Medical Negligence and Law
Application of the Bolam and Bolitho Rules in India

M P RAM MOHAN, VISHAKHA RAJ

India has adopted the Bolam rule from the United Kingdom and has been using it to adjudicate cases of medical negligence. The evolution of the Bolam rule in the UK as well as the way the rule is applied in India by the Supreme Court reflects a balance between judicial intervention and deference to medical expertise. Although it is settled that it is the courts and not medical experts who must finally decide on whether the conduct of a doctor is negligent, the standards to be used when evaluating expert evidence and the extent to which such cases must be deferred to are evolving. The Supreme Court has not clearly stated the judicial standard against which it will test these differing opinions of medical experts and has not been consistent in its willingness to do so. Therefore, the application of the Bolam rule in India has been inconsistent and this is likely to have an impact on the decisions made by medical practitioners.

The Bolam rule has become a standard in medical jurisprudence in the United Kingdom (UK) and in India. In the recent past, this rule has been consistently applied in order to determine whether doctors have been guilty of negligence. Over time, this rule has evolved and has become the foundation for discussions surrounding the conduct and level of skill the courts can expect from doctors, and more importantly, where from these conduct and level of skills should be derived. This is important because neither judges nor doctors can work on their own to decide what standards must be used when deciding cases of medical negligence. The laws in India acknowledge the role of deference when dealing with subjects in which judges and lawyers may not possess any expertise, by allowing them to refer to expert opinion in accordance with the Indian Evidence Act, 1872. However, this deference is not absolute in nature as the courts are not bound by these opinions. Experts increase the amount of information available to a judge so as to make the right decision. However, expert evidence can never take away the authority of the court as being the final arbiter in a case such as in Dayal Singh v State of Uttaranchal (2012).

The Bolam v Friern HMC (1957) case (henceforth, Bolam case/rule) has its origins in a similar rationale. It posits that doctors need to act with only a reasonable amount of skill, which is normally expected from a professional in the medical community. However, the rule has been criticised for the manner in which it has been applied by courts in the UK. The rule has put too much power in the hands of the medical practitioner and eroded the adjudicatory powers of the court with respect to cases of medical negligence (Brazier and Miola 2000). Under the Bolam rule, doctors not only prescribe the standards to be followed by members of the profession but also suggest how the transgressions of their peers are to be judged (Brazier and Miola 2000).

Although the rule is derived from an English tort law case, it is widely used by Indian courts. Since some cases refer to the ratio laid down in the Bolam case without referring to the rule itself, there are indications that Achutrao Haribhau Khodwa v State of Maharasthra (1996), Dr Laxman Balakrishna Joshi v Dr Trimbak Bapu Godbole (1969) and the Indian Medical Association v VP Shanta (1995) were some of the first cases to use the Bolam case. The Jacob Mathew v State of Punjab (2005) case is one of the cases that explicitly refers to the Bolam rule. It held that the Bolam rule could be used to determine whether a medical practitioner has been negligent, and made a declaration.
that the rule would be applicable in India. To contextualise the
importance of the Bolam rule, every decision rendered by the
Supreme Court after 2010 on the question of medical negligence
of doctors made a reference to the Bolam rule. Given its extensive
use in India, this paper will attempt to examine the manner in
which the Supreme Court applies the Bolam rule to ascertain
whether a doctor is guilty of negligence.

Before examining the aforementioned issue, the paper will
provide a context on the different types of decisions taken by
doctors. This will be followed by a discussion on the role of the
law in regulating the conduct of doctors. The paper will then
examine the Bolam rule and how it has been interpreted and
applied in the UK and in India. The paper concludes with
suggestions on how the Bolam rule may be optimally used in
India, while focusing on what insights may be applied from its
evolution in the UK to Indian jurisprudence.

Guiding Doctors’ Decisions

The existing literature on the application of the Bolam rule
divides doctors’ decisions into two categories: technical deci-
sions and non-technical decisions (Kennedy 1981: 78). A technical
decision pertains to how a procedure or treatment is carried
out. The expertise of a doctor is required to make technical
decisions (Kennedy 1981). Thus, if an organ is to be removed
from a deceased person, all decisions that relate to the con-
cerned processes would be technical decisions (Miola 2015: 274).
Non-technical decisions determine whether a procedure
is to be carried out or whether a course of treatment is to be
followed. An example of this may be whether or not to perform
an abortion on a minor who does not consent to the same
(but the parents of the minor do) or whether the organs of a
deceased person must be removed (Miola 2015: 275).

The law is a powerful tool in regulating the conduct of doctors
and the decisions they make, but it is not the only factor that
influences a doctor in this regard (Foster and Miola 2015: 506).
Medical ethics, professional standards, and the conscience of
the doctor also greatly affect their behaviour.

The law as enforced through courts can deter doctors from
acting negligently. In addition to this, it also regulates the
behaviour of doctors through statutes that prescribe and
proscribe actions to be taken by doctors. For instance, Section 4(1)
of the UK Abortion Act, 1967, mandates that a doctor must
perform an abortion despite their conscientious objection to
the practice if it is necessary to save the life of the woman who
is pregnant. In India, the circumstances under which an abortion
can be performed are governed by the Indian Penal Code, 1860,
and the Medical Termination of Pregnancy Act, 1971. Initially,
the Bolam rule did not encourage the scrutiny of technical
decisions made by doctors. As long as these decisions were
shown to follow accepted medical protocol, the courts would
not venture into deciding whether they were negligent by
applying another standard or test (Brazier and Miola 2000: 108;
Miola 2015: 272). However, this perception that the role of the
courts must be restricted to deciding non-technical questions
and that they cannot examine technical questions has undergone
some change. This transition is examined later in the paper.

The next factor that influences the decisions taken by a
doctor is medical ethics. A distinction must be made between
philosophical medical ethics and professional medical ethics.
Philosophical medical ethics have been defined by David
Raphael as a critical inquiry into medico-moral decisions
(Gillon 1985). It is a critical evaluation of assumptions and
arguments, and of moral philosophies, which prescribe what
is right, wrong and what ought to be done. An example of this
is the discussions which followed Arthur’s case in the UK (Ferguson 1998). In the Arthur case, a reputed pediatrician
took a decision to effectively end the life of a child with
Down’s syndrome when there was nobody willing to be
responsible for the child. Professional medical ethics pre-
scribe professional standards of behaviour. Thus, they are not
as concerned with a critical inquiry into what is right and
wrong as they are arriving at the decision with a set of stand-
ards through consensus in the profession (Gillon 1985).
Doctors are expected to follow these standards in their
practice, and may face repercussions in the form of disciplinary
action taken by the professional community for not doing so
(Karnataka Medical Council 2015).

The final force of regulation to be discussed is that of the
conscience of the doctors themselves (Foster and Miola 2015:
506). A doctor exercises their conscience in the regulatory
space left by legal and ethical regulation. Since very few
decisions of doctors are completely unhindered by any other
regulating force, there is not a lot of room for the exercise
of the conscience or “moral” of doctors (Miola 2015: 268).
Furthermore, these decisions have been qualified as being
decisions that do not harm the rights of the patient as in the
Ms B v An NHS Hospital Trust (2002) case. For instance,
Section 4(1) of the Abortion Act, 1967, in the UK makes room
for the conscience of the doctor, only to the extent that it
does not endanger the life of a patient. Thus, the doctor’s
moral objection to an abortion is secondary to the interest of
the patient (Miola 2015).

The extent to which each regulating factor ought to influence
the practice of medicine is not a settled question. There is a
concern that excessive legal regulation with respect to the
decisions which can be made by doctors, has the effect of
suffocating them (Montgomery 2006: 185). Thus, doctors
become less equipped to make moral decisions when they need to
and this has, in some cases, led to the inhume treatment of
patients. However, scholars also view increased judicial and
legislative interference in the decisions made by doctors as a
warranted response to various medical scandals (Woolf 2001).
They argue that it is safer for courts to look at medical care
from the perspective of the rights of a patient than to trust
the “beneficence of doctors” (Woolf 2001). The scope of this
paper does not permit these questions to be fully answered.
However, it would suffice to say that the law has been consid-
ered a legitimate regulator of decisions even though it
impinges on the ability of doctors to freely exercise their
conscience (Miola 2015: 281–82).

The relationship between medical ethics and the law in
regulating the behaviour of doctors is slightly more contentious
than the one between individual conscience and the law. It is clear that the law wields more authority to the extent that a practice should arguably not be justified by medical ethics if it is contradictory to the law. This is a corollary to the common law system itself, that is, professional ethics do not overrule legislation and cannot bind courts of law. However, the permissible degree of legal evaluation and regulation of doctors’ decisions has been subject to much debate (Montgomery 2006; Miola 2015). As a result, the extent to which courts can use their own wisdom and discretion to adjudicate cases of medical negligence has evolved over time (Mulheron 2010). Some are of the opinion that courts must defer to professionals in the field to determine what comprises the right course of action as has been done in the Bolam case. However, there are others who would say that the courts must give themselves the liberty to evaluate medical evidence and be the final arbiter in cases of medical negligence without completely deferring to the medical community (Miola 2015). It is the struggle between these two opinions that has been distilled in the evolution of the Bolam rule.

**Introducing the Bolam Rule**

The Bolam rule has its genesis in a 1957 case that involved Bolam, a voluntary patient at the Friern Hospital and the Friern Hospital Management Committee. The ratio of the decision is what is followed in several jurisdictions as the Bolam rule. The case dealt with the complaint of Bolam, who had suffered a hip fracture after being given electroconvulsive therapy (ECT). There were three issues before the High Court of England and Wales. First, whether the patient ought to have been informed about the risk of sustaining a fracture due to ECT. Second, whether he should have been given any relaxant drugs before the procedure. Third, whether he was adequately physically restrained during the procedure so as to ensure his safety and prevent the fracture.

During the time of this decision, there was a divergence in opinion on the use of drugs and restraints to subdue the patient during the procedure and on the question of whether the patient should have been informed that he was at the risk of sustaining fractures due to ECT. The judges in this case were of the opinion that the usual test for negligence, that of an “ordinary reasonable man” cannot be applied to cases which deal with special skill sets such as those possessed by doctors. Thus, it formulated a different test to assess negligence where professional skill is involved and this is now commonly referred to as the Bolam rule. The test posited that persons who practise in a profession like medicine, which requires a special skill, need not possess the highest level of that skill. What is required is that they show the ordinary level of skill, which may be reasonably expected of a member of that profession.

The three issues that the court discussed in the Bolam case were not of the same nature. The second and third issues seem to be technical questions or decisions which require the expertise of doctors. One would have to know the side effects of these relaxant drugs and the role they play in the treatment in order to decide whether or not they needed to be administered. However, the first issue regarding the patient’s right to be informed of the risks of the procedure seems to be a non-technical question. It does not seem like a question that requires the aid of medical expertise to be answered, especially when a patient has the mental capacity to understand the risks of a particular treatment. However, the court in the Bolam case seems to have used the same test to decide both types of questions. This set a precedent for the cases decided after the Bolam case, which continued to use the rule for both technical and non-technical decisions taken by doctors. This phenomenon was referred to as the “bolamisation” of medical ethics (Foster and Miola 2015: 524).

The courts eventually “de-bolamised” non-technical questions such as: What was in the best interest of the patient (Miola 2015: 274)? There exists a subtle distinction between deciding the best course of treatment and deciding to administer the same. Thus, although a doctor may take a decision to conduct a certain procedure in certain cases where the patient is not in a state to give their consent, it does not follow that the doctor must decide the question of consent on the behalf of the patient. Euthanasia is a good example. Although doctors may be of the opinion that it is best for a patient to remain on a ventilator, it does not mean that they will decide whether the patient actually stays on the ventilator. That is often decided by their family or legal representatives, or the law, depending on the country.

With the application of the Bolam rule to non-technical questions, there came to be a circular relationship between the court and the medical profession (represented through medical standards and ethics). The Re W (1992) case illustrates this. The court was posed the question of whether an abortion would be performed on a minor without their consent as long as her parents consented. Lord Donaldson remarked that while the law permitted a forceful abortion on a minor with the consent of their parents, medical ethics would not allow it. It was thus thought appropriate for medical ethics to fill this lacuna in the law (Foster and Miola 2015: 514). However, the General Medical Council (GMC) guidelines in the UK did not have any specific provisions for such cases. These guidelines state that parents cannot override the competent consent of minors; however, they still urge doctors to seek expert legal advice as the law on the subject is complex (GMC nd). Such circularity leads to a dangerous outcome of courts deferring to a profession, which itself has contested and differing ethical standards. In such situations, the subjective perception of individual medical practitioners who give testimony as expert witnesses was likely to prevail. This rule of deference, thus, had to change and the courts could not continue to implement it in the same manner as it was in the Bolam case.

The Bolam rule also attracted criticism for how it determined what would be “reasonable” with respect to the level of a doctor’s skill and decisions (Brazier and Miola 2000: 87). The courts would defer to the medical profession in order to determine this, and in case the expert opinion presented by either side supported differing approaches, the court had no way of
deciding between the two. It would err on the side of caution and absolve the doctor of liability. Thus, the court was unable to strike a balance between acknowledging that there can be legitimate differences in the medical profession and evolving a judicial standard to test these opinions.

Bolam to Bolitho: Application of ‘Logical Analysis’

The extent of deference that courts in the UK show to doctors has changed over the years. The beginning of this shift can be seen in the Bolitho v City and Hackney Health Advisory (1996; henceforth, the Bolitho case). In the Bolitho case, an infant had died from cardiac arrest caused by respiratory difficulties. The nurse alerted the doctor in charge that the child’s condition was getting worse. However, the doctor did not come to check on the infant and intubate (insert a tube into the trachea for ventilation), or send a deputy to do so. It was known to the court that had the child been intubated, the cardiac arrest could have been prevented. There was a divergence of medical opinion at that time with respect to whether the infant should have been intubated based on the information about her condition at the time of the cardiac arrest. Thus, the defence argued that even if the doctor was present, she would not have intubated the patient. Based on this rationale, the trial court acquitted the doctor. The House of Lords upheld this decision of the trial court on appeal, but the reasoning of the House of Lords showed its willingness to move away from the erstwhile deference to the Bolam test, shown by the court. It held that courts would be allowed to choose between differing medical opinions based on standards such as the reasonableness of the opinion, how responsibly it was made and acted upon, and whether it could withstand “logical analysis.” Thus, courts were no longer forced to err on the side of caution and refrain from finding a doctor guilty of negligence because there were differing medical opinions.

The House of Lords decision in the Bolitho case reinterpreted the Bolam rule by holding that the courts would always be the final arbiters of whether or not there has been any negligence. The Bolitho case used the Bolam rule to determine the level of skill required from a doctor. However, what changed in the Bolitho case was that it required what was considered to be the reasonable level of skill or course of action to withstand logical analysis. This is significant as until Bolitho, when presented with differing medical opinions, the court decided to choose neither and absolved the doctor of liability as their course of action was considered reasonable by some responsible members of the profession (the Bolam rule in its purest form). After the Bolitho case, expert opinions would still be given by the members of the profession, but the evaluation of the persuasiveness of these opinions was left to the courts.

Precisely what would comprise “logical analysis” was not enunciated in the Bolitho case. However, guidance may be sought from instances wherein the court considered the opinions of experts as being illogical or indefensible. Rachael Mulheron (2010) has identified six categories of instances where the court tends to apply the Bolitho case’s interpretation of the Bolam rule. One such instance is when the expert opinion has overlooked a clear precaution which could have been taken to avoid adverse outcomes faced by the patient. “Clear precautions” are normally ones that are obvious as a matter of ordinary common sense and are relevant in cases that are not very complicated. The other cases when courts tend to apply the Bolitho case’s interpretation are when the expert opinion fails to weigh the comparative risks and benefits of the chosen course of conduct or treatment, or when the expert medical opinion is given by applying the incorrect legal standard. The latter happens when the expert witness applies a lower standard of care and certifies that the doctor has followed the correct protocol in order to achieve the same. When an incorrect legal standard is applied, it would be irrelevant that the doctor has followed the accepted protocol as the standard of care sought to be exhibited was inadequate in itself (Mulheron 2010: 635).

Effects of the Bolitho Case

The effects of the Bolitho case can be seen in the decisions of cases which followed it such as ARB v IVF Hammersmith Ltd (2017), Asante v Guy’s and St Thomas’ NHS Foundation Trust (2018), and Holdsworth v Luton and Dunstable University Hospital NHS Foundation Trust (2016). For instance, in the case of Pearce v United Bristol Health Care NHS Trust (1999) (henceforth, the Pearce case) the court had to decide whether the failure to inform a woman that there was a minor chance of stillbirth in case she did not opt for a caesarean, was an act of negligence. Although the court decided the case in favour of the defendant, the court showed a shift from the type of reasoning on the subject of disclosure of information and consent under the Bolam rule. The court held in the Pearce case that it behoves the reasonable doctor to give all such information that would affect the judgment of a “reasonable patient.” Thus, the touchstone for reasonableness was no longer within the medical profession alone; it had shifted to the patients, and what they are entitled to know. This is markedly different from the conclusion of the court in the Bolam case, which held that no doctor should “be criticised if he does not stress the dangers which he believes to be minimal involved in that treatment” (emphasis added).

In a broader sense, the shift from the Bolam case to the Bolitho case represents a shift from applying the rule as a sociological test to applying it as an ethical test. In a sociological test, if a body of individuals are shown to be responsible, then their behaviour will also be considered reasonable and responsible (Maclean 2002; LJ 1959). Unlike a sociological test, an ethical test is a normative test. It is concerned with what ought to be done, and this standard is not derived solely from the general practice of members of the profession. When applying an ethical test, the courts will not be bound to consider all opinions as reasonable, simply because they come from responsible members of the profession (LJ 1959: 259). With respect to the transition from the Bolam case to the Bolitho case, the addition in the latter that the opinions given on medical negligence must be able to withstand “logical
analysis” is emblematic of a shift in the manner in which the courts are applying the rule. By adding this criterion for evaluating expert opinions, the courts are using the Bolam case as an ethical test.

Understanding the Bolam Case in India

In Jacob Mathew v State of Punjab (2005), the Supreme Court stated that “the test for determining medical negligence as laid down in Bolam’s case holds good in its applicability in India.” The question before the Supreme Court was whether a doctor can be held liable for the non-availability of an oxygen cylinder in the hospital. While answering the question in the negative, the Court held that the Bolam rule would be applicable in India.

The following sections examine the application of the Bolam rule in India by looking at three specific issues: how the Supreme Court has arrived at the “reasonable” level of skill under the rule; to what types of decisions does the Court apply the rule; and how the Court applies the rule when there is a difference of medical opinion. While examining these issues, the extent to which the Bolitho case’s interpretation of the Bolam rule has been adopted by the Court will also be discussed. Before delving into these specific issues, it is worth examining whether the Bolam rule is applied in India as a sociological test or an ethical test.

The deference towards the medical profession by the Supreme Court was in the case of Dr Martin D’Souza v Mohd Ishfaq (2009) (henceforth, the Martin D’Souza case). In this case, the patient was suffering from acute renal failure. While awaiting a kidney transplant, it was found that the patient also had acute urinary tract infection. The patient only responded to the treatment for the infection, which used the drug Amikacin. However, this drug has a known side effect of causing tinnitus or hearing loss. The question before the Supreme Court was whether the doctor must be held liable for the hearing loss caused by administering this drug. When the Court held that the doctor would not be liable, it heavily relied on the fact that this was an emergency situation and the doctor had administered a life-saving drug. However, this was not the instance of deference that is most significant. The Court went on to hold that in cases of medical negligence, the consumer forum must first refer the case to a committee of competent medical practitioners. It was only after this committee makes a prima facie finding of medical negligence that the consumer forum concerned should issue a notice to the hospital/doctor against whom the complaint was filed. This was an application of the Bolam rule as a sociological test to the extent that it allowed doctors to not only decide the standards for negligence, but also apply them. The rationale behind creating this mechanism was that doctors must not be unnecessarily burdened with litigation and must not be made to stand trial for frivolous reasons. The Court not only expressed a willingness to consider the opinions of medical experts, but it was also willing to be bound by them.

The aforementioned dictum of the decision in the Martin D’Souza case did not go uncontested. In the case of V Kishan Rao v Nikhil Super Specialty Hospital (2010) (henceforth, the V Kishan Rao case), it was held that the part of the decision in the Martin D’Souza case which held that reference must be made to a committee of competent doctors was obiter dicta, meaning that they were observations of the Court which are not binding. The Court in the V Kishan Rao case grounded its reasoning in the beneficial nature of the Consumer Protection Act, 1986, and held that to ensure that consumer courts remain approachable and effective in giving relief to consumers, the courts must be allowed to take cognisance of obvious instances of medical negligence. In the V Kishan Rao case, a patient who had malaria was treated for typhoid; this was held to be an instance of medical negligence. Importantly, in the V Kishan Rao case, the Court made a distinction between complicated and non-complicated cases of medical negligence. The case gave an illustrative list of non-complicated cases of medical negligence wherein the Court need not seek expert medical opinion in order to decide it. However, on a closer examination of the cases cited in the V Kishan Rao case, which were considered to be “non-complicated,” it was found that some of these cases used expert medical evidence in order to decide whether or not the doctor had been guilty of negligence. Beyond this illustrative list, the Court did not give any guidance of identifying non-complicated cases and stated that such a characterisation must be made depending on the facts and circumstances of each individual case.

Furthermore, though the V Kishan Rao case held that courts ought to take cognisance and give relief to complainants in non-complicated medical cases, it did not explicitly rule out the mechanism created by the Martin D’Souza case with respect to complicated cases. However, it may be noted that no case after the V Kishan Rao case decided by the Supreme Court has supported the initial reference to a complaint of medical negligence to a committee of competent doctors. Since the part of the judgment in the Martin D’Souza case, which proposes the reference of a complaint to a committee of doctors, has been declared to be not binding by the Court in the V Kishan Rao case, it is unlikely that courts will give it the force of law.

It thus seems that the Bolam rule is applied as an ethical test in India. Just as in the case of the UK, it is applied as a rule of interpretation and not as an absolute rule of law. The courts still remain the final arbiter of whether the doctors were guilty of negligence.

Many judgments of the Supreme Court refer to literature (medical textbooks and journal articles) on the subject which has been quoted by expert witnesses giving their opinions. In the Bijoy Sinha v Vishwanath Das (2017) (henceforth, the Bijoy Sinha case) the case first came before the consumer protection forum and eventually reached the Supreme Court on appeal. The question, in this case, was with respect to the required blood pressure and haemoglobin of the patient necessary to carry out a hysterectomy. In order to prove the case, the complainant and opposite parties relied on medical literature. The literature on the subject presented on each side was contradictory and, in this situation, the National Consumer
Disputes Redressal Commission (ncdrc) held that it could not show preference for one medical opinion over the other, since both were opinions presented by members of the profession and considered legitimate by some members therein. The Supreme Court agreed with the ncdrc to the extent that there was no negligence on the part of the doctors while carrying out the surgery.

When Does the Supreme Court Turn to Bolam?

Though the V Kishan Rao case makes a distinction between complicated and non-complicated cases in its judgment, the distinction has not been used in other cases. Furthermore, the distinction does not have an impact on the application of the Bolam rule as the judgment did not state how the courts’ approach to adjudicating non-complicated cases must be different from its approach to complicated cases. Thus, despite the extensive use of the Bolam rule in cases of medical negligence, there has not been any extensive discussion on the nature of decisions to which it will apply. This has made it difficult to understand how the Supreme Court will go about appreciating evidence and deciding the more complicated cases of medical negligence. For instance, it is clear that doctors rely on medical texts and opinions of doctors in order to determine the reasonableness of the decision made. The Court has done this in several instances. In Nizam's Institute of Medical Sciences v Prashanth S Dhananka (2009) (henceforth, the Nizam case), the Court found that the texts quoted by the counsel for the doctors also supported the claim of the plaintiff that a neurosurgeon should have been present for the operation.

However, in that same case, there was also a question of whether consent for a biopsy of a mass in the body would amount to consent for its extraction. In deciding this question, the Court focused on the right of the patient to be informed and held that consent for a biopsy would not imply consent for an operation for its extraction. There was no reference made to the practice that is normally followed by doctors in such cases, and the techniques normally used to ascertain whether a decision was reasonable when applying the Bolam rule were not used. The approach of the Court in the Nizam case seems to be in consonance with the existing literature on the Bolam rule and the decisions in the uk after the Bolitho case. In the Nizam case, the Court did not rely on expert medical evidence in order to decide the question of consent. It rejected the notion that doctors could decide procedures based on convenience or what they perceived to be in the best interest of patients. The only exception made by the Supreme Court in the Nizam case was for situations where it is not possible to procure consent given the risk to the patient's life.

Even in the Bijoy Sinha case, the Supreme Court applied the Bolam rule in deciding whether the decisions taken by doctors and the skills possessed by them were reasonable. However, there was another question before the Court. The Court had to weigh upon whether the doctor should have reasonably foreseen that there might arise a need for the services of an Intensive Care Unit (icu) after the operation. In deciding this question, the Court did not rely on the Bolam rule. Rather, it held by applying tort negligence that it was reasonably foreseeable that complications might arise during the surgery and the doctors were thus negligent in deciding to perform it in a nursing home where no icu was available. However, the Court did not go into the details on how it decided that the need of an icu was reasonably foreseeable. It may be noted here that in both the Nizam case and the Bijoy Sinha case, the Court did not refer to the expert opinion of doctors to decide the non-technical questions of the case, that is, whether a procedure was consented to, and whether a particular risk was foreseeable, respectively.

This trend of not “bolamising” non-technical decisions is a welcome but inconsistent one. For instance, in the Martin D'Souza case, it was held by the Supreme Court that the use of Amikacin was not questioned by any of the expert witnesses. However, it was found that the doctor had not conducted any hearing tests on the patient after administering the drug. Although no medical expert contested the use of the drug, some were of the opinion that audiogram tests should have been conducted when it was being administered and the patient’s hearing should have been monitored. The ncdrc, on the basis of these expert opinions, held that the doctor was negligent in not conducting the audiogram tests and was thus liable for the loss of the hearing of the patient. On appeal, the Supreme Court did not mention this contention of the complainant which related to conducting of audiogram tests. In its judgment, the Supreme Court focused on how the doctor in the case was faced with an emergency situation, and no expert had expressed an opinion against the use of the drug. What part of this emergency prevented the carrying out of audiogram tests was not addressed by the Supreme Court. By not engaging with this contention of the claimant and the ncdrc’s treatment of the same, the Supreme Court seemed reluctant to cast upon the doctor the entire breadth of what experts thought was “reasonable.”

This is very different from the approach of the Court in the Bijoy Sinha case where the Court cast a duty upon a doctor to prepare for situations that could be reasonably foreseen and did so without making any reference to expert opinion. Given that the judgment of the ncdrc in the Martin D'Souza case was based on the opinion of multiple medical experts, it would have been appropriate for the Court to state why it did not find some of these opinions persuasive. This lack of clarity makes it difficult to determine which medical opinions will be accepted by the Court and on what basis.

Applying Judicial Standard to Technical Decisions

When the judges in the Bolitho case had decided that technical decisions would be subject to judicial scrutiny and evaluation if they failed to withstand logical analysis, they essentially decided to apply a judicially evolved standard to technical decisions. In India, the Supreme Court does not always shy away from adjudicating cases of medical negligence where there is a cleavage of opinion regarding the reasonableness
of the technical decisions taken by the doctor. However, unlike the UK, the Supreme Court has not clearly stated the judicial standard against which it will test these differing opinions of medical experts and has not been consistent in its willingness to do so.

The case of Malay Kumar Ganguly v Dr Sukumar Mukherjee (2009) (henceforth, the Malay Kumar Ganguly case) is significant when understanding the approach of the Supreme Court in appreciating differences in medical opinions. To reiterate briefly, in the Bijoy Sinha case, the NCDRC preferred to err on the side of caution and held that if some experts were of the opinion that a particular decision was reasonable, then the doctor cannot be held liable for making one of the many alternate but legitimate decisions. This approach is similar to that adopted in the Bolam case. However, in the Malay Kumar Ganguly case, the NCDRC and the Supreme Court were also confronted with a “cleavage” of medical opinion. In this case, medical experts gave different opinions on the use of steroids for treating toxic epidermal necrolysis. The commission held that the doctors who prescribed steroids were not negligent in doing so as there was a group of experts who supported this course of treatment.

However, the Supreme Court treated the cleavage of opinion differently. It acknowledged that both courses of treatment had support within the medical profession. After doing so, the Court looked into whether the doctors who prescribed the steroids actually complied with the protocol for doing the same. The experts testifying stated that when steroids are used for the treatment, they must be used only at the preliminary stage and withdrawn later. In this case, the doctors had prescribed and continued steroids without asking themselves the question of persistent suffering of the patient. The Court also noted other instances where doctors did not act as per the prevailing practice even while prescribing the steroids.

Based on the abovementioned circumstances, the Court held that the doctors were negligent and remanded the matter back to the commission to decide the compensation. The approach taken by the Court in the Malay Kumar Ganguly case is significant as it shows the willingness of the Court to go into the nuances of a case even when there is a divergence of opinion on the face of it. Here, the Court relied on the fact that the doctors did not even strictly follow the protocol of the method of their chosen method of treatment (administering steroids but not strictly in the manner supported by medical literature and expert opinion). This case also shows a willingness of the Court to apply its mind in understanding expert opinion. These cases would require doctors to act extremely cautiously especially when there is a cleavage of opinion. The compensation awarded by the commission was appealed in the Supreme Court in the case of Dr Balram Prasad v Dr Kunal Saha (2014) (henceforth, the Balram Prasad case). The Supreme Court partly allowed the appeal and awarded a final compensation of ₹6,08,00,550.

In another example on dealing with differing medical opinions, the Supreme Court in Vinitha Ashok v Laxmi Hospital and Ors (2001) (henceforth, the Vinitha Ashok case) had to decide whether the doctors were negligent in terminating the pregnancy of the appellant. There was a difference in opinion with respect to the protocols that had to be followed while treating the patient. The Court held that when there was a difference of opinion on the right course of action, a doctor could not be held liable for negligence if they followed a course of treatment which was prevalent in the locality where they practised. Here, the Supreme Court attempted to formulate a legal standard to decide a case despite the existence of a divergence of medical opinion. This is precisely the Bolitho standard.

Differing Medical Opinions

Although the Supreme Court has shown a willingness to scrutinise technical decisions and hold expert opinions accountable to a judicial standard, there are only three Supreme Court cases which have explicitly referred to the Bolitho case. These are the Malay Kumar Ganguly case, the Vinitha Ashok case and the Samira Kohli v Prabha Manchanda (2008) (henceforth, the Samira Kohli case). In the Samira Kohli case, the Court only made a reference to the Bolam rule and the Bolitho case addendum, which dealt with the question of consent and what amounts to informed consent. Thus, this was a non-technical question and the Court answered it by referring to legal principles rather than expert medical evidence on the procedure involved.

The Malay Kumar Ganguly case and the Vinitha Ashok case refer to the Bolitho case and affirm its interpretation of the Bolam rule. However, despite this, there seems to be a reluctance to adjudicate between differing medical opinions while using judicial standards such as reasonableness and logical analysis (refer to the preceding discussion on the Martin D’Souza case). The Balram Prasad case focused on the compensation awarded and the standards set out for this purpose. However, it missed the opportunity to explicitly vindicate the approach taken in the Malay Kumar Ganguly case with respect to adjudicating cases where there is a difference in expert medical opinion and apply the Bolitho case’s interpretation to India. It is quite possible that the reason the Supreme Court has not made this clarification is because it may not have been acquainted with the existence of such ambiguity and inconsistency in its application of the Bolitho case’s interpretation of the Bolam rule in India.

From the aforementioned cases, it is clear that the Supreme Court is cognisant of the fact that in the field of medicine, there can be different but equally legitimate opinions and hence the doctor cannot be held negligent for simply making an error in judgment. This would leave one with a final question of the role of the Bolam rule within the Indian system. How must courts allow doctors to make (responsible) judgments freely, but still not cede too much authority to them? Some authors are of the opinion that the Bolam rule must be a starting point for courts to ascertain the reasonableness of a doctor’s decisions (Foster and Miola 2015: 519). The same applies for doctors; they must refrain from making any decisions that do not fall within the broad scope of the Bolam test. This is a proposition that can be applied by the Indian courts as
well. It would add immense clarity to when and how the Bolam rule is to be used.

Conclusions

In this paper, we have highlighted the law in regulating decisions made by doctors and the scope of this regulation. It is now clear that neither the UK nor India use the Bolam rule in its purest form as seen in the Pearce case. The Supreme Court is cognisant of the Bolitho case’s interpretation of the Bolam rule, and has used this interpretation in its judgments. However, this has not been done consistently. This is shown through the Court’s use of “logical analysis” to test medical evidence. When a clear precaution (one of the instances is shown through the Court’s use of “logical analysis” to test judgments. However, this has not been done consistently. This tation of the Bolam rule, and has used this interpretation in its caution was overlooked in the Malay Kumar Ganguly case the Martin D’Souza case, the Court did not hold the doctors involved guilty of negligence. However, when such clear precaution was overlooked in the Malay Kumar Ganguly case the Martin D’Souza case, the Court did not hold the doctors involved guilty of negligence. Something as simple as a reference to the the Bolitho case’s interpretation whenever the Bolam rule is used would go a long way in ensuring that lawyers and judges do not restrict themselves to the traditional interpretation of the rule when preparing and deciding cases, respectively.

Another area of concern is the manner in which the courts ascertain the ordinary level of skill, which can be expected from a doctor. Courts have extensively relied on literature in order to determine this. However, the texts referred to in the process are not always the same. Different medical experts quote different medical treatises and journals. One way of resolving this difficulty would be to establish clinical guide- lines. Such guidelines are systematically developed to assist the practitioner and patient to make decisions about appropri- ate healthcare for specific clinical circumstances (Ministry of Health and Family Welfare 2018). This is not to say that courts will be bound by these guidelines, but rather these standards act as a touchstone for the decisions of doctors and the opinions of medical experts. Thus, when the Court thinks that a particular standard is deficient or inapplicable to some situations, the Court can convey this to the medical community, thus moulding its discussion around that standard. This will enable the medical community to easily identify the area of disagreement and how it must be resolved.

NOTES

1 The ratio in the Bolam case was that a doctor must not be held liable if the treatment or course of action carried out by them is considered proper in the opinion of trained medical professionals. In other words, the court changes the classic tort law, which states the “reasonable person” to accommodate the specialisation involved in medical treatment and training. However, the practical implication of this was that judges began to rely quite heavily on expert opinions and testimony and did not scrutinise the same using legal standards. This was because judges and lawyers are not medical experts and were thought to not possess the expertise to evaluate medical evidence, and comes to a conclusion different from that to the expert witness/es representing the opinion of trained medical professionals.

2 The R V Arthur (1981) case seems to be an un-reported one and the authors were unable to find a citation from a reporter. Thus, the paper relies on a summary of the case as provided in Ferguson (1998).

3 In the specific contexts referred to, “court” is not used to signify a particular court. “Courts” in the context of de-bolamisation refers to the courts in England. In the context of a “circular relationship,” “court” refers to the adjudicatory mechanism of the legal system. Generally, when a court has not been specified, “court” or “courts” is used to refer to the adjudicatory mechanism of the legal system.

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