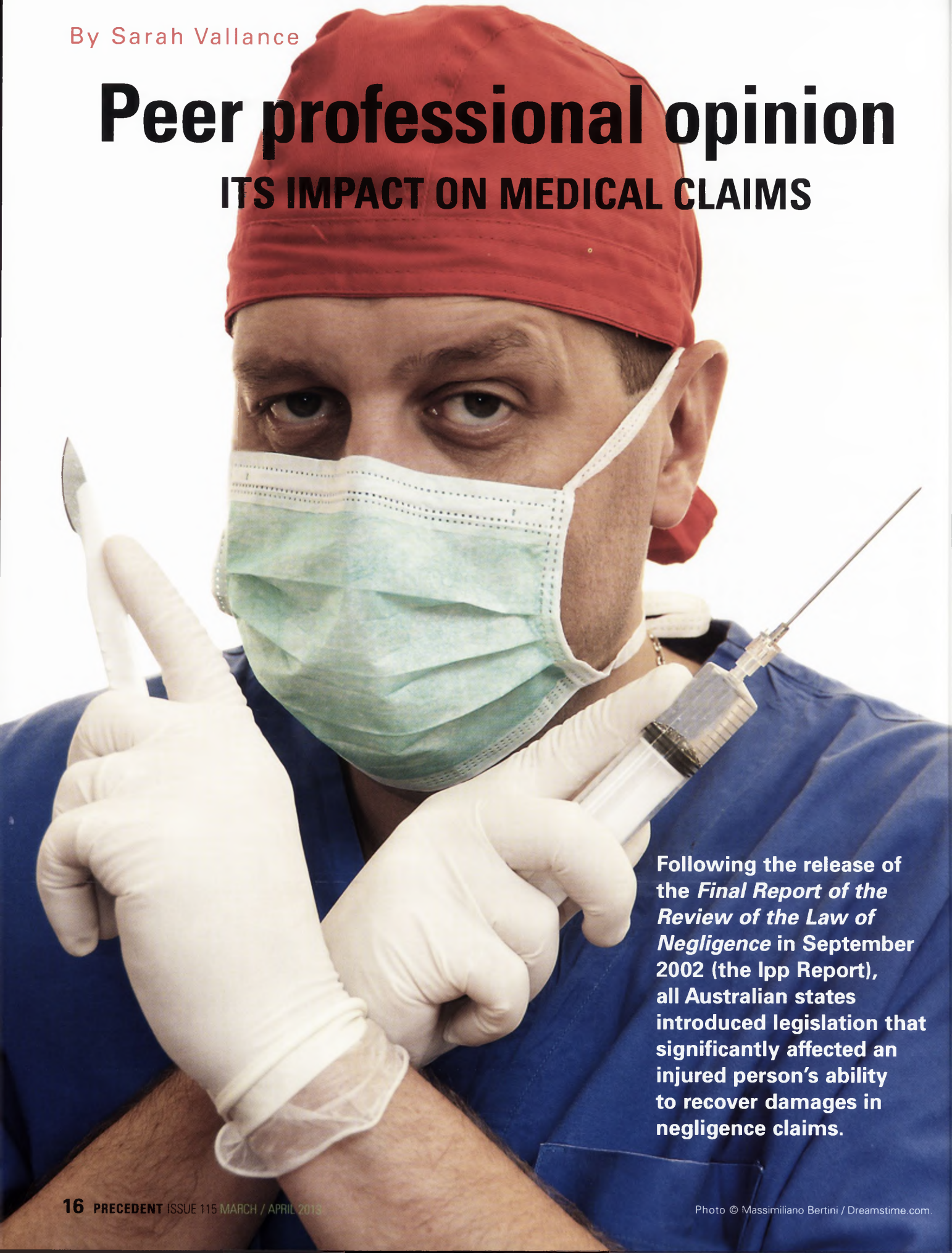
By Sarah Vallance

Peer professional opinion

ITS IMPACT ON MEDICAL CLAIMS



Following the release of the *Final Report of the Review of the Law of Negligence* in September 2002 (the Ipp Report), all Australian states introduced legislation that significantly affected an injured person's ability to recover damages in negligence claims.

In relation to claims against medical practitioners, one of the most significant reforms was the introduction of a modified 'Bolam' principle, which allowed medical practitioners to escape liability if they had acted in accordance with 'peer professional opinion'.

While it was well established that the standard of care was that of the ordinary skilled person exercising and professing to have that special skill,[1] the introduction of a modified 'Bolam' principle meant that the standard of care was to be determined largely by reference to the practices of the medical profession rather than by the courts. The intention of these changes was to provide a shield for the medical profession against claims.

This article focuses on s5O of the *Civil Liability Act* 2002 (NSW) (s5O), as there have been several judgments that have decided whether the section replaced the common law standard of care as set out in *Rogers v Whitaker*[2] or provided a defence for professionals. While there have been instances where the courts have found that the defendant acted in accordance with peer professional opinion, the limitations of s5O have also become apparent, indicating that the defence of 'peer professional opinion' may not provide such a strong shield for doctors against claims, as first feared by plaintiffs.

COMMON LAW

Prior to the High Court decision in *Rogers v Whitaker*, the scope and content of a doctor's duty of care was thought to be determined by applying the Bolam principle, even though the principle had not been applied consistently in Australia.[3] The Bolam principle derived from a statement by Justice McNair to the jury in the case of *Bolam v Friern Hospital Management Committee*,[4] that a doctor was not guilty of negligence if he or she acted in accordance with a practice accepted as proper by a responsible body of doctors skilled in the relevant field of practice merely because there was a body of opinion that would take a contrary view.[5]

In *Rogers v Whitaker*, a case involving the failure of a doctor to warn his patient of the risk of developing sympathetic ophthalmia, the High Court held that the standard of care 'is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade'.[6] Further on, it stated that 'while evidence of acceptable medical practice was a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care…'[7]

Following the decision in *Rogers v Whitaker*, it was considered that the Bolam principle would still apply in cases involving diagnosis and treatment. However, in *Naxakis v Western General Hospital*,[8] a case involving the failure of the respondent neurosurgeon to consider undertaking an angiogram, the High Court held that if there was evidence upon which the jury could reasonably find negligence on the part of a doctor, the issue was for them to decide irrespective of how many doctors thought that the defendant was not negligent or careless.

STATUTORY REFORM – *CIVIL LIABILITY ACT* 2002

The demise of a number of insurers, including HIH Insurance in 2001, contributed to a growing perception in the community that negligence claims were on the increase and awards of damages were unsustainable. As a result, the Commonwealth, states and territories commissioned a panel chaired by Justice Ipp to conduct a number of inquiries into the law of negligence, including to 'develop and evaluate options for a requirement that the standard of care in professional negligence matters (including medical negligence) accorded with the generally accepted practice of the relevant profession at the time of the negligent act or omission'.[9]

The modified 'Bolam' principle meant that the standard of care was to be determined largely by the practices of the medical profession, rather than by the courts.

The Ipp report was released in September 2002.[10] One of its recommendations was that a modified version of the Bolam rule be introduced so that a medical practitioner was not negligent if the court was satisfied that the treatment provided was in accordance with an opinion widely held by a significant number of respected practitioners in the relevant field.[11] The requirement for the opinion to be 'widely held' was suggested to prevent reliance being placed on localised practices and filter out idiosyncratic opinions.[12] In addition, it was suggested that a proviso could be included if the court considered the opinion to be 'irrational'. Although the panel considered it would be a rare case where an opinion widely held by a significant number of respected practitioners in the field was also irrational, it recommended that the court should have the power to intervene should that circumstance arise.[13]

In response to the recommendation in the Ipp report for the introduction of a modified version of the Bolam rule, the NSW government implemented s5O, which states:

'(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. >>

The case law shows that defendants face difficulties in establishing that their practice accorded with peer professional opinion.

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

Similar provisions have been enacted in all states.[14]

In NSW, Queensland, Victoria and Tasmania, the provisions apply to professionals and are not limited to the medical profession. The South Australian provisions apply to a 'person who provides a professional service'. The Western Australian provisions apply to a 'health professional'.

In Queensland and Western Australia, there is no qualification that the peer professional opinion must be widely accepted in Australia.

In Victoria and Western Australia, the peer professional opinion being relied on must not be unreasonable as opposed to being irrational.

Section 5O does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information in respect of the risk of death of or injury to a person associated with the provision by a professional of a professional service.[15] All the states have enacted similar provisions.[16]

INTERPRETATION OF s5O

Following the enactment of s5O, it was unclear whether it was intended to replace the standard of care in claims against professionals as set out in *Rogers v Whitaker* or whether it provided a defence for professionals.

In *Halverson & Ors v Dobler Halverson by his tutor v Dobler* (*Halverson v Dobler*),[17] the defendant argued that s5O set the standard of care and that the plaintiff must prove that the provision of professional services was not widely accepted in Australia by peer professional opinion as competent professional practice. The defendant relied on the heading of the section 'Standard of Care for Professionals' and referred to the Ipp Report, the relevant Second Reading Speech and the explanatory memorandum in support of their argument.

The plaintiff submitted that the section was best characterised as a special defence in professional negligence claims. They argued that the standard of care described in *Rogers v Whitaker* still applied, but that a defendant could avoid liability if they could establish that they acted in accordance with peer professional opinion. The plaintiff submitted that as the rule was expressed in the negative, it indicated that Parliament did not intend a more radical change in the standard of care for claims against professionals. Chief Justice McClellan held that s5O operated as a defence, which meant that the onus was on the defendant to establish that they had acted in accordance with peer professional opinion. The decision was upheld on appeal.[18]

In *Sydney South West Area Health Service v MD*,[19] the appellant doctor unsuccessfully appealed a decision of a judge who had found that it was necessary to specifically plead s5O in order to rely upon it as a defence. It was again held that s5O operated as a defence and that the onus of proof lay upon the appellant doctor. The relevant procedure rules required the relevant facts contemplated by s5O to be pleaded.

APPLICATION OF s5O

Since its enactment, s5O has been considered and applied in a number of cases. These cases have shown that a defendant will not succeed simply because there is a divergence in expert opinion.

One reason why a defendant might not succeed is that the assumptions upon which its expert has based their opinion may be inaccurate or not accepted by the court. For example, in *Halverson v Dobler*, Chief Justice McClellan stated that 'to the extent the opinions of the GPs called by the defendant differed from those of the plaintiff, this has resulted from inappropriate assumptions about the facts...'[20] His Honour went on to find that it had not been established that it was widely accepted as competent professional practice that when a boy is hospitalised following a third episode of syncope, in the presence of a viral illness and recently detected heart murmur, to treat only the viral illness and not investigate the syncope or perform basic cardiological investigations.[21]

In *Hollier v Sutcliffe*,[22] all of the experts agreed that if a contraceptive device had been inserted as described by the defendant, she had acted in accordance with peer professional opinion. If the contraceptive device had been inserted as described by the plaintiff, the defendant had not acted in accordance with peer professional opinion. Therefore, the central issue in the case was whether the defendant's or the plaintiff's version of events was accepted.

In *Hope v Hunter and New England Area Health Service*,[23] the case involved the removal of a half centimetre ganglion from the left middle finger which had resulted in the division of the digital nerve. The defendant tried to rely upon the evidence of a plastic surgeon to establish what constituted peer professional opinion. During the trial, the plastic surgeon gave evidence that he had consulted a colleague as to her views on the issue and that his colleague's practices accorded with his own. While there were issues with how the evidence had been introduced, it had also not been established how the colleague's practice related to the procedure for removing ganglia that were the size of a little rice grain as distinct from ganglia that were a half centimetre in diameter, as in the plaintiff's case. His Honour Judge Levy decided to attach no weight to that evidence.[24] In addition, the plastic surgeon gave no evidence as to the Australian standards of teaching, training or practice other than his own practice. No opinion evidence was called to establish by reference to literature, texts or professional development conference or seminar papers or otherwise, to establish that what the plastic surgeon described as his own practice

constituted widely accepted peer practice in Australia.[25]

In *Hope v Hunter,* Judge Levy also considered the interpretation of the term 'irrational'. His Honour did not consider the term to mean 'without reason' and instead construed it to refer to 'reasons that are illogical, unreasonable or based on irrelevant considerations'.[26] In that case, it was found that there was a foreseeable risk that the plaintiff could suffer nerve damage if such structures were cut without being exposed for visibility in the direct field of vision of the operating surgeon. His Honour said 'in my view it would be illogical, unreasonable and therefore irrational to operate in the vicinity of such structures without first identifying them and protecting them from damage through contact with surgical instruments…'[27]

In *Melchior and Ors v Sydney Adventist Hospital Ltd and Anor,*[28] one of the allegations made by the plaintiffs was that the deceased should have been given an adequate prescription of Clexane (7-10 days) to avoid a fatal pulmonary embolus following Achilles tendon surgery. The experts called by the defendant gave evidence that it was not standard practice to administer Clexane or low molecular weight Heparin (LMWH) after Achilles tendon surgery in May 2004. The experts that were called by the defendant all had experience within the relevant field and the reasons they put forward as to why it would not have been standard practise to administer Clexane were as follows:

- The experts regarded the deceased as a low-risk patient;
- Statistically, the risks of developing a deep vein thrombosis or venous thromboembolism in patients undergoing Achilles tendon surgery were very low;
- The risks of administering Clexane/LMWH were outweighed by the advantages; and
- The medical literature was unanimous in recommending that LMWH should not be routinely administered for that kind of surgery.

Justice Hoeben was not persuaded that the failure by the surgeon to administer Clexane or another LMWH for 7 to 10 days following the operation constituted a failure to comply with the appropriate professional standards.[29] However, he went on to say that if he was wrong in that conclusion, the evidence clearly established the defence in accordance with s5O.[30]

CONCLUSION

The confirmation by the courts that s5O does not replace the standard of care as described in *Rogers v Whitaker* and instead creates a defence means that a plaintiff does not have the onus of identifying and negating peer professional opinion. If it had been found otherwise, it would have been very difficult for a plaintiff to succeed in a claim against a medical practitioner. While s5O has been raised by defendants in a number of cases, the case law has shown the difficulties faced by a defendant in establishing that its practice accorded with peer professional opinion. In addition, the interpretation of the term 'irrational' was given a broad definition in *Hope v Hunter*. If this definition continues to be applied, it may result in more circumstances in which a court is prepared to find that a practice is irrational, despite that practice being widely accepted by professionals as competent professional practice. Although there is no doubt that s5O and the equivalent provisions in other states have created additional difficulties for plaintiffs to succeed in claims against medical practitioners, the cases that have been decided indicate that the impact on plaintiffs may not be as wide-reaching as once feared. ■

Notes: **1** For example, see *Rogers v Whitaker* (1992) 175 CLR 479, [6]. **2** 175 CLR 479. **3** For example, see *F v R* (1983) 33 SASR 189; *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542. **4** [1957] 1 WLR 582. **5** *Ibid,* p587. **6** *Rogers v Whitaker* (1992) 175 CLR 479, [12]. **7** *Ibid.* **8** [1999] 197 CLR 269. **9** Australia, *Review of the Law of Negligence – Final Report* (Honourable David Ipp, Chairperson), Canberra, September 2002, px. **10** *Ibid.* **11** *Ibid,* p1. **12** *Ibid,* p40. **13** *Ibid,* p41. **14** *Wrongs Act* 1958 (Vic), s59; *Civil Liability Act* 2002 (WA), s5PB; *Civil Liability Act* 1936 (SA), s41; *Civil Liability Act* 2002 (Tas), s22; *Civil Liability Act* 2003 (Qld), s22. **15** *Civil Liability Act* 2002 (NSW), s5P. **16** *Wrongs Act* 1958 (Vic), s60; *Civil Liability Act* 2002 (WA) s5PB(2); *Civil Liability Act* 1936 (SA) s41(5); *Civil Liability Act* 2002 (Tas), s22(5); *Civil Liability Act* 2002 (Qld), s22(5). **17** [2006] NSWSC 1307. **18** *Dobler v Kenneth Halverson and Ors; Dobler v Kurt Halverson (by his tutor)* [2007] NSWCA 335. **19** [2009] NSWCA 343. **20** Above note 17, [188]. **21** *Ibid.* **22** [2010] NSWSC 279. **23** [2009] NSWDC 307. **24** *Ibid,* [169]. **25** *Ibid,* [171]. **26** *Ibid,* [174]. **27** *Ibid,* [176]. **28** [2008] NSWSC 1282. **29** *Ibid,* [139]. **30** *Ibid,* [140].

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