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The Professional Standard of Care in the Republic of Ireland and the United Kingdom

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Abstract: This article discusses the rules applied by the courts in the Republic of Ireland and the United Kingdom in determining whether the defendant in a negligence action attained the required standard of care in performing a professional task. It will discuss the effect of the defendant's adherence to a practice widely accepted in the relevant profession at the time, and the effect of expert witnesses testifying that they regard the defendant's conduct as proper. This article also discusses the different rules applying to the provision of certain information by a professional.

I Introduction

A general principle of tort law in European and other legal systems is that a person who negligently causes harm to another must compensate the resulting loss, at least where the harm is bodily injury or damage to property.[1] A key requirement of liability is that the defendant was negligent. This is determined by comparing the defendant's conduct to what a hypothetical person in the same circumstances would have done. Under the law in the United Kingdom,[2] the hypothetical person is gen-

1 See *C van Dam*, European Tort Law (2nd edn 2013) 230ff; *F Ferrari*, Comparative Remarks on Liability for One's Own Acts (1993) Loyola of Los Angeles International and Comparative Law Journal 813. For the jurisdictions discussed in this article, see eg *J Goudkamp*/*D Nolan*, Winfield & Jolowicz on Tort (20th edn 2020) para 5-001ff; *EC Reid*, The Law of Delict in Scotland (2022) para 1.15ff; *BME McMahon*/*W Binchy*, Irish Law of Torts (hereinafter: Irish Law of Torts) (4th edn 2013) para 5.01ff.

2 The United Kingdom has three jurisdictions with their own legal system: England and Wales, Northern Ireland and Scotland. The rules discussed in this article are practically identical in the three legal systems. For convenience, this article refers to the three legal systems as 'UK law'.

Note: I would like to thank the anonymous reviewer for helpful comments. Any error is mine.

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erally the ordinary reasonable person,[3] often described as the person on the Clapham omnibus (Clapham being a suburb of London).[4]

A defendant who was exercising some special skill or competence (such as performing a surgery) will not be judged against the skills of the ordinary person (the person on the Clapham omnibus) but against a higher standard, which has been expressed as the skill of an ordinary competent member of the profession in UK law,[5] and as the skill of a reasonable member of the profession in Irish law.[6]

If the issue is contested, the court will have to decide whether the defendant attained the relevant standard of care. Where the defendant's conduct involved no special skill, judges are able to make that decision based on their own knowledge and experience. For example, judges need no assistance in deciding whether the defendant's manner of riding a bicycle was in accordance with the standard of a reasonable person. The actual behaviour of people will be relevant. It will be of substantial weight if what the defendant did is commonly done by others in similar circumstances.[7] But such a fact is not conclusive, since the court may regard the whole practice as negligent.[8] Nor would a court hear witness testimony on what reasonable people would have done in the circumstances. 'The behaviour of the

3 The classical statement is that of Alderson B in *Blyth v Birmingham Waterworks* (1856) 11 Exchequer Reports (Exch Rep) 781, 784; 156 ER 1047, 1049: 'Negligence is the omission to do something which a 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.'

4 Eg *JD Williams & Co Ltd v Michael Hyde & Associates Ltd* (2001) 3 Technology and Construction Law Reports (TCLR) 1 (CA) 16. The first reported judgment containing the phrase 'the man on the Clapham omnibus' is *McQuire v Western Morning News Co Ltd* [1903] 2 King's Bench (KB) 100 (CA) 109, where Collins MR ascribed the phrase to Lord Bowen. The phrase has also been used in the Republic of Ireland; see eg *Director of Public Prosecutions v Benko* [2021] Irish Court of Appeal (IECA) 143 [41].

5 *Hunter v Hanley* 1955 Session Cases SC 200 (Scotland Court of Session, Inner House – CSIH) 206; *Bolam v Friern Hospital Management Committee* [1957] 1 Weekly Law Reports (WLR) 582, 586; *Whitehouse v Jordan* [1981] 1 WLR 246 (HL) 258 (Lord Edmund-Davies). The same test applies to the performance of a contractual duty of care by a professional; see *First National Commercial Bank plc v Barnet Devanney (Harrow) Ltd* [1999] Commercial Law Cases (CLC) 11, 14–15. See *M Cannon*/*H Evans*/ *R Stewart* (eds), Jackson & Powell on Professional Liability (9th edn 2021) (hereinafter: Jackson & Powell) paras 2–175, 2-189ff.

6 *Daniels v Heskin* [1954] Irish Reports (IR) 73 (SC) 79 (Lavery J, with whom Murnaghan and O'Byrne JJ agreed); *O'Donovan v Cork County Council* [1967] IR 173 (SC) 183 (Lavery J); *Morrissey v Health Service Executive* [2020] Supreme Court of Ireland (IESC) 6, [2020] Professional Negligence and Liability Reports (PNLR) 17 [6.6]-[6.7]. See Irish Law of Torts (fn 1) para 14.01ff.

7 *Morton v William Dixon Ltd* (1909) SC 807 (CSIH) 809; *Morris v West Hartlepool Steam Navigation Co Ltd* [1956] Appeal Cases (AC) 552 (House of Lords – HL) 579.

8 *Cavanagh v Ulster Weaving Co Ltd* [1960] AC 145 (HL). See also *Bank of Montreal v Dominion Gresham Guarantee and Casualty Co Ltd* [1930] AC 659 (PC) 666 (Lord Tomlin): 'Neglect of duty does not cease by repetition to be neglect of duty.'

reasonable man is not established by the evidence of witnesses, but by the application of a legal standard by the court'.[9]

Judges do generally need assistance where the defendant was exercising a special skill. In those circumstances, expert witnesses need to explain the relevant scientific matters.[10] They may also testify as to general practices in the relevant profession, and they may express an opinion as to whether they regard the defendant's conduct as proper.

Where expert witnesses testify that the manner in which a professional defendant acted is one widely adopted in the relevant profession, or that they regard the defendant's conduct as proper, the question arises as to whether it is still open to the court to find that the defendant was negligent. In the legal systems of Continental Europe, it is firmly established that the courts are the final arbiter of whether a professional exercised the appropriate standard of care.[11] By contrast, in Irish law and UK law, certain expert evidence precludes the court from finding that a professional was negligent.[12] In particular, adherence to a practice widely accepted as proper at the time precludes a finding of professional negligence unless the practice was inherently defective.

This article reviews the principles in Irish law and UK law as to a court's determination of whether a professional attained the applicable standard of care. It will discuss the effect of the defendant's adherence to a practice widely accepted in the relevant profession at the time, and the effect of expert witnesses testifying that they regard the defendant's conduct as proper. This article also discusses the differ-

9 *Healthcare at Home Ltd v Common Services Agency* [2014] United Kingdom Supreme Court (UKSC) 49, 2014 SC 247 [3] (Lord Reed). See also *Davis Contractors Ltd v Fareham Urban District Council* [1956] AC 696 (HL) 728 (Lord Radcliffe): 'the spokesman of the fair and reasonable man, who represents after all no more than the anthropomorphic conception of justice, is and must be the court itself'.

10 In order to be admissible, the expert's opinion must be honestly held and unbiased: *Kennedy v Cordia (Services) LLP* [2016] UKSC 6, 2016 SC 59 [51]–[53]; *O'Leary v Mercy University Hospital Cork Ltd* [2019] IESC 48; *McCulloch v Forth Valley Health Board* [2021] CSIH 21, 2021 Scots Law Times (SLT) 695 [32]. See, generally, *M Tottenham*, The Reliable Expert Witness (2021) 13 ff.

11 See *D Giesen*, Vindicating the Patient's Rights: A Comparative Perspective (1993) 9 Journal of Contemporary Health Law and Policy (J Contemp Health L & Pol) 273, 289 fn 78 (citing cases from Austria, France and Germany); *E Hondius*, The Development of Medical Liability in the Netherlands, in: E Hondius (ed), The Development of Medical Liability (2010) 143 (for Dutch law).

12 Eg *Dunne (an infant) v National Maternity Hospital* [1989] IR 91 (SC) 109 (Finlay CJ: 'An honest difference of opinion between doctors as to which is the better of two ways of treating a patient does not provide any ground for leaving a question to the jury as to whether a person who has followed one course rather than the other has been negligent.'); *Adams v Rhymney Valley District Council* (2001) 33 Housing Law Reports (HLR) 41 [41] (Sir Christopher Staughton: 'the judge or jury have to accept the opinion of a body of responsible practitioners unless it is unreasonable'); *McCulloch v Forth Valley Health Board* [2021] CSIH 21, 2021 SLT 695 [41].

ent principles applying to the provision of certain information by a professional. UK law will be discussed first as it has influenced Irish law.

II The law in the United Kingdom

In UK law, either one of two factors generally precludes a court from finding that a defendant was negligent when engaging in a professional activity: the fact that the defendant was adhering to a practice widely accepted as proper at the time, and testimony of reputable experts that they regard the defendant's conduct as proper. Each general rule has its own specific exception. In addition, neither rule applies to the provision of certain information by a professional. The vast majority of cases in which all these rules were developed involved alleged medical malpractice. However, the rules apply to all professionals. The rules and their exceptions will now be discussed.

A Adherence to a widely accepted practice

1 The general rule (the *Bolam* principle)

A finding of professional negligence is generally precluded where the defendant was adhering to a practice widely accepted as proper at the time.[13] This rule was expressed in *Bolam v Friern Hospital Management Committee*.[14] During electroconvulsive therapy (ECT) treatment at the defendants' mental hospital, the plaintiff sustained fractures of the acetabula. ECT treatment consisted in the passing of an electric current through the patient's brain. If undertaken without the prior administration of a relaxant drug, it results in violent muscular contractions and spasms, with an accompanying slight risk of bone fracture. The doctor treating the plaintiff gave the ECT treatment without a relaxant drug and without applying manual restraints other than to hold the plaintiff's chin and shoulders. In the plaintiff's action for negligence, expert witnesses gave evidence as to their techniques in giving ECT treatment. Some used relaxant drugs, some restraining sheets and some manual restraint, but all agreed that there was a firm body of medical opinion opposed to

13 Jackson & Powell (fn 5) para 2-177ff.

14 [1957] 1 WLR 582. The principle laid down in that case had already been pronounced in *Marshall v Lindsey County Council* [1935] 1 KB 516 (CA) 539–540 (Maugham LJ).

the use of relaxant drugs, and that a number of competent practitioners considered that the less manual restraint there was, the lower the risk of bone fracture.

In his instructions to the jury,[15] McNair J said that a doctor 'is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art', and that 'a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view'.[16] The jury found for the defendants.

McNair J's reference to 'a practice accepted as proper' might be considered ambiguous as to the time at which the practice needs to be accepted. Is it the time of the defendant's allegedly negligent conduct or is it the time of the court proceedings? Subsequent decisions have interpreted McNair J's statement as requiring the practice to have been accepted at the time of the allegedly negligent conduct.[17] For example, Lord Scarman stated in *Sidaway v Board of Governors of the Bethlem Royal Hospital*:[18]

> The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice.

The *Bolam* principle, which has also been accepted in Scots law[19] and the law of Northern Ireland,[20] applies not only to medical professionals but also to other professionals.[21] It does not come into play where the defendant faced a novel scena-

15 Today, in England, juries are no longer used in personal injury cases and are rare in civil cases generally; see Senior Courts Act 1981 (UK) s 69.

16 [1957] 1 WLR 582, 587.

17 That this was in fact McNair J's view is clear from a speech he gave three months before his judgment in *Bolam*: *Justice McNair*, Medical Responsibility in Hospitals (1956) 24 Medico-Legal Journal 129, 133 ('Was the technique in fact adopted one commonly adopted by competent practitioners ... at the material time?').

18 [1985] AC 871 (HL) 881. See also *Nye Saunders & Partners v Bristow* (1987) 37 Building Law Reports (BLR) 92 (CA) 103 (Stephen Brown LJ); *Re F (mental patient: sterilisation)* [1990] 2 AC 1 (CA) 32; *Department of National Heritage v Steensen Varming Mulcahy* (1998) 60 Con LR 33 [122]; *R (on the application of Heather Moor & Edgecomb Ltd) v Financial Ombudsman Service* [2008] England and Wales Court of Appeal (EWCA Civ) 642, [2008] Business Law Reports (Bus LR) 1486 [54], [56].

19 Scots courts usually cite *Bolam* together with the Scots case *Hunter v Hanley* 1955 SC 200 (CSIH) (discussed below); see eg *Moyes v Lothian Health Board* 1990 SLT 444, 449; *Honisz v Lothian Health Board* [2006] Scotland Court of Session, Outer House (CSOH) 24, 2008 SC 235 [37]; *Stevens v Yorkhill NHS Trust* [2006] CSOH 143, 2006 SLT 889 [85]. But they apply the same rules as English courts; see *Reid* (fn 1) para 11.07f.

20 Eg JR55 *v Northern Ireland Commissioner for Complaints* [2014] Northern Ireland Court of Appeal (NICA) 11, [2015] Northern Ireland Law Reports (NI) 97 [22], [32], [61].

21 *Gold v Haringey Health Authority* [1988] Queen's Bench (QB) 481 (CA) 489. See eg *Adams v Rhymney Valley District Council* (2001) 33 Housing Law Reports (HLR) 41 (CA) (selection of window lock design);

rio[22] or made a mistake that even an unskilled person applying due care would not have made.[23] The English Court of Appeal has suggested that the *Bolam* principle is typically appropriate where the defendant made a conscious choice between multiple accepted practices,[24] but the scope of the principle has not been confined to those circumstances.[25]

2 The exception

As an exception to the *Bolam* principle, it is established that adherence to a widely accepted practice does not exculpate a professional if the court takes the view that the practice was unsound. Arguably, the exception was already recognised in *Bolam* itself, where McNair J referred to a 'responsible' body of professionals accepting the practice as proper. This may be understood as leaving it open to the court to regard the acceptance of the practice as irresponsible.[26]

The court's power to reject a widely accepted practice as unsound was firmly recognised by the English Court of Appeal in *Hucks v Cole*.[27] The defendant general practitioner failed to administer penicillin when a laboratory report identified a potentially lethal bacterial infection of the patient. Expert witnesses testified that the defendant's inaction was consistent with the practice of other responsible doctors. The trial judge held the defendant liable in negligence, and the Court of Appeal dismissed the appeal. Sachs LJ said:[28]

Bowen v National Trust for Places of Historic Interest or Natural Beauty [2011] EWHC 1992 (QB) [7] (tree inspection); *Natixis SA v Marex Financial* [2019] EWHC 2549 (Comm), [2019] 2 Lloyd's Rep 431 (document authentication).

22 *AB v Tameside and Glossop Health Authority* [1997] Professional Negligence and Liability Reports (PNLR) 140 (CA) 154. See Jackson & Powell (fn 5) para 2–196.

23 *Royal Brompton Hospital NHS Trust v Hammond (No 6)* (2000) 76 Construction Law Reports (Con LR) 131 [26]; *JD Williams & Co Ltd v Michael Hyde & Associates Ltd* (2001) 3 TCLR 1 (CA) 18.

24 *JD Williams & Co Ltd v Michael Hyde & Associates Ltd* (2001) 3 TCLR 1, 26.

25 See eg *Adams v Rhymney Valley District Council* (2001) 33 Housing Law Reports (HLR) 41 (CA) [43], [59].

26 *JL Montrose,* Is Negligence an Ethical or a Sociological Concept? (1958) 21 Modern Law Review 259, 262.

27 [1993] 4 Medical Law Reports (Med LR) 393. The usual warning given to patients in particular circumstances was considered unsound in *Clarke v Adams* (1950) 94 Scottish Jurist (SJ) 599.

28 [1993] 4 Med LR 393, 397. See also *Nye Saunders & Partners v Bristow* (1987) 37 BLR 92 (CA); *Joyce v Merton Sutton and Wandsworth Health Authority* [1996] Personal Injuries and Quantum Reports (PIQR) P121 (CA) P134; *VG v Kingsmill* [2001] EWCA Civ 934 [65].

> When … a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then … the courts must anxiously examine that lacuna … If the court finds … that … there is no proper basis for the lacuna … its function is to state that fact and where necessary to state that it constitutes negligence.

The Court of Appeal confirmed this rule in *Patel v Daybells*: 'We would unhesitatingly accept the general principle … that conformity to a common (or universal) professional practice is not an automatic defence against liability; the practice must be demonstrably reasonable and responsible if it is to give protection'.[29] There have been further cases in which professional practices were found to be neither reasonable nor responsible.[30]

3 Evaluation

It has been argued that the *Bolam* principle 'involves an abdication by the courts of their responsibility to determine the amount of care that the law requires people to exercise'.[31] Lord Scarman has in fact said that 'the law imposes the duty of care: but the standard of care is a matter of medical judgment'.[32]

These statements imply that it is not open to courts to review a standard of care set by a profession. Attempts might indeed be made to defend such a position with the argument that a frequent finding of professional liability would increase insurance premiums and thus the cost of professional services. However, this additional cost may be outweighed by the additional harm caused by a prevalence of unsafe professional practices.

In any event, the statements neglect the exception to the *Bolam* principle recognised in *Hucks v Cole*. Where the defendant acted in accordance with a widely accepted practice, it is open to the court to characterise the entire practice as unsound and find the defendant liable in negligence. A professional who adopts a proper practice is not negligent, but a professional who adopts an unsound practice is neg-

29 [2001] EWCA Civ 1229, [2002] PNLR 6 [41] (Robert Walker LJ speaking for the Court). The Court also relied on *Bolitho*, discussed below. The Court regarded the practice in question as defensible and denied liability in negligence.

30 Eg *Edward Wong Finance Co Ltd v Johnson Stokes & Master* [1984] AC 296 (PC) (a particular conveyancing practice in Hong Kong); *Newell v Goldenberg* [1995] 6 Med LR 371 (practice of some surgeons performing a vasectomy not to warn patients of risk of vasectomy reversing naturally); *B v IVF Hammersmith Ltd* [2018] EWCA Civ 2803, [2020] QB 93 [58] (fertilisation clinics' practice of leaving it to one of two separated persons to obtain the other person's consent to the thawing of an embryo created by using gametes from both persons).

31 Winfield & Jolowicz (fn 1) para 6–027.

32 *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871 (HL) 881.

ligent. The legal position is not fundamentally different to that in Continental legal systems.[33]

It is true that the UK courts have rarely characterised a medical practice as unsound. But the reason for this is not the lack of power to do so. The reason is a deference of the judges to the medical profession in the second half of the last century.[34] It is the judges' attitude rather than the legal position that created (and perhaps still creates) a difference to the situation in Continental legal systems. A fundamental legal difference between UK law and Continental legal systems is created not by the rule laid down in *Bolam* but by a different rule, which will be discussed next.

B Opinion evidence in favour of the defendant

1 The general rule (the *Maynard* principle)

It is established that a finding of professional negligence is generally precluded not only by expert witnesses testifying that the defendant adopted a practice widely accepted as proper at the time, but also simply by expert witnesses testifying that they regard the defendant's conduct as proper. This rule has sometimes been described as the '*Bolam* test',[35] even though it was not laid down in *Bolam*. It was laid down, without reliance on *Bolam*, by the House of Lords in *Maynard v West Midlands Regional Health Authority*.[36] The defendants, a physician and a surgeon, diagnosed the plaintiff's illness and took the view that, while the most likely diagnosis was tuberculosis, Hodgkin's disease was also a possibility. They decided that, rather than await the result of a sputum test, a mediastinoscopy should be performed to provide them with a biopsy. Even though the operation was performed competently, the plaintiff's left laryngeal recurrent nerve was damaged (an inherent risk of a mediastinoscopy), paralysing the left vocal cord. It was subsequently confirmed that the plaintiff was suffering from tuberculosis and not Hodgkin's disease. The plaintiff sued the defendants, contending that their decision to perform a mediastinoscopy

33 The difference between English law and German law, for example, is a matter of degree; see *M Stauch*, The Law of Medical Negligence in England and Germany: A Comparative Analysis (2008) 45.

34 *H Teff*, The Standard of Care in Medical Negligence – Moving on From *Bolam*? (1998) 18 Oxford Journal of Legal Studies 473, 476; *Lord Woolf*, Are the Courts Excessively Deferential to the Medical Profession? (2001) 9 Medical Law Review 1, 1–2.

35 Eg *J Herring*, Medical Law and Ethics (8th edn 2020) 108. Conversely, *Maynard* has sometimes been cited as authority for *the* exculpating effect of compliance with a widely accepted practice; see eg *Riyad Bank v Ahli United Bank (UK) plc* [2006] EWCA Civ 780, [2006] 2 All England Law Reports (All ER) (Comm) 777 [65].

36 [1984] 1 WLR 634.

rather than await the result of the sputum test had been negligent. At the trial, distinguished expert witnesses approved the defendants' action, whereas another expert witness stated that it had been wrong to perform the mediastinoscopy. The trial judge preferred the evidence of the latter expert and held the defendants liable. The Court of Appeal reversed this decision, and the House of Lords dismissed the appeal.

Lord Scarman, who gave the only reasoned speech, stated that the expert evidence approving of the defendants' actions had prevented the judge from finding negligence:[37]

> It is not enough to show that there is a body of competent professional opinion which considers that their [sic] was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. It is not enough to show that subsequent events show that the operation need never have been performed, if at the time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper.

Lord Scarman did not mention that expert witnesses had testified that the defendants had acted in accordance with a practice accepted as proper at the time. Such testimony had either not been given or was not considered relevant by Lord Scarman. His Lordship's rejection of negligence was based on the mere fact that expert witnesses had regarded the defendants' actions as proper.

Lord Scarman thus laid down that expert testimony approving of a defendant doctor's decision exculpates the doctor.[38] The only authority his Lordship cited[39] in support of this principle is the following statement by Lord President Clyde in the Scottish case *Hunter v Hanley*:[40]

> In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men ... The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care ...

In the first sentence of this passage, Lord President Clyde said that a doctor is not negligent only because another doctor would have acted differently. This is unremarkable. The second sentence is also unremarkable if it proceeds on the basis that the standard of care is set by the courts and not the medical profession. Lord Scar-

37 [1984] 1 WLR 634, 638.

38 This rule may loosely be described as one of evidence, but it is characterised as a rule of substance for choice-of-law purposes; see *Naraji v Shelbourne* [2011] EWHC 3298 (QB) [19]–[24].

39 [1984] 1 WLR 634, 638.

40 1955 SC 200 (CSIH) 204–205. The other Law Lords agreed with Lord President Clyde's judgment.

man in *Maynard* interpreted the second sentence as meaning that as soon as reputable expert witnesses testify that some members of the profession[41] would have acted like the defendant if they had been in the same circumstances, it cannot be said that 'no doctor of ordinary skill' would have done what the defendant did. The principle laid down by Lord Scarman for English law has also been accepted as representing Scots law.[42]

In one case, the English Court of Appeal stated that the *Maynard* principle requires expert evidence as to the presence of a responsible body of opinion or of a recognised practice.[43] In other cases, the same Court held that the two expert witnesses called by the defendant themselves constituted a responsibly body of professional opinion.[44] There have also been cases where opinion evidence by a single expert was considered sufficient for a denial of liability.[45]

The *Maynard* principle, which has also been applied outside the medical context,[46] applies regardless of whether or not there was a standard practice for the activity undertaken by the defendant. Since *Maynard*, there have been cases in which the defendant deviated from an established practice,[47] or there was no established practice,[48] and a claim in negligence was rejected on the ground that expert witnesses testified that the defendant's actions had been proper. This is in stark contrast to the position in Continental legal systems.[49]

The *Maynard* principle makes the *Bolam* principle redundant. A defendant who followed an accepted practice can find reputable peers willing to testify that some members of the profession would have acted in the same way as the defendant did.

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41 Not necessarily the expert witnesses themselves; see *MA Jones*, The Bolam Test and the Responsible Expert (1999) 7 Tort Law Review (Tort L Rev) 226, 235.

42 Eg *Gerrard v Royal Infirmary of Edinburgh NHS Trust* [2005] CSIH 10, 2005 1 SC 192 [77]; *MacLeod's Legal Representatives v Highland Health Board* [2016] CSIH 25, 2016 SC 647 [119]; *McCulloch v Forth Valley Health Board* [2021] CSIH 21, 2021 SLT 695 [41].

43 *JD Williams & Co Ltd v Michael Hyde & Associates Ltd* (2001) 3 TCLR 1, 18.

44 *Ratty v Haringey Health Authority* [1994] 5 Med LR 413, 416; *De Freitas v O'Brien* [1995] PIQR P281, P290-P291. See also *SD v Grampian Health Board* [2022] CSOH 63 [146].

45 Eg *Hughes v Waltham Forest Health Authority* [1991] 2 Med LR 155 (CA); *Abbas v Kenney* [1996] 7 Med LR 47, 57; *Ministry of Justice v Carter* [2010] EWCA Civ 694 [22]; *McCulloch v Forth Valley Health Board* [2021] CSIH 21, 2021 SLT 695 [41].

46 *Calver v Westwood Veterinary Group* [2001] PIQR P11 (CA) (veterinary surgeon).

47 Eg *Gerrard v Royal Infirmary of Edinburgh NHS Trust* [2005] CSIH 10, 2005 1 SC 192 [86]–[87]; *Scott v Lothian University Hospitals NHS Trust* [2006] CSOH 92 [34]–[35].

48 Eg *McCulloch v Forth Valley Health Board* [2021] CSIH 21, 2021 SLT 695 [46]–[47].

49 See *BS Markesinis/J Bell/A Janssen*, Markesinis's German Law of Torts: A Comparative Treatise (5th edn 2019) 140 (for German law); *S Taylor*, The Development of Medical Liability and Accident Compensation in France, in: E Hondius (ed), The Development of Medical Liability (2010) 102f (for French law).

That testimony generally precludes a finding of professional negligence, and it is no longer relevant that the defendant was following an accepted practice.

2 The exception (the *Bolitho* principle)

An exception to the *Maynard* principle was recognised by the House of Lords in an *obiter dictum* in *Bolitho v City and Hackney Health Authority*.[50] A two-year-old boy was admitted to the defendant's hospital suffering from respiratory difficulties. There were two episodes of acute respiratory difficulty, but the doctor in charge, who was called by the nurse, did not attend. Subsequently, the boy suffered a cardiac arrest and sustained severe brain damage. Prophylactic intubation after the second episode of respiratory difficulty would have prevented the cardiac arrest. In an action for negligence, the trial judge found that the doctor's failure to attend on the first two episodes was a breach of duty, but that the doctor would not have intubated the boy even if she had attended. The question was whether it would have been negligent for the doctor not to intubate had she attended the boy. Five expert witnesses reported that, at least after the second episode, any competent doctor would have intubated. Three other expert witnesses said that, based on the boy's symptoms, intubation would not have been appropriate. The judge regarded both views as a responsible body of professional opinion, and held, referring to *Maynard*, that the doctor's decision not to intubate (if she had attended) corresponded to a proper level of skill. Thus, the doctor's failure to attend was not a cause of the cardiac arrest. The Court of Appeal upheld the judge's decision, and the House of Lords dismissed the appeal.

While the House of Lords held that the *Maynard* principle required a rejection of the instant claim, an important limitation on the *Maynard* principle was recognised in an *obiter dictum*. After citing cases such as *Hucks v Cole* (discussed above), Lord Browne-Wilkinson, who gave the only reasoned speech, stated:[51]

> These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence ... In my judgment, that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable and responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion ... But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

50 [1998] AC 232.

51 [1998] AC 232, 243.

His Lordship added: 'I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable'.[52] He went on to explain that the instant case did not fall within the exception to the *Maynard* principle as the view that intubation had not been appropriate in this case could not be dismissed as illogical.[53]

The courts have since expressed their willingness to examine whether expert evidence has a rationally defensible basis,[54] and have sometimes found practitioners negligent despite favourable evidence of eminent expert witnesses, on the ground that the defendant's action involved too high a risk of serious damage.[55] *Bolitho* was also invoked in the case of a failure to diagnose a malignant melanoma, where an expert witness's view that the defendant's error was excusable was rejected on the ground that the view 'proceeds from an application of a lesser standard than that of reasonable skill and care which the law imposes'.[56]

Nevertheless, for the court to be permitted under *Bolitho* to find negligence, it is not sufficient that the court regards the opinion evidence of the claimant's experts as being superior on the merits to that of the defendant's experts. The court must be satisfied that the view of the defendant's experts is illogical.[57] But logic is an unusual criterion for the evaluation of a clinical judgement.[58] There is also an asymmetry. The claimant's experts need to persuade the court that their view is logical and that the view of the defendant's experts is illogical. The defendant's experts only need to persuade the court that their view is logical. They do not need to demonstrate that the view of the claimant's experts is illogical.[59]

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52 [1998] AC 232, 243.

53 [1998] AC 232, 243f.

54 Eg *Wisniewski v Central Manchester Health Authority* [1998] PIQR P324 (CA) P335-P336; *Jones v South Tyneside Health Authority* [2001] EWCA Civ 1701 [25]; *Burne v A* [2006] EWCA Civ 24; *Honisz v Lothian Health Board* [2006] CSOH 24, 2008 SC 235 [39]; *R v Health Service Commissioner* [2008] EWHC 2315 (Admin), [2009] 1 All ER 415 [21].

55 *Marriott v West Midlands Regional Health Authority* [1999] Lloyd's Law Reports Medical (Lloyd's Rep Med) 23 (CA); *Lowe v Havering Hospitals NHS Trust* (2001) 62 Butterworth's Medico-Legal Reports (BMLR) 69; *Smith v Southampton University Hospital NHS Trust* [2007] EWCA Civ 387, (2007) 96 BMLR 79 [44].

56 *Muller v King's College Hospital NHS Foundation Trust* [2017] EWHC 128 (QB), [2017] QB 987 [97]. See also *Penney v East Kent Health Authority* [2000] PNLR 323 (CA) 330f.

57 *Khoo v Gunapathy d/o Muniandy* [2002] Singapore Court of Appeal (SGCA) 25, [2002] 2 Singapore Law Reports (SLR) 414 [65]. Seven factors that the courts have regarded as relevant in this context are identified by *R Mulheron*, Trumping *Bolam*: A Critical Legal Analysis of *Bolitho's* 'Gloss' (2010) 69 Cambridge Law Journal 609, 620ff.

58 *GT Laurie/SHE Harmon/ES Dove*, Mason & McCall Smith's Law & Medical Ethics (11th edn 2019) para 5.46.

59 *Zarb v Odetoyinbo* [2006] EWHC 2880 (QB), (2007) 93 BMLR 166 [33].

3 Evaluation

Expert witnesses provide opinion evidence on facts: the decision is for the court to make.[60] Yet, under the *Maynard* principle, expert testimony that a professional defendant acted competently precludes the court from deciding that the defendant was negligent. This is highly problematic, as it prevents the courts from exercising their constitutional role of ensuring the full and consistent protection of the rights of individuals.[61] The objection might be raised that the *Bolitho* exception restores the right balance. But this is not the case, as it permits the court to disregard opinion evidence in favour of the defendant only where it is illogical. An unreasonable opinion can still be logical.[62] The *Bolitho* exception does not permit a finding of negligence where both sets of expert witnesses give clear and defensible reasons for their opinions.[63] The *Bolitho* exception is not sufficient to remove the constitutional concern of the *Maynard* principle.

Nor are there convincing policy reasons for the *Maynard* principle. Lord Scarman in *Maynard* stated that a court should not choose between competing professional opinions. However, courts are regularly required to choose between differing views of expert witnesses in other contexts, for example, in the content of foreign law to be applied.[64]

It has also been argued that the *Maynard* principle allows different schools of thought and practice to develop within professions.[65] However, there is no evidence that the absence of the *Maynard* principle would stultify innovation. Innovation in the medical and other professions takes place in legal systems in which courts set the professional standard of care. Similarly, the fear that the absence of the *Maynard* principle would create defensive medical practices[66] does not seem to have an empirical basis.[67]

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60 *Davie v Magistrates of Edinburgh* 1953 SC 34 (CSIH) 40; *Dingley v Chief Constable, Strathclyde Police* 2000 SC (HL) 77, 89.

61 *Giesen* (1993) 9 Journal of Contemporary Health Law and Policy (J Contemp Health L & Pol) 273, 289.

62 *Jones* (1999) 7 Tort Law Review (Tort L Rev) 226, 238f.

63 *McCulloch v Forth Valley Health Board* [2021] CSIH 21, 2021 SLT 695 [56].

64 Winfield & Jolowicz (fn 1) para 6–027.

65 *Hughes v Turning Point Scotland* [2019] CSOH 42, 2019 SLT 651 [103].

66 See *E Reid*, *Montgomery v Lanarkshire Health Board* and the Rights of the Reasonable Patient (2015) 19 Edinburgh Law Review (Edin LR) 360, 366.

67 See *G van Dijck*, Should Physicians be Afraid of Tort Claims? Reviewing the Empirical Evidence (2015) 6 Journal of European Tort Law (JETL) 282 (rejecting the existence of defensive medical practice); *P Case*, The Jaded Cliché of 'Defensive Medical Practice' From Magically Convincing to Empirically (Un)Convincing? (2020) 36 Journal of Professional Negligence (Prof Negl) 49 (claiming that any defensive medical practices are not caused by rules of law).

C The duty to warn of risks

In *Bolam* (discussed above), adherence to an established practice was regarded as having an exculpatory effect, not only in relation to the way of conducting the therapy in question, but also as regards the amount of information about the therapy that the doctor should have given the patient before the latter agreed to undergo it.[68] In *Sidaway v Board of Governors of the Bethlem Royal Hospital*,[69] the House of Lords rendered an ambiguous decision on whether a general practice is relevant to a doctor's duty to warn a patient of risks inherent in a proposed treatment.[70] In the Scottish case *Montgomery v Lanarkshire Health Board*,[71] the UK Supreme Court stipulated that neither a general practice nor approving expert opinion has an exculpatory effect in the context of the duty to warn of risks.

In *Montgomery*, the pursuer was pregnant. Because she was diabetic, she was likely to have a large baby, and there was a 9–10 % risk of the baby suffering shoulder dystocia in the course of a vaginal delivery. The pursuer's obstetrician did not inform her of this risk because, in the obstetrician's estimation, the risk of grave problems arising for the baby as a result of shoulder dystocia was very small. During the delivery, shoulder dystocia occurred. The baby was deprived of oxygen and was born with severe disabilities. The pursuer brought an action in negligence, arguing that the obstetrician should have advised her of the risk of shoulder dystocia, in which case she would have opted for a caesarean section. There were two sets of competing expert evidence as to whether the failure to warn of the risk of shoulder dystocia had been proper.

The lower courts held that, because the risk of grave adverse consequences had not been sufficiently high to require a warning regardless of medical practice, the

68 There were other cases in which the *Bolam* principle was applied to the duty to warn of risks; see eg *Gold v Haringey* Health *Authority* [1988] QB 481 (CA); *Moyes v Lothian Health Board* 1990 SLT 444, 449; *Gordon v Wilson* 1992 SLT 849, 852.

69 [1985] AC 871.

70 Lord Scarman regarded a general practice as irrelevant. Lord Diplock regarded it as relevant. Lord Bridge, with whom Lord Keith agreed, regarded it as generally relevant, but recognised a duty to warn of substantial risks of grave adverse consequences irrespective of a general practice. Lord Templeman made no reference to whether a general practice is relevant, implying that it is not. For an analysis of the judgments, see *K Williams*, Pre-Operative Consent and Medical Negligence (1985) 14 Anglo-American Law Review 169.

71 [2015] UKSC 11, [2015] AC 1430. A duty to warn of significant risks, irrespective of any general practice, had already been recognised in *Pearce v United Bristol Healthcare NHS Trust* [1999] European Commercial Cases (ECC) 167 (CA) [21] and – in relation to architects – in *JD Williams & Co Ltd v Michael Hyde & Associates Ltd* (2001) 3 TCLR 1 (CA) 26 f. See also *Chester v Afshar* [2004] UKHL 41, [2005] 1 AC 134 [5], [15]–[16], [92].

presence of expert evidence regarding the failure to warn as appropriate precluded a finding of negligence.[72] The Supreme Court allowed the pursuer's appeal. Lords Kerr and Reid JJSC, with whom the other judges agreed, held that it had been incumbent on the obstetrician to advise the pursuer of the risk of shoulder dystocia inherent in a vaginal delivery of the baby, and to discuss the alternative of a caesarean section.[73]

Lords Kerr and Reid JJSC made the following observations on the law. The doctor-patient relationship has changed in that patients are now widely regarded as persons holding rights rather than passive recipients of medical care.[74] This is reflected in the guidance given to doctors by the General Medical Council, which asks doctors to respect their patients' right to make decisions about their treatment and care.[75] Furthermore, the Human Rights Act 1998 made courts conscious of the extent to which the common law reflects fundamental values.[76] These developments point towards an approach to treating patients as adults who are capable of understanding the uncertainty and risks of medical treatment and who accept responsibility for the taking of risks affecting their lives.[77] Doctors are obliged to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in a proposed treatment, and of alternative forms of treatment.[78] A risk is material if a reasonable person in the patient's position would likely attach significance to it, or if the doctor is, or should be, aware that the particular patient would likely attach significance to it.[79] Responsibility for determining the nature and extent of a person's right rests with the courts, not with the medical profession.[80] In this context, 'the *Bolam* test' has no application.[81]

72 [2010] CSOH 104 [227]–[235]; [2013] CSIH 3, 2013 SC 245 [16]–[30].

73 [2015] UKSC 11, [2015] AC 1430 [94].

74 [2015] UKSC 11, [2015] AC 1430 [75].

75 [2015] UKSC 11, [2015] AC 1430 [77]–[79].

76 [2015] UKSC 11, [2015] AC 1430 [80].

77 [2015] UKSC 11, [2015] AC 1430 [81].

78 [2015] UKSC 11, [2015] AC 1430 [87]. Lords Kerr and Reid JJSC added (at [88]) that a duty to warn of risks does not exist where disclosure would be seriously detrimental to the patient's health (therapeutic privilege) or the patient requires treatment urgently but is unconscious or otherwise unable to make a decision.

79 [2015] UKSC 11, [2015] AC 1430 [87], citing in support *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871 (HL) 889 (Lord Scarman). It is unclear what characteristics of the individual patient (such as the level of education) the reasonable person needs to possess: *Reid* (2015) 19 Edinburgh Law Review (Edin LR) 360, 364f.

80 [2015] UKSC 11, [2015] AC 1430 [83].

81 [2015] UKSC 11, [2015] AC 1430 [84]–[85].

Even though Lords Kerr and Reid JJSC referred to the '*Bolam* test', it is clear that they rejected both the *Bolam* principle and the *Maynard* principle in the context of the duty to warn of risks. Their Lordships took the view that Lord Scarman in *Maynard*, when pronouncing the exculpating effect of expert evidence, had followed the approach adopted in *Bolam*.[82]

The decision in *Montgomery* is to be welcomed. A patient's consent to particular treatment should exclude the doctor's liability in negligence[83] only if the consent was given in the knowledge of all material risks involved in the treatment. The courts should be the final arbiter of whether sufficient information was provided.

Immediately after the decision in *Montgomery*, clinicians in the UK complained that the decision required them to spend more time with patients, thus increasing their already high workloads.[84] This complaint may be justified, but the solution should be an increase in the number of clinicians and not a disregard for the legitimate expectations of patients. Nor should doctors fear that they need to force information upon patients who do not want it or that they now lack any clinical discretion in dealing with vulnerable patients.[85]

It is important to determine the reach of the *Montgomery* principle. It clearly applies to the advice to undergo particular medical treatment. It is also clear that a doctor is obliged to warn not only of material risks that the doctor is aware of but also of material risks that the doctor ought to be aware of.[86] However, the courts have stated that the *Montgomery* principle does not apply to the question of whether a doctor was negligent in not being aware of a particular risk,[87] or in not

82 [2015] UKSC 11, [2015] AC 1430 [39]–[40]. The same view has been expressed in some other cases; see eg *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL) 239.

83 Surgery without the patient's consent or other justification constitutes the tort of battery: see eg *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (HL) 71 (Lord Goff); *Re MB (Medical Treatment)* [1997] 2 Family Law Reports (FLR) 426 (CA) 432. Where the patient consents to a procedure and is at least broadly aware of its nature and purpose, the doctor is not liable in battery, and the (even intentional) non-disclosure of any risk can only lead to liability in negligence; see eg *Chatterton v Gerson* [1981] QB 432, 443; *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871 (HL); *Walsh v Family Planning Services Ltd* [1992] 1 IR 496 (SC) 512, 533.

84 See *JM Laing*, Delivering Informed Consent Post-*Montgomery*: Implications for Medical Practice and Professionalism (2017) 33 Professional Negligence (Prof Negl) 128, 139 f.

85 *AM Farrell*/*M Brazier*, Not So New Directions in the Law of Consent? Examining *Montgomery v Lanarkshire Health Board* (2016) 42 Journal of Medical Ethics 85, 88.

86 *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307, [2018] PIQR P18 [33], [42]. What a reasonable doctor ought to be aware of must depend upon the doctor's specialism. However, it may be negligent for a non-specialist to provide particular advice rather than referring the patient to a specialist.

87 *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307, [2018] PIQR P18 [33], [43]–[44]; *AH v Greater Glasgow Health Board* [2018] CSOH 57, 2018 SLT 535 [55].

presenting alternative treatment to the patient because the doctor believed that it was not indicated in the circumstances of the case.[88]

In *Montgomery* itself, the *Montgomery* principle was applied to the failure to advise of particular treatment (a caesarean section) in the context of a known, but rare risk. In *Webster v Burton Hospitals NHS Foundation Trust*,[89] the English Court of Appeal applied the *Montgomery* principle to an obstetrician's failure to order further ultrasound scans of a pregnant woman, which would have revealed complications and led to the recommendation of induced delivery. The *Montgomery* principle has also been applied to the failure to advise a patient who had undergone a general anaesthetic to look out for early signs of vein thrombosis and pulmonary embolism,[90] to the failure to advise a patient who had a tumour removed that regular CT scans were necessary,[91] and to the failure to advise a pregnant woman of the benefits of screening for Down's syndrome.[92]

The *Montgomery* principle has also been applied outside the medical context.[93] Relying on *Montgomery*, the Northern Ireland Court of Appeal has said that 'a solicitor is bound to take reasonable care to ensure that the client understands the material legal risks that arise in any transaction which the client has asked the solicitor to handle on his behalf'.[94] In *O'Hare v Coutts & Co*,[95] the principle was applied to investment advice by a financial adviser. However, in *Barker v Baxendale Walker Solicitors*,[96] the English Court of Appeal regarded the *Montgomery* principle inapplicable to a solicitor advising on the efficacy of a tax avoidance scheme, on the ground that 'legal service was the very service which was being provided and which was being relied upon. There can be no separation between the advice and any

88 *AH v Greater Glasgow Health Board* [2018] CSOH 57, 2018 SLT 535 [41]–[45]; *McCulloch v Forth Valley Health Board* [2021] CSIH 21, 2021 SLT 695 [40]. This may conflict with the statement in *Montgomery* that a doctor must ensure that the patient is aware 'of any reasonable alternative or variant treatments': [2015] UKSC 11, [2015] AC 1430 [87] (Lords Kerr and Reed JJSC).

89 [2017] EWCA Civ 62, [2017] Med LR 113.

90 *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058 (QB).

91 *Gallardo v Imperial College Healthcare NHS Trust* [2017] EWHC 3147 (QB), [2018] PIQR P6.

92 *Mordel v Royal Berkshire NHS Foundation Trust* [2019] EWHC 2591 (QB), (2020) 172 BMLR 106.

93 For criticism, see Jackson & Powell (fn 5) para 2–188; *V Ooi*, 'Decisional' and 'Operational' Negligence (2018) 34 Prof Negl 171.

94 *Baird v Hastings* [2015] NICA 22 [34] (Girvan LJ speaking for the Court), where the Court added that 'the test of materiality is whether a reasonable client would be likely to attach significance to the risks arising which should be reasonably foreseeable to the competent solicitor'.

95 [2016] EWHC 2224 (QB) [202]–[208].

96 [2017] EWCA Civ 2056, [2018] 1 WLR 1905.

appropriate caveats as to risk'.[97] The Court left open whether the approach taken in *O'Hare v Coutts & Co* had been correct.[98]

The cases do not provide a clear picture as to the scope of the *Montgomery* principle. The Supreme Court in *Montgomery* enunciated the principle in relation to consent to medical treatment, and the Court's reasons referred to the relationship between doctor and patient. No doubt the principle must also be applied where a professional other than a medical professional obtains consent to interfere with a person's body. An extension to interests other than bodily integrity or life, even to financial assets, could be justified on the ground that people's autonomy in relation to those other interests deserves the same protection as their autonomy in relation to their bodily integrity. It may be said that the *Montgomery* principle should apply whenever a professional provides information to a person in order to obtain that person's consent to the professional taking actions that will impact on the person's bodily integrity, financial assets or any other interest. Any such consent should be fully informed.[99]

The need to ensure fully informed consent cannot, however, explain the application of the *Montgomery* principle in those cases where a professional provided information, not in order to obtain consent to particular actions, but in order to warn of a risk inherent in actions taken by the advisee. If the number of such cases grows, the *Montgomery* principle may spread to the provision of any information by a professional. This would leave little room for the *Bolam* and *Maynard* principles in relation to those professionals whose sole or main task is to provide information, such as financial advisors. This would be a significant shift in the law, and the prevention of this shift may be the reason for the Court of Appeal's decision in *Barker v Baxendale Walker Solicitors*.

Since the *Maynard* principle is indefensible, as explained above, any extension of the *Montgomery* principle must be welcomed. Many claimants affected by negligent professional advice will now attempt to invoke the *Montgomery* principle. The *Montgomery* decision may even be the starting point for a general attack on the *Bolam* and *Maynard* principles, beyond the provision of information.[100]

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97 [2017] EWCA Civ 2056, [2018] 1 WLR 1905 [64] (Asplin LJ, with whom Henderson LJ and Patten LJ agreed). These remarks were *obiter dicta* as the Court held that the defendant had been negligent.

98 [2017] EWCA Civ 2056, [2018] 1 WLR 1905 [64].

99 However, an application of the *Montgomery* principle to advice given by an art dealer in order to obtain the client's authority to sell a painting was rejected in *Feilding v Simon C Dickinson Ltd* [2022] EWHC 3091 (Ch) [88].

100 This is predicted by *R Jackson*, The Professions: Power, Privilege and Legal Lability (2015) 3 Prof Negl 122, 133f.

III The law in the Republic of Ireland

A The *Dunne* principles

The Irish Supreme Court developed the principles of Irish law as to the professional standard of care in a line of cases culminating in *Dunne (an infant) v National Maternity Hospital*.[101] The plaintiff's mother was pregnant with twins. There were complications during labour. The plaintiff was born naturally with severe brain damage and the other twin was born dead. What is important for present purposes is that, during labour, the consultant obstetrician adhered to the hospital's standard practice of seeking to identify only one foetal heart in the case of a known twin pregnancy. In the plaintiff's negligence action against the consultant obstetrician and the hospital, expert witnesses were divided on whether the obstetrician ought to have attempted to discover a second foetal heartbeat. The jury delivered a verdict for the plaintiff. The Supreme Court ordered a retrial on the issue of liability, on the ground that the judge had misdirected the jury.

Finlay CJ laid down the following five principles:[102]

1. The true test for establishing negligence in diagnosis or treatment on the part of a medical practitioner is whether he has been proved to be guilty of such a failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care.
2. If the allegation of negligence against a medical practitioner is based on proof that he deviated from a general and approved practice, that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualifications.
3. If a medical practitioner charged with negligence defends his conduct by establishing that he followed a practice which was general, and which was approved of by his colleagues of similar specialisation and skill, he cannot escape liability if in reply the plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.

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101 [1989] IR 91. The key earlier cases were *Daniels v Heskin* [1954] IR 73; *O'Donovan v Cork County Council* [1967] IR 173; *Reeves v Carthy* [1984] IR 348. For a detailed review of the earlier cases as well as the first two *Dunne* principles, see *C Craven*, Medical Negligence and the *Dunne* Principles: What Do the First and Second Principles Mean? (2006) 1 Quarterly Review of Tort Law (Q Rev Tort L) 1.

102 [1989] IR 91, 109. There was a sixth principle that matters of fact, including whether a particular medical practice is or is not general and approved, must in a trial with a jury be left to the jury for determination. Juries are now abolished in Ireland in actions for personal injury caused by negligence and some other civil actions: Courts Act 1988 (Ireland) s 1.

4. An honest difference of opinion between doctors as to which is the better of two ways of treating a patient does not provide any ground for leaving a question to the jury as to whether a person who has followed one course rather than the other has been negligent.
5. It is not for a jury (or for a judge) to decide which of two alternative courses of treatment is in their (or his) opinion preferable, but their (or his) function is merely to decide whether the course of treatment followed, on the evidence, complied with the careful conduct of a medical practitioner of like specialisation and skill to that possessed by the defendant.

The Supreme Court confirmed the *Dunne* principles in *Morrissey v Health Service Executive*,[103] which involved alleged negligence in the failure to detect abnormalities in a cervical smear test. The applicability or correctness of the *Dunne* principles was not in dispute, but the Supreme Court used the opportunity to re-affirm them because the trial judge had applied an exacting standard (requiring absolute confidence before returning a negative test result), which some commentators had interpreted as a stricter standard than the *Dunne* principles.[104] Clarke CJ, who gave the judgment of the Supreme Court, said that the *Dunne* principles, which were expressed in relation to medical treatment, apply in that context to both diagnosis and treatment,[105] and also apply to other professionals.[106] Clarks CJ made the following observations on the role of expert evidence in determining the applicable standard of care:[107]

> [T]he question of the standard of approach which should be applied by an ordinarily competent professional is ultimately a matter of fact. It requires expert evidence as to how professionals of the type in question would generally go about their work and the way in which they would have dealt with the case in question. It follows that, at least in many cases, the court has no role in determining the standard to be applied other than to assess the evidence given by professionals as to the standard to [sic] which they themselves regard as being appropriate to someone of the standing and skill of the defendant.

103 [2020] IESC 6, [2020] PNLR 17. For a review of the decision, which addressed other legal issues too, see eg *S Moorhead/M Watson*, Damage Limitation (2020) 25 Bar Review (Bar Rev) 104; *E Quill*, Ireland, in: E Karner/BC Steininger (eds), European Tort Law 2020 (2021) 302, no 3ff.

104 See [2020] IESC 6, [2020] PNLR 17 [2.5], [6.1].

105 [2020] IESC 6, [2020] PNLR 17 [6.11].

106 [2020] IESC 6, [2020] PNLR 17 [6.5].

107 [2020] IESC 6, [2020] PNLR 17 [6.13]. Clarke CJ used the phrase 'standard of approach' instead of 'standard of care' to avoid confusion with care in the medical sense (see [6.3]).

Clarke CJ then mentioned the exception, where an accepted practice had inherent defects,[108] and said that where (as in the instant case) that exception is not being invoked, 'a court has no role in imposing a standard of approach on a professional. Rather, it is the standards of the profession itself, as demonstrated by the evidence, which impose the standard required'.[109] In that case, all experts agreed that a screener should not classify a smear as negative if the screener was in any doubt about what was on the slide.

B Adherence to a general and approved practice

The third of the *Dunne* principles implies that adherence to a general and approved practice generally precludes a finding of professional negligence, but it also states that this does not apply where the practice has 'inherent defects which ought to be obvious to any person giving the matter due consideration'. Both the general rule and the exception had already been recognised by the Irish Supreme Court in *O'Donovan v Cork County Council* where Walsh J (with whom Ó'Dálaigh CJ agreed) said that 'a medical practitioner cannot be held negligent if he follows general and approved practice in the situation with which he is faced',[110] but added the following:[111]

> If there is a common practice which has inherent defects, which ought to be obvious to any person giving the matter due consideration, the fact that it is shown to have been widely and generally adopted over a period of time does not make the practice any the less negligent.

Walsh J also addressed the effect of conflicting evidence as to the existence of a general and approved practice: 'If some witnesses say that a particular practice is a general and approved one and other medical witnesses deny that, then it is an issue of fact to be determined as any other issue of fact'.[112] The Supreme Court has reiterated this position in subsequent cases.[113]

108 [2020] IESC 6, [2020] PNLR 17 [6.13].
109 [2020] IESC 6, [2020] PNLR 17 [6.14].
110 [1967] IR 173, 193.
111 [1967] IR 173, 193. The practice adopted by the defendant in that case was not regarded as inherently defective.
112 [1967] IR 173, 194.
113 *Reeves v Carthy & O'Kelly* [1984] IR 348, 358; *Dunne (an infant) v National Maternity Hospital* [1989] IR 91, 115.

An application of the 'inherent defects' exception does not require expert evidence in support.[114] But the exception needs to be pleaded[115] and, as mentioned by Walsh J in *O'Donovan*, the defectiveness of the practice that the defendant was following needs to be 'obvious to any person giving the matter due consideration'. This is a high threshold, which Keane J in the Supreme Court has recognised:[116]

> [A] lay tribunal will be reluctant to condemn as unsafe a practice which has been universally approved in a particular profession. The defects in a practice universally followed by specialists in the field are unlikely to be as obvious as the test requires: if they were, it is a reasonable assumption that it would not be so followed.

Keane J was assuming that a profession would always respond to obvious defects. But this is doubtful. As was observed in an Australian case, 'professions may adopt unreasonable practices. Practices may develop in professions ... not because they serve the interest of the clients, but because they protect the interests or convenience of members of the profession'.[117]

The Irish Supreme Court did apply the 'inherent defects' exception in *Roche v Peilow*.[118] The plaintiffs (husband and wife) entered into a contract with a building company for the erection of a house on land owned by the company and the subsequent grant of a 999 year lease of the house to the plaintiffs, for a sum to be paid by them in instalments payable at different stages of the construction. Unbeknown to the plaintiffs, the company had granted a charge over the land to a bank as a security for all moneys due by the company to the bank. After the plaintiffs had paid most of the instalments, but before a lease was granted, the building company became insolvent and the bank refused to release the charge unless the company's debt was paid. The plaintiffs sued their solicitors, alleging that they had been negligent in failing to make a search in the Companies Office (which would have shown the bank's charge) before the plaintiffs entered into a binding contract with the building company. Evidence showed that it was a common conveyancing practice among solicitors at the time to leave the search in the Companies Office until the time of conveyance. The Supreme Court held that the defendants were liable in negligence.

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114 *C Craven*, Medical Negligence and the Dunne Principles: The Third and Later Principles (2006) 1 Q Rev Tort L 12, 13.

115 *Griffin v Patton* [2004] IESC 46.

116 *Collins v Mid-Western Health Board* [1999] IESC 73, [2000] 2 IR 154 [4]. An additional challenge for Irish plaintiffs is the rule that a plaintiff may normally use only one specialist expert witness in any one field; see *K Cross*, Medical Negligence: A View from the Bench (2019) 25 Medico-Legal Journal of Ireland 90.

117 *F v R* (1983) 33 South Australian State Reports (SASR) 189 (FC) 191 (King CJ).

118 [1986] Irish Law Reports Monthly (ILRM) 189.

The Court referred to both the general rule and the exception recognised in *O'Donovan v Cork County Council*, and held that the practice followed by the defendants was defective considering that a search in the Companies Office before the client entered into a binding contract involved no undue delay, expense or difficulty but prevented a foreseeable financial disaster for the client.

In the context of alleged medical malpractice, the high threshold of the 'inherent defects' exception has traditionally been compounded by the courts' deference to the medical profession and the reluctance of medical practitioners to criticise their peers.[119]

C Opinion evidence in favour of the defendant

In *Shuit v Mylotte*,[120] the question was whether the defendant gynaecologist was negligent in deciding to perform a radical hysterectomy on the plaintiff. There was no suggestion that the defendant had followed a general and approved practice. Two expert witnesses expressed the view that the defendant had been negligent. Three expert witnesses testified that, if placed in the defendant's position, they would have performed the same operation, and that the defendant had acted properly. White J in the Irish High Court was satisfied that all five expert witnesses had testified truthfully and in good faith. He made no assessment as to the merits of the two sets of opinion evidence. Instead, White J said that because some reputable obstetricians had testified that they would have acted as the defendant did, the plaintiff had not established that no obstetrician of like skill, acting with ordinary care, would have performed the surgery performed by the defendant.

Similarly, in *Griffin v Patton*,[121] O'Donovan J in the High Court took the view that expert evidence that the defendant had not been negligent would have precluded a finding of negligence but for the fact that those experts proceeded on an assumption of fact that O'Donovan J found to be wrong. These two first instance decisions thus expressed the view that the first of the *Dunne* principles precludes a finding of professional negligence as soon as reputable expert witnesses testify that they would have acted as the defendant did. This is like the *Maynard* principle in UK law.

However, when *Griffin v Patton* came before the Irish Supreme Court, the Court rejected such a principle. Geoghegan J, speaking for the Court, said: 'There is nothing in *Dunne* to support the view that if two medical experts express an honestly

119 *W Binchy*, Tort Law in Ireland: A Half-Century Review (2016) 56 Irish Jurist (NS) 199, 211.
120 [2006] IEHC 89.
121 [2004] IESC 46.

held opinion on the negligence issue to opposite effect, the judge is precluded from making a finding of negligence in relation to the way a particular treatment is carried out'.[122] Indeed, the Supreme Court had expressed the same view in *Dunne* itself,[123] and already in *O'Donovan v Cork County Council* where Walsh J, with whom Ó'Dálaigh CJ agreed, stated:[124]

> In the absence of evidence that the procedure adopted by [the anaesthetist] was a general and approved procedure for such a condition, the fact that other medical witnesses were of opinion that he acted in a competent and skilled manner does not take the matter from the hands of the jury. It is the function of the jury, not of the medical witnesses, to decide whether or not negligence is established.

In several cases, conflicting opinion evidence has been assessed on the merits.[125]

D The duty to warn of risks

It was for a long time unsettled whether the *Dunne* principles apply to a doctor's duty to warn the patient of material risks inherent in a proposed treatment. The current rules have been shaped by three cases, which will be considered in chronological order.

In *Walsh v Family Planning Services Ltd*,[126] the plaintiff suffered orchialgia (constant testicular pain) and resulting impotence after undergoing a vasectomy, which was carried out competently. The advising doctor had warned the plaintiff of the risk of long-term pain but had also said that his sex life would not be affected. Expert witnesses were divided on whether the risk of impotence should have been mentioned. The minority in the Supreme Court (McCarthy J and Egan J) took the view that it should have been mentioned and that the hospital was liable in negligence. McCarthy J, with whom Egan J agreed, set out the *Dunne* principles[127] but said that no reasonably prudent medical doctor would have failed to mention the risk of impotence in the circumstances.[128] The majority held that the warning given to the plaintiff had been sufficient. But there was disagreement among the three majority

122 [2004] IESC 46.
123 [1989] IR 91, 115.
124 [1967] IR 173, 207.
125 Eg *Gottstein v Maguire* [2004] IEHC 416; *O'Gorman v Jermyn* [2006] IEHC 398; *Clifford v Health Service Executive* [2019] IEHC 896 [39]–[40].
126 [1992] 1 IR 496.
127 [1992] 1 IR 496, 516f.
128 [1992] 1 IR 496, 520f.

judges as to whether the *Dunne* principles applied to the standard of care to be exercised by a medical practitioner in the giving of advice.[129]

In *Geoghegan v Harris*,[130] a dental implant procedure left the plaintiff with a condition of severe pain at the mid line of his chin known as chronic neuropathic pain. The plaintiff had not been warned of the risk of such a condition, which was remote. Even though all expert witnesses took the view that it had not been necessary to warn of the remote risk of neuropathic pain, Kearns J in the High Court stated that the Supreme Court's decision in *Walsh* required him to hold that there had been an obligation to warn of that risk.[131] Kearns J went on to consider in general whether the *Dunne* principles or the reasonable patient test should apply to the duty to warn of risks. He rejected an application of the *Dunne* principles to a medical practitioner's duty to warn of risks, stating that, 'as a general principle, the patient has the right to know and the practitioner a duty to advise of all material risks associated with a proposed form of treatment. The Court must ultimately decide what is material'.[132]

In *Fitzpatrick v White*,[133] the plaintiff underwent a cosmetic operation to correct a squint in his left eye. The operation was performed competently, but the plaintiff suffered a slippage of the medial rectus muscle (a very rare complication) resulting in double vision. The plaintiff was warned of the risk of muscle slippage and double vision about 30 minutes before the start of the operation. He argued that the warning had been given too late and was therefore ineffective in law. The Supreme Court rejected that contention,[134] but used the opportunity to review the law as to the duty to warn of risks. Kearns J, who spoke for the Court, said that *Walsh* had laid down the principle that 'a warning must in every case be given of a risk, however remote, of grave consequences involving severe pain continuing into the future and involving further operative interventions'.[135] In cases not involving the risk of ongoing severe pain and further operations, Kearns J stated, 'if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of

129 Finlay CJ (at 510 f) considered the *Dunne* principles applicable whereas O'Flaherty J (at 535), with whom Hederman J agreed, took the opposite view. For a review of this aspect of the decision, see *R Byrne/W Binchy*, Annual Review of Irish Law 1992 (1994) 561ff.

130 [2000] 3 IR 536.

131 [2000] 3 IR 536, 539–545.

132 [2000] 3 IR 536, 549.

133 [2007] IESC 51, [2008] 3 IR 551.

134 For a critical analysis of this aspect of the decision, see *E Quill*, Ireland, in: H Koziol/BC Steininger (eds), European Tort Law 2007 (2008) 352, nos 15–17.

135 [2007] IESC 51, [2008] 3 IR 551 [34].

that significant risk'.[136] He added that 'a risk may be seen as material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it'.[137] Kearns J also indicated that a warning must be given where the doctor is aware that the particular patient, if warned of the risk, would be likely to attach significance to it while another patient might not.[138]

Kearns J adopted the test that had been expressed by Lord Scarman in *Sidaway v Board of Governors of the Bethlem Royal Hospital*,[139] and would later be adopted by the UK Supreme Court in *Montgomery v Lanarkshire Health Board*.[140] Thus, the rules governing the standard of care of a doctor in providing information to a patient prior to a medical procedure are the same in Irish law and UK law. It remains to be seen whether the rules laid down in *Fitzpatrick v White* will be applied in other contexts of information being provided by a professional, as has been the case with the *Montgomery* principle in UK law. There may be less pressure for such an extension, as Irish law has no equivalent to the *Maynard* principle in UK law.

IV Conclusion

A professional is expected to attain the standard of a reasonable or ordinary member of the relevant profession in Irish law and UK law, respectively. However, compared to the legal systems in Continental Europe, both Irish law and UK law make it more difficult for courts to find that the standard was not met. The courts developed the relevant legal rules in relation to medical professionals, and the vast majority of cases in which the rules have been applied involved alleged medical malpractice, but the rules apply in principle to all professionals. The rules differ between Irish law and UK law.

Irish law protects a professional who followed a 'general and approved practice'. Such a professional can be found negligent only if evidence provided by the plaintiff satisfies the court that the practice is inherently defective and that the defects are obvious to any reasonable observer. This is a high threshold, which has not been met in many cases. Whether a professional who did not follow a general and approved practice fell below the applicable standard of care will be decided by the

136 [2007] IESC 51, [2008] 3 IR 551 [35], relying on *Pearce v United Bristol Healthcare NHS Trust* [1999] ECC 167 (CA) [21].
137 [2007] IESC 51, [2008] 3 IR 551 [35].
138 [2007] IESC 51, [2008] 3 IR 551 [35].
139 [1985] AC 871 (HL) 889.
140 [2015] UKSC 11, [2015] AC 1430 [87].

court in the same manner as for non-professional defendants. Competing expert evidence will be assessed on its merits.

UK law generally precludes a finding of professional negligence where the professional adhered to a practice widely accepted at the time. However, the court can find negligence if the court regards the entire practice as unsound. Formally, the threshold is lower than in Irish law, as UK law does not require that the defectiveness of the practice be obvious. Nevertheless, there are not many cases in which a practice was found unsound.[141]

The power of Irish and UK courts to regard an entire practice as unsound and find a defendant professional negligent is an important qualification of the generally exculpating effect of adherence to an accepted practice, and prevents the general rule from creating a huge difference between Irish law and UK law and the legal systems of Continental Europe.

A more significant difference to Continental legal systems is created by another rule in UK law. Where reputable expert witnesses testify that they regard the defendant's conduct as proper, a finding of professional negligence is precluded unless the court is satisfied that the expert's opinion 'is not capable of withstanding logical analysis'. This rule applies regardless of whether or not the defendant followed an established practice. It also protects a professional who used a novel method (possibly in conscious deviation from an established practice) and only subsequently finds peers in support of that method. The threshold for the exception – that the expert's opinion is illogical – is very high. An unreasonable opinion can still be logical. It is highly problematic that the decision on professional negligence is effectively made by expert witnesses and not by courts. The courts are deprived of their constitutional function to enforce the rights of citizens.

All these rules in Irish law and UK law are subject to an exception. They do not apply where a doctor provides information to a patient in order to obtain the patient's consent to a particular medical procedure. The doctor is required to disclose any risk to which a reasonable person in the patient's position would attach significance, and the court decides on whether the doctor discharged that duty. Neither a general practice nor the opinion of expert witnesses binds the court in its decision. This rule is to be welcomed as it ensures that a patient's consent to a medical procedure is fully informed. In the UK, this rule has been applied in some other contexts in which a professional was obliged to provide particular information to a patient or client. This extension is to be welcomed, as it narrows the field in which opinion evidence can bind the court. It may even be the starting point for a welcome reconsideration in the UK of both rules that preclude a finding of professional negligence.

141 *Jones* (1999) 7 Tort Law Review (Tort L Rev) 226, 240.