

BOLAM IN AUSTRALIA – MORE BARK THAN BITE?

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I INTRODUCTION

The terms of reference for the Expert Panel convened to consider reform to civil liability in Australia required the Panel to ‘develop and evaluate options for a requirement that the standard of care in professional negligence matters (including medical negligence) accord with the generally accepted practice of the relevant profession at the time of the negligent act or omission’.¹ This was an invitation to the Panel to recommend the adoption of the UK *Bolam* principle, which established the professional standard as the relevant standard of care in medical negligence cases. The Panel recommended the adoption of a professional standard as the relevant standard of care but did so with important qualifications that significantly circumscribe its effect. The Panel’s recommendations were largely adopted in the civil liability reforms.²

The focus of this article is the medical profession and the application in Australia of the *Bolam* test at common law and under the statutory professional standard. The article argues that the statutory standard will rarely alter the outcomes in medical negligence claims in Australia. The qualifications to the standard requiring that peer opinion be widely accepted as competent professional practice avoids the adoption of self interested, localised practices that are out of step with mainstream medicine. The backstop that allows the court to reject peer opinion if it is ‘irrational’ may be interpreted to give courts significant scope to reject professional peer opinion that is not substantiated and based on reliable medical evidence. The paper argues that the original *Bolam* test and the introduction of the statutory peer professional standard provide testimony to the power and influence of the medical profession and that a convincing case cannot be made for giving special protection to medical professionals.

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1 The Negligence Review Panel, *Review of the Law of Negligence: Final Report* (2002) reference 3(d) (*‘Ipp Report’*). The Report is referred to as the *Ipp Report* after its chairperson, Ipp J of the NSW Court of Appeal.

2 *Civil Liability Act 2002* (NSW) ss 5O, 5P; *Civil Liability Act 2003* (Qld) ss 20–2; *Civil Liability Act 1936* (SA) s 41; *Civil Liability Act 2002* (Tas) ss 21–2; *Wrongs Act 1958* (Vic) s 59; *Civil Liability Act 2002* (WA) ss 5PA, 5PB. The common law continues to apply in the Australian Capital Territory and Northern Territory.

The NSW provisions are referred to in this article and analysed in detail as broadly illustrative of the legislative response. The NSW section provides that:

- (1) A person practising a profession ('a professional') does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.
- (2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.
- (3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.
- (4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.³

This article is set out as follows. The following part, Part II, discusses the UK *Bolam* standard on which the statutory standard is based and whether the various rationales for its introduction can be justified. The common law approach in Australia and the rejection of the *Bolam* test is then examined. This Part concludes with an examination of how a professional is defined and why professionals should be specially privileged. Part III of the article provides a detailed examination of the statutory provisions. Part IV gives special attention to the legislative exclusion of irrational peer opinion.

II PROFESSIONALS AND THE *BOLAM* TEST

A The UK *Bolam* Standard

The statutory standard has as its foundation the UK *Bolam* standard, named after the 1957 English case *Bolam v Friern Hospital Management Committee*.⁴ There the plaintiff sued for serious fractures sustained as a consequence of electroconvulsive therapy received as a voluntary patient at the Friern Hospital. He was not warned of any treatment risks and was neither restrained nor given relaxant drugs to prevent a violent reaction. There was significant opposition within the profession to the use of relaxant drugs and a view that use of restraints could increase the risk of fractures. The common practice was not to warn of treatment risks unless the patient specifically asked. The jury found that the defendant was not negligent. Justice McNair held that there was no negligence if the defendant

3 *Civil Liability Act 2002* (NSW) ss 5O, 5P. See also *Civil Liability Act 2003* (Qld) ss 20–2; *Civil Liability Act 1936* (SA) s 41; *Civil Liability Act 2002* (Tas) ss 21–2; *Wrongs Act 1958* (Vic) s 59; *Civil Liability Act 2002* (WA) ss 5PA, 5PB. The common law continues to apply in Australian Capital Territory and Northern Territory.

4 [1957] 1 WLR 582 ('*Bolam*').

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 around, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.⁵

The test was described by Lord Scarman in *Sidaway v Governors of Bethlem Royal Hospital* in the following terms:

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 the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment.⁶

Justice McNair in *Bolam* did not regard peer opinion as wholly dispensing with all standards of medical practice. In a part of the judgment rarely cited, McNair J said it would be negligent if the practitioner continued the ‘obstinate and pigheaded use of outdated techniques’ proven to be contrary ‘to what is really substantially the whole of informed medical opinion’.⁷ In recent times, *Bolam* has been rejected in duty to warn cases and qualified in cases involving diagnosis and treatment.⁸ In *Bolitho v City and Hackney HA*, the House of Lords held that professional practice under the *Bolam* test would not qualify as respected peer opinion unless it withstood ‘logical analysis’⁹ but cautioned that it would be rare or exceptional for the court to reach the conclusion that the views of a competent medical expert were unreasonable:

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 ... the weighing of risks and 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.¹⁰

The *Bolitho* decision demonstrates the waning influence of the *Bolam* test in the UK and a growing reluctance to apply the professional standard where a proper assessment of risks has not been made. The decision is directly relevant to the interpretation of the irrational exception to the statutory standard. This is discussed in Part IV(C): *Bolitho* and the Irrational Exclusion.

The following discussion questions whether the *Bolam* principle giving special protection to the medical profession can be justified. The discussion is also relevant to the question as to whether the introduction of the peer

5 Ibid 587.

6 [1985] AC 871, 881.

7 [1957] 1 WLR 582, 587.

8 The authorities are referred to in Part IV(C), below.

9 [1998] AC 232 [242] (Lord Browne-Wilkinson, with Lord Slynn, Lord Nolan, Lord Hoffmann and Lord Clyde agreeing) (*Bolitho*); see extended discussion below. This statement was possibly in response to counsel’s argument that the decision was not logical or sensible: T R Hickman, ‘The Reasonableness Principle: Reassessing Its Place in the Public Sphere’ (2004) 63 *Cambridge Law Journal* 166, 181 fn 92.

10 *Bolitho* [1998] 1 AC 232, 241–2. See also Jo Samanta and Ash Samanta, ‘Clinical Practice Guidelines and Risk Management: A Medicolegal Perspective’ (2007) 13(5) *Clinical Risk* 169, 170.

professional standard in civil liability legislation was warranted on policy or other grounds, which is examined in Part II(C).

In the UK, *Bolam* was regarded as important in preventing medical negligence litigation and limiting the practice of defensive medicine,¹¹ neither of which was a significant concern in 1957 when *Bolam* was decided. An alternative explanation is that the standard when first introduced reflected excessive deference to the medical profession.¹² It confirmed the profession's power and influence in being able to set its own standards and exclude outside interference. Lord Denning in *Whitehouse v Jordan* warned:

Take heed of what has happened in the United States. 'Medical malpractice' cases ... are tried by juries who have sympathy for the patient and none for the doctor, who is insured. The damages are colossal. The doctors insure but the premiums become very high ... 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.¹³

It is doubtful whether the *Bolam* test has had any significant impact in reducing medical negligence litigation in the UK;¹⁴ it is unlikely that 'young men' will have been deterred from entering the medical profession¹⁵ and there is little hard evidence that medical malpractice liability *actually* results in a significant withdrawal of medical services.¹⁶ An alternative justification is that courts lack expertise in assessing scientific evidence¹⁷ or reviewing clinical judgment: courts are not in a position to choose between competing respected

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- 11 Ian Kennedy and Andrew Grubb, *Medical Law* (Oxford University Press, 3rd ed, 2000) 430. In relation to defensive medicine, see David Studdert et al, 'Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment' (2005) 293(21) *Journal of the American Medical Association* 2609; Jonathan Montgomery, *Health Care Law* (Oxford University Press, 2nd ed, 2003) 209; Daniel P Kessler, Nicholas Summerton and John R Graham, 'Effects of the Medical Liability System in Australia, the UK, and the USA' (2006) 368 *The Lancet* 240.
- 12 Lord Woolf, 'Are Courts Excessively Deferential to the Medical Profession?' (2001) 9(1) *Medical Law Review* 1.
- 13 [1980] 1 All ER 650, 658.
- 14 Harold Luntz, 'Medical Indemnity and Tort Law Reform' (2003) 10 *Journal of Law and Medicine* 385. Thus far no decision has turned directly on the statutory standard, Bill Madden, 'The Doctor as God – Medical Litigation's Horizons' (Paper presented at Australasian Law Teachers Association Conference, Sydney, 6 July 2009). See also *Freidin v St Laurent* (2007) 17 VR 439 (Court of Appeal) [16].
- 15 In Australia there appears to be continuing high demand for medical places. Contrast US evidence suggesting some connection with recruitment: Kessler, Summerton and Graham, above n 11.
- 16 Luntz, above n 14. In relation to obstetricians, see Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care: Final Report* (1995) [10.101] ('*Compensation and Professional Indemnity in Health Care Report*'). For US evidence see Michelle Mello et al, 'Changes in Physician Supply and Scope of Practice During a Malpractice Crisis: Evidence from Pennsylvania' (2007) 26(3) *Health Affairs* 425. Cf Alastair MacLennan et al, 'Who Will Deliver Our Grandchildren?' (2005) 294(13) *Journal of the American Medical Association* 1688.
- 17 Note the older arguments about science courts that came to nothing. See Albert Matheny and Bruce Williams, 'Scientific Disputes and Adversary Procedures in Policy-Making' (1981) 3(3) *Law & Policy*, 341.

professional opinions.¹⁸ This argument is less persuasive when courts are called on to choose between conflicting expert knowledge and opinion on issues not involving the standard of care, especially causation issues. Since the *Bolam* rule and the statutory standard are concerned with standards of care, they are not directly relevant to determinations of fact and causation.¹⁹ An alternative explanation is that the *Bolam* rule may be seen as a rule that protected the medical profession against outside interference and confirmed its status as a self-regulating profession with power and influence.

B *BOLAM* IN AUSTRALIA

The Australian courts rejected the *Bolam* principle in determining the standard of care at common law.²⁰ At common law the requisite standard of care is the objective standard of the reasonable person. Where a professional is offering professional services, the higher standard related to that occupation is required.²¹ In relation to medical specialists, the standard is related to the reasonable practitioner²² exercising that specialty or recognised subspecialty.²³ The standard is not the 'best practice standard'.²⁴ Reflecting the accepted common law position, the Victorian and South Australian civil liability legislation specifically provides that if there is a representation of a particular

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- 18 But judges might be qualified to choose between competing professional opinion if professional legal practice was at issue. See, eg, *Edward Wong Finance Co Ltd v Johnson Stokes & Master* [1984] AC 296; *Vella v Permanent Mortgages Pty Ltd* (2008) 13 BPR 25343.
- 19 In UK, the *Bolam* rule has a limited role to play in causation cases involving omissions. See below, Part III(B): Limits on its Application.
- 20 *Rogers v Whitaker* (1992) 175 CLR 479. In Australia at common law, independently of the *Bolam* standard, if the expert evidence when tested indicated more than one respected peer opinion and if those opinions were justifiably held, then there would be nothing unusual in finding that the plaintiff has not proven negligence. See, eg, *Piwonski v Knight* (2002) 83 SASR 400; *Piwonski v Knight* [2003] SASC 169 (6 June 2003) appeal dismissed.
- 21 *Rogers v Whitaker* (1992) 175 CLR 479, 487 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). *Imbree v McNeilly* (2008) 236 CLR 510, 532 (Gummow, Hayne and Kiefel JJ).
- 22 *Rogers v Whitaker* (1992) 175 CLR 479, 483–4 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ), 492 (Gaudron J), which refers to the 'ordinary' rather than the 'reasonable' practitioner. The reference to the 'ordinary' competent professional suggests that the standard is what the profession actually does; whereas the test of a 'reasonably competent' practitioner involves a normative judgment about what a hypothetical reasonable practitioner ought to be done: J L Montrose, 'Is Negligence an Ethical or a Sociological Concept?' (1958) 21 *Modern Law Review* 259. The plaintiff's success in *Rogers v Whitaker* makes clear the High Court did not intend to adopt current professional practice as the appropriate standard despite the language used. The test in civil liability legislation is that of the reasonable practitioner captured in the statutory adoption of the breach of duty test in *Wyong v Shirt* (1980) 146 CLR 40. See, eg, *Civil Liability Act 2002* (NSW) s 5B; *Wrongs Act 1958* (Vic) s 48(1).
- 23 A subspecialty presumably requires professional recognition as well as holding out by the defendant of special skills: see *Defreitas v O'Brien* (1995) 6 Med LR 108 (specialist spinal surgeon). There might be a higher standard of care for centres of excellence, see *Re R (A Minor)* (1996) 33 BMLR 178; *Birch v University College London Hospital NHS Foundation Trust* [2008] All ER (D) 113.
- 24 Which is the standard for solicitors: see *Vella v Permanent Mortgages Pty Ltd* (2008) 13 BPR 25343 (Supreme Court of NSW) (Hungerford J). See also *Heydon v NRMA Ltd* (2000) 51 NSWLR 1; *Yates Property Corporation v Boland* (1998) Aust Torts Reports 81-490, 65-348, 65-349, rev'd on different grounds (1999) 74 ALJR 209.

skill, the relevant standard is what could be reasonably expected of a person possessing that skill.²⁵

At common law a distinction is drawn between what is actually done (professional practice) and what ought to be done. The latter is a normative question for the court to be decided on community standards. The *Bolam* principle was taken as accepting that the relevant standard was that established by respectable professional practice; what was actually done rather than what ought to be done.²⁶ In Australia, acceptable professional practice ‘followed or supported by a responsible body of opinion’ is obviously relevant to what reasonable care requires, but it is not conclusive. This is because it is for the court rather than the profession to determine if the conduct is negligent based on community standards.²⁷

Australian courts rejected the *Bolam* test²⁸ well before the authoritative statement of principle by the High Court in *Rogers v Whitaker*. The common law position was summed up by the High Court in *Rogers v Whitaker*:

In Australia ... the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill ... that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade ... Even in the sphere of diagnosis and treatment ... the *Bolam* principle has not always been applied. ... Further ... in the field of non-disclosure of risk, and the provision of advice and information, the *Bolam* principle has been discarded and, instead, the courts have adopted ... the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to the ‘paramount consideration that a person is entitled to make his own decisions about his life’.²⁹

While *Rogers v Whitaker* rejected the *Bolam* test in cases concerning the provision of advice and information, it was assumed that *Bolam* would continue to apply where negligence involved diagnosis and treatment. But to the surprise and dismay of the medical profession, the High Court in *Naxakis v Western General Hospital* also rejected the application of the *Bolam* test to diagnosis and treatment cases.³⁰ The Court noted however that in cases involving diagnosis and treatment professional opinion will ‘often have an influential, *often a decisive*,

25 *Wrongs Act 1958* (Vic) s 58; *Civil Liability Act 1936* (SA) s 40 confirming the common law: see *Ipp Report*, above n 1, 44 [3.33].

26 Kennedy and Grubb, above n 11, 429.

27 *Mercer v Commissioner for Road Transport* (1936) 56 CLR 580; *Florida Hotels Pty Ltd v Mayo* (1965) 113 CLR 588 (architect); *Rosenberg v Percival* (2001) 205 CLR 434, 439 (Gleeson CJ).

28 See, eg, *Florida Hotels Pty Ltd v Mayo* (1965) 113 CLR 588, 593, 601; *Albrighton v Royal Prince Alfred Hospital* (1980) 2 NSWLR 542, 562–3; *E v Australian Red Cross* (1991) 99 ALR 601, 648–50; *F v R* (1983) 33 SASR 189, 196, 200, 202, 205; *Battersby v Tottman* (1985) 37 SASR 524, 527, 534, 539–40.

29 (1992) 175 CLR 479, 487 (Mason CJ, Dawson, Brennan, Toohey and McHugh JJ).

30 (1999) 197 CLR 269, 275–6 (Gaudron J), 285 (McHugh J), 297 (Kirby J) with Gleeson CJ and Callinan J agreeing that there should be a new trial.

role to play'.³¹ In very exceptional cases, a court might be prepared to put aside professional opinion if the court, applying community standards, formed the view that the profession had closed ranks³² or where there had been a failure to consider and test for alternative diagnoses where there were very serious risks of harm.³³ Despite the fact that rejection of peer expert opinion was extremely rare, it gave rise to sufficient disquiet within the medical profession for it to lobby government and achieve statutory change.³⁴ Now the statutory standard adopts widely accepted peer professional opinion as setting the relevant standard of care unless the court decides that peer opinion is irrational (see Part IV: Irrational Peer Opinion).

As with the UK *Bolam* standard, professionals are the beneficiaries of the new statutory standard. Whilst *Bolam* almost exclusively applied to medical professionals, the statutory standard in most states applies to all professionals. What makes professionals unique in this respect?

C Professionals

The two principal issues considered here are: (1) who is a professional and (2) why special protection should be given to professionals? The adoption of the peer professional standard assumes there is something special about professionals and that it is these features that warrant statutory protection. But many of the attributes of a profession are not unique and the case for special protection may be overplayed. The introduction of the peer professional standard is more about power and political influence than the justified need for special protection.

Turning to the first question, the NSW, Queensland, Victorian and Tasmanian provisions apply generally to professionals, meaning those practising

31 *Rogers v Whitaker* (1992) 175 CLR 479, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ), 593–4 (Gaudron J) (emphasis added). See, eg, *Shead v Hooley* [2000] NSWCA 362 (4 December 2000); *Ambulance Service of NSW v Worley* [2006] NSWCA 102 (3 May 2006) [36] (Basten JA, McColl and Tobias JJA agreeing) special leave to appeal to High Court of Australia refused; *Livingstone v Mitchell* [2007] NSWSC 1477 (18 December 2007), affd [2008] NSWCA 305; *Marko v Falk* [2008] NSWCA 293 (10 November 2008); *Hookey v Paterno* [2009] VSCA 48 (19 March 2009). In relation to uncontradicted expert evidence, see *Taylor v R* (1978) 45 FLR 343, 364; *Lowns v Woods* (1996) Aust Torts Reports 81-376, 63-160, 63-161 (Mahoney JA).

32 Hinted at in *Albrighton v Royal Prince Alfred Hospital* (1980) 2 NSWLR 542, which allowed the admission of overseas expert evidence as to professional practice.

33 *Naxakis v Western General Hospital* (1999) 197 CLR 269, which involved a 12-year-old boy who suffered a trivial blow to the head but showed serious symptoms. There was a division of expert opinion whether alternative diagnoses should have been considered and tested for. See especially: [21] (Gaudron J); [46], [47] (McHugh J); [81] (Kirby J). It is now considered an obvious case where additional testing should have been carried out.

34 See, eg, Julian Morris, *The Insurance Crisis in Australia – Assessment and Proposals for Reform with Special Reference to Medical Indemnity* (2002) Australian Doctors Fund
<http://www.adf.com.au/contents.php?subdir=library/2002/&filename=insurance_crisis>.

a profession.³⁵ The courts are left to determine who is a professional for these purposes.³⁶ There is potential for a very large of number of occupations to qualify as ‘professions’ if the standard definitions, referred to below, are applied. The term ‘professional’ is used in a wide variety of contexts. But the context and statutory purposes may be very different so that a person described as a professional in one situation might not necessarily qualify in a different context or statutory regime. So, for example, classifications of professionals for employment purposes based on a period of learning or relevant experience³⁷ may not be helpful in examining the reach of civil liability legislation. The statutory regulation of health professionals may have as its primary concern the protection of the health and safety of the public.³⁸ It is not concerned with restricting liability³⁹ and limiting payable compensation.⁴⁰ There may be complementary statutory purposes under Professional Standards legislation that permit limitation of liability for financial losses for registered occupational schemes.⁴¹ In this context, professional standards legislation might be seen as one facet of a broader statutory response to limiting liability of professionals. Consequently a professional for those purposes might shed some light on who is a professional for purposes of the statutory standard. However, a person who is a professional in

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- 35 The *Wrongs Act 1958* (Vic) s 58 and *Civil Liability Act 2003* (Qld) s 20 define a professional as ‘an individual practising a profession’. The *Civil Liability 2002* (NSW) s 50(1) and the *Civil Liability Act 2002* (Tas) s 22 refer to ‘[a] person practising a profession (a professional)’. The *Civil Liability Act 1936* (SA) s 41 does not define a ‘person who provides a professional service’. The Western Australian legislation – *Civil Liability Act 2002* (WA) ss 5PA, 5PA(m) – is limited to the medical profession and other health professionals practising a ‘discipline or profession ... that involves the application of a body of learning.’ Note also the wider reach of the national registration system for health professionals, *Health Practitioner Regulation National Law Act 2009* (Qld).
- 36 The Ipp Committee reviewed the various options but regarded the reach of the provision as a matter for political judgment: *Ipp Report*, above n 1, 43 [3.25]–[3.31].
- 37 See Australian Bureau of Statistics, *Australian and New Zealand Standard Classification of Occupations*, cat no 1220.0 (26 June 2009) <<http://www.abs.gov.au/ausstats/abs@.nsf/mf/1220.0>>, in which very large numbers are classified as professionals for employment purposes. Professional groups for these purposes are: arts, media, business, human resource, marketing, design, engineering, science, transport, health, ICT, legal, social and welfare professionals. Professionals are defined for these purposes as:
those who perform analytical, conceptual and creative tasks through the application of theoretical knowledge and experience in the fields of the arts, media, business, design, engineering, the physical and life sciences, transport, education, health, information and communication technology, the law, social sciences and social welfare.
- 38 See *Health Practitioner Regulation National Law Act 2009*.
- 39 The *Health Care Liability Act 2001* (NSW) linked compulsory insurance with restrictions on compensation as a forerunner to the more general civil liability legislation. A similar example is the limitation of liability schemes under Professional Standards legislation. See, eg, *Professional Standards Act 2003* (Vic) s 36, *Professional Standards Act 2004* (Qld) s 35.
- 40 But the reach of professional indemnity insurance may be tangentially relevant because of the interaction between civil liability and compulsory insurance requirements. See *Toomey v Scolaro’s Concrete Constructions Pty Ltd (No 5)* [2002] VSC 48 (7 March 2002) (insurance policy, breach of duty in a professional capacity).
- 41 *Professional Standards Act 1994* (NSW) s 3; *Professional Standards Act 2004* (Qld) s 4; *Professional Standards Act 1994* (SA) s 3; *Professional Standards Act 2005* (Tas) s 3; *Professional Standards Act 2003* (Vic) s 3; *Professional Standards Act 1997* (WA) s 3; *Civil Law (Wrongs) Act 2002* (ACT) sch 4 cl 4.1; *Professional Standards Act 2004* (NT) s 3; *Treasury Legislation Amendment (Professional Standards) Act 2004* (Cth).

a particular statutory context might not necessarily qualify as a professional for purposes of civil liability legislation. This means that case law on who is a professional in different statutory settings must be viewed with caution.

When the question of who is a professional has arisen, principally in relation to consumer protection legislation regulating conduct in trade and commerce, courts have largely adopted a traits based definition.⁴² This essentially describes those occupations that are accepted as professions by reference to what are considered to be their essential attributes. But there is no universal agreement about what features are essential to the definition of a profession, nor do such descriptive approaches explain why professions should be specially privileged.⁴³ Common descriptors of a profession are the requirements of intellectual skill, ‘professional standards of competence, training and ethics ... reinforced by some form of official accreditation accompanied by evidence of qualification’.⁴⁴ The study of professions from the field of sociology suggests other features that are said to be typical of professional relationships. These include relationships of trust and confidence,⁴⁵ high levels of autonomy, significant levels of self regulation by the professional organisation⁴⁶ and rights of exclusive professional practice coupled with professed altruism in the unbiased service to the general community and promotion of the client’s welfare.⁴⁷

The traits based analysis is at least descriptive of the learned professions of law and medicine. But the traits that are said to set professions apart are no longer the exclusive province of the older, learned professions. There are a vast array of organisations and occupations whose members offer ‘professional services’.⁴⁸ Many of these organisations promulgate professional standards, require compliance with codes of ethics, provide professional development and training, require registration and member insurance and self regulate with quality

42 *Commissioners of Inland Revenue v Maxse* [1919] 1 KB 647, 657 (Scrutton LJ); *Currie v Commissioners of Inland Revenue* [1921] 2 KB 332; *Robbins Herbal Institute v Federal Commissioner of Taxation* (1923) 32 CLR 457; *Carr v Inland Revenue Commissioners* [1944] 2 All ER 163, 166 (Du Parcq LJ); *Holman v Deol* [1979] 1 NSWLR 640, 649; *NRMA v John Fairfax* [2002] NSWSC 563 (26 June 2002), [147]; *GIO General Ltd v Newcastle City Council* (1996) 38 NSWLR 558, 568; *Prestia v Aknar* (1996) 40 NSWLR 165, 184–6 (Santow J); *King v Besser* [2002] VSC 354 (30 August 2002); *Shahid v Australasian College of Dermatologists* (2008) 168 FCR 46, 93 (Jessup J reviewing the authorities). Also adopting a traits based analysis, see Stephen Walmsley, Alister Abadee and Ben Zipser, *Professional Liability in Australia* (Lawbook Co, 2nd ed, 2007) 10–12.

43 Mike Saks, *Professions and the Public Interest: Medical Power, Altruism and Alternative Medicine* (Routledge, 1995) 12.

44 *Prestia v Aknar* (1996) 40 NSWLR 165, 184–6 (Santow J). See also *King v Besser* [2002] VSC 354 (30 August 2002); *Shahid v Australasian College of Dermatologists* (2008) 168 FCR 46, 93 (Jessup J reviewing the authorities).

45 But not sufficient to make a medical practitioner a general fiduciary. See *Breen v Williams* (1996) 186 CLR 71 (no fiduciary duty to make medical records available).

46 *Currie v Inland Revenue Commission* [1921] 2 KB 332, 343 (Scrutton LJ); but see Paul Boreham, Alec Pemberton and Paul Wilson (eds), *The Professions in Australia* (University of Queensland Press, 1976) 6–10.

47 Bryan Turner, *Medical Power and Social Knowledge* (Sage Publications, 1st ed, 1987) 131. For review and critical evaluation of the literature, see Saks, above n 43.

48 See Professions Australia membership covering 350,000 ‘professionals’: <www.professions.com.au>.

assurance mechanisms such as complaints policies and procedures.⁴⁹ But many occupations displaying these traits are not necessarily professions for the purposes of the civil liability legislation. There are two features typical of the legal and medical professions that are usually absent. First, the relationship between the ‘professional’ and the client may not be one where the professional is the repository of esoteric knowledge and the client especially vulnerable and dependent. Secondly, the occupation lacks state recognition as a self-regulating monopoly⁵⁰ with the ability to restrict entry to its ranks, with its exclusivity providing status⁵¹ and high levels of remuneration.⁵²

Individuals turned to professionals for help in times of crisis. They sought access to a professional’s esoteric expertise ... gained through a protected period of formal education and an apprentice style process of on the job training. The combination of personal vulnerability and information asymmetry placed the professional in a position of considerable power. However he could be relied upon not to exploit this power because he was motivated by a strong sense of vocation and public service.^[53] According to trait-based theories ... these twin characteristics of esoteric expertise and service ethic justified the third fundamental trait of a profession: the maintenance of monopolistic barriers by the profession’s regulatory body.⁵⁴

The claims to special privilege based on high ethical standards and public service have been seen by some commentators as myths in creating and maintaining preferential market access and monopoly status.⁵⁵ The crucial features according to this view are not the special relationship between the professional and the client or altruism and public service, but the exercise of

49 Some examples with some or all of the elements listed: The Career Industry Council of Australia with Professional Standards for Australian Career Development Practitioners; Records Management Association of Australasia, Professional Status Guidelines; Commercial Asset Finance Brokers Association of Australia; SEQUAL, Senior Australians Equity Release Association of Lenders; Professional Celebrants Association; Professional Historians Association (WA) Inc; Association of Consulting Foresters of Australia standards; Direct Selling Association of Australia; Australian Radio Communications Industry Association; Professional Association of Climbing Instructors Pty Ltd; Australian Lawn Mowers Association. There are also a vast array of allied health professional associations.

50 Historically some occupations retained this attribute but others such as guilds did not. Many occupations such as accountants, actuaries and architects did not have formal qualifications or standardised training, nor were they members of an occupational organisation and yet these groups would normally be regarded as professionals: Wilfrid Prest, ‘Introduction: The Professions and Society in Early Modern England’ in Wilfrid Prest (ed), *The Professions in Early Modern England* (Taylor & Francis, 1987) 14, 15.

51 There was no necessary correlation between the professions and ‘gentlemen’: Ibid 8–11.

52 But not always, witness the nursing ‘profession’, investment bankers at opposing ends of the spectrum. See Laura Empson, ‘Professions’ in Stewart Clegg and James Russell Bailey (eds), *International Encyclopedia of Organization Studies* (Sage Publications, 2007).

53 And claimed protection because of this: see Jonathan Montgomery ‘Medicine, Accountability, and Professionalism’ (1989) 16 *Journal of Law and Society* 319, 328.

54 Empson, above n 52 (footnote added).

55 Ibid. For an alternative approach, see Robert Dingwall and Paul Fenn, “‘A Respectable Profession’? Sociological and Economic Perspectives on the Regulation of Professional Services’ (1987) 7 *International Review of Law and Economics* 51.

political power demonstrated by autonomy, self-regulation⁵⁶ and market monopoly. The medical profession has been, up until now, the most successful in maintaining its monopoly, particularly through the ability of colleges to control specialist accreditation and recognition.⁵⁷ Its power and influence are attested by its ability to persuade governments to put in place indemnity provisions⁵⁸ and the inclusion in civil liability legislation of other special provisions aimed at providing protection to medical practitioners.⁵⁹ But even if a profession is defined by its monopoly status, political power and influence, the courts are unlikely to find this helpful in interpreting the civil liability provisions. Courts have adopted a trait based analysis that accords with common conceptions of what is a profession.⁶⁰ Doubtless, law and medicine would, on this basis, be considered professions.⁶¹

The issue remains, why should medical professionals be given special protection? Do the traits that define what is a profession and who is a professional explain why professionals, particularly medical professionals,

56 Medical professionals see a waning of professional autonomy and influence with greater state control and regulation.

57 Medical specialists are required to undertake supervised training leading to the award of a fellowship by a specialist medical college accredited by the Australian Medical Council. Note also the changes to the national registration scheme achieved by the profession: see Australian Medical Association, National Registration and Accreditation Scheme – Changes lobbied for by the AMA (18 September 2009) <<http://www.ama.com.au/node/4962>>; Medical Board of Australia, *Proposals for Registration Standards for Limited Registration, a Code of Practice for the Medical Profession and a Revised List of Specialties and Specialist Titles: Consultation Paper 2* (2009) 13–15 Appendix C.

58 *Medical Indemnity Act 2002* (Cth).

59 In NSW, earlier legislation limited recoverable compensation: see *Health Care Liability Act 2001* (NSW), which was carried through, with some variation, to the *Civil Liability Act 2002* (NSW). In some jurisdictions civil liability legislation withdraws liability for the costs of raising a healthy unwanted child. See *Civil Liability Act 2002* (NSW) s 67; *Civil Liability Act 2003* (Qld) ss 49A, 49B; *Civil Liability Act 1936* (SA) s 67. There are signs of diminution in prestige and influence at the lower end of the professions, see ‘Professions’, above n 53. Other threats include alternative health professionals, a national registration scheme, bureaucratic control over health care, deskilling of medical practice and access to Medicare billing by other health care providers. See *Health Practitioner Regulation National Law Act 2009* (Qld); Mike Saks, ‘Professionalization, Regulation and Alternative Medicine’ in Judith Allsop and Mike Saks (eds), *Regulating the Health Professions* (Sage Publications, 2002) 148; Montgomery, above n 53, 332.

60 As it has been in other statutory contexts; see eg, *Commissioners of Inland Revenue v Maxse* [1919] 1 KB 647, 657 (Scrutton LJ); *Currie v Commissioners of Inland Revenue* [1921] 2 KB 332; *Robbins Herbal Institute v Federal Commissioner of Taxation* (1923) 32 CLR 457; *Carr v Inland Revenue Commissioners* [1944] 2 All ER 163, 166 (Du Parcq LJ); *Holman v Deol* [1979] 1 NSWLR 640, 649; *NRMA v John Fairfax* [2002] NSWSC 563 (26 June 2002), [147]; *GIO General Ltd v Newcastle City Council* (1996) 38 NSWLR 558, 568; *Prestia v Aknar* (1996) 40 NSWLR 165, 184–6 (Santow J); *King v Besser* [2002] VSC 354 (30 August 2002); *Shahid v Australasian College of Dermatologists* (2008) 168 FCR 46, 93 (Jessup J reviewing the authorities); *Prestia v Aknar* (1996) 40 NSWLR 165, 184–6 (Santow J). See also *King v Besser* [2002] VSC 354 (30 August 2002); *Shahid v Australasian College of Dermatologists* (2008) 168 FCR 46, 93 (Jessup J reviewing the authorities). Also adopting a traits based analysis, see Stephen Walmesley, Alister Abadee and Ben Zipser, *Professional Liability in Australia* (Lawbook Co, 2nd ed, 2007) 10–12.

61 See, eg, *Holman v Deol* [1979] 1 NSWLR 640, 649 (Lee J); *Prestia v Aknar* (1996) 40 NSWLR 165, 186 (Santow J).

should be in a privileged position? The traits that might suggest a basis for special protection are the requirement of intellectual skills, ethics of public service and altruism in the unbiased service to the community.

First, there is the argument that the nature of the professional task warrants special measures. The professional is seen as providing an intellectual bridge between the needs of the public and the capabilities of the science.⁶² A professional may be called upon to exercise fine judgments in the face of uncertainty, conflicting information and rapidly changing knowledge. This is reflected in Justice McHugh's judgment in *D'Orta-Ekenaike v Victoria Legal Aid*:

Competing demands, matters of fine judgment with heavy potential consequences, unexpected outcomes and new information at a crucial moment, for example, are all features of defences to claims of negligence in medical practice. The *Bolam* test of professional liability, which has now been adopted in most Australian jurisdictions by statute, is intended to preclude judges and legal practitioners imposing their own views as to what is negligent practice in many professions. This is particularly so in the case of medical practice where lawyers cannot be expected to appreciate the true reality of participation in that profession. If lawyers and judges had such insight, arguably the common law might have adopted immunities, or higher thresholds of negligence in other professions.⁶³

But this may overstate the position when a great deal of professional work becomes relatively routine with reasonably predictable outcomes. It also assumes that only professionals operate in an environment of uncertainty with imperfect knowledge. Moreover, professionals are paid for the exercise of skill in the face of uncertainty and the higher the skills, judgment and risk involved, the greater the financial rewards. This may be perceived to be inconsistent with limitation of liability of highly remunerated professionals when the price of the product or service reflects the complexity, difficulty and fine judgments to be made. Moreover, the negligence test is not blind to the problems of operating on limited information with unpredictable outcomes. The test is the reasonable defendant in those circumstances. That would include the difficulty of making a determination in the face of what may be an emergency situation, conflicting evidence, a rapidly changing scientific environment⁶⁴ and uncertain outcomes.

Secondly, there is the claim for special protection based on the medical profession's ethics of public service and altruism.⁶⁵ Altruism in the context of the professions is viewed more broadly than the narrow definition of providing

62 Alec Pemberton and Paul Boreham, 'Towards a Reorientation of Sociological Studies of the Professions' in Paul Boreham, Alec Pemberton and Paul Wilson (eds), *The Professions in Australia* (1976) 30.

63 (2005) 79 ALJR 755, [189].

64 *South Eastern Sydney Area Health Service v King* [2006] NSWCA 2 (1 March 2006) (duties where there is 'radical, controversial and experimental treatment').

65 Autonomy has been seen as a necessary trade off for unselfish public service: Montgomery, above n 53, 328.

service without anticipation of payment or reward.⁶⁶ It is used in the sense that societal interests are placed above individual⁶⁷ and the profession's self-interest.⁶⁸ Assuming this is the case and that it is somehow unique to professions, it is counter posed in relation to individual practitioners by the commercialisation and incorporation of medical practices and conduct by a very, very small minority of practitioners that the general public may see as the antithesis of altruism.⁶⁹ But the argument is that the *profession* is to be protected because the profession as a whole serves the public interest over its own sectional interests. But even if it were possible to reach consensus on what is the public interest,⁷⁰ and agreement as to what evidence would satisfy the claim, it does not explain why a profession and its individual members should be rewarded by restricting liability.⁷¹ The law of torts has long dispelled the view that charitable organisations should be subject to a lower standard of care because of their charitable status.⁷² The statutory provision may be seen as an illustration of the special preference given to professions over other occupations and, at least in relation to the medical profession, a demonstration of continuing power and influence.

There is the further argument that protection is essential to ensure the continuance of desirable social goods, particularly the availability of affordable

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- 66 The *Civil Liability Act 2002* (NSW) s 56 adopts a similar definition for a good Samaritan. Medical practice might be seen as involving self-sacrifice – the long period of training, the arduous nature of internship and the very long hours of work. But these attributes are not exclusive to the medical profession and nor is it the case that this is not suitably rewarded. With the advent of Medicare and private health insurance many medical services are at least partially rewarded/funded. Unlike the legal profession, there is no formal evidence of the extent of altruism in this limited sense. In relation to the legal profession, see <<http://www.nationalprobono.org.au>>.
- 67 Groups such as school teachers and social workers who put student/client's interests ahead of their own may rank higher on the scale of altruism, see: Robert Baum, 'Who is a Real Professional?' (2001) 23 *Park Ridge Center Bulletin* 7 <www.parkridgecenter.org/Page1550.html>.
- 68 Sylvia R Cruess, Sharon Johnston and Richard L Cruess, 'Professionalism for Medicine: Opportunities and Obligations' (2002) 177(4) *Medical Journal of Australia* 208.
- 69 Indicative are excessive fees, anti-competitive conduct, Medicare fraud, kickbacks from pathology providers, financial interests in private hospitals and continuing questions concerning relationships with pharmaceutical companies and pathology providers. In relation to disclosure of interests in private hospitals, see *Health Insurance Act 1973* (Cth) s 129AA, pt IIBA; *Private Hospitals and Day Procedures Centres Act 1988* (NSW) s 46.
- 70 Saks, above n 43, ch 2.
- 71 This might be warranted if there was conflict between the professions acting in the public interest and individual duties of care. There is greater scope in the legal profession where a duty to a client conflicts with a lawyer's duty to the court.
- 72 *Gold v Essex County Council* [1942] 2 KB 293, 302, 310 (Lord Greene MR and Goddard LJ). On breach of duty issues, see *PQ v Australian Red Cross* [1992] 1 VR 19, 33. But the argument is reflected in the statutory protection given to volunteers and good Samaritans in civil liability legislation. See *Civil Liability Act 2002* (NSW) ss 55–8; *Wrongs Act 1958* (Vic) ss 31A–31D. Montgomery, above n 53, 328, remarks:

Such altruism legitimates the protectionist attitudes which the law displays because otherwise the professional would be put at the mercy of the free market. It implies that a plaintiff pushing for money is renegeing on the basis of the doctor-patient relationship by lowering it from an (exalted) ethical service to a (sordid) commercial transaction. The doctor's selflessness therefore renders him or her vulnerable to the impliedly devious patient, and the court must protect medical innocence.

medical services to the public.⁷³ The threat of withdrawal of specialist medical services from public hospitals was one of the catalysts for civil liability reform.⁷⁴ It is, however, difficult to find hard evidence that a medical malpractice crisis does in fact result in a significant withdrawal of medical services.⁷⁵ In the light of the extensive measures introduced under the civil liability legislation to reduce the impact of civil liability claims, the introduction of the professional standard may have only a marginal effect on the costs of claims and attendant indemnity insurance and is unlikely in itself to lead to a diminution in medical services. The argument for special protection is not made out.

III THE STATUTORY STANDARD⁷⁶

A Introduction

This section examines the statutory professional standard. It first considers the NSW section 5O as providing a defence and contrasts the Victorian provisions. In Part B, it discusses the limitations on the application of the statutory standard. The standard does not apply to duty to warn cases or issues not involving the standard of care. Whether the standard should be applied to cases not involving medical expertise or judgment is also considered. This is followed in Part C by discussion of the statutory standard and its moderation of the common law *Bolam* test. It examines the various elements of the requirements that peer professional opinion must be (a) ‘widely accepted’, (b) as competent professional practice, (c) in Australia. Part D considers what is the relevant peer professional opinion for these purposes.

The statutory standard imposes significant limitations on the common law *Bolam* test. It is argued that the requirement of ‘wide acceptance’ avoids the worst aspects of the *Bolam* rule by excluding ‘extreme views held by few experts’, ‘rogue’ practitioners and experts working in the same institution.⁷⁷ The opinion must also be widely accepted as *competent professional practice*. This

73 For example, in 1995 in one of the high exposure areas, obstetrics, there was little evidence of withdrawal of services caused by rising negligence claims. See *Compensation and Professional Indemnity in Health Care Report*, above n 17, [10.101].

74 See Luntz, above n 14, 385.

75 There is good US evidence on this issue: see Mello et al, above n 16; cf MacLennan et al, above n 16. The Australian evidence is referred to by Luntz, above n 14, 385. In relation to obstetricians, see *Compensation and Professional Indemnity in Health Care Report*, above n 16, [10.101].

76 The statutory standard applies also to contractual claims based on negligence: *Civil Liability Act 2002* (NSW) s 5A; *Wrongs Act 1958* (Vic) s 44. As to contractual implied duties of reasonable care: see *Breen v Williams* (1996) 186 CLR 71; *Thake v Maurice* [1968] 1 All ER 497 (no warranty in relation to sterilisation); *Dunning v Scheibner* (Unreported, Supreme Court of NSW, Wood J, 15 February 1994) (no warranty in relation to tattoo removal). Public hospital patients would not normally have a contractual relationship with the provider but private patients generally would: see *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542; *Ellis v Wallsend District Hospital* (1989) Aust Torts Reports 80-259 (private hospital, patient selected specialist); *Edelsten v Health Insurance Commission* (1994) 35 NSWLR 522 (patient bulk billing).

77 *Ipp Report*, above n 1, 39 [3.8].

ensures that practices that are completely outdated and not evidence based are similarly excluded. The more stringent requirements of the statutory standard means that it will only very rarely produce a different outcome to what would have occurred under the general law. It has already been noted that at common law in diagnosis and treatment cases, it was exceptional for Australian courts to reject peer professional opinion and to hold a practitioner negligent where there was justifiable professional opinion that the conduct was not negligent.⁷⁸ Indeed in NSW, where there is now a body of case law in which the provision has been argued, there is no medical negligence case where the defence has made a difference in the result.⁷⁹ Courts have been astute in finding common ground in differing professional opinions or finding that there is good reason to prefer one expert opinion over another.⁸⁰

Although the NSW provision is referred to as setting the standard of care, the section has been held to provide a defence⁸¹ to a negligence claim, and must be specifically pleaded.⁸² In NSW, where a defendant wishes to argue a defence based on this section, the plaintiff must first establish the common law standard of care.⁸³ If the defendant pleads a defence based on the statutory provision, it is then up to the plaintiff to establish that the peer opinion is irrational.⁸⁴ The equivalent Victorian states that a professional is ‘not negligent’.⁸⁵ The language of the NSW statute differs in that it states a professional ‘does not incur a liability’. Consequently, the Victorian provision may not operate as a formal defence, in which case the defendant will have only an evidentiary burden of adducing evidence of widely accepted peer opinion.

78 See Part II(B), above.

79 At the time of publication, the most recent was *Sydney South West Area Health Services v MD* [2009] NSWCA 343 (21 October 2009).

80 See, eg, *Dobler v Halversen* (2007) 70 NSWLR 151. The evidence when tested may make it unnecessary to rely on the statutory standard: see, eg, *Melchior v Sydney Adventist Hospital Ltd* [2008] NSWSC 1282 (9 December 2008) [96]; *Hawes v Holley* [2008] NSWDC 147 (22 August 2008) [100] *Sydney South West Area Health Services v MD* [2009] NSWCA 343 (21 October 2009); *Hope v Hunter and New England Area Health Service* [2009] NSWDC 307 (27 November 2009).

81 The phraseology employed in section 50 that ‘[a] person *does not incur a liability*’ (emphasis added) is consistent with other provisions setting up defences. See *Civil Liability Act 2002* (NSW) ss 52, 57, 58C. South Australia uses a similar phrase, ‘incurs no liability’: *Civil Liability Act 1936* (SA) s 41.

82 The section provides a formal defence, despite the heading ‘Standard of Care for Professionals’. See *Dobler v Halversen* (2007) 70 NSWLR 151, 167 [59]–[61] (Giles JA, Ipp and Basten JJA agreeing); *Sydney South West Area Health Services v MD* [2009] NSWCA 343 (21 October 2009).

83 Adopted in the *Civil Liability Act 2002* (NSW) s 5B. Current professional practice is evidence of whether there is negligence for the purposes of section 5B. In contrast, section 50 requires the court to accept peer professional opinion that meets the section 50 tests unless it is irrational: *Sydney South West Area Health Services v MD* [2009] NSWCA 343 (21 October 2009) [32] (Hodgson JA, Allsop P and Sackville AJA agreeing).

84 *Vella v Permanent Mortgages Pty Ltd* (2008) 13 BPR 25343, [547], [548] (Young CJ in Equity) (Supreme Court of NSW); *Sydney South West Area Health Services v MD* [2009] NSWCA 343 (21 October 2009).

85 *Wrongs Act 1958* (Vic) s 59. The defence sections use the phrase ‘is not liable’, *Wrongs Act 1958* (Vic) ss 31B, 31F, 37, 55. Similarly, the Queensland and Tasmanian sections referring to no breach of duty might not provide a formal defence: *Civil Liability Act 2003* (Qld) s 22; *Civil Liability Act 2002* (Tas) s 22; cf *Civil Liability Act 2002* (WA) s 5PB(6).

B Limits on Its Application

There are significant limits on the application of the statutory standard. It is not a ‘lay down mezzaire’ simply because there is divergent expert opinion. The issues discussed below are: the normal trial processes of testing expert witness evidence; whether there are implicit limits in cases where no professional expertise or judgment is required and where broader societal interests are involved; the problems of overlap with a professional duty to warn to which the standard does not apply and limitation of the statutory test to standard of care questions.

The NSW cases where the statutory test has been argued make it clear that expert opinion is to be rigorously tested as a normal part of the trial process.⁸⁶ Expert evidence must be evaluated and tested in the light of the expert’s experience, knowledge and the relevant literature. Expert opinion might be attacked on the ground that the expert has limited day to day experience in the particular field,⁸⁷ the evidence is beyond the field of expertise or the opinion does not reflect peer opinion in the field.⁸⁸ There may be gaps or errors in the evidence or the opinion might not be supported by the evidence. The factual basis on which it is based may be inaccurate or the opinion inconsistent or lack currency.⁸⁹ Nor is it necessarily sufficient to simply point to a common practice as the basis of the application of the statutory test⁹⁰ without determining its appropriateness in the individual case.⁹¹

The statutory standard is not a straight out adoption of the common law *Bolam* standard. It is expressly excluded where a professional has a duty to warn of risks.⁹² Professional opinion does not trump an individual’s right to personal autonomy to decide whether to undergo treatment, a view accepted by the High Court in *Rogers v Whitaker*, in the passage cited above. Are there implied limitations to the statutory standard in cases involving broader societal values and interests? Presumably the statutory standard would not apply where the

86 See, eg, *Dobler v Halversen* (2007) 70 NSWLR 151. The evidence when tested may make it unnecessary to rely on the statutory standard: see, eg, *Melchior v Sydney Adventists Hospital Ltd* [2008] NSWSC 1282 (9 December 2008) [96]; *Hawes v Holley* [2008] NSWDC 147 (22 August 2008) [100] *Sydney South West Area Health Services v MD* [2009] NSWCA 343 (21 October 2009); *Hope v Hunter and New England Area Health Service* [2009] NSWDC 307 (27 November 2009).

87 *Melchior v Sydney Adventists Hospital Ltd* [2008] NSWSC 1282 (9 December 2008) [41], [42], [117].

88 *Marriott v West Midlands Regional Health Authority* [1999] Lloyd’s Rep Med 23.

89 Robert Stitt QC ‘Cross-Examination of Expert Witnesses: A Practical Approach via a Personal Excursion’ (2005) 26 *Australian Bar Review* 219. The Ipp Committee recommended using court appointed experts to obviate the problems: *Ipp Report*, above n 1, 55 [3.79]–[3.81].

90 *Vella v Permanent Mortgages Pty Ltd* (2008) 13 BPR 25343 (Supreme Court of NSW).

91 *Ibid* [558].

92 *Civil Liability Act 2002* (NSW) s 5P; *Civil Liability Act 2003* (Qld) s 22(5); *Wrongs Act 1958* (Vic) s 60. *Civil Liability Act 1936* (SA) s 41; *Civil Liability Act 2002* (WA) s 5PB (includes unborn children); see also *Ipp Report*, above n 1, [3.1]. This is consistent with the developments in UK, which have increasingly refused to apply the *Bolam* test in duty-to-warn cases, where patient autonomy is at stake: *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR 334; *Pearce v United Bristol Healthcare NHS Trust* (1998) 48 BMR 118; *In Re Organ Retention Group Litigation* [2005] QB 506; *Chester v Afshar* [2004] 4 All ER 587 (House of Lords).

conduct was unlawful.⁹³ But should professional opinion determine whether nutrition should be withdrawn from an incompetent dying patient?⁹⁴ This type of case is not one in which a court is unable to make a judgment or is being asked to second guess clinical knowledge, expertise or judgment.⁹⁵ It involves more important ethical questions in which community interests should surely override professional opinion. Similarly, professional judgment and clinical expertise is not called into question where there is continued use of faulty equipment or the continued use of diagnostic instruments that are known to be unreliable.⁹⁶ If the statutory standard did apply, it is, of course, arguable that even if this practice were supported by peer opinion, that support opinion might nonetheless be held to be irrational. This is discussed in Part IV. Since the legislature has made specific limited exceptions to the statutory standard, it is likely that courts will not read in limitations to the application of the standard, particularly because the qualification of irrationality leaves scope to reject peer professional opinion in exceptional cases.

The statutory standard determines the relevant standard of care. Consequently, it does not apply where the standard of care is not in issue even where there is a division of expert opinion. For example, the test has no relevance if the question is whether a cyst has grown since last examined⁹⁷ or what was the state of knowledge⁹⁸ at the time the alleged negligent conduct occurred.⁹⁹

93 Specific exclusion in *Civil Liability Act 2003* (Qld) s 22(2).

94 Cf *Airedale National Health Service Trust v Bland* [1993] AC 789; *Re F (A Mental Patient: Sterilisation)* [1990] 2 AC 1 (sterilisation of severely retarded female), doubted by McHugh J in *Department of Health and Community Services (NT) v JWB & SMB (Marion's Case)* (1992) 175 CLR 218, [31]. See also Andrew Grubb, 'Causation and the Bolam Test: *Bolitho v City & Hackney Health Authority*' (1993) 1 *Medical Law Review* 241, 246. Other possible examples include: duty to warn patient of partner's HIV positive status: *BT v Oei* [1999] NSWSC 1082 (5 November 1999); *Harvey v PD* (2004) 59 NSWLR 639; or organ retention from deceased babies without parents' consent: *Re Organ Retention Group Litigation* [2005] QB 506, [230].

95 It might be possible to argue that this is not a 'professional service' for the purposes of section 5O of the *Civil Liability Act 2002* (NSW) s 5O. Section 5O only applies to 'negligence arising from the provision of a professional service' (emphasis added). I am indebted to an anonymous referee for suggesting this point. The term 'professional service' is not defined in the Act but is also referred to in section 5H(2)(c) (duty to warn of obvious risk not applying) and section 5P (excluding duty to warn cases from the operation of section 5O). The section would be further weakened in its effect if this involved a dissection of the particular tasks and a distinction between the professional service and ancillary matters. Note the argument in the different context of the fair trading legislation: *Prestia v Aknar* (1996) 40 NSWLR 165, 188 (Santow J); *Shahid v Australasian College of Dermatologists* [2008] FCR 46, [171]–[173] (Lee J).

96 For example, equipment used in blood testing: (2001) 323 *British Medical Journal* 805. See also *Joyce v Merton, Sutton and Wandsworth Health Authority* [1996] 7 Med LR 1 (instructions given to patient on discharge inadequate). For comment, see Grubb, above n 94.

97 *O'Gorman v Sydney South West Area Health Service* [2008] NSWSC 1127 (29 October 2008), rev'd on different grounds: *Sydney South West Area Health Service v Stamoulis* [2009] NSWCA 153 (24 July 2009). Other illustrations: *Hawes v Holley* [2008] NSWDC 147 (22 August 2008) [27], [37] (whether the defendant observed signs of peritonitis at a particular point of time); *Fallows v Randle* [1997] 8 Med LR 160 (why a surgical device was not in the correct position); *Penney v East Kent Health Authority* [2000] Lloyd's Rep Med 41, [48], [62] (Lord Woolf MR) (what a slide showed).

98 An expert witness's evidence may be rejected where the witness is not able to testify as to the practice at the time of the negligence, see *Reynolds v North Tyneside Health Authority* [2002] Lloyd's Law Rep Med 459.

Similarly, the statutory standard does not directly apply to causation issues where there are differences of expert opinion.¹⁰⁰ Lord Justice of Appeal Stuart-Smith in the English case *Fallows v Randle* referring to the common law *Bolam* test said that the principle does not apply:

where what the judge has to decide is, on balance, which of two explanations – for something which has undoubtedly occurred which shows that the operation has been unsuccessful – is to be preferred. That is a question of fact which the judge has to determine on the ordinary basis on a balance of probability. It is not a question of saying whether there was a respectable body of medical opinion here which says that this can happen by chance without any evidence, it is a question for the judge to weigh up the evidence on both sides, and he is, in my judgment, entitled in a situation like this, to prefer the evidence of one expert witness to that of the other.¹⁰¹

But standard of care questions may interact with causal issues where the question is whether the failure to provide treatment is a cause of the plaintiff's harm. In the House of Lords decision in *Bolitho* a doctor failed to attend to assist a very ill child in hospital.¹⁰² The hospital admitted negligence. It was argued that even if the doctor had attended, the doctor would not have intubated the child with the consequence that the defendant's negligence did not cause the harm. There was conflicting expert evidence on whether the child should have been intubated if the doctor had attended. In the House of Lords, Lord Browne-Wilkinson said there were two questions to be asked.¹⁰³ First, what would the doctor have done if she had attended the child? Second, if the doctor would not have intubated, would that have been negligent?¹⁰⁴ The *Bolam* test was not relevant to the first question but 'central' to the second question. It was held that failure to intubate would have been consistent with reputable professional opinion and the defendant was not liable. The House of Lords adopted the following statement:

a plaintiff can discharge the burden of proof on causation by satisfying the court either that the relevant person would in fact have taken the requisite action (although she would not have been at fault if she had not) or that the proper discharge of the relevant person's duty towards the plaintiff required that she take that action. The former alternative calls for no explanation since it is simply the factual proof of the causative effect of the original fault. The latter ... involves the factual situation that the original fault did not itself cause the injury but that this was because there would have been some further fault on the part of the defendants; the plaintiff proves his case by proving that his injuries would have been avoided if proper care had continued to be taken. In the *Bolitho* case the

99 But if the question is how far a defendant should have been aware of recent advances in knowledge, this is a matter where opinions may differ and relevant to determining the standard of care: *Penney v East Kent Health Authority* [2000] Lloyd's Rep Med 41, [31] (Lord Woolf MR).

100 The section headings refer to 'Standard of Care for Professionals', which suggests that it does not apply to causation issues: *Civil Liability Act 2002* (NSW) s 5O; *Wrongs Act 1958* (Vic) s 59(1).

101 [1997] 8 Med LR 160; see also *Loveday v Renton* [1990] 1 Med LR 117, 123–4 (Stuart-Smith LJ).

102 [1998] AC 232.

103 [1998] AC 232, 239–40 (Lord Slynn, with Lord Nolan, Lord Hoffman and Lord Clyde agreeing).

104 Where a defendant failed to refer a patient to a specialist unit for treatment, the second question was not relevant if the plaintiff would have been operated upon if referred. See *Gouldsmith v Mid Staffordshire General Hospitals NHS Trust* [2007] EWCA Civ 397 (27 April 2007).

plaintiff had to prove that the continuing exercise of proper care would have resulted in his being intubated.¹⁰⁵

In the UK, the *Bolam* test may be relevant to causation where the issue is whether the defendant's negligent omission caused the plaintiff's harm.¹⁰⁶ Similarly, the statutory test might be relevant to causal issues in line with the *Bolitho* decision. A counter argument is that the statutory standard does not modify the operation of the civil liability causation provisions, which are intended to have a general operation.¹⁰⁷ Otherwise causation issues will operate differently depending on whether professional negligence is involved.

C The Statutory Standard: Moderating the *Bolam* Test

The statutory standard introduces important qualifications to the common law *Bolam* principle. The Ipp Committee thought that the *Bolam* principle as originally formulated gave too much weight to 'extreme views held by few experts', 'rogue' practitioners, and experts working in the same institution.¹⁰⁸ Some of these particular difficulties are avoided by the requirement that peer opinion must be widely accepted as competent professional practice.¹⁰⁹ Codes of conduct relating to expert witnesses¹¹⁰ may also operate to disqualify rogue witnesses.¹¹¹

The next part of the discussion examines the requirement that peer opinion be 'widely accepted' and the importance of current professional practice in this context. Under the statutory standard, evidence of customary practice may satisfy

105 [1998] AC 232, 239–40 adopting the views of Hobhouse LJ in *Joyce v Merton, Sutton and Wandsworth Health Authority* [1996] 7 Med LR 1, 20. It was held that it would not have been negligent not to intubate.

106 This is the accepted position in the UK: see *Joyce v Merton, Sutton and Wandsworth Health Authority* (1995) 27 BMLR 124; *Jones v South Tyneside Health Authority* [2001] EWCA 1701; *Zarb v Odetoyinbo* (2006) 93 BMLR 166; cf Andrew Grubb, 'Commentary: Causation and the Bolam Test' (1993) 1 *Medical Law Review* 241, 243, 245; Andrew Grubb, 'Commentary: Joyce v Merton, Sutton and Wandsworth Health Authority' (1996) 4 *Medical Law Review* 86. The issue was left open by the NSW Court of Appeal in *South Eastern Sydney Area Health Service v King* [2006] NSWCA 2 (1 March 2006) [49]–[51].

107 This is arguably inconsistent with the legislative 'but for' (necessary condition) test of causation. See *Civil Liability Act 2002* (NSW) s 5D(1); *Wrongs Act 1958* (Vic) s 51(1)(a). Note also *Civil Liability Act 2002* (NSW) s 5E, *Wrongs Act 1958* (Vic) s 52 – plaintiff bears the onus of proof of 'any fact' relevant to causation.

108 *Ipp Report*, above n 1, 38 [3.8].

109 *Ipp Report*, above n 1, 40 [3.1.1]. See also *Dobler v Halversen* (2007) 70 NSWLR 151.

110 See, eg, *Supreme Court Rules* (NSW) r 13K; *Uniform Civil Procedure Rules 2005* (NSW) sch 7; *Supreme Court (General Procedure Rules) 2005* (Vic) r 44.03. In an English survey, 70 per cent of UK expert witnesses had been asked to modify their report and about one third had done so. About 25 per cent of respondents suggested alterations beyond clarifications and errors were requested. See Harvey Teff, 'The Standard of Care in Medical Negligence – Moving on from *Bolam*' (1998) 18 *Oxford Journal of Legal Studies* 473, 481–3. See also Richard Cooper, 'Federal Court Expert Usage Guidelines' (1998) 16 *Australian Bar Review* 203.

111 But self-interested evidence from an expert might be admitted but given less weight: *Sydney South West Area Health Service v Stamoulis* [2009] NSWCA 153 (24 July 2009).

the requirement that peer opinion be widely accepted.¹¹² If current professional practice is flawed, it calls into question whether the practice is accepted as competent professional practice, (discussed later in this section) or, in the extreme case, whether the opinion is irrational (see Part IV). Clinical practice guidelines may also provide evidence of widely accepted professional practice.¹¹³ Clinical practice guidelines have been accepted in the UK as responsible relevant professional opinion for the purposes of the *Bolam* test.¹¹⁴ They are also highly influential on the issue of liability and relied on extensively, particularly by plaintiffs.¹¹⁵ In Australia, guidelines could provide evidence of peer professional opinion where the guidelines are supported by expert evidence as to relevance to the individual case and currency.¹¹⁶ The limitations of clinical practice guidelines and the question whether expert opinion or professional practice in opposition to clinical guidelines is irrational is considered in Part IV(E) below. The statutory test may extend beyond common professional practices. It may apply to one-off decisions provided there is evidence the defendant's conduct was widely accepted as competent professional practice.¹¹⁷ The statutory language does not suggest a limitation on its application.¹¹⁸

The statutory test qualifies the *Bolam* test by requiring peer professional opinion: (a) be widely accepted (this does not require universal acceptance); (b) as competent professional practice; (c) in Australia. On the requirement that peer opinion be widely accepted, the Ipp Committee commented:

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- 112 A plaintiff may, however, dispute whether expert evidence in fact represents customary practice at the time of the negligence, *Haylock v Morris* [2006] ACTSC 86 (7 September 2006) [55] (based on common law as there was no statutory provision in the Australian Capital Territory). There are occasional instances where it has been argued that compliance with guidelines was negligent: *Early v Newham Health Authority* [1994] 5 Med LR 215 (not liable for complying with guidelines).
- 113 A significant advantage is that the guidelines may reduce the practice of ordering unnecessary tests: Studdert et al, above n 11, 2616.
- 114 The British Medical Association Medical Ethics Committee guidelines relating to end of life decisions on withdrawal of nutrition and hydration were accepted by Lord Goff in *Airedale NHS Trust v Bland* [1993] AC 789. See also, *Zarb v Odetoyinbo* (2007) 93 BMLR 166. For other cases, see Samanta et al, 'The Role of Clinical Guidelines in Medical Negligence Litigation: A Shift from the Bolam Standard' (2006) 14 *Medical Law Review* 321, 334–7.
- 115 Samanta et al, above n 114, 331–4.
- 116 I am indebted to Bill Madden of Slater & Gordon for this information. See also *Greater Southern Area Health Service v Dr Angus* [2007] NSWSC 1211 (2 November 2007); *Sydney South West Area Health Services v MD* [2009] NSWCA 343 (21 October 2009); *Evidence Act 1995* (NSW) s 79.
- 117 In UK, Beldam LJ in *Marriott v West Midlands Regional Health Authority* [1999] Lloyd's Rep Med 23, 27 (CA) suggested otherwise. See also Andrew Grubb, Commentary 'Causation and the Bolam Test; *Bolitho v City and Hackney Health Authority*' (2003) 1 *Medical Law Review* 241, 245; Kennedy and Grubb, above n 11, 430.
- 118 The Victorian and NSW sections state that a professional is not negligent if 'the professional acted in a manner that was widely accepted ... as competent professional practice': *Civil Liabilities Act 2002* (NSW) s 50; *Wrongs Act 1958* (Vic) s 59(1). The Victorian section adds 'in the circumstances'.

It is well-established that in many aspects of medical practice, different views will be held by bodies of practitioners of varying size and in different locations. This can result in the development of localised practices that are not regarded with approval widely throughout the profession. Thus the *Bolam* rule is not a reliable guide to acceptable medical practice.¹¹⁹

This avoids the worst aspects of the *Bolam* principle. The requirement of wide acceptance excludes, for example peer opinion from small private hospitals, clinics or small groups of practitioners whose views are not accepted widely within the profession.¹²⁰ In short, the statutory test adopts mainstream medicine as the relevant standard and applies where there is a genuine divergence of peer opinion. But how will this requirement be applied where there may be only small numbers in a specialty or in an emerging subspecialty? Will peer opinion from that subspecialty qualify as being 'widely accepted' by peer professional opinion? A related question is how the courts will define the relevant 'field' (Victoria) or 'peer professional opinion' (NSW) and how far this recognises emerging subspecialties (see Part III(D): The Relevant Field/Peer Professional Opinion).

Where there is a recognised subspecialty¹²¹ and practitioners within that subspecialty regard the defendant's practice as competent professional practice, then it is widely accepted within that group for the purposes of the statutory standard. A defendant would not then be disadvantaged if part of a small subspecialty with few practitioners.¹²² In the English case *De Freitas v O'Brien*,¹²³ the evidence was that there were just 11 orthopaedic surgeons and neurosurgeons specialising in spinal surgery. This was out of a total group of over 1000 practitioners in the general field. Expert evidence accepted that normal medical opinion was that surgery should not be undertaken. The Court of Appeal accepted that the conduct of the defendant should be judged by reference to the specialism of spinal surgery. In relation to that subspecialty, the practice complied with the opinion of a responsible body of practitioners within that field.¹²⁴ The statutory standard might not be met where there is a small emerging specialty not yet recognised by the medical colleges. This does not automatically

119 *Ipp Report*, above n 1, 40 [3.11].

120 *Ipp Report*, above n 1, 39 [3.8].

121 This requires recognition by the appropriate college and a period of training in that subspecialty. For example, in relation to orthopaedics, members specialise in joint reconstruction, spine surgery, hand surgery, knee surgery (sports injuries), foot and ankle surgery, shoulder and elbow surgery, paediatric orthopaedics, and orthopaedic trauma. See Australian Health Directory, Medical Specialists Directory <http://www.healthdirectory.com.au/Medical_specialists/>; Australian Medical Council, List of Australian Recognised Medical Specialties (12 January 2009) <<http://www.amc.org.au/images/Recognition/AMC-list-of-specialties.pdf>>.

122 Sufficient if a particular legal practice existed only in NSW: *Vella v Permanent Mortgages Pty Ltd* (2008) 13 BPR 25343 (Supreme Court of NSW).

123 (1995) 25 BMLR 51. There was no indication in the case that at that time the relevant College recognised this as a subspecialty.

124 *Ibid* 61 (Otton LJ, Leggatt and Swinton Thomas LJJ agreeing). The English test refers to a responsible body of opinion; there is no requirement that it be a substantial body of opinion.

mean that a practitioner in that field is negligent but it may mean that the statutory standard might not provide a defence.

A similar issue arises where only a few members of the profession practice a novel procedure for which there is not yet established a body of local expert opinion.¹²⁵ If the procedure is still experimental, the obligations of a defendant in providing advice to a patient will be more stringent, particularly in relation to advice on the efficacy of available alternative treatments or procedures.¹²⁶ The adoption of new procedures and treatments is not negligent simply because they are novel or only a few practitioners have adopted them but the statutory provision may not assist in shutting the door on a plaintiff's claim. The problem is what will be a sufficient number for these purposes. For example, if 50 gynaecologists adopt a new technique for treatment of incontinence, would that be sufficient? The answer is likely to be coloured by additional information that the procedure was not part of the specialist college examinations and was not considered the appropriate standard for Australia.¹²⁷ The novel therapy might not be regarded as 'widely accepted' by a significant number of respected practitioners (Victoria) or widely accepted by peer professional opinion (NSW) as competent professional practice. If it did qualify, it might be excluded as irrational if the procedure involved unnecessarily serious risks to the patient and was not evidence based.

There is a further qualifier on peer professional opinion before it can be accepted as the professional standard. Peer professional opinion must be widely accepted as *competent professional practice*.¹²⁸ The article now turns to consider this further aspect of the statutory test.

The statutory provision refers to *peer opinion* as to what is competent. Does this protect outmoded treatments that continue to be used? In the medical field, many practitioners do not follow recommended treatments with proven efficacy; outdated practices continue to linger despite the clear evidence that those practices cause harm and practices have developed that are not evidence based.¹²⁹

125 See *Ipp Report*, above n 1, 42 [3.23]. Where there is more than one opinion this can protect practitioners at the 'cutting edge' of medical practice provided the procedure was in accord with an opinion that meets the description. It is questionable whether under the *Bolam* test, it would have been 'responsible': see *ibid* 59.

126 *South Eastern Sydney Area Health Service v King* [2006] NSWCA 2 (1 March 2006) (pre-dates legislation, duties exist where 'radical, controversial and experimental' treatment); *Hall v Petros* [2004] WADC 87 (27 May 2004) (new technique, predates civil liability legislation). See also *AB v Tameside & Glossop HA* (1996) 35 BMLR 79 (Court of Appeal).

127 *Hall v Petros* [2004] WADC 97 (27 May 2004) (pre-dates civil liability legislation discussed in (2004) 12(10) *Australian Health Law Bulletin*). It may be especially suspect where the practitioner earns royalties from use of a device, see *James v Hickling* [2004] WASC 235 (16 November 2004); *Hepworth v Kerr* [1995] 6 Med LR 139.

128 The Victorian provision adopts the standard of 'respected practitioners (peer professional opinion)'; the NSW provision refers just to 'peer professional opinion'. Similarly *Civil Liability Act 2003* (Qld) s 22(1); *Civil Liability Act 2002* (Tas) s 22(1). Compare *Civil Liability Act 1936* (SA) s 41 'widely accepted by members of the same profession as competent professional practice'; *Civil Liability Act 2002* (WA) s 5PB(1) 'widely accepted by the health professional's peers as competent professional practice.' See also: *Ipp Report*, above n 1, 40 [3.14].

129 See illustrations on evidence based medicine, in Part IV(E), below.

But the translation of research and clinical findings into professional practice can take time and professionals are not necessarily negligent if their knowledge lags behind current knowledge. Nevertheless professionals are required to make reasonable efforts to keep up to date with new developments.¹³⁰ It has been suggested that it takes ‘an astonishing 17 years for evidence to be incorporated into practice’.¹³¹ In a case not involving the statutory test, *Black v Tomislav Lipovac* the Court remarked:

some quite respectable medical authorities would have found nothing wrong with Dr Black's treatment. ... [F]ollowing an accepted practice, albeit one that carries more risk than another, may be justifiable. ... Dr Black could not be adjudged as other than a caring, well-experienced and qualified general practitioner. However, if a practice is flawed, it is the duty of the courts to say so.¹³²

There Dr Black gave the drug aminophylline to a mild to moderately asthmatic child. The drug caused brain damage. At the time, the administration of this drug was accepted by a substantial body of medical opinion as appropriate asthma treatment. However, there was also a body of opinion that the drug was very dangerous and should only be used in extreme cases and in hospital. Since this was not an extreme case, the child should not have been given the drug and Dr Black was negligent. How would this case be treated under the current statutory provisions? It might be argued that the practitioner was not negligent applying the statutory standard.¹³³ The statutory test is whether *peer opinion* regards the practice as competent practice so that the defendant's conduct may well have satisfied the statutory standard.¹³⁴ This would place the onus on the plaintiff to show that the professional practice was irrational, as discussed below.

A further qualification to the *Bolam* standard is the requirement in NSW, South Australia, Tasmania and Victoria (but not Queensland)¹³⁵ that the relevant peer opinion must be widely accepted *in Australia*.¹³⁶ The Ipp Committee saw this requirement as preventing reliance on localised practices that did not have the support of the general profession.¹³⁷ It also means that evidence of overseas

130 *South Eastern Sydney Area Health Service v King* [2006] NSWCA 2 (1 March 2006) (responsibility where radical, controversial and experimental' treatment was utilised). For other illustrations, see Kennedy and Grubb (eds), *Principles of Medical Law* (Oxford University Press, 1998) 352–3.

131 Australian Commission on Safety and Quality in Health Care, Submission No 428 to National Health and Hospitals Reform Commission, 26 September 2008, [5.2] cited in *National Health and Hospitals Reform Commission, a Healthier Future for All Australians: Interim Report* (2008) 339 [15.1].

132 [1998] FCA 699 (4 June 1998) [30] (common law, asthma treatment involving serious risks not warranted by patient's condition).

133 Under the UK *Bolam* test, any practice that did not adequately consider risk and benefits would not be respectable and responsible practice. See *Bolitho* [1998] AC 232 (Browne-Wilkinson LJ).

134 *Naxakis v Western General Hospital* (1999) 197 CLR 269 may have been decided differently under the statutory standard unless irrational/unreasonable.

135 In Queensland, it is sufficient if widely accepted, see *Civil Liability Act 2003* (Qld) s 22.

136 *Civil Liability Act 2002* (NSW) s 50; *Wrongs Act 1958* (Vic) s 59; *Civil Liability Act 1936* (SA) s 41(5); *Civil Liability Act 2002* (Tas) s 22.

137 *Ipp Report*, above n 1, 40 [3.11]. The old locality rule may have meant no more than the defendant's conduct was to be judged in light of the particular circumstances, the usual negligence rule, see Theodore Silver, 'One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice' (1992) *Wisconsin Law Review* 1193.

practice is inadmissible on the question of standard of care for the purposes of the statutory provision.¹³⁸ Overseas practices or treatments that are not yet supported by local practice might not qualify as widely accepted in Australia for the purposes of the statutory test. The imposition of an Australia wide standard accepts that if Australian practice lags behind international standards, a plaintiff will have no remedy unless peer opinion is irrational.

If there were some variation in relevant practice because of differing conditions, this does not necessarily mean that the practice is not widely accepted. In *Vella v Permanent Mortgages Pty Ltd* it was argued that the defendant's practice complied with the Australian practice relating to 'all monies' mortgages.¹³⁹ There was an objection on the ground that the only evidence before the Court was from NSW solicitors. Chief Justice Young in Equity pointed out that the statutory provisions varied in each state and the particular risks related to NSW with no reported problems in other jurisdictions.¹⁴⁰ Chief Justice Young in Equity commented:

it would accord with the intention of the legislature if one said that where one had an industry which was only practised in part of Australia that that part was the Australian peer professional practice for the purpose of s 50 ... [I]f one has different though similar professions in different parts of Australia, it would seem to me that one does not dismissively say that there is no Australian professional practice but one looks to see the professional practice that exists in the particular locality where the negligent act or omission took place. There may also be other problems where, for instance, things would be done differently on King Island ... from Thursday Island ... because one is in the cold wet south and the other in the monsoonal north.¹⁴¹

D The Statutory Standard – The Relevant Field/Peer Professional Opinion

The relevant peer professional opinion is that of practitioners within the particular field of the defendant. This is explicitly stated in the Victorian and Queensland sections¹⁴² but implicit in other jurisdictions.¹⁴³ It would be expected that the relevant peer opinion or field would be related to the defendant's special expertise where this is a recognised specialty or subspecialty and related to the

138 *Hope v Hunter and New England Area Health Service* [2009] NSWDC 307 (27 Nov 2009) [170]–[171]. It could be relevant to whether the opinion was irrational/unreasonable. Contrast the position prior to the civil liability legislation, *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542, 562–563 (Reynolds JA); *Lowns v Woods* (1996) Aust Torts Reports 81-376; *E v Australian Red Cross Society* (1991) 27 FCR 310, 357, 360 (Wilcox J).

139 [2008] NSWSC 505 (25 May 2008).

140 *Ibid* [551]–[552].

141 *Ibid* [554]–[555].

142 *Civil Liability Act 2003* (Qld) s 22; *Wrongs Act 1958* (Vic) s 59(1); *Civil Liability Act 1936* (SA) s 41(1) acceptance by the 'same profession as competent professional practice'.

143 The qualification of expert witnesses requires such a correlation and is also relevant to the admission of evidence: see *Forder v Hutchinson* [2005] VSCA 281 (30 November 2005) [43] (Nettle JA, Maxwell P and Habersberger AJ agreeing) (evidence of professor of chiropractic accepted as to osteopathy standard).

relevant standard against which the defendant's conduct is measured.¹⁴⁴ The decision *De Freitas v O'Brien* has been referred to above on the importance of the delineation of the field or relevant peer opinion, particularly in emerging subspecialties.¹⁴⁵

The issue may not always be straightforward. Quite different opinions may be held, for example, by specialist surgeons and specialist physicians working in related fields, and between academic and clinical opinion.¹⁴⁶ The issue was raised in *Hawes v Holley*.¹⁴⁷ The expert witness said in relation to the question whether a particular drug should have been used first before resorting to surgery:

the two camps ... would ... be very disparate in size ... the number of surgeons who were [not] enthusiastic advocates of [the drug] would be by several orders of magnitude larger than those who espoused this treatment. If one looks at the literature on the [drug] treatment, the vast majority of it comes from physicians, medical doctors, not surgeons ... and physicians of course are generally enthusiastic about pharmacological treatments. ... there would be a wide body of surgical opinion that would not use [the drug] treatment.¹⁴⁸

In answer to the question whether 'both views ... represent at this point of time widely accepted professional views as to appropriate means of treatment', the expert witness agreed and said that for surgeons it would only be used where particular risks were ruled out.¹⁴⁹ The Court found it unnecessary to apply the statutory standard.¹⁵⁰ The decision, however, points out a number of issues concerning the application of the statutory test. There can be significant disagreement between specialties with surgeons less enthusiastic than physicians about drug treatment. The trial judge in *Hawes v Holley* did not specify whether the relevant 'field' (peer professional opinion) was colo-rectal surgeons or

144 See, eg, *Rogers v Whitaker* (1993) 175 CLR 479 (ophthalmic surgeon specialising in corneal an anterior segment surgery); *Melchior v Sydney Adventist Hospital Ltd* [2008] NSWSC 1282 (9 December 2008) [113] (orthopaedic surgeons specialising in foot and ankle surgery in Australia in May 2004); *Marko v Falk* [2007] NSWSC 14 (25 January 2007) [28], affd [2008] NSWCA 293 (10 November 2008) (surgeon specialising as an upper gastrointestinal endoscopist who practiced at a tertiary referral centre). Presumably the higher standard also applies for those professing skills in as yet unrecognised specialties. For a list of accredited medical specialties, see Australian Medical Council, above n 121; Australian Health Directory, above n 121. Credentialing in the hospital system may also be a relevant consideration, see Australian Council for Safety and Quality in Health Care, *Standard for Credentialing and Defining the Scope of Clinical Practice* (2004).

145 (1995) 25 BMLR 51; see also n 123 and accompanying text. There may also be difficulties where the practitioner's expertise cuts cross a number of specialties, for example trauma surgery. See G E Brouwer, *Whistleblowers Protection Act 2001: Report on an Investigation into Issues at Bayside Health*, Ombudsman Victoria (2008).

146 *Dr Ibrahim v Arkell* [1999] NSWCA 95 (27 May 1999); *Shead v Hooley* [2000] NSWCA 362 (14 December 2000).

147 [2008] NSWDC 147 (22 August 2008).

148 *Ibid* [84].

149 *Ibid*.

150 Hungerford ADCJ found that there was common ground that in particular circumstances the drug should not be used. As those circumstances existed in the present case, it was unnecessary to directly rely on section 50: *ibid* [84], [100]. A number of other decisions have likewise avoided the application of the statutory test. See *Vella v Permanent Mortgages Pty Ltd* (2008) 13 BPR 25343 (NSW Supreme Court); *Dobler v Halversen* (2007) 70 NSWLR 151; *Melchior v Sydney Adventists Hospital Ltd* [2008] NSWSC 1282 (9 December 2008) [96] (Hoeben J).

surgeons practising in a broader field. It appeared to be assumed that the relevant peer opinion was not limited to a defendant's particular specialty or subspecialty and that it was sufficient if peer opinion in a related specialty would have regarded the defendant's practice as competent practice.¹⁵¹ But the relevant peer opinion should not effectively impose a different standard of care. So, for example, if the negligence involves a home birth and the question is whether a midwife was negligent in allowing the second stage of labour to continue for too long, the relevant peer opinion is that of midwives not obstetricians.¹⁵² Again, this would be subject to the argument that the professional standard was irrational.

In summary, the statutory standard is not likely to have a dramatic effect on medical litigation in NSW. It is a case of more bark than bite. This is for a variety of reasons. First, divergent peer professional opinion is subject to the normal litigation processes. This may allow courts to find common ground between apparently conflicting peer opinion¹⁵³ or to discount conflicting peer opinion on a variety of grounds such as consistency and currency. As noted previously, in NSW there is no medical negligence case in which the outcome has turned directly on the effect of section 5O. Secondly, the statutory test applies only to the setting of the relevant standard of care. So, for example, it does not apply to conflicting peer opinion on causation questions. Duty to warn cases have been specifically excluded. Thirdly, the statutory test is hedged with limitations that did not apply to the original *Bolam* test. Peer opinion must be widely accepted as competent professional practice. This ensures that extreme and outdated views that are not supported by the medical profession are not accepted as setting the relevant standard of care. The effect is that the statutory provision applies where divergent views are genuinely and justifiably held. But as noted earlier, at common law there was nothing unusual about courts holding that where there were divergent views genuinely and justifiably held a defendant was not negligent.¹⁵⁴

The article now considers the irrational exception with separate mention of the differing Victorian qualification in relation to unreasonable peer opinion.

151 *Hawes v Holley* [2008] NSWDC 147, [84]. See also *Joyce v Merton, Sutton Wandsworth Health Authority* (1995) 27 BMLR 124 (the relevant body of medical opinion was not limited to cardiac surgeons, evidence of vascular surgeons also relevant).

152 Bill Madden of Slater & Gordon suggested this example: Madden, above n 15. See also *Ambulance Service of NSW v Worley* [2006] NSWCA 102 (3 May 2006) (special leave to appeal to High Court refused), (ambulance officer, pre-dates civil liability legislation); *Shakoov v Situ* [2000] 4 All ER 181 (Chinese herbalist). See also *Reynolds v North Tyneside Health Authority* [2002] Lloyd's Law Rep Med 459.

153 See, eg, *Hawes v Holley* [2008] NSWDC 147 (22 August 2008); above n 148.

154 See above n 31.

IV IRRATIONAL PEER OPINION

This Part examines the exclusion of peer opinion if it is ‘irrational’. Firstly, the article canvasses whether the exclusion is just about rational thinking and whether theories relating to rational choice may enlighten the meaning. It concludes that this line of inquiry is unlikely to be helpful. Secondly, the article looks to whether public law concepts of irrationality might be informative and concludes that, in NSW, there are strong indicators that the statute should not be interpreted as importing public law concepts. Thirdly, this Part reviews the Ipp Committee’s suggestion that the exclusion of irrational peer opinion was intended to reflect the approach in the House of Lords case of *Bolitho v City and Hackney HA*.¹⁵⁵ Fourthly, the very different Victorian provision excluding unreasonable opinion is contrasted. It concludes with an examination of how the exclusionary test might be applied.

The article argues that if the ‘irrational’ exclusion is interpreted in line with the House of Lords decision in *Bolitho*, peer opinion must be logically defensible; it would not be so unless the risks and benefits of the procedure had been considered. Viewed broadly, the exclusion will allow a general assessment as to whether the defendant’s conduct overall was reasonable. If this is so, the statutory standard will have achieved very little. The courts would still be able to exclude unreasonable peer opinion under the exclusion. As one commentator has remarked, what is the point of enacting a *Bolam* type standard if it achieves little more than the current common law position?¹⁵⁶ The terms of reference for the Ipp Panel mandated the inclusion of a *Bolam* style test.¹⁵⁷ But it is clear from the tenor of the Committee report that there was disquiet about introducing *Bolam* without significant limitations.¹⁵⁸ These limitations give little scope for the application of the section except in cases where there is a genuine and substantiated division of peer professional opinion. This gives little occasion for the irrational exclusion to operate. It must however be assumed that Parliament would not have legislated for an exclusion that was redundant. While a public law test of irrationality may have restricted a court’s ability to disallow expert opinion, this interpretation in the NSW statute seems to be precluded.¹⁵⁹

What is clear from the Ipp Report is that the irrational exclusion was intended to allow interference by the court only in exceptional circumstances. But the suggestion that the exclusion is an adoption of the House of Lords’ *Bolitho* decision leads to further confusion as it appears to open up to the court the opportunity to review the overall reasonableness of the defendant’s conduct. The differing Victorian legislation, which allows the court to exclude unreasonable peer opinion does appear simply to revert to the common law position. That is, in exceptional cases the court will refuse to follow peer opinion. As one

155 [1998] AC 232.

156 I am indebted to the anonymous referee for this insightful observation.

157 See *Ipp Report*, above n 1.

158 *Ibid.*

159 See nn 196, 197 below.

commentator has remarked, it reflects a more ‘light handed’ approach in the Victorian civil liability legislation with a preference for maintaining the common law¹⁶⁰ and preserving the important role of the court in setting community standards.¹⁶¹ In contrast, the NSW legislation reflects a more punitive response to plaintiffs with a greater determination to shackle judges to prevent greater leniency to plaintiffs. This is apparent with the draconian NSW provisions, especially in relation to intoxication and illegality.¹⁶²

The article now turns to explore the arguments in detail. The statutory standard does not apply where peer opinion¹⁶³ is ‘irrational’¹⁶⁴ or in Victoria ‘unreasonable’.¹⁶⁵ As this is cast as an exception, the normal rule is that the plaintiff will have to show that peer opinion is irrational or unreasonable.¹⁶⁶ Peer opinion may pass the first test of wide acceptance as competent professional practice even if it is irrational or unreasonable. Otherwise the exception will have no role to play. The Expert Panel (the Ipp Committee) referred to the decision in *Hucks v Cole*¹⁶⁷ and the circumstances giving rise to the New Zealand Cartwright Inquiry involving research and treatment of cervical cancer¹⁶⁸ as illustrations of rare and exceptional cases where peer opinion might be regarded as irrational and

160 *Wrongs Act 1958* (Vic) ss 14F, 47.

161 I am indebted to the anonymous referee for this perceptive observation of this light handed touch in comparison to NSW in such areas as peer professional opinion, illegality and intoxication, see *Wrongs Act 1958* (Vic) ss 14F–14H, 47.

162 *Civil Liability Act 2002* (NSW) ss 50, 54.

163 Are the defendant’s individual reasons relevant? Would it be irrational if the defendant continues a practice known to be unnecessary, wrong or ineffective? Commentators on rational choice theory would argue that conduct cannot be rational unless the action was in response to the defendant’s desires, beliefs and evidence. See, eg, Jon Elster, ‘Introduction’ in Jon Elster (ed), *Rational Choice* (Blackwell, 1986) 1, 2. Similarly, according to rational choice theory, the conduct is not rational where the defendant, through oversight, omits a precaution even if this omission complied with peer professional opinion. *Contra* Kennedy and Grubb, above n 130, 349 citing *Moyes v Lothian Health Board* [1990] 1 Med LR 463, 470 (failure to give usual warning, current practice not to warn); *Gascoigne v Ian Sherian & Co* [1994] 5 Med LR 437, 458 (Mitchell J) (no negligence if accidentally complied with current practice); *Newell v Goldenberg* [1995] 6 Med LR 371 (Mantell J) (there is no defence for those who know better).

164 Adopting the recommendation in the *Ipp Report*, above n 1, 41 [3.18]. NSW, Queensland, South Australia and Tasmania exclude the professional standard if it is irrational: *Civil Liability Act 2002* (NSW) s 50, *Civil Liability Act 2003* (Qld) s 22(2) (or if it is contrary to a written law); *Civil Liability Act 1936* (SA) s 41(2); *Civil Liability Act 2002* (Tas). Western Australia adopts a *Wednesbury*-style unreasonableness test: *Civil Liability Act 2002* (WA) s 5PB(4).

165 *Wrongs Act 1958* (Vic) s 59(2). It has been said that it would a ‘very courageous lawyer’ to argue this when a personal costs order or misconduct finding could be made under the *Legal Profession Act 1987* (NSW) divs 5B, 5C: Bill Madden, ‘Developments in Medical Negligence Law – 2005’ (Paper presented at Continuing Legal Education Seminar, University of Western Sydney, 8 August 2005) 11.

166 The *Ipp Report*, above n 1, 41 [3.18] suggests that this is the correct approach.

167 [1993] 4 Med LR 393 (Court of Appeal). The case was decided 1968. It is extracted in Kennedy and Grubb, above n 11, 439.

168 Silvia Cartwright, *The Report of the Committee of Enquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women’s Hospital and into Other Related Matters* (1988) <http://www.nsu.govt.nz/Files/NCSP/The_Cartwright_Inquiry_Introduction.pdf>. Discussed by Charlotte Paul, ‘The New Zealand Cervical Cancer Study: Could It Happen Again?’ (1988) 297 *British Medical Journal* 533.

inconsistent with community values.¹⁶⁹ In *Hucks v Cole* the treating practitioner did not prescribe penicillin (the standard treatment) for an infection despite the extremely serious risk of septicaemia. Lord Justice Sachs said that the defendant was negligent as there was a very serious risk that could be easily and inexpensively avoided. His Lordship said that if there is no proper basis for refusing to take these precautions, the court can, 'in the light of current professional knowledge' find that it was not reasonable that those risks were taken.¹⁷⁰ In the cancer research study, patients were unaware that they were part of a research study; they did not consent to take part nor were they warned that they were not being given the standard treatment for their condition. Treatment was withheld or delayed as part of the research study. It is debatable whether the withholding or delay in treatment for research purposes would be considered widely accepted by peer opinion as competent practice under the statutory standard. Additionally, claims related to failure to warn of risks would have been excluded from the statutory standard. These two illustrations may assist in interpreting the meaning of the exclusion.¹⁷¹

A Irrational

Dictionary definitions of 'irrational' shed little light on the meaning of the statutory term.¹⁷² Irrationality is often described in terms of logical reasoning and reasonableness, so that irrationality and unreasonableness are linked concepts. But reasonableness may be broader than rationality, taking into account moral considerations, community values and the interests of others.¹⁷³ There is a large field of research exploring rational decision making in economics, philosophy and the social sciences. One model of rational choice is the means-ends model that requires 'a choice of the best means available for achieving a given end'.¹⁷⁴ It requires an assessment of the available options, the ranking of these options and the choice of the option that will best achieve the selected end.¹⁷⁵ Used in this sense rationality, like the torts standard, is an objective standard concerned with what should be done to achieve the given end.¹⁷⁶ So in relation to a professional, a decision may be irrational if it is not the best means available to attain a

169 *Ipp Report*, above n 1, 39–40 [3.8]–[3.11].

170 [1993] 4 Med LR 393, 397. Query whether expert evidence represented customary practice. See Jonathan Montgomery, *Health Care Law* (Oxford University Press, 1st ed, 1997) 172.

171 Although the hypothesis that carcinoma in situ of the cervix is not a pre-malignant disease was supported by postgraduate teaching of the day, it was subject to qualification by colleagues. See Paul, above n 168, 533.

172 The Oxford dictionary defines 'irrational' as 'not endowed with reason, not in accordance with reason; illogical, absurd', and 'illogical' as 'not logical, devoid of or contrary to logic, ignorant or negligent of the principles of soundness': *Shorter Oxford English Dictionary* (Oxford University Press, 3rd ed, 1978).

173 I am indebted to Geoff Airo-Farulla, who alerted me to this literature. See Geoff Airo-Farulla, 'Rationality and Judicial Review of Administrative Action' (2000) 24 *Melbourne University Law Review* 543, 573.

174 John Harsanyi, 'Advances in Understanding Rational Behavior' in Jon Elster (ed), *Rational Choice* (Blackwell, 1986) 83.

175 Elster, above n 163, 4.

176 Harsanyi, above n 174, 83.

particular outcome. The choice may involve discounting alternative ends as unsuitable.¹⁷⁷ The choice is contextual as it depends upon what resources are available and the particular circumstances in which choices are to be made.

But the means-end model is an ideal that does not take sufficient account of situations where choices have to be made in the face of incomplete information, uncertainty and rapidly changing conditions – frequently the domain of medical decision making.¹⁷⁸ This makes it difficult to choose the best means to a given end. In the face of this uncertainty, choice must be based on rational beliefs derived from ‘sufficient’ and appropriate evidence.¹⁷⁹ There are many difficulties. These include deciding when there is sufficient evidence particularly when time may be of the essence for patient safety.¹⁸⁰ There is also the problem that choices are influenced by an individual’s intuitions, habits,¹⁸¹ implicit biases and preferences and their distorting effects.¹⁸² Moreover, decisions may be rational from the point of view of the actor but paternalistic and self serving by ignoring patient needs, preferences and community values. Rational choice theory may offer some insight into how choices are made in the face of uncertainty. But if it is merely descriptive of what human beings actually do in making decisions in the face of uncertainty and is divorced from patient and community interests, it may be unhelpful in deciding the normative question whether peer opinion is irrational for the purposes of liability.

If the exclusion of irrational peer opinion is simply about rational decision making, there is potential for considerable overlap with the standard negligence tests. Presumably both bring into consideration risks, burdens, benefits and utility. If the exclusion significantly mirrors negligence tests, then the statutory standard is significantly curtailed. Irrationality would have a narrower meaning if public law concepts were relevant.

B Public Law Reflections

The irrational/unreasonable terminology is familiar to public lawyers as integral to grounds of review for administrative decisions. Decisions can be reviewed on the grounds of ‘irrationality’ and/or what has become known as *Wednesbury* unreasonableness, named after the case bearing that name.¹⁸³ Unreasonableness was frequently a shorthand description for review on the

177 Ibid 86.

178 See Daniel Kahneman, ‘Maps of Bounded Rationality: Psychology for Behavioural Economics’ (2003) 93 *The American Economic Review* 1449.

179 Jon Elster, *Nuts and Bolts for the Social Sciences* (Cambridge University Press, 1989) 25.

180 Ibid 35.

181 Kahneman, above n 179.

182 Particularly the preference to view evidence in ways that confirm initial views, preferences and beliefs (confirmation bias). See Raymond Nickerson, ‘Confirmation Bias: A Ubiquitous Phenomenon in Many Guises’ (1998) 2 *Review of General Psychology* 175.

183 *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223.

grounds of irrationality¹⁸⁴ but in recent times in Australia, unreasonableness seems to stand as an independent ground for review.¹⁸⁵ In the public law context, a distinction is drawn between discretionary decisions to which the *Wednesbury* unreasonableness rule applies, and the separate irrationality/illogicality tests. The former is an assessment of ‘evaluative choices’ in exercising discretion, the latter the scrutiny of the decision makers’ ‘reasoning or fact finding processes’.¹⁸⁶

The standard public law unreasonableness test was established in *Associated Provincial Picture Houses Ltd v Wednesbury Corporation*.¹⁸⁷ Lord Greene MR said that a decision was not reviewable unless it was ‘so unreasonable that no reasonable authority could ever have come to it’.¹⁸⁸ Lord Diplock described the relevant decision giving rise to review as ‘so outrageous in its defiance of logic or accepted moral standards that no sensible person ... could have arrived at it’.¹⁸⁹ Despite the above tests suggesting the near impossibility of challenging a decision on the grounds of unreasonableness, there are cases where the courts have found decisions wanting.¹⁹⁰

The original *Bolam* case did not refer to public law as underpinning or explaining the refusal to review respected peer opinion.¹⁹¹ The most explicit reference is by Dillon LJ in the Court of Appeal in the *Bolitho* case. Lord Justice Dillon said that the Court could only reject medical opinion if the opinion was *Wednesbury* unreasonable, that is, ‘the views [were] such as no reasonable body

184 Mark Aronson, Bruce Dyer and Matthew Groves, *Judicial Review of Administrative Action* (Lawbook Co, 9th ed, 2009) 369. Lord Diplock adopted ‘irrationality’ as the preferred term for *Wednesbury* unreasonableness despite its connotations of mental incapacity: *Council of Civil Service Unions v Minister for the Civil Service* [1985] AC 374, 410.

185 It applies only to unreasonable discretionary decisions: Aronson, Dyer and Groves, above n 184, 371. The authors argue that this differentiation is generally applicable and not simply a product of limitations on unreasonableness grounds for review under the *Migration Act 1958* (Cth) s 476(2)(b), *ibid* 373.

186 Aronson, Dyer and Groves, above n 184, 270. A decision is irrational in the public law sense if it fails to take into account relevant considerations or takes into account irrelevant matters: *TCN Channel Nine Pty Ltd v Australian Broadcasting Tribunal* [1992] FCA 492 (30 September 2002) [103]. In relation to medical decisions, this requires an assessment based on the risks and benefits of a procedure or treatment: see *Bolitho* [1998] 1 AC 232, 241–2 (Lord Browne-Wilkinson).

187 [1948] 1 KB 223.

188 *Ibid* 230. An extreme example is a person dismissed because of their hair colour: at 229 (Lord Green MR) citing *Short v Poole Corporation* [1926] Ch 66, 90–1 (Warrington LJ). Lord Diplock preferred to describe the test as the ‘irrationality test’, *Council of Civil Service Unions v Minister for the Civil Service* [1985] AC 374, 410.

189 *Council of Civil Service Unions v Minister for the Civil Service* [1985] AC 374, 410 (Lord Diplock).

190 Sir William Wade and Christopher Forsyth, *Administrative Law* (Oxford University Press, 9th ed, 2004) 364–5; Australian courts take a more restrictive approach: Aronson, Dyer and Groves, above n 184, 367, 368, 374, 377.

191 McNair J did however approve Lord Clyde’s statement in *Hunter v Hanley* 1955 SLT 213, 217, that the test was whether no doctor of ordinary skill would have so acted, see *Bolam* [1957] 1 WLR 582, 587.

of doctors could have held.¹⁹² This reference to *Wednesbury* unreasonableness was not taken up or commented upon on appeal in *Bolitho*, the House of Lords preferring instead to exclude peer opinion where it was not logically defensible (see Part IV(C): *Bolitho* and the Irrational Exclusion).

If ‘irrationality’ bears its limited public law meaning, it would severely restrict a court’s capacity to make an overall assessment of the reasonableness of peer opinion. But public law concepts should not be relevant to medical negligence claims. The policies driving limitations on public law review are quite different from the reasons for adopting a modified standard of care for professionals. The restricted power of courts to review administrative decisions is seen as a consequence of the doctrine of separation of powers, whereby the court’s role is neither to balance community interests against individual interests nor to determine which course of action best achieves the balancing of these interests.¹⁹³ Within this constraint courts seek to ensure rational standards of decision making.¹⁹⁴ It is argued by this author that no purpose is served by adopting public law tests for limiting tort liability. At best, the public law tests of irrationality and unreasonableness can only serve as an admonition against rejecting expert opinion and substituting the court’s own assessment unless there are exceptional reasons for so doing.

Indeed, it is reasonably clear that (except for Western Australia)¹⁹⁵ the statutory terms do not make reference to the public law *Wednesbury* unreasonableness test. This inference may be drawn from the distinct use in NSW and Victoria of a *Wednesbury*-style test of unreasonableness in dealing with the liability of public authorities for the exercise or failure to exercise a function.¹⁹⁶ This suggests that if the legislature had intended the irrational exception to be an application of *Wednesbury* test, it would have used similar language to so indicate.

An alternative approach to the interpretation of the exception is based on the Ipp Panel’s statement that the ‘irrational’ proviso adopted the law as stated by the

192 *Bolitho v City & Hackney HA* (1993) 13 BMLR 111 (Court of Appeal), the relevant passage is extracted Ian Kennedy and Andrew Grubb, *Medical Law: Text with Materials* (Butterworths, 2nd ed, 1994) 459. See also *Adderley v North Manchester Health Authority* (1995) 25 BMLR 42 (Court of Appeal) (Butler Sloss LJ): the defendant’s opinion was not one ‘that no reasonable doctor ... would have reached’. The *Wednesbury* unreasonableness test was rejected by Hobhouse LJ as unhelpful in *Joyce v Merton, Sutton and Wandsworth Health Authority CA* [1996] 7 Med LR 1, 20 (Court of Appeal).

193 *Attorney General (NSW) v Quin* (1990) 170 CLR 1, 37–8 (Brennan J).

194 Geoff Airo-Farulla, ‘Rationality and Judicial Review of Administrative Action’ (2000) 24 *Melbourne University Law Review* 543, 554–5.

195 See *Civil Liability Act 2002* (WA) s 5PB(4) mirroring the *Wednesbury* unreasonableness test.

196 See, eg, *Civil Liability Act 2002* (NSW) ss 43(2), 43A, which refer to conduct that is ‘so unreasonable that no authority having the’ functions or powers of the authority in question could ‘properly consider the act or omission to be a reasonable exercise’ of its functions or powers; Grant Scott Watson, ‘Section 43A of the *Civil Liability Act 2002* (NSW): Public Law Styled Immunity for the Negligence of Public and Other Authorities?’ (2007) 15 *Torts Law Journal* 153; *Wrongs Act 1958* (Vic) s 84. See also *Limitation Act 1969* (NSW) s 62D (irrational failure to bring action for a minor).

House of Lords in *Bolitho*.¹⁹⁷ The article now turns to examine the *Bolitho* decision.

C *Bolitho* and the Irrational Exclusion

The House of Lords in *Bolitho v City and Hackney HA*¹⁹⁸ said that professional practice would not qualify under the *Bolam* principle as ‘reasonable or responsible’¹⁹⁹ unless it was logically defensible,²⁰⁰ but it would be rare or exceptional for the court to reach the conclusion that the views of a competent medical expert were unreasonable.²⁰¹ Lord Browne-Wilkinson went on to say that one such exceptional case was the decision in *Hucks v Cole*.²⁰² There Sachs LJ indicated that if a practitioner contrary to current professional knowledge took very serious risks that could be easily and inexpensively avoided, the defendant should be held to be negligent despite contrary expert opinion.

The test of logical defensibility at its narrowest refers to formal principles of logical argument.²⁰³ More broadly, it may mean clear and rational reasoning based on appropriate evidence.²⁰⁴ Lord Browne-Wilkinson’s judgment in *Bolitho* suggests that the term is used in its wider sense. This is because peer opinion in order to qualify as ‘reasonable or responsible’ must evaluate the relevant risks and benefits of a particular course of conduct.²⁰⁵ Andrew Grubb comments:

The reference to illogical is curious, since many medical decisions will not be based upon logic and deductive reasoning at all but rather upon judgment. What he [Lord Browne-Wilkinson] appears to contemplate is a three-fold review of the expert evidence: (1) have the experts directed their mind to all the relevant matter and facts; (2) have they applied a sensible coherent and, if appropriate, logical process to this material to reach a conclusion; (3) is their decision itself defensible as a rational and reasonable one. The first two looked to the decision-making process and the latter to the decision reached itself.²⁰⁶

197 *Ipp Report*, above n 1, 41 [3.18]. Resort to the *Ipp Report* is permitted where there is uncertainty, *Interpretation Act 1987* (NSW) s 34(2)(b); *Interpretation of Legislation Act 1984* (Vic) s 35(iv).

198 [1998] AC 232.

199 *Ibid* 243.

200 *Ibid* 242. Query whether this responded to counsel’s argument, Hickman, above n 9.

201 *Bolitho* [1998] 1 AC 232, 241–2, in which it was held that it was not illogical to subject a child to a very small risk of respiratory collapse rather than undertake a very invasive procedure of intubation. See Samanta and Samanta, above n 10, 170.

202 [1993] 4 Med LR 393 (Court of Appeal), decided in 1968. The case is extracted in Kennedy and Grubb, above n 11, 439. The House of Lords also referred to *Edward Wong Finance Ltd v Johnson Stokes* [1984] AC 296, rejecting as negligent the invariable practice of Hong Kong lawyers.

203 ‘Logical’ means: ‘(1) of or pertaining to logic; also of the nature of formal argument; (2) That is in accordance with the principles of logic; conformable to the principles of current reasoning; (3) That follows as a reasonable inference or natural consequence ... (5) Characterised by reason; rational reasonable’: *Oxford English Dictionary* (Oxford University Press, 1978).

204 See, eg, MSN Encarta, <<http://uk.encarta.msn.com/dictionary/>> (definition of ‘logical’):

1. sensible and based on facts: based on facts, clear rational thought, and sensible reasoning; 2. able to think rationally: able to think sensibly and come to a rational conclusion based on facts rather than emotion; 3. of philosophical logic: relating to philosophical logic.

205 See above n 10.

206 Kennedy and Grubb, above n 11, 445.

Grubb concludes:

Practices based upon habit or uninformed by subsequent medical developments or knowledge may not stand up to this objective scrutiny and rightly so ... Practices that expose patients to a risk which the court can objectively determine to be unreasonable will also fall foul of the ‘new *Bolam*’ test.²⁰⁷

Some later authorities illustrate the potential of the *Bolitho* decision to be read liberally and open the door to an assessment of the overall reasonableness of peer opinion,²⁰⁸ not just whether it was logical in a narrow sense. English courts have been prepared to intervene when peer opinion or current practice ignored a very serious risk of harm to the patient. In *Marriott v West Midlands Health Authority* a doctor did not refer a patient back to hospital after a serious head injury where the patient had been unconscious for a significant period and had continuing headaches and other indications of neurological problems.²⁰⁹ The doctor was held to be negligent despite contrary expert opinion. Similarly, in *Reynolds v North Tyneside Health Authority* failure to conduct a vaginal examination of a pregnant woman when the membranes had been ruptured was not logical or defensible where there was a small but extremely serious risk endangering the baby.²¹⁰ On the other side of the line is the decision in *Wisniewski v Central Manchester Health Authority*, in which Brooke LJ (other members of CA agreeing) said that the policy of ‘wait and see’ where there were suspicious signs of foetal problems prior to delivery was not illogical even if waiting and seeing was not entirely risk free.²¹¹ The defendant’s conduct will not be logically defensible if it is based on inconsistent reasoning. So in *Penney v East Kent Health Authority*, it was held that expert opinion was illogical when experts said that they would have reported an uncertain pap smear slide as negative despite acceptance of the principle that short of absolute confidence a slide should not be reported as negative.²¹²

If the irrationality test used in the statutory standard is intended to adopt the *Bolitho* logically defensible test, then arguably there is scope for a wider

207 Ibid; Teff, above n 110, 480–1. Cf the restrictive view by Joanna Manning ‘The Standard of Care and Expert Evidence of Accepted Practice in Medical Negligence’ (2007) 15 *Journal of Law & Medicine* 394, 399.

208 Kenyon Mason and Graeme Laurie, *Mason and McCall Smith’s Law and Medical Ethics* (Oxford University Press, 7th ed, 2006) 316; *Stevens v Yorkhill* (2006) 95 BMLR 1, 31; *Sutcliffe v BMI Healthcare Ltd* (2007) 98 BMLR 211, 222 (May LJ, other members of the Court of Appeal agreeing) where the failure to make further observations ‘had a logical basis, that it was reasonable to decide to let a patient who had had little sleep since his operation continue to sleep’; *Cowley v Cheshire and Merseyside Strategic Health Authority* (2007) 94 BMLR 29 (QBD) (hospital’s policies within a reasonable range of policies concerning pre-term labour that might have been adopted). Predating *Bolitho* [1998] AC 232, see Andrew Grubb, ‘Medical Negligence: Breach of Duty and Causation; Joyce v Merton, Sutton and Wandsworth Health Authority’ (1996) 7 *Medical Law Review* 1.

209 [1999] Lloyd’s Rep Med 23.

210 (Unreported, Queens Bench Division, Gross J, 30 May 2002). This risk was not counter balanced by a small risk of infection. See also *Kingsberry v Greater Manchester Strategic Health Authority* (2005) 87 BMLR 73.

211 [1998] Lloyd’s LR Med 223 (Court of Appeal).

212 (2000) Lloyd’s Rep Med 41.

examination of peer opinion than just whether it is logical in a formal sense.²¹³ On the assumption that the statutory provision allows an overall assessment of the reasonableness of peer opinion, the following section first considers the Victorian provision excluding unreasonable peer opinion before turning to whether failure to follow professional guidelines or to adopt evidence based medicine could come within the exception.

D Victoria: Unreasonable

The Victorian section allows the court to reject peer opinion if it is unreasonable. The explanation for substituting ‘unreasonable’ for the Expert Panel’s recommended exclusion of ‘irrational’ opinion is that the term irrational is ambiguous: its meanings include ‘illogical’ and ‘absurd’, as well as ‘unreasonable’. The word ‘unreasonable’ is used ... because it *better reflects the role of the courts in determining whether conduct is negligent*.²¹⁴

If ‘unreasonable’ is intended to reflect negligence tests, does this just mean that a court can reject peer opinion if it believes it would be negligent to follow it?²¹⁵ If this were the case, the exception may simply reflect the common law position that ultimately the negligence question is a question for the tribunal of fact based on community rather than professional standards with the additional requirement that the court explicitly spell out the reasons for rejecting peer opinion.²¹⁶ If a jury decides that peer opinion is unreasonable, it is not required to give reasons for this finding.²¹⁷ This suggests that community standards of what is unreasonable continue to apply in Victoria. This makes it unlikely that a more restricted meaning that reflects public law tests of unreasonableness or the House of Lords approach in the *Bolitho* case might also open. It is remarkable that the Victorian provision sets out a modified *Bolam* standard but returns to the court the overriding power to set the standard of care based on community standards.²¹⁸

On the assumption that the exceptions of irrationality/unreasonableness permit an overall review of reasonableness, the next section considers how far failure to follow applicable clinical guidelines or the adoption of practices that are not evidence based may come within the exclusion.

213 Supported by the Ipp Committee’s reference to medical practice that should not be followed if it is inconsistent with community values, *Ipp Report*, above n 1, 39 [3.11]. See also *Hope v Hunter and New England Area Health Service* NSWDC 307 (27 November 2009) [175]–[178]; *Greater Southern Area Health Service v Dr Angus* [2007] NSWSC 1211 (19 Nov 2007) [58].

214 Victoria, *Parliamentary Debates*, Legislative Assembly, 30 October 2003, 1423 (John Brumby, Treasurer) (emphasis added).

215 Indeed the *Wrongs Act 1958* (Vic) states that the Part is not intended to affect the common law except as provided by that part: s 47.

216 *Wrongs Act 1958* (Vic) s 59(5). This is not required if the decision on unreasonableness is determined by the jury: s 59(6).

217 *Wrongs Act 1958* (Vic) s 59(6). On this view *Naxakis v Western General Hospital* (1999) 197 CLR 269 might be decided the same way under the Victorian legislation.

218 I am indebted to the perceptive observations of an anonymous referee for this point.

E Applying the Exclusionary Test

Is deviation from clinical guidelines irrational within the exception? Professional/clinical guidelines can be used in conjunction with expert evidence as evidence of respectable peer professional opinion (see Part III(C) above). Here the question is whether peer professional opinion that does not follow these guidelines is irrational or unreasonable. Failure to follow guidelines is not necessarily negligent but tactically, a defendant should be able to explain why a relevant guideline was not followed.²¹⁹ In the absence of such justification, a finding of negligence is more easily made.²²⁰

Guidelines such as those promulgated by the UK National Institute for Health and Clinical Excellence ('NICE') are intended to represent benchmarks on appropriate medical care based on the best medical evidence. Although it is clear that compliance with guidelines can save lives,²²¹ there are substantial barriers to their acceptance in professional practice.²²² Practitioners were often unaware of the guidelines or hostile to them and refused to follow them,²²³ especially where the guidelines conflict with existing practice.²²⁴ Practitioners also objected to them on the grounds that guidelines adopt a 'cook book' style of medicine that was contrary to the need to exercise clinical judgment and discretion in the individual case.²²⁵ As consensus documents, they did not recognise professional dissent or individual patient choice.²²⁶ Guidelines might not be current and may be used as a mechanism to ration health care.²²⁷ They may provide minimum rather than reasonable standards.²²⁸ Commentators also point out that there is a mismatch between validity for scientific purposes and the negligence probability standard.²²⁹ There is the further difficulty that medical standards look to whole populations whereas the negligence standard is concerned with the position of the individual.²³⁰ Consequently there is considerable room for the argument that what might be appropriate practice in relation to a whole population is not necessarily

219 See, eg, *Loveday v Renton* [1990] 1 Med LR 117; *Thompson v James* (1996) 31 BMLR 1 (QBD); Samanta and Samanta, above n 10, 170, 'deviation from well recognised guidelines may be *Bolam* defensible'; Brian Hurwitz, 'How Does Evidence Based Guidance Influence Determinations of Medical Negligence' (2004) 329 *British Medical Journal* 1024, 1027.

220 See, eg, *Voli v Inglewood Shire Council* (1963) 110 CLR 74 (non-compliance with the Australian Standards Association standards); Samanta and Samanta, above n 10, 170.

221 See, eg, Raymond J Gibbons, Elliot M Antman and Sidney C Smith, 'Head to Head: Has Guideline Development Gone Astray? No' (2010) 340 *British Medical Journal* 343.

222 Ash Samanta and Jo Samanta, 'NICE Guidelines and Law: Clinical Governance Implications for Trusts' (2004) 9(4) *Clinical Governance: An International Journal* 212. Guidelines may be inconsistent and of variable quality, see Howard Marsh and John Reynard, 'Clinical Guidelines: A Sword or a Shield in Clinical Negligence Litigation?' (2009) 103 *BJU International* 1608.

223 Samanta and Samanta, above n 222.

224 *Ibid.*

225 Samanta et al, above n 114, 321–66, 349–50; Hurwitz, above n 219, 1025, 1027.

226 Hurwitz, above n 219, 1027.

227 Samanta et al, above n 114, 350.

228 *Ibid* 344.

229 *Ibid* 352.

230 *Ibid.*

appropriate for a particular individual,²³¹ so that failure to follow clinical guidelines is not necessarily negligent and not necessarily irrational/unreasonable. But if substantially the whole of medical opinion concurs with these guidelines, then following the approach in *Hucks v Cole*²³² and if, in accord with McNair J's statement in *Bolam*, it would be 'pig-headed' not to do so,²³³ then opposing peer opinion may be irrational or unreasonable. It may have been discounted earlier as not being widely accepted as competent professional practice.

The earlier discussion on the professional standard also referred to medical practices that are not evidence based.²³⁴ The ready availability of information through the internet, the drive for evidence based medicine and continuing professional education²³⁵ make it harder to make the argument that a body of opinion ignoring these medical advances is reasonable and rational. But the evidence is that medical practitioners continue practices not supported by medical evidence and in some cases not only lacking efficacy but positively harming the patient. There is US evidence that about 50 per cent of patients treated do not receive recommended health care, and some 10 per cent receive care that was not recommended and potentially harmful.²³⁶ Within the health care system, practices have developed that have never been tested so that there is no evidence that they actually work.²³⁷ Similarly, there are practices demonstrated to be inefficacious that continue to be used.²³⁸ Should professional ignorance be

231 Ibid.

232 [1993] 4 Med LR 393 (Court of Appeal).

233 [1957] 1 WLR 582, 587.

234 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': David L Sackett et al, 'Evidence Based Medicine: What It Is and What It Isn't' (1996) 312 *British Medical Journal* 71. The emphasis is on 'a hierarchy of evidential reliability, in which conclusions related to evidence from controlled experiments are accorded greater credibility than conclusions grounded in other sorts of evidence', combining the best evidence and judgment: Hurwitz, above n 219, 1024.

235 Practitioners prefer to continue practices that they have been taught making continuing education even more important: Australian Broadcasting Commission, *Facing the Evidence – Part One*, Health Report, (15 January 2007) <<http://www.abc.net.au/rn/healthreport/stories/2007/1814634.htm>>.

236 Elizabeth A McGlynn et al, 'The Quality of Health Care Delivered to Adults in the United States' (2003) 348(26) *New England Journal of Medicine* 2635. There is limited evidence in Australia; see National Institute of Clinical Studies, *Evidence-Practice Gaps Report Volume 1 – A Review of Developments: 2004–2007*. National Health and Medical Research Council (2008); National Institute of Clinical Studies, *Evidence-Practice Gaps Report Volume 2*, National Health and Medical Research Council (2005).

237 See, eg, the Benjamin Spock recommendation that newborns sleep on their tummy greatly increased the risk of cot death: Australian Broadcasting Commission, above n 235; or the potential harm arising out of the unproven Heimlich manoeuvre to treat choking: Australian Broadcasting Commission, *The Heimlich Manoeuvre*, Health Report, (27 July 2009) <<http://www.abc.net.au/rn/healthreport/stories/2009/2634253.htm>>. For other illustrations, see W B Runciman and J Moller, *Iatrogenic Injury in Australia*, Australian Patient Safety Foundation (2001) [1.3.2.6].

238 For example, arthroscopic surgery for osteoarthritis of the knee: A Kirkley et al, 'A Randomized Trial of Arthroscopic Surgery for Osteoarthritis of the Knee' (2008) 359 *New England Journal of Medicine* 1097; J B Moseley et al, 'A Controlled Trial of Arthroscopic Surgery for Osteoarthritis of the Knee' (2002) 347 *New England Journal of Medicine* 81. See also, Australian Broadcasting Commission, above n 235.

forgiven under the statutory standard when the practitioner ought to know?²³⁹ If these widespread outdated practices constitute a body of widely accepted professional opinion within the statutory standard, it is arguable that these practices are irrational or unreasonable. If near universal ‘informed’ medical opinion is that older treatments are completely wrong,²⁴⁰ then it might be said that peer professional opinion that thought otherwise was irrational or unreasonable.

V CONCLUSION

The civil liability legislation in NSW, Queensland, South Australia, Tasmania, Victoria and Western Australia introduced a modified *Bolam* test as the professional standard of care. In relation to the medical profession, the justifications for the original *Bolam* rule and for creating a special statutory standard that privileges professionals are questionable. The *Bolam* test in the UK probably has not resulted in a significant reduction in medical negligence litigation or deterred ‘entrants to the profession. Moreover, it is difficult to find hard evidence that medical negligence claims actually result in significantly reduced availability of medical services. The arguments for special protection based on the nature of the professional task requiring fine judgment in the face of uncertainty and incomplete knowledge overplay the need for a special rule. Nor are the claims to privilege based on the nature of the intellectual tasks and assumed altruism and public service necessarily persuasive.

The statutory standard modifies the *Bolam* standard by requiring wide acceptance by peer professional opinion as competent professional practice in Australia. This provides a threshold for ensuring that marginal and localised practices are not protected under the standard. There is the further backstop excluding irrational peer opinion. The interpretation of the exception is unclear. The exclusion of ‘irrational’ peer opinion, it has been argued, permits the court to make an assessment of the overall reasonableness of peer opinion. Consequently practices that are not evidence based or ignore clinical guidelines without justification could be caught by the exception. The Victorian exclusion of ‘unreasonable’ peer opinion may do no more than endorse the common law position.

The article’s central argument is that the statutory standard is unlikely to have any significant impact on the outcome of medical negligence claims.²⁴¹ The

239 Out-of-date practice held not negligent in *Hallatt v North West Anglia Health Authority* [1998] EWCA Civ 675 (9 April 1998).

240 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 587 (McNair J); *Hucks v Cole* [1993] 4 Med LR 393, 397 (Sachs LJ).

241 At the time of writing, there is no NSW decision where the defendant has succeeded in a medical negligence case by relying exclusively on the statutory professional standard. For a recent illustration avoiding the application of the NSW s 50, see *Sydney South West Area Health Services v MD* [2009] NSWCA 343 (21 October 2009).

reasons, set out in Part III, include: apparently conflicting peer professional opinion is often discounted as part of the normal testing of evidence; the statutory standard does not apply to duty to warn cases and is limited to standard of care issues; the qualifications contained in the statutory standard requiring wide acceptance as competent professional practice exclude peer opinion that is not accepted in mainstream medicine. The exclusion of irrational peer opinion, it is argued, permits the court to review the overall reasonableness of that peer opinion and exclude it if it is unreasonable. This may not be far removed from the position at common law. Even before the introduction of the statutory standard, at common law in diagnosis and treatment cases, only in very exceptional cases did courts applying community standards find negligence in the face of respectable peer professional opinion as to competent practice: in diagnosis and treatment cases professional opinion had ‘an influential, *often a decisive, role to play*’.²⁴² Consequently it has been argued that the statutory standard is unlikely to have any significant impact on the outcome in medical negligence claims. It is a case of more bark than bite.

If the statutory provision is a response to the power and influence of the medical profession rather than a principled response to liability and achieves little more than the common law position, a case might be made for its repeal.

242 See Part III(B), above; *Rogers v Whitaker* (1992) 175 CLR 479, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ), 594–3 (Gaudron J) (emphasis added).