Professional liability: what the law actually is

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On December 5, 1979 Lord Justice Donaldson, later to become Master of the Rolls and senior judge of the Court of Appeal, delivered a dissenting judgment in a major medical negligence case [1]. It was a case of alleged obstetric negligence, and it was finally decided by the House of Lords. It concerned an allegation of negligence against Mr Joe Jordan, then a senior obstetric registrar and now a distinguished consultant in the field. A female patient whose child he delivered, in what transpired to be a sadly and severely brain-damaged state, alleged that he had pulled "too hard and too long" on forceps. Mrs Eileen Whitehouse, the plaintiff, was legally aided and she fought her case, unsuccessfully in the event, to the House of Lords [2].

DIVERGENT JUDICIAL APPROACHES

Lord Justice Donaldson, as he then was, had been in favour of finding Mr Jordan legally liable for professional negligence. His two brethren in the Court of Appeal, Lord Denning and Lord Justice Lawton, disagreed with him; and so did the Law Lords. Nevertheless, the words chosen by Lord Justice Donaldson to describe the case before him remain a succinct and memorable expression of the basis of professional liability in medical practice. He said:

"Mr Jordan is entitled to think and to say that the judge's judgment was wrong. I cannot. But I can and do say this, if it is of any comfort to him. There are very few professional men who will assert that they have never fallen below the high standards rightly expected of them. That they have never been negligent. If they do, it is unlikely that they should be believed. And this is as true of lawyers as of medical men. If the judge's conclusion is right, what distinguishes Mr Jordan from his professional colleagues, is not that on one isolated occasion his acknowledged skill partially deserted him, but that damage resulted. Whether or not damage results from a negligent act is almost always a matter of chance and it ill-becomes anyone to adopt an attitude of superiority" [3].

Lord Denning, then himself Master of the Rolls, took an entirely different line. He began his judgment by stating categorically: "Being born is dangerous for the baby." That equally memorable commencement to his judgment coloured the whole of it. He described the state of Stuart Whitehouse, which was pitiful.

He described the distress and hard work on the part of Mrs Whitehouse, the child's mother. "The saddest part of it", he said, "is that she blames it all on the hospital and particularly on Mr Jordan, the surgeon who delivered the child." This expression of opinion was unnecessary to his judgment, and despite the traumatic effect of a negligence allegation upon a professional person, there are probably few practitioners who would isolate that trauma as the saddest part of a situation in which a patient is, however, innocently, pitifully affected.

Lord Denning had still to find the basis in law for acquitting the defendant of negligence. This he did with the following formulation: "We must say, and say firmly, that in a professional man, an error of judgment is not negligent" [4]. He was of course referring to professional medical practice, and a similar formulation of professional innocence despite mistakes is not to be found in other areas of professional liability. Everyone makes mistakes, but it is not, in law, negligence unless someone is injured or harmed. The essential elements of the tort, or civil wrong, of negligence are fourfold; a duty of care, which is breached by the failure to reach an acceptable standard of practice, leading, as a matter of cause and effect to the final element of damage or injury. As Lord Justice Donaldson put it, though more elegantly, in Whitehouse v. Jordan, it is an unlucky coincidence if somebody is harmed as well.

Judges are not sued, but they can be gently chided for steering the law in unsuitable directions. There were many who considered that Lord Denning had done just this in his Court of Appeal judgment in the Whitehouse case. Their suspicion was confirmed in the judgment of Lord Edmund-Davies in the House of Lords. His Lordship said:

"The principal questions calling for decision are: (a) in what manner did Mr Jordan use the forceps? and (b) was that manner consistent with the degree of skill which a member of his profession is required by law to exercise? Surprising though it is at this late stage in the development of the law of negligence, counsel for Mr Jordan persisted in submitting that his client should be completely exculpated were the answer to question (b), 'Well, at the worst he was guilty of an error of clinical judgment'."

It was unsurprising that Mr Jordan's counsel should have so submitted, for the argument he employed reflected precisely the opinion expressed by Lord Denning in the court below. But Lord Edmund-Davies continued:

(\textit{Br. J. Anaesth.} 1994; 73: 3–9)

KEY WORDS

Anaesthetist: medicolegal. Medicolegal.
"My Lords, it is high time that the unacceptability of such an answer be finally exposed. To say that a surgeon committed an error of clinical judgment is wholly ambiguous, for, while some such errors may be completely consistent with the due exercise of professional skill, other acts or omissions in the course of exercising 'clinical judgment' may be so glaringly below proper standards as to make a finding of negligence inevitable" [5].

And again chiding Lord Denning via the medium of defendant counsel (now himself a distinguished judge of appeal), Lord Edmund-Davies concluded:

"Indeed, I should have regarded this as a truism were it not that, despite the exposure of the 'false antithesis' by Lord Justice Donaldson in his dissenting judgment in the Court of Appeal, counsel for the defendant adhered to it before your Lordships" [5].

THE LEGAL STANDARD OF CARE

What did Lord Edmund-Davies mean by "the degree of skill which a member of [the medical] profession is required by law to exercise?" What have lawyers' standards, albeit those of judges, got to do with professional medical standards, when it is medical expertise that a patient seeks? The answer is generally a simple one, and should be perfectly satisfactory to any profession, including the medical profession. The expected standard was formulated by Mr Justice McNair, when he said that:

"where you get a situation which involved the use of some special skill or competence, then the test as to whether there has been negligence is not the test of the man on the top of a Clapham omnibus because he has not got the special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill" [6].

As Lord Edmund-Davies pointed out in the House of Lords, having quoted this locus classicus of legal liability in medical practice, "If a surgeon fails to measure up to that standard in any respect ('clinical judgment' or otherwise), he has been negligent and should be so adjudged." That is, of course, if damage has as a matter of cause and effect ensued.

How can a medical standard become a legal standard? The answer is, at least in principle, clear though difficulties can arise in cases based on complex evidence. In order to make a finding of negligence against a medical practitioner, a judge must be satisfied, on the balance of probabilities, that the practitioner has failed to act according to a standard of skill and care acceptable to an ordinarily skilled and competent specialty of medicine. The legal standard of care for anaesthetic practitioners is simply the ordinary skill and competence across the profession of anaesthetics. Or at least, among an established and bona fide school of thought which may differ in its practice from the majority but which is not negligent for so doing—even in the unfortunate event of harm to a patient.

This latter principle, the narrower of two principles established in the case of Bolam v. Friern Hospital Management Committee [7] is essential. It is a principle designed by the law of liability, which expects acceptable standards without stagnating or stultifying medical practice. It is a principle which has no application to a case in which a practitioner, alleged to have negligently harmed a patient, departs from a precaution accepted across the profession to avoid the particular kind of injury which in fact occurs. That was decided by Mr Peter Pain, in the case of Clarke v. Maclennan [8], and sets an important practical limit to the freedom allowed by the Bolam principle.

The legal standard of liability on the balance of probabilities, based on falling below acceptable professional standards, requires further elaboration into respects. First, the legal standard of proof in any civil liability case is said to be the standard "on the balance of probabilities." That means, in plain terms, that it is more likely than not that negligence has been established on the facts of the particular case. Lest it be thought that a judge would be satisfied by (for the sake of hypothesis) 51 medical voices saying the standard of care was unacceptable, against 49 which maintained its acceptability, the "balance of probabilities" test in medical negligence actions requires to be set in its context and really convincing evidence must in point of fact be given. It would be quite wrong, at the other end of the spectrum, to maintain that a standard of proof beyond reasonable doubt, which is appropriate to a criminal charge, were required; or even, somewhat less demanding than that though nevertheless high, the standard of proof required of fraud in a civil case. Many cases decided by Lord Denning imply as much, but there is no basis in law elsewhere of such an approach. Indeed, in the unreported but significant case of Taylor v. Guernsey Board of Health [9], Sir Louis Blom-Cooper QC emphasized the necessary middle way by saying that:

"So long as we have a system of compensation based on proving that someone has been guilty of fault, it is necessary that the same burden of proof and the same standard of proof be retained for all cases alleging a breach of the duty to take care in exercising the relevant skill and judgment of the defendant."

A JUDGE'S "PREFERENCE"?

Second, however, there is the highest judicial authority in this country to deny that a trial judge is entitled to make a finding of negligence against a defendant medical practitioner simply because he or she "prefers" the evidence of the plaintiff to that of the defendant. In Maynard v. West Midlands Regional Health Authority [10] the trial judge made a finding of negligence against two physicians on the basis of his preference for the admittedly compelling and experienced evidence of the medical expert for the plaintiff patient. Two consultants, while recognizing that the most likely diagnosis of the plaintiff's condition was tuberculosis, took the view that Hodgkin's disease, carcinoma and sarcoidosis were also possibilities. Because Hodgkin's disease is fatal unless remedial steps are taken in its early stages, they performed a mediastinoscopy to provide them with a biopsy. Mediastinoscopy is an operation involving some risk of damage to the neurological system, even if properly performed, so there was a risk inherent in the procedure. Unfortunately, this risk materialized and the plaintiff received severe neurological injury.

At the trial, a distinguished body of expert medical opinion was called approving the action of these two doctors in carrying out the procedure. The judge,
however, preferred the evidence of an expert witness called for the plaintiff who stated that the case had almost certainly been one of tuberculosis from the outset; and, consequently, should have been so diagnosed, and that it had been wrong and dangerous to undertake the operation which was performed to the injury of the plaintiff. Judgment was given for the plaintiff, but the Court of Appeal reversed the judge’s decision [11]. The House of Lords agreed with the Court of Appeal. They held that in the medical profession, as in others, there is room for differences of opinion and practice; and a court’s preference of one body of opinion over another is no basis for a conclusion of negligence.

Accordingly, where it is alleged that a fully considered decision by two consultants in their own special field has been negligent, it is not sufficient to establish negligence for the injured plaintiff to show that there is a body of competent medical opinion which considers that the decision was wrong, if there is also a body of professional opinion, equally competent, which supports the decision as having been reasonable in the circumstances in which it was taken. How is a trial judge to avoid the error of finding for a plaintiff simply on the basis of a “preference”, as his or her way of giving practical effect to the standard of proof on the balance of probabilities (more likely than not)?

The answer seems to be that, while the burden of proof is always ultimately on the plaintiff, and while the standard of proof must be the civil standard on the balance of probabilities and not anything approaching a standard beyond reasonable doubt, the quality or “pedigree” of the medical evidence will be highly significant.

While certainly no lottery, the outcome of individual litigation is neither entirely predictable nor entirely consistent. In a case of expert evidence outside the medical field, but nevertheless in point, two separate actions were brought against a company carrying out welding operations at Sydney harbour. One action was in negligence the other in nuisance. The standard of proof is the same for both actions. In one action, the court accepted expert forensic evidence to the effect that the combination of sparks from oxyacetylene welding and oil-soaked waste amid the harbour flotsam could not foreseeably result in a fire which badly damaged a ship some distance away. In the other action, the finding of fact was precisely that such a result was foreseeable [12]. More specifically in the present context the expert medical evidence, in a case involving the birth of a child following allegedly negligent advice on sterilization, was that information as to outcome of sterilization was not volunteered as standard; but in another, albeit less widely reported, case precisely the opposite conclusion was reached on the basis of evidence given by the distinguished obstetrician, Professor Peter Huntingford [13].

**PROOF OF THE ALLEGATION OF NEGLIGENCE**

Given that the basis of liability and negligence is proof of fault in professional practice leading to the patient’s injury, and given that a court of law will neither require proof beyond reasonable doubt nor allow itself to rely on a mere “preference” of evidence, what real opportunity does a plaintiff have to establish negligence in a complex case? In the case of an anaesthetic accident, the cause of an alleged injury may be complex, and an injured patient’s difficulties may be compounded by the fact that they were, or at least should have been, at all material times unconscious. Here the courts allow an injured plaintiff some leeway. While falling far short of making the defendant practitioner disprove negligence, which is anathema to the civil justice process, an event may sometimes “speak for itself”. In lawyer’s Latin, res ipsa loquitur. The plea must be raised, if desired, by the injured plaintiff and will not be invoked by the court at its own instance. It gives a helping hand to an injured plaintiff over some initial obstacles in the process of proof which might otherwise be insurmountable.

It applies when the event which is complained of would not ordinarily happen in the absence of negligence; and all the surrounding circumstances must be totally in control of the defendant. The latter condition is essential, for it will be contrary to all justice for one practitioner to be legally liable for the wrongful actions of another.

**“THE MATTER SPEAKS FOR ITSELF”**

A memorable way of stating the effects of *res ipsa loquitur* is to be found in the judgment of Lord Justice Denning (as he then was, before becoming Master of the Rolls) in the case of *Cassidy v. Ministry of Health* [14]. It was a case which did not, as such, involve the “error of judgment” controversy described above, and it can still be cited as good instructive law. “If the plaintiff had to prove that some particular doctor or nurse was negligent, he would not be able to do it. But he was not put to that impossible task.” He says, “I went into the hospital to be cured of two stiff fingers [it was a case of Dupuytren’s contracture of the hand]. I have come out with four stiff fingers, and my hand is useless. That should not have happened if due care had been used. Explain it, if you can.” In *Mahon v. Osborne* [15] a swab was negligently left in the patient’s body after an operation. While the Court of Appeal differed in their application of the maxim *res ipsa loquitur* to the particular facts, it was agreed that a court must be satisfied that control over the relevant situation, or environment or events, rests solely with the defendant and that “in the ordinary experience of mankind such an event does not happen unless the person in control has failed to exercise due care” [16].

When successful the plea of *res ipsa loquitur* has the practical effect of putting the defendant practitioner to an explanation of what happened, either that the event complained of could happen even with proper care, or that events outside the immediate control of the defendant were to blame. Not every instance of injury is sufficient in itself to put the defendant to the task of explanation.

In *Fish v. Kapur* [17] a judge declined to apply the plea in favour of a plaintiff whose jaw had been
fractured in the course of the extraction of a tooth. Expert dental evidence was accepted by the court to the effect that fracture of the jaw can happen on extraction even with the exercise of adequate care.

On the other hand, merely because things often do go wrong, or in the experience of the particular branch of medical practice have in the past gone wrong, is no reason for the court to refuse the application of the maxim res ipsa loquitur. Matters may still speak for themselves, and point to negligence, even if many mishaps have occurred in the past. Saunders v. Leeds Western Health Authority [18] is a case in point. The action was brought against the defendant health authority and the consultant anaesthetist who had participated in a procedure which was allegedly negligent. The girl patient received the anaesthetic in the course of an operation to correct a congenitally dislocated hip. Two hours after anaesthesia began the girl’s heart stopped, and attempts to start her heart were successful only after the expiration of between 30 and 40 minutes. In consequence, her brain was permanently damaged by hypoxia and as a result she is permanently quadriplegic, mentally retarded and blind.

It was held by Mr Justice Mann that “a fit heart does not stop under anaesthesia in the absence of negligence.” In such a case, he said, the plaintiff need not show the cause of the cardiac arrest which caused the damage. The defendant had, in his Lordship’s opinion, offered no explanation which would not involve negligence. It may be commented, on the one hand, that many have long held the view that, as anaesthesia offers no intrinsic therapeutic value (at least in such a case), therefore the only acceptable morbidity or mortality is nil. There has, however, for many years been an apparent acceptance by public and lawyers alike that patients may die under anaesthesia, or at least be severely injured as in the Saunders case for no discernible reason, and certainly not due to negligence. The Saunders ruling, even though given by a judge at first instance and not appealed to an appeal court, put an end to a process in which inexplicable anaesthetic cardiac arrest was often successfully defended unless the injured plaintiff could in some way make out the causal process leading to the result complained of.

WHO JUDGES MEDICAL PRACTICE?

One further rider must be added to this explanation of the practical use to which courts of law put expert medical evidence. Despite the vital role played by expert medical or other appropriate expert evidence in cases where the professional judgment of the practitioner is called into question, the courts will not allow themselves to be dictated to by such evidence. The law retains the upper hand, and if expert evidence dictated the result then the law would be the servant of professional liability and not its master. Needless to say, judges need to take exceptional care to avoid any semblance of interfering in professional practice.

Such was the concern expressed by the Law Lords in Maynard, above, at a judge exercising a simple preference for one body of expert evidence over another that such an approach was ruled out as an apparent interference with medical practice. It is, indeed, only very rarely that a court will be bold enough to rule that a practice established across a profession, or a significant part of it, is not acceptable and forms the basis of a negligence action if injury results. Such a case is Clarke v. Adams [19] in which treatment given to the plaintiff by a physiotherapist was alleged to have been negligent. The patient was receiving treatment for a fibrositic condition in the process of which diathermy caused such burning that the plaintiff’s leg had eventually to be amputated below the knee. Before applying the treatment the physiotherapist gave the patient the following warning: “When I turn on the machine I want you to experience a comfortable warmth and nothing more; if you do, I want you to tell me.” Expert evidence was given by the chief examiner for the Chartered Society of Physiotherapy that this warning was entirely proper and in accordance with accepted professional practice. The judge stated, however, that there must be a warning of the danger sufficiently specific to make it absolutely clear to the hypothetically reasonable person.

Would the words used here, he asked, warn such a person that their safety depended upon informing the physiotherapist the very moment they felt more than a comfortable warmth? The warning, he added, must make it abundantly clear that it was a warning of danger. In the circumstances of this particular case, the judge was not satisfied that the warning given, despite its being the very warning which the defendant physiotherapist had been taught to give, was adequate. It is, however, rare that a practice spread across a whole profession, or even across an established minority school of thought, will be disapproved of in this way.

This account of liability in professional medical practice has, it is hoped, demonstrated that the law must remain non-partisan and must, as it has done, develop devices and approaches to the establishment of professional medical liability which strike a just and realistic balance between non-defensive professional practice and the deserving claims of an injured patient. Much closer to the everyday practice of anaesthetists and all medical practitioners are the standards involved in accountability and audit.

ACCOUNTABILITY, RESPONSIBILITY AND LEGAL LIABILITY

Health care professionals, including medical practitioners, are these days frequently referred to as being “accountable” for their actions and conduct within their professional frame of activity. If that means simply that a practitioner is expected to exercise careful professional judgment and to display skill and competence in the exercise of professional discretion then no harm is done. The fact is, however, that health care professionals are frequently described as “accountable” without specifying any particular end point to which that accountability is linked. A medical practitioner’s accountability may be to his patient or client; to the
That act defines the term “responsible medical officer” by the Mental Health Act 1983 [21]. Others, given the use of the term “responsible medical officer,” as meaning the registered medical practitioner in charge of the treatment of the patient [22]. That practitioner has a wide variety of powers and duties which are respectively conferred or imposed by that act. One such power is the power to make a written report to the health authority or trust that an in-patient should be lawfully held in the hospital so that an application for formal admission detention (under Part II of the Mental Act 1983) may be made [23]. While the medical practitioner in charge of the patient’s treatment is certainly charged with responsibility, and may consequently be legally liable in negligence for incompetent practice, the person in charge of a decision-making process is by no means exclusively in charge. Although perhaps not widely appreciated, this so-called holding power applies to any in-patient on any hospital ward. It would be wrong to imagine that any such practitioner were by definition exclusively responsible for all elements in relation to the decision upon such a patient, or indeed exclusively liable in negligence in the event of incompetence.

What is clear beyond doubt is that members of multidisciplinary teams, or juniors within a firm, or nursing staff seeking instructions from medical practitioners, are not able to exclude their personal responsibility by reliance on orders, instructions or recommendations which are manifestly wrong or reasonably to be considered so by the person receiving them [24].

The case of Jones v. Manchester Corporation and others [25], though primarily concerned with a rather different point from that now under consideration, demonstrates that a junior member of a team or firm, or other professional of a multidisciplinary team, may be partially liable in law for an injury which is primarily the fault of another. The plaintiff, a patient suffering harm as a result of the negligence of a relatively inexperienced anaesthetist of “house officer” status. The defendant hospital board allowed the doctor to administer thiopentone without adequate supervision or training. In the administration of the anaesthetic to the patient, the house officer was additionally negligent in not carrying out precisely what she had been taught in her training. The apportionment of liability was 20% to the house officer, 80% to the hospital board.

A member of a team or firm, either of junior status or a member of a different health care profession, could shoulder partial liability in the event of participation in an incompetent decision. The point is of particular importance when it is remembered that the decision as to 20% liability on the house officer in Jones v. Manchester Corporation and others was a majority decision only. Lord Justice Hodson, who dissented, would have granted full indemnity to the defendant hospital board, with the result that full liability would have fallen on the house officer. A decided case in which the preponderance of legal liability fell on a health care professional implementing instructions of another is Prendergast v. Sam & Dee Ltd [26]. The plaintiff was awarded damages against a pharmacy, the dispensing pharmacist and a general medical practitioner who wrote a prescription. The plaintiff, an asthmatic, had been
used to the prescription of Ventolin inhalers, Phyllocontin and Amoxil tablets, a commonplace combination of drugs for an asthmatic with a chest infection. Part of the prescription was illegible and therefore unclear, and the pharmacist, instead of dispensing Amoxil (amoxycillin) dispensed Daonil (glibenclamide) instead. Daonil is a drug used for diabetics to reduce the sugar content in the body. The plaintiff was not a diabetic, and taking the Daonil caused him to suffer symptoms of hypoglycaemia which caused him permanent brain damage.

Mr Justice Auld found that had the pharmacist paid attention he should have known that there was something wrong with the prescription and should have checked it. Any competent pharmacist should know that taking Daonil is dangerous to non-diabetics. In the result, his Lordship held that the proper apportionment of damages was 25% on the general practitioner, while the pharmacist was 75% to blame. The decision, while involving medical negligence, marked a major advance in the extent to which a pharmacist may be liable in law for a failure to identify the negligence of another practitioner earlier in the chain of delivery of personal health care. While the general practitioner could not escape liability by saying that there was sufficient information on the prescription as a whole to have put the pharmacist on alert, the decision clearly identified the primary fault as resting with the professional (in this case the pharmacist) who was principally instrumental in implementing the negligent treatment.

MEDICAL AUDIT, STANDARD SETTING AND LEGAL LIABILITY

In January 1991 the Department of Health issued health circular HC (91) 2, entitled “Medical Audit in the Hospital and Community Health Services”. The circular outlined the arrangements which health authorities and NHS trusts were required to make in order to ensure that a framework for a medical audit could be in place in the hospital and community health services by April 1, 1991. The introduction to the circular states “Health authorities have a responsibility to oversee the quality of services delivered to their population. In order to do this they will require sufficient information to be satisfied about the medical audit policies followed by provider units with whom they have contractual arrangements.” Since the inception of NHS trusts, the “first wave” of which came into existence on April 1, 1991 [27], the same exhortation has applied to them as well as to directly managed units within health authorities. The circular defines medical audit as “the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient.” It goes on to state that an effective programme of medical audit will help to provide reassurance to doctors, patients and managers that the best possible quality of service is being achieved having regard to the resources available.

It is clear even from these basic definitions and objectives that medical audit has implications both for the use of resources and for the delivery of adequate care.

Herein lie possible pitfalls for departments of medical practice within provider units, given the tension which is apt to exist between the minimum standards expected in order to avoid negligence, and the much higher standards and aspirations to which medical audit aims in the optimal use of limited resources. In referring to “the best possible quality of service”, the health circular envisages standards which would be in their nature much higher and more demanding than the minimum standard below which an action for negligence might be contemplated. The “accountability” of medical practitioners to the managers of their particular provider unit may therefore be much more demanding than the accountability, by way of the civil law of negligence, to their patients and clients. To say this is not to point to any difficulty, but simply to underline the distinction between civil liability in tort for professional negligence, and the particular incidence of contractual obligations to a particular employer. Care must at all times be taken, however, that neither practitioners nor their managers in services providing personal health care identify the two levels of accountability as amounting to one and the same thing.

The parallel exercise of standard-setting across the nursing profession is already being perceived in some quarters as raising the level of legal responsibility not only to an employing service but also to clients. To distinguish the two obligations, one can do no better than cite the frequently quoted words of Lord President Clyde in the Scottish case of Hunter v. Hanley [28], in which the Lord President said that it is of “crucial importance” that “it be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care.” Certainly, medical audit and standard-setting exercises may over the course of time serve to raise expectations, not only of the health care services of themselves but of clients in relation to the services they provide, through the advancement and refinement of techniques and procedures. But in relation to liability in the tort of negligence, the courts are very wary of the nursing profession is already being perceived in some quarters as raising the level of legal responsibility not only to an employing service but also to clients. To distinguish the two obligations, one can do no better than cite the frequently quoted words of Lord Justice Maugham in Marshall v. Lindsey County Council [29], when he said that “an omission may become negligent if, and only if, at some future date it becomes the general custom to take such a precaution among skilled practitioners.”

REFERENCES

2. [1981] 1 All ER 267.
5. [1981] 1 All ER 267, 276.
7. [1957] 2 All ER 118.
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9. See Personal and Medical Injuries Law Letter Vol. 6, No. 7 (October 1990) 50–52.
10. [1984] 1 WLR 634.
15. [1939] 2 KB 14.
16. Per Lord Justice Scott.
17. [1948] 2 All ER 176.
18. Personal and Medical Injuries Law Letter Vol. 1, No. 10, 82.
22. Mental Health Act 1983, section 34(1).
27. See National Health Service and Community Care Act 1990, section 5 and Schedule 2.
29. [1935] 1 KB 516.