounds for making it. The full implications of this part of the judgment for potential claims against PCTs are not completely clear. However Gray J then turned to the claim that the first defendant was vicariously liable for the breaches on the part of its own employees. It was conceded that the claim was probably a novel one as no one had unearthed any authority for its existence. However, he accepted, as Lord Slynn had observed in Waters v Commissioner of Police common law develops incrementally and so the fact that there is no such reported case is not necessarily a ground for striking it out. He contended that a preliminary question was whether there was anything in the 1977 Act which excluded a private law remedy. He held that he was unable to detect anything within the 1977 Act which could be said to exclude the existence of the common law duty

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182 In deciding the existence of a public bodies duty of care, and the manner in which it might come into existence the court referred to Gorringe v Calderdale Metropolitan Borough Council [2004] UKHL 15 [2004] 2 All ER 326 where Lord Hoffman had considered that reasonable foreseeability was insufficient to justify the imposition of liability upon someone who does nothing to either create the risk nor avert it. Lord Scott had noted in Gorringe at para 71 that there were situations where a public body had a particular relationship with a member of the public that justified imposing on the public authority a private law duty of care towards that person, and that the steps required to be taken to discharge that private law duty of care may be steps comprehended within the public duties.

183 At para 12 of Godden.

184 That they were owed a duty at common law but one which would not arise but for the existence of the statute.

185 At para 15 of Godden.

186 By virtue of a breach of a freestanding common law duty of care.

187 Domestic, commonwealth, or United States authority for the existence of the duty for which the claimant contended.

188 Waters v Commissioner of Police [2000] 4 All ER 934.

189 Godden para 18 per Gray J.
of care and that the existence of what might be termed a public law scheme did not rule out the vicarious responsibility contended for by the claimants. He held that the conditions which must be satisfied in order for the duty to be owed by the employees were those laid down in Caparo.\textsuperscript{190} The defence raised no issue as to foreseeability but contended that neither proximity, nor fairness, justice and reasonableness were satisfied, as it could not be said that there was any relationship between the claimants and the employees, at least in the majority of cases. Gray J explained “The peg for the existence of the duty is the receipt of information about Dr Ayling and his activities” He went on:

In my view neither the fact that the claimants had been unknown to most if not all, of the employees nor the number of claims which may be let in by the floodgates being opened rule out the existence of the duty alleged.\textsuperscript{191}

He continued:

There is in my view force in the submission...that the court should hesitate before striking out this part of the claimants case...I proceed on the assumption that the claimants would be able to establish at trial that by 1993 there existed a wealth of information, known to some at least of the health care workers employed by the first defendant, about the kind of threat which Dr Ayling posed for women under his treatment.\textsuperscript{192} In all these circumstances I have concluded that I should not strike out the claimant’s argument that the first defendant is vicariously liable for the duty owed by its employees to the claimants at common law.\textsuperscript{193}

The basis of this decision appears to rest on the acceptance that the Health Authority could be liable if they should have known and acted on information that a GP was not providing appropriate care.\textsuperscript{194} The centrality of the commissioner in making provision for primary care makes a compelling case for an ‘organisational’ duty in the context of out of hours services.\textsuperscript{195} It is contended that this duty at least extends to GP practices, as it is the

\textsuperscript{190} Caparo v Dickman [1990] 1 All ER 568.

\textsuperscript{191} Godden para 21.

\textsuperscript{192} Godden para 22.

\textsuperscript{193} Godden para 23.

\textsuperscript{194} Brazier and Beswick n2. Does this case provide an interesting precedent when considering the case of alternative out of hours providers? It is noteworthy that in 2007 only one in fifty meet performance targets Editorial ‘NHS condemned for ‘gross failings’ that killed mother’ The Daily Mail (London April 13 2007) Would a PCT’s knowledge that it (or its out of hours providers) were not meeting performance targets be sufficient to trigger such a duty?

\textsuperscript{195} Brazier and Beswick n2 p196 akin to the second type of duty described by Lord Phillips in A (a Child).
commissioner which places the GP in a particular locality and which is the first recipient of information of complaints about general practitioners within their region.\textsuperscript{196}

It is argued there are good reasons for not restricting commissioner responsibility for primary care to this extent, as whereas “the GP had been the cornerstone of NHS care, enjoying the closest relationship with patients. GP Care has changed. Personal relationships between GP’s and families are ebbing away\textsuperscript{197} …What was once a classic doctor/patient relationship, where the doctor assumed overall responsibility for an individual’s care, has been replaced by the delivery of a service. The form and quality of that service rests largely in the hands of the PCTS.”\textsuperscript{198} As the nature of primary care has been changed in this way it is only proper that commissioners should be accountable in law to answer allegations that they have not provided \textit{reasonable care}.\textsuperscript{199}

\textbf{CONCLUSION}

A comprehensive primary direct duty of care placed on commissioners and providers of healthcare is imperative to maintain the integrity of care in the changing system of providing state funded healthcare. As hospitals continue to use more independent contractors and outsourcing arrangements the \textit{de facto} assumption of responsibility by Hospital Trusts to ensure care is taken cannot be sufficient. Primary care is no longer provided principally by General Practitioners who were both easily identifiable in most communities and answerable for their locums.\textsuperscript{200}

If commissioners are to be liable for negligent treatment delivered at their behest, sufficient distinctions between a defendant commissioner and the Ministry of Defence need to be found or a compelling argument of policy advanced to locate within the NHS an expanded duty excused the Ministry of Defence.\textsuperscript{201} It has been argued that compelling policy reasons do indeed exist. Newdick\textsuperscript{202} contended that the approach in \textit{Child A} which distinguished

\textsuperscript{196} As illustrated in \textit{Godden} which would make PCT liable for failure to monitor primary care provision provided by GP’s.

\textsuperscript{197} PCT’s might soon be instructed to let patients have two GPs.

\textsuperscript{198} Brazier and Beswick n2 p 196.

\textsuperscript{199} This would be an extension of the duty required by \textit{Godden}; it would require the imposition of the duty to ensure care is taken like that propounded in \textit{M v Calderdale}.

\textsuperscript{200} \textit{Barnes v Crabtree}, The Times 1 and 2 November 1955.

\textsuperscript{201} Brazier and Beswick n2 p192.

\textsuperscript{202} Newdick n33 p238.
between the locations at which patients are treated may well make the government’s policy of extending patient choice to non NHS providers less attractive to patients.\textsuperscript{203} The issues of patient autonomy, informed consent and information disclosure arise. If an NHS patient is to be treated by an alternative provider, and in the event of misadventure an NHS institution is not to be legally accountable,\textsuperscript{204} should that not be made very clear to such patients? The question is complicated even further by the decision in \textit{Farraj v Kings Healthcare NHS Trust}\textsuperscript{205} where the Court of Appeal rejected the trial judge’s conclusion that a hospital’s non-delegable duty to the patient, if there was one, extended to supervising the quality of tests contracted out to an independent laboratory.\textsuperscript{206} As Brazier and Cave\textsuperscript{207} contend Mrs. Farraj was not being treated by Kings College Hospital but by a hospital in Jordan. \textit{Farraj} leaves the question of whether an NHS patient who undergoes tests organised by the hospital treating her could argue that the hospital owed her a ‘non-delegable’ duty.\textsuperscript{208} Newdick\textsuperscript{209} suggested that “the government may have to direct that NHS bodies retain legal responsibility for those treated outside the NHS even in the absence of clinical responsibility for the patient’s care.” It is argued that it is a duty that the courts should insist on.\textsuperscript{210} It should be remembered that “The birthright of the tort of negligence is its commitment to protecting the vulnerable, and in that

\textsuperscript{203} This assumes there will necessarily be a choice involved on the part of the patient. It might well be there is not one, that a particular PCT does not commission the particular treatment required by an individual from an NHS hospital trust it only commissions it from one of the alternative providers. \textit{Miss M} was given no choice about the location for the performance of her termination.

\textsuperscript{204} Other than to the extent which the Ministry of Defence conceded they were responsible in \textit{Child A} a duty to use reasonable care to ensure that the hospital staff, facilities and organisation provided are those appropriate to provide a safe and satisfactory medical service for the patient.


\textsuperscript{206} Dyson LJ’s judgment was as follows (at [92]): “In my judgment, there is a significant difference between treating a patient who is admitted to hospital for that purpose and carrying out tests on samples which are provided by a person who is a patient. Such tests are not necessarily carried out in a hospital. The special duty that exists between a patient and a hospital arises because the hospital undertakes the care, supervision and control of persons who, as patients, are in special need of care. I accept that, if a patient who is admitted to hospital for treatment has tests carried out in the hospital, then the non-delegable duty of care, which for present purposes I am assuming to exist, would extend to the carrying out of the tests. But that is because the conducting of the tests is part of the treatment that the patient is receiving in the hospital.”

\textsuperscript{207} Brazier and Cave n55 p221.

\textsuperscript{208} Ibid.

\textsuperscript{209} Newdick n33 p238.

\textsuperscript{210} It might be contended that some indicators of voluntary assumption are not hopeful e.g. government attempts to deflect concerns about the Health and Social Care Bill 2011 have sought to reassure, those concerned about the expanded involvement of the private sector in the provision of NHS Care, thereby creating a expectation of quality without explaining the potential lack of accountability.
pursuit, adapting itself to reflect societal changes and to meet new challenges.\(^{211}\)

While \textit{prima facie} Lord Phillips’ seemingly dismissive reference to \textit{M v Calderdale and Kirklees Health Authority} that ‘it did not represent the current state of English law’\(^{212}\) might be seen as offering scant hope to prospective claimants.\(^{213}\) The different bases on which Judge Garner had considered \textit{M’s} case should be remembered.\(^{214}\) It is suggested that Lord Phillips’s disapproval was confined to certain sections of the judgment.

The judgment of Bell J might offer some hope for prospective claimants. He reflected that the Australian authority required for a non-delegable duty ‘protective attitude or acceptance of a special responsibility on the part of the defendant and dependency or lack of choice of the claimant.’\(^{215}\) While he found such a relationship lacking in \textit{Child A} it is asserted that where the patient is referred ‘out of’ NHS care without a choice, like Miss M, that just such a situation of dependency and lack of choice exists. Equally it is argued that given the changes to the provision of primary care and the current centrality of the PCT there is, as argued above, no good reason for not requiring the duty to ensure care is administered reasonably. Particularly as it is explicitly recognised that the categories of attributing that certain institutions owe a direct duty to individuals to ensure care is taken in certain circumstances are not closed.\(^{216}\) It is asserted there are convincing policy reasons why commissioners should owe the third duty of care to patients, a duty to ensure that treatment administered to the patient is administered with reasonable skill and care. That despite the institutional structure of the NHS changing, its accountability for the care it provides free at the point of contact should not. The commissioners and not the patient would and should bear the risk. The concern that the NHS should be forced to foot the bill for mistakes made by others is easily countered. In contracting with the alternative providers the commissioners should ensure that it is indemnified against any liability arising from the negligence of that

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\hspace{1cm}\footnotesize\textsuperscript{211}Amirthalingam Kumaralingham in Neyers et al n163 p380.  \\
\footnotesize\textsuperscript{212}At para 52.  \\
\footnotesize\textsuperscript{213}Brazier and Beswick n2 p 192.  \\
\footnotesize\textsuperscript{214}At one point Judge Garner considered \textit{M’s} claim from perspective of breach of statutory duty.  \\
\footnotesize\textsuperscript{215}[2003] PIQR 607 at 625.  \\
\footnotesize\textsuperscript{216}Bell J cited \textit{Rogers v Night Riders} as evidence of this. This means that the institutions primary liability amounts to a direct duty to ensure that reasonable care is taken of an individual.
\end{flushright}
provider.\textsuperscript{217} It is contended that this is necessary if NHS care is to maintain uniformity.\textsuperscript{218}

\textsuperscript{217} Ibid.
\textsuperscript{218} This is not wishing to suggest that medical advancements will be constrained but merely that the law will guarantee a minimum, irreducible standard of care regardless of where the patient is treated.
CHAPTER SEVEN

Institutional Liability: Standard of Care

INTRODUCTION

The previous chapter argued that providers and commissioners (whether a primary care trust or consortia)\(^1\) owe a direct duty of care to ensure that treatment delivered to patients is administered with reasonable skill and care.\(^2\) This chapter, which in part draws on my previously published work,\(^3\) will examine how breach of an institutional direct duty of care should, and would be likely to be, judged in practice. The issues surrounding and methods of ascertaining an appropriate standard of institutional care will be examined. The weight, if any, which should be accorded to the common practice of other such institutions in ascertaining breach, particularly the appropriateness and operation and use of *Bolam* will be discussed, as it had been considered\(^4\) that *Bolam* was largely applicable to individual liability and it was unclear to what extent, if at all it would operate in institutional liability.\(^5\) It might be questioned what benefit (if any) an institutional duty would provide to patient claimants, as opposed to pursuing their grievance through the classic individual action and focusing on the vicarious liability of the NHS institution which depended wholly on whether negligence could be proven against its employee. One benefit both practical and theoretical of an institutional duty is NHS patients would be able to pursue in a court an answer as to why standards were not achieved (if this is

\(^1\) It is once again noted as in the previous chapter that the days of the PCT are limited. It is intended that the arguments advanced could as well apply to their likely replacements. The exact timescale and remit of all replacements is still not completely clear at the time of writing 31\(^{st}\) July 2011. It appears some commissioning consortia will be ready to begin functioning in 2013 with Clinical Senates to oversee consortia. In the areas where groups are not ready the National Commissioning Board will expand to control budgets until Consortia are ready and willing to take over the function.

\(^2\) The third category of duty outlined by Lord Philips in *Child A*.


\(^4\) Andrew Grubb, *Principles of Medical Law* (Second edition Oxford University Press 2004)) p 473 where he questioned the relevance if any of the *Bolam* test when considering the process for establishing breach of duty by an institution.

\(^5\) The reasoning of Spencer J in *Garcia v St Mary’s NHS Trust* [2006] EWHC 2314 (QBD) appears to proceed on the basis that *Bolam* will operate in the sphere of determining an institutions standard of care much as it would in the case of an individual professional. Common practice within other hospitals, which might not necessarily be determined by medical professional judgment and is far more likely to have been determined by managerial judgment is approached through the arguably ‘soft lens’ of *Bolam*.\)
found by the court to be the case) and if appropriate, gain damages for harm suffered without showing any individual to be at fault. However, as this chapter will show, increased litigation based on institutional standards rather than the individual professional’s negligence could paradoxically lead to a modified or lowered standard of care.

The crucial question of the exact relevance if any, which ought to be accorded to the issue of the availability of resources when determining an institutional private law duty, will be addressed. A distorted view of Bolam cannot be tolerated particularly if used to permit the lowering of the appropriate standard of care. That the question of the availability of resources is an integral part of NHS care cannot be doubted. As Newdick explained “Government avoids the use of the word ‘rationing’, preferring ‘priority setting’ as a euphemism.” “Priorities are what ministers boast of; rationing is what opposition politicians accuse them of.” Government practices encourage an opposite belief to the service being resource driven, it is portrayed that, “if you are ill or injured there will be a national health service there to help; and access to it will be based on need and need alone.” The Bristol Inquiry was critical of this portrayal of the NHS to patients. It observed that:

Governments of the day have made claims for the NHS which were not capable of being met on the resources available. The public has been led to believe that the NHS could meet their legitimate need, whereas it was patently clear that it could not...The NHS was represented as a comprehensive service which met all the needs of the public. Patently it did not do so...

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6 This would ensure that NHS standards were the same no matter where the patient was treated and whether by an employee, it might avoid unacceptable divergence of practice as has transpired in relation to ISTC practices in comparison to hospital trusts.

7 This distorted view equating to what has earlier in this thesis been referred to as a ‘conventional’ interpretation of Bolam. Institutional resource limitations cannot be used to exclude or modify the usual standard of reasonable care Johnstone v Bloomsbury [1991] 2 All ER 293 examined more fully later in the chapter. While it is recognised the appropriate standard is reasonable care in the circumstances of the case Watt v Hertfordshire County Council [1954] 1 WLR 835 it still requires an irreducible minimum.

8 There are whole books dedicated to the topic for example Christopher Newdick, Who Should we Treat? Rights, Rationing and Resources in the NHS (2nd Edition Oxford University Press 2005).

9 ibid p 45 as he explains the first report on priority setting did not appear until 1976, see Priorities for Health and Personal Social Services in England: a consultative document (Department of Health, 1976).


11 As the then Prime Minister Tony Blair said shortly after his election extracted from Newdick, op.cit. p 45 http:www.conservatives.com/policy/where_we_stand/health.aspx declares “We are increasing investment in the NHS year after year” accessed on 2/9/2011.

The Bristol Report warned;

…what government cannot do is to renew its commitment to a comprehensive, accessible healthcare service free for all and then fail to fund it to the level of the demand the governments make of it. Governments have got away with this in the past, but not now. Expectations have been raised and the public is watching.13

The courts have been involved in the consideration of health authorities’ rationing decisions in the public law arena of judicial review for some time, as Newdick14 explains during the 1980’s and early 90’s, the courts were entirely deferential to health authority decision making in this area. He explained that today there is a much greater willingness to scrutinise resource allocation decisions and, if necessary, refer them back for reconsideration.15

The law of negligence also has to consider cases where resource issues might have led to the damage. Newdick contends that there has been concern to insulate public authorities from liability in negligence, partly driven by the fear that substantial sums of money, through damages and costs, will be diverted away from crucial services.16 Bailey and Brown caution that public authorities unlike private companies are not free to withdraw, or vary a service if it becomes uneconomic.17 The difficult question as to what extent, in clinical negligence claims, reasonable standards are resource dependent will be examined in more depth shortly. It will be argued that even in judgments where resource constraints are not specifically mentioned, judges are mindful of such logistical limitations on NHS organisations. A judgment which touched on this and offers worrying albeit not conclusive answers on the issue is Garcia v St Mary’s NHS Hospital Trust.18

The facts of Garcia

The claimant, Mr Garcia, underwent coronary artery bypass surgery at St Mary’s Hospital. Mr Garcia was returned to the recovery room after apparently

13 Ibid para 17. One way in which this aim of the Bristol inquiry could be achieved is through the tort of clinical negligence taking a firm stance on an irreducible standard of institutional care regardless of funding issues.
14 Newdick n8 p93.
15 Newdick n8 p93.
16 Newdick n8 p169.
18 Garcia v St Mary’s NHS Trust [2006] EWHC 2314 (QBD) at para 88.
uneventful surgery, later that evening nursing staff extubated the patient. Shortly afterwards Mr Garcia lost consciousness, there was a rapid fall in his blood pressure and an acute bleed in his chest area. A crash team were called at 23:54. The anaesthetic team arrived at 23:56. Two minutes later the specialist on call registrar, Mr Krasopoulos was notified at his home. The bleeding was controlled at 00:40. As a result of the haemorrhage Mr Garcia suffered hypotension and hypo-perfusion of the brain. 19

“It was argued by Counsel for Mr Garcia that a system which allowed a delay of over half an hour, between the crash call and the commencement of the re-sternotomy, is a system which condemns the claimant in the circumstances to suffer damage to his brain.” 20 Evidence from neurological experts indicated that even if the system at St Mary’s was working to full efficiency 21 severe neurological damage was very likely”. 22 Mr Garcia’s claim did not involve a claim that any individual was negligent, what he alleged was rather the institution’s standard of providing care was inadequate in not providing cover to allow crucial treatment at an appropriate time, that the courts should determine it did not reach the requisite standard the law required to discharge the hospital’s direct duty of care.

The judge went on to deal with the question of the appropriateness of the hospital’s staffing levels 23 on the basis of how he interpreted Bolam 24 /Bolitho 25 principles. “The Court accepted the expert evidence as to the divergence of practice in other hospital trusts at this time. 26 As to the delay involved in responding to Mr Garcia’s emergency, he emphasised that both experts were of the opinion that the time taken in this case was not unreasonable”. 27 Does this indicate that the courts will not be assertive in this area and that there is a

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19 Beswick n3.
20 Beswick n3 Mr. Garcia was injured by the effects of a ‘catastrophic bleed’ resulting in brain damage.
21 Neurologists retained by both the claimant and defendant agreed on the likely effects of varying periods of hypotension and hypo-perfusion. They explained to the court that a period of (a) 15 minutes was likely to result in either none or slight neurological injury (b) 20 minutes would probably have significant neurological damage and (c) 30 minutes severe neurological damage was very likely, probably as severe as at 40 minutes at para 11 of judgment.
22 Beswick n3 p 248.
23 Garcia v St Mary’s NHS Trust [2006] EWHC 2314 (QBD) at para 88.
24 Bolam v Friern Hospital Management Committee [1957] 2 All ER 118.
25 Bolitho (administratrix of the estate of Bolitho deceased) v City and Hackney Health Authority [1998] AC 232.
26 Garcia v St Mary’s NHS Trust [2006] EWHC 2314 (QBD) para 85 for expert view on what was reasonable in such units. “The evidence of Mr Hamilton, the expert for the defence, was post-operative bleeds were not uncommon and while in some hospitals an experienced surgical registrar would ‘live-in’ the hospital, sometimes actually in the ICU, in other units, the surgical registrar would be on call from home” from Beswick n 3 p 249.
27 Beswick n 3 p 249.
likelihood they will defer too readily to medical opinion? If this is the case this
could see a re-emergence of blaming Bolam for the consequential ills rather
than openly and publicly addressing the question of modifying the standard of
care in the NHS to consider available resources. “Counsel for Mr Garcia urged
despite the system being accepted by the consultant surgeons, it should be
rejected as a proper system evidencing appropriate care by virtue of Lord
Browne Wilkinson’s speech in Bolitho”.28 Spencer J held he was not in the
situation envisaged in Bolitho, “I am dealing, not with simply what is described
in ...Bolitho as a body of medical opinion saying one thing, the only medical
opinion which I have on each side says the same thing.”29 It suggests that he
favoured a particularly non-interventionist interpretation of Lord Browne
Wilkinson’s judgment.30 It also suggests that those limitations of review
discussed in Bolitho will be carried through into judicial consideration of the
appropriate standard of institutional care.31 The question arises as to whether
Spencer J was missing the real essence of the matter. Bolitho or Bolam would
have permitted him to reject even unanimous medical opinion. All the imposition
of Bolam necessitates is that common practice be considered. The
interpretation given to Bolam/ Bolitho here would abdicate responsibility over
the control of appropriate institutional standards to the medical professionals
and healthcare managers placing them beyond the law’s remit with the
associated problems of this.32 It would have been open to him within Bolam to
hold that the system in place at St Marys where the specialist surgeon was
called from his home did not discharge the appropriate standard of reasonable

28 Bolitho v City and Hackney Health Authority [1998] AC 232 at para 241 and Beswick n 3 p 249.
29 Garcia v St Mary’s NHS Trust [2006] EWHC 2314 (QBD) at para 91. In Bolitho there was a clear
divergence of opinion between the plaintiff’s five experts and the defendant’s three and where the trial
judge in effect asserted that he was disqualified from scrutinising the expert evidence. Their Lordships in
that same case made clear that this was not the case although the excerpts as to when it might be
appropriate to disregard suggested caution which Spencer J appears to pick up on. It is not clear whether
he believes he is unable to reject the unanimous expert opinion put before him in Garcia or if he simply
considers it imprudent.
30 Bolitho v City and Hackney Health Authority [1998] AC 232. Where Lord Browne-Wilkinson talked of
rare cases and it seldom being right to reach the conclusion that views held by a competent medical
practitioner are unreasonable. As I argue in Beswick n3 p249.
31 Margaret Brazier and Emma Cave, Medicine, Patients and the Law (5th edition Penguin 2011) page 187
explain expert evidence remains of the highest importance in clinical negligence claims. In Bolitho Lord
Browne-Wilkinson despite extolling the courts authority to determine the appropriate standard of care in
clinical negligence still displayed a certain deference to expert medical opinion. By judging institutional
standards under the Bolam/ Bolitho approach this deference is more likely to be transferred to the
treatment of common practice of institutions.
32 Such an interpretation is in line with a ‘conventional interpretation’ of the Bolam test and highlights
how the test became infamous and was subjected to so many criticisms.
care despite the fact that it was in line with other medical units, as it did not reach a minimum or irreducible standard of care.\footnote{33}

Although in Garcia experts for both sides agreed that the system provided by St Mary’s was reasonable it might be argued that Spencer J could and should have rejected the unanimous expert medical opinion on this matter. I would argue that he both could and should have done this, and that it would not have required any extension of existing principles as such, but rather a bold conviction evidenced in practice that it was proper that the courts should remain the ultimate arbiters of the standard of care owed.\footnote{34} Was Spencer J really satisfied that the system operated by St Mary’s NHS Trust was both logical and defensible? Or was it his awareness that such a decision might trespass into the realm of resource allocation within the NHS that deterred him from holding other than he did.\footnote{35} It is suggested that his reliance on Hall v Simons\footnote{36} indicates his acceptance that resource constraints are relevant within the NHS. While such an approach is understandable when used to limit the classic liability of the individual practitioner as in Hall it is contended the issue is rather different when examining direct institutional responsibility particularly if extended so as not to even require objectively reasonable care. However it is questionable whether Spencer J was really satisfied a reasonable standard of care had been achieved? Or if his awareness of the probable justification of the hospital, they were doing their best with the resources which had been allocated to them, led him to conclude; to hold otherwise than he did would touch upon politically sensitive topics. Yet he avoided an open, policy based decision that reasonable care should be departed from, basing his decision instead on Bolam compliance.

\footnote{33} As judged by the court, rather like the decision in Bull v Devon Area Health Authority [1993] 4 Med LR 117 Where they could see nothing ideal about a system which left the foetus at risk despite expert testimony in support of such an arrangement.

\footnote{34} Lord Browne-Wilkinson in Bolitho v City and Hackney Health Authority [1998] AC 232 at para 242 had declared that: …the court has to be satisfied that the exponents of a body of opinion relied on can demonstrate that such opinion has a logical basis. In particular, in cases involving as they often do, the weighing up of risks and benefits, the judge before accepting a body of opinion as being reasonable, responsible or respectable, will need to 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.

\footnote{35} Below where he quotes from Arthur JS Hall Ltd v Simons [2002] 1 AC 690.

\footnote{36} Arthur JS Hall Ltd v Simons [2002] 1 AC 690.
Resource constraints implicit in *Garcia* were not specifically mentioned by Spencer J although he did remind himself that the Trust operated under the provision of the NHS\(^ {37}\) and quoted from Lord Hoffmann in *Hall v Simons*.\(^ {38}\)

The doctor owes a duty to the individual patients. But he owes a duty to his other patients, which may prevent him from giving one patient the treatment or resources he would ideally prefer.

This would appear to be a judicial recognition, of a necessary limitation on the classic negligence liability of the individual medical practitioner\(^ {39}\) and an implicit acceptance that resources for healthcare will be finite.

However a number of decisions appear to highlight the courts’ reluctance to address the adequacy of NHS resources at all. In *R v Cambridge H.A ex parte B*\(^ {40}\) Sir Thomas Bingham said:

> ...it is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like; they cannot provide all the treatments they would like; they cannot purchase all the extremely expensive medical equipment that they would like; they cannot carry out all the research that they would like; they cannot build all the hospitals and specialist units that they would like. Difficult and agonizing judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment that the court can make.

Yet despite this recognition by the Court of Appeal of the relevance of resource issues on the question of the adequacy of services, their decision and the subsequent rejection of Law J’s attempt\(^ {41}\) to require greater transparency of decision making in cases concerning resource allocation, partly rested on

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37 At 95.
38 *Arthur JS Hall Ltd v Simons* [2002] 1 AC 690.
39 This reasoning might be considered appropriate as traditionally individual medical practitioners have little power over resource and funding decisions. Can the same argument be extended to hospital trusts and PCTs? Also Lord Hoffman refers to treatment which would be ‘ideally preferred’ which could easily be a higher standard than objectively *reasonable* care.
40 [1995] 2 All ER 1291.
41 (1995) 25 BMLR 16 at 17 where he issued an order requiring the authority to reconsider the evidence, as he noted; ‘they must do more than toll the bell of tight resources.’
clinical grounds and had been influenced by the medical evidence that such
treatment was not in B’s best interests.\textsuperscript{42}

Decisions on the availability of medical treatment have continued to come
before the courts and there have been successful challenges to PCT decisions
not to fund treatment, for example, Herceptin for early stage breast cancer. \textit{R
(Ann Marie Rogers) v Swindon Primary Care Trust}\textsuperscript{43} the PCT’s policy was not to
fund ‘off licence’ drugs unless the patient’s case was exceptional. It therefore
conducted an ‘exceptional case review’ of Mrs. Rogers circumstances, and
decided that, because she was in the same position as other sufferers of stage
1 breast cancer, her case could not be considered exceptional\textsuperscript{44} Sir Anthony
Clarke MR:

\begin{quote}
The essential question is whether the policy was rational...Where the clinical needs are equal and resources
not an issue, discrimination between patients in the same eligible group cannot be justified...
\end{quote}

As Jackson\textsuperscript{45} pointed out the PCT had not said in that instance that its decision
was based on cost and if the PCT had cited cost as a reason for not funding
Herceptin, the Court of Appeal found they would have been on stronger ground:

\begin{quote}
If that policy had involved a balance of financial
considerations against a general policy not to fund off-licence
drugs not approved by NICE and the healthcare needs of a
particular patient in an exceptional case, we do not think that
such a policy would have been irrational.
\end{quote}

As Syrett\textsuperscript{46} contends providing that cost plays a part in the decision making of a
PCT and it is acknowledged as pertinent, a court will allow a PCT considerable

\textsuperscript{42} Brazier and Cave n29 p 44, despite the contrary view of B’s father and the child herself. Overall the
contested course of ‘experimental treatment’ would only have offered B a four per cent chance of
‘recovery’. Despite these differing considerations which had influenced this decision, the suspicion
remains that the Court of Appeal were acutely aware of funding constraints like Spencer J was in \textit{Garcia}.
Although they choose to emphasise the less politically controversial grounds of their decision and despite
the purported inappropriateness of the court’s consideration of actual budgetary decisions Sir Thomas
Bingham MR noted “I have no doubt that in a perfect world any treatment which a patient… sought
would be provided if doctors were willing to give it no matter how much it cost...It would, however, be
shutting one’s eyes to the real world if the court were to proceed on the basis that we do live in such a
world.” at para 8-9.
\textsuperscript{43} \textit{R (Ann Marie Rogers) v Swindon Primary Care Trust and the Secretary of State} [2006] EWCA Civ
392.
\textsuperscript{44} Emily Jackson, \textit{Medical Law Text, Case and Materials} (Second edition Oxford University Press 2010)
p 84 Mrs. Rogers sought judicial review of the decision on the ground that the decision was arbitrary and
irrational. See failed at first instance but the Court of Appeal overturned the rejection and found that the
PCT had acted irrationally.
\textsuperscript{45} Jackson n42 p84.
scope to do as it pleases. Syrett contended “the case is most usefully read as a judicial exhortation to PCTs to be transparent as to the part played by financial considerations in making difficult choices…” This requirement of transparency of resource factors which has emerged in some of the judicial review decisions might be followed by decisions in clinical negligence. The consequence of this could be increased disclosure, if resource issues are to be taken into consideration when determining the institutional standard of care owed. If this approach were followed it might at least ensure that like the claimants in Child A people understood there might be changes to the ethos behind the provision of healthcare services. One limitation on the permitted influence of resource issues on the treatment offered by PCTs could be where the cost of such treatment would be relatively modest and would not jeopardize the Trusts’ capacity to provide care for other patients. The express recognition of resource constraints will limit the courts scrutiny of Trusts decisions for judicial review purposes, potentially allowing the Trusts greater discretion in these circumstances and limiting the courts influence. It is contended that such a development should be approached with great caution before extending it to clinical negligence as the difference of purpose between the two claims should be clearly acknowledged. Where the service and provision thereof under consideration was the ambulance service the Court of Appeal recognised that there might be competing demands on the service which might impact on the standard of care. It was acknowledged in Kent v

47 Syrett suggests that court intervention would only occur where the policy is egregious in the extreme or where it fails to admit of the possible relevance of exceptional individual circumstances. He explains that if the PCT either has or purports to have sufficient funds available for treatment the court will scrutinize the decision making process much more closely to ensure that any policy to deny treatment can be properly justified by reference to clinical factors, since it is expected that the PCT will meet all clinical needs if it operating under no resource constraints.
48 Syrett n44.
49 This would result in Government rhetoric on healthcare services needing to be tempered or delivered upon. On Syrett’s reasoning, if the lack of resources were explicitly acknowledged by Government and the approach taken in judicial review cases followed in clinical negligence cases scarcity of resources and explicit recognition thereof could persuade the courts to be less assertive towards PCTs when considering the standard of care owed. This would result in the recognition of the relevance of resources in considering institutional liability which if pushed to its logical conclusion could support the argument for a specially modified standard of care in clinical negligence below that of reasonable care.
50 R (on the application of Otley) v Barking and Dagenham NHS Trust [2007] EWHC 1927 (Admin) this could offer a minimum standard of care owed by the NHS were standards to be modified as discussed later in this chapter. However, the measure of jeopardising the Trust’s capacity to provide care for others would be a rather flexible criterion to measure.
51 The request for judicial review involves a prospective consideration whereas the action in clinical negligence is not merely hypothetical, tangible harm has been suffered by the claimant.
Griffiths52 by Kennedy LJ (in the interlocutory appeal) that account would have to be taken of the service’s cash limits and competing claims on limited resources when the case went to trial. Due care on the part of the ambulance service demanded a reasonably prompt response in these circumstances.53 It is proper and not extraordinary that all the circumstances of the case be taken into account when determining reasonable care.

However, there are dangers in the determination of standards of medical care being entirely resource dependent, Mustill LJ for instance recognised in Bull v Devon AHA54 that necessary limitations must exist on this exercise when he held:

There are other public services in respect of which it is not necessarily an answer to allegations of unsafety that there were insufficient resources to enable administrators to do everything that they would like to. I do not for a moment suggest that public medicine is precisely analogous, but there is perhaps a danger in assuming that it is completely sui generis, and that it is a complete defence to say that even if the system in any hospital was unsatisfactory, it was no more unsatisfactory than those in force elsewhere [or was the best that could be done].

He questioned ‘Is there not a contradiction’ he asked ‘in asserting that at the same time as the system put the foetus at risk that it was good enough?’55

This would appear to indicate that Mustill LJ envisaged a certain minimum standard of care below which healthcare providers must not fall irrespective of how (in)adequately funded they are.56 This approach would require reasonable

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53 Brazier and Cave n29 p 157.
54 (1989) 4 Med LR 117 The hospital in this case operated over two sites one mile apart, obstetric services were located on one site and gynaecological were on the other. This could mean that at any one time the specialist who was required for abnormal deliveries might have been at either of the sites, at the GP unit, at home or in transit. The plaintiff was born after placental bleeding. He showed signs of hypoxia and was found to be affected by severe brain damage and spastic quadriplegia. He brought a suit in negligence, arguing that the system of assembling appropriately qualified staff in cases where specialist supervision of delivery was required was deficient and/or that the system was negligently operated. Due to the delay in summoning either the on-call or reserve specialist there was a 68 minute delay in delivering the second twin (the plaintiff) and this was held by the court to be unreasonably long notwithstanding the logistics of the hospital. It was determined that reasonable care would have required a reasonable possibility of delivering the second twin within 20 minutes.
55 Extracted from Grubb n4 p484. Nevertheless, the Court of Appeal accepted that less than ideal care will sometimes be inevitable. A delay of 20 minutes would have been acceptable but a delay of 68 minutes was negligent. As Jackson n42 p 95 explains the duty was not to have a system in place which would eliminate the possibility of delay. Rather the duty was to provide ‘a staff reasonably sufficient for the foreseeable requirements of the patient.
56 Beswick n3 this is in line with the position taken in general negligence actions. Also see PQ v Australian Red Cross Society[ 1992] 1 VR 19 where the Australian court firmly rejected the notion that the standard to be expected of the Red Cross in testing blood samples should be determined in light of the
care (as determined by the court) as a minimum rather than constantly lowering the standard accepted as reasonable by the law. 57 Other decisions appear contradictory as to whether or not resources are relevant when determining the standard of care in clinical negligence. 

Knight v Home Office 58 suggests that standards of care in negligence are resource dependent. An inmate of Brixton prison who was held in the hospital wing as a result of his serious mental illness and the fact that he was a recognised suicide risk succeeded in hanging himself from the bars of his cell. On behalf of the deceased it was argued that he was not provided with reasonable care. Owing to the lack of staff and facilities he was treated in a way that would not have been considered adequate by a psychiatric hospital outside of the prison system. 59

Pill J said:

In making the decision as to the standard to be demanded the court must, however, bear in mind as one factor that resources available for public service are limited and that the allocation of resources is a matter for Parliament. 60

This would appear to be a judicial endorsement that a lack of resources should be taken into consideration in a medical negligence claim. Although, it was also recognised the lack of resources to provide a better staff/patient ratio would not constitute a complete defence. 61 Pill J stated that if it was said that there were no funds to provide any medical facilities to prisoners, there would be a breach of duty, again using the analogy of the scenario of a public body which operated financial constraints of the charity. They emphasized that the charity had a choice and that if it lacked appropriate resources it should not offer to provide the service. However as is pointed out in Anthony Dugdale and Michael Jones Clerk and Lindsell on Torts (20th edition Sweet and Maxwell 2010) p 401 in the context of the liability of occupiers and public authorities, the defendant’s lack of choice may justify taking into account his actual resources.

57 Constantly lowering standards to reflect available resources both limits the courts effective role as the ultimate arbiters and risks confusing the proper theoretical basis of the action in clinical negligence from what ought to be done to what is in fact done as discussed many years ago by A Montrose ‘Is Negligence an Ethical or Sociological Concept’ (1958) 21 Modern Law Review 259.

58 Knight and others v Home Office and Another [1990] 3 All ER 237.

59 As Newdick n8 p 187 explains he was confined alone for long periods of time and not provided with counselling, or continuous observation, treatments that would have been expected in a non-prison setting. He eventually succeeded in hanging himself from the bars in his cell. On behalf of the deceased, it was said that management had fallen below the standard required of reasonable doctors under Bolam. It was argued that it was no defence that the standard was as good as other prisons, the hospital facilities in the prison were inadequate with reference to what ought to have been available to patients suffering from this form of mental illness in an appropriate hospital.

60 Ibid at 243. It was held that the standard of care required of a mentally ill prisoner detained in prison was not required to be as high as a psychiatric hospital outside the prison, since they performed different functions.

vehicles on the highway without any system of maintenance. This appears to reinforce the notion that the standard of care below which the law will not drop below is reasonable care in the circumstances of the case. In his own words Pill J explains:

It is for the court to consider what standard of care is appropriate to the particular relationship and in a particular situation. It is not a complete defence for a Government department any more than it would be for a private individual or organisation to say that no funds are available for additional [but deemed necessary] safety measures. I cannot accept what was at one time submitted by counsel for the defendants that the plaintiff’s only remedy would be a political one. To take an extreme example, if the evidence was that no funds were available to provide any medical facilities in a large prison there would be a failure to achieve the standard of care appropriate for prisoners.62

He went on to elaborate:

In a different context [from the provision of medical services by a public body] lack of funds would not excuse a public body which operated its vehicles on the public roads without any system of maintenance for the vehicle [or, it may be added, an inadequate system of maintenance] if an accident occurred because of lack of maintenance. The law would require a higher standard of care towards other road users.

Newdick questioned the basis on which the court was satisfied that a reasonable standard of care had been achieved and no breach of duty had occurred.63

In *Brooks v Home Office*64 where the standard of care owed to an expectant mother detained in prison was considered. Garland J held that the court could not regard *Knight* as authority for the proposition that the plaintiff should not, while detained in Holloway prison, be entitled to expect the same degree of care as if she were at liberty.65 Garland J noted that ‘There must always be a distinction between counsel of perfection and the day- to- day balancing of risk management and practicality.’ While a consideration of this matter by the Court

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62 It is suggested that this judgment reinforces the idea of a minimum, irreducible standard of care being required by the common law. Newdick n8 p188 suggests that such reasoning (if accepted) that the medical care is measured on a sliding scale, depending what ought to be expected in the circumstances given the limited funds available subject to a minimum obligation could mean that the standards demanded in negligence will diminish dramatically in circumstances of scarce resources. Newdick is critical of the absence of discussion of principle on which such a rule would depend in this judgment.

63 Newdick n8 p 188.


65 Beswick n3.
of Appeal would no doubt be useful\textsuperscript{66} and the cases might seem to send mixed messages about the relevance of resources. There is perhaps a way to reconcile the decisions; the claimant in \textit{Knight} was arguing that “the standard of care owed by the prison service should be the same as that owed by a specialist psychiatric hospital. \textit{Brooks}, however, succeeded on the more limited claim that the same standard was owed to a pregnant woman in prison as was owed to a pregnant woman generally\textsuperscript{67}. Does this reinforce the contention that while the standard of care will be adapted according to the circumstances, including available resources, that the law expects a certain minimum standard of care below which no provider should fall? Therefore while prison authorities did not have to match specialist psychiatric facilities they had to match a basic obstetric service, to put it another way while you do not have to offer the best you have to attain an acceptable standard.\textsuperscript{68} This reflects the same principle in essence as in the wider tort of negligence where the required standard of care is \textit{reasonable} care. The crucial question then becomes, how (and where) the standard of reasonable care will be set.

Before moving on to consider the theoretical argument for and against a modified standard of institutional care, where there are resource constraints; it might be timely to consider a case settled out of court\textsuperscript{69} which provides a graphic illustration of the possible consequences of service constraints placed on NHS hospital trusts. A baby boy died minutes after birth, because the hospital had no anaesthetist on duty for an emergency caesarean.\textsuperscript{70} The claimant had first presented at the hospital three days before she gave birth. She was admitted initially but discharged. Only hours later she returned to the hospital a midwife sought out a doctor to carry out an examination. By the time it was established the foetus was in distress and the on call consultant Dr

\textsuperscript{66} Newdick n8.
\textsuperscript{67} Beswick n3 p 251.
\textsuperscript{68} In this case there had been a five-day delay in seeking specialist advice when a scan revealed that one of the prisoner’s twins was not growing normally. Garland J held that this fell below the standard of care which could be reasonably expected. However, a two-day delay before admission to hospital would have been permissible. The court also accepted in \textit{Brooks} that the ante-natal care would be subject to the constraints of her having to be escorted and to some extent, her movement being retarded by those requirements. This would explain why the delay of two days was permissible. Is \textit{Knight} distinguishable on the basis that the lack of counselling and interactive support which would have been given in a non prison setting was limited by these same issues but the treatment actually provided was akin to the scenario of a delay of a mere two days in the \textit{Brooks} scenario and therefore reasonable. Although, as Newdick n8 p 188 contends ‘one is left wondering precisely on what basis the court was satisfied that reasonable care had been achieved and that no breach of duty had occurred.’

\textsuperscript{69} Six years after the incident the hospital settled in December 2008 for an undisclosed five figure sum.
\textsuperscript{70} Editorial ‘Hospital’s Shock Admission to a Mum: your baby died because he was born at night… we had no-one to perform the vital op’ \textit{Sunday Mirror} (London January 4 2009).
Gornhill arrived to hospital she had almost given birth naturally. Dylan died minutes after being born on November 29 2003.\textsuperscript{71} The claimant had required a caesarean. However the hospital had a policy of not having an anaesthetist during the night. The hospital trust conceded mistakes had been made.\textsuperscript{72} Dr Gornhill, the consultant who delivered Dylan stated “If it had been 12.25 in the daytime there would have been a team on. We have to work within our limitations. It's a resource policy decision.”\textsuperscript{73} This case raises a number of questions, although as the case has been settled, they are not ones which will receive judicial consideration. On this occasion; there might be some suggestion of classic individual practitioner negligence and, there might also be some suggestion that there might have been a systems breakdown as illustrated in \textit{Robertson}. However, assuming neither of the above instances were proven the question would remain, was this hospital trusts service negligent through not having an anaesthetist available 24 hours a day? As it would appear that other trusts also operate without 24 hour cover due to resource constraints, if \textit{Bolam} were applied in the manner of Spencer J in \textit{Garcia} that fact alone might be enough to act to exonerate the trust. It is argued standards should not be permitted to fall below reasonable care by misapplication of the \textit{Bolam} test.\textsuperscript{74}

**SHOULD CLINICAL NEGLIGENCE CLAIMS AGAINST THE NHS BE SUBJECT TO A MODIFIED STANDARD OF CARE**

Christian Witting\textsuperscript{75} identifies two ways in which the law can respond to inadequacies in NHS funding. The first is to apply the ordinary rules of negligence and hold that ‘he who wishes to act must act carefully or not at all.’\textsuperscript{76} If a defendant cannot afford to do something to a standard that is regarded as reasonable, the law’s answer is usually that he should not do it, rather than he should be excused doing it badly.\textsuperscript{77} Alternatively he suggests a possible

\textsuperscript{71} The umbilical cord had become wrapped around him, starving him of blood and oxygen.
\textsuperscript{72} It was conceded: medical records of Dylan's condition had been lost and notes from the day his mother's waters had broken were wrong; the claimant should not have been sent home and that it had taken too long to alert the consultant about her condition.
\textsuperscript{73} Ibid.
\textsuperscript{74} By a court adopting what has in earlier chapters been termed a ‘conventional’ interpretation of \textit{Bolam}.
\textsuperscript{76} \textit{Stovin v Wise} [1996] AC 923 at 933, per Lord Nicholas.
\textsuperscript{77} Grubb n4 p539.
response to under-funding is to take inadequate resources into consideration when determining the standard of care in clinical negligence.\textsuperscript{78} He\textsuperscript{79} argued that there is a need to reformulate the standard of care in so far as it is applied to the National Health Service. Witting\textsuperscript{80} contended it is counterintuitive to require ‘ideal’ standards in the face of funding constraints. It appears that his argument conflates the notion of ‘ideal’ with that of reasonable care. Moreover he advocated this standard to be determined by ‘the wisdom of hospitals and their professional employees’ which would clearly limit the courts influence. He contended that even \textit{Bull v Devon} is not an unambiguous statement in support of the proposition that resources are irrelevant in determining the proper standard of care.\textsuperscript{81} There appears an irony in the argument that this ‘diluted care provision’ is the best way forward for clinical negligence particularly when the public are assured that ‘the Government is determined that all patients should receive a first class service and that all patients in the NHS are entitled to high quality care.’\textsuperscript{82} Rather I suggest that we should share the view of Newdick\textsuperscript{83} ‘that one intuitively senses a danger in the courts permitting standards to fall and fall in response to financial pressures.’ Although standards in NHS care do not exist in a vacuum, standards should not be rubber stamped as good enough by the courts when even if working to maximum efficiency and not in extraordinary circumstances they condemn the claimant to a certain poor prognosis.

\textsuperscript{78} Beswick n3.
\textsuperscript{79} Witting n72.
\textsuperscript{80} Ibid.
\textsuperscript{81} Witting n72 cites from the judgment of Slade LJ to support this. Slade LJ refuted the suggestion that the authority in that case should have ‘ensured’ that proper treatment was given, as exemplified by the provision of an extra specialist at all times. His Lordship said that the obligation to provide proper treatment was not ‘absolute and unqualified’. He also noted in a reactive profession such as the practice of medicine, ‘inescapable other commitments’ might arise. Witting interprets this as support for an alternative formulation of the standard of care in such cases. Rather it is suggested that these comments from Slade J serve to illustrate \textit{reasonable care}. In this instance the defendant trust was negligent as there were no extraordinary or emergency circumstances which might impact on the determination of what \textit{reasonable care} would be expected to deliver that would serve to justify why it had taken 68 minutes to deliver the second twin. The duty considered and refuted by Slade LJ above that the hospital should have ensured that proper treatment was given, a duty which would require the provision of an extra specialist at all times might correspond with duty four discussed in \textit{Child A}. Whereas what the court actually held in \textit{Bull} (68 minutes too long, no prospect of treatment within 20 minutes) would correspond with the third duty outlined by Phillips LJ “A duty to ensure that treatment administered by the hospital to the patient is administered with reasonable skill and care.” And this duty had been breached by the service provision provided in this instance but that it was limited to \textit{reasonable care} as determined by the court and reasonable care would not necessarily amount to perfect care.
\textsuperscript{82} The foreword by Frank Dobson to, \textit{A First Class Service: Quality in the New NHS} (Department of Health, 1998). Other emotively titled papers \textit{The New NHS: Modern and Dependable} Cm 3807 (1997).
\textsuperscript{83} Newdick n8.
In *Garcia* Spencer J correctly emphasised that the duty owed was one of reasonable\(^84\) care. It is arguable that on the facts, the treatment of Mr Garcia did not meet this standard of care. In his consideration of what was reasonable, Spencer J opined, that the presence of an onsite surgeon would not necessarily have meant they would have been available for Mr Garcia and that this was a relevant consideration. It is suggested that if this possibility had in fact been the case\(^85\) it would have been a different proposition from what actually occurred.\(^86\) On the facts there were no direct competing demands preventing an on site surgeon from attending to Mr Garcia. The qualification ‘direct’ competing demands is intended to limit such consideration to competing demands occurring on the same service at the same time (as with the example given by Brazier and Cave.\(^87\)) This also is presumably what Spencer J had in mind as he appears to consider that if a surgeon like Mr Krasopoulous had been on site he might have been engaged in another emergency. The limitations (or not) of the breadth of relevance of competing demands is questionable. Spencer J considered the situation where a specialist was unavailable due to already being engaged with another patient of the same specialty. It is argued this is different to the situation where a surgeon was unavailable due to a policy decision to prioritise one area over another and that competing demands should be narrowly constrained.

While considering the arguments of the relevance of resource constraints “an NHS Trust may reply that from its position, the provision of some, albeit substandard, service is a better option than no service at all, that in other words, the logic of the law must give way to the realities of the imperfect world”.\(^88\) Witting also contends ‘There may be circumstances when the hospital has to offer treatment which falls short of what it would acknowledge as the best available, because the alternative is to offer nothing at all and turn the patient away.’\(^89\) There may be a certain fatalistic truth in these approaches, but whilst

\(^{84}\) My emphasis.

\(^{85}\) Surgeon on-site but engaged with another emergency.

\(^{86}\) Brazier and Cave n29 p 157 discuss the possibility of conflicting demands on the ambulance services duty to provide a reasonably prompt response as outlined in *Kent v Griffiths*. “For example, two major road accidents take place in the same city at the same time as the winter flu epidemic. The elderly flu patient, whose call is given lower priority than the crash victims, is still owed a duty by the ambulance service. In the circumstances there may be no breach of duty because confronted by competing demands, the ambulance service responds reasonably.”

\(^{87}\) Ibid.

\(^{88}\) Grubb n4 p540.

\(^{89}\) Witting n72 where he contended ‘it is more advantageous to make some healthcare services available even though that treatment is not to the ideal standard. This is consistent with the Government’s
the rhetorical boasts of politicians are so far removed from this, a judicial acceptance of this would seem to be wrong particularly with the emphasis placed on reasonable expectations in *Child A*, as while the Ministry of Defence went to some considerable effort to inform service personnel and their families of the changes in health provision in Germany, the contrary seems true about

the NHS. There is little transparency as to the standards that can routinely be expected in the NHS, where government rhetoric appears different from reality.\(^{90}\) The problem with this dichotomy between expectation and reality is how it impacts on the reasonable expectations of public services and the relevance of this in fixing the legal standard of care. In *Child A* Bell J ruled and Lord Phillips concurred that the fact that the duty owed by the Ministry of Defence ‘met the reasonable expectations of service personnel and their families’ was important.\(^{91}\) Equally there is the expectation of the public that the law will ensure minimum standards of care. The ‘high’ standards of NHS care are pivotal to political campaigns.\(^{92}\)

\(^{90}\) Beswick n3.

\(^{91}\) Brazier and Beswick n86.

\(^{92}\) It is assumed that there is some political mileage and possible electoral benefit in professing to care about standards of healthcare. That the British Public care about the NHS is undoubted and receives some statistical support if one visits [http://www.ipsos.mori.com/content/turnout/the-most-important-issues-facing-britain-today](http://www.ipsos.mori.com/content/turnout/the-most-important-issues-facing-britain-today) which presents the responses received when the sample were asked; what is the most important issue facing Britain today? Looking back over responses to this question since 1998 the only times less than 35% of respondents say the NHS were as follows; 1998 Dec -34%, May 99-33%. August and September 05 both 28, February 08 24% and March 08 25%, May and June 08 both 19%. Very high proportions of interest were noted in February 1998 50%, January 2000 70% and February 2002 72%. No other single category scored 50% or above in the same ten year period. The importance given to the NHS in the responses should also be considered in the light of the fact that 42 different responses were encoded by the pollsters. This was a review in 2008 looking back at the previous decade. There was a more recent poll in July 2011 where the NHS is the fourth (of top ten) most frequently mentioned ‘most important issue facing the country today.’
What has the tort of negligence had to say when resource policies inevitably lead to damage?

Challenges to policy decisions in negligence will be unusual, but such an example was considered feasible in *Re HIV Haemophiliac Litigation*. A group action taken by haemophiliac patients and their relatives after the patients had been transfused with Factor VIII which was contaminated with HIV. The plaintiffs alleged negligence against the Secretary of State, the health authorities of England and Wales, and the Committee on the Safety of Medicines on the basis of their purchasing policy of blood products. They alleged in light of knowledge of HIV the defendants ought to have become self-sufficient with respect to blood and blood products and if that were not possible they ought to have done more to inform patients of the dangers, screen donors in this country and to introduce a system of heat-treatment of blood to minimise the risks of contamination. The defendants argued no duty of care was owed in negligence because there was no sufficient relationship of proximity between the plaintiffs and defendants and it would not have been fair and just and reasonable to impose a duty between the parties. In preliminary proceedings the Court of Appeal allowed the case to proceed to trial on the basis the plaintiffs had presented an arguable case that the defendants policy was unreasonable and amenable to an action in negligence, the court observed that the prospects of success were not guaranteed. The government ultimately settled the case before it went to trial but as Newdick contends it illuminates the potential for negligence actions in matters of deliberate policy making. He contends the distinction between defensible and indefensible decisions will be difficult but as *Re HIV Haemophiliac Litigation* demonstrates ‘it is not limited to cases of bad faith and may extend to decisions were obvious precautions were not taken, especially if the costs of doing so were modest’.

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93 Newdick n8 p183.
94 *Re HIV Haemophiliac Litigation* (1990) 41 BMLR 171.
95 Newdick n8 p183.
96 Ibid.
97 Ibid.
98 *Re HIV Haemophiliac Litigation* (1990) 41 BMLR 171.
99 Newdick n8 p183.
A third way that the courts could respond to limited resources?

A possible middle way for the courts to react to cases where resource constraints might have played a part was suggested in Richards v Swansea NHS Trust\textsuperscript{100} where it was held that once a decision to carry out an emergency caesarean section had been carried out, a duty of care was owed to J (the child) to deliver him within 30 minutes of the decision. Although there was evidence that NHS hospital trusts did experience difficulties in meeting the 30 minute standard, for the Trust to avoid liability their failure to deliver J within either the 30 minute standard or even within 45 minutes, should have been due to ‘exculpatory external constraint on the team.’ The onus was on the defendants to adduce evidence of exculpatory reasons to explain why it took so long to deliver J. As the Trust was unable to produce evidence of logistical constraints on the team looking after J’s mother, the inference was that there were no such constraints, following Bull v Devon\textsuperscript{101} the Trust were held liable. A useful parallel might be found in Kent v Griffiths\textsuperscript{102} where there was a duty to respond when an identifiable patient needed and summoned them and due care demanded a reasonably prompt response. There might be a case of competing demands where priorities need be determined and where there may be no breach of duty because, confronted by competing demands, the ambulance service responds reasonably.\textsuperscript{103} This approach would prevent providers and commissioners from simply declaring that the adverse event only occurred due to resource constraints faced by that service without more. This is to suggest that the courts must take a ‘hard look’ before assuming the circumstances which arose in the case, must necessarily have been influenced by constrained resources. An example of the court doing this can be found in Kent v Griffiths\textsuperscript{104} the facts of which are neatly summarised by Williams\textsuperscript{105} “a pregnant woman had a serious asthma attack at home. The visiting GP made a 999 call asking for an emergency ambulance to take her patient to hospital as soon as possible. When it failed to arrive, two further calls were made and reassurances received

\textsuperscript{100} Richards v Swansea NHS Trust [2007] EWHC 487(QB).
\textsuperscript{101} Bull v Devon [1993] 4 Med LR 117.
\textsuperscript{102} Kent v Griffiths [2000] 2 All ER 474 CA.
\textsuperscript{103} Brazier and Cave n29 p157.
\textsuperscript{104} Kent v Griffiths [2001] QB 36.
\textsuperscript{105} Kevin Williams, 'Litigation Against English NHS ambulance services and the rule in Kent v Griffiths (2007) 15 Medical Law Review 153.
that an ambulance was on its way. Eventually one arrived, 40 minutes after the
first call, having taken at least 14 minutes longer than the trial judge found was
reasonable. He held that the respiratory attack Mrs. Kent suffered, which
resulted in a miscarriage and brain damage, would be likely to have been
averted had there been no unreasonable delay. The Court of Appeal confirmed
that the defendants were liable to pay compensation for all the damage that
would have been averted by a timely arrival.\textsuperscript{106}

\textit{Treatment offered}

As Browne-Wilkinson LJ put it in \textit{Wilsher}\textsuperscript{107} the health authority may be directly
liable if it ‘so conducts its hospital that it fails to provide doctors of sufficient skill
and experience to give the treatment offered at the hospital.’ Grubb suggested
that the reference ‘to the treatment offered’ is crucial,\textsuperscript{108} that it means that the
hospital will be judged on what it represented as being available by way of
treatment services. He\textsuperscript{109} continues that Browne-Wilkinson LJ’s reference to the
treatment offered provides a second general principle by reference to which an
institution’s duty can be judged. Thus an institution that claims to have a
specialist unit will be expected to have available an appropriate range of skilled
staff and equipment to meet the needs of such a unit. Witting argues a good
policy reason in favour of adopting the modified standard of care he proposes in
cases of systemic negligence is that this will ensure that hospitals keep services
open, rather than being tempted to close down wards because of the lack of
resources

\textbf{BREACH OF DUTY AND PRIMARY CARE}

Brazier and Cave\textsuperscript{110} explain that at first sight legal problems concerning general
practitioners appear less prevalent than claims against hospital doctors.\textsuperscript{111} NHS

\textsuperscript{106} According to Lord Woolf MR the facts were ‘unusual in the extreme’ at para 54. It was certainly
extraordinary that no explanation was offered for what was plainly a very late arrival or for the fact that
the times in the ambulance log book had been falsified see Williams n103.
\textsuperscript{107} \textit{Wilsher v Essex Area Health Authority} [1987] QB 730.
\textsuperscript{108} Grubb n4 p473.
\textsuperscript{109} Ibid.
\textsuperscript{110} Brazier and Cave n29 p 172 where they discuss how patients traditionally enjoyed a long-standing
personal relationship with their GP and how that relationship could be jeopardized through the changes in
the provision of care. Also Brazier and Cave explain that the difficulties of proving clinical negligence
arrangements for general practice and the consistent quality of care meant that family doctors were and are still held in high esteem. Until 2004 primary care was only provided by GP’s acting as independent contractors, in agreement with their health authorities. As well as GP’s, commissioners may enter into agreements with NHS employees or private companies to the extent to which it considers it necessary to meet all reasonable requirements, to provide or secure the provision of primary medical services within its area. These changes raised various issues relating to the standard of care in the primary care sector. It remains to be seen how they will impact on traditional GP care and whether the standard of care delivered by alternative providers will be the same, and how the presence of multiple primary care providers will further increase traditional difficulties experienced by claimants in clinical negligence actions in this primary care sector. Finally the standard of care owed by commissioners in the selecting and monitoring the provision of these services will be examined.

The appeal in *Holt v Edge* raised some of the issues relating to breach of duty in the primary care setting, given that GP’s have been relieved of 24 hour responsibility for patient care. It contains no answers but raises some worrying possibilities; including increasingly complex practical situations leading to confusion, as to the limits of each provider’s duty and illustrating how increasingly factually complex questions of causation could lead to a diminution in the standard of primary care. On returning home from work Mrs Holt had slipped and her GP practice was telephoned for help. A Dr Iserloh of the

and consequential harm have always been multiplied in cases involving GP’s. It is likely that those difficulties will be further exacerbated with the new methods of provision of primary care.

111 See National Health Service Litigation Authority (NHSLA), Factsheet 3 (2010) accessible at www.nhsla.com where based upon the total number of reported claims since the scheme began in 1995 GP care was the second lowest (12th place) with 197 claims with Surgery topping the list for most claims of thirteen specialities with 22,472 then Obstetrics and Gynaecology 11,533, Medicine 10,154 and Accident and Emergency 6,498 all of which are normally carried out in a hospital. Ranked according to the value of the claims the GP is still in the lowest three (position 11of thirteen) with the value of claims amounting to £14,871 the most costly claims by specialty were found in Obstetrics and Gynaecology costing £4,386,700. This notwithstanding the fact that on average patients visit according to Brazier and Cave n29 p 172 their GP on average four or five times a year and make one or two hospital visits in a lifetime.

112 Brazier and Cave n29 p 172.
113 Newdick n8 p 86.
114 Newdick n8 p 86.
115 This much more limited duty than a direct primary duty, as held *Godden v Kent and Medway Strategic Health Authority* [2004] Lloyd’s Rep Med 521.
117 Mr Holt spoke to the receptionist Miss Kennedy as the doctor in surgery at the time Dr Stagg did not come to the telephone Miss Kennedy spoke to Dr Stagg who said that Mrs Holt should be referred to the
MEDS service arrived at 9pm, some six hours after the incident and diagnosed a musculo-skeletal injury. The next morning Mrs Holt was still unwell and Mr Holt again telephoned her GP practice. Finally her GP, Dr Edge, visited. Dr Edge agreed with Dr Iserloh's earlier diagnosis. The following morning she attended the accident and emergency department of the Tameside Hospital where she was admitted. A CT scan was taken revealing a subarachnoid haemorrhage. Three days later she was operated on, suffering a stroke in the course of the operation. Counsel for Mrs Holt raised the argument, which was conceded, that it was negligent of the practice not to have had a telephone triage carried out by a doctor at the time of the first phone call. Although, Mrs Holt’s case ultimately failed, on the basis that even if a telephone triage had been carried out by a doctor, it would not have changed the outcome. It is disquieting that the question of whether or not the outcome could have been different, appeared to be bolstered in the defendants' favour by fact that Dr Iserloh also did not diagnose the seriousness of the matter and therefore on the courts view it can be concluded that if she had been triaged properly at first call to surgery it would have made no difference. The conduct of the visit by Dr Iserloh is not examined by the courts other than to just accept that because another doctor visited and also did not refer seemingly concludes legal liability. This might well be seen as overly deferential and not pro-active enough particularly if the evidence regarding pressures on these out of hours alternative providers' doctors are to be believed.
It is most worrying that there was no explicit discussion at any time about Mrs Holt’s GP surgery’s decision not to visit her at home, even though the initial call was made during their core hours, this must raise questions about responsibility for patient care. The standard of care received in the primary care setting under the new system of out of hours provision was brought to the fore following the death of Mr. Gray. This incident might both cast doubt on the notions that the standard of care received will be unchanged under the new provisions of out of hours care, and that there are effective mechanisms in place to ensure consistency in the provision of such primary care.

THE EUROPEAN CONVENTION ON HUMAN RIGHTS DIMENSION

In order to maintain the integrity of NHS care it has been argued that such care should be subject to the usual requirements of the tort of negligence, that reasonable care must be achieved. Even if the arguments of Witting that negligence standards should be especially modified, potentially below reasonable care because of financial constraints were to appeal to the judiciary in our jurisdiction there are other developments, which might provide external constraints which needed to be considered before reducing the required standard in line with growing financial pressures. Claimants who can show the denial or curtailing of treatment which results in discomfiture of the necessary degree might take some action under Article 3 as outlined below. Human rights law would demand a certain minimum, this external development would curtail Witting’s hypothesis providing a base line below which could not be varied. It is not envisaged that many instances where resources were in question would engage this provision, yet in certain instances rationing decisions might have such severe consequences as to amount to an article 3 breach.

So far this chapter has concentrated on questions of institutional liability in clinical negligence, and the question of whether the standard of care owed in clinical negligence should be varied according to the resources made available by the government to the health care provider. This section will address the possibility of a patient invoking the Human Rights Act 1998 to challenge

by commercial market concerns hitherto not immediately impacting on primary care through the traditional GP as discussed in chapter 6.

124 The conceded duty of telephone triage was focused on.

125 This incident is discussed fully in the previous chapter of this thesis.

126 Whether PCT or District General Hospital.
treatment decisions and the likely weight attached to resource considerations in such cases. If a patient is denied treatment that might save their life, would it be possible to argue that their right to life, protected under Article 2 had been violated? Patients will not generally be able to invoke Article 2 to force health authorities to fund treatment which has been refused on the grounds of cost or clinical judgment. \footnote{Jackson n42 p87.} In the \textit{Osman case}, \footnote{Osman v UK (Case 87/1997/871/1083) [1999] 1 FLR 193.} it was found that the right to life ‘must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities.’ \footnote{Extracted from Jackson n42 p87.} The possibility of a denial of treatment amounting to inhuman and degrading treatment has also been considered. In \textit{R (on the application of Watts) v Bedford Primary Care Trust} \footnote{R (on the application of Watts) v Bedford Primary Care Trust and Another [2003] EWHC 2228 (Admin).} Munby J rejected the claim that having to wait a year for a hip replacement operation, with all the pain and suffering to be endured in the meantime might be a breach of Article 3, as “…the simple fact in my judgment is that nothing she had to endure was so severe or humiliating as to engage Article 3.” While it would be difficult for a claimant to establish that failure to provide medical treatment did infringe their rights under HRA it would not be impossible. \footnote{Jackson n42 p 88.} The Court found in \textit{Price v United Kingdom}: \footnote{Price v United Kingdom (2001) 34 EHRR 1285.}

\[\ldots\text{to detain a severely disabled person in conditions where she was dangerously cold, risks developing sores because her bed is too hard or unreachable, and is unable to go to the toilet or keep clean without the greatest of difficulty, constitutes degrading treatment contrary to Article 3.}\]

In \textit{Kaprykowski v Poland} \footnote{Kaprykowski v Poland (2009) Application number 23052/05.} the applicant was a prisoner who suffered from a number of neurological disorders including epileptic seizures. At issue were both his environment while detained and the medical treatment which he received. The applicant complained that he required specialised medical care and direct and constant assistance with his daily activities. He further submitted that the management of the Poznan remand centre refused to supply him with the anti-convulsant drug Gabitril, \footnote{A foreign non-generic medicine instead the Poznan doctors prescribe a Polish generic.} which had been prescribed in the past by a
doctor outside of the remand centre.\textsuperscript{135} He argued that the change in the pharmacological treatment had been ordered by doctors specialising in internal medicine not neurology, and that the alternative treatment had no medical grounds but was rather dictated by a wish to reduce medical expenses. Taking the applicant off Gabitril resulted in more frequent and serious epileptic seizures accompanied by stress and urinary incontinence. He asserted the lack of adequate medical treatment and assistance constituted a breach of the prohibition of inhuman and degrading treatment as provided by Article 3 of the convention.\textsuperscript{136} The Polish Government submitted that the applicant’s complaint was ‘manifestly ill founded’ because he had received adequate medical care and medicines which had been prescribed by the doctors.\textsuperscript{137} The court began by stating ill treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The court found they must determine whether during his detention in the Poznan the applicant needed regular medical assistance,\textsuperscript{138} whether he was deprived of it and, if so, whether this amounted to inhuman and degrading treatment contrary to Article 3.\textsuperscript{139} The court reiterated that the Convention does not guarantee a right to receive medical care which would exceed the standard of health care available to the population generally.\textsuperscript{140} Nevertheless they noted that the applicant’s submission which was not contested by the Government that the change to generic drugs resulted in an increase in the number of his daily seizures and made their effects more severe and as such contributed to the applicant’s increased feeling of anguish and physical suffering. The court held the lack of adequate medical treatment in the Poznan Remand Centre and the placing of

\textsuperscript{135} He had been prescribed Gabitril as the internal disease ward of the Szczecin Prison Hospital and on the neurology ward of the Gdansk Remand Centre. Instead the in-house doctors at Poznan prescribed cheaper Polish generics.

\textsuperscript{136} \textit{Kaprykowski v Poland} (2009) Application number 23052/05 para 49.

\textsuperscript{137} It was noted that whenever the applicant’s state of health had raised concerns, a report had been obtained from independent experts. When necessary the applicant had been transferred to Gdansk Remand Centre hospital to receive better medical care.

\textsuperscript{138} The evidence from various medical sources submitted by both parties confirms that the applicant had at least three serious medical conditions which required regular medical care; epilepsy, encephalopathy and dementia.

\textsuperscript{139} This could have parallels to cases in the NHS where vulnerable patients have been allegedly left in appalling conditions.

\textsuperscript{140} Does this make clear that as prisoners cannot rely on a right to receive medical care that would exceed the standard available to the population, that we can discount the idea that the courts decision in the applicant’s favour was at least partially dependant on the fact that he was forcibly detained, leaving it open to potentially any member of the public who had suffered in a similar way to Mr. Kaprykowski to argue that their treatment was so inadequate as to breach Article 3. If this is so then Human Rights law could influence the notion of reasonable care in negligence offering a safety net of a guarantee of a minimum standard.
the applicant in a position of dependency and inferiority *vis-a-vis* his healthy cell mates undermined his dignity and entailed particularly acute hardship that caused anxiety and suffering beyond that inevitably associated with any deprivation of liberty.\textsuperscript{141} In conclusion, the court considered that the applicant’s continued detention without adequate medical treatment and assistance constituted inhuman and degrading treatment, amounting to a violation of Article 3 of the convention.

In this case the applicant was forcibly detained and it is not clear how important that factor was to the court’s findings.\textsuperscript{142} The exact implications of the decision for the NHS are uncertain. If the situation were replicated, could an individual being taken off the non-generic medication that was most effective for their condition and instead placed on a cheaper generic drug that was less effective successfully bring a complaint under Article 3? What of the individual who had never been on the other drug and had always been on the cheaper alternative, would the court treat them any differently? Hypothetical breaches\textsuperscript{143} could occur in the following scenarios; where a NHS Hospital Trust made the decision that in order to save money and keep within budgets, some wards would be staffed by health care assistants rather than trained nurses. If a patient on one of these wards were to suffer some untoward event for example a heart attack, which went unrecognised by staff until a doctor next made rounds during which time the patient was suffering. An example involving a commissioner of care could be if the commissioner adopted a policy of not providing cancer treatment for individuals over the age of 80. Such a policy would not only have to be threatening to life as this would be, it would also need to produce suffering of sufficient magnitude which alas this example could well do.

Syrett\textsuperscript{144} contends that regardless of the Human Rights Act 1998’s usefulness to patients unhappy with rationing decisions it has led to a shift from *Wednesbury* unreasonableness to proportionality as the standard of scrutiny and that this will make it easier to successfully challenge the decision of public

\begin{footnotesize}
\begin{enumerate}
\item It is speculative whether the lack of adequate medical treatment would without more have amounted to a breach of Article 3 or whether it was necessary that it was combined with the consequent placing of the applicant in a position of dependency and inferiority *vis-a-vis* his healthy cell mates. If it was the combination of the two, can it be assumed that if assessing a similar situation pertaining to a non-prisoner that the court would find the position of dependency and inferiority re other members of society, if an individual’s health was affected through changes in treatment as Mr. Kaprykowski’s was?
\item Although it could be argued that due to financial constraints English NHS patients are actually no freer than Mr Kaprykowski was to seek alternative medical treatment and or advice.
\item I am most grateful to Professor Margaret Brazier for the suggestion of these scenarios.
\end{enumerate}
\end{footnotesize}
bodies, because it necessarily requires the decision maker to give reasons.\textsuperscript{145} It is argued this change of approach within public law might provide the impetus for a more assertive stance by the courts in private law actions such as clinical negligence. The cases above will provide a base line below which negligence based standards could not fall.

**CONCLUSION**

This chapter concludes that common practice should be no more conclusive in determining the appropriate standard of care in instances of institutional negligence than it is elsewhere in general negligence. The precedent of those areas in which *Bolam* went awry should not be followed here. Also it is argued the standard of care required is reasonable care in the circumstances of the case and should not be varied from this. It is asserted that this should be subject to a minimum or irreducible standard. Caution should be exercised before adopting the views of authors such as Witting\textsuperscript{146} where he argues; “We should on the basis of utility of the provision of medical treatment accept modified standards which ensure healthcare is available even though the treatment is not of the ideal standard.”\textsuperscript{147} Witting cites *Watt v Hertfordshire County Council*\textsuperscript{148} to illustrate his theory of modified standards, but failed to note that although the standard of care was modified in that case there was also present an irreducible minimum. The fire services were only exonerated due to the emergency of the situation.\textsuperscript{149} The service did possess an appropriate vehicle in which to transport the jack but it was already deployed elsewhere. It was not argued that due to funding constraints they did not have the appropriate vehicle at all, and therefore used an alternative. It is contended that the difference between the two scenarios illustrates the difference between ideal

\textsuperscript{145} Ibid.
\textsuperscript{146} Witting n72.
\textsuperscript{147} It is not so much this statement which is objected to, as it is recognised that reasonable care might well not equate with ideal care, it is rather the sentiment which appears to permeate Witting’s work that standards should be modified according to available resources with no irreducible minimum.
\textsuperscript{148} *Watt v Hertfordshire County Council* [1954] 1 WLR 835.
\textsuperscript{149} Furthermore it should be noted that an emergency situation does not exonerate the defendant it merely adapts the standard required. Thus if a fire engine goes recklessly through a red light on the way to a fire there may still be liability see *Ward v London County Council* [1938] 2 All ER 341. The service must respond reasonably in the circumstances of the case. This is rather like the example of competing demands on an ambulance service posed by Brazier and Cave n 29 p 157 where they discuss *Kent v Griffiths*. 

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standards and *reasonable* standards.\(^{150}\) Witting contended that if his views were accepted a number of well known cases would have been decided differently\(^{151}\) his explanations being; *Barnett* involved a tired and unwell doctor, the inference being that the hospital was understaffed. That in *Bolitho* the non-attendance must have meant that the doctors were busily engaged elsewhere, therefore the hospital must have been under-funded and finally *Marriott*, which he attributed to the plaintiff being released from hospital too early to the premium on keeping beds free. His argument seemingly ignored the possibility that notwithstanding the issues of funding (if present he appears simply to assume) mistakes were made. It is another example of deference towards the behaviour of the medical professionals. It is argued that Witting’s confidence of a modified standard producing a different result is particularly worrying when considering the provision of accident and emergency care and his conclusion of an alternative finding on breach being likely in *Barnett*. This would entail an acceptance of such a curtailed service provision that effectively no adequate accident and emergency care could be said to be provided. It also illustrates that the actual withdrawal of some services, a spectre held out by Witting so as to justify diminished standards might be preferable\(^{152}\) to the outcomes he suggests. It is argued that varying the appropriate standard of care from reasonable in the circumstances of the case could be a dangerous path to follow, with lack of resources being blamed routinely as it is unlikely that the healthcare system will not be subject to some financial pressures. In support of the assertion that resources (or lack of) should not dictate to the courts, and that the courts may be amenable to this view, that reasonable standards should not be permitted to fall and fall due to financial pressures, Newdick\(^{153}\) cited the Court of Appeal’s

\(^{150}\) Morris LJ stated: ‘Had the station been a larger station, had there been unlimited resources, unlimited space and an unlimited number of vehicles, it might be that another fitted vehicle would have been available; but that was not reasonably practicable or possible’ Ibid at 839. It is suggested that here Morris LJ was exploring ideal standards. A parallel could also be found in Spencer J’s imagining in *Garcia* that an onsite surgeon may have been deployed elsewhere; this would have been like not having two (or more) specially fitted engines whereas the situation which actually arose in Garcia was akin to the station having no specially fitted engine.

\(^{151}\) *Barnett v Chelsea & Kensington Hospital Management Committee*[1969] 1 QB 428; *Bolitho v City & Hackney Health Authority* [1998] AC 232 and *Marriott v West Midlands Health Authority* [1999] Lloyd’s Rep Med 23.

\(^{152}\) From the ideological perspective, in so much as the theoretical consistency of reasonable care would be maintained without constantly effectively treating any situation within a constrained NHS as an emergency one, and also delivering on people’s reasonable expectations of a service. From the practical perspective it would be better for the public to know not all hospitals in the area provided emergency services so as not to waste what may prove to be valuable time in accessing care rather than perpetuating false impressions.

\(^{153}\) Newdick n8 p189.
view on resourcing medical posts in NHS hospitals.\textsuperscript{154} Johnstone illustrated that institutional limitation, in that particular case resources with which to provide and pay staff, should neither exclude the negligence action nor should it necessitate that Trusts do not achieve \textit{reasonable} care of their employees, in this instance junior doctors. The court rejected the notion that the Trust due to limited resources should be allowed to place unreasonable demands on such employees. If this line of reasoning were to be followed when considering standards of medical treatment it seems likely that the logic of Witting would be resisted, and reasonable care would be required.

\textsuperscript{154} Newdick n8 p189 where he explained that for many years doctors in NHS hospitals were required to work an average of 88 hours per week. He asserted that the policy reason for this was clear, however in \textit{Johnstone v Bloomsbury} [1991] 2 All ER 293 a doctor had been regularly on duty without proper rest for 90 hours as required by his contract of employment and he sought damages on the basis that the burden of work had affected his health. The Court of Appeal was sympathetic and allowed the claim to proceed. This according to Newdick suggested that the institutional limitations placed on managers as to the manner in which they engage junior doctors did not constitute a blanket ban on actions in negligence by junior doctors, or entitle employers to impose unreasonable demands on their employees. It is asserted that a similar line of reasoning could prevent institutional managers from imposing unreasonable standards of care, for example not reasonable care on the basis of policy reasons.
CONCLUSION

This thesis has argued that it is crucial for the courts in clinical negligence claims to play a proactive role, in ensuring effective standards in medicine and providing adequate redress if they are not met. I have argued that the courts are, and always have been, the ultimate arbiters of the standard of care in clinical negligence and that it is only right and proper for this to be so. *Bolam* of itself did not offer any sort of privilege to doctors. The judgment was misinterpreted for too long, during which period undue weight was accorded to the opinion of medical expert witnesses, and common practice (of clinicians) became perilously close to being determinative rather than informative of the standards required by law.¹ The *Bolitho* decision, in and of itself, will not be sufficient impetus to insure that such unjustified weight is not accorded to the profession’s own views again. Chapter 1 of this thesis examined how deference seized the courts in relation to clinical negligence and demonstrated that this undue reliance accorded to common practice was not followed in other areas of professional negligence in England or certain other jurisdictions of the Commonwealth in relation to clinical negligence. It was not the inevitable consequence of McNair J’s judgment which had lead to this sorry state of affairs, but rather a mix of sociological factors. Chapter 2 examined some of these factors, including judicial fear of defensive medical practices and the perceived ‘special’ status of doctors and their decisions, as possible explanations of why the interpretation of *Bolam* went so awry during this period. Chapter 3 of this thesis argued that no pronouncements of a new *Bolam*² were necessary nor was technical modification of the test required, but rather a judiciary willing to take both the hard look necessary at expert medical evidence and confine it to its proper degree of importance. Evidence of common clinical practice should be treated as would evidence of any other common practice of

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¹ Andrew Grubb *Principles of Medical Law* (Second Edition Oxford University Press 2003)p341 suggested there were some judicial statements which suggested that the practice of the medical profession was determinative of the issue and that it was not open to the court to condemn as negligent a commonly adopted practice. It was this view of *Bolam* which became so prevalent in the years in which *Bolam* went awry that it is termed in this thesis the ‘conventional’ view of *Bolam*.

the community in determining the appropriate standard of care in the tort of negligence.

During this period there were also changes to clinical professional practice largely led by the medical profession themselves such as the increased practice of evidence based medicine and the increased incorporation of clinical guidelines in treatment. These changes occurred alongside unprecedented government regulation. The government reforms involved moving from a system where policy makers were satisfied with following the professions own view of how quality should be assessed, where clinicians were accorded a good deal of discretion, to a system where clinical professional practice became subject to a more interventionist system of external regulation. Unfettered professional practice based entirely on extolling ‘clinical judgment’ became greatly restricted. The outcomes of these movements on the courts were twofold; they both provided a source of evidence of appropriate care which was not dependent on partisan witnesses and demystified clinical practices to some extent. Chapters 1 to 5 have shown that the mechanisms are in place for the courts to interpret Bolam as McNair J intended allowing a ‘brave new Bolam’ to operate in practice in instances of classic clinical negligence. It is noteworthy that the more interventionist regulatory era post 1999 was introduced at a time post Bolitho when there was a renewed focus on the courts as the ultimate arbiters of the standard of care. Certain of this current Coalition Government’s statements, not least the very title of its White Paper Enabling Excellence Autonomy and Accountability for Healthcare workers, might suggest a retrenchment of national prescriptive control with policy makers content to return to reliance on the professions’ own views of how quality should be assessed. If this is the case, it is imperative that the reminder provided by Bolitho that the judiciary are the ultimate arbiters of the standard of care is not unheeded, particularly as the last time when healthcare regulation went through

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3 Changes to clinical practice which were examined in chapter 4 of this thesis.
4 Margaret Brazier and Emma Cave, Medicine, Patients and the Law (Fifth edition Penguin 2011) p5.
5 ACL Davies ‘Don’t Trust Me, I’m a Doctor Medical Regulation and the 1999 NHS Reforms’ (2000) Oxford Journal of Legal Studies 437. The 1999 reforms were according to Davies ‘remarkable’ for the amount of direct intervention particularly as this direct intervention was aimed at clinical care.
6 Classic clinical negligence has been framed so even where the case is brought against the NHS hospital Trust it is based on the trust being vicarious responsibility for the torts of their employees. An example is provided by the case of Wilsher v Essex Area Health Authority [1986] 3 All ER 801.
such a phase the courts were passive and deferential to the professions’ own view of how quality of care should be assessed.

In order to provide comprehensive effective redress within the modern NHS the existence and extent of various institutional primary direct duties of care must be determined. The Health and Social Care Bill 2011 is the latest in a long line of statutory reforms of the provision of healthcare provided free at the point of treatment. At the time of writing the Primary Care Trust is the means by which patients obtain access to both primary and secondary care as the constant in this system of increased diversity. The 2011 Bill provides for their replacement by commissioning consortia by 2013; commissioners will act as gatekeepers to care which is free at the point of treatment. The traditional provision of care, via national health hospital trusts and general practitioners, responsible for ‘their’ patients care 24 hours a day, 7 days a week, and 365 days of the year has altered the current system being far more complex with the increased diversity of actors. Until Margaret Thatcher’s accession to power, it was rare for patients in NHS hospitals to be treated other than by NHS employees, and even in cases where the exact status of an individual had been in doubt, often vicarious liability has been assumed by the hospital. This might explain why the distinction between the two species of a hospital trust’s liability primary/direct and vicarious/secondary was not one that has received more consideration by the courts, in this jurisdiction. Chapter 6 argued that both providers and commissioners of care within the National Health Service must owe a direct primary duty to ensure that reasonable care is provided to patients. Such a duty would amount to what some have termed a non-delegable duty; such duties are not without conceptual difficulties.

8 In the past NHS care was provided via only two avenues, dependant on the type of care required by the patient either a GP or a hospital. Legal responsibility was largely located with this direct provider the public understood this duality and law met these expectations. In an increasingly complex system where fragmentation of responsibility has led in some instances to a plurality of different bodies providing care in the most direct sense it has been contended that it is necessary for the courts to adopt the policy of locating responsibility for NHS treatment where it might be said to meet public expectations. It was argued in chapter 6 that all NHS care is now provided effectively by the commissioner within the system and that legal responsibility for all care ‘provided free at the point of treatment’ should rest on this body even GP care which has evolved enormously over the years. The simple duality of NHS care no longer exists. This period of change has not been accompanied by explanation of the changing face of care. Therefore as a matter of policy it was argued in chapters 6 that the commissioner of this care must owe a duty to ensure reasonable care is provided.

9 Brazier and Beswick n 2 p186.

10 Jones with Lyons n4 p780 where he stated the fact that hospital authorities accept vicarious responsibility for consultants and agency staff removed much of the practical importance of the arguments about whether a hospital is under a non delegable duty to patients.

Ministry of Defence\textsuperscript{12} and Farraj v King's Healthcare NHS Trust\textsuperscript{13} might be said to indicate an unwillingness to extend the limits of direct liability\textsuperscript{14} with neither claimant successful. It is argued that each decision needs to be viewed on its own specific facts. There are crucial distinctions between the Ministry of Defence and commissioners of healthcare within the NHS. Furthermore Farraj leaves open the question of whether an NHS patient undergoing tests organised by an NHS hospital but carried out by an independent laboratory would be owed a direct duty of care.\textsuperscript{15} The institutional changes combined with the relationship of dependency and lack of choice provide potent policy reasons why providers and commissioners should owe the duty to ensure that reasonable care is provided. Particularly as it was explicitly recognised that the categories of attributing that certain institutions owe a direct duty to individuals to ensure care is taken in certain circumstances are not closed.\textsuperscript{16}

The likening of the clinical negligence action to the general negligence action was continued when considering the weight which ought to be accorded to the matter of limited resources when determining the standard of care owed, in determining the standard of care owed in institutional breaches a question examined in depth in chapter 7. It was asserted that when considering the circumstances of the case and the possible modification of the standard of care owed, the courts must not compromise on a minimum or irreducible standard which they will demand of healthcare providers. It is impractical and improper to modify the rules in relation to institutions below a certain minimum; the bell of tight resources cannot be tolled in a manner to exclude the courts where harm has been suffered as a consequence of treatment.\textsuperscript{17} If institutional standards are allowed to diminish and diminish based solely on their being in accordance with the practices of other institutions, a new era of deference could occur.

\textsuperscript{12} Child A v Ministry of Defence [2004] EWCA Civ 641.
\textsuperscript{13} Farraj v King's Healthcare NHS Trust [2009] EWCA Civ 1202.
\textsuperscript{14} Brazier and Cave n4 p 231.
\textsuperscript{15} Farraj v King's Healthcare NHS Trust [2009] EWCA Civ 1202 where Dyson J was persuaded of both the vulnerability of patients and their special relationship with the hospital being in accordance with it being fair and just and reasonable that a hospital should owe a duty of care under Caparo Industries Plc v Dickman [1990] 1 All ER 568. He distinguished Farraj as on the facts of the case there was no contact between the claimants and the Trust. Muiris Lyons 'Case Comment' (2010) 1 Journal of Personal Injury Law 9 argued “if the contracted out service forms part of the wider treatment of a patient in the hospital then there is likely to be a non-delegable duty of care.”
\textsuperscript{17} The argument of Christian Witting was examined in chapter seven where it was argued contrary to his view care should not be reduced below reasonable on the courts assessment. Furthermore it was argued that his worst case scenario the withdrawal of services if standards cannot be modified as needed might not in fact be the worst thing which could happen.
where ‘the new master could be managers’, an era which viewed pessimistically could see standards in other institutions operate as a *de facto* defence under a skewed interpretation of *Bolam*.

To permit the delegation of the courts’ responsibility to anyone is most undesirable and precludes the tort of negligence from carrying out one of its important functions the regulation of professional practices. It is crucial that the dual objectives of ensuring effective medical standards and providing adequate redress if they are not met are achieved. The tort of negligence, with an appropriately proactive judiciary could provide this without substantive modification. *Bolam* could be truly brave in its operation.

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18 This is not intended to imply a nostalgia for the days of what might have been termed trial by expert, nor is it blind to the problems associated with such expertise, not least the courts possible readiness to conflate a person’s credentials with reasonableness of the view which they expressed, nor the expert ‘shopping’ which might have taken pace in the past. It is also recognised that at the time of writing it is likely that a good proportion of those managers might be clinicians also, but the duality of their role if not physical identity should it is argued not be forgotten.

19 The sort of interpretation which was so prevalent in the years in which *Bolam* went awry I refer to it in this thesis a ‘the conventional interpretation’ of *Bolam*. 
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