The standard of medical care under the Australian Civil Liability Acts: Ten years on
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It has been more than a decade since the modified Bolam test was legislatively enacted by the Australian States following the medical indemnity crisis. Since its implementation, the modified Bolam test has been configured by judges as a defence to the common law standard of care in medical diagnosis and treatment. The article argues against this interpretation and suggests an alternative way of implementing this statutory test. It is proposed that the modified Bolam test ought to have been applied as a single yardstick to determine the required standard of care in diagnosis and treatment. Changes are also recommended to reform the test with a view to striking a balance between the interests of patients and doctors in medical disputes, and strengthening judicial supervision of the medical profession. These proposed reforms could resolve the shortcomings of the common law more effectively. They may also enhance the standard of medical care in Australia in the long run.

INTRODUCTION

The codification of the modified Bolam test† in six State jurisdictions between 2002 and 2004 in various Civil Liability Acts‡ presented a significant step in the development of the law of medical negligence in Australia. The overarching effects of the modified Bolam test are manifest in two main aspects. One is that it reduces liability of medical practitioners and thereby moderates insurance premiums in the wake of the medical indemnity crisis in Australia.§ The other, arguably more profound, is that it introduces statutory elements to the determination of the standard of care in medical diagnosis and treatment in Australia, which was previously a purely common law area.¶

Subsequent legal development, however, has shown that the modified Bolam test does not replace the common law standard of care in medical diagnosis and treatment in its entirety. It has been held by a series of Australian Court of Appeal and Supreme Court cases that the test serves as a defence under the broad realm of the common law. This article critiques the justifiability of this approach and argues

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† The term “modified Bolam test” has previously been used by leading medico-legal scholars Professors Loane Skene and Harold Luntz: see Skene L and Luntz H, “Effects of Tort Law Reform on Medical Liability” (2005) 79 ALJ 345 at 351.
‡ The term “Civil Liability Acts” refers to the various Australian States’ legislation implementing the modified Bolam test under different names. They are the Civil Liability Act 2002 (NSW), s 50; the Civil Liability Act 2003 (Qld), s 22; the Civil Liability Act 1936 (SA), s 41; the Civil Liability Act 2002 (Tas), s 22; the Wrongs Act 1958 (Vic), s 58; the Civil Liability Act 2002 (WA), s 5PB.
§ New South Wales, Legislative Assembly, Parliamentary Debates (23 October 2002) p 5764 (Carr, Premier of New South Wales, Minister for the Arts and Minister for Citizenship); Queensland, Legislative Assembly, Parliamentary Debates (11 March 2003) pp 366-367 (Welford, Attorney General and Minister for Justice); South Australia, House of Assembly, Parliamentary Debates (16 February 2004) p 1186 (Foley, Deputy Premier); Tasmania, House of Assembly, Parliamentary Debates (24 June 2003) pp 52-54 (Jackson, Minister for Justice and Industrial Relations); Victoria, Legislative Assembly, Parliamentary Debates (30 October 2003) p 1421 (Brumby, Treasurer); Western Australia, Legislative Assembly, Parliamentary Debates (16 June 2004) p 3770 (McGowan, Parliamentary Secretary).
¶ See, for example, McDonald B, “Legislative Intervention in the Law of Negligence: The Common Law, Statutory Interpretation and Tort Reform in Australia” (2005) 27 Syd LR 443 at 443.
for a more effective way of implementing the statutory test. It begins by revisiting the Australian common law standard of medical care in diagnosis and treatment, with particular emphasis on identifying the weaknesses that were related to the medical indemnity crisis. The analysis serves two objectives. One is to provide background to the implementation of the modified Bolam test in the Australian States. The other is to demonstrate the interplay between the common law and the modified Bolam test in negligent diagnosis and treatment cases. The rationale for the judicial interpretation of the test is also examined. Policy considerations are proffered to support the contention that the modified Bolam test should have been applied as a standalone principle to negligent diagnosis and treatment cases. This proposal is subject to two major reforms within the test, namely conferring unlimited restriction upon the court to reject expert medical opinion and providing clearer guidance to facilitate judicial evaluation of this opinion.

THE STANDARD OF MEDICAL CARE IN DIAGNOSIS AND TREATMENT UNDER THE COMMON LAW

The Australian High Court decision in Naxakis v Western General Hospital represents the common law position on the standard of care in the areas of diagnosis and treatment in general. It is accordingly appropriate, at the outset, to identify the relevant principles in Naxakis and their application by the court.

The facts in Naxakis

Naxakis was concerned with alleged misdiagnosis and failure to treat. The appellant, a 12-year-old boy, suffered a head injury and was admitted to the first respondent hospital. At the hospital, the appellant was under the care of Dr Jensen, the second respondent doctor, a neurosurgeon. Dr Jensen treated the appellant for a subarachnoid haemorrhage. He did not order an angiogram to check for the possibility of a burst aneurysm. The appellant collapsed two days after his discharge and was then admitted to another hospital. There it was discovered that the appellant had a major intracranial bleed from a burst aneurysm, which caused him to suffer permanent physical and intellectual impairment, despite having undergone a successful surgical operation to stem the bleeding. The appellant pursued a number of claims in an action for negligent misdiagnosis against, inter alia, Dr Jensen. At first instance, Harper J dismissed the appellant’s action on the grounds that there was no case for the jury to consider. The appellant’s appeal to the Court of Appeal was unsuccessful. Ultimately, though, the High Court later granted special leave to appeal. The legal question for the High Court centred upon sufficiency of evidence to justify leaving the case to the court to determine the issue of breach of duty of care.

The significance of Naxakis

Two aspects, at least, of the decision in Naxakis are significant. The first is the High Court’s expressed disapproval of the Bolam test in relation to the doctors’ duty of care in diagnosis and treatment.

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5 Naxakis v Western General Hospital (1999) 175 CLR 269.
6 An angiogram is a medical imaging technique that is commonly used to examine the internal space of blood vessels, veins and the heart chambers. It involves injecting a radio-opaque contrast agent into the blood vessels and images are produced by using an X-ray based technique such as fluoroscopy.
7 An aneurysm is a blood-filled balloon-like bulge in the wall of a blood vessel. An aneurysm may grow in size, and if ruptured, can lead to internal bleeding and death.
8 Naxakis v Western General Hospital (1999) 197 CLR 269 at 270-271.
9 The High Court Justices were Gleeson CJ, Gaudron, McHugh, Kirby and Callinan JJ. Gleeson CJ only delivered a brief judgment.
10 The case was settled out of court after further interlocutory proceedings and before the new trial commenced: see Luntz H, “Rogers v Whitaker: The Aftermath” (2003) 11 HLB 102 at 103.
11 The Bolam test derived its name from the English High Court decision in Bolam v Friern Hospital Management Committee [1957] 2 All ER 118. The test states that doctors would not breach their duty if the act or omission in question complies with a
Relying on the High Court decision in Rogers v Whitaker,\(^\text{12}\) the court held that, even though there was overwhelming medical opinion in support of Dr Jensen’s omission to conduct an angiogram, the evidence in itself was not conclusive of the issue of breach of duty of care. The court reiterated the long-established principle under the Bolam test that the relevant standard of care is that of “the ordinary skilled person exercising and professing to have that special skill”.\(^\text{13}\) However, it emphasised that this standard is to be determined by the court based on all available evidence rather than solely referring to the customary practice or responsible opinion of the medical profession.\(^\text{14}\)

Of the four justices, namely Gaudron, McHugh, Kirby and Callinan JJ, who addressed the law on the standard of care in Naxakis, only Gaudron J expressly provided a qualification to her rejection of the Bolam test.\(^\text{15}\) Her Honour held that the jury in Naxakis should have been allowed to assess the issue of negligence on the basis of “reasonableness of particular precautionary measures” because this issue was within their knowledge and understanding. Gaudron J phrased this approach as follows:

> [It] is important to bear in mind that the test for medical negligence is not what other doctors say they would or would not have done in the same or similar circumstances … To treat what other doctors do or do not do as decisive is to adopt a variant to the direction given to the jury in Bolam v Friern Hospital Management Committee (the Bolam rule) … In Rogers v Whitaker, I pointed out that at least in some situations, “questions as to the reasonableness of particular precautionary measures are … matters of commonsense.”\(^\text{16}\)

This approach, in retrospect, is an extension of the principle governing the breach of duty of care in general negligence, as established by the Australian High Court in Wyong Shire Council v Shirt, to the context of medical diagnosis and treatment.\(^\text{17}\) In Shirt, it was held that the reasonableness of precautionary steps to avoid foreseeable risk\(^\text{18}\) of injuries is evaluated against a number of criteria: the magnitude of risk, the degree of probability of the risk eventuating, the expense, difficulty and inconvenience of taking the alleviating step, and any other conflicting responsibilities which the defendant may have.\(^\text{19}\)\(^\text{6}\)

The other significant aspect of Naxakis is the notion that the court could decide the issue of breach of duty of care in medical diagnosis and treatment on the basis of one direct medical opinion, or in certain circumstances, the absence of expert medical testimony. McHugh J managed to identify one responsible body of medical opinion which supported the view that an angiogram should have been performed. According to his Honour, that evidence alone would have been sufficient to enable the court to decide whether Dr Jensen had breached the duty of care.

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\(^{12}\) Rogers v Whitaker (1992) 175 CLR 479 dealt with the issue of duty to warn of medical risks. The High Court of Australia held that doctors have a duty to warn patients of all material risks that are inherent in a proposed medical treatment. Materiality of risks, the court ruled, is to be decided by judges on the basis of a “reasonable” or “particular” patient and evidence of accepted medical practice is only influential, not conclusive of this issue. See the subsequent High Court decision in Rosenberg v Percival (2001) 205 CLR 434 at 459-460 for an analysis of the “particular” and “reasonable” patient tests. Queensland is the only jurisdiction in Australia that has legislated this common law duty wholly under the Civil Liability Act 2003 (Qld), s 21.

\(^{13}\) Naxakis v Western General Hospital (1999) 197 CLR 269 at 274-275 (Gaudron J), 285-286 (McHugh J), 293-294 (Kirby J).

\(^{14}\) Naxakis v Western General Hospital (1999) 197 CLR 269 at 274-275 (Gaudron J), 285-286 (McHugh J), 293-294 (Kirby J).

\(^{15}\) In comparison, the English House of Lords decision in Bolitho v City and Hackney Health Authority [1998] AC 232 at 242 qualified the Bolam test by conferring upon judges the ultimate authority to decide whether expert medical opinion has a “logical basis”:.

\(^{16}\) Naxakis v Western General Hospital (1999) 197 CLR 269 at 275-276.

\(^{17}\) Wyong Shire Council v Shirt (1980) 146 CLR 40.

\(^{18}\) At common law, a risk is foreseeable if it is not far-fetched or fanciful: see Wyong Shire Council v Shirt (1980) 146 CLR 40 at 48 (Mason J).

\(^{19}\) Wyong Shire Council v Shirt (1980) 146 CLR 40 at 47-48 (Mason J).
Two other judges, Kirby and Gaudron JJ, were of the view that the jury could decide the required standard of care without the presence of any direct medical opinion indicating negligence. Kirby J, in particular, justified this approach in the following statements:

Special caution is needed before withdrawing from the jury the resolution of a dispute of facts where the case is not one of direct proof but of the reasonable and definite inferences which are to be derived from the evidence given. Because claims in negligence quite often depend upon circumstantial evidence and the inferences therefrom, once some evidence is adduced which, if accepted, could found a verdict in favour of the plaintiff, it requires the clearest case to support the conclusion that, for legal purposes there is no evidence at all or that the jury could not reasonably accept such evidence as exists or act upon it.\(^{20}\)

Their Honours opined that the jury should have been left to decide, among others, the issue of breach of duty of care based on the following facts:\(^{21}\)

1. the opinion of the appellant’s expert that a subarachnoid haemorrhage usually follows a significant blow to the head;\(^{22}\)
2. the persistent signs and symptoms displayed by the appellant on admission to hospital were consistent with a cause other than trauma;\(^{23}\)
3. the result of the CT scan revealed an unusually large amount of blood in the left ventricle;\(^{24}\) and
4. there was evidence that the risks of angiogram were relatively slight, and that it would almost certainly have revealed the true condition.\(^{25}\)

In a nutshell, the entirety of the evidence that their Honours took into consideration consisted of indirect expert medical opinion and circumstantial evidence.

A CRITIQUE OF NAXAKIS

A critique of the judgments in Naxakis follows. It aims to highlight the shortcomings of the common law standard of care in medical diagnosis and treatment in Australia as established by Naxakis. Two criticisms are related to the rationale for the subsequent statutory implementation of the modified Bolam test in the Australian States.

Failure to provide a clear mechanism for evaluating expert medical opinion

A major weakness of Naxakis is the failure of the court to proffer an unambiguous and predictable mechanism to facilitate the evaluation of expert medical opinion. Although most justices in Naxakis addressed the standard of care issue, only Gaudron J articulated a definite principle for the evaluation of expert medical opinion. In Rogers, Gaudron J had called for the need to scrutinise medical opinion on the basis of its “reasonableness of precautionary measures”\(^{26}\) and reiterated this statement in Naxakis.\(^{27}\) The other judges, McHugh, Kirby and Callinan JJ, were rather cryptic on the exact methodology by which the court should evaluate the reasonableness of clinical conduct or medical opinion. What seems clear is that the three justices based their decision on the reasonableness of adopting an angiogram as an alternative means of diagnosis.\(^{28}\) This reasoning, it has been argued, is consistent with the approach of Gaudron J to assess the feasibility of taking precautionary steps to avoid serious injuries.\(^{29}\) However, the court in Naxakis was arguably insufficiently explicit to provide

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\(^{20}\) Naxakis v Western General Hospital (1999) 197 CLR 269 at 293.

\(^{21}\) Naxakis v Western General Hospital (1999) 197 CLR 269 at 276-277 (Gaudron J), 293 (Kirby J), 311 (Callinan J).

\(^{22}\) Naxakis v Western General Hospital (1999) 197 CLR 269 at 277 (Gaudron J), 295 (Kirby J).

\(^{23}\) Naxakis v Western General Hospital (1999) 197 CLR 269 at 295 (Kirby J), 311 (Callinan J).

\(^{24}\) Naxakis v Western General Hospital (1999) 197 CLR 269 at 277 (Gaudron J), 311 (Callinan J).

\(^{25}\) Naxakis v Western General Hospital (1999) 197 CLR 269 at 312 (Callinan J).

\(^{26}\) Rogers v Whitaker (1992) 175 CLR 479 at 493.

\(^{27}\) Naxakis v Western General Hospital (1999) 197 CLR 269 at 276.


\(^{29}\) Corbett, n 28 at 286.
clear guidance on how the court may adjudicate clinical decisions concerning diagnosis and treatment. Lacking clear criteria for assessment of expert medical opinion, doctors are left with little concrete and predictable guidance as to what actions or omissions might, in this regard, render them liable for negligence.

Even if Naxakis stands as an authority requiring the court to evaluate the sufficiency of precautionary steps, the court did not fully evaluate this benchmark standard against the assessing criteria as established by Shirt. In Naxakis, the court did not appear to take into account the fact that the burst aneurism sustained by the appellant was a serious injury that was “very unlikely to occur.” Nor did it call for the need to weigh the inconvenience that might be caused to the appellant against the necessity to adopt alternative diagnoses. It has been argued that the vagueness of the standard of care in Naxakis could potentially result in an increase in defensive medical procedures and a surge in medical indemnity insurance.

The Australian medical profession may be vulnerable to negligence suits

Worrying for the medical profession is the upshot of Naxakis that the plaintiff patients could prove a breach of duty of care in the areas of diagnosis and treatment by inference and without direct medical opinion indicative of negligence. Excepting McHugh J, who identified a responsible body of medical opinion from one expert testimony, the remaining three justices chose to leave the case to the court to make a finding of breach of duty of care based on an inference from circumstantial evidence. This approach raises the important question of whether judges are capable of deciding the issue of breach of duty of care in more complex medical diagnosis and treatment cases. Naxakis certainly involved a straightforward issue of whether an angiogram should be taken as an alternative diagnostic procedure. More importantly, given that the doctors’ diagnosis and treatment are based largely on their skills, it is more appropriate to adjudicate an alleged breach of duty solely or primarily against the standard of reasonableness of the medical profession, more specifically, expert medical opinion.

It has been argued that the decisions of Gaudron, Kirby and Callinan JJ to decide the standard of care in medical diagnosis and treatment with evidence other than expert medical opinion exposes medical practitioners to increased risk of liability for negligence. Injured patients could still succeed in their negligence suits even though they may only have one medical expert or no direct medical opinion at all to support their case. The doctors’ fear that they may be vulnerable to medical negligence suits may arguably subject them to unnecessary pressure while treating patients. This may not be in the best interest of patients and the long-term delivery of medical care in Australia.

The background of the legislative reform

It has been widely accepted that the medical indemnity crisis in Australia, which occurred in the early 2000s, precipitated the implementation of the modified Bolam test. The crisis most notably referred to the imminent collapse of Australia’s largest medical defence organisation, United Medical Protection (UMP), and the steep rise in medical indemnity premiums that affected doctors in rural and 

30 Corbett, n 28 at 286.
31 There was a possibility that the appellant might suffer further brain injury if he were to undergo further diagnostic tests. Research has shown that patients suffering from head injury may sustain additional harm if they are subjected to extensive head movements: see especially Society of Neurosurgical Surgeons et al, Recommendations for the Safe Transfer of Patients with Brain Injury (2nd ed, Association of Anaesthetists of Great Britain and Ireland, 2006) p 4, http://www.aagbi.org/sites/default/files/braininjury.pdf.
33 See, especially, the dicta of the majority judgment in Rogers v Whitaker (1992) 175 CLR 479 at 491.
34 Skene L, “Withdrawing Cases from Juries after Naxakis v Western General Hospital” (November 2000) LIJ 78 at 79.
35 Skene, n 34 at 81.
36 See, for example, Skene L, Law and Medical Practice: Rights, Duties, Claims and Defences (3rd ed, LexisNexis Butterworths, 2008) pp 1-2.
One of the main concerns regarding the implementation of the modified *Bolam* test was the lack of empirical studies drawing a direct correlation between the standard of care in medical diagnosis and treatment under the common law and the medical indemnity crisis. The genesis of the legislative reform could be traced back to an actuarial report commissioned by the Australian Treasury and prepared by Trowbridge Consulting. This report revealed that there has been “a long term … ‘stretch’ in the interpretation of negligence in the common law” in Australia. The report did not adduce any legal nor empirical analysis concerning the standard of care in medical diagnosis and treatment under the common law nor the impact of the law on the trend of claims against doctors. Nonetheless, there was a separate statistical study conducted by Trowbridge Consulting in 2001, suggesting a drastic increase in medical negligence claims in the early 1990s and the late 1990s, although a lower level of medical negligence was a separate statistical study conducted by Trowbridge Consulting in 2001, suggesting a drastic increase in medical negligence claims in the early 1990s and the late 1990s, although a lower level occurred in the latter period. There are two major shortcomings in this study. One was its narrow scope of research, merely confining its analysis to data provided by the UMP and Medical Defence Associations in Victoria, South Australia and Western Australia. The other was its omission to draw a direct linkage between the development of common law standard of care in diagnosis and treatment and the surge in medical negligence claims. The reliability of the 2001 analysis of the Trowbridge Consulting was further undermined by other empirical research either urging caution in interpreting the data by Trowbridge Consulting or suggesting a lack of evidence to support an alarming surge in medical claims in Australia. Academic scholars have also argued that the crisis might have been caused by a lack of regulatory supervision within the medical indemnity industry rather than the law of medical negligence.

The issue of lack of thorough assessment of the relationship between the common law of standard of medical care in diagnosis and treatment and the crisis was equally evident in the review process of the Ipp Committee and the procedure of the State Parliaments. It was stated in the report prepared by...
the Ipp Committee\textsuperscript{44} that there was a “widely held view in the Australian community” that the law of negligence was, inter alia, “unclear”, “unpredictable” and “has become too easy for plaintiffs in personal injury cases to establish liability for negligence”.\textsuperscript{45} These comments exhibit a resonance with the criticisms levelled against, among others, \textit{Naxakis}, as has been highlighted earlier. The Ministerial Meeting on Public Liability comprising of Ministers from the Commonwealth, State and Territory governments concluded that there was a relationship between common law standard of care in medical diagnosis and treatment and the sudden surge in medical indemnity premiums.\textsuperscript{46} The Ipp Committee, however, did not conduct any empirical research to verify the reliability of this assumption.\textsuperscript{47} An analysis of the States’ \textit{Hansards} also indicates no independent research conducted by the legislatures to test the assumption. Given these factors, the Australian Territories, which opted against the implementation of the modified \textit{Bolam} test, were not convinced that the common law had caused the medical indemnity crisis.\textsuperscript{48} The Northern Territory maintains the status quo as established by \textit{Naxakis}, while the Australian Capital Territory statutorily qualified the common law.\textsuperscript{49}

It should be noted that neither the Ipp Report nor the States’ \textit{Hansards} were explicitly clear on the position of the common law in the face of the modified \textit{Bolam} test. None of these items of extrinsic evidence expressly indicated the relevance of the common law in the determination of the standard of care in medical diagnosis and treatment following the legislative reform.\textsuperscript{50} In the absence of this, two possible interpretations of the test may arise: either the modified \textit{Bolam} test qualifies the common law; or the test replaces the common law completely. Judicial interpretation of the test is elucidated later. Meanwhile, it is necessary to provide an overview of the modified \textit{Bolam} test.

\textbf{The Modified \textit{Bolam} Test in the Australian States}

One important feature of the statutory implementation of the modified \textit{Bolam} test by the Australian States is that it has not been consistent. Queensland was the only State adopting an almost identical provision to the Ipp Report’s recommendation.\textsuperscript{51} Section 22(1) of the \textit{Civil Liability Act 2003} (Qld) provides that a professional, including a medical practitioner, is not negligent if:

\begin{quote}
[It] is established that the professional acted in a way that (at the time the service was provided) was widely accepted by peer professional opinion by a significant number of respected practitioners in the field as competent professional practice.
\end{quote}

All the States implemented the material wording “widely accepted” opinion in their respective versions of the modified \textit{Bolam} test although New South Wales, South Australia, Tasmania and Victoria qualify this requirement to only “in Australia”.\textsuperscript{52} The Western Australia and Queensland

\begin{footnotes}
\item[45] This conclusion was drawn from written submissions from the public, personal consultations by members of the Law of Negligence Review Panel, and the Ministerial Meeting on Public Liability comprising Ministers from the Commonwealth, State and Territory governments: see Ipp Report, n 44 at [1.4].
\item[46] Ipp Report, n 44 at [1.16].
\item[47] Ipp Report, n 44 at [1.16].
\item[49] In the Australian Capital Territory, the issue of breach of duty of care in medical diagnosis and treatment is determined on the basis of whether the act or omission of the defendant doctor is supported by a widely accepted expert medical opinion: see \textit{Civil Law (Wrongs) Act 2002} (ACT), s 87(4). This statutory provision is arguably a modification of the decision in \textit{Naxakis}, and brings the application of the common law in the Australian Capital Territory closer to the modified \textit{Bolam} test, except without the statutory proviso stating when judges may reject expert medical opinion.
\item[50] See, for example, the observation of Macaulay J in \textit{Brakoulias v Karunaharan} [2012] VSC 272 at [31].
\item[51] Recommendation 3 of the Ipp Report, n 44, proposes the following for codification in legislation: “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.”
\item[52] \textit{Civil Liability Act 2002} (NSW), s 50(1); \textit{Civil Liability Act 2002} (Tas), s 22(1); \textit{Wrongs Act 1958} (Vic), s 59(1); \textit{Civil Liability Act 1936} (SA), s 41(1).
\end{footnotes}
models are silent on the locality of “widely accepted” opinion. The terms “significant” and “respected practitioners in the field” only appear in the Queensland and Victorian legislation. None of the Hansards from the State Parliaments provide any information on the material distinctions of the different wording in the statutory provisions.

The other significant discrepancy lies in the stipulation that authorises judges to reject a “widely accepted” opinion. New South Wales, Queensland, South Australia and Tasmania implemented the “irrationality” qualification as proposed by the Ipp Report. The term “irrational” is not defined in any of the Acts, being intentionally left to judicial interpretation in due course. Nonetheless, parliamentary debates indicate that “irrationality” is to be assessed against the “normal bounds of community expectation”. Those debates also reveal that the proviso was designed to make it “much harder for the court to disregard” the opinion of medical experts, as compared with the position of the common law.

Victoria and Western Australia adopted the “unreasonable” proviso. However, the Acts in both States make no attempt to define the scope of unreasonableness or how it should be interpreted. The only assistance, given by the Victorian Parliament, was that the “unreasonable” requirement would give greater discretion to the court to overrule peer professional opinion than the “irrational” proviso. Two reasons for rejecting the “irrational” proviso appear: that the criterion had not been tested in Australian jurisdictions, and the ambiguity of the term “irrational”, in that its dictionary definition includes meanings such as “illogical”, “absurd” or “unreasonable”.

The “unreasonable” provisos under the Victorian and Western Australian legislation contain one material difference from one another. The former authorises judges to dismiss a widely accepted opinion that is considered “unreasonable”. The latter, structured upon the principle of Wednesbury unreasonableness, enables the court to reject a widely held opinion if it is “so unreasonable that no reasonable health professional in the health professional’s position could have acted or omitted to do”. This public law doctrine of Wednesbury unreasonableness is derived from the English House of Lords’ case of Associated Provincial Picture Houses Ltd v Wednesbury Corporation. In the context of medical negligence cases concerning diagnosis and treatment, the principle was applied by Dillon LJ in the English Court of Appeal decision in Bolitho v City and Hackney Health Authority:

In my judgment, the court could only adopt the approach of Sachs LJ and reject medical opinion on the ground that the reasons of one group of doctors do not really stand up to analysis, if the court, fully

53 Civil Liability Act 2003 (Qld), s 22(1); Wrongs Act 1958 (Vic), s 59(1).
54 Civil Liability Act 2002 (NSW), s 50(2); Civil Liability Act 1936 (SA), s 41(2); Civil Liability Act 2002 (Tas), s 22(2); Civil Liability Act 2003 (Qld), s 22(2).
57 New South Wales, Legislative Assembly, Parliamentary Debates (23 October 2002) p 5766 (Carr, Premier of New South Wales, Minister for the Arts and Minister for Citizenship).
58 Wrongs Act 1958 (Vic) s 59(2); Civil Liability Act 2002 (WA), s 5PB(4).
59 Victoria, Legislative Council, Parliamentary Debates (30 October 2003) p 1856 (Strong, Chair of the Legislative Committee).
61 Victoria, Legislative Council, Parliamentary Debates (30 October 2003) p 1857 (Strong, the Chair of the Legislative Committee).
62 Wrongs Act 1958 (Vic), s 59(2).
63 Civil Liability Act 2002 (WA), s 5PB(4).
64 Associated Provincial Picture Houses Ltd v Wednesbury Corporation [1948] 1 KB 223. In the House of Lords decision in Council of Civil Service Unions v Minister for the Civil Service [1985] AC 374 at 410, Lord Diplock likened “Wednesbury unreasonableness” to the “irrationality” ground for judicial review of public administrative bodies’ decisions.
conscious of its own lack of medical knowledge and clinical experience, was none the less clearly satisfied that the views of that group of doctors were Wednesbury unreasonable, ie views such as no reasonable body of doctors could have held.\(^65\)

As regards the discretion of the court to reject a widely accepted opinion, it has been noted that the Western Australian proviso is more restricted than its comparable “unreasonable” proviso under the Wrongs Act 1958 (Vic). The effect of the Western Australian model was said to resemble the application of the Bolam test in its original form.\(^66\)

**THE MODIFIED BOLAM TEST IN PRACTICE**

A number of Australian first instance and appellate decisions, principally from New South Wales and Victoria, have provided some guidance as to how the modified Bolam test should be construed and applied. The most important case to date is arguably the New South Wales Court of Appeal’s decision in *Dobler v Halverson*,\(^67\) a case concerning failure to conduct alternative diagnosis, bearing some resemblance to Naxakis. The respondent patient in *Dobler* sued the appellant doctor, a general practitioner, for medical negligence alleging that the doctor failed to refer him for an electrocardiogram (ECG) and to a cardiologist in view of his heart condition. The respondent later suffered from cardiac arrest and hypoxic brain damage, claiming medical negligence on the part of the appellant. One of the main issues before the court was the construction and application of the modified Bolam test, namely s 5O of the Civil Liability Act 2002 (NSW), and in particular, who could rely on the test.

The submission of the appellant in *Dobler* is important to understand the reasoning of the court and it is worthwhile highlighting them. It was contended by the appellant that s 5O\(^68\) defined the content of the standard of care owed by him to the respondent. As such, the appellant argued that the respondent must prove that the omission to conduct an electrocardiogram (ECG) test or to refer the latter to a cardiologist was not an accepted practice widely supported by a significant number of medical practitioners in Australia. In support of this argument, the appellant referred to s 5 of the Civil Liability Act, which defines “negligence” to mean “failure to exercise reasonable care and skill”.\(^69\) This definition, the appellant contended, also applied to s 5O of the Act.

The court, consisting of Giles JA, Basten JA and Ipp JA,\(^70\) unanimously rejected the appellant’s submission and held that s 5O provides a defence to medical negligence cases in the areas of diagnosis and treatment. It cited two extrinsic materials to support this interpretation. One was the Ipp Report which states that the modified Bolam test “provides a defence for any medical practitioner whose treatment is supported by any such opinion”.\(^71\) The other was the New South Wales’ Hansard, which likewise stated that the legislative provision was “an additional defence to alleged professional negligence”.\(^72\) This interpretation of s 5O, said the court, meant that the respondent bore the burden of proving negligence. Once this burden was discharged, the appellant must satisfy the court that the requirements under s 5O were met.\(^73\)

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\(^{65}\) Bolitho v City and Hackney Health Authority (1993) 4 Med LR 381 at 392.

\(^{66}\) Western Australia, Legislative Council, Parliamentary Debates (19 August 2004) p 5220 (Griffiths, Minister for Housing and Works).

\(^{67}\) *Dobler v Halverson* (2007) 70 NSWLR 151.

\(^{68}\) Section 5O of the Civil Liability Act 2002 (NSW) states, inter alia, that a doctor is not liable for negligence if her or his action or omission is supported by an opinion widely accepted by other competent medical professionals in Australia, unless the court considers that the opinion is irrational.

\(^{69}\) Cited in *Dobler v Halverson* (2007) 70 NSWLR 151 at [62].

\(^{70}\) Ipp JA was the Chairperson of the Law of Negligence Review Panel: see n 44.

\(^{71}\) *Dobler v Halverson* (2007) 70 NSWLR 151 at [63], citing Ipp Report, n 44 at [3.22].

\(^{72}\) *Dobler v Halverson* (2007) 70 NSWLR 151 at [63], citing New South Wales, Legislative Assembly, Parliamentary Debates (23 October 2002) p 5766 (Carr, Premier of New South Wales, Minister for the Arts and Minister for Citizenship).

\(^{73}\) *Dobler v Halverson* (2007) 70 NSWLR 151 at [60].
The arguably more significant aspect of Dobler, however, was that s 5O does not completely replace the principle in Naxakis. Giles JA, who delivered the judgment of the court, stated that the standard of care as claimed by a plaintiff:

[will] be that determined by the Court with guidance from evidence of acceptable professional practice unless it is established (in practice, by the defendant) that the defendant acted according to professional practice widely accepted by (rational) peer professional opinion.\(^74\)

The court found that the respondent had established an initial case of negligence, and the appellant doctor had failed to prove that the criteria under s 5O were satisfied.

The decision in Dobler has since been endorsed, at first instance and on appeal, in cases dealing with the modified Bolam test.\(^75\) In Sydney South West Area Health Service v MD, the New South Wales Court of Appeal particularly stated the legal position of the modified Bolam test unambiguously as follows:

[It] is clear that s 5O modified the common law and provides a defence not available at common law, with an onus of proof lying on a defendant: see Dobler v Halverson [2007] NSWCA 335; (2007) 70 NSWLR 151 at [61].\(^76\)

This trend suggests that the determination of the standard of care in medical negligence litigation concerning issues of diagnosis and treatment in the Australian States presently involves three main steps:

1. A plaintiff patient discharges the legal burden to prove a breach of duty on the part of the defendant doctor under the common law standard of care in medical diagnosis and treatment.
2. If the court finds that the burden is discharged, the defendant doctor is to be found in breach of the duty unless he or she can establish that the defence, as provided by the modified Bolam test, applies.
3. The court determines whether the “irrational” or “unreasonable” proviso should apply.\(^77\)

While these so-called “three dimensions of the standard of care”\(^78\) have been the settled position in the Australian States, the law is unsatisfactory. The standard of care in medical diagnosis and treatment ought to be determined on the basis of a single principle, namely the modified Bolam test. The reasons for these arguments are proffered below.

**THE MODIFIED BOLAM TEST: A CASE FOR FURTHER REFORM**

The implementation of the modified Bolam test is a novel step in the development of the law of medical negligence in Australia. Fundamentally, the determination of the standard of care in medical diagnosis and treatment in the Australian States can no longer be regarded as largely a common law field. The issue, however, boils down to the extent to which the common law ought to be replaced. Subsequent case law development suggests that the common law is still maintained, at least in relation to the standard of care to be established by plaintiff patients.\(^79\) This development may be explained by two policy reasons. One is that the legislatures and judges might have considered the need to preserve the common law due to its flexibility. The other relates to evidential reasons, notably the lack of

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\(^74\) Dobler v Halverson (2007) 70 NSWLR 151 at [61].


\(^76\) Sydney South West Area Health Service v MD [2009] NSWCA 343 at [21] (Hodgson JA with whom Allsop P agreed).


\(^78\) This phrase was used by Madden B and Cockburn T, “Three Dimensions of the Standard of Care in Professional Negligence Cases” (2008) 4 Australian Civil Liability 95 at 95.

\(^79\) For an illustration of how the court examined the issue of breach of duty of care from the perspective of plaintiff patients, see, for example, Mazza v Webb [2011] QSC 163 at [40]-[46] (McMurdo J); Melchior v Sydney Adventist Hospital [2008] NSWSC 1282 at [122]-[126] (Hoeben J); Hope v Hunter and New England Area Health Service [2009] NSWDC 307 at [143]-[162] (Levy SC DCJ).
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cogent proof establishing the causal link between the common law of standard of care in diagnosis and treatment, and the medical indemnity crisis in Australia. Hence, jettisoning the common law could not have been validly justified.

There are, however, merits for adopting a single principle for determining the standard of medical care in diagnosis and treatment in Australia. The current legal position in the State jurisdictions arguably creates a double standard of medical care, namely the common law for plaintiff patients, as established by Naxakis and Shirt, and the modified Bolam test for defendant doctors. These two standards are distinctive. The common law, read together with the Civil Liability Acts, requires the court to examine all available evidence to evaluate the reasonableness of precautionary measures in alleviating foreseeable, but not insignificant, risks of injury. The modified Bolam test, on the other hand, calls for consideration of “widely accepted” medical practice and to examine the rationality or reasonableness of this practice. The requirement for “widely accepted” has been defined as entailing mainstream practice of the medical profession, or a practice that “is supported by the relevant medical literature”. This criterion is absent in the common law, although the court may have to rely on expert medical opinion in deciding whether plaintiff patients have discharged their burden of proof. On the other hand, the “irrational” or “unreasonable” provisos of the modified Bolam test contain no specific mechanism upon which the court may evaluate expert medical opinion. Having these “three dimensions of the standard of care” in a medical negligence dispute may create complication and confusion in the adjudication of the issue of breach of duty of care. This is compounded by the need for the court to analyse complex and technical matters concerning medical diagnosis and treatment. Conversely, adopting a uniform test may provide simplicity and create a level playing field in deciding the standard of care in disputes with respect to negligent diagnosis and treatment.

The modified Bolam test could operate on its own without forming part of the common law. The test was essentially grounded upon the principle enunciated in the House of Lords decision in Bolitho v City and Hackney Health Authority. Lord Browne-Wilkinson, who qualified the Bolam test in Bolitho, held that an expert medical opinion could be considered as a “responsible body of medical opinion” if the court is satisfied that this opinion has a logical basis. The “logical basis” test, which

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80 The criteria for assessing the reasonableness of precautionary measures enunciated in Woyong Shire Council v Shirt (1980) 146 CLR 40 have largely been codified in the States’ Civil Liability Acts: see Civil Liability Act 2002 (NSW), s 5B; Civil Liability Act 2003 (Qld), s 9; Civil Liability Act 1936 (SA), s 32; Civil Liability Act 2002 (Tas), s 11; Wrongs Act 1958 (Vic), s 48; Civil Liability Act 2002 (WA), s 5B. The codified version, however, contains one additional requirement, namely “the social utility of the activity that creates the risk of harm”. This criterion appears in all the States’ legislation except in Civil Liability Act 2002 (Tas). Section 11(2)(d) of the Civil Liability Act 2002 (Tas) adopts the wording “the potential net benefit of the activity that exposes others to the risk of harm”.

81 Foreseeability risk has been given a more specific definition than its common law version under the States’ Civil Liability Acts. In New South Wales, Victoria and South Australia, it is defined as a risk that a defendant “knew or ought to have known”. This is in contrast to the Queensland, Western Australia and Tasmania models which contain a slightly different wording, namely “knew or ought to have reasonably known”: see Civil Liability Act 2002 (NSW), s 5B(1)(a); Civil Liability Act 2003 (Qld), s 9(1)(a); Civil Liability Act 1936 (SA), s 32(1)(a); Civil Liability Act 2002 (Tas), s 11(1)(a); Wrongs Act 1958 (Vic), s 48(1)(a); Civil Liability Act 2002 (WA), s 5B(1)(a).

82 See Civil Liability Act 2002 (NSW), s 5B(1)(b); Civil Liability Act 2003 (Qld), s 9(1)(b); Civil Liability Act 1936 (SA), s 32(1)(b); Civil Liability Act 2002 (Tas), s 11(1)(b); Wrongs Act 1958 (Vic), s 48(1)(b); Civil Liability Act 2002 (WA), s 5B(1)(b). This statutory criterion is an addition to the common law requirement for foreseeability.

83 Western Australia, Legislative Assembly, Parliamentary Debates (16 June 2004) p 3771 (McGowan, Parliamentary Secretary).

84 Dobler v Halberson (2007) 70 NSWLR 151 at [104].

85 See the dicta of Giles JA in Dobler v Halberson (2007) 70 NSWLR 151 at [61].

86 The judgments in Dobler v Halberson (2007) 70 NSWLR 151 at [66]-[110] and King v Western Sydney Local Health Network [2011] NSWSC 1025 at [80]-[140] may serve to illustrate this argument. In these instances, the courts considered whether the defendant doctors had taken reasonable precautionary measures to prevent injuries, and then adjudicated the extent to which the same act or omission complies with the mainstream medical practice and whether it is irrational or unreasonable.

87 Ipp Report, n 44 at [3.18], citing Bolitho v City and Hackney Health Authority [1998] AC 232.
applies to expert medical opinion adduced by injured patients and defendant doctors, entails a consideration of two elements: that expert medical opinion must consist of a comparative risks and benefits assessment, and that this analysis must reach a defensible conclusion.\textsuperscript{88}

A major similarity between the English \textit{Bolitho} principle and the modified \textit{Bolam} test is that the court has to defer to expert medical opinion in the adjudication of the standard of care. In other words, the authority of the court to overrule this opinion under the principle in \textit{Bolitho} and the modified \textit{Bolam} test should only be exercised sparingly.\textsuperscript{89} However, there are a number of main differences between the two models. One is that the \textit{Bolitho} principle defines the standard of care in medical diagnosis and treatment in the United Kingdom, in which plaintiff patients bear the burden of proving that the act or omission in question is without a “logical basis”.\textsuperscript{90} Comparatively, the modified \textit{Bolam} test serves as a defence not available in common law in Australia. In other words, the defendant doctors bear the onus of establishing the requirements under the test. The other major difference lies in the manner in which the court may reject expert medical opinion. The English \textit{Bolitho} principle emphasises the “logical basis” test. The modified \textit{Bolam} test, on the other hand, focuses on the provisos of “irrational” and “unreasonable”, both of which, as stated earlier, are to be assessed against community expectation. Given that the modified \textit{Bolam} test is the replica of the English \textit{Bolitho} principle, there is no reason why the statutory test could not operate independently.

Implementing the modified \textit{Bolam} test as the basis for defining the standard of care in medical diagnosis and treatment is arguably a better option than applying it as a defence to the common law. The standard of care in medical diagnosis and treatment under the common law, as the analysis in the previous section shows, leans towards plaintiff patients and lacks a clear guidance to enable the court to evaluate expert medical opinion. Conversely, the modified \textit{Bolam} test was designed to strike a balance between providing the minimum standard that is expected of doctors and the role of the court as the final arbiter of the issue of breach of duty of care. This statutory test gives considerable weight to compliance with accepted practice of the medical profession. The test also provides circumstances in which the court may reject expert medical opinion, an element that is lacking in the common law.\textsuperscript{91}

Merely implementing the test as a supplementary to the common law arguably does not resolve the shortcomings of the latter. The adverse implication of \textit{Dobler} is that it may encourage more injured patients to commence legal proceedings against doctors. It has been highlighted in the previous section that a plaintiff patient could easily prove negligence under the common law. The extent to which plaintiffs must adduce expert medical opinion to support their claims under the first “dimension” enunciated in \textit{Dobler}, namely the common law element as established by \textit{Shirt} and \textit{Naxakis}, has not yet been clarified by the Australian High Court. In view of the absence of the requirement for “widely accepted” opinion under the common law, plaintiff patients could discharge their burden of proof with just one piece of direct evidence indicating a breach of duty of care. The plaintiffs may not be interested to pursue their claims until the final stage. Instead, they may use court actions as a strategy for negotiating out-of-court settlements with defendant doctors whose reputation may have been adversely affected by the litigation. The High Court may or may not have the opportunity to revisit the lacunae under the common law element in \textit{Dobler}. This is dependent on the accident of litigation. On this basis, it is suggested that substituting the common law for the modified \textit{Bolam} test is the more holistic approach to address the ambiguity in the present legal position once and for all.

The proposal for a standalone statutory test may, however, create rigidity in the determination of the standard of care in medical diagnosis and treatment. The inflexibility of the statutory regime may prevent judges from “moulding” the principle to suit the advancement of medical science and the

\textsuperscript{88} \textit{Bolitho v City and Hackney Health Authority} [1998] AC 232 at 242.

\textsuperscript{89} \textit{Bolitho v City and Hackney Health Authority} [1998] AC 232 at 243; Ipp Report, n 44 at [3.20].


\textsuperscript{91} Ipp Report, n 44 at [3.17].
changing ethical and societal values. Judges may also be unnecessarily bound by the theoretical and practical issues concerning statutory scope and interpretation. There are also concerns that the modified Bolam test might have been implemented at the expense of creating “arbitrary and dogmatic” boundaries within the statutory regime. The introduction of the provisos under the modified Bolam test may support this argument. For reasons only known to the legislature, the requirement of “logical basis” under the English Bolitho principle has been replaced with “irrational” and “unreasonable” provisos, both of which are to be judged against the broad notion of “community expectation”. There has also been overwhelming criticism that the implementation of the modified Bolam test was a political mechanism to protect doctors and to provide a short-term solution to the medical indemnity crisis in Australia, with the ramification of setting the bar too low for defendant doctors.

The problems associated with the modified Bolam test may be resolved by reforming its criteria. The modified Bolam test arguably contains two major limitations that need to be addressed. One is that the test overly protects the medical profession at the expense of injured patients. It does not provide for an in-depth judicial analysis of the bases of expert medical opinion, placing emphasis on the quantity of expert medical opinion, rather than the quality of this opinion. Moreover, the authority of the court to reject expert medical opinion is limited as situations in which expert medical opinion may be ruled “irrational” or “unreasonable” would be rare. The implication of this is that defendant doctors would most likely be exonerated from liability for negligence. It is suggested that the objective of the law reform should not be based on the basis of “limiting liability” of doctors, given that the correlation between the law on the standard of care and the medical indemnity crisis has not been proven. Instead, the legislative changes should have been structured on the rationale for enhancing the quality of health service in Australia and creating a standard of medical care that takes into account the interests of patients and doctors. On this basis, it is proposed that the restrictions on judicial rejection of expert medical opinion attached to the provisos should be removed. This recommendation would ensure that all expert medical opinion adduced by parties in medical negligence disputes be scrutinised by the court on an equal footing.

The other weakness of the test concerns the role of the court under the provisos. The requirement for the court to consider the notion of “community expectation” under the provisos is arguably vague and ambiguous. It is unclear whether judges should take into account the interests of parties who are not directly involved in medical disputes, say the insurers or the Australian public generally. In common law, it is a rarity for judges to consider the interests of those who are not parties to the disputes before them. The Hon Michael McHugh, a former judge of the High Court of Australia, has extra-curially commented that the open-ended notion of “community expectation” might require judges to consider the concerns of those who do not have direct interest in medical disputes, for instance, the insurers. This comment might be helpful. However, the better view is that only the interests of those who are directly involved in medical negligence disputes should be taken into account, or it risks creating unfairness for the affected parties.

The role of the court could be more effectively discharged if an unambiguous and flexible mechanism for evaluating expert medical opinion is included in the provisos. The current
interpretations of the provisos arguably could not achieve these results. The “irrational” proviso, for
instance, has been interpreted to encompass either of these meanings, namely “illogical, unreasonable
or based on irrelevant considerations”, or unreasonable. These interpretations, however, fall short
of providing a clear methodology to assist judicial evaluation of expert medical opinion. The
preferable approach is not to attribute any meanings to the provisos or it may create disputes over their
dictionary definitions. Instead, the court should be given guidance on how to apply the provisos.

The court could examine expert medical opinion based on two main aspects, namely the
reasonableness of precautionary measures and the defensibility of the risk and benefit analysis of any
medical procedure or treatment. The former is an extension of the principle in Shirt to medical
diagnosis and treatment, presently applied to examine whether plaintiff patients have proved a breach
of duty of care. The assessing requirements for the reasonableness of precautionary measures in Shirt
have been modified and codified in the States’ Civil Liability Acts. The latter is an elaboration of
the “logical basis” test enunciated in Bolitho. Both are common benchmarks in medical practice and
could be applied collectively to scrutinise expert medical opinion in all negligent diagnosis and
treatment cases. The onus of proof under the proposed modified Bolam test should rest with
plaintiff patients. They must satisfy the court that the act or omission in question does not comply with
the mainstream practice of the medical profession, and that the supporting expert medical opinion is
irrational or unreasonable. If the court considers that the plaintiffs have proved their claims, the onus
then shifts to the defendant doctors to prove otherwise. The court may prefer the expert medical
opinion of one party to that of another having considered the weight of the evidence.

CONCLUSION

The main objectives of this article have been to provide a critique on the legislative reform relating to
the modified Bolam test and to recommend a more appropriate way of implementing the statutory test.
Case law development has indicated that the test modifies the common law rather than replacing the
latter outright. The common law standard of medical care in Australia has a long history tracing back
to the English Bolam test, which has evolved for more than 100 years. Substituting the modified
Bolam test completely would mean taking away the flexibility and the historical development that the
common law has to offer. Thus, the present judicial interpretation may be seen as providing a balance
between the operation of the common law and the statutory modified Bolam test in the adjudication of
the standard of care in medical diagnosis and treatment in Australia.

It has been argued that the modified Bolam test could operate on its own effectively without
forming part of the common law. The adoption of the Bolitho principle in the United Kingdom as a
standalone test may support this view. The major difference between the two is that the British version
is solely under the realm of common law. While the common law standard of care in medical
diagnosis and treatment in Australia consists of shortcomings, there is a lack of empirical studies
attributing the law to the crisis. Arguably, the main rationale for spearheading the legislative reform,
namely to reduce liability of doctors in Australia, was untenable. The implementation of the present
version of the modified Bolam test may alleviate another wave of medical indemnity crisis in

100 See Mazzar Webb [2011] QSC 163 at [40]-[46].
101 See n 80.
102 Interview with Dr Albert Erasmus, neurosurgeon and former director of the Neurosurgical Department, Royal Hobart
Hospital, Tasmania (21 November 2013).
103 See, for example, Giles JA in Dobler v Halverson (2007) 70 NSWLR 151 at [103], although his Honour stated this principle
in the context of the modified Bolam test serving as a defence.
104 The development of the Bolam test could be traced back to two 19th century English cases: Lanphier v Phipos (1838) 8 Car &
P 475 at 479; 173 ER 581 at 583 and Rich v Pierpoint [1862] 3 F & F 35 at 35; (1862) 176 ER 16 at 16-17. Lanphier
established the general principle that negligence in the medical context is evaluated with the standard of reasonable care and
skill, not the highest professional skills. This threshold standard, Rich held, is satisfied by reference to what an ordinary
competent doctor would or would not have done in the circumstances.
Australia. However, the test might have been adopted at the expense of enhancing the quality of health care service in Australia due to its protective nature in favour of the medical profession.

This article argued for a more considered and comprehensive modified Bolam test with a view to addressing the shortcomings of the common law, implementing it as a standalone principle, and improving the delivery of health service in Australia in the long run. The current version of the modified Bolam test is devoid of a clear guideline for judicial intervention and unduly restricts the court’s authority to reject expert medical opinion. The proposed reforms comprise of two main parts. One is to remove the constraints relating to the court’s authority to disregard expert medical opinion. The other is to specify the benchmarks upon which judges may scrutinise expert medical opinion under the provisos and to provide a clear guidance on how these matters may be adjudicated. This latter proposal may enhance the quality of judicial scrutiny and achieve consistency in the outcomes of medical disputes. The implementation of these proposed reforms calls for political will and requires co-ordination as well as consultation among the State jurisdictions to achieve uniformity in those changes. In the event that the States were to implement this significant law reform as recommended, it would be appropriate for the Australian Territories to legislate the proposed modified Bolam test. A single legislatively enacted modified Bolam test that is well-structured and considered may benefit litigants and judges and lead to the long-term improvement of the standard of medical care in Australia.