

Pre Edited text of chapter subsequently published as

Lord Montgomery of Botley (Jonathan Montgomery). "Judgment 1—Bolitho v Hackney Health Authority [1998] AC 232." Ethical Judgments: Re-Writing Medical Law. Ed. Stephen W Smith, John Coggon, Clark Hobson, Richard Huxtable, Sheelagh McGuinness, José Miola and Mary Neal. Oxford: Hart Publishing, 2017. 119–124. Bloomsbury Collections. Web. 23 Jan. 2017. <<http://dx.doi.org/10.5040/9781509904136.006a>>.

Ethical Judgments – Bolitho

Lord Montgomery of Botley

This case raises issues of clinical judgment and moral integrity that invite analysis of the very foundations of medical malpractice law. Medicine is a calling that requires the application of knowledge but also the exercise of both skill and judgement. Doctors must be scientists applying their expertise in the interests of their patients. They also embody an ethical tradition that has been developed over centuries and thus must possess moral integrity. It is on the combination of this scientific expertise and ethical orientation that the social contract is built that offers the medical profession a privileged position in our society in return for the care that it provides.

These privileges manifest themselves in the law in many ways. Doctors are entrusted with the power to dispense with the usual criminal sanctions that relate to the use of powerful drugs; prescription-only medicines can be deployed only under medical authorisation (and in limited cases that of other health professionals such as midwives). The law has accepted that even the law of murder needs to be able to accommodate the challenges of medical practice at the extremes of life, acknowledging that it cannot be acceptable that following proper professional practice should place doctors at risk of prosecution (see *R v Adams* [1957] and *R v Arthur* (1981)). That most difficult question of determining whether someone is dead or alive has been entrusted by English law to the medical profession; both Parliament (Human Tissue Act 1961, s1(4), (4A)) and the courts (*Re A* [1992] 3 Med LR 303) have endorsed the application of the tests developed by that profession.

These are privileges that bring great responsibility. There has been much criticism of the law of negligence for its apparent lenience to doctors. It is true that, in the leading case of *Sidaway*, Lord Scarman raised concerns that the test for the standard of care might abrogate the responsibility of the law; 'The implications of this view of the law are disturbing. It leaves the determination of a legal duty to the judgment of doctors' [1985] 1 All ER 643, 649. Yet, that great judge applied the very same test of negligence on behalf of the House of Lords in *Maynard v West Midlands AHA* [1985] 1 All ER 635.

The *Bolam* test was formulated by McNair J in the following terms

[A doctor] is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art. [1957] 1 All ER 118, 121.

It is beyond any serious contention that the *Bolam* test provides the sound foundation of clinical negligence. This House made that clear in *Whitehouse v Jordan* [1981] 1 All ER 267 when considering whether care was negligent. Indeed, this House has endorsed the use of the same test in every case that has come before it concerning the exercise of medical professional judgement. In *Sidaway*, it was applied to determine the scope of doctors' duties to volunteer information to their patients. In *Maynard*, it was applied to professional judgment as to the appropriate management of risk. In *Airedale NHS Trust v Bland* [1993] 1 FLR it was used to define the extent of the obligations of doctors to sustain life. In *re F* [1989] 2 FLR 376 it was used to determine the liability of doctors when treating incapacitated patients. It would take a very bold judge to reach the conclusion that such an august House could be so consistently misguided in its acceptance of the *Bolam* test.

Their Lordships reasoning in *re F* provides an important guide to the rationale behind English law's approach to the regulation of medicine. They were presented with a situation in which it was suggested that two fundamental values were in tension; the right to physical integrity (protected by the legal doctrines of assault and battery, with the doctor's liability waived by the patient's consent to invasive treatment) and the right to proper care (enforced via actions in negligence for medical malpractice). Lord Bridge reasoned that it would be wrong to place doctors in a position where their behaviour would be judged differently depending on the cause of action pleaded by the plaintiff in any subsequent case against them.

It would be intolerable for members of the medical, nursing and other professions devoted to the care of the sick that, in caring for those lacking the capacity to consent to treatment, they should be put in the dilemma that, if they administer the treatment which they believe to be in the patient's best interests, acting with due skill and care, they run the risk of being held guilty of trespass to the person, but, if they withhold that treatment, they may be in breach of a duty of care owed to the patient. If those who undertake responsibility for the care of incompetent or unconscious patients administer curative or prophylactic treatment which they believe to be appropriate to the patient's existing condition of disease, injury or bodily malfunction or susceptibility to such a condition in the future, the lawfulness of that treatment should be judged by one standard, not two. It follows that if the professionals in question have acted with due skill and care, judged by the well-known test laid down in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, [1957] 1 WLR 582, they should be immune from liability in trespass, just as they are immune from liability in negligence. [1989] 2 All ER 545 at 548-9

There needs to be a single standard, to enable the doctors to be free to deliver the care that the patient requires. That standard is captured in the *Bolam* test. No action for assault or battery can be permitted to deter doctors from providing the patient with the care that she needs on the tendentious basis that treatment without consent is unlawful. If it were indeed the law that all treatment of an incompetent patient, for whom no one can give a legally valid consent, would be an assault, then the interests of such patients would be undermined because barriers would be placed in the way of delivering good medicine.

The most fundamental purpose of the law is to facilitate the delivery of the medical care that patients need. The legal duty of a doctor is to apply their professional skills in order to do good for their patients, usually described in the bioethical literature as a duty of beneficence. Lord

Templeman captured this in *Sidaway* when he pointed out that the duty to have regard to the patient's best interests overrode any putative obligation to inform patients or everything that was known about a treatment:

The objectives, sometimes conflicting, sometimes unattainable, of the doctor's services are the prolongation of life, the restoration of the patient to full physical and mental health and the alleviation of pain....The doctor, obedient to the high standards set by the medical profession impliedly contracts to act at all times in the best interests of the patient.... An obligation to give a patient all the information available to the doctor would often be inconsistent with the doctor's contractual obligation to have regard to the patient's best interests.... The duty of the doctor in these circumstances, *subject to his overriding duty to have regard to the best interests of the patient*, is to provide the patient with information which will enable the patient to make a balanced judgment if the patient chooses to make a balanced judgment. [1985] 1 All ER 643, 665-6 (emphasis added).

Similar sentiments can be seen in the speech of Lord Diplock, who pointed out that the doctor had a 'duty of care to exercise his skill and judgment to improve the patient's health' [1985] 1 All ER 643, 657. Even Lord Scarman's speech in *Sidaway* recognises that where there is a clear clash between informing patients and protecting them from harm, then the obligation on doctors to protect their patients prevails over the duty to inform them. That is precisely the function of the 'therapeutic privilege' that he recognises would be required if a reasonable patient test was used to define the obligation to disclose information:

it is plainly right that a doctor may avoid liability for failure to warn of a material risk if he can show that he reasonably believed that communication to the patient of the existence of the risk would be detrimental to the health (including, of course, the mental health) of his patient. [1985] 1 All ER 643, 654.

It is this facilitative purpose that lies behind the law's jealous protection of clinical freedom. This has sometimes been understood as a principle that serves to insulate doctors from external scrutiny, but this is a fundamental misconception of both the workings of the law and its rationale. For clinical freedom is not a matter of the absence of external control, but of the promotion of the conditions in which medicine can flourish. It is only because these conditions are in place that the law is justified in applying more onerous standards to those of a professional calling over and above what could be expected of a reasonable traveller on the Clapham Omnibus.

The defence that an ordinary citizen might make that they did all that could be expected of them cannot protect someone of professional standing. In *Bolam* itself, McNair observed that

where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a 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 special skill. [1957] 1 W.L.R. 582, 586.

For professionals, it is not enough to meet the standards of an ordinary reasonable person. They must meet the extraordinary standards of professional practice. Thus, as Lloyd LJ stated in *Gold* (having quoted the passage just set out), the *Bolam* test

extends the duty of care, as the second of the two passages I have quoted from McNair J.'s summing up in the *Bolam* case makes clear. The standard is not that of the man on the top of the Clapham omnibus, as in other fields of negligence, but the higher standard of the man skilled in the particular profession or calling.... It depends on a man professing skill or competence in a field beyond that possessed by the man on the Clapham omnibus [1988] Q.B. 481, 489-90.

As Lord Edmund-Davies pointed out in *Whitehouse v Jordan* [1981] 1 All ER 267 at 277 by adoption of words of the Privy Council in *Chin Keow v Government of Malaysia* [1967] 1 WLR 813, a professional cannot be judged not against the standard of the 'man on the top of the Clapham Omnibus because he has not got this special skill'.

It would be quite unfair to hold professionals to such standards if the law did not also work to ensure that they were in a position to provide the care that their calling requires of them. Thus, in *Thake v Maurice* the court resisted the seductive temptation of an argument that a contractual term could warrant success, holding that it was not compatible with the uncertain nature of medical practice. A similar point was made about liability in negligence by Lord Denning in the Court of Appeal in *Whitehouse v Jordan* and expressly approved by Lord Fraser in the House of Lords; 'if they are to be found liable whenever they do not effect a cure, or whenever anything untoward happens, it would do a great disservice to the profession' [1980] 1 All ER 650, 658; approved [1981] 1 All ER 267, 281.

Perhaps the clearest explanation of these issues is that offered by Lord Donaldson of Lynton MR in two seminal cases. He explained how clinical imperatives related to legal doctrine, and how the latter should serve rather than compromise the former. Consent, he pointed out, has both clinical and legal purposes

The clinical purpose stems from the fact that in many instances the co-operation of the patient and the patient's faith or at least confidence in the efficiency of the treatment is a major factor contributing to the treatment's success. Failure to obtain such consent will not only deprive the patient and the medical staff of this advantage, but will usually make it much more difficult to administer the treatment....The legal purpose is quite different. It is to provide those concerned in the treatment with a defence to a criminal charge of assault or battery or a civil claim for damages for trespass to the person. *Re W* [1992] 2 FCR 785, 799-800.

In *Re J*, he turned to the role of the doctor in the following terms

No one can *dictate* the treatment to be given to any child, neither court, parents nor doctors... The doctors can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C on the grounds that it is medically contra-indicated or for some other reason is a treatment which they could not conscientiously administer. The court or parents for their part can refuse to consent to treatment A or B or both, but cannot insist on treatment C. The inevitable and desirable result is that choice of treatment is in some measure a joint decision of the doctors and the court or parents. *Re J* [1991] Fam 33, 41

It is clear from this formulation that the law protects clinical freedom, in all its scientific and moral richness, because it is that which provides the bedrock on which the benefits medicine can give patients is built. For the law to require a doctor to treat patients in a way that was inconsistent with their clinical judgment or conscience would be a betrayal of the great promise of medicine not its fulfilment. As Lord Donaldson put it,

The fundamental issue in this appeal is whether the court in the exercise of its inherent power to protect the interests of minors should ever require a medical practitioner or health authority acting by a medical practitioner to adopt a course of treatment which in the bona fide clinical judgment of the practitioner concerned is contraindicated as not being in the best interests of the patient. I have to say that I cannot at present conceive of any circumstances in which this would be other than an abuse of power as directly or indirectly requiring the practitioner to act contrary to the fundamental duty which he owes to his patient. *Re J* [1992] 4 All ER 614, 622

The respect for clinical judgment leads the law to expect the highest standards of integrity from members of the medical professional. It is regard to this integrity that prevents due respect collapsing into mere deference, something that the law could not permit. This is a case about the exercise of professional judgement, but it should always be remembered that judgement is a complicated thing to exercise. In part it is about assessment of the factual situation about which the professional judgement is to be made. The forensic process must seek first to determine how the question appeared to the doctor. Hindsight is a wonderful and seductive thing. It would be unfair to judge doctors on the basis of what turned out to be the case, rather than what was apparent to them at the time. After all, it is their judgment that is being assessed. There is, however, always a risk of self-serving testimony; both claimants and professionals may genuinely or dishonestly believe that the facts were as they wished them to be. This is a matter on which it is quite proper for the court to settle disputes of fact in the usual way, evaluating the reliability of witness and examining the evidence presented. Judgment is also about the application of knowledge. Here, professionals can expect respect for their judgments provided they are exercised in good faith and with integrity.

The facts in the case before the House have been summarised succinctly by my learned friend Lord Browne-Wilkinson and need not be repeated here. Suffice it to say that the case turns on two key issues about clinical judgments made by Dr Horn. First, we are required to consider whether the failure of Dr Horn to attend Patrick (or arrange for someone else to do so) was negligent. Second, we must consider whether Dr Horn was entitled to rely on the fact that she would not have intubated Patrick had she in fact attended. It is accepted before this court that only intubation would have saved Patrick's life and so other issues of fact have now become immaterial to the disposition of the case. It is immaterial to this speech that the second only calls to be considered because of questions of causation, a matter explored fully in Lord Browne-Wilkinson's speech.

In essence, we must ask whether Dr Horn acted with integrity as a responsible professional. This is a two-stage test, examining firstly her personal integrity, and secondly her position as a responsible professional. The first stage is often obscured in reported litigation, but is brought into sharp relief by this case. For, on the facts of this case, the two questions fall to be resolved by applying very different legal tests. It is clear that Dr Horn could not resist a finding of negligence against her in respect of not attending Patrick, because she had in fact decided that it was her professional duty to

do so. She had told Sister Sallabank that she would attend 'as soon as possible' (see [1997] 3 All ER 771, 773g). There is no issue here about professional standards, expert evidence or the *Bolam* test. The matter concerned her personal integrity. Having exercised her professional judgment, she had defined the standard of care that applied to her and she failed to meet it.

No doubt, this occurs in numerous cases that are never reported because it will commonly result in an acceptance of liability and the case being settled out of court. Similarly, if a defendant admits they are at fault, liability will follow (see *Whitehouse v Jordan* [1981] 1 All ER 267, 288 per Lord Bridge). The matter usually only arises in cases contested in the courts because of disputes about what in fact happened. An instructive example is *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR 334. The doctor, Mr Cook, was of the professional opinion that it was necessary to warn the young sexually active male patient that there was a risk of impotence from the procedure in question. The plaintiff's experts agreed, but the defendants' experts did not. Mr Cook believed that he would have given the requisite warning, and that if he had not done so, he would have considered himself to be in breach of his duty. The Health Authority, for whom Mr Cook worked, resisted the claim. It argued that Mr Cook had in fact warned the patient. In the alternative, it further contended that if it was found by the court that he had not done so, then this was not negligent because there was no legal duty to warn in such circumstances.

Morland J approached the case as governed by the *Bolam* test, as elucidated in *Sidaway*, and found that a practice of non-disclosure would have been 'neither reasonable nor responsible'. With the greatest of respect to the judge, this approach was clearly incompatible with the decision of the House of Lords in *Maynard v West Midlands RHA*. The expert evidence showed that there was a contemporary school of thought, including a leading textbook, which would not have regarded such a warning as necessary. Morland J chose between two schools of thought and, as the House of Lords had specifically held, he was not entitled to do so. No doubt, his approach would have been criticised on appeal. But there was no appeal, and for good reason. The fact that some doctors might have escaped liability in negligence in these circumstances did not mean that Mr Cook could have done so. For Mr Cook could not with integrity have asserted that he should not have given the warning. On the contrary, his professional judgment was that he should have done so. The law held him to the standard of that judgement. In the same way, Dr Horn could not have asserted with any integrity that she need not have attended Patrick and it is to her employer's credit that it did not seek to require to her to make any such claim once the court have made its finding on the evidence that she had in fact decided to attend.

We turn, therefore to the second problem. The judge found as a fact that even if she had attended Patrick at 1400, as she had intended, Dr Horn would not have arranged for him to be intubated. This was her honest opinion and she was fully entitled to assert it without compromising her personal integrity. Things would be very different she had been of the view that intubation was appropriate. In such circumstances, it would be immaterial that others might have thought differently. To allow her to defend the claim on the basis that others might have done differently would be to undermine the expectation that society, and the law, has that the professional ethics requires doctors to act with integrity. A doctor without integrity has breached the social contract that provides the context for the standard of care expected by the law of negligence.

This is not a novel concept. The law has long been familiar with this argument from integrity. It is the principle that lies behind the two of the traditional maxims of equity; that 'he (sic) who comes to equity must come with clear hands' so that equity will not allow someone to take advantage of their own wrong, and that equity will not allow a statute to be used as the instrument of fraud. Both these maxims show how the law can recognise that an argument can be valid in the abstract, but be unavailable to someone in a specific case because of their conduct. The equitable doctrine of estoppel is another example of this line of thought; those who indicate that they will not exercise their legal rights in such a way as to induce reliance by another are not permitted to renege on that representation even though the legal right remains fundamentally sound.

This point has rarely been articulated in the medical cases, but its presence nevertheless can be traced. In the recent case of *Re T* [1997] 1 All ER 193 the Court of Appeal took the unusual step of endorsing a mother's decision that a liver transplant was not in her son's best interests despite the clinical team's assertion that it was. Amongst the features of the case was the fact that the hospital had committed itself to the position that the operation would only be appropriate with the full support of a child's family. The change of position on this point undermined their claim to be making a decision with integrity.

It might be suggested that the doctrine was rejected when the court permitted Diane Blood to take advantage of the legal wrong of taking sperm without consent or justification from her dying husband (*R v Human Fertilisation and Embryology Authority, ex p Blood* [1997] 2 All ER 687). However, this was not a case of a professional seeking to take advantage of their unethical behaviour, but a lay person experiencing a personal tragedy. The law's expectation of moral integrity from professionals did not therefore extend to her. Thus, the contrast of approach to these two cases serves to demonstrate the law's expectations of the personal integrity of health professionals in return for its respect for clinical judgment.

If that were the end of the story, then the Health Authority would not be vicariously liable for Patrick's death. However, we must go on then to consider whether Dr Horn's professional integrity permits to rely on her (admittedly speculative) judgment that intubation was unnecessary. This is where the *Bolam* test falls to be considered. We must consider whether the judgements that she made were professionally acceptable in the sense that a responsible body of opinion would have regarded them as proper. For a professional cannot, with integrity, claim respect for a specific clinical judgment that would not be supported by her colleagues. That would be closer to an immunity from suit than the promotion of clinical freedom in the wider interests of patient.

The case law demonstrates consideration of a number of ways in which expert opinion and practice may fall short of the requirement of integrity. Space permits only a brief illustrative summary, and it is certainly not exhaustive. On the issue of expert evidence, it may be that such evidence is influenced by 'the exigencies of litigation', in which case it would become 'self-defeating' as no professional could present it, or seek to rely on it, with integrity (see Lord Wilberforce in *Whitehouse v Jordan* [1981] 1 All ER 267, 276). Lord Bridge developed this theme most eloquently, saying that interpreting a defence witness' report as the trial judge had done implied that it was 'a dishonest attempt to whitewash a subordinate' and would reveal the author as a 'not only a knave but also a fool' [1981] 1 All ER 267, 287. This was not the case and the judge's finding could not stand. If such a

lack of integrity had been displayed, the court would have been amply justified in disregarding the evidence, however eminent the witness.

Nevertheless, this is a risk that may be as much the fault of lawyers as the medical profession and it would be tragic if the moral integrity of medicine was degraded by its contact with the less altruistic values of the legal profession. In the Court of Appeal in *Whitehouse v Jordan*, Lord Denning MR had drawn attention to the pernicious tendency of lawyers to undermine the integrity of medical experts by 'settling' their evidence so as to bias it towards their client's care – 'A striking instance is the way in which Professor Tizard's report was 'doctored'. The lawyers blacked out a couple of lines in which he agreed with Professor Strang that there was no negligence' [1980] 1 All ER 650, 655.

Turning to issues of professional practice, it seems clear that no doctor could rely on fear of litigation as an excuse for an unnecessary test that caused the patient harm or for being so risk-averse as to avoid modern treatment (a position described as 'defensive medicine with a vengeance' by Lord Diplock in *Sidaway* at p 657, see also Lord Scarman in the same case at p 653). That would lack professional integrity because it would depart from the ethical orientation to patient welfare.

These examples show that the court should take care to understand the basis on which health professionals assert that a decision was made in the exercise of clinical judgment directed to securing the welfare of the patients. It would only be human for professionals to succumb to the desire to protect themselves, but if their actions are 'only human', rather than 'professional' – by which we mean taken with integrity in the exercise of professional judgement, then they are not entitled to the special respect that professional judgements are due. Judgements that fail to 'withstand logical analysis', as Lord Browne-Wilkinson puts it in his speech, have not been shown by defendants to be taken with integrity in this sense.

However, with respect, I would depart slightly from his formulation in that it is not, in my view, a matter of whether a professional opinion is '*capable* of being logically supported' (emphasis added) but whether it has in fact been properly supported. Lord Browne-Wilkinson's assertion concentrates on the logic of the argument, but the issue is the integrity of the professional. Not all logical arguments can be asserted with integrity, as has already been noted. By concentrating on the evidence of experts, rather than the case made by the defendant, Lord Browne-Wilkinson removes the spotlight from the doctor.

Nevertheless, in the case before us, this subtle difference is immaterial. The evidence shows that Dr Horn could properly say with personal integrity that she would not have intubated. She could also assert her professional integrity in this decision by showing that her genuine judgment would have been within the range of decisions that might properly have been made. There will be circumstances in which a decision supported by experts would be acceptable if taken by them, but negligent on the part of a particular defendant whose integrity commits them to a different view (see *Smith v Tunbridge Wells HA*, above) or whose reason for reaching a judgment was based on extraneous factors (such as protecting themselves rather than the patient, see the *dicta* in *Sidaway*). However, this is not such a case.

In conclusion, therefore, it can be seen that the plaintiff cannot show that the failure to intubate Patrick Bolitho was negligent. It did not exceed the scope of professional judgment. Nor has it been shown that Dr Horn, the professional in question, failed to act with integrity. Along with Lord Slynn

of Hadley, Nolan, Hoffman and Clyde, I agree, therefore with Lord Browne Wilkinson that the appeal should be dismissed. I have added this lengthy alternative only because it may be in subsequent cases that the differences between approaches that we have taken will be significant.