A new Bolam test?

Changes to standards of care for doctors

By Kathy Sant

Like so much else in tort reform, changes in standards of professional care are taking plaintiffs back to the future.

Since the High Court decision of *Rogers v Whitaker* in 1992,[1] Australian courts have taken a different path to their English counterparts in determining the relevant standard of care for doctors. In both cases the relevant standard of care is that of the ordinary skilled person exercising and professing to have the special skill. In Australia this has been determined by the court, while English courts determine the standard by reference to the practices of the profession. In the words of Justice McNair, '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'.[2]

Recently, state governments around Australia have enacted legislation effectively delegating determination of the standard of care to the medical professions. This article focuses on the changes in NSW.

THE CHANGES

The NSW *Civil Liability Act* 2002 now includes the following provisions, which deal with the standard for care for all professionals (s5O):

'(1) A person practising a profession (a professional) does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

'(2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.

'(3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.

'(4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.'

Victoria,[3] Queensland[4] and Tasmania[5] have enacted very similar provisions, while Western Australia has a bill currently progressing through its parliament that makes the same changes with respect to health professionals only.[6]

The Victorian and Queensland versions are confusing and seemingly contradictory. The Victorian Act states that conduct will not be negligent if widely accepted as competent in Australia by a significant number of respected practitioners in the field.[7] The Queensland Act refers to conduct that is 'widely accepted by peer professional opinion by a significant number of respected practitioners'.[8] The Explanatory Note to the Queensland Act states that peer professional opinion is to be widely accepted geographically and also to be accepted by a significant number of peers.

Generally, the duty to warn of risks of treatment has been excluded from the changes and *Rogers v Whitaker* continues to apply in this area.[9] For example, s5P of the NSW Act excludes a warning, advice or other information in respect of the risk of death of or injury. The exclusion does not extend to other information and advice.[10] In the context of medical advice, this means that a doctor who is advising a patient on proposed surgery must comply with court-imposed standards in relation to possible complications of the suggested operation. But in relation to other possible options for treatment, it will be a good defence to show that the amount of information given was in accordance with that widely accepted as competent practice within the profession, even if it was insufficient for the patient to make an informed choice or was less information than the patient requested.[11] It is clear that s5P was inserted in recognition that the doctor does not always know best when it comes to deciding how much information a patient should have but that purpose is undermined by its restricted application.[12]

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The other exception in the NSW Act is provided by s5O(2), which enables a court to disregard opinion it considers irrational.[13] It is likely that there is more scope for the operation of this provision with regard to information and advice than to diagnosis and treatment. This may mitigate the harshness of bringing other information and advice under the new test.

WHAT DO THE CHANGES MEAN FOR PLAINTIFFS?

The differences between *Bolam* and *Rogers v Whitaker* can easily be overstated. *Bolam* only approved practices accepted as proper by *responsible* opinion, leaving room for disapproval of unreasonable practices. This happened occasionally in cases like *Hucks v Cole*,[14] and the House of Lords confirmed in *Bolitho v City and Hackney Health Authority*[15] that a body of opinion may be rejected if it is not reasonable or responsible. On the other hand, expert evidence has remained central to Australian medical negligence cases, particularly in diagnosis >>

and treatment cases where it has generally been determinative of the outcome. Indeed, it is difficult to imagine that a practice accepted as proper by a responsible body of opinion could fall outside what could be expected of an ordinarily skilled professional.

Arguably, the real difference is not in the standard but the way in which the standard is proven. The English approach has meant that a court faced with competing views from competent experts could not really choose between them. In *Bolitho*, Lord Browne-Wilkinson emphasised that the rejection of medical opinion as unreasonable or irresponsible would be rare. Australian judges have been able to make their own decisions, informed – but not bound – by expert evidence and, if necessary, preferring one set of experts over another. It was unnecessary to label the rejected medical opinion as irresponsible or irrational to do so. Of course, it has always been open to defendants to submit that differences in expert opinion reflect the fact that there are a variety of acceptable practices and the court cannot be satisfied of negligence. Such submissions are frequently made and often successful. But not invariably so.

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In this respect, the new *Bolam* test is like the old and it will be more difficult for a judge to prefer one opinion over another. Once a defendant has produced reasonably credible evidence that a practice is widely accepted as competent, the game will be all but over. However, there are some crucial differences in the new approach.

First, there is the need for the practice to be widely accepted. This raises the intriguing possibility that minority views, including cutting-edge treatments, may not be as strongly protected under the new legislative provisions as they would be by the *Bolam* test. More importantly, there is a real question as to how appropriate such a test is in the litigation context. How is it to be established what is widely accepted? Some experts may take to informal surveys of friends and colleagues to support their assertion that a practice is or is not widely accepted, but such evidence is of dubious utility and may well be inadmissible. A more useful approach would be increased use of textbooks and practice guidelines. If a practice is not approved in such standard works, an advocate may have a hard time persuading anyone that it is widely accepted as competent.

Secondly, there is the fact that the provision reads like a defence. It may follow that the defendant bears the burden of establishing that a practice was in accordance with that widely accepted as competent. This could make it a little easier for courts to effectively prefer a plaintiff's over a defendant's experts.

Finally, there is the scope of the irrationality exception. Is a practice that is not reasonable necessarily irrational? Mr Carr thought not, saying in his second reading speech, 'irrationality is not the same as unreasonableness. We are making it much harder for the court to disregard experts in the field.'[16] Certainly, it is a more emotive term. It would take a confident (some might say arrogant) non-medical decision-maker, faced with the usual array of eminent experts and persuaded that the practice in question is widely accepted as competent within the profession, to decide that the widely accepted view is irrational. The provisions clearly reflect a conscious choice to move away from what is reasonable and focus on practices in the profession, and therefore it would have been self-defeating to allow courts to reject practices as unreasonable. If we have returned to *Bolam*, it is a harsher *Bolam*, and exceptions to the view of the profession will probably be extraordinarily rare.

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upon the irrationality exception. Instead, aided by textbooks, guidelines and journals, they will show that the defendant has not established that the practice was widely accepted as competent, or the defendant's experts have failed to take some important factor sufficiently into account, and therefore have not addressed the precise circumstances of the case as well as the plaintiff's experts.

CONCLUSION

Life has undoubtedly just got a little harder for plaintiffs in medical negligence cases. This is not because of some great shift in philosophy, but because of the practical difficulties presented by a test that makes it harder to reject a defendant's experts. I expect the irrationality exception to be of little help, and the best approach will be a carefully prepared case that establishes that the relevant practice is not widely accepted as a proper one in all the circumstances of the case. ■

Notes: **1** (1992) 175 CLR 479. **2** *Bolam v Friern Hospital Committee* [1957] 2 All ER 118,122. **3** *Wrongs Act* 1958 s59. **4** *Civil Liability Act* 2003 s22. **5** *Civil Liability Act* 2002 s22. **6** Civil Liability Amendment Bill 2004, which has already passed the Legislative Assembly and is currently before the Legislative Council. **7** Section 59(1). **8** *Civil Liability Act* 2003 s22(1). **9** *Civil Liability Act* 2002 (NSW), s5P; *Civil Liability Act* 2003 (Qld), s22(5); *Civil Liability Act* 2002 (Tas), s22(5); *Wrongs Act* 1958 (Vic), s60. **10** The position may be different for provisions in other states. For example, s60 of the *Wrongs Act* 1958 (Vic) refers to 'a warning or other information in respect of a risk or other matter' and would not appear to be so confined. Additionally, in some jurisdictions specific provisions deal with when there is a duty to warn. **11** I have put aside the question of irrationality for the moment. **12** In relation to duty to warn, I have not considered the impact, if any, of the changes to the duty to warn of obvious risks as they do not apply to the duty to warn of the risk of death or personal injury from the provision of medical services in NSW: s5G. However, the provisions are somewhat different in other states and should be checked. **13** See also *Civil Liability Act* 2003 (Qld), s22(2); *Civil Liability Act* 2002 (Tas), s22(2); *Wrongs Act* 1958 s59(2). The latter provision refers to practices that are unreasonable. **14** [1993] 4 Med LR 393. **15** [1998] AC 252. **16** Hansard. Legislative Assembly, 23 October 2002, p5766.

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