Medical Negligence — the Duty to Attend Emergencies and the Standard of Care: *Lowns & Anor v Woods & Ors*

1. *Introduction*

In *Lowns & Anor v Woods & Ors*[1] the New South Wales Court of Appeal has handed down a decision on two controversial issues in medical negligence: the existence of a common law duty requiring doctors to attend non-patients in an emergency, and the relevance of usual medical practice to the standard of care. For the first time in Australia a court has held that a medical practitioner owes a common law duty to attend a person in an emergency who is not (nor has ever been) his or her patient.[2] That such a duty did not previously exist may be surprising to the general community, as indicated by the media attention which has surrounded the case. However there is a long history of the Australian common law in which there has been no duty to rescue a person, even when death or injury is foreseeable as a result of a failure to assist.[3] In other common law jurisdictions it has been held that a doctor has no duty to attend a person who is sick, despite there being an emergency, if that person is not nor has ever been the doctor's patient.[4] *Lowns v Woods* thus continues the development of an increasingly distinct Australian law of torts.[5] It also illustrates the increasing expansion of liability in the tort of negligence into professional contexts by reference to the principle of proximity. In this decision, the New South Wales Court of Appeal opens up the liability of medical practitioners for negligent failure to attend and treat non-patients in an emergency, while leaving uncertain the implications of such a duty in practice. It also revisits the sensitive issue of who sets the standard of care in medical negligence, considering the implications of the High Court's decision in *Rogers v Whitaker*[6] for cases involving the "heartland of the skilled medical practitioner"[7] — diagnosis and treatment.

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1 *Lowns & Anor v Woods & Ors* (1996) *Aust Torts Reports* 81–376 (*"Lowns v Woods"*).

2 *Woods v Lowns* (1995) 36 NSWLR 344 (Badgery-Parker J at first instance).

3 For example *Quinn v Hill* [1957] VR 439 at 446; *Sutherland Shire Council v Heyman* (1985) 157 CLR 424 at 477–81 per Brennan J; *Jaensch v Coffey* (1984) 155 CLR 549 at 578 per Deane J.

4 For example Jones, M A, *Medical Negligence* (1991) at 24 par2.21; Kennedy, I, and Grubb, A, *Medical Law*, (2nd edn, 1994) at 79; *Hurley v Eddingfield* 59 NE 1058 (1901); *Childers v Frye* 158 SE 744 (1931); *Buttersworth v Swint* 186 SE 770 (1936); *Findlay v Board of Supervisors of the County of Mohave* 230 P 2d 526 (1951); *Agnew v Parks* 343 P 2d 118 (1959) at 123; *Hiser v Randolph* 617 P 2d 774 (1980).

5 This development of an indigenous body of tort law has been the subject of prior academic comment such as: Trindade, F A, "Towards an Australian Law of Torts" (1993) 23 *UWALR* 74; Vines, P, "Proximity as Principle or Category: Nervous Shock in Australia and England" (1993) 16 *UNSWLJ* 458; Keeler, J, "The Proximity of Past and Future: Australian and British Approaches to Analysing the Duty of Care" (1989) 12 *Adel LR* 93.

6 *Rogers v Whitaker* (1992) 175 CLR 479.

7 Id at 487 per Mason CJ, Brennan, Dawson, Toohey and McHugh JJ.

2. *Facts and Background*

The facts of the case were outlined in detail by Cole JA.[8] The plaintiff, Patrick Woods, was an 11 year old boy with a history of epileptic seizures. One morning his mother returned from a walk to find him in a seizure. She immediately sent her other son to summon an ambulance, and her daughter to get a doctor. At the trial, her daughter claimed to have run to the surgery of Dr Lowns, a general practitioner, about 300 metres from the unit where the family lived. When she asked Dr Lowns to come and treat her brother, Dr Lowns asked her to bring the plaintiff to his surgery. To this she replied "he's having a bad fit, we can't bring him down".[9] The doctor had then told her to get an ambulance, to which she had answered "we need a doctor. We have already got an ambulance".[10] Following this, the GP had refused to come.[11] Although Dr Lowns denied having had such a conversation with the daughter, the trial judge accepted her testimony.[12] When the daughter returned to the flat, ambulance officers were trying to treat the plaintiff, but were unable to administer valium intravenously. They arranged for an intensive care ambulance to meet them at another nearby surgery.[13] The doctors at that surgery were similarly unable to stem the fit. The plaintiff was taken to the local hospital where the fit was eventually stopped by massive doses of other medication. However, the plaintiff had been deprived of oxygen to the brain to such an extent that he suffered extensive brain damage and quadriplegia as a result.[14] The plaintiff succeeded at first instance in a claim for damages for negligent breach of the practitioner's duty in failing to attend him.

Since his first seizure as an infant, the plaintiff had been occasionally treated by Dr Procopis, a specialist paediatric neurologist.[15] Dr Procopis had advised the plaintiff's parents that in the event of a prolonged epileptic fit, they should get him to hospital as quickly as possible.[16] The plaintiff also brought a claim against Dr Procopis for negligent failure to inform his parents about the use of rectal valium, and how to administer it to him in emergencies. All but one of the expert witnesses with extensive experience in treating epileptic children, stated that Dr Procopis' advice had conformed with the highest standard of medical practice in Australia at the time.[17] Accepting the evidence of the dissentient, a specialist practising in the United Kingdom,[18] the trial judge, Badgery-Parker J found that in failing to so advise the plaintiff's parents, Dr Procopis had breached his duty of care to the plaintiff as his patient.[19]

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8 Above n1 at 63, 171–3.
9 Id at 63, 172.
10 Ibid.
11 Ibid; *Woods v Lowns*, above n2 at 346–7.
12 *Woods v Lowns*, above n2 at 352. This part of the decision was not appealed.
13 Above n1 at 63, 174 per Cole JA.
14 Id at 63, 178 per Cole JA, 63, 156 per Kirby P.
15 Id at 63, 171 per Cole JA.
16 Id at 63, 157–8 per Kirby P, 63, 164 per Mahoney JA.
17 Id at 63, 157-8 per Kirby P.
18 Id at 63, 158.
19 *Woods v Lowns*, unreported, New South Wales Supreme Court, 9 February 1995 at 38. This aspect of the trial judge's decision was not reported in (1995) 36 NSWLR 344.

3. *The Duty of Care to Attend Persons in Emergencies*

The majority of the Court of Appeal (Kirby P and Cole JA) upheld the decision that Dr Lowns had owed a duty of care to the plaintiff, which he had breached by failure to attend the boy.[20] They recognised the reluctance of the common law to impose positive duties, even to prevent foreseeable injury.[21] Foreseeability of harm alone was insufficient to ground a duty. However, the majority found that there was in addition sufficient proximity between the doctor and the plaintiff to establish the existence of a duty to attend.

A. The Basis of the Duty of Care — Proximity

The plaintiff's main argument for the existence of a duty of care had been that the request made to Dr Lowns, in the particular circumstances, engendered a relationship of proximity, which gave rise to a duty of care. The principles of proximity by which a court determines and controls the categories in which a duty of care exists are now well established,[22] and were applied by the Court. They involve factors of physical closeness between the plaintiff and defendant (in space and time), circumstantial proximity (for example, in relationships such as employer and employee, or professional and client) and causal proximity (in the sense of a close connection between the conduct in question, and the loss suffered).

The majority of the Court of Appeal (Kirby P and Cole JA) agreed with the trial judge's analysis of proximity.[23] The factor of physical proximity was satisfied as Patrick was only 300 metres from Dr Lowns' surgery, a matter of three or four minutes walk, and the daughter had reached it on foot.[24] The factor of causal proximity was satisfied in that Dr Lowns was apprised of Patrick's condition and recognised it as a major medical emergency, which was life threatening and required urgent attention.[25] Other factors leading to the conclusion that there was sufficient proximity were Dr Lowns' knowledge of the appropriate treatment and the consequences in the event that it was not administered, and that he was competent and equipped to administer it.[26] Badgery-Parker J described as aspects of circumstantial proximity: the background of statutory provisions making failure to treat a person in an emergency professional misconduct; the fact that Dr Lowns was at his place of practice for the purpose of carrying on practice as a doctor (that is, "in a professional context") when a request for assistance was made; that he was prepared to begin work; and that he was not involved in professional activity which would have impeded him from treating the plaintiff.[27] Two other factors noted by Badgery-Parker J were that to attend involved no risk to Dr

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20 Above n1 at 63, 156 per Kirby P; at 63, 176 per Cole JA.

21 Id at 63, 155 per Kirby P; at 63, 175 per Cole JA.

22 *Jaensch v Coffey* (1984) 155 CLR 549 per Deane J; *Sutherland Shire Council v Heyman* (1985) 157 CLR 424 per Deane J especially at 497-8; *Cook v Cook* (1986) 162 CLR 376 .

23 Above n1 at 63, 155 per Kirby P; at 63, 176 per Cole JA. *Woods v Lowns*, above n2 at 359–60.

24 For example above n1 at 63, 176 per Cole JA. *Woods v Lowns*, above n2 at 359.

25 *Woods v Lowns*, ibid.

26 Id at 359–60.

27 Ibid.

Lowns' health or safety, and that he was not "disabled by any physical or mental condition from travelling to and treating the plaintiff (for example, he was not tired, ill or inebriated)".[28] Kirby P also appeared to rely substantially on the testimony of Dr Lowns, who stated that had the conversation taken place between himself and the daughter, he would and should have gone to the plaintiff,[29] and the provisions of section 27(2) of the *Medical Practitioners Act* 1938 (NSW) as indicative of standard medical practice. However it remains unclear from Dr Lowns' testimony whether he regarded such compulsion as a legal duty grounding civil liability, or a mere ethical and professional duty.[30] The latter is not necessarily a concession of civil liability.

B. The Role of Public Policy

The trial judge, with whom the majority of the Court of Appeal agreed, referred to dicta of Deane J in *Sutherland Shire Council v Heyman*[31] which enunciated the role of public policy as underlying the existence and content of the requirement of proximity for the imposition of a common law duty of care. Badgery-Parker J considered the provisions of section 27(1)(h) of the *Medical Practitioners Act* to be a "very clear statement of public policy in respect of the obligation of a medical practitioner in relation to a person in need of urgent treatment".[32] Section 27(2)(d) of the Act provides that it is professional misconduct for a doctor to fail to attend a person without reasonable excuse.[33] The fact that the section refers to a "person" and not a "patient" was held to be significant in the extension of the duty to people in general.[34] Under the Act a doctor found to have committed professional misconduct may be subject to disciplinary action such as deregistration. However the Act falls short of founding a civil action upon which a plaintiff can sue for damages.[35] In the light of the considerable debates both inside and outside Parliament when this section was being introduced,[36] it can be seen that there was concern about the ambit of the section, and the vagueness of some of its terms such as "in urgent need of attention" and "reasonable". In this sense it could be argued that for many situations, the policy of the legislation is not in fact clear.

The plaintiff had submitted that such a provision would have led to an expectation in society that the medical profession would comply with its terms and attend persons in need of urgent attention. The trial judge was of the opinion that the law should generally accord with community expectations,

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28 Id at 360.

29 Above n1 at 63, 155 per Kirby P.

30 This was recognised in id at 63, 169 per Mahoney JA.

31 *Woods v Lowns*, above n2 at 356; *Sutherland Shire Council v Heyman*, above n22 at 497–8 per Deane J.

32 *Woods v Lowns*, above n2 at 358.

33 This Act has now been repealed and replaced by the *Medical Practice Act* 1992 (NSW). Section 36 of the new Act is substantially identical to the previous s27(1)(h) and s27(2)(d).

34 Above n26.

35 See generally Whitelaw, C J, "Proving Professional Misconduct in the Practice of Medicine or Law: Does the Common Law Test Still Apply ?" (1995) 13 *Aust Bar Rev* 65.

36 See Volume 41 *NSW Parliamentary Debates*, 11 Eliz 11, Third Series, 11 Sep 1962 at 262, Volume 45 at 3801–11, Volume 46 at 3973–4015. See also Bain, J J G, and Foster, M L, "Should the Doctor Come ?" (1976-80) 6 *Proceedings of the Medico-Legal Society* 181 at 183–4, 192–4.

particularly when assessing the "reasonableness" of conduct.[37] He stated that "there is no reason to suggest that societal developments and public perception of what the content of a particular duty should be are not to be taken into account when the imposition of a new duty of care is being considered".[38] Recent statements from the High Court also clearly acknowledge the legitimate role of policy influenced by community standards in the proximity rule, confluent with this decision:

> Inevitably, the policy considerations which are legitimately taken into account in determining whether sufficient proximity exists in a novel category will be influenced by the courts' assessment of community standards and demands.[39]

However the extension of the tort of negligence by reference to proximity, backed by community values is still contentious. It can be seen that in a real sense such a judicial decision may be establishing those community values.[40]

i. The Significance of the *Medical Practitioners Act* 1938 (NSW), section 27(2)

It is clear that the decisions of both the trial judge and the majority of the NSW Court of Appeal were substantially influenced by the precise wording of section 27(2) of the *Medical Practitioners Act* [41] which made failure to attend in such instances professional misconduct. It is thus likely that the degree to which doctors in other States are subject to such a duty may depend on the existence and wording of such a provision. All States and Territories have legislation regulating the conduct of the medical profession.[42] In each piece of legislation there is reference to some concept of professional misconduct or unprofessional conduct, however the definition varies widely from State to State.[43] Only in New South Wales and the Australian Capital Territory does the legislation specifically provide that doctors are required to respond to a person in an emergency or arrange for some other qualified doctor to attend.[44] Most States have primarily general definitions such as "improper or unethical conduct", "incompetence or negligence", in relation to the practice of medicine.[45] The provision in Queensland is a little more complicated, providing

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37 *Woods v Lowns*, above n26 at 358–9, making reference to *Bankstown Foundry Pty Ltd v Braistina* (1986) 160 CLR 301 at 314 per Deane and Brennan JJ, and at 309 per Mason, Wilson and Dawson JJ (in the context of industrial safety and the understanding of the "reasonably prudent employer").

38 Id at 359.

39 *Bryan v Maloney* (1995) 69 ALJR 375 at 377.

40 Santow, G F K, "Aspects of Judicial Restraint" (1995) 13 *Aust Bar Rev* 116 at 121–2.

41 This provision was incorporated into the Act by the *Medical Practitioners Amendment Act* 1963 (NSW) s4(1).

42 These are: *Medical Practice Act* 1992 (NSW); *Medical Practice Act* 1994 (Vic); *Medical Act* 1939 (Qld); *Medical Practitioners Act* 1983 (SA); *Medical Act* 1894 (WA); *Medical Act* 1959 (Tas); *Medical Practitioners Act* 1930 (ACT); *Medical Act* 1995 (NT).

43 The relevant provisions are *Medical Practice Act* 1992 (NSW), s36; *Medical Practice Act* 1994 (Vic), s3; *Medical Act* 1939 (Qld), s35; *Medical Practitioners Act* 1983 (SA), s5; *Medical Act* 1894 (WA), s13(1); *Medical Act* 1959 (Tas) s25(6); *Medical Practitioners Act* 1930 (ACT), s35(1); *Medical Act* 1995 (NT), s38(1)(g),(h), 38(2).

44 *Medical Practice Act* 1992 (NSW), s36; *Medical Practitioners Act* 1930 (ACT) s35(1)(h).

45 *Medical Practitioners Act* 1983 (SA), s5; *Medical Act* 1894 (WA), s13(1); *Medical Practice Act* 1994 (Vic), s3; *Medical Act* 1959 (Tas) s25(6); *Medical Act* 1995 (NT),

that, although it is generally misconduct to knowingly enable a person other than a medical practitioner to attend a patient requiring professional attention, it is not misconduct to give advice in an emergency to enable urgent treatment where no medical practitioner is available, and the circumstances warrant the advice being given.[46] This legislative provision does not directly support a duty of medical practitioners to attend non-patients in emergencies. Any argument that it could support such a duty by implication is certainly ambiguous, as the provision does not speak in terms of the actual duties of medical practitioners, unlike its New South Wales and Australian Capital Territory counterparts.

It is difficult to assess the degree of importance of the specific statutory reference in the Court's decision to a duty to attend persons in emergencies, as an indication of whether more general provisions in other States may support such a duty at common law. The Court's simultaneous reliance on other factors of proximity in giving rise to a duty of care, and its emphasis on the doctor's receiving the request to attend in a "professional context" may mean that such a duty is likely to be upheld in other States on this basis, regardless of the exact nature of the statutory provisions. It has been recognised that different combinations of factors may satisfy the element of proximity in different types of cases.[47] However, given the particular importance placed on the wording of section 27(2) and its reference to a "person" not a patient, in extension of the duty, it is perhaps unlikely that the more general legislative provisions in other States will be held to ground a common law duty.

C. *An Alternative Logic — Mahoney's JA Dissent*

Mahoney JA vehemently dissented with the finding of a common law duty. Although he allowed that it was not beyond the ability of a court to impose a new legal obligation, he considered it unwarranted in this case.[48] He emphasised the distinction between a common law duty of care, and moral, charitable, professional or statutory obligations, and concluded that Dr Lowns was not liable in the tort of negligence due to any moral or professional obligations to go to the plaintiff.[49] He also noted that if such an obligation was to be imposed, it would need many qualifications and exceptions to take into account the field of practice of the doctor, the time of night, the doctor's judgment of the requirements of the illness, and the appropriateness of treatment at home or in a surgery.[50] The ability of ambulance officers, paramedics or hospital staff to alleviate the condition, the nature of the patient and the doctor's previous experience of their complaints were envisaged as further qualifying conditions.[51]

Although Mahoney JA acknowledged that "the balance of social utility would lie in favour of the imposition of some form of obligation to attend a person upon call", he was of the opinion that it should not be a judicial decision. He was

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s38(1)(g),(h), 38(2).

46 *Medical Act* 1939 (Qld), s35.

47 *Sutherland Shire Council v Heyman*, above n31; *Woods v Lowns*, above n2 at 356.

48 Above n1 at 63, 166–7.

49 Id at 63,165–6.

50 Id at 63, 168.

51 Ibid.

guided not only by the nature of the obligation, but also by the fact that the legislature had already made some provision in relation to it, stopping short of creating a civil action, and by the opinion that the legislature is best fitted to deal with the matter.[52] He showed great concern that the retrospective imposition of such an obligation would be unjust, particularly noting the implications, seriousness and financial sum ($3.2 million) at issue in the case.[53]

How such qualifications could be satisfactorily legislated was not addressed. Others have expressed the view that "ethical codes are in the domain of the unenforceable",[54] as it is impossible to legislate for all eventualities regarding professional standards which are binding in conscience. Nor did Mahoney JA give great weight to the fact that the common law may better accommodate the consideration of widely varying individual cases and circumstances.

4. *The Requirement of Request in a "Professional Context"*

It has been suggested that this duty of care reflects the statutory obligation to answer emergencies under the *Medical Practitioners Act*.[55] However judicial emphasis was placed on the fact that the request was made in a "professional context" as an aspect of the circumstantial proximity requisite for the duty.[56] This is an interesting point as it would appear to maintain by implication that doctors still have no common law duty to assist in an emergency occurring in a social setting. It is particularly notable that although the statutory provision was regarded as a clear statement of public policy in relation to the existence of such a duty, and was used to support the extension of the duty to "persons" other than "patients", the trial judge insisted on the requirement of a "professional context" as part of the proximity necessary to found the duty. There is no indication in the legislation itself that the statutory obligation is limited only to professional contexts. No real reasoning is acknowledged in the judgments in support of this qualification, except for the discussion of Kennedy and Grubb, reproduced by the trial judge.[57] They were of the opinion that although at law in the United Kingdom a doctor must have undertaken the care of an individual before any legal duty of care will arise, if the call for help occurs in the context in which the doctor practises medicine, the doctor is deemed to undertake to provide emergency care. It is possible that an 'undertaking' was thought necessary given its traditional importance in determining whether there is a doctor-patient relationship,[58] and whether a duty to act has arisen.[59]

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52 Id at 63, 167-9. Quotation to be found at 63, 169.

53 Id at 63, 169.

54 For example, Bain and Foster, above n36 at 193.

55 For example, Ottley, R, "Duty of care: a $3.2m question" (1995) 9 *J Medical Defence Union* 32 at 33.

56 *Woods v Lowns*, above n2 at 359.

57 Id at 357. Kennedy and Grubb, above n4 at 80.

58 For example, Kennedy and Grubb, id at 73–5, 78–80; *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

59 *Sutherland Shire Council v Heyman* , above n22 at 479 per Brennan J, stating that for a duty to act to arise "[t]here must also be either the undertaking of some task which leads another to rely on its being performed, or the ownership, occupation or use of land or chattels to found the duty".

However this reasoning seems a little artificial and forced in the present context. Perhaps it really reflects unvoiced concerns that such a duty must have limits falling short of a duty of constant vigilance and not impose too onerous a burden on the medical profession.

5. *The Relationship Between Common Law and Statute*

The decision of the majority can be seen to illustrate what Finn has identified as a theme of the development of our common law — the progressive acceptance of liability in tort, based on reasonable reliance and reasonable expectations.[60] An increasing tendency to link power with obligation has also been noted.[61] This seems to be implicit in the present case where reference was made to the position of doctors in our society, and it was stated that the requirement of proximity should not be divorced from what is "fair and reasonable".[62] The trial judge then noted the circumstance that:

> a medical practitioner is, by virtue of his training, qualifications and registration, permitted by the community to become and be a member of a relatively small group of persons in the community who alone are recognised as having the capacity and are accorded the privilege of affording medical treatment to those who require it.[63]

Kirby P also referred to "the noble profession of medicine" and the fact that section 27(2) of the *Medical Practitioners Act* imposes a "high standard" which "goes beyond what is expected, and imposed by the law, in the case of other professions".[64] The suggestion would seem to be that the unique position of doctors in our society is a factor which makes fair and reasonable the extension of proximity to encompass a duty to attend non-patients in an emergency.

The common law has been developed with reference to the aims and values apparent in legislation for centuries.[65] However caution has been urged in doing so, largely out of concerns relating to the status of the court as neither a legislature nor a law reform body, nor as suitable for the functions of such bodies.[66] The approaches of Kirby P (in the majority) and Mahoney JA (in dissent) in the Court of Appeal differed with respect to their understanding of the policy of the legislature as embodied in the *Medical Practitioners Act* and the way in which the common law should respond. Both approaches have considerable persuasive power, and make the prospect of other States following the minority opinion a real possibility. Kirby P and the trial judge were influenced by community expectations engendered by the legislation, understood to be that the medical profession would comply with the legislation and attend persons in urgent need of attention.[67] The minority decision understood

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60 Finn, P, "Statutes and the Common Law" (1992) 22 *UWALR* 7 at 16; id especially per Mason J at 462–4; *Hawkins v Clayton* (1988) 164 CLR 539 per Gaudron J.

61 Finn, id at 17; *Nicholson v Permakraft* (1985) 3 ACLC 453 at 459 per Sir Robin Cooke.

62 *Woods v Lowns*, above n2 at 356.

63 Id at 358.

64 Above n1 at 63, 155.

65 Finn, above n60 at 14.

66 For example, *State Government Insurance Commission (SA) v Trigwell* (1979) 142 CLR 617.

67 *Woods v Lowns*, above n2 at 358–9; above n1 at 63, 155 per Kirby P.

that the legislature had shown concern for and regulated the behaviours in question, but had stopped short of creating a civil action upon which a complainant could sue for damages.[68] Hence Mahoney JA found insufficient legislative policy for the existence of a common law action for damages. The legislation reasonably supports both views. This makes difficult a prediction of the outcome of similar litigation in other States, or of the present case if the High Court grants special leave to appeal.

6. *Practical Implications for the Medical Profession*

Despite the clear setting of precedent in the legal sphere, it would seem that the decision with respect to the duty of care owed in emergencies, could have less impact on the medical profession than might be anticipated. It is clear that doctors have a statutory duty under the *Medical Practice Act* 1992 (NSW), section 36, a breach of which may lead to disciplinary proceedings and deregistration. Dr Lowns himself stated in evidence that to respond to such an emergency call is within the ordinary standards of a local medical practitioner in his position.[69] The reaction of the medical profession to the judgment against Dr Lowns has not been agitated.[70] The profession has for some time made it clear that it has considered assistance in such circumstances to non-patients as well as patients to be at least an ethical obligation.[71] It was stated over a decade ago that:

> [t]he old ethic prevails; in an emergency, a doctor must provide the treatment he thinks appropriate, at a place he thinks offering the best support for recovery, certainly the best at that time. This ethic does not discriminate in favour of persons usually being his patients.[72]

Consequently it is arguable that the majority of doctors would not themselves have refused to attend. Similarly the effect of section 27 of the *Medical Practitioners Act* on the medical profession was described some time ago as "almost insignificant, rarely attracting intra-professional discussion and certainly never generating inter-professional friction and ill-will".[73]

However the decision does raise issues which would appear to be of enormous importance to health professionals in practice. For example, the decision leaves unclear whether a doctor will be in breach of the duty if he or she asks for the person to be brought to them. When the best practice advises getting the person to hospital as soon as possible, it is unclear whether a doctor would have to attend if an ambulance has already been called, or arrived. Where the doctor's field of practice is not relevant to the emergency, the extent of the duty remains to be seen. It is well established that the appropriate standard of reasonable care and skill is that of the ordinary skilled person exercising or professing to have that special skill and competent to practice in the field.[74]

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68 Above n1 at 63, 168–9 per Mahoney JA.
69 Id at 63, 155 per Kirby P, at 63, 173–4 per Cole JA, at 63, 169 per Mahoney JA.
70 For example Jopson, D, "'Sanity' as court supports experts", *SMH*, Feb 7, 1996, at 4.
71 Bain and Foster, above n36 at 185, 187, 189–90.
72 Id at 185.
73 Id at 182.
74 Above n6 at 483.

Presumably then, in an emergency, a doctor would be expected to do as much as could be expected of one with his or her degree of skill, and where possible make arrangements for a more appropriately qualified physician to attend the person. The implications of the duty are also not patent where the doctor is not confident or conversant with the treatment needed. If the doctor is already attending a patient it is far from certain what will be required by the duty. Must the doctor balance the needs of the patient against the seriousness of the emergency, or will he or she be immediately absolved of the duty to attend? It is also unclear what effect the duty could have on other health professionals such as nurses and paramedics, especially where they are subject to statutes which provide only very general definitions of professional misconduct.[75] These issues are unanswered by the present decision but of practical importance to the medical profession in understanding the nature and extent of the duty. It is difficult to predict from the analysis of proximity proffered when a court would be sufficiently satisfied to find a duty to attend.

Unfortunately Dr Lowns did not argue at trial that he was not negligent because it was reasonable for him to request that the plaintiff be brought to the surgery or a hospital for treatment, and that he had no reason to believe that the plaintiff would not be brought to his surgery immediately. Given that standard medical practice in such emergencies as disclosed in evidence was to get the victim to hospital as soon as possible, the argument that the general practitioner was not negligent in the circumstances seems quite persuasive. Cole JA accepted that such a case could have been met by the evidence.[76] The decision also did not consider whether a doctor could be protected from liability if an ambulance is summoned, by analogy or extension of the statutory exception to professional misconduct when a doctor organises for another doctor to attend. Whether a practitioner may have reasonable cause not to attend because the child is in the care of ambulance officers or because those officers should have brought the child to his surgery is an extremely important issue for health professionals in emergency cases, for which the implications of the decision will unfortunately remain uncertain until further adjudication.

7. *Implications for a General Common Law Duty to Rescue*

Both the Court of Appeal and the trial judge upheld the general principle of common law that there is no duty to rescue a person, even where death or injury is foreseeable as a result of inaction.[77] This is unsurprising given the clear dicta of Brennan J on the issue in *Sutherland Shire Council v Heyman*.[78] However there is considerable literature which is critical of the failure to recognise such a duty,[79] and provides a persuasive argument that it is an anachronistic

75 For example the *Nurses Act* 1991 (NSW) s4(1).

76 Above n1 at 63, 174.

77 *Woods v Lowns*, above n2 at 354, 359; id at 63, 155 per Kirby P, at 63, 166 per Mahoney JA, at 63, 175 per Cole JA.

78 Above n22 at 477–81 per Brennan J.

79 For example, Weinrib, E, "The Case for a Duty to Rescue" (1980) 90 *Yale LJ* 247; McInnes, M, "The Question of a Duty to Rescue in Canadian Tort Law: An Answer From France" (1990) 13 *Dalhousie LJ* 85.

relic of a society "based on a philosophy of rugged individualism".[80] A duty to rescue is also prevalent in numerous other legal systems.[81] It would appear to necessitate no less than a decision of the High Court to change the traditional rule — an unlikely outcome. In the present case, the courts seemed to be proposing only a narrow exception to the general rule, which is highly dependent upon a duty specifically embodied in legislation, and the particular position of doctors in our society. The emphasis on the need for a "professional context" to give rise to the duty seems to be congruent with this interpretation. It seems largely to be a duty arising out of professional obligation perhaps peculiar to medicine. In placing such limits on the extension of affirmative duties, the case is unlikely to be a step towards a more general duty of rescue.

8. *The Relevance of General Medical Practice to the Standard of Care*

The Court considered a second controversial aspect of medical negligence cases, being the weight to be given to the standard practice of the profession, in determining the standard of care owed under the common law. Interestingly, this aspect of the case has elicited far more reaction from the medical profession than the novel finding of a duty to attend emergencies.[82] There has been great concern shown over the ability of the court to set the standard of care, particularly in the area of clinical judgments. The decision of the New South Wales Court of Appeal in *Lowns v Woods* has gone some way towards clarifying the implications of the High Court's decision in *Rogers v Whitaker* for situations involving clinical decisions concerning diagnosis and treatment.

A. *Decision on the Failure to Advise on the Use of Rectal Valium*

At the trial Badgery-Parker J found that the specialist paediatric neurologist, Dr Procopis, did not satisfy the standard of care owed to the plaintiff, his patient, by failing to inform the plaintiff's parents about the use of rectal diazepam (valium), and how to administer it in emergencies. A majority of the Court of Appeal (Kirby P and Mahoney JA, Cole JA in dissent) reversed this decision on the grounds that it did not accord with the better view of the evidence and that (per Kirby P) any such default of advice was not the cause of Patrick's injuries.

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80 For example McInnes, id at 112.

81 Feldbrugge, F J M, "Good and Bad Samaritans: A Comparative Survey of Criminal Law Provisions Concerning Failure to Rescue" (1966) 14 *Am J Comp L* 630; Ruzinski, "The Duty to Rescue: A Comparative Analysis" in Ratcliffe, J, (ed)*The Good Samaritan and the Law* (1966) at 91.

82 For example, Jopson, above n70; Eagleton, M, "Compensation awards on the rise", *The NSW Doctor*, September 1995 at 4; Pike, E, "Agenda for legislative reform growing", *The NSW Doctor*, February 1996 at 5; Ottley, R, "Court of Appeal supports peer opinion", *The NSW Doctor*, February 1996 at 15–6.

B. *The Bolam principle and* Rogers v Whitaker[83]

In *Rogers v Whitaker* the High Court rejected the test which prevails in the United Kingdom, referred to as the *Bolam* principle, which maintains that a doctor is not negligent if he or she acts according to a practice accepted by a responsible body of medical opinion at the time.[84] Under the *Bolam* principle the standard of care required by the common law duty becomes a matter of medical judgment. This has been described as a "comfortable" principle by members of the medical profession.[85] However the High Court favoured the approach of Lord Scarman (in dissent) in *Sidaway v Board of Governors of the Bethlehem Royal Hospital,*[86] and of the Full Court of the Supreme Court of South Australia in *F v R* [87] which did not dismiss the relevance of normal medical practice, but held that the courts, rather than the medical profession or another section of the community, have the ultimate responsibility for assessing whether behaviour conforms to the standard of reasonable care. This approach was also preferred by the Canadian Supreme Court in *Reibl v Hughes.*[88]

The Court of Appeal in *Lowns v Woods* applied the principle established by the High Court in *Rogers v Whitaker* that it is ultimately for the court to decide whether the conduct of the defendant practitioner conforms to the standard of reasonable care demanded by the law of negligence.[89] The Court recognised that acceptance of the principle in *Rogers v Whitaker* means that in some cases the Court may substitute its conclusion of what a duty requires for that of the medical profession, as was done in that case.[90] This implication of the decision in *Rogers v Whitaker* appears to have raised the ire of some members of the medical profession and provoked comments such as the following:

> Judges present a problem in other ways. Some are relying on their own misinformed opinion, sometimes lacking objectivity, and ignoring expert medical opinion. To quote just one "the law, not the medical profession, will determine the standard of care".[91]

C. *Clinical Judgments in the Area of Diagnosis and Treatment*

However it was emphasised in *F v R* and by Mahoney JA in the present case, that the principle in *Rogers v Whitaker* does not mean that a court will be quick to put aside the considered opinion and judgment of people skilled in the area of practice, particularly in cases of diagnosis and treatment. It was clear in *Rogers v Whitaker*, as well as the instant case that at least in cases involving clinical judgments, there must be reasons in the factual material which justify the court substituting its judgment for that of the doctor concerned.[92] However Kirby P held that it would be wrong to qualify the

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83 Above n6.
84 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.
85 Browning, T, "Prevention better than cure" (1995) 9 *J Medical Defence Union* 34.
86 *Sidaway v Board of Governors of the Bethlehem Royal Hospital* [1985] AC 871.
87 *F v R* (1983) 33 SASR 189.
88 *Reibl v Hughes* [1980] 2 SCR 880 at 894–5.
89 Above n1 at 63, 160 per Mahoney JA, at 63, 155 per Kirby P.
90 For example, id at 63, 165 per Mahoney JA.
91 Eagleton, above n82 at 4. See also Browning, above n85.
92 Above n1 at 63, 165 per Mahoney JA.

clear decision of the High Court in *Rogers v Whitaker*, and to restore the *Bolam* principle by imposing an evidentiary test which required a patient to show that current medical practice was "manifestly wrong".[93] However he also held that if the doctor sued establishes that his or her conduct conformed with ordinary medical practice within the relevant branch of medicine, the forensic burden shifts to the plaintiff to show the court that the ordinary practice did not conform to the reasonable care demanded by the law in the circumstances.[94]

The Court of Appeal refused to accept submissions that the principle in *Rogers v Whitaker* was limited to cases involving warning of risks inherent in treatment or advice.[95] This is unsurprising as such a submission is directly contrary to dicta of the High Court in that case.[96] However the conceptual distinction between advice and information given by a doctor and diagnosis and treatment was clearly significant, both in *Rogers v Whitaker* [97] and the decision of the Court of Appeal in *Lowns v Woods*. In *Rogers v Whitaker* the High Court emphasised that the duty to warn of material risks involves the provision of information sufficient to allow the patient to choose whether to undergo treatment or not. The sufficiency of the information provided does not depend solely upon medical standards and practice, but involves the individual needs of the patient, who is actively making the actual decision. Hence the amount of information required is not to be determined from the perspective of the practitioner or profession alone.[98] However in *Rogers v Whitaker* the High Court stated that standard medical practice would also have "an influential, often a decisive, role" in cases involving clinical decisions of treatment and diagnosis.[99] This was supported in the decision of the Court of Appeal in *Lowns v Woods*. Mahoney JA noted that in a clinical decision of the kind involved in this case, the Court will be slow to find the decision wrong.[100] This would appear to place a higher burden of proof on the plaintiff in the case of clinical judgments, and is perhaps difficult to distinguish from the "manifestly wrong" criterion eschewed by Kirby P as approaching the *Bolam* test in practice.[101] Disagreement existing amongst the Court of Appeal over whether this case was one involving advice or treatment[102] suggests that such a distinction may not always be clear, and may leave uncertainty as to the weight that will be given to standard practice in a determination of the relevant standard of care.

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93 Id at 63, 157.
94 Ibid.
95 Id at 63, 157 per Kirby P, at 63, 165 per Mahoney JA.
96 Above n6 at 493 per Gaudron J, at 489 per Mason CJ, Brennan, Dawson, Toohey and McHugh JJ.
97 Id at 489 per Mason CJ, Brennan, Dawson, Toohey and McHugh JJ, at 492 per Gaudron J.
98 Id at 489 per Mason CJ, Brennan, Dawson, Toohey and McHugh JJ.
99 Ibid. Similar comments were made by Gaudron J at 493–4.
100 Above n1 at 63, 161.
101 Id at 63, 157.
102 Id. Kirby P considered the situation to be one of advice (at 63, 157). Mahoney JA considered it to be in the nature of a clinical decision (at 63, 161).

9. *Implications of the Court's Ruling on the Weight to be Given to Expert Evidence of the Standard Practice of the Medical Profession*

The decision of the NSW Court of Appeal in *Lowns v Woods* built on the judgment of Handley JA in *Ainsworth v Levi*,[103] which established that it is not negligence to use one technique when an alternative procedure also exists. Handley's JA judgment drew some support from the decision of *Maynard v West Midlands Regional Health Authority*[104] which acknowledged that doctors have different opinions and practices and although a court may prefer one body of opinion to another, this is no basis for a conclusion of negligence. The fact that the court accepts that there may be more than one responsible body of medical opinion means that expert evidence contradicting a certain practice would be unlikely to sufficiently discharge the onus of proof established in *Lowns v Woods*. As Mahoney JA recognised, the burden of persuading a court that those skilled in a field are wrong, for example, in concluding that a particular treatment should or should not be followed, "will ordinarily be a heavy one",[105] and may in effect require proof that such a practice is "manifestly wrong" despite the dictum of Kirby P to the contrary. It is particularly made so if professional solidarity discourages doctors from expressing disagreement with the treatment provided by colleagues.[106] In practice it may be that compliance with a reasonable body of medical opinion will make it very unlikely that an action in negligence in the area of diagnosis and treatment will succeed, despite rejection of the *Bolam* principle in Australia. The decision has been heralded as "a step in the right direction" by medical commentators[107] and welcomed by the State's largest medical defence union.[108]

10. *Issues Raised by the Claims for Nervous Shock*

It is noted in passing that the plaintiff's parents also both brought claims for negligently inflicted nervous shock, although only the father's claim succeeded. The plaintiff's mother was his primary carer. His father had not been involved in his ongoing care, residing in Queensland and rarely seeing him. The plaintiff's father developed a severe depressive illness after an occasion four or five weeks after the plaintiff had been transferred from the intensive care unit, when Dr Procopis told him of his son's massive brain damage. The plaintiff's mother's life had been greatly affected by his disablement. She had been diagnosed as suffering from a chronic depression of sufficient intensity to constitute a psychiatric illness. Badgery-Parker J stated that "[T]he sad fact appears to me that she has continually experienced emotional stress from the time of her original discovery of Patrick's fit".[109] However she was unable to

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103 *Ainsworth v Levi* (unreported, New South Wales Court of Appeal, 30 August 1995).

104 *Maynard v West Midlands Regional Health Authority* (1984) 1 WLR 634.

105 Above n1 at 63, 161.

106 For example, Germov, J, "Duty of Disclosure: Medical Negligence and New Patient Rights" (1995) 30 *Aust Jnl Social Issues* 95 at 97.

107 For example Ottley, R, "Negligence: who is the umpire?" (1996) 10 *Journal of the Medical Defence Union* 18 at 18.

108 Jopson, above n70.

109 Not reported. Henry, S, "*Woods v Lowns*: negligence and expert medical opinion" (1995)

recover damages for negligently inflicted nervous shock because to succeed, a claimant must demonstrate that a "sudden sensory perception" caused the psychiatric condition.[110]

The application of the principle in this instance raises two salient issues. One is the lack of accord between this principle and medical knowledge. The requirement of a "sudden sensory perception" causing the illness is maintained despite the fact that advances in the understanding of psychiatric illness and human psychology now recognise that nervous shock "is rarely (if ever) explicable as the result of an isolated 'shock'" and that "psychological injury is a much more complex process".[111] This requirement has been seriously criticised for forcing claimants "to try to squeeze their claims into outmoded formulae".[112] The second salient issue raised is that such a requirement has particularly denied recovery to plaintiffs whose injury arose through caring for a tortiously injured spouse or relative, or whose illness has been the result of a gradual chain of disastrous events due to the defendant's negligence.[113] Due to the fact that ongoing care is often provided by close family members, who are most often women,[114] such legal doctrine has a gendered impact vividly illustrated in this case, and yet subject to no comment by either the trial judge or Court of Appeal.

11. *Conclusions*

It appears likely that applications will be made for special leave to appeal to the High Court, on both the issues of the duty to attend and the applicable standard of care.[115] It will be interesting to see whether the Court will reconsider the analysis of proximity; in particular the importance and policy of the legislation, and the context in which the duty will arise. It also remains to be seen whether the more general statutory provisions of other States are considered to encompass such a duty. Unfortunately it will rest upon future litigation to stake out the implications of this duty, both for medical practitioners and other health professionals. As to the relationship between usual medical practice and the standard of care, the decision has clarified the implications of *Rogers v Whitaker*, drawing out the conceptual distinction between warning and advice, as opposed to diagnosis and treatment, and appears to have put to rest the fears of the medical profession.

KYLIE DAY*

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3 *Aust Health L Bull* 81 at 87.

110 *Jaensch v Coffey*, above n22.

111 As recognised in *Campbelltown City Council v MacKay* (1988) 15 NSWLR 501 at 503–4 per Kirby P, at 507 per McHugh, Samuels JJA.

112 Id at 503–4 per Kirby P.

113 *Pratt v Pratt* [1975] VR 378; *Spence v Percy* (1991) Aust Torts Rep 81–116 at 69, 075 per Priestley JA; above n110 at 503–4 per Kirby P, at 507 per McHugh, Samuels JJA.

114 Graycar, R, "Women's Work: Who Cares ?" (1992) 14 *Syd LR* 87; Graycar, R, "Damaged awards: the vicissitudes of life as a woman" (1995) 3 *TLJ* 160 at 161 n11.

115 Pincott, L, "NSW Court of Appeal decision" *The NSW Doctor*, April 1996, at 27.

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