GREENWAY CHAMBERS

HICKSONS HEALTH LAW FORUM 2018

SECTION 5O OF THE *CIVIL LIABILITY ACT 2002* (NSW)

HOW SHOULD CLINICIANS AND HOSPITALS RESPOND TO THE EXISTING LEGALLY UNCERTAIN APPROACH TO 'COMPETENT PROFESSIONAL PRACTICE'?

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THE CURRENT APPROACH TO SECTION 5O

INTRODUCTION

1. To understand how s 5O the *Civil Liability Act 2002* (NSW) (**the Act**) works, one needs to have an appreciation of two preliminary matters.

   - The evolution of the term 'competent professional practice' as presently formulated; and
   - How the term 'competent professional practice' is presently interpreted.

2. Section 5O of the Act commenced on 6 December 2002.[1] It provides:

> **5O Standard of Care for Professionals**
>
> (1) A person practising a profession (**"a professional"**) does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.
>
> (2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.
>
> (3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.
>
> (4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.

EVOLUTION OF THE TERM 'COMPETENT PROFESSIONAL PRACTICE'

i. Ancient history

3. In 1856 Baron Alderson was responsible for the classic formulation of negligence:[2]

> Negligence is the omission to do something which the reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do.

[1] *Civil Liability Amendment (Personal Responsibility) Act 2002* (NSW).
[2] *Blyth v Birmingham Waterworks Company* (1856) 156 ER 1047 at 1049.

4. The modern common law of negligence, including medical negligence, has its genesis in the decision of *Donoghue v Stevenson*[3] in 1932 and Lord Atkin's famous speech:[4]

> You must take reasonable care to avoid acts and omissions which you can reasonably foresee would be likely to injure your neighbour. Who the, in law, is [your] neighbour? The answer seems to be persons who are so closely and directly affected by [your] act that [you] ought reasonably to have them in contemplation when [you] are directing [your] mind to the acts or omissions which are called into question.

5. In practice, Lord Atkin's formulation resulted in the tort of negligence requiring three things to be established by a plaintiff:

- That the defendant owed to the plaintiff a duty to take reasonable care at the time of the alleged negligent conduct;
- That the defendant had breached the duty owed to the plaintiff; and
- That the plaintiff suffered damage as a result of the defendant's breach (provided the damage was not too remote).

6. Significantly, the Court was careful to state that the effect of the formulation was not to result in any guarantee of safety.[5]

ii. Modern history

7. By 1992, however, some argued that the law in Australia was slowly wending its way toward a guarantee.

8. In *Rogers v Whitaker* the High Court of Australia took the approach that it was a matter for the courts, not the medical profession, to determine whether a professional person was in breach of a requisite standard of care, namely: [6]

> . . . that of the ordinary skilled person exercising and professing to have that special skill.

9. In arriving at this approach the High Court of Australia took a different path to the law as it had developed in England. That is, the High Court had rejected the '*Bolam* principle'. In short, in *Bolam v Friern Hospital Management Committee* the House of Lords held that a medical practitioner was not negligent as he had acted in accordance with a practice accepted as proper by a "reasonable body of medical men skilled in that particular art".[7] That is to say, the House of Lords determined liability on the basis of what the medical

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[3] [1932] AC 562.
[4] *Donoghue v Stevenson* at 580 per Lord Atkin.
[5] *Donoghue v Stevenson* at 612 per McMillan LJ, and 569 per Atkin LJ.
[6] *Rogers v Whitaker* (1992) 175 CLR 479 at 483.
[7] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 per McNair J at 587.

profession (not the court) considered to be the standard of proper professional practice.

10. Lord Scarman subsequently described the *Bolam* principle as:[8]

> . . . a rule that a doctor is not negligent if he acts in accordance the practice accepted at the time as proper by a reasonable body of medical opinion even though other doctors adopt different practice. In short, the law imposes the duty of care, but the standard of care is a matter of medical judgment.

11. In rejecting the *Bolam* principle the High Court in Australia in *Rogers v Whitaker* stated that while acceptable medical practice is a useful guide for the court it is for the court to adjudicate as to what is an appropriate standard of care.[9]

iii. Reform of the law

12. In July 2002 all Australian governments convened a review of the law of negligence, including the law relating to the standard of care required of professionals. The Panel undertaking the review became known as the Ipp Committee.

13. The recommendation the Ipp Committee made in relation to medical professionals propounded what the Committee described as a "modified version" of the *Bolam* principle:[10]

> In the Proposed Act, the test for determining the standard of care in cases in which a medical practitioner is alleged to have been negligent in providing treatment to a patient should be:
>
> > A medical practitioner is not negligent if the treatment provided was in accordance with an opinion widely held by a significant number of respected practitioners in the field, unless the court considers that the opinion was irrational.

14. For the purposes of the law generally, s 5O is not confined to medical negligence. It is not even confined to common law claims in tort. The definitions provisions of the Act including s 5A have result that the provisions of Part 1A including s 5O will apply to any claim for economic loss alleged to result from a failure to exercise reasonable care and skill, whether brought in tort, in contract, under statute or otherwise.[11]

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[8] *Sidaway v Board of Governors Bethlem Hospital* [1985] AC 871 at 6.
[9] *Rogers v Whitaker* at [487] per Mason CJ, Brennan, Dawson, Toohey and McHugh JJ.
[10] Negligence Review Panel, *Review of the law of Negligence,* Final Report (September 2002).
[11] Section 5A of the Act.

CIVIL LIABILITY ACT 2002 (NSW)

i. Who is a professional?

15. The opening words of s 5O(1) refer to a "person practising a profession (**a professional**)".

16. In the context of persons working in the medical setting one can confidently say that medical practitioners and nurses (whether registered nurses, registered midwives or enrolled nurses) are professionals.

17. But who else might be a 'person practising a profession'? Usually, a profession requires minimum educational and other qualifications. Typically, professions have colleges, guilds or associations. Likewise, practitioners are required to be registered and their conduct is regulated by statute.

18. Applying these and other like touchstones, there is likely little dispute that allied health and related professions are also reasonably considered to be 'professionals'. For example, physiotherapists, speech pathologists, occupational therapists, social workers, radiographers, and so on would all be considered in the course of their ordinary daily work to be engaged in professional practice.

ii. What is 'professional practice'? – (the tricky bit)

19. Having determined whether the defendant is a person 'practising a profession' s 5O requires determination of whether a person is engaged in a 'professional practice'. The meaning of this fundamental part of the section remains unresolved.

a. Dobler v Halverson

20. The decision in *Dobler v Halverson*[12] set out three relevant considerations.

21. First, it made it clear that s 5O was intended to introduce, and modify, the *Bolam* principle. The importance of s 5O lay in who was to determine the standard of care that should be provided by a professional. In essence, the court in *Dobler v Halverson* stated that s 5O had the effect that if the defendant's conduct accorded with the professional practice of that person's peers as competent professional practice then, subject to rationality (discussed below) that professional practice set the standard of care for the professional defendant.

22. Secondly, a finding regarding the relevant standard of care is to be determined by the court but with guidance from evidence of accepted professional practice

[12] (2007) 70 NSWLR 151.

that the defendant acted according to professional practice widely accepted by peer professional opinion.

23. Thirdly, s 5O operates differently to other defences available under the Act. In the case of other defences under the Act,[13] a defence is invoked only after a finding of negligence. In contrast, when invoking the defence under s 5O a court determines the issues raised under that section without regard to any application of s 5B and consideration of whether the professional has been negligent in failing to discharge a duty of care owed to a patient.

24. The distinction is helpfully explained by Simpson JA (underlining added):[14]

> Whether [the defendant] acted in accordance with widely accepted peer professional practice is a question of fact; it is not a question of the kind referred to in *Rogers v Whitaker* and *Rosenberg v Percival*, involving determination of whether a medical practitioner failed to conform to standards of the ordinary skilled medical practitioner (in this case, practising as an anaesthetist). Under s 5O, the task of the court is not to evaluate the merits of the competing views (if there is evidence competing views) but to determine whether, as a factual matter, the service had the acceptance of peer opinion, even if other peer opinion was different.

25. It should be noted that the descriptor of s 5O being a defence is not strictly correct. Notwithstanding the section is referred to in such terms judicially,[15] s 5O is not a defence. Rather, it is a provision that goes to determining the standard applicable to the determination of breach. Properly, a defence arises where liability (breach and causation) has been made out. In contrast, s 5O does its work before breach is determined.

26. In *Sparks v Hobson* the point is made by Basten JA that the characterisation of s 5O as a defence is problematic because one normally does not consider a defence until negligence has been made out. As referred to above, this is not the case. Rather, s 5O sets the standard by which breach is determined. If the standard is met it follows that the conduct was not negligent.[16]

b. McKenna v Hunter & New England Local Health District

27. In *McKenna v Hunter & New England Local Health District* the question of what is a 'professional practice' was parsed further. As Macfarlan JA stated (emphasis in the original):[17]

[13] Eg. s 43A relating to public authorities exercising statutory functions.
[14] *Sparks v Hobson; Gray v Hobson* [2018] NSWCA 29 at [345].
[15] Eg. *McKenna v Hunter & New England Local Health District; Simon v Hunter & New England Local Health District* [2013] NSWCA 476, per Macfarlan JA at [160].
[16] *Sparks v Hobson* at [17].
[17] *McKenna* at [160].

> To establish a defence under s 5O a medical practitioner needs to demonstrate, first, that what he or she did conformed with a *practice* that was in existence at the time the medical service was provided and, secondly, to establish that that *practice* was widely, although not necessarily universally, accepted by peer professional opinion as competent professional practice.

28. The Court of Appeal held that for s 5O to be invoked, a practice applicable to the circumstances of the case had to be made out. That is, the circumstances of the matter before a court has to have sufficient features in common with other cases to enable it to be said that there was 'a practice' concerning how such a situation was dealt with a competent peer professional.

29. For example, prior to surgical procedures an anaesthetist typically makes enquiry of a patient's age, height, weight, current medications, relevant conditions such a sleep apnoea, previous anaesthetic history, and so on, in order that the anaesthetist can determine the most appropriate and safe approach to, and method of, the sedation and intubation of the particular patient. Such conduct is a professional practice in anaesthetics.

30. Likewise, there is a professional practice in nursing that medications are obtained, drawn up, disposed of, and administered in company of a nursing colleague to ensure, *inter alia*, that the order is correctly carried out to the right patient, drug, dose, route and frequency is achieved. Typically, such matters of practice are not in issue.

31. Often, however, in the course of carrying out one's profession there can be many features of providing care which are unique or unusual such that it cannot be said that the conduct of the professional was consistent with 'a practice' of that profession.

32. The circumstances of *McKenna* was one such case. The defendant's employed psychiatrist discharged a psychiatric patient into the care of the patient's friend who was later killed by the patient on the journey home. The Court of Appeal determined that in light of the wide variety of circumstances bearing upon the decision to discharge a patient it would be surprising that any practice could be identified.

33. The Court noted the distinction between the circumstances arising in *McKenna* and other circumstances in which warnings might be given about certain procedures, circumstances in which operations might be performed, the types of treatments that might be administered or the circumstances in which tests might be ordered.

34. The High Court considered an appeal from *McKenna* but found it unnecessary to deal with the Court of Appeal's finding on s 5O.

c. Sparks v Hobson

35. On 1 March 2018 the Court of Appeal delivered judgment in *Sparks v Hobson; Gray v Hobson*.[18] The decision involved appeals brought by a surgeon (Dr Gray) and an anaesthetist (Dr Sparks) against findings at trial that each was negligent. The appeal by the surgeon, Dr Gray, was upheld unanimously. The appeal by Dr Sparks was dismissed by majority (Macfarlan, Simpson JJA; dissenting Basten JA).

36. The facts are complex. Put simply, the plaintiff suffered from a rare genetic disorder (Noonan's Syndrome) that caused spinal curvature and resulting compression of his chest. Ultimately, ICU intensivists determined that they could no longer properly ventilate the plaintiff without surgery. The first of two planned surgeries was undertaken in an attempt to correct the spinal condition so as to allow oxygenation of the plaintiff's lungs to occur. There was no issue that it was likely that plaintiff would die without the planned surgery.

37. Unfortunately, the plaintiff suffered a spinal cord stroke during the course of the surgery. The sole breach found by the trial judge was that in response to deteriorating metabolic factors during the surgery (principally oxygen saturation and blood pressure), the surgery should have been terminated earlier than in fact occurred.

38. In his defence, Dr Sparks relied, *inter alia*, on s 5O in contending that the continuing the surgery to a particular point in time was consistent with acting in a manner that was widely accepted by peer professional opinion in Australia at that time to be competent professional practice.

39. Dr Sparks (and Dr Gray) called expert evidence from anaesthetists in support of their contention. Ultimately, the evidence of the expert anaesthetics was unchallenged to the effect that in the circumstances which confronted Dr Sparks, Dr Sparks conducted himself in a manner which his professional peers regarded as consistent with competent professional practice.

40. In his judgment, Macfarlan JA reiterated the approach he took in *McKenna* to the question of what is 'a practice'. That is, where an expert said no more than that a professional's conduct was reasonable in a way that would be widely regarded as acceptable without pointing to any particular practice, such statement by the expert is insufficient to establish the existence of 'a practice' for the purposes of s 5O. On such basis, Macfarlan JA rejected the expert anaesthetic opinions as a basis for relying on s 5O as the standard for determining the conduct of Dr Sparks. In other words, given the exceptional and essentially unique circumstances that confronted Dr Sparks during the subject surgery, s 5O could have no application.

[18] [2018] NSWCA 29.

41. Basten JA (referring to *Dobler*) first of all made it clear that s 5O will be engaged where there is evidence of a widely accepted professional practice supporting the defendant's conduct. Where there is such evidence it will fix the relevant standard.[19] In this respect there is clarity.

42. It is the further view of Basten JA, however, that formulating the language in s 5O to be 'a practice' adopted by a group of professionals as a regular course of conduct adopted in particular circumstances was a risky approach to interpreting the statutory language.

43. In Basten JA's view, the phrase 'competent professional practice' is want to cover the whole gamut of professional services provided by a practitioner whether or not the particular circumstances have arisen sufficiently often to result in an established practice. He refers to a number of reasons why this is so.

44. It is not necessary to deal with his reasoning other than to note that in Basten JA's view, while the language used in *McKenna* (by Macfarlan JA) may well sufficiently describe many circumstances in which s 5O can be invoked, such language is not understood as a general proposition as to the constraints imposed by s 5O(1).[20]

45. On the question of s 5O, Simpson JA (who otherwise dissented in the *Sparks* appeal) nevertheless concurred with Macfarlan JA on the s 5O ground. That is, she agreed with Justice Macfarlan that there was no established practice at play to invoke s 5O.

46. In doing so, Simpson JA stated that she understood she was bound by the decision in *McKenna* and the approach taken therein. Otherwise, but for the fact that she felt bound to follow the approach, she considered that the language of s 5O makes it plain that the reference to 'a practice':[21]

> . . . signifies professional practice in a general sense rather than an identifiable, specific and discrete aspect of the profession or method of providing the professional practice.

47. Her Honour explained that the result of the narrow interpretation of 'a practice' (the approach propounded in *McKenna* per Macfarlan JA) is twofold. One, s 5O can apply in limited circumstance where the defendant can, or seeks to, identify a discrete practice to which he or she conformed. Two, it follows that 'a practice' necessarily excludes unusual factual circumstances such as occurred in *McKenna* or in *Hobson*.

48. As referred to above, while Simpson JA did not agree with this dichotomy, she felt herself constrained to follow the approach in *McKenna*. Her Honour's

[19] Ibid at [69].
[20] Ibid at [34].
[21] Ibid at [335].

rationale for preferring the approach of Basten JA rather than the approach of Macfarlan JA was on the basis that, as she understood the section, the task of the court was not to evaluate the merits of competing views (if there were competing views) but to determine whether, as a factual matter, the service had the acceptance of peer opinion even if other peer opinion was different.[22]

d. South Western Sydney Local Health District v Gould

49. On 13 April 2018 the Court of Appeal handed down the decision in *South Western Sydney Local Health District v Gould.*[23] In *Gould* the treating hand surgeon under whose care the young plaintiff was admitted to hospital for treatment of a severe and complex fracture of the left thumb, gave evidence as to his decision to proceed with a particular antibiotic regime. The evidence the surgeon gave was given expressly as a matter of fact rather than as a matter of opinion.

50. It was a specialist's evidence that on the basis of the understood facts of the presentation of the patient and Dr Scott's experience at eight other hospitals in the State a particular antibiotic regime was adopted. His evidence was uncontradicted as to the standard antibiotic treatment for wounds of this kind in those other hospitals. The evidence in the case was that the antibiotic regime administered was consistent with the Therapeutic Guidelines – Antibiotic, 14th Edition.

51. It is convenient to divide consideration of the decision in Gould into two areas.

Section 5O – Irrationality

52. In *Gould* the Court of Appeal for the first time considered s 5O(2):[24]

> However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.

53. Following *Gould* it would seem that circumstances giving rise to invoking the operation of s 5O(2) would be very rare indeed.

54. The trial judge rejected expert opinion of a microbiologist and a hand surgeon as to whether or not the antibiotic regime was 'competent professional practice' on the basis that both opinions were 'irrational' within the meaning of that term in s 5O(2).

55. In the view of Leeming JA (Basten and Meagher JJ agreeing) it is a "seriously pejorative and exceptional thing to find that a professional person has expressed an opinion that is "irrational".[25] On this aspect of the appeal,

[22] Ibid at [345].
[23] [2018] NSWCA 69.
[24] Ibid at [29].
[25] Ibid at [96].

Basten JA added that peer professional opinion will only be rejected "if the court can, on the evidence, be satisfied that there is *no* rational basis for it".[26] The evidential onus for rejection rests on the plaintiff.[27]

56. The expert opinion relied upon by the defendant cannot be rejected on the basis that it is 'irrational' merely because it does not articulate the reasoning process leading to conclusions of opinions set out in the report. A failure to set out the facts upon which the opinion is based may be grounds for objection as to the admissibility of the report but it is not a basis for finding that the report is 'irrational'.

57. In any event, and contrary to the plaintiff's case, the expert opinion in *Gould* was to the effect that a particular drug, Gentamycin, need not, or even should not, have been administered to the plaintiff consistent with the *Therapeutic Guidelines – Antibiotic, 14th Edition*.

Professional practice

58. To the extent that the position was unclear, Leeming JA (Basten and Meagher JJA agreeing) made it plain that the primary judge had erred in failing to determine the standard of care by reference to the evidence of what was regarded by peer professional opinion as competent professional practice. In other words, the effect of s 5O, where preconditions of a practice referred to above have been met, is to place the standard of care against which breach is to be assessed. That is, there is no occasion to compare the s 5O standard with that which would be considered in the application of s 5B.

59. The defendant bears the onus of establishing the preconditions:

- That the defendant was 'practising a profession'; and
- Was doing so in a manner that ". . . was widely accepted in Australia by peer professional opinion as competent professional practice".

60. If the preconditions are not established then liability falls to be determined in accordance with s 5B and s 5C of the Act.[28] Separate considerations under s 5B and s 5C followed by consideration of s 5O will lead to error.

61. As Leeming JA notes, the question of what in fact is a standard practice of professional peers throughout Australia is, at least in part, a question of fact in some cases the distinction between an opinion and fact might be difficult to draw. In *Gould* the evidence of the treating surgeon as to the antibiotic regime did not fall into this category. Rather, the evidence was entirely factual. The evidence was squarely relevant to: One, the issue of whether the practice was

[26] Ibid at [6] (emphasis per Basten JA).
[27] Ibid at [7].
[28] *Gould* at [123]-[124].

widespread in Australia; and two, whether the practice was irrational. The trial judge's failure to consider (or even refer to) the surgeon' s evidence was an error.

e. 14 September 2018 – Special leave refused in Sparks v Hobson

62. On 14 September 2018, the High Court refused an application brought by Dr Sparks for special leave to appeal from the decision of the NSW Court of Appeal. The special leave point prosecuted was the need to determine the difficulty wrought by the competing approaches to the interpretation of s 5O by NSW Court of Appeal in *McKenna* and *Sparks*.

63. The respondent on the special leave application did not dispute that the issue was a matter of sufficient importance to satisfy the granting of special leave. On the application, however, the respondent did put in issue whether the matter was a suitable vehicle for such leave.

64. Special leave was refused. In short, leave was not granted. In refusing leave, Bell and Gordon JJ referred to the manner in which the matter was conducted at first instance and on appeal.

WHERE TO NOW?

65. Relying on s 5O is a two-step approach; One, pleading the section; and two, proving the pleading.

i. Pleading the section

66. The first point to make is that to rely on s 5O it must be pleaded.

67. The rationale for the requirement that the section be pleaded was made clear in *Sydney South West Area Health Service v MD*.[29] As Allsop P explained: [30]

> It is not just a matter of evidence. It transfers, to a degree, the onus of proof. It transforms what would otherwise be relevant evidence as to negligence to be weighed by a judge in the familiar calculus into evidence that may be determinative of the appeal.

68. In the same decision Hodgson JA (Allsop P and Sackville JA agreeing) stated:[31]

> . . . in my opinion the material facts contemplated by s5O should be pleaded in a defence . . .

69. That is, as referred to above, the pleading is a formal statement by the defendant that the duty should be determined in accordance with s 5O and not s 5B. Of course, while the section is pleaded in the formal defence, the section

[29] [2009] NSWCA 343.
[30] Ibid at [51].
[31] Ibid at [23].

is not a defence *per se* to a cause of action. Rather, if enlivened, it is the standard by which breach is to be determined.

70. Arguably, merely restating the words of the section may be inadequate. When pleading s 5O it may be prudent to provide a sufficient articulation of the defendant's manner of practice in the particular case and/or an articulation of the competent professional practice being relied on to invoke the section. That is, the context may need to be pleaded.

71. For the sake of abundant prudence, until the issue of what is 'a practice' is settled the pleading might be framed in the following way (to reflect the approach taken by Macfarlan JA in *McKenna*):[32]

> Further, and in the alternative, if, which is denied, s5O requires that the defendant establish that he acted pursuant to a practice that was in existence at the relevant time then the defendant:
>
> i. Says that the manner in which s/he acted accorded with a practice in existence at that time; and
>
> ii. Relies upon the following facts as establishing that practice:
>
> a. . . .

72. The facts pleaded will be informed by the assumptions put to the experts (on the basis that they will be made out) and the opinion of the experts.

ii. Proving the section

73. The first matter to note is that there is no available formulaic approach. And of course, reasonable minds may differ about what constitutes evidence sufficient to invoke the section. So much is clear from the different views expressed in *Hobson* (Basten JA regarded the evidence in Dr Spark's case as insufficient whereas Simpson JA would have regarded as sufficient).

74. That said, there are some propositions which can be stated.

75. Lest there be any doubt, it is not sufficient for a peer expert, no matter how well qualified and eminent, to baldly state that the practice engaged in was widely accepted by the defendant's peers as competent professional practice. Broad assertions are not enough.

76. Rather, an expert must engage with the specific facts giving rise to the claim in negligence. As Basten JA observes, the expert's evidence is more likely to be accepted if the expert grapples with possible conflicting views in a reasoned manner. [33]

[32] Richard Cheney SC, Greenway Chambers.
[33] *Sparks v Hobson* at [88].

77. In practice whether expert medical opinion is readily accepted as an opinion of what is widely held amongst peers as competent professional practice will depend on a range of factors.[34] To improve the prospects of acceptance, the following approach should be considered:

- Setting out the relevant facts of the practice in issue (often done by way of statement of assumptions).
- A statement from the relevant clinician as to the clinician's conduct in the subject circumstances.
- A demonstration of the expert's experience consistent with the assumptions and/or the clinician's statement.
- The extent to which peer reviewed journal articles or other publications, conferences and symposiums, advisory committees, policies, guidelines and so on reflect the asserted widely held professional opinion.
- A reasoned explanation as to why what is asserted by a plaintiff is unnecessary or inappropriate or too risky as the case may be.

iii. Going to trial

78. At some point in time in all litigation a forensic decision must be made as to whether a claim is to be defended at trial. Such decision necessarily involves a consideration of the extent to which the defendant can rely on s 5O and, if so, how the necessary elements are going to be proved.

79. In practical terms, decisions need to be made about whether the facts of a practice can be established. This in turn requires consideration as to which clinician/s need to be called and investigation as to the clinician/s availability. Assessment needs to be made as to whether the clinician's evidence is likely to be accepted. Relevant expert peer opinion is required to establish that the defendant was 'practising a profession' and was doing so in a manner that 'was widely accepted in Australia by peer professional opinion as competent professional practice'.

80. Ultimately, going to trial requires significant commitment from defendants, witnesses and legal advisors.

COSTS

81. In *Gould (No 2)* the Court of Appeal considered the question of costs of the proceedings. Specifically, the Court addressed the appellant's application for a

[34] See eg. *Hobson* per Basten JA at [28].

costs order in a specific gross sum.[35] The application was denied. Instead, the usual orders applicable to formal offers of compromise was made.

82. In denying the application for a gross sum order, the Court reiterated the nature of the evidence which must be before the Court before such order could be made.[36] In short there must be evidence of:

- The likely amount of the costs recovered on assessment.
- Costs incurred before the date of the offer of compromise and those incurred after the offer of compromise.
- Hourly rates of solicitor and counsel.
- Disbursements.
- Whether the process of assessment would be unusually arduous or time consuming or expensive.

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[35] Pursuant to s 98(4) of the *Civil Procedure Act 2005* (NSW).
[36] *South Western Sydney Local Health District v Gould (No 2)* [2018] NSWCA 160 at [10]-[12].