

# PROFESSIONAL NEGLIGENCE

## RECONSIDERED

*An analysis of the duty and  
standard of care of the  
professional service provider  
in Ireland*

By

Ubalduſ R.M.Th de Vries

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Philosophy This work was completed at  
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Tomkin The thesis is based on the  
candidate's own work

DECLARATION

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor in Philosophy is entirely my own work and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed: \_\_\_\_\_



I.D. No.: \_\_\_\_\_

419/0520

Date: \_\_\_\_\_

June 1996

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Throughout this thesis please assume that where appropriate "he" embraces "she"

## ABSTRACT

This thesis examines the concept of professional negligence. In doing so, it aims to find the distinguishing factors that characterize professional negligence as against other types of negligence. It seeks to emphasize the functions, duties and activities of professional people, rather than any examination of their status. The thesis demonstrates that this concept is based on a "broad-spectrum" duty of care with specific obligations, particular to professional conduct.

Consequently, this thesis argues whether society is looking at some change to the presumed responsibilities of a particular socio-economic grouping in Ireland or whether the law of tort merely seeks to accommodate technical and other changes by imposing liability in different ways.

The thesis is arranged into three parts. In Part A, the thesis examines the existing literature on professional negligence to provide the context and background against which it explores the characteristics of professional negligence. It also justifies, in Chapter Three, what is meant by "professions". It examines the nature and function of professions and emphasizes, in particular, their autonomous nature, and the demand of professional judgment.

In Part B the thesis examines the standard of care. Chapter Four examines the tests as used in Ireland and England. Chapters Five and Six review the paramount Irish and English cases dealing with the alleged negligence of, in particular, medical practitioners and solicitors. The objective of Part B is the description of a model or concept of professional negligence in Ireland.

Part C examines, in Chapter Eight, the nature of the professional relationships underlying the interaction between clinicians and their patients, solicitors and their clients, and auditors and their companies for which they fulfil the requisite statutory and other functions.

It also examines, in Chapter Nine, the imposition of a duty of care towards third parties. This involves a discussion of the development of negligence generally.

Finally, in Chapter Ten, the thesis examines recent implications with regard to professional responsibility and professional discretion in Ireland.

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## LIST OF ABBREVIATIONS

A 2d	Atlantic Reporter, Second Series
A C	Appeal Cases
A C L R	Australian Company Law Reports
A L R	Australian Law Reports
A R 2d	Alberta Reports Second Series
Acct L R	Accountancy Law Reports
All E R	All England Law Reports
Ariz	Arizona Supreme Court Cases
Aust Torts Reports	Australian Torts Reporter
B & M	Brown & MacNamara's Railway Cases
B C L C	Butterworths Company Law Cases
B M L R	Butterworths Medical Law Reports
Bing	Bingham's Common Pleas Reports
Build L R	Building Law Reports
C L R	Commonwealth Law Reports
C P	Command Paper
Cal App	California Appellate Reports
Cal Rprt	California Law Reports
Ch	Chancery
Ch D	Law Reports, Chancery Division
D L R	Dominion Law Reports
D L R 3d	Dominion Law Reports, Third Series
D L R 4th	Dominion Law Reports, Fourth Series
E R , Eng Rep	English Reports
Exch , Ex	Exchequer Reports
F 2d	Federal Reporter, Second Series



H L	House of Lords Appeals
I L R M	Irish Law Reports Monthly
I L T R	Irish Law Times Reports
I R	Irish Reports
K B	King's Bench
Kan	Kansas Supreme Court Reports
L J	Law Journal
L Med Q	Legal Medical Quarterly
L R	Law Reports
L R Irl	Law Reports Ireland
Ld Raym	Lord Raymond's King's Bench Reports
Macq	Macqueen's Scotch Appeal Cases
Med L R	Medical Law Reports
N E	North Eastern Reporter
N J	New Jersey Supreme Court Reports
N S W L R	New South Wales Law Reports
N W	North Western Reporter
N W 2d	North Western Reporter, Second Series
N Y	New York Court of Appeals Reports
N Z L R	New Zealand Law Reports
New L J	New Law Journal Law Reports
O J	Official Journal of the European Union
O R	Ontario Reports
O R 2d	Ontario Reports, Second Series
P 2d	Pacific Reporter, Second Series
P N L R	Professional Negligence Law Reports
Q B	Queen's Bench
S A S R	South Australian State Reports

S C	Scots Session Cases
S C R	Supreme Court Reports
S Ct	Supreme Court Reporter
S I	Statutory Instrument
S J / Sol Jo	Solicitors' Journal
S L T	Scots Law Times
S W 2d	South Western Reporter, Second Series
So 2d	Southern Reporter, Second Series
S S C R	Sind Sudder Court Reports
Th Raym	Sir Thomas Raymond's King's Bench Reports
U S	United States Supreme Court Reports
W L R	Weekly Law Reports
Wash 2d	Washington Reports, Second Series

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## Chapter One

### General Statement of Aims

#### 1.1. The Argument

This thesis reviews the received or presumed incidents of professional negligence. It suggests that no coherent principle existed to describe the concept of professional negligence in Ireland. It aims therefore to define and describe professional negligence. It also aims to ascertain the distinguishing factors of professional negligence. It differentiates professional negligence from other sorts of negligence. It concludes that the duty of care and the standard of care are the two most critical elements of professional negligence.

This thesis demonstrates that the concept of professional negligence is changing. Though the concept of professional negligence may appear to be based upon a "broad-spectrum" duty of care, it will be shown that, in fact, the concept of professional negligence has become defined by the obligations and characteristics of the various individual professions. It is therefore true, as we shall show, that the specific duties and activities of professional people are emphasized, rather than the fact

that such persons are described as, or describe themselves as professional people. In other words, it is the conduct and activity in which professional persons engage, rather than their status, which is crucial to the definition of both the duty of care and the application of the specific standard of care.

This distinction may be of particular importance in cases where there is, prior to the commission of an alleged tort, an existing relationship between the parties (as opposed to those situations where no such prior connection obtains).

It could be argued that the law of tort is in many ways, especially politically and socially, responsive to changes in the economic structure of society. Are we looking at some change to the presumed responsibilities of a particular socio-economic grouping in Ireland, or does the law of tort merely seek to accommodate technical and other changes by imposing liability in different ways, as life itself changes? Is there a logical connection between the analogy of liability for defective medical treatment and the snail in the ginger beer?

## 1.2 The Outline and Strategy

This thesis is divided into three parts. It commences with a commentary on the existing extensive literature on the various aspects of professional negligence (Chapter

Two) This analysis and discussion follows the rubrics listed in the Table of Contents of the thesis. In Chapter Three, the thesis explains and discusses the researcher's use of the term "profession", stressing its paramount characteristics and arguing that the term connotes a particular function in the socio-economic reality of today. This Chapter will discuss what is meant by "professional judgment" and how this term is used, and will relate to the function of professional autonomy and control within the concept of professional negligence. Thus, Part A forms the context and background against which the thesis explores the characteristics of professional negligence.

In Part B, this thesis examines the principal English and Irish cases. These form the cornerstone of the presumed standard of care to the construct of professional negligence in Ireland. Chapter Four discusses the test which is used in England and Ireland to assess the standard of care required of a professional person. This Chapter seeks to identify certain fixed points that distinguish professional negligence from other types of negligence.

Chapters Five and Six review Irish and English cases which deal specifically with the alleged negligence of, in particular, medical practitioners and solicitors. From this analysis and discussion it appears as if certain terms are of key importance, for example the concepts of, *inter alia*, "obvious inherent defects", advice and information, and scientific disputes.

Chapter Seven moves from the examination of specific

instances of professional negligence to a consideration of the differences between professional negligence and other sorts of negligence. The thesis identifies certain characteristics which are exclusive or particularly relevant to professional negligence cases. This analysis is taken further in Part C.

Part C of the thesis (commencing with Chapter Eight) examines the underlying professional relationship between the professional person and his client, patient, or in the case of an auditor, those retaining his services whether directly or indirectly. It seeks to provide an intellectual rationale for the existence of the professional relationship and, subsequently, the existence of a duty of care. The thesis then tests whether the suggested rationale is in fact provable by applying it to specific cases involving, respectively, a medical practitioner, a solicitor and an accountant acting as an auditor.

The thesis will show that a particularly interesting conflict arises between the general duty to take care (endemic to all negligence actions) and the specific exceptions, or more properly, incidences of professional negligence, such as the barrister's limited immunity from suit. The analysis offered, suggests that the courts' perception of the function of the concept of negligence is tied to the imposition of the duty of care and the question of third-party liability. Each of these interacts with the courts' assessment of the role and function of professional negligence and, specifically, the societal expectations

required of the professional

In Chapter Ten, the thesis identifies certain developments which may be detrimental to the status of professional people and to their autonomous function in society. It appears that professions are less likely to take responsibility for their own actions. As a consequence, it seems that a professional person, in following the law, contravenes his profession's ethical or professional code of conduct.

PART A.

Chapter Two

The Literature Review

2.1. Introduction

Chapter One provided the argument and outline. This Chapter examines and comments on the relevant literature on professional negligence and allied issues. The outline of this Chapter follows broadly the general structure of the thesis. The commentary on each article, book or paper follows the rubrics in the Table of Contents.

2.2 The Presumed Model of Professional  
Negligence in Ireland and England  
The Standard of Care

2.2.1. This section of the literature review addresses the standard of care in professional negligence. It reviews the literary comments on the various aspects of the BOLAM test. It also reviews the academic position in Ireland. It reviews some general remarks with regard to the use of a separate test in professional negligence cases.

In addition, the literature review discusses comments,

not specifically dealt with in the thesis, in relation to computer malpractice and the standard of care of mental health professionals. The features of a professional negligence test appear to cause problems in these two areas.

### The BOLAM test

2.2.2. A majority of commentators criticize the test developed in *BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE* [1957] 2 All E R 118. It is said to be too objective in its application, without reference to the interests of the patient involved. It does not refer to the reasonableness of the professional person's conduct. It leaves the court without a legal determination of the standard of care.

A minority believes that the BOLAM test is the proper test in this area of negligence. They justify this by reference to the professional expertise that underlies the practitioner's conduct and the patient's reliance upon it.

2.2.3. Goldrein (1994) questions the value of the BOLAM test for today's professional negligence cases. He claims that the test carries two undesirable consequences. First, the test is unsatisfactory as to the three separate avenues of analysis of professional conduct, i.e. risk, precaution and a balance between them. Second, there is an inconsistency between the courts' attitude to and the use of principle in general cases of tort on the one hand and

in medical negligence cases on the other. Thus, expert witnesses in medical negligence cases eschew the "internal logic" of medical opinion in the particular factual nexus, and strive to propound some abstract zenith of "accepted practice" <sup>1</sup>

Goldrein suggests a test based on true tort principles <sup>2</sup> This test, to determine the standard of care, involves the assessment of three criteria <sup>3</sup>

(I) The magnitude of the risk, by reference to the seriousness and likelihood of the risk on the one hand, and the degree of care on the other hand <sup>4</sup>

(II) The practicability of safety measures, what is feasible and what is reasonable<sup>5</sup>

(III) General and approved practice This is a reliable determinant, but there must be a limit to its relevance, it cannot be conclusive <sup>6</sup> It remains up to the judge to decide whether safety measures (i.e. what practice) should have

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<sup>1</sup>The thesis argues that this inconsistency is justified by McNair J referring to the presence of a special skill, see *infra* Subparagraph 4.2.2

<sup>2</sup>The existence of a duty of care is based on proximity (Goldrein, 1994: 1238)

<sup>3</sup>Goldrein (1994: 1237)

<sup>4</sup>Cf. *PARIS v STEPNEY BOROUGH COUNCIL* [1951] A.C. 367

<sup>5</sup>Goldrein relies here on Munkman (1990: 44)

<sup>6</sup>*Ibid.*, at 45. Goldrein refers to the proverb that 'neglect of duty does not cease by repetition to be neglect of duty', see *CARPENTERS' CO v BRITISH MANUAL BANKING CO LTD* [1937] 3 All E.R. 811 at 820, per Slesser L.J. In Ireland the test is subjected as to whether the general and approved practice carried any inherent defects which should have been apparent, see *DUNNE v NATIONAL MATERNITY HOSPITAL* [1989] I.R. 91



been carried out.<sup>7 8</sup>

Kennedy & Grubb (1994) identify and comment on the discrepancy between medical autonomy and judicial decision making. They too explain that in a subtle way, courts have empowered the medical profession to both determine what the standard of care should be, and whether or not it has been breached in a particular case. The judiciary empower the profession to enforce the profession's own determinations. But Kennedy and Grubb point out, and the thesis carries this point further,<sup>9</sup> that the trial of a negligence action involves what is essentially - even in so specialized an area as medical negligence - a legal judgment. Thus, the judgment of what is reasonable (the essence in tort law) should not be made by the doctor; a unanimously approved practice is not necessarily reasonable.<sup>10</sup>

As to the idea that a difference of opinion amongst doctors is not something that can be decided upon in court, the writers argue that the BOLAM test is wrongly interpreted. In their view the court is very well able to prefer one practice over the other by emphasizing what was reasonable in the circumstances of the case.

In Kennedy & Grubb's view, therefore, adherence to a

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<sup>7</sup>See also: BOLITHO v. CITY HACKNEY HEALTH AUTHORITY [1993] 4 Med. L.R. 381.

<sup>8</sup>Goldrein discusses another important issue in his article: the role of the court and conflicting expert evidence. This issue is taken into the thesis; see: *infra* Subparagraph 5.5.3.

<sup>9</sup>See: *infra* Subparagraph 4.2.2. and 4.4.3.

<sup>10</sup>Kennedy & Grubb (1994: 449-450).

standard accepted practice is not conclusive as to the reasonableness of the practice. Hence, a doctor can still be held negligent if he adhered to an accepted practice that the court considers unreasonable. The court should distinguish between what is ordinarily done and what ought to be done, taking into account the interests of the plaintiff (and society at large). The court's omission to do this may be explained in terms of the complexity of the case and the wish to avoid creating an atmosphere of defensive practice.<sup>11</sup>

This line of thought is supported by Montrose (1958). Negligence is about what ought to have been done by the defendant. It is, even in the context of its judicial use, a concept with an ethical component rather than one which is merely sociologically descriptive. The BOLAM test, therefore, lacks an important qualification. Namely, the requirement that it is up to the courts to decide whether 'the ordinary practice of those possessed of "special skill and competence", is reasonable and prudent'.<sup>12</sup> Conformity is evidence that a practice is not negligent. However, it cannot be conclusive.

This view is shared by Stallybrass, who states that 'the general practice itself may not conform to the standard of care required of a reasonable prudent man. In such a case it is not a good defence that the defendant

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<sup>11</sup>*Ibid* , at 461-462

<sup>12</sup>Montrose (1958 262)

acted in accordance with the general practice' <sup>13</sup>

Jones (1991) agrees with Stallybrass on this point. He asserts that this is the true interpretation of the decision in HUNTER v HANLEY [1955] S C 200. There, Lord Clyde referred to the reasonable competent man. This test is concerned with what ought to be done by reference to a reasonable doctor. The BOLAM's ordinary skilled man refers to medical or professional standards and must be reserved as an important indicator <sup>14</sup>

Comyn (1987) points out that medical practitioners are generally under a greater protection than the law, in fact, permits them to be. Under the BOLAM test the defendant may to a far greater extent rely on responsible colleagues than a similarly-circumstanced defendant in a general negligence case. Thus, the medical negligence rules, as applied, offer greater protection to medical practitioner defendants than general negligence rules afford other defendants <sup>15</sup>. Clinicians' rules of professional conduct even extend to professional negligence litigation, both expressly and by implication.

This is, according to Comyn, a dangerous development. The courts should be able to exercise a 'judicial or

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<sup>13</sup>Stallybrass (1945 437)

<sup>14</sup>Jones (1991 59)

<sup>15</sup>Comyn (1987 139). The thesis points out that there is a justification for this greater protection, by reference to Lord Denning's decision in ROE v MINISTRY OF HEALTH [1954] All E R 131, see *infra* Subparagraph 4.2.7

judicious choice' between differences in expert opinion <sup>16</sup>  
It is not appropriate to curb the court's power to accept  
one set of evidence over the other. It can do it in other  
negligence cases.

In most cases expert evidence is offered without,  
according to Comyn, the experts having experienced the  
circumstances of the case. Only the court can weigh the  
support for the defendant against the other evidence and  
the circumstances of the case. The court must be left with  
a reasoned choice between fact and opinion and to consider  
all the circumstances of the case and not be forced to find  
for the defendant <sup>17</sup>

2.2.4. Mason & McCall Smith (1987) set out another  
unfortunate consequence of the BOLAM test. A strict  
application of the BOLAM test implies that the novice  
medical practitioner is assessed according to the same  
standard of care as his experienced counterpart. The  
objective nature of the test renders the qualifications of  
a doctor (of equal specialization) irrelevant <sup>18</sup>

A justification for this may, however, be found in the  
public expectation and demand to be provided medical  
services by reasonably competent practitioners <sup>19</sup>

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<sup>16</sup>Comyn (1987 139)

<sup>17</sup>*Ibid* , at 140

<sup>18</sup>Mason & McCall Smith (1987 173)

<sup>19</sup>Cf WILSHER v ESSEX AREA HEALTH AUTHORITY [1986] 3  
All E R 801

Mason & McCall Smith suggest that this complication can be overcome. The novice is required to consult more experienced doctors to meet the proper standard of care<sup>20</sup>. In other words, he must reassure himself whether he is capable of doing what he is asked or obliged to do. If he is unable to do this, he must consult other, more experienced doctors.

2.2.5. Howie (1983) compares the decision in BOLAM with the decision in HUNTER v HANLEY [1955] S L T 200. He makes two observations<sup>21</sup>. First, the decision in HUNTER requires a higher standard of care from the medical practitioner than the BOLAM test. Under HUNTER the doctor is negligent if no practitioner of like specialization would have done what the defendant doctor did<sup>22</sup>. Under BOLAM reference is only made to a "responsible body of opinion"<sup>23</sup>.

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<sup>20</sup>Mason & McCall Smith (1987: 174). In Ireland, this issue was addressed in DUNLEAVY v MCDEVITT AND ANOTHER [1995] P N L R 362. In this case, the plaintiff alleged that the first defendant was negligent in not having sufficient experience to carry out a particular operation (this more complicated operation was preceded by a less complicated operation that had failed). The Supreme Court dismissed the claim, stating that when a doctor faces a problem during treatment, the decision that has to be made is at his discretion and responsibility. See also Byrne & Binchy (1992: 556-557).

<sup>21</sup>Howie (1983: 200).

<sup>22</sup>HUNTER v HANLEY [1955] S L T 200 at 205, per Lord Clyde.

<sup>23</sup>This is argued by Norrie (1987). The reference to "ordinary care" or "reasonable care" is not relevant. He argues that the courts look for a standard that is 'legally acceptable', (*supra*, at 162). He comments that both terms

Second, the BOLAM test carries a contradiction of thought. McNair J referred to the "reasonable man" as the point of departure and put the reasonable man in a medical context. However, McNair J subsequently assessed the defendant's conduct by reference to medical opinion, not by reference to the reasonableness of his conduct. As a result, medical support for the defendant's conduct relieves him from liability.

This begs the following question. Howie asks whether the courts, under the BOLAM test, determine if the practice that is followed and approved of by medical opinion is also reasonable, or whether this practice is *ipso facto* reasonable. Having reviewed a number of professional negligence cases, Howie asserts that the BOLAM test lies between the "ordinary care" test (HUNTER) and the more general "reasonable" test. This implies that the BOLAM test does not offer an absolute defence if the defendant's conduct is supported by professional opinion.<sup>24</sup>

2.2.6. Khan & Robson (1995) assert that the BOLAM test begs the question what is meant by a "responsible body of medical opinion"? Does it refer to quality or quantity? In *DE FREITAS v O'BRIEN* [1993] 4 Med L R 128, the court held that a body of responsible opinion must refer to the quality of the opinion offered. In this specific case, the

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have been and are used concurrently in judicial analysis of professional negligence.

<sup>24</sup>Howie (1983: 222)

defendant was an orthopaedic surgeon specializing in spinal surgery. He was only one of eleven "spinal surgeons" in the country out of a group of 1,000 orthopaedic surgeons. The question was whether the evidence established that the defendant acted in accordance with a responsible group of medical opinion. The court answered this in the affirmative referring to the super-specialism of spinal surgery.

This implies, according to Khan & Robson, that there is a higher standard than the ordinary specialist. Crucial then, as a preliminary question, is in what category a defendant specialist fits: ordinary specialism or "super-specialism"?

But as Khan & Robson (1995) point out the test could also be defined as consisting of a substantial group of medical opinion.<sup>25</sup> This would mean that "substantial" must be equated with quantity. The question is then, according to Khan & Robson, whether eleven specialists constitute a substantial group of medical opinion.

Keown (1995) criticizes the attitude of the English courts which rely on the BOLAM test, that there could be no negligence were an accepted practice to be followed. Only recently, in two cases,<sup>26</sup> the courts were willing to assess whether conduct alleged to be negligent was both an

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<sup>25</sup>(1995 122) See, for example, the decision in HILLS v POTTER [1983] 3 All E R 716. This argument is not shared by this researcher, see *infra* Subparagraph 4.2.3.

<sup>26</sup>SMITH v TUNBRIDGE WELLS HEALTH AUTHORITY [1994] 5 Med L R 334 and MCALLISTER v LEWISHAM AND NORTH SOUTHWARK HEALTH AUTHORITY AND OTHERS [1994] 5 Med L R 343.

accepted practice and a reasonable practice. In doing so, the question of what constituted negligence remained within the ambit of the courts, rather than relying on medical judgment.<sup>27</sup>

Both cases dealt with the insufficient disclosure of information. As a matter of causation it had to be shown in each case that if the plaintiff was properly informed he would not have undergone the treatment, and such treatment would not have been tortious. In not following a medical judgment test, the courts were prepared to accord the plaintiff the benefit of the doubt. In doing so, they relieved some of the burden of proof that rested on the plaintiff.<sup>28</sup>

### The Irish Position

2.2.7. The test as it applies in Ireland has been commented upon by a number of writers. Most writers comment on specific elements of the test and these writers are discussed elsewhere. However, a number of general remarks can be offered at this stage.

The standard of care in medical negligence is defined on the basis of two questions, according to Binchy (1995), discussing the decision in *DUNNE v NATIONAL MATERNITY HOSPITAL* [1989] I R 91. First, did a doctor conform to a

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<sup>27</sup>Keown (1995: 32)

<sup>28</sup>*Ibid*



customary practice<sup>29</sup> Second, if so, did this practice have any obvious inherent defects?

The second question submits the medical (and other) professions to the notion that the courts may at all times have a final say in the matter<sup>30</sup> For the remainder, the professions are said to be competent to set their own standards All that is required is that a doctor should exercise reasonable care and skill with regard to diagnosis and treatment by reference to a general and accepted practice An error of judgment is excusable, as well as a difference of opinion, as long as this difference is not based on an 'unreasonable belief as to the desirability of a particular mode of treatment'<sup>31</sup>

With regard to informed consent cases the important aspect deals with what standard information ought to be disclosed The DUNNE test applies However, the observation of Finlay C J in DUNNE v NATIONAL MATERNITY HOSPITAL [1989] I R 91 expressly reserved power to the judiciary to retain the final say in the determination of what constitutes negligence, a comment which was also made in BEST v WELLCOME FOUNDATION LTD [1993] 3 I R 421<sup>32</sup>

This position indicates, according to Binchy, 'a

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<sup>29</sup>The answer to this question is debated The thesis does not agree with Binchy on this point, see *infra* Subparagraph 7 1 2

<sup>30</sup>Binchy (1995 4) The thesis addresses this issue in more detail, see, *infra* Subparagraph 4 3 5

<sup>31</sup>Binchy (1995 4-5)

<sup>32</sup>See *infra* Subparagraph 5 5 3

sensitivity to the fact that disclosure of risks to patients involves issues ranging beyond matters of medical judgment' <sup>33</sup> This position is, therefore, in line with the approach taken in America and Australia,<sup>34</sup> and is similar to the dissenting judgment of Lord Scarman in *SIDAWAY v BETHLEM ROYAL HOSPITAL GOVERNORS* [1985] 1 All E R 643 <sup>35</sup>

The implied term with regard to diagnosis and treatment within a doctor-patient relationship, whether in contract or otherwise, is, according to Tomkin & Hanafin (1995), the undertaking that reasonable care and skill shall be deployed

However, if an action is based on contract, the action may be covered by the Sale of Goods and Supply of Services Act, 1980. Here, the doctor regards the patient as a consumer and may, under section 40 of the Act, exclude his liability if this is reasonable and expressly made known to the patient <sup>36</sup>

In most cases involving medical decision-making, the

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<sup>33</sup>Binchy (1995 12)

<sup>34</sup>In the United States, see, for example, the recent decision in *LARGEY v ROTHMAN* (1988) 110 N J 204, 540 A 2d 504. In Australia, see *ROGERS v WHITAKER* [1992] 16 B M L R 148

<sup>35</sup>The aspect of "informed consent" is addressed in detail in Subparagraphs 2 3 7 ff

<sup>36</sup>Tomkin & Hanafin (1995 66). If this is so, this course of action may, according to this researcher, be relevant where goods are used as part of the treatment, i e prostheses, artificial hearts or even, it is suggested, transplantation material.

The thesis asserts that the relationship is based on more than purely contractual arrangements, see *infra* Subparagraph 8 2 1

implied term will generally be taken from tort reasonable care and skill. The doctor is said to be negligent because he 'has failed to do competently what should have been done' <sup>37</sup> Litigation is increasing, and decisions must be made between two parameters: the support of medical development without fear of litigation and the consequences of failure for the dependent patient.

The degree of care and skill is, in Ireland, determined by comparison to what is usual in, or demanded by, the profession or specialization. Thus, in Ireland the doctor's conduct is assessed by reference to general and approved practice of a person of the same qualifications and experience as that of the defendant. Here, the Irish judiciary differ from that of England, according to Tomkin & Hanafin. In England, the doctor's view on diagnosis, treatment and information disclosure is measured by reference to some hypothetical body of reasonable opinion <sup>38</sup> In addition, the test in Ireland is restricted only to those practices that do not carry any obvious inherent defects. According to Tomkin & Hanafin, the Irish courts hold that some inherently defective practices will be *ipso facto* inherently negligent <sup>39</sup>

In a recent Paper, Tomkin (1995) sets out the two possible implications of this restriction. First, it may

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<sup>37</sup>Tomkin & Hanafin (1995 70)

<sup>38</sup>Cf BOLAM v, FRIERN HOSPITAL MANAGEMENT COMMITTEE [1957] 2 All E R 118

<sup>39</sup>Tomkin & Hanafin (1995 74)

mean that a doctor is negligent if, on consideration, he would not have adopted the practice he followed. Second, the court may hold that the practice in question, which the doctor failed to examine, carried an inherent defect of which he ought to have been aware. By implication, the doctor must at all times consider current practices to see whether they, in his view, carry any inherent defects.<sup>40</sup>

Healy (1995) argues as to whether medical negligence is assessed by the ordinary principles of negligence or whether it depends on some general and approved practice. This appears to be of particular relevance with regard to "information disclosure" cases.

Under the DUNNE test,<sup>41</sup> Healy agrees that the legal standard of reasonable care and skill is determined by reference to a general and approved practice. It minimizes proportionally more a finding of negligence than a standard in other negligence cases. It has effectively disabled the courts to find for a plaintiff on any professional judgment that is in line with 'a legitimate school or practice within the medical profession'.<sup>42</sup>

However, Healy argues that two other cases indicated some recognition for the application of the ordinary negligence principles. In DANIELS v HESKIN [1954] I R 73

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<sup>40</sup>Tomkin (1995: 4). This point appears also to be relevant with regard to the professional conduct of solicitors. The thesis carries Tomkin's argument further, see, *infra* Paragraph 5.2

<sup>41</sup>Cf. DUNNE v NATIONAL MATERNITY HOSPITAL [1989] I R 91

<sup>42</sup>Healy (1995: 196)

the test was applied with regard to the disclosure of inherent risks, although the Chief Justice (dissenting) found for the plaintiff despite expert opinion. Again, in *WALSH v FAMILY PLANNING SERVICES LTD* [1992] 1 I R 486 the test was applied, despite the emergence of the American doctrine of informed consent (applying the "prudent patient test"), the considerations in *SIDAWAY v BETHLEM ROYAL HOSPITAL GOVERNORS* [1985] 1 All E R 643 and, according to Healy, McCarthy J's empathy in *WALSH* with the prudent patient test<sup>43</sup>

Healy argues that the outcome of the Irish test does not materially differ from the prudent patient test. The latter is subject to "therapeutic privilege" which minimizes the effect of its practical application. In addition, the court must in both tests rely on specialized clinical judgment and medical theory as to the definitions of general and specific risks. In doing so the outcome remains subject to medical paternalism. A case-by-case approach as to disclosure of material risks will undermine

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<sup>43</sup>*Ibid*, at 197, 199. In *FARRELL v VARIAN*, Unreported, High Court, 19 September 1994, O'Hanlon J, it was a general practice not to disclose a particular, minute risk (the occurrence of Reflex Sympathetic Dystrophy after surgery on the hand). Judge O'Hanlon found for the defendant, stating that the disclosure of information must primarily be a matter of clinical judgment, except where disclosure is so 'obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it' (Unreported, High Court, 19 September 1994, at page 51 of O'Hanlon J's judgment). However, in *BOLTON v THE BLACKROCK CLINIC*, Unreported, High Court, 20 December 1994, Geoghegan J held that the disclosure of information does not depend on any general or approved practice but, instead, on the ordinary principles of negligence.

legal certainty

Where the two tests differ is in their respective starting points. The professional negligence test focuses on the doctor's duty, whereas the prudent patient test relies on the patient's right to be informed. If not frustrated by the exception of therapeutic privilege and, more importantly, proximate causation, the latter would demand more rigorous requirements of disclosure.

Healy asserts that the duty to disclose is part of the general professional duty to exercise reasonable care and skill. This duty is, therefore, subject to the professional negligence test as laid down in *DUNNE v NATIONAL MATERNITY HOSPITAL* [1989] I R 91. A breach of this duty is, accordingly, determined by reference to general and approved practice or, alternatively, by reference to the exception of inherent defects to a general and approved practice. This implies that a doctor may be negligent if the duty to disclose would have been so obvious to any person who had given the matter due consideration.<sup>44</sup>

#### General Remarks

**2.2.8.** Jones (1991) sets out a number of issues concerning medical negligence cases.

First, Jones argues that although the liability of doctors in negligence is based on the principle of fault liability, it does not necessarily follow that a negligent

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<sup>44</sup>Healy (1995 224)

doctor is morally blameworthy. The question addressed by the law is rather what type of medical accidents should be compensated. The assessment of liability - although objective - depends to a large extent on an *ex post facto* analysis of the facts of the case. According to Jones, the tort judgment cannot focus on broader questions, such as to how medical care can be improved and accidents be avoided. This can only be done by the medical profession itself by adhering to established liability rules and their critical re-appraisal.<sup>45</sup>

Second, the duty of care determines whether the type of loss suffered by the plaintiff is actionable as a matter of policy. The standard of care is a measure of the actual alleged negligent conduct.

The duty question is only really relevant in situations where a professional person's alleged negligence is not based on a pre-existing relationship. Here, the existence of a duty of care demands further examination before the courts can adjudicate whether the professional person is negligent and, subsequently, liable.

However, in the doctor-patient relationship a duty of care is often easily established. The standard of care is the paramount feature in medical negligence cases. The doctor must act with reasonable care in all circumstances. In other words, what ought to have been done is compared with what is actually done, by reference to the reasonable doctor, common professional practice, the actual conduct

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<sup>45</sup>Jones (1991 1-2)

complained of, compliance/deviation of common practice and policy <sup>46</sup>

According to Mason & McCall Smith (1987), the courts make a balance between the interests of the individual patient and the reluctance to award damages against doctors. This reluctance is based on policy considerations, the patient is supported by relieving the burden of proof in some medical negligence cases <sup>47</sup>

These policy considerations determine that a doctor's conduct must be judged by reference to what is standard practice within his segment of the medical profession. Thus, a trial of forceps delivery which results in a medical misadventure will require explanation by reference to standard obstetrical practice. This does not exhaust the legal inquiry. It must then focus on whether the trial of forceps was well or badly handled, a question relating to the standards of that particular practitioner, and scarcely relevant to general gynaecological custom and practice <sup>48</sup>

The standard of care remains constant. It is the reasonably competent doctor. It applies at each instance of the overall medical intervention: the diagnosis and treatment, deviation from standard practice if any, innovative techniques, keeping abreast with scientific developments, and anything similarly relevant. The BOLAM

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<sup>46</sup>*Ibid* , at 62, 68

<sup>47</sup>Mason & McCall Smith (1987 165)

<sup>48</sup>*Ibid* , at 170-172. They refer to the decision in *WHITEHOUSE v JORDAN* [1980] 1 All E R 650



test addresses a divagation or departure from custom and practice from the profession <sup>49</sup>

2.2.9. Kidner (1991) provides an alternative argument to justify the standard of care in professional negligence

He asserts that the courts attribute certain characteristics to the standard of care. These characteristics are based on the particular circumstances of the case and the defendant's specific duties or obligations which derived from the nature of the underlying relationship. This relationship is based on proximity. In "ordinary" negligence cases (cases of physical damage) the degree of proximity is normally assessed through the foreseeability of damage. This implies that the courts look at the source of the obligation - the duty of care - to assess the standard of care <sup>50</sup>

However, in professional negligence cases the relationship is normally based on something more substantial than ordinary proximity. It requires more than reasonable foresight in a general sense. The relationship must at each time be re-considered, and its critical features assessed to form the required standard of care <sup>51</sup>. This implies an examination into the specific obligations

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<sup>49</sup>Mason & McCall Smith (1987 167)

<sup>50</sup>Kidner (1991 6)

<sup>51</sup>This is made in clear in the thesis by reference to the factual situation of which Mr Walsh alleged to have been negligently informed (WALSH v FAMILY PLANNING SERVICES [1992] I R 496), see *infra* Subparagraph 5.6.1

and duties of the defendant to assess the required standard of care. This raises the question as to the position of the defendant and the standard should be that which the defendant holds himself out as possessing.<sup>52</sup>

Accordingly, Kidner suggests that the nature of the relationship tells us whether the defendant could have acted differently than he did. The standard of care, therefore, must also be considered from the point of view of the defendant.

According to this view, it is submitted by this researcher, the violation of the standard of care by the defendant demands an examination of the contents of the duty of care. This is nothing new. However, Kidner stresses the point that in situations where the relationship is less obvious the standard of care is not determined by reasonable care alone. In these situations the standard of care is determined by reference to the breach of specific duties that established the relationship between the plaintiff and the defendant. This point in particular is picked up by this researcher and the thesis carries Kidner's argument further.<sup>53</sup>

### The Standard of Care of Computer Consultants and Mental Health Professionals

2.2.10. A new area of professional negligence may be

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<sup>52</sup>Kidner (1991: 22-23)

<sup>53</sup>See *infra* Subparagraph 4.4.2

found in computer malpractice. Together with the negligence of mental health professionals, discussed below,<sup>54</sup> a general professional negligence test proves problematic in this area of professional negligence. The features of such a test, as summarized in the thesis,<sup>55</sup> do not take into account the specific nature and position of professionals in these two areas.

2.2.11. Condo (1991) explores the liability of a computer consultant who fails to advise a client competently as to computer systems. The question is how a professional negligence standard applies in such a novel field.

The underlying problem is that the computer consultant has not yet been subsumed within the confines of the term "profession". Yet the occupation is one which requires autonomy of judgment and where failure to maintain high standards can lead to economic loss. But there is no uniform certification procedure for computer consultants. Therefore, reference to "equally competent men" would be misleading, comparisons are difficult to make in the absence of uniform standards of education, training and practice.<sup>56</sup>

One alternative is to avoid applying the definition of

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<sup>54</sup>See *infra* Subparagraph 2 2 12

<sup>55</sup>See *infra* Subparagraph 4 4 2

<sup>56</sup>Condo (1991: 323) Equally, reference to the BOLAM or the DUNNE test will be problematic. These tests refer, respectively to a "body of responsible opinion" or an "accepted and approved practice", see *infra* Subparagraphs 4 4 2 and 4 4 3

"professions" at all to such cases and instead to search for another basis on which they may be resolved. The courts could consider the particular relationship between client and service provider upon the subject matter of the transaction and the degree of reliance of the client.<sup>57</sup>

Yet another alternative, proposed by Condo, would be to apply the idea of implied warranties to service providers, including computer consultants. This suggests that the provided services carry an implied warranty that they are performed competently. As a result it generalizes the concept of malpractice (or negligence) and covers all types of non-professional services.<sup>58</sup>

Whether the professional malpractice standard should be extended to computer professionals depends, according to Graziano (1991), on the nature of the damage and the nature of the defendant's conduct. She agrees with Condo (*supra*) that to establish this there must be some sort of uniformity within the profession, based on educational or licensing standards. Until this is achieved the ordinary negligence rules should apply.<sup>59</sup>

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<sup>57</sup>Condo (1991 327-328). See, for example, the decision in *DIVERSIFIED GRAPHICS LTD v GROVES* (1989) 868 F 2d 293.

This approach suggests the application of the rules laid down in *HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD* [1963] All E R 575 and *CAPARO INDUSTRIES PLC v DICKMAN* [1990] 2 All E R 568, see *infra* Subparagraphs 9 4 2 and 9 4 3.

<sup>58</sup>Condo (1991 333). He refers to the decision in *MELODY HOME MANUFACTURING CO v BARNES* ((1987) 741 S W 2d 349).

<sup>59</sup>Graziano (1991 186).

That a professional malpractice standard in this field depends on the nature of the loss and the nature of the defendant's conduct is also recognized by Reed (1987) With regard to the provision of computer services particular legal problems arise due to different software technologies on the one side, and the nature of the plaintiff's loss on the other <sup>60</sup>

The problem that exists is where a client or plaintiff relies on the results produced by software This reliance, if misplaced, may result in huge losses for the client or plaintiff This imposes an even greater burden on the computer professional The limitations on the imposition of a duty of care, therefore, must ultimately depend on the limiting criteria initially laid down in HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD [1963] 2 All E R 575 <sup>61</sup>

2.2.12. It is obvious that in situations where a medical practitioner owes a duty towards third parties, the duty question plays an important role in the assessment of the practitioner's liability It proves that the existence of a duty is important for the standard of care required by mental health professionals <sup>62</sup>

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<sup>60</sup>Reed (1987 444)

<sup>61</sup>*Ibid* , at 445 See *infra* Subparagraph 9 4 2

<sup>62</sup>This is particularly relevant in situations where a mental health professional is under a duty to warn third parties of a dangerous psychiatric patient For more information on the specific difficulties of the duty question in this area, see Gammon & Hulston (1995) and James (1995)

As to the standard of care expected from mental health professionals a number of difficulties arise, according to Leesfield (1987) The writer argues that an accepted general practice standard is unlikely The reasons for this are the hugely conflicting schools of thought as to what constitutes mental illness and types both of diagnosis and treatment thereof This is consonant with the disparity of opinion among professional persons within the mental health profession <sup>63</sup>

The cases reviewed by the writer establish that in this field the courts in the United States take an incremental approach towards the imposition of both a duty and standard of care, depending on various factors <sup>64</sup> These factors include the foreseeability of risk (for example suicide), the likelihood of injury and the social utility of the conduct of the professional person

In assessing these factors it must, according to the writer, be emphasized that high legal and ethical standards must be maintained, particularly in the light of the added vulnerability of the more than dependent mentally ill patient <sup>65</sup>

Another reason not to use a general standard of care

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<sup>63</sup>Leesfield (1987 57) Again, a general professional negligence test such as the BOLAM and the DUNNE test is unlikely

<sup>64</sup>These factors were discussed in, *inter alia*, TARASOFF v REGENTS OF THE UNIVERSITY OF CALIFORNIA (1976) 551 P 2d 334, FREESE v LEMMON (1973) 210 N W 2d 576 and JABLONSKI v UNITED STATES (1983) 712 F 2d 576

<sup>65</sup>Leesfield (1987 60)

with regard to mental health professionals is that it is difficult, according to Michak, to make psychiatric predictions with any degree of certainty<sup>66</sup> This is particularly problematic where the issues involve a psychiatrist/psychologist owing a duty of care towards third parties of danger to them at the hand of psychiatric patients the TARASOFF syndrome<sup>67</sup>

In addition, one must first determine the professional status of a mental health professional before one can impose a duty Thus, a higher degree of care is required from, for example, a psychiatrist than it is from an (undefined) mental health therapist<sup>68</sup>

Jones (1991) argues that the mental health professional's duty towards third parties should in England be based on the following considerations, leaving no space for a universal standard (i) the psychiatrist's general duty towards society, (ii) the specific relationship between doctor and patient that may underlie the "special relationship" between the doctor and the third party, (iii) the doctor's duty to control the patient and his special knowledge about the plaintiff and (iv) the foreseeability

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<sup>66</sup>(1986 346-348)

<sup>67</sup>CF TARASOFF v REGENTS OF UNIVERSITY OF CALIFORNIA (1976) 551 P 2d 334

<sup>68</sup>Michak (1986 348-349) However, the BOLAM test and the DUNNE test apply to those who hold themselves out as having a special skill, for example, psychiatrists, psychologists and other therapists, see BOYLE v MARTIN (1932) 66 I L T R 187, *infra* Subparagraph 4 3 3

of inflicting harm <sup>69</sup> Hence, Jones favours an incremental approach in this area of professional negligence

Johnson (1991) suggests a "professional judgment" standard to determine whether the duty was breached. He rejects the "professional malpractice" test. That test compares the defendant's conduct with that of his peers. Under the former, the question is whether the defendant acted in accordance with identified criteria. These criteria relate to, for example, whether the patient was committed voluntarily or involuntarily or was an out-patient. In addition, this approach provides a satisfactory solution to the problem of whether dangerous behaviour of a psychiatric patient is foreseeable or not <sup>70</sup>

Johnson's test purports to promote more effective treatment, without exposing the public to undue risks. Thus, his proposed standard, it seems, has in mind a balance between the well-being of the potentially harmful patient, and the protection of the public at large. However, this equation may overlook consideration of some important issues, such as that of confidentiality and the nature of psychiatric treatment, in particular with respect to committal policies.

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<sup>69</sup>Jones (191 41-45)

<sup>70</sup>Johnson (1991 242)



### 2.3. The Standard Examined

2.3 1. This section reviews the comments on specific attributes of the standard of care in professional negligence. It immediately becomes apparent that the "information disclosure" cases provoke academic debate. The interpretation of "standard accepted practice" is also an issue that requires consideration.

This researcher, however, must point out that this Paragraph (2.3) overlaps significantly with the previous Paragraph (2.2). In addition, the arguments of a number of commentators are discussed in the thesis itself under the relevant rubrics.

#### Standard Accepted Practice<sup>71</sup>

2.3.2. The thesis points out that the courts rely on some sort of standard practice in professional negligence cases. They refer either to a body of responsible opinion (BOLAM) to assess the practice, or they refer to whether the practice is general and accepted (DUNNE)<sup>72</sup>

By some, "standard accepted practice" is also referred

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<sup>71</sup>This sub-heading relates to the following rubrics: (1) "Obvious Inherent Defects", (11) Errors of (Clinical) Judgment, (111) Difference of Professional Opinion and (1V) Scientific Disputes.

<sup>72</sup>See *infra* Chapter Four.

to as customary practice <sup>73</sup> However, according to King (1975), the former differs from custom in a number of ways Standard accepted practice is controlled by the members of, for example, the medical professions According to King, the medical profession is 'instrumental' in defining the standard of care in medical malpractice <sup>74</sup> In other words, the medical profession preserves the hegemony of the profession and ensures, at the same time, a higher quality of care than does custom This implies that those practices that are accepted by the profession are controlling and are something of greater forensic importance than mere customary

The standard is applicable to novel situations It does not, unlike custom, look at historical conduct but rather at present developments Furthermore, the standard is based on what ought to be done It may, on occasion, deviate from a universal belief and follow a respected minority of the medical profession <sup>75</sup>

The test should be conclusive evidence in assessing the defendant's liability,<sup>76</sup> although exceptions remain in "common sense" cases,<sup>77</sup> informed consent cases,<sup>78</sup> and those

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<sup>73</sup>See, *inter alios*, McMahon & Binchy (1990 259) This issue is also addressed in the thesis, see *infra* Subparagraph 7.1.2

<sup>74</sup>(1975 1236)

<sup>75</sup>*Ibid* , at 1238-1239

<sup>76</sup>Cf *HELLING v CAREY* (1974) 83 Wash 2d 514, 519 P 2d 981

<sup>77</sup>King (1975 1257) "Obvious inherent defects" under Irish law?

cases holding that a doctor should simply exercise his best judgment

The endorsement of an accepted practice standard of care must be based on the idea that medical decisions are not generally a matter of common sense, to be answered by the lay judge or jury. This is supported, *inter alia*, by the fact that the "bending" of hard medical evidence by the lay jury or judge could undermine the allocation of medical resources. In addition, a professional standard offers certainty as to the outcome of one's (the doctor's) actions and may prevent, by implication, defensive practice.<sup>79</sup> It offers a higher level of medical care.<sup>80</sup>

This approach bears two consequences, according to this researcher

First, it preserves the bases of tort of negligence: no liability without fault. However, "fault" must be viewed in the context of medical or professional negligence and relates only to what the medical profession regards as socially unacceptable behaviour by one of its members in the exercise of his duties.

Second, if this is accepted, there is a dangerous implication. It could mean that professional conduct or

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<sup>78</sup>King (1975 1261). This is contrary to the position under English and Irish law, see *SIDAWAY v BETHLEM ROYAL HOSPITAL GOVERNORS AND OTHERS* [1985] 1 All E R 643 and *WALSH v FAMILY PLANNING SERVICES LTD* [1992] 1 I R 486.

<sup>79</sup>The concept of defensive practice, in the context of the standard of care, is discussed below. It appears that an escape into defensive practice can lead to surprising consequences, see *infra* Subparagraph 2.3.5.

<sup>80</sup>King (1975 1244).

misconduct may be evidence of negligent conduct. This would blur the line between negligence (a matter for the court to decide) and professional misconduct (a matter for the medical profession to resolve) <sup>81</sup>

Reference to "custom" or "common practice" is normally relevant and admissible. The standard is a community standard, and it is at least an 'indication of conformity', according to Keeton et al <sup>82</sup>. To be relevant it must be 'reasonably brought home to the actor's locality and must be so general, as well as known, that the actor may be charged with knowledge of it or with negligent ignorance' <sup>83</sup>. In this sense "custom" is defined by Fleming as a 'practice accepted as normal and general by other members of the community in similar circumstances' <sup>84</sup>.

Using this standard, the burden of proof shifts to the defendant. If it has been demonstrated that he did not act according to a custom, it is up to him to justify his conduct. However, this presumption of custom is not conclusive. Otherwise, new methods cannot be created <sup>85</sup>.

Opponents to this standard argue that -

[t]here are, no doubt, cases where courts seem to make the general practice of the calling the standard of proper diligence, we have indeed

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<sup>81</sup>See also *infra* Subparagraph 8.3.10

<sup>82</sup>(1984 195)

<sup>83</sup>*Ibid*

<sup>84</sup>(1992 119)

<sup>85</sup>Cf HUNTER v HANLEY [1955] S C 200 at 206

given some currency to the notion ourselves [ ] Indeed in most cases reasonable prudence is in fact common prudence, but strictly it is never its measure, a whole calling may have unduly lagged in the adoption of new and available devices It may never set its own tests, however persuasive be its usages Courts must in the end say what is required, there are precautions so imperative that even their universal disregard will not excuse their omission <sup>86</sup>

2 3.3. How do the principles attributed to medical negligence differ from general negligence principles, in particular with regard to the required standard of care? The thesis points out that the presence of a special skill, professional opinion and the autonomous position of professional persons are three major distinguishing factors <sup>87</sup>

McCoid (1959) too, recognizes the presence of a special skill as essential in medical negligence cases He argues that the standard in the United States carries both subjective and objective elements The standard becomes more subjective, shifting from that of the ordinary prudent man to exigencies of the specific defendant, holding himself out to possess some special skill or competence However, at the same time the standard will be formed or set by objective medical opinion the ordinary degree of skill and competence exercised by physicians of equal

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<sup>86</sup>Learned Hand in THE T J HOOPER (1932) 60 F 2d 737 at 740

<sup>87</sup>See *infra* Subparagraph 4 4 2

standing who practice in the same or similar community (the "locality"-rule) <sup>88</sup>

According to McCoid, adherence to a general accepted practice protects the doctor from liability. It provides conclusive evidence of due care. Nevertheless, the adoption of a practice embraced by a distinguished minority does not automatically relieve a doctor from liability. There must be proof that there is some actual difference of opinion and that there is expert support for the practice followed by the defendant <sup>89</sup>

McCoid points out that there are certain principles of particular importance in the context of medical negligence. These principles exemplify the existence of a distinctive standard of care. They include the duty to keep up to date,<sup>90</sup> special rules concerning medical experimentation (however, it is suggested by this researcher that this is merely a deviation from the accepted practice standard and should be assessed accordingly),<sup>91</sup> and, above all, the duty to inform and disclose facts which derives from the quasi-fiduciary relationship between doctor and patient <sup>92</sup>

The measure of the standard of care of accepted practice appears, at least historically, to be set by custom, according to McCoid (1959). This measure is

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<sup>88</sup>McCoid (1959 558-559)

<sup>89</sup>*Ibid* , at 565

<sup>90</sup>*Ibid* , at 575

<sup>91</sup>*Ibid* , at 581

<sup>92</sup>*Ibid* , at 586

justified by the propositions that the legal fiction of custom had been developed before any coherent concept of the tort of negligence existed, the fact that the evaluation of medial facts is not easily done by a lay jury or judge and the 'peculiar nature of the "professional" activity' <sup>93</sup> However, one criticism remains it does not disclose whether the practice or custom is, in fact, reasonable <sup>94</sup>

2.3.4. Robertson (1981b) argues that the decision in WHITEHOUSE v JORDAN [1981] 1 All E R 267 shows what is wrong with medical negligence litigation In this case the House of Lords had the opportunity to discuss in general terms the standard of care required in medical negligence One can even argue that the House of Lords had the opportunity to distinguish the BOLAM test and replace it for a more "patient-centred" approach

First, Robertson considers the court's approach regarding an "error of clinical judgment" They upheld the decision in the Court of Appeal that the defendant was negligent However, the Law Lords disagreed with Lord Denning M R who stated that an error of judgment can never be negligent The House of Lords appreciated Lord Denning's concern, according to Robertson, to protect 'the professional reputation of the doctor' <sup>95</sup> However, the

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<sup>93</sup>*Ibid* , at 608

<sup>94</sup>*Ibid* , at 606

<sup>95</sup>(1981b 459)

House of Lords found that one cannot distinguish an error of judgment from negligence. In their view, such an error must still be able to stand the BOLAM test because some errors may be consistent with the due exercise of professional skill while other errors may fall below 'the standard of the ordinary skilled surgeon exercising and professing to have the special skill of a surgeon' <sup>96</sup>

Second, the decision remains a pro-defendant decision. Robertson disagrees with the court's attitude towards the evidence produced in first instance and accepted by the trial judge that the defendant was negligent in pulling 'too hard and too long' <sup>97</sup>. The justification for the reversal of the finding of fact by the Court of Appeal and the House of Lords can only be found, according to Robertson, in policy, to protect the medical profession's professional reputation and the fear of American litigation practices <sup>98</sup>. Generally, Robertson welcomes policy decisions as a useful tool of deterrence against plaintiffs. But, contrary to the Court of Appeal's belief, policy must only

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<sup>96</sup>WHITEHOUSE v JORDAN [1981] 1 All E R 267 at 269. See also Jones (1991 77) and Jackson & Powell (1992 509-510)

<sup>97</sup>WHITEHOUSE v JORDAN [1981] 1 All E R 567 at 268

<sup>98</sup>This prejudice is unjustified. Teff (1985) argues that American malpractice litigation differs on at least three accounts. First, medical services are provided on a more private or fee-for-service basis. Second, the attitude of, in particular, specialists is more entrepreneurial, and specialists stand normally in direct contact with patients. Third, the American legal system with its jury trials, contingency fees, and the liberal rules regarding standing and discovery, differs from that in England. See also Kennedy (1988)



be used in combination with the case's own merits<sup>99</sup> If this was done, the outcome in WHITEHOUSE might have well been different. The case shows the 'underlying indictment of the present system of compensating victims of medical accidents'<sup>100</sup> It shows all that is wrong with medical negligence litigation: costly, lengthy, uncertain and unpredictable.

2.3.5. Special attention must be given to the concept of "defensive practice" in the context of the requisite standard of care. Throughout the case law and literature this concept is put forward as a justification to relieve the professional practitioner from liability.

An explanation for this refuge into defensive practice is offered by Mason (1992). He argues that the general principles of tort (that still rule professional liability) do not take into account factors that influence the decision making process with regard to the administration and provision of treatment.<sup>101</sup> These factors include an interaction between, *inter alia*, the ever increasing costs of medical health care and the increasing compensation mentality that renders practitioners into exercising "defensive practice".

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<sup>99</sup>This is contrary to Lord Scarman's opinion in *SIDAWAY v BETHLEM ROYAL HOSPITAL GOVERNORS* [1985] 1 All E R 643, according to Lee (1985). Policy matters must be left to the legislators, courts are concerned with legal principles.

<sup>100</sup>Robertson (1981b: 457)

<sup>101</sup>Mason (1992: 133)

At the same time, attitudes have changed and professional services are no longer accepted at face-value. The public perception does not meet the professional ideal. This is induced by, for example, the clear presence of profit-incentives, particularly in the bigger accountancy and solicitor firms. This unhesitating lust for money seems to influence the quality standard of the provided professional service. At the same time, the pressure of litigation forces professions to take refuge into "defensive practice" <sup>102</sup>

Tribe & Korgaonkann (1991) argue that "defensive practice" is misunderstood and may lead to a higher standard of care required by professionals. Medical practitioners are under the misconception as to what is meant with medical negligence and related aspects, in particular the appropriate standard of care.

Against the background of increased litigation, the consequence of this misconception is the adoption of unjustified and defensive medical practices.

Defensive practice in this concept is defined as unjustified medical care to reduce the threat of litigation. In other words, the 'doctor's professional judgment is influenced by legal rather than clinical considerations' <sup>103</sup>

However, the BOLAM test asserts that a particular practice does not amount to negligence if a doctor fails to

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<sup>102</sup>*Ibid* , at 134

<sup>103</sup>Tribe & Korgaonkann (1991 2)

perform it and a responsible body of opinion regards this practice as unnecessary. Nevertheless, the more unnecessary practices are adopted by medical practitioners the more they may lead to acceptance of an (even more restrictive) standard of care. They will, accordingly, stand the BOLAM test. As a result, the test may become progressively more rigorous, resulting in an increasing financial burden for both the health services and the patient.

"Defensive practice" in medical care must be avoided. This will be achieved, if one is prepared to understand and appreciate the objectives and philosophy that underpins the development of medical services.<sup>104</sup>

#### Consent and Information Disclosure

2.3.6. Before the evolutive doctrine of "informed consent", the duty to disclose information had been accepted into the common law, according to McCoid, on the basis of the quasi-fiduciary relationship between the doctor and patient.<sup>105</sup>

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<sup>104</sup>See also O'Sullivan (1991). He argues that without such an understanding cost management and resource allocation cannot take place. There must be clarity between the ends and means. Cost control must go hand in hand with service quality, instead of regarding it as an ultimate and separate goal. To achieve this, the professional relationship must be personal and intimate. The service must be understood on a personal level, i.e. the patient-doctor relationship. This must be safe-guarded and emphasized. This is even more apparent, according to this researcher, taking into account the increasing impersonalization of and the decreasing reliance on the "family doctor".

<sup>105</sup>(1959 586)

The existence of such a duty appeared to be helpful to a plaintiff in at least three situations <sup>106</sup> The duty to disclose was relevant (i) with regard to a patient's claim for malpractice that in the ordinary course would already have been statute-barred, (ii) where insufficient disclosure rendered the consent ineffective (this may have caused the doctor to be subjected to a claim of unauthorized treatment) and (iii) where a claim was based on the breach of the duty to inform, a failure to disclose facts

The discharge of this duty is subjected to medical paternalism and this is, according to Teff (1985),<sup>107</sup> sanctioned by the courts in cases like *BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE* [1957] 2 All E R 118 and *SIDAWAY v BETHLEM ROYAL HOSPITAL GOVERNORS* [1985] 1 All E R 643 Medical paternalism is a reasonable approach when it comes to diagnosis and treatment However, with regard to advice and the disclosure of information the approach is open to a number of question marks Other than pure medical considerations may be relevant The duty to disclose must be based on the patient's right to decide

In addition, this paternalistic approach is somehow confrontational This confrontational nature has burdened a more mature conception of informed consent due, in part, by the exception of therapeutic privilege and the emphasis

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<sup>106</sup>*Ibid* , at 586-592

<sup>107</sup>This is also identified in the thesis, which carries Teff's argument further, see *infra* Subparagraph 5.6.4

on quantity rather than quality of disclosure

Teff suggests that there are reasons to promote a less confrontational approach based on enhanced communications that aims at 'establishing a "therapeutic alliance"' <sup>108</sup> This alliance aims, instead, at some sort of mutual understanding or perception regarding the proposed treatment and allied factors. Informed consent should therefore entail a -

genuine dialogue [ ] facilitating a broad appreciation by the patient of the seriousness of his illness, the anticipated benefits and risks of proposed treatment and any reasonable alternatives, bearing in mind the particular patient's values and objectives <sup>109</sup>

Harris too sees the BOLAM test as out-moded in this specific area <sup>110</sup> It served its function well in a time where medicine was less complicated and sophisticated

It appears also as if the expert's evidence as to what should have been done did not always conform to that expert's own evidence about his or her practice. Since this is so, the courts must take this fact into consideration and use their power more frequently to overrule expert defence opinion <sup>111</sup>

Harris also suggests another area of reform. A large

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<sup>108</sup>Teff (1985 434) See also Gutheil, et al (1984)

<sup>109</sup>Teff (1985 443)

<sup>110</sup>(1992 105) His reasons are discussed in the thesis, see *infra* Subparagraph 5.6.4

<sup>111</sup>*Ibid* , at 106

group of plaintiffs can not afford to undertake action and are not eligible for legal aid To overcome this hurdle, Harris suggests a limited form of contingency fee arrangement for these people, without threatening the strict control of the means by which legal aid is granted <sup>112</sup>

2.3.7. Some commentators view the decision in *SIDAWAY v BETHLEM ROYAL HOSPITAL GOVERNORS* [1985] 1 All E R 643 as an extension of the BOLAM test <sup>113</sup> This extension is based on the fact that the Law Lords in *SIDAWAY* allowed the disclosure of substantial risks of grave consequences They made an exception for the non-disclosure of substantial risks bearing grave consequences In other words, this exception would hint towards a "prudent patient" test

Jones rejects this view <sup>114</sup> In his view the BOLAM test is also applied in the "disclosure of information" cases, notwithstanding the different points of view on the subject matter that were expressed in *SIDAWAY*

According to Jones, the minority view would contravene the BOLAM test, because its objective nature allows the courts 'to determine, ultimately, what constitutes negligence on the basis of the evidence presented' <sup>115</sup> Evidence of common professional practice is not conclusive

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<sup>112</sup>*Ibid* , at 107

<sup>113</sup>See, *inter alios*, Kennedy (1988 201, *infra*)

<sup>114</sup>(1991 239)

<sup>115</sup>*Ibid*

The so-called "exception" is rather an instance where the court can condemn a particular practice as negligent

Grubb (1985) argues that the existence of a risk in medical treatment is a matter of professional judgment. However, its disclosure, where appreciated by the clinician, is at least arguably obligatory. The reason for the application of the BOLAM test in *SIDAWAY* is, therefore, not convincing, the patient has a right to know and this right is protected by the 'reasonable doctor' <sup>116</sup>

At least one aspect could generate further litigation. It has been said that questions must be answered truthfully. According to Grubb (1985), a failure then, could amount to actionable negligent misrepresentation. However, the scales are tipped in favour of an attitude which could be excoriated as medical paternalism. This is the doctrine of therapeutic privilege in disguise <sup>117</sup>

On analysis, Kennedy (1988) argues, contrary to Jones (*supra*), that the House of Lords decision in *SIDAWAY* attempted to free from BOLAM the law relating to the doctor's duty to inform his patients. Lord Scarman accepted the doctrine of informed consent. So did Lords Bridge and Templeman, but to a lesser extent. It proves that the common law is adaptable and the BOLAM test is not 'set in stone' <sup>118</sup>

The disclosure of information is an ethical concept

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<sup>116</sup>Grubb (1985 200)

<sup>117</sup>See also Brahams (1985)

<sup>118</sup>Kennedy (1988 202)

and entails the doctor's respect for the patient's autonomy. With regard to the amount of information, the ethical principle demands disclosure of what the patient would regard as material. The balance must be struck between medical paternalism and 'patient's sovereignty',<sup>119</sup> this balance is shifting all over the common law world in favour of the latter.<sup>120</sup> The parties must reach an optimum of 'shared decision-making'.<sup>121</sup>

As we have seen, it is generally accepted from the literature that elements of the doctrine of informed consent have been incorporated into English law.<sup>122</sup> The principle of therapeutic privilege allows the doctor to exercise a proper discretion concerning the disclosure of information. In addition, according to Kennedy (1988), the doctrine would, contrary to common belief among practitioners, be in conformity with judicial respect for the doctor-patient relationship. This harmonizes with its underlying aspects: confidence and trust.

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<sup>119</sup>*Ibid*, at 178

<sup>120</sup>See, for example, the recent decision in *ROGERS v WHITAKER* [1992] 16 B M L R 148

<sup>121</sup>Kennedy (1988: 178). See also Teff (1985), *supra* Subparagraph 2.3.6

McDonough, *et al* (1995) stress that the concept of safety has changed over recent years. This change has partly come about due to patient consumerism and the stress on quality improvement. They emphasize the need for documentation by the doctor of the informed consent, as well as the need for a verification procedure that the patient was informed and did agree to the proposed treatment.

<sup>122</sup>This view is interpreted in two ways, see *infra* Subparagraph 5.6.4



2.3.8. As to the idea of "therapeutic privilege", Epstein asks himself what is to be gained by the hostility against it <sup>123</sup> The courts often seek to justify the doctrine Epstein offers a convincing rationale for the espousal by various courts of criticism of this doctrine The vindication of individual self-determination is central to the common law of both tort and contract, to the questions regarding the type of risks that must be disclosed and the extent of the disclosure itself <sup>124</sup>

However, a form of generalized consent enables the medical practitioner to exercise his discretion to use his best judgment as to information obtained during an operation In addition, is it wise to inform a patient, prior to a serious operation, of 'a catalog[ue] of horrors' he might face?<sup>125</sup> The exercise of discretion and common sense of both patient and doctor must be recognized and awarded Epstein proposes that explicit rules governing their relationship - the terms and conditions of the relationship - should be encouraged prior to the commencement of the actual relationship or administration of treatment <sup>126</sup>

But the therapeutic privilege must be confined within bounds, according to Jones (1991) It does not allow a doctor simply to be silent about material risks if he

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<sup>123</sup> (1976 122)

<sup>124</sup> *Ibid* , at 119

<sup>125</sup> *Ibid* , at 125

<sup>126</sup> *Ibid* , at 127

thinks that disclosure would prompt the patient to forego the operation. If it would extend to this, the 'exception might become so wide as to undermine the requirement of disclosure' <sup>127</sup>

2.3.9 The decision in *ROGERS v WHITAKER* [1992] 175 C L R 479 emphasized the need to look in each case to the particular patient with regard to the disclosure of information <sup>128</sup>. This emphasis underscores, however, according to Kerridge & Mitchell (1994), the misinterpretation of the idea of consent as a single event. The decision in *ROGERS* only reflected superficial changes (a fuller disclosure of information and the doctor should be reasonably aware what a specific patient might want to hear), it omitted to address the nature of consent as a process. Therefore, the court in *ROGERS* missed the opportunity to guide doctors as to what is ethically needed: a shift towards an understanding of the process of information provision and shared decision making <sup>129</sup>.

In this process, the patient's autonomy and interests must guide clinical management of the patient's problem or illness. Doctors must be regarded as 'advocates for their

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<sup>127</sup>Jones (1991: 236)

<sup>128</sup>Apart from its decision concerning the disclosure of risks, *ROGERS* is significant in the context of this thesis for its explicit rejection of the BOLAM test, see *infra* Paragraph 7.2

<sup>129</sup>Kerridge & Mitchell (1994: 242)

patients' health' <sup>130</sup>

2.3.10. Merz points out that the doctrine of informed consent, in the United States, serves four goals <sup>131</sup> First, an ethical goal that emphasizes the patient's autonomy Second, a decision-making goal, here, the law champions the patient's ability to make a decision on the basis of provided information Third, a regulatory goal that controls the doctors' disclosure practices Fourth, a compensatory goal to provide the patient with pecuniary compensation in the case of loss

However, the goals are not equally met Merz (1993) argues that the courts at each time find a compromise between them They employ different standards to assess the doctor's conduct Some courts emphasize the patient's right to autonomy, while others support a professional-centred and paternalistic approach

Merz argues that all goals can be achieved fully if the informed consent inquiry is directed 'to the adequacy of information to support patient decision-making' <sup>132</sup> This involves a better understanding of what information is material and wanted by the specific patient What are the requirements for making decisions? Thus, the adequacy of disclosure must not be judged by the particular risk that may materialize but should be judged taking into account

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<sup>130</sup> *Ibid* , at 243

<sup>131</sup> (1993 231)

<sup>132</sup> *Ibid*

how the disclosure of the whole body of information would have influenced the decision

Daar (1995) points out that the legal idea of consent is changing in the United States. This change will affect the parameters of disclosure within the doctor-patient relationship. These parameters are, on the one side, medical paternalism and, on the other side, patient autonomy.

Recently, in two cases, the issue came up whether disclosure of non-medical information falls within the scope of informed consent.<sup>133</sup> For example, should a physician disclose his sero-positive status to his client or provide statistical life expectancy information to a cancer patient, to enable the patient to come to an "informed choice"?

Daar argues whether the physician is only confined to assess the patient merely *qua* patient or whether he has an obligation to disclose information that is unrelated to the patient's treatment options. The decisions in recent cases emphasize the relevance of this information. The courts stressed the importance of disclosure of information with regard to the physicians' interests, on the basis that details of, for example, the physician's health or economic records may affect the physician's medical judgment and performance.

Daar does not receive this development with open arms

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<sup>133</sup>Daar (1995 188). These two cases are ARATO v AVEDON (1993) 858 P. 2d 598 and FAYA v ALMARAZ (1993) 620 A. 2d 327.

She ponders whether the provision of this type of information will actually help the patient to come to a more informed choice <sup>134</sup>

Robertson (1991) appears to be sceptical about the reception of the professional judgment test in REIBL v HUGHES (1978) 21 O R 2d 14 In his view the case did not have a significant impact on medical malpractice litigation Its true effect may be the symbolic importance It reflects a fundamental change in the doctor-patient relationship

**2.3.11.** Kibble-Smith & Hafner (1986) set out one of the consequences of the increased use of computers and data banks for the provision of information

They argue that the general principle of tort liability must undergo a change due to this increase, for example, the requisite standard of care The efficiency of these data banks imposes a greater burden on the doctor to keep up to date with relevant information for his specialization <sup>135</sup>

Kibble-Smith & Hafner also point out that this has necessary consequences for the procedures by which informed consent is obtained Improved access to computer information will broaden the doctor's duty in this area He will have a higher duty to search for and report on side-

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<sup>134</sup>(1995 208-209)

<sup>135</sup>Kibble-Smith & Hafner (1986 70)

effects and other treatment options <sup>136</sup>

2.3 12. A different look at the doctor's duty to disclose is offered by Jakobovits (1989), the former Chief Rabbi. He submits that, from the perspective of Jewish law, those who are qualified to provide medical services have a moral and religious obligation to do so. This duty is absolute. As a consequence, a doctor does not need to obtain consent in life-saving treatment, among his tasks is the preservation of life.

The implication of Jakobovits' argument which has powerful adherence, not just among the Jewish religion but among those of fundamental persuasion generally, is that the role of consent is of diminished importance. The primary responsibility of a patient who agrees with this view is to preserve life by consenting to life-saving treatments. The underlying religious basis is that our body is not our property. Consent is merely a safeguard for the treating clinician.

Informed consent is regarded by the former Chief Rabbi as a cloak for relinquishing what is essentially the doctor's responsibility in decision making. The patient is not competent to take the necessary decisions which must be

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<sup>136</sup>*Ibid*, at 87. This researcher argues that access to computer provided information may evoke the question whether a medical practitioner is limited to inform his patient only of treatments which are not excluded from medical professional opinion. This may mean that a doctor has a duty to inform a patient about treatment options which lie outside the traditional area of medicine, i.e. homeopathy, acupuncture and other options.

left to those with appropriate professional judgment

## 2 4 Specific Attributes of the Standard of Care of Solicitors

2.4.1. The thesis addresses the standard of care of a solicitor in Ireland in a separate Chapter (Chapter Six) It stresses that the DUNNE test equally applies to solicitors However, it appears that the Irish courts have a greater input into the decision making process This is particularly relevant with regard to the exception of "obvious inherent defects"

This Paragraph deals with some issues that are generally relevant to the conduct and standard of care of solicitors, for example, representation and information provision These issues of solicitors' negligence are surpassed in the literature by others aspects, for example, the duty question with regard to third parties <sup>137</sup>

2.4.2. Client representation is one of the primary duties of a solicitor Munneke & Loscalzo hold that the essence of the provision of advocacy services is the presentation of accurate information <sup>138</sup>

*Ex hypothesi*, the essence of misrepresentation (and thus, conflict) is miscommunication Ill advice leads to a

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<sup>137</sup>See *infra* Subparagraph 2 7 8

<sup>138</sup>(1989 391)

lack of informed decision making that may result in loss. Relating this to the doctrine of informed consent in medical malpractice cases, the authors pose the question whether an informed consent action should be recognized in legal malpractice.<sup>139</sup> Relying on the agency nature of the relationship between lawyers and their clients, Munneke & Loscalzo infer that a common law duty exists with regard to the provision of information and the requirement to obtain informed consent as to the scope of the exercise of the lawyers' responsibilities.

However, it should be limited to situations where the courts have already established the client's right to make a decision, for example, with regard to settlement offers, conflicts of interest and mediation. This right should not be expanded. A client should not be entitled to control all aspects of the representation. It cannot, contrary to medical malpractice, depend on 'an ill-defined right to autonomy'.<sup>140</sup>

Informed consent must also be distinguished from cases involving misrepresentation. The crucial difference lies in the fact that in the former the quality of the information is inadequate. The latter involves a false statement of fact upon which the client relies.<sup>141</sup>

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<sup>139</sup>*Ibid* , at 392-393. This argument is addressed in the thesis, see *infra* Subparagraphs 6.2.4 and 6.2.5.

<sup>140</sup>Munneke & Loscalzo (1989: 430)

<sup>141</sup>*Ibid* , at 397



**2.4.3.** In some American States, the attorney is measured by a higher standard if he holds himself out as a specialist, according to Rensberger (1990) A parallel can be drawn with medical specialists <sup>142</sup>

This development, first recognized in *WRIGHT v WILLIAMS* 121 Cal Rptr 194, went hand in hand with a relaxation of the advertisements regulations for legal practitioners Accordingly, the standard refers to 'one who holds himself out as a legal specialist [performing] in similar circumstances to other specialists but not to general practitioners of the law' <sup>143</sup>

Thus, according to Rensberger, there are two standards of care One for general or ordinary practitioners, predicated on an implied representation of general skill and care and one for specialists, predicated on an express representation of some superior standard of skill and care <sup>144</sup>

In other words, the standard that must be used appears to depend primarily on whether or not a practitioner holds himself out as a specialist This could, among other things, be established by referring to the advertisement tactics of the practitioner in question

**2.4.4.** The decision in *WHITE v JONES* [1995] 1 All E R 691 has also consequences for the standard of care of

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<sup>142</sup>Rensberger (1990 24)

<sup>143</sup>121 Cal Rptr 194 at 199

<sup>144</sup>Rensberger (1990 27)

solicitors, according to Kessel (1995) <sup>145</sup>

The decision in WHITE demanded the application of practical justice. In this case a disappointed plaintiff would otherwise be left without any remedy for her losses. Neither contract, nor the pure HEDLEY BYRNE principles could apply in the absence of, respectively, a contract between the solicitor and the beneficiary, or reliance of the beneficiary under HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD [1963] 2 ALL E R 575 <sup>146</sup>

The desire to fill the gap is, according to Kessel, twofold. First, the desire to compensate an innocent third party who had no remedy in contract. Second, the injustice whereby an obviously careless lawyer would escape liability.

If this was so, it would have further consequences for the solicitor's role in the community. The general public relies and expects a certain standard of care of people with a special skill. This is especially so with regard to hidden defaults in wills. Kessel suggests that some form of consumer protection is politically necessary <sup>147</sup>

2.4.5. Crowley suggests that the solicitor's autonomous position, both as a professional and agent, requires from him an independent attitude as to the required standard of

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<sup>145</sup>Other aspects of the WHITE case are discussed elsewhere, see *infra* 2 7 8

<sup>146</sup>Kessel (1995 500)

<sup>147</sup>*Ibid*

care

According to Crowley, the solicitor is under a 'heavy onus' to exercise the necessary skill and care which is required to safeguard his client's interests <sup>148</sup> He has a general duty to exercise the degree of care that can be expected from a reasonably careful and skilful solicitor in the circumstances of the case This is, however, qualified The solicitor does not act reasonably if he automatically and mindlessly follows the practice of others <sup>149</sup>

This means, according to Crowley, that a solicitor will not escape liability by relying, for example, on a common conveyancing practice At each time, he must consider the practice he wishes to follow from the perspective of the circumstances of the case,<sup>150</sup> taking into account the relevant legislation and regulations <sup>151</sup>

Consequently, it can be argued that Crowley considers the standard of care as being partially subjective Although the solicitor defendant will be compared with a reasonably careful and skilful solicitor, the defendant solicitor's own actions are assessed without reference to the prudent solicitor where it is argued that he mindlessly followed the practice of others His autonomous position allows him to deviate from accepted practice within

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<sup>148</sup>(1987 95)

<sup>149</sup>Cf ROCHE v PEILOW [1986] I L R M 189 at 197, per Henchy J

<sup>150</sup>Cf MCGRATH v KIELY [1968] I R 97

<sup>151</sup>Crowley (1987 95)

established parameters In this situation the question is whether the defendant made up his mind as to what practice to follow If he did, he is not negligent <sup>152</sup>

## 2.5 Recent Developments A Different Standard

2.5.1. This section first reviews the literature that came about after the decision in the Australian High Court in *ROGERS v WHITAKER* [1992] 16 B M L R 148 This case rejects the BOLAM test as a means of conclusively determining the negligent conduct of a medical practitioner or any other professional person

This section also reviews some of the literature with regard to alternative compensation schemes Many commentators share the belief that the law of tort is at present aimless,<sup>153</sup> it cannot deal sufficiently with its underlying concepts, such as deterrence and compensation This aspect is addressed in detail in Paragraph 2 7

Voices have come up to address this problem differently, in particular in the area of medical negligence, and suggest alternative compensation measures This is not specifically dealt with in the thesis, but this researcher believes that these alternatives demand a brief examination

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<sup>152</sup>This argument is also set out in the thesis, see *infra* Subparagraph 6 4 1

<sup>153</sup>See, *inter alios*, Steele (193) and Howarth (1991), *infra* Subparagraph 2 7 3

ROGERS v WHITAKER

2.5.2. The decision in ROGERS v WHITAKER [1992] B M L R 148 is welcomed by Jones (1994) This case rejects the BOLAM test with regard to information disclosure cases It applies the reasonable standard demanded by law, to be decided by the court the reasonable prudent patient, so Jones says <sup>154</sup>

Jones points out that one of the deficiencies of BOLAM is that, if adopted, it disentitles a court from ever holding that a commonly accepted practice can never be negligent Since it can be argued that doctors make a regular practice of withholding information on therapeutic grounds, it must follow that this can never constitute professional negligence This is obviously wrong It is to deny the patient his or her rights This has two consequences

First, it follows from Jones' reasoning that both under BOLAM and ROGERS, the onus is on the patient who requires satisfactory answers, to pose only questions which, according to accepted medical practices, clinicians must answer <sup>155</sup> This begs a vital question, how does the patient, as a lay person, know which questions conform to this criterion?

Second, it also follows from Jones' reasoning that BOLAM certainly and ROGERS possibly, if followed literally,

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<sup>154</sup>(1994 183)

<sup>155</sup>*Ibid* , at 185

entitle the courts to hand over the definition of reasonable professional conduct to the professions themselves

Tomkin & Hanafin (1995) are less critical. The decision in *ROGERS v WHITAKER*, they argue, could well be a guide for the Irish courts in adjudicating cases involving the non-disclosure of medical risks<sup>156</sup>. The Australian test refers to the reasonable patient as the determinant of which risks are material and therefore to be disclosed. This reasoning may find favour in the Irish courts, taking into account the judgment of O'Flaherty J in *WALSH v FAMILY PLANNING SERVICES LTD* [1992] 1 I R 486, where the alleged negligent disclosure of information for elective surgery was determined along the ordinary principles of negligence<sup>157</sup>. Both in *ROGERS* and in *WALSH* the respective judges did not depend in their decision on professional opinion or accepted practice. Instead, what was determined was the reasonableness of disclosure.

2.5.3. It is clear from Australian medical negligence cases, that the courts there reject the *BOLAM* test as the test of the standard of care, in particular with regard to

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<sup>156</sup>Tomkin & Hanafin (1995 75)

<sup>157</sup>Also relevant here, is the dissenting judgment of Lord Scarman in *SIDAWAY*. He stated, according to Tomkin in a recent Paper (1995 6-7), that disclosure must be determined by the 'court's view as to whether the doctor in advising the patient gave the considerations which the law requires him to give'. In other words, the question is 'did the patient obtain enough information in the appropriate way to make up his or her mind?', (*supra*, at 7)

cases concerning the disclosure of medical information <sup>158</sup>  
The implicit ramification of the decision in ROGERS is,  
according to McDonald & Swanton, that the patient's need  
for information is assessed from his perspective rather  
than from the perspective of medical opinion <sup>159</sup> Where a  
question becomes more difficult, the courts will need more  
assistance from expert evidence However, the disclosure of  
medical information is not such a question A general  
practice or shared opinion among practitioners may not  
conform to the standard required of the reasonable man <sup>160</sup>

Tickner (1995) gives three reasons why the court in  
ROGERS did not apply the BOLAM test

First, the nature of the decision in SIDAWAY v  
BETHLEM ROYAL HOSPITAL GOVERNORS [1985] 1 All E R 643 was  
discordant,<sup>161</sup> although the BOLAM test was applied, the Law  
Lords (Lords Scarman, Bridge and Templeman) appeared to be  
generous towards the patient These qualifications  
undermine the test <sup>162</sup> In addition, ROGERS, contrary to  
SIDAWAY or BOLAM, dealt with the doctor's duty to answer  
questions

Second, the rationale of applying the BOLAM test would

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<sup>158</sup>See ALBRIGHTON v ROYAL PRINCE ALFRED HOSPITAL  
[1980] 2 N S W L R 542, FLORIDA HOTELS PTY LTD v MAYO  
(1965) 113 C L R 588 and MERCER v COMMISSIONER FOR ROAD  
TRANSPORT (1936) 56 C L R 580 See also Skene (1995  
108)

<sup>159</sup>(1993 147)

<sup>160</sup>*Ibid*

<sup>161</sup>Tickner (1995 111)

<sup>162</sup>See also Dunn (1993)

be flawed <sup>163</sup> There is a fundamental difference between diagnosis and treatment on the one hand and information disclosure on the other hand Only the latter deals with communication skills <sup>164</sup> ROGERS did not deal with a medical issue Consequently, referring to medical practice totally disregards the patient's right to chose and abdicates what professions stand for <sup>165</sup>

Third, the application of the BOLAM test in England is out of line with other English decisions that do emphasize the patient's autonomy, according to Tickner <sup>166</sup> An example is the decision in RE T (ADULT REFUSAL OF TREATMENT) [1992] 3 W L R 782 She suggests that the House of Lords should look at the complex factors of each individual medical negligence case and to give weight to the needs and characteristics of the patient involved In doing so the House of Lords will not have to adopt the prudent patient test but is able to reject the BOLAM test <sup>167</sup>

**2.5.4.** Cassidy (1992) suggests that the Australian standard of care test does not do justice to the concept of

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<sup>163</sup>Tickner (1995 112)

<sup>164</sup>But in fact communication skills lie at the centre of the practice of all medicine First in respect of the acquisition of information from the patient by which diagnosis is made and in the way therapeutic options are retailed Second, diagnosis and treatment themselves represent skills learned from scientific communications of various sorts

<sup>165</sup>See also Thacker (1993)

<sup>166</sup>(1995 115)

<sup>167</sup>*Ibid* , at, 118



medical negligence. The dissenting judgment of Lord Scarman in *SIDAWAY* is also incorrect as to the proper assessment of medical negligence, even with regard to information disclosure cases. The *BOLAM* test remains in the author's view the proper test. Cassidy justifies this with three arguments.

First, the case law in England suggests that the *BOLAM* test applies authoritatively to the standard of care of all professional persons.<sup>168</sup> In particular where the defendant has exercised his duties in accordance with professional opinion. The test is generally applicable whenever the defendant professes a special skill.

Second, with regard to the duty of disclosure of information, Cassidy argues that it is not a question whether a duty to warn or disclose is owed, but rather what the extent is of this duty.<sup>169</sup> Here, the source of this duty is no different from that of the medical practitioner's other duties (diagnosis and treatment). This source is skill, competence and reasonable care, not the right of the patient's bodily integrity asserted by Lord Scarman in *SIDAWAY*.

Finally, the question of breach of the duty of care is not a question of law but a question of fact.<sup>170</sup> The defendant breached his duty if he had not conformed to a certain practice. It cannot be decided upon what the

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<sup>168</sup>Cassidy (1992: 72)

<sup>169</sup>*Ibid*, at 85

<sup>170</sup>*Ibid*, at 85-86

defendant ought to have done. If this is accepted, 'nothing other than the *Bolam* [sic] test can be applied' <sup>171</sup>

### Alternative Compensation Schemes

2.5.5. According to Maguire (1993), the present compensation system for medical negligence does not suffice the demands of the patient. The patient wants to find out what went wrong, whether his doctor was incompetent and whether he can obtain compensation for his loss. The tort system has become too slow, expensive, burdensome and uncertain to provide a proper answer to the above questions <sup>172</sup>

He agrees with others that a "no-fault" scheme would overcome the identified difficulties under the present tort system. However, he also warns against the disadvantages. Such a scheme, as in New Zealand,<sup>173</sup> does not have a deterrent effect the tort system suggests to have <sup>174</sup>

McLean (1988) examines the possibility of legislation by referring to a no-fault liability scheme as it exists in

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<sup>171</sup>*Ibid*, at 86 (Cassidy's italics)

<sup>172</sup>Maguire (1993: 250). In his article Maguire refers, *inter alia*, to the proposals suggested by the Pearson Commission (Report of the Royal Commission on Civil Liability and Compensation for Personal Injury, H M S O, Comnd 7054). These proposals are considered elsewhere by McLean (*supra*).

<sup>173</sup>See McLean (*supra*).

<sup>174</sup>Maguire (1993: 251).

New Zealand <sup>175</sup>

In England, the medical profession objected to the Pearson Commission's proposals <sup>176</sup> The medical profession indicated that the fault liability principle as it exists today is 'one of the means whereby doctors could show their sense of responsibility and, therefore, justly claim professional freedom' <sup>177</sup> In addition, the profession felt that a no-fault liability scheme would create an intrusion in and a bureaucratization of medical practice

According to McLean, there are, nevertheless, valid reasons to consider such a scheme The scheme as it exists in New Zealand avoids higher insurance premiums and "defensive practice" for one thing It also covers more cases than just cases resulting from negligent conduct, cases of medical accidents are widely covered Contrary to the scheme, litigation is costly, time-consuming and compensation is often not there when it is needed Finally, litigation undermines the doctor-patient relationship <sup>178</sup>

However, in New Zealand, the scheme has proven to include some obstacles First, one may encounter problems as to who is eligible under the scheme <sup>179</sup> Second, whether

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<sup>175</sup>The Accident Compensation Act, 1972

<sup>176</sup>The Royal Commission on Civil Liability and Compensation for Personal Injury, H M S O , Cmdd 7054/1978

<sup>177</sup>*Ibid* , para 1342

<sup>178</sup>McLean (1988 148-150)

<sup>179</sup>The scheme covers loss from accidental injury and is not restricted to medical accidents, see McLean (1998 150)

medical accidents are covered depends on the interpretation of "error", "mishap" or "medical misadventure" In one case a medical error was defined as a failure to observe 'a standard of care and skill reasonably to be expected of [the doctor]' <sup>180</sup> The test is similar to that in negligence, but it is said to be coinciding A medical mishap has been accorded a wider interpretation It is -

an intervention or intrusion into the administration of medical aid, care or attention of some unexpected and undesigned incident, event or circumstance of a medical nature which has harmful consequences for the patient <sup>181</sup>

Finally, a last obstacle regards how the no-fault scheme deals with issues of informed consent McLean argues that this is a central problem to the scheme It fails to respect the patient's bodily integrity and right to self-determination regarding the inadequate disclosure of risks and alternative methods Only those risks are compensated which are unexpected But unexpected by whom? It is not enough for the patient that he did not know about them, if it is known to the doctor, although he did not inform the patient, the patient is not compensated <sup>182</sup> In addition, Mclean points out that under the scheme compensation aims at loss of earnings, it does not compensate for an insult

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<sup>180</sup>*Ibid* , at 154

<sup>181</sup>*Ibid* , at 155

<sup>182</sup>*Ibid* , at 156-157

to bodily integrity <sup>183</sup>

The problem of consent and bodily integrity in no-fault schemes has also been recognized by Epstein (1976) Nevertheless, Epstein stresses that a no-fault liability scheme takes seriously the idea that the law is an allocator of losses and spreads these losses over the entire class of consumers of medical services <sup>184</sup> He also accepts the difficulties identified by McLean (1988), including the definition of the 'compensable event' in relation to causal complexities <sup>185</sup> This leads to his conclusion that the question of fault cannot be avoided, even in a no-fault scheme <sup>186</sup>

The same and other difficulties are identified by Murphy (1989) Not all cases of medical negligence appear to be covered by the New Zealand scheme, for example, damage that has occurred as a result of disease infection, such as V D (Venereal Diseases) Administrative and moral difficulties have resulted from distinguishing accidents from disease causes However, Murphy argues that the basic aim is met by the scheme - simplifying compensation for accident victims, and that existing difficulties are of an administrative nature rather than a threat to the basic concept <sup>187</sup>

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<sup>183</sup>*Ibid* , at 158

<sup>184</sup>(1976 141)

<sup>185</sup>*Ibid* , at 143

<sup>186</sup>*Ibid* , at 147

<sup>187</sup>Murphy (1989 217)

Bolt (1989) provides a general outline of the proposal of the Council of the British Medical Association to set up an alternative, no-fault compensation scheme for medical accidents. The tort of negligence is in the Council's view inappropriate to deal with loss resulting from medical health care <sup>188</sup>

In the medical profession's view, compensation should depend on the need for it, not on the proof of negligent conduct. A no-fault scheme relieves the victim of the burden of proving culpability. It does not imply that a medical mishap is without fault. In doing so, the proposal increases the number of compensable events. However, on the other hand, the hint of litigation disturbs the professional relationship which is avoided under the alternative scheme <sup>189</sup>

The proposal is intended to be supplementary and it is generally confined to physical injury. It does not include loss resulting from progress of the underlying disease. Nor does it include injuries arising from diagnostic error which is judged reasonable by a panel of experts. The recognized complications of any procedure competently performed (disclosed inherent risks) are also excluded. The actual compensation concentrates upon identifiable financial loss and takes into account other sources of

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<sup>188</sup>Bolt (1989: 109) It is said to be unfair and slow. The burden of proof limits compensation and the customarily provision of lump sums disregard the needs of both the victim, the N H S and the Social Services.

<sup>189</sup>*Ibid*

reimbursement that are or have been made available to the victim <sup>190</sup>

Another proposal is discussed by Witcomb (1991) This proposal establishes a Compensation Board that is composed of representatives from the legal and medical professions, and consumer organisations <sup>191</sup> It is chaired by a High Court judge It aims at speedy handling of claims on a more equitable basis Once compensated, the victim, however, must give up any other legal rights in relation to his loss

According to Witcomb, the proposal replicates two problems that already exist in medical negligence litigation <sup>192</sup> (i) the burden of proof (causation), this remains in any no-fault scheme, and (ii) the provision of financial compensation alone does not benefit all the interests of the victim or claimant

In addition to compensation, victims often demand an explanation of what has happened and demand accountability of the doctor or doctors in question In doing so, the Board would be able to seek the explanations and apologies and may refer the doctor to a disciplinary tribunal The waiver of legal rights after acceptance leaves the victim astray and is left with the unsatisfactory existing disciplinary tribunals procedures

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<sup>190</sup>*Ibid* , at 109-110

<sup>191</sup>Witcomb (1991 109)

<sup>192</sup>*Ibid*

2.5.6. In the United States attempts have been made to reform the system for claims for medical injuries

King (1975) explains that in the nineteen seventies, the adoption of a strict or no-fault liability system was rejected. Such a system was thought of as being inapt to reduce the costs of litigation. The difficult causation issue remained. The added expense of additional recoverable injuries or losses were also problematic. In addition, a no-fault plan would enhance a 'distributive justice' question.<sup>193</sup> It would burden those who needed health care the most, due to their medical condition, in the absence of a national health plan.

Since then tort reform has taken place on two levels. Although it is not proposed to examine in great detail the reform in this area, some general remarks must be made.

Furrow et al (1995) point out that the huge increase in medical malpractice litigation necessitated reform.<sup>194</sup> They describe the current situation as a 'malpractice "crisis"'.<sup>195</sup> This crisis has coincided with a crisis of insurance availability, putting a financial burden on medical health care providers.

One level of reform addresses changes in the structure of the insurance industry. New types of insurance providers

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<sup>193</sup>(1975 1228)

<sup>194</sup>This increase was due to, *inter alia*, higher levels of medical treatment, the complexity of medical treatment, and the unrealistic expectations of the patient (Furrow et al., 1995 333).

<sup>195</sup>(1995 334)



have emerged,<sup>196</sup> and the type of policy has changed<sup>197</sup>

A second level involves changes to the litigation process<sup>198</sup> These changes were intended to reduce the frequency of malpractice litigation by, for example, reducing the filing of claims, or limiting the size of the settlement or judgment awarded to plaintiffs Other changes reflect an alteration of the plaintiff's burden of proof

In addition to these reforms, voices have been heard proposing an alternative system for compensating victims The rationale for this is based on a growing critique of the current system the administrative costs are too high, compensation is not effectively achieved for many medical injuries, juries are inefficient, the role of the judgments as a deterrent is unclear,<sup>199</sup> the awarding of damages bears little relationship with the defendant's negligence and access to medical services is in rural areas in America impaired due to the inability of physicians to pay their premiums<sup>200</sup>

At least seven proposals are discussed by Furrow et

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<sup>196</sup>Furrow et al (1995 339) name, for example, joint underwriting associations, reinsurance exchanges, hospital self-insurance programs, state funds and provider owned insurance companies

<sup>197</sup>Policies are written on a claims-made basis rather than on an occurrence basis (Furrow et al , 1995 339)

<sup>198</sup>Furrow et al (1995 340-346)

<sup>199</sup>See also Saks (1992) He states 'Where a deterrence system directly touches only a fraction of the cases it is intended to have impact upon, it needs to find a way to make up for the reduced probability that any potential injurer will feel its effect (*supra*, at 1286)

<sup>200</sup>Furrow et al (1995 349-351)

al <sup>201</sup> In Florida and Virginia, a limited no-fault system has been implemented with regard to birth-related neurological injuries. The system excludes, in Virginia, all other tort remedies except where the birth-related neurological injury was caused intentionally or wilfully by the medical practitioner. Compensation is for net economic loss only, compensation for pain and suffering, as well as expenses covered by insurance are excluded. Participation is voluntary. However, due to its limiting range, the system is regarded as a failure: the definition of those losses covered by the system is too narrow, and most of the patients eligible for compensation die as infants.

Medical adversity insurance covers certain expenses and losses of medical outcomes which are listed as compensable. Outcomes that are not listed are subjected to the normal routes of litigation or arbitration.

Another proposal prefers a contractual approach to liability. Here, providers of medical services contract with insurers to cover certain outcomes which, if they occur, would be paid on a no-fault basis. The patient contracts too, with the provider, to accept those amounts on possible outcomes listed in the policy.

The American Medical Association has proposed an administrative system to resolve malpractice claims. This system is based on the physician's negligence. It aims to compensate small claims. In addition, it aims at the enhancement of quality control, every liability

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<sup>201</sup>*Ibid* , at 354-362

determination can give rise to an initial screening of the practice of the defendant physician as reported by the claimant. Thus, the system covers both aspects of compensation and deterrence.<sup>202</sup>

Other proposals concern a system of enterprise liability, changing the locus of liability for patient injuries, and a persuasive system of social insurance. Under the first proposal the focus of malpractice litigation shifts. Instead of the individual medical practitioner, the health care organization under whose auspices the patient is treated, will be liable to the affected patient.<sup>203</sup> A negative aspect of this proposal is that it affects the medical practitioner's autonomy. He becomes merely an employee of the health care institution with an 'attendant loss of power'.<sup>204</sup>

With regard to a system of social security, society must bear the costs of adverse outcomes. Furrow et al refer here to the Accident Compensation Act, 1972 in New Zealand. This has already been discussed by McLean (1988).<sup>205</sup>

These alternatives to the existing tort system appear to be favoured by Furrow et al. They make sense,

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<sup>202</sup>A critical analysis of this proposal is offered by Paglia (1991).

<sup>203</sup>This proposal is developed more fully by Abraham & Weiler (1994). See also Priest (1985), for an historical analysis of enterprise liability.

<sup>204</sup>Furrow et al (1995: 359)

<sup>205</sup>See *supra* Subparagraph 2.5.5

'particularly if reform is combined with changes in the reimbursement of health care' <sup>206</sup> However, this means that the quality of care must go hand in hand with cost-effective care

It is not proposed to offer a further discussion on the secondary literature on the health care system in the United States, as it is expressly outside the scope of this thesis

## 2.6. The Professional Relationship

2.6.1. This section discusses various aspects of the professional relationship which are relevant to the Irish situation. The thesis addresses the problems that professionals face in Ireland in negotiating incidences of the professional relationship with their client or patient.

The thesis points out that the relationship between a professional and his client or patient reaches further than pure contractual terms. It follows Dahrendorf's (1984) argument that the relationship implies some sort of a social contract. This contract makes the professional accountable and responsible for his actions, either inside or outside the professional relationship <sup>207</sup>

The literature review first examines a number of incidences of the professional's responsibility, such as

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<sup>206</sup>Furrow et al (1995 362)

<sup>207</sup>See *infra* Subparagraph 8.2.1

the balance of power, discipline and confidentiality

The medical profession, in particular the role of the Medical Council in Ireland, is subject to criticism. However, there appears to be a gap in the existing literature in Ireland with regard to the role and function of the medical practitioner as a professional.

The position of lawyers has also been subject to criticism with regard to their increasingly different role in society. The literature review focuses on the lawyer's responsibilities and responses to the changing environment in which they provide their services, as well as the role and function of the codes of conduct which regulate the lawyer's behaviour.

Since the decisions in *CAPARO INDUSTRIES PLC v DICKMAN* [1990] 1 All E R 586 the position of auditors has been re-examined.

This section precedes the discussion on third-party liability. It commences with some general remarks and comments on the professional relationship of the medical practitioner, the solicitor and the auditor.

### General Remarks

**2.6.2.** Within a professional relationship, it is argued that both parties are not dealing with each other on an equal footing. There is an element of dependency on the professional service provider through the need for knowledgeable advice. Consequently, the professions are

able to set standards of performance (what ought to be done) over what is actually done

According to Lane (1966), the increase of knowledge and changes of ways of thought and thought processes influence and alter decision-making mechanisms. The gap that then exists creates 'within the profession a kind of strain towards remedial action'<sup>208</sup>. As a result professional persons and their associations have 'a role in the preformulation of policy [ ], generally responsive to the needs of society'<sup>209</sup>.

This may explain the distinction between business and professional practice. According to Behrman (1988), the aspect of social responsibility is inherent to the professions and the professional relationship. In the author's view, professions as a socio-economic group are founded upon and delineated by ethical considerations, their particular skill and knowledge is more the basis for differentiating professional roles<sup>210</sup>.

Although the word "profession" has become meaningless and alienated from its original concept, Behrman still identifies some characteristics<sup>211</sup>. To name but a few, he mentions a defined field of expertise, education and training, selection, testing and licensing, social dedication/obligation (altruism), services for income or

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<sup>208</sup>Lane (1966 657)

<sup>209</sup>*Ibid* , at 662

<sup>210</sup>Behrman (1988 96)

<sup>211</sup>*Ibid* , at 97-98

without charge for the indigent, a sliding scale of fees, self-regulation, ethics and self-surveillance

In his view medicine and the law are clearly distinctive as being professional groups *pur sang*, due to their distinct and unique roles in society. However, Behrman also identifies that the medical and legal professions do not act as professions any more, due to, *inter alia* (1) an increased specialization, which distances the relationship between professional and client or patient and (11) an increased mobility of the individual members of society. This leads to the inability to develop an enduring professional relationship <sup>212</sup>

The distinction between professions and business remains relevant. Behrman provides four reasons <sup>213</sup>. First, the appearance of the unique quality of esoteric knowledge and practice is still present as a most important factor. Second, there is still an overwhelming and, often involuntary, need for this knowledge and practice. Third, professions benefit society as a whole and those who cannot financially afford them must be served as well. Hence, the idea of differential pricing. As an ideological consequence, the price of the service is disengaged from the quality of the service. Finally, the expertise is the basis for licensing by the State and the basis to set rules of behaviour towards the society or the demanding public.

On a final note, Behrman discusses the role of

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<sup>212</sup>*Ibid* , at 102-103

<sup>213</sup>*Ibid* , at 99-100

professional and ethical codes of conduct <sup>214</sup> Many professionals are dissatisfied with the role and function of these codes. The codes cannot deal with the complexity of issues. They also have created, in many instances, a gap between what professions desire and what society demands <sup>215</sup> However, Behrman argues that the codes of conduct are said to be a necessary requirement to enforce self-discipline. The need for codes are given in by, *inter alia*, the willingness to lie or deceive, the absence of ethical training, the prevalence of "group-thinking" (sharing responsibility for unethical decisions), and the need for gain without responsibility to the society at large. Professionals must learn to take responsibility for their own actions, particularly within the professional relationship.

2.6.3. The element of dependency on knowledge bears its consequences with regard to abuse of the dominant position. This is particularly relevant with regard to sexual exploitation, according to Allen (1996). He describes the remedies that a client or patient may have in common law against sexual exploitation. When is intervention justified and on what grounds?

As we have identified, the paramount aspect within the professional relationship is that the parties do not stand

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<sup>214</sup>*Ibid* , at 154 ff

<sup>215</sup>An example of this can be found in the Medical Council's attitude towards the decision in RE A WARD OF COURT [1995] 2 I L R M 401, see *infra* Subparagraph 2.6.7



on an equal footing Allen contrasts this with the common belief that in tort the parties are independent and equal, and are concerned with their own interests <sup>216</sup> There ought to be a balance between power and dependency The justification to implement a civil duty is where this balance is disturbed,<sup>217</sup> the patient's or client's choice is impaired (no consent), harm is suffered or the trust in the relationship given by the victim is breached These aspects may give rise to either an action in battery or negligence However, these remedies are, according to Allen, inadequate to fully compensate for the damage suffered by the victim in a variety of circumstances In battery, the issue of consent is ambiguous, while in negligence the harm suffered is not always actionable

Jorgenson & Sutherland (1993) provide a number of reasons that explain the vulnerability of a client within, for example, the relationship between him or her and his or her lawyer In addition to the instability of the relationship in terms of power and knowledge, the nature of the legal problem, the disclosure of confidential information, the idealization of the lawyer and the stress of the litigation process demonstrates the importance of a well-balanced relationship

With regard to the dependent nature of the professional relationship, particularly within a doctor-

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<sup>216</sup>Allen (1996 77) He refers here to the decision in NORBERG v WYNRIB (1992) 92 D L R (4th ) 449

<sup>217</sup>Allen (1996 58-61)

patient relationship, confidentiality must be maintained. The public intervention of Dr Browne concerning the controversy surrounding Father Michael Cleary,<sup>218</sup> raised new questions regarding medical confidentiality, according to Scally (1995) <sup>219</sup> Does the very intimacy of the subject matter mean that the given advice transcends the boundaries of friendship and enters the realms of professional practice?

Scally indicates that there are four exceptions to the confidentiality rule (i) the court directs the doctor to do so, (ii) the patient has explicitly consented to disclosure, (iii) to prevent the patient from causing harm to society or others, (iv) to prevent patients from doing harm to themselves.

However, situations do exist where both the maintenance and breach of the confidentiality rule may cause harm, i.e. where HIV or AIDS patients whose partners wish to start a family risk infection. In these cases there must be a balance between the public interest and the right to confidentiality.<sup>220</sup>

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<sup>218</sup>Father Cleary sought help from Dr Browne. The former was the father of the child of Mrs Phyllis Hamilton who also was a patient of Dr Browne.

<sup>219</sup>Confidentiality is also one of the lawyer's contractual duties. This duty extends to the lawyer's staff. The use of computer based data poses, however, a problem, according to Barry (1991). Maintenance of computer systems exposes the data to others such as the maintenance engineer or mechanic who is able to copy the data and use it for improper or fraudulent purposes.

<sup>220</sup>See, for example, X v Y AND OTHERS [1987] 3 B M L R 1, W v EGDELL AND OTHERS [1989] 4 B M L R 96 and R v CROZIER [1990] 8 B M L R 128.

Having regard to the doctor's primary ethical responsibility - *non-maleficence*, a new culture of transparency is required, according to Scally. This culture must provide patients with all the required information on all aspects of their treatment. This transparency is also in the interest of the health care professional. According to Scally, it has been indicated that medical litigation can, to a large extent, be traced back to some communication failure between patient and doctor, rather than the latter's incompetence or negligence.

2 6.4. Epstein characterizes the doctor-patient relationship as consensual.<sup>221</sup> This consensual nature forms the basis of the obligations of both parties in the relationship. The sources of these obligations are found in tort and contract. Medical malpractice illustrates the importance of these two sources. Epstein states that to recognize the interaction between tort and contract in medical malpractice litigation one may come to a better understanding of the boundary line between them.<sup>222</sup>

Consequently, he argues that to determine liability it is wrong to look merely at the rules of tort. Instead, one should focus on the possibility that the parties in the relationship can vary the rules *inter se*, by their mutual

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<sup>221</sup> (1976 94)

<sup>222</sup> *Ibid*

agreement <sup>223</sup> Greater emphasis should be placed on private initiative and control rather than an increase in government <sup>224</sup> This increase may result in a wider gap between legal rules and the contractual norm

Thus, Epstein favours a position where the professional service provider and the client or patient may come to an agreement as to the limitation of liability

However, James (1987) argues that professional persons may limit or exclude their liability But the limitation or exclusion must be reasonable <sup>225</sup> Among other things, the writer argues that where the service provider limits the service through a two-tier service system, the provider may exclude liability by emphasising the limits of the service to the client in clear and unambiguous terms

The question is then, when is exclusion or limitation reasonable? Apart from the guidelines provided by the Unfair Contract Terms Act, 1977,<sup>226</sup> James argues that the reasonableness may be assessed by reference to (i) insurance,<sup>227</sup> and (ii) the operation of a two-tier service <sup>228</sup>

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<sup>223</sup>This has also been identified by Furrow *et al*, as one of the tort reform proposals, see *supra*, Subparagraph 2 5 6

<sup>224</sup>Epstein (1976 95)

<sup>225</sup>See section 2(1)&(2) of the Unfair Contract Terms Act, 1977 (England)

<sup>226</sup>See, for example, section 11 of the Act and Schedule 2, accompanying the Act

<sup>227</sup>James (1987 289 ff )

<sup>228</sup>*Ibid* , at 292 ff

Under (1), it can be argued that professional persons may limit their liability, particularly in the absence of a compulsory indemnity insurance. This limitation is reasonable insofar as it regards the strength of each party, the obligations that are accepted, the apportioning of risk, whether the plaintiff was covered by insurance and the wording of the limitation (whether it is clear and unambiguous). Great emphasis is put on the equal bargaining power of the parties. However, it has already been recognized that with regard to professional services this power is, in most cases, absent due to the nature of the professional service and the superior knowledge of the provider.<sup>229</sup>

#### The Medical Practitioner

2 6.5. Perhaps the most surprising gap in the existing literature appears to be any hard data, relevant to the Irish situation, on the role and function of the medical practitioner as a professional person, apart from text-book material.<sup>230</sup>

The literature discusses in great detail the way in which the medical practitioner is qualified, licensed, is subject to ethical and legal control, and may be censured or disqualified. But these are all attributes, there is

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<sup>229</sup>See *supra* Subparagraph 2 6 3

<sup>230</sup>See, *inter alios*, Hensey (1988) and Tomkin & Hanafin (1995)

little up-to-date in Ireland about the doctor as a professional person. This indicates the paucity of material and also, the importance of this thesis as a contribution to debate in such a vital area.

2.6.6. The articles selected for review deal with three central aspects of the medical practitioner's role. The first article deals with the recognition of the legal problem concerning a doctor as an independent contractor or employee.

Though throughout the common law world, there has been a great deal of judicial analysis of the doctor's employment position, the central question remains one of liability. In Ireland, it is well accepted that for the purpose of medical negligence, the hospital is vicariously liable for the torts of its doctors, the same is true in England.<sup>231</sup>

By way of exemplification, we here mention the Canadian position, discussed by Fridman (1980). This important article stresses a change in the area of the liability of hospitals for wrongs committed by its staff.<sup>232</sup> Fridman holds that the changes in hospital health

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<sup>231</sup>See McMahon & Binchy (1990 754-755)

<sup>232</sup>The traditional Canadian approach, embodied in *FLEMING v SISTERS OF ST JOSEPH OF THE DIOCESE OF LONDON* (1937) O R 512, (1938) S C R 172, was that the hospital was vicariously liable for the negligently performed acts of its employees. In this case, the incorrect application of diathermy, which was part of a nurse's routine duties

care provision, for one thing its public nature,<sup>233</sup> mean that liability should be grounded less in outmoded concepts derived from "master and servant law" Instead, it should be based on principles deriving from administrative law, statutory duty or simply tort This suggestion reflects the minority decision of two judges of the Ontario Court of Appeal in YEPREMIAN v SCARBOROUGH GENERAL HOSPITAL (1979) 3 L Med Q 278, (1980) 28 O R 2d 494

The consequence of this is that failure by the hospital to provide non-negligent care is actionable on the basis of breach of a "public duty" In other words, the hospital can be held directly liable and owe a personal, public duty to the recipients of health care provisions In doing so, it is suggested that it widens and enlarges the scope of the hospital's liability<sup>234</sup> Fridman's perception of hospital liability is particularly interesting and relevant in the current climate of financial emasculation of public health providers and the concomitant necessity to ration services<sup>235</sup>

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<sup>233</sup>Fridman states that public duties may give rise to liability and regulate as to how hospital bodies carry out their activities (1980 85)

<sup>234</sup>Fridman (1980 83)

<sup>235</sup>According to Bettle (1987), three options are open to render a hospital liable for negligent conduct of its staff Apart from vicarious liability, a hospital could be held liable on the basis of a 'non-delegable duty of care' (1987 573) This can exist in a duty with regard to the organisation of the hospital For example, to provide sufficient qualified and competent staff, cf WILSHER v ESSEX AREA HEALTH AUTHORITY [1986] 2 All E R 801 It also may exist in a non-delegable duty to take reasonable care This is wider and may render a hospital liable for the negligence of a private practitioner providing medical

The literature has largely failed to take up Fridman's very important point about the application of administrative law to medical negligence and professional conduct generally. His suggestion that failure by a hospital to provide non-negligent care carries considerable weight in societies where access to health care has been subject to overriding financial and other constraints. Though it may appear to be something of a huge jump, the issues outlined by Fridman have not been judicially taken up by the English courts until the decision in *R v CAMBRIDGESHIRE HEALTH AUTHORITY, EX PARTE B (A MINOR)* [1995] 3 B M L R 5 and the decision in *X v BEDFORDSHIRE COUNTY COUNCIL* [1995] 3 W L R 152.

In the former case the Court of Appeal considered whether it could interfere with the Health Authority's discretion with regard to its public duty of the allocation of health care services.<sup>236</sup> Although the Court of Appeal recognized that a local authority was under a public duty to provide medical services, it stated that it could not interfere with the Authority's decision as to how to spend its money. The Court of Appeal stated that the judge in first instance was not, on an application of judicial

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services from the hospital. Bettle argues that this duty should be restricted to organizational aspects of hospital management.

<sup>236</sup>In this case, the Health Authority refused a ten year old girl, who suffered from acute myeloid leukaemia, life-saving treatment. It was said that this treatment stood at the frontiers of medical science, had a low success rate and that medical opinion was divided as to whether this treatment was in the best interest of the patient.



review, allowed to decide between conflicting medical opinion or how a local authority is to spend its budget with regard to the allocation of resources between opposing claims

A similar outcome was reached in the BEDFORDSHIRE case <sup>237</sup> The House of Lords recognized the authority's public duties but it rejected a claim in negligence for a breach of statutory duties

It shows that the judiciary in England are, as of yet, not willing to afford compensation for the negligence of public authorities <sup>238</sup>

Brodie (1996) explains this attitude, referring to the courts' introduction of public law elements such as discretion and *vires* In addition, the courts relied on the dichotomy between policy considerations and operational measures In doing so, they could offer a clearer indication as to the reasons for rejecting a claim in negligence against public authorities The decision as to, for example, the allocation of resources made by a democratic elected body should not, on the grounds of policy, be interfered with <sup>239</sup>

The BEDFORDSHIRE case showed, according to Brodie,

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<sup>237</sup>This case involved a number of appeals involving claims of breach of a number of statutory and common law duties against the statutory background of the Child Care Act, 1980 and the Education Act, 1981

<sup>238</sup>That this area of law is not as clear-cut as other areas of negligence law has been recognized since the decision in HOME OFFICE v DORSET YACHT CO LTD [1970] A C 1004

<sup>239</sup>Brodie (1996 132)

that an action may succeed if the defendant exceeded the proper limits of his discretion <sup>240</sup>

2.6.7 In Ireland, the medical practitioner is subjected to codes of professional and ethical conduct. These codes are governed by the Medical Council. However, it appears that the role and function of the Medical Council is unclear with respect to the implementation and use of these codes. This is also addressed in the thesis <sup>241</sup>

Again, this is an area of Irish law that demands further examination. The recent decision in RE A WARD OF COURT [1995] 2 I L R M 401 showed, as one commentator observed,<sup>242</sup> that a medical practitioner, in following the law, may be guilty of professional misconduct.

Tomkin & Mc Auley (1995a) argue that the medico-legal area demand legislative change. This area appears to be full of gaps. These gaps are paramountly present in the statutes under which, for example, the Medical Council operates and issues guidelines <sup>243</sup>

An example is the apparent lack of power of the Medical Council to sanction ethical conduct. Thus, a medical practitioner who is accused of ethical misconduct and is punished accordingly, may seek to have his penalty squashed on the basis that the Medical Council does not

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<sup>240</sup>(1996 141)

<sup>241</sup>See *supra* Subparagraph 8.3.9

<sup>242</sup>See Tomkin (1995)

<sup>243</sup>Tomkin & Mc Auley (1996 20)

have the power to do so

The power to sanction professional misconduct is afforded to the Medical Council under section 45 of the Medical Practitioners Act, 1978. However, the Act and the Council are unclear as to what exactly constitutes professional misconduct.

Tomkin & Mc Auley discuss another, related problem<sup>244</sup>. Section 69(2) of the Medical Practitioners Act, 1978 imposes on the Medical Council a statutory duty to issue guidelines of ethical conduct. However, the Council does not have an obligation to issue guidelines addressing professional conduct. The writers argue that the Council may act *ultra vires* where those guidelines regulate, as they appear to do, professional conduct<sup>245</sup>. As a consequence, a doctor who is accused of breaching those guidelines which attempt to regulate professional conduct, may have his case open for judicial review.

In England, the General Medical Council has, according to Samuels (1986), broadened the concept of serious professional misconduct by including acts of negligent or gross negligent conduct. Negligence then, involves serious professional misconduct if it is shown that the doctor, as well as breaching his common law duty of care, disregarded his professional duties or responsibilities as to raise a question of serious professional misconduct. This means that the traditional distinction between the General

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<sup>244</sup>*Ibid*

<sup>245</sup>See also Tomkin (1995)

Medical Council and the courts has blurred This is the distinction between 'moral turpitude' and professional negligence <sup>246</sup>

2 6.8. A final observation is made by Barker (1995) Health care provision in England has become more competitive and consumerist in nature, according to Barker The patients are afforded rights and health care is provided through contracts in the N H S system <sup>247</sup> Barker argues that this new system affects the malpractice liabilities of health care providers <sup>248</sup>

Patients are not part of the N H S contract However, this redefined contract and the recognition of patients' rights may lead to more successful negligence claims First, the contract may ease the burden of proof Second, the new system may raise the standard of care A doctor may be held to a higher standard if he, through his contract, represents himself as capable of conforming to this standard <sup>249</sup>

Tormey (1992) adds to this that in Ireland new drugs and medical technologies have dramatically changed the outlook for the individual patients The evaluation of these developments in terms of human welfare and scientific

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<sup>246</sup>Samuels (1986 461) See also McFarland (1989)

<sup>247</sup>See section 4(1) of the National Health Service and Community Care Act, 1990

<sup>248</sup>(1995 161)

<sup>249</sup>*Ibid* , at 162

validity is a key role for the medical profession <sup>250</sup>

In addition, the medical profession must bare in mind that it ought to preserve its professional integrity with regard to the provision of medical services This means, according to Tormey, that medical practitioners must on ethical grounds guard against the presently existing incentives to preferentially treat private patients only <sup>251</sup>

### The Lawyer

2.6.9. The thesis sets out a number of aspects that are particularly relevant to the role and function of solicitors in Ireland <sup>252</sup> The solicitor's role and function is, however, changing This has been recognized by many

A number of aspects, therefore, demand further examination This section of the literature review pays particular attention to the role of codes of ethical conduct in the United States This aspect is underexamined in Ireland In doing so, it reflects the problems analyzed in the thesis with regard to the meaning of codes of ethics in the world of the professions Although this may not be directly relevant in the context of this thesis, it contributes to the question whether the use of ethical and professional codes may be relevant to the standard of care

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<sup>250</sup>Tormey (1992 376)

<sup>251</sup>*Ibid* , at 377

<sup>252</sup>See *infra* Paragraph 8 4

in the negligence inquiry This section of the literature review shows that this issue has been debated at length in the United States This is illustrated with a discussion on the perception of ethical codes by lawyers in the United States

2.6.10. The lawyer owes responsibilities to his client as well as to others These responsibilities are often conflicting and lead to a higher accountability for lawyers and their conduct An anonymous article in the Harvard Law Review (1994) points out that this constrains the lawyer He cannot act solely in the interest of his client

The increase in responsibilities are due to, *inter alia*, the apparent connection of lawyers to misconduct of others, the changing nature and composition of the legal profession, the newly emerging business approach and, finally, the type of work or specialization Among those different parties are his clients, private third parties and the legal profession

A lawyer owes responsibilities towards his client and other third parties His responsibilities here, entail competent legal representation and is extended to 'intended beneficiaries' <sup>253</sup>

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<sup>253</sup>Anon (1994 1552) The article suggests that the current tort system dealing with legal malpractice claims is not sufficiently working in America Its two main functions - compensation and deterrence - are under scrutiny Victims appear to be undercompensated and the deterrence factor is nullified through insurance safety nets Legislative tort reform, the increase in administrative costs and litigation procedures have contributed also to the decline of the current system,

The lawyer's responsibilities to his profession entail the adherence to its code of ethics and professional conduct. The enforcement of these codes are in the hands of the profession's associations. Thus, the profession itself has an important voice in its own regulation.<sup>254</sup> However, this must be reconsidered in the light of recent developments. These developments show a shocking contrast between the content of the rules and the reality of the lawyer's discipline. This is partly caused by the interpretation problems of some of the rules,<sup>255</sup> and the inefficient control mechanisms.

The article suggests that the ethical rules need more consistency and certainty through reformation of the substantive rules, improvement of enforcement proceedings, as well as co-operation with others, 'including the public, to improve [the profession's] discipline and image'.<sup>256</sup>

The lawyers' responses to the increasing number of

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(*supra* at 1574-1576)

The article, therefore, suggests an alternative: an administrative fault-based compensation scheme. Here, claims are assessed and awarded by an administrative board, replacing the adversarial system of tort litigation. It is cost-efficient and enables more people to be compensated and more people to gain access to the system, (*supra* at 1579 ff.)

<sup>254</sup>Anon (1994: 1582). In America the enforcement of the codes is in the hands of the American Bar Association. The rules are laid down in, for example, the Canons of Professional Ethics (1908), the Model Code of Professional Responsibility (1980) and the Model Rules of Professional Conduct (1983).

<sup>255</sup>For example, the rules governing the conflicts of law and the anti-contact rules.

<sup>256</sup>Anon (1994: 1604). This aspect is examined further, see *infra* Subparagraph 2.6.11.

responsibilities towards different parties aim at either restricting personal liability of lawyers, or covering their liability through insurance or indemnity clauses

This is, in the short term, an easy option. A reference to increasing standards of competence and clarity in codes of conduct - a long term approach - has not been made, or attempts have failed. The lawyers appear to be more concerned, according to the article in the Harvard Law Review (1994), with the reallocation of financial loss caused by malpractice <sup>257</sup>. This reallocation takes various forms and are here summarized

First, lawyers reallocate loss through professional liability insurance <sup>258</sup>. However, the increase in litigation and the concomitant increase in size of awards have made it difficult for lawyers to obtain insurance. In any event, the costs of the lawyer's services will rise (re-allocation) or lawyers will avoid involvement in "risky" areas of the law

Second, the law firm may be incorporated into a limited liability company, whereby the losses are born by the company, not the respective partners <sup>259</sup>

A final option is to reallocate risks through

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<sup>257</sup>Anon (1994 1652)

<sup>258</sup>*Ibid*

<sup>259</sup>*Ibid*, at 1658. However, this researcher argues that incorporation may appear to circumvent liability but, of course, it may be that subsequent courts will allow negligence claims against lawyer directors of law firm corporations



contracting with the client <sup>260</sup> This can be achieved through, for example, indemnity clauses or to submit malpractice claims to binding arbitration tribunals

Feldman (1992) also identifies the tendency to view the profession as a business, at the expense of the public responsibilities of a lawyer and his function in society Soliciting and advertising lie at the root of the problem,<sup>261</sup> as well as the obstruction of access to legal aid He stresses that lawyers must realize that they pursue a 'Learned Art' and act in the 'Public Interest' to 'resolve conflicts of clients, often implicating issues that bind the very core of the hope for civilised existence' <sup>262</sup>

**2.6.11.** According to Wilkins (1990), the traditional model of legal ethics does not disclose the effects of legal realism on the understanding of the role of the lawyer The question is how legal ethics should respond to reality, taking into account the legal realist's claim that the law is indeterminate <sup>263</sup>

Within the traditional model the lawyer's duties are two-fold and are often conflicting First, the lawyer has

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<sup>260</sup>Anon (1994 1664)

<sup>261</sup>Cupel (1995) argues that advertising has adversely affected the legal profession Clients are now exposed to the promotion of lawyers as 'fungible products', (*supra*, at 71)

<sup>262</sup>Feldman (1992 219)

<sup>263</sup>Wilkins (1990 470)

his responsibilities towards his client. Second, he has a public duty as an officer of the court. The model aims at a balance between private interests and public obligations: client representation within the bounds of the law and the lawyer's professional ethics and responsibilities. Wilkins calls this the 'boundary claim'.<sup>264</sup> Within this model legal rules are said to be objective, consistent and legitimate.

This is rejected by the legal realists. They claim that the law is indeterminate. The reasons are threefold.<sup>265</sup> First, there are different theories and sources that may provide a legal answer to an ethical dilemma. Second, many legal terms are vague and ambiguous ("good faith", "proximity", "reasonableness", etc.). This may lead to contradictory interpretations. Third, indeterminacy results from the discrepancy between the general nature of a rule and its practical application.

Therefore, as the lawyer is engaged in practice for a particular purpose, he will pursue the interpretation of a legal rule that suits his client's interests. Although this is sanctioned by the rules of professional conduct, this partisanship may become unacceptable where controversial issues are closer to the boundary claim. This may, subsequently, lead to legal nihilism, according to Wilkins, where any construction is acceptable without 'restrictions of zealous advocacy'.<sup>266</sup>

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<sup>264</sup>*Ibid* , at 471

<sup>265</sup>*Ibid* , at 478 ff

<sup>266</sup>*Ibid* , at 484

The effect of legal realism, however, is modified because it is not the practical experience of the practising lawyer. There are meaningful constraints. There is a legal culture that brings coherence of legal interpretation, for example, established custom. Lawyers are able to predict the outcome of the action of the legal decision makers.<sup>267</sup> Finally, indeterminacy is limited by the lawyer's practical desire and ability to engage in legal argument.<sup>268</sup>

Nevertheless, legal realism undermines the normative foundation of the boundary claim because lawyers can manipulate it. Within the traditional framework, zealous advocacy is limited by finetuning the regulatory system. This, however, maintains the existence of partisanship as an underlying force of the boundary claim.<sup>269</sup>

Wilkins argues that this assumption of partisanship should be modified and replaced as reference point for interpreting legal boundaries.<sup>270</sup> He suggests that lawyers should be more supportive to the essential and public purposes and the social role of the legal rules, including

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<sup>267</sup>*Ibid*, at 490. However, according to Wilkins (*supra* 492-493), this prediction may exceed the boundary of the law and may lead to a breach of professional ethics, through knowledge of external, non-legal circumstances. Is a rule enforced, is there enough man power, etc.?

<sup>268</sup>Here, the question whether boundaries are legitimate depends on factors other than pure democratic principles, i.e. economic disparity.

<sup>269</sup>Wilkins (1990 497-498)

<sup>270</sup>*Ibid*, at 505

ethics ('purposivism')<sup>271</sup> This means that lawyers must accept their responsibility as playing an important role in the preservation of society, act in good faith and use their discretion over the contents of legal rules accordingly

But this can only work with the assistance of some form of pressure This could be achieved, according to Wilkins, by taking into account the context in which lawyers interpret and apply legal ethics, and, subsequently, modify this incremental, case-by-case approach through the developments of 'middle-level principles'<sup>272</sup> These principles isolate and respond to the relevant differences in social and institutional contexts and provide 'a structural foundation for a widespread compliance in the areas where they apply'<sup>273</sup>

Although it is submitted by Wilkins that this approach entails difficulties, he believes that it is the best alternative of professional regulation It 'incorporates the truth about legal realism for lawyers while maintaining a commitment to systemic values'<sup>274</sup> It provides a meaningful way to assist individual lawyers, balancing purposive advocacy against, among other things, the private interests of their clients

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<sup>271</sup>*Ibid*

<sup>272</sup>*Ibid* , at 516

<sup>273</sup>*Ibid*

<sup>274</sup>*Ibid* , at 523

2.6.12. In America the Code of Professional Responsibility is an authoritative guideline for professional ethical conduct of lawyers<sup>275</sup> The Code expressly asserts that it does not purport to be a standard of care in negligence claims<sup>276</sup>

However, courts have frequently applied the Code as a standard in itself,<sup>277</sup> especially in the areas of conflicts of interest<sup>278</sup> Some courts assume that the Code embodies the common law duties between counsel and client<sup>279</sup> It is asserted that the impact of being labelled "unethical" may prejudice the defendant in a negligence claim<sup>280</sup>

Getter (1983) asserts in that to use ethical guidelines as a standard of care in professional negligence claims is unhelpful He argues that it removes the discretionary power of a lawyer to use his own professional judgment as to the ethicality of the particular relationship with the particular client<sup>281</sup>

However, a recent anonymous article in the Harvard Law

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<sup>275</sup>Model Code of Professional Responsibility (1980)

<sup>276</sup>This is supported by many commentators, including practising lawyers, see, *inter alios*, Mallen & Calladine (1995) and Munneke & Loscalzo (1989) These commentators maintain that ethical rules are not intended to be used in a civil action but merely require disciplinary procedures

<sup>277</sup>Cf PRESSLEY v FARLEY (1991) 579 So 2d 160 See also Mallen & Calladine (1995 20)

<sup>278</sup>Cf NOLAN v FOREMAN (1982) 665 F 2d 738

<sup>279</sup>LIPTON v BOESKY (1981) 313 N W 2d 163

<sup>280</sup>See Mallen & Calladine (1995 20)

<sup>281</sup>Getter (1983 1323)

Review (1996) refutes the present justification that the ethical codes, as they exist for attorneys,<sup>282</sup> should not be extended to the malpractice context

This justification is founded on the basis that ethical rules are present for the protection of the legal profession and the public at large, not for the individual claimant in aid for his action.<sup>283</sup> The courts claim, *inter alia*, that the nature of ethical codes preclude their role in malpractice litigation (the codes are rules of discipline and are not parliamentary represented) In addition, the rules' application is problematic Many judges fear that the codes only provide vague guidelines, and the standard of care that would be derived from them would be too broad.<sup>284</sup>

This is rejected Ethical rules could be useful in helping to establish the standard of care in malpractice suits The ethical codes express the duties to which an attorney is bound and they provide evidence of the existing duties between the plaintiff and defendant The use of ethical rules should be at the discretion of the judiciary, maintaining fairness to the defendant lawyer and allowing clients 'to hold attorneys to the same standard to which

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<sup>282</sup>See, for example, the Model Rules of Professional Conduct (1983) and the Model Code of Professional Responsibility (1980) of the American Bar Association

<sup>283</sup>Cf HIZEY v CARPENTER (1992) 830 P 2d 646 at 653-654

<sup>284</sup>Anon (1996 1106)

attorneys hold themselves' <sup>285</sup>

### The Accountant as Auditor

2.6.13. The thesis points out that the auditor exercises his functions on behalf of the members of the company. At the same time he must co-operate with the Board of Directors. As well as this *menage a trois*, the auditor also owes duties to outsiders. This may, occasionally cause friction <sup>286</sup>

Lasok & Grace identify this problem as to the auditor's relationship with both the members and directors. They point out that the accountancy profession must exercise its functions, demonstrating on the one hand some degree of flexibility and on the other maintaining required professional standards with a degree of rigidity. This can lead to unsatisfactory results. The auditor can exercise too much flexibility and thus fail to properly discharge his functions. Too much rigidity may obscure the truth and may compromise the advent of a fair view of the audited accounts <sup>287</sup>

The solution (to remain within the bounds of flexibility and rigidity) demands courage and discipline from the regulatory accountancy bodies. It cannot and must not rely on a set of definitive rules. In this accountants

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<sup>285</sup>Anon (1996 1119)

<sup>286</sup>See. *infra* Paragraph 8 5

<sup>287</sup>Lasok & Grace (1993 132)

differ from lawyers. Lawyers, according to Lasok & Grace, are bound by the rigidity of legal rules. Within auditing, the law only determines the parameters in which auditors function and defines their task. Accounting standards should not be interpreted as legal rules. They are a guide for the auditor, so that he can ultimately form his opinion whether the company's accounts give a true and fair view. To give them legal force would render them too rigid and inappropriate. After all, the standards are a distillation of professional expertise and experience subject to interpretation and individual opinion.<sup>288</sup>

Percival (1991) refers to the perception of the auditor's role by outsiders, including the general public. According to Percival, there is an expectation gap between the auditor's understanding of his responsibilities under company law and the perception of outsiders or the general public as to what constitute these responsibilities.<sup>289</sup> The outsider and the public at large both believe that the auditor's watchdog role is ineffective. This is recognized by the accountancy bodies, especially with regard to the growing take-over mentality. However, steps to improve the public's perception have, as of yet, not been undertaken or have failed.

This resulted in an attack on the profession's objectivity and independence. The accounts became a weapon to sell off the company or to protect it against take-

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<sup>288</sup>*Ibid* , at 131

<sup>289</sup>(1991 743)



overs Corporate clients tend to switch financial advisers This commercial activity resulted in a number of negligence claims that were decided on a all-or-nothing approach with regard to the imposition of the duty of care <sup>290</sup>

The question is whether this existing framework is sufficiently equipped to deal with commercial life According to Percival, all parties involved aspire a compromise Investors seek "privity letters" to establish sufficient proximity The auditor acknowledges the fact that the investor relies on the accounts Other examples include the proposal of a statutory liability cap <sup>291</sup>

2.6.14. As a result of the increasing litigation, Savage (1983) argues that the auditor escapes into insurance to avoid potentially devastating actions against them, rather than seeking an up-to-date statement of their responsibilities <sup>292</sup> As a result his responsibilities remain the subject of speculation, creating a gap between the public expectations and the auditor's idea of his function (for example with regard to his role in the detection of fraud) The court cannot fill this gap because

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<sup>290</sup>*Ibid* See, for example, the decisions in MORGAN CRUCIBLE CO PLC v HILL SAMUEL & CO LTD [1991] 2 W L R 655, JAMES MCNAUGHTON PAPER GROUP v HICKS ANDERSON & CO [1991] 2 W L R 641, AL NAKIB INVESTMENTS (JERSEY) LTD v LONGCROFT [1990] 1 W L R 1390 and CAPARO INDUSTRIES PLC v DICKMAN [1990] 2 W L R 358, [1990] 1 All E R 568

<sup>291</sup>Percival (1991 744-745)

<sup>292</sup>(1983 187-188) This line of thought has already been uttered with regard to the liability of lawyers, see *supra* Subparagraph 2 6 10

most actions are, subsequently, settled out of court

Two levels fuel, according to Savage, the discrepancy in the perception of the auditor's role

First, it appears that the auditor's duties extend beyond matters arising out of his statutory duty. These duties reflect the increasing corporate and personal accountability of directors with regard to company funds and directors' dealings, and the detection of fraud <sup>293</sup>

Second, the auditor's independence is vital to corporate accountability. It is central to the profession and has always been regarded as a state of mind by the auditing profession and governing bodies. However, the decline of the credibility of auditors is partly due to the fact that this independency is only apparent, not real. It lacks a clear code of conduct or legislative provisions <sup>294</sup>

Finally, Mitchell (1995) critically assesses the function of the Auditing Practices Board and sets out what is wrong with it. His conclusions are sharp and to the point <sup>295</sup>. He argues that there was no internal or external consultation on forming the Board. The Board remains the captive of the major firms. Its structures are undemocratic and its decisions are not accountable and contested.

Mitchell suggests the creation of a new body that is accountable to Parliament and which represents the plurality within the accountancy profession.

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<sup>293</sup>Savage (1983 188-189)

<sup>294</sup>*Ibid* , at 196

<sup>295</sup>Mitchell (1995 76)

## 2.7. Tort Development Third-Party Liability and Immunity

2.7.1. This section of the literature review discusses the consequences of modern tort development for both the auditor and solicitor in Ireland and England

It reviews the existing literature on important and influential negligence cases. It discusses the concept of duty and other elements such as proximity and foreseeability. It also considers the influence of policy considerations with regard to the liability question. The literature review identifies how this development is received in Ireland.

Against this background, the literature review discusses the consequences of modern tort development for both the auditor and the solicitor in England and Ireland. It also sets out some of the implications of recent decisions affecting the liability of the auditor.

Finally, the literature review discusses briefly the issue of immunity in advocacy. The debate concerning advocates' immunity has recently been highlighted by two cases awaiting judgment in the English Court of Appeal.<sup>296</sup>

### Modern Tort Development

#### Foreseeability, Proximity and Public Policy

2.7.2. The courts, both in Ireland and England, struggle

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<sup>296</sup>See Slapper (1996)

with the concept of duty. It appears that the courts often justify the imposition of a duty of care with the help of policy considerations.

The thesis shows that the concept of duty is developed as a means to limit or expand liability on justified grounds. It stresses that one of these grounds is the need to compensate loss.<sup>297</sup> This need is largely based on policy considerations.<sup>298</sup> The thesis asserts that this policy aspect renders the outcome of negligence claims uncertain or even arbitrary.

This has also been identified in the literature. One of the questions relates to what the underlying notion is of the duty of care. The literature has debated extensively the question of the nature of duty in tort. Is it ethical, does it have a connotation with morality, or is it a pragmatic concept based on utility to promote enterprise?

Harper (1932) points out that historically the concept of duty bore elements of moral blameworthiness. He argues that this idea of moral blameworthiness is closely connected to the existence of a duty of care. Both aspects are interrelated, emphasizing the importance of the nature of the defendant's conduct. Harper stresses that the existence of a duty of care is only constructive where a defendant is 'morally culpable'.<sup>299</sup> In Harper's view "duty" is primarily a moral concept. He stated that 'it

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<sup>297</sup>See *infra* Paragraph 9.2

<sup>298</sup>*Ibid*, Paragraph 9.3

<sup>299</sup>Harper (1932: 1013)

misdescribes the character of the defendant's conduct in cases where there is no moral fault' <sup>300</sup>

This implies that negligence as a proper cause of action ought to be reserved in cases where the defendant is morally wrong. However, case law shows that this is not so. Harper here identifies the core problem of the tort of negligence: the helplessness of the courts to justify the imposition of a duty of care in the absence of fault as a moral concept.

Kretzmer (1994), however, argues that at the close of the nineteenth century the imposition of a duty of care bore the nature of utility. The courts' attitude shifted from causation as the basis of liability towards the idea that the defendant ought to have avoided the loss. Imposing a duty, the courts struck a balance between risk-generating and cost-avoidance factors.

Kretzmer sets out how this change came about <sup>301</sup>. He argues that the causation rule examined the abnormal factor that accounted for the plaintiff's loss and whether this factor could have been ascribed to a deliberate act or activity of the defendant. However, the important question became whether the defendant ought to have behaved differently than he did. This shift was due to, *inter alia*, the introduction of the steam engine and other consequences of the industrial revolution. Industrialization changed the

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<sup>300</sup>*Ibid* , at 1014

<sup>301</sup>(1994 76-77)

nature of the risk-generating conduct of the defendant <sup>302</sup>  
It could no longer be maintained that each time an engine generated a risk the defendant was liable simply because he owned or used the engine. These defendants, for example, railway companies, had, at the same time, a statutory power to use these engines. Therefore, if this inherent contradiction was not addressed and the old causation principle was not changed the courts argued that enterprise would have been 'stifled' <sup>303 304</sup>

The notion of due care, expressed in cases such as *BLYTH v BIRMINGHAM WATERWORKS* (1856) 156 Eng Rep 1047, solved this problem. The test of reasonableness became the general test of negligence. In doing so, the courts were capable to strike the balance between the protection of personal interests and freedom of action. In other words, some risks were excusable, others demanded compensation.

However, the nature of a duty of care was not based on morally blameworthy conduct, according to Kretzmer. The law had to concern itself with man's external behaviour 'rather

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<sup>302</sup>Another development, discussed by Kretzmer (1994 80-85) was the introduction of the "assumption of risk" theory, developed in *RYLANDS v FLETCHER* (1868) L R 3 H L 330

<sup>303</sup>Kretzmer (1994 47). From this point of view it can be argued, according to this researcher, that this change was inspired by policy considerations, whereby the interest of the individual plaintiff gave way for the interest of, ultimately, the common good.

<sup>304</sup>See also Magnus (1996). He stresses that fault lies at the basis of liability. However, the presumption of fault is not exclusive anymore. It fitted the *zeitgeist* of the 19th century. Now it has become objective and supplemented with notions of, for example, strict liability (*supra*, at 430-431).

than man's innermost thoughts' <sup>305</sup> The imposition of a duty of care was based on "fault" but the defendant's conduct was assessed as to whether he ought to have avoided the loss-generating conduct by reference to the "reasonable man" The end-result was, according to Kretzmer, that liability questions were solved on the basis of a normative evaluation of the defendant's conduct <sup>306 307</sup>

2.7.3. Kretzmer's outline of the development of negligence perhaps shows the difficulties the courts face in striking the right balance between excusable and inexcusable risks This century has shown that this balance can shift both ways The decision in DONOGHUE laid down the "neighbour" principle This principle has, accordingly, been interpreted in favour of the plaintiff in ANNS v MERTON LONDON BOROUGH COUNCIL [1978] A C 728 and recently in favour of the defendant in MURPHY v BRENTWOOD DISTRICT COUNCIL [1990] 2 All E R 908 and CAPARO INDUSTRIES PLC v DICKMAN [1990] 1 All E R 568 <sup>308</sup>

Steele (1993) examines this aspect of the law of negligence further She argues that, though it is obvious,

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<sup>305</sup>Kretzmer (1994 47)

<sup>306</sup>This was made clear in STANLEY v POWELL [1891] 1 Q B 86

<sup>307</sup>The thesis stresses that the recognition of a duty of care was first identified in situations where there was already an underlying relationship flowing from, for example, a propriety relationship or contract or quasi-contract between the plaintiff and the defendant, see *infra* Paragraph 9 2

<sup>308</sup>See *infra* Subparagraph 9 3 2

it has been consistently overlooked when it comes to the analysis of professional obligations Dworkin argues, according to Steele,<sup>309</sup> that the common law is both constraint and flexible Dworkin supports the traditional argument, much beloved by tort lawyers, that the development of negligence has a logic of its own<sup>310</sup>

Steele's contribution is to indicate some of the ways in which the development of tort is governed less by the constraints of an interior logic than by conflicting and irreconcilable requirements of policy She illustrates this by arguing that the retreat from the ANNS' approach was a reinstatement of principle However, this retreat of principle to limit liability was in itself a policy aim In addition, criteria such as proximity are described as being merely a label, although still applied as principle by the courts<sup>311</sup>

Steele's comparison of ANNS and CAPARO shows with some elegance that whereas the former case pushes the boundaries outwards, the latter maintains and even retrenches these This comparison does not depend on the fact that ANNS relates to economic loss, and CAPARO to liability (two separate questions) It shows, according to Steele,<sup>312</sup> that it is impossible to find a particular aim that the tort of

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<sup>309</sup>(1993 440)

<sup>310</sup>See Dworkin (1986)

<sup>311</sup>See CAPARO INDUSTRIES PLC v DICKMAN [1990] 1 All E R 568

<sup>312</sup>(1993 437)



negligence fulfils But taking Steele's general point, this thesis examines the reasons implicit in CAPARO'S limitation of liability, carrying Steele's argument further <sup>313</sup>

The recent decisions in MURPHY v BRENTWOOD DISTRICT COUNCIL [1990] 2 All E R 908 and CAPARO INDUSTRIES PLC v DICKMAN [1990] 1 All E R 568 overruled ANNS and retrenched the boundaries of liability <sup>314</sup>

Howarth (1991) argues that the new line of thinking is hollow and cannot be said to offer a clear guideline as to what is understood with the concept of negligence Howarth considers in particular whether the concept of the duty of care is a 'superfluous notion' <sup>315</sup>

As Steele did, Howarth too identifies that the courts do not know what to do with the tort of negligence This explains the reigning confusion about the meaning of

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<sup>313</sup>See *infra* Paragraph 9 4

<sup>314</sup>Prior to the decisions in MURPHY and CAPARO, a number of dissenting judgments indicated a dissatisfaction with the Wilberforce test See, for example, the dissenting judgment of Lord Brandon in JUNIOR BOOKS v VEITCHI [1983] A C 520, Lord Keith in GOVERNORS OF THE PEABODY FOUNDATION v SIR LINDSAY PARKINSON & CO LTD [1985] A C 210 and the unanimous approval of Lord Brandon's dissent in JUNIOR BOOKS by the Australian High Court in LEIGH AND SILLAVAN v ALIAKMON SHIPPING CO [1986] A C 785

<sup>315</sup>(1991 68) Howarth adopts here the words of Buckland (1935) in his attack on the concept of duty Buckland argues that the duty of care is 'certainly a part of our law, but [ ] an unnecessary fifth wheel on the coach, incapable of sound analysis and possibly productive of injustice', (*supra* at 639) In his view, a duty exists not to harm others and this duty is owed to everyone This is different than a duty not to be careless One has a right to be as careless as one likes If not, the breach of one's duty would imply a remedy, but only for nominal damages 'But in fact that there is no action apart from actual damage', (*supra* at 641) The duty question is one of remoteness

negligence deterrence or compensation? Howarth offers two explanations. First, he argues that recent case law shows that negligence does serve neither deterrence nor compensation aims. Instead, it appears that the categories of liability are closed and that the tort of negligence is only applied successfully where there is a 'settled expectation that negligence law will apply' <sup>316</sup>

Second, at the same time the courts' present apprehension to negligence shows their fear that expansion under ANNS may have resulted in an attitude that loss was expected to be compensated. This line of argument offers an explanation for the sign of the times in which negligence operates from indulgence to self-reliance. In addition, the retreat to self-reliance is fed by the courts' prejudiced fear of American litigation numbers <sup>317</sup>

But the courts themselves are also to blame. This time with regard to their conceptualization of the duty of care. Howarth argues that a normative premise must be re-introduced to consider whether a situation is a duty situation <sup>318</sup>. In doing so, it will help to bridge the gap between what is done and what ought to be done. He continues, and blames the courts of a lack of willingness to discuss the normative premise, in particular where this premise is controversial. Instead, the courts attempt to justify the existence of a duty to bring the case within

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<sup>316</sup>Howarth (1991 64)

<sup>317</sup>*Ibid* , at 66

<sup>318</sup>*Ibid* , at 69

the facts of a previous case in which a duty was held to exist <sup>319</sup> That this is also disguised with the re-introduction of proximity is merely an excuse for the courts' passive attitude to analyze precisely the underlying notion of the defendant's conduct Howarth argues that

the main functions of "proximity" are to give a less controversial, more factual sounding name to Lord Wilberforce's second stage [ ], and to provide an excuse for the intellectual laziness of those who cannot be bothered to analyze carefully the precise normative force of the points they make <sup>320</sup>

Howarth asserts that proximity is nothing more than 'an allusion to proximate cause [or] remoteness' and is used to cover public policy elements, i e the second stage of the Wilberforce test <sup>321</sup> He argues that the relationship between the auditor and the plaintiff in *CAPARO INDUSTRIES PLC v DICKMAN* [1990] 1 All E R 568 was, *de facto*,

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<sup>319</sup>This has been abundantly made clear by Lord Bridge in *CAPARO INDUSTRIES PLC v DICKMAN* [1990] 2 W L R 358 at 365 See also Brennan J in the Australian High Court's decision in *SUTHERLAND SHIRE COUNCIL v HEYMAN* (1985) 60 A L R 1 at 43-44, who stated 'It is preferable, in my view, that the law should develop novel categories of negligence incrementally and by analogy with established categories'

<sup>320</sup>Howarth (1991 72)

<sup>321</sup>*Ibid* , at 82 Martin (1990) interprets the proximity element by analogy He argues that the courts, by reintroducing the proximity element, sought to justify the imposition of a duty of care on principle A duty falls in recognized categories by analogy In doing so the courts equated proximity with duty and as a result proximity has become a meaningless requirement

nothing more than an issue of remoteness

This ties in with the argument, put forward in the thesis in Paragraph 9.3, that negligence at present has all to do with policy who deserves to be compensated, not because of an underlying normative premise but by reference to the allocation of financial resources. If this is really the case, the tort of negligence may be accused as being nothing more than a political mechanism.

As well as the absence of a normative premise, the duty concept is also flawed in that it implies a certain standard that is known in advance by the defendant. But, this means that the standard of care must have been formulated independently. This is not done by the courts, according to Howarth. In many instances the courts confuse breach and duty.<sup>322</sup>

The above criticism does not mean that Howarth suggests that negligence law is outmoded. He agrees with Calabresi (1978) that tort law serves its function in a society that is sceptical to both state regulation and self-regulation as separate avenues.<sup>323</sup> It offers a combination of both, it leaves room for society to order

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<sup>322</sup>(1991 72-73) Howarth illustrates this point further, referring to the decision in SMITH v LITTLEWOODS LTD [1987] A C 241

<sup>323</sup>According to Calabresi tort law and the liability rule in particular, is the 'paradigmatic law of the mixed society', (1978 521) It fits between two opposing theoretical ideologies: libertarianism which focuses on contractual freedom, and collectivism that aspires complete state control through criminal sanctioning of any conduct.

itself without excluding some degree of state regulation <sup>324</sup> If this is accepted, the role of duty must be re-addressed Howarth submits that the courts' role will become much clearer All duty cases are, accordingly, cases that may give the defendant an immunity against liability Thus, for example, the purpose of the audited accounts in CAPARO may render the auditor immune against an action of an investor or shareholder This duty can be absolute or limited If a duty exists, the other issues refer, subsequently, to carelessness (the standard of care or the reasonableness of the defendant's conduct), remoteness (proximity and foreseeability) and causation (for example, reliance on the audited accounts)

If this system works, judges can explain the normative premise upon which a defendant is held liable In this system the notion of proximity can be forgotten as a precondition for the existence of a duty and interpreted as an aspect of remoteness

2.7.4. Stanton argues that recent case law indicates a decline of tort liability for professional negligence <sup>325</sup> Tort law, in particular with regard to financial loss and professional liability, has departed from general principles laid down in cases such as DONOGHUE v STEVENSON

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<sup>324</sup>Howarth (1991 91-92)

<sup>325</sup>(1991 83) He refers to the decisions in, *inter alia*, SMITH v ERIC S BUSH and HARRIS v WYRE FOREST DISTRICT COUNCIL [1989] 2 All E R 514, CAPARO INDUSTRIES PLC v DICKMAN [1990] 1 All E R 568 and MURPHY v BRENTWOOD DISTRICT COUNCIL [1990] 2 All E R 908

[1932] All E R 1 and HEDLEY BYRNE & CO LTD v HELLER & PARTNERS [1963] 2 All E R 575 Instead, the courts pay more attention to analogous cases and develop the law on an incremental basis Consequently, the law on professional liability has become unpredictable

Stanton explains this unpredictability by reference to the difficulty in professional negligence cases to draw the line between professional functions Stanton argues that it does not make sense to distinguish between professional functions solely for liability purposes <sup>326</sup> Is there a difference between drafting a will and advising a client? And, reviewing the case law in this area, <sup>327</sup> Stanton states that the courts' interpretation of the decision in CAPARO was subjected to other sentiments than just the application of the facts by analogy to the decision in CAPARO

Stanton offers an explanation for this decline of tort law He refers to three possible causes

First, the decline of tort law is a result of the changing political climate Here, the idea of the social welfare state is vanishing and the balance between collectivism and libertarianism strikes in favour of the latter <sup>328</sup>

Second, the law was unfairly prejudiced against the

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<sup>326</sup>Stanton (1991 89)

<sup>327</sup>See JAMES MACNAUGHTON PAPER GROUP LTD v HICKS ANDERSON & CO [1991] 1 All E R 134 and MORGAN CRUCIBLE CO PLC v HILL SAMUEL & CO LTD [1991] 1 All E R 148

<sup>328</sup>Stanton (1991 99-100) See also Calabresi (1978) and Howarth (1991)

professions Their response to the excessive expansion of professional liability may have influenced the courts' attitude to this expansion In particular the huge increase in costs for the professional and the threat of defensive practice may have contributed to the new line of thought <sup>329</sup>

Stanton, however, does not believe that the above two explanations can stand on their own In his view, the change is based on the doctrine of legal principle <sup>330</sup> In this doctrine tort and contract have their predefined role and cases must be decided accordingly

Where the thesis emphasizes the influence of policy in the decision making process in professional negligence cases, <sup>331</sup> Stanton explains that the type of damage must be assessed on the basis of the underlying relationship between the defendant and plaintiff In this view, the neighbour principle is, according to Stanton, effectively reserved for personal injury Contract will offer recovery in cases involving financial loss <sup>332</sup> The decision in HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD will be restricted to what Stanton calls 'neo-contractual relationships' <sup>333</sup> The decision in ROSS v CAUNTERS offers a justification for a limited extension of contract to

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<sup>329</sup>Stanton (1991 101-103)

<sup>330</sup>*Ibid* , at 103

<sup>331</sup>See *infra* Paragraph 9 4

<sup>332</sup>Stanton (1991 103)

<sup>333</sup>*Ibid* , at 105

protect the beneficiary on the basis of a contractual expectation derived from the consideration given by the testator to the solicitor <sup>334</sup>

Third Party Liability and Economic Loss, the Imposition of a Duty of Care Auditors and Solicitors

2.7.5. The thesis makes a clear distinction between forms of reliance <sup>335</sup> In the narrow approach, reliance means that a third party relied and acted upon the representation of a professional person The wider approach describes reliance as an expectation that a professional person exercises his functions with due care and skill

The thesis asserts that the first interpretation is confined to the principles initially set out in HEDLEY BYRNE [1963] 2 All E R 575 The latter interpretation embraces the DONOGHUE principles

The literature is divided Some see the HEDLEY BYRNE principles as an extension of DONOGHUE Others prefer to differentiate between HEDLEY BYRNE and DONOGHUE

2.7.6. It appears that the literature in the nineteen eighties made a clear distinction between the principles laid down in DONOGHUE and HEDLEY BYRNE

Lord Denning first recognized a remedy for negligent misrepresentation His dissenting judgment in CANDLER v

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<sup>334</sup>*Ibid*

<sup>335</sup>See *infra* Subparagraph 9 4 1



CRANE CHRISTMAS & CO [1951] 2 K B 164 was approved in HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD [1964] A C 465 He argued, according to Charles, that the DONOGHUE principles justified an examination into the viability of a remedy for negligent misstatements <sup>336</sup>

Charles identifies two elements that demanded a different approach from DONOGHUE First, the nature of the defendants conduct words Second, the absence of a contractual or fiduciary relationship, or a sufficient degree of proximity <sup>337</sup> At the same time, the plaintiff relied on the statement and the defendant's professional competence

The different approach or justification was found in the notion of the nature of the voluntary assumption of responsibility Under DONOGHUE it is interpreted as foreseeability of damage and the proximity between the parties In HEDLEY BYRNE the plaintiff had to prove the existence of a "special relationship" This relationship exists, according to Charles, if the defendant has reason to believe that the plaintiff would reasonably rely on his statements for a particular transaction <sup>338</sup>

Greer & Harkness (1985) also stress the importance of a "special relationship" with regard to the liability for

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<sup>336</sup> (1988 23)

<sup>337</sup> *Ibid* See also Cane (1981) He stresses another important distinction that justified a different approach under HEDLEY BYRNE, DONOGHUE was concerned with physical loss, HEDLEY BYRNE was concerned with economic loss

<sup>338</sup> (1988 23)

negligent misstatements. It restricted the degree of proximity and, therefore, liability. The special relationship demanded a closer degree of proximity.<sup>339</sup> The defendant ought to know that people could rely on him. Under DONOGHUE, the defendant would be liable if he could reasonably foresee that the plaintiff could suffer damage. This would imply that the defendant could be liable for losses suffered by unidentifiable plaintiffs.

In this view, Greer & Harkenness distinguish acts from words. Words would pose a threat to the defendant in that he could be liable to anyone who had relied on him. Acts, on the other hand, are normally addressed to one specific person. This is seen as the basis for the differentiation between DONOGHUE and HEDLEY BYRNE.

Cane (1981) explains what the real significant distinction is between DONOGHUE and HEDLEY BYRNE. He argues that this distinction lies in the nature of the loss: physical or economic. Unlike other writers, he stresses that we do need a different liability test for both types of losses, but that we do not need 'separate tests according to whether the loss was caused by words or deeds'.<sup>340</sup>

Cane (1989) stresses in a later article that the interpretation of the term "reliance" in HEDLEY BYRNE is important with regard to liability for economic loss, because it is this reliance that eventually will trigger

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<sup>339</sup>Greer & Harkenness (1985: 17)

<sup>340</sup>Cane (1981: 862)

off the loss. It is essential, but Cane argues that it is not legally significant.<sup>341</sup> He asserts that reliance goes, in fact, to causation. It is, in his view, not an element of the special relationship. Reliance is only relevant as a means to prove damage, damage, not words, is the gist of the tort of negligence.<sup>342</sup>

Normally, under *DONOGHUE*, reliance means that people expect others to behave in a certain way, for example, road users. If damage occurs, the defendant will be liable if he could reasonably foresee this damage. Under *HEDLEY BYRNE* reliance is subjected to a much more narrow interpretation. Here, a person relies on a statement or particular conduct of the defendant to the extent that the latter acts in a particular way as part of an undertaking towards another. According to Cane (1989) reliance is not a necessary condition. There are cases where a plaintiff got a remedy without any reliance at all.<sup>343</sup> Its real function, in its narrow sense, is to limit the number of plaintiffs.<sup>344</sup>

In addition, however, Cane asserts that "reliance" as a basis for recovery of economic loss is obscure. It is an attempt to justify compensation for economic loss sufferers. Cane argues also that the term "reliance" itself is far from obvious. The task left for the courts is to

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<sup>341</sup>(1989 202), see also Cane (1981 863)

<sup>342</sup>*Ibid*

<sup>343</sup>Cane illustrates this argument with the decision in *ROSS v CAUNTERS* [1980] Ch 297, (1989 202)

<sup>344</sup>Cane (1989 202)

find some rule that defines the proper role of tort in compensating for economic loss <sup>345</sup>

2.7.7. More recent literature favours an approach that unifies the HEDLEY BYRNE principles with DONOGHUE

Huxley (1990) discusses the conceptual ideas of the English appeal courts in the nineteen eighties with regard to the duty of care in economic loss cases and the relationship between the "neighbour" principle and the decision in HEDLEY BYRNE & LTD v HELLER & PARTNERS LTD [1963] 2 All E R 575. He argues whether economic loss cases are now also recoverable under the "neighbour" principle, in adopting the new three-stage test to cases argued under HEDLEY BYRNE.

Huxley reviews the decided cases in the nineteen eighties. He concludes that there are two options <sup>346</sup>

Some judges are willing to extend the three-stage test to cases of pure economic loss <sup>347</sup>. They seem willing to incorporate the HEDLEY BYRNE criteria of reliance and the special relationship within the criteria of reasonable foresight and proximity. Huxley justifies this attitude <sup>348</sup>. First, he argues that professional negligence no longer finds its rationale in an implied contractual term between

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<sup>345</sup> *Ibid* , at 212-213

<sup>346</sup> Huxley (1990 375-376)

<sup>347</sup> Cf SMITH v ERIC S BUSH AND HARRIS v WYRE FOREST  
D C [1989] 2 W L R 790

<sup>348</sup> (1990 375)

defendant and plaintiff <sup>349</sup> Second, the analysis of cases shows that there is no longer a clear distinction between negligent misstatement and negligent activity <sup>350</sup>

Others hold the decision in HEDLEY BYRNE as an independent tort <sup>351</sup> For them the assumption of responsibility forms the crucial element for negligent misstatements The more the relationship approaches a contractual nature, the more likely the courts will assume such an assumption At the same time, they accept that a category of cases, such as ROSS v CAUNTERS [1980] Ch 297, are an extension of DONOGHUE This approach is described by Huxley as the 'quasi-professional negligence approach' <sup>352</sup>

Murphy (1996) goes a step further and suggests a return to principle He demonstrates that the proximity element divided the House of Lords in WHITE AND ANOTHER v JONES AND OTHERS [1995] 2 A C 704 At the same time he suggests that the case could have been easily solved if the Law Lords had applied the principles laid down in DONOGHUE v STEVENSON [1932] All E R 1

The problem that divided the Law Lords was, according to Murphy, 'the nature of the assumption of responsibility

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<sup>349</sup>Cf NAYLOR v PRESTON HEALTH AUTHORITY [1987] 1 W L R 958

<sup>350</sup>The preparation of the audited reports by the auditor in CAPARO can under DONOGHUE be described as "failing to take care in conducting an audit" Under HEDLEY BYRNE it can be described as "negligently misstating the company's current financial position", (Huxley, 1990 375)

<sup>351</sup>Cf Gibson L J in REID v RUSH & TOMKINS [1989] 3 All E R 228 at 230

<sup>352</sup>(1990 375)

considered to be necessary to create the requisite "special relationship" <sup>353</sup> In other words, what is the requisite degree of proximity necessary to establish the existence of a duty of care Is it the absence of any other remedy for the beneficiary, <sup>354</sup> the assumption of responsibility for a particular task - to draw up a will and do it correctly, <sup>355</sup> or the display of mutuality where both 'the plaintiff and defendant played an active part in the transaction' <sup>356</sup>

Murphy argues that a retreat to principle, rather than relying on an incremental approach by analogy of decided cases, would have offered a better alternative The question must be was the plaintiff in WHITE "closely and directly" affected by the omission of the solicitor?

In applying the DONOGHUE test the assumption of responsibility would not have been an issue Although the undertaking was initially directed to the testator, his daughters were closely and directly affected after the testator had died because only then the will took effect <sup>357</sup>

Murphy reiterates here the problem in recent tort law This problem involves the inability of the courts to address tort problems on principle to ascertain certainty

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<sup>353</sup>(1996 46)

<sup>354</sup>WHITE v JONES [1995] 2 A C 207 at 268, per Lord Goff

<sup>355</sup>*Ibid* , at 274, per Lord Browne-Wilkinson

<sup>356</sup>*Ibid* , at 283, per Lord Mustill

<sup>357</sup>Murphy (1996 53)

and consistency

2.7.8. The decision in *WHITE v JONES* was preceded by the decision in *ROSS v CAUNTERS*. It is interesting to note that the literature is impressed with the decision in *ROSS* and its subsequent approval in the *WHITE* case. In addition to their significance for solicitors,<sup>358</sup> the decision in *WHITE* may, as Murphy has set out,<sup>359</sup> indicate a return to principle.

Banakas (1985) argues that the decision in *ROSS* carries two implications.

First, *ROSS* allowed the beneficiary to a will a remedy for economic loss. Without the presence of any "reasonable reliance" the judge in *ROSS* could not rely on *HEDLEY BYRNE*. Instead, he applied directly the *DONOGHUE* principle of reasonable foreseeability.<sup>360</sup> This implies that Banakas adopts the position that the decision in *ROSS* justifies the application of *DONOGHUE* in economic loss cases.

Second, this could suggest that the decision in *HEDLEY BYRNE* is made redundant. Banakas argues that this is not so. In *ROSS* the beneficiary did not rely on the defendant's professional skill and expertise. This is, however, a precondition under *HEDLEY BYRNE*. Banakas concludes that *HEDLEY BYRNE* forms a distinct category of negligence.

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<sup>358</sup>See *infra* Subparagraphs 9.4.6 and 9.4.7

<sup>359</sup>See *supra* Subparagraph 2.7.7

<sup>360</sup>As interpreted under *ANNS*, (Banakas, 1985: 373)

law <sup>361</sup> It is capable of operating as an independent source of professional liability Economic loss sufferers can find a remedy if they relied on the negligent performance of professional skill

Consequently, the decision in HEDLEY BYRNE is equal to DONOGHUE as to the recovery of economic loss, an alternative source of negligent liability, independent from DONOGHUE <sup>362</sup>

Evans originally suggested that the decision in ROSS, prior to its approval in WHITE, was not good law <sup>363</sup>

First, in ROSS the plaintiff did not rely on the solicitor and the degree of proximity was subjected to the two-stage test in ANNS v MERTON LONDON BOROUGH COUNCIL [1978] A C 728 This test has subsequently been overruled by the House of Lords <sup>364</sup>

Second, Evans argues that there was no loss, merely an expectation of gain Evans asserts that this is only recoverable in contract As a consequence Evans argues that the decision in ROSS is too wide It undermines the privity of contract This may render a person liable in all cases where there was a contract between two parties for the benefit of an identified third person <sup>365 366</sup>

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<sup>361</sup>(1985 374) See also Jones (1994 188)

<sup>362</sup>Banakas (1985 372)

<sup>363</sup>(1991 137)

<sup>364</sup>Cf MURPHY v BRENTWOOD DISTRICT COUNCIL [1990] 2 All E R 908

<sup>365</sup>Evans (1991 140)



Evans (1993) accepts, after the decision in WHITE, that ROSS is approved and extended. However, Evans still remains convinced that both decisions carry some problems. He is again particularly worried with regard to situations where the relationship between the plaintiff and defendant is less obviously close. For example, where the solicitor is not aware of the identity of the intended beneficiaries.<sup>367</sup>

Jones (1994) argues that the decision in ROSS is an example where tort fills the gap of contract law. The person who suffered the damage but who had not the remedy was afforded one. The decision was affirmed in the WHITE case.

The WHITE case in particular shows that the three-step test - foreseeability, proximity and justice and reasonableness - does not carry any real content, according to Jones (1994). It is an example where the courts spuriously look for circumstances upon which 'to pin the labels "proximity" or "just and reasonable"'.<sup>368</sup> If tort law is about weighing pro's and cons of imposing liability,

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<sup>366</sup>According to Baughen (1992), the decision in ROSS has been extended in SMITH v CLAREMONT HAYNES & CO, The Times, 3 September 1991. In this case the testator requested a solicitor to draw up a new will. The testator died and the new will was never completed. The beneficiaries were known to the solicitors. This implies, according to Baughen, that a solicitor owes a duty of care towards intended beneficiaries from the moment the solicitor's client, the testator, asks him to draw up a will.

<sup>367</sup>Evans (1993 172)

<sup>368</sup>Jones (1994 194)

Jones suggests that the courts are better off to articulate more on policy instead of toying with the duty issue <sup>369</sup>

The decision in WHITE goes too far. It justifies compensation to any person who suffered loss and is without a remedy <sup>370</sup>. But, in reality this is not true. Jones refers here to the absence of a remedy for home owners for economic loss in the context of defective buildings <sup>371</sup>. Therefore, Jones concludes that the WHITE case may only be applied as a limited solution to defective wills.

Weir (1995) picks up this point <sup>372</sup>. He speculates whether the decision is exceptional or principled and will have the far-reaching consequences as DONOGHUE had for physical damages <sup>373</sup>. It depends, according to Weir, on the court's underlying justification for imposing a duty of care. If the courts accept to impose a duty on the basis that a solicitor must assume legal responsibility in the exercise of his functions, the consequences could be, indeed, far-reaching. This responsibility is owed to the

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<sup>369</sup> *Ibid*

<sup>370</sup> *Ibid*, at 195. This viewpoint is not shared in the thesis. The thesis' justification is that the person reasonably relied on the fact that a solicitor generally carries out his functions with reasonable care and skill, see *infra* Subparagraph 9.4.1.

<sup>371</sup> For example, latent defects discovered by subsequent purchasers have no remedy against the builder. The original owner has a remedy, but he has not suffered any loss (Jones, 1994-195). Cf. *D & F ESTATES LTD v CHURCH COMMISSIONERS FOR ENGLAND* [1988] 2 All E R 992 and *MURPHY v BRENTWOOD DISTRICT COUNCIL* [1990] 2 All E R 908.

<sup>372</sup> In fact, Weir suggests that the proper solution should have been found in the law of wills (1995: 359).

<sup>373</sup> Weir (1995: 357).

client, the testator, on the basis of mutuality This is, accordingly, extended to the intended beneficiaries of the testator Consequently, the decision reflects the expansionist approach of ANNS but Weir argues that its consequences will not be as far-reaching <sup>374</sup>

Marshall (1994) asserts that in ROSS and WHITE the underlying relationship between the solicitor and the testator existed for the purposes of the third party, the beneficiary This is contrary to, for example, the relationship between the company and the auditor A solicitor who is negligent and frustrates the expectations of the third party is, accordingly, held to be liable if this third party is readily identifiable and has no other remedy <sup>375</sup>

The WHITE case also applied the new three stage test laid down in CAPARO INDÚSTRIES PLC v DICKMAN [1990] 1 All E R 568 Marshall indicates the discrepancy here The WHITE case extended liability for solicitors, while the aim in CAPARO was to limit the liability of auditors on the "just and reasonable" grounds <sup>376</sup>

However, Marshall rejects the idea that liability under WHITE is expansionist in nature He argues that under the third CAPARO condition (is it just and reasonable to impose a duty of care?), a solicitor may go scott-free Marshall illustrates this, referring to the decision in

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<sup>374</sup>*Ibid* , at 362

<sup>375</sup>Marshall (1994 155)

<sup>376</sup>*Ibid*

Here, the attempt to increase the solicitors' liability, this time with regard to a negligently drafted *inter vivos* transaction, failed. The transaction could be altered, there was an alternative remedy <sup>377</sup>

McDonald & Swanton perceive the decision in *WHITE v JONES* [1993] 3 All E R 481 as representing 'an indirect and surreptitious erosion by tort of the retrenched contractual principles' <sup>378</sup> Tort has increasingly expanded into the economic loss area, formerly the exclusive domain of contract law

McDonald & Swanton argue that this is hard to reconcile with the common law principles of obligations. They identify a series of difficulties <sup>379</sup> the solicitor owes his duty solely to his client, liability is limited through the retainer, no contract exists between the solicitor and the beneficiary, the damage is not typical tort loss, the beneficiary has no claim in contract. In addition, the testator does not owe a duty to the beneficiary, so why should the solicitor owe a duty to him or her? Finally, the testator's estate increases at the expense of the solicitor.

No doubt, McDonald & Swanton recognize that tort law has overcome these problems. It aims at the relationship between the plaintiff and defendant to deduce a sufficient

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<sup>377</sup> *Ibid*

<sup>378</sup> (1995 576)

<sup>379</sup> *Ibid* , at 576-577

degree of proximity to impose liability McDonald & Swanton support the thesis' assertion that in cases such as the WHITE case the testator and the plaintiff both relied on the defendant solicitor's care and skill <sup>380</sup> This underlines the importance of duty in professional negligence In other words, a professional person is said to owe a duty of care to anyone he could reasonably foresee would rely on his expertise, either to act on it or to expect something from it This is more than a voluntary assumption of responsibility It is inherent to the nature of the function of professions

Greenfield & Osborn (1995) argue that the decision in WHITE v JONES [1993] 1 All E R 481, together with the recent decision in SPRING v GUARDIAN ASSURANCE PLC [1994] 3 All E R 129,<sup>381</sup> indicate a new approach of the House of Lords towards the tort of negligence The ramification of the decision in SPRING and WHITE is as of yet unclear However, the authors argue that the extension of HEDLEY BYRNE criteria and the use of the just-and-reasonable rule in SPRING and WHITE may indicate a retreat to ANNS The decision in SPRING was made by a 'revitalized House of Lords, [ ] willing to apply notions of policy in a

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<sup>380</sup>See *infra* Subparagraph 9 4 1

<sup>381</sup>In this case the House of Lords allowed the subject of a reference a remedy in negligence against the referee, his former employer It held that the defendant's negative opinion was honest but unreasonable The House of Lords indicated that it was fair, just and reasonable to do so The responsibility of a referee to provide a proper and careful reference serves, according to Allen (1994 113-114), the public interest and leads to more accuracy See also Weir (1993) and O'Dair & Halson (1996)

pragmatic and sympathetic way' <sup>382</sup> It suggests a retreat to ANNS and may in particular threaten the liability of professional advisers

Passmore (1996) too argues that the solicitor's liability towards third parties is expanding He asserts that the justice and reasonableness criterium is not used in recent case law to limit the liability of a solicitor with regard to negligent statements <sup>383</sup> He refers also to the decision in WHITE v JONES [1995] 2 A C 207

In addition, Passmore argues that in another recent case, MCCULLAGH v LANE FOX & PARTNERS (1995) The Times, 22 December 1995, the court re-emphasized the importance of the assumption of responsibility as the underlying notion of liability <sup>384</sup> The judgment of Hobhouse J in this case, although *obiter*, indicated a retreat from the policy argument, laid down in GRAN GELATO LTD v RICHLIFF (GROUP) LTD [1992] Ch 560, not to impose liability <sup>385</sup> The assumption of responsibility in GRAN GELATO was overlooked in favour of the fact that it was not fair and reasonable to impose a duty <sup>386</sup>

2.7.9. Donnelly (1996) argues that the Irish courts have

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<sup>382</sup>Greenfield & Osborn (1995 57)

<sup>383</sup>Passmore refers to three unreported judgments (1996 410)

<sup>384</sup>See also HENDERSON v MERRETT SYNDICATES LTD [1994] 3 W L R 761, discussed by Haydon (1995 239)

<sup>385</sup>Passmore (1996 410)

<sup>386</sup>*Ibid* See also *infra* Subparagraph 9 4 6

recently moved away from the limited interpretation of the HEDLEY BYRNE principles, laid down by Kenny J in BANK OF IRELAND v SMITH [1966] I R 646 <sup>387</sup> In this case Judge Kenny stated that the relationship between defendant and plaintiff needed to be equivalent to contract <sup>388</sup>

It is a clear sign that the Irish courts are not reluctant to expand liability and have done this for negligent misstatements also. Contrary to the position in England, the development of negligent misstatement in Ireland indicates an expansionist approach of liability issues. Donnelly too, accepts this view. The ANNS approach is still favoured by the Irish courts <sup>389</sup>

Donnelly indicates that the public policy argument that may prevent the existence of a duty of care must, in Ireland, be 'extremely serious' <sup>390</sup> For this reason, Donnelly concludes that the Irish courts will allow a finding that the subject of a reference is owed a duty of

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<sup>387</sup>Cf POTTERTON LTD v NORTHERN BANK LTD [1993] I L R M 225, MCANARNEY v HANRAHAN AND OTHERS [1993] I R 492 and DONNELLAN v DUNGOYNE LTD [1995] 1 I L R M 388

<sup>388</sup>Donnelly (1996 126)

<sup>389</sup>This is also recognized by Byrne & Binchy (1992 553). Reviewing the decision in DOHERTY TIMBER LTD v DROGHEDA HARBOUR COMMISSIONERS [1993] I L R M 401, they conclude that this case 'afford no weight to the argument of those who contend that' the Irish courts too will retreat from the application of the "two-stage" test, (*supra*)

<sup>390</sup>(1996 125) See, for example, the decision in MULALLY v BUS EIREANN [1992] I L R M 722

care by the referee <sup>391</sup>

McMahon (1982) suggests that the Irish courts are generally favourable to the plaintiff. Although McMahon stated this fourteen years ago, it still appears to be true that the floodgates arguments, or the 'opening of Pandora's box, have not impressed or intimidated the Supreme Court' <sup>392</sup>

O Ceidigh also recognizes this Irish attitude <sup>393</sup>. The existence of a duty of care therefore, is differently recognized in Ireland and England <sup>394</sup>. This divergence in the law of negligence results from the different interpretation in both jurisdictions of terms such as "principle", "test" and "standards" <sup>395</sup>

Kerr (1988) previously, recognizes that McCarthy J , although citing English authorities which feared a too

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<sup>391</sup>Cf *SPRING v GUARDIAN ASSURANCE PLC AND OTHERS* [1994] 3 W L R 354. This case has been discussed in the literature review by Greenfield & Osborn (1995) and Allen (1994), see *supra* Subparagraph 2 7 8

<sup>392</sup>McMahon (1982 3)

<sup>393</sup>Although Costello J referred in the High Court to the new "just and reasonable" test (*WARD v MCMASTER AND OTHERS* [1985] I R 29) the Supreme Court on appeal was reluctant to approve this part of Costello J 's judgment. The Supreme Court (*per* McCarthy J ) rather interpreted the liability test according to the rationality in *ANNS*. There must be proximity and foreseeability. A remedy is only denied if there is a 'compelling exemption based upon public policy' (*WARD v MCMASTER* [1988] I R 337 at 349, *per* McCarthy J )

<sup>394</sup>See also Cherniak & Stevens (1992). They assert that the *ANNS* approach is sound and accepted in CANADA. In that jurisdiction the test is broader and has a more sensitive focus. It is a mechanism that does justice to the compensable aim of tort law. Under *ANNS* the Canadian courts, contrary to the English, can take into account 'a wider range of social expectations', (*supra* at 179)

<sup>395</sup>O Ceidigh (1990 123)



literal application of the ANNS test,<sup>396</sup> allowed an action in negligence to succeed once foreseeability and proximity are established. Policy consideration must be very powerful to deny the plaintiff a remedy.<sup>397</sup>

Kerr welcomes the consistency of the Supreme Court in its approach to negligence.<sup>398</sup> He typifies the range of decisions as 'both rational and intelligible'.<sup>399</sup>

Byrne & Binchy (1988) argue that McCarthy J's lack of enthusiasm for a reversal of ANNS was due to, *inter alia*, his insistence to hold on to the power of a general principle to answer future and novel liability questions. For this reason Byrne & Binchy welcome the decision in *WARD v MCMASTER*. However, at the same time they warn against the continuing endorsement of English decisions which have been repudiated by subsequent English decisions, and the lack of a proper analysis of principle of these cases by the Irish courts.

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<sup>396</sup>Cf *GOVERNORS OF THE PEABODY FOUNDATION FUND v SIR LINDSAY PARKINSON & CO LTD* [1985] A C 210 and *YUEN KUN YEU v ATTORNEY GENERAL OF HONG KONG* [1988] A C 175

<sup>397</sup>An aspect also recognized by Byrne & Binchy (1988 407)

Stapleton (1991) argues that in essence the decision of ANNS does not materially differ from the recent "retrenchment" decisions. The principles are similar and equally applied. Where ANNS differs from the recent decisions is that policy has changed in favour for the defendant (*supra* at 294)

<sup>398</sup>In cases such as *PURTILL v ATHLONE U D C* [1968] I R 205, *MCNAMARA v E S B* [1975] I R 1 and *FINLAY v MURTAGH* [1979] I R 249

<sup>399</sup>Kerr (1988 187)

Specific Attributes to the Duty Question and Auditor's Liability

2.7.10. Case law showed that the liability of an auditor is limited. At the same time, the solicitor's duties are extended to intended beneficiaries. This has been discussed <sup>400</sup>

The divergence with regard to the imposition of liability to a solicitor and an auditor lies in the courts' attitude to tort law. As we have identified, the courts employ an incremental approach towards professional liability <sup>401</sup>. What are the specific consequences for the auditor of the decision in *CAPARO INDUSTRIES LTD* [1990] 1 All E R 568?

*CAPARO* states that the existence of a duty depends on foreseeability, proximity and justice and reasonableness. Weir (1995) recognizes that this contains general principles with regard to the tort of negligence. However, he argues that a general principle does not provide the solution to each liability question <sup>402</sup>.

The novelty of *CAPARO*, however, is that it characterizes the courts' refusal to impose liability on auditors by categorizing the different cases of auditors'

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<sup>400</sup>See *supra* Subparagraph 2.7.8

<sup>401</sup>*Ibid*, Subparagraph 2.7.4

<sup>402</sup>(1990: 212) Weir argues that categories of negligence are not subject to one principle. The cases in one category may have common factors but 'the categories themselves have no common denominator', (*supra* at 213)

liability The House of Lords did not consider in CAPARO the special relationship between the parties nor did it consider the assumption of responsibility Instead, the House of Lords established new factors for the assessment of the existence of a duty of care It rather emphasized the precise form of reliance, not whether it was reasonable In doing so, the court looked at the nature of the transaction or the purpose of the representation <sup>403</sup>

Weir suggests that the plaintiff (Caparo Plc ) should have sued the directors of Fidelity Plc for fraud or breach of contract Weir appears thus to emphasize the importance of a "special relationship", overlooked by the House of Lords in CAPARO At the same time he suggests that people who can afford it should consider their investment options in these cases He argues that, contrary to other cases, the investor was not 'wet behind the ears', nor was it an individual who had invested his or her savings in a government supported investment scheme <sup>404</sup>

Morris (1991) argues that, with regard to the liability of professional advisers, the law remains unsatisfactory

The trial judges have gained more discretion to decide cases either on narrow variations of proximity or on the broader issues of policy Thus, apparent analogous cases

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<sup>403</sup>The result of this examination was that their Lordships held that the purpose for relying on the accounts was that the shareholders could exercise informed control over the management of the company

<sup>404</sup>Weir (1995 214)

are distinguished on narrow issues, for example, the economic status of the plaintiff and defendant,<sup>405</sup> or the availability of insurance <sup>406</sup>

He argues that these factors are not for the courts to decide, particularly in the absence of a contractual relationship. Within such a relationship the parties could allocate the risks among themselves within the confines of the Unfair Contract Terms Act, 1977 <sup>407</sup>

However, others do not hesitate to emphasize that the courts must take into account the economic status. On the one hand there is a difference between the individual professional and the manufacturer of market products, and on the other there is a difference between professional investors and consumers of market products. Fleming (1990) argues that professional investors are in a better position to protect themselves against risks and often benefit freely from the advice, manufacturers can spread their costs, while the auditor normally deals with one client at the time <sup>408</sup>

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<sup>405</sup>Morris (1991 46) Morris illustrates this with the different approaches undertaken in SMITH v ERIC S BUSH (A FIRM) AND HARRIS v WYRE FOREST D C [1989] 2 All E R 514 and JAMES MCNAUGHTON PAPER GROUP LTD v HICKS ANDERSON AND CO [1991] 2 W L R 641

<sup>406</sup>This was considered by Hoffman J in MORGAN CRUCIBLE CO v HILL SAMUEL BANK LTD [1990] 3 All E R 330 at 336

<sup>407</sup>Morris (1991 47)

<sup>408</sup>See also Bishop (1980) He argues that statements are made from different economic considerations. These considerations allow the courts to discriminate more precisely between cases. Hence, liability can be excluded or imposed based on the realization of an 'optimal allocation of scarce resources among competing ends',

2.7.11 The auditor's liability, according to Mulcahy (1994), is determined largely on policy accountability of the auditor's work to those who rely on it and limitation of liability, i.e. to whom is a duty of care owed the unknown plaintiff, the class of the plaintiff or the specific plaintiff who relied on the misrepresentation

This policy has shifted in favour of the auditors since the decision in *CAPARO INDUSTRIES PLC v DICKMAN* [1990] 1 All E R 568, basically limiting their liability for negligent misstatements contained in auditors' reports to the shareholders in general meeting <sup>409</sup>

Mulcahy points out, comparing the decision in *CAPARO* with some recent Canadian authorities,<sup>410</sup> that the extent of liability depends on whether emphasis is put on financial information disclosure and investor protection or upon the need to protect a professional grouping against disaffected stakeholders of a company <sup>411</sup>

According to Chua (1993, 1995), the public policy considerations could also be used to extend the liability of auditors towards, for example, individual shareholders Chua illustrates this with two examples <sup>412</sup>

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(*supra* at 363) See also Chapman (1992) and Cheffins (1991)

<sup>409</sup>Mulcahy (1994 195) See also Pugh-Thomas (1990 1467)

<sup>410</sup>He refers to, *inter alia*, *HAIG v BAMFORD* [1976] D L R (3d) 68

<sup>411</sup>(1994 297)

<sup>412</sup>(1995 16, 1994 38)

Shareholders who buy inflated shares due to a negligently prepared report suffer loss. They sell the shares after the discovery of the negligence. However, they do this before the initiation of the action against the auditor. They are thus without a remedy. The other shareholders, however, can as an organ of the company sue the auditor. Subsequently, they are, according to Chua, enriched if the action is successful at the expense of the defenceless shareholders who sold their stake.

Equally, shareholders could be unjustifiably enriched if they had bought shares prior to the publication of the negligently prepared report and benefit from an action of the company against the auditor.

Contrary to the decision in *CAPARO*, Chua argues that the annual accounts should be public documents. Persons who deal or wish to deal with the company in good faith will have constructive notice of their contents. Hence, the auditor should be responsible if these public documents were negligently prepared.<sup>413</sup>

Finally, Stephenson (1990) argues that audited accounts have a legal and commercial dimension. The legal aspect consists of the exercise of informed control. The commercial aspect is that audited accounts will frequently provide a basis for existing shareholders to increase or decrease their shareholding. This approach suggests that at least existing shareholders should be able to sue an auditor for the negligent representation of the audited

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<sup>413</sup>*Ibid*, at 20, (1994 40)

accounts

### Immunity

2.7.12. The thesis now discusses the barrister's immunity from suit <sup>414</sup> It sets out the law as it is in England In Ireland, this issue has not been fully addressed The thesis emphasizes the unique nature of the advocate's functions However, the arguments in *RONDEL v WORSLEY* [1967] 3 All E R 993 appear not fully convincing

Currently, two cases in the English Court of Appeal are challenging the immunity of barristers <sup>415</sup> *Slapper* (1996) argues whether it is such a bad thing to reopen a case where someone has been imprisoned due to the lawyer's negligence This question becomes even more apparent if the dissatisfied client has been released and there is "fresh evidence" of the lawyer's negligence *Slapper* perceives the immunity rule as anachronistic, where there is a wrong, there must be a remedy

*Gill* (1987) reviews the consequences of the expansion of professional liability for lawyers He does not address directly the issue of immunity but the review implies that this expansion may eventually limit the lawyer's immunity

According to *Gill* (1987), the expansion of liability with regard to professional people was due to the

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<sup>414</sup>See *infra* Subparagraph 9 5

<sup>415</sup>See *Slapper* (1996) See also *Greenfield & Osborn* (1995 57)

elimination of the principle of privity of contract, the subsequent establishment of liability towards third parties and the principles governing negligent misstatements and economic loss. This expansion went hand in hand with the awareness of "consumer rights" <sup>416</sup>

The response of the legal profession in Australia to these developments is, according to Gill, minimal in the absence of any alternatives. They do not have much options to avoid liability, other than to avert negligent conduct, to minimize costs through compulsory indemnity schemes and to lobby for appropriate limitations of liability <sup>417</sup>

Osborne (1986) contests the reasons in *RONDEL* to grant immunity. Since the decision in *HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD* [1963] 2 All E R 575 the omission of a contract is no justification for not suing a barrister.

The barrister's higher duty to the court is no excuse. It is rather a caution as to the standard of care required by him with regard to the administration of justice. He will not be liable if his conduct was justified to fulfil this higher duty.

Defensive practice is speculation, as well as the warning that the capacity to sue an advocate would lead to an increase in litigation.

The obligation to act with due care exceeds the advocate's obligation to accept clients (the advocate holds

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<sup>416</sup>Gill (1987 552)

<sup>417</sup>*Ibid* , at 561



himself out to possess a special skill)

The fear that a negligence action will lead to a re-trial of the original procedure is unfounded Osborne points out that an action for negligence will normally focus on a detail of the original procedure rather than the procedure itself

Finally, the decision in SAIF ALI v SIDNEY MITCHELL & CO [1978] 3 All E R 1033 restricted the barrister's (and solicitor's) immunity to pre-trial work and advocacy

Zander (1979) argues that this restrictive interpretation may pave the way to narrow immunity even further <sup>418</sup> Osborne (1986), however, argues that the decision in SAIF ALI hints towards a greater protection of the consumers' interests of services Osborne argues that in Canada the public interest is not served when damage remains uncompensated The nature of the legal profession in Canada justifies the imposition of a duty of care <sup>419</sup>

## 2.8. Professional Autonomy and Responsibility

2.8.1. Doctors need to make practical decisions, according to Freeman (1988) Their outcome may have consequences for the particular patient, the doctor and for society at large These decisions are often to be made in

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<sup>418</sup> (1979 323-324)

<sup>419</sup> See, for example, DEMARIO v UNGARO (1979) 21 O R (2 ed ) 673

a legal context, especially where it involves decisions regarding ethically controversial cases, for example, contraceptive advice to the underaged <sup>420</sup>

If this results in a conflict, the courts are regarded as the arbiters, the legislature is reluctant to intervene in these areas, being afraid of political repercussions and consequences of moral conflict. And, if there is legislation, it is often a compromise which does not entail the solutions which were required in the first place <sup>421</sup>. In some instances problems are solved through self-regulation within the medical profession. However, it appears that doctors are less likely to take responsibility for certain decisions.

This problem is examined in Chapter Ten of the thesis. It discusses the implications of the recent decision in *RE A WARD OF COURT* [1995] 2 I L R M 401. The interpretation of the different medical terms such as P V S (Permanent Vegetative State) and "treatment", and the court's analysis of the relevant constitutional rights may indicate that the Supreme Court, unwillingly, permits euthanasia in a disguised form.

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<sup>420</sup>Freeman (1988 1) See *GILLICK v WEST NORFOLK & WISBECH AREA HEALTH AUTHORITY* [1986] A C 112

In Ireland, controversial cases were, *inter alia* the "Right to Die" case (*RE A WARD OF COURT* [1995] 2 I L R M 401), the "X-"case (*ATTORNEY GENERAL v X* [1992] 1 I R 1, [1992] I L R M 401) and the "Abortion information" cases (*ATTORNEY GENERAL (S P U C (IRELAND) LTD v OPEN DOOR COUNSELLING LTD* [1988] I R 593 and, more recently, *RE THE REGULATION OF INFORMATION (SERVICES OUTSIDE THE STATE FOR THE TERMINATION OF PREGNANCIES) BILL, 1995* [1995] 2 I L R M 81)

<sup>421</sup>Freeman (188 1-2)

This and other implications reflects the profession's problems in solving matters of professional and ethical conduct. The case may imply a decline in the autonomy of the medical profession.

The literature review sets out the reception of RE A WARD OF COURT in Ireland and its implications for the future.<sup>422</sup>

2.8.2. As of yet the decision in RE A WARD OF COURT has not produced the required quantity of academic comment it demands. The available literature stresses the importance of the decision, both in its narrow and wider context. The decision is also criticized.

Tomkin & Mc Auley (1995c) argue that the distinction between euthanasia and withdrawal of treatment does not work in this particular case. This is due to the court's description of artificial nourishment and hydration as medical treatment. Tomkin & Mc Auley, however, stress that not all treatment was withdrawn from the ward. The doctors maintained providing her with medicine to 'ease her passage'.<sup>423</sup> This part of the decision is 'contentious' and the writers assert that as a result it may not be accepted in other jurisdictions.<sup>424 425</sup>

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<sup>422</sup>The reaction of the Medical Council and its consequences has already been discussed in the context of the role of the Medical Council, see *supra* Subparagraph 2.6.7. See also, *infra* Subparagraph 10.6.2.

<sup>423</sup>Tomkin & Mc Auley (1995c 1235)

<sup>424</sup>*Ibid*, at 1234

Tomkin & Mc Auley also examine other parts of the Supreme Court's decision. Three points demand attention.

The first point of criticism is that the majority judges did not debate fully whether the ward was in a P V S state. Judge Egan made a point about this in his dissenting judgment because the withdrawal of treatment would subsequently involve an assessment of the quality of the ward's life. The writers regret that this point was not taken up further by the other judges.<sup>426</sup>

Second, the proceedings were adversarial rather than inquisitorial. The writers argue, and the thesis agrees with them on this point,<sup>427</sup> that the latter form of procedure must be favoured in this type of cases. They agree with Blayney J on this point. Tomkin & Mc Auley stress that the court's function in this case was to make a decision on all relevant facts 'in loco parentis'.<sup>428</sup>

Finally, the writers welcome the judicial analysis as to the tests used by the Supreme Court judges in the WARD case. Although the Supreme Court applied the "best interest" test, the authors appreciate Lynch J's

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<sup>425</sup>An editorial in the Irish Law Times (1995) stresses that in permitting the continued provision of palliative care and the withdrawal of artificial feeding the Supreme Court recognizes what is reality in other jurisdictions. A doctor is allowed to relieve pain, even if the ultimate effect results in the death of the patient. This has been justified by 'the doctrine of "double effects"', (*supra*, at 205)

<sup>426</sup>Tomkin & Mc Auley (1995c 1234)

<sup>427</sup>See *infra* Subparagraph 10.5.4

<sup>428</sup>(1995c 1235)

compromise in his High Court judgment<sup>429</sup> between the "best interest" test and the "substitute judgment" test<sup>430</sup>

Feenan (1996) agrees with much of the analysis offered by Tomkin & Mc Auley (1995c) Feenan stresses that its immediate effect underlines the shortcomings of the law to regulate professional conflicts, the decision to follow the court order may render a practitioner guilty of professional misconduct The powerful judicial supremacy under the *parens patriae* jurisdiction implies, according to Feenan, a demise in medical autonomy<sup>431</sup>

In addition, Feenan criticizes the court's analysis of individual autonomy and self-determination He argues that despite the popularization of self-determination in other areas of the law, the Supreme Court, in using the "best-interest" test, ignored 'the much needed exploration of patient values'<sup>432</sup> It rather preferred the traditional paternalistic approach

However, according to this researcher, it must be argued whether the "best interest" test was in fact paternalistic in nature The thesis asserts that the test is "child-centred", the wishes of the family for example,

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<sup>429</sup>RE A WARD OF COURT, Unreported, High Court, 5 May 1995, Lynch J

<sup>430</sup> According to Feenan (1996 91), the Supreme Court's greatest dilemma was to overcome the divergence between the recognition of autonomy and proxy decision-making This dilemma was, logically, not justified in applying the "best interest" test

<sup>431</sup>(1996 94) This point is taken up by the thesis in, *infra* Subparagraph 10 5 1 , and discussed further

<sup>432</sup>Feenan (1996 at 93)

were not prevalent in the court's consideration <sup>433</sup>

The decision has wider implications too. It recognizes a shift to a more pluralist and secular society, according to Feenan. It is an example of the dynamic nature of the Irish Constitution. It acknowledges the unenumerated rights to privacy, self-determination and bodily integrity. In doing so these rights will alter the doctor-patient relationship in counteracting the medical paternalistic approach and recognizing the patient's right to consent or refuse treatment <sup>434</sup>

An editorial in the Irish Law Times (1995) stresses that the importance of the Supreme Court decision lies in the attempt to respond to the demands of a pluralist society. Reflection and debate must now pave the way for legislative change <sup>435</sup>

## 2.9. Summary

The literature review clearly showed that the development of the tort of negligence is under continued criticism. This criticism included, as most relevant factors, the issue of third-party liability and economic

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<sup>433</sup>See *infra* Subparagraph 10.5.3

<sup>434</sup>Feenan (1996: 91)

<sup>435</sup>In another article Tomkin & McAuley (1995b: 50) propose that the State should nominate a forum that will facilitate medical practitioners which are willing to withdraw treatment. See also Cullen (1995)

loss (the duty question) and the standard of care in relation to professional conduct, in particular with regard to the doctor's task to provide information and advice of medical treatment and allied matters

In addition, the literature review included issues that are not discussed in this thesis but are considered by this researcher to be relevant in the context of professional negligence, such as the role and nature of ethical and professional rules or codes of conduct and alternative compensation schemes

## Chapter Three

### The Idea of a Profession A Justification

#### 3.1 Introduction

3.1.1. Recent years have shown a vast increase in negligence litigation involving people who are presumed to have gained a certain professional status in society <sup>1</sup> This type of negligence appears to differ from "ordinary" negligence in a number of ways, and indeed this can be said to have been the real incentive for writing this thesis

The review of the presumed professional negligence cases will show that the Irish and English courts rely on certain characteristics which, it is asserted, are inherent to the nature of a profession. These characteristics include

(I) professional judgment, the courts rely on professional judgment or professional opinion in the assessment of the alleged negligent behaviour of the professional person,  
(II) an accepted or approved practice, this suggests that there is a connection between theory and practice, and the

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<sup>1</sup>According to Steven Grundy of the Medical Protection Society, Ireland has become the "U S A of Europe" in suing doctors. An Irish consultant is between 10 to 20 times more likely to be sued than fellow members of the Society in 40 other countries, (Anon (1995))



manner in which professionals are educated,

(III) individual autonomy, a practitioner may deviate from an accepted practice within accepted parameters

This has been identified by a number of writers, including McMahon & Binchy, who observe that 'professions are regarded by the courts as being substantially competent to determine and require a satisfactory standard of competence in the performance of professional duties' <sup>2</sup>

This raises an obvious but nevertheless important question Why are the professions - by reference to a certain practice, their presumed professional autonomy and professional opinion - regarded as competent to set their own standard in the performance of their duties? This is above all a sociological issue An answer involves an examination into the nature and function of the professions in the socio-economic environment in which their members provide the professional service

However, as Freidson (1988) points out, the word "profession" is not easily defined A single and unified definition cannot be given and has as of yet not been given Therefore, caution is required A number of reasons justify this and are, amongst others, identified by Freidson He perceives the word as descriptive and evaluative The definition differs in terms of the application, depending on the occupation involved, and the purpose or intent of the definition is either malignant or

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<sup>2</sup>(1990 259)

analytical <sup>3</sup>

Freidson, therefore, does not attempt to define professions but rather reveals to the reader whatever the writers have in mind when they use the term -

to indicate the definition upon which their exposition is predicated and, for even greater clarity, examples of the occupations they mean to include and those they mean not to include <sup>4</sup>

Adopting Freidson's approach, the thesis puts a definition or description of professions in the context of professional negligence. In this context those occupations can be presumed to be professions which are regarded by the courts as 'substantially competent to determine and require a satisfactory standard of competence' <sup>5</sup> Examples of these professions are the medical, legal and accountancy profession. These professions are used throughout the thesis to clarify the arguments in the context of the characterization of professions, the professional relationship and professional negligence.

3.1.2 This Chapter examines first the process of "professionalization" and identifies the importance of autonomy and dominance in the context of professional

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<sup>3</sup>(1988 3-4)

<sup>4</sup>(1983 35) It must, according to Freidson, be treated as 'an empirical entity about which there is little ground for generalising as an homogenous class or a logically exclusive conceptual category', (*supra*, at 33)

<sup>5</sup>McMahon & Binchy (1990 259)

negligence Second, the chapter examines the variety of definitions given by sociologists and lawyers to find some consensus on relevant traits or attributes inherent to the professions The aim of this examination is the identification of certain characteristics which are said to be inherent to what professions are and the manner in which professional status is gained

### 3.2. Professionalization

3.2 1. It is in man's nature to divide the society in which he lives into various hierarchical groupings This phenomenon has been observed by writers such as Dahrendorf (1959), Bottomore (1966) and Mayer & Buckley (1969) Professions can be regarded as being part of such hierarchy and, within the Western market-economy, two hierarchical frameworks underlie the notion of profession and professionalization

3.2.2. The first viewpoint is primarily represented by Parsons (1939), who suggests that professional practice must be seen as separate from any business activity Although some goals may coincide, such as personal achievement, material gain and recognition, the difference between a professional practitioner and a business man is 'determined by the differences in [their] respective

occupational situations' <sup>6</sup>

The key-note in business enterprise is predominately the pursuit of profit. This pursuit of self-interest dominates the modern economic system, what Parsons terms the 'acquisitive society' <sup>7</sup>

Professional practice places the disinterested service to its clients at a premium, on the basis of a fixed fee or tariff. The practitioner is presumed to be more altruistic than egotistic. Within this context professions 'were seen to have a stabilising effect on industrial societies, which are competitive, commercial and individualistic' <sup>8</sup>. The reason for this is that professions modify the dominant ethos and organization of capitalism, where the making of profit is foremost.

This approach describes professions as vocations 'based upon universalism, disinterested service and affective neutrality' <sup>9</sup>. It emphasises the notion of ethical behaviour. The professional motivation lies in the commitment to the ethics of responsibility. The profession itself portrays altruistic or selfless values because professions are 'within the social division of labour, officially committed to various forms of personal service

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<sup>6</sup>Parsons (1939: 464). That this difference is at present blurred in relation to the legal profession is identified by Mason, see *supra* Subparagraph 2.3.5 and Wilkins (1990), see *supra* Subparagraph 2.6.11.

<sup>7</sup>Parsons (1939: 458).

<sup>8</sup>Turner (1985: 38).

<sup>9</sup>Turner (1987: 133).

and community welfare' <sup>10</sup> Its role embodies, according to Turner, a 'disinterested commitment to community values' and may be characterized by its ethical qualities, the service to the individual and its basis in technical knowledge <sup>11</sup>

Hence, adherence to a list of certain traits or characteristics distinguishes a profession from other occupations To "become" a profession (professionalization) an occupation simply acquires those traits or characteristics Millerson includes in this list <sup>12</sup> theoretically based skills, a period of education and training, formal examinations, codes of practice with respect to the professional integrity, internal regulations (professional associations aiming at the regulation of the activities of its members), and, finally, public services, the services are said to be for the public good

This view describes a profession as an occupation with a number of traits, wherein the dominant features are knowledge and ethics It distinguishes itself from the 'business economy' or the 'profit system' through disinterestedness and altruism <sup>13</sup>

3.2.3. The second viewpoint radically alters the idea of professions and professionalization , This view is

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<sup>10</sup>*Ibid* , at 131

<sup>11</sup>*Ibid*

<sup>12</sup>(1964 9-16)

<sup>13</sup>Turner (1985 46)

represented by writers like Freidson (1988) and Hughes (1958) They challenge the idealistic view of professions In their view professionals are privileged workers who, by virtue of their activities, are able to apply certain strategies to limit competition In doing so they preserve 'their elite control over occupational prestige' <sup>14</sup>

In this context the concept of professions is described as those occupations that obtain professional autonomy through strategic market control rather than adherence to a list of traits In this description social groups attempt to maintain their place in the market and 'the status and power of professions depends on their ability to maintain a market situation and access to appropriate clients' <sup>15</sup>

It is argued that the social distance in a relationship between a professional person and his client depends on the 'social and economic dependence' within the professional relationship <sup>16</sup> An increase in this dependency results, on the one hand, in a greater helplessness of the client and, on the other hand, in an increased autonomous position for the profession Turner and Johnson detect three systems of professional relationships <sup>17</sup>

First, a system of collegiate control In this system it is the service provider who defines the needs of the

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<sup>14</sup>*Ibid*

<sup>15</sup>Turner (1987 140)

<sup>16</sup>Johnson (1972 41)

<sup>17</sup>*Ibid* , at 45-46, Turner (1987 136-137)

client and the way those needs are satisfied Through a corporate system of regulation and surveillance the profession controls itself

Second, a patronage system, where clients define their own needs and determine the nature of the satisfaction of those needs This is either oligarchic or corporate

Third, mediation through intervention of a third party (often the State) Here, the third party regulates and controls the practice of professional men and the service provided to the client

Tomkin & Hanafin (1995) assert that the collegiate model is used by the medical profession This control mechanism holds, according to the authors, two implications (i) professions control the education of newcomers and (ii) professions are self-directive and self-regulatory <sup>18</sup>

The three systems also indicate certain processes which may involve changes in the nature of professions This change may indicate either more control and prestige or may imply 'de-professionalization or proletarianization' <sup>19</sup> This "de-professionalization" is effected through (i) bureaucratization, which undermines the professional autonomy and decreases the professional status of the profession, (ii) socialization and development of knowledge, which may lead to the division of a profession into specific groupings (fragmentation) and (iii) pressure

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<sup>18</sup>(1995 12)

<sup>19</sup>Turner (1985 39) See also Oppenheimer (1973 213)

from new and para-professional groupings to take over

3.2.4. So far, professional dominance has been created through power and the application of market control strategies. Turner, however, explains that the presence of a body of esoteric knowledge cannot be ignored. Instead, it is a vital attribute to the issue of professional status and should not be overlooked as something obvious to the nature of professions.

The reason for this assertion is the fact that a profession must attempt to maintain and extend its clientele by creating a monopoly in its field of expertise. Market control mechanisms are not enough. There must be a gap between knowledge and the application of knowledge (the specialized skill). If such a gap does not exist 'knowledge can be routinely applied without the intervention of professional judgment'<sup>20</sup>. The importance of knowledge in this model is therefore the 'range and necessity of professional judgment'<sup>21</sup>. With respect to the medical profession, Turner defines dominance as -

a set of strategies requiring control over the work situation, the institutional features of occupational autonomy within the wider medical division of labour, and finally occupational sovereignty over related occupational groups<sup>22</sup>

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<sup>20</sup>Turner (1985 42)

<sup>21</sup>*Ibid* , at 46

<sup>22</sup>(1987 141)



Accordingly, he identifies three strategies of occupational control through power and knowledge <sup>23</sup> First, subordination where professional persons delegate certain activities to others This results in less independence, autonomy and self-regulation for those other occupations, for example, nursing and midwifery

Second, professional dominance is created through limitation This involves a form of limitation to, for example, in medicine, a specific part of the body or a specific therapeutic method, for example, dentistry, optometry and pharmacy

Finally, professional dominance is created through exclusion Other related occupations, offering alternative practices, are not allowed legitimate access by denying their registration, for example, chiropractic and the clergy, the latter being excluded from psychological counselling

### 3.3. Definitions and Descriptions of the "Profession"

3.3.1 It will be immediately apparent that we are dealing with two types of characterizing professions (i) definitions and (ii) descriptions by characteristic, function or attribute Furthermore, some definitions or descriptions are narrow and exclusive while others are

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<sup>23</sup>*Ibid*

inclusive and cover a wide range of occupations

3 3.2. Freidson (1988) describes professions by function, within the division of labour in the socio-economic environment. He emphasizes the social organisation of the profession, rather than using discriminants such as norms, attitudes or ethics. As an occupation it is autonomous or self-directing, and it has 'assumed a dominant position in a division of labor [sic], so that it gains control over the determination of the substance of its own work' <sup>24</sup>

Freidson does not attach any specific characteristics to the word "profession". He suggests that the word can be applied to those occupations who have obtained a degree of independence in the division of labour. This independence is a consequence of being in command over other occupations. The result is that the profession is autonomous and self-directing. Its dominant position is granted through the 'trustworthiness' of its members, which includes 'ethicality' and 'knowledgeable skill' <sup>25</sup>. The important feature in this definition is the role of power. According to Turner, Freidson's idea of a profession is that it is 'ultimately defined by its autonomy from external control and this autonomy is determined by power

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<sup>24</sup>Freidson (1988 xv)

<sup>25</sup>*Ibid*

conflicts and not by the elaboration of knowledge' <sup>26</sup>

Thus, Freidson sees professions as an independent and autonomous body of knowledgeable skill in an economic context. This autonomous position has been acquired through the use of power to dominate other occupations. This has been characterized as a position of 'occupational control of market strategies', that aims at autonomy and dominance <sup>27</sup>

Carr-Saunders defines a profession as 'an occupation based upon specialized intellectual training, the purpose of which is to supply skilled advice and service to others in return for a definite fee or salary' <sup>28</sup>. The two principal elements in this definition - high level of specialized expertise and a remuneration accordingly - reflect a capitalistic division of labour. It is not the nature of the occupation that is paramount, but rather the level of expertise. This, in relation to other professions or occupations, determines the fee or salary. Accordingly, any occupation providing a specialized service falls within this definition of a profession.

Others, such as Wickenden, characterize professions as 'a body of knowledge or of art' <sup>29</sup>. They uphold standards of

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<sup>26</sup>(1985 38) However, it must be understood, in the opinion of this researcher, that without the existence of a body of knowledge the role of power cannot satisfy the public's demand for professional services

<sup>27</sup>Turner (1985 39)

<sup>28</sup>(1937 63)

<sup>29</sup>Lewis & Maude (1952 55)

conduct and qualifications (a self-defining oligarchy) and enjoy a recognition of status. This status is 'an implied contract to serve society over and beyond all specific duty to client or employer in consideration of the privileges and protection society extends to the profession' <sup>30</sup> Wickenden emphasizes the importance of the vocational aspect or altruism, which denotes the aforementioned "implied contract", the professional duties are owed to the specific client as well as to society at large. It is obvious that in this context ethicality is a paramount feature in the definition of professions. As a "body of knowledge or of art" professions are well capable of giving specialized advice, but the reward for this advice is more than just pecuniary. Through the ethical regulation of their behaviour, professional men contribute more to society than simply the resolution of a particular and individual problem. They are rewarded accordingly. Not only through a high remuneration but also through the recognition of their status and protection of their standard of competence. They also enjoy certain privileges. They are sellers of knowledge, but they are also guardians of a body of knowledge and expertise.

Among lawyers, a consensus on what professions are has not yet been found. McMahon & Binchy confine professions to the so-called learned professions: the church, medicine and law <sup>31</sup>. This traditional view characterizes professions as

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<sup>30</sup>*Ibid* , at 56

<sup>31</sup>(1990 258)

(i) providing specialized intellectual work, (ii) owing a moral (and overriding) duty to the general public, and (iii) enjoying a high social status in society Jackson & Powell add to this view a fourth characteristic collective organisation <sup>32</sup> However, McMahon & Binchy do recognize that this characterization seems 'arbitrary, elitist and undemocratic' <sup>33</sup>

Others exclusively emphasize the presence of a special skill and thereby pave the way for a wider application Professions are distinguished from those occupations which involve 'substantially the production or sale or arrangements for the production or sale of commodities' <sup>34</sup> This professional skill is obtained through 'some special qualifications derived from training or experience' <sup>35</sup> In *BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE* [1957] 2 All E R 118, McNair J also emphasized the notion of skill in the assessment of negligence of a medical practitioner '[t]he only question is really a question of professional skill' <sup>36</sup>

3.3.3. Thus far, it can be asserted that there is consensus with regard to at least three distinguishing

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<sup>32</sup>(1992 2)

<sup>33</sup>McMahon & Binchy (1990 258)

<sup>34</sup>Cf *COMMISSIONERS OF INLAND REVENUE v MAXSE* [1919] 1 K B 647 at 657, per Scruton L J

<sup>35</sup>Cf *CARR v INLAND REVENUE COMMISSIONERS* [1944] 2 All E R 163 at 166-167, per Du Parq L J

<sup>36</sup>[1957] 2 All E R 118 at 121

factors describing or defining professions as distinct from other occupations or trades

The first distinguishing feature is the presence of specialized skill, based upon intellectual training and knowledge. The intellectual content separates professions from trades and other crafts. The professional men are the providers or sellers of that skill. The remuneration, however, gives rise to two separate views on professions. It is either pecuniary or involves more than that.

The second distinguishing feature is the ethicality of professional behaviour or social altruism. This aspect considers the ethical paramountcy of the interests of the client or patient, collegiality among professional men of the same specialization and professional responsibility. Professional men owe not only a duty to the individual client or patient, but owe that duty to society as a whole. It emphasizes not only the vocational aspect. It also means that this duty towards society is sometimes wider, and may surpass the duty owed to their clients or patients.

The third distinguishing feature is professional autonomy. It is said to be self-directive and self-regulatory. This aspect is reflected in the importance the courts grant to the significance of "professional judgment."

### 3.4. Typical Characteristics of a Profession

3 4 1 The previous sections reviewed and synopsized some ideas of professions and professionalization. A number of characteristics were identified which were common to several definitions of professions and to the process of professionalization. This section describes those and other characteristics in the context of professions in Ireland and in the context of professional negligence. It is not the intention to describe and examine whether particular occupations are regarded as professions. Instead, it seeks to exemplify the particular position of professions in the context of professional negligence, as explained in the introductory paragraph.

3.4.2. The first characteristic is that professions are in some sense "public". Thus, the services in question are or should be generally and directly available to members of the public. Alternatively, professional services are either provided directly to the State or to a State agency (forensic scientists, pathologists) and only indirectly involving members of the public as clients.

Medicine is an example of a service which is predominantly provided publicly. Hence, the entire population of Ireland is eligible for hospital services in

the public wards of public hospitals <sup>37</sup>

In each case, the public interest is perceived to be served by the existence of an independent profession. The bar is an excellent example because, although the barrister may have an individual client to whom he owes a duty of care and skill, this duty is subject to an overriding duty to the court and indirectly to society <sup>38</sup>. On a practical level, it is suggested that the obligations of the professional person, within the professional relationship between him and his client, reach in most instances much further than the implicit and explicit contractual responsibilities mirrored in such a relationship.

3.4.3. The second feature of professions is that many writers identify the code of practice or rules of conduct as somehow critical to professional status. These rules involve not only questions of best practice and rates of pay, but rather seek to amplify and thus resolve difficulties inherent in the practice of the profession. For example, in questions where a conflict of interest in respect to a duty may be discerned,<sup>39</sup> these rules can cover

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<sup>37</sup>According to Tomkin & Hanafin (1995 234-235), many V H I members are both privately insured and are entitled to public hospital services at the State's expense. In addition, personal income tax relief is available under section 145 of the Income Tax Act, 1967. Thus, according to the same authors (*supra*), 'some private spending is supported indirectly from the public purse'.

<sup>38</sup>Cf. RONDEL v WORSLEY [1967] 3 All E R 993

<sup>39</sup>In Ireland the medical profession is subject to the guidelines issued by the Medical Council under section 69(2) of the Medical Practitioners Act, 1978.



both professional and ethical behaviour <sup>40</sup>

In many cases, the code itself will reflect the fact that the profession is somehow identified as being important to some sense of public order or cohesive society or common good. In such cases, codes or regulations will attempt to draw a balance between the practitioner, the client, society and its organs or institutions, and suggest how such professional dilemmas should be resolved. In many cases, the dilemmas are not only important and age-old, but are incapable of satisfactory simple resolution, viz the withdrawal of life-sustaining treatment from the terminally ill <sup>41</sup>

3.4.4. Third, the thesis explained that the element of skill or craft is critical to several views of what constitutes a profession. It is composed of intellectual and/or manual ability. By some it is regarded as 'the chief distinguishing feature in professions' <sup>42</sup>. It is acquired as a result of intellectual training and the desire of professional man to solve practical problems through academic or scientific research.

It is secured through selection and entrance into the

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<sup>40</sup>The meaning of professional ethics goes beyond aspects such as pride of workmanship or devotion or altruism. The job is more than just a mere condition of wages. According to Lewis & Maude (1952: 59), professional ethics derive from ancient oaths. They are expressed in the individual relationship between the professional person and his client or patient.

<sup>41</sup>Cf RE A WARD OF COURT [1995] 2 I L R M 401

<sup>42</sup>Carr-Saunders & Wilson (1964: 307)

profession, specialization and expertise or experience through practical training <sup>43</sup>

3.4.5. The fourth is that professions are seen as identifiably structured, typically with a professional body at its apex,<sup>44</sup> a live register of qualified persons and usually, but not always, a disciplinary code, administered in conformity with the requirements of natural and procedural justice by an established committee of the professional body. It also holds an education programme which includes both the training of new entrants and the continuing education of existing practitioners. For clarity's sake we are here emphasizing not so much the type of structure, but rather that the profession is formally structured.

The purpose of the formal organization can be said to be two-fold. It aims to protect members from non-members as a means of occupational control. In doing so the public is protected against the unqualified practitioner and the qualified practitioner is safe to discharge his professional responsibilities without fear. This is achieved through the monopolization of the professional service rather than through economic interests.

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<sup>43</sup>Specialization is a necessary consequence of a complex and demanding society and the constant development of professional skill and technique.

<sup>44</sup>A profession is said to exist only where there are 'bonds between the practitioners', (Carr-Saunders & Wilson, 1964: 298), and the desire for 'social intercourse' with contemporaries, (*supra*, at 301).

Additionally, the formal organization emphasizes the protection of competence, honour and material interests and the development and maintenance of private and public activities <sup>45</sup> <sup>46</sup>

3.4.6 The fifth category relates not to the fact that the profession is typically structured, but a feature of most or some of these structures. The main point here, is that the profession restricts entry into the profession by means of autonomic control. This, for example, permits entrants to the profession and existing practitioners to be controlled by disciplines or codes of practice within the profession.

3.4.7. The sixth is that professional status is perceived as something socially desirable. The possessor is marked out as being distinctive from others without such skill or qualification. This may be reflected in earnings, or earnings may be a function of professional status.

This status is either granted through common consent or through statutory regulations recognizing the high intellectual calibre inherent to the profession. However, in view of occupational control, the profession gains its

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<sup>45</sup>Carr-Saunders & Wilson (1964 301)

<sup>46</sup>The Law Society of Ireland and the Medical Council are both examples of formalized structured professions. Both are created by statute, and govern with statutory powers the registration, education, professional and ethical conduct of its members, see the Medical Practitioners Act, 1978 and the Solicitors Act, 1994.

status by maintaining an open access with its clients through, for example, subordination, exclusion and limitation <sup>47</sup>

It is also perceived as important that the profession preserves its professional integrity This is relevant with regard to health services and the provision of health care to public and private patients in Ireland Relman proposed four suggestions to maintain this integrity for medical practitioners <sup>48</sup> First, they should guard against referring patients to institutions where they have no professional control but where they do have a financial interest Second, they should avoid making arrangements with "for-profit" organisations for referral of specific patients Third, they should avoid working directly for commercial hospitals In other words, they should remain self-employed as to maintain clinical responsibility and to be able to pursue a personal policy, rather than being constrained in some outside interests which may impose on the quality of their service Finally, the doctor should avoid the acceptance of rewards to not treat patients, either directly or indirectly

**3 4.8.** The seventh is the connection between the professions and various intellectual bodies whose input is something more than regulatory In other words, many writers identify a close proximity between professional

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<sup>47</sup>See Turner (1987 155)

<sup>48</sup>(1988 784)

education and education at universities, or other third level institutions <sup>49</sup> The precise nature of this relationship is uncertain

Thus, in some jurisdictions, the possession of a university degree *ipso facto* entitles the possessor to practise In others, a university degree is a requirement to enter some further professional training course Often these are run by or with input from the professions Within this category are included professions such as medicine and law (where the subjects of study are regarded as part of the curriculum of any humane university faculty), and others, such as accountancy, where a university degree in certain subjects entitles the possessor to claim exemption from some or other subjects taken as part of a professional course, administered not by the university, but by a professional training school

However, one can argue that today the relationship between the professions and universities is, at most, a necessity to obtain a professional licence to practice Universities and colleges provide students with the possibilities of sitting examinations, which, if successfully passed, result in the obtainment of a degree This degree, in its turn, is a prerequisite for entry into a profession

**3.4.9.** The eighth factor is that of State regulation or

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<sup>49</sup>See, for example, Carr-Saunders & Wilson (1964) See also Birks (1996)

interference. At first, this characteristic may seem to be at odds with some of those previously identified. How may a profession be autonomous and subject to State control or regulation? Nevertheless, there are obvious examples. Thus, the Medical Council is composed of statutorily appointed State representatives, its functions, officers, powers and duties are statutorily defined.<sup>50</sup> But, within the extensive and liberal boundaries of statute, the profession may and does regulate itself. The point here is that a function of the professions may be that the parameters are described by the State, or, as Dahrendorf suggests, the professions themselves are subsumed into State control.<sup>51 52</sup>

However, these parameters may at times be subject to, for example, judicial review. An example can be found in the recent High Court decision regarding the exemption of Northern Irish law students from sitting the entrance exams of the Incorporated Law Society.<sup>53</sup>

The High Court held in this case (where 35 Belfast

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<sup>50</sup>See the Medical Practitioners Act, 1978

<sup>51</sup>(1984 178) According to Dahrendorf, the foundations of liberty of the professions will be threatened, once the State interferes in the provision of important services ' [b]y substituting the State for society, it prevents the natural osmosis between the professions and the general public', (1984 184)

<sup>52</sup>Carr-Saunders & Wilson (1964 307) argue that once a profession is statutorily regulated the formal association representing the profession becomes an organ of the State, commissioned in the mechanism of administration. It loses its freedom and is dependant on being employed to undertake effective action. They are 'limited to protective functions and public activity', (*supra*)

<sup>53</sup>BLOOMER v INCORPORATED LAW SOCIETY OF IRELAND, Unreported, High Court, 22 September 1995, Laffoy J

students sought damages from the State and the Law Society of Ireland) that the Belfast graduates had been discriminated against under E U law They were not exempted from the entrance exams of the Law Society, in contrast to those students who had obtained a law degree in the Republic However, it was also held that the legislation under which the exemptions were granted was invalid It was held that the legislation was *ultra virus* the powers of the Law Society <sup>54</sup> The judge stated that it had technically contravened with the prohibition on discrimination on the grounds of nationality in Article 6 of the Treaty of Rome, 1957 The High Court had no jurisdiction to enact an alternative regulation to Regulation 15 <sup>55</sup> There was no evidence that the Society knew it was acting *ultra virus* in making the said Regulation The case fell

As a result, it appears that students in the Republic, having obtained a law degree must sit the entrance exams also <sup>56</sup> A significant incidental factor for the Law Society is the reaction of students with an Irish law degree, who thought they had secured free entry into the course It might now be argued that these students enjoy a "legitimate expectation" that their assumption of free entry will be upheld Currently, this is argued by the law students in

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<sup>54</sup>Regulation 15 of the Apprenticeship and Education (Amendment No 2) Regulations, 1992, S I 360/1992

<sup>55</sup>Cf *MHICMHATHUNA v IRELAND* [1995] 1 I L R M 69

<sup>56</sup>See Morgan (1995)

the High Court

**3.4.10.** The ninth factor is that the professions form a stable yet evolutionary force within society, regulating and monitoring change. Professional activities are an important mechanism in maintaining a 'relative balance of stability [in a] dynamic and precariously balanced society' <sup>57</sup> Professional men are able to overcome the 'gap between state-created laws and the actual condition of social life' <sup>58</sup> An example of this occupational morality is the way the medical profession has dealt with the problem of euthanasia in the Netherlands. Initially, euthanasia was forbidden by statute, but permitted by judge-made law after a careful balancing of medical ethics, the law and the interests of the patient. This resulted in a public debate leading up to a set of rules, created by the legal profession, allowing a doctor to carry out euthanasia in certain conditioned circumstances <sup>59</sup>

The introduction of pharmacologically dynamic substances into the pharmacopoeia is not permitted without rigorous professional clinical trials. In Ireland the position with regard to non-therapeutic research on human beings is controlled by the Control of Clinical Trials and Drugs Act, 1987 and 1990.

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<sup>57</sup>Parsons (1954 385)

<sup>58</sup>Cotterrell (1984 90)

<sup>59</sup>See Dillmann & Legemaate (1994) and Van Der Wal & Dillmann (1994)



Pound & Llewellyn describe the legal profession as playing an important role in social integration, because it promotes legal values and juristic method <sup>60</sup> However, on the other hand, it can be argued that the legal profession is regarded as undermining legal stability by pursuing high compensation claims with regard to, for example, medical accidents on a "no-win-no-fee" basis This may imply a reluctance to provide a disinterested service

**3 4 11.** The tenth factor is the nature of the relationship between a professional man and his client or patient This relationship, it is asserted in this thesis, is based on a collegiate model, where the professional man determines and satisfies the needs of the individual client The profession controls itself through a 'corporate system of regulation and surveillance' <sup>61</sup>

### **3.5. Conclusion**

In the assessment of professional negligence the courts rely much on "professional judgment" as a distinguishing feature This judgment is subject to the presence of a specialized intellectual technique or special competence which is based on an esoteric body of knowledge It is the gap-filling practical application of scientific

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<sup>60</sup>Quoted by Cotterrell (1984 90)

<sup>61</sup>Turner (1987 136)

or academic research. As a result, the profession is able to create a degree of independence in providing specialized services and, subsequently, a dependency on those services by the public. As a result, autonomy is maintained through the application of certain control mechanisms. A successful application results in a domineering position with regard to the exclusive supply of certain knowledge to the public. In addition, it is a reliable source for the courts in assessing alleged negligent conduct of professional men.

It can, therefore, be asserted that the courts only regard those occupations as professions where the standard of care is said to be a matter of professional judgment. This judgment is based on some sort of accepted practice or shared professional opinion. In other words, the activity, undertaken by the professional man, is autonomously defined.

In this context it is suggested that a model of professions should be established, not on particular occupations in society distinct from others, but on aspects of the behaviour of a professional person in relation to the special skill he has exercised. Thus, it may be relevant, prior to an assessment of liability, to determine whether the conduct of a professional person included the exercise of a special skill.

## PART B.

### Chapter Four

#### The Presumed Model of Professional Negligence in Ireland and England The Standard of Care

##### 4.1. Introduction

Chapter One of this thesis provided the argument and outline Chapter Two reviewed the existing literature Chapter Three described what is meant by "professions" in this thesis and emphasized the importance of professional autonomy and judgment Thus, Part A formed the background against which the concept of professional negligence is explored

Part B examines the standard of care in professional negligence cases This element, and the duty of care are the two decisive elements in which professional negligence distinguishes itself from other types of negligence

Chapter Five examines the specific attributes that can be inferred from the professional standard of care Chapter Six addresses specific attributes to the negligent conduct of solicitors

This Chapter (Chapter Four) reviews the received or presumed standard of care in professional negligence as

described by McMahon & Binchy <sup>1</sup> It examines the grounds on which negligent conduct is assessed and, more importantly, it seeks to identify the decisive factors of the standard of care and its underlying principles

The cases which underlie this examination, together with some more recent cases in the same area, may reasonably be termed "professional negligence cases" Indeed, one could argue that the point of this thesis is that prior to it no coherent principle existed that distinguished professional negligence cases from other types of negligence cases It appears that this type of negligence is retained for specific professional groupings, whether or not they exercise their respective specialized expertise or skill

The questions this examination raises relate to the tortfeasor as a professional person, the grounds that determine his conduct to be negligent or not, and by whom these grounds are determined Is the standard of care a matter of professional or legal judgment? The conclusions that derive from this examination are useful to identify the typical characteristics of professional negligence and to identify the methodological changes of the judiciary in assessing negligent conduct

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<sup>1</sup>(1990 258-281)

## 4.2. The Initial Model The BOLAM test

4.2.1. It is asserted here, and by others,<sup>2</sup> that the presumed or received standard of care has derived from the decision in *BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE* [1957] 2 All E R 118. This case was predated by two earlier decisions, both dealing with the alleged negligent conduct of a medical practitioner *ROE v MINISTRY OF HEALTH* [1954] All E R 131 and *HUNTER v HANLEY* [1955] S L T 213.

These cases are examined and compared with the position in Ireland. In Ireland, the position derives from the "summary" decision in *DUNNE v NATIONAL MATERNITY HOSPITAL* [1989] I R 91.<sup>3</sup> The outcome shows that the point of departure is largely similar in both countries. The difference lies in the application of the tests.

4.2.2. In *BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE* [1957] 2 All E R 118, McNair J set out the fundamentals of a professional negligence test. In this case the plaintiff, who suffered from a mental illness, was advised to undergo electro-convulsive therapy. During the course of the therapy he suffered injuries. He sued the defendants for damages for negligence in the administration of the

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<sup>2</sup>See, *inter alios*, McMahon & Binchy (1990 260) and Heuston & Buckley (1992 237).

<sup>3</sup>The Supreme Court in *DUNNE* relied on and summarized two earlier cases it had dealt with. These cases were *O'DONOVAN v CORK COUNTY COUNCIL* [1967] I R 173 and *DANIELS v HESKIN* [1954] I R 73.

treatment The plaintiff's counsel stated that his client had not been warned of the risks inherent to the treatment and, secondly, that he had not been administered a relaxant drug or some form of manual control to reduce the risk of injury

The court made preliminary points First, the medical evidence showed that the medical doctors differed in opinion as to the application of the chosen treatment (whether to use relaxant drugs or some form of manual control) Second, electro-convulsive therapy was at that time a treatment in development There was 'no standard settled technique to which all competent doctors [would] agree' <sup>4</sup>

These two observations induced the court to state that the defendants could not be negligent if they had followed a certain practice in preference to another practice and both practices were approved of by medical practitioners Thus, although there was no consensus as to the application of a particular type of treatment, it was not asserted that one treatment was inherently flawed There was merely a difference of opinion <sup>5</sup>

The question which had to be answered in this case

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<sup>4</sup>[1957] 2 All E R 118 at 120, per McNair J

<sup>5</sup>This was recently reaffirmed in BOLITHO v CITY HACKNEY HEALTH AUTHORITY [1992] 13 B M L R 111 See also ADDERLEY v NORTH MANCHESTER HEALTH AUTHORITY [1995] 25 B M L R 42 at 42 it is not enough to show that there is 'a body of competent professional opinion that considers that there was a wrong decision if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances'

related to the professional conduct of a medical practitioner and was, according to McNair J , 'really a question of professional skill' <sup>6</sup> For this reason the judge argued that negligent behaviour of a doctor cannot be judged along the lines of "common" negligence - the "ordinary man" approach The judge justified this departure in that the "ordinary man" or "the man in the street" did not possess such professional skill "Common" negligence - conduct not subjected to a particular skill - could only be understood as -

[s]ome failure to do some act which a reasonable man in the circumstances would do, or doing some act which a reasonable man in the circumstances would not do, and if that failure or doing of that act results in injury, then there is a cause of action <sup>7</sup>

In this line of thought the assessment of negligence depends on the common sense of a reasonable man in the specific circumstances of the case The defendant is held to have acted negligently if his conduct was not similar, that is, reasonable to what the ordinary man would have done under the same circumstances <sup>8</sup> He breached his duty of

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<sup>6</sup>[1957] 2 All E R 118 at 121

<sup>7</sup>*Ibid*

<sup>8</sup>In tort law much is argued about what constitutes "ordinary" and "reasonable" The former may relate to a certain standard of behaviour, while the latter is normative and refers to what ought to be done In both approaches the outcome is often similar However, many, including McNair J , do not distinguish one from the other See also Howie (1983), *supra* 2 2 5

care and this is decided upon by the court as a matter of judicial judgment without reference to the nature of the defendant's behaviour

McNair J continued and examined the conduct of the defendant in a professional context. He agreed with counsel for the defendants that negligence must be defined here as 'a failure to act in accordance with the standards of reasonable competent medical men' <sup>9</sup> He stated that the professional negligence test is 'the standard of the ordinary skilled man exercising and professing to have that special skill', and he should exercise 'the ordinary skill of an ordinary competent man exercising that particular art' <sup>10</sup>

At first sight it appears that the test is more subjective than the test used in "ordinary" negligence cases. There, the conduct of the defendant is compared to the hypothetical reasonable man, whatever his disposition may be. With respect to professional negligence, however, the reasonable man is confined to the reasonable acting man able, or holding himself out, to exercise a particular skill. This is the distinguishing factor between the two tests and for this reason it appears to be more subjective.

However, what the reasonable skilled doctor would have done in the circumstances of the case is determined by reference to medical opinion in BOLAM. The defendant's behaviour is assessed to what is common by other doctors

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<sup>9</sup>[1957] 2 All E R 118 at 121

<sup>10</sup>*Ibid*



They, in fact, determine the standard to which the defendant has or has not adhered to. Thus, the defendant was not negligent, according to McNair J, 'if he had acted with a practice accepted as proper by a responsible body of [professional] men skilled in that particular art' <sup>11</sup>

Reference is made to the reasonable skilled professional person (a reasonably skilled medical practitioner) and medical or professional opinion. Although the test appears to be subjective by reference to a reasonable skilled man, the test is, in fact, objective because the standard which is used is not exposed to subjective elements. It therefore 'eliminates the personality of the judge' <sup>12</sup>. The assessment of the professional person's conduct is a clinical operation by reference to professional opinion. Adherence to it relieves the professional person from liability.

The test merely asks what do professions do? If a responsible body of professional men does X, then it is not negligent to do X. Here, it fundamentally differs from the approach in general negligence cases. The "general negligence test" suggests that there can be reasonable and unreasonable acts and the latter may result in a finding of negligence. The justification is made by the court based on the evidence of the case, while in a case of professional negligence the court merely determines whether there is a standard, set by the profession, to which the behaviour of

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<sup>11</sup>*Ibid*, at 122

<sup>12</sup>See Rogers (1989 111)

the tortfeasor may fit. If so, he is not negligent. In doing so, the test is "professional-centred" and disregards the interests of the client or patient.

4.2.3. What can be regarded as a responsible body of medical or professional men? Is it the quality of the opinions advocated or the number of the adherents? The answer is intangible in that, at least in BOLAM, a responsible body is not defined any further. Must one conclude that if a professional person, alleged to have acted negligently, finds a body of responsible men whose practice is similar to the alleged negligent practice, he is therefore not negligent? If so, who is to test that this practice is authoritative, both as a body and in its judgment?

The answers are closely related to the fact that the standard of care is a matter of professional (in this case medical) judgment.<sup>13</sup> McNair J clarified this link in BOLAM as follows. He stated that -

it is not essential for you [the jury] to decide which of two practices is better practice, as long as you accept that what [was done] was in accordance with a practice accepted by reasonable persons.<sup>14</sup>

The question of what constitutes a responsible body of opinion was recently addressed in the decision in DE

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<sup>13</sup>The duty of care is imposed by law

<sup>14</sup>[1957] 2 All E R 118 at 122

FREITAS v O'BRIEN [1995] 25 B M L R 51 In this case the plaintiff alleged that his medical practitioner was negligent. The treatment he provided did not have any clinical justification in the context of his specialism, orthopaedic surgery. However, the defendant regarded himself as a "super-specialist", specializing in spinal surgery. He was one of eleven spinal surgeons out of a group of 1,000 orthopaedic surgeons in England.

The question was whether the defendant had acted in accordance with a responsible body of medical opinion. The court answered he had, referring to the sub-specialism of spinal surgery. The court emphasized that it was not the quantity of the adherents that constituted a responsible body of opinion. Otton L J agreed with the trial judge that '[i]t was sufficient that there was a responsible body',<sup>15</sup> it did not need to be substantial. That would be a wrong interpretation of the BOLAM test. A reference to a "substantial" body of opinion has only been made, in England, by Hirsh J in the decision in HILLS v POTTER [1983] 3 All E R 716.<sup>16</sup>

Brahams points out that the extension of the BOLAM test to its outer limits could prove 'a double edged sword

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<sup>15</sup>[1995] 25 B M L R 51 at 61

<sup>16</sup>He stated '[i]n every case the courts must be satisfied that the standard contended for on their own behalf accords with that upheld by a substantial body of medical opinion, and that this body of medical opinion is both respectable and responsible', ([1983] 3 All E R 716 at 728)

for defendant doctors in the future' <sup>17</sup> This researcher argues whether the BOLAM test should have been applied in this case. In DE FREITAS the defendant's conduct was hard to assess under BOLAM because the defendant had a virtually "intellectual" monopoly in his field. The phrase "a responsible body of opinion" has meaning only where it relates to a specialism and not a super-specialism or is counterpoised by other or minority opinions.

**4.2 4** Under the BOLAM test a professional person enjoys a certain degree of autonomy in the exercise of his duties. However, a personal belief that a particular technique is best is no defence, unless it is based on reasonable grounds. Therefore, one cannot continue with a particular practice or technique, according to McNair J, 'if it has been proven to be contrary to what is really substantially the whole of informed medical [or professional] opinion' <sup>18</sup>

In effect, McNair J appears to suggest in BOLAM that a certain practice advocated by a responsible body of medical men is always correct. Thus, as long as there are expert witnesses who express the opinion that the practice exercised by the defendant is medically accepted, he cannot be held negligent, regardless of the damage suffered by the plaintiff. Although it is reasonable to argue that, because of the special skill involved, it should be left to the professions to set the standard, the weakness is that the

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<sup>17</sup>(1995 5)

<sup>18</sup>[1957] 2 All E R 118 at 122

court merely becomes the "nodding-donkey" of the professions. It should, instead, be able to give a valid judgment whether an act is also reasonable or not by reference to the defendant's conduct.

4.2 5. BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE [1957] 2 All E R 118 dealt with three issues which related to the doctor's duties with regard to diagnosis, treatment and information or advice.

The first issue concerned the failure to give a warning with regard to some inherent risks of the proposed treatment. Applying the professional negligence test on the circumstances of this issue, McNair J concluded that 'the practice of saying very little and waiting for questions from the patient',<sup>19</sup> was a proper standard of competent professional opinion.

The second and third issue dealt with the actual treatment, whether it was negligent not to use a relaxant drug or some sort of manual control. With regard to both issues, there were two recognized schools of thought. This appeared from the expert evidence. Thus, it became evident that the defendant doctor could not be negligent in BOLAM for choosing one practice rather than the other, as long as the practice or treatment he administered was in accordance with a practice accepted as proper by a responsible body of professional medical men.

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<sup>19</sup>*Ibid*, at 124

4.2.6. Historically, the decision in HUNTER v HANLEY [1955] S L T 213 is important in the understanding of the BOLAM test. The decision in this case by the Lord President (Lord Clyde) expressed a view similar to that of McNair J in BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE [1957] 2 All E R 118.

In HUNTER a general practitioner was alleged to have acted negligently by not using a suitable hypodermic needle when, after a series of injections, the needle broke. Part of it remained in the patient's hip. It was alleged that the doctor's conduct amounted to negligence because he did not follow a normal practice. Two issues were dealt with in this case: (1) what were the circumstances that indicated negligence and (11) were there degrees of negligence?

It was directed by the presiding judge in the jury trial in First Division that '[t]here must be such a departure from the normal and usual practice of general practitioners as can reasonably be described as gross negligence'.<sup>20</sup> Both the counsel for the pursuer (the patient) and the Lord President could not agree with this direction, especially with regard to the reference to "gross negligence". However, both argued the direction on different grounds.

Counsel argued that a medical man was not in a special position. The foundation of all negligence was fault without any degree. It was just a simple breach of a duty to take reasonable care. There was no authority on the

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<sup>20</sup>[1955] S L T 213 at 215

professional negligence of medical men, gross negligence was not a test which was applied in England Counsel referred to an earlier Scottish case where the court preferred the ordinary concept of negligence, '[w]hether the defendant, in violation of his duty to the pursuer, negligently failed to give sufficient and proper attention and care' <sup>21</sup>

The Lord President argued that there must be a deviation from reasonable care, but this did not have to lead to gross negligence He argued that to establish liability there must be a breach of a duty to take care, a duty which is required by law The degree of want of care could vary, depending on the circumstances of the case In a normal situation those circumstances were more precise and clear-cut, but where professional conduct was concerned it was different In establishing negligence in these cases the true test was whether a doctor 'has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care' <sup>22</sup> Therefore, he cannot be held negligent 'merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown' <sup>23</sup>

Gross negligence only indicates a departure from the normal standard of conduct in relation to a lack of

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<sup>21</sup>FARQUHAR v MURRAY [1901] S L T 45 at 46

<sup>22</sup>[1955] S L T 213 at 217, per Lord Clyde

<sup>23</sup>*Ibid*

ordinary care which a professional man must display It cannot mean that there are degrees of negligence and that simply departing or deviating from a normal practice amounts to (gross) negligence There must be something more than that to establish negligence of professional men

Lord Clyde suggested three requirements, necessary to examine whether a doctor was negligent if he deviated from a normal practice (i) there is a usual and normal practice, (ii) the defendant has not employed that practice, (iii) the practice the doctor did use was one 'which no professional man of ordinary skill would have taken if he had been acting with ordinary care' <sup>24</sup>

The extent of the deviation is not the test It is rather whether or not the deviation is of a kind that satisfies the third requirement <sup>25</sup>

**4.2.7.** Both the BOLAM test and the decision in HUNTER leave it up to the medical profession to set the standard In doing so, the decision whether a doctor is negligent has become a matter of medical judgment

A justification for this proposition is found in McNair J 's reference in BOLAM to the decision in ROE v MINISTRY OF HEALTH [1954] 2 All E R 131 <sup>26</sup> In this case, Lord Denning emphasized that there are always risks

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<sup>24</sup>*Ibid*

<sup>25</sup>The test laid down by Lord Clyde in HUNTER v HANLEY [1955] S C 200 was recently applied in FISHER v MCKENZIE [1994] 26 B M L R 98

<sup>26</sup>[1957] 2 All E R 118 at 128



involved in the administration of treatment Therefore, one should guard against being 'wise after the event and to condemn as negligence that which was only a misadventure' <sup>27</sup>

A proper balance must be found between an ordinary skilled doctor and what is expected of him in society Denning L J stated in the ROE case that -

[w]e should do a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong Doctors would be led to think more of their own safety than of the good of their patients Initiatives will be stifled and confidence shaken <sup>28</sup>

This is a warning in two ways First, one should not disregard the interests and good of the patients or clients, medical opinion cannot reach that far as to accept those practices that are inherently unreasonable Second, "defensive" medicine should not be promoted at the expense of the individual patient or the public at large

Lord Denning set out the parameters of professional conduct In assessing alleged negligent professional conduct, one must consider the interests of the profession and the individual professional person, as well as the victim of the professional practice and the public at large The balance can be, at one time, in favour of the victim In other situations, the professions benefit It

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<sup>27</sup>[1954] 2 All E R 131 at 137, per Denning L J

<sup>28</sup>*Ibid*

appears that, at least under the BOLAM test, the professions enjoy the benefit of the doubt

4.2.8. One question remains unanswered and relates to the liberty of the professions, in particular the medical profession, to set their own standards in professional negligence litigation. Although this issue shall be addressed in more detail, a number of inferences can be drawn from the BOLAM case

First, it has been said that there is a logical connection between theory and practice. Professional opinion is formed by a responsible body of men. It is based on theory and is taught to the professional persons through specialized education by a formalized professional representative body or organisation<sup>29</sup>. By means of examinations entry is restricted. In this approach a profession is made up of a grouping with a set of traits and attributes by which they can be distinguished.

However, there is a need to distinguish between kinds of practices. The first distinction is a moral one: is something good or bad, optimal or careless? Another distinction is whether or not the practice is one recommended by a professional body or imposed by law. The third distinction is whether or not the practice in question is adopted by "all", "most", "some" or "no" doctors. Finally, a fourth distinction is whether or not the practice in question is an acceptable or pragmatic

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<sup>29</sup>See Tomkin & Hanafin (1995: 10)

balance between the rigorous demands of untrammelled theory, (an optimum) and the exigencies of the circumstance, a "reasonable man" test. The problem appears to be that the cases are enigmatic in regard to the various methods of evaluation of human behaviour in the context of the provision of services.

The third distinction is essentially a sociological approach: what is done, and what justification is there for departure from the majority view? Essentially the BOLAM test lies in this category. The question in this category is: would the course of conduct be approved of by a body of professional opinion of those professionals skilled in the particular art?

Second, there is an interaction between the professional body and the professional person. The latter is obliged to act according to specific standards or formalized regulations. These are devised, codified, implemented and often policed by the relevant profession and taught to the individual member. He can be charged for misconduct by a disciplinary board if and when he violates those sets of standards in such a way that he causes a client or patient to complain about him *qua* professional. It may even give rise to civil litigation in which he can be held negligent. This aspect, as part of the organizational structure and functions, is said to be a typical characteristic of a profession.<sup>30</sup>

Third, by reference to professional opinion, the court

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<sup>30</sup>See *supra* Subparagraph 3 4 3

can mediate between what is done and what can be done (optimum) or what ought to be done (reasonableness) The professional body represents, on the one hand, professional opinion because it has authorized the creation of practice On the other hand, the profession must not only be seen as embracing a certain practice, but also as representing the individual professional person who practices according to professional opinion

From this it follows that accepted practice is determined by the professional persons themselves through expert evidence, representing the professional body of which they are presumed to be a member They do this either individually or collectively By determining this practice they also set the standard of skill and competence by which they are obliged to act This freedom of autonomous behaviour, within accepted parameters, is another characteristic inherent to the concept of a profession

In each negligence case the court looks for a criterion by which it can judge liability The question is where this criterion can be found in professional negligence cases Does the court look for guidance in valid professional opinions, (is it told which practice is accepted as proper), or does the court impose a rule upon professional persons, whatever their view may be? Under the BOLAM test the court's role is minimized to observe whether the defendant's conduct was in line with accepted professional opinion

4.3. The Irish Position as Represented  
in the DUNNE case

4.3.1. In the general law of negligence there are certain principles which are of special interest to professional persons lawyers, medical men, etc They have been set out in DANIELS v HESKIN [1954] I R 73 and O'DONOVAN v CORK COUNTY COUNCIL [1967] I R 173 The principles were summarized by the Supreme Court in DUNNE v NATIONAL MATERNITY HOSPITAL [1989] I R 91

The principles which are referred to in these two older cases must be applied in medical negligence cases to treatment, diagnosis and the provision of information alike, according to the Chief Justice in DUNNE <sup>31</sup>

The Chief Justice also restricted, as did Lord Denning in ROE v MINISTRY OF HEALTH [1954] 2 All E R 31, the freedom of professional conduct, the principles must be developed and applied taking into consideration the parameters, which 'underline their establishment' <sup>32</sup> In medical negligence cases these parameters are the importance of the development of medicine on the one hand, and the dependence of the patient on the practitioner's skill and care, and the gravity of his failure on the other hand

The principles raise questions with regard to professional negligence generally With regard to the

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<sup>31</sup>[1989] I R 91 at 109

<sup>32</sup>*Ibid* , at 110

professional status of the defendant they raise questions in three situations in particular. These situations are where a practitioner (i) acts with ordinary care, (ii) applies or deviates from a general and approved practice or (iii) has a difference of opinion.

4.3.2. In *DANIELS v HESKIN* [1954] 1 R 73 the plaintiff sued her doctor for damages for negligence. It was alleged that the doctor was negligent and unskilful in three ways. (I) He was negligent in permitting and causing a needle to break at the time he was stitching the perineum of the plaintiff. The plaintiff held that this was due to an imperfection of technique, rather than to a defect in the instrument.

(II) He was negligent in permitting the broken needle to be left in the body for considerable time and failing to remove it, instead of taking adequate steps to ensure that the needle would be removed (only six weeks later the broken portion was removed after the plaintiff was X-rayed).

(III) He was negligent in failing to inform the plaintiff of the existence of the broken needle.<sup>33</sup> Counsel submitted that there is an obligation to inform the patient when,

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<sup>33</sup>The above three submissions relate (a) to treatment and (b) the overarching duty of professional care which involves the doctor's judgment, knowledge and opinion. Submission 2 clearly reflects an overall duty to take care, which also involves a specific duty of medical opinion and judgment, while submission 1 reflects a specified duty towards treatment. Submission 3 reflects a specified duty towards information. This distinction is asserted throughout the thesis.

during the course of an operation, a foreign object is left in the patient's body which is normally not supposed to be left there. An exception is, when it would be impairing the health of the patient to do so <sup>34</sup>

The trial judge held that there was no evidence for the jury to consider that the defendant was negligent. The plaintiff appealed to the Supreme Court. It affirmed the decision of the trial judge, based on the following grounds <sup>35</sup>

With regard to the first submission, the evidence of the case showed that the breaking of the needle was not due to negligence on the part of the defendant. The fracture must be put down to a flaw in the steel of the needle, or a mishap which may happen to even the most skilful doctor. Kingsmill Moore J stated '[t]o fall short of perfection is not the same thing as to be negligent' <sup>36</sup>

This clearly shows that the standard of competence which is required from a doctor - a general practitioner or specialist, is not a standard of absolute perfection. This may seem obvious, but at the same time the expectations of the plaintiff were not fulfilled. She suffered additional injury and loss as a result. The question could be asked whether or not this is justified. That it is, is clearly illustrated by the parameters, set by both Lord Denning and Finlay C J. The development of medical science is not

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<sup>34</sup>Cf GERBER v PINES (1934) 79 Sol Jo 13

<sup>35</sup>Maguire C J dissenting ([1954] I R 73 at 75)

<sup>36</sup>[1954] I R 73 at 84

supported if a medical practitioner is under constant threat of litigation or is subjected to a strict liability regime <sup>37</sup>

In a situation where a doctor, or any other person possessing a professional skill and exercising a certain technique, causes loss or injury to his patient or client, this additional suffering must be taken into account. The interest of the patient/client must be weighted against the interests of the professional person. The former will only be compensated when the skill or technique exercised by the doctor fell under a certain level of competence. Maguire C J stated -

[a] medical practitioner is liable for injury caused to another person to whom he owes a duty to take care if he fails to possess that amount of skill which is usual in his profession or if he neglects to use the skill which he possesses or necessary degree of care demanded or professed <sup>38</sup>

It is clear from this statement the Chief Justice employs a "professional-centred" model to determine whether the professional person is negligent and the injured party can be compensated. But who shall determine that level? The court, the profession, or the professional person?

In a "client/patient-centred" model negligence may be

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<sup>37</sup>See also HUGHES v STAUNTON AND OTHERS [1995] P N L R 244. In this case Lynch J stated that these two principles underlie 'the rights, duties and liabilities of medical practitioners in relation to their patients', (*supra*, at 273)

<sup>38</sup>[1954] I R 73 at 75



determined by reference to the expectations of the client or patient. A doctor can be held negligent when he violates those expectations, and those expectations were reasonable.

Another issue must be addressed here. The Supreme Court did not clarify in DANIELS the two grounds on which it decided that the defendant was not negligent with regard to the first submission (the breaking of the needle). It was either an inherent flaw in the instrument used by the defendant, or a "mishap".

The Supreme Court omitted to distinguish the one from the other, instead it mentioned the two exemptions concurrently. In other words, the Supreme Court (1) did not hold a doctor liable for damages for any inherent flaws in the instruments he used, and (11) it acquitted a doctor who committed a 'mishap'. The first argument is valid, but only when it is taken into consideration whether or not the doctor had applied the proper technique in using that instrument. But a mishap, rather than an inherent flaw, could be the reason that the instrument malfunctioned. This should be taken into account when deciding on the negligence of any professional person in these circumstances. The question is then, whether the "mishap" can be excused.

The first submission, the way the patient was treated, related to the doctor's skill and technique. The second and third submissions were related to each other and were of a different nature than the first submission. These submissions were about professional judgment and opinion,

not about skill and technique .

The evidence showed that with regard to the second submission there were two methods of treatment open to the doctor when he discovered that he could not immediately find the broken portion of the needle. The first option was to transport the plaintiff to a hospital to have the broken portion removed. The second option was to continue the stitching and wait for six or seven weeks and then operate. Both options were regarded by the expert witnesses as equally valid. Therefore, there was nothing wrong with the doctor's decision to choose the second option. In his professional opinion this was the right option at the time. Accordingly, Kingsmill Moore J stated -

[A]n honest difference of opinion between eminent 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 guilty of negligence. It would be different if a doctor had expressed the opinion that the course adopted was definitely erroneous.<sup>39 40</sup>

The third submission dealt with the provision of information with regard to the two options of treatment available to master the complication and the choice between

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<sup>39</sup>*Ibid* , at 84

<sup>40</sup>This has recently been reaffirmed in *BOLTON v THE BLACKROCK CLINIC LTD AND OTHERS*, Unreported, High Court, 20 December 1994, Geoghegan J. It was held by the learned judge that a doctor is not negligent when he honestly differs in opinion with another doctor as to which course of action is the better one, and he decides to follow one course rather than the other.

those options The question was, whether the doctor was obliged to provide this information and if so, was he negligent in not doing so?

The Supreme Court expressed two views on this issue Both views, however, share the idea that the answer to this question is tied to the previous question regarding the choice of course the doctor had adopted

Maguire C J in a dissenting judgment argued that the rule laid down in GERBER v PINES (1934) 79 Sol Jo 13 was correct This rule embodies the idea that, 'a patient in whose body a doctor found that he had left some foreign substance was entitled to be told at once' <sup>41</sup> Exceptions did exist, but Maguire C J saw no reason 'why the defendant should be excused what seems to [him] to be his obvious duty' <sup>42</sup> The learned judge could not see any serious consequences of the disclosure of this information, and only those consequences should be regarded as an exception to the rule

One of the reasons for this opinion lay in the fact that there were two options open for the doctor to follow These two options should have been disclosed to his patient (or next of kin) together with the opinion of the doctor on which course was best to follow This would have enabled the patient to make a choice This was, according to Maguire C J , 'the prerogative of the patient' <sup>43</sup> In

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<sup>41</sup>DANIELS v HESKIN [1954] I R 73 at 76

<sup>42</sup>*Ibid*

<sup>43</sup>*Ibid* , at 77

denying this right the doctor acted negligently

It is clear that the Chief Justice put the interest of the patient first. He applied a "patient-centred" approach and suggested that the patient has a definite right to choose between options on the basis of provided information. Where a foreign body has been left in the wound, the patient must be able to make a decision which of the proposed treatments or courses of action to follow. An exception on this rule can only lie in the interest of the patient.

In this he differed from the second view, expressed by the majority of the Supreme Court. This view widened the rule and emphasized the doctor's discretion with regard to the nature and extent of the provision of information. Lavery J expressed the majority opinion that -

there are some matters which a doctor must disclose in order to afford his patient an opportunity of deciding whether she accepts his view or wishes to consult another doctor and to make an opportunity to make a choice between alternative courses [ ] On the other hand there are matters which the doctor must decide for himself having accepted the responsibility of treating his patient and having regard to his professional skill and knowledge upon which she relies <sup>44</sup>

It is obvious that this is a "professional-centred" approach. The learned judge left it to the doctor to determine the nature and extent of information to be disclosed. In some circumstances he is obliged to provide

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<sup>44</sup>*Ibid* , at 80

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information, for example, a dangerous operation. In other circumstances it is up to the doctor's professional judgment whether or not to inform the patient. For example, complications in the course of an operation and the fear of the patient's health when information is provided.<sup>45</sup>

Kingsmill Moore J too, shares the opinion that it is the doctor's judgment whether to give advice or not, as long as this advice 'is honest and considered and if, in the circumstances known to him at the time, it can fairly be justified he is not guilty of negligence.'<sup>46</sup>

One reason given by the expert witnesses as to whether or not to inform a patient, correlated with the self-interest of the doctor Kingsmill Moore J stated -

All the doctors who were examined were of opinion that it would be wise for a doctor to tell a patient or some member of her family of such a mishap - but wise in a self-regarding way, so as to protect the doctor from the possibility of future vexatious actions.<sup>47</sup>

This is an example of a "professional-centred" approach. The right of the patient to be informed, in so far as such a right exists in this line of reasoning, depends on the discretion of the doctor.

The following can be concluded and summarized from this case. First, the Supreme Court distinguished treatment

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<sup>45</sup>This is called "therapeutic privilege"

<sup>46</sup>[1954] I R 73 at 86-87

<sup>47</sup>*Ibid* , at 87

from care and advice. The distinction lies in the fact that regarding the former, skill is a decisive factor, whilst care and advice deal with opinion and judgment.

Second, the test whether a practitioner is negligent depends on which duty is violated - a specific or an overarching and general duty to take care. With regard to the specific duty of treatment, a doctor is negligent when he fails to exercise his skill on a certain accepted level. Or, in the words of Maguire C J -

A medical practitioner is liable for injury caused to another person to whom he owes a duty to take care if he fails to possess that amount of skill which is usual in his profession or if he neglects to use the skill which he possesses or the necessary degree of care demanded or professed.<sup>48</sup>

With regard to medical judgment and opinion - another specific duty - a practitioner is negligent when, *inter alia*, his opinion differs from that of his contemporaries on the choice of course he wishes to follow and that opinion is not honest and definitely erroneous.

Finally, with regard to information, a practitioner is only negligent, according to the majority of the Supreme Court, when he does not disclose information in serious matters (a dangerous operation) or when the non-disclosure caused damage. And, according to Kingsmill Moore J, a practitioner may be negligent in cases where -

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<sup>48</sup>*Ibid*, at 75

the nature of the judgment formed or the advice given is such as to afford positive evidence that the physician has fallen short of the required standard of knowledge and skill, or that his judgment could not have been honest and considered<sup>49 50</sup>

Finally, it can be concluded from DANIELS that a medical practitioner, or any other professional person, has an overriding duty to take care. This is again unambiguously expressed in DANIELS by Kingsmill Moore J -

A doctor owes certain well recognised duties to his patient. He must possess such knowledge and skill as conforms to the recognised contemporary standards of his profession and, if he is a specialist, such further and particularised skill and knowledge as he holds himself out to possess. He must use such skill and knowledge to form an honest and considered judgment as to what course, what action, what treatment is in the best interest of his patient. He must display proper attention in treating, or in arranging suitable treatment for, his patient<sup>51</sup>

Both Maguire C J and Kingsmill Moore J share the opinion that one component of the test must be as expressed above the doctor-patient duty. Where Maguire C J and Kingsmill Moore J differ is in relation to the emphasis that can be placed on the fact that one section of professional opinion (not necessarily the largest or the

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<sup>49</sup>*Ibid* , at 87

<sup>50</sup>As to the duty to diagnose, Judge Moonan held in *BOYLE v MARTIN* (1932) 66 I L T R 187 that 'an erroneous diagnosis was not evidence *per se* that would justify a jury in finding negligence, as a mere error of judgment was not negligence', (Judge Moonan's italics)

<sup>51</sup>[1954] I R 73 at 86

most influential) would have supported the doctor's conduct, even if the procedure undertaken was not strictly the best way of carrying out the doctor-patient duty

**4.3.3.** In O'DONOVAN v CORK COUNTY COUNCIL AND OTHERS [1967] I R 173 the plaintiff claimed that her husband's death was caused through negligence of the defendants during an operation for the removal of his appendix. The facts were as follows

The county surgeon (the second defendant) authorised the house surgeon (the third defendant) in a telephone call to carry out this operation. At the conclusion of the operation, while closing the wound, the house surgeon discovered a seepage of blood. He could not stop it and notified the county surgeon who left his home and arrived at the hospital some time later. At the time of the doctor's arrival the patient developed convulsions. The county surgeon and the anaesthetist (the fourth defendant) diagnosed these symptoms as ether convulsions. The county surgeon closed the wound and gave advice to the anaesthetist. The latter tried to stop the convulsion by increasing the supply of oxygen and stopping the supply of ether. However, the anaesthetist did not administer a relaxant drug. He did not think of doing so, although it was an accepted procedure in these circumstances. The convulsions continued and the patient died.

It was held in the High Court that the first, second and fourth defendants were negligent. The defendants



appealed to the Supreme Court

The plaintiff alleged that the second defendant was negligent on two accounts (1) he was negligent in allowing the third defendant to do the operation without his supervision and (11) he was negligent in the treatment of the patient after the convulsions had started. The fourth defendant was alleged to have been negligent in that his treatment was inexpert omitting to administer a relaxant drug, it was not sufficient to only cut off the ether and to supply oxygen.

It is clear from the allegations that the duty the second defendant owed to his patient was not a duty in skill or competence in surgery but, according to Walsh J, 'rather that he was lacking in care for the patient'<sup>52</sup> It was also alleged that he was without the required competence and skill in the field of anaesthetics. Yet, the duty the fourth defendant owed to the patient was solely one of skill and competence in his specialised field anaesthetics.

To decide whether there was any negligence on the part of the defendants, the standard of care which is required by a medical man must be set out. This standard must be based on expert evidence. According to Lavery J there is no real difference between the general law of negligence and what can be called "professional" negligence. In each case the person who owes a duty to another must 'discharge

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<sup>52</sup>[1967] I R 173 at 190

that duty with reasonable care' <sup>53</sup> When the person claims to have a special skill or knowledge, and a duty arises from this special skill or knowledge, he must possess and exercise a reasonable degree of such knowledge and skill <sup>54</sup>

In other words, there is an overall duty to take reasonable care. This duty exists in "ordinary" negligence cases and negligence cases which involve a special skill or a certain degree of knowledge. However, with regard to the latter, the test whether such duty is violated depends on a different standard. With respect to medical negligence that standard is that of accepted medical practice. A medical practitioner is not negligent if he exercised his duties in accordance with general accepted practice.

A deviation from that standard does not, however, imply that the defendant is automatically negligent. This depends on three questions. Here, Lavery J. quoted Lord Clyde in *HUNTER v HANLEY* 1955 S C 200. If a medical practitioner deviated from an accepted medical practice three questions must be answered to determine whether or

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<sup>53</sup>*Ibid* , at 183, per Lavery J

<sup>54</sup>Whether he actually possesses the required skill is irrelevant. This was debated in *BOYLE v MARTIN* (1932) 66 I L T R 187. Judge Moonan argued that a person who holds himself out to the public as being a competent doctor is in no different position from any other person holding himself out to the public as being competent in a particular skill. He stated that '[a] watchmaker or motor repairer is in exactly the same position as a doctor or a solicitor', (*supra*, at 188). By holding themselves out to the public as being competent, they indicate that they possess a reasonable amount of knowledge and skill. Each of those persons, possessing a certain skill and knowledge, may therefore be liable for injuries through negligence or sheer ignorance when they fall below that reasonable amount of skill and knowledge.

not he is liable -

First of all it must be proved that there is usual and normal practice, secondly it must be proved that the defender has not adopted that practice, and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one no professional man of ordinary skill would have taken if he had been acting with ordinary care <sup>55</sup>

The principle is settled now and the defendants must be judged on this principle This meant that, according to Lavery J , 'the defendants can only be held liable if there is evidence that they acted or failed to act otherwise than in a manner approved by a responsible body of opinion' <sup>56</sup>

This means that an accepted general practice and a responsible body of opinion do not necessarily have to coincide If a doctor deviates from a general and approved practice, but a responsible body of medical opinion approves of it, he cannot be held negligent Here, the BOLAM test differs The BOLAM test does not refer to "general accepted practice" or a deviation from it It merely asked whether the defendant's conduct was approved of by professional opinion

The bottom line in O'DONOVAN v CORK COUNTY COUNCIL [1967] I R 173 is whether it can be inferred from the evidence that both the second and fourth defendant can be held negligent for deviating from a general accepted

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<sup>55</sup> [1967] I R 173 at 184

<sup>56</sup> *Ibid* , at 186

practice. If not, they are not negligent. If so, the question is whether their procedure was unacceptable to a responsible body of medical opinion. If it can be inferred it was unacceptable, it is for a jury to hold them negligent. If not, the case should be withdrawn from the jury and a verdict should have been directed in favour of the defendants.

However, the proposition (to follow a general and approved practice as evidence of non-negligent conduct) is not without qualification. This can be inferred from the judgment of Walsh J. In his view it cannot be said that a practice which is 'widely and generally adopted over a period of time does not make the practice less negligent'.<sup>57</sup> A general and accepted practice can be negligent if it 'carries inherent defects which ought to be obvious to any person given the matter due consideration'.<sup>58</sup>

The first allegation made against the second defendant (lack of care due to not being personally present during the operation) failed according to Walsh J. The reason for this was that the practice conducted by the second defendant was a general and accepted practice and did not carry any obvious inherent defects. And, if there was a conflict in the evidence whether or not the followed practice was general and approved it cannot, as an issue of fact, be withdrawn from a jury for that very reason.

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<sup>57</sup>*Ibid*, at 193

<sup>58</sup>*Ibid*

The second allegation against the second defendant must fail too, according to Walsh J. This allegation dealt primarily with responsibility and the division of tasks. Although he was in charge of the operation when he arrived on the scene, it could not be said that he was immediately responsible for the administration of the anaesthetics, another field of medicine. His primary duty lay in his field: surgery. Lawfully he did not owe the patient a duty outside his field. He was entitled to assume and rely on the skill and competence of his fellow doctor, until 'he has a reason to believe otherwise' <sup>59</sup>

With regard to the allegations against the fourth defendant, the anaesthetist, Walsh J. expressed the opinion, and was supported by the Chief Justice, that on the evidence it was open to the jury to hold the anaesthetist negligent. He stated that -

there was a general and approved practice applicable to the condition of the patient in question in this case and it is not disputed that [the fourth defendant] did not follow that particular practice <sup>60</sup>

This does not necessarily mean that he is negligent. To initiate negligence it must be established that the practice that was followed by the fourth defendant 'was one which no anaesthetist of ordinary skill would have taken had he been taking ordinary care required from an

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<sup>59</sup>*Ibid* , at 194, *per* Walsh J

<sup>60</sup>*Ibid* , at 199

anaesthetist' <sup>61</sup> It was held he was

This case confirms that there is an overall duty to take care as well as a duty to possess a certain degree of skill and competence. With regard to the latter it can be said that this degree does not have to be the highest degree of skill and competence. A doctor specialised in a particular field is, according to Walsh J, 'required to attain to an ordinary level of skill amongst those who specialise in the same field' <sup>62</sup> With regard to the conduct of a professional person so far as care is concerned, this conduct must be judged 'in the light of the particular circumstances prevailing at the time when he is called upon to act, and the degree of care may vary in proportion to the magnitude of the risk involved' <sup>63</sup>

The violation of his duty to take care depends on whether he had followed a general and approved practice. If so, a professional person is still negligent when such a general and approved practice carried an inherent defect which ought to be obvious to any person who had given the matter due consideration.

If not, a professional person is negligent when (i) there is a usual and normal practice, (ii) this practice is not adopted by him, and (iii) he adopted a practice which no professional person of ordinary skill would have taken, if he had been acting with ordinary care.

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<sup>61</sup>*Ibid*

<sup>62</sup>*Ibid* , at 190

<sup>63</sup>*Ibid*

4.3.4. In DUNNE v NATIONAL MATERNITY HOSPITAL [1989] I R 91 the plaintiff, a child (suing through his mother and best friend), claimed that while he was in his mother's womb he suffered severe brain damage due to the negligence of the defendants

In this case, Finlay C J set out the principles which cover the tort of negligence and are of special interest to professional people. These principles have already been recognized in the previous two cases and are here summarized by the Chief Justice

The first principle gives the general rule for establishing medical or professional negligence. Finlay C J stated -

The true test [ ] is whether [a medical practitioner] has been proved to be guilty of such failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care <sup>64</sup>

The test is an ordinary skilled doctor acting with ordinary care who follows a general and accepted practice <sup>65</sup>. This practice does not need to be universal. It is sufficient when it is approved of by a substantial number of respectable practitioners holding the relevant qualifications

But, if it is proven that a general and approved

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<sup>64</sup>[1989] I R 91 at 109

<sup>65</sup>This was recently reaffirmed by the Supreme Court in EDWARDS v SOUTHERN HEALTH BOARD, Unreported, Supreme Court, 26 July 1994

practice carries inherent defects, he will nevertheless be negligent when these defects ought to have been obvious to any person giving the matter due consideration

However, negligence can also be based on the allegation that the defendant has not acted in accordance with a general and approved practice. Instead, he deviated from a general and accepted practice. He is allowed to do this within accepted parameters. Nonetheless, he will be negligent if this deviation is proven to be one -

which no medical practitioner of like specialization and skill would have followed had he been taking the ordinary care required from a person of his qualifications<sup>66</sup>

Doctors may differ in opinion as to which treatment must be applied. When this opinion is honest, it provides no 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'<sup>67</sup>. It is honest when the course of treatment complies with 'the careful conduct of a medical practitioner of like specialization and skill to that professed by the defendant'<sup>68</sup>. It is not important for the judge to decide which of the opinions or courses of treatment is favourable -

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<sup>66</sup>DUNNE v NATIONAL MATERNITY HOSPITAL [1989] I R 91 at 109, per Finlay C J

<sup>67</sup>*Ibid*

<sup>68</sup>*Ibid*



This court as a court of appeal cannot and must not reach a conclusion or express a view as to which of two conflicting expert opinions it (the Court [sic]) would prefer <sup>69</sup>

In short, the prevalent rule is the professional person of equal specialist or general status and skill acting with ordinary care. But where the defendant has not acted according to a general and approved practice, it must also be proved that the followed course is a course no man of equal skill would have followed. And, when the defendant has acted according to a general and approved practice that practice must not carry inherent defects.

Finally, within this context an honest difference of opinion is no ground to establish negligence <sup>70</sup>

4.3.5. It can be concluded from the decision in *DUNNE v NATIONAL MATERNITY HOSPITAL* [1989] I R 91 that there are three situations where a medical practitioner, (or any other professional person) might be negligent. However, these three situations are not exclusive and they are also co-extensive.

In the first situation, it can be said that a practitioner has at any time a duty to take ordinary care. This duty will cover all other duties or obligations he might have. This duty to take ordinary care derives from

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<sup>69</sup>*Ibid*, at 108, per Finlay C J

<sup>70</sup>This was recently reaffirmed in *HEALY v NORTH WESTERN HEALTH BOARD*, Unreported, High Court, 31 January 1996, Flood J

his position as someone who has a special skill Through this he distinguishes himself from the ordinary man It can be said that this special skill relates to the professional status of the practitioner, being part of 'a grouping which possesses a distinct set of traits and attributes' <sup>71</sup>

The second and third situation cannot be seen apart from this to take ordinary care The second situation is where a practitioner has deviated from a general and approved practice In this situation he can be negligent on two accounts (1) he may be negligent if he has not acted with ordinary care, although the practice he professed was not necessarily flawed, and (11) he may be negligent if the practice he followed was flawed, and was one no other practitioner would have followed taking ordinary care In other words, a practitioner must take ordinary care regarding the practice he wishes to follow and he must take ordinary care regarding the exercise of this practice

A general and approved practice is defined as a practice which is accepted by a substantial number of respectable practitioners holding the relevant qualifications This is essentially a sociological approach, in which two questions are relevant is the practice adapted by "all", "most", "some", or "no" practitioners, and what is the justification for departure from the majority view? Another question is how a practice becomes general and approved of Is it through custom, professional opinion, or theoretical knowledge? Is it the

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<sup>71</sup>See Tomkin & Hanafin (1995 10)

number of adherents or the quality of the adherence?

As to a practice that carries obvious inherent defects, it is argued whether a practitioner who follows it automatically violates his duty to take ordinary care as described in the first situation. Apparently not, because any other practitioner, taking ordinary care would have followed that practice. In this case a practitioner takes ordinary care, but is doing (inadvertently) the wrong thing. How ought he have known this? It is said that those defects should be so obvious to any person, who would have given the matter due consideration. But why, when the defects are so obvious, can it still be a general and approved practice and is it still adhered to? The defects did not seem obvious to those who upheld the practice as accepted and approved.

One suggestion could be that inherent defects in a general and approved practice should be regarded as "genuine faults", such as leaving instruments behind in the body after an operation, or not sterilising surgical equipment.

Another suggestion could be that the profession itself is aware of those aspects of the practice which may render the practice defective or may damage the patient. However, the profession takes these consequences into account as inherent risks of proposed treatment rather than an inherent defect. The question that follows is whether the courts interpret an inherent defect as unreasonable in order to render the practice negligent and thus, to

compensate the victim's loss? If so, this would mean that the courts, as a matter of policy, do have the final word on the matter

4.3.6. It is suggested that in *DUNNE v NATIONAL MATERNITY HOSPITAL* [1989] I R 91 the key components of the "professional" approach to ascertain liability are

(1) the reference to a hypothetical or actual body of qualified opinion, i.e. standards of education and training,

(2) the reference to the attainment of manual skill or dexterity and aptitude,

(3) the negotiation of procedures of diagnosis or treatment with a degree of skill or care which is hypothesized as "ordinary" or "average",

(4) following approved procedures in such a way as to discriminate on the one hand between procedures with an inherent defect and, on the other, those which are not inherently defective, and only selecting the latter,

(5) departing from a responsible body of professional opinion only within accepted parameters

There are some questions or issues which must be addressed in such an approach. These are

(A) The reference to a hypothetical or actual body of qualified opinion begs the question how is the court to infer what such standards are? Is it by reference to an external body of knowledge? If so, where is the repository for that knowledge? If not, surely, the only way of

ascertaining what such standards of training or education are, is by reference to practitioners. This is a circular and self-perpetuating process, which would exclude innovation and development.

(B) The problem with the reference to the attainment of manual skill or dexterity and aptitude lies with the distinction between such skills in a "professional" as opposed to a manual labour context. Perhaps, the distinction can be found in the degree of esoteric and theoretical based knowledge, and the dependency on it.

(C) The negotiation of procedures of diagnosis or treatment with a degree of skill or care which is hypothesized as "ordinary" or "average" begs the question how far is it possible to hypothesize what constitutes average or ordinary care in the context of professional advice, diagnosis and treatment, except by reference to *res ipsa loquitur* and to specific catalogues?

(D) Following approved procedures in such a way as to discriminate on the one hand between procedures with an inherent defect and, on the other, those which are not inherently defective and only selecting the latter, is this a red herring? Again, there is nothing intrinsically peculiar to professional persons in the requirement that in order not to be negligent, one should not perform a procedure with inherent defects.

(E) The right to depart from a responsible body of professional opinion only within accepted parameters discloses the key element of the professional person: the

liberty to form one's own view of a proposed course of action within proper limits, agreed or negotiated by other professional persons

The question which should be addressed, before one can apply an approved practice, is whether it is necessary to have professionally made one's mind up as to the route to follow. If so, it is obvious that the process whereby all persons follow or institute "approved practice" must be to hold a "professional opinion". This, of course, disposes of two problems: certain professional opinions may lead to inherently objectionable or flawed procedures which should, according to DUNNE, explicitly not be followed. The second is that this encapsulates one of the idiosyncratic distinctions between professional opinion, on the one hand, and non-professional opinion, on the other, by demonstrating that professional opinion has a necessary connection with theory.

This thesis draws a line between the majority judgment in DANIELS v HESKIN [1954] I R 73, the dissenting judgment of Maguire C J in DANIELS and the decision in DUNNE v NATIONAL MATERNITY HOSPITAL [1989] I R 91. Possibly, the main line of opinion is that of Maguire C J and Finlay C J, whereby it may be asserted that where the courts follow Kingsmill Moore J they are really following that part of it that does not differ from Maguire C J's dissenting judgment in DANIELS and tacitly ignoring the rest.

Both Maguire C J and Finlay C J stress that some

duties or situations are so obvious that they do not require a "professional-centred" approach Maguire C J made this clear in his dissenting judgment in DANIELS v HESKIN [1954] I R 73 He suggested that, with regard to the defendant's duty to disclose certain information, the defendant cannot be excused of negligence of something which is so obviously his duty only because his conduct coincides with medical opinion

Finlay C J agreed with him on this point In his view, the courts adjudicate, where a practice carried inherent defects, whether these defects are so obvious that they render the practice flawed because they should have been obvious to any man giving the matter consideration, not merely the medical profession

#### 4 4. Conclusion

4.4.1. Two aspects need to be addressed here First, the thesis identified certain fixed points on the negligence spectrum which may be relevant to defining what differentiates "professional" negligence from general negligence Second, the thesis demands a brief discussion as to how the DUNNE test relates to the BOLAM test This is of particular relevance in the discussion on the specific attributes of professional negligence, subject of the following Chapter

4.4.2. Thus, certain fixed points are identified. These are equally applicable to both the BOLAM and the DUNNE test.

First, particularly in medical negligence there is a clear distinction between on the one hand the duty of ordinary care and specific other duties. In DANIELS v HESKIN [1954] 1 R 73 these specific duties related to treatment and information or advice. This is suggested throughout the thesis. BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE [1957] 2 All E R 118 demonstrated that besides the specific duties such as a duty to diagnose, a duty to inform etc., there is a general duty as between a doctor and his patient which "over-arches" all the incidences of the doctor-patient relationship (and includes as sub-sets of the main relationship the subsidiary duties such as the duty to diagnose and the duty to inform). Going back to BOLAM, it is clear that there are two different tests which must be applied simultaneously when it is alleged that a doctor is negligent in (1) his general duty to take care (the over-arching duty) and (2) breaching one of the sub-set duties, such as the duty to inform.

Second, there are professional standards which embody twin expertise, theory, and manual or professional skill, dexterity. (There is no question of this being relevant to cases not being in the professional negligence category.)

Third, there is "approved" or "recommended" professional practice, which may include a variety of alternative approaches selected from within a



professionally defined norm In non-professional negligence cases, the standard appealed to is that of the "ordinary man", the "reasonable man", the "man on the Clapham omnibus", as opposed to the person with education, training, qualifications, manual ability and dexterity At the very least, the points of reference are different There is an implied appeal, in the case of professional negligence, to external and defined standards of behaviour imposed on those belonging to a defined group, by the group itself

Fourth, there is an ordinary or average standard of behaviour Here, at first sight, there is a similarity of approaches between professional negligence cases and the other sorts of negligence cases But it is necessary to remember that in *DUNNE v NATIONAL MATERNITY HOSPITAL* [1989] I R 91, the qualifying factor is that it hypothesizes an appeal, not to a global or universal standard of behaviour, but to a standard which is perceptible by examination of a particular group those of similar qualifications, skill and expertise

Fifth, there is a requirement to expressly recognize and distinguish procedures by the presence or absence of inherent defects It is questionable whether this criterion applies to all cases of negligence, or only to professional negligence However, in the context of *DUNNE*, it is not "definitional" That is to say, what *DUNNE* appears to be maintaining is that no professional practice which includes the carrying out of an inherently defective procedure is

admissible. The key may be that a higher standard will be expected from a professional person as to the recognition and avoidance of obvious inherent defects. The relevant part of professional education and training is the recognition and critical appraisal of conventional procedures in specific practical contexts, and the rejection of inappropriate procedures where this would result in damage. Finlay C J is referring in *DUNNE v NATIONAL MATERNITY HOSPITAL* [1989] I R 91 to a critical part of professional education.<sup>72</sup>

What remains to be considered, is the way in which professional practice is codified or recognized and the way it allows innovation and technical or academic development of its procedures and education. There may be several ways of ascertaining this. The first is by professional evidence about what people actually do. The second is by reference to text-books, codes of practice, what people ought to do. It is suggested that the former is "accepted practice", the latter is "optimal practice".

**4.4.3.** Both the *BOLAM* and *DUNNE* test depart from the ordinary principles of negligence. At the core of both tests no reference is made to the "ordinary man". This, for stated reasons, is irrelevant or, at least, questionable. Instead, both tests appeal to the concept of a professional person (the medical practitioner) of equal qualification and skill, acting with ordinary care.

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<sup>72</sup> [1989] I R 91 at 109-110

Both tests agree that the professional person has a certain professional autonomy within accepted parameters. Consequently, a honest difference of opinion is no evidence of negligence if one practice is preferred over another practice and both deserve equal recognition.

However, in addressing of what constitutes an equally skilled practitioner acting with ordinary care, both tests differ. The BOLAM test refers to a responsible body of opinion to determine whether the practice is an accepted practice. It does not argue the reasonableness or unreasonableness of the defendant's conduct. The test merely asks what professions do. If the defendant's conduct is unreasonable in the eyes of the profession (non-conformity with professional opinion), the defendant is negligent. In other words, not the courts, but the profession sets the parameters within which the individual practitioner is free to exercise his skill and competence.

The DUNNE test makes a distinction between a general and approved practice on the one hand, and the conduct of the practitioner who deviates from a general and approved practice on the other. Adherence to a general and approved practice is normally evidence of non-negligent behaviour.

Upon either test, the professional person has individual autonomy to deviate from an accepted practice. However, this autonomy is limited, it is set within certain parameters, taking into account the interests of the profession and its development on the one hand, and the interests of the patient or client on the other.

The court may intervene if it concludes that a general and accepted practice carries an obvious inherent defect. Here, the court retains, according to this researcher, the freedom to question the reasonableness or unreasonableness of the practice. Emphasis is put on what is commonly done by the profession, not, as is the case in BOLAM, whether the defendant's conduct conformed to professional opinion. Professional opinion is only relevant where the defendant deviated from the common practice.

## Chapter Five

### The Standard Examined

#### 5.1. Introduction

This Chapter addresses a number of specific attributes that can be inferred from the described and presumed standard of care in professional negligence as represented in *BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE* [1957] 2 All E R 118 and *DUNNE v NATIONAL MATERNITY HOSPITAL* [1989] I R 91. This analysis consists of both Irish and English cases. The following attributes are discussed: (i) "obvious inherent defects", (ii) errors of (clinical) judgment, (iii) difference of professional opinion, (iv) scientific disputes and (v) consent and information disclosure.

#### 5.2. "Obvious Inherent Defects"<sup>1</sup>

5.2.1. In *ROCHE v PEILOW* [1985] I R 232 a solicitor was held to have acted negligently in not executing a

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<sup>1</sup>The exception of "obvious inherent defects" is one of the distinguishing factors of the professional negligence test in Ireland and England, see *supra* Subparagraph 4.4.3

search in the Companies Office regarding the registration of a mortgage according to the requirements of section 99 of the Companies Act 1963. The plaintiff had entered into, *inter alia*, a building agreement unaware of this mortgage. It appeared from the evidence that this omission was considered among all solicitors as a universal conveyancing practice in Ireland.

The High Court held that the defendants were not negligent because they had adhered to a universal conveyancing practice. This practice was 'to make searches immediately prior to completion of a transaction only and that pre-contract searches were not known as a custom or practice in ordinary conveyancing in this country'.<sup>2</sup> The defendants asserted that -

to hold them guilty of negligence in failing to avail of a precaution which, though it would have avoided the particular loss the plaintiffs have suffered in this case, was not one known as part of the conveyancing practice of solicitors, would be to apply a false standard of care and skill which the law requires from a solicitor in the carrying out of his professional work.<sup>3</sup>

However, Finlay P argued that in *O'DONOVAN v CORK COUNTY COUNCIL* [1967] I R 173 the above proposition was not without qualification. In this case Walsh J stated that -

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<sup>2</sup>[1985] I R 232 at 242, *per* Finlay P

<sup>3</sup>*Ibid*, at 242

[i]f 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 less negligent <sup>4</sup>

But Finlay P , in ROCHE, accepted an exception to this rule, claiming that the -

universality of a particular practice adopted by an entire profession must itself be evidence that it is not a practice which has inherent defects which ought to be obvious to any person giving the matter due consideration <sup>5</sup>

To make such an exception valid, the emphasis must be put down on the universality of the particular practice This means that such a practice must have been accepted as universal by the whole body of professional or legal opinion Only then is the practice accepted as not carrying inherent defects <sup>6</sup>

Finlay P initially accepted this exception In his view the universal application of a particular practice indicated that that practice did not carry any inherent defects which ought to be obvious to any person giving the matter due consideration The legal profession in ROCHE regarded such a practice as obviously non-defective

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<sup>4</sup>[1967] I R 173 at 193

<sup>5</sup>[1985] I R 232 at 244

<sup>6</sup>In England, in DELANEY v SOUTHMEAD HEALTH AUTHORITY [1992] 26 B M L R 111, it was held that the evidence that the practice was universally adopted and acceptable, rebutted the application of the maxim *res ipsa loquitur*

The learned judge in ROCHE did not define or describe what could be regarded as a general and accepted practice. It can only be implied from the judgment of the President that a practice is not universal if it carried obvious inherent defects.

The aspect of "universality" was reasserted by Finlay C J (by then Chief Justice) in DUNNE v NATIONAL MATERNITY HOSPITAL [1989] I R 91. In this case it was reaffirmed that a practitioner is negligent if he followed a general and approved practice, which is proven to carry inherent defects that ought to be obvious to any person giving the matter due consideration. Finlay C J, however, went on and stated that -

"[g]eneral and approved practice" need not to be universal but must be approved of and adhered to by a substantial number of reputable practitioners holding the relevant specialist or general qualifications.<sup>7</sup>

Without this reassertion, the courts would have used, in the opinion of this researcher, different criteria with regard to "deviation from a general and approved practice" and a "practice carrying inherent defects". Considering the former it is enough that the practice is accepted by a responsible body of opinion for a professional not to be negligent. In the latter the practice is assumed to be universally accepted.

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<sup>7</sup>[1989] I R 91 at 109



5.2.2. The decision by Finlay P in ROCHE was reversed in appeal. The Supreme Court held that -

as the universal conveyancing practice relied upon by the defendants had inherent defects which ought to have been obvious to any person giving the matter due consideration, the defendants were negligent in failing to execute a search in the Companies Office<sup>8</sup>

The reasons for this approach were outlined by, in particular, Walsh, Henchy and McCarthy JJ. Walsh J argued that it cannot be true that a general practice is based on the fact that in most of the cases nothing really goes wrong. That proposition 'does not obviate the risk clearly inherent in such a practice'<sup>9</sup>. The danger of such a risk materializing does not decrease due to the fact that it was often undertaken, nor can it be said that in this particular case the consequences of such a risk being materialized were unforeseeable.

The defendants, according to Walsh J, were therefore negligent in failing to exercise the duty to advise the plaintiff. The judge considered hereupon, *inter alia*, Finlay P's decision in TAYLOR v RYAN [1995] P N L R 47. In this case the omission to make a direct inquiry regarding the validity of a liquor licence led to damages. It was held by Finlay P that 'such an inquiry, in the particular circumstances of the case was a necessary

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<sup>8</sup>[1985] I R 232

<sup>9</sup>*Ibid*, at 250, *per* Walsh J

reasonable standard of professional skill and care on the part of the defendants' <sup>10</sup>

Henchy J 's reasoning in ROCHE was based on the following arguments. Apart from a duty to advise, a solicitor owes a general duty to his client. He is obliged to show his client the degree of care which can be expected from a reasonable careful solicitor in the particular circumstances of the case. In most cases he fulfils this duty when he follows a practice common to his colleagues. However, the learned judge stated that it cannot be said that a person acted reasonably if -

he automatically and mindlessly follows the practice of others when by taking thought he would have realised that the practice in question was fraught with peril for his client and was readily avoidable or remediable <sup>11</sup>

He must be held negligent if an alternative and safe procedure was open to him and the procedure which he did follow was not in the interest of his client. This means that a professional person is obliged to form his own opinion. At all times he must make up his mind as to whether a practice which is commonly used is a valid practice and consider whether there is an alternative practice open to him which, in his opinion, does not carry inherent defects. This obligation follows from his status as a professional, enjoying individual autonomy in the

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<sup>10</sup>[1995] P N L R 47 at 48

<sup>11</sup>[1985] I R 232 at 254

exercise of his functions within accepted parameters

It is suggested by this researcher that a professional person is not negligent if he can show that he has not without consideration followed an accepted or universal practice. In doing so, he, consequently, formed his own professional opinion as to whether this practice carried any inherent defects, because this ought to be obvious to any person giving the matter due consideration.

In other words, the emphasis must not be put on whether the practice carried any inherent defects. Instead, the emphasis must be whether the professional person has discharged his duty to see whether a practice was inherently flawed.

Finally, McCarthy J argued that the court should guard itself against being wise after the event, particularly in a case of professional negligence. This argument is based on the warning given in *KELLY v CROWLEY* [1985] I R 212. Murphy J stated in this case that -

[1]n all cases involving allegations of negligence, but particularly negligence alleged to have been committed by experts, there is a danger of judging the conduct of the defendant with the benefit of knowledge emerging after the event or indeed by reference to a standard more theoretical than practical.<sup>12</sup>

However, according to McCarthy J, this can be avoided by adopting an approach that is based on the expectations of a client, instead of an approach that considers the

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<sup>12</sup>[1985] I R 212 at 229

evidence regarding the nature of the practice exercised at the time. Based on the former approach, it is clear that a client would not have been satisfied with the practice which was adopted, although it was regarded as a general and approved practice. The loss that has been suffered was foreseeable and, therefore, evidence to examine whether the adopted practice was inherently defective. Consequently, according to *McCarthy J*, it -

cannot be a legal principle that a profession is, so to speak, entitled to "one free bite" - to wait until damage has occurred before taking an obvious means of avoiding such damage.<sup>13</sup>

*McCarthy J* applied here an approach which is "client-centred" and can be compared with the approach taken in America with regard to the "prudent patient" test.<sup>14</sup> The standard must be set by law and the doctor must realize that the risk involved is material if the patient 'would be likely to attach significance to the risk'.<sup>15</sup> One of the reasons given for this approach was the fact that medical custom is a façade for non-disclosure.<sup>16</sup>

One can also suggest that the "ordinary" negligence principles apply. The solicitor must have known that through his conduct, his client would have been adversely

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<sup>13</sup>[1985] I R 232 at 263

<sup>14</sup>Cf *CANTERBURY v SPENCE* (1972) 464 F 2d 772

<sup>15</sup>*Ibid*, at 778

<sup>16</sup>See *Robertson* (1981a 106)

affected <sup>17</sup>

5 2.3 The different approaches given by the three learned judges all lead to the same conclusion. A professional person is negligent when he follows a practice which, although universally accepted by his profession, carries inherent defects. Those defects must be obvious when given the matter due consideration.

From this case it follows that there is a conflict of interest between the attitude of the profession with regard to a specific practice and the attitude of the court. On the one hand, there is the interest of the profession that has been given discretion by the courts as to determine a certain standard of competence, skill and care. On the other hand, there is the interest of the public and the individual client. Their rights must be safeguarded properly. Where these interests clash, the court must decide as to which interest has to prevail. The question here is whether the status of the tortfeasor *qua* professional is critical. Or does the court impose liability irrespective of professional opinion?

A closer look at the judgments of the learned judges may give some indication that the court imposes liability regardless of professional opinion, at least with regard to inherently defective practices. In *ROCHE v PEILOW* [1985] 1 R 232 the omission to execute a search in the Companies Office prior to a contractual agreement was regarded as

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<sup>17</sup>Cf *DONOGHUE v STEVENSON* [1932] A C 562

(part of) a universal practice Therefore, it was not considered in the legal profession as a flaw in the exercise of the duties of a solicitor Accordingly, the practice was regarded as proper If not, 'a false standard of skill and care' would be required from a solicitor <sup>18</sup> Finlay P in the High Court agreed with this, stating that a universally accepted practice cannot carry inherent defects

The Supreme Court reversed this decision The learned judges did not approve of the opinion that the aspect of universality is proof that a practice does not carry inherent defects

Walsh J appreciated that the practice followed in ROCHE encapsulated an omission in advising Accordingly, Judge Walsh emphasized the right of a client to be properly informed before he entered into a contract or any other agreement or relationship with another party Walsh J stated -

The whole object of a search is to discover these matters and no solicitor can permit his client to purchase lands or to commit himself irrevocably financially in the purchase or developments of lands unless he has first of all ascertained whether or not the land is free from encumbrances If it is not he must bring that fact to the notice of his client and allow the client, after proper advice, to decide whether or not he should take the risk of accepting the transaction with the risk posed by the existence of the encumbrance <sup>19</sup>

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<sup>18</sup> [1985] I R 232 at 242

<sup>19</sup> *Ibid* , at 250-251

The omission therefore resulted in negligence because the solicitor or defendant did not meet a reasonable standard of professional skill <sup>20</sup>

Henchy J argued in ROCHE that the defendant should be held negligent because of his status as a professional person. A person who held himself out as such was obliged to take on board the responsibilities to exercise that particular skill with a certain degree of care. In this, the professional person distinguished himself from other persons. The professional person acquired the capacity to form his own professional opinion, and was obliged thereto. He should not have, according to Henchy J, 'automatically and mindlessly [followed] the practice of others', because after some deliberation 'he would have realised that the practice in question was fraught with peril for his client and was readily avoidable or remediable' <sup>21</sup>. In the process of forming his own professional opinion he would have given the matter due consideration and he would have discovered that the inherent defects were obvious and would have adopted an alternative practice.

According to McCarthy J, status or position had nothing to do with it. In his view it was the violation of the client's expectations which made the practice negligent. This can be concluded from the judge's approach. He did not take into account the evidence as regard to the general practice but he emphasized to what was done in the

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<sup>20</sup>Cf TAYLOR v RYAN [1995] P N L R 47

<sup>21</sup>[1985] I R 232 at 254

cross-examination of the expert witness McCarthy J stated that -

[t]his was not a consideration in respect of the capacity of the builder, the quality of his workmanship, the efficiency or speed of completion, it was a consideration more fundamental and more akin to what one might expect from a solicitor in the purchase of an existing house<sup>22</sup>

Although a general and approved practice was followed in this case, the court has restricted the profession's freedom and discretion to set a standard of care

A reason for this approach may be that in ROCHE the defendant did not consider the practice as being defective. After all, it was universally accepted and applied. The professional person enjoys, however, a certain degree of autonomy within which he can deviate from or adhere to an accepted practice. As a lawyer, he is allowed to maximize, within the accepted parameters, the interests of his client. In not doing so, the defendant disregarded his client's interest and he waived his responsibility which he, as a professional, owed to his client. He is said to provide a disinterested service and should not take into account his own interests in ignoring his responsibilities to and denying the interests of his client.

This is a case where the court, contrary to the whole of the legal profession, imposed liability to compensate for the loss suffered by the plaintiff. The court did not

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<sup>22</sup>*Ibid* , at 263



take into account the nature and function of the legal profession and the position of the defendant as a professional person. Here the law of tort accommodates a change by imposing liability in a different way.

### 5.3. Errors of (Clinical) Judgment

5.3.1. In *WHITEHOUSE v JORDAN* [1981] 1 All E R 267, the facts concerned a trial of forceps delivery which went wrong. It was alleged by the mother, acting as next friend to the plaintiff, that the defendant had pulled too long and too hard on the plaintiff's head thereby causing brain damage. She claimed damages for negligence.

It was concluded from the evidence in the High Court that 'the amount of force to be properly used in a trial of forceps was a matter of clinical judgment'.<sup>23</sup> Subsequently, the learned judge concluded from the evidence of the mother, the defendant and from the report of the consultant professor that the defendant had pulled too long and too hard. In doing so, he had fallen below the standard of skill expected from the ordinary competent specialist and was held negligent.

This decision was reversed in the Court of Appeal.<sup>24</sup> It ruled that 'an inference of negligence should not necessarily be drawn from the fact that a baby is born with

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<sup>23</sup> [1981] 1 All E R 267 at 268

<sup>24</sup> *WHITEHOUSE v JORDAN* [1980] 1 All E R 650

brain damage sustained in the course of delivery' <sup>25</sup> The pulling of the forceps, if it was accepted that the pulling was too hard and too long, could only amount to an error of clinical judgment and therefore was not negligence in law. The question was, according to Donaldson L J -

whether there had been any failure by the defendant to exercise the standard of skill expected from the ordinary competent specialist having regard to the experience and expertise which that specialist holds himself out as possessing <sup>26</sup>

If he failed to exercise the skill he had or claimed he had, he was in a breach of duty and therefore negligent. However, 'if he exercised that skill to the full, but nevertheless takes what, in hindsight, can be shown to be the wrong course, he is not negligent and is liable to none' <sup>27</sup> To test whether an error of clinical judgment does not amount to negligence is whether the average competent and careful practitioner would have made that sort of error.

The plaintiff appealed to the House of Lords <sup>28</sup> This appeal was dismissed on the grounds that, although the inference made by the High Court from the evidence heard before it was of special value, the Court of Appeal was not

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<sup>25</sup>*Ibid* , at 651

<sup>26</sup>*Ibid* , at 662

<sup>27</sup>*Ibid*

<sup>28</sup>WHITEHOUSE v JORDAN [1981] 1 All E R 267

precluded from drawing its own inference from the same evidence <sup>29</sup> It concluded that no justification could be found from the evidence that the defendant negligently pulled too long and too hard Therefore the Court of Appeal was entitled to reverse the judge's decision

More significantly, their Lordships stated that -

[t]he test whether a surgeon has been negligent is whether he has failed to measure up in any respect, whether in clinical judgment or otherwise, to the standard of the ordinary skilled surgeon exercising and professing to have that special skill of a surgeon <sup>30</sup>

5 3 2. The House of Lords made reference to 'an error of judgment or otherwise' <sup>31</sup> It did not explain what should be understood as (1) "an error of clinical judgment" and (11) "otherwise"

It seems that an error of judgment should be interpreted as an error which cannot be foreseen or anticipated upon, whether or not it is negligent does not matter

When does a doctor fail to measure up otherwise? Obviously when the error is not an error of clinical judgment On the one hand, errors which do not necessarily

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<sup>29</sup>According to Robertson (1981b), the Court of Appeal did not justify its reversal of facts made by the trial judge with any convincing reason This was not in line with existing case law

<sup>30</sup>[1981] 1 All E R 267 at 269

<sup>31</sup>*Ibid*

have to be made with reference to the particular skill or knowledge, i e leaving foreign objects in the patient's body, or neglecting to obtain relevant facts regarding the patient's medical history. On the other hand, errors which are made with reference to the doctor's skill or knowledge, but are not clinical. For example, not keeping in touch with the mainstream medical journals, pigheadedly carrying on with some old and out of date practice, etc.

It is, however, wrong to say that without any qualification an error of clinical judgment does not amount to negligence. According to the affirmative decision of the House of Lords in *WHITEHOUSE* such an error of judgment is only not negligent when it complies with the test as set in *BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE* [1957] 2 All E R 118: the ordinary skilled doctor who acts according to a practice accepted as proper by a responsible body of medical opinion. Thus, in the context of medical or professional negligence the phrase "error of clinical judgment" cannot be accepted in that it exonerates a doctor or professional person from negligence just like that. It still must stand the test of *BOLAM*. In the opinion of this researcher it is the qualification of certain behaviour which amounts to negligence.<sup>32</sup> The term "error of clinical judgment" is legally irrelevant.

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<sup>32</sup>The implications of this decision are set out by Robertson (1981b), see *supra* Subparagraph 2.3.4. The thesis cannot but agree with him that the House of Lords missed the opportunity to fully address what is wrong with medical negligence under the *BOLAM* test.

#### 5.4. Differences of Professional Opinion

5.4.1. In *MAYNARD v WEST MIDLANDS REGIONAL HEALTH AUTHORITY* [1985] 1 All E R 635, the plaintiff suffered injuries due to an exploratory operation. This was necessary in order to diagnose whether she suffered from tuberculosis, for which she was treated, or from Hodgkin's disease which could have been another possibility. It was found out that she indeed suffered from tuberculosis. As a result of the operation her speech was impaired due to damage to a nerve affecting her vocal cords. It was said that such damage is an inherent risk of the operation.

The plaintiff sued the defendants for negligence, claiming that the operation was not necessary at the time because the defendants did not wait for the results of the tuberculosis test. In other words, it was alleged that this decision, to carry out an exploratory operation, was not well considered and therefore the defendants were negligent.

With regard to the necessity of the operation there were two conflicting bodies of opinion. One supporting the plaintiff that the decision was wrong. The other supporting the decision as 'being reasonable in the circumstances'<sup>33</sup>

The question in this case was, according to Lord Scarman, whether the defendants 'were guilty of an error of professional judgment of such a character as to constitute

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<sup>33</sup> [1985] 1 All E R 635

a breach of their duty of care' <sup>34</sup> It would constitute such a breach if they failed to measure up 'to the standard of the ordinary skilled man exercising and professing to have that special skill' <sup>35</sup> This is the test as formulated by McNair J in BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE [1957] 2 All E R 118

This does not mean that only one practice may constitute negligence. If there is a conflict of medical opinion resulting in several practices available and applicable, which is the case in MAYNARD, it does not necessarily mean that one practice is good and the other bad. That is not a task for the court to decide. Lord Scarman stated -

It is not enough to show that there is a body of competent professional opinion which considers that theirs was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances <sup>36</sup>

It is not for the court to decide that the defendants were negligent if it preferred one opinion rather than the other. It must be recognized that in professions such as medicine the existence of differences of opinion and practice is common, and that 'there is seldom any one answer exclusive of all others to problems of professional

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<sup>34</sup>*Ibid* , at 636

<sup>35</sup>*Ibid* , at 638 Lord Scarman citing Lord Edmund Davies in WHITEHOUSE v JORDAN [1981] 1 All E R 267 at 277

<sup>36</sup>[1985] 1 All E R 635 at 638

judgment' <sup>37</sup>

The decision in MAYNARD was applied, in England, in ADDERLEY v NORTH MANCHESTER HEALTH AUTHORITY [1995] 25 B M L R 42 <sup>38</sup> In the ADDERLEY case the defendant psychiatrist diagnosed the plaintiff, concluding that he suffered from encapsulated schizophrenia. As a result, the plaintiff claimed that he suffered from his health, and his well-being was undermined. He sued the defendant. The expert evidence concluded that the plaintiff did not suffer from schizophrenia but they stated that the plaintiff did have some mental disorder. The diagnosis of schizophrenia at the time was, however, a reasonable diagnosis.

The court held that the diagnosis, although it was wrong, was not 'an opinion that no reasonable doctor within their specialisation would have reached, based on the clinical picture presented to the psychiatrist in 1986' <sup>39</sup>

5.4.2. In Ireland, this issue was subject to debate in, *inter alia*, HEALY v NORTH WESTERN HEALTH BOARD, Unreported, High Court, 31 January 1996, Flood J. In this case it was claimed that the alleged negligence of the Health Board resulted in the suicide of the father of the plaintiff, who was discharged after nine days from a psychiatric hospital, after he was administered there for

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<sup>37</sup>*Ibid*

<sup>38</sup>See also BOLITHO v CITY AND HACKNEY HEALTH AUTHORITY [1992] 13 B M L R 111

<sup>39</sup>[1992] B M L R 111

depression

In particular, it was claimed that the discharge procedure was not properly conducted. This included, with regard to depressions, a consideration as to suicidal traits of the patient. One of the expert witnesses concluded from the hospital notes that there appeared to have been no proper assessment of the risks prior to the discharge. Apart from one note there was no indication that the staff had carried out a suicide risk assessment. Another expert witness for the plaintiffs believed that it was not sufficient to only ask the patient ones about suicide, moreover because there were some pointers towards suicidal ideas.

As to suicide risk assessment there were two schools of thought. One view considered that such a procedure must be formal. This procedure existed in a formal, consistent and continuous inquiry into the mental state of the patient. The discharge must be the result of an informed decision and accompanied with a summary of the assessment.

The other school of thought expressed a more informal approach. This approach included a type of checklist, discussions with the nurses and Registrars and to look out for indicators or manifestations of suicide. One witness here, took the view that where a patient does not bring it up, proper practice was to not follow it up with further questions. This practice was said to be, contrary to the more formal one, commonly used in Ireland.

The test as to the standard of care in medical



negligence cases has been set out by the Supreme Court in DUNNE v NATIONAL MATERNITY HOSPITAL [1989] I R 91 This test related to whether the defendant acted with ordinary care of an equally competent practitioner as to the administration of a general practice approved of by a substantial amount of reputable practitioners of like specialization An honest difference of opinion is no ground to establish liability

Applying the test on the circumstances of the case, Flood J came to the following conclusions

(I) As to the different schools of thought - the formal and informal discharge assessment procedures - it is not up to the judge to decide which one is to be preferred However, both schools accepted that suicidal risks are inherent to depression and therefore the patient should be monitored and prior to release the risk of suicide must be assessed (either formal or informal)

(II) Having accepted that the followed procedure was not incorrect - one could say that the learned judge did not consider whether this practice carried any obvious inherent defects - the learned judge considered whether this practice was carried out in a manner sufficient to relieve the defendant from liability Flood J held that it was not There was no indication that a pre-discharge assessment was carried out, contrary of what would have been good practice, and to report this assessment in the clinical notes There was, therefore, no evidence that the patient was in a state of "firm remission" Such evidence

would other wise not lead to the suicide of the patient  
(III) Hence, the defendant was negligent in not having carried out an assessment and, if he had carried out an assessment, it would have been inadequate or inadequately considered

Thus, although a difference of opinion does not result in negligence, the practice that was followed must, subsequently, be approved of by a substantial amount of reputable practitioners of like specialization

It could be suggested that the decision in this case could open up litigation in this particular category It could change, according to some,<sup>40</sup> clinical and medical legal practice in Ireland

Flood J emphasised two aspects of medical care in his judgment The defendant failed in his duty of care First, by not keeping proper clinical records of the plaintiff's father This can only lead to a change for the better Second, the judge considered the practical application of the general and approved practice as not sufficient to meet the standard of care He came to this conclusion by stating that, in his view, this standard was not met because the patient was not in a "firm remission" Otherwise he would not have committed suicide Obviously, the judge had here the benefit of hindsight

This second aspect demands further consideration In effect, the judge ruled that only persons who are no longer suffering from the symptoms for which they were admitted

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<sup>40</sup>See, *inter alios*, Webb (1996)

may be discharged. At least, if this is what he meant with "firm remission", the medical interpretation of the term<sup>41</sup> It would have been suffice for the judge to conclude that, due to the absence of proper clinical records, it could not be established whether the defendant acted with reasonable care, and, knowing the result of the discharge, he could conclude that the defendant was negligent<sup>42</sup> But interpreting, as a laymen, medical terms, the judge may, in effect, have made a policy decision as to the care for psychiatric patients. Furthermore, it could be argued whether the actual procedure was not flawed in itself, having obvious inherent defects.

## 5.5 Scientific Disputes

5.5.1. It has already been acknowledged by the courts, both in England and Ireland, that an honest difference of opinion is not a ground to find a professional practitioner negligent. However, in some instances the courts are required to come to a solution as to the cause of the dispute in order to reach a balanced decision. The absence of any knowledge regarding the nature of the specific scientific dispute and not being able to rely on expert

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<sup>41</sup>*Ibid*

<sup>42</sup>If this argument is accepted, it would imply that a doctor owes a duty directly towards his patient to keep proper clinical records. He is negligent if he fails to discharge this duty.

evidence, which after all is a reflection of the dispute, requires the courts to take a different viewpoint and to seek an innovative and different solution

5 5.2. In *BEST v WELLCOME FOUNDATION LTD* [1992] I L R M 609, the plaintiff suffered injuries - he became severely mentally retarded - as a result of vaccination against D T P (diphtheria, tetanus and pertussis) The alleged negligence was, *inter alia*, based on the fact that the first defendant, Wellcome, released a batch of vaccine which was excessively potent and toxic The High Court held that Wellcome were negligent in that release, but that there was no temporal link between the vaccination directed by the general practitioner and the onset of the symptoms of the plaintiff <sup>43</sup> The plaintiff could not discharge himself from the onus of proof which rested on him, the evidence given by the plaintiff was rejected, and the claim was dismissed The plaintiff appealed

The relevant questions which had to be answered by the Supreme Court were (1) can the manufacturer of the vaccine be held negligent, (11) what is the role of the courts in solving scientific disputes and (111) did the injuries arise from the vaccination, i e was the inference drawn from the evidence correct?

With regard to the first question, the evidence showed that the vaccination with D T P could cause, however remote or rare, a reaction resulting in injuries as

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<sup>43</sup>*BEST v WELLCOME FOUNDATION LTD* [1993] 3 I R 421

described in this case. On these grounds a manufacturer of such a product has, according to O'Flaherty J, a duty -

to exercise all reasonable care having regard to the importance of what they are doing to avoid exposing the recipient to undue danger or risk of harm from the use of their product. Failure to meet this standard of reasonable care will subject the manufacturer to liability for any resulting injury.<sup>44</sup>

This means that, as opposed to the provisions of the E U directive on product liability,<sup>45</sup> a manufacturer is not automatically liable for negligence, merely because the injuries were proximately caused by the manufacturer's product. At all times the manufacturer must exercise the proper standards of care in the production and testing of his product. He must, in particular, consider 'current scientific and medical knowledge and experience as well as his own experience concerning the propensities of the vaccine'.<sup>46</sup> It is therefore not sufficient for a manufacturer to comply with 'mandatory or minimum requirements demanded by national health authorities in the area in which the vaccine was manufactured', nor is it sufficient 'to rely on one particular point of view in a debated question concerning the risks involved'.<sup>47</sup> It was held that Wellcome was negligent because the tests were

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<sup>44</sup> [1992] I L R M 609 at 640

<sup>45</sup> O J No L210/29

<sup>46</sup> [1992] I L R M 609 at 640, per O'Flaherty J

<sup>47</sup> *Ibid*, at 626, per Finlay C J

carried out inadequately

With regard to a "debated question", Finlay C J remarked that it is not the court that was able to or should resolve disputes among scientists regarding technical topics. Instead, the court had to -

apply common sense and a careful understanding of the logic and likelihood of events to conflicting opinions and conflicting theories concerning a matter of this kind <sup>48</sup>

A vaccination with D T P can cause a reaction, called post-pertussis vaccine encephalopathy (P P V E ) which can produce symptoms similar to those of the plaintiff's. This was inferred from expert evidence given to the trial judge. However, this was not an issue. Instead the issue was whether or not it can be established that the injuries the plaintiff suffered were a result of the particular vaccination. A necessary link is a close temporal association between vaccination and the occurrence of the symptoms. To establish this link one must rely on the evidence of the defendants and the plaintiffs. The plaintiffs argued that the symptoms started hours after the vaccination, thus an indication that the reactions were caused by the vaccination. The defendant argued that those symptoms were not recorded until weeks later.

These records were found inadequate by the Supreme Court. Finlay C J was therefore, as opposed to the High

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<sup>48</sup> *Ibid*

Court, driven to the conclusion 'that the inference made by the learned trial judge is not a sound inference and it is not one which I can draw from a perusal of the [evidence]' <sup>49</sup>

This decision is not without qualification. The Supreme Court did not justify this position. It is inferred from the produced antagonistic evidence. In doing so, the court ignored the position of the defendants as being professional. If the Supreme Court would not have departed from a professional centred approach, it could have come to the conclusion that the defendant's evidence ought to prevail because the professional practitioner is supposed to keep proper medical records <sup>50</sup>. However, in *BEST v WELLCOME FOUNDATION LTD* [1992] I L R M 609 it was not disputed whether or not the practitioner had acted negligently. Had this been inferred, although not an issue, it could have given the court a valid reason to reject the general practitioners evidence on the grounds that he had violated his duty to keep proper medical records.

**5.5.3.** The question is whether this case can be regarded as a professional negligence case. The interpretation of the general practitioner's behaviour cleared the way for a claim for damages based on the negligence of a manufacturer.

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<sup>49</sup>*Ibid*

<sup>50</sup>See, for example, *ARMSTRONG v EASTERN HEALTH BOARD* [1995] P N L R 291. The preparation of medical records benefit both the practitioner and the patient. They are specifically prepared for this purpose and must be used in the ordinary course of the doctor's duties.

of pharmaceutical products, i e negligence based on product liability

Nevertheless, the role of the general practitioner remains important His behaviour was in dispute, to the extent that the courts addressed the issue as to whether they could rely on his evidence

The case's importance from the point of view of this researcher, is, that it addressed the question as to what the role of the court is in resolving issues of conflicting scientific (or even professional) disputes or "debated questions" Although both courts examined the batch of vaccine on its potency and toxicity thoroughly, the deciding factor in attributing negligence was not the upholding of one, rather than another professional or scientific opinion, or both Instead, the courts reached their decision on what they regarded as grounds of common sense and understanding by holding (as a matter of evidence) that the particular batch was not produced and tested according the proper standards of care In a passage which has subsequently been criticised by Goldrein,<sup>51</sup> Finlay C J stated -

I am satisfied that it is not possible either for a judge of trial or for an appellate court to take upon itself the role of a determining, scientific authority resolving disputes between distinguished scientists in any particular line of technical expertise The function which a court can and must perform in the trial of a case in order to acquire a just result, is to apply common sense and a careful understanding of the

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<sup>51</sup>(1994 1415)



logic and likelihood of events to conflicting opinions and conflicting theories concerning a matter of this kind <sup>52</sup>

Goldrein<sup>53</sup> described this approach as somehow conflicting with the approach described in *BOLITHO v CITY OF HACKNEY HEALTH AUTHORITY* (1993) 4 Med L R 381 which characterized the function of the judge, sitting as a jury, as in part assessing the credibility of the expert witness *qua* witness, and by implication preferring the evidence of one rather than another where two conflict (However, it must be stressed that Finlay C J is contemplating situations where expert evidence is directly contradictory)

It is suggested that there is a possible misconception here. A judge's function is to consider and evaluate expert evidence, as suggested in *BOLITHO*. But, where there is a genuine dispute among experts (and the dispute is not resolvable as an issue of evidence), then the function of the judge is to apply 'common sense and a careful understanding of the logic and likelihood of events' in assessing the evidence <sup>54</sup>. In other words, where a conflict of evidence exists, the judge may prefer one expert to another, but where the dispute is not about which expert is to be preferred but about a conflict of theory, then the judge must use common sense.

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<sup>52</sup> [1992] I L R M 609 at 626

<sup>53</sup> (1994 1411)

<sup>54</sup> [1992] I L R M 609 at 626, *per* Finlay C J

The Finlay C J approach could be misstated. It could be said that the Chief Justice was suggesting that a court, when faced with conflicting experts, must not arbitrate between them. With respect, this is not so. What it seems to this researcher is, that Finlay C J is suggesting that, on being faced with an irreconcilable conflict of professional evidence, a judge may be unable to prefer one expert to another and must accordingly apply his own techniques to the evaluation of evidence.

Applying this to the issue of professional negligence generally, what the BEST case seems to be saying is that in certain cases (particularly those involving a dispute as to expert evidence, or about professional conduct) it is almost inevitable that experts disagree. Two sorts of disagreements may be differentiated. On the one hand, there is the situation where one "expert" may be less reliable or less convincing than another. Clearly here the judge may actively prefer the better evidence. On the other hand, there are situations where expert opinion is divided and the credibility of both witnesses is not really in question. There, Finlay C J asserted that the job of the judge is to apply judicial techniques to discover a fair and just outcome.

In the latter case, the "professionalism" of the witnesses is only an issue insofar as the judge must tacitly acknowledge that in complex scientific (or medical) matters experts can and do differ. These differences are legitimate. But legitimate differences of expert

professional opinion must not inhibit a judge from reaching a decision, making a verdict or rewarding pecuniary damages. Finlay C J, far from abjuring the requirement to make a decision, is defining and describing the decision making process at the limits of professional or medical knowledge and superimposing, as is perfectly proper, the requirements of justice which involve making a decision.

This, in one way sets the limit to the freedom of professional people to make decisions. It suggests that if there is a genuine dispute at the professional margins, the law will take over and, however rough and ready this may seem, will apply logic and common sense.

What this case therefore adds to our understanding of professional autonomy, is a boundary line or *terminus ad quem*, within which professional judgment is permitted and upheld.

At this stage, the model of professional negligence that applies in Ireland may be seen to have three important components. The first is reference to a practice approved of by a responsible body of professional opinion. The second is the inadmissibility of any procedure with inherent defects which ought to be obvious. The third is the prerogative of the courts to apply "logic" and "common sense" to situations where experts of equal standing and acceptability disagree on a matter which is not capable of solution by reference to a decided body of expert opinion.

## 5.6. Consent and Information Disclosure

5.6.1. In WALSH v FAMILY PLANNING SERVICES [1992] I R 496 the plaintiff underwent voluntarily a vasectomy operation. He subsequently contracted orchelgia. He sued the defendants on three grounds: (i) negligence in the treatment, (ii) negligence, assault and battery in failing to advise him regarding the consequences of the operation, and (iii) because he had not given his consent to the third defendant, (the doctor who undertook the operation).

The first question which must be answered is whether an action could be brought in assault or battery. The Supreme Court ruled, contrary to the High Court, that -

[w]here the gist of the plaintiff's plea is lack of informed consent to a surgical procedure, then his action should be determined on ordinary negligence principles rather than assault and battery purporting to rest upon some vitiated consent<sup>55</sup>

A reason for this was that -

a claim of assault should [ ] be confined to cases where there is no consent to the particular procedure or where an apparent consent has been vitiated by fraud or deception<sup>56</sup>

Thus, only a failure to obtain consent is subject to the principles of assault or battery. Where consent has

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<sup>55</sup> [1992] I R 496 at 498

<sup>56</sup> *Ibid*, at 513, per Finlay C J

been given, but is debated as to what or how it has been given, the rules of negligence apply

From the facts it is clear that an initial question of professionalism must have been introduced when the patient volunteered for counselling about the merits and objections to vasectomy. From there on professional counselling shapes the basis of the doctor-patient relationship. It is suggested that where this initial counselling takes place, at least two possibilities may be inferred. First, there is the supposition that the doctor is informing the patient of the pros and cons of intervention, so that, if a medical accident occurs or the patient suffers complications, what was said at the initial counselling session will be relevant to defining the patient's willingness to undergo the defined risks. The second hypothesis is that the doctor/counsellor is re-defining the entire basis of the doctor-patient relationship, not so much by consulting the patient about treatment options (a process to be taken for granted in all but emergency dealings between patient and doctor) but going further, i.e. explaining to the patient what the patient's expectations may realistically be.

It is suggested that, by implication, one of the reasons for MacKenzie J's award of pecuniary damages for breach of the plaintiff's bodily integrity might be attributable to the fact that the patient, in his counselling session, clearly understood not just that he would (if he acceded to the operation) be treated, but would be treated (a) in a specific way and (b) by a

specific doctor The counsellor/doctor, in providing this pre-interventive counselling is thus raising the legitimate expectations of the patient, as well as merely running through the pros and cons of intervention

If this is accepted, then it can readily be understood that a differentiating factor between simple cases of negligence, on the one hand, and cases of "professional negligence", on the other, lies in the extra counselling or advice provided in some of the latter cases This would be consonant with the fact that in most cases the opinion of the professional provider of services is more highly influential on the decision to purchase these services, than would be the case in a non-professional context Hence, the award of damages for breach of bodily integrity might be attributable to the patient's reliance on the representations of the doctor as to how and by whom his bodily integrity would be violated

Of course, it may be objected that two members of the Supreme Court (Finlay C J , and McCarthy J ) appear to suggest that because the operation was under the control of the second named defendant, there was no basis to the claim that the plaintiff had not consented to the operation being performed by another doctor However, it should be noted that Finlay C J pointed out that, as a matter of evidence, it was not proven that the counselling session dealt with who precisely should perform the operation There was no suggestion that the counselling session could not have specifically addressed this issue, rather that in this case

the counselling session in question did not do so

Speaking generally, it could be extrapolated from this case that where it is possible to elect whether to avail of professional services or not, a higher responsibility will be expected of a professional person who outlines the options and "counsels" a client or patient, than will be expected from a non-professional provider. More weight is attached to the professional opinion. This is consonant with common sense and everyday experience.

That this is so, may be inferred from the emphasis placed by the Supreme Court on disclosure to all patients about shortcomings of the proposed treatment. It is quite clear that there are two different views on the quantum of disclosure required.

According to Finlay C J, a practitioner has a 'clear obligation' to warn against the consequences and risks of an operation or treatment.<sup>57</sup> The extent of this obligation is likely to vary, depending on the elective nature of the operation concerned. This elective nature may be 'implied', 'apparent' or 'real'.<sup>58</sup>

In cases where the carrying out of a particular surgical procedure is, as a matter of medical knowledge, necessary to maintain the life or health of the patient, a limited discussion regarding the consequences may be appropriate and proper. In other cases where a particular procedure is not, as a matter of medical knowledge

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<sup>57</sup>[1992] I R 486 at 510

<sup>58</sup>*Ibid*, at 517, per McCarthy J

immediately necessary to maintain the life or health of the patient, this obligation may be more stringent and onerous. The standard of care in these situations is similar as to the standard of care exercised in the giving of treatment, as laid down in *DUNNE v NATIONAL MATERNITY HOSPITAL* [1989] I R 91.

A different opinion is given by McCarthy J. In his view the practitioner had in this particular case, an elective surgical procedure, a duty to supply the patient with all the material facts 'which are so obviously necessary to an informed choice [ ] that no reasonably prudent doctor would fail to make it'<sup>59</sup>. The question was now, which facts must be regarded as material? McCarthy J gave the impression that these were facts which were directly related to the patient's physical and mental health after the operation.

Thus, the Supreme Court is divided not about the counselling issue, but about the principles which govern the doctor's duty regarding the quantum of disclosure. The difference is purely one of degree.

But the professional issue (in the context of the two judgments of Finlay C J and McCarthy J), so to speak, is not about quantum of disclosure since these two Supreme Court judges do not materially differ. The professional issue surely is related to the role and function of pre-interventive counselling, and how this may shape and mould and modify the doctor patient relationship. This theme

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<sup>59</sup>*Ibid* , at 520



shall be re-addressed in the consideration of later cases

Where it is suggested that a professional issue does come into play in the context of consent to treatment and information about treatment options, is found in the judgment of McCarthy J. In this judgment a thorough analysis was made of the options open to a responsible treating doctor. There may be some doubt as to how McCarthy J defined these options.

This is because he appeared to differ from McMahon & Binchy who summarised the options as threefold<sup>60</sup>. They stated them as either (a) the BOLAM option (would generally accepted practice support disclosure), (b) the self-determination requirement (the patient has "absolute rights") or (c) the mean approach generally accepted practice would permit non-disclosure save where disclosure 'was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it'<sup>61</sup>.

The error (pace McMahon & Binchy) in their argument is that they misdescribe the BOLAM test. The BOLAM test refers not to what would be supported by generally accepted practice, but what would be supported as reasonable by a responsible body of professional opinion<sup>62</sup>. The

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<sup>60</sup>(1990 268)

<sup>61</sup>[1992] I R 486 at 520, per McCarthy J

<sup>62</sup>Reference to the latter interpretation may mean that the fact that a practice may be inherently flawed renders the practitioner, performing that particular practice, negligent by reference to a reasonable body of opinion

disadvantage of applying this test is that it will produce a solution which provides an *imprimatur* to practice, even if such practice is on the borderline of what is professionally acceptable, or is regarded as acceptable by only a minority of informed opinion

But this error has been compounded by another error. This time, it is respectfully suggested, one made by McCarthy J. It is impossible that solutions (b) and (c) could be the same. This is because (b) suggests some absolute right, and (c) suggests some qualified right which may be expanded if it was "obviously necessary". It is illogical to suggest that an absolute right can ever be essentially the same as a qualified right. What can happen is that the circumstances may suggest the application of a qualified right, rather than the application of an absolute right and to this, one would have to unhesitatingly agree. The difference between the two is that if the doctor is wrong, or an error occurs, it must be clear beyond peradventure that exemplary damages must accrue where an absolute right has been infringed, on the mistaken assumption that the circumstances permitted this infringement of a right.

Of course, here the dilemma of the professional provider of services is absolutely exposed. If one adopts the position that there is an absolute right which cannot be taken away ((b) in *McMahon and Binchy, supra*), in hard cases, the professional either sacrifices professional discretion, and fulfils the law, or breaks the law to

safeguard the interests of the patient. If one adopts the alternative approach, the professional will have maximum discretion to state that the circumstances were such that no reasonably prudent medical man would fail to make the (amount of) disclosure.

Therefore, the judgment of McCarthy J does suggest that the judgment of the professional person is at least a matter for debate. That is to say, McCarthy J suggested that the features which mark out the professional person's duty to make the requisite amount of disclosure involve (i) whether the operation is elective or not (ii) the risk of unwanted *sequelae*, and (iii) the "obviousness" of the decision, i.e. accepted professional practice.

It is significant that the degree of disclosure which is required can, on the analysis of McCarthy J, never be reduced to some simple formula. Yet on the absolutist approach ((b) on the analysis of McMahon & Binchy, *supra*), the degree can be so reduced. As a consequence, it is quite clear that disclosure to McCarthy J is a question of professional skill and judgment.

The common feature between McMahon & Binchy's approach and that of McCarthy J lies in their implicit acceptance that, essentially, professional negligence, in the context of failure to inform the patient, lies in a judgment call. It is submitted that this is quite different in questions on "non-professional" negligence.

O'Flaherty J divided the question regarding counselling into two parts. First, which criteria should

determine whether a duty of care exists to give warning in relation to a particular procedure? Second, how far must this duty of care reach?

The first question should, according to O'Flaherty J , 'be resolved on the established principles of negligence' <sup>63</sup> It should not be answered according to the criteria regarding general and approved practice, set out in *DUNNE v NATIONAL MATERNITY HOSPITAL* [1989] I R 91 A reason for this can be found in the argument that general and approved practice does not always take into account the legitimate expectations of the patient, but leaves a wide discretion to the practitioner as to whether he should give a warning or not In addition, it can be argued that disclosure *per se*, is not a matter of medical judgment This can be justified with the answer O'Flaherty J gives to the second question -

where there is a question of elective surgery which is not essential to health or bodily well-being, if there is a risk - however exceptional or remote - of grave consequence [ ] the exercise of the duty of care owed by the [practitioner] requires that such possible consequences should be explained in the clearest language to the [patient] <sup>64</sup>

This reasoning seems to tie in with the absolutist approach ((b) the requirement of self-determination) A patient has an absolute right to be informed of all

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<sup>63</sup>[1992] I R 486 at 535

<sup>64</sup>*Ibid*

consequences of an elective operation. The duty is based on established principles of negligence. Once it is established, it is absolute and not depending on the discretion of the practitioner.

It can be argued on which established principles this duty should be based, surely not the "ordinary skilled man". This would, as we have seen, involve a professional judgment. It could be argued that we must refer to the "prudent patient". O'Flaherty, however, did not give an answer. He left this up to the trial judge to determine in each particular case.

It can be said that in this approach professional negligence does not lie in a judgment call, but depends on whether or not the patient's absolute right on information has been infringed. If this is the case, can it be distinguished from "non-professional" negligence?

5 6.2. In England "information disclosure" cases are, as well as cases concerning diagnosis and treatment, subject to the BOLAM test. This observation can be inferred from the main line of reasoning in *SIDAWAY v BETHLEM ROYAL HOSPITAL GOVERNORS* [1985] 1 All E R 643. However, in *SIDAWAY* and other cases, for example, *CHATTERTON v GERSON* [1981] 1 All E R 257, the extent and contents of the duty to disclose were subject to debate and have given rise to fundamentally different interpretations. These interpretations vary from an unrestricted application of the BOLAM test to the absolutist approach, discussed in the

WALSH case (*supra*) Nevertheless, the end-result appears to be the acceptance of the BOLAM test The decision of the Court of Appeal in GOLD v HARINGEY HEALTH AUTHORITY [1987] 2 All E R 888, interpreted the decision in SIDAWAY as an unrestricted application of the BOLAM test <sup>65</sup> It is argued that this does not justify the extensive debate in both SIDAWAY and CHATTERTON, and totally disregards the dissenting judgment of Lord Scarman in SIDAWAY In GOLD the Court of Appeal stated -

[W]here medical advice had been given by a doctor the standard of care required of the doctor did not depend on the context in which the advice was given but on whether there was a substantial body of doctors who would have given the same advice <sup>66</sup>

5 6 3. In CHATTERTON v GERSON [1981] 1 All E R 257, the plaintiff suffered injury due to treatment for chronic and intractable pain, which was the result of a hernia operation This treatment consisted of two subsequent intrathecal injections, ("pain blockers") The injuries she obtained after the second operation were numbness in the right leg and foot which impaired her mobility and loss of muscle power She claimed damages, alleging that (1) the defendant had committed trespass, because she could not give an informed consent, (11) he had been negligent in not

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<sup>65</sup>See also HEATH v BERKSHIRE HEALTH AUTHORITY [1991] 8 B M L R 98

<sup>66</sup>[1987] 2 All E R 888 at 889

giving an explanation regarding the treatment and its implications, and (iii) this explanation was part of his duty to take care 'to treat a patient with the degree of professional skill and care expected of a reasonably skilled medical practitioner' <sup>67</sup>

Evidently, in CHATTERTON, the action by the plaintiff is based on the doctor's duty to inform the patient about the proposed treatment and inherent risks. This is recognized by Bristow J. The plaintiff claimed damages alleging that '[the doctor] had not given her an explanation of the operations and their implications so that she could make an informed decision whether to risk them' <sup>68</sup>. A medical practitioner ought to warn of what may happen by misfortune <sup>69</sup>. However, Bristow J. restricted this duty to situations, only where 'there is a real risk of a misfortune which is inherent in the treatment or operation' <sup>70</sup>.

Consequently, the next question is what must be considered as a "real" risk? Judge Bristow's decision implied that a risk is real when it is a foreseeable risk of the operation or treatment. Thus, a doctor has a duty to explain the treatment or operation and its consequences, and if there are real risks of misfortune inherent in the

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<sup>67</sup>[1981] 1 All E R 257

<sup>68</sup>*Ibid*

<sup>69</sup>See also *STOBIE AND ANOTHER v CENTRAL BIRMINGHAM HEALTH AUTHORITY* [1994] 22 B M L R 135 and *LYBERT v WARRINGTON HEALTH AUTHORITY* [1995] 25 B M L R 91

<sup>70</sup>[1981] 1 All E R 257 at 266

treatment or operation, those risks too <sup>71</sup>

The evidence of the case showed that the doctor disclosed some sort of information. The operation - intrathecal pain block injection - was described as very severe. While there was a body of opinion which claimed that 'it is right to try it on patients suffering from pain other than that caused by terminal cancer',<sup>72</sup> there was another body of opinion which respected the above view but retains this treatment only to terminal cancer patients.

The defendant, a specialist in this area of medicine, stressed in an article on the subject of pain management the fact that in some cases treatment may carry the risk of complications and that -

advantages and disadvantages of any line of treatment should be put to the patient so that he may choose. The vast majority of patients with severe pain are willing to risk considerable side effects if there is a hope of relief. However, it is still necessary to be explicit about these <sup>73</sup>

It was his regular practice to explain all about the

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<sup>71</sup>In *KITCHEN v MCMULLEN* [1989] 5 B M L R 59 the defendant omitted to provide the plaintiff with information with regard to inherent risks of the administration of a certain type of blood product. These risks were expressly stated on the package of the blood product. The plaintiff developed the risks described. The general practice was said to be not to warn a patient of these risks because they were extremely minimal. It was held that, as a general principle, only material risks must be disclosed. In this case the risk was material because of the express warning on the product itself.

<sup>72</sup>[1981] 1 All E R 257 at 260

<sup>73</sup>*Ibid*, at 259



process of the treatment and possible side effects numbness and possible muscle weakness There was no reason why he should have departed from this practice in this case, although the plaintiff's recollection was otherwise Therefore Bristow J accepted, on the balance of possibilities, that the defendant had exercised his regular practice He explained the treatment, its consequences and he had warned of real risks inherent in the operation This did not need to be repeated in a follow-up operation of the same type However, after the follow-up operation the plaintiff obtained the injuries which lay at the basis of her claim numbness in the right leg which impaired her mobility and loss of muscle power

Whether the claim was subject to the tort of battery or negligence depended on whether the consent was real The plaintiff claimed that she was not able to give a real consent to the treatment because the doctor did not explain to her the procedure and its implications Therefore, the 'operation was in law a trespass to her person, that is, a battery' <sup>74</sup> It would be if the consent was not real However, Bristow J argued that the consent was real -

In my judgment once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass <sup>75</sup>

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<sup>74</sup>*Ibid* , at 264

<sup>75</sup>*Ibid* , at 265

Citing the Canadian authority on information disclosure (REIBL v HUGHES (1978) 21 Q R 2d 14), Bristow J stated that where a doctor had acted in "good faith" and in the interest of the patient, and he had been negligent in doing so, the action of battery was inappropriate <sup>76</sup>

It depended on the extent and amount of information given by the doctor whether he was negligent, whether he was in breach of his duty 'to explain what he intends to do, and its implications, in the way a careful and responsible doctor in similar circumstances would have done' <sup>77</sup> The learned judge did not apply the BOLAM test, although the evidence showed that none of the three expert witnesses could 'really help over the adequacy of the explanation', given by the defendant to the injured patient <sup>78</sup> Instead, Bristow J stated -

The fundamental assumption is that he knows his job and will do it properly But he ought to warn of what may happen by misfortune however well the operation is done, if there is a real risk of a

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<sup>76</sup>In other words, trespass is not a valid remedy in this type of litigation because, in the opinion of this researcher, there is always some sort of real consent, either implicit or explicit A patient is always aware, at least to some extent, that he shall be operated upon or given treatment This is even more apparent in elective surgery A consequence of the difference between negligence or trespass (battery) is that with regard to the latter it is not necessary for the plaintiff to prove that, if he was properly informed, he would not have undergone the treatment See, for example, COBBS v GRANT (1972) 8 Cal 3d 229, 104 Cal Rprt 505

<sup>77</sup>[1981] 1 All E R 257 at 265

<sup>78</sup>*Ibid* , at 266

misfortune inherent in the procedure <sup>79</sup>

Accordingly, he must 'take into account the personality of the patient, the likelihood of the misfortune, and what in the way of warning is for the particular patient's welfare' <sup>80</sup>

The defendant in this case was not held negligent. He did not violate his duty, and the risks that materialized - loss of sensation and control of the right leg and foot - were not foreseeable -

The condition of her leg and foot was not a possibility inherent in the operation of which [the defendant] should have warned her. Accordingly the claim of negligence fails <sup>81</sup>

The BOLAM test was not applied. Instead, the judge asked what the doctor ought to have done, by taking into account the interests of the patient and his welfare. Whereas the BOLAM test reflects a "professional-centred" approach, Bristow J applied a "client-centred" approach.

One of the reasons for this may be that the learned judge is of the opinion that in cases where disclosure of information is involved, it is not a special skill or knowledge that underlays the amount of disclosure.

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<sup>79</sup> *Ibid*

<sup>80</sup> *Ibid*

<sup>81</sup> *Ibid*

5.6.4. In *SIDAWAY v BETHLEM ROYAL HOSPITAL GOVERNORS* [1985] 1 All E R 643 the plaintiff suffered injuries due to an operation which was performed with due care and skill by the defendant, a neuro-surgeon. However, she claimed that the doctor was in breach of his duty of care in not warning her prior to the operation against all the possible risks. This had caused her to fail to give an "informed consent" to the operation. The trial judge dismissed the claim. The Court of Appeal upheld his decision, stating that under English law the doctrine of informed consent is not based on full disclosure of all the facts to the patient. The plaintiff appealed to the House of Lords.

The question in this case was threefold and related to (i) the right of the patient to be informed of inherent risks by her doctor, (ii) the amount of disclosure a doctor ought to give to his patient prior to the treatment to enable his patient to come to a balanced decision (must there be full disclosure or does the doctor have a discretion?) and (iii) what should be the criterion to judge whether the disclosed amount suffices the right of the patient.

In answering the third question all their Lordships but one (Lord Scarman) considered that a doctor's duty to warn or inform the patient of inherent risks, must be tested along the same lines as to his duty regarding diagnosis and treatment is tested, *BOLAM* applied. A doctor is required to 'act in accordance with a practice accepted at the time as proper by a responsible body of medical

opinion' <sup>82</sup>

Lord Diplock could not find a reason to substitute the rule, as it was laid down by McNair J in *BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE* [1957] 2 All E R 118, for a new and different rule for that part governing a doctor's duty to advise and warn the patient of risks His Lordship concluded -

To decide what risks to existence of which a patient should be voluntarily warned and the terms in which such warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in just the same way The *Bolam* [*sic*] test should be applied <sup>83</sup>

However, Lord Scarman was of the opinion that the failure to warn or give advice should not be tested according to the *BOLAM* test Reference to the current state of responsible and competent professional opinion and practice should not be the exclusive reference It is a consideration the court may take into account Instead, according to Lord Scarman, the failure should be tested referring to -

whether a doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment

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<sup>82</sup> [1985] 1 All E R 643

<sup>83</sup> *Ibid* , at 659 (Lord Diplock's italics)

which he proposes <sup>84</sup>

The reason for this was that his Lordship did not agree with the fact that medical opinion is to judge whether a doctor has a duty to inform his patient of inherent risks and the scope of that duty. The implication is that '[i]t leaves the determination of a legal duty to the judgments of doctors' <sup>85</sup> He stated that -

[i]t would be a strange conclusion if the courts should be let to conclude that our law, which undoubtedly recognises a right in the patient to decide whether he will accept or reject the treatment proposed, should permit the doctors to determine whether and in what circumstances a duty arises requiring the doctor to warn his patient of the risks inherent in the treatment which he proposes <sup>86</sup>

A clear distinction can be made between the two judicial opinions. The former is primarily based on a "professional-centred" model, qualified by some exceptions in certain circumstances, which are explained later. The latter, however, departs from this model and exercises a "client-centred" approach, containing the two main arguments that (i) a client has the right to determine for herself whether or not to undergo treatment, and (ii) medical opinion as to what is best for the patient must be

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<sup>84</sup> *Ibid* , at 645

<sup>85</sup> *Ibid* , at 649

<sup>86</sup> *Ibid*

limited in favour of this right <sup>87</sup>

This does not mean that the patient has a right to have all risks disclosed, or the doctor a duty to reveal all risks. A risk should be disclosed, according to Lord Scarman, 'when a *reasonable person*, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy' <sup>88</sup> Here, Lord Scarman relied on the so-called "prudent-patient" test developed in America in *CANTERBURY v SPENCE* (1972) 464 F 2d 772

The doctor, however, has, according to Lord Scarman, a 'therapeutic privilege', implying that a 'doctor should have the opportunity of proving that he reasonably believed that disclosure of the risk would be damaging to his patient or contrary to his best interest' <sup>89</sup>

The majority of the House of Lords relied on the BOLAM test and agreed that the amount or extent of disclosure is one of clinical judgment. However, in certain situations their Lordships acknowledged that the test can be modified

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<sup>87</sup>According to Kennedy (1988), the judgment of Lord Scarman in *SIDAWAY* should not be regarded as a dissenting judgment. He rather took two steps forward. First, he emphasized the patient's right from which the doctor's duty to inform arises and he agrees here with Lords Bridge and Templeman. Second, he goes further and regards this right as "overriding", the determination of disclosure cannot be left in the hands of the medical profession but must be in the hands of the courts, see *supra* Subparagraph 2.3.7

<sup>88</sup>[1985] 1 All E R 643 at 653 (Lord Scarman's *italics*)

<sup>89</sup>*Ibid*, at 654

First, their Lordships considered that where a patient asks specific questions regarding the risks involved in the proposed treatment and he is of sound mind, a doctor must answer truthfully and as thoroughly the patient requires

Second, in the absence of specific questions, Lord Bridge accepted that certain circumstances demand something else than clinical judgment. First, the disclosure of a particular risk may 'be so obviously necessary to an informed choice on the part of the patient that no reasonably prudent doctor would fail to disclose that risk'<sup>90</sup> Second, Lord Templeman held that the duty to inform included the requirement to inform the patient of 'danger which by its nature or magnitude or for some other reason requires to be separately taken into account by the patient in order to reach a balanced judgment'<sup>91</sup> However, this duty must be used in the best interest of the patient and it remains at the discretion of the doctor to decide what information he thinks should be disclosed and the terms of disclosure

The cynic would argue that the consequences of the two tests would not materially differ. The exception of "therapeutic privilege" may largely nullify the justification that the patient has a fundamental right to be informed and can be regarded as a BOLAM test in disguise. Again, an absolute right cannot be the same as a qualified right. Many other writers conclude that the

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<sup>90</sup>*Ibid* , at 663, per Lord Bridge

<sup>91</sup>*Ibid* , at 664



English approach sanctions medical paternalism <sup>92</sup>

However, on the other hand, it can be argued - by the realist - that the English courts slowly begin to recognize that clinical judgment cannot be conclusive when it comes to the imposition of liability. The "professional-centred" approach can be described as 'out-moded' <sup>93</sup>. Not only because medical science has become more sophisticated and complicated, other reasons may justify this recognition. For example, the increasing awareness of consumer rights which has already been recognized in areas such as product liability. In this approach medical services must, accordingly, be regarded as a consumer product, defined and determined by the market, whether or not this market is private or publicly controlled, and may lead to a change in the professional-client relationship, deviating from a collegiate model.

5.6.5. The discussion in *SIDAWAY* evolved around the recognition of a patient's right to be informed. Constitutionally, this can be expressed in terms of the right to autonomy and self-determination. This ideology is, in America, reflected in the doctrine of "informed consent", according to Robertson (1981a). In broad terms the doctrine requires a doctor to -

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<sup>92</sup>See, *inter alios*, Teff (1985), *supra* Subparagraph 2 3 6

<sup>93</sup>See Harris (1992), *supra* Subparagraph 2 3 6

give his patient sufficient information about proposed treatment so as to provide him with the opportunity of asking an "informed" or "rational" choice as to whether to undergo the treatment <sup>94</sup>

It is a legal concept. It imposes on the doctor a duty to inform the patient about the nature of the treatment, its consequences and inherent risks of the treatment. The fundamental question is how much and who determines the amount which ought to be disclosed?

Two tests apply. The first leaves it up to the doctor. The disclosure remains a matter of medical judgment determined by the evidence of medical experts in relation to normal medical practice <sup>95</sup>. The second test was developed in *CANTERBURY v SPENCE* (1972) 464 F 2d 772. In this case the amount of disclosure was determined by reference to the "prudent patient". The standard was set by law and the amount which ought to be disclosed depended on the materiality of the risk. The risk is material or real -

when a reasonable person in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in determining whether or not to forego the proposed therapy <sup>96</sup>

Three reasons were given to justify this departure

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<sup>94</sup>Cf *NATANSON v KLINE* (1960) 186 Kan 393 at 410, 350 P 2d 1093 at 1106

<sup>95</sup>*Ibid* See also *SALGO v LELAND STANFORD JR UNIVERSITY BOARD OF TRUSTEES* (1957) 154 Cal App 2d 560, 317 P 2d 170

<sup>96</sup>(1972) 464 F 2d 772 at 787

from the medical judgment test, according to Robertson <sup>97</sup> First, the acknowledgement of the patient's right to self-determination Second, medical custom could appear to be a façade for non-disclosure This could indicate a sceptical attitude to the value of the self-disciplined and self-regulatory aspects of the medical profession Third, the determination of what is material is possible without having special knowledge (when the test is taken from the patient's perception and expectation)

As a consequence, the concept of professional negligence, as being based on a special skill where damage occurs as a result of the insufficient disclosure of information, can no longer be maintained Negligence in these situations can now be determined on the normal principles of negligence proximity and foreseeability of damage In CANTERBURY two steps were needed

(I) Was there a duty to inform? This can be determined using a medical standard However, what should have been disclosed is answered by referring to the "prudent patient"

(II) What could reasonably be foreseen (a) what would damage the patient or (b) what would the patient be expected to be informed of? This is the "prudent-patient" test <sup>98</sup>

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<sup>97</sup>(1981a 106)

<sup>98</sup>However, the "prudent patient" test is rendered invalid due to the doctor's "therapeutic privilege" Consequently, that what must be foreseen, remains a matter of medical judgment, taking into account the best interest of the patient, see Robertson (1981a 106)

The CANTERBURY case was recently affirmed by the New Jersey Supreme Court. In *LARGEY v ROTHMAN* (1988) 110 N J 204, 540 A 2d 504 it held that the disclosure of information must be based on the individual patient and should not be subject to 'the whim of the medical community' <sup>99</sup> In addition, it stated that medical opinion would have effect if only medical factors had to be considered. However, other factors, such as the emotional and psychological condition of the patient must play a role in the determination of the scope of disclosure. Finally, the doctor's discretion in establishing the scope of disclosure must yield for the patient's exclusive right of self-determination and autonomy. This right does often challenge the medical profession's 'anachronistic paternalism' <sup>100</sup>

The function of the doctrine is two-fold and derived, as has been shown, from the premise that the patient has a right to self-determination (i) to promote individual autonomy and (ii) to encourage individual decision making <sup>101</sup>

Thus, it reflects the ideal that the decision to undergo medical treatment is foremostly the patient's <sup>102</sup> The patient should be informed or advised properly to

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<sup>99</sup> (1988) 110 N J 204 at 212-213

<sup>100</sup> *Ibid* , at 214

<sup>101</sup> See Robertson (1981a 108-109)

<sup>102</sup> Exceptions could be made in emergency or life-saving treatment

provide him with an opportunity to come to a decision in a rational manner

However, realists see the function of the doctrine differently and argue that the doctrine's true function is to expand liability to victims of "medical accidents"<sup>103</sup> This realistic or sceptic view may have derived from the idea that the imposition of liability depends on risk assessment, it being a simple abstraction the cost-benefit analysis<sup>104</sup>

In doing so, the court places emphasis on the costs of eliminating the risks of injury The balance between risks and costs to avoid or decrease risks, tips to the former when the costs are unreasonable high to avoid a small risk<sup>105</sup> However, where the risk of injury appears to be substantially more, the analysis loses its value<sup>106</sup>

Whether this is true in England remains to be seen Lord Denning said in *HUCKS v COLE* (The Times, 9th May 1968) that a doctor cannot be held negligent simply because something goes wrong Thus, under a no-fault system, as in

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<sup>103</sup>See, *inter alios*, Meisel (1977 51)

<sup>104</sup>It is based on the idea, according to Harris (1980 42), that man 'is a rational maximizer of his satisfactions' In this analysis, economic factors form the basis of the assessment of negligent behaviour One is negligent if 'the loss caused by the accident, multiplied by the probability of the accident's occurring exceeds the burden of the precautions that the defendant might have taken to advert it', (according to Learned Hand in *UNITED STATES v CARROLL TOWING COMPANY* (1947) 159 F 2d 169)

<sup>105</sup>Cf *CALLAGHAN v KILLARNEY RACE CO LTD* [1958] 1 R 366

<sup>106</sup>Cf *MORRIS v LUTON CORPORATION* [1946] 1 All E R

England and Ireland, a large number of patients are necessarily deprived of compensation

It can be said that one other purpose of the CANTERBURY case was to relieve the plaintiff's burden of establishing negligence by medical evidence alone. The judicial emphasis prior to it lay on the doctor's duty to disclose information without making any reference to the patient's understanding of such information. So much for self-determination and individual autonomy. In other words, now the courts can vindicate to impose liability in the event of loss occurring without actual fault or negligent behaviour of the doctor in the actual administration of the treatment, the prudent patient is provided with a remedy to have his losses compensated.

The question of patients' comprehension is overlooked. It is in America, according to Robertson, merely a 'legal mechanism to expand the liability of the medical profession in order to compensate a greater number of victims of medical accidents'<sup>107</sup>

The scope of the doctrine is in England and Ireland still restricted. This was recently reaffirmed in Ireland in FARRELL v VARIAN, Unreported, High Court, 19 September 1994. In this case, Judge O'Hanlon relied on the majority decision in SIDAWAY. The plaintiff in FARRELL suffered from contraction in his left hand for which he was successfully operated. However, the symptoms returned some time later and had spread to his right hand as well. He was operated

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<sup>107</sup>(1981a 112)

again on his left hand This was unsuccessful and a remote risk developed Reflex Sympathetic Dystrophy Syndrome (R S D Syndrome) This is a rare phenomenon which cause is not yet known The patient argued that he should have been informed about it because if he had known of it he would not have undergone the second operation This was rejected by O'Hanlon J The defendant had informed the plaintiff properly about the nature of the operation and ailment The omission not to warn a patient about the R S D Syndrome was accepted as a general and approved practice O'Hanlon J said that this was a matter of clinical judgment, to be made in the best interest of the patient Relying on the decision in *SIDAWAY* the judge said that this warning was not 'obviously necessary to make an informed choice on the part of the patient' <sup>108</sup> He concluded that 'the standard warning given by the [d]efendant [ ] was adequate in all the circumstances' <sup>109</sup>

Thus, it is accepted that the patient has some sort of right to be properly informed, but the determination of disclosure remains, according to a majority of the cases, a matter of medical judgment This approach is based on a number of reasons <sup>110</sup> These are

(I) The judicial policy in England is against expansion of

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<sup>108</sup>Unreported, High Court, 19 September 1994, at page 51 of O'Hanlon J 's judgment

<sup>109</sup>*Ibid* , at 51-52

<sup>110</sup>Robertson (1981a 125-126)

medical liability <sup>111</sup>

(II) The fear of defensive medicine, linked with the fear of an increase in medical litigation, impedes the introduction of the doctrine

(III) The disclosure of inherent real risks is seen as a part of the overall (medical) duty of care and in that way restricts the development of the doctrine

(IV) The influence of expert evidence denies the reasonableness of disclosure

(V) A strict application of the causation rules will create difficulties of proof for plaintiffs in informed consent litigation

The last reason has been exemplified in the decision in *KITCHEN v MCMULLEN* [1989] 5 B M L R 59. The test of consent in England is two-folded. It is important to first establish whether a risk needs to be disclosed, before it could be considered whether a reasonable person would have consented to the treatment if he was properly informed. In the circumstances of the case, the risk should have been disclosed. However, the plaintiff's action failed because he could not prove that, if the risk was disclosed, he would not have undergone the treatment.

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<sup>111</sup>This has been made clear in decisions like *WHITEHOUSE v JORDAN* [1980] 1 All E R 650 and *SIDAWAY v BETHLEM ROYAL HOSPITAL GOVERNORS* [1985] 1 All E R 643



**Chapter Six**  
Specific Attributes of the Standard of  
Care of Solicitors

**6.1. Introduction**

The standard of care of solicitors in Ireland demands special consideration. One of the reasons for this, is that unlike the position with regard to medical law judges are scarcely to be considered as lay persons when it comes to the assessment of lawyerly conduct. This is particularly clear, at least in Ireland, with regard to the exception of "obvious inherent defects". Although specialist areas exist, the judges are regarded as well capable to form an opinion with regard to the standard of care and to consider the reasonableness of the solicitor's conduct.

In Ireland the standard of care for solicitors is in most cases similar to the standard of care expected from medical practitioners. This has been made clear in *HANAFIN v GAYNOR* [1995] P N L R 278. In this case the defendant solicitor acted for the plaintiff with respect to a property transaction. The plaintiff claimed that his solicitor did not properly investigate the title to the property with regard to planning permission and had advised

him inadequately, resulting in loss for the plaintiff

Egan J dismissed the claim. He held that the principles laid out in *DUNNE v NATIONAL MATERNITY HOSPITAL* [1989] I R 91 also applied to the alleged negligence of a solicitor. The question was whether the solicitor followed a general and approved practice, without any obvious inherent defects. On the evidence, he concluded that the solicitor was not guilty of such a failure as no equally competent solicitor would have been guilty of, if acting with ordinary care. Proper requisitions on title were carried out and searches were undertaken.<sup>1</sup>

The specific attributes this Chapter examines are (i) advice, (ii) representation and instructions to counsel and (iii) information and enquiries.

## 6 2. Advice

6 2 1. This section illustrates that a solicitor has a duty to advise his client with regard to the subject matter for which he represents his client. Some have debated whether it would be feasible to draw a comparison with the

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<sup>1</sup>In England, Oliver J, in *MIDLAND BANK TRUST CO LTD v HETT STUBB & KEMP* [1972] Ch 384 at 403-403, pointed out that the standard of care of solicitors was 'what the reasonably competent practitioner would do having regard to the standards normally adopted in his profession'. This standard is determined by reference to the other members of the relevant profession, see Jackson & Powell (1992 39)

solicitor's duty to advise and the doctor's duty to inform<sup>2</sup> After all, as Kennedy points out, advice and information is to a solicitor what treatment and diagnosis is to a medical practitioner<sup>3</sup> It remains to be seen whether this is practical

In this context it may be debated what exactly is the nature of the duty to advise and its extent, in the context of the discretionary powers of the solicitor and the autonomous nature of his position

6.2.2. In *PARK HALL SCHOOL LTD v OVEREND AND OTHERS* [1987] I L R M 345 the plaintiff offered certain lands for sale When a buyer was found, the negotiations commenced and a contract was drawn up but not signed by the purchaser in the specified time The plaintiff therefore withdrew the offer and put the lands on the market again

The original purchaser anticipated this by bringing an action for specific performance of an oral agreement to sell him the lands This resulted in a finding by the High Court (and upheld by the Supreme Court in *KELLY v PARK HALL SCHOOL LTD* [1979] I R 340) that a valid contract was made A letter, confirming the terms for the sale to the first purchaser and written by the plaintiff's auctioneer to one of the plaintiff's advisers, constituted a sufficient note or memorandum of the agreement to sell for

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<sup>2</sup>See, *inter alios*, Munneke & Loscalzo (1989), *supra* Subparagraph 2 4 2

<sup>3</sup>(1988)

the purpose of the Statute of Frauds (Ireland) Act, 1695, despite the letter stating that the terms had been agreed "subject to contract" This was held to postpone contractual liability

The plaintiff, however, accepted during this process - believing that the purchaser's action would fail - the highest tender for the lands Unable to show good title to the new purchaser, this new purchaser brought an action for damages against the plaintiff

The plaintiff argued that its solicitors (the defendants) were negligent on two accounts First, they had failed to advise the plaintiff that a valid contract existed with the first purchaser Second, that its solicitors had allowed the plaintiff to enter into a contract with another purchaser before the determination of the action for specific performance of the first contract

It was held in the High Court that -

(1) The defendants were under no obligation to bring to the notice of the plaintiff the mere possibility that the purchaser might assert the existence of contractual rights, until some hint emerged that he intended to do so

(2) Once the action for specific performance had been initiated, the defendants had acted as prudent solicitors should do in such a situation, by seeking the advice of counsel, and acting upon it at every successive stage of the proceedings <sup>4</sup>

According to McMahon & Binchy a solicitor may be held

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<sup>4</sup>[1987] I L R M 345 at 346, per O'Hanlon J

negligent in failing to give advice <sup>5</sup> This depends mainly on the relevance and urgency of the neglected advice <sup>6</sup> In PARK HALL SCHOOL, however, O'Hanlon J decided, taking into account the difficult state of the law as to offer and acceptance, especially with regard to the phrase "subject to contract", that the defendants had not failed to give advice Instead, there was no obligation to inform the plaintiff The defendants had taken the right course of action, they followed the proper procedure

An important matter is the manner in which the defendants applied the law as it was at the time when the contractual arrangements were made Did the defendants apply the correct procedure or did they make a signal omission?

It is, therefore, necessary to discuss the validity of the above contract as it stood at the time of the judgment (1983) On the basis of this discussion it may implicitly be concluded whether or not the defendants, in not informing the plaintiff that a doubtful situation existed, followed a general and approved practice, and if so, whether or not the defendants properly formed their own opinion as to whether or not this practice carried inherent defects

First, one must ask the following question did the defendants realize that, when they came across the letter, sent by the plaintiff's auctioneer to the plaintiff's

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<sup>5</sup>(1990 277-278)

<sup>6</sup>Cf LAKE v BUSHBY [1949] 2 All E R 964

adviser, their client was contractually bound to the first purchaser before the execution of the contract? In this letter the auctioneer confirmed that he had agreed the terms, subject to contract, for the sale of the lands

The state of the law at that time in England showed, according to Clark, that -

if a document contains the hallowed phrase, "subject to contract" that document cannot constitute a memorandum because the memorandum must acknowledge that an oral contract exists <sup>7</sup>

Or, according to Lord Denning in TIVERTON ESTATES LTD v WEARWELL [1975] Ch 146 -

The effect of the words "subject to contract" is that the matter remains in negotiation until a formal contract is executed

The cases in Ireland, however, indicate a different approach to the "subject to contract" formula. In O'FLAHERTY v ARVAN PROPERTY, Unreported, High Court, 3 March 1976, McWilliam J, it was decided that the vendor can introduce parol evidence to show that an oral agreement was reached. The letter containing the phrase "subject to contract" will not be allowed to operate because it was added after the oral agreement had been struck.

A second distinction is found in another Irish authority, according to Clark, expressing the view that

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<sup>7</sup>(1982 45)

'the phrase "subject to contract" may be ignored if it, within the context of the contract in question, is a meaningless phrase' <sup>8</sup> <sup>9</sup>

This clearly shows that the phrase "subject to contract" might have been interpreted in two antithetical ways. It may be inferred that whatever else the solicitors could have assumed, they should have been aware that uncertainty existed in this area.

6 2.3 A surprising omission in the judgment in *PARK HALL SCHOOL LTD v OVEREND AND OTHERS* [1987] I L R M 345 was any clear indication as to the degree of information and participation that should be accorded to the client as soon as a potential difficulty arose.

Did the defendants apply the correct procedure, anticipating English and Irish law, to assume that no binding contract had yet been concluded and proceed to send on a draft contract to the first purchaser? According to O'Hanlon J they did and when the unsigned contract was subsequently sent back the defendants owed a duty to their client (the plaintiff) to ask themselves was it or was it

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<sup>8</sup>(1992 33)

<sup>9</sup> In *KELLY v PARK HALL SCHOOL* (1979) I R 340, the case where the first purchaser put an action against the plaintiff in this case for specific performance, the Supreme Court were 'prepared to scrutinise the negotiations to see if all the terms have been settled and, if so, "subject to contract" added in any letter will be treated as if it were an ambiguous or meaningless phrase', (Clark, 1992 33). According to Clark (*supra*) the decision in this case is controversial and may stand on its own particular facts.

not safe to proceed (to put the lands back on the market again)? In doing so, the defendants had the opportunity to form their own professional opinion. They came to the conclusion that, in their view, it was safe to proceed. This was based on the fact that there was no indication that the first purchaser had the intention to pursue the matter any further. The defendants did not have an obligation at this stage to notify their client of the mere possibility of such a claim. Therefore, O'Hanlon J was prepared to hold that -

the defendants had conducted the plaintiff's affairs as a prudent solicitor would have done, had he been equipped with that knowledge of the law which I consider an experienced conveyancing solicitor should have had at the time <sup>10</sup>

The property was put back for sale again and a tender was accepted by the plaintiff. During this process the solicitors of the first purchaser had contacted the defendants without referring to a possibility of a claim. The defendants were lulled into a false sense of security, until the possibility of a claim became reality with the issue of a plenary summons.

According to O'Hanlon J, the only possibility open to the defendants was 'to consult counsel as to the steps which should be taken as a matter of urgency to protect their client's interest' <sup>11</sup>. This they did and for this

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<sup>10</sup> [1987] I L R M 345 at 355

<sup>11</sup> *Ibid*, at 356



reason it was asserted that they took the course of a prudent solicitor, acting in similar circumstances

6.2.4. Having reviewed this case step by step and having discussed the difficult state of the law, can it now be concluded that the defendants took at both stages a proper course of action?

On the one hand, at each stage they considered their client's interest and, more importantly, they formed their own opinion as professionals with regard to what steps they should undertake. Having acted as prudent solicitors, they followed a general and approved practice.

On the other hand, is it possible to argue that the solicitors were perhaps cavalier in failing to inform their client that the state of the law was difficult and that it might have been unsafe to offer the lands for re-sale, until assurances were received from the initial purchaser. Surely, it behoved the solicitors to explain to their clients the potential liability at a stage prior to the issuing of proceedings.

This has general implications. If a procedure is potentially inherently flawed (whether by uncertainty in the law or something more) it surely should not be adopted without at least some consultation with the client, without transgressing the requirements set out in *ROCHE v PEILOW* [1985] I R 232. For the court to find that a sale to A, and a re-sale to B did not pose any questions to the mind of experienced conveyancing solicitors until after

proceedings were initiated, is surely rather hard to credit

Hence, where the law is uncertain, a solicitor may safely assume that current practice may be followed, even if at a later stage the presumptions inherent in current practice are incorrect <sup>12</sup> What is surprising is, that in medical law it may be assumed that practice does change and any *indiciae* that a current practice is unsatisfactory should, all things being equal, be communicated to the patient so that he may, within his intellectual and emotional limits, make up his own mind

O'Hanlon J does not go into this, but at all stages the learned judge took into consideration the professional status of the defendants and expressed the opinion that the defendants acted as prudent solicitors From this it follows that the defendants exercised their duties according to a general and approved practice, not by mindlessly following a certain practice, but considering their client's interests and forming their own professional opinion

In the opinion of this researcher, two alternative

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<sup>12</sup>However, a solicitor is obliged to anticipate on a clear change in the law, for example, the enactment of a new Statute See MCMULLEN v FARRELL & PARTNERS AND OTHERS [1992] I L R M 776

In this case the plaintiff claimed that the defendants were negligent in failing to advise him that he had a statutory right (to compel a change of user of lands) under the enactment of a new and relevant act It was held by Barron J that as to advice on pending legislation, a solicitor must, *inter alia*, consider the relevance of the new legislation and the likely date of enactment If prior to it, the solicitor had advised his client differently, he must correct this as soon as possible

conclusions result. By strictly following the O'Hanlon J decision, one could state that the practice adopted by A & L Goodbody was held not to have carried any inherent defects, obvious to any person giving the matter due consideration. This conclusion is supported by following the line of thought of McMahon & Binchy: the defendants were not negligent in the failure to give advice, because this advice was not urgent or relevant.<sup>13</sup> In support of this, it is only necessary to refer to O'Hanlon J's assertion that 'up to the stage the matter had reached as of March 1978, [he was] prepared to hold that the defendants had conducted the plaintiff's affairs as a prudent solicitor would have done'<sup>14</sup>

But, considering the decision in the context of medical law cases, it must be argued that (1) the consultation with counsel took place at a late stage, (11) the plaintiff was not informed about the possible choices open to him prior to the commencement of litigation and (111) therefore, whilst the solicitors might not have been *stricto sensu* negligent, they surely, to adopt McCarthy J's language in a later case,<sup>15</sup> contravened one of the expectations of the plaintiff that in any routine conveyancing procedure, where a possible ambiguity of interpretation or an accepted conveyancing technique throws

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<sup>13</sup>(1990 277-278)

<sup>14</sup>[1987] I L R M 345 at 355

<sup>15</sup>See WALSH v NATIONAL MATERNITY HOSPITAL [1992] 1 I R 486

up a possibility of financial loss, at least the client must be apprised of the difficulty and some input requested from him

This case highlights another difference between Irish medical negligence cases and legal and other negligence cases. In the former, consent is critical and in turn, information and instruction is vital to the existence of consent. But, in the PARK HALL SCHOOL case there is virtually no mention of the requirement that a professional person should inform the client of the nature of the transaction and any inherent flaws therein. This is virtually inexplicable. It suggests that one of the ingredients of professionalism is absent in the solicitor-client relationship: the necessity to keep the client informed of possible ambiguities in the practice of conveyancing, even where such ambiguities are the result of disharmony in the case-law.

In case it might be suggested that the researcher is being wise after the event, it should be stressed that the judgment itself provided ample evidence of the fluctuating state of the law. O'Hanlon J described the process as 'fraught with uncertainty'<sup>16</sup>

The proposition to be derived from this case, then, must run as follows: a solicitor will not be held negligent for adopting a particular course where this course proves harmful to his client, even where the position is fraught with uncertainty and his client has not been afforded the

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<sup>16</sup> [1987] I L R M 345 at 353

opportunity to consider the uncertainties and determine with his solicitor what course should be adopted. This is truly astonishing and surely should not be accepted as good law in the professional (or indeed in any other) context.

6.2.5. In other cases, a parallel can be drawn with medical negligence cases also. The solicitor is under a duty to provide information, as well as advise his client, so that she can come to a correct decision.

In *WARD v LANE* [1995] P N L R 11 the plaintiff sought to secure a premises with living accommodation to run it as an antique shop. To this, she agreed with an occupying tenant to purchase his interest. However, the defendant solicitor omitted to furnish any requisitions on title prior to the sale of the interest. He had not obtained consent of the landlord, who objected to the change of lease also, restricting it solely to a grocery business. Subsequently, the landlord got an order for possession which was affirmed on appeal. It also ordered the plaintiff to pay the costs of the appeal. The plaintiff sought damages for negligence.

The solicitor in this case failed to provide information. He failed to furnish requisitions on title and failed to inform the plaintiff that, until permission was obtained, she could not conduct any business other than grocery. In doing so, the solicitor concealed from the plaintiff that she was in breach of the conditions attached to the purchase agreement and, subsequently, left her open

to any action by the landlord without having any defence Hence, the plaintiff was unable to come to a correct decision

Murneghan J was satisfied that the defendant solicitor failed to act as a reasonable solicitor in similar circumstances should and would have acted No information, which was vital for the plaintiff's aim, was given to her This rendered her in breach of the tenancy requirements and open, without defence, to a subsequent action by the landlord This would have been avoided if the defendant solicitor had taken it upon himself to inform his client as to her position with regard to the former tenant's interest In not doing so, he was clearly negligent, knowing or ought to have known the consequences <sup>17</sup>

The obstacle in these cases is that, contrary to medical negligence cases, consent is not an explicit requirement for a solicitor It may, among other things, be justified that the personal or bodily integrity is not an issue here The thesis agrees with Munneke & Loscalzo (1989) that the solicitor-client relationship is one of

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<sup>17</sup>See also HARTE v SHEEHY AND OTHERS (THIRD PARTIES) [1995] P N L R 132 In this case the solicitor was negligent in failing to advise his client as to the consequences of the omission to meet the repayment requirements of a bridging loan, i e that this could result in a breach of contract with the plaintiff In KEHOE v LOUTH & SON [1992] I L R M 282 the solicitor was held negligent in failing to advise the plaintiff that, in order to purchase a particular premises, there was a necessity to revalue the property which would lead to financial implications

agency<sup>18</sup> Therefore, the solicitor must be left with a degree of discretion to act and he shall do this, in normal cases, in the interest of the client. If he fails, his conduct is, subsequently, tested against general and approved practice, not on the basis that the client did not give a valid consent to whatever the solicitor was doing in the interest of his client.

### 6.3. Representation and Instructions to Counsel

6.3.1. In *DESMOND AND OTHERS v BROPHY AND OTHERS* [1985] I R 449 the first defendant (a solicitor) was alleged to have been negligent in failing to take care of his clients' interests. The plaintiffs asked for the services of the first defendant (Brophy) to act on their behalf in the purchase of two apartments. They paid a deposit on the apartments, assuming that their solicitor would arrange matters so that the deposit was held by the second defendants (the solicitors of the vendor, a building company) as stakeholders and not as agents. However, this was not made clear by Brophy to the vendor's solicitors. Instead, on receipt of the deposits the vendor's solicitors, in accordance with instructions and normal policy, endorsed them in favour of the vendor. Before completion of the contracts the building company went into

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<sup>18</sup>See *supra* Subparagraph 2.4.2

receivership and the plaintiffs lost their deposit

The question was whether the first defendant looked after his clients' interests with reasonable professional care and skill. Barrington J held he did not. The plaintiffs could recover their losses against the first defendant. The learned judge gave the following reasons for this decision:

The defendant was aware of the practice of builders demanding and receiving booking deposits. Consequently, he knew the risks which purchasers were running. He explained these risks to the plaintiffs and took, in his opinion, proper steps to protect his clients' interests. He sent the deposits to the vendor's solicitors, who were acting as agents for the vendor and accompanied the deposits with a letter. However, from this letter it could not be concluded that the defendant, acting on behalf of the purchasers, wished to send the deposits to the vendor's solicitors as stakeholders. It could not be concluded that they were sent 'in accordance with what they [the vendor's solicitors] knew to be their instructions from their client and their client's general course of business' <sup>19</sup>

The vendor's solicitors endorsed the cheques *sans recours* on behalf of the first defendant's firm and sent them to their client. This seems to be in accordance with the state of the law at the time.

According to Barrington J, the letter did not show sufficient evidence that the first defendant took proper

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<sup>19</sup> [1985] I R 449 at 457, per Barrington J



steps to safeguard his clients' interests Therefore, the first defendant, although there was not any lack of concern, did not show 'reasonable professional skill in defending those interests and the clients, as a result, are at a loss' <sup>20</sup>

This case makes clear that a solicitor acts (as an agent) on instructions of his client This means that he has a certain discretion as to how he shall fulfil his instructions This freedom to zealously pursue his clients' interests has been recognized by many <sup>21</sup> Of course, it derives from his autonomous professional position However, if a solicitor fails to act or conduct his duties according to his instructions, his discretionary powers cannot be a defence against liability

6.3.2. In FALLON v GANNON [1988] I L R M 193 the plaintiff sued his solicitor for negligence and breach of contract The solicitor conveyed a licensed premises but the sale was repudiated by the purchasers The plaintiff (the vendor) claimed that the solicitor mishandled the defence of the action brought by the purchasers for rescission of the contract The reason for the purchasers' rescission lay in the false representations made by the plaintiff with regard to the turnover of the licensed premises (in reality it was a third of what had been

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<sup>20</sup>*Ibid*

<sup>21</sup>See, *inter alios*, Wilkins (1990), *supra* Subparagraph 2 6 11

represented) The plaintiff's claim was dismissed in the High Court The plaintiff appealed

The Supreme Court upheld the decision of the High Court Finlay C J concluded that the defendants were not negligent with regard to the sale of the licensed premises up to the time it was repudiated, and that the defendants were not negligent in their defence of the action brought by the purchasers for the rescission of the contract

One of the plaintiff's submissions was that the defendant solicitor was negligent in not attending the auction The plaintiff claimed that, if his solicitor would have been present, he would have prevented his client from making a false representation or 'that he had been subsequently available as a witness to deny the making of any representation by the plaintiff' <sup>22</sup>

The case showed on this point that the relationship between a professional person and his client is essentially based on trust It is more than a contract One must accept that in such a relationship there is something more than just the negotiations of pure commercial regulation of overt mutually agreed terms and one may regard the relationship as a "covenant"

This element of trust reflects the idea that in a solicitor-client or doctor-patient relationship, the seeker of the professional service, as well as the service provider, is under a fiduciary duty in addition to his explicit contractual duty It cannot be true that a person

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<sup>22</sup>[1988] I L R M 193 at 196

who seeks professional help is freed from the burden of responsibility whenever he enters into a relationship for which he needs professional assistance. That this burden (to prevent mistakes, make inquiries, provide information, etc.) is entirely placed on the shoulders of the professional person does not equate with socio-economic reality.

In the opinion of this researcher this has never been the idea of a profession. It aims, instead, to resolve or avoid conflicts. Perhaps the most important skill is clear and proper communication between the adviser and the client. Therefore, a solicitor, as was the case in *FALLON*, is right in withdrawing his services when this element of communication fails. The relationship is vitiated.

6 3.3. Furthermore, the Supreme Court held in *FALLON v GANNON* [1988] I L R M 193 that -

[t]he duty of a solicitor with regard to the conduct of a case in court where counsel has been briefed is first to brief appropriate and competent counsel and secondly, to instruct them properly in regard to the facts of the case which he has obtained from his client, and to make provision for the attendance of appropriate witnesses and other proofs. A solicitor has not got any vicarious responsibility for the individual conduct of counsel.<sup>23</sup>

This has been recognized in previous decisions and was recently affirmed in *MCMULLEN v CARTY AND OTHERS* [1995]

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<sup>23</sup>[1988] I L R M 193 at 195-196

P N L R 408 In MILLARD & KINSELLA v MCMAHON [1995]  
P N L R 1 - an older case - the plaintiffs sued their  
solicitor for negligence on the grounds that he had not  
initiated proceedings in time, in accordance with the  
Statute of Limitations, 1957 The proceedings entailed the  
recovery of debts of a moribund company by winding up the  
company and to follow the monies paid over to the receiver

The defendant claimed that he merely had to compel the  
receiver to vouch his accounts and that he had instructed  
counsel only one day after he himself was instructed  
Counsel advised the clients that the claim appeared to be  
statute barred unless it was revived by part payment  
However, one of the plaintiffs had a letter from the  
auditor of the moribund company acknowledging the debt If  
so, it would take the claim out of the Statute of  
Limitations This failed because the letter was written by  
the auditor after he had ceased to work for the company

The claim was dismissed by Henchy J He held that  
where a solicitor lays his client's claim fully before  
competent counsel and, accordingly, acts on the counsel's  
advice, the solicitor is not negligent

With regard to a claim which may be statute barred, a  
solicitor is under a number of duties First, he is to be  
aware of the Statute Second, to inform his client on his  
position Henchy J quoted Scruton L J who stated in  
FLETCHER & SON v JUBB BOOTH AND HELLIWELL [1920] 1 K B  
275 that 'the period of limitation [is] one of those  
matters which [solicitors] as [ ] legal advisors ought to

have borne in mind' <sup>24</sup>

Although the solicitor did not regard the limitation for contracts, he cannot be liable, according to his counsel in this case because the claim was already statute barred (the plaintiffs instructed him after it became statute barred) This was not upheld Instead, the solicitor escaped liability because he had instructed counsel, who, subsequently, advised the plaintiffs properly as to the limitation period Henchy J stated that '[1]f the plaintiffs had to rely solely on the personal exertions of their solicitor on their behalf, I would find him guilty of negligence' <sup>25</sup>

#### 6.4. Information and Enquiries

6.4.1. In the following case the solicitor was alleged to have been negligent with regard to the gathering of information and the making of inquiries

In *KELLY v CROWLEY* [1985] I R 212 the plaintiff instructed his solicitor to acquire, on his behalf, a licensed premises which he wanted to operate as a public house The solicitor, aware of his client's intentions, negotiated the sale In the requisitions on title raised by the solicitor, the vendor was asked to specify the exact type of licensing attached to the premises The vendor, in

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<sup>24</sup> [1920] 1 K B 275 at 281

<sup>25</sup> [1995] P N L R 1 at 10

return, handed over the licence. The solicitor failed to inspect the Register of Licences. Had he inspected the Register, he would have found out that the premises had a hotel license only.

The plaintiff took possession of the premises and operated it as a public house. When he sought to renew the licence it was refused on the grounds that the premises was not operated as a hotel within the meaning of the licensing laws.<sup>26</sup> As a result the plaintiff suffered substantial loss and sued his solicitor for negligence and breach of contract.

It was alleged by the plaintiff that his solicitor (the defendant) had failed to carry out any or any adequate search in the Register of Licences and had failed to exercise 'any or any reasonable skill or diligence in raising Rejoinders to the Replies furnished by the vendor's solicitors as to the nature of the licence attaching to the said premises'.<sup>27</sup>

It is clear that in a case like this the existence of a general practice may be critical to the imposition of liability. If it is shown that a solicitor deviated from such a practice, professional liability is imposed. However, if it can be shown that the solicitor adhered to a general accepted practice, despite the financial loss suffered by his client, this would provide him with a

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<sup>26</sup>See subsection 2(2) of the Licensing (Ireland) Act, 1902

<sup>27</sup>[1985] I R 212 at 220

defence to a professional negligence claim, unless this practice carried any obvious inherent defects

However, each case stands on its own and according to Murphy J , 'there are cases in which professional practices and procedures themselves may be so deficient that reliance upon them would not provide a defence to a claim for negligence' <sup>28</sup> He continued that -

there must always be room for the application of the professional expertise of the individual lawyer to the particular circumstances of the individual case and the needs of his own client <sup>29</sup>

In other words, it is an obligation of a solicitor or any other professional person to form their own professional opinion and not mindlessly follow the practice of others A solicitor who exercises a general accepted practice which carries inherent defects is negligent when these defects are obvious to any person giving the matter due consideration These observations have already been made by this researcher in O'DONOVAN v CORK COUNTY COUNCIL [1967] I R 173, ROCHE v PEILOU [1985] I R 232, PARK HALL SCHOOL v OVEREND AND OTHERS [1987] I L R M 345 and other cases

One of the particular facts of this case is the licensing The legislation with regard to the licensing of premises is not transparent In certain cases it is

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<sup>28</sup>*Ibid* , at 221

<sup>29</sup>*Ibid*

difficult to distinguish premises for which a licence was granted, either by inspection of the licence or the premises itself, between hotels and other premises (a public house) <sup>30</sup> The difficulty is especially great where a solicitor is unfamiliar with the licensing laws

However, according to Murphy J -

a person familiar with the relevant legislation and the proper interpretation thereof would appreciate the importance of distinguishing between a licence granted to a public house and a licence granted to a hotel <sup>31</sup>

Accordingly, the judge considered whether -

the defendant in the present case failed in his contractual obligation to the plaintiffs by neglecting to ensure that the licence attaching to the licensed premises in question was granted in respect of a public house rather than a hotel <sup>32</sup>

The judge affirmed that a solicitor has a duty to exercise care, he is assumed to possess and properly apply that degree of skill and knowledge in the conduct of his client's affairs. However, this does not mean that a solicitor should give a guarantee that a particular result will be achieved. Or, in the words of Lord Fullerton, as

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<sup>30</sup>The form of a publican's licence is identical to certain hotel licences. Whether the licence is granted for a public house or a hotel is pointed out on the back of the licence

<sup>31</sup>*Ibid* , at 224

<sup>32</sup>*Ibid*



quoted by Hodson L J in SIMMONS v PENNINGTON & SON [1955]

1 W L R 183 -

A professional man does not warrant that what he does will certainly have the effect which is expected from him. He warrants only that he should bestow on the matter committed to him the skill generally possessed by his brethren in the profession.<sup>33</sup>

This is a characteristic element of the professional relationship between a solicitor and his client.

After this consideration Murphy J came to the conclusion that 'a solicitor acting on behalf of a lay client in the purchase of a licensed premises is bound to make appropriate enquiries as to the nature of the licence attached thereto'.<sup>34</sup> The main reason for this conclusion was inspired by the reality that the licence and its nature were a substantial part of the consideration for the sale of the premises.

The learned judge stated that -

the defendant had a duty not only to make the necessary enquiries so as to advise his client adequately with regard to the licence attaching to the [ ] premises but also to make those enquiries at a time when his advice based on the replies to the enquiries would be of maximum value to his client.<sup>35</sup>

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<sup>33</sup> [1955] 1 W L R 183 at 189

<sup>34</sup> [1985] I R 212 at 226

<sup>35</sup> *Ibid* , at 228

He concluded that -

in the absence of any evidence of some proper established professional practice to the contrary, [ ] the defendant/solicitor should have enquired from the vendor's solicitor prior to the auction, or indeed enquired from the auctioneer at the auction itself, as to whether the licence referred to in the brochure advertising the premises was a licence granted in respect of an hotel premises or some other type of premises <sup>36</sup>

6.4.2. The defendant in KELLY deviated from an established general and approved practice. He breached two principal duties he ought to have exercised in this case.

His first duty was to make relevant and necessary enquiries, and to advise his client accordingly, so that the latter could make an informed decision. A violation of this duty meant that the solicitor did not meet the reasonable standard of professional skill and care. This can be inferred from Finlay P's decision in TAYLOR v RYAN ' [s]uch an enquiry, in the particular circumstances of the case was a necessary reasonable standard of professional skill and care on the part of the defendant' <sup>37</sup>

The violation of the second duty which the defendant ought to have exercised was a consequence of the first. Having omitted to make the necessary enquiries, the

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<sup>36</sup>*Ibid*

<sup>37</sup>[1995] P N L R 47 at 48

defendant could not have advised his client on a time where this advice would have been of "maximum value" to his client <sup>38</sup>

A defence that the time to make those enquiries was limited cannot be accepted. This defence is invalid for someone who holds himself out as possessing professional expertise and knowledge about the law. In a situation where a professional man did not have the time to gain important information, he should advise his client accordingly and warn him of possible risks. Basically, a professional person is obliged to exercise his duties in such a way that his client can make an informed decision and instruct his solicitor accordingly. The value and contents of that information depends on (i) the time available, (ii) the complexity of the case and (iii) the intricacy of the law.

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<sup>38</sup>See also LAKE v BUSBY AND ANOTHER [1949] 2 All E R 964. The plaintiff, after contracting for the purchase of a property with the first defendant, suffered damages because his solicitors failed to communicate relevant information regarding the planning permission of his property. In failing to do so they were found negligent. It was not enough to see that the plaintiff had obtained good title.

## Chapter 7

### The Standard of Care Conclusion,

#### Recent Developments

#### 7.1. The Standard of Care Reference Points

7.1.1. The thesis asserted in the previous Chapters that a general duty of care "over-arches" a sub-set of specific duties. These specific duties arise from the specific attributes of the particular relationship between a professional person and his client or patient. They correspond, in most cases, with the presence of a special skill or competence, inherent to the profession, upon which the client relied and depended. These duties relate to the specific phases of the professional person's service. This is clearly illustrated with regard to the provision of medical services. The doctor's duties relate to diagnosis, treatment and advice or information (risk disclosure). As well as these specific duties, it is obvious that there is an "over-arching" duty to take care <sup>1</sup>

It has been demonstrated previously how the courts

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<sup>1</sup>It is suggested here that this duty is given its content also through the professions' internal regulations, such as the professional and ethical codes of conduct and other disciplinary regulations. See also Wilkins (1994), *supra* Subparagraph 2.6.11

assessed negligence in those cases where duties were violated. The justification for the existence of an overarching duty of care is found, both in England and Ireland, in the fact that the standard of care refers, first of all, to the concept of the professional practitioner of equal specialization and skill, acting with ordinary care. This reference to ordinary care is nothing new. It is consonant with the general idea of the tort of negligence. This was abundantly made clear by McNair J. in *BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE* [1957] 2 All E R 118 and has been applied throughout the development of the tort of negligence.<sup>2</sup>

The question whether the courts look at the presumed responsibilities of a particular socio-economic grouping in Ireland, or whether they merely seek to accommodate technical and other changes by imposing liability in different ways can now be answered, at least, in relation to the standard of care. The thesis suggests that the courts look at the responsibilities of professional groupings. This is justified by the presence of a special skill. For this reason, the standard must differ.

Here, the relevance of the existence of a sub-set of duties comes to light and explains the reference by McNair J. to the professional practitioner with equal qualification and skill. This also underlines the importance of the professional practitioner's conduct,

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<sup>2</sup>Cf *BLYTH v BIRMINGHAM WATERWORKS CO* [1856] 11 Exch 781

rather than assessing the practitioner *qua* professional

Thus, reference is made to "ordinary" care, this is consonant with negligence itself. Second, reference is made to a special skill or aptitude. The professional person possesses some knowledge which is desired and relied upon. Here, the professional man distinguishes himself from the ordinary man. Third, reference is made to his peers (equally competent men). He must possess an average or ordinary degree of skill and competence, inherent to his expertise. He is not required to hold any higher degree of skill. The question then runs as follows: would the ordinary skilled man have adopted the conduct or practice which has been exercised by the defendant professional person? This question is resolved by the courts, relying on expert evidence.

In England, under the BOLAM test, this is achieved by reference to a responsible body of expert opinion. It suggests a connection between theory and practice. The courts rely on this theoretical foundation, although it refers to an optimum, as the exclusive determinant of average or ordinary practice. In doing so, the courts throw the ball into the profession's corner. The courts merely ask what the profession does. If it is similar to the defendant's conduct, the defendant is not negligent. The duty is imposed by law, the standard is matter of professional judgment.

The Irish courts resolve the question by reference to a general and approved practice. It emphasizes the

practical application of theoretical knowledge. It must be distinguished from, on the one hand, optimum practice and, on the other hand, custom. As a result, the defendant practitioner is not negligent if he has acted in accordance with a practice accepted as general by the profession. This does not mean that a deviation from it renders the practitioner automatically negligent. Deviation is accepted within established parameters. What is done and what is the justification for departure from the majority view? Here lies the reflection of the individual autonomy of a professional person. It is the liberty to form one's own view of a proposed course of action within proper limits.

Essentially, the Irish test does not differ, to this point, from its English counterpart. However, the Irish courts have reserved themselves the right to disregard expert evidence in favour to common sense and logic. On two fronts it may impose liability whatever the profession's view may be. First, the courts may hold a practitioner liable if they establish that the course he adopted was, although general and accepted, flawed. In the courts' view it consisted of inherent defects that ought to have been obvious, not only to the profession or the defendant, but to 'any person given the matter due consideration'<sup>3</sup>

Second, the courts have the prerogative to apply logic and common sense in situations where experts of equal standing and acceptability disagree on a matter which is

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<sup>3</sup>Cf O'DONOVAN v CORK COUNTY COUNCIL AND OTHERS [1967] I R 173 at 193, per Walsh J

not capable of solution by reference to a decided body of expert opinion <sup>4</sup>

7.1.2. Characteristic of both tests is that they are "professional-centred" It is confined to the conduct of professional people and, in most cases, the exercise of a special skill At the basis, it is disposed of all subjective elements, including the personality of the judge and the interests and expectations of the injured party

McMahon & Binchy (1990) argue that this test refers to customary practice The authors, reviewing the decision in O'DONOVAN v CORK COUNTY COUNCIL [1967] I R 173, state -

[I]f a member of a profession can show that he or she adhered to the customary practice of his or her profession, this should normally relieve him or her of the accusation of negligence <sup>5</sup>

Custom could be defined as a 'practice accepted as normal and general by other members of the community in similar circumstances' <sup>6</sup> It consists of '[c]ommon practices, sanctioned by general usage' <sup>7</sup> Paramount here is whether there is a 'level of routine repetition that custom

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<sup>4</sup>Cf BEST v WELLCOME FOUNDATION LTD [1993] I R 421 An honest difference of opinion is, however, allowed and a defendant is not negligent in following one practice in preference to another and both practices earn equal recognition

<sup>5</sup>(1990 259)

<sup>6</sup>Fleming (1992 119)

<sup>7</sup>Epstein (1992 6)



presupposes' <sup>8</sup> Thus, there is a degree of conformity with regard to a certain practice which has been exercised. This degree is subsequently proof that the defendant acted with due care, thus escaping liability.

Epstein (1992) argues that, in cases where negligence is consequent to an already existing relationship, the proper standard of liability is custom, especially where both parties had knowledge about the custom. But, in an underlying relationship where only one party, for example, the professional service provider, is familiar to a custom, a preliminary question arises: did the alleged tortfeasor take a risk of mis-communication under the circumstances? In other words, was the plaintiff properly informed regarding the custom prior to the alleged negligent conduct if he was ignorant to the custom? If so, is adherence to custom sufficient evidence to escape liability?

However, it must be argued that there is a difference between custom and standard practice. The latter is a measure to assess the practice or conduct of the defendant, it must be demonstrated that his conduct was accepted as proper by comparing him to the ordinary skilled man. With regard to custom, the defendant has acted either in accordance or contrary to custom, and is not compared with the conduct of an ordinary skilled man. It can be suggested, therefore, that the defendant's conduct must be recognized within definite principles. His conduct must be more or less similar to a line of thought of at least a

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<sup>8</sup>*Ibid* , at 7

respectable minority of the profession

Customary practice does not equate to approved or accepted practice. The latter refers to the connection with theory which inherently strives at an optimum. Custom does not really answer what is demanded as a standard of care. Certainly, it may give an indication to what is demanded or expected by the professional grouping but it is not conclusive as to whether it is the correct practice. The case review has shown that practices may be inherently flawed, rendering the defendant's conduct negligent. It also showed that practitioners were allowed to deviate within accepted parameters.

The point is that in terming a practice "customary" one is really reserving one's position on whether such a practice is (i) accepted but flawed or (ii) accepted and optimal or (iii) accepted as an adequate compromise in the face of alternative and conflicting demands. The term "customary" is no more than an insufficiently precise epithet for describing what is often done, whether by those who are expert, inexpert, careful or careless. It is therefore a term better to be avoided.

7 1.3. The previous Chapters showed that the assessment of the standard of care is, *de facto*, in the hands of the professions. This was recognized by Lord Scarman in *SIDAWAY v BETHLEM ROYAL HOSPITAL GOVERNORS* [1985] 1 All E R 643. He stated that 'the law imposes a duty of care, but the

standard of care is a matter of [professional] judgment' <sup>9</sup>  
He found the view of the law disturbing and criticized it  
in relation to the doctor's duty to disclose risks -

It would be a strange conclusion if the courts  
should be led to conclude that our law [ ]  
should permit the doctors to determine whether  
and in what circumstances a duty arises requiring  
the doctor to warn his patient of the risks  
inherent in the treatment which he proposes <sup>10</sup>

In England and Ireland, nevertheless, the standard of  
care is conditioned by general accepted practice or  
professional opinion. This attitude may be explained by the  
belief that it is the professional person's duty which is  
at stake (professional negligence aims at the conduct of  
the defendant) and not the client's right to, for example,  
self-determination or reasonable expectations. Therefore,  
the judgment of what is demanded in the interest of the  
client or patient, calls for professional expertise.  
However, and one has to agree with Fleming, that one must  
always warn against 'passing too cavalierly upon the  
conduct and decisions of experts' <sup>11</sup>

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<sup>9</sup>[1985] 1 All E R 643 at 649

<sup>10</sup>*Ibid.*

<sup>11</sup>(1992 120)

## 7.2. Recent Developments

### ROGERS v WHITAKER

7.2.1. An indication for a different approach in assessing professional negligent conduct has been expressed by Lord Scarman in *SIDAWAY v BETHLEM ROYAL HOSPITAL GOVERNORS* [1985] 1 All E R 643 and, in Ireland, by Maguire C J in *DANIELS v HESKIN* [1954] I R 73 and Finlay C J in *WALSH v FAMILY PLANNING SERVICES LTD* [1992] 1 I R 486. Some situations or duties are so obvious that they do not require a "professional-centred" approach. It can be argued that in these situations the judges refer to what ought to have been done by reference to the reasonableness or unreasonableness of the defendants' conduct.

This line of thought has been subjected to examination in Australia. In *ROGERS v WHITAKER* [1992] 16 B M L R 148, the Australian High Court demoted the *BOLAM* test to a "rule of thumb". The decision in this case underlies an approach similar to that in "ordinary" negligence cases. The question that can, subsequently, be inferred is: does the presence of a body of esoteric knowledge justify the need for professional judgment in the assessment of the standard care in professional negligence cases?

7.2.2. In *ROGERS v WHITAKER* [1992] 16 B M L R 148, a medical negligence case, an ophthalmic surgeon (the appellant) was sued by his patient (the respondent) for negligence. This was based on the allegation that the

surgeon had failed to warn her against an inherent risk of the operation (the development of sympathetic ophthalmia in her left eye as a result of surgery on the patient's right eye) despite "incessant" questioning by the patient about the inherent risks. The operation was performed with due care and skill. However, the patient developed the risk as described above.

The question in this case was twofold. First, did the failure to warn against the inherent risks result in negligence, a breach of duty of care of the surgeon? Second, should, to provide an answer to this question, the BOLAM test be applied in this case?

The trial judge concluded that the surgeon was negligent, because 'a warning was necessary in the light of her [the patient's] desire for such relevant information'.<sup>12</sup> The judge was not satisfied with the proper medical practice not to warn a patient if she had not expressed a desire for such information. In other words, a doctor is only negligent if he fails to disclose information when he is asked for such information.

The defendant appealed. The Australian High Court rejected the appeal, but on different grounds. These are set out below.

A doctor must exercise reasonable care and skill. This duty is imposed upon the doctor by law. The standard which is required is that of an ordinary skilled person exercising and professing to have that special skill. This

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<sup>12</sup>[1992] 16 B M L R 148 at 151

is said to be a matter of medical judgment This follows from BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE [1957] 2 All E R 118 and SIDAWAY v BETHLEM ROYAL HOSPITAL GOVERNORS [1985] All E R 643 In these cases it was considered that the BOLAM test should be applied in cases of negligent information and advice

However, in SIDAWAY Lord Scarman dissented He refused to apply the BOLAM test in cases where the alleged negligent conduct lay in the non-disclosure of such information and advice He expressed the opinion that in these cases it is up to the court to decide whether or not an omission to warn a patient resulted in a breach of a doctor's duty of care

The Australian High Court followed the dissenting judgment in SIDAWAY and stated that 'the question of whether a patient has been given sufficient information to consent to treatment does not generally depend on medical practice'<sup>13</sup> The essence is whether the conduct of the doctor followed the standard of care which is demanded by law, not by the medical profession

One reason for this departure from BOLAM lies in the insignificance of direct questions and inquiries by a patient in the BOLAM test In applying the test, medical opinion determines whether or not information should be disclosed to a patient This opinion does not logically alter by an express desire of a patient, asking a doctor about the proposed treatment

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<sup>13</sup>*Ibid* , at 148

The majority of the Law Lords in SIDAWAY shared the opinion that direct inquiries from a patient should be answered truthfully, but 'subject to therapeutic privilege'<sup>14</sup> This indicated, according to the Australian High Court, a shortcoming in the application of the BOLAM test The recognition in SIDAWAY that answers should be answered truthfully, without reference to a particular medical standard but subjected to the idea of therapeutic privilege, does not attach sufficient significance to the interests or expectations of the patient When a patient asks a question regarding the nature of, or a particular inherent risk in the treatment, it should be clear to his doctor that it is of concern to that patient that her question is answered truthfully, whatever the reason may be

Unlike in England (and Ireland), the principles set out in BOLAM do not find much acceptance in the Australian courts, especially not in cases relating to the disclosure of information Instead, the Australian courts have adopted a different principle This principle was applied in F v R (1983) S A S R 189 In this case, King C J stated -

The ultimate question is not whether the defendant's conduct accords with the practice of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by law That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community<sup>15</sup>

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<sup>14</sup> [1985] 1 All E R 643

<sup>15</sup> [1983] S A S R 189 at 194

This implied, according to the court in *ROGERS v WHITAKER* that -

it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to the paramount consideration that a person is entitled to make his own decisions about his life<sup>16</sup>

The evidence of acceptable medical practice should only be used as a guideline for the courts. For this reason the BOLAM test must fail.

Following this, the next question concerns the amount of information which must be disclosed to a patient. The answer must take into account, according to the High Court in *ROGERS*, 'the nature of the treatment, the patient's state of health and temperament and all the general circumstances'<sup>17</sup>. Above all, a doctor has the duty to inform a patient of material risks inherent in the treatment. This information is only in special circumstances subject to therapeutic privilege. A risk is material, according to the Australian High Court 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 or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it<sup>18</sup>

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<sup>16</sup> [1992] 16 B M L R 148 at 154

<sup>17</sup> *Ibid*, at 148-149

<sup>18</sup> *Ibid*, at 156



Gaudron J added that a doctor should inform his patient of 'real and foreseeable risks', and, 'if the patient does not ask specific questions about the treatment the doctor has a duty to provide information which would reasonably be required by a person in the position of the plaintiff' <sup>19</sup>

7.2.3. The case clearly demonstrated that, at least in Australia, the BOLAM test is regarded as insufficient in the context of information and advice. This insufficiency was demonstrated by the court, having reviewed the evidence in ROGERS. The medical opinion given in expert evidence was that the patient should have been told of the inherent risk of sympathetic ophthalmia, but only if the patient would have asked for it. This seems at odds with the interests and desires of the patient. She might not have asked the specific question - it is needless to say that most patients are laymen - but from her anxiety that nothing would happen to her "good" eye, the doctor must have understood that she would have attached significance to the risk if she was informed accordingly.

According to Gaudron J, there was, even in cases concerning diagnosis and treatment -

no legal basis for limiting liability in terms of the rule known as "the Bolam [sic] test", in which a doctor is negligent, only if he does not act in accordance with a practice accepted as proper by a responsible body of doctors skilled

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<sup>19</sup>*Ibid*, at 149

in the relevant field of practice <sup>20</sup>

Such a test is only useful as 'a "rule of thumb" in some jury cases', although expert evidence remains important <sup>21</sup> The reason for this observation was that in Gaudron J 's view 'the nature of particular risks and their foreseeability are not matters exclusively within the province of medical knowledge or expertise [T]hey are often matters of common sense' <sup>22</sup>

The relevance of this case lies in the fact that no reference is made to a special skill In this jurisdiction and in England, this element is the distinguishing factor in the concept of professional negligence The reason for a different approach is the fact that the court in ROGERS took into account, as the courts have done in American cases dealing specifically with the notion of "informed consent",<sup>23</sup> the position of the patient within the professional or medical relationship

It can be asserted that the imposition of liability in ROGERS was based on the idea of proximity (the doctor-patient relationship) and foreseeability (not of the risks inherent to medical treatment, but the idea whether the doctor should have been aware that the patient ought to have been informed)

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<sup>20</sup>*Ibid* , at 158

<sup>21</sup>*Ibid*

<sup>22</sup>*Ibid*

<sup>23</sup>Cf *CANTERBURY v SPENCE* (1972) 464 F 2d 772

This may indicate a shift or change with regard to the presumed responsibilities of professional men and the manner in which society deals with the allocation of compensation for losses of an injured party as a result of professional behaviour or the behaviour of professional men <sup>24</sup>

It is suggested by this researcher that the rejection of the BOLAM test in Australia may have been based on some policy consideration to be able to compensate more victims of medical accidents. However, the negligence test, as used by the Australian High Court, reflects the application of pure tort principles: proximity and foreseeability.

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<sup>24</sup>This latter distinction is important, in that it suggests that the involvement of a special skill appears not always to be essential to the imposition of liability.

PART C:

Chapter 8

The Professional Relationship

8.1. Introduction

This Chapter seeks to identify the particular aspects of the professional relationship between, on the one hand, the professional service provider and his client or patient and, on the other hand, the professional person and those who, for whatever reason, rely on his skill and expertise but are not *stricto sensu* part of the professional relationship

In order to describe the legal structure of a professional relationship, this Chapter takes three professions as examples<sup>1</sup> The aim is to identify the particular characteristics of each relationship

The contractual relationship regarding a general practitioner under the G M S , and other health care contracts, demands an examination of the legal status of the patient and doctor in the professional medical

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<sup>1</sup>The thesis has outlined in Chapter Three that, in order to understand what is meant in this thesis with a "profession", it takes three professions at its point of departure to describe the concept of professional negligence These are the medical and legal professions and accountancy

relationship Whether the rights and obligations are confined to what is agreed in the contract is also examined

A solicitor's express duties derive normally from the contract of retainer However, it is said that the relationship is of a fiduciary nature, implying other duties and obligations <sup>2</sup> <sup>3</sup>

The auditor appears to be in a legal limbo with regard to whom he owes his contractual and fiduciary duties He is there to exercise his functions for the company members but in an independent manner

It must, however, be remembered here that the contracting parties may differ from the parties involved in the actual professional relationship between client or patient and the professional service provider In some instances there is an intervening third party as, for example, the Health Boards in relation to health care services under the G M S , or the Board of Directors contracting as agents with an auditor for services provided primarily to the members in general meeting of a company

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<sup>2</sup>Cf NOCTON v LORD ASHBURTON [1914-15] All E R 45 and BROWN v I R C [1964] 3 All E R 119

<sup>3</sup>As for a barrister, he cannot contract with a client, but this does not mean that he is exonerated from certain duties and obligations, which derive predominantly from public policy

## 8.2. The Intellectual Basis

8.2.1. The thesis asserts that the "profession" enjoys a high degree of independency and professional autonomy, it being a particular socio-economic grouping in society <sup>4</sup> This has also been identified by a number of writers, including Dahrendorf (1984) Such characterization may be consequential to the idea that the profession is a collective organisation, whereby its independency is set within accepted parameters which are sometimes subject to State regulation <sup>5</sup> The reason for this independency is the interpretation given to the "professional status" of the professional service provider This status implies, according to Dahrendorf, a contract between society and the professions <sup>6</sup> This contract is based on (i) responsibility and (ii) confidence or reliance

By means of accepting the responsibilities inherent to professional performance, professions can maintain their independency Within an organisational structure they are private bodies with public functions Their services, to

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<sup>4</sup>See *supra* Chapter Three In addition, the professional person enjoys individual autonomy It has been demonstrated in Chapter Four that a professional person may deviate from an accepted or standard practice as long as this deviation is within accepted parameters

<sup>5</sup>Professions in England (and Ireland) differ from the professions on the Continent which are directly subject to statutory regulation and State supervision with regard to, for example, education, examination, admission and sanctioning of the violation of professional or ethical conduct, (Dahrendorf, 1984 182)

<sup>6</sup>(1984 179)

meet the demands in society, exceed the immediate relationship with their clients. These demands are said to be served by -

rules and standards which are defined and upheld by the professions themselves. At the same time, their protection and privileges are provided if not as a matter of course then through voluntary agreement.<sup>7</sup>

An example of such privilege is the tenure of the academic professional person. It permits him to exercise his functions in an autonomous and impartial fashion without an obligation to, or under control by, the State.<sup>8</sup> Indeed, Dahrendorf asserts that those privileges must be earned and should not be used in order to protect professional monopoly in an abusive manner. Privileges cannot be unlimited, and the 'other side of the protection is responsibility'.<sup>9</sup> The privilege of tenure and protection must be earned. Only then can one vindicate these privileges.

The second foundation on which the implied contract is based is confidence or reliance. The reliance on professional expertise by individual clients is the reflection of the confidence in the professions by society.

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<sup>7</sup>*Ibid* , at 179

<sup>8</sup>However, it has been argued by some (Veblen, 1957) that this supervision has shifted to serve commercial goals. Academic research is directed through sponsoring and other financial incentives.

<sup>9</sup>Dahrendorf (1984: 180)

in general The value of the implied contract will be curtailed if this wider confidence is frustrated

This confidence is settled within the professions themselves, for example, in their codes of conduct More importantly, it is judged as to how the professional person is engaged in society in matters where his professional skill is not directly a concern In other words, professionals may have opinions on matters that concern society These opinions are developed from their respective professional backgrounds The question, however, is do or should they have an opinion as a professional person? If so, this will undermine their independence because, according to Dahrendorf, questions of a topical political nature are not questions 'to which professionals have a privileged answer Indeed they abuse their privileges and protection if they pretend to have such an answer' <sup>10</sup> They should express their opinion as a citizen, not as a professional This distinction may be artificial, 'but crucial' <sup>11</sup>

Thus, the professional relationship between the service provider and the public is based on some sort of implied (social) contract The obligations on the part of the professional person encapsulate, on the one hand, the responsibility of performance and, on the other hand, the reliance or confidence by the public or society at large in the nature of the profession

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<sup>10</sup>*Ibid* , at 183

<sup>11</sup>*Ibid*



8.2.2. But, how can the professional relationship be described between the service provider and the individual client or patient? Is this characterized as purely contractual, governed by the law of contract or is there something more to it? The assertion that there is something as an implied contract with society, suggests that the duties of a professional person go beyond that of the particular obligations he is asked to perform by his client or patient. If so, the relationship is fiduciary, implying obligations which are not or cannot necessarily be incorporated within a contractual arrangement.

This is asserted throughout the thesis and can be illustrated with the duty question. Apart from redefined, specific duties based on the performance of specific tasks, the professional practitioner is subjected to an "over-arching" duty of care. This duty is based on the altruistic nature of the profession, as well as the practical implication that most professions, unlike a shopkeeper,<sup>12</sup> cannot guarantee their product. The professional person cannot warrant a particular result. The law does not demand this either.<sup>13</sup>

The duties arising from contract consist of executing specific and pre-determined services and the payment of a specific and reasonable fee. These obligations are agreed

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<sup>12</sup>See, for example, sections 13, 14 and 15 of the Sale of Goods Act, 1979 (England)

<sup>13</sup>Cf GREAVES & CO v BAYNHAM MEIKLE & PARTNERS [1975] 1 W L R 1095 at 1100, per Lord Denning

solely between the two parties and may be negotiated upon <sup>14</sup> But the nature of a profession brings along two overarching duties which are not necessarily implied in a contract between a professional person and his client <sup>15</sup>

The first of these duties is that the service shall be exercised with reasonable care and skill <sup>16</sup> In *GREAVES & CO v BAYNHAM MEIKLE & PARTNERS* [1975] 1 W L R 1095 Lord Denning stated that '[t]he law does not usually imply a warranty that [a professional person] will achieve the desired result, but only a term that he will use reasonable care and skill' <sup>17</sup> This general duty can be interpreted in two ways First, it regards the dimension of the duty (its contents) and second, it regards the range or scope of the duty - to whom is it owed?

Subsequently, professional persons are required to possess a certain minimum of competence This follows from, on the one hand, the requirement to use reasonable skill and, on the other hand, the characteristics of a profession, notably a body of esoteric knowledge, restricted entry, education and examination Hence, it is

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<sup>14</sup>However, contractual arrangements for medical services provided under the G M S contract or V H I Scheme are made between the health care provider and the relevant Health Board or the V H I Board respectively, not with the addressee of the services

<sup>15</sup>The two duties are not exhaustive, other terms may be implied but depend on the nature of the supplied service

<sup>16</sup>See section 39(b) of the Supply of Goods and Services Act, 1982 (England) 'he will supply the service with due skill, care and diligence'

<sup>17</sup>[1975] 1 W L R 1095 at 1100

the professional person's duty to keep up to date with relevant developments in his field of expertise, for example, reading the mainstream literature, attend seminars and visit study groups <sup>18 19</sup>

The two overarching duties form the basis for more specific duties inherent in each profession. These distinctive duties are normally not specifically circumscribed in the contractual agreement but flow from, or are inherent to, the facts of each individual case.

The duty to exercise reasonable care and skill is an implied term within the (contractual) relationship between a professional person and client and does not necessarily derive from the professional status of the service provider. It is imposed on him through, for example, statutes,<sup>20</sup> codes of conduct or other external factors.

One of these factors is public policy. This derives from the fact that professional persons not only owe a duty to the individual client but also to the society at large. In some cases, the courts are privileged to overrule professional discretion and impose rules, irrespective of

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<sup>18</sup>Cf CRAWFORD v BOARD OF GOVERNORS OF CHARING CROSS HOSPITAL, *The Times*, 8 December 1953. See also MAYNARD v WEST MIDLANDS REGIONAL HEALTH AUTHORITY [1985] 1 All E R 635 and ROE v MINISTRY OF HEALTH AND OTHERS [1954] 2 All E R 131.

<sup>19</sup>According to Jackson & Powell (1992: 6), this degree of care and competence depends on the type of professions and the reasonable expectations of the client.

<sup>20</sup>See, for example, the Medical Practitioners Act, 1978 and the Supply of Goods and Services Act, 1980.

professional opinion <sup>21</sup> Other factors which may be mentioned here are elements of legal, moral and ethical principles which have an overriding application and cannot be exonerated

Thus, the doctor's specific duties relate to diagnosis, treatment and advice. A number of cases show that the duty to take reasonable care "over-arches" all the incidences of the doctor-patient relationship and includes, as sub-sets of the main relationship, the subsidiary duties such as the duty to diagnose, the duty to treat and the duty to inform. This position was exemplified in the examination of the decision in DANIELS v HESKIN [1954] I R 73. The facts of this case have been set out in detail in Chapter Four and are here summarized. The plaintiff in DANIELS sued her doctor for damages for negligence. It was alleged by the plaintiff's counsel that the doctor was negligent and unskilful in three ways

(I) He was negligent in permitting and causing a needle to break at the time he was stitching the perineum of the plaintiff

(II) He was negligent in permitting the broken needle to be left in the body for a considerable time and failing to remove it

(III) He was negligent in failing to inform the plaintiff of the existence of the broken needle

The above three submissions relate both to the over-

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<sup>21</sup>See, for example, the decisions in BEST v WELLCOME FOUNDATION LTD [1992] I L R M 609 and RE A WARD OF COURT [1995] 2 I L R M 401

arching and sub-duties of a medical practitioner Submission (11) clearly reflects an overall duty to take care and a specific duty of medical opinion and judgment, submission (1) reflects a specific duty towards treatment, while submission (111) reflects a specific duty towards information

8.2.3. In other professions, many specific duties exist as sub-sets of a general duty of skill and care For example, an architect and other building professionals have the duty that their designs reasonably fit the purpose and if not, they have a duty to correct the design<sup>22</sup> In addition, they are required to exercise the service within a reasonable time,<sup>23</sup> to supervise work, to inform a client on his degree of knowledge,<sup>24</sup> etc

With regard to accountants and auditors Jackson & Powell (1992) identify that many negligence disputes involve the precise scope and nature of the agreed task between accountant or auditor and client<sup>25</sup> In any event, one of his specific duties involves the verification of the

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<sup>22</sup>Cf BRICKFIELD PROPERTIES LTD v NEWTON (1983) 25 Build L R 99

<sup>23</sup>See subsection 14(1) of the Supply of Goods and Services Act, 1982 (England)

<sup>24</sup>Cf RICHARD ROBERTS HOLDINGS LTD v DOUGLAS SMITH STIMSON PARTNERSHIP AND OTHERS [(1988) 46 Build L R 50

<sup>25</sup>(1992 610) See also TRUSTEE OF THE PROPERTY OF APFEL (A BANKRUPT) v ANNAN DEXTER & CO (1926) 70 Acct L R 57 and SMITH v SHEARD (1906) 34 Acct L R 65

'substantial accuracy' of the accounts <sup>26</sup> In addition, an auditor has a number of statutory duties, under which the duty to carry out his task with professional integrity (s 193(6) Companies Act 1990) Other, more specific duties are found in s 202 Companies Act 1990 An example of a fiduciary duty of an auditor or accountant is a duty not to disclose confidences <sup>27</sup>

Solicitors owe specific duties which relate, *inter alia*, to the provision of urgent and relevant information,<sup>28</sup> to carry out adequately relevant searches in, for example, the Companies Registration Office,<sup>29</sup> or to make direct inquiries regarding the validity of a liquor licence <sup>30</sup> These duties have already been addressed in Chapter Six of the thesis

### 8.3. The Medical Practitioner

8.3.1. By way of introduction it is necessary to examine the way in which the explicit terms of the contract between a doctor and patient are laid down In doing so certain distinctions ought to be made First, there is a

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<sup>26</sup>Cf LEEDS ESTATE, BUILDING AND INVESTMENT CO v SHEPHERD (1887) 36 Ch D 787 at 802, *per* Stirling J

<sup>27</sup>Cf FOGG v GAULTER AND BLANE (1960) 110 L J 718

<sup>28</sup>Cf LAKE v BUSBY AND ANOTHER [1949] 2 All E R 964

<sup>29</sup>Cf ROCHE v PEILOW [1985] I R 232

<sup>30</sup>Cf TAYLOR v RYAN (1995) P N L R 47

distinction between (1) general practitioner care and (11) hospital care. Second, one must realize that a medical practitioner may deal with either the public or the private sector. The former is eligible under the schemes provided by the Health Board, i.e. the G M S (General Medical Service). The private sector generally obtains medical care under the Voluntary Health Insurance Scheme (V H I Scheme). However, the relationship between a private patient and a general practitioner is often not insured, and eligibility to payment lies upon the patient himself. In these instances the contracting parties are similar to the parties involved in the provision and reception of medical services.

The primary relationship between the health care provider and patient may be taken to be that made under the contract between the general practitioner and the G M S (general health care for the public sector). It is by virtue of this contract that patients are taken on by the doctor. A similar contractual arrangement, outlining the inter-relational structure between doctors, patients and hospitals is the "Consultant's Contract". It replaced the salary and fee's scheme which existed prior to 1980. The contract was first initiated on proposals made by the Health Boards, the Voluntary Hospitals and the professional medical organisations.<sup>31</sup> Further inter-relational structures are subject to private contracts between doctors

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<sup>31</sup>See "Working Party on a Common Contract and Common Selection Procedure for Consultants", Interim Report (1978), Dublin Department of Health

and (private) hospitals and to the rules laid down under the Voluntary Health Insurance Scheme. In addition, the Patient's Charter sets out certain rights of the patient relying on hospital services. Finally, the Medical Practitioners Act, 1978 provides a procedure as to the practitioner's fitness to practice.

### The General Practitioner

8.3.2. In Ireland, the terms of the contract between the G M S and the general practitioner is not to be found in one document. However, Section 58 of the Health Act, 1970 provides that the Health Boards are obliged to make available general medical services, free of charge, to eligible persons.

The contractual terms are set out in the Schedule to the "Form of Agreement with Registered Medical Practitioner for Provision of Services"<sup>32</sup>. The Agreement itself consists of an undertaking to provide services in accordance with section 58 for a particular Health Board area. It specifies the places at which the doctor will attend and the hours of attendance. It provides that such attendance will not be varied. It permits the deduction of 5% of the capitation payments from gross receipts which are paid into a superannuation fund. This superannuation fund is

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<sup>32</sup>(1995), Dublin Department of Health (hereafter the Agreement). The Agreement followed the agreement which exists between the Minister and the Irish Medical Organisation under section 26 of the Health Act, 1970 (subparagraph 41(1) of the Schedule to the Agreement).



constituted by Deed of Trust

The terms of the contract are subject to alteration every three years, according to the outcome of the review between the existing agreement between the Minister and the Irish Medical Organisation <sup>33</sup>

It was recently asserted in ASSOCIATION OF GENERAL PRACTITIONERS LTD AND OTHERS v MINISTER OF HEALTH [1995] 2 I L R M 481 that the Minister acted illegally and ultra virus by entering into an agreement with the Irish Medical Organisation. It was also claimed that the refusal to consult the Association of General Practitioners, as part of the review procedure, was unfair and contrary to practitioners' legitimate expectations. However, these assertions were not upheld. The Minister had a discretion in how to exercise his function and, according to O'Hanlon J, as an employer he 'has freedom of choice as to whether he will negotiate or consult with any organisation on such matters' <sup>34</sup>

In the Schedule to the Agreement certain terms and conditions are explicitly set out in 41 paragraphs and a schedule for payment rates is provided. Though it is not intended to provide an exhaustive description of this contract, this section discusses the main paragraphs of the Agreement.

The main paragraphs can be divided into at least three

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<sup>33</sup>See subparagraph 41(2) of the Schedule to the Agreement

<sup>34</sup>[1995] 2 I L R M 481 at 482

distinctive groups The first group of paragraphs relate to the eligibility of patients and their acceptance or assignment - who may avail of general public health services<sup>35</sup> The second group consists of the duties of the medical practitioner and his remuneration <sup>36</sup> The third group deals with complaints and identifies the paragraphs which provide conflict resolution procedures <sup>37</sup>

8 3.3. The first group of paragraphs of the Schedule deals with whom the medical practitioner may or must provide medical services to Services are provided to people who are eligible and accepted by the medical practitioner or people who are assigned to him by the relevant Health Board <sup>38</sup>

The assessment of eligibility is set out in sections 45 and 46 of the Health Act, 1970 There are two categories First, adult persons and their dependants who cannot avail of medical services without undue hardship enjoy full eligibility Second, people with limited eligibility

An eligible person is accepted by the practitioner if that person lives within seven miles from the principal centre of practice This condition does not apply if a person lives more than seven miles from the practice and no

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<sup>35</sup>See paragraphs 1-10 of the Agreement

<sup>36</sup>*Ibid* , paragraphs 11-27

<sup>37</sup>*Ibid* , paragraphs 16, 28, 30-41

<sup>38</sup>*Ibid* , paragraph 1

doctor practices within seven miles of his residence or alternative arrangements have been made with the relevant Health Board <sup>39</sup>

A medical practitioner ordinarily accepts patients on his panel. In the event he does not wish to accept a particular patient he must, if so requested, give a reason in confidence for this decision <sup>40</sup>

In two circumstances the Health Board has the power to assign people on a practitioner's panel <sup>41</sup>. These assignments are open for review on request by the medical practitioner after six months of the assignment taking effect. The Health Board shall assign persons if (1) it is satisfied that the eligible person has not been accepted by at least three medical practitioners in the area the person resides, unless there were good reasons to the contrary or (11) the Agreement with a medical practitioner is terminated or suspended. In this event, the Health Board assigns the persons who were on the practitioner's panel to another, with these persons' consent, until the suspension is lifted or another practitioner has succeeded the practitioner whose Agreement has been terminated.

In addition, three other categories of people may avail of the practitioner's medical services: (1) temporary residents with established eligibility,<sup>42</sup> (11) children of

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<sup>39</sup>*Ibid* , paragraph 3

<sup>40</sup>*Ibid* , paragraph 2

<sup>41</sup>*Ibid* , paragraph 4

<sup>42</sup>*Ibid* , paragraph 5

eligible people, not being children under section 63 of the Health Act, 1970,<sup>43</sup> and (111) eligible people who require emergency treatment <sup>44</sup>

At any time the medical practitioner may ask the Health Board to remove a person from his panel, unless that person is assigned to him. The petition must be given in confidence and provided with a reason if so requested <sup>45</sup>

Under the Agreement a medical practitioner must be available for services for a total of 40 hours each week for at least five days. These times must be known to his panel and suitable arrangements must be made in events of urgency <sup>46</sup>

**8.3.4.** The second group of paragraphs entails the duties and rights of the medical practitioner under the Agreement. He is contractually bound to the relevant Health Board to fulfil these terms, but the terms are designed to take into account the interests of his panel. However, whether a breach of these duties constitutes a cause of action for an individual patient on his panel remains to be seen. The duties or obligations relate to, *inter alia*, the practitioner's competence, responsibilities, impartiality to treatment and clinical records.

First and foremost, the Schedule expects the medical

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<sup>43</sup>*Ibid* , subparagraph 1(d)

<sup>44</sup>*Ibid* , paragraph 6

<sup>45</sup>*Ibid* , paragraph 9

<sup>46</sup>*Ibid* , paragraph 10

practitioner 'on behalf of the relevant Health Board', to provide 'proper and necessary treatment of a kind usually undertaken by a general practitioner' <sup>47</sup> He is not required to provide treatment involving the degree of skill or experience normally expected from a specialist

Does this imply that if a medical practitioner fails to provide treatment usually undertaken by him, the relevant Health Board is answerable for this failure to a patient, having regard to the exact meaning of 'on behalf of', or is the medical practitioner responsible for this failure to the patient on his own account?

According to McMahon & Binchy, it is now well established that, since the decision in O'DONOVAN v CORK COUNTY COUNCIL AND OTHERS [1967] I R 173, full time medical staff of hospitals are servants for the purpose of vicarious liability <sup>48</sup> The question is whether general practitioners who have entered into the Agreement with the relevant Health Board can also be regarded as servants of the Health Boards

It appears that the requirements under the Agreement and the Schedule are similar to those under the contract between medical staff and the hospitals

In other instances, a hospital can owe a direct duty of care towards patients In KELLY v THE BOARD OF GOVERNORS OF ST LAURENCE'S HOSPITAL [1988] I R 402 the plaintiff - suffering from epilepsy - was off medication in

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<sup>47</sup>*Ibid* , paragraph 11 (top)

<sup>48</sup>(1990 754-755)

order to undergo tests During his stay in the hospital he fell out of a toilet window and suffered severe injuries The question was whether the hospital was negligent in leaving the patient unattended while going to the toilet It was held to be so in the High Court The defendants appealed

The Supreme Court dismissed the appeal, stating that the evidence was sufficient for the jury to find for the plaintiff Henchy J (in a dissenting judgment) outlined the duty a hospital owes to its patients He stated that -

the duty the defendants owed to the plaintiff was to take reasonable care to avoid permitting him to be exposed to injury which a reasonable person ought to foresee, in this case the duty of a reasonable hospital administration to provide a reasonable nursing service <sup>49</sup>

Thus, the test is the reasonable careful person in the position of the defendants, i e the hospital

Finlay C J refused to treat the case as one of medical negligence The issue was one of 'care and attention which a reasonable careful hospital would have afforded to the plaintiff' <sup>50</sup> The foreseeability of risk from a medical point of view is important but not vital to come to a decision

Thus, there is a distinction between the liability for duties owed by a hospital and a practitioner The former

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<sup>49</sup> [1988] I R 403

<sup>50</sup> [1988] I R 402 at 406, per Henchy J

may be liable if it fails to provide a safe system of hospital services, to provide staff with a proper system in which they can exercise their duties. Where the doctor fails to discharge his duties, such as diagnosis, treatment and advice, the hospital may be vicariously liable.

The Schedule points out that the medical practitioner is required to take full clinical responsibility for the people on his panel who require treatment and all other people who may legitimately avail of his services.<sup>51</sup> Thus, the practitioner is subject to the clinical well-being of his patients, whereby "clinical" means the direct treatment of the ill-health of his patients.

The practitioner must guard against or must take reasonable steps to avoid discrimination or differentiation regarding treatment of public (listed) and private patients.<sup>52</sup> This includes the arrangement of surgery provisions. It implies that the practitioner is obliged to employ a similar standard of care and treatment to public and private patients.<sup>53</sup>

The medical practitioner is required to administer treatment and provide care in a sufficient and economic

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<sup>51</sup>See paragraph 11 of the Agreement. It cannot be said that for all other persons the practitioner does not carry any responsibility. The question is whether he is personally responsible or "on behalf of the relevant Health Board".

<sup>52</sup>See paragraph 11 of the Agreement.

<sup>53</sup>According to Tormey (1992: 379), it is on ethical grounds important that 'the present financial incentives for doctors to preferentially treat private patients should be removed'.

manner having regard to the needs of the patient <sup>54</sup> This duty indicates that the practitioner has a responsibility to the Health Board with regard to the management of health care expenditure, whereby the interests of the patient must be taken into account

He must keep abreast with developments in clinical care relevant to the general practice <sup>55</sup>

He shall reside in his area of practice or within reasonable access to it <sup>56</sup>

In accordance with article 5 of the Health Services Regulations, 1971<sup>57</sup> the Health Board and its officers are required to keep and maintain a confidential register of clinical records of eligible persons. These records cannot be disclosed so as to identify the name of the patient without the written consent of the relevant patient. In order to satisfy the requirements of the Act the medical practitioner is obliged under paragraphs 22 and 23 of the Schedule to the Agreement to keep a register of clinical records of his panel <sup>58</sup>

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<sup>54</sup>See paragraph 11 of the Agreement. With regard to the prescribing and dispensing of drugs, medicines or appliances, the practitioner must also take into account the need for economy, but his primary concern is the interest of the patient. In doing so he shall have regard to the recommendations made jointly by the Minister and the Irish Medical Organisation, see paragraph 18 of the Agreement.

<sup>55</sup>See paragraph 11 of the Agreement.

<sup>56</sup>*Ibid*

<sup>57</sup>S I 105/1971

<sup>58</sup>See also *ARMSTRONG v EASTERN HEALTH BOARD* [1995] P N L R 291



In addition, the practitioner is advised to keep his own records, including, at least, a simple list of names of patients seen each day <sup>59</sup>

Subject to a written consent from the patient, the practitioner provides, on transfer of the patient to another practitioner, the latter with a summary of the patient's medical history and condition <sup>60</sup> The Health Board must notify the patient, on retirement or resignation of a practitioner, the name of the new practitioner The patient must also be notified that if he does not want his clinical records to be transferred to the new practitioner, he should indicate so On the death of the practitioner however, the records are transferred without giving notice of the possibility to oppose against this transferral <sup>61</sup>

The clinical records may be taken into custody by the Director of Community Care and the Medical Officer of Health Records deposited with him may be destroyed by him after a reasonable time <sup>62</sup> It is, however, not clarified what a reasonable time constitutes, does it refer to the records itself or the duration after a patient has ceased to be a member of the practitioner's panel or the duration after the practitioner has ceased to provide medical services under the Agreement?

With respect to these clinical records other questions

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<sup>59</sup>See paragraph 24 of the Agreement

<sup>60</sup>*Ibid* , paragraph 23

<sup>61</sup>*Ibid*

<sup>62</sup>*Ibid*

arise regarding the ownership of and access to these records. It seems that the Health Services Regulations, 1971,<sup>63</sup> by imposing the obligation on the Health Boards to keep clinical records, imply that the records are held by the relevant Health Boards on behalf of the Minister of Health and are prepared or kept by the medical practitioner under the Agreement. However, no reference is made as to whom the records may be examined by other than an authorised person under regulation 5(4) of the Health Services Regulations, 1971. Authorized persons are a registered medical practitioner, the Chief Executive Officer or the Minister. In addition, no reference is made to the possibility of access to clinical records by the patients. Is it possible for a patient to give consent to the disclosure of his clinical records, without having knowledge of its contents?<sup>64</sup>

The remuneration of the general practitioner is dealt with in paragraphs 26 and 27. Payments to him are made in accordance with the scale of fees, allowances and other payments approved or directed by the Minister in accordance with the contract. The rate and frequency of the payments are set out in Appendix A of the Schedule to the Agreement. Under the contract the medical practitioner (or his deputy) is not allowed to demand or accept any other payments.<sup>65</sup>

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<sup>63</sup>S I 105/1971

<sup>64</sup>Under the Patient's Charter the patient has a right to access to his clinical records, subject to "therapeutic privilege" of the doctor.

<sup>65</sup>See paragraph 27 of the Agreement.

The payment system under the General Medical Services contract was subject to debate in *O'CONNOR v GIBLIN AND OTHERS* [1989] I R 583. Under the contract, the general practitioner must keep a register of attendance in order to receive the required remuneration. It was alleged in this case that the plaintiff had an excessive rate of attendance. The matter was investigated and it was decided that there was indeed an excessive rate of attendance. The plaintiff's remuneration was reduced accordingly. The Health Board came to this conclusion by means of a statistical comparison with the average rate of attendance of other practitioners. The plaintiff claimed a declaration that the decision was *ultra vires*.

It was held that the statistical comparison as a single test was not an appropriate standard of judgment. An excessive rate of attendance must be defined as 'a rate of attendance for consultation or treatment which exceeds what is reasonably necessary for the proper discharge of [the practitioner's] contractual obligations'.<sup>66</sup> In deciding on whether the attendance rate was excessive the Health Board was required to investigate the medical and other circumstances of the patients on the practitioner's panel. In not doing so the defendant had failed to address the question and the decision was arbitrary, unreasonable and *ultra vires* its powers.

At all times the general practitioner is allowed to terminate the contract, giving at least three months

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<sup>66</sup>[1989] I R 583 at 589, *per* Lardner J

notice <sup>67</sup> The Health Board may terminate the contract on four instances (i) where the practitioner's name is erased from the register under the Medical Practitioners Act, 1978,<sup>68</sup> (ii) where the Health Board is satisfied that the medical practitioner is suffering from a permanent infirmity of mind or body (against which an appeal lies to the Minister of Health),<sup>69</sup> (iii) the medical practitioner has reached the age of 65, (or 70 years in the case of those entering into contracts on the commencement date of the Agreement under section 58 of the Health Act, 1970),<sup>70</sup> and (iv) if there is a serious breach of the Agreement <sup>71</sup>

The third instance was disputed in GREHAN v NORTH-EASTERN HEALTH BOARD AND OTHERS [1989] I R 422 The plaintiff objected against the new conditions of the Schedule regulating the termination of the service contract between a general practitioner and the relevant Health Board with regard to the new age-limit (65) These conditions were a result of negotiations between the Irish Medical Organisation (I M O ) and the first defendant The plaintiff said that she was not a member of the I M O and therefore claimed that her agreement with the first defendant could not be terminated or altered without her consent The defendant claimed that it could terminate the

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<sup>67</sup>See paragraph 34 of the Agreement

<sup>68</sup>*Ibid* , paragraph 35

<sup>69</sup>*Ibid* , paragraph 37

<sup>70</sup>*Ibid* , paragraph 38

<sup>71</sup>*Ibid* , subparagraph 30(3)

agreement after giving her reasonable notice. Thus, the question was whether the court could imply a term into the contract that entitled the Health Board to terminate the contract after giving reasonable notice. Costello J held in the High Court that the express terms of the Agreement were so clear and unambiguous that the court could not justify an implied term that modified these express terms, in particular the express term that the contract will be terminated on the practitioner reaching the age of seventy. The implied term did not give efficacy to the contract, nor was there any intention to do so, upon construction of the contract.

The Health Board may suspend the contract under paragraph 31, or where an order is made by the High Court under paragraph 35.

**8.3.5.** The third group of paragraphs deals with (1) complaints regarding the non-compliance of any of the terms under the Agreement and (11) conflict resolution procedures with regard to disputes arising out of the operation of the Agreement between the two parties to the contract.

Under paragraph 28 both parties to the Agreement must co-operate with each other to see that the terms of the contract are realized. In the event of a conflict the parties agree to the conflict resolution procedure set out in subparagraph 41(5). It provides that the parties of the Agreement agree to arbitration in the event of a dispute concerning the operation of the Agreement. In such an

event, reference is made to a third party to which both parties agree, or a third party is nominated by the Chairman of the Labour Court in the event of the parties not being in agreement. An example of a conflict which is subject to this procedure concerns matters regarding the use of Health Board premises.<sup>72</sup>

The procedures which are to be followed are set out by the arbitrator and his decision is accepted unless both parties agree that the decision goes outside the terms of the Agreement. On request of one of the parties the Chairman of the Labour Court may decide whether the decision is outside the terms. This decision is binding to the parties. However, this does not waive the right of both parties to have the operation of the contract judicially reviewed. Consequently, the decision, although assumed to be accepted by both parties, carries the nature of a recommendation.<sup>73</sup>

The Chief Medical Officer addresses a complaint if he has reason to believe that the medical practitioner does not comply with the terms set out in the Agreement, or when an individual (living) patient complains with respect to his practitioner within six weeks of the alleged event.<sup>74</sup> The Agreement does not make clear whether a complaint of an

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<sup>72</sup>*Ibid* , paragraph 16 (bottom)

<sup>73</sup>*Ibid*

<sup>74</sup>*Ibid* , paragraph 30. The Chief Executive Officer cannot consider a complaint that relates to an individual patient, without that patient initiating the complaint procedure.

individual patient must relate to the terms set out therein

The Chief Executive Officer may follow three courses of action (i) he may require the medical practitioner to maintain any additional records, (ii) he may refer the matter to the Complaints Officer (who may, after investigation, (a) decide that the complaint is of no substance, (b) issue a warning and/or impose a deduction of payments or (c) he may refer the issue back to the Chief Executive Officer because of the serious nature of the matter complained of) and (iii) the Chief Executive Officer may, in any other case of serious breaches of the contract or by reference of the Complaint Officer, terminate the contract or take other disciplinary action <sup>75</sup>

Prior to this, the Chief Executive Officer communicates the reasons of the complaint to the practitioner and notifies him that he shall consider any representations made by the practitioner within one month of the issue of the notification

Disciplinary action consists of either terminating the contract or suspending the Agreement pending the investigation of the complaint, and the care of the patient or patients involved is in jeopardy. The decision may be appealed by the medical practitioner to the G M S tribunal <sup>76</sup>

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<sup>75</sup>See subparagraphs 30(1), (2) and (3) of the Agreement

<sup>76</sup>*Ibid* , paragraph 33

## The Consultant's Contract

8.3.6 Since 1991 the Consultant's Contract<sup>77</sup> is revised and its content is based on the terms of the common contract (in existence prior to 1991) and the contents of the Interim Report of the Working Party on a Common Contract, 1978<sup>78</sup>. This reported included the recommendations of the Review Body on Higher Remuneration in the Public Sector as well as the outcome of the negotiations with the representative bodies of the medical profession. The Guidelines of *Comhairle na nOspideal* are now part of the Contract Documents in accordance with subsection 41(1)(b)(1) of the Health Act, 1970.

8.3.7. The Contract Documents consist of (1) the Contract for Appointment (the actual contract), (11) the Memorandum of Agreement which explains the terms and conditions of the contract, such as, *inter alia*, the nature and structure of the appointment, the remuneration and the conditions of employment, and (111) Appendices.

The appointment is permanent (with an initial probation period of twelve months for consultants not under an existing contract) and the pensionable age is set at 65. A superannuation fund is provided for, by either the Local Government Scheme or the Voluntary Hospital Superannuation

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<sup>77</sup>"Consultant's Contract Documents" (1991), Dublin Department of Health

<sup>78</sup>Dublin Department of Health



Scheme Where the appointment is under a Health Board, Part II of the Health Act will apply to the appointment <sup>79</sup>

The contract provides for three categories of posts geographical wholetime, existing wholetime and part-time Under a wholetime position the consultant has a commitment of 10-11 fixed and flexible sessions plus 2 non-schedulable sessions per week Consultants are allowed to engage in a private practice, taking into account the conditions set out in the Memorandum of Agreement (subparagraph 5 16) <sup>80</sup> Part-time consultants have scheduled sessions which are proportionate to their commitment

A consultant is defined in clause 5 1 of the Contract for Appointment as -

a registered medical practitioner in hospital practice who, by reason of his training, skill and experience in a designated speciality, is consulted by other registered medical practitioners and undertakes full clinical responsibility for patients in his care, or that aspect on which he has been consulted, without supervision in professional matters by any other person He will be a person of considerable professional capacity and personal integrity

The essence of his work involves the diagnosis, analysis, treatment or description of treatment for his patients He carries ongoing responsibility for them as long as they remain in his care In doing so, he enjoys

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<sup>79</sup>See clause 4 of the Contract for Appointment

<sup>80</sup>*Ibid* , clause 8 2

'clinical independence' <sup>81</sup> This independence is exercised within presumed limits and it derives from the concept of the specific relationship between doctor and patient, whereby the latter trusts the doctor in taking the decisions in the patient's best interests and continues to have full responsibility for their consequences

Regardless of the manner of referral, the doctor-patient relationship is a personal one once a patient and doctor come into contact <sup>82</sup> The limits are said to be set by the patient's consent, the law and professional and ethical standards <sup>83</sup>

Other responsibilities include the management of the consultant's own practice and practice plan as well as the co-operation and participation in the running of the department or unit in which the consultant practices <sup>84</sup>

The consultant has a duty to keep abreast with new developments in his area of expertise. He must, therefore, take the initiative with regard to 'a programme of

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<sup>81</sup>See subparagraph 6 3 2 of the Memorandum of Agreement

<sup>82</sup>In an American case, the plaintiff argued that a professional relationship had been established between her and the doctor who was consulted for advice by the doctor who was actually treating her, based on the principles of a third-party-beneficiary contract. This was rejected by the court stating that to see whether a doctor-patient relationship had been established should, among other things, be based on the consideration 'to what extent the consultative physician had exercised professional judgment', (GILINSKY v INDELICATO, The National Law Journal, 18 August 1995)

<sup>83</sup>See subparagraph 6 3 4 of the Memorandum of Agreement

<sup>84</sup>See clause 6 of the Contract for Appointment

continual medical education relevant to his responsibilities both as practising consultant and as a manager of resources' <sup>85</sup>

Complaints or disputes arising out of the contract are dealt with within the 'normal structures of the employing authority' <sup>86</sup> If resolution proves impossible, the problem shall be referred to a mutually agreed upon third party

#### The Patient's Charter<sup>87</sup>

**8.3.8.** The Charter is designed to put the patient first It emphasizes that, on the one hand, the patient is aware of his rights and, on the other hand, the health services become more aware of patients' needs and desires These rights are not new but have already been recognized and include topics such as access to hospital and out-patient services, information and consent, confidentiality and complaints

Generally the patient has access to hospital services But it is at the discretion of the hospital to determine where and when This discretion is used in the event of unavailability or the cancellation of the recommended

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<sup>85</sup>See subparagraph 4 15 of the Memorandum of Agreement

<sup>86</sup>See clause 8 8 of the Contract for Appointment of Consultant and subparagraph 8 1 of the Memorandum of Agreement

<sup>87</sup>"A Charter of Rights for Hospital Patients" (1995), Dublin Department of Health, p 1 (hereafter the Charter)

medical procedure

The patient has the right to be informed about the nature of the illness, medical procedures and risks, and the name of his consultant. He also has the right to consent to the treatment, the doctor must obtain consent prior to the administration of treatment. In doing so, he must have informed the patient about the nature and consequences of the proposed treatment, in a form of language understandable to the patient.<sup>88</sup>

In the view of this researcher, it must be emphasized that the right to consent must be understood as a right to be informed about the nature and consequences of the treatment. The consent itself is, at least in Ireland, a precondition for treatment. In other words, it is the doctor's duty to obtain consent, it is the patient's right to be informed.

The patient has the right to have access to details of relevant confidential medical records, either directly or by communication through the family doctor, but subject to the doctor's discretion.<sup>89</sup> This seems curious, it is at the discretion of the doctor whether or not the information being disclosed would harm the patient's physical or mental well-being. However, could, as a consequence, the patient's anxiety have been raised even further? Or, is the patient left in doubt or ignorance as to whether information is disclosed, either fully or partially?

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<sup>88</sup>See articles 7 and 8 of the Charter

<sup>89</sup>*Ibid*, article 9

In England this problem was addressed in R v MID GLAMORGAN FAMILY HEALTH SERVICES AUTHORITY AND ANOTHER, EX PARTE MARTIN [1994] 21 B M L R 1 The Court of Appeal held that the patient has a right of access to his medical records, both under common law and statute (subsections 5(1) and (2) of the Access to Medical Records Act, 1990 However, this right is qualified The relevant authority may deny access if it is in the best interest of the patient to do so

#### Professional Misconduct

8.3.9. The Medical Practitioners Act, 1978 provides a procedure with regard to the fitness to practice The conduct of a medical practitioner may under section 45 of the Act be subjected to an inquiry with regard to professional misconduct or fitness to engage in practice by reason of mental or physical disability

If the practitioner is accordingly guilty of professional misconduct or it is proven that he is unfit to practice he may be suspended or struck off from the General Register of Medical Practitioners or from the Register of Medical Specialists <sup>90</sup> The practitioner concerned may apply to the High Court for cancellation of the decision <sup>91</sup> In any event, the Council must itself apply to the High Court

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<sup>90</sup>The Register of Medical Specialists is as of yet not established

<sup>91</sup>See subsection 46(3) of the Medical Practitioners Act, 1978

to have its decision confirmed <sup>92</sup> On the hearing of an application before the High Court, it may regard 'evidence of any person of standing in the medical profession as to what is professional misconduct' <sup>93</sup>

The Guidelines of the Medical Council describe professional misconduct as 'conduct which doctors of experience, competence and good repute consider disgraceful or dishonourable' <sup>94</sup> The doctor's fitness to practice must be examined, taking into account the 'merits of the case' <sup>95</sup>

In England the definition of professional misconduct was recently addressed in *MCCANDLESS v GENERAL MEDICAL COUNCIL* [1996] 1 W L R 167 In this case, a doctor was found guilty of serious professional misconduct by the Professional Conduct Committee of the English General Medical Council The Committee directed to erase the doctor from the register, taking into account the poor standard of medical care provided by the doctor to the three patients, who initially complained

The doctor appealed, alleging that the Committee applied a wrong test to determine serious professional misconduct, it should mean conduct that is morally blameworthy, in line with the pre-Medical Act, 1969

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<sup>92</sup>*Ibid* , subsection 46(4)

<sup>93</sup>*Ibid* , subsection 46(9)

<sup>94</sup>A Guide to Ethical Conduct and Behaviour and to Fitness to Practice" (1994) 4th Edition, Dublin The Medical Council, subparagraph 12 07

<sup>95</sup>*Ibid* , subparagraph 12 08

interpretation

This was rejected. Their Lordships first found that the old authorities did not apply a similar approach. They referred to, for example, the decision in *REX v GENERAL COUNCIL OF MEDICAL EDUCATION AND REGISTRATION OF THE UNITED KINGDOM* [1930] 1 K B 562. In this case an objective standard was used. The conduct was judged 'according to the rules written or unwritten governing the profession'<sup>96</sup>. In *FELIX v GENERAL DENTAL COUNCIL* [1960] A C 704 reference was made whether conduct was based on an honestly held opinion.

Second, their Lordships held that the variation of measures, whereby erasure is the most serious one, indicated to include serious cases of negligence.

Third, the public expectation of professional, including medical, services is higher in relation to those professions which are given a self-regulatory mandate.

Fourth, the authoritative statement is at present objective. Serious professional misconduct, judged by proper professional standards and the circumstances of the case (the objective facts of the individual patient), is conduct that no doctor of reasonable skill exercising reasonable care would carry out and may include serious negligent conduct. This test derived from the decision in *DOUGHTY v GENERAL DENTAL COUNCIL* [1987] A C 164. The meaning of the wording "serious professional misconduct" was authoritatively stated as being objective. The conduct

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<sup>96</sup>[1930] 1 K B 562 at 569, per Scrutton L J

of the practitioner must be -

judged by proper professional standards in the light of the objective facts about the individual patients [ ] the dental treatments criticised as unnessecary [were] treatments that *no dentist of reasonable skill exercising care would carry out*<sup>97</sup>

8.3.10. There is a thin line between practitioners who are guilty of professional misconduct and practitioners who were negligent in the exercise of their practice. However, the two must be distinguished. It cannot be said that professional misconduct automatically leads to negligence and negligent conduct does not automatically entail professional misconduct.

The distinction lies in the fact that professional misconduct may involve a much wider scale of events. In negligence the doctor's conduct is confined to the breach of a duty of care that was owed to the patient. The failure to act in accordance with ethical rules or guidelines may involve some kind of moral blameworthiness and discredit the professional standard, and for that reason the practitioner may be guilty of professional misconduct.

The Irish Medical Practitioners Act, 1978 is unclear what is meant by professional misconduct on the one hand,

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<sup>97</sup>[1987] A C 164 at 173 (italics added). In *GEE v GENERAL MEDICAL COUNCIL* [1987] 2 B M L R 100 at 101 it was held that a course of conduct could amount to serious professional misconduct, 'even though the particular instances making up that course did not'.



and ethical conduct on the other Tomkin (1995) asserts that the Medical Council cannot impose sanctions for alleged ethical misconduct Neither can it issue codes of professional conduct dealing with 'ethical conduct and behaviour' <sup>98</sup> The writer suggests that this is beyond the powers of the Medical Council <sup>99</sup> If so, the decision in RE A WARD OF COURT [1995] 2 I L R M 401 may have two implications First, in following the court order the practitioner is not in breach with the constitutional rights of the patient, but it may render him liable for professional misconduct Second, adhering to the Guidelines, issued by the Medical Council, the practitioner breaches the constitutional rights of the patient <sup>100</sup>

#### 8.4. The Solicitor

8.4.1. The professional relationship as it exists between a solicitor and his client is recognized in equity as a fiduciary relationship It imposes on the solicitor a general duty to take care as well as special obligations This was recognized in, *inter alia*, NOCTON v LORD ASHBURTON [1914-15] All E R 45 and BROWN v I R C [1964]

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<sup>98</sup>See section 69 of the Medical Practitioners Act, 1978

<sup>99</sup>See also Tomkin & Mc Auley (1995a), *supra* Subparagraph 2 6 7

<sup>100</sup>The decision in RE A WARD OF COURT [1995] 2 I L R M 401 is examined in detail in Chapter 10

Generally the solicitor must act in good faith, must disclose fully and honestly all facts within his knowledge to his client and maintain his confidentiality to third parties. A conflict of duties is no excuse to discharge himself from that duty.<sup>101</sup> Finally, it is said that the solicitor provides a disinterested service.<sup>102</sup>

**8 4.2.** The practising solicitor in Ireland is governed by the statutory regulations of the Solicitors Act, 1994.<sup>103</sup> He is also subjected to the ethical and professional guidelines issued by the Law Society of Ireland,<sup>104</sup><sup>105</sup> and other European and international associations.<sup>106</sup>

The obligations under which a solicitor performs his functions are based on contract - the retainer, and are

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<sup>101</sup>Cf *GOODY v BARING* [1956] 2 All E R 11, approving *MOODY v COX & HATT* [1917] 2 Ch 71

<sup>102</sup>See Horne (1988 10)

<sup>103</sup>The Solicitors Act, 1994 replaces to a large extent the previous Solicitors Acts of 1954 and 1960. However, certain sections of the previous Acts remain relevant, for example section 7 of the Solicitors Act, 1954

<sup>104</sup>See "A Guide to Professional Conduct of Solicitors in Ireland" (1988), Dublin: The Incorporated Law Society of Ireland (hereafter the Guide)

<sup>105</sup>Since 1994 the Law Society has altered its name under section 4 of the Solicitors Act 1994 from the "Incorporated Law Society of Ireland" into the "Law Society of Ireland"

<sup>106</sup>See, for example, the "International Code of Conduct" (1986), Washington: International Bar Association and the "Code of Conduct for Lawyers in the European Community" (1988), Strasbourg: European Bar Association

either express or implied obligations. It is a contract whereby, 'in return for the offer of a client to employ him, a solicitor, expressly or by implication, undertakes to fulfil certain obligations'<sup>107</sup> The express obligations are set specifically in the retainer and must be considered in the light of the actual contract.

As in England, it can be argued that in Ireland the solicitor is subject to the terms set out in Part IV of the Sale of Goods and Supply of Services Act, 1980. The implied terms deal with, *inter alia*, the use and possession of reasonable skill in the performance of the service provider's duties (section 39(a) and (b) of the 1980 Act).

The purpose of the Solicitors Act, 1994 is to provide a better protection to clients of solicitors. It includes (i) a new complaints procedure,<sup>108</sup> (ii) powers by the Law Society to intervene in the solicitor's practice, (iii) new supervisory functions of the High Court (Part III of the 1994 Act), (iv) financial protection of clients (Part IV of the 1994 Act) and (v) regulations for qualification and admission (Part V of the 1994 Act) and registration (Part VI of the 1994 Act).

There are three types of complaints procedures, each involving a number of stages.

First, under section 8 of the Solicitors Act, 1994,

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<sup>107</sup>See paragraph 1.8 of the Guide.

<sup>108</sup>At present, the complaints procedure is being reviewed by the Law Society. It has pledged to act on a recommendation to protect future clients of solicitors who have had a number of complaints made about them, see Anon (1996).

the Law Society has the power to investigate a complaint from a solicitor's client alleging that the solicitor's services were inadequate and were not of a quality that could reasonably be expected of a solicitor. The aim is to solve the matter by agreement. The Law Society has in section 9 of the Solicitors Act, 1994 the power to sanction those solicitors who charge excessive fees. Again, the matter is attempted to be solved by agreement between the parties involved. On both occasions the solicitor can be summoned by the Society to produce documents which are relevant for the complaint.<sup>109</sup>

Second, the Law Society is required to maintain and fund a scheme for the examination and investigation of written complaints by an independent adjudicator.<sup>110</sup>

Third, the President of the High Court may under section 16 of the 1994 Act appoint from time to time (the members of) the Disciplinary Tribunal. This Tribunal is empowered to initiate an inquiry into the conduct of a solicitor on the grounds of alleged misconduct as described under section 7 of the Solicitors Act, 1960. On conclusion of the inquiry two courses of action are open. The first course of action empowers the Tribunal to report to the High Court, which on its turn may, *inter alia*, strike the solicitor off the roll or suspend him.<sup>111</sup> The second course of action empowers the Tribunal to (1) advise and admonish

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<sup>109</sup>See section 10 of the Solicitors Act, 1994

<sup>110</sup>*Ibid*, section 15

<sup>111</sup>*Ibid*, subsection (18)(1)(a)

or censure the solicitor, or (11) direct the solicitor to (a) pay a sum to the Compensation Fund, (b) pay (part of) the costs of the Society or any person appearing before them or (c) pay a sum as restitution to any aggrieved party <sup>112</sup>

The solicitor as well as the Society has a right to appeal the decision of the Tribunal to the High Court

The financial protection of the solicitors' clients is guaranteed under Part IV of the Solicitors Act, 1994. The Society is empowered to make such regulations with regard to the provision of indemnity against losses arising from civil liability claims against a solicitor

**8.4.3.** The Guide to Professional Conduct of Solicitors in Ireland provides a description of guidelines with regard to professional and ethical conduct of the solicitor in his practice. Although it is not as specific as its English equivalent,<sup>113</sup> it governs the fundamental aspects of the solicitor's practice, such as his professional relationship with his clients, the courts, third parties, colleagues and counsel, remuneration and confidentiality

The foreword to the Guide explains that it must be used as a reference as to what is proper in the particular situation. It is a practical set of rules and conditions, based on common sense. It is a guide to enhance

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<sup>112</sup>*Ibid*, subsection 17(9)

<sup>113</sup>See "Guide to Professional Conduct of Solicitors" (1993) 3rd Edition, London: The Law Society of England and Wales

professional conduct which 'is largely a matter of self-discipline' <sup>114</sup>

It is beyond the scope of this section to examine the Guide on its merits, but some basic assumptions can be put forward <sup>115</sup>

The solicitor is said to stand in a fiduciary relationship with his client. It is based on the retainer of contract and the solicitor is required to use 'his utmost skill and care' <sup>116</sup>. The standard is that of a reasonable competent solicitor. The relationship is governed by both law and principles of practice. Where a conflict of interest arises between two clients for which the solicitor acts, he must cease to act for both of them <sup>117</sup>

Contrary to most other professions he owes certain other duties to other parties. As an officer of the court he owes certain duties to the court. These duties are encapsulated in the idea of a due administration of justice. Most importantly, he must not keep back relevant information within his knowledge and must not mislead the

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<sup>114</sup>See p v of the Guide

<sup>115</sup>The literature has set out the changing role of codes of ethics in the United States. By some commentators it is suggested that proof of ethical misconduct may be admissible in a negligence action, see *supra* Subparagraph 2 6 12

<sup>116</sup>See subparagraph 1 9 of the Guide

<sup>117</sup>The solicitor has a duty to inform his client if there is a conflict of interest between him and his client, see, for example, the decision in *HALIFAX MORTGAGE SERVICE LTD v STRYSKY* [1995] 3 W L R 701

court by stating untrue facts <sup>118</sup>

In his relationship to counsel it is the solicitor's duty to properly instruct counsel and provide him with all the necessary information relevant to the case. The reason for a correct communication is that 'counsel can only be as effective as the instructions he receives allow' <sup>119</sup>

Finally, with regard to confidentiality and the disclosure of information the solicitor cannot be compelled to disclose information passed between him and his (potential) client. This privilege exists only where there is a professional basis for the exercise of the solicitor's functions <sup>120</sup>

**8 4.4.** One question which remained unanswered thus far regards the lack of willingness of solicitors and their clients to contract on all matters, i.e. the rights and duties which are over-arching or relate to the specific services provided by the solicitor. Is this notion due to the desire to sue, in the event of damages, in tort rather than for breach of contract or is it simply impossible to contract on all terms?

The desire to sue in tort is contrary to a legal doctrine that asserted that the solicitor-client relationship rested entirely on the contractual agreement

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<sup>118</sup>See subparagraph 4.1 of the Guide

<sup>119</sup>*Ibid*, paragraph 8.2. It has already been explained in the thesis that a solicitor is not vicariously liable for his counsel, see *supra*, Paragraph 6.3

<sup>120</sup>See subparagraphs 3.1 and 3.2 of the Guide

between the two parties <sup>121</sup> In *DEIGNAN v GREENE*, Supreme Court, Unreported, 21 October 1954, O'Dálaigh J stated -

It may indeed be that the categories of negligence are never closed, but it does not necessarily follow that all the rejected claims of other branches of the law can there find sanctuary [ ] I much doubt if refuge can be found for claims which must flee the inconvenience of the doctrine of consideration <sup>122</sup>

However, in *FINLAY v MURTAGH* [1979] I R 249 this topic was readdressed In this case the Supreme Court granted a right to sue a solicitor in tort The importance of this case lay in the following two questions

(I) In what circumstances can a tortious right of an action in negligence be realized?

(II) Is this right restricted to the party who entered into a contract with the solicitor or can this be extended to non-contractual parties?

In *FINLAY v MURTAGH* the plaintiff claimed damages for the alleged negligence of the defendant Acting as the plaintiff's solicitor the defendant failed to institute an action on behalf of his client against a third party within the permitted period, as stated in the Statute of Limitations, 1957 The plaintiff served notice of the trial of the action by a judge and jury to the defendant The defendant contended that the action should be tried by a

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<sup>121</sup>See McMahon & Binchy (1990 275-276)

<sup>122</sup>Supreme Court, Unreported, 21 October 1954, *per* O'Dálaigh J, at p 6 of his judgment



judge alone. However, the High Court dismissed an application by the defendant for an order, setting aside the plaintiff's notice of trial. The defendants appealed.

The defendant's counsel held that -

where loss is sustained which is attributable to the negligent performance of a contractual obligation, an action in tort does not lie in respect of that loss [ ] The relationship of solicitor and client is a contractual one <sup>123</sup>

Furthermore, they argued that the decision in HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD [1964] A C 465 would not apply to the negligent performance of a contractual obligation. In HEDLEY BYRNE it was decided that where a person relied on the skill and judgment of a professional person, a tortious duty of care must be implied if that party represented himself as having that special skill or judgment. In FINLAY v MURTAGH, however, the defendant's counsel argued that the defendant's failure did not embody a failure to exercise a special skill, but a failure to act (to institute an action within the limited period). This failure constituted a breach of a contractual obligation <sup>124</sup>. The plaintiff, on the other hand, sought to widen the "neighbour" principle, so as to blur the distinction between liability in tort and breach of contract.

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<sup>123</sup>[1979] I R 249 at 252

<sup>124</sup>It can be suggested that, in this situation, the solicitor limited his liability in contract alone.

Henchy J held in the Supreme Court that -

the conclusion that an action by a client against a solicitor for damages for breach of his professional duty of care is necessarily and exclusively one in contract is incompatible with modern developments in the law of torts and should be overruled <sup>125</sup>

On consideration of the authorities mentioned in a number of English and Irish cases<sup>126</sup>, Henchy J came to three conclusions, and answered the above two questions <sup>127</sup>

First, the learned judge was satisfied that -

the general duty of care created by the relationship of solicitor and client entitles the client to sue in negligence if he has suffered damage because of the solicitor's failure to show due professional care and skill

Second, he added that -

the client [notwithstanding] could sue alternatively in contract for breach of the implied term in the contract of retainer that the solicitor will act with the matter in hand with due professional care and skill

He concluded that -

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<sup>125</sup>*Ibid*, at 255

<sup>126</sup>HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD [1964] A C 465, SOMERS v ERSKINE [1943] I R 348, MIDLAND BANK v HETT STUBBS & KEMP [1979] Ch 384, BATTY v METROPOLITAN PROPERTY REALISATIONS LTD [1978] Q B 554, PHOTO PRODUCTION LTD v SECURICOR LTD [1978] 1 W L R 856

<sup>127</sup>[1979] I R 249 at 257

[t]he solicitor's liability in tort under the general duty of care extends not only to a claim for reward, but to any person for whom the solicitor undertakes to act occasionally without reward, and also to those [ ] with whom he has made no arrangement to act but who, as he knows or ought to know, will be relying on his professional care and skill <sup>128</sup>

However, there is one exception to this rule. Henchy J stated that a client does not have a tortious right to sue when the solicitor's default arises 'from a breach of a particular and special term of the contract in respect of which the solicitor would not be liable if the contract had not contained such term' <sup>129</sup>

Examples of those terms are to issue proceedings within a specified time not regulated by statute, to close a sale on a particular date and so on and so forth. This exception may be justified with the argument, derived from HEDLEY BYRNE and argued by the defendants, that when a solicitor is in breach of such a particular and special term, his client did not rely on the skill and judgment of the solicitor.

It can be argued, according to this researcher, that such a breach in itself constitutes a breach of the general duty to take care. Hence, a reason for an action to sue in tort of negligence could be established. This line of thought may be justified with the argument put forward by Kenny J in FINLAY that -

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<sup>128</sup>For a discussion regarding the liability towards third parties, see *infra* Chapter Nine

<sup>129</sup>[1979] I R 249 at 257

[t]he professional person, however, owes the client a general duty, which does not arise from contract but from the "proximity" principle to exercise reasonable care and skill in the performance of the work entrusted to him. This duty arises from the obligation which springs from the situation that he knew or ought to have known that his failure to exercise care and skill would probably cause loss and damage. This failure to have or to exercise reasonable skill and care is tortious or delictual in origin.<sup>130</sup>

In other words, a breach of a specific term of the contract could be regarded as a breach of a general duty to exercise reasonable care and skill because that breach could cause loss or damage, which a solicitor knew or ought to have foreseen.

The case showed that there was a tortious right to sue a professional person, over and above the right to sue *ex contractu*. A professional person can be held negligent by his client who suffered damage or loss and relied on the professional person's skill and judgment. This derived from the general duty to take reasonable care.

**8.4.5.** It is significant that where an Irish court is faced, in a context such as this, with the choice of deciding an action in either contract or tort, that it places such reliance on the tort remedy.

Realist jurisprudence might seek to interpret such reliance as a decision to eschew the limiting features of the award of contract damages as opposed to calculating damages on the more generous scale awarded in tort. Others

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<sup>130</sup>*Ibid*, at 264

might point to the historical point that all tort cases were heard with a jury, until 1988,<sup>131</sup> and that contract cases were determined by a judge alone

But it is at least worth considering a deeper point. Public policy elements are also present. The way in which tort has evolved as a body of remedies appropriate to an evolving society, in which political and social change and an altered sociology re-define the nature of the society in which litigation takes place. This is the particular facility of tort law, to act as a "mirror" of societal change. It has been noted both by Heuston & Buckley (1992) and McMahon & Binchy (1990) and by hundreds of other commentators also.

The question remains why professional persons do not seek to contract on all the implied terms and duties with their clients? This seems not feasible. Most implied duties depend on and are consequences *ex post* the particular facts of the case and can, in most cases, only be anticipated after the event. In addition, there is more to it than a contract *pur sang*. To speak of a contract between, for example, a doctor and patient or solicitor and client is perfectly correct - legally speaking. But the incidence of the doctor-patient relationship or the solicitor-client relationship both extend beyond what is normally thought of as a contract (in some cases, is there a contract at all?). The word "covenant" is sometimes used. This term seems to

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<sup>131</sup>See Courts Act, 1988 (The right to a jury trial in the lower courts was abolished in the Courts Act, 1971, under section 6)

reflect the on-going, fiduciary and extra-financial relationship more accurately

It is for this reason that it can be argued that the courts are willing to apply the more generous measures of damages available in tort to situations involving the default of professional people. It may even reflect the judicial attitudes about the more complex relationship which subsists between a client and his professional adviser. However, the nature of this relationship is not "static". In some cases the normal incidence of contract may prevail. *Henchy J* was prepared to allow a professional person to limit his liability in tort where this seemed appropriate.

Thus, it is asserted that where a professional person can only be held liable for specific contractual terms, and no tortious right is admitted, his professional status is insignificant to the imposition of liability. This, of course, means that it is necessary to look again at the concept of the "relationship" between a professional person and his client or patient. Certainly, elements of contract are contained within the general relationship, and may (through limiting or excluding liability by means of exoneration clauses) modify the rules of the relationship. But where one refers to the defining factor as a "covenant" or "relationship", one must accept that, as between a doctor and patient or a solicitor and client, there is something other than the negotiation of pure commercial relations of overt mutually agreed terms, which is endemic

to the professional element, provided by the solicitor or doctor or any other person considered a professional

#### 8.5. The Accountant Acting as Auditor

8.5.1. The auditor's duties derive from either statute (the Companies Act 1963-1990) or the common law. He has a professional relationship with two parties: (1) the Board of Directors, from whom he obtains instructions and upon whom he relies with respect to the accounts and (11) the company in general meeting, it being his contracting party *in iure*, its members rely on his expertise. In doing so, the members are able to exercise effective control of the company's mainstream (financial) policy. Under certain circumstances, the auditor may owe a duty in tort to outsiders who he believed relied on his expertise in relation to the company's accounts. However, under *CAPARO INDUSTRIES PLC v DICKMAN* [1990] 1 All E R 568, his liability was, at least in England and under the criteria of the case, restricted to the members in general meeting.<sup>132</sup>

The auditor's function is two-fold. He is (1) to see that proper books are kept and (11) to examine whether those books give a true and fair view of the state of affairs of the company. Consequently, the auditor owes the

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<sup>132</sup>For a full review on third-party liability, see *infra*, Chapter Nine

greatest duty to the members of the company, who have the power to appoint<sup>133</sup> or remove<sup>134</sup> him and to fix his remuneration<sup>135</sup>

However, the auditor is obliged to be independent in the exercise of his duties. This requires further analysis

**8.5.2.** The company enters, through its agents (the directors), into a contract with the auditor. It governs the relationship between them, and the rights and obligations arising from it are restricted to these two parties. It includes details such as his appointment, remuneration, duration of office, and the duties and rights of the auditor as statutorily provided in the Companies Acts 1963 - 1990

The auditor is normally regarded as an officer of the company<sup>136</sup>. Consequently he may be held liable under any statutory provision of the Companies Acts 1963 - 1990, directed specifically to "officers"<sup>137</sup>. But, in relation to the exercise of his duties he may be regarded as an agent of the company<sup>138</sup>. As a consequence, it can be asserted

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<sup>133</sup>See subsection 160(1) of the Companies Act, 1963

<sup>134</sup>*Ibid*, subsection 160(5), as amended by section 183 of the Companies Act, 1990

<sup>135</sup>See subsection 160(8) of the Companies Act, 1963

<sup>136</sup>Cf RE SHACTER [1960] 1 All E R 61

<sup>137</sup>See Courtney (1995 560)

<sup>138</sup>Cf RE TRANSPLANTERS (HOLDING CO) LTD [1958] 2 All E R 711. See also Keane (1991 361)



that his duties are of a fiduciary nature <sup>139</sup>

He may be contractually liable to the company for breach of his statutory duties or other contractual arrangements, resulting in loss to the company. In tort he may be held liable for breach of his duty of care <sup>140</sup>

His rights are explained in section 193 of the Companies Act, 1990. First and foremost the auditor has the right to access of all the relevant information. He is empowered to require from all officers and employees of the company to give such information and explanation with regard to what the auditor thinks proper for the exercise of his function. He is entitled to attend the general meetings and to be questioned regarding all aspects of the company's business which are of his concern.

His statutory duties are four-fold. First, he has a duty to exercise his functions with 'professional integrity' <sup>141</sup>. The 1990 Act does not contemplate any further on what this provision necessitates. It is suggested here that there is a link with professional and ethical misconduct, whereby guidelines or regulations, such as provided by the Institute of Chartered Accountants, provide the auditor with an indication of how to exercise his functions in a professional manner. He must exercise

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<sup>139</sup>Another question is, whether statements or acts made by the auditor in the exercise of his duties and relied upon by outsiders are binding to the company.

<sup>140</sup>Cf *CANDLER v CRANE CHRISTMAS & CO* [1951] All E R 426 and *CAPARO INDUSTRIES PLC v DICKMAN* [1990] 1 All E R 568.

<sup>141</sup>See subsection 193(6) of the Companies Act, 1990.

this duty with due regard to all other statutory and common law duties

Further more, he is required to notify the Registrar and the company if the company fails to keep proper books in accordance with section 202 of the Companies Act 1990,<sup>142</sup> to make a report to the members,<sup>143</sup> and to disclose directors' emoluments where they do not appear in the accounts <sup>144</sup> These statutory duties are specific duties for which the auditor may be held liable under the statutes as an officer of the company <sup>145</sup>

Under common law his duties can be synopsized as a duty to exercise reasonable care and skill in the performance of his function, he has a duty not to breach his statutory duties, for which he can be held liable in tort <sup>146</sup> Again, it is shown here that the auditor's specific duties are sub-sets to the "over-arching" duty to take reasonable care

The standard of care is that in comparison to his peers Hanna J , in LEECH v STOKES [1937] I R 787, stated that an auditor is 'to exercise such skill and care as a diligent, skilled and cautious auditor would exercise

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<sup>142</sup>*Ibid* , section 194

<sup>143</sup>*Ibid* , subsection 193(1)

<sup>144</sup>*Ibid* , subsection 191(8)

<sup>145</sup>Cf RE SHACTER [1960] 1 All E R 61

<sup>146</sup>See Courtney (1995 562)

according to the practice of his profession' <sup>147</sup>

An indication as to what involves an accepted or approved practice, in the meaning of the discussed model of professional negligence,<sup>148</sup> can be found in the decision in LLOYD CHEYHAM & CO LTD v LITTLEJOHN & CO [1987] B C L C 303. In this case it was said that compliance with the so-called "accounting principles"<sup>149</sup> is strong evidence that the books of accounts give, in accordance with section 202 of the Companies Act, 1990, a true and fair view. Consequently, this may mean that adherence to this accepted and standard practice shows that an auditor has conformed to the required standard of care. However, adherence is not 'conclusive' evidence <sup>150</sup>. There is room for departure within accepted parameters, although the members of the accountancy bodies are required to follow the prescribed practice <sup>151</sup>.

In FOMENTO (STERLING AREA) LTD v SELSDON FOUNDATION CO [1958] 1 All E R 1. Lord Denning concluded that an auditor is not required to search for irregularities <sup>152</sup>.

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<sup>147</sup> [1937] I R 787 at 789. See also IRISH WOOLLEN CO LTD v TYSON (1900) 26 Acct L R 13.

<sup>148</sup> See *supra*, Chapter Four.

<sup>149</sup> These principles are laid down by the Accounting Standards Committee of the Consultative Committee of Accounting Bodies of the U K and Ireland, in the Statements of Standard Accounting Practice (S S A P 's) and by the independent Accounting Standards Board in the Financial Reporting Standards (F R S 's).

<sup>150</sup> [1987] B C L C 303 at 313, *per* Woolf J.

<sup>151</sup> See Courtney (1995 497).

<sup>152</sup> [1958] 1 All E R 1 at 11.

All that is required is that, when he comes across irregularities, he deals with them. He is 'a watchdog, not a bloodhound' <sup>153</sup>

8.5.3. Persons who are qualified to be appointed as an auditor are, among others, those who are members of the Ministerial recognized bodies, such as in Ireland the Institute of Chartered Accountants in Ireland and the Institute of Certified Public Accountants in Ireland <sup>154</sup>

The Minister must, in order to be able to recognize these bodies, be satisfied that certain standards have been met <sup>155</sup>. The Minister may require from these bodies a code of professional and ethical conduct, which may be subjected to regulations providing for the monitoring of compliance with the code <sup>156</sup>. The Registrar of Companies is required to keep a register of persons who are qualified to be appointed as an auditor <sup>157</sup>

The ethical code of conduct provided by the Institute of Chartered Accountants in Ireland <sup>158</sup> contains a detailed description of guidelines in respect to the various aspects of the auditor's function. It is not exhaustive and it is

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<sup>153</sup> *Ibid*, per Lord Denning

<sup>154</sup> See sections 191 and 192 of the Companies Act, 1990

<sup>155</sup> *Ibid*, section 191

<sup>156</sup> *Ibid*, subsection 192(4)

<sup>157</sup> *Ibid*, section 198

<sup>158</sup> "Ethical Guide for Members" (1995), Dublin. The Institute of Chartered Accountants in Ireland (hereafter the Ethical Guide)

recommended that the auditor should also be guided by the spirit of the Guide <sup>159</sup> It is beyond the scope of this section to discuss its contents in full The discussion is restricted to some fundamental principles and other aspects relevant in the context of this Chapter

The auditor is required to behave with integrity, which includes not only honesty but also fair dealing and truthfulness <sup>160</sup> He is regarded to strive for objectivity, which is said to be a 'state of mind' <sup>161</sup> This objectivity is protected and demonstrated by maintaining his independency from outside influences which could undermine his objective judgment with regard to the accounts of the company

The auditor must be competent to do the work he is asked to do If not, he must reject the work or must obtain such advice and assistance necessary to perform the work competently <sup>162</sup>

The auditor must exercise his work with 'due skill, care, diligence and expedition' <sup>163</sup> He is expected to have regard to the professional and technical standards of the profession This implies that he must keep up to date with developments and adhere to the practice laid down by the professional body of accountancy

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<sup>159</sup> *Ibid* , at 1

<sup>160</sup> *Ibid* , at 4

<sup>161</sup> *Ibid*

<sup>162</sup> *Ibid*

<sup>163</sup> *Ibid*

An auditor has the duty to disclose a relationship to any relevant party if that relationship threatens his objectivity in relation to the relevant party <sup>164</sup>

The auditor has to regard the confidentiality of information which he obtained in the course of the exercise of his functions <sup>165</sup> This information can only be disclosed where consent has been obtained or if disclosure derives from a legal right or duty He must guard against using information for his advantage or for the advantage of third parties

8.5.4. As of yet the accountancy profession has not been subject to statutory intervention, apart from the provisions in the Companies Acts in relation to auditors At the same time, the regulatory bodies in Ireland do not have a controlling mechanism with sanctioning powers such as the Review Panel in England This Panel is presumed to form a counterbalance against the influence of the directors in respect to the audited accounts In doing so the Review Panel aims at the preservation of the independency of the auditor with respect to his relationship with the Board of Directors

This independency is subject to certain pre-conditions <sup>166</sup> Among them are the conditions that the auditor should avoid undue dependence on the client,

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<sup>164</sup>*Ibid* , at 5

<sup>165</sup>*Ibid* , at 45

<sup>166</sup>*Ibid* , at 5 ff

pressure from third parties, beneficial interests in the client company, loans from or to the client company and acceptance of goods, hospitality or services from the client company. The Companies Act, 1990 defines in subsection 187(2) persons who are disqualified from being appointed as a company auditor.

The relationship between the auditor and the directors is ambiguous in the sense that the terms of the relationship are not clear with respect to the auditor's function of independent verification. Being an auditor, his task is to check whether the books are kept properly and whether they give a fair and true view of the state of affairs of the company. In doing so, the auditor must rely on information provided by or requested from the officers of the company, notably the members of the Board of Directors. This reason makes it essential that the relationship with directors is properly drafted, consisting of collaboration and shared responsibility.<sup>167</sup>

It has been recognized that complete independency cannot be possible.<sup>168</sup> The independent position of auditors is often jeopardized, due to the insurmountability that certain preconditions cannot be properly safeguarded against. On the one hand, the auditor depends on the directors and officers of a company. On the other hand, the auditor's opinion is devalued if it was not reached on an

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<sup>167</sup>See also "Guide to Boardroom Practice No 2, The Board and the Auditors" (1983), London. The Institute of Directors.

<sup>168</sup>See Auditing Practices Board (1995: 122).

objective basis. Subsequently, according to the Auditing Practices Board,<sup>169</sup> in the event of a company's failure to produce proper books, the public outcry is directed to the auditors, were they truly objective or not?<sup>170</sup>

One of the reasons that created this situation is the fact that auditors 'find themselves on a "half-built bridge" between directors and shareholders'<sup>171</sup> In other words, the auditor is in some sort of legal limbo. He owes his responsibility towards the members in general meeting, but he cannot discharge this responsibility sufficiently without the co-operation of and shared responsibility with the Board of Directors and other officers. One step forward to enhance the public perception of objectivity and independency of auditors is, according to the same Board, a critical examination of 'the process of accepting an appointment or resigning'<sup>172</sup>

In the event of a failure, the auditor, as well as the directors, can be held liable in negligence. A peculiar aspect of this is that the assessment of the alleged negligent conduct for the same losses depends on the nature and function of the tortfeasor. The auditor, as a professional individual, must have deviated from some sort of accepted practice. The director, on the other hand, is

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<sup>169</sup>*Ibid*

<sup>170</sup>See also Percival (1991), *supra* Subparagraph 2.6.13 and Savage (1983), *supra* Subparagraph 2.6.14

<sup>171</sup>*Ibid*

<sup>172</sup>*Ibid*



liable if he had failed to 'take reasonable care in circumstances where the director was under a duty to take care' <sup>173</sup> He is required to show skill and diligence but this duty is assessed without particularly referring to directors as a distinctive group in society (his peers) or the nature of the company's activities, but to a person of his knowledge and experience <sup>174</sup> In this sense the duty may involve a higher standard where the director is an accountant <sup>175</sup>

Another, even more peculiar aspect, is that a director can discharge his responsibilities and escape liability if he can justify that he could leave the performance of certain duties up to other officers of the company, 'where such duties may properly be left to such an official having regard to the provisions of the articles and the exigencies of the business' <sup>176</sup> Thus, where a director has delegated certain duties or tasks, it seems that he has delegated his responsibility with regard to the proper performance of such duties or tasks as well. It remains to be seen whether

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<sup>173</sup>See Keane (1991 312)

<sup>174</sup>Cf RE CITY EQUITABLE FIRE INSURANCE CO LTD [1925] 1 Ch 407, per Romer J

<sup>175</sup>In a recent case in Australia, DANIELS v ANDERSON (1995) 16 A C L R 607, the New South Wales Court of Appeal addressed, among other things, the standard of care of directors. It raised the standard to a level much closer to the standard that is popularly expected from directors. Directors and non-executive directors are not accessories. They are expected to have a certain degree of skill and competence independent of their respective abilities. See also Nolan (1996 91) and Passmore (1995 131-132)

<sup>176</sup>Keane (1991 312) See also RE CITY EQUITABLE FIRE INSURANCE CO LTD [1925] Ch 407

the words of Lord Halsbury L C in DOVEY v CORY [1901] A C 477 are still applicable He stated that '[t]he business of life could not go on if people could not trust those who are put into a position of trust for the express purpose of attending to details of management' <sup>177</sup>

#### 8.6. Conclusion

The doctor-patient relationship may be regarded as the cornerstone example of the nature of the professional relationship It is fiduciarily characterized and includes a degree of expertise, responsibility and reliance, without any pre-arranged result but to exercise the powers in the best interest of the patient This affords to the medical practitioner a great degree of discretion with regard to the exercise of his duties The patient has only a few rights to protect his position as both subject and object of the relationship Generally he has no input into the shape and outcome of the relationship

That a doctor enjoys individual autonomy and independence within the doctor-patient relationship was recently emphasized by the Court of Appeal in England in RE R (A MINOR) [1991] 4 All E R 177 Lord Donaldson M R stated that the decision to treat is dependent upon the doctor's own professional judgment and he cannot be required by the court or anyone else to treat others

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<sup>177</sup> [1901] A C 477 at 486

The fundamental aspects of the relationship appear to be directed to the practitioner, either as a specialist or a general practitioner. The patient has not much input in the relationship. His only predominant right is that he is entitled to treatment. In addition, he has some ancillary qualified rights, such as the right to be informed and the right to have access to his medical records <sup>178</sup>

Thus, although the patient has a right to treatment, it is at the discretion of the doctor to administer treatment to him, or to take him, under the G M S , on board his panel. Once a relationship is constituted, the practitioner is subject to certain duties and obligations. He is required to possess a certain degree of competence and skill, to keep up to date with relevant developments in his area of expertise and he has to keep confidential and proper medical records. At all times he takes full clinical responsibility for his patients. This must be understood in the light of individual professional autonomy, whereby the doctor is entitled to deviate from a normal practice within accepted parameters.

The relationship between the solicitor and his client is not as clear-cut as the relationship between a medical

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<sup>178</sup>However, there are indicators that suggests a greater awareness of patients' rights. In other areas consumer organisations protect consumer interests. The newly set up Irish Patients Organisation proposes to protect and enhance the rights of hospital patients. It emphasizes the problems that exist in medical health care in Ireland, for example, communication problems between doctor and patient, and aims at co-operation with medical health care organisations to improve the quality and safety of the services provided, see Dempsey (1996)

practitioner and his patient. This can be attributed to the fact that a solicitor exercises his functions autonomously and independently from certain governing bodies, such as in medicine the Health Boards or Public and Voluntary Hospitals. This means that a well-defined and omnipresent structure is absent.

In each case the contractual and unique duties are specified in the contract of retainer. In addition, particularly under common law and equity, the solicitor has duties that apply to his professional conduct and over-arch his contractual obligations.

The position of an accountant as an auditor is predominantly determined by his asserted role as an independent control mechanism with regard to the financial affairs of the company. This means that his professional relationship with his client - the company - does not exist by virtue of the need of professional services by the company, as it exists in, for example, the relationship of a solicitor and his client or the medical practitioner and his patient.<sup>179</sup> The relationship is required by virtue of statutory regulations, i.e. subsection 160(1) of the Companies Act, 1963. Those regulations are enacted for the benefit of the company. However, according to this researcher, the regulations also benefit the public as a means to exercise effective control over an artificial and law-made entity. The purpose of accountancy has been

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<sup>179</sup>A company can avail of the normal services of an accountant or employ an accountant to keep the books of accounts.

shifted from a predominantly internal affair to an external and public concern to avoid disappointment and to protect against unbridled business adventures those who have taken the financial risks, for example, shareholders, investors or creditors

## Chapter 9

### Tort Development Third-Party Liability and Immunity

#### 9.1. Introduction

Lord Reid stated in HEDLEY BYRNE & CO LTD v HELLER & PARTNERS [1963] 2 All E R 575 that '[h]ow wide the sphere of the duty of care in negligence is to be laid depends ultimately on the court's assessment of the demands of society for the protection from the carelessness of others'<sup>1</sup>

This is particularly relevant in professional negligence, at least in the absence of an underlying relationship, hence, the title of this Chapter. It immediately becomes apparent that the Chapter deals with the general negligence issues proximity, foreseeability and policy as a basis for the imposition of a duty of care. But, to say that third-party liability is confined to the context of professional negligence is an assertion that must be rejected. Negligence, as an independent tort, is about third parties. This is, of course, illustrated with the "mile-stone" decision in DONOGHUE v STEVENSON [1932]

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<sup>1</sup>[1963] 2 All E R 575 at 615

All E R 1 Where it differs, in the context of professional negligence, is that the third party has suffered loss as a consequences of an already existing relationship between the professional person and another, for example, a company, a testator, etc This aspect created the need for a different assessment of the professional person's duties At the same time, however, the case law on the tort of negligence developed general principles

This Chapter looks at the historical development of the tort of negligence and discusses its underlying aspects The question refers to what the reasons are to assert the existence of a duty of care and to impose liability This demands a discussion of the important cases in this area, starting with the decision in DONOGHUE v STEVENSON [1932] All E R 1 However, the development that lead to the decision in DONOGHUE is also relevant and illuminates the philosophical, socio-political and economical changes in Western society

In DONOGHUE, Lord Macmillan recognized that the categories of liability are never closed <sup>2</sup> However, the law of tort of negligence operates as a legal mechanism to limit liability The courts set the limits with regard to the existence of a duty of care and its extent The limits are not static They change from time to time as life itself changes, and it can be argued that they reflect the political climate or the socio-economic reality we live in

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<sup>2</sup>[1932] A C 562 at 619

It appears that at each stage the courts are looking for a justification to impose liability or to relieve the tortfeasor from his compensation obligations. This is particularly illustrated with regard to some specific duties of, on the one hand, auditors and, on the other hand, solicitors. The assertion of a duty of care appears to depend on the construction of the plaintiff's expectation and the purpose of the specific duty that has been violated. Liability is imposed as a matter of policy. It seems that, at least in England, a solicitor who fails to perform adequately must pay up, while an auditor who negligently prepares the accounts of a company gets away with his negligent conduct, why?

This Chapter deals with the following issues

First, it looks at the development of negligence as an independent tort and the emergence of the duty concept. This involves an examination of the existing literature represented by scholars such as Pollock (1916), Winfield (1926), Holdsworth (1957), Baker (1990) and Kretzmer (1994).

Second, it reviews the modern negligence cases. This review is divided into three stages, starting with the decision in *DONOGHUE v STEVENSON* [1932] All E R 1, followed by the decision in *ANNS v MERTON LONDON BOROUGH COUNCIL* [1978] A C 728 and ends with the decision in *CAPARO INDUSTRIES PLC v DICKMAN* [1990] 1 All E R 568.

Third, it illustrates the justification to impose or assert a duty of care, or to deny the existence of a duty.



of care of an auditor and a solicitor <sup>3</sup>

Finally, the Chapter briefly discusses the policy argument of a barrister's immunity for court work. This privilege has recently been subjected to criticism.

## 9.2. The Origins of the Tort of Negligence and the Duty of Care

9.2.1. In any tort, it is alleged that a "wrong" has been committed against the plaintiff. Therefore this "wrong" appears to form the paramount element in the law of tort <sup>4</sup>. This wrong precedes some form of damage and results in a conflict between the plaintiff and tortfeasor, and, subsequently, asks for a resolution in court. A cause of action is based on, *inter alia*, the infringement of the plaintiff's rights, personal mental or physical integrity, or the plaintiff's property.

Apart from tortious wrongs there are other wrongs which a defendant may be answerable for in law: criminal, contractual or restitutional wrongs. Tort, however, distinguishes itself from those types of wrongs by

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<sup>3</sup>Arguably, the medical practitioner can owe duties to third parties as well. This is particularly relevant with regard to, for example, a duty to warn third parties about dangerous psychiatric patients. This area of third-party liability was developed in America. It is briefly discussed in the literature review where it ties in with requisite standard of care, see *supra* Subparagraph 2.2.12.

<sup>4</sup>In fact, "tort" is a Norman word (White, 1980: x1). It was commonly used in the English language, meaning literally "twisted" or "wrong" (Keeton, et al., 1984: 1).

emphasizing the need for compensation <sup>5</sup> When there is an allegation of a tortious wrong, the defendant is liable because his conduct resulted in loss to another for which the law shall redress with damages Thus, tort is a wrong due to a breach of a legal duty which the defendant owed to the plaintiff and this wrong demands pecuniary compensation

This is preeminent in tort liability and requires closer examination The law of tort (or torts)<sup>6</sup> is concerned with the allocation of losses arising from our activities in daily life It arises when there is a conflict between, on the one hand, the interest in protection or safety and, on the other hand, the interest in freedom of action (or in some cases inaction) The law of tort, by imposing legal duties, imposes liability in those cases where the need to compensate supersedes the freedom of action of the tortfeasor Its task is to do this exemplary and justifiably It has 'to differentiate between the various kinds of interests for which individuals may

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<sup>5</sup>Criminal law carries an important element of punishment, a form of compensation to society as a whole In contract law, duties and obligations of either parties are primarily made between the parties themselves and a duty imposed by contract does not necessarily have to be imposed by law Restitution deals with the reimbursement of unintentional and unjustified benefits

<sup>6</sup>The answers in each case - whether there is a law of tort or laws of torts - do not exclude each other, according to Glanville Williams (1939) In his view, tort is 'either (1) a concrete wrongful act or (2) a species of wrong coming within the generic conception of tort', (*supra*, at 115)

claim protection against injury by others' <sup>7</sup>

How does the tort law impose legal duties? Two views are prevalent. The first view, expressed by, *inter alia*, Salmond sees the law of torts as consisting of 'a number of specific rules prohibiting certain kinds of harmful activity, and leaving all the residue outside the sphere of legal responsibility' <sup>8</sup> Others, like Winfield,<sup>9</sup> support the view that the law of tort consists of a general principle that causing harm is wrongful, unless there is some ground for justification or excuse. This view accepts new torts in the 'virtue of the principle that unjustifiable harm is tortious' <sup>10</sup> The former denies the possibility of the emergence of a new tort.

However, according to Glanville Williams,<sup>11</sup> the two views deal with the same problem: can torts be expanded and if so, how? The two views merely disclose that there are some general rules for creating liability (protection and safety) as there are for exempting liability (freedom of action). In other words, in what circumstances does the law of tort impose legal duties upon the alleged tortfeasor?

9.2.2 Negligence is long since considered an independent tort and is nowadays the dominant cause of

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<sup>7</sup>Fleming (1992 4)

<sup>8</sup>Heuston & Buckley (1992 17-18)

<sup>9</sup>Rogers (1989 4)

<sup>10</sup>*Ibid* , at 14

<sup>11</sup>(1939 131)

action for accidental injury <sup>12</sup>

As an independent tort it can be placed between intentional torts, for example, trespass, and those torts upon which strict liability is imposed, i.e. products liability and the rule in *RYLANDS v FLETCHER* <sup>13</sup> It has been described by many, including the well-known and often cited description by Alderson B. In *BLYTH v BIRMINGHAM WATERWORKS CO* [1856] 11 Exch 781 he stated that -

[n]egligence 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 <sup>14</sup>

This approach determines liability by assessing the conduct of the defendant, rather than focusing on the kind of harm done to the plaintiff, and recognizes negligence as an independent tort <sup>15</sup> At this point it can be asserted that liability in negligence deals with the legal duties which are imposed on the tortfeasor and he is liable if his conduct is of such nature that he violates these duties

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<sup>12</sup>Keeton, et al (1984 160)

<sup>13</sup>(1868) L R 3 H L 330

<sup>14</sup>[1856] 11 Exch 781 at 784

<sup>15</sup>In addition, negligence is understood as a method of commission to commit other torts, i.e. nuisance or trespass (if, for example, negligent conduct causes direct physical harm) In this sense, negligence means carelessness and must be distinguished from other degrees of wrongful conduct such as inadvertence, recklessness or intent (Heuston & Buckley, 1992 199-200)

This was not always the case, according to Holdsworth (1957) In medieval times it was believed that a man acted at his own peril Liability was founded on a primitive basis The theory contained that -

[a] man is liable for all the harm which he has inflicted upon another by his acts, if what he has done comes within some one of the forms of action provided by law, whether that harm has been inflicted intentionally, negligently or accidentally <sup>16</sup>

The main argument was the causation between loss and the defendant's conduct The latter had only a few defences Holdsworth mentions <sup>17</sup> (i) the conduct was permitted by law - it served the public interest or the defendant's conduct was a necessary defence of his own personal rights or property, (ii) the conduct was the plaintiff's and (iii) the conduct was unavoidable by reason of an "act of God"

It follows from this theory that in all other cases the defendant's liability depended on a causal connection between his conduct and the loss suffered by the plaintiff This notion of causation reflected 'the primitive concepts of responsibility' <sup>18</sup> The idea that the defendant had a legal obligation to take care with regard to his conduct and that a breach of this obligation could lead to

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<sup>16</sup>Holdsworth (1957 446)

<sup>17</sup>*Ibid*

<sup>18</sup>Kretzmer (1994 46)

liability was not yet proclaimed. The theory excluded immediate references to negligence as a cause for liability.

This theory survived for a long period. However, at the close of the nineteenth century it was replaced by what is now known as the individual tort of negligence. Three developments precluded this. First, the emergence of new torts based on some sort of wrongful intent. Second, the development of the (modern) doctrine of employers' liability. Third, and foremost in the context of this Chapter, the courts began to base an action for liability, not on the defendant's conduct *per se*, but on his negligent conduct. One of the reasons for this new approach was that the old causation theory stifled enterprise.<sup>19</sup> The new principle favoured the interest of freedom of action and 'relieved enterprises of some of the costs of their activities'.<sup>20</sup> This became particularly apparent with regard to damage caused by industrial machinery, for example, accidents involving railway trains.<sup>21 22</sup>

According to Holdsworth, negligence was latently present in the medieval theory because it appeared that 'a man was only liable for the damage which [was] the

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<sup>19</sup>See also *supra* Subparagraph 2 7 2

<sup>20</sup>Kretzmer (1994 47)

<sup>21</sup>Winfield (1926 195)

<sup>22</sup>It can also be argued, according to this researcher, that society became aware of the recognition of individual rights and the proclamation of the democratic principles.

proximate consequence of his act' <sup>23</sup> This appeared to be of special importance in cases where the connection between the act and the loss was not so obvious. It gradually familiarized the courts with the genesis of and empathy for the concept of negligence. They became accustomed to contemplate upon the concept of proximate cause in cases where the crux of the action on the case was damage <sup>24</sup> Consequently, the courts began to apply an objective standard and negligence became analogous to the existence of a duty not to harm the plaintiff. This standard was adopted to find out whether there was a sufficient proximate consequence of the defendant's acts, having regard to what 'an ordinary prudent man would have foreseen' <sup>25</sup>

The underlying duty - as correlative to negligence - was first recognized in cases where it arose out of some proprietary relationship, contract or quasi-contract. In most cases this involved people who professed a 'common calling', such as inn-keepers, carriers, artificers, surgeons and attorneys <sup>26</sup> It was held, according to Baker, that -

a person who embarked upon a requested service which brought him into contact with the person or

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<sup>23</sup>(1957 449)

<sup>24</sup>The concept of foreseeability, as we use now, is relatively modern (Holdsworth, 1957 449)

<sup>25</sup>Holdsworth (1957 450)

<sup>26</sup>Baker (1990 460)

property of another was liable if he performed the service with want of care or skill and damage resulted <sup>27</sup>

Thus, the underlying aspect of negligence was the presence of an undertaking. There already had to be some sort of relationship between the defendant and the plaintiff before damage occurred.

But why not an action in breach of contract? Baker argued that the obligation which arose out of the undertaking was only to do the work the defendant was asked to do <sup>28</sup>. And, according to Pollock, the duty to take care reached further than a contract, whereby in tort 'the primary question of liability may itself depend [ ] on the nearness or remoteness of the harm complained of' <sup>29</sup>. The harm resulted from want of care and this care was imposed by law <sup>30</sup>.

Thus, in the context of an already existing relationship between defendant and plaintiff, based on a common calling, negligence became the cause of action. In this sense the departure of the causation principle limited the liability of those persons, liability was based on a breach of an over-arching duty of care which was owed by

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<sup>27</sup> *Ibid*

<sup>28</sup> *Ibid*

<sup>29</sup> (1916 30)

<sup>30</sup> The overlap between tort and contract still exists today with regard to men 'whose duties to be careful arise both by reason of their physical nexus with the plaintiff or his property and by reason of their dealings with them', (Baker, 1990 461)



the defendant to the plaintiff. For some defendants this limitation was based, according to Holdsworth, 'on matters of public policy'<sup>31</sup>

In the absence of an underlying relationship, liability was still ruled by the medieval causation principle. Normally an action was brought in, for example, trespass *vi et armis*. Here the conduct was either negligent or otherwise and caused damage to the plaintiff. The act or conduct in trespass was deemed unlawful and liability was imposed, even if the damage was accidentally brought about. In *LAMBERT v BESSEY* (1681) Th Raym 421 it was held that 'in all civil acts the law doth not so much regard the intent of the actor, as the loss and damage of the party suffering'<sup>32</sup>. This restatement of the medieval principle was again approved in *RYLANDS v FLETCHER* (1868) L R 3 H L 341.

However, a number of other cases were seen as more lenient and restricted the application of the medieval principle in a number of ways. The reason for this lenience was the fact that the damage did not flow directly from a violent act (normally trespass). Therefore, the act was not necessarily unlawful, but the need for compensation remained.

In *MITCHELL v ALLESTREE* (1676) B & M 572 (a running down case) the act was not unlawful but liability needed to be imposed. Therefore, a duty to take care was imposed upon

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<sup>31</sup>(1957 452)

<sup>32</sup>(1681) Th Raym 421 at 422-423

the defendant The horse had no abnormally vicious characteristics and the master and servant (the defendants) had tried everything they reasonably could do to avoid an accident The essence of the action, therefore, lay in the wrong of bringing a horse into a square 'improvidently, rashly, and without due consideration of the unsuitability of the place' <sup>33</sup> The idea was applied that -

common law liability for negligence was so extended as to make one liable, in action on the case, for damage flowing from the negligent performance of his own projects and undertakings, unconnected with the duty arising from statute, public calling, bailment, or prescription <sup>34</sup>

In MASON v KEELING (1700) 1 Ld Raym 606 the principle was stated that a man was 'answerable for all mischief proceeding from his neglect or his actions, unless they were of unavoidable necessity' <sup>35</sup> According to Baker, this opened up a new category which could also include 'the kinds of negligence cases which had formerly been actionable as trespass' <sup>36</sup> This became even more apparent in WILLIAMS v HOLLAND (1833) 10 Bing 112 It dealt with the directness of the wrong in trespass It was now held that the plaintiff could have an election Apart from trespass, he could also sue in case whenever the injury he

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<sup>33</sup>(1676) B & M 572

<sup>34</sup>Holdsworth (1957 453)

<sup>35</sup>(1700) 1 Ld Raym 606 at 607

<sup>36</sup>(1990 466)

suffered was not direct and wilful. As a result, trespass became more and more associated with wilful injuries, such as battery and assault.

Finally, in *STANLEY v POWELL* [1891] 1 Q B 86, it was eventually dismissed that a man could be liable for purely accidental trespass.

9 2 3. This short historical overview shows a modification of the civil responsibilities of persons towards their neighbours. First, causation imposed liability, later this principle was replaced by the imposition of a duty of care upon the defendant. Causation became one of the elements in the tort of negligence, to be proved by the plaintiff. This modification first became paramount where the damage flowed from want of care in an already existing relationship between plaintiff and defendant. Eventually a duty arose in situations where damage occurred in relation to the individual conduct of the tortfeasor and the damage became the cause of the relationship between plaintiff and defendant.

But when does - in those situations - the defendant owe a duty to the plaintiff? This has been subject of debate, ever since the decision in *DONOGHUE v STEVENSON* [1932] A C 562. This case forms the basic assumption for the existence of a duty of care in the tort of negligence. It dealt with the expansion or limitation of liability, based on foreseeability and proximity, not just causation. The case itself was an expansion of the duty of care a

manufacturer was held liable in negligence for injury to the ultimate consumer

### 9.3. Modern Tort Development Foreseeability, Proximity and Public Policy

9.3.1. Thus, the duty of care acts as a limitation device This has been recognized by many <sup>37</sup> Negligence, as an independent tort, is a type of conduct A cause of action, however, depends on more than just negligent conduct There must be a duty that is owed by the defendant to the plaintiff This duty must conform to a required standard In addition, there must be a legal or proximate cause and actual loss or damage to the interest of the plaintiff to whom this duty is owed

According to Rogers (1989), the existence of a duty serves two functions First, the duty must actually exist and it must be owed to a specific person in specific circumstances Second, it must have been breached Thus, negligence is, according to Rogers, 'the breach of a legal duty to take care which results in damage, undesired by the defendant,<sup>38</sup> to the plaintiff'<sup>39</sup>

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<sup>37</sup>See Fleming (1992) In addition to the duty of care, there are three other limitation devices remoteness of damage, contributory negligence and a voluntary assumption of risk (*supra*, at 102) See also Rogers (1989)

<sup>38</sup>And, of course, generally undesired by the plaintiff

<sup>39</sup>(1989 72) However, one must understand that the defendant will find his conduct undesirable *ex post* In

The duty of care is used by the courts to limit 'the range of liability within what they consider reasonable bounds' <sup>40</sup> Alternatively, the courts can expand this range. A duty in this sense is defined as 'an obligation recognized by law, to avoid conduct fraught with unreasonable risk of danger to others' <sup>41</sup>

The discussion on the nature of the duty of care can be divided in three stages, each related to the legal development of the tort of negligence. The basis for it was laid down in the early decades of this century by Lord Atkin in *DONOGHUE v STEVENSON* [1932] A C 562.

9.3.2. The principle of law, laid down by Lord Atkin, dealt with the expansion and limitation of liability based on (1) foreseeability and (11) proximity. The learned judge generalized the nature of the duty of care as follows -

The rule that you love your neighbour becomes in law you must not injure your neighbour, and the lawyer's question, who is my neighbour? receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can

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most cases the defendant might not be aware that his conduct, which he thought as reasonable, could cause damage in the light of the circumstances of the case. It can be asserted that the defendant realized after the event that he has breached a specific duty which is of such a nature that he breached his "overarching" duty to take reasonable care.

<sup>40</sup>McMahon & Binchy (1990 88)

<sup>41</sup>(Fleming, 1992 125) Another definition perceives a duty as 'the existence of a legally recognized obligation requiring the defendant to conform to a certain standard of behaviour for the protection of others against unreasonable risks', (McMahon & Binchy, 1990 85)

reasonably foresee would be liable to injure your neighbour Who then, in law, is my neighbour? The answer seems to be - persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question <sup>42</sup>

This general principle - the "neighbour" principle - consists of two paramount elements or conditions for the existence and extent of the duty of care First, the reasonable foreseeability of damage from acts or omissions Second, the closeness and directness between defendant and plaintiff proximity Thus, a duty is imposed if the defendant could reasonably foresee that his acts or omissions could cause injury and if he could reasonably foresee that the specific plaintiff could be affected by his acts or omissions because of the degree of proximity, created by the act or omission of the defendant

The principle combines two elements (i) the condition for the existence of a duty and (ii) to whom it is owed (the extent of the duty) The condition of reasonable foreseeability is the determinant for the imposition of the duty

In addition to foreseeability and proximity, public policy too became a determinant and a basis to reject the imposition of a duty of care but only in exceptional cases This opened up endless categories of negligence unless 'there was some other and secondary policy demanding a

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<sup>42</sup>[1932] A C 562 at 580

total or partial immunity from suit' <sup>43</sup>

In HOME OFFICE v DORSET YACHT CO LTD [1970] A C 1004, Lord Reid suggested that the time had come to regard the neighbour principle as applicable in all cases where there was no justification or valid explanation for its exclusion. This line of thought was followed and clearly demonstrated in ANNS v MERTON LONDON BOROUGH COUNCIL [1978] A C 728. In this case Lord Wilberforce developed his two-step formula, giving way to a radical application of the principle and the function of public policy. It was aimed at the tension between principle and policy. He stated -

First one has to ask whether, as between the alleged wrongdoer and the person who has suffered damage, there is a sufficient relationship of proximity or neighbourhood such that, in the reasonable contemplation of the former, carelessness on his part may be likely to cause damage to the latter, in which case a prima facie duty arises. Secondly, if the first question is answered affirmatively, it is necessary to consider whether there are considerations which ought to negative, or to reduce or limit the scope of, the duty or the class of person to whom it is owed or the damages to which a breach of it may rise <sup>44</sup>

This two-step formula gained recognition for some time and gave rise to an enormous extension of the duty of care. This culminated in the decision in JUNIOR BOOKS LTD v VEITCHI CO LTD [1983] 1 A C 520. In this case liability

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<sup>43</sup>Heuston & Buckley (1992 205)

<sup>44</sup>[1978] A C 728 at 751

was imposed for pure economic loss as a result of non-dangerous defects. The decision in JUNIOR BOOKS was regarded as more than a mere linguistic interpretation of the neighbour principle. It was even suggested that the first step equated the duty of care with the foreseeability of damage.<sup>45</sup> It was seen as a mandate for an extensive application of liability for all foreseeable harm, unless opposed by 'a specifically defined, preemptory legal policy'.<sup>46</sup>

Many opposed the extensive interpretation of ANNS. They refused to accept the *prima facie* identification of a duty of care with foreseeability. The neighbour principle could not be represented by foreseeability of harm alone which 'would only exceptionally yield to a specific opposing "policy"'.<sup>47</sup>

As time passed, the courts narrowed down the unrestricted application of the ANNS test. In YUEN KUN YEU v ATTORNEY GENERAL OF HONG KONG [1988] A C 175, it was held that 'foreseeability of harm is a necessary ingredient of a [proximate] relationship, but it is not the only one'.<sup>48</sup> The present law includes other factors, otherwise, according to Rogers, 'there would be liability in negligence on the part of one who sues another about to

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<sup>45</sup>McMahon & Binchy (1990 92)

<sup>46</sup>Fleming (1992 137)

<sup>47</sup>*Ibid*, at 138

<sup>48</sup>[1988] A C 175 at 192. See also GOVERNORS OF THE PEABODY DONATION FUND v SIR LINDSAY PARKINSON & CO LTD [1985] A C 210



walk over a cliff with his head in the air, and forbears to shout a warning' <sup>49</sup> What was wrong with ANNS was its application. It involved the danger that if the first stage was easily passed, the limiting device of the second step was insufficiently working, thus risking the unreasonable extension of the boundaries of liability. As a result, 'the creation of a duty [was] likely to involve a much more gradual, step by step process with greater emphasis on analogy with previous decisions' <sup>50</sup>

This was recognized in *CAPARO INDUSTRIES PLC v DICKMAN* [1990] 1 All E R 568 and *MURPHY v BRENTWOOD DISTRICT COUNCIL* [1990] 2 All E R 908. Both cases rejected the ANNS test in favour of an incremental approach. Lord Bridge stated, relying and quoting the words of Brennan J in *SUTHERLAND SHIRE COUNCIL v HEYMAN* [1985] 60 A L R 1 -

It is preferable in my view, that the law should develop novel categories of negligence incrementally and by analogy with established categories, rather than by a massive extension of a prima facie duty of care restrained only by indefinable "considerations which ought to negative, or to reduce or limit the scope of the duty or the class of person to whom it is owed" <sup>51</sup>

Thus, the English courts are guided by existing situations that imposed, restricted or limited (the scope of) a duty of care. The three criteria to impose a duty of

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<sup>49</sup>(1989 79)

<sup>50</sup>*Ibid* , at 80

<sup>51</sup>[1990] 1 All E R 568 at 574

negligence are, subsequently, the foreseeability of damage, the proximity of the relationship and the 'reasonableness or otherwise of imposing a duty' <sup>52</sup>

It is true that in many cases the proximity element appears to equate foreseeability <sup>53</sup> However, the two elements are not similar There is more to proximity than just foreseeability The former contains the elements that binds the two parties, and induces certain responsibilities Proximity limits the category of people to whom a tortfeasor would owe a duty if he solely had to depend on foreseeability It could therefore be argued that a tortfeasor is not liable towards the "unforeseeable plaintiff", not because the conduct of the defendant could not be foreseen to cause the loss to the plaintiff but rather the absence of a sufficient proximate relationship *per se* <sup>54</sup> Negligence does not embrace one definable concept It is merely, according to Lord Oliver in *CAPARO*, 'a description of circumstances from which, pragmatically, the courts conclude that a duty of care exists' <sup>55</sup>

The idea of "just and reasonable" is more often used to deny the imposition of liability in the tort of negligence, because, for example, another defendant or the

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<sup>52</sup>*Ibid* , at 568

<sup>53</sup>See, for example, the decision in *ALCOCK v CHIEF CONSTABLE OF SOUTH YORKSHIRE POLICE* [1991] 3 W L R 1057

<sup>54</sup>Or, liability cannot be imposed because of the impossibility to assess the amount of damages in absence of a reference point An example of this can be found in the so-called "wrongful life" actions, see *Stolker* (1994)

<sup>55</sup>[1990] 2 A C 605 at 633

plaintiff is pictured as the person more suitable to bare the loss, or an alternative remedy exists with which the tort of negligence may conflict. It is, of course, a policy argument but<sup>f</sup> is portrayed as principled by means of its application.

9.3 3. In Ireland, the "neighbour" principle has been endorsed in cases such as *PURTILL v ATHLONE U D C* [1968] I R 55 and *MACNAMARA v E B S* [1975] I R 1. In both cases the proximity element was strongly emphasized as 'the lynchpin of the duty of care'<sup>56</sup>. However, McCarthy J, in *WARD v MCMASTER AND OTHERS* [1988] I R 337, did not attenuate the words of Lord Wilberforce in *ANNS v MERTON LONDON BOROUGH COUNCIL* [1978] A C 728.

In the *WARD* case the plaintiffs had bought from the first defendant a bungalow for £24,000, built by him. Both before and after the conclusion of the purchase agreement the premises was inspected by the second defendants. However, no professional survey was carried out. The plaintiffs had applied to the second defendants - the Housing Authority - for a loan under subsection 39(1) of the Housing Act, 1966. In granting such a loan the Authority's Council was required, under article 12(b) of the Housing (Loans for Acquisition or Construction of Houses) Regulations, to value the house. It engaged the third defendant - a valuer - to carry out this valuation. He reported that the house was in good repair and its value

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<sup>56</sup>See McMahon & Binchy (1990 95)

was approximately £25,000. However, the valuer did not have any qualifications as to building constructions. The plaintiffs moved in to find out that the house was damp and had a smoking chimney. Having surveyed the house at their own costs it was found that the house was structurally unsound and hazardous to the health of the occupants.

The plaintiffs proceeded an action for damages. The question was whether each of the defendants owed, under common law, a duty of care to the plaintiffs. It was held that the first two defendants did.<sup>57</sup>

Costello J, in the High Court, dealt first with the alleged breach of duty of the first defendant as the builder/vendor of the house. The judge reviewed the relevant case law and concluded that the builder/vendor owed a duty of care.<sup>58</sup>

Having established that the first defendant was under a duty of care, Costello J considered its scope and

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<sup>57</sup>The plaintiffs could not establish that the third defendant did not conform to the standard of an ordinary skilled auctioneer, the test as it was laid down in *BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE* [1957] 2 All E R 118. He was there in a capacity of an auctioneer placing a market value on the property. On the basis of an examination of the evidence, Costello J concluded that the defects were defects which would have been discovered by 'a reasonable careful inspection carried out by a person with ordinary professional qualifications in house construction such as those that an architect or engineer would have obtained' ([1985] I R 29 at 36).

<sup>58</sup>Formerly, it was held that if a builder was also the owner of the house he enjoyed immunity against liability. However, this was abolished in *DUTTON v BOGNOR REGIS URBAN DISTRICT COUNCIL* [1972] 1 Q B 373. In Ireland a duty arose in *SINEY v CORPORATION OF DUBLIN* [1980] I R 400 and *COLGAN v CONNOLLY CONSTRUCTION CO (IRELAND) LTD*, Unreported, High Court, 29 February 1980, McMahon J.

extent He considered whether, since the decision in JUNIOR BOOKS v VEITCHI [1982] 3 W L R 477, the scope was limited to avoid causing foreseeable harm to persons or property, or that it could be extended to a duty to avoid pure economic loss Costello J applied the ANNS test and held the first defendant liable for defective workmanship In other words, reasonable foresight not only established the existence of a duty but also its scope Thus, in WARD v MCMASTER [1985] I R 29 the defendant's duty related to hidden defects that could not be discovered 'by the kind of examination which he could reasonably expect his purchaser to make before occupying the house'<sup>59</sup> This duty extended to avoid causing the plaintiffs consequential financial loss arising from the hidden effects of the house itself There were no compelling policy reasons to decide otherwise

Second, Costello J considered the liability of the second defendants - the Housing Authority The plaintiffs, alternatively, alleged that the Council owed them a common law duty to carry out its statutory functions under the Housing Act, 1966 and the Housing Authority (Loans for Acquisition or Construction of Houses) Regulations, 1972<sup>60</sup> This common law duty consisted, in the WARD case, of a duty to act with care as to the inspection and valuation of the house

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<sup>59</sup>[1985] I R 29 at 44

<sup>60</sup>Since the action against the third defendant failed (he was not negligent), the second defendant (the Housing Authority) could not be held vicariously liable

Costello J held that the existence of a duty cannot be based on proximity or the "neighbour" principle alone. All the circumstances of the case must be taken into account to determine the scope of the duty, for example, the purpose of the statutory powers. Thus, first one must establish the required degree of proximity. Second, one must take into account the circumstances of the case, i.e. the purpose of the statutory powers. Third, was it just and reasonable that a duty should exist?

The Housing Act and Regulations imposed upon the Housing Authority statutory powers. The purpose of the particular powers, relevant in this case, was to value the house in order to determine whether the house would be re-saleable in the event of default of payment by the loan applicant. The plaintiffs considered this inspection as to the state of the house in order to approve of the loan. For this reason they did not employ a person to examine the house individually. Costello J held that the Housing Authority should have been aware of this aspect. It should have contemplated that the plaintiffs would not go to extra expenses to examine the house individually and that they would rely on the Authority's inspection. Costello J concluded, therefore, that there was a sufficient degree of proximity, 'such that in the reasonable contemplation of the Council carelessness on their part in the carrying out of the valuation of the bungalow the plaintiffs were going to purchase might be likely to cause him damage'.<sup>61</sup> They

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<sup>61</sup>[1985] I R 29 at 52

should have been aware that it would have been unlikely that the plaintiffs employed an engineer personally to inspect the (construction of the) house. Taking into account all the circumstances, for example, the Council's statutory powers, it became clear that the purpose of the powers should be accompanied with a common law duty of care. It was, therefore, just and reasonable to impose a duty. The plaintiffs relied on the valuation and the Council should have been aware that they did so.

The Council appealed.<sup>62</sup> It claimed that (i) no duty existed (the plaintiffs had to safeguard their own interests), (ii) if there was a duty, there was no reasonable foreseeable risk of damage and (iii) the manner of valuation was a policy decision, in which the Council had absolute discretion.

The appeal failed. The Supreme Court held, *inter alia*, that the private duty was not created from the Housing Act, 1966 but, instead, from the relationship between the parties. The Council could have reasonably foreseen that the plaintiffs would lack the means for a personal inspection and would rely on its valuation (although statutorily it served a different purpose). In addition, McCarthy J stated that a duty arose from 'the proximity of the parties, the foreseeability of damage, and the absence of any compelling exemption based upon public policy'.<sup>63</sup>

It is clear from the judgment that, where Costello J

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<sup>62</sup>WARD v MCMASTER [1988] 1 R 337

<sup>63</sup>[1988] 1 R 337 at 349

in the High Court relied on the just and reasonable test, the Supreme Court (per McCarthy J ) expressed the desire to base the imposition of a duty on the proximity between the parties and the foreseeability of damages in the absence of any compelling reasons to decide otherwise In other words, the Supreme Court relied on the two-stage approach in ANNS v MERTON LONDON BOROUGH COUNCIL [1978] A C 728

In DOHERTY TIMBER LIMITED v DROGHEDA HARBOUR COMMISSIONERS [1993] I R 315, the High Court relied on the decisions in both ANNS and MCMASTER In this case the plaintiff - a timber merchant - was the consignee of a cargo of timber The timber remained on the quayside, which was open to the public, and was set alight by children The plaintiff sued the defendants for negligence and breach of their statutory duty to take proper measures for, *inter alia*, the control of their harbour The plaintiff failed Although it was obvious that it could be reasonably foreseen that loss was suffered, this fact was manifest to both the defendant and plaintiff The reality of the relationship between the two parties did not go any further for the simple reason that any additional care would have been virtually impossible

#### 9.4. The Imposition of a Duty of Care Auditors and Solicitors

9.4.1. This section addresses the situation where a



professional person is sued for negligence by a third party

The law has created, it is suggested, general principles for negligent statements. However, it appears that these principles are employed incrementally and, to a certain extent, pragmatically, taking into account considerations of policy. This can be explained, looking at the function and nature of, in particular, auditors and solicitors. They are information providers. This information is communicated to others. They can either be the direct addressee - the party in the underlying relationship, or a third party who relied on the representation of the professional person.

The existence of a duty of care towards third parties in professional negligence is since long recognized.<sup>64</sup> In *FINLAY v MURTAGH* [1979] I R 249 Henchy J remarked that a solicitor can be held liable in tort 'to those [ ] with whom he has made no arrangement to act, but who, as he knows or ought to know, will be relying on his professional care and skill'.<sup>65</sup>

This "reliance" is believed to form the justification to impose liability on, for example, auditors and solicitors. The case law suggests that this liability is imposed as a matter of policy to put the loss on the

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<sup>64</sup>Cf *HEDLEY BYRNE AND CO LTD v HELLER & PARTNERS* [1963] 2 All E R 575

<sup>65</sup>[1979] I R 249 at 257. This remark must, arguably, be regarded as *obiter*, in *FINLAY* a client sued his solicitor for negligence.

shoulders of those who are assumed to be capable to carry it. This involves, of course, an assessment of the amount of damages suffered, the position of the defendants, insurance safety-nets and other issues. It does not depend whether the conduct of the solicitor or auditor was negligent. In most cases they were.

The reliance as a pre-condition for the existence of a duty of care is an interpretation of the proximity element, laid down in *DONOGHUE v STEVENSON* [1932] All E R 1. The thesis asserts that reliance can take two forms to justify the existence of a duty of care.

First, third parties rely on the representation of a professional person, expecting it to be made with due care and skill and, consequently, act on this representation and suffer loss as a result.

Second, the third party remains inactive. Here, he relies, as an outsider, on the skill and care of the professional person that some future result or expectation shall be materialized. In other words, the third party expects, as a member of the general public, that a professional person exercises his duties with due care and skill. Through the professional person's negligence the third party suffers loss. The appearance or condition of a physical degree of proximity is normally absent and may be irrelevant.

This distinction is consonant with recent case law, both in England and Ireland. The first situation is a reflection of third-party liability in cases like *HEDLEY*

BYRNE & CO LTD v HELLER & PARTNERS LTD [1963] 2 All E R 575 and CAPARO INDUSTRIES PLC v DICKMAN AND OTHERS [1990] 1 All E R 568, and in Ireland in POTTERTON LTD v NORTHERN BANK LTD [1993] I L R M 225 The second situation has found its roots in case like ROSS v CAUNTERS [1979] 3 All E R 580 and recently in WHITE AND ANOTHER v JONES AND ANOTHER [1995] 3 All E R 691 In Ireland, WALL v HEGARTY [1980] I L R M 124 governs this area of professional liability

In these cases, the courts recognize the existence of a duty of care differently than in cases of "ordinary" negligence It can, therefore, be argued, that, contrary to the standard of care, the imposition or recognition of a duty of care is, politically and socially, responsive to the economic structure of society Does the law of tort accommodate technical and other changes by imposing liability in different ways?

#### Reliance and Action

9.4.2. In HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD [1963] 2 All E R 575 the appellant's bank questioned the respondents regarding the financial position of one of the respondent's customers, Easipower Ltd They replied that their customer was financially trustworthy but expressly disclaimed responsibility for this information The bankers report was channelled to the appellant's customer - an advertising agent, who subsequently placed

orders for advertising time on behalf of Easipower Ltd. The advertising agent was personally responsible for these contracts. Easipower Ltd. went into liquidation and the agent lost £17,000 on contracts. They sued the respondents, alleging the negligent misstatement of information.

It was held by the House of Lords that the respondents might have owed a duty of care to the appellants, but their disclaimer of responsibility regarding their replies was adequate to exclude this assumption. The importance of the decision, however, lies in the criteria under which a maker of a statement must assume a duty of care.

First of all, it was made clear that in the HEDLEY BYRNE case negligent misstatements differ from negligent acts. The former cannot give rise to a cause of action if it is innocently given on, for example, 'social or informal occasions'.<sup>66</sup> There must be something more. A reasonable man must know that he was relied upon or trusted on his skill and judgment to reply to inquiries. This suggests that the injured person is aware that the alleged tortfeasor had a certain expertise. Accordingly, the professional man has three options if asked for advice. He declines to reply, disclaims any responsibility or replies without such a disclaimer. In the event of the latter he must realize, according to Lord Reid, to -

have accepted some responsibility for his answer being given carefully, or to have accepted a relationship with the inquirer which requires him

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<sup>66</sup>[1963] 2 All E R 575 at 580, per Lord Reid

to exercise such care as the circumstances require<sup>67</sup>

In other words, someone who is asked to provide certain information or to give a professional opinion and is not contractually bound to it must at some stage assume responsibility. This could be regarded as a red herring. It is, in the view of this researcher, inherent to the nature of a profession that the professional practitioner assumes responsibility at all times he is asked or voluntarily provides expert information, either in or outside a contractual capacity. However, Lord Reid continued and stated, more importantly, that the professional practitioner must also have, or ought to have, realized that the person seeking the information relied on this information or opinion for a particular future transaction.<sup>68</sup> Lord Reid goes a step further here. Apart from assuming responsibility, the professional person must also anticipate the consequences of his information or advice for the person who relies or may rely on it, and who acts accordingly. It follows, that he must give this information honestly and with reasonable care.<sup>69</sup>

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<sup>67</sup>*Ibid*, at 583

<sup>68</sup>Lord Reid ([1963] 1 All E R 575 at 583-584) relied here on, *inter alia*, a judgment by Cardozo C J in *GLANZER v SHEPARD* (1922) 233 N Y 236

<sup>69</sup>See also *BEWLEY RYAN & CO v CRUESS-CALLAGHAN* [1995] P N L R 21. In this case it was held that a stockbroker was under a same duty of care as any other professional person. If he is asked for advice or brings it upon himself to give advice he must do this honestly and to the best of his ability.

Lord Morris of Borth-Y-Gest stated that there was authority which showed that 'irrespective of any contractual or fiduciary relationship and irrespective of any direct dealing, a duty may be owed by one person to another' <sup>70</sup> Logically he could not see a difference between injuries caused by negligent words or the reliance on the safety of the contents of a bottle of ginger ale or other negligent acts. So did Lord Hodson, who stated that 'it is difficult to see why liability as such should depend on the nature of the damage' <sup>71</sup>

This can even be extended, according to Lord Morris, to situations where a 'service is voluntarily undertaken' <sup>72</sup> Here, the initiative lay on the alleged tortfeasor instead of anticipating on a request to provide certain information or advice. His Lordship gave the example of a doctor who came across an unconscious man, a complete stranger and in need of medical attention. If the doctor decided to intervene, his duty required him to exercise reasonable care and skill <sup>73</sup> The same applies to a person who issues a document, crafted with the requirements of his profession, knowing that others will

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Where advice is given carefully there is no negligence, even where the advice did not generate the anticipated effect, see *MCSWEENEY AND LYNCH v BOURKE* [1995] P N L R 35

<sup>70</sup> [1963] 2 All E R 575 at 589-590

<sup>71</sup> *Ibid*, at 598

<sup>72</sup> *Ibid*, at 589

<sup>73</sup> See also *BANBURY v BANK OF MONTREAL* [1918-19] All E R 1

rely on it who are not in direct dealings with him

In both these situations the person takes it upon himself to give information or advice, knowing that others will rely and act on it. In these situations a duty of care arises. This is particularly true where the person who relied on the statement can be named or identified.

Lord Devlin added that the law would be defective if 'it would leave a man without a remedy where he ought to have one and where it is well within the scope of the law to give him one'.<sup>74</sup> For this reason, it would be illogical not to extend the tort of negligence to words, just as it would be illogical to confine a cause of action for words to a contractual or fiduciary relationship between defendant and plaintiff.

Prior to *HEDLEY BYRNE* it was held that, in the absence of an underlying relationship, no such duty was imposed by law to exercise care in the giving of information.<sup>75</sup> There was only a duty to do this honestly. A prime example of this was the decision in *CANDLER v CRANE CHRISTMAS & CO* [1951] 1 All E R 426. However, the significance of this case lay in the dissenting judgment of Denning L J which, in fact, formed the basis for the House of Lords' decision in *HEDLEY BYRNE*. Denning L J held that the defendant (an accountancy firm) owed a duty to his client and -

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<sup>74</sup>[1963] 2 All E R 575 at 602

<sup>75</sup>However, information given fraudulently may give rise to a cause of action. See *LE LIEVRE AND DENNES v GOULD* [1893] 1 Q B 491 at 498, per Lord Esher 'in the absence of contract, an action for negligence cannot be maintained when there is no fraud'

to any third person to whom they themselves show the accounts, or to whom they know their employer is going to show the accounts so as to induce him to invest money or take some other action on them <sup>76</sup>

'The same reasoning', according to Denning L J , 'applies to others' <sup>77</sup>

The criteria for negligent misstatements can be summarized as follows

(I) The tortfeasor possesses a special skill or expertise or holds himself out to possess such expertise or skill

(II) He knows or ought to know that people rely on that skill or expertise for the purpose of a particular transaction known to the maker of the statement It cannot be upheld that the defendant owed a duty to anyone relying on him This would mean he would be 'liable in an indeterminate amount for an indeterminate time to an indeterminate class' <sup>78</sup> It is irrelevant that he is in direct dealings with those persons, whether in a contractual or fiduciary relationship, or otherwise

(III) He is asked or took it upon himself to provide information or to give advice (voluntary assumption of responsibility), whereby it is immaterial whether the

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<sup>76</sup>[1951] 1 All E R 426 at 434

<sup>77</sup>*Ibid*

<sup>78</sup>Cf *ULTRAMARES CORPORATION v TOUCHE* (1931) 174 N E 441 at 444, *per* Cardozo C J (quoted by Denning L J in *CANDLER v CRANE CHRISTMAS & CO* [1951] 1 All E R 426 at 435)



service was given gratuitously or not <sup>79</sup>

If these three criteria are fulfilled the tortfeasor is considered to owe a duty to those who rely on him, and he is liable if his advice or information is negligent. The relationship which then exists can either be general (for example between solicitor and client or doctor and patient) or particular, similar to the circumstances in HEDLEY BYRNE. With regard to the former it is merely necessary to prove its existence and the duty follows. With regard to the latter it is necessary 'to examine the particular facts to see whether there is an express or implied undertaking of responsibility' <sup>80</sup>

In a number of other cases the decision in HEDLEY BYRNE was upheld. See, for example, SMITH v ERIC S BUSH (A FIRM) and HARRIS v WYRE FOREST D C [1989] 2 All E R 514 (the House of Lords heard the two appeals together). A conspicuous feature in these two cases was that the defendants were fully aware of the nature of the transaction and that their subsequent statements or representations would be directly or indirectly communicated to, or relied upon by, the plaintiffs <sup>81</sup>. In

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<sup>79</sup>Cf COGGS v BERNARD (1703) 2 Ld Raym 909 and SKELTON v LONDON & NORTH WESTERN RAILWAY CO (1867) L R 2 C P 631

<sup>80</sup>HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD [1963] 2 All E R 575 at 611, *per* Lord Devlin

<sup>81</sup>In the SMITH case, the respondent was furnished with a valuation report of a house, stating, negligently, that no repairs were necessary. In the HARRIS case, the plaintiffs also relied on a valuation report, made by the defendant, to purchase a house.

addition, in the SMITH case, Lord Griffiths rejected that an assumption of responsibility was conclusive to impose liability. It can only have real meaning if this assumption was 'understood as referring to the circumstances in which the law will deem the maker of the statement to have assumed responsibility to the person who acts on the advice' <sup>82</sup>

**9.4.3** In *CAPARO INDUSTRIES PLC v DICKMAN AND OTHERS* [1990] 1 All E R 568 the criteria were modified. In this case the respondents invested in a public limited company, relying on the audited accounts. Following the investments (resulting in a take-over of the company) the respondents sued the auditors for negligent misrepresentation (the accounts showed a substantial profit rather than the actual position of the company). They claimed that the auditors owed them a duty of care because they knew or ought to have known that the figures would make the company vulnerable to a take-over bid and/or would make individual and existing shareholders interested in buying more shares in the company.

The question which needed to be answered was two-fold: (1) did the auditors owe a duty to potential investors and (11) did the auditors owe a duty to existing (individual) shareholders?

Generally, it was held by the House of Lords that a

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<sup>82</sup>*SMITH v ERIC S BUSH* [1989] 2 All E R 514 at 534, per Lord Griffiths

duty of care did not exist where there was no relation or proximity between the maker of a statement and any person relying on it. There is no such relation where the maker of such statement had no precise reason to foresee that the statement, put into more or less general circulation, might foreseeably be relied on by strangers for a purpose the statement was made for.

Thus, foreseeability is not sufficient.<sup>83</sup> There must be something more in order for the court to infer that the maker of a statement owed a duty to those who relied on the statement. It must also be shown that -

the maker knew that his statement would be communicated to the person relying on it, either as an individual or as member of an identifiable class, specifically in connection with a particular transaction or a transaction of a particular kind and that that person would be very likely to rely on it for the purpose of deciding whether to enter into that transaction.<sup>84</sup>

Thus, it is not sufficient that a maker of a statement ought to have known, he had to be actually aware that a particular person or a member of a particular class of persons relied on his statement, particularly in connection with a transaction. In the words of Denning L J in *CANDLER v CRANE CHRISTMAS & CO* [1951] 3 All E R 426 'Did the accountants know that the accounts were required for

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<sup>83</sup>See also *DANNS AND ANOTHER v DEPARTMENT OF HEALTH* [1995] 25 B M L R 121

<sup>84</sup>[1990] 1 All E R 568 at 568-569

submission to the plaintiff and use by him'<sup>85</sup> This is the degree of proximity that is required

Finally, the House of Lords held that, apart from foreseeability of damage and a sufficient degree of proximity, it must be just and reasonable, in the circumstances of the case, to impose a duty of care on the maker of the statement

Thus, the HEDLEY BYRNE criteria may be modified as follows Generally, a maker of a statement is not liable towards persons other than those to whom the statement is directly addressed, except when

(I) The maker of the statement possessed a special skill or expertise or held himself out to possess such expertise or skill

(II) He knew that his statement or information would be communicated to those who relied on it (foreseeability)

(III) The person or persons who relied on it were no strangers but individuals or members of an identifiable class (proximity)

(IV) It was very likely that they relied on his statement in deciding to enter into a particular transaction known or ought to be known by the maker of the statement (foreseeability of damage)

(V) It was just and reasonable to recognize the existence of a duty of care In CAPARO, the purpose of the statement must have been to entice the plaintiffs to invest

As a consequence, the group of people to whom a duty

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<sup>85</sup>[1951] 3 All E R 426 at 434

is owed and the group of people owing such a duty has been limited, whereby the central issue involves the existence of a "special relationship" <sup>86</sup> In the circumstances of the case in CAPARO, such a relationship was absent. An auditor, auditing the accounts of a public company, was not considered by the Law Lords to owe a duty to a potential investor, it being a member of the public at large. To deduce a relation of proximity between them would lead to an unlimited liability on the part of the auditor. An individual shareholder, relying on those reports, was held to be in no better position than a member of the public at large <sup>87</sup>

Thus, there was not a sufficient degree of proximity to establish a duty of care. The House of Lords also held that, as a matter of policy,<sup>88</sup> the auditor's duty was solely owed to the shareholders in general meeting. This policy argument was justified by the Law Lords with reference to the purpose of the auditor's statutory duty to audit the accounts of the company <sup>89</sup> This duty or task enabled the general meeting to exercise an informed control regarding the state of affairs of the company. The purpose

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<sup>86</sup>See also SCOTT GROUP LTD v MCFARLANE [1978] 1 N Z L R 553 at 566, per Richmond P

<sup>87</sup>On the same grounds it was held in AL SAUDI BANQUE v CLARK PIXLEY (A FIRM) [1989] 3 All E R 361 that an auditor was not considered to owe a duty towards creditors of a company which accounts were audited by him

<sup>88</sup>The third criterium in CAPARO the "just and reasonableness" test

<sup>89</sup>See section 384 of the Companies Act, 1985 (England)

was not to 'enable individual shareholders to buy shares with a view of profit' <sup>90</sup>

The extent of the auditor's duty was limited solely to the purpose of the audited accounts informed control by the shareholders in general meeting. Thus, in addition to the foreseeability and proximity elements, the scope of the duty of care must extend to the damages incurred to the plaintiff. In other words, whether it was, as a matter of policy, just and reasonable to impose a duty of care on the maker of statement. Whether this was so, depended in CAPARO on the purpose of the statement or duty.

9 4.4. In Ireland, the courts take the decision in HEDLEY BYRNE & CO LTD v, HELLER & PARTNERS LTD [1963] 2 All E R 575 as the point of departure <sup>91</sup>. This can be concluded from a number of cases, most recently in the decisions in COUGHLAN v WHELTON AND ANOTHER [1995] P N L R 456 and POTTERTON LTD v NORTHERN BANK LTD [1993] I L R M 225.

In TULSK CO-OPERATIVE LIVESTOCK MART v ULSTER BANK LTD [1995] P N L R 55 the plaintiff - an operator of mart facilities - became concerned about the credit worthiness of one of his business partners. He was concerned about the

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<sup>90</sup>[1990] 1 All E R 569

<sup>91</sup>However, according to McGrath (1981), there is an Irish authority at hand that predates the decision in HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD [1963] 2 All E R 575. The Circuit Court decision in MACKEN v MUNSTER AND LEINSTER BANK LTD (1961) I L T R 17 set out similar criteria for negligent misrepresentation.

delay of payments and, subsequently, loss of interest on the overdrawn account. This could indicate that his business partner might not be able to meet his liabilities. The plaintiff contacted his bank manager who assured him that, although payments were slow, they were sure. The delay of payments was caused by the bank itself, it was said. (Although the partner banked with the same bank, the payments by the partner were made via a bank in England). However, the partner was in actual fact, according to the evidence, in financial difficulties. Eventually, he went into liquidation and, as a consequence, the mart closed. The plaintiff sued the bank for negligence, alleging, *inter alia*, the misrepresentation of the partner's financial position.

It was held by Gannon J, in the High Court, that the plaintiff relied on the information provided by the bank. It must have been aware of the importance of that information for the plaintiff and his dependence upon it for the purpose of continuing to give credit facilities and to run his business. The bank must have been alerted by the delay in payments, the unsatisfactory explanation by the branch manager of the bank and the anxiety of the plaintiff.

The bank's duty of care in this situation reached further than that between a simple banker and customer relationship. This duty consisted, *inter alia*, of active investigation, to make an honest and skilful assessment of the partner's financial situation and to provide discreet

disclosure of information to the plaintiff, so that he could him to come to his own business decision as to the relationship between him and his business partner

Thus, it was clear that the bank, in this situation, owed a duty to the plaintiff to provide him with sufficient and honest information to enable him to come to a proper decision. In failing to do so, the bank was held negligent.

The nature of the duties depended, according to Gannon J 'upon the circumstances of the relationships between the parties and the harm, loss or detriment to either party which would reasonably be foreseeable from such circumstances and relationships' <sup>92</sup> Liability in negligence did not depend solely on 'identifiable classifications of relationships', but depended on the existing circumstances deriving from the relationships that 'may import with the duty of care they demand' <sup>93</sup>

The judge relied in his decision on the decisions in *PURTILL v ATHLONE U D C* [1968] I R 205 and *HEDLEY BYRNE & PARTNERS LTD v HELLER & CO LTD* [1964] A C 465. In other words, liability depended on the proximity of the relationship, rather than on the specific relationship itself. Consequently, the duty was not an implied term of the specific relationship, but was based on the idea that one has to take reasonable care to those parties within one's proximity. Thus, the party is within one's proximity if one knows or ought to know that these parties rely and

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<sup>92</sup>[1995] P N L R 55 at 60

<sup>93</sup>*Ibid* , at 71



act on the information provided

In the TULSK CO-OPERATIVE case the delay of the clearance of a cheque could not be justified on the grounds of the bank's practice or the inconvenience that it had caused for the bank's staff. Instead, it had to be 'measured by the nature and requirements of the business in which the cheque is used to effect payment as known or made known to the banker'<sup>94</sup>. In other words, in these circumstances a higher duty of care is necessary, higher than the normal or customary banking procedures as to clearance of cheques.

It is suggested here that, as in the HEDLEY BYRNE case, the proximity, although not expressed in these words, derived from the fact that the plaintiff relied upon statements made by the defendant, who knew or ought to have known that these statements were important for him. The banker in the TULSK CO-OPERATIVE case must be assessed accordingly, as to the information provision of the credit worthiness of one of the co-operative's business partners.

In GOLDEN VALE v BARRETT [1995] P N L R 157 the plaintiff commissioned the defendants to investigate the financial position of another company that needed a cash injection to avoid liquidation. The plaintiff was anxious to know whether a rival company had expressed an interest in acquiring that company as well. The urgency forced the auditors to produce a limited audit report. They were aware that the plaintiff needed as much information as possible.

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<sup>94</sup>[1995] P N L R 55 at 76

to come to the right decision, which included a substantial financial commitment. Money was invested on the basis of the report. However, it became clear that the company needed more investments after the full audit report was produced. A new scheme was developed in which the plaintiff participated by buying shares. But, the company nevertheless went into liquidation and the plaintiff's money was irretrievably lost.

The plaintiff claimed damages against the defendants for negligence. It stated that it was induced to invest on the basis of the defendant's advice and the information laid down in the first report. It further stated that the defendants had not properly investigated the company, hereby relying on the difference between the first report and the audited accounts.

O'Hanlon J. allowed the claim and stated that the defendants were in some degree negligent in failing to protect their client from falling into error. The report was encouraging rather than objective, knowing that the plaintiff was more than willing to go ahead. The encouragement was more than warranted by the state of the company. Although this is not a case of third-party liability *per se*, it showed that the makers of the statements must do this objectively. They did not so but, instead, enticed the plaintiffs into investing in the company. It showed that the purpose of the advice - contrary to the purpose in *CAPARO INDUSTRIES PLC v DICKMAN* [1990] 1 All E R 568 - was for the plaintiffs to

anticipate on it

In *MCANARNEY AND ANOTHER v HANRAHAN AND OTHERS* [1994] 1 I L R M 210 the first named defendant - an auctioneer - was held liable because he took it upon himself to provide information. He knew that the plaintiffs would rely on it. This information was negligent. He misrepresented to the plaintiffs the value at which a premises would be withdrawn from the auction and he misrepresented the value of the freehold attached to it. The plaintiffs bought the premises with the intention to buy the freehold some time later, only to discover the real value of it.

The auctioneer was negligent because, in voluntarily providing that information, he created an express assumption of responsibility that established a special relationship, imposing on him a duty of care.<sup>95</sup>

With regard to negligent misrepresentation of auditors two cases deserve attention. First, the decision in *SISK & SON LTD v FLINN* [1995] P N L R 80 was subjected to the principles laid down in *HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD* [1963] 2 All E R 575. However, the auditor was not negligent because he had qualified the report, the accounts were qualified as work-in-progress figures.

The plaintiff, nevertheless, relied on this qualified

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<sup>95</sup>See also *POTTERTON LTD v NORTHERN BANK LTD* [1993] I L R M 225. In this case the bank voluntarily provided information that was, subsequently, negligent. The plaintiff relied on this information. The bank should have known this, as well as the financial consequences for the plaintiff. The bank's action constituted a sufficient degree of proximity to justify a special relationship and the imposition of a duty of care, in the absence of a contract between the two parties.

report to buy more shares in the company. Although the work-in-progress figures were overstated and the defendant knew that the plaintiff would rely on the report, he was free to qualify the report. Furthermore, the evidence showed that the entire accounts, including the qualifications, were sent to the plaintiff's solicitor weeks before the deal was struck.

In *KELLY AND OTHERS v BOLAND T/A HAUGHEY BOLAND & CO* [1989] I L R M 373 the plaintiffs were directors of a company wishing to purchase Tara China Ltd. Before the conclusion of the transaction, the directors were furnished with the audited accounts and discussed it with the defendants, in particular with regard to the stock figures. After the purchase the plaintiffs became aware that these figures were understated and resulted in an exaggerated view of the company's trading position. They sued the defendants in negligence, claiming that the duty they owed to them was breached. Lardner J. relied on the *HEDLEY BYRNE* principles and stated -

The defendants owed a duty of care to the plaintiffs in respect of those accounts prepared at a time when they knew or ought reasonably to have known that they would be used by a third party who would rely on the accounts in taking a decision as whether to invest in Royal Tara.<sup>96</sup>

9.4.5. The case law shows that the Irish courts employ

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<sup>96</sup> [1989] I L R M 373 at 373

a less restricted test for liability for negligent misstatements. A duty is imposed if it is shown that, as a matter of proximity, the information provider knew or ought to have known that a third party would rely and act on it. This is also true in England but to the extent that policy determines that it was not just and reasonable to recognize such a duty. The justification for this policy-decision is found in the purpose of the statement or advice. Thus, although a professional person provided information negligently, the plaintiff has his only remedy taken away. That this is a pragmatic approach, arguably based on a cost-benefit analysis, is demonstrated by comparing this approach with the approach undertaken by the English courts in the second set of cases. Here, the plaintiff did not act on the basis of provided information but, merely, relied on the professional person's skill and care in order to have a future expectation materialized.

#### Reliance and Expectation

9.4.6 This aspect of third-party liability is particularly exemplified with regard to the solicitor who has negligently drawn up a will.<sup>97</sup> As a result the beneficiary is disappointed and seeks redress via the solicitor. This position was first addressed in England in *ROSS v CAUNTERS* [1979] 3 All E R 580.

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<sup>97</sup>It can be argued, as did Jones (1994), whether this type of negligent representation should be confined to wills only, see *supra* 2.7.8.

Certain activities of solicitors give rise to specific problems, whereby the absence of an undertaking based on the representation of a solicitor and the nature of the loss are domineering factors. This justified the reason for a departure of the principles laid down in *HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD* [1963] 2 All E R 575 and *CAPARO INDUSTRIES PLC v DICKMAN AND OTHERS* [1990] 1 All E R 569. It has been argued whether the decision in *ROSS v CAUNTERS* was good case law. This is addressed later.

*GRAN GELATO LTD v RICHCLIFF (GROUP) LTD AND OTHERS* [1992] 1 All E R 865 was decided upon the rules laid down in *CAPARO*. In this case the plaintiff claimed damages for negligence against, *inter alia*, the second defendants who were the solicitors of the first defendants. It was alleged that the second defendants breached their duty. They incorrectly answered preliminary inquiries, made by the plaintiff, regarding the underlease of a premises granted to the plaintiff. The premises held two head leases which included a "redevelopment-break-clause", unknown to the plaintiff.

The question was whether the second defendants did owe a duty towards the plaintiff. This depended, according to Sir Donald Nicholls V-C, 'upon the solicitors themselves owing directly to [the plaintiff] a duty to take reasonable care when answering the preliminary inquiries on behalf of their client'<sup>98</sup>. Whether such duty existed, did depend on

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<sup>98</sup> [1992] 1 All E R 865 at 871

the principles set out in CAPARO INDUSTRIES LTD v DICKMAN AND OTHERS [1990] 1 All E R 568 There must be foreseeability, proximity and it must be considered, according to Sir Donald in GRAN GELATO, to be "fair, just and reasonable" that the law should impose a duty of a given scope upon the one party for the benefit of the other' <sup>99</sup>

In ROSS v CAUNTERS [1979] 3 All E R 580 the defendant - a solicitor - negligently failed to warn the testator, for whom he had drawn up a will, that the execution by the testator could not be witnessed by the spouse of a beneficiary <sup>100</sup> As a result the plaintiff (a beneficiary), whose husband witnessed the execution, waived her benefit under the will

A principal difference with GRAN GELATO, CAPARO and HEDLEY BYRNE is the absence of any kind of express reliance upon which the plaintiff had come to a certain decision, as was the argument in those cases <sup>101</sup> The plaintiff can merely be described as someone who relies or expects that a solicitor generally exercises his duties with due care and skill Sir Robert Megarry V-C , in ROSS v CAUNTERS, could not see a valid reason not to impose a duty of care on the basis of this distinction -

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<sup>99</sup>*Ibid* , at 872

<sup>100</sup>See section 15 of the Wills Act, 1837 (England)

<sup>101</sup>See, *inter alia*, HEDLEY BYRNE & CO LTD v HELLER & PARTNERS [1963] 2 All E R 575 and CAPARO INDUSTRIES PLC v DICKMAN AND OTHERS [1990] 1 All E R 568

If a solicitor negligently fails to secure the due execution of a will, I can see no rational ground for distinguishing between those who knew that a will in their favour was being made and passively relied on the solicitor's skill or his implicit representation of the due execution of the will, and those who knew nothing of the making of the will and relied on nothing<sup>102</sup>

It was not argued that the defendant was negligent in (i) failing to warn the testator about section 15 of the Wills Act, 1837, (ii) failing to check whether the testator duly executed the will, (iii) failing to observe the plaintiff's husband as attesting witness and (iv) failing to draw this to the attention of the testator. It was evident that the defendant owed these duties to the testator, but he was not to suffer any loss. Hence, the person to whom the duty is owed has a remedy but does not need it and the person who suffered loss is deprived of a remedy. The plaintiff, as a beneficiary, did not have a remedy but suffered the loss. However, it was argued by counsel for the defendant that he did not owe a duty of care towards the plaintiff. Counsel relied here on the decision in *ROBERTSON v FLEMING* (1861) 4 Macq 167<sup>103</sup>

This could not be upheld. The reasons which Sir Robert provided to justify the imposition of a duty of care appeared to derive from the principles set out in both *HEDLEY BYRNE & CO LTD v HELLER & PARTNERS* [1963] 2 All

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<sup>102</sup>[1979] 3 All E R 580 at 591

<sup>103</sup>In this case it was decided that a duty could be established 'only by showing privity of contract between the parties', ((1861) 4 Macq 167 at 177, per Lord Cambell L C )



These reasons were three-fold

(I) There was a sufficiently close degree of proximity between the plaintiff and the defendant (the plaintiff was known to the defendant, she was named and identified in the will) Accordingly, the defendant ought to have known that she could be affected by his conduct

(II) This proximity followed the duty of care which the defendant owed to the testator

(III) The defendant could not be held to be exposed to an unlimited class of liability, the liability was to one person only the plaintiff

Thus, the absence of any reliance was irrelevant in ROSS v CAUNTERS Megarry V-C stated -

If the duty of care is imposed on what I may call pure [DONOGHUE v STEVENSON] principles, and the loss occurs without being dependent on any reliance by the plaintiff, then I cannot see how the presence or absence of reliance by the plaintiff can affect liability<sup>104</sup>

In other cases, express reliance is an essential precondition for the imposition of liability, the loss occurred solely because the plaintiff relied on a particular statement and acted upon it This is the crucial difference between ROSS v CAUNTERS [1979] 3 All E R 580 and cases like HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD [1963] 2 All E R 575 Thus, in HEDLEY BYRNE the pure

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<sup>104</sup>[1979] 3 All E R 580 at 591

DONOGHUE principles are interpreted in favour of the argument that the plaintiff trusted 'the defendant to exercise due care in giving information on a matter in which the defendant [ ] knew or ought to have known of the plaintiff's reliance on his skill and judgment' <sup>105</sup> Proximity is expounded in the sense that the defendant should have realized that the plaintiff relied on his statements and acted accordingly <sup>106</sup>

The question remains whether the decision in ROSS v CAUNTERS [1979] 3 All E R 580 is an extension of the principle laid down in HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD [1963] 2 All E R 575 or a direct application of the principles laid down in DONOGHUE v STEVENSON [1932] A C 562 The decision indicated the latter, emphasizing that reliance was not a pre-condition in this particular case, but rather the degree of proximity It has been argued,<sup>107</sup> whether this case extends liability to all cases where there is a contract between two persons for the benefit of a third party However, in the view of this researcher, it must be understood that the defendant party in those cases possessed a special skill which he subsequently exercised in an unsatisfactory manner This special skill forces the professional person to contemplate that his act may effect others Again, this exemplifies the

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<sup>105</sup>*Ibid* , at 592

<sup>106</sup>In addition, in CAPARO, the statement must have been made for a particular purpose

<sup>107</sup>See Jackson & Powell (1992 321)

assertion that a professional person has an "over-arching" duty to take care, irrespective of possible and identifiable plaintiffs

9.4.7. The decision in ROSS v CAUNTERS [1979] 3 All E R 580 was affirmed in England in WHITE AND ANOTHER v JONES AND OTHERS [1995] 3 All E R 691. In this case a testator instructed the defendants to change his will cutting both plaintiffs out of his estate. The will was executed accordingly. However, after the testator had reconciled himself with the plaintiffs, the former sent instructions to the defendants to prepare a new will. These instructions included substantial gifts to the two plaintiffs. They were not dealt with for a month. The testator died in that period - before the new dispositions were put into effect. As a result, the new will was not executed and the plaintiffs were left with nothing. They sued the defendants for damages for negligence, based on loss of expectation. It was held, in the court of first instance, that the plaintiffs were not owed a duty of care by the defendants. The plaintiffs appealed.

The Court of Appeal, applying the rule laid down in ROSS v CAUNTERS (A FIRM) [1979] 3 All E R 580, reversed the decision of the judge -

A solicitor who was instructed to prepare a will for a client and, in breach of his professional duty, failed to do so was liable in damages to a disappointed prospective beneficiary if the client died before the will had been prepared or

executed <sup>108</sup>

This decision was based on the grounds that (i) financial loss was foreseeable, (ii) the degree of proximity was foreseeable, and (iii) the imposition of liability was fair, just and reasonable, because there was no remedy in contract and the client's estate 'had no effective remedy for the client's purpose being thwarted by the solicitor's failure to carry out the instructions properly' <sup>109</sup> It can also be suggested that the purpose of the representation was, implicitly, to benefit the third parties, being the addressees of the will

The decision of the Court of Appeal was affirmed by the House of Lords <sup>110</sup> Lord Goff and Lord Nolan particularly emphasized the assumption of responsibility of a solicitor They agreed that this responsibility should be extended to intended beneficiaries In this case the solicitor could reasonably foresee that they would be deprived of the legacy through his negligence In doing so the Law Lords in WHITE were able to fill the gap that was created in this case They were able to overcome the injustice in this particular case that the person who suffered a loss was deprived of a remedy

This approach appears to restrict the solicitor's liability to the facts of this particular case, the

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<sup>108</sup> [1993] 3 All E R 481

<sup>109</sup> *Ibid*

<sup>110</sup> WHITE v JONES [1995] 1 All E R 691

negligent drafting of wills. However, Lord Browne-Wilkinson and Lord Nolan added that a special relationship existed between the solicitor and the plaintiffs by analogy with established categories of relationships which gave rise to a duty of care. The Law Lords relied here on, *inter alia*, *CAPARO INDUSTRIES PLC v DICKMAN* [1990] 1 All E R 568.

This may imply, according to this researcher, that the restrictive nature of cases like *CAPARO INDUSTRIES PLC v DICKMAN* [1990] A C 728 and *MURPHY v BRENTWOOD DISTRICT COUNCIL* [1990] 2 All E R 908 have not created the desired effect to generally restrict the imposition of a duty of care. *CAPARO* intended to offer a narrow interpretation of a "special relationship".

The *WHITE* case has broadened the interpretation. The effect of the decision in *WHITE* may indeed be catapulted into claims where a person has suffered loss due to the consequences of a relationship between others. It is at least arguable that, contrary to the position of the auditor, the solicitor must guard himself against third parties who would ordinarily benefit from his actions.

This decision may support the argument in this section of the thesis. It appears that people who expect a professional person to exercise his functions with due care and skill but do not expressly rely and act on a particular statement are afforded a remedy. This can be justified with the assertion that those people are normally not in a position to exercise some form of control (the plaintiffs might not have known that they were beneficiaries). A

professional investor or entrepreneur, on the other hand, has the possibility to protect himself against possible risks. He is aware of the functions of an auditor, he relies on the accounts and contemplates to act on them. He is, however, able to examine the situation or the accounts independently, he is able to make a decision.

It is interesting to note that the decision in *WHITE* formed the basis for a claim in medical negligence. In *GOODWILL v BRITISH PREGNANCY ADVISORY SERVICE* (1996) 146 New L J 173, the plaintiff sued her partner's doctor. She became pregnant from her partner (Mr M) although he had told her that he, before they met, had undergone a vasectomy. His doctor had assured him that the operation had been successful and that he did not need to use contraceptives. The plaintiff herself was told by her doctor that the chances of becoming pregnant were minute.

The plaintiff asserted that she was in the same position as the beneficiary in the *WHITE* case. She asserted that the doctor was employed to confer a benefit (not getting pregnant) on a particular class of people (potential future partners of Mr M, who was sterilized by the doctor). She suffered loss as a result of the doctor's negligence to advise Mr M correctly.

Gibson L J was not persuaded. The *WHITE* case belonged to a specific set of cases. The facts in *GOODWILL* could not be compared with it. The decision in *WHITE* was to overcome the injustice that a person who suffered the loss did not have a remedy, while the person who had the remedy did not

suffer the loss. In any event, the judge held that there was not a sufficient degree of proximity, for the doctor, the plaintiff was 'a member of an indeterminately large class of females who might have sexual relationships with [Mr M] during his lifetime'<sup>111</sup> It would not be fair, just or reasonable to impose on the doctor a duty of care.

The decision in *GOODWILL* indicates that the courts do not favour extending the decision in *WHITE* to other areas of professional negligence. Gibson L J expressly stated that *WHITE* belongs to a specific set of cases<sup>112</sup>

In *HEMMENS v WILSON BROWNE (A FIRM)* [1993] 4 All E R 826 the court did not impose a duty of care because an alternative remedy was available. The defendant was asked to draft a document for P, giving the plaintiff the right to call on P for a substantial amount of money for the purchase of a house. However, the document did not grant the plaintiff enforceable rights in the event that P was asked to fulfil his promise. The plaintiff sued the defendant for negligence alleging that the fact that the defendant owed her a duty of care to carry out P's instructions with reasonable care and skill. Subsequently, by breaching this duty she had lost the benefit of a substantial amount of money and she had suffered damage by relying on misrepresentations of the defendant regarding the nature of the document.

The court decided that, although the document was

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<sup>111</sup> (1996) 146 New L J 173, per Gibson J

<sup>112</sup> *Ibid*

carelessly and unskilfully drafted, damages were reasonably foreseeable and that there was a sufficient degree of proximity -

it would not be fair, just or reasonable for a duty of care to be imposed on the defendants because [P] was still alive and therefore able to rectify the situation [ ] and had a remedy for breach of contract against [the defendant], who accordingly would not go unpunished <sup>113</sup>

9 4 8 In Ireland the court decided in WALL v HEGARTY [1980] I L R M 124, to impose a duty of care, applying the broad principles laid down in DONOGHUE v STEVENSON [1932] A C 562 as discussed in ROSS v CAUNTERS [1979] 3 All E R 580

In the WALL case the defendant solicitor did not see to the fact that a will was duly attested as required by section 78 of the Succession Act, 1965. As a result, the plaintiff - a beneficiary in the will - suffered a loss of the legacy worth £15,000. It was held that a solicitor owed a duty of care to a legatee named in a draft will which appeared to be invalid. The plaintiff could also recover the legal expenses in attempting to prove the will invalid because 'the solicitor must know that if he fails in his professional duty properly to draft the will, there is considerable risk the legatee will suffer damage' <sup>114</sup> There

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<sup>113</sup> [1993] 4 All E R 826

<sup>114</sup> [1980] I L R M 124 at 129, per Barrington J



was a sufficient degree of proximity, the defendant's 'contemplation of the plaintiff [was] "actual nominate and direct"',<sup>115</sup> and the legatee was named

## 9.5. Immunity

9.5.1. Some professional persons, notably barristers and, to a lesser extent, solicitors, enjoy a degree of immunity in the exercise of their functions. This privilege has of yet not been debated in the Irish courts. However, in England their position is discussed in a number of cases. Two issues must be addressed

(I) Whether a plaintiff may succeed in an action against a barrister acting as counsel, and whether he may succeed in an action against a solicitor with regard to litigation which would normally be in the province of counsel, if counsel had been engaged. These issues are discussed in *RONDEL v WORSLEY* [1967] 3 All E R 993

(II) Whether this immunity is absolute or qualified, i.e. should there be lines drawn within which this immunity is granted. This was debated in *SAIF ALI v SYDNEY AND MITCHELL & CO AND OTHERS* [1978] 3 All E R 1033

9.5.2. In *RONDEL v WORSLEY* [1967] 3 All E R 993, the plaintiff sued his counsel for negligence. He claimed that counsel did not properly question witnesses in the

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<sup>115</sup>*Ibid*

plaintiff's criminal case and that this led to his conviction

It has been law for over two hundred years that barristers cannot be sued. An argument to the contrary could be that today all other professional men, including solicitors, can be made answerable in tort for alleged negligent conduct, 'so why should not barristers be under the same liability?'<sup>116</sup>

This rhetorical question was rejected. Barristers enjoy immunity and this rule is based on considerations of public policy. However, public policy is not inert but variable and the question is whether this rule 'is justifiable in the present day conditions' <sup>117</sup>

This question must be answered in relation to the duties of a barrister and his position in so far as his work relates to litigation. At least three different duties are imposed, each relating to different classes.

First, a barrister owes a duty towards his profession. This derives from the rules of his profession. He is obliged to accept any client, at least if it is in his field of expertise. He cannot refuse. Lord Diplock in *SAIF ALI v SYDNEY AND MITCHELL & CO AND OTHERS* [1978] 3 All E R 1033 stated -

[i]f he is disengaged and a proper fee is tendered to him, he is bound to accept instructions to act on behalf of any client

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<sup>116</sup>[1967] 3 All E R 993 at 998, per Lord Reid

<sup>117</sup>*Ibid*

desirous of his service in a field of law in which he holds himself out as practising<sup>118</sup>

In Ireland it can be argued that this position is strengthened with the constitutional guarantee of access to court<sup>119</sup> It appears that the right to access to court is implied under Article 40 3 of the Irish Constitution This can be inferred from a number of cases In *MACAULEY v MINISTER FOR POSTS AND TELEGRAPHS* [1966] I R 345 the Attorney General refused the plaintiff access to sue the Minister who had failed to provide him with an adequate telephone service This refusal was within the powers of the Attorney General under section 2 of the Ministers and Secretaries Act, 1924 The plaintiff argued that this section was invalid because it impeded free recourse to the courts This argument was upheld by Kenny J in the High Court<sup>120</sup>

Second, a barrister owes a duty to his client This duty implies that he shall do everything which the law permits him in helping his client's case This is common to all professional men and is emphasized by Lord Upjohn in the *RONDEL* case He stated that -

if someone possessed of special skill undertakes, irrespective of contract, to apply that skill for

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<sup>118</sup>[1978] 3 All E R 1033 at 1043

<sup>119</sup>See *McMahon & Binchy* (1990 273)

<sup>120</sup>See *Kelly* (1994 386) See also *THE STATE (QUINN) v RYAN* [1965] I R 70 and *O'BRIEN v KEOGH* [1972] I R 144

the assistance of another person who relies on such skill, a duty of care arises <sup>121</sup>

Finally, a barrister owes a duty to the courts. He owes this duty as an officer of the courts, concerned with the administration of justice. This duty is regarded as a public duty.

The latter two duties often coincide. In acting in the interest of his client, he is regarded as a watchdog of the system of justice and must safeguard the public interest against unjust administration. However, the duties may also conflict. If so, there is nevertheless a strong belief that 'where there is any doubt the vast majority of counsel put their public duty before the apparent interests of their client' <sup>122</sup>

It shows that the position of a barrister engaged in litigation is unique among the professions. He owes his duties to at least three parties: his client, the courts (and the public) and his profession. But, one can argue that most professions owe these duties to these parties. This follows from, *inter alia*, the altruistic and disinterested characteristics inherent to the profession. Thus, why immunity for barristers? It appears that in the advocacy the public duty is paramount and should not be jeopardized for a number of reasons.

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<sup>121</sup>[1967] 3 All E R 993 at 1032 (citing Lord Morris of Borth-y-Gest in *HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD* [1963] 2 All E R 575 at 594)

<sup>122</sup>[1967] 3 All E R 993 at 999, *per Lord Reid*

First, immunity avoids the 'hampering and weakening of the judicial process'<sup>123</sup> In any other case it would burden the process of justice because a barrister would not be able to do his work properly if he is constantly watched in relation to the possibility of a cause of action in tort It would create "defensive practice" which is already not uncommon among medical practitioners They, however, can be sued While this may lead to defensive practice it may also affect hospital management, if not the development of modern medicine Nevertheless, an argument against it is that in medicine the primary duty is owed to the patient, rather than to society or the public at large

Second, liability would prolong litigation It is not desirable that, once the initial litigation is over, the work of the barrister and, indeed, the court is open for any review in the form of an action in negligence '[T]he attainment of finality must be an aim of any legal system', according to Lord Morris of Borth-y-Gest<sup>124</sup>

However, the review will probably focus on a detail of the initial litigation To suggest, therefore, that the initial case lies open for analysis is exaggerated and premature<sup>125</sup>

Third, the independent position of a barrister contributes greatly to the course of justice and is of noble value to 'the integrity, the efficiency [and] the

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<sup>123</sup>*Ibid* , at 1026, per Lord Pearce

<sup>124</sup>*Ibid* , at 1015

<sup>125</sup>See also Osborne (1986), *supra* 2 7 12

elucidation of truth' <sup>126</sup> This independent position is partly guaranteed in Ireland with the prohibition to form partnerships or other business corporations among barristers <sup>127</sup> This, as a result, means that a barrister would be exposed to all losses and costs of litigation if he could be sued In addition, it was held by Finlay J in *FALLON v GANNON* [1988] I L R M 193 that '[a] solicitor has not got any vicarious responsibility for the individual conduct of counsel' <sup>128</sup>

Finally, public policy necessitates immunity for two reasons (1) a barrister may not readily refuse litigation and (11) counsel performs a vital part in the true administration of justice

The position of solicitors engaged in advocacy does not dramatically differ from the position of a barrister However, the scope of immunity is more restricted A solicitor enjoys immunity, 'only while acting as advocate on behalf of his client or when settling pleadings' <sup>129</sup>

This distinction may be explained that a solicitor, unlike a barrister, enters into a contract with his client and that, historically, his function was not advocacy, he did not stand 'between the client and the judge' <sup>130</sup>

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<sup>126</sup> [1967] 3 All E R 993 at 1030, per Lord Pearce

<sup>127</sup> The Bar Council in Ireland specifically prohibits the formation of partnerships

<sup>128</sup> [1988] I L R M 193 at 197

<sup>129</sup> [1967] 3 All E R 993

<sup>130</sup> *Ibid* , at 1023, per Lord Pearce

9.5.3. The decision in the RONDEL case was reaffirmed in SAIF ALI v SYDNEY MITCHELL & CO (A FIRM) AND OTHERS, P (THIRD PARTY) [1978] 3 All E R 1033. The important question in this case was where the lines of immunity should be drawn.

The plaintiff in this case (a solicitor) sued a barrister for negligence in failing to advise him within the limitation period regarding an action against certain defendants in a running down case. The Court of Appeal reversed the decision in first instance and held that a barrister was immune from litigation. The plaintiff appealed, questioning the scope of the immunity: does immunity cover pre-trial acts or omissions?

It was held by the House of Lords that immunity was an exception on the general rule that professional persons can be held liable in the tort of negligence. But, it should not be 'given any wider application than was absolutely necessary in the interest of the administration of justice'<sup>131</sup>. For this reason, immunity is granted to a barrister who acts only as counsel involved in litigation. This is based primarily on the grounds of public policy and to facilitate a smooth administration of justice. However, it may be extended to -

those matters of pre-trial work which were so intimately connected with the conduct of the cause in court that they could fairly be said to be preliminary decisions affecting the way that

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<sup>131</sup> [1978] 3 All E R 1033 at 1034

cause was conducted when it came to a hearing<sup>132</sup>

In Ireland this topic has not yet been addressed by the courts. It is unlikely that the Irish courts would not follow the line of thought expressed in both *RONDEL v WORSLEY* [1967] 3 All E R 993 and *SAIF ALI v SYDNEY MITCHELL (A FIRM) AND OTHERS, P (THIRD PARTY)* [1978] 3 All E R 1033<sup>133</sup>. However, at present the English courts are faced with two actions against barristers for negligence<sup>134</sup>. The outcome of these cases is, as of yet, unknown. Is the tide turning? Should barristers be under the same liability?

## 9.6. Conclusion

9.6.1. Third-party liability evolves around the existence of a "special relationship", "expectation losses", "reliance" and "assumption of responsibility"

The interpretation of these terms depends on whether third parties relied and acted on negligent statements. In these circumstances the courts rely on the principles initially set out in *HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD* [1964] A C 465. In this set of cases the

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<sup>132</sup>*Ibid* , at 1034

<sup>133</sup>See McMahon & Binchy (1990 97)

<sup>134</sup>See Slapper (1996)



"special relationship" depends on the different interpretation of foreseeability and proximity, and, at least in England, liability is imposed if it is just and reasonable to recognize a duty of care

The proximity element in England differs, however, from Ireland. In England the third party must be a member of an identifiable class and the maker of the statement must be aware that the third party relies on his statement and, possibly, acts accordingly. There is even a further restriction in England. Policy demands that the duty or statement must have been made for the specific conduct of the third party. For any other purpose it would not be just and reasonable to impose a duty of care.

In Ireland, the imposition of a duty of care is less restricted and depends on the unqualified criteria laid down in *HEDLEY BYRNE & CO LTD v HELLER & PARTNERS LTD* [1963] 2 All E R 575. The proximity element is, accordingly, interpreted as follows: the maker of the statement should have assumed that the third party relied and acted on the basis of his statements. If this statement is negligent he is liable.

If third parties were either oblivious or aware that a statement or representation was made in their favour but had merely a general expectation that a professional person acts with due care and skill, the courts tend to rely on the general principles of negligence set out in *DONOGHUE v STEVENSON* [1932] A C 562. Here, the tortfeasor should have had the third party in contemplation. He must or ought to

foresee that his conduct could affect the particular plaintiff This plaintiff is identified by name, for example, a possible beneficiary, or as a member of a particular class

The thesis suggests, as a concluding argument in this Chapter, that the fundamental criteria are

(I) proximity, i.e. the third party is either identifiable as a person or a class of persons, or is directly and reasonably affected by the conduct of the professional person

(II) the purpose of the statement, i.e. the contents of the statement is ultimately beneficial to the third party or the statement itself is directed towards the third party

9.6.2. As to the tort of negligence generally, two remarks are justified

First, under CAPARO, the imposition of a duty of care depends on proximity, foreseeability and whether it is just and reasonable to do so The third element is a policy element Although it is said to be principled, it cannot escape this description It is a safety net for the courts to avoid implications of liability that are not desired, not only for the specific defendant but also for society generally In Ireland, the courts refer to the second stage in the Wilberforce test,<sup>135</sup> and are, accordingly, more inclined to award damages without being subjected to a

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<sup>135</sup>ANNS v MERTON LONDON BOROUGH COUNCIL [1978] A C 728 at 751

wider restriction policy

Second, the proximity element causes interpretation difficulties. At present it is described as a label and causes uncertainty. The interpretation depends on the type of care owed by the tortfeasor by analogy to existing case law. This has been illustrated previously. Under CAPARO proximity refers to the ability to identify people who rely on statements and act accordingly.

The decision in, for example, *WHITE AND ANOTHER v JONES AND OTHERS* [1995] 1 All E R 691 refers to the defendant's knowledge that his conduct may affect others who do not necessarily rely on that conduct. This decision is by some commentators received as a return to an expansion of liability, a retreat to *ANNS v MERTON LONDON BOROUGH COUNCIL* [1978] A C 728.<sup>136</sup> In Ireland, proximity is understood as the foreseeability of the consequences of one's actions or statements to others.

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<sup>136</sup>See, *inter alios*, Murphy (1996), *infra* Subparagraph 2 7 7 and Greenfield & Osborne (1995), *infra* Subparagraph 2 7 8

## Chapter 10

### Professional Autonomy and Responsibility

#### 10.1. Introduction

10.1.1 The thesis has analyzed and described in the previous Chapters the concept of professional negligence in Ireland. It emphasized that the professions have a certain autonomy accorded to them in solving matters of negligent conduct. The thesis pointed out that the professions are in most cases well capable to take this responsibility.

Although it may appear to be something of a big jump, the thesis analyzes in this Chapter the decision in *RE A WARD OF COURT* [1995] 2 I L R M 401. This case has little to do with the concept of professional negligence, it dealt with the withdrawal of treatment of a *non compos mentis* patient. However, the case does show what is at present wrong with the medical profession in Ireland. The decision in *RE A WARD OF COURT* seems to indicate that the medical profession is less likely to take responsibility of decisions for which they are best equipped.

This is not to say that all decisions in the realm of the doctor-patient relationship require clinical or professional judgment. Decisions on controversial medical

matters deserve a balanced discussion within the medical profession in order to provide the individual practitioners with a set of parameters within which they can exercise their duties. This discussion involves not only clinical considerations but must also include matters of an ethical and professional nature, having regard to (i) the requirements of society and (ii) the demands of the individual practitioner.

The medical profession, and indeed other professions, must adopt a "front-runner" role in fulfilling medical questions and dilemmas. The legislature can anticipate on it and may consider whether certain issues demand legislation for the protection of the public and the medical practitioner alike. In each instance, a long term option must be preferred for the solution of societal problems. The courts should not only attempt to solve individual problems piecemeal. In situations where the courts are asked to adjudicate on these matters they seek to do this with the utmost clarity and understanding. The decision, subsequently, must be adhered to.

It may well be that the medical profession's status or autonomy is under threat. An example of the unwillingness to accept responsibility is found in the medical profession's reaction to the decision in *RE A WARD OF COURT*, on the withdrawal of treatment. The court laid down the foundation upon which life can legitimately be withdrawn. It also defined types of treatment and cause of death. Normally, this is or should be a task for the

medical profession

Indeed, it now appears as if the medical profession seems unwilling to give effect to the judgment. However, in the long run it is unlikely that the medical profession, or professions generally, will fail to give effect to a conclusive order. Nevertheless, the reluctance that is shown by the Medical Council may indicate that the medical profession may effectively be uttering its "last gasp"

The decision in RE A WARD OF COURT [1995] 2 I L R M 401 raised a number of issues that involved questions about the scope and autonomy of professional medical judgment. In this sense the decision may be relevant to the concept of professional negligence. The case illustrated the surfacing conflicts between judicial authority and professional discretion, whereby the autonomy of the medical profession must yield for the application of the law and, perhaps, the common good. In the words of O'Flaherty J -

[I]t would be strange if our courts which are called upon to pronounce on so many issues touching the welfare of the individual [ ] would not be regarded as having the necessary jurisdiction, not to say expertise, to adjudicate on an issue of such paramount importance as is embraced by the instant case<sup>1</sup>

10.1.2. This Chapter sets out the implications of the recent Supreme Court decision and examines its significance for professional negligence with regard to consent and

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<sup>1</sup>[1995] 2 I L R M 401 at 430-431

allied issues It also discusses the discrepancy between professional and ethical conduct and sets out the consequences for the medical profession in Ireland

## 10.2. RE A WARD OF COURT The Facts

This case dealt with a woman who for some twenty years suffered grave brain damage following a minor gynaecological operation under general anaesthetic As a result she had since then spent her life in a persistent, or near persistent, vegetative state (P V S ) Completely dependant on others she required full time nursing care The early signs of recovery faded She was artificially fed, first by means of a nasogastric tube which, after having found this to be distressing, was replaced under general anaesthetic by a gastrostomy tube in 1992 This tube had to be surgically replaced several times Her routine medication included morphine, valium and melleril Her cognitive functions appeared to be minimal eye-tracking, showing distress or recognition, reaction to pain-stimuli and pulling out of the nasogastric tube However, there was little or no evidence whether these reactions were intentional or whether they were reflexes from the brain stem During this time the patient was made a ward of court

In the spring of 1995 the Committee (the mother) and the family of the ward applied to the trial judge, assigned

by the President of the High Court with the jurisdiction,<sup>2</sup> requesting an order enabling the family to withdraw the artificial means of nourishment. They also asserted that, according to Article 41.1 of the Constitution, 'it was the family's prerogative, acting in the best interest of the Ward [sic], to decide whether the life support [ ] should be maintained or withdrawn'.<sup>3</sup>

The trial judge, Lynch J, agreed that the Committee and the family acted *bona fides* and acted, as they did, solely in the best interest of the ward. He consented, on behalf of the ward, to (i) the withdrawal and termination of the abnormal and artificial means of nourishment, (ii) the non-treatment of infection or other pathological conditions and (iii) he authorized the family to make such arrangements to transfer the ward to an institution whose ethics and philosophy agreed to pursue the above two declarations.

Lynch J rejected, however, the argument that it was the family's prerogative to decide whether treatment should continue. The views of the family carried weight in his decision, but the trial judge held that it was for him to decide being endowed with the *parens patriae* jurisdiction.<sup>4</sup>

The Attorney General, the institution in which the

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<sup>2</sup>See subsection 9(1) of the Courts of Justice Acts, 1936 and section 9 of the Courts (Supplemental Provisions) Act, 1961.

<sup>3</sup>[1995] 2 I L R M 401 at 413.

<sup>4</sup>Cf RE J (A MINOR) [1990] 3 All E R 930 at 941, *per* Balcombe J.



ward was treated and the Solicitor General who was made *Guardian Ad Litem* appealed the decision to the Supreme Court. The Committee and the family applied to vary the judgment. The appellants generally held that the decision of the trial judge was contrary to the Constitution and that he was not entitled to make such a decision.

The Supreme Court dismissed the appeal (Egan J dissenting) and maintained that the withdrawal of treatment was lawful. But, the Supreme Court failed to support its decision with a clear and convincing analysis of the various constitutional issues.<sup>5</sup>

### 10.3. Artificial Hydration and Nutrition Treatment or Not?

10.3.1. An important aspect of the *WARDSHIP* case was whether the nourishment of the ward, by means of a nasogastric and later a gastrostomy tube, constituted medical treatment for which consent was required. It was held by the trial judge that the provision of nourishment constituted medical treatment. This finding was supported by the Supreme Court. The trial judge found that it was artificial and therefore abnormal. In this he was supported, according to Blayney J,<sup>6</sup> by 'clear expressions

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<sup>5</sup>For a comprehensive review of these (and other) aspects of the case, see Tomkin & Mc Auley (1995b 45-50)

<sup>6</sup>[1995] 2 I L R M 401 at 443

of opinion' made in an American case In CRUZAN v DIRECTOR, MISSOURI DEPARTMENT OF HEALTH (1990) 110 S Ct 2841 it was held that, because the feeding-technique involved a surgical operation implanting the gastrostomy tube into the patient's stomach through incisions in her abdominal wall, '[a]rtificial feeding cannot readily be distinguished from other forms of medical treatment' <sup>7</sup>

The submission that the treatment became normal because it had been administered for so long was not upheld by both the High and Supreme Court Lynch J in the High Court argued that the essential nature of the treatment could not be changed by reason of duration In addition, he stated that, in his view, "normal" must be regarded differently from "getting used to" In other words, '[i]t may be that a patient may get used to the abnormal artificial method of providing nourishment [ ], but that does not make the tube feeding normal' <sup>8</sup>

Another factor which was considered, was whether the artificial nourishment by means of a nasogastric and, later, a gastrostomy tube was an intrusive and invasive type of treatment which interfered with the bodily integrity of the ward Denham J argued that the exercise of medical duties constitute treatment if consent is needed, and it is invasive if there is no element of co-operation by the patient If there was co-operation,

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<sup>7</sup>(1990) 110 S Ct 2841 at 2857, per O'Connor J

<sup>8</sup>RE A WARD OF COURT, High Court, Unreported, 5 May 1995, Lynch J at 21

according to Denham J , in the form of, for example, ingesting or inhaling, the voluntary effort would each time reveal the patient's consent to her carers. Consequently, it did not matter whether the treatment was 'ordinary' (a simple medical procedure) or 'extraordinary', constituting a gross and disproportionate interference with the ward's bodily integrity<sup>9</sup>

It was also debated whether the provision of nourishment and hydration merely constituted ordinary care. It was submitted that they were basic needs of every living being, even where a person cannot take in nutrition voluntarily and on his own account. This was not upheld. Both Lynch J in the High Court and the Chief Justice compared the provision of nutrition to an involuntary patient with the insulin injection for the diabetes and the mechanical provision of oxygen to those who cannot take in air voluntarily. It was not an issue whether or not treatment was curative and merely intended to prolong life. In the context of the ward's situation therefore, food or insulin or air prolonged life as a matter of treatment. In all other situations medical practice was not treatment but simply medical care.

**10.3.2.** The consequences of this aspect of the decision require analysis. On the one hand, it may seem unimportant that nutrition and hydration constitute "medical treatment", it could be argued that this is a forensic

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<sup>9</sup>RE A WARD OF COURT [1995] 2 I L R M 401 at 456

truism But, on the other hand, it could be argued that in distinguishing, as Lynch J did, between various sorts of medical treatment, and consenting to the withdrawal of nutrition and hydration, but permitting the continuation of administration of medication such as morphine and valium, the Court is effectively making a complex decision, with an end point that is far from clear Surely, the consequence of Lynch J 's judgment must be that, in withdrawing nutrition and hydration, but permitting the continuance of palliative care involving morphine and valium, the High Court is effectively "easing the transition between life and death"

Were the High and Supreme Court judgments to be taken literally, it can only be that they are permitting or even compelling what would otherwise be explicitly unprofessional conduct, namely the termination of life by withdrawal of some medical treatment and the continuation of other medical treatment Hence, we pass from a world in which the limits of medical treatment are defined by the Medical Council under statute, to a situation in which, in exceptional circumstances, the judiciary may decide what is permissible and not permissible

Notwithstanding the fact that the courts have now become the adjudicator of the moment when medical care may be withdrawn, the Medical Council chose to re-emphasize its own pre-existing Guideline,<sup>10</sup> and to purport thereby to

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<sup>10</sup>See A Guide to Ethical Conduct and Behaviour and to Fitness to Practice (1994) 4th Edition, Dublin The Medical Council (Article 43)

suggest that withdrawal of treatment on the lines suggested by the decision in RE A WARD OF COURT [1995] 2 I L R M 401 could be legally permissible but nevertheless constitute a breach of professional ethics, or professional misconduct <sup>11</sup> That the Medical Council has no power to assert that withdrawal of treatment constitutes a breach of professional conduct *ex ante* is supported by a reading both of the Medical Practitioners Act 1978 and the Constitution Any alternative reading would be to usurp the functions of the legislature and courts <sup>12</sup>

Hence, the first problem posed by this decision is that it represents one of the most significant departures by the Supreme Court into the area of medical practise in this generation, and the predictable reaction by the Medical Council must be ineffective

The second problem is the nature and extent of this departure or intervention Is the Supreme Court permitting euthanasia by another name, and if not, why does the order ensure that some but not all forms of medical treatment may be withdrawn?

#### 10.4 Consent to Treatment

##### The Implications of the Decision

10.4.1. It could be said that the WARDSHIP case defines

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<sup>11</sup>See, *inter alios*, Kerrigan (1995)

<sup>12</sup>See also Tomkin (1995), *supra* Subparagraph 2 6 7

medical treatment and consent thereto symbiotically  
Medical treatment is dependent on consent, if there is no  
consent it is either a crime, a tort or a breach of the  
constitutional rights of a patient. It is at least arguable  
that what defines medical treatment and sets it apart from  
the general run of unwarrantable interference with personal  
rights, is the particular nature of the consent  
accompanying it.

According to the WARDSHIP case it seems that medical  
duties which are intrusive and invasive, in the sense that  
they make up a violation of the right to bodily integrity  
(whether they are curative or not), constitute medical  
treatment for which consent is required. If this consent is  
not acquired by the doctor the violation of bodily  
integrity is unlawful and unconstitutional, except in  
certain circumstances of emergency.<sup>13</sup>

However, the Supreme Court's decision is ambiguous  
about the status and nature of consent to medical treatment  
in relation to other constitutional rights, other than the  
right to bodily integrity. On the one hand, treatment  
without consent is a breach of the "fundamental right of  
autonomy". But on the other, the fundamental and principal  
right is the right to life, and the principle of autonomy  
is - or must be - subordinated to the right to life. These  
principles are starkly contradictory, and explain why the  
right to resist medical treatment may involve the right to  
privacy or the right to be treated with dignity or the

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<sup>13</sup>See Tomkin & Hanafin (1995: 36)

right to autonomy

This contradiction could be explained, in the opinion of this researcher, in that there is no such right as a right to autonomy. Autonomy or self-determination is a device by which man can exercise his fundamental rights, such as the right to life, the right to bodily integrity, etc. Being able to choose for one self, to take responsibility for one's own actions is the essence of autonomy. In the WARDSHIP case the ward cannot exercise her autonomy. It can even be asserted that she has lost her autonomy on the basis that she is *non compos mentis*. As a consequence, it can be debated whether autonomy can be exercised on her behalf. Nonetheless, it does not alter the fact that the court should come to a decision.

Furthermore, the question remains whether Denham J is right in asserting that the refusal may be "unreasonable"? She may be right in the sense that treatment can be refused for other than medical reasons.<sup>14</sup> What seems unreasonable from a doctor's or an outsider's point of view may seem reasonable in the eye of the patient. These "unreasonable reasons" need not be medical reasons *per se*, but can be based on personal or private considerations.<sup>15</sup> In addition, it may not be facile to assess whether refusal of treatment is unreasonable or not. In most cases this demands a subjective judgment. However, if there are no grounds based

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<sup>14</sup>[1995] 2 I L R M 401 at 454

<sup>15</sup>See, for example, RE C (ADULT REFUSAL OF TREATMENT) [1994] 1 W L R 29

on morality, common good or public order to deny the patient's refusal it seems inevitable that a doctor must respect the patient's refusal to give consent to treatment This line of thought was expressed in, *inter alia*, R v HALLSTROM, EX PARTE W (NO 2), R v GARDNER & ANOTHER, EX PARTE L [1986] Q B 1090 Lord Goff stated that -

unless clear statutory authority exists, no one is to be detained in hospital or to undergo medical treatment or even to submit himself to a medical examination without his consent This is true of a mentally disordered person as of anyone else <sup>16</sup>

The WARDSHIP case throws a new light upon the concept of consent and medical treatment Its implications seem to differ from previous decisions, which require analysis The development of the concept can be divided into three stages First, the stage before the decision in WALSH v FAMILY PLANNING SERVICES LTD [1992] 1 I R 486 Second, the decision in WALSH and third, the decision in the WARDSHIP case <sup>17</sup>

10 4 2 Previous to WALSH the concept of consent to medical treatment was governed by the decisions in two English cases BOLAM v FRIERN HOSPITAL MANAGEMENT COMMITTEE [1957] 2 All E R 118 and SIDAWAY v BETHLEM ROYAL HOSPITAL GOVERNORS AND OTHERS [1985] 1 All E R 643

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<sup>16</sup>[1986] Q B 1090

<sup>17</sup>The decision in WALSH has also been discussed comprehensively in, *supra* Subparagraph 5 6 1



Generally, the test in BOLAM expressed the idea that a doctor is obliged to give certain information to his patient in order to gain his consent with respect to medical treatment. The quantity and quality of this information is assessed by the doctor himself and he is not negligent as long as he has complied with a practice approved of by a body of medical opinion. The same test was used for diagnosis and treatment.

In SIDAWAY this test was again applied by a majority of the House of Lords (Lord Scarman dissenting). In their view the application of the test was justified by the fact that a practitioner's duty to warn was 'as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient'.<sup>18</sup> However, Lord Scarman<sup>19</sup> opposed this line of thought. In his view it left the determination of a legal duty to the judgment of doctors. He supported the idea that the patient has a right to make up his own mind in the light of the relevant information regarding treatment.

In Ireland the law governing medical negligence was debated in DUNNE v NATIONAL MATERNITY HOSPITAL [1989] I R 91. It was held that - but only with regard to diagnosis and treatment - the BOLAM test does apply but subject to patent defects. This meant that where a doctor relied upon a general and approved practice which did not carry an inherent defect, he is not liable.

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<sup>18</sup>[1985] 1 All E R 643 at 659, per Lord Diplock

<sup>19</sup>*Ibid*, at 645

An action based on a lack of consent was not yet an issue In DANIELS v HESKIN [1954] I R 73 the issue of information was addressed, but it must be pointed out that this became an issue after treatment had commenced Nevertheless, it was held that non-disclosure of information must be reasonable in the circumstances based on the professional judgment of the medical practitioner

10.4.3. So far, lack of consent, based on the insufficient provision of information lead to liability in the tort of negligence In WALSH - the first Irish case to deal comprehensively with information and consent - a number of facts were addressed

First, it was argued whether an action could be brought in assault or battery in failing to advise a patient regarding the consequences of an operation It was held by the Supreme Court, reversing the High Court's decision on this point, that an action could be brought in battery or assault only when there was no consent given prior to the treatment, or 'where an apparent consent has been vitiated by fraud or deception' <sup>20</sup> In cases where lack of informed consent is argued an action must be determined on ordinary negligence principles

It is clear that in WALSH the concept of consent was addressed two-fold The Supreme Court first addressed the situation where no consent was given prior to treatment This could lead to assault or battery Secondly, the court

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<sup>20</sup>[1992] 1 I R 496 at 513, per Finlay C J

dealt with the situation where consent was given prior to the treatment based on the provision of information, but it appeared that this information was insufficient and therefore the consent was unsupportable. It was argued in retrospect that the information was not sufficient for the patient to consent to treatment.

Second, the case addressed the issue of professionalism, the nature of the doctor-patient relationship regarding the provision of information. What kind of information is needed, is it confined solely to treatment options or does it go beyond that, taking into account the patient's expectations with regard to, for example, the performer of the operation, as was the case in *WALSH*? At this stage a distinction must be made between the situation where particular information has not been given and the situation where information has been given but was not complied with. Regarding the latter it can be argued that the counsellor/doctor has raised the legitimate expectations of the patient.

Third, the judges are divided with regard to the principles governing the quantum of information a medical practitioner is obliged to provide. It must also be borne in mind that an operation can either be elective or required. For the former, a higher amount of information may be expected.

Two opinions were expressed by the Supreme Court in *WALSH*. According to McCarthy J,<sup>21</sup> disclosure is a question

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<sup>21</sup>[1992] 1 I R 486 at 520

of professional skill and judgment the doctor has a duty to provide information which is obviously necessary for the patient to make an informed choice

O'Flaherty J , on the other hand,<sup>22</sup> expressed the opinion that a patient has an almost absolute right to be informed of all consequences of treatment, in particular in the event of elective surgery, regardless the discretion of the doctor However, this absolute right is qualified, if "therapeutic privilege" demands the non-disclosure of information

10.4 4. In the RE A WARD OF COURT [1995] 2 I L R M 401 it was again firmly established that consent is a precondition to medical treatment, i e artificial nutrition and hydration A patient has a right to refuse treatment The consent is, according to Denham J , 'a matter of choice It does not necessarily have to be based on medical considerations' <sup>23</sup>

However, this right is not an absolute It can be overruled by public order, the common good or morality For example, in cases of contagious diseases the right to refuse treatment can be set aside in the name of the common good or public order The right to bodily integrity may also be overruled when it cannot be harmonized with a constitutional right of another or when it conflicts with

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<sup>22</sup>*Ibid*, at 535

<sup>23</sup>[1995] 2 I L R M 401 at 454, per Denham J

morality <sup>24</sup>

It is clear from the WARDSHIP case that the right to refuse treatment implied the application of a number of constitutional rights. However, it has not been made clear in which order those rights should have been ranked. First, the constitutional right to bodily integrity, second, the constitutional right to privacy and third the constitutional right to life. At the same time the right to refuse treatment implied the exercise of self-determination and individual autonomy. For this reason it seemed that Denham J asserted that the right to consent did not necessarily have to be based on medical considerations, although this is paramount in a normal situation. Instead, Denham J asserted that the right to consent is a matter of choice. In this case it was a choice to have treatment continued or withdrawn, or, less euphemistically spoken, a choice between life and death. This strongly implied the exercise of the right to life, which is materialized by refusing treatment to maintain the right to bodily integrity and privacy. It follows that the right to life must be ranked higher than the other rights in this case. The latter are subordinated to the right to life. The ward was not anxious to give an informed consent, she did not want to consent at all.

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<sup>24</sup>For example, in the situation of a pregnant woman, who refuses to give consent to her doctor for treatment in order to save the life of the unborn child she is carrying. A complication may be added whether it is the child who needs treatment in the womb or whether the woman needs treatment herself, which could result in the death of the child if it is not carried out.

In this sense, a violation of the right to consent may lead, according to the decision in WALSH v FAMILY PLANNING SERVICES LTD [1992] 1 I R 486, to assault or battery if consent was not given or vitiated by fraud or deception. Alternatively, it may lead to a breach of the constitutional right to bodily integrity if this violation was deliberate, conscious and unjustifiable.<sup>25</sup>

10.4.5. It follows that with regard to the concept of consent two positions must be firmly distinguished. In the first position no consent is given whatsoever. In the second position consent is given but is based on insufficient or inadequate information.

With regard to the former position it implies a right to bodily integrity. In the researcher's view, it deals with cases where a doctor goes beyond the powers granted to him by his patient. The patient did not consent to a specific form of treatment or any treatment. For example, if a doctor realizes during the first operation that the patient needs a second operation which he can perform at the same time he will violate the patient's bodily integrity if he does not ask for consent with regard to the second operation. The excuse that it would be convenient for the doctor cannot be upheld. It must be necessary, i.e. it would be unreasonable to postpone the second

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<sup>25</sup>Cf KENNEDY & ARNOLD v IRELAND [1987] I R 587, [1988] I L R M 472

operation <sup>26</sup> Denham J argued therefore, quite rightly, in her summary that consent should be obtained before medical treatment is administered. However, in cases of emergency, consent is implied if the patient is unconscious and the treatment was required in order to save the life of the patient or to preserve his health <sup>27</sup>

Where a breach of consent leads to negligence it is asserted that it implies a violation of the right to be informed. It indicates that the patient already made a concession towards his doctor to have a medical problem solved, be it elective or required. In this situation a doctor omitted to provide sufficient information and failed to regard the (legitimate) expectations of a prudent patient or the doctor did not adhere to an approved or accepted practice.

However, a doctor can under specific circumstances rely on therapeutic privilege. This privilege implies that a doctor can make the necessary decisions he thinks are fit to make during the course of the doctor-patient relationship. It does not solely apply on emergency situations, a doctor may rely on this privilege 'where prevailing medical standards hold that disclosure of certain facts would have a detrimental effect on the

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<sup>26</sup>Cf MURRAY v MCMURCHY (1949) 2 D L R 442 and MOHR v WILLIAMS (1905) 104 N W 12

<sup>27</sup>Cf MARSHALL v CURRY (1933) 3 D L R 260 at 275. In PARMLEY v PARMLEY AND YULE (1945) 4 D L R 81, the Canadian Supreme Court stated that in an emergency, greater leeway must be given to doctors.

patient' <sup>28</sup> This is a matter of medical judgment, in other words, although a doctor is obliged to inform his patient, this obligation is, to a large extent, rescinded by his therapeutic privilege

Thus, there may be two types of unlawful treatment (1) violation of the right to bodily integrity without consent and (11) violation of the right to be informed prior to consent. The first type may lead to assault or battery (WALSH) or a breach of constitutional rights (RE A WARD OF COURT). The second type may lead to negligence (WALSH). It is based on the fact that a patient would not have undergone treatment if she had been properly informed. Her right to be informed was violated and therefore the patient could not make a proper decision towards the exercise or administration of treatment. It is not the fact that she did not consent to treatment, but the fact that she was not properly informed. It was not her bodily integrity which had been violated, it had been interfered with already. It was rather the violation of the relationship between doctor and patient in which the patient is both object and subject.

Finally, it must be added that a cause of action based on the insufficient provision of information is a modern development in Ireland and England. It is asserted that it has in recent years become a right to be properly informed, which can lead to negligence when it is shown that consent could not have been validly given. The idea that a patient

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<sup>28</sup>See Tomkin & Hanafin (1995 30)



requires proper provision of information - informed consent - stems from a number of American cases <sup>29</sup> It expresses the idea of the patient's autonomy <sup>30</sup> In CANTERBURY v SPENCE (1972) 464 F 2d 772 the court stated that the standard with regard to the patient's right to self-determination on his treatment or therapy was a matter of judicial judgment, not medical <sup>31</sup> However this is largely nullified by the exception of therapeutic privilege

In Ireland the notion of "informed consent" is not new, but it has, as of yet, not been defined or described by either the judiciary or legislature Nevertheless, it can be made clear that a doctor is obliged to provide his patient (or patient's guardian or parent) with information about the condition of the patient, the (side-) effects of treatment, and alternative forms of treatment The quantum of information depends on (i) the patient's capacity to comprehend and decide on the relevant issues, (ii) the quantum and nature of the risks involved, (iii) the patient's wish to be informed, (iv) the nature of the procedure and (v) the effect of information on the patient <sup>32</sup>

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<sup>29</sup>See, for example, SALGO v LELAND STANFORD JR UNIVERSITY BOARD OF TRUSTEES (1957) 154 Cal App 2d 560, 317 P 2d 170 and CANTERBURY v SPENCE (1972) 464 F 2d 772

<sup>30</sup>Cf SCHLOENDORFF v SOCIETY OF NEW YORK HOSPITAL (1914) 105 N E 92

<sup>31</sup>(1972) 464 F 2d 772 at 784

<sup>32</sup>For a comprehensive review on consent in Ireland, see Tomkin & Hanafin (1995 30-49)

10.5. The Quality of Life Argument  
and Professional Discretion

10.5.1. This section addresses the value of the arguments in the respective judgments with regard to the quality of life and life itself. What is the value of the dissenting judgment of Egan J and what is the role of the medical practitioner in prolonging life and maintaining the quality of life?

The majority of the Supreme Court held that in the underlying case, the quality of the ward's life was never an issue and had never been an issue. She was alive but, according to O'Flaherty, 'she ha[d] no life at all' <sup>33</sup> The ward had to be distinguished from a severely mentally handicapped person, who is 'conscious of her situation and is capable of obtaining pleasure and enjoyment of life', even when she was not fully P V S <sup>34</sup>

Somehow this appeared to be an arbitrary statement, because it was not made clear in the evidence whether the ward was fully P V S or whether she had some, although extremely minimal, cognitive function. However, according to this researcher, the supposition appeared to be justified by the majority judges with the argument that the case was not about whether life was meaningful or not, and on that basis have treatment withdrawn. Instead, the case was about having nature take its course, based on the

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<sup>33</sup>RE A WARD OF COURT [1995] I L R M 401 at 432

<sup>34</sup>*Ibid*

presumption that every individual has a right to life which is exercised in this particular case by refusing treatment

Egan J could not agree with this line of thought <sup>35</sup> In his view it would require a strong and cogent reason to justify, in the light of the Constitutional guarantees, the taking of a life He argued that the ward still had some cognitive function Therefore, it was impossible and prohibited to draw a line He did not seek a common principle found in other cases <sup>36</sup> Cognitive function was absent or not If it was not, any effort to measure its value would have been dangerous Hence, the court could not have been able to make a decision whether treatment should have been withdrawn

Whereby the majority of the Supreme Court questioned the maintenance of life itself, Egan J argued that the judiciary cannot make a decision to withdraw treatment which is based on an assessment of the quality of life In his view, according to this researcher, this can only be done by the patient or ward herself if she had had a moment of *compos mentis* A decision which could lead to an inevitable outcome is not one the court can make on behalf of a patient who has some cognitive function, despite a constitutional guarantee of equality under the law If she was fully P V S a value judgment need not be made In this situation the quality of life is not an issue, nor need it

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<sup>35</sup>*Ibid* , at 437

<sup>36</sup>See, for example, AIREDALE N H S TRUST v BLAND [1993] A C 789

be an issue

10.5 2. Where a decision needs to be made the judges agree that this must be done in the best interest of the patient. The majority of the Supreme Court agreed that a decision can be made regardless of the mental state of the patient, because it attached value to the equality rule. Egan J argued that a decision can only be made where a patient has no quality of life whatsoever. In any other situation it is not up to the court to come to a decision. This does not mean, in the opinion of this researcher, that a patient is left to her own fate.

The medical profession in this case was predominantly concerned with the maintenance of life itself. This is illustrated with the fact that the doctor argued that, even if the ward was fully P V S, his attitude would not have changed towards the treatment she received, although it did not improve the quality of the ward's life. Whether this is standard medical practice is another question and differs from country to country, based on moral, ethical, social and philosophical considerations. It can, however, be asserted that the Medical Council accepts the maintenance of life in this particular situation (a *non compos mentis* patient who has extremely minimal cognitive function) as standard medical practice and non-compliance may constitute professional misconduct although legally permissible. In normal situations the medical profession has the discretion to decide or advise what is in the best interest of the

patient<sup>37</sup> The doctor's autonomy is normally vitally important with regard to decisions concerning the quality of life However, in this case (a ward in a particular medical exigency) the *parens patriae* jurisdiction of the court overruled the authority of the medical profession with regard to the exercise of its medical and legal duties

Can it be argued that in cases where a doctor cannot satisfy the demands of a patient and a conflict arises between supply and demand, the medical profession loses its collegiate characteristic and one or both parties instigate mediation from a third party?

In a normal situation - where a patient is *compos mentis* - a doctor-patient relationship is, according to Tomkin & Hanafin,<sup>38</sup> and argued by this researcher throughout the thesis, governed by a collegiate model In this model the doctor defines the needs of the patient and determines the way those needs are satisfied,<sup>39</sup> for example, the type of treatment and the degree of information which should be provided to the patient In doing so, it is between the doctor and patient to come to decisions with regard to treatment and other forms of medical care

In the underlying case there was a conflict between

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<sup>37</sup>See, for example, the decision in *GILLICK v WEST NORFOLK AND WISBECH AREA HEALTH AUTHORITY AND ANOTHER* [1985] 2 B M L R 11

<sup>38</sup>(1995 12)

<sup>39</sup>See Turner (1987 136-137)

the patient and the medical carers with respect to her needs and her desire in the way those needs should have been satisfied. Here, wherein the patient is *non compos mentis*, the decision making process enters a dead-lock which needs to be resolved by third party intervention. The status of the patient in the underlying case - a ward of court - made it obvious that intervention needed to be judicial.<sup>40</sup>

However, it was submitted by the counsel for the institution where the ward was cared for that, in relation to the exercise of self-determination, no one could have made a decision on her behalf, due to her incapacity she had lost the 'right of choice'.<sup>41</sup> In these situations the decision should have been made by the court using an 'objective medical standard', taking into account, *inter alia*, 'the views and opinions of the medical attendants and carers'.<sup>42</sup> In other words, the court should have applied a standard which conformed to accepted medical practice which, in this case, appeared to necessitate the continuation of treatment or, according to appellants, normal medical care.

This was not upheld by the Supreme Court. The ward's constitutional rights could not be restricted. It would

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<sup>40</sup>In *RE DANIEL FIORI* (1995) 652 A R 2d 1350 the majority of the court held that only where a conflict arises between the medical carers and the family (or other carers) with regard to the withdrawal of treatment, court intervention was necessary.

<sup>41</sup>[1995] 2 I L R M 401 at 451, *per Denham J*

<sup>42</sup>*Ibid*

have meant a violation of her right to equality under Article 40 1 of the Constitution. The decision must be made on her behalf and in her best interest, taking into account the wishes of the family.

At this moment the doctor-patient relationship came effectively to an end. The medical profession could no longer and was no longer asked to define the needs of the patient in this particular situation. Instead, the needs were defined by the family on behalf of the ward and under Article 41 1 of the Constitution. Subsequently, the court was asked to intervene and come to a decision. This hints towards another model: mediation. In this model a third party (often the State) intervenes between professional persons and their clients.<sup>43</sup> In this case the court was asked to intervene between the medical profession and its patient to regulate professional activities and practice. Generally, it is argued that in the application of this model the State increases its control and management of the professions.<sup>44</sup>

This needs careful consideration. The court, endowed with the *parens patriae* acted on behalf of the patient, as if it was the patient herself making the decision. At the same time however, it was forced to resolve a conflict between two parties. A number of aspects may help clarify this position. First, the test which was used - the "best interest" test - needs consideration. Second, the role and

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<sup>43</sup>See Turner (1987 137)

<sup>44</sup>*Ibid*

nature of the court in this decision making process demands deliberation, ought its role to be adversarial or inquisitorial?

10 5.3 In deciding this case the court employed the "best interest" test. This test is logically not determined by means of professional judgment, wherein professional opinion obviously does not alter by an express desire of a patient (or a desire submitted on her behalf). This is evident because professional judgment exercises a professional centred approach, it reflects a certain medical practice based on esoteric knowledge and normally accepted or approved of by the members of the profession.<sup>45</sup> In addition, the decision in this case was one which was thought of not being exclusively in the domain of professional opinion or expertise.

However, the trial judge also considered evidence with regard to the ward's dislike of hospitals and treatment and other factors. In doing so, he took into account the wishes of the ward and concluded that the evidence was clear and convincing that the ward - if she had a moment of mental

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<sup>45</sup>However, in *F v WEST BERKSHIRE HEALTH AUTHORITY* [1989] 4 B M L R 1 at 2, it was held that 'in determining whether the operation [sterilization] was in the best interest of the patient the court should apply the established test of what would be accepted as appropriate treatment at a time by a reasonable body of medical opinion skilled in that particular form of treatment', the BOLAM test applied. In this case the patient suffered from a mental disability and had the capacity of a child. She had formed a relationship with a male patient in the hospital and the staff considered that, based on medical evidence, it would be in her best interest to sterilize her.



competence - would deny treatment This is a substituted judgment, which has been applied on its own in other cases <sup>46</sup> The courts use this test when the surrogate decision maker can demonstrate the preferences of the incompetent patient with reasonable certainty According to O'Flaherty J , this test cannot be adopted in this case without the foresight of the ward to 'provide for future eventualities' <sup>47</sup> It seemed to him that the evidence was not sufficient in this case to reasonably ascertain the ward's own view For this reason the "acid test" had to be in the best interest of the ward

The court was assumed to adopt the attitude of a 'responsible parent' and had to come to its decision in the best interest of the ward <sup>48</sup> This implied that the wishes of the family or others concerned could not prevail, but were taken into account The nature of the *parens patriae* was therefore "child-or-individual centred", rather than "parent-or-carer centred" Nonetheless, this can be argued The best interest test remains an extremely subjective test and its decision making process is not without prejudice towards the patient, the family and perhaps society as a whole An objective medical test on the contrary, bases its decision on knowledge and expertise and the outcome is not an assessment of other considerations, it is "professional-

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<sup>46</sup>Reference was made to the decision in RE DANIEL FIORI (1995) 652 A R 2d 1350

<sup>47</sup>RE A WARD OF COURT [1995] 2 I L R M 401 at 434

<sup>48</sup>Cf RE J (A MINOR) [1990] All E R 930 at 941, *per* Balcombe J

centred"

In exercising this parental duty it became clear that there was a conflict between this duty and the medical duty of those upon whom the ward relied for care and treatment. In other words, a conflict between professional discretion and the law. It appeared that the professional discretion - the medical duty - did not take into account the best interest of the ward from her perspective. Instead, it employed a professional and collective and common centred attitude by asserting that the ward was best served by employing a medical standard and holding that '[i]f society can sustain life then life must be sustained' <sup>49</sup> This was based on the contention that the ward was not terminally ill and that there was an element of cognition.

The court order by Lynch J prevailed over the duty of a doctor to his patient. '[t]he decision of the Court is in accordance with the Constitution and the law and is wider than the doctor's clinical judgment' <sup>50</sup> It was said to be wider, because it took into account other factors. Those factors were only partially addressed by the Supreme Court judges: the best interest of the ward and the wishes of the family. Tomkin & Mc Auley<sup>51</sup> have proposed a number of other factors which the courts may take into account, i.e. the degree of humiliation and dignity, the various treatment

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<sup>49</sup>[1995] 2 I L R M 401 at 448

<sup>50</sup>*Ibid*, at 462

<sup>51</sup>(1995 48) In doing so the writers relied on, *inter alia*, the decision in RE DANIEL FIORI (1995) 652 A R 2d 1350

options and their effect on life expectancy and prognoses

However, the case made clear that the court had to consider legal ethics against medical ethics. The former encapsulated the idea that the ward's constitutional rights could not be taken away or replaced by some other (medical) standard.

10.5.4. It was argued by Blayney J whether the court's function in the WARDSHIP case was either adversarial whereby the court should approach the case as *lis inter partes*, or inquisitorial of character.<sup>52</sup> In the former, the court is confined to the evidence produced by the opposing parties, on the basis of which the court must come to a decision. Blayney J, however, expressed the opinion that in the underlying case the trial judge need not have exercised the adversarial function. He established this finding, relying on the judgment of Lord Ashborne in *RE BIRCH* (1892) 29 L R Irl 274. His Lordship stated that being endowed with the jurisdiction of a ward of court the assigned judge is free in directing 'such enquiries and examinations as justice [ ] may require'.<sup>53</sup>

This line of thought logically correlates with the "best interest" test. If a judge considers that further inquiry is necessary to come to a proper decision in the interest of the ward, he should be free to conduct such inquiries.

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<sup>52</sup> [1995] 2 I L R M 401 at 444-445

<sup>53</sup> (1892) 29 L R Irl 274 at 276

## 10.6. The Consequences for the Medical Profession

10.6.1. Modern medical technology appears to give rise to two problems. First, the WARDSHIP case clearly illustrated that legal issues arose from conflicts between modern medicine and medical ethics. Second, there appears to be a conflict between the law and ethical and/or professional guidelines, issued by the Medical Council. The medical practitioner in the WARDSHIP case could, according to the Medical Council, be accused of professional misconduct in following a court order (the termination of treatment).

This demands careful consideration. If so, it would mean that a professional organization which is statutorily recognized, may have sanctioning powers as to what is legally permitted with regard to medical care and treatment.

On the one hand the law restricts medical development on the basis of ethical and other considerations (pharmaceutical testing, genetical research),<sup>54</sup> but on the other hand the law values, in the WARDSHIP case, medical ethics as burdensome for the solution of particular legal and constitutional problems.

It is made clear from the case that previous certainties are affected by modern medicine. The concept of death has changed. The time and manner of death are no

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<sup>54</sup>See, for example, the Pharmacy Act, 1977, the Misuse of Drugs Act, 1977 and the Control of Clinical Trials and Drugs Act, 1990.

longer dictated by nature but are, in many instances, determined by human decisions. At the same time there seems to be a conflict as to who must take responsibility for these decisions. Modern medical technology has resulted in some instances in -

rendering a patient a prisoner in a ward from which there may be no release for many years without any enjoyment or quality of life indeed without life in any acceptable meaning of that concept except in the sense that by means of various mechanisms life is kept in the body <sup>55</sup>

The current state of the ward was a result from an application of modern medical science, according to Denham J. Without it, she said, 'she would not have long survived a catastrophe over twenty years ago' <sup>56</sup>. The case illustrated the problems arising out of modern medical technology and consequent legal issues.

In *CRUZAN v DIRECTOR, MISSOURI DEPARTMENT OF HEALTH* (1990) 497 U S 261, 110 S Ct 2841, Brennan J. posed the question whether the ward is a 'prisoner of medical technology' <sup>57</sup>. If so, 'is it', according to Denham J., 'in

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<sup>55</sup>RE A WARD OF COURT [1995] 2 I L R M 401 at 433. See also *RASMUSSEN BY MITCHELL v FLEMING* (1987) 154 Ariz 207, 741 P 2d 674. In this case the Supreme Court of Arizona stated '[a]s more individuals assert their right to refuse treatment, more frequently do the disciplines of law, medicine, philosophy, technology, and religion collide'

<sup>56</sup>*Ibid*, at 445

<sup>57</sup>(1990) 110 S Ct 2841 at 2864

keeping with her right as a human person to dignity'<sup>58</sup>

With regard to the conflict between the law and medical ethics in the underlying case, the paramount question is not whether care can be given, but whether care should be given

10.6.2. The decision of the Supreme Court, approving of the court order directed by Lynch J, permitted the withdrawal of treatment from a nearly P V S patient, who was a ward of court. Apart from the constitutional consequences this case raised and affected society as a whole, a number of other consequences have been inferred in this section in relation to the medical and para-medical professions

With regard to the medical profession the case may indicate a decline of its autonomous and independent status towards those characteristics. It is asserted by Tomkin & Hanafin,<sup>59</sup> and this researcher, that the medical profession employs a collegiate model, whereby the doctor is the gap-filling authority between esoteric knowledge and its practical application.<sup>60</sup> However, did the issues at stake demand the practical application of esoteric knowledge only? The discussion showed that the issues primarily evolved around the right to life. This was interpreted by a majority of the Supreme Court to allow nature take its

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<sup>58</sup>RE A WARD OF COURT [1995] 2 I L R M 401 at 461

<sup>59</sup>(1995 11-12)

<sup>60</sup>See Turner (1985 42)

course by refusing to consent to treatment (as an act of self-determination and individual autonomy)

The underlying case dealt with a patient who was a ward of court and was nearly P V S with some, but extremely minimal cognitive function. This gave rise to a number of conflicts regarding, *inter alia*, the nature of the treatment, the nature of the illness, professional discretion and medical duty, professional judgment, modern medicine and the quality of life. In other situations this conflict does not seem to appear. It is known, according to Cusack,<sup>61</sup> that in cases of patients with severe compromised lung function, treatment is often withdrawn.

The thesis asserted that the Supreme Court was a mediator in solving the disputes. The court explained the essence of the dispute and defined matters of a medical nature. It defined the nature of the treatment as medical treatment (not medical care) and it defined the nature of the illness as being terminal, stating that the initial operation would be the ward's cause of death.

The court proceeded to set a standard by which the demands or desires of the patient could be assessed. Instead of depending on professional and medical judgment, the court favoured to take into account the best interest of the patient. The problems, constituted by modern medicine, were addressed from a legal point of view, not by medical considerations alone.

Regretfully, the court employed an adversarial

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<sup>61</sup>Cusack (1995)

approach. It was confined to the evidence produced by the opposing parties. If it had opted for an inquisitorial approach, as suggested by Blayney J, it would have been free to conduct inquiries on its own behalf and to exercise its jurisdiction solely in the interest of the ward.

Essentially, the role of the medical profession in this case was decreased to maintain or prolong life. The medical practitioners involved in this case were unwilling to consider alternatives and were, subsequently, unwilling to exercise the court order.

O'Morain,<sup>62</sup> among others, indicated that the issues which remain unresolved include the way the relevant professional bodies shall respond to the decision. An Bord Altranais (the Nursing Authority) told its members that in this case they could not 'participate in the withdrawal and termination of the means of nutrition and hydration by tube'.<sup>63</sup> The attitude of the Medical Council remains unresolved thus far.<sup>64</sup> It only stipulated that access to nutrition and hydration was one of the basic needs of human beings. It could not advise its members in individual cases. It appears that participation in the court order could lead to an act of professional misconduct. It is hard to see how professional bodies can punish members for acting in accordance with a ruling of the Supreme Court. It implies, according to this researcher, a conflict between

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<sup>62</sup> (1995)

<sup>63</sup> *Ibid*

<sup>64</sup> *Ibid*



the law, medical ethics and professional conduct

The role of the medical professional person is effectively reduced in this case to following an order which contravenes with his medical duties. His professional discretion is at stake. His legal position is uncertain and the position of the Medical Council towards the aspects discussed in the WARDSHIP case is not yet clear. Is it effectively controlled by the State (or courts), or shall it be able to make up its own mind and regain its autonomy in the exercise of medical duties? If not, what would be the consequences in the context of professional negligence?

Generally, it can be asserted that the medical profession is close to losing its autonomy and self-esteem, if it does not provide guidelines to demonstrate that it is able to adapt to societal change. Can it decide on the maintenance of human life and other controversial matters? Legislation, subsequently, must provide the framework for this burdensome prospect.

## Chapter 11

### Summary of Study

The thesis analyzes the duty and standard of care of the professional service provider in Ireland. Taking three professions as examples, it explains and discusses various models of professional negligence. The thesis concentrates on describing and defining the duty and standard of care in the context of professional negligence, since these are clearly seen to be the two distinguishing factors in the preferred version of the various models analyzed and discussed.

The thesis' novelty lies in the way in which it seeks to tie the questions of duty and standard of care to the concept of the profession, to received ideas about what constitutes professional conduct, professional relationships generally, and the scope and extent of professional duties and responsibilities.

The thesis reviews the case law and literature on negligence generally and professional negligence in particular. In the context of this review, the researcher establishes that there does indeed exist a special concept of professional negligence in Irish jurisprudence.

Though a complete review of the individual features of

professional negligence would be out of place in this context, it is suggested that the thesis clearly demonstrates that two of the distinguishing factors are the manner in which the courts first impose a duty of care and second assess what is the required standard of care

The review further explained that the concept of professional negligence does not refer solely to a general or a "broad-spectrum" duty to take ordinary care. This is endemic to all negligence cases. Specifically in the context of professional negligence, the courts concentrate on the consideration of the specific obligations and responsibilities of the individual professional. These obligations and responsibilities are not confined to the mutually agreed obligations within the professional relationship. They often reach further. This is particularly clear in cases where there is, prior to the negligent event, no pre-existing relationship between the plaintiff and defendant. Thus, the thesis emphasizes the reciprocity of conduct and concentrates on the activities of the professional person rather than simply examining the problem in terms of status.

The thesis also shows that the concept of professional negligence is applicable to those professions to which certain characteristics can be attributed. A key factor is uniformity of accepted practice within the "professional" cadre.

Three of the characteristic features contribute to this uniformity. These involve education, examination and,

subsequently, restriction of entrance to the profession  
All three are within the context of self-regulation and a  
requirement to adhere to codes of conduct

The thesis explains that these features are based on  
a theoretical underpinning to the more commonly understood  
skills and knowledge which characterize professional  
conduct. The profession will in general make significant  
and extensive decisions about this theoretical  
underpinning, although there may be input from outside the  
profession. Not only the nature but the amount of skill and  
knowledge is decided by the profession. Hence, the  
profession itself both by choice of the theoretical  
underpinning as well as its endorsement of practical  
standards creates a basis for some consensus or uniformity  
of practice within the profession.

The existence of some degree of uniformity within the  
professions assists the courts towards a particular method  
of inquiry of assessment of questions relating to both duty  
and standard of care. The thesis explains that this is  
particularly marked in the way in which courts consider  
general and accepted practice, and the extent to which  
deviations are not merely permitted but encouraged. Here,  
the thesis shows another specific feature inherent in the  
concept of professional negligence: the freedom to deviate  
from a decided practice within certain limits.

Yet another feature of professional negligence is the  
way in which the courts both can and must intervene, where  
experts of equal standing disagree on matters which are not

capable of solution by reference to agreed professional or scientific opinion

Up to this stage of the thesis, the researcher concentrates upon those features of the professions which are to some degree common. The researcher then moved to examine the differences between three professions (medical practitioner, solicitor and auditor/accountant) and how these differences may be explained. Significant differences were shown to be referable first to the nature and extent of "client" input into the definition of the relationship, and second to modification by considerations of public policy and third party expectation.

The thesis explains that there are a certain category of decisions for which professions are unwilling to take responsibility. Generally these decisions concern matters where broader societal implications are concerned. Particularly in Ireland, though also in other jurisdictions, the courts assume a special role. This is done even where, in so doing, the courts may curb the autonomy of the professional organization. Endorsement is ethically and professionally not desired by the profession. Subsequently, non-adherence to a court order may effectively render the profession as being out-played in matters of societal importance. This may have wider implications for the profession's autonomous position to set standards of professional conduct and practice. It is up to the profession itself to overcome this.

The thesis concludes with a question as to how if both

society and professions within society evolve, such changes contribute to the formation of "new" professions, and the decay of existing professions. Though the reasons for this mutation are beyond the scope of the thesis, the study does explain that one of the virtues of the concept of professional negligence identified in this thesis is that it is able to accommodate such changes. The concept employs certain criteria that necessitates a degree of formal uniformity within individual professions which ensure certainty and consistency. This is particularly important in the context of current changes within society, both as to how information is presented and used, and how the professions must redefine themselves by reason of the major changes in information provision. The prognostication of how such changes will affect future professions is however beyond the scope of this particular work.