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CURIAL INCONSISTENCIES IN THE DOCTOR'S DUTY OF CARE

1. INTRODUCTION

At a time when medical negligence suits are considered amongst the most aleatory of actions[1] it is of concern to note the divergent trends in English and South Australian authorities on the appropriate test for the standard of care required of medical practitioners in the provision of 'diagnosis, advice and treatment'[2], the three phases of the doctor's professional function. On what might conveniently be labelled the *objective*[3] formulation of the doctors' duty and standard of care, no English Court would quarrel with these observations of the Chief Justice of South Australia in *F* v *R*:

> 'The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. The standard of care is that to be expected of an ordinarily careful and competent practitioner of the class to which the practitioner belongs.'[4]

This formulation of the practitioner's duty is consistent with time-honoured tests of tortious liability. First, a duty to act with reasonable care is imposed and then that duty is measured by the standard of care required of the 'reasonable man of ordinary prudence'[5] or, where there is the exercise of a particular skill, by the standard of the class possessing that skill,[6] eg 'the ordinarily careful and competent practitioner'. This standard is necessarily objective for the 'question of negligence is one of what *ought* to be done in the circumstances, not what *is* done in similar

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1 As Stephen Smith observed in a recent edition of this journal: see Smith 'Some Recent Cases on Informed Consent' (1984) 9 Adel LR 413, 413. Of the 13 cases discussed in the text of this casenote, the patient succeeded in only four of them, and in two of those the order on appeal was merely for a retrial.

2 Lord Bridge of Harwick in *Sidaway* v *Governors of Bethlem Royal Hospital and the Maudsley Hospital and others* [1985] AC 871 at 896. See also Lord Templeman in *Sidaway* at 903. Cox J describes the medical practitioner's functions in similar terms in *Gover* v *State of South Australia and Perriam* (1985) 39 SASR 543 at 551.

3 I propose to refer to the Chief Justice of South Australia's formulation of standard of care in *F* v *R* (see infra n 4) as the 'objective' standard. This standard is to be contrasted with McNair J's reformulation in *Bolam* v *Friern Hospital Management Committee* [1957] 1 WLR 582 at 586-587 in which the standard of care of the medical practitioner is to be judged by accepted medical practice (the subjective test) rather than the objective criteria of the 'ordinarily careful and competent practitioner' (see infra n 4 and casenote generally). This use of the term 'objective' was adopted by Lord Bridge in *Sidaway*, supra n 2 at 897 and Cox J in *Gover*, supra n 2 at 564.

4 (1983) 33 SASR 189, 190 per King CJ.

5 Fleming, *The Law of Torts* (6th edn 1983) 102.

6 See generally, Fleming, supra n 5 at 104ff, *Salmond and Heuston on Torts* (18th edn 1981) 215ff and Lord Nathan, *Medical Negligence* (1957) 20. See also Montrose, 'Is Negligence an Ethical or a Sociological Concept?' (1958) 21 MLR 259 esp 259-260 and the cases cited at fn 3 thereof.

circumstances by most people or even by all people'.[7] It is for the court to determine whether or not the tortfeasor's conduct satisfies that objective standard.

However, in the context of medical negligence, the English courts have chosen to 'crystallise the required standard into more definite and uniform legal rules',[8] at least in the context of diagnosis and treatment.[9] Whilst acknowledging that the appropriate formulation of the standard of care is that of the 'ordinarily careful and competent practitioner', the House of Lords has recently reaffirmed that this standard is to be measured, at least in matters of clinical judgment, by 'whether [the doctor]...has acted in accordance with a practice accepted as proper by a body of responsible and skilled medical opinion'.[10] This test dates from McNair J's charge to the jury in *Bolam* v *Friern Hospital Management Committee*:

> '[A doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.'[11]

The so-called '*Bolam* test' represents a departure from objective standards of tortious liability. It is therefore not surprising that the test should have its critics, with one writer recently arguing that it 'permits the medical profession to set the standards...by which they are to be judged'.[12] It is because of the danger that this test will foster unsuitable professional practices that the South Australian Courts have chosen not to follow *Bolam*.

The purpose of this commentary is to examine a number of South Australian and English decisions which have considered and/or applied the *Bolam* test and thereby highlight differences in the judicial approach of the two jurisdictions. For the most part, the cases considered deal with the doctor's duty to advise patients of risks inherent in medical procedures (hereafter, the duty to disclose). For South Australian law, nothing turns on this because the duty to disclose is generally considered to be one aspect of 'the whole of the professional relationship'.[13] However, the position in England is less straightforward, with appellate support for a distinction between diagnosis and treatment on the one hand (said to be of the essence of the clinical function) and advice where it is suggested that the court might more readily impose its own assessment of whether the extent of disclosure is sufficient. This distinction has added

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7 Montrose, supra n 6 at 259, his emphasis. The consequences of the courts abdicating the responsibility for scrutinising the reasonableness of an industry's or profession's practices should be obvious. Unsuitable practices are often tolerated in disregard of obvious risks.

8 Fleming, supra n 5 at 101.

9 As for advice (ie disclosure), the third of the practitioner's functions, the House of Lords in *Sidaway* (supra n 2) was divided as to whether an objective or subjective standard should apply. Reference should be made to that discussion infra.

10 Lord Diplock in *Sidaway*, supra n 1 at 893.

11 Supra n 3 at 587.

12 Jones, 'Doctor Knows Best' (1984) 100 LQR 355, 357. See also Montrose supra n 6, Laskin CJ in *Reibl* v *Hughes* (1980) 114 DLR (3d) 1, 13; the casenote by Kennedy in (1984) 47 MLR 454; Robertson, 'Informed Consent to Medical Treatment' (1981) 97 LQR 102 and Bromberger, 'Patient Participation in Medical Decision Making' (1983) 6 UNSWLJ 1.

13 Cox J in *Gover*, supra n 2 at 551.

a further complexity to the debate over *Bolam* and will be examined in due course.

2. THE BOLAM TEST

(a) The decision:

Lord Nathan's 1957 text *Medical Negligence* states:

> '[A]lthough in the greater majority of cases a charge of negligence can be measured by showing that what was done accorded with general and approved practice, it is the courts themselves and not the medical profession, who decide whether negligence is established in a particular case; and the courts will not be deterred from categorising as negligent a practice which has inherent and obvious risks, by the fact that the practice has been widely followed over a period of time.'[14]

Clearly, this passage accurately depicts the approach ordinarily employed in special skills cases, both prior to and since *Bolam*. Nevertheless, in the same year as Lord Nathan's publication, McNair J was equating a breach of the medical practitioner's duty of care with a failure to act 'in accordance with a practice of competent respected professional opinion'.[15] McNair J placed reliance upon the 1955 Scottish Court of Sessions' decision in *Hunter* v *Hanley*,[16] a decision cited by Nathan to affirm the objective standard.[17] McNair J made particular reference to this passage from Lord President Clyde's speech in *Hunter* v *Hanley*:

> 'The true test for establishing negligence in diagnosis or treatment...is whether [the doctor]...has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.'[18]

Somewhat surprisingly, McNair J asserted that this passage was simply another way of expressing the rule that the appropriate standard of care was that of accepted medical practice.[19] However, there is nothing in either this passage nor, indeed, in the rest of Lord President Clyde's judgment to support the view that compliance with accepted medical practice is a sufficient defence to a claim in negligence. His Lordship's only reference to accepted practice is to state that a deviation from the same 'is not necessarily evidence of negligence'.[20]

It is submitted that McNair J must have misread *Hunter* v *Hanley*. This contention is supported by Lord Nathan's references to the case. In finding that liability for negligence is to be ultimately measured by the 'doctor of ordinary skill...acting with ordinary care',[21] *Hunter* v *Hanley* is quite consistent with South Australian authority and lends no support to the *Bolam* test.

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14 Lord Nathan, *Medical Negligence* supra n 6 at 26.
15 Supra n 3 at 587.
16 [1955] SC 200; [1955] SLT 213.
17 Lord Nathan, *Medical Negligence* supra n 6 at 21.
18 Supra n 16 at SC 205, SLT 217.
19 'It is', said McNair J, 'just a question of expression': *Bolam* supra n 3.
20 Supra n 16 at SC 206, SLT 217. See also Lord Nathan, *Medical Negligence* supra n 6 at 28.
21 Supra n 18.

Whereas in *Hunter* v *Hanley* the Court of Sessions discharged a verdict in favour of the defendant practitioner, the jury in *Bolam* dismissed the plaintiff's action despite evidence from an expert that the risks associated with the treatment prescribed by the defendant could have been avoided or, at the very least, should have been made known to the plaintiff prior to the procedure. No such warning had been given. The *Bolam* test enabled the practitioner to escape liability by calling experts to testify that the procedure adopted, including the failure to warn, was consistent with practices accepted by a responsible body of medical opinion. The correctness of the decision in *Bolam* is not the critical issue (at least for us). Our concern must be that the *Bolam* direction effectively precluded the jury from assessing the conduct of the defendant practitioner. As soon as evidence was adduced to show that some, albeit responsible, body of medical opinion endorsed the practitioner's technique, then the question of negligence was necessarily resolved in the defendant's favour.[22] The danger of the *Bolam* test is that it allows no opportunity for the Court to assess the adequacy of accepted practices, even where there is a body of medical opinion, perhaps equally, possibly more responsible, critical of those procedures. It is also difficult to see why the label 'responsible' should make it any less important that the Court scrutinize the practices endorsed.

(b) Bolam since: the UK experience

Professor Montrose was an early critic of *Bolam* arguing in 1958 that 'It is for the court to say whether the...ordinary practice...is reasonable and prudent'[23] and not the medical profession. Montrose shows that *Bolam* fell outside hitherto accepted tortious principles.[24]

The reaction of English courts to *Bolam* has been more favourable than the academic. Leaving aside for the moment the 1985 decision of the House of Lords in *Sidaway* v *Governors of Bethlem Royal Hospital* (which will be examined in detail shortly), the House of Lords considered and approved *Bolam* in *Whitehouse* v *Jordan*[25] and *Maynard* v *West Midlands Regional Health Authority*.[26] In the former, the decision was approved in so far as it had adopted the objective standard of care of the 'ordinary skilled man',[27] their Lordships making no comment as to whether that standard was to be further refined. However, in *Maynard's* case, Lord Scarman stated:

> 'It is not enough to show that subsequent events show that the operation need never have been performed, if at the time

22 In fact, according to Lord Scarman in *Sidaway* supra n 2 at 885, there is a positive burden upon the plaintiff to prove that there is no responsible body of medical opinion which would support the practitioner's conduct, a heavy onus indeed. Interestingly, the Court of Appeal would appear to have overlooked this obligation in *Thake* v *Maurice* [1986] 1 All ER 497. In this case neither plaintiff nor defendant called any expert evidence as to accepted medical practice and yet neither the trial judge [1984] 2 All ER 513 nor the Court of Appeal felt constrained in finding negligence within the *Bolam-Sidaway* criteria. See esp Kerr LJ in the Court of Appeal at 506-507. See also *Albrighton* v *Royal Prince Alfred Hospital & Others* [1979] 2 NSWLR 165 (Yeldham J, at trial) and [1980] 2 NSWLR 542 (C of A) discussed infra.

23 Supra n 6 at 261-262.

24 Supra n 6 at 261ff.

25 [1981] 1 WLR 246; [1981] 1 All ER 267.

26 [1984] 1 WLR 634.

27 Lord Edmund-Davies, supra n 25 at WLR 258; All ER 277.

> the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper.'[28]

When at trial, the judge in *Maynard's* case had been confronted with a conflict on the expert evidence as to the necessity for surgery, the result of which was paralysis of the plaintiff's left vocal cord. The trial judge preferred the evidence of the plaintiff's expert witness and found the defendants negligent. However, both the Court of Appeal and House of Lords reversed that finding on the ground that there existed 'a body of professional opinion, equally competent, which supports the [medical] decision as reasonable in the circumstances'.[29] Lord Scarman revealed the extent to which the *Bolam* test diminishes curial responsibility:

> 'I have to say that a judge's 'preference' for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred.'[30]

Lord Scarman recognised that cases such as the one in question presented 'certain difficulties of proof'.[31]

High Court and Court of Appeal decisions have added both express and tacit endorsement to *Bolam*. In His Honour's extensive discussion of authority in *Hills* v *Potter and others,*[32] Hirst J concludes that *Bolam* 'clearly upheld the medical standard as the correct test'[33] and that this standard is applicable to 'advice prior to an operation, as well as to diagnosis and to treatment'.[34] Having found that the defendant neurosurgeon's scant warning to his patient about the risk of paralysis in proposed surgery was 'fully acceptable'[35] by the standards of the three expert neurosurgeons who gave evidence for the practitioner (apparently three experts are sufficient to constitute a responsible body of medical opinion!), Hirst J applied *Bolam* to reject the plaintiff's claim.

In *Chatterton* v *Gerson and Another,*[36] *Bolam* is again cited but on the objective standard of care only; ie 'a careful and responsible doctor in similar circumstances'.[37] Bristow J clearly proceeds on the basis that

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28 Supra n 26 at 638.

29 Ibid.

30 Supra n 26 at 639. Clearly, no objection can be taken to the proposition that negligence cannot be established *merely* by showing that the practitioner's practice is disapproved of by some school of medical thought (see Lord Nathan, *Medical Negligence* supra n 6 at 28-29). Where *Bolam* departs from the objective standard is to preclude the courts from ruling that some practices are inappropriate, eg by the community's standards the risks are unreasonably high.

31 Supra n 26 at 638. See infra n 22.

32 [1983] 3 All ER 716.

33 Ibid at 722.

34 Ibid at 727. Hirst J was justified in reaching this conclusion as the plaintiff in *Bolam* alleged breaches of both the duty to provide proper treatment and the duty to warn. At page 587 of *Bolam* McNair J directs the jury to have regard to the 'three major topics' meaning diagnosis, treatment and advice. Whether Hirst J would be able to reach the same conclusion given the differences of opinion expressed by the House of Lords in *Sidaway* supra n 2 (discussed infra) is debatable.

35 Supra n 32 at 720.

36 [1981] QB 432 per Bristow J.

37 Ibid at 443.

the question of whether the practitioner 'fell short of his duty'[38] is ultimately for the Court.

It should be noted that neither *Whitehouse* v *Jordan* nor *Maynard's* case dealt with the duty to disclose. *Sidaway's* case was the first opportunity for their Lordships to rule on this aspect of the practitioner's duty. Their reasoning (and that of the Court of Appeal) is considered below.

(c) Sidaway's Case

(i) *Court of Appeal*[39]

In *Sidaway*, the plaintiff sued a neurosurgeon for failure to disclose risks inherent in surgery necessitated by persistent neck and shoulder pain. That surgery carried a risk of injury to the plaintiff's spinal cord put at between one and two per cent. As a result of the operation (which was in all respects performed competently) the plaintiff's spinal cord was damaged, rendering her severely disabled. At the trial, Skinner J found that the surgeon did not make clear to the patient that the surgery was a matter of choice, not necessity,[40] and that whilst referring to nerve root damage he had not mentioned the possibility of the more serious consequence of damage to the spinal cord. Nevertheless, applying *Bolam* and relying upon the evidence of four neurosurgeons, Skinner J concluded that the extent of the defendant's disclosure was consistent with 'a practice which, in 1974, would have been accepted as proper by a responsible body of skilled and experienced neuro-surgeons'.[41] This was apparently 'all that in law she was entitled to expect'.

During argument in the Court of Appeal, Dunn LJ observed:

> 'The issue in this case is whether the standard is to be set by the professional or by the courts.'[43]

When asked by Browne-Wilkinson LJ,[44] '[S]ay there was a medical practice not to warn at all?', counsel for the defendant practitioner responded:

> 'On *Maynard*...a doctor would be justified in following that practice'.

With this last observation the Court of Appeal was not entirely in agreement and nor was the central issue as straightforward as Dunn LJ had first imagined. For the Court of Appeal was called upon to consider whether the *Bolam* test applied to all *three* of the medical practitioner's functions.

Sir John Donaldson MR began by affirming *Bolam* in its application to diagnosis and treatment.[46] His Lordship acknowledged that the House of Lords was silent on the applicability of *Bolam* to non-clinical

38 Ibid at 444.
39 [1984] QB 493.
40 Ibid at 504, 'meaning thereby that it could be postponed or even refused at the price of enduring pain...', per Donaldson MR.
41 Supra n 39 at 505 (where Skinner J's findings are restated in the judgment of the Master of the Rolls).
42 Supra n 39 at 503.
43 Supra n 39 at 501.
44 Ibid.
45 Ibid.
46 Supra n 39 at 508.

judgment,[47] ie the duty to disclose, but adds that *Bolam* was so applied in both *Chatterton* v *Gerson* (although this may very much be doubted) and *Hills* v *Potter*.[48]

Upon examination of the various facets of the duty to disclose, Donaldson MR concluded that this function likewise involved 'professional expertise'[49] and, being a 'matter for professional judgment'[50] it necessarily followed that:

> '[W]hether or not a particular doctor has or has not fallen below the requisite standard of care must be tested in the first instance by reference to the way in which other doctors discharge their duty...'[51]

The Master of the Rolls' subsequent discussion evidences a confusing twist. Canadian authority[52] is cited to assert that 'the duty of care is a matter for the law and the court'[53] and then the *Bolam* test is reaffirmed 'subject to an important caveat'[54] which apparently applied only to the duty to disclose. That caveat amounted to this:

> 'The duty is fulfilled if the doctor acts in accordance with a practice *rightly* accepted as proper by a body of skilled and experienced medical men.'[55]

Whilst it is not entirely clear what the Master of the Rolls intended by this,[56] His Lordship does say (and again one presumes this is only to apply in the context of the duty to disclose) that 'a judge would be entitled to reject a unanimous medical view if he were satisfied that it was manifestly wrong and that the doctors must have been misdirecting themselves as to their duty in law'.[57] This last observation shows that Donaldson MR was not prepared to forgo court-controlled objectivity entirely. His Lordship's ultimate decision to reject Mrs Sidaway's appeal appears to rest on the fact that the defendant's professional peers 'took the same view'[58] on the need for disclosure and, having assessed the evidence, His Lordship was unable to conclude that they were wrong.

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47 Lord Scarman classifies diagnosis and treatment as matters of 'clinical judgment' in *Maynard*, supra n 26 at 638.

48 Supra n 39 at 508. At 512 Donaldson MR acknowledges that the judge in *Chatterton* v *Genson* 'did appear to be applying a test which was independent of current professional practice'.

49 Supra n 39 at 513.

50 Supra n 39 at 512.

51 Supra n 39 at 513.

52 Ibid. The case cited is *Reibl* v *Hughes*, supra n 12. It is not proposed to consider Canadian authorities here although the following cases should be noted: *Anderson* v *Chasney et al* (1949) 4 DLR 71 which denies that expert evidence of approved medical practice is ever conclusive on an issue of negligence; *Reibl*, supra n 12, which is consistent with *Anderson* v *Chasney* and was also cited with approval by King CJ in *F* v *R* supra n 4 at 193-194 and *Dendaas* v *Yackel* [1985] WWR 272, which, contrary to the earlier Canadian authority, holds that standard of care is determined by reference to accepted practice although the result of the case may not be entirely consistent with that conclusion.

53 Ibid.

54 Ibid.

55 Supra n 39 at 514.

56 Kennedy, supra n 13 at 465, expresses similar bewilderment and paraphrases the ruling thus: 'In other words the standard is for the medical profession, provided they get it right...'

57 Supra n 39 at 513-514.

58 Supra n 39 at 514.

Dunn LJ also rejected Mrs Sidaway's appeal. His Lordship was even more clearly of the opinion that the duty to warn was merely 'part of the overall clinical judgment of the doctor'.[59] That judgment, said his Lordship, 'can only be tested by applying the standards of the profession'.[60]

Browne-Wilkinson LJ also concluded that 'whether the risk is material and the adequacy of the disclosure will fall to be determined by reference to the accepted practices of the medical profession and not, as in the ordinary case of the professional man, by the court applying its own standards'.[61] His Lordship observed that the accepted practice revealed that the risk of spinal cord damage was too remote to warrant a specific warning.

But like the Master of the Rolls (although for different reasons), Browne-Wilkinson LJ conceded that accepted practice, whilst it might govern here, cannot govern every individual case. His Lordship stated:

> 'All questions of disclosure will be decide by reference to the practice of the profession save that an omission to disclose risks could not be justified solely by reference to a practice of the profession which does not rely on the circumstances of the particular patient.'[62]

In other words, whilst the disclosure of certain information might have a deleterious effect on the majority of patients suffering a particular condition, there may be individuals in that class whose capacity to make informed decisions on the basis of that information is not at issue.[63] In the case of the latter, disclosure may be necessary, especially where the risk is material. Of course, the difficulty with this, as is shown in the psychiatric cases such as the South Australian Full Court's decision in *Battersby* v *Tottman and the State of South Australia*,[64] is that any question as to whether a particular patient will be able to digest the information rationally may itself be a matter for clinical judgment. As such, the court might, adopting *Bolam*, again feel compelled to defer to the very medical opinion it was called upon to evaluate.

(ii) *House of Lords*[65]

Mrs Sidaway's further appeal afforded the House of Lords the opportunity to rule on the applicability of the *Bolam* test to the duty to disclose. Counsel for the appellant conceded that the *Bolam* test applied to diagnosis and treatment[66] — 'matters of professional skill and competence'[67] — but argued that an objective test applied to disclosure, citing Bristow J in *Chatterton*.[68]

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59 Supra n 39 at 516.
60 Ibid.
61 Supra n 39 at 522.
62 Supra n 39 at 522. See also the discussion by Kennedy, supra n 12 at 464.
63 Mrs Sidaway was presumably not such an individual.
64 (1985) 37 SASR 524.
65 Supra n 2.
66 Whilst the House of Lords had not formulated any specific reservatiion on the applicability of *Bolam* in either *Whitehouse* v *Jordan* supra n 25 or *Maynard's* Case supra n 26, neither of those cases concerned the duty to warn. It was therefore accepted by both Court of Appeal and House of Lords that they were free to rule on this question unhindered by previous authority.
67 Supra n 2 at 874.
68 Ibid.

Whilst the plaintiff's appeal was unanimously dismissed and the *Bolam* test confirmed in its application to diagnosis and treatment, their Lordships were divided on whether the duty to disclose necessitated different considerations. Lord Scarman, alone of their Lordships, adopted the appellant's submission that both 'trial judge and the Court of Appeal erred in law in holding that in a case where the alleged negligence is a failure to warn the patient of a risk inherent in the treatment proposed, the '*Bolam* test'...is to be applied'.[69]

Although the 'current state of responsible and competent professional opinion'[70] was clearly relevant, Lord Scarman accepted that the duty to disclose warranted different considerations from those applicable in diagnosis and treatment, this exception stemming from the patient's 'right of 'self-determination' '.[71] According to his Lordship, the duty to dislcose was to be tested 'by the court's view as to whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes'.[72] What the law required of the practitioner was put in terms similar to those which have found favour in the South Australian Supreme Court:[73] a duty to warn of material risks to which a reasonable person in the position of the patient would attach significance (with the proviso that the practitioner is entitled not to warn of material risks 'if upon a reasonable assessment of his patient's condition he takes the view that a warning would be detrimental to his patient's health'[74]).

His Lordship offers no real explanation why it is that his concern not to leave the determination of this legal duty to the judgment of doctors should not extend to all aspects of the professional relationship other than to say that diagnosis and treatment involve 'medical objectives'[75] which are different from those which determine whether or not treatment is accepted at all.

Lord Bridge (with whom Lord Keith concurred) viewed the duty to disclose as 'primarily...a matter of clinical judgement'.[76] As such, a breach of duty by non-disclosure was to be 'decided primarily on the basis of expert medical evidence'[77] in accordance with the *Bolam* test. Lord Bridge does consider at length the North American cases on informed consent and it is Laskin CJC's 'cogently stated'[78] attack on *Bolam* in *Reibl* v

69 Supra n 2 at 876.
70 Ibid.
71 Supra n 2 at 882 where Lord Scarman acknowledges that his 'right of self-determination' is born out of the trans-Atlantic 'doctrine of informed consent'.
72 Supra n 2 at 876.
73 But emphasising that it is the materiality of risk as the *prudent patient* sees it rather than as the reasonable practitioner would view it (the latter being more in accord with the South Australian position). See infra.
74 Supra n 2 at 889-890. Lord Scarman concluded that the doctor treating Mrs Sidaway was not in breach of his duty of disclosure. It will be recalled that the doctor in question failed to advise the plaintiff that the surgery was elective rather than necessary and that the operation carried a risk of spinal cord damage (and paralysis) of between one and two per cent. His Lordships considered that these circumstances were not sufficiently material to warrant a warning (see 879). Nor was there any evidence that Mrs Sidaway wished to be informed of anything other than material risks.
75 Supra n 2 at 886.
76 Supra n 2 at 900.
77 Ibid.
78 Supra n 2 at 899.

Hughes[79] that compels his Lordship to qualify the *Bolam* test in cases of non-disclosure:

> 'But even in a case where, as here, no expert witness in the relevant medical field condemns the non-disclosure as being in conflict with accepted and responsible medical practice, I am of opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it.'[80]

His Lordship even quantifies the magnitude of risk at which point the court would 'step in' as 10 per cent.[81]

It is doubtful whether such an arbitrary ceiling really advances the patient's cause (paralysis is paralysis, be the risk one or 10 per cent) and it is certainly inconceivable that a risk as great as this would not be revealed anyway.

The most striking thing about Lord Templeman's speech in *Sidaway* is the absence of specific discussion of the *Bolam* direction. The instant case could apparently be decided as a matter of principle. His Lordship commenced with a spirited defence of medical paternalism, asserting that 'A patient may prefer that the doctor should not thrust too much detail at the patient'.[82] If the patient seeks anything other than a 'simple and general explanation of the nature of the operation'[83] then the plaintiff need only ask the appropriate questions. Where such an explanation has already been given and the patient seeks no further information he 'cannot complain of lack of information'.[84] On Lord Templeman's analysis, a failure to pose questions meant that the patient already appreciated the unspoken dangers and thought them 'sufficiently remote to be ignored'[85] though just how and why the general public should be attributed with so sophisticated a medical expertise is not made clear. Lord Templeman does however suggest that even where the practitioner gives his explanation and answers the patient's questions, he may still be liable for failure to disclose 'some danger which by its nature or magnitude or for some other reason requires to be separately taken into account by the patient in order to reach a balanced judgment...'.[86] Such a danger is to be classified as a special, as opposed to a general, danger. The latter will ordinarily be covered by the practitioner's initial explanation and the patient's own appreciation (ie extrapolation?) of the risks involved. Lord Templeman says that the courts must determine if the danger in question is general or special.[87] If general, 'the court must decide whether the information afforded...was sufficient to alert the patient to the possibility

79 Supra n 12 at 13.
80 Supra n 76.
81 Ibid. His Lordship did not consider that the risk of paralysis facing Mrs Sidaway, being between one and two per cent, was sufficient to invoke the objective standard and he dismissed the appeal.
82 Supra n 2 at 902.
83 Ibid.
84 Ibid.
85 Ibid.
86 Ibid.
87 Supra n 2 at 903.

of serious harm of the kind in fact suffered'[88] so that the patient can make further inquiry if he wishes. Where 'the practice of the medical profession is to make express mention of a particular kind of danger, the court will have no difficulty in coming to the conclusion that the doctor ought to have referred expressly to this danger as a special danger...'.[89] However,

> 'Where the practice...is divided or does not include express mention, it will be for the court to determine whether the harm suffered is an example of a general danger inherent in the nature of the operation and if so whether the explanation afforded to the patient was sufficient to alert the patient to the general dangers of which the harm suffered is an example...It is for the court to decide, after hearing the doctor's explanation, whether the doctor has in fact been guilty of a breach of duty with regard to information.'

It may be helpful to summarise Lord Templeman's conclusions. Firstly, the doctor must give a 'simple and general explanation' as to the nature of the treatment proposed and answer any questions put by his patient. This explanation must alert the patient, if in general terms only, of the seriousness of the operation and possible consequences, ie the general danger inherent in the treatment. The fewer questions, the less specific need the doctor be. In the case of special dangers where the nature or magnitude of risk is greater, the practitioner is apparently under an absolute obligation to make disclosure.[91] A 10 per cent risk of stroke as in *Reibl* v *Hughes* provides an illustration of such a danger.

Where the patient complains of lack of information about the general dangers of treatment prescribed, it is the court which decides whether the explanation was sufficient to alert the patient to that danger. Where the practice of the profession is specifically to mention a particular danger as part of that general explanation then the court will 'have no difficulty' in concluding that it should have been made known. Where medical opinion is divided then the court itself is free to rule one way or the other on the necessity to disclose. Special dangers of the magnitude seen in *Reibl* are in a class of their own: the law will require disclosure without reference to the state of medical opinion.

As can be seen, Lord Templeman's approach is to foster the traditional paternalism of the doctor-patient relationship but only to the point where risks ordinarily ancillary to treatment become more serious. At this point there is no room for *Bolam* and accepted practice must give way to an absolute obligation to disclose.

Lord Diplock's analysis was much simpler. The doctor's duty of care 'is not subject to dissection into a number of component parts to which different criteria of what satisfy the duty of care apply'.[92] It followed that if *Bolam* governed diagnosis and treatment it must also govern the duty to disclose. His Lordship so held, joining Lords Bridge and Keith

88 Ibid. His Lordship considered that the explanation Mrs Sidaway had received was sufficient for this purpose.
89 Ibid.
90 Ibid.
91 The level of risk of spinal cord damages in *Sidaway* was not sufficient to constitute a 'special danger'.
92 Supra n 2 at 893.

in applying the *Bolam* test, though without the caveat advocated by the latter. The evidence being that the defendant's warning was acceptable by a responsible body of medical opinion, his Lordship dismissed the appeal.

(iii) *Critique*

What are we to make of the House of Lords' decision in *Sidaway*? Clearly, the *Bolam* test remains unchallenged in matters of diagnosis and treatment. In the context of non-disclosure, those of their Lordships who considered that the duty to warn was one aspect of the doctor's overall duty of care, namely Lords Diplock, Bridge and Keith, endorsed *Bolam*. Lords Scarman and Templeman considered that the duty to warn deserved separate treatment and both speeches can be seen as a rejection of *Bolam* for this purpose. In its place, an objective test based on the materiality or seriousness of the risk emerges. But despite the support of three of their Lordships, the qualification placed upon *Bolam* by Lord Bridge (and with him Lord Keith) that, in the last resort, a court is entitled to say that a certain risk is such that no reasonably prudent medical man would fail to disclose it, suggests that any difference in practice between the approaches of Lords Bridge and Keith on the one hand, and Lord Templeman on the other, will be of little significance. Lord Scarman's advocacy of informed consent is perhaps a little too radical for Lords Bridge, Keith and Templeman's analysis.

The question remains, if the *Bolam* test is considered inappropriate in the context of disclosure, why is it justified in matters of diagnosis and treatment? Lord Scarman's answer would be that there is often no immediately obvious right or wrong procedure in diagnosis or treatment, that they are uniquely matters of clinical judgment. This is a view the origins of which lie in that unobjectionable remark of Lord President Clyde in *Hunter* v *Hanley*:

> 'In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men...'[93]

But this is a truism applicable to the practices of any profession or industry. It is no basis for excluding the courts from ruling on the reasonableness of a practice. Everyday courts are called upon to evaluate and rule upon professional opinion. As Bollen J observed in the Supreme Court of South Australia in *F* v *R*:

> 'A court cannot be expected to know the correct procedure for performing a surgical operation. The court cannot be expected to know why a manufacturer should guard against metal fatigue. A court cannot be expected to know how to mix chemicals.'[94]

Yet, as His Honour went on to observe,[95] these are matters upon which courts are commonly asked to rule, having assessed the expert evidence much of which probably conflicts. In what sense can the court be said to be fulfilling its judicial function if it says, 'there is a conflict on

93 Supra n 16 at SC 204-205; SLT 217. See Bollen J in *F* v *R* supra n 4 at 206.
94 Supra n 4 at 201.
95 Ibid.

the expert evidence as to whether this procedure was correct, therefore we are not entitled to entertain the action'?

An alternative way of viewing the problem is to ask whether or not it is possible to separate the duty of disclosure from clinical judgment. Lord Scarman (and presumably Lord Templeman) thought it possible, but three of their Lordships, Lords Diplock, Bridge and Keith, refused to concede that diagnosis, treatment and advice were other than part of the overall duty of care and that, as Lord Diplock stated:

> 'To decide what risks the existence of which a patient should be voluntarily warned...having regard to the effect that the warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care...'[96]

But, as we have seen, Lords Bridge and Keith could only support this up to a point, eg where the risk is 10 per cent. It is apparently here that clinical judgment runs out and an objective rule takes over. The fudging of the issue, by Lords Bridge and Keith especially, illustrates the difficulty of characterising disclosure one way or the other. It is submitted that Lord Diplock's view is preferable and that in practice the duty of disclosure cannot be effectively distinguished from the doctor's other, 'more clinical', functions. The fact that a majority of their Lordships was prepared to make that distinction must create doubts about the validity of the *Bolam* test.

3. SOUTH AUSTRALIAN CASES

Before 1983 the duty and standard of care required of medical practitioners had not been stated with any degree of particularity in South Australia. In *Goode* v *Nash*[97] the plaintiff suffered a burn to his eye when a doctor placed a hot tonometer to his cornea. The instrument had failed to cool after sterilisation. The doctor contended that 'the mishap occurred in the course of following an accepted medical practice'.[98] Without indicating whether this would have been an adequate defence to a charge of negligence, the Court found that the very existence of the burn meant 'that he could not have followed his usual practice on this occasion'.[99] Nevertheless, the Court cited Canadian authority[100] in rejecting the conclusiveness of expert evidence as to accepted medical practice prefacing the citation with the observation that the medical practitioner 'was under a very high duty of care to guard against dangers inherent in the method he employed'.[101]

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96 Supra n 2 at 895. Lord Scarman's advocacy of a distinction between the clinical judgment (diagnosis and treatment) and disclosure appears to rest not on any real conceptual distinction but an overriding commitment to the doctrine of informed consent.

97 (1979) 21 SASR 419.

98 Ibid at 422.

99 Ibid.

100 *Anderson* v *Chasney*, supra n 52.

101 Supra n 96 at 422. In the subsequent case of *Giurelli* v *Girgis* (1980) 24 SASR 264 White J at trial specifically relied upon *Bolam* to hold that a surgeon was entitled to adopt whichever of the three accepted medical practices he thought appropriate (but was nevertheless held liable for failure to pay heed to the patient's complaints). Bollen J is right when he observes in *F* v *R* (supra n 4 at 202) that White J 'did not merely 'rubber stamp' the medical opinion' but when that judgment is viewed as a whole, was merely guided by it 'in the exercise of his function as a judge'.

A more thorough and, now, the leading examination of the question occurred in *F* v *R*. Here, the female plaintiff sought a sterilisation operation and was advised by her specialist to undergo a tubal ligation, a widely favoured sterilisation technique and, apparently, 'the only medically acceptable sterilisation'[102] option for the plaintiff. The specialist was well aware that medical opinion viewed this technique as having a failure rate at 'between .5 per cent and one per cent'.[103] This risk of failure was not made known to the plaintiff despite her husband's (also a plaintiff) specific enquiry as to the desirability of his having a vasectomy.[104] Whilst competently performed, recanalisation occurred rendering the plaintiff fertile again. A pregnancy resulted.

Of the doctor's duty to disclose the risk of the technique's failure, King CJ adopted the standard of care formulated by Bristow J in *Chatterton*, being that of the 'careful and responsible doctor in similar circumstances'. The *Bolam* test was rejected. The Chief Justice said:

> '[M]uch assistance will be derived from evidence as to the practice obtaining in the medical profession. I am unable to accept, however, that such evidence can be decisive in all circumstances: *Goode* v *Nash*...*Reibl* v *Hughes*...
>
> In many cases an approved professional practice as to disclosure will be decisive. But professions may adopt unreasonable practices...The Court has an obligation to scrutinise professional practices to ensure that they accord with the standard of reasonableness imposed by the law.'[105]

King CJ acknowledges that in the specific context of disclosure the balance between benevolent paternalism and the right to self determination is finely poised.[106] Nevertheless, the Chief Justice affirms that the court's function is to ensure that the medical practitioner performs all of his duties 'in the way a careful and responsible doctor in similar circumstances'[107] would do. The Chief Justice's approach is consistent with the general tortious principle. As can be seen from His Honour's discussion of the factors relevant in determining what the careful and responsible doctor should disclose (see pp192-3 of *F* v *R*), the Chief Justice charts a course between paternalism and informed consent, but based always on the objective standard of the 'careful and responsible doctor in similar circumstances'.

The Chief Justice's view that professions are apt to 'adopt unreasonable practices'[108] was sufficient justification for precluding the courts from evaluating the standard of care against anything other than an objective test.

The Chief Justice concluded[109] that because: (i) pregnancy would not endanger the female plaintiff's life; (ii) the tubal ligation was 'the only medically acceptable method of sterilisation'; (iii) the plaintiffs were definite

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102 Supra n 4 at 195.
103 Ibid.
104 Supra n 4 at 190.
105 Supra n 4 at 193-194.
106 Supra n 4 at 191.
107 Ibid; this is the expression used by Bristow J in *Chatterton* supra n 36 at 443.
108 Supra n 4 at 194.
109 Supra n 4 at 195-196.

'indeed, vehement in their expressed desire for sterilisation'; (iv) the plaintiffs 'made no inquiry as to the possibility of the operation not achieving its objective'; (v) the possibility of failure was statistically remote; and (vi) there was a non-disclosure practice for this risk amongst a section of the profession (a not irrelevant consideration);[110] the instant failure to disclose the risk of future pregnancy was not a breach of the duty of care.

Of the other members of the Full Court in *F* v *R*, Bollen J was equally adamant that the Court should reject any submission that medical opinion should prevail over the views of the court:

> 'If the court did merely follow the path apparently pointed by expert evidence with no critical consideration of it and the other evidence, it would abdicate its duty to decide, on the evidence, whether in law a duty existed and had not been discharged. Acceptance of [this]...submission could amount to abdication here.'[111]

His Honour adopted the objective standard of care, approved Bristow J's analysis of the duty to warn and held that the medical practitioner was entitled to view pregnancy as an 'extremely remote risk';[112] no warning was necessary as a matter of law.

Legoe J recognised that accepted practice was a guide to the reasonableness of advice but appears like his brethren to reject any suggestion that the court be dictated to by 'expert medical advice'.[113]

The authority of *F* v *R* has not been assailed. Four judges (including Cox J at first instance)[114] affirmed the reasoning in *F* v *R* in *Battersby* v *Tottman and State of South Australia*.[115] In *Battersby* the plaintiff suffered serious eye damage as a result of the prolonged prescription of high dosages of the drug 'melleril'. That drug was known to carry a risk of eye damage, especially at high dosage, but the plaintiff's doctor, aware that other forms of treatment for the plaintiff's condition (reactive depression) including melleril at lower dosages had so far failed, decided that the likely advances to be derived from higher dosages outweighed the risk of eye damage. That risk was not disclosed to the patient. After some two years on melleril at high dosage serious and permanent eye injury was detected. The plaintiff subsequently sued alleging negligence in diagnosis, treatment and advice, the latter framed in terms of the failure to disclose the risk of serious eye injury posed by the drug in question.

King CJ reaffirmed the objective standard of care set out in *F* v *R*.[116] On the issue of disclosure, the Chief Justice endorsed his earlier remarks in *F* v *R* and held that failure to disclose to a 'mentally normal and emotionally sound patient information as to a material risk'[117] would be a breach of duty. However, the caveat evident in this formulation of the duty (and stated more fully in *F* v *R*)[118] was directly applicable on

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110 Supra n 4 at 193.
111 Supra n 4 at 201.
112 Supra n 4 at 207.
113 Supra n 4 at 200.
114 (1984) 35 SASR 577 (Cox J).
115 Full Court, see supra n 64.
116 Supra n 64 at 527.
117 Ibid.
118 Supra n 4 at 193.

the facts in *Battersby*, for the evidence was clear that had the possibility of eye damage been disclosed, the plaintiff was at risk of blindness being induced by hysteria and/or suicide. There was little likelihood of the information being digested in a rational and deliberative way. Without melleril, the practitioner was of the view that the plaintiff's future prospects were 'indeterminate close confinement in a mental institution with a high risk of suicide'.[119]

The Chief Justice held that the plaintiff's mental condition justified both the decision to use melleril and the decision not to disclose its risks. Both those decisions were taken on reasonable grounds, that is to say, the Chief Justice assessed evidence as to the advantages and risks of using melleril in such doses and the plaintiff's emotional state and concluded that it was impossible to say that 'a doctor who possessed ordinary competence and exercised reasonable care'[120] would not have reached the same conclusions.

Jacobs J was of the same opinion, approving *F* v *R* on the duty of disclosure and stating:

> 'The learned trial Judge, like Dr Tottman himself, had to weigh the risk in relation to the options for treatment...He had to weigh the risk having regard to the consequences of the possible side-effects of the drug, as well as the likelihood of their occurrence. Both are elements of the magnitude of the risk. The learned trial Judge's view on those matters...must have been crucial to his decision that the assumption of the risk, and the management of the patient in relation to that risk was, in the circumstances, reasonable and justifiable.'[121]

His Honour's characterisation of the trial judge's function is clearly at odds with the *Bolam* direction. In fact, Jacobs J himself noted[122] that the opinion he expressed and the Full Court's earlier decision in *F* v *R* were inconsistent with the Court of Appeal's decision in *Sidaway*. His Honour reaffirmed that it is the task of the court and not professional opinion and practice to say what is 'reasonable and proper according to the circumstances'.[123] Minded also of the academic criticism of *F* v *R*[124] (and perhaps Zelling J's judgment in the instant case), Jacobs J expressed his disquiet at the thought of 'an absolute and unqualified duty to disclose'.[125]

Zelling J dissented and would have allowed the plaintiff's appeal, saying:

> 'In my view no doctor is entitled to give a patient treatment which may blind her or seriously damage her eyesight without first discussing it with the patient and obtaining her consent to the treatment.'[126]

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119 Supra n 64 at 527.
120 Supra n 64 at 528.
121 Supra n 64 at 544.
122 Ibid.
123 Ibid.
124 By Bromberger, supra n 12 at 14-16.
125 Supra n 64 at 544.
126 Supra n 64 at 534.

That His Honour may not have been intending an *absolute* duty to disclose is suggested by the subsequent observation:

> 'The severity of the consequences...when balanced against the plaintiff's mental condition comes down heavily in favour of her being consulted.'[127]

It is difficult to see how His Honour can make this finding, given that the evidence of the plaintiff's mental condition suggested disclosure of the risk of blindness would have induced, at the very least, hysterical blindness and, quite probably, the likelihood of suicide. Still, His Honour sought to justify his opinion in terms other than an *absolute* duty, perhaps because the latter is not always workable, eg a comatose patient whose life is placed at risk for inability to consent to a dangerous operation.

Despite His Honour's dissent on the facts, Zelling J did not question the authority of *F* v *R* save that he would have extended the obligation to disclose to a point bordering on absolute where very serious consequences, such as blindness, are a possibility.[128]

Obviously, Zelling J's view of the duty of disclosure is even further from the *Bolam* test than *F* v *R*. His Honour acknowledged his departure from English authority when he said:

> 'I do not agree with the English decisions on the decisive weight to be accorded to medical opinion...I consider that liability should not be measured from the point of view of the medical practitioner and that to apply ordinary principles of tort liability...will not mean that medical practitioners will not do their job properly. Those were the same sort of arguments which were used with regard to claims against legal practitioners until a generation ago. They have been rightly disgarded in regard to the law and they have no place in relation to the medical world today.'[129]

Mrs Battersby subsequently sought leave to appeal to the High Court from the Full Court's decision, arguing that the conflict between English and South Australian authority needed resolution. Leave to appeal was refused.[130]

Since *Battersby*, Cox J's decision at trial in the case of *Gover* v *State of South Australia and Perriam*[131] has been reported. His Honour considered and applied *F* v *R* and *Battersby* in dismissing an action maintained primarily for failure to disclose risks inherent in surgery performed on the plaintiff's eyes. Much of the evidence dealt with prevailing medical practices and Cox J noted 'considerable disagreement among the experts about the postulated risks...and about the propriety of warning...'.[132] Whereas the *Bolam* test would have prohibited the court from evaluating that evidence, Cox J reviewed the expert opinion and made findings on what 'the community, and the law, are entitled to

127 Ibid.
128 Supra n 64 at 534-535.
129 Supra n 64 at 537.
130 High Court of Australia, 26 April 1985.
131 Supra n 2.
132 Supra n 2 at 560.

expect'[133] of the 'ordinarily careful and competent practitioner' of the class to which the defendant belonged.

The *Bolam* debate has also surfaced in New South Wales. In *Albrighton* v *Royal Prince Alfred Hospital*,[134] Yeldam J at first instance entered a verdict by direction for the defendant hospital and surgeon because the absence of evidence as to approved medical practices made it impossible for the jury to conclude that the defendants failed to maintain those standards. The Court of Appeal in turn ruled that this direction proceeded on 'a wrong assumption'.[135] Reynolds JA said:

> '[I]t is not the law that, if all or most of the medical practitioners in Sydney habitually fail to take an available precaution to avoid foreseeable risk of injury to their patients, then none can be found guilty of negligence.'[136]

In other words, accepted practice was not the yardstick of negligence. The Court of Appeal ordered a retrial.

4. SUMMARY

The traditional emphasis of the English authorities on the need to avoid so-called defensive medicine[137] has now been confronted by the demands of patients for greater accountability from the profession. This conflict gave rise to the divisions in the House of Lords in *Sidaway* where *Bolam* was challenged in the context of disclosure. It appears likely that the English courts will develop a different standard of care for the duty of disclosure from that applied to the supposedly purely clinical functions of diagnosis and treatment. If one attempted a synthesis of each of the approaches of Lords Scarman, Bridge, Keith and Templeman, one might find that this test closely resembles that adopted by the South Australian Full Court in *F* v *R*, eg that the practitioner is required to disclose any special or material risks inherent in a procedure sufficient to ensure that the patient is able to make an informed choice about whether to accept or reject the treatment. A special or material risk is a risk that no reasonably prudent medical man would fail to make known in these circumstances.

The departure of the South Australian authorities from the trend of English case law appears to involve a two-fold approach. First, the decision not to elevate *Bolam* into an irrebutable presumption that there can never be a finding of negligence where there is at least one body of responsible medical opinion in the defendant's favour. Secondly, the decision not to distinguish between the standard of care to be demanded in diagnosis and treatment and that required in disclosure; in all instances that standard is to be judged objectively. The South Australian cases recognise that there is little merit in trying to distinguish between clinical and non-clinical functions.

It might be said that the continued importance of accepted practice in assessing reasonable care will render any differences between an objective

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133 Supra n 2 at 562.
134 Supra n 22.
135 Supra n 22, Court of Appeal at 562.
136 Supra n 22, Court of Appeal at 562-563.
137 See Dunn LJ in *Sidaway*, C of A, supra n 36 at 517 (criticised by Kennedy, supra n 12 at 468-469) and Lord Diplock in *Sidaway*, H of L, supra n 2 at 893.

and subjective approach immaterial. This is not necessarily borne out by the cases reviewed. Whilst it is impossible to say whether an objective standard would have altered the outcomes of the English decisions (although it may well have done in *Maynard's* case), the adherence to the *Bolam* test has at least prevented courts even evaluating competing practices. To argue that an objective test places the profession under additional strain is also dubious. As the South Australian cases show, the practitioner is afforded considerable latitude in decision-making, in part a recognition of the peculiarities of the doctor-client relationship. In few of the reported South Australian cases has the patient succeeded.

A final observation. It is clear that the *Bolam* test sought primarily to ensure that a practitioner was not condemned in negligence merely because he chose one out of two or more procedures, all of which had the support of a responsible body of medical opinion. As Bollen J noted in *F* v *R*,[138] this was the 'real point' of *Bolam*; it was certainly a major emphasis of Lord President Clyde's speech in *Hunter* v *Hanley*.[139] Unfortunately, the English courts chose to tip this otherwise unobjectionable rule on its head and, with it, the law of medical negligence. After *Bolam*, not merely could the choice of one accepted practice over another never of itself be evidence of negligence - the very choice of such a practice positively excluded the possibility of negligence altogether. It is, however, one thing to say that a professional is entitled to adopt one of a number of accepted practices and that this choice per se is not evidence of negligence. It is quite another to say that the courts are never entitled to rule that one or other of these practices fails to meet the standards which the community, through the law of tort, demands.

138 Supra n 4 at 206.
139 Supra n 16 at SC 204-205; SLT 217.