Setting the Standards for Medical Negligence:

The Bolam test post Rogers v Whitaker.

The High Court, in Rogers v Whitaker\(^1\), rejected the Bolam\(^2\) test of medical negligence, at least with respect to the giving of information and obtaining consent to medical treatment. This decision caused concern among the medical profession who felt that they were now to be judged by lawyers rather than their medical peers. The ‘Retrospectoscope’\(^3\) was to be turned upon them by people with no experience of their profession. In this paper I will look at the judgment in Rogers v Whitaker and consider some cases that have had to consider how the standard of care in medical negligence cases is to be determined.

The Bolam Test

In Sidaway v Governors of Bethlem Royal Hospital\(^4\) Lord Scarman said:

The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgement.\(^5\)

The application of the Bolam principle means that where there are two conflicting views on acceptable medical practice, then, as a matter of law, the jury (using that term generically to mean the tribunal of fact) could not find the defendant medical practitioner negligent\(^6\).

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1. (1992) 175 CLR 479
2. Bolam v Friern Hospital Management Committee [1957] 1 WLR 582 per McNair J.
4. [1985] 1 AC 871
5. ibid., p. 881
6. see Ainsworth v Levi, Unreported, NSW Court of Appeal, 30 August 1995 per Handley JA.
The High Court in *Rogers v Whitaker* had to deal with a case where the plaintiff underwent surgery on her right eye. She had been blind in that eye for many years, but her treating surgeon advised her that surgery could improve the appearance of the eye, and probably improve her sight. What the surgeon did not tell her was that there was a 1:14000 risk of developing ‘sympathetic ophthalmia’. She did develop this condition and was rendered totally blind. She sued Dr Rogers on the basis that he had been negligent in failing to provide her with the relevant advice about the surgical risk, and further, that if she had been given that information, she would not have consented to the surgery. Dr Rogers argued that the matter should be resolved by reference to the *Bolam* test and, because there was evidence that ‘a body of reputable medical practitioners...would not have warned the respondent of the danger of sympathetic ophthalmia’ he could not, at law, be found to have been negligent.

In a joint judgement, Mason CJ, Brennan, Dawson, Toohey and McHugh JJ were not prepared, as the *Bolam* principle requires, to leave the question of what constituted reasonable medical care to the medical profession. They said:

> In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill. But, that standard 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. Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the *Bolam* principle has not always been applied.

They then went on to consider some cases where *Bolam* had not been applied, and concluded that there was a difference between the giving of

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7 *Rogers v Whittaker*, ibid., at p. 484
8 ibid.
9 ibid., p. 487
information in order to obtain consent to treatment, and the skill and care required in making a diagnosis or effecting treatment\textsuperscript{10}. They said:

\textit{Whether} a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question the resolution of which responsible professional opinion will have an influential, often a decisive, role to play; \textit{whether} the patient has given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends on medical standards or practices.\textsuperscript{11}

The majority clearly rejected the \textit{Bolam} test when it came to the provision of information, arguing that it was necessary to view the question of whether adequate information had been given from the patient's perspective not the treating practitioners, but they left the door open for the \textit{Bolam} principle to apply (or a modified version that would allow some exceptions) in the areas of diagnosis and treatment.

In a separate concurring judgement, Gaudron J clearly rejected the application of the \textit{Bolam} principle in Australia. She said that the duty owed by a medical practitioner to a patient was a 'single comprehensive duty'\textsuperscript{12} and that:

\ldots even in the area of diagnosis and treatment there is, in my view, no legal basis for limiting liability in terms of the rule known as "the \textit{Bolam} test" \ldots That is not to deny that \ldots having regard to the onus of proof, "the \textit{Bolam} test" may be a convenient statement of the approach dictated by the state of the evidence in some cases. As such, it may have some utility as a rule-of-thumb in some jury cases, but it can serve no other useful function.\textsuperscript{13}

According to Gaudron J there was no room for the \textit{Bolam} test in Australian law. The majority, on the other hand left the issue in some doubt for they did

\begin{footnotes}
\item[10] ibid., p. 489
\item[11] ibid.
\item[12] ibid., p. 492
\item[13] ibid., p. 493
\end{footnotes}
not categorically rule out the application of the Bolam test in matters regarding to diagnosis and treatment. The High Court did not give guidance as to how subsequent courts were to approach the question of determining what was the relevant standard of care, whether it had been met in a particular case, or the weight to be given to expert medical evidence. It is those issues that subsequent cases have addressed.

Post Rogers v Whitaker

In Ainsworth v Levi\textsuperscript{14} the appellant was a professional singer who had surgery to remove ‘singer’s nodes’ from her vocal cords. The operation was successful but her singing voice never returned and her career was ruined. She sued her treating surgeon alleging negligence both in the treatment, and in his advice to her both about the possible consequences of the surgery and about ‘conservative’ alternatives to surgery. The defendant, at trial, was able to call evidence about the normal practice of ear, nose and throat surgeons.\textsuperscript{15} The appellant sought to argue that the trial had miscarried on the basis that the trial judge had not applied the law as developed in Rogers v Whitaker.

The Court, without expressly stating it, accepted that the decision of the majority in Rogers v Whitaker meant that Bolam did not apply whether the allegation was of negligence in failing to advise, or negligent practice in the actual performance of the surgery. On the facts of the case however, the main issue was whether the surgeon had failed to advise the plaintiff of alternative treatments and the decision was therefore squarely within the area of the ratio in Rogers v Whitaker.

In this case, Mahoney JA (notwithstanding that the trial was held before the decision in Rogers v Whitaker) accepted that the relevant law was that set out

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\item[14] Unreported, NSW Court of Appeal, 30 August 1995
\item[15] It should be noted that the injury occurred in 1971, the action was commenced in 1974 but did not come on for hearing until 1984. Following a verdict for the defendant, the plaintiff appealed. The appeal was not determined until 1994, some 20 years after the action was commenced, and 23 years after the initial injury. The
in the judgement of the High Court. He held however, that the decision in Rogers v Whitaker did not mean that evidence of normal practice was irrelevant to the question of whether or not the relevant standard of care had been met, that is such evidence could be useful to determine whether or not the defendant had acted in accordance with the standard of the reasonable practitioner.

Handley JA found that the plaintiff’s case, at it’s highest, established no more than there were two alternatives form of treatment, a conservative approach and the more ‘radical’ surgical approach. He held that the mere existence of an alternative was not sufficient to show that the doctor’s choice of one treatment in preference of another was negligent. That is, notwithstanding the decision in Rogers v Whitaker, it was still the case that if the evidence only showed that there were two or more schools of thought on the issue, the jury could not find negligence merely by preferring one school to another. To put it another way, Bolam would require, as a matter of law, that negligence could not be found where the practitioner acted in accordance with a view held by a body of respected medical opinion, Rogers v Whitaker said that was wrong (at least in the area of information giving and consent) and in law, the courts could reject a course of action as being reasonable even when it was supported by a responsible body of medical opinion. In Ainsworth v Levi, Handley JA held that where the matter only came down to preferring one school over another, and where there was no evidence, ‘expert or otherwise’ to suggest that one course of action had greater risks or benefits than the other, then the jury could not find the practitioner negligent merely for exercising his or her preference for one view over the other.

In Youkhana v Western Sydney Area Health Service the defendant, a trainee dentist, splashed sterilising solution into the eye of her patient. The case was one involving alleged negligence in the performance of treatment, not negligence in failure to advise. Again, the Court assumed that the

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16 Unreported, NSW Court of Appeal, Hearing Date 28 August 1995
decision in *Rogers v Whitaker* meant that even in the area of diagnosis and treatment, the *Bolam* test would not apply. Mahoney AP said:

It is in my opinion important to stress that the court [in *Rogers v Whitaker*], ... did not indicate that it would ordinarily put aside expert medical evidence as to whether the choice or application of a treatment was in accordance with what a skilled and careful expert would do. As I have indicated, if the evidence in that regard was unanimous and credible, the court would not (extraordinary cases apart) depart from it.... In such a case the court will ordinarily not substitute its view for that of a responsible and credible body of expert opinion: at least, it will not hold the adoption of it to have been negligence. But there may be circumstances in which such a body of opinion is, for example, thought not ‘credible’ or otherwise not acceptable. There may perhaps be other circumstances in which the court may feel justified in putting aside such a body of opinion...

That is, on the question of whether there has been a breach of a duty of care, the issue is ‘what would a reasonable person have done in the circumstances, in response to the foreseeable risk?’. Where the issue is professional negligence, then the question is what would the reasonable person in that profession have done. In that case, the court cannot, usually, answer that question without reference to the testimony of experts, for the question of what the reasonable dentist (as in this case) does is not a matter that a court can determine by reference to ‘general experience’. Expert medical evidence will therefore be important, but not determinative, of the issue before the Court. The Court will, however, be reluctant to find a doctor negligent who complies with the accepted practice of the profession at the time.

In the view of the medical profession both the high and low point in the decisions following *Rogers v Whitaker* was the decision in *Woods v Lowns and Procopis*. This case is famous for the decision by Badgery-Parker J at first instance, (upheld on appeal by Kirby P and Cole JA) that the defendant Dr Lowns owed a duty to the plaintiff to provide emergency medical care when called upon, even though there was no pre-existing patient-doctor

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17 Ottley, op. cit.
relationship. (It is Badgery-Parker's decision on this point that is reported in the NSW Law Reports.) That decision is not, however, the decision that concerns us today. The relevant decision was in the action against Dr Procopis. (That part of the decision (at first instance) remains unreported.)

The plaintiff in this case was Patrick Woods who was 11 years old at the time of the injury. Patrick was found to be in an epileptic fit whilst on holidays with his family. His mother sent his sister for a doctor (Dr Lowns) who refused to come. Because of the prolonged nature of the fit, Patrick suffered permanent and serious brain damage. He, his mother and his father sued Dr Lowns and Dr Procopis. Dr Procopis was a consultant neurologist who had been treating Patrick for epilepsy. The allegation was that he had been negligent as he had failed to advise Patrick's mother on the use of rectal Valium to control epileptic fits that extended beyond one half to one hour. The plaintiff's mother alleged that had she been instructed on the use of Valium per rectum, then she could have administered the treatment, the fitting would have stopped and the brain damage would have been avoided.

At first instance, Badgery-Parker J found against Dr Procopis notwithstanding that he had, on the evidence, 'acted in accordance with the overwhelming, if not invariable practice of specialist neurologists in Australia at the relevant time'  

18  (1995) 36 NSWLR 344 per Badgery-Parker J at first instance; (1996) Aust Torts Reports 63,151 per Court of Appeal per Kirby P, Cole and Mahoney JJ.

19  (1996) Aust Torts Reports 63,151 at 63,156 per Kirby P.

20  (1980) 146 CLR 40
its likelihood of occurring, its severity if it did occur and the cost of any steps to avoid the risk; and found that in his view it would have been reasonable for Dr Procopis to instruct Patrick’s mother on the use of rectal Valium notwithstanding that the efficacy of the treatment was in doubt, and that Valium was not packaged or otherwise provided for rectal administration. Here Badgery-Parker, taking the decision in *Rogers v Whitaker* as authority, undertook the same type of risk benefit analysis that Dr Procopis did, but came to a different conclusion and substituted his view for that of the Doctor to find that Dr Procopis had been negligent.

The only evidence to support the use of rectal Valium came from a British doctor who was acting as an expert witness in the matter. Notwithstanding His Honour’s view that ‘in some respects he [the expert witness] abandoned the role of independent expert in favour of that of advocate’ His Honour accepted his evidence as to the use that had been made of rectal Valium in the UK. Notwithstanding that the evidence from Australian practitioners was ‘unanimous and credible’, the court did ‘depart from it and did substitute its view for that of a responsible and credible body of expert opinion’ and did in fact ‘hold the adoption of it to have been negligence’. This decision was contrary to Handley JA’s obiter in *Ainsworth v Levi* (decided after this case) and was an example of the worst fears of the medical profession come true.

On appeal, the decision against Dr Procopis was reversed, and the latest comments on how the decision in *Rogers v Whitaker* is to be applied were handed down by the NSW Court of Appeal. In this case the appellant argued that *Bolam* still applied as *Rogers v Whitaker* was only concerned with cases where the alleged negligence arose out the giving of advice or information to the patient. In obiter, Kirby P said ‘I take the principle in *Rogers v Whitaker* to be one of general application, governing the relevant communications between a medical practitioner and a patient’ however, on the facts before him, Kirby P was of the view that even if the distinction argued for by the appellant was correct, this case would more properly be considered a case of

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21 *Ainsworth v Levi*, op. cit.
‘advice rather than treatment’ and therefore squarely within the decision in *Rogers v Whitaker*.

Kirby P went on to apply Handley JA’s judgement in *Ainsworth v Levi* and, agreed that if the defendant doctor could show that he or she had acted in accordance with the practices of ‘ordinary medical practice’ then the burden would shift to the plaintiff to show that the ‘ordinary practice’ did not meet the standard required by law. (To say that it would shift the burden seems anomalous as it would be expected that the plaintiff would carry the burden of proof in any event.) Because, it is still possible, in appropriate circumstances for the Court to substitute its own judgement for that of the doctor, Handley JA’s judgement could not be seen as reintroducing *Bolam* through the ‘back door’. Notwithstanding that in some cases it would be appropriate to substitute their views of that of the doctor, according to Kirby P, this was not such a case.

Mahoney JA agreed that the appeal against Dr Procopis must be upheld. On the weight to be given to expert medical evidence, he said that the court would not simply or readily ‘put aside the considered judgement and/or experience of those skilled in the field’22. A plaintiff, if faced with a defendant who can show that he or she has complied with the ordinarily accepted practice of the profession, must convince the court that the practice, even though accepted, should not be regarded as acceptable by the law. To do that they will need to show not just that there were alternative opinions, for the Courts would be unwilling make a judgement simply on the preference of one view over the other, rather the plaintiff would need ‘cogent reasons’ and the ‘burden of factual persuasion will ordinarily be a heavy one’.23

Mahoney JA considered that the question in this case was one of clinical judgement and although the Court had the right, in appropriate cases, to

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22 ibid., p. 63,160
23 ibid., p. 63,161
substitute its judgement for that of the doctor the court should be slow to do so, particularly where:

... what is involved is the weighing up of advantages and disadvantages, medical necessities and the like by the profession ... there must I think, be strong reasons why a clinical judgement properly arrived at is to be put aside as wrong and, a fortiori, as negligent.24

Cole JA would have dismissed both appeals on the basis that the findings of fact were open to the trial judge and should not be disturbed by the Appeal Court. As a result the appeal of Dr Procopis was upheld by a 2:1 majority.

Conclusion

In conclusion, notwithstanding the perceived ambiguity that some commentators felt about the judgement of the majority in Rogers v Whitaker it seems that subsequent courts, dealing with matters of medical negligence, are prepared to accept that the decision in that case is of general application, that is the decision in Rogers v Whitaker has excluded the Bolam test in all cases, not just in the provision of information. It should be noted however, that this view has either been assumed without argument or has been obiter only, so that question may still be open to debate in an appropriate case.

The rejection of Bolam does not however mean that there is no role for expert medical evidence in medical negligence hearings. The evidence is necessary to show what the ordinary practice in the field is so that the court can assess whether, as a matter of law, the defendant doctor has complied with the standard required of a reasonable person practising in the field. The fact that a defendant doctor has complied with ordinary practice will not determine the matter, for the court has the right and obligation to determine, in each case, what is the requisite standard of care, however the court should be slow to intervene to substitute its judgement for the clinical expertise of a

24 ibid., p. 63,165
treating doctor when it can be shown that the decision in the particular case accorded with the ordinary practice.

The mere fact that there are two alternative treatments available will not establish negligence where the defendant has chosen or recommended one treatment over another and a court will not, by mere preference of one view over another, find that the doctor was negligent for making a choice that the court, in retrospect, would not have chosen. There must be more than a mere preference before a court will find that a choice between competing views was wrong, and negligent.

Despite the fears of the medical profession that the decision in Rogers v Whitaker represented the abdication of professional responsibility to the courts, the decision has not been as ‘monstrous ... as first imagined’ as trial courts will continue to rely on expert medical evidence to guide the court on the issue of what a reasonable medical practitioner should do in any particular circumstances. Where a medical practitioner can show that he or she has complied with a practice that is accepted by a responsible body of medical opinion, then the plaintiff will have an extra burden to show that the accepted practice is not sufficient and this burden will be ‘a heavy one’.

Rogers v Whitaker has placed the medical profession on the same footing as other defendants. As Mahoney JA said in Ainsworth v Levi, citing with approval the decision of the majority in Burnie Port Authority v General Jones Pty Ltd:

Each person who has a duty of care must decide what things these principles [as set out in Burnie Port Authority v General Jones Pty Ltd] require that he do; if he had been sued, it remains for the judge at the trial to decide what he should have done. If the defendant has erred in applying these principles to the facts of his case, that is, if he has not done what the

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26 Woods v Lowns and Procopis, op. cit. per Mahoney JA (CA).
27 (1994) 179 CLR 500
judge decides in retrospect that he should have done, he is liable for damage caused by his omission.28

_Bolam_ meant that it was not the judge, but the medical profession who decided in ‘retrospect [w]hat he should have done’. Now, for the medical profession like any defendant, it is the judge who has that task, but the judge will continue to be assisted by expert medical evidence, and medical practitioners will still, to a large extent, be able to rely on the fact that, at least in areas of diagnosis and treatment, that they have acted in accordance with views accepted within the medical profession.

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28 _Ainsworth v Levi_, op. cit.