Bolam under attack: Muller v Kings College Hospital and Webster v Burton Hospitals

Two judgments handed down this month explore the boundaries of the Bolam principle and limit its application. In the first, Kerr J doubted that Bolam was apposite where the court is concerned, not with a choice between two courses of treatment, but instead with a missed diagnosis. In the second, the Court of Appeal rejected the judge’s application of Bolam, in circumstances where a patient had been entitled to information about risks before deciding between treatment options.

In Muller v Kings College Hospital [2017] EWHC 128 (QB), the claimant had a wound on the sole of his foot. In November 2011 a histopathologist (Dr G) examined a biopsy and diagnosed a non-malignant ulcer. The wound failed to heal and in July 2012 the claimant underwent surgery in the form of a narrow local excision. On this occasion a biopsy revealed a malignant melanoma, necessitating a second extensive operation to remove the tumour. Further investigations revealed that the cancer had spread to the lymph nodes. When the November 2011 biopsy was reviewed, signs of malignant melanoma were found. At trial the judge had to determine whether Dr G’s failure to diagnose the melanoma in November 2011 was a breach of her duty to exercise reasonable skill and care.

The defendant trust submitted that the standard Bolam test applied: whether Dr G, when diagnosing an ulcer and not a malignant melanoma, was acting in accordance with the practice of a body of competent respected professionals. The trust called an expert whose opinion was that the misdiagnosis had not been negligent and could easily have been made by a histopathologist acting with reasonable care and skill. The trust’s submission was that, applying Bolam, their expert’s evidence was necessarily sufficient to exonerate Dr G.

The claimant submitted that it was the role of the court, not of the experts, to determine, firstly, the objective facts about what pathological features could be seen on the biopsy slides taken in November 2011 (at trial it was common ground that the slides in fact revealed signs of melanoma); and, secondly, whether a failure to report those signs demonstrated a want of reasonable care and skill. The claimant submitted that the court ought not to abdicate its responsibility to resolve the conflict of expert opinion by falling back upon the “Bolam derived notion of a respectable body of medical opinion.”

Kerr J examined the authorities and noted that the Bolam principle had been forged in the context of what he categorised as “pure treatment” cases. The issue in Bolam itself was whether it was negligent to have failed to anaesthetise the claimant before administering ECT. The claimant’s own expert had conceded in evidence that, although he was in favour of the use of anaesthetics, there was a large body of competent practitioners, whose opinion he respected, that took a contrary view. Similarly, in Maynard v West Midlands RHA [1984] 1 WLR 582, the issue related to a decision whether or not to undertake a mediastinoscopy. The appeal courts overturned the decision of the judge, who had preferred the evidence of the claimant’s expert criticising the decision to undertake that procedure, despite evidence from a distinguished body of expert medical opinion approving of the action of the doctors in carrying out the procedure.

Kerr J distinguished these “pure treatment” cases from cases where the issue was one of pure diagnosis: in the latter situation “there is no weighing of risks against benefits and no decision to treat or not to treat; just a diagnostic … decision which is either right or wrong, and either negligent or not negligent.”

Such an issue had arisen in Penney v East Kent HA [2000] Lloyd’s Rep. Med. 41, a case that concerned false negative reports of cervical smear tests. The claimants had undergone testing to detect existing or potential cervical cancer cells. Slides were examined by cytology screeners, who were required to report them on a scale from “negative” (no indication of cancerous cells) to “glandular neoplasia” (severe glandular cell changes showing possible carcinoma). The screeners pronounced slides to be negative, when in fact they contained cells that were potentially cancerous and the claimants went on to develop invasive cervical cancer.
As in Muller, the experts agreed on what the slides in fact revealed: in that cells with pre-cancerous abnormalities. The issue was not whether a particular course of professional conduct was acceptable, but rather whether it was negligent to report the slides as negative. The trial judge described the Bolam principle as “ill-fitting to the facts” and went on to prefer the expert evidence called by the claimant. In case he was wrong about the need to apply Bolam, the judge went on to consider the exception to Bolam set out in Bolitho v City and Hackney HA [1998] AC 232. In a well-known passage, Lord Browne-Wilkinson emphasised the role of the court in assessing the opinion of the body of experts relied upon:

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

The judge in Penney held that the defence experts’ evidence did not stand up to logical analysis: that the abnormalities were there to be seen and that an opinion that, nonetheless, such a slide could, non-negligently, be reported as negative, made no sense.

The Court of Appeal upheld the judgment in Penney. Kerr J was disappointed that Lord Woolf had not clearly endorsed the judge’s proposition that Bolam did not apply and accordingly felt bound himself at least to pay lip service to it: “even in a pure diagnosis case such as this, the exercise of preferring one expert to another must be viewed through the prism of the Bolitho exception, rather than, as would be preferable, by rejecting the very notion that the Bolam principle can apply where no Bolam-appropriate issue arises.” However, he concluded that the Court of Appeal had at least endorsed a “liberal invocation” of the Bolitho exception in these circumstances.

Kerr J went on to reject the defendant’s submission that “the ipse dixit of” its expert was necessarily sufficient to exonerate Dr G, regarding Penney as authority permitting a court to choose between competing expert opinions, albeit only if satisfied that one was “untenable in logic or otherwise flawed in some manner rendering its conclusion indefensible and impermissible”. After a detailed analysis of the evidence of the experts, Kerr J rejected the evidence of the defence expert and concluded that Dr G’s failure to diagnose malignant melanoma in November 2011 had been negligent. Unfortunately for the claim, this proved something of a pyrrhic victory, as the Kerr J went to find, on the balance of probabilities, that the cancer had already metastasised by November 2011 and that Dr G’s negligence had had a very limited effect on the course of events.

In Webster (A Child) v Burton Hospitals NHS Foundation [2017] EWCA Civ 62 the claimant was born on 7 January 2003 with profound physical and cognitive impairment, caused by a brain injury which occurred between 72 and 48 hours prior to delivery. The experts agreed that, had he been delivered prior to 4 January, he would have avoided these injuries. An ultrasound scan carried out on 18 November 2002 had revealed certain abnormalities: the foetus was small for the gestational age; there was asymmetry in the circumferences of the head and abdomen; and there was excess liquor. It was common ground that the consultant obstetrician’s failure to note these abnormalities and to arrange for further scans was a breach of duty. The main issue at trial was what the further scans he should have arranged would have shown and whether the management of the pregnancy would have materially altered. Using Kerr J’s categorisation in Muller, this could be characterised as a “pure treatment” case.

On 26 December 2003 the claimant’s mother (Ms B) was admitted to hospital feeling unwell. Her due date was the following day and she assumed that the delivery would go ahead then. The claimant’s case was that an induction of labour should have been offered on 27 December which, had it gone ahead, would have avoided the brain injury. The hospital’s case was that, if the two omitted ultrasound scans had been carried out, they would have provided reassurance and would not have given rise to the need for any heightened vigilance or advice about the dangers which might be avoided by early induction.

There was recent research evidence before the judge that demonstrated that the abnormalities revealed by the ultrasound scan could, on the basis of an extremely small statistical base, be associated with an increased risk of perinatal mortality, including ante-natal mortality. The judge pointed out, however, that there was no accompanying advice or guidance related to management of the pregnancy. The Claimant’s expert gave evidence that, in the light of the scans, the balance of risk was strongly in favour of inducing labour at term, rather than waiting two weeks for spontaneous labour. The Defendant’s expert would not, from the point of view of management, have
attached importance to the scans.

The judge concluded that there was a respectable body of medical opinion that would not have been deflected from the usual management of labour by, what he characterised as, “the recent and incomplete material showing increased risks of delaying labour in cases with this combination of features”.

The first instance judgment was handed down before the publication of the decision of the Supreme Court in *Montgomery v Lanarkshire Health Board* [2015] AC 1430. The principal judgment in *Montgomery* was written by Lord Kerr and Lord Reed. At paragraph 87 they set out the modern law on consent:

> “An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.”

The consequences for the *Bolam* principle were spelt out by Lady Hale at paragraph 115:

> “once the argument departs from purely medical considerations and involves value judgments of this sort, it becomes clear … that the *Bolam* test, of conduct supported by a responsible body of medical opinion, becomes quite inapposite. A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth in the “natural” and traditional way and of giving birth by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risks to herself and her baby. She may place great value on giving birth in the natural way and be prepared to take the risks to herself and her baby which this entails. The medical profession must respect her choice, unless she lacks the legal capacity to decide …. There is no good reason why the same should not apply in reverse, if she is prepared to forgo the joys of natural childbirth in order to avoid some not insignificant risks to herself or her baby. She cannot force her doctor to offer treatment which he or she considers futile or inappropriate. But she is at least entitled to the information which will enable her to take a proper part in that decision.”

In the light of *Montgomery*, the Court of Appeal had little hesitation in overturning the decision of the trial judge. The judges’ concern was over whether there was sufficient material before them to allow them to conclude what information should have been given to Ms B about the scans and what course of action she would have taken in the light of that information. The Court found that the consultant would have been obliged to inform Ms B of the recent and incomplete research showing increased risks associated with delaying labour in cases with this combination of features on the scan; and that, in the light of that information and her own training as a nurse, Ms B would certainly have requested an early induction, rather than to wait for spontaneous labour. Causation was therefore made out, as the claimant would have been delivered before he suffered brain damage.

Although *Bolam* remains good law, these two cases illustrate the very substantial inroads that have been made into its scope in recent years. In a pure diagnosis case, the court is not able hide behind *Bolam* and shirk its responsibility to analyse the contradictory evidence of competing experts, where appropriate, preferring one expert to another. Equally, even in a pure treatment case, a doctor cannot simply defend a failure to adopt a particular course of treatment by reference to the conduct of a respectable body of practitioners. He is obliged to inform the patient about all the material risks, in order to enable the patient to reach his or her own decision on treatment; and the responsibility for judging whether or not a particular risk is material is for the court, not the medical profession.