# What is the value of professional opinion? The current medicolegal application of the "peer professional practice defence" in Australia

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## ABSTRACT

- Under state laws, a medical practitioner will not be found negligent if they acted in a manner that was widely accepted in Australia, by a significant number of respected practitioners in the field, as competent professional practice in the circumstances. This is known as the "peer professional practice defence".
- The professional opinion being relied on must not be unreasonable (Victoria and Western Australia) or irrational (New South Wales and other states).
- The peer professional practice defence does not apply to claims of negligence arising from failure to warn patients about risks associated with medical treatment. This reinforces the importance of warning patients of material risks as determined by the High Court of Australia in *Rogers v Whitaker*.
- Recent cases demonstrate the successful operation of the peer professional practice defence, but also highlight its limitations. In practice, the legislation may not shield doctors from negligence claims as fully as originally intended.


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In the late 1990s, Australian governments were confronted with a perceived medical litigation and insurance crisis. Rates of medical negligence claims against doctors were increasing and professional indemnity insurance premiums rose to reflect the cost of claims.[1] This led to fears that doctors would practise defensive medicine and avoid training in specialties that are considered to have a high risk of litigation.[1] In response, state governments enacted legislation which established broader defences to negligence claims against professional service providers, including doctors.[2-7]

Perhaps the most significant reform for doctors was the introduction of what is referred to as the "peer professional practice defence". It states that a professional is not negligent in providing a professional service if the professional acted in a manner that was widely accepted in Australia, by a significant number of respected practitioners in the field, as competent professional practice in the circumstances.[2] This provision, from the *Civil Liability Act 2002* (NSW), is mirrored by similar provisions in all other Australian states.

The intention of the legislation was to provide a shield for professionals against negligence claims. Typically, in medical negligence cases, the party claiming negligence (the plaintiff) and the doctor (the defendant) will call experts to give evidence to assist the court in deciding whether the doctor's conduct has met the standard of care required by the law. The peer professional practice defence, interpreted literally, means the doctor need not prove that his or her evidence should be given greater weight than the plaintiff's, merely that the doctor acted according to widely accepted professional practice. Here, we describe the common law background to this defence and how courts in Australia have interpreted some of the exceptions to the defence, so that its relevance to clinical practice might be better understood by clinicians.

## Common law background

The peer professional practice defence codified the Bolam principle, a common law doctrine established in the 1957 English case of *Bolam v Friern Hospital Management Committee*.[8] In that case, a patient sustained a fractured acetabulum during electroconvulsive therapy, but the doctor and hospital were found not negligent because they acted in accordance with practice accepted at the time as proper by a responsible body of medical opinion. The 2002 legislation containing the peer professional practice provisions[2] represents a return to the principle that doctors determine the standard of care in matters of medical negligence. As restated in a recent Australian case,[9] "the law imposes the duty of care: but the standard of care is a matter of medical judgment".[10]

The peer professional practice defence marks a major divergence from one of the Australian common law positions established in 1992 by the High Court of Australia in *Rogers v Whitaker*.[11] In this case, the court decided it was not for the medical profession to solely, or even primarily, set the standard of care required in medical negligence cases. Instead, it was for the court to determine the relevant standard of care (after hearing expert evidence to assist it). The new provisions realign the standard of care with professional opinion, not judicial opinion. However, the Northern Territory and the Australian Capital Territory have not enacted mirror legislation to include the peer professional practice defence and, as such, the position on this matter in these territories is still that established in *Rogers v Whitaker.*

## Application of the peer professional practice defence

Recent medical negligence cases have considered and applied the new legislation.[9,12-17] The courts have considered the peer professional practice provisions a defence in the sense that, where an action for negligence has been brought and the provisions are relevant, they have the effect of setting the standard of care. Many of the cases in which the peer professional practice provisions have been considered are from the New South Wales jurisdiction and, although influential, they are not necessarily indicative of the approach courts may take in other states.

The use of the provision as a defence for medical professionals was adopted by the Supreme Court of NSW in 2007 in *Halverson v Dobler*[16] and followed in 2008 in *Melchior and Ors v Sydney Adventist Hospital Ltd and Anor*.[13] These cases held that the onus of proving that a professional acted in a manner widely accepted by peer professional opinion lies with the person against whom the action is brought. This will generally be the medical practitioner.

Although the peer professional practice defence has been applied successfully, some decisions appear to have diminished the breadth of the protection that the legislation provides doctors. Two recent NSW cases highlight important limitations to the defence.

### *Hope v Hunter and New England Area Health Service*[18]

Sections of the relevant Acts stipulate that the peer professional practice defence cannot be relied on if the court considers the professional opinion unreasonable (Victoria and Western Australia) or irrational (NSW and other states). This significant limitation to the defence was tested in this 2007 case.

The patient underwent surgical removal of a retinacular ganglion on the volar aspect of the flexor tendon on his left middle finger. He claimed that during the operation he suffered an unexpected division of the digital nerve and artery of his left middle finger which resulted in lasting disability.

The patient claimed that the doctor's conduct had not met the standard of care required under the law. The defendant denied this breach, relying on the peer professional practice provisions to set the standard of care. Two well qualified experts gave conflicting evidence as to the standard of care required by the doctor. When considering whether the opinion of a witness was irrational, the limitation to the defence was construed to refer to peer professional opinions that are illogical, unreasonable or based on irrelevant considerations.

The court held that, when considering an opinion used as the basis of a peer professional practice defence

> the focus should be on the practical nature of the risk that attracted the duty of care and the consideration of patient safety concerning sources of potential intra-operative harm if reasonable precautions … are not reasonably taken.[19]

Although there were several reasons leading to the court's ultimate conclusion, the court considered, in its reasoning, that because the defendant had completed much of his training in the United Kingdom and the United States, the evidence that he gave was not necessarily indicative of professional practice in Australia for the purposes of the statute. Furthermore, evidence given by one of the expert witnesses for the defence included the fact that this expert had consulted a colleague regarding her views and details of her practice concerning ganglion excision. The court noted that this witness for the defence was in sufficient doubt to consult another practitioner — this may have partly informed the court's decision to reject the expert's evidence for the purposes of the defence of peer professional practice in this case.

The court held that evidence from the defendant's expert witness was unrepresentative of rational peer professional opinion, and the peer professional practice defence was unsuccessful. Clinical decision making in the face of uncertainty is frequently supported by consulting colleagues, even at the most senior level, and many Australian clinicians have undertaken training abroad at some stage in their careers.[20] Therefore, the decision that the expert's evidence should not be given substantial weight on the question of whether an adopted practice was widely accepted in Australia — in the context of the elements which comprise irrationality in this case — may reasonably cause apprehension for clinicians relying on the peer professional practice defence. It should be noted that other states word the limitation differently, using the word "unreasonable" in place of "irrational". As the majority of cases which have considered this limitation have been in NSW, courts in other Australian states may take a different approach with respect to their interpretation of these provisions.

In Victoria, unlike NSW, there are additional provisions such that, where a court has determined peer professional opinion to be unreasonable, it must provide written reasons as to why that determination was made, although not when the determination is made by a jury.[21]

### *Melchior and Ors v Sydney Adventist Hospital Ltd and Anor*[13]

The peer professional practice defence does not apply to allegations of negligence for failure to warn patients about the risks of medical and surgical treatments. Although the plaintiff's attempt to claim "failure to warn" ultimately failed in this case, it highlights an important exception to the peer professional practice defence.

The plaintiff brought an action in negligence against the doctor, an orthopaedic surgeon, after a patient who was not administered postoperative enoxaparin after an Achilles tendon repair developed a fatal pulmonary embolus. The plaintiffs' claim was that not only should the defendant have prescribed enoxaparin after the surgery, but the defendant should also have ensured that the dosage of enoxaparin was sufficient to prevent or substantially reduce the chance of developing the embolus.

Medical experts disagreed on several critical issues regarding postoperative administration of enoxaparin in this case, and the court held that this was due to a genuine difference of opinion about the appropriateness of its use, stemming from the diverse experiences of the witnesses and inconsistency in the medical literature. The court found that the peer professional practice provisions were in operation and the surgeon was not found negligent.

Yet, despite the successful application of the peer professional practice defence in this case, the plaintiff claimed that the surgeon should still be found negligent for failing to warn the deceased of the risk of thromboembolism. They argued that the doctor knew, or ought to have known, that the deceased was at risk of forming an embolus and, therefore, should have warned of that risk. They relied on section 5P of the *Civil Liabilities Act 2002* (NSW), which states that the peer professional opinion defence

> 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.[22]

Unfortunately, the court never comprehensively addressed the issue of failure to warn in this case because the amended claim was submitted late and was excluded on procedural grounds. However, it is important for clinicians to note that failure to warn claims can overcome otherwise available defences based on peer professional practice. In such cases, the standard of care will revert to the stricter common law standard established in *Rogers v Whitaker*. The standard of care required will be decided on by the court, not peer professional opinion. On that basis, the importance of informing patients of the material risks associated with medical treatment remains essential.

## Conclusion: what is the value of professional opinion?

The peer professional practice defence provisions enacted by the states make professional opinion the cornerstone of establishing the standard of care in negligence cases. The doctor defending a negligence claim need only prove that they acted in a manner

considered to be competent professional practice by a significant number of medical practitioners in the field. This is a much more favourable legal position for Australian doctors than that which existed previously.

However, the cases of *Hope v Hunter and New England Area Health Service*[18] and *Melchior and Ors v Sydney Adventist Hospital Ltd and Anor*[13] show the potential danger for doctors relying solely on the peer professional practice defence. First, the court may consider the professional opinion being relied on to be irrational or unreasonable. Second, the claim may be based on the doctor's failure to warn about the risk of a medical treatment. Strict interpretation of these exceptions by the courts makes the defence less effective for doctors than it first appears.

Even so, the value of peer professional opinion cannot be overstated, particularly when seeking to ensure that medical practice falls within the boundaries of competent professional practice formulated by the accumulation of evidence-based guidelines, knowledge and authoritative expert opinion. The direct benefit that peer professional opinion and practice has on patients in this context should always outweigh the importance of avoiding legal liability in the clinician's mind.

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## Competing interests

None identified.

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