

3. Professional Negligence

Term of Reference

3 *In conducting this inquiry, the Panel must:*

- (d)** *develop and evaluate options for a requirement that the standard of care in professional negligence matters (including medical negligence) accords with the generally accepted practice of the relevant profession at the time of the negligent act or omission.*

Preliminary: the dichotomy between treatment and information

3.1 Issues about the standard of care in medical negligence cases may arise in relation to treatment (which includes diagnosis, the prescribing of medications and the carrying out of procedures) and to the giving of information about treatment. The Panel considers that the distinction between treatment, on the one hand, and the provision of information, on the other, is a very important one, and that the law should deal with these two activities in different ways. The standard of care therefore has to be discussed separately in regard to each.

Treatment

The principal issue

3.2 The issue that principally causes controversy in regard to the standard of care applicable to the treatment of patients is whether the court should be the ultimate arbiter of the standard of care or whether it should defer to some designated body of opinion within the medical profession. Until *Rogers v Whitaker* (1992) 175 CLR 479, it was thought by many that the law on this question in Australia was embodied in the so-called '*Bolam* rule', although courts had expressed reservations about its application in Australia. The rule derives from a famous statement by McNair J in the English case of *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582:

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 ... merely because there is a body of opinion that would take a contrary view.

3.3 There are several points that need to be made about this statement:

- (a) Although it refers specifically to medical practitioners, there are reasons to think that it may apply to other occupational groups.
- (b) The *Bolam* case involved treatment rather than the giving of information about treatment.
- (c) Under the rule the defendant will be held to have exercised reasonable care if what was done was in accordance with 'a responsible body of medical opinion'.

3.4 Our consultations suggest that there is a significant body of opinion, especially among the medical profession, in favour of reinstating the *Bolam* rule in its original form. However, the Panel has formed the view, for the reasons which follow, that it should not recommend the reintroduction of the *Bolam* rule in its original form but rather a modified version of that rule.

Should the court defer to expert medical opinion?

3.5 Under the current law, courts are never required to defer to expert opinion as such. What the law says is that the court is entitled to accept a responsible body of expert opinion, unless there is a strong reason to reject it. The principle underlying this approach is that it is always for the court to decide what the test of reasonable care requires in particular cases, and it is always for the court to decide whether to defer to any particular body of expert opinion in the case before it. By contrast, the traditional *Bolam* rule requires courts to defer to responsible medical opinion, so that if the defendant acted in accordance with a responsible body of expert opinion, the court cannot decide that the defendant acted without reasonable care.

3.6 The choice between these two options may depend, in part at least, on how the body of professional opinion to which deference is accorded is defined. There are various options in this regard.

The *Bolam* rule

3.7 As already noted, under the *Bolam* rule, deference is accorded to a 'responsible body' of medical opinion. A common objection to the *Bolam* rule is that it gives too much weight to opinions that may be extreme and held by only a very few experts, or by practitioners who (for instance) work in the same institution and so are unrepresentative of the views of the larger body of practitioners. The *Bolam* rule also gives added importance to the influence of so-called 'rogue experts'. The problems with the *Bolam* rule in its original form are well-illustrated by two instances.

3.8 The first is discussed in *Bolitho v City and Hackney Health Authority* [1998] AC 232 by Lord Browne-Wilkinson, referring to *Hucks v Cole* [1993] 4 Med. L.R. 393, 397 (a 1968 case), in which 'a doctor failed to treat with penicillin a patient who had septic spots on her skin even though he knew them to contain organisms capable of leading to puerperal fever. A number of distinguished doctors gave evidence that they would not, in the circumstances, have treated [the patient] with penicillin'. Despite this body of supportive opinion, the Court of Appeal held the doctor to have been negligent because he had knowingly taken a risk of causing grave danger even though it could have been easily and inexpensively avoided.

3.9 The second instance concerns the events described in the *Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters* (1988). The report arose out of a research programme, conducted over the course of almost 20 years, at the National Women's Hospital (Auckland, New Zealand), to determine the natural history of carcinoma-in-situ of the female genital tract. The programme involved leaving untreated women who returned positive Pap smears. A positive Pap smear may be indicative of carcinoma-in-situ, which may develop into invasive cancer. This procedure involved deliberately omitting to treat women in accordance with standards accepted elsewhere, in order to determine whether they would later develop invasive cancer. The approach followed in the programme was accepted by many other practitioners, within and outside the hospital, and formed the basis for under-graduate and post-graduate teaching. According to the Report, several women died as a result of the failure to offer conventionally-accepted treatment. Under a strict application of the *Bolam* rule as originally formulated, the practitioners involved arguably were not negligent.

3.10 These examples demonstrate that the *Bolam* rule, when strictly applied, can give rise to results that would be unacceptable to the community. They show the main weakness of the *Bolam* rule to be that it allows small pockets of

medical opinion to be arbiters of the requisite standard of medical treatment, even in instances where a substantial majority of medical opinion would take a different view. It is well-established that in many aspects of medical practice, different views will be held by bodies of practitioners of varying size and in different locations. This can result in the development of localised practices that are not regarded with approval widely throughout the profession. Thus, the *Bolam* rule is not a reliable guide to acceptable medical practice. The Panel therefore recommends that *Bolam* rule, in its original form, not be reinstated.

3.11 The question then is whether deference to a body of expert medical opinion would be acceptable if the relevant body of opinion were differently defined.

3.12 Term of Reference 3(d) suggests that deference should be paid to 'the generally accepted practice' of the medical profession. A problem with this formulation is that it does not allow for cases in which there is a genuine difference of opinion about whether generally accepted practice represents best practice, and it gives no scope for the properly regulated development of new techniques with a view to their future general adoption as best practice.

3.13 A third possibility, which would overcome the problems both of the *Bolam* test as originally formulated, and of the test suggested by Term of Reference 3(d), is a rule that a defendant could not be held liable where the court is satisfied that the conduct in question was in accordance with an opinion widely held by a significant number of respected practitioners in the relevant field.

3.14 In this formulation, the requirement that the opinion be 'widely held' is designed to prevent reliance being placed on localised practices that develop in isolation from the mainstream of professional activity. The requirement of 'a significant number' is designed to filter out idiosyncratic opinions. The requirement of 'respected practitioners' is designed to ensure that the opinion deserves to be treated as soundly based.

3.15 The Panel considers that the test set out in paragraph 3.13 is preferable both to the *Bolam* rule as originally formulated, and to the test suggested by Term of Reference 3(d). If it were thought right to require courts to defer to expert medical opinion relating to the standard of care applicable to medical treatment, the Panel's view is that the rule for determining the standard of care in all cases in which a medical practitioner is alleged to have been negligent in providing treatment to a patient should be as follows: 'A medical practitioner is not negligent if the court is satisfied that the treatment provided was in

accordance with an opinion widely held by a significant number of respected practitioners in the relevant field'.

3.16 As we have noted, however, under current law a court is never required to defer to medical opinion, although in the normal run of cases, it will. A serious problem with this approach is that it gives no guidance as to circumstances in which a court would be justified in not deferring to medical opinion.

3.17 This problem could be addressed by adding to the rule suggested in paragraph 3.15 the following proviso: 'unless the court considers that the opinion was 'irrational'. This proviso follows the law as laid down by the English House of Lords in *Bolitho v City and Hackney Health Authority* [1998] AC 232. In the opinion of the Panel, this formula gives doctors as much protection as is desirable in the public interest, because the chance that an opinion which was widely held by a significant number of respected practitioners in the relevant field would be held irrational is very small indeed. But, if the expert opinion in the defendant's favour were held to be irrational, it seems right (in the opinion of the Panel) that the defendant should not be allowed to rely on it. The Panel therefore recommends that this formula be adopted as the test of standard of care in relation to medical treatment administered by medical practitioners.

3.18 The proviso relating to 'irrational treatment' needs further elaboration. Under the recommended rule, it is for the court to decide whether treatment is irrational. It would be rare indeed to identify instances of treatment that is both irrational and in accordance with an opinion widely held by a significant number of respected practitioners in the field. Such a rare instance is the finding of the court in *Hucks v Cole* [1993] 4 Med. L.R. 393, referred to in paragraph 3.8.

3.19 Although some might think that this proviso is unnecessary, the Panel is of the opinion that there may be very exceptional cases (for example, *Hucks v Cole*) where such a situation may arise. In those circumstances, the court should have the power to intervene. As was argued in paragraph 3.17, if the court considers that the expert opinion on which the defendant relied is 'irrational', it seems right that the defendant should not be allowed to rely on it.

Recommendation 3

In the Proposed Act, the test for determining the standard of care in cases in which a medical practitioner is alleged to have been negligent in providing treatment to a patient should be:

A medical practitioner is not negligent if the treatment provided was in accordance with an opinion widely held by a significant number of respected practitioners in the field, unless the court considers that the opinion was irrational.

Advantages of the Panel's recommendation in respect of provision of treatment

3.20 The recommended rule contains sufficient safeguards to satisfy the reasonable requirements of patients, medical practitioners and the wider community. It is hoped that the test will address the sense of confusion, and the perception of erratic decision-making, which (the Panel has been told) have contributed to the difficulty that medical practitioners face in obtaining reasonably priced indemnity cover and which have, in consequence, harmed the broader community.

3.21 The recommended rule recognises, first, that there might be more than one opinion widely held by a significant number of respected practitioners in the field. It provides a defence for any medical practitioner whose treatment is supported by any such an opinion, provided the court does not consider it irrational. It would not be for the court to adjudicate between the opinions.

3.22 Because there may be more than one opinion that meets the description in the recommended rule, it protects the practitioner who is at the cutting edge of medical practice provided that the procedure followed was in accordance with an opinion that meets that description.

3.23 The 'irrational treatment' proviso enables the community, through the court, to exercise control over the very exceptional cases where even the modified *Bolam* test does not provide adequate safeguards.

The scope of the rule about treatment: to which occupational groups should it apply?

3.24 If the rule contained in Recommendation 3 is adopted, the next issue to consider is to which occupational groups the rule should apply. Although the rule has been framed in terms of treatment of patients by medical practitioners, it could be applied more widely. Term of Reference 3(d) contemplates application to all professional groups. The Panel has identified four options in this regard.

Option 1

3.25 A first possibility is to limit the application of the rule to 'medical practitioners' within the meaning of s 3 of the *Health Insurance Act 1973* (Cwth).

Option 2

3.26 A second possibility is to extend the application of the rule to all health-care professionals.

Option 3

3.27 A third possibility is to extend the application of the rule to all 'professionals'.

Option 4

3.28 A fourth possibility is to extend the rule to 'all professions and trades'. This formula was used by the majority in the leading decision of the High Court of Australia in *Rogers v Whitaker* (1992) 175 CLR 479.

Assessment of the options

3.29 Which of these options ought to be adopted is ultimately a political question for governments to determine. In the Panel's view, there is no principled basis on which a decision between the various options could be made. Historically, the *Bolam* rule and variations on it have been discussed and applied chiefly in the context of medical negligence cases. The questions whether the rule applies to other occupational groups and, if so, to which ones, have not been authoritatively answered. Given the historical context, the Panel's view is that the recommended rule in Recommendation 3 should be stated to apply to medical practitioners, but in such terms as to leave it open to the courts to extend the rule to other occupational groups.

3.30 The discussion so far has been in terms of the provision of medical treatment to patients by medical practitioners. If Option 2, Option 3 or Option 4 were adopted, the recommended rules would need to be rephrased along the following lines: A service provider is not negligent if the service was provided in accordance with an opinion widely held by a significant number of respected service-providers in the relevant field, unless the court considers that the opinion was irrational. This formulation reflects the distinction between the provision of a service (which is analogous to the concept of

'treatment' in the medical context) and the giving of information about the service (see paragraph 3.1).

The need for restatement of the basic rule about the standard of care

3.31 In the course of its consultations and investigations, the Panel has formed the view that there is a considerable amount of misunderstanding, especially amongst medical practitioners, about personal injury law. We believe that this is a source of a certain amount of unnecessary fear and anxiety on the part of medical practitioners (in particular) about the risk of being successfully sued, and a source of unrealistic expectations in society about the role of personal injury law in providing compensation for personal injury and death. For this reason, we believe that there are certain respects in which it would be worthwhile legislatively to restate the law to make it more widely known and understood, even if a decision is made not to change it.

3.32 One area in which we believe that such a legislative restatement would be helpful concerns the basic rule about the standard of care applicable to cases where defendants have held themselves out as possessing a particular skill. In such cases, the standard of care is determined by reference to what could reasonably be expected of a person exercising the skill that the defendant professed to have. We recommend legislative restatement of this rule in order to make it clear that skilled persons are not required by the law to exercise skills that they have not held themselves out as having.

3.33 The wording of Term of Reference 3(d) also suggests that there may be some value in restating the basic rule that the standard of care should be determined by reference to the date when the service was provided, and specifying that changes of practice after that date are not relevant. This raises a larger question about the dangers of hindsight that arises in relation to certain other of the Panel's Terms of Reference. Even so, it is worth considering dealing with it specifically in this context. We recommend that this be done.

Recommendation 4

The Proposed Act should embody the following principles:

In cases involving an allegation of negligence on the part of a person holding himself or herself out as possessing a particular skill, the standard of reasonable care should be determined by reference to:

(a) What could reasonably be expected of a person professing that skill.

- (b) The relevant circumstances at the date of the alleged negligence and not a later date.**

The provision of information

Basis for treating provision of information differently: the patient's right to decide

3.34 People have the right to decide for themselves whether or not they will undergo medical treatment. Originally, consent to medical treatment was seen as relevant only to the question of whether a medical practitioner administering the treatment could be sued for trespass to the person (battery), for interfering with the patient's bodily integrity. In this context, the law only required the medical practitioner to tell the patient, in general terms, about the nature of the proposed treatment.

3.35 Under current law, however, the giving of information by the medical practitioner, and the giving of consent by the patient, are seen as relevant to the issue of whether the medical practitioner has exercised reasonable care in relation to the patient. More importantly, it is now thought that medical practitioners must provide the patient with sufficient information to enable the patient to give 'informed consent' This obligation is commonly (although inaccurately) referred to as the 'duty to warn'.

3.36 An important implication of the patient's right to give or withhold consent is that the opinions of medical practitioners about what information ought to be given to patients should not set the standard of care in this regard. The giving of information on which to base consent is not a matter that is appropriately treated as being one of medical expertise. Rather, it involves wider issues about the relationship between medical practitioners and patients and the right of individuals to decide their own fate. The court is the ultimate arbiter of the standard of care in regard to the giving of information by medical practitioners.

To whom the duty should apply: the relevant occupations

3.37 As stated, the obligation of medical practitioners to provide information derives originally from the law relating to trespass to the person.

3.38 In regard to professions and occupations other than the medical profession, the law does recognise duties on the part of service providers to give particular categories of information in particular circumstances. The historical source of these duties, and their nature and scope, differ from the duty of medical practitioners to inform their patients. Moreover, while duties to inform have from time to time been imposed, they have yet to be analysed and categorised into a principled set of rules. This is very much a developing area and in the view of the Panel it is desirable to make a legislative statement of certain aspects of duties to inform in the medical context only.

3.39 Accordingly, the Panel recommends that any legislative statement of duties to provide information should relate only to medical practitioners. When dealing with the duty to provide information, the Panel will confine the discussion accordingly.

Recommendation 5

In the Proposed Act, the professional's duties to inform should be legislatively stated in certain respects, but only in relation to medical practitioners.

When the duty arises and who owes it

3.40 In all of the cases to which the Panel has been referred and which the Panel has considered in its own research, it has been assumed by the parties that it is the treating medical practitioner who owed the relevant duty to inform. While in most instances this will be the case, it is not necessarily so.

3.41 In many instances of modern medical practice, the treatment of a patient, while under the direction of what (in common practice) is known as the 'attending medical officer', is shared by several health care providers. For example, in the course of pre-operative treatment, the operation itself and post-operative treatment, the patient might be attended by the general practitioner, a physician, a radiologist, a principal surgeon and an assisting surgeon, a registrar, an intern, an anaesthetist, theatre nurses and ward nurses. Each one of these persons may administer treatment to the patient. It is unlikely that each will incur an obligation to inform the patient about the treatment administered, but it is quite possible that more than one of these persons will incur such an obligation.

3.42 The law is undeveloped in regard to determining precisely when a duty to inform will arise and on whom it will be imposed. The Panel considers it inadvisable to attempt to lay down any rules or principles in this connection.

Often, the answer will lie in responsibilities assumed by the various practitioners, and orders given and accepted. The Panel considers that this aspect should be left for the development of the common law.

The nature of the duty: a duty to take reasonable care

3.43 Some of the statements made concerning the duty to provide information make no reference, either expressly or impliedly, to the duty to inform being a duty of reasonable care. In these statements, the content and scope of the duty to inform are looked at solely from the point of view of the patient. In the Panel's view, however, this should not be the case. It should always be borne in mind that the duty to inform is part of the law of negligence, and accordingly is a duty to take reasonable care to inform. This means that consideration must be given to the situation of the practitioner.

3.44 It is by no means unknown, for example, for general practitioners in country areas to conduct surgery of a kind that elsewhere would be conducted by specialist surgeons. We are not here talking of instances where general practitioners profess skill that they do not have. The example we are giving is of general practitioners who hold themselves out as having only the skill of a general practitioner, but who are requested by their patients to carry out surgery that would elsewhere be carried out by specialist surgeons. Such general practitioners may not have the same knowledge as specialist surgeons would have of (for instance) risks of surgery. The law must accommodate this fairly, and will do so if it is recognised that the practitioner only has a duty to exercise reasonable care in giving information, and does not have a duty to give whatever information can be obtained.

Recommendation 6

The medical practitioner's duties to inform should be expressed as duties to take reasonable care.

3.45 An express statement that obligations to give information are obligations only to take reasonable care may help to reassure doctors that the law does not require of them unrealistic standards of behaviour, even though the law does not defer to medical opinion in this area to the extent that it does in relation to treatment. For instance, a doctor is not required to ensure that the patient fully comprehends the information given, but only to take reasonable care in this and other respects.

3.46 On the other hand, it is important to note that the information that the doctor must take reasonable care to provide is the information necessary to

enable the patient to give informed consent, not the information that the reasonable doctor would consider necessary for this purpose.

Analysis of the categories of information to be provided

3.47 It is necessary to distinguish between two different kinds of obligation to provide information.

3.48 An obligation to give information about treatment might be imposed on the practitioner regardless of whether the practitioner knows or ought to know that the patient wants to be given the information. The Panel will call this the 'proactive duty to inform'. On the other hand, an obligation to give certain information might be imposed only when the practitioner knows or ought to know that the patient wants or expects to be given the information. The Panel will call this the 'reactive duty to inform'.

3.49 The proactive duty to inform relates to information that the practitioner must give a patient even when the particular patient does not ask for it or otherwise communicate a desire to be given it. The reactive duty to inform relates to information the practitioner must give when the particular patient asks for information, or otherwise communicates a desire to be given it.

The proactive duty to inform

3.50 Under current Australian law, the proactive duty to inform requires the medical practitioner to put the patient in a position to make an informed decision about whether or not to undergo the treatment by telling the patient about material risks inherent in the provision of the treatment, and by providing other relevant information. A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position would attach significance to it in deciding whether or not to undergo the treatment.

3.51 It seems clear that the proactive duty to inform is not confined to information about risks but extends to other types of information that may be needed to enable patients to make an informed decision about their health. What types of information are required to be given will depend on the circumstances of each case, and it is not possible or desirable to make general provision about this matter.

3.52 The test for determining what information the proactive duty to inform requires to be given should be objective, but should take account of the personal characteristics of the patient. In determining what information the

reasonable person would want, relevant factors might include the nature and effects of the treatment, the nature and probability of inherent risks of the treatment, and alternatives to the treatment.

3.53 Accordingly, we recommend that the proactive duty to inform should be formulated to the effect that the practitioner must exercise reasonable care to give the patient such information as the reasonable person in the patient's position would, in the circumstances, want to be given before making a decision whether or not to undergo treatment.

3.54 It is important that this formula be applied by reference to the time at which the decision whether or not to undergo the treatment was made and not with the benefit of hindsight. This is the current law. Research by psychologists suggests that it is very difficult to eliminate the effects of 'hindsight bias'. This problem may be thought particularly great where the question is what a person would have done if they had been given certain information that they were not given. So, in this context (at least), the Panel recommends providing explicitly that the question of what information the reasonable person in the patient's position would have wanted to be given is to be answered by reference to the time at which the relevant decision was made and not at a later time. This provision will, at least, require the issue of hindsight to be explicitly addressed.

Giving the proactive duty to inform greater specificity

3.55 On the basis of its consultations and investigations, the Panel has formed the view that the medical profession finds the current legal specification of the proactive duty to inform unsatisfactory because it gives insufficient guidance as to what information the medical practitioner has to give to the patient in order to avoid legal liability for negligence. There is anecdotal evidence that this may be having an adverse and distorting effect on medical practice. For example, it is sometimes said that medical practitioners may spend more time giving patients information than examining them. The Panel wishes to avoid further distortion of medical practice.

3.56 One way of addressing this concern might be to attempt to frame detailed, prescriptive legislative provisions specifying the matters about which information must be given to satisfy the proactive duty to inform. The Panel's considered view, however, is that this course of action would be impractical and undesirable. The precise content of the obligation has to depend on the facts and circumstances of individual cases, which are likely to be extremely diverse and incapable of being dealt with in such a way.

3.57 Another proposal that has been made in this regard is that the medical colleges (or the National Health and Medical Research Council) should develop guidelines, protocols or codes of practice concerning provision of information. We have not been able to investigate the feasibility of such developments. However, our view is that while compliance (or non-compliance) with such advisory regimes would (in accordance with current law) be relevant to the legal issue of reasonable care, it could never be treated as conclusive of the issue. For this reason, such proposals are not directly relevant to the Panel's Terms of Reference.

3.58 A specific issue raised in the course of the Panel's consultations is whether the proactive duty to inform requires the practitioner to tell the prospective patient that the treatment is also available from other more skilled or experienced practitioners. This question cannot be answered in the abstract. Although, generally, such an obligation would not arise, there might be exceptional circumstances in which it would. It would be neither desirable nor practicable to attempt to spell these out in legislative form.

Persons to whom the proactive duty to inform is owed, and the circumstances in which it does not arise

3.59 There are cases in which the proactive duty to inform would be appropriately owed to someone other than the patient (who might be called 'the substitute decision-maker'): for instance, where the patient is an infant, or unconscious, or otherwise lacking in decision-making capacity. The identity of the appropriate substitute decision-maker would be determined in accordance with the law of the relevant jurisdiction dealing, for instance, with the rights and obligations of parents and guardians of minors. In such cases, the content of the proactive duty to inform would be to give the substitute decision-maker such information as, in the circumstances, a reasonable person in the substitute decision-maker's position would want to be given to enable him or her to make a decision in the best interests of the patient.

3.60 There are three main situations in which the proactive duty to inform would not arise:

- (a) Where its performance has been waived by the person to whom it is owed. This would be the case where the person to whom the duty to inform is owed has explicitly or impliedly told the person who owes the obligation that he or she does not want to be given information, or information of a particular kind, about proposed treatment.

- (b) Where the treatment is provided on an emergency basis. To constitute an emergency, three conditions must exist: first, a threat of death or serious physical or mental harm to the person to whom the duty to inform is owed; second, the person to whom the obligation is owed temporarily lacks decision-making capacity; third, there is no appropriate substitute decision-maker for that person. In such cases, the proactive duty to inform is suspended, but not cancelled.

When the person to whom the treatment is provided regains decision-making capacity, the practitioner is under a proactive duty to give that person such information as a reasonable person in the patient's position would, in the circumstances, want to be given about the treatment that was provided.

- (c) Where a medical practitioner reasonably believes that the very act of giving particular information to a patient would cause the patient serious physical or mental harm. This is the so-called therapeutic privilege. In this context, the phrase 'serious physical or mental harm' does not include harm likely to be suffered by reason only of a decision not to undergo the treatment in question. If it did, the patient's freedom to choose whether or not to undergo the treatment could be seriously compromised by a decision of the practitioner that the patient did not know what was in his or her own best interests.

3.61 The Panel considers that the development of these principles is best left to the common law.

Obvious risks

3.62 In the course of the Panel's consultations, the suggestion was repeatedly made that an obligation to give information should not entail an obligation to warn of obvious risks. Such a provision is consistent with the principle underlying the Terms of Reference that people should take more responsibility for their own safety. The Panel therefore recommends enactment of a legislative provision to the effect that a medical practitioner cannot be held to have breached the proactive duty to inform merely by reason of a failure to give the patient information about a risk or other matter that would, in the circumstances, have been obvious to the reasonable person in the patient's position, unless giving the information was required by statute.

3.63 The term 'obvious risk' is intended to include risks that are patent or matters of common knowledge. In the Panel's view, the mere fact that a risk is of low probability does not prevent it being an obvious risk. Beyond this, however, the Panel considers that it would be undesirable and impractical to attempt to define obviousness of risk. Whether or not a risk is obvious must ultimately depend on the facts of individual cases and, in the end, will be a matter for the court to decide.

The reactive duty to inform

3.64 Under current law, the reactive duty to inform is an obligation to take reasonable care to give to the particular patient information about risks inherent in the treatment (and other matters) to which the practitioner knows or ought to know the patient would attach significance in deciding whether or not to undergo the treatment. In other words, the reactive obligation relates to information that the patient has asked for or otherwise communicated a desire to be given.

3.65 As in the case of the proactive duty to inform, the reactive obligation is not limited to information about risks but may extend to other types of information about the treatment that the practitioner knows or ought to know the patient wants to be given before making the decision about whether or not to undergo the treatment.

3.66 So far as concerns the issue of to whom the reactive duty is owed (see paragraph 3.59) , it is the view of the Panel that, in cases where the proactive duty to inform would be owed to a substitute decision-maker, the reactive duty to inform would also be owed to that person.

3.67 Concerning the issue of the circumstances in which the reactive duty might not arise, waiver (described in paragraph 3.60(a)) is obviously not relevant in this context. In emergency situations, described in paragraph 3.60(b), the Panel's view is that the reactive duty to inform would be suspended in the same way and to the same extent as the proactive duty to inform. The application of the therapeutic privilege, described in paragraph 3.60(c), to the reactive duty to inform raises difficult questions of policy that the Panel has not had time to consider.

3.68 The application of these issues to the reactive duty to inform has yet to be settled. The Panel considers that this should be left to the common law to develop

3.69 So far as obvious risks are concerned, if a medical practitioner knows or ought to know that the patient wants to receive particular information before making the decision whether or not to undergo treatment, then the practitioner should be under an obligation to give that information, even if it concerns a risk or other matter that would, in the circumstances, have been obvious to the reasonable person in the patient's position.

Recommendation 7

The legislative statement referred to in Recommendation 5 should embody the following principles:

- (a) There are two types of duties to inform, a proactive duty and a reactive duty.**
- (b) The proactive duty to inform requires the medical practitioner to take reasonable care to give the patient such information as the reasonable person in the patient's position would, in the circumstances, want to be given before making a decision whether or not to undergo treatment.**
- (c) The information referred to in paragraph (b) should be determined by reference to the time at which the relevant decision was made by the patient and not a later time.**
- (d) A medical practitioner does not breach the proactive duty to inform by reason only of a failure to give the patient information about a risk or other matter that would, in the circumstances, have been obvious to a reasonable person in the position of the patient, unless giving the information is required by statute.**
- (e) Obvious risks include risks that are patent or matters of common knowledge; and a risk may be obvious even though it is of low probability.**
- (f) The reactive duty to inform requires the medical practitioner to take reasonable care to give the patient such information as the medical practitioner knows or ought to know the patient wants to be given before making the decision whether or not to undergo the treatment.**

Expert evidence

3.70 A matter that has arisen repeatedly in the course of our consultations, and that is relevant in the present context, is that of the procedures for the giving of expert evidence. Problems associated with expert evidence have been very recently summarised in a Discussion Paper, published by the Family Court of Australia, entitled *The Changing Face of the Expert Witness* (2002).

3.71 In most jurisdictions, there is deep dissatisfaction with expert evidence, although this is not uniform throughout Australia. From the Panel's investigations, it seems that in some States the issue is not a pressing one.

3.72 The problems are of two kinds, one general and the other particular.

3.73 The general problem arises in many cases involving conflicting expert testimony. There is a widespread perception that, in many instances, expert witnesses consciously or sub-consciously slant their testimony to favour the party who retains them. There is also a widespread perception that, in many instances, the trial process does not afford a reliable means of adjudicating between groups of what might crudely be described as biased experts. Although this general problem has for many years been recognised and discussed throughout the common law world, it remains — to varying degrees — unresolved.

3.74 Generally, there has been growth in the expert evidence 'industry', with the result (so the Panel was told) that certain experts, including medical practitioners, devote their time substantially (and even in some cases entirely) to the giving of evidence. Many experts in this category become identified as plaintiffs' experts or defendants' experts.

3.75 The particular problem manifests itself in those States where case-management practices and the prevailing legal culture have resulted in expert evidence being given completely in writing, that is, where the evidence-in-chief is in writing and there is no cross-examination. This is the result of an understandable desire to reduce delays and ensure that cases are heard as cheaply and quickly as possible. But it may result in the judge having to choose between competing views contained in expert reports. Such decisions, taken in the absence of seeing and hearing the witnesses, may be thought to be in themselves contrary to accepted tenets of the adversarial system. They also may be thought to be inherently unreliable; and, as they usually turn on questions of fact, they are difficult to set aside on appeal.

3.76 From the submissions made to the Panel, we are satisfied that a significant body of the medical profession in particular has strong objections to the expert evidence system. On the other hand, there are some medical practitioners and lawyers who (so the Panel was told) oppose any change to this system. Some of this opposition is founded on an idealistic view of the adversarial system. In relation to the particular problem, objections that are so based are not persuasive as, in the situation in question, basic safeguards of the adversarial process have been lost. As regards the general problem, its long history suggests that it is questionable whether the adversarial system is adequately equipped to deal reliably and justly with conflicting expert evidence.

3.77 The Panel considers that careful attention needs to be given to these issues.

3.78 In the light of the differing conditions in various jurisdictions, the Panel does not recommend the introduction of national legislation. The Panel does recommend, however, in those jurisdictions where serious problems with expert evidence are recognised, that a system of court-appointed experts be implemented on a trial basis for 3 years and then evaluated.

3.79 The Panel is aware that O 34 r 2 of the *Federal Court Rules* provides for a 'court expert'. The system that the Panel recommends, however, is different in principle from that in O 34 r 2 in that it precludes the parties, of their own accord, from calling expert witnesses.

Recommendation 8

Consideration should be given to implementing trials of a system of court-appointed experts.

Suggested elements to underpin a system of court-appointed experts

3.80 In the time available, the Panel has not been able to provide a detailed exposition of what such a system would entail. Broadly, however, it should be based on the following elements:

- (a) The judge would require a particular expert or experts to be called on particular issues.

- (b) The expert(s) so called would, in effect, be 'joint' as contemplated by Civil Procedure Rules (CPR) Pt 35¹ (the Rules of Court now operative in England).
- (c) No party would be entitled to call an expert witness on the party's own initiative. However, all parties would be entitled to cross-examine the court-appointed expert(s).
- (d) The system should cater for the possibility that in the disputed area more than one opinion exists — in which case more than one expert might be appointed. This issue should be resolved in pre-trial directions hearings, although it should be open to the judge at any time to call any other expert witness should that be required by the circumstances.
- (e) The decision as to which expert or experts should be called, and the issues on which the expert(s) should testify, should also be determined at pre-trial directions hearings.
- (f) Any expert appointed should be:
 - i) A person agreed by the parties; or
 - ii) If the parties cannot agree on the person, a person appointed by the judge from a list agreed by the parties; or
 - iii) If the parties cannot agree on a list, one or more persons appointed by the judge, after hearing submissions by the parties at a pre-trial directions hearing.
- (g) The Panel has not had sufficient time to investigate fully the mechanism that should be adopted in the event the parties cannot agree on a list. It may be that rules reflecting procedures developed in consultation with appropriate professional bodies would assist in this regard. Careful consideration should be given to adopting or adapting the system under CPR Pt 35.
- (h) The costs of the expert should initially be shared equally between the parties, but the court should have power at any time to order that the costs should be shared differently.

¹ See *Peet v Mid-Kent Healthcare NHS Trust* [2002] 3 All ER 688.

Another procedural issue

3.81 One other procedural issue has been raised with the Panel.

3.82 The Panel has been informed that the so-called '90 day rule' in South Australia has been very successful, particularly in resolving matters of professional negligence. This rule essentially provides that, at least 90 days before commencing an action, a plaintiff must give the defendant notice of the proposed claim. The notice must give sufficient detail of the claim to give the defendant a reasonable opportunity to settle the claim before it is commenced (see Rule 6A of the Supreme Court Rules of South Australia).

3.83 In the Panel's opinion this rule has considerable practical utility, and the Panel recommends that it be considered by all jurisdictions in which a significant number of professional negligence actions are brought.

Recommendation 9

Consideration should be given to the introduction of a rule requiring the giving of notice of claims before proceedings are commenced.

Other relevant issues

3.84 There are three other issues that are of particular relevance to this Term of Reference, but which fall more squarely under other Terms of Reference about which the Panel is not required to report until 30 September. They concern the medical practitioner's obligations to give information about the provision of services, and are:

- (a) Whether an objective or a subjective test should be applied to determine whether the patient would have decided to undergo the treatment if the relevant duty to inform had been performed.
- (b) The proper basis for the assessment of damages in cases of breach of a duty to inform.
- (c) The standard of care applicable in circumstances where a medical practitioner or other health-care professional voluntarily renders aid to injured persons in an emergency.

3.85 These issues will be addressed in detail in the Panel's second report.

