

This paper is an amended version of: ““Red in Tooth and Claw”: The Idea of Progress in Medicine and the Common Law’, *Social & Legal Studies*, 11(2), June 2002

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Published in Italy in October 2002
European University Institute
Badia Fiesolana
I – 50016 San Domenico (FI)
Italy

EUROPEAN UNIVERSITY INSTITUTE, FLORENCE

DEPARTMENT OF LAW

EUI Working Paper LAW No. 2002/12

**Progress Through Pluralism
Towards an Epistemology of Medical Negligence Law**

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PROGRESS THROUGH PLURALISM

TOWARDS AN EPISTEMOLOGY OF MEDICAL NEGLIGENCE LAW¹

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ABSTRACT

The interaction of medicine and the common law is best understood through an examination of the epistemic properties shared (or taken to be shared) by both disciplines. One such property is represented in the ideal of evolutionary progress through a conflict of ideas, as developed in the work of Karl Popper on science and politics. This ideal also provides an orientation for judicial and theoretical reflections on the role of the dissenting judge in the development of the common law. It can be linked furthermore with broader ideologies of progress which valorize liberal political and economic arrangements. The medical negligence jurisprudence of the English courts has until recently been structured by an understanding that medicine, as a science, participates in this dynamic of progress. Consequently the protection of medical pluralism from close judicial scrutiny has been taken to be a matter of public interest. However, this weak liability regime is now threatened by increased judicial activism, regulatory intervention and patient consumerism. The latter are in turn underpinned by a series of fundamental critiques directed at the idea of progress in medicine and science.

PROGRESS THROUGH PLURALISM

TOWARDS AN EPISTEMOLOGY OF MEDICAL NEGLIGENCE LAW

Surely every medicine is an innovation; and he that will not apply new remedies must expect new evils; for time is the greatest innovator; and if time of course alter things to the worse, and wisdom and counsel shall not alter them to the better, what shall be the end? (Bacon 1625/ 1999: 55)

1 INTRODUCTION

Discussion of medical law is commonly concerned with the effectiveness of the law in promoting ethical values in the health care context. This essay seeks to develop a different perspective, one which is informed more by epistemology than by ethics.² It aims to uncover some important similarities between the way in which law and medicine are taken to be practised. In short we maintain that both disciplines are held by their practitioners, and by their spokespersons, to obey an evolutionary dynamic. On this view medicine and law embody a widely shared ideal of progress driven by conflict. In advancing this thesis, the present essay will focus on the manner in which law reconstructs medical practice and subjects it to normative evaluation. In cases of alleged negligence, where witnesses testifying to standard practice are in conflict, the law generally adopts a benign, if limited agnosticism as between them. This indulgent stance has been significantly motivated by a recognition of the progressive, scientific nature of modern medicine and by a more or less explicit acceptance of the public interest in not hindering its evolutionary development (Montgomery 1989). The law on negligence took this form not only, or even chiefly, because of crude favouritism, but because of what Tim Murphy (1991) has described in another context as the ‘epistemic undercore’ shared by both practices.

The essay is structured as follows. It will first provide some evidence of the importance of the idea of scientific progress to doctors’ collective self-perceptions since the early nineteenth century. Thereafter an attempt will be made to reconstruct this idea in terms of Karl Popper’s work on epistemology. The ideal-typical attributes of the scientific method thus elaborated provide an

interpretative framework for understanding the English case law on medical malpractice. It will then be shown that the notion of medicine evolving through a competitive pluralism of ideas resonates with the historical idea of the common law progressing through dissent and conflict. This overlapping self-understanding can also be linked with broader ideologies of progress current in western society since the Enlightenment. These ideologies valorize liberal political ideals and the institutional arrangements through which they are realized. Both doctors and lawyers have found it useful to draw upon these discursive resources in order to achieve and legitimate their professional status. We conclude by examining a counter-theory of scientific development. The work of Thomas Kuhn disputes the notion of orderly progress and identifies instead a secretive and non-cumulative sequence of scientific revolutions; an opaque world which neither reflects nor validates liberal ideals. This darker vision is reflected in critiques of medical work by both radical sociologists and consumer-oriented legal scholars; and it has of late been manifested in a tentative re-orientation of judicial attitudes to medical mishaps.

2 MEDICINE AS A PROGRESSIVE SCIENCE

According to sociologists the development of a unified and autonomous scientific knowledge base has been essential to the professional status of medicine (Larson 1977: 23-51). The association of medicine with science has never been complete or uniform, however. Rival conceptions of medicine have been advanced to further the strategic ambitions of the profession as a whole, or of specific groups within it. In the early decades of the nineteenth century English general practitioners and provincial doctors sought to overcome the social and occupational barriers to their advancement erected by the metropolitan, consultant elite. They did so by promoting a scientific idea of medicine in imitation of that which emerged in post-revolutionary France. In the eyes of marginalized English medics, two hundred of whom were found to be studying pathological anatomy in Paris in 1828 (Warner 1991: 144), French success was based upon a rigorously empiricist approach to medical knowledge and a legislatively supported ‘medical polity’ which linked medical work with the interests of the state. If established in England, a scientific basis to practice would allow the cleverest, rather than the most refined or best connected, to advance furthest.³ Equally, a system of medical legislation would proscribe and delegitimate the work of competitors from below, so to speak, such as herbalists and midwives. As well as having a keen admiration for France, it is significant that members of the scientific faction in English medicine at the time were frequently associated with political radicalism and religious dissent. More likely to have been educated at Edinburgh or Glasgow, than Oxford or Cambridge, they viewed the ideal doctor not as a gentleman ministering to the needs of the

upper classes, but as an agent of physical and moral improvement in society as a whole (Lawrence 1994: 42). Also notable is the fact that the élite initially resisted reform by emphasizing the irreducible, non-scientific element of personal judgment in diagnosis and therapy. This rhetorical distinction between science and art in medicine resonated with a more profound controversy between reform and reaction in the period after 1789 (Warner 1991: 137). It has also been frequently employed by professionals resisting increased regulation or the re-organization of medical care up to the present day (Anderson 1992; Lawrence 1985; Armstrong 1977).⁴

A unified profession was achieved in Britain with the passing of the Medical Act 1858, which created a single register of practitioners and bestowed a legal monopoly of medical work on doctors. Fundamental conflict over the form and content of medical knowledge ceased and medicine attained a position of unprecedented prestige and influence. First physiology, then microbiology emerged as the ‘lead’ disciplines in medical practice during the latter half of the nineteenth century. Science-driven progress in these areas was personified in a new elite of physician and surgeon scientists, of whom the most famous was perhaps Joseph Lister. Self-styled leader of the ‘antiseptic revolution’, Lister was regarded by late Victorians and Edwardians as a hero in the manner of engineers and colonial explorers, and was made a baron in 1900 (Porter 1997: 428-461). Bacteriology, on which antiseptic techniques were based, also provided the platform for some of the most famous medical advances in the late nineteenth and early twentieth century: the identification of the micro-organisms which caused cholera, tuberculosis, diphtheria and rabies, and the subsequent development of cures and vaccines (Maulitz 1979). These breakthroughs established the laboratory as the hub of medical progress and a ‘fresh source of power for modifying society’ (Latour 1983: 158; see also Worboys 1992: 85).

Indeed,

far from just turning to science as an established source of authority, nineteenth century medical practitioners were themselves among the most influential proponents of a new culture in which science was so regarded (Sturdy 1992: 127).

Consequently, during this period the once marginal view of medical advance as essential to the well-being of the general population and to the prosperity of the nation became professional and political orthodoxy (Canguilhem 1994: 280). Medical categories of thought began to replace those of religion as the dominant frame of reference for understanding the world; inequalities of class, gender and race coming to be invested with naturalistic, medically-sanctioned meanings (Lawrence 1994: 70).

In the twentieth century the profession adapted to democratic and welfarist politics by successfully translating the problems of established and emerging interest groups in to health care issues (see Latour 1983: 144). Medicine spoke to the concerns of the military that troops be fighting-fit, and to the need of industrialists for a healthy workforce. Health, as defined and produced by doctors, was also claimed as a right by the labour movement (Lawrence 1994: 78). These tendencies culminated in an extension of state sponsorship beyond the statutory monopoly of practice to the point where the government took over the funding of almost all medical work in Britain with the establishment of the National Health Service (NHS) in 1948 (Berridge 1999: 15). The notion of scientific progress remained crucial to the effective translation of others' interests in the decades after the Second World War (Cantor 1992). (Indeed we shall see that most of the case law on medical negligence, the substance of which is premised upon a public interest in such progress, dates from this period.) The 'lead' discipline at the time was indisputably pharmacology, which gained massively in prestige from the introduction into practice of penicillin, cortisone, sulphonamides and a sequence of other 'wonder drugs'. Drug development itself represented a fusion of the interests of medical scientists and capital: systematic synthesis of possible drug compounds was only possible with massive financial support and this depended on the likelihood of a substantial return on investment (Le Fanu 2000: 206). In addition, clinical practice itself became the site of a new experimental science which sought to rationalize diagnosis and treatment. Each case came to have a significance beyond the interests of the individual patient. Each presented the scientifically-minded practitioner (usually male) with an opportunity to gather 'clinical material' which he could analyse and publish, thereby improving his colleagues' practice and advancing his own career. This flourishing scientific culture was promoted by governments, aware of the importance of the pharmaceutical industry to the British economy; indeed state support for medical research increased fivefold from the 1950s to the mid-1970s (Strong 1984: 341).

The contradictions underlying advances in pharmacology and clinical science have become more apparent in recent years and consequently the ideology of scientific progress has lost much of its former purchase. Medical experimentation is now hedged about with regulation to protect patients' interests, previously ignored by researchers at the cost of much suffering and many lives (Rawlings 1992). With the resulting decline in genuine innovation, the pharmaceutical industry has sought profits through marketing 'lifestyle' and 'copycat' drugs which have little marginal utility (Le Fanu 2000: 246-252). Popular faith in orthodox biomedicine has declined, as patients and the 'worried well' take to consuming the products of esoteric and non-western systems. The state too has moved to qualify the statutory monopoly and to impose financial and technical limits to medical work in the NHS (Klein 1995: 158). We shall see

that this growing scepticism has been both reflected in and augmented by critical scholarship in philosophy, medical sociology and law. This coalition of the laity, the ‘reforming’ state and radical intellectuals has seriously threatened the elevated status of modern medicine and its practitioners.

3 THE DYNAMIC OF SCIENTIFIC PROGRESS

We have seen the importance of the idea of scientific progress to medical professionalism in the nineteenth and twentieth centuries. In this section we draw on the work of Karl Popper in elaborating a number of ideal-typical components of this idea. These will then help to structure our analysis of the law on medical malpractice. For Popper ‘the history of science [was], by and large, a history of progress’ (Popper 1981: 94) Many activities are taken as exhibiting change and improvement over time: crafts and technologies, for example. But progress is only ‘scientific’ if it is understood by practitioners and observers to happen in an orderly, open and intelligible manner. Popper’s work on this is a particularly useful source since he promoted a model of rational progress accepted by many scientists and by the wider lay public (Magee 1985: 10; Lakatos 1981 113). (Its particular influence on judicial reconstructions of medical action will be demonstrated in the following section of this essay.) The model was also anticipated by the pioneering French physiologist Claude Bernard in his *An Introduction to the Study of Experimental Medicine* (1865).⁵

Change in science, Popper argued, can be modelled upon Darwinian evolutionary biology (1979a). Like plant and animal life, scientific knowledge develops through repeated stages of variation and selection. At the first stage, just as the gene structure of an organism responds to environmental pressures by internal mutation and recombination, so science responds to theoretical problems by developing tentative new theories. At the second stage, just as there is selection between available genetic mutations and variations, so scientific theories are tested experimentally and the erroneous eliminated. The process of testing (or falsification) generates further problems which scientists respond to with further theories and so on. This incremental process is well-reflected in Bernard’s declaration that ‘with theories there are no more scientific revolutions... [rather] science grows gradually and steadily’ (quoted Canguilhem 1994: 139).

The evolutionary model and the method of falsification allow us, with Popper, to elaborate certain characteristics of scientific activity and, thus, to distinguish it from non-science. These are:

- 1) Statements which are not capable of being falsified by observation and experiment are by definition not scientific.
- 2) Scientists take (or should take) a thoroughly critical attitude both to their own theories and to those which are already well established. It is not permitted systematically to reject experimental results which confound theoretical explanations. The latter is generally characteristic of dogma or ideology and is a hindrance to progress (Popper 1981: 96).
- 3) Scientific truth is emergent rather than transcendental; its rationality is procedural. Thus, the content of scientific knowledge is contingent and revisable.
- 4) The evolutionary model is based on a process of rational learning by feedback (Popper 1979b: 117). This is aided by the availability of scientific knowledge for study and criticism in the form of written sources. Although contingent, scientific knowledge is thus objective (Popper 1979b: 106).
- 5) Science is most likely to evolve under conditions of free and open competition. In other words, theoretical pluralism drives progress.⁶ As another philosopher of science has written, '[d]ialectical confrontations are essential to the growth and improvement of scientific knowledge; like nature science is red in tooth and claw' (Laudan 1981: 153). Centralization and uniformity in the production of scientific ideas leads inevitably to a failure of adaptation and, thus, to stagnation and backwardness.
- 6) Finally, the existing state of scientific knowledge sets limits to the extent of theoretical pluralism at any given time. New theories can only be generated recursively; they must draw upon, modify and explain previous theories. In Popper's words scientific discovery depends 'on a conservative or traditional or historical element, and on a revolutionary use of trial and the elimination of error by criticism' (1981: 87).

From this discussion we can extract a number of ideal-typical attributes of science which will be found in judicial representations of medical activity. These are: change as progress; progress through pluralism; ordered or bounded pluralism; objective knowledge; and rational learning.

4 REPRESENTING MEDICINE AS A PROGRESSIVE SCIENCE IN THE COMMON LAW

Judges seized of malpractice cases have frequently emphasized both the progressive nature of medicine and the benefits which this has conferred upon society as a whole. In furtherance of this public interest doctors have generally been allowed to define the standard of care in negligence by which their peers are held to account (Powell 1997: 639). The test laid down in the leading case of Bolam v Friern Hospital Management Committee [1957] that a doctor will not be held responsible if his practice conformed to that of a responsible body of medical practitioners. Consistent with the ideal of science as plural and competitive, a practice may be acceptable even where it is only followed by a minority of doctors or specialists. Until the House of Lords decision in Bolitho v City and Hackney Health Authority [1997] expert witnesses had a more or less sovereign role in deciding on fault in cases of malpractice (Dugdale and Stanton 1998: 319). This liability regime was exceptional: in cases involving all other occupational groups the courts reserve the power to set the standard of care in negligence themselves.⁷ We shall see that even after Bolitho the scope for judicial reconsideration of medical evidence remains rather slim. In addition, as will be shown, the ideal-typical elements of scientific activity outlined above continue to structure English case law to the benefit of the medical profession.

A *CHANGE AS PROGRESS*

Recitations of great medical breakthroughs appear consistently in the case law on malpractice; for example, in Bolam which concerned a psychiatric patient who suffered fractures because he had not been restrained during the administration of electro-convulsive therapy (ECT). In his direction to the jury on the question of negligence, McNair J traced the development of ECT. He noted ‘the enormous benefits which are conferred upon unfortunate men and women by this form of treatment’ (p. 586). In order to facilitate such advances in clinical science, therapeutic and diagnostic negligence must be judged according to a standard set by the profession itself. A similar homage to progress preceded the House of Lords’ decision in Sidaway v Bethlem Royal Hospital Governors [1985] to extend the Bolam test to cover a doctor’s duty to make disclosure of the risks accompanying treatment. For Lord Diplock:

[P]ractices are likely to alter with advances in medical knowledge. Experience shows that, to the great benefit of humankind, they have done so, particularly in the recent past. That is why fatal diseases such as smallpox and tuberculosis have within living memory become virtually

extinct in countries where modern medical care is generally available (p. 657).

English law seems accordingly to have adopted the notion of medicine as dynamic and experimental. As such it is necessarily accompanied by the possibility of mishaps. In Roe v Minister of Health [1954] Lord Denning stated that

Medical science has conferred great benefits on mankind; but these benefits are attended by considerable risks... We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks (p. 83).

This tragic dimension to progress corresponds, in Popper's terms, to the error elimination stage of the falsification procedure. It is at this point that the public interest in medical science begins to bite. To quote again Lord Diplock in Sidaway:

The members of the public who seek medical or surgical aid would be badly served by the adoption of any principle that would confine the doctor to some long-established, well-tried method of treatment only, although its past record of success might be small, if he wanted to be confident that he would not run the risk of being held liable in negligence simply because he tried some more modern treatment, and by some unavoidable mischance it failed to heal but did some harm to the patient (p. 656).

The law thus constructs an image of the doctor as an intrepid researcher and of the patient as a bundle of 'clinical material' whose greatest significance lies, not necessarily in his or her immediate physical needs, but in being one moment in a sequence of scientific experiments.

B PROGRESS THROUGH PLURALISM

Cognitive pluralism is normally suppressed by the law as a threat to effective decision-making. Carol Jones has shown, for example, how expert witnesses are effectively forced by legal procedures to conceal dissent within their ranks (1994: 9). A flight into monism shores up the credibility and legitimacy of both medicine and law in the context of fact-finding. The law on medical malpractice is different, however, in that it is based on an acceptance of diversity. As has been stated, a practitioner may follow a minority practice and still not be held liable for any damage resulting from his or her work. In Maynard v West Midlands Regional Health Authority [1985] the plaintiff suffered damage to her vocal cords as a result of the conduct of invasive tests for Hodgkin's disease; less risky, non-invasive tests for tuberculosis had been equally indicated but were not carried out until later. At first instance the trial judge found for the

plaintiff on the basis of his substantive preference for the testimony of her expert witnesses. Unusually this finding of fact was overturned by the House of Lords. The trial judge was severely criticized by Lord Scarman who held that

Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other, but that is no basis for a conclusion of negligence (p. 638).

In Bolam it was held to be permissible for a psychiatrist not to restrain a patient undergoing ECT, where professional opinion was divided as to whether this was necessary. The practitioner had applied his ‘inquiring mind’ to the possible alternatives and that was sufficient (p. 592). This option, which indeed is also an obligation, to exercise individual judgment in the specific case, will not be removed by the existence of a treatment guideline covering the procedure (Hurwitz 1999).

At bottom courts have valorized intra-medical conflict in this way because they have assumed it to be the engine of scientific progress. As Lord Clyde put it in the Scottish case of Hunter v Hanley

[A] deviation from ordinary professional practice is not necessarily evidence of negligence. Indeed it would be disastrous if this were so, for all inducement to progress in medical science would be destroyed (p. 217).

This reasoning ‘could not be bettered’ according to McNair J who adopted it as the basis of the relevant English law in Bolam. It is set in the context of medical history (or mythology) by Kenneth McK Norrie’s comment that

Every medical advancement since Hippocrates has at some stage been a departure from the normal and accepted practice, and to castigate such departure as per se negligence is a nonsense (1985: 158).

Like Popper’s ideal science, medical practice is thus necessarily and productively plural: only where there is variation, in the form of a range of recommended practices, can the system select and thus progress. The Canadian scholar and judge Allen Linden recast the importance of tolerating this diversity in quasi-religious language:

The courts recognizing that the heresy of today may become the orthodoxy of tomorrow have wisely refused to halt all experimentation...(1968: 165).

In other words monism is equivalent to dogmatism and therefore against the public interest.

C **BOUNDED PLURALISM**

Dissent is, however, confined by canons of rationality, particularly as to the methods of discovering new truths. In medical negligence law we find

recognition of this procedural rationality in the requirement that the defendant's practices have been in conformity with those of a responsible body of practitioners. This qualification was widely seen as redundant until the decision of the House of Lords in Bolitho v City & Hackney Health Authority [1997]. The facts of that case were that the plaintiff's child, who suffered from croup, developed breathing difficulties while in hospital. He was not attended to in time and died from respiratory failure. As well as issues of causation, their Lordships addressed the matter of fault. It appeared that there was division in the profession as to whether a child in that position should have been intubated or not. Lord Browne-Wilkinson held that this plurality of views did not automatically decide the issue in favour of the defendants. To be held to be 'responsible' a body of opinion must also be shown to have a logical basis (p. 778).⁸ This clarification of the Bolam test has been greeted by commentators as a first move towards substantial judicial control over medical decision-making (Brazier and Miola 2000); and indeed, the Lord Chief Justice, Lord Woolf, has recently drawn on Bolitho as a warrant of greater judicial intrusiveness into the domain of professional judgment.⁹ The decision in Bolitho itself does not give grounds to anticipate a truly radical change in the liability regime, however. Lord Browne Wilkinson stated there that medical opinion is likely to be upheld as rational and responsible in the vast majority of cases (p. 779). What Bolitho mandates is a form of procedural, as opposed to substantive control over the exercise of clinical judgment. As long as a process of risk assessment has been gone through by the proponents of a course of action that is sufficient to exculpate the practitioner who follows it. This is indeed a weak standard of review. It simply seeks to promote among doctors the critical attitude which Popper holds to be definitive of the good faith among researchers and essential to the progress of science.

In the eyes of the law plural medical opinion is generally constituted as 'schools of thought'.¹⁰ A defendant who deviates from orthodoxy, without being able to show that he or she was following any such school, will be required to justify this departure.¹¹ The progressive nature of medicine does not, in other words, provide a licence for random or unsupported experimentation by the individual practitioner. Like Popper's scientists, doctors are forced in the first instance to refer to the accrued knowledge of the discipline. A 'conservative or traditional or historical element' to medical practice is thus preserved (Popper 1981: 87). The limits of tolerated plurality are also reached in cases where the defendant is charged with having made basic errors such as failing to count swabs after an operation or amputating the wrong limb.¹² Mistakes of this sort are effectively treated as being beneath medical science, allowing the court to set the standard of care itself. By contrast with doctors, moreover, nurses, radiographers and so on are treated by the law as performing more or less routine functions. Their work does not in itself obey the experimental dynamic of science. As members

of ‘lesser professions’ they do not benefit from Bolam regime (Dugdale and Stanton 1998: 318); testimony surely to the triumph of medical ideology.

D OBJECTIVE KNOWLEDGE AND RATIONAL LEARNING

The progressive nature of medicine, as ratified by the courts, means that a doctor may also be held liable if he or she falls behind universally implemented improvements in practice. In Bolam itself it was stated that the doctor-centred test of professional negligence

does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is substantially the whole of informed medical opinion. Otherwise you might get men today saying: "I don't believe in anaesthetics. I don't believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century". That would clearly be wrong (p. 587).

This passage evokes a heroic history according to which medicine moves continually from a state of (relative) unknowing to one of (relative) enlightenment. Its discoveries have become part of general common sense knowledge; those who resist its dynamic are condemned as dangerous dogmatists.

Medical practitioners participate in the scientific enterprise by adapting to change produced by trial and the elimination of error. They also contribute to it by recording their own experiences and feeding them back into the scientific system through medical records and publications. The status of this corpus as objective scientific knowledge is reinforced by the legal obligations on doctors to maintain comprehensive and detailed files and to keep abreast of recent developments in their fields (Powell 1997: 614; Giesen 1988: 114). Furthermore law cases themselves may be a means by which the risks of a given procedure are discovered and publicized, as for example in Roe v Minister of Health [1954]. There the anaesthetic used on the plaintiff had been contaminated by near-colourless disinfectant liquid, which had seeped through invisible cracks in the phial in which it was stored. As a result, the plaintiff was left permanently paralysed after the operation. The Court of Appeal, however, refused to hold the defendants liable in negligence since the possibility of contamination was wholly unforeseeable at the time. As Lord Denning put it, ‘[w]e must not look at the 1947 accident with 1954 spectacles’ (p. 84). Nonetheless, the medical profession would be on notice, partly as a result of the case, of the perils presented by the old method of storing anaesthetic substances. In future the disinfectant liquid would have to contain dye to facilitate recognition of leakages.

5 PROGRESS IN THE COMMON LAW

In the present section we seek to show how the scientific understanding of medicine resonates with the self-perceptions of common law judges and theorists. It is, of course, impossible to demonstrate an exact correspondence between these ideological formations. Historically the natural sciences have been much more deeply implicated in medical practice and talk about it, than in law. Furthermore the social roles and functions of each discipline are significantly different: medicine operates primarily on the phenomenal level, aiming to produce tangible effects on or in the bodies of its subjects; law operates primarily on the noumenal level, defining values and stabilizing normative expectations (Luhmann 1999: 73-91). The ‘logic of scientific discovery’ is, thus, more prominently displayed in medicine than in law. Nonetheless strong mutual affinities can be found which reflect the central elements of Popper’s thesis: the notion of cumulative progress; and the proposition that this is achieved through a competitive pluralism of ideas. The first can be found in pervasive and influential theories of legal history, which portray law as evolving over centuries from primitive origins to modern complexity. The second is evident in the quotidian phenomenon of the dissenting judgment.

A *EVOLUTIONARY PROGRESS IN WESTERN LAW: THE INFLUENCE OF MAINE*

The most important formulation of the evolutionary understanding of the common law is contained in Henry Maine’s *Ancient Law* (1860/ 1870). Maine sketched a history of law, from pre-customary decrees, through the law of the Roman republic and empire, and on to the legal systems of Western Europe in the nineteenth century. Law had developed, he argued, from custom to rule-based systems, from disparate to centralized power structures, and from dominating its subjects to guaranteeing individual self-determination. He encapsulated this dynamic in the famous maxim that ‘the movement of the progressive societies has hitherto been a movement from *Status to Contract*’ (1860/ 1870: 141). Two features of Maine’s work are significant for this discussion. First, he distinguished evolving from stationary societies. This was necessary to explain the divergence between contemporary European law and that of colonised regions such as India. The colonies were Europe’s past made present to itself, affirming both its origins and the immense progress which it had achieved (Fitzpatrick 1992: 100). Second, Maine’s work was influenced by the uniformitarian doctrine of Charles Lyell, a contemporary geologist. According to this, changes in the Earth’s surface were constant, gradual and

imperceptible, the result of regular physical forces. As Peter Stein has noted, ‘this provided an attractive analogy with the traditional view of the common law’ (1980: 88).

Maine’s grand generalizations rapidly became ‘the common currency of legal thought’, notwithstanding his lack of detailed research (Stein 1980: 98). Their popularity was due to both a formal and a substantive association with contemporary science. As regards form, Maine’s work was born of a concern to provide an empirico-historical account of law’s growth rather after the fashion of Savigny. To distinguish himself from his rivals he invoked the positivist, experimental methodology typical of the leading natural and medical sciences, claiming that

The inquiries of [other jurists] are in truth prosecuted much as inquiry in physics and physiology was prosecuted before observation had taken the place of assumption. Theories plausible and comprehensive, but absolutely unverified ... enjoy a universal preference over sober research into the primitive history of society and law (1860/70: 3).

As regards substance, contemporary law gained depth and order through being shown to contain its past within itself, rather like plant and animal life in Darwin’s evolutionary schema (Fitzpatrick 1992: 93). This perspective was keenly taken up by Maine’s contemporaries, susceptible as they were to theories ascribing the immense changes through which they were living to ineluctable and irresistible forces. To lawyers in particular, the evolutionary perspective revealed that the law was able to adapt itself gradually, that is without convulsion or revolution, to new social and economic circumstances. The good was thus equated with the existent (Stein 1980: 99; Sugarman 1986: 43). As we have seen this pattern was also taken to be characteristic of medicine in the later 1800s, whereby the sectarianism and epistemic disjunctures of the early century were replaced by a unified knowledge base and a dispensation of orderly progress (Lawrence 1994: 55).

B PROGRESS THROUGH PLURALISM: THE DISSENTING JUDGMENT

The common law it can be argued progresses, not just over the longue durée from time immemorial to the present, but also from case to case. The engine of this progress is, in the higher courts at least, the production of plural opinions and dissenting judgments. Both phenomena can be seen, in Darwinian terms, as instances of variation produced by the legal system in response to changes in its environment; for example, social and economic developments (Luhmann 1994: 241). The system selects from the variety of judgments in future cases where a similar point arises. Any selection can be revised or overturned subsequently with the result that the content of legal knowledge, like that of science, is

inherently contingent. The necessary variation (and selection) is possible because of the tolerance, indeed the valorization, of a vigorous contest of judicial opinions in the common law tradition. It is not surprising that English judges, embedded as they are in that tradition, have taken pluralism to be emblematic of progressive and beneficent medical science as well.

Majority, as opposed to consensus decision-making has been practised in the English courts since at least the fifteenth century. In a recent study, John Alder has illuminated some of the practical justifications for, and political resonances of the dissenting judgment (2000). He surmises, for instance, that the possibility of open contradiction serves to sharpen majority judgements. Like science and nature, the common law too would appear to be ‘red in tooth and claw’. In addition, whatever the outcome of the case, minority opinions endure in the law reports and constitute a resource for future correction and reform of the law. To paraphrase EH Carr they are the ‘[p]regnant failures ... of today [which] may turn out to have made a vital contribution to the achievement of tomorrow’ (1987: 128-129) Benjamin Cardozo went even further, inserting the minority judge into a (lightly) secularized version of Judæo-Christian tradition:

The dissenter speaks to the future and his voice is fixed to a key that will carry through the years ... The prophet and the martyr do not see the hooting throng. Their eyes are fixed on eternities (Alder 2000: 241).

On Alder’s account, however, the ultimate justification for plurality and dissent in the common law is moral rather than practical. From a moral perspective judgments in the higher courts have a double nature: expressive on the one hand, representative on the other (Alder 2000: 223). As regards the first, judges must be taken to have their own profoundly-held views on matters of ethical and political importance. Their rights as ordinary citizens demand that these views should not be suppressed. As regards the second, judges can be said to give utterance in their reasoning to the range of moral positions held in society. Thus, a move to single-judgment decisions would effectively stigmatize unorthodox beliefs and disenfranchise their adherents. Furthermore, with increasing disputes over human rights, bioethics and governance, dissent has become more likely and the need for toleration more pressing. The foregoing, essentially liberal and democratic reasons only run so far however: plurality must be managed, as well as tolerated (Luhmann 1994: 325). It is successfully managed by the shared professional culture of judges and by the need to incorporate previous authorities in any valid decision, even if only to distinguish them. These ideological and operational constraints on dissent correspond to the ‘conservative or traditional or historical element’ in Popper’s model of scientific advance (1981: 87). They mean, of course, that many views are neither expressed nor represented in the common law.

6 THE IDEA OF PROGRESS

In the foregoing sections it has been shown that judicial evaluation of doctors' work is structured by an understanding of medicine as a progressive, conflict-driven science; and that this resonates with lawyers' understanding of their own discipline. The idea of progress that informs these insights is best apprehended from three overlapping perspectives (philosophical, religious and political), which are the focus of this section of the essay. By attending to the 'background metaphorics'¹³ of the idea, it should be possible for us to specify its enduring significance in elite, professional discourses.

Some idea of progress has provided an orientation for philosophical and practical endeavour in Europe since Pascal proposed that the course of all humanity was as 'one man always subsisting and incessantly learning' (Bury 1955: 68). There has been no agreement on the content of the idea. Scholars note, however, that it occupies the position formerly held by providence in the worldview of Europeans (Bury 1955: 7; Nisbet 1980: 124; Blumenberg 1999 39). The latter set the horizon of Christian faith and expectation in the future; all earthly history tending towards the Second Coming of Christ.¹⁴ With the fragmentation of religious belief in the late seventeenth century this eschatology was secularized (Löwith 1949: 83). For moderns the fulfilment of time will no longer take the form of a transcendental intervention. Rather the new providence is immanent to the world, its duration infinite, its telos unspecified. The attitude of faith and expectation remain, but they are now imbued with confidence in steady human self-improvement (Löwith 1949: 202). 'Progress' thus functions as an integrating ideal; providing security and stability to the individual and the collective in the face of a hostile environment and the indifference of God. It has been felicitously described as 'the continuous self-justification of the present by means of the future that it gives itself, before the past with which it compares itself' (Blumenberg 1999: 32).

Thus the profound importance of the idea of progress derives, at least indirectly, from its theological antecedents. Beyond this we can suggest that the precise mode of progress, valorized in judicial discourse, is informed by distinct confessional forms which are themselves deeply implicated in ideas of Britishness. As Linda Colley has well demonstrated, the creation of a common British political identity in the eighteenth and nineteenth centuries was crucially dependent on the shared Protestantism of its otherwise diverse peoples (1992: 232). This identity was achieved by contra-distinction with the 'other' of Catholicism which menaced it from across the Channel. Britain's economic and scientific advances, as well as its parliamentary practices, were consequently taken to be part of the nation's 'Protestant inheritance' (Colley: 52). Continental equivalents had developed slowly, or not all, wherever the dead hand of church

authority and the threat of persecution stifled enterprise and inquiry.¹⁵ It is certainly true that from the mid-nineteenth century onwards the specifically religious influence of Protestantism on the British began to wane; indeed, as we have noted, the rise of modern medical science contributed significantly to this. Nonetheless, the now latent national self-understanding continued to facilitate an association of pluralism and dissent with the achievement of progress (see Jardine 1999). As much is evident in the terminology ('dogma', 'heresy', 'martyr', 'visionary', 'prophet') which we have seen used to describe the nature and function of minority opinions in medicine and law. Clearly the rhetoric of dissent still has purchase in an otherwise secular context.

Liberal political theory, itself built upon the same 'Protestant inheritance', also contributes to the background metaphysics of the idea of progress in medicine and law. Most important in this regard is JS Mill's defence of free speech on the ground that truth is most likely to emerge from unregulated, competition in ideas (1859/ 1989: 23).¹⁶ Mill condemned censorship as a restraint upon 'the invisible hand' of the intellectual marketplace, which risked privileging the false and suppressing the true (Schauer 1982: 15). A robust competition of ideas was responsible for the progressive dynamic of European nations, which, like Maine, he distinguished from the stationary societies of the Orient (Mill 1859/ 1989: 72). Accordingly freedom of expression deserved protection on instrumental grounds first and foremost. As we have seen, a survivalist theory of truth also underpins Karl Popper's philosophy of science; a philosophy which he extended to the political sphere in *The Open Society and its Enemies* (1966). There Popper recommended an incremental, problem-solving approach to social questions rooted in the method of trial and elimination of error which characterized good science. A Darwinian concern with adaptation and evolution, as well as a fallibilist scepticism concerning established truths, led him to see progress as infinite, but unpredictable. Both Mill and Popper, thus, appear to locate the origins of liberal political arrangements and progressive science in the struggles of nature and in the naturalized realm of the marketplace. Change is accordingly absorbed into mythic processes; 'the new appears as predetermined' and the present is justified endlessly (Adorno and Horkheimer 1944/ 1997: 27). Furthermore, each area of social activity is constructed and legitimated as a sphere of free and beneficent competition pursued by formally equal actors, where scientific theories and political opinions gain acceptance solely by reason of their plausibility.¹⁷

7 THE RADICAL CRITIQUE

The complex interlacing of critical-rational science, medical advance and weak legal regulation, discussed in this essay, has been fundamentally challenged in

the last twenty-five years. At each point a radical critique has disputed the transparency, order and beneficence of progress. The English common law has been indicted as an accomplice in the exploitation of patients by a rapacious medical science. Cumulatively this critique confirms our inductive conclusion as to the ideological and, therefore, contestable nature of the idea of progress in science, medicine and the law. In the following discussion we examine its three main moments.

The work of Thomas Kuhn throws into question the Popperian ideal of scientific activity which underpinned the legal representation of medicine. According to Kuhn, scientific work is only possible within ‘paradigms’ which mark out the phenomena to be investigated and indicate appropriate research questions. Research in this mode is in the nature of puzzle-solving; that is, continually refining the paradigm without ever transcending it (Kuhn 1996: 35). Normal science is, therefore, characterized not by a vigorous competition of ideas, but by a high degree of consensus and closure. Kuhn also rejects the notion of an orderly, cumulative increase in knowledge which underlies Popper’s notion of rational learning by feedback in science. Change only occurs when a given paradigm is beset by a multiplicity of experimental anomalies and is ultimately abandoned in favour of a new paradigm. The latter is often wholly incommensurable with its predecessors, and its adoption by individual scientists is more a matter of conversion than of rational persuasion (Kuhn 1996: 151). Scientific progress, thus, manifests itself in the form of a series of ruptures or revolutions. These are like their political equivalents in seeking to change institutions in a manner prohibited by the institutions themselves (Kuhn 1996: 93). Kuhn’s theories break the closed circle of legitimation which Popper establishes between the liberal polity and the ‘republic of science’.¹⁸ They hint instead at the structures of domination and inequality by which scientific facts are produced.

Ivan Illich’s similarly influential critique of modern medicine is structured around the classical idea of nemesis. In Greek mythology, this divine revenge was called down by human impudence, or hubris. Prometheus stole fire from Mount Olympus and was cruelly punished over centuries by Zeus; Narcissus was bound to suffer for spurning Echo’s affections. Nemesis also structured the Greek view of profane history as cyclical. The passage to each new stage was marked by the downfall of the precedent order as a result of hubris (Löwith 1949: 7). This worldview is sharply distinct from that of the secular, post-Christian era. As we have seen, the latter is oriented towards the open horizon of the future and supports an idea of cumulative, linear progress in science and in human affairs. Illich reverts to the classical model precisely in order to place himself beyond the consensus in favour of therapeutic advance (1976: 43). Medical nemesis, he contends, is a specific form of cosmic retribution for

industrial hubris; that is, the pursuit of material progress without regard to the limits of taboo or myth.¹⁹ Consequent human suffering takes three forms (Illich 1976: 41-43). Clinical iatrogenesis: the fact that patients are increasingly sickened not so much by external agents, as by the medical system itself. Social iatrogenesis: the growing power of the profession and the economic costs of its untrammelled monopoly.²⁰ Cultural iatrogenesis: the commodification of health which degrades the capacity of the laity to respond to illness and mortality.²¹ Nemesis is structural and endemic, a product of the ambitions of the medical profession, the passive greed of the general public, and the penetration of capital into all corners of social life. Things get worse, not better.

For Illich, medical solutions to the crisis, drawing as they do on the bankrupt logic of scientific progress, are doomed simply to reinforce the iatrogenic loop. Escape from medical nemesis is only possible through political action aimed at a recovery of authentic, pre-scientific meanings of illness and mortality, and at the restoration of autonomous capacities for curing and healing (1976: 233, 239). Illich's thesis was taken up by Ian Kennedy in his BBC Reith Lecture series, published under the suggestive title of *The Unmasking of Medicine* (1980). The latter was also informed by historical work showing that the great improvements in health since the Victorian era were mainly due, not to scientific progress, but to improvements in the diet and environment of the population (McKeown 1979). Consistent with this Kennedy argued that resources should be directed away from curative, scientific medicine and towards health education, welfare spending and accident prevention (1980: 53). The assurance of quality and the protection of the vulnerable, required that professional autonomy be ended and that medicine be subject to comprehensive external regulation. As a lawyer, Kennedy was also concerned with the medicalization of questions which he saw as properly a matter of ethics or law. The recovery of the individual's power of decision making in regard to medical questions was for him a matter of civil liberties, best promoted through civil litigation in support of the requirement of informed consent. While favouring a move to 'no-fault' liability in the long term, he also vigorously defended negligence litigation as a means of channelling compensation to victims of medical torts (1980: 116). In subsequent work Kennedy and other scholars argued that, by automatically deferring to medical opinion, the judiciary had failed in its constitutional obligation to protect the patient as consumer and bearer of fundamental rights (Kennedy 1991; Brazier 1992; Teff 1994; Harrington 1996).

8 CONCLUDING REMARKS

The idea of progress through conflict in science and medicine which justified the Bolam test has, thus, been subjected to intense criticism. These left-radical

critiques have ironically provided support to neo-liberal governments seeking to unmake the institutions of the post-war welfare state. The latter have been more concerned with the emancipation of capital from taxation, than with the emancipation of the laity from medical power. Both have agreed, however, that the self-propelling juggernaut of scientific medicine must be stopped. As a result, twenty-one years on Ian Kennedy's list of desiderata has been implemented to a perhaps unexpected degree (see Davies 2000). Medical audit, evidence-based practice, a national standards inspectorate, and a national rationing body are now all in place (Department of Health 1997). The General Medical Council has, as he proposed, extended its disciplinary role from etiquette to competence (2001). Budgetary limitations combined with population-focussed public health strategies have led to the revival of preventative medicine and primary care (Department of Health 1998). These trends are reflected in still tentative moves toward a more intrusive liability regime for medical malpractice. The 'golden age' has passed; the profession is increasingly obliged to forego its formerly exalted status and the collective freedoms which went with it (Le Fanu 2000: 405). The great coupling of medical progress and the public interest achieved in the mid-nineteenth century may at last be coming undone.

NOTES

¹ This paper was completed during the period of my Jean Monnet Fellowship at the European University Institute, Florence (2001-2). Versions of it were presented to the Working Group on Science Studies, EUI, and to the Department of Law at the EUI. I am grateful to the participants on both occasions for their stimulating comments. Thanks are also due to Gavin Anderson, Charles Baron, Karl-Heinz Ladeur, John McEldowney, Ambreena Manji, Sue Millns and Gary Watt for helpful discussion of some of the issues raised here. Responsibility is, of course, mine alone.

² For a consideration of the co-evolution of medical knowledge and the legal regulation of health behaviours, see Harrington (1999).

³ George Eliot has left us with a convincing portrait of the reforming provincial doctor of the 1820s and 30s in the character of Tertius Lydgate. ‘[For him] there was fascination in the hope that the two purposes [i.e. of healing and research] would illuminate each other: the careful observation and inference which was his daily work, the use of the lens to further his judgment in special cases, would further his thought as an instrument of larger inquiry. Was this not the special pre-eminence of his profession?’ (1872/ 1994: 142).

⁴ This distinction has had a notable impact on English medical law, see Harrington (2001).

⁵ This debt is acknowledged in Popper (1979a: 258). For further discussion of Bernard’s career see Porter (1997: 337).

⁶ This corresponds to ‘organized scepticism’, one of the four organizational norms of science according to Merton (1973).

⁷ See the decisions in Edward Wong Finance Co Ltd v Johnson Stokes & Master [1984]; and Cavanagh v. Ulster Weaving Co. [1960].

⁸ See also, Joyce v Merton, Sutton and Wandsworth Health Authority [1996].

⁹ In the inaugural Provost’s Lecture at University College London, 16th January 2001, see Dyer (2001).

¹⁰ De Freitas v O’Brien [1995] For further discussion, see Khan and Robson (1995).

¹¹ Hucks v Cole [1993]; Clark v MacLennan [1983].

¹² Mahon v Osborne [1939]; Anderson v Chasney [1949].

¹³ This has been defined as ‘a process of reference to a model that is operative in the genesis of a concept but is no longer present in the concept itself’ (Blumenberg 1960: 73).

¹⁴ ‘But in those days, after that tribulation, the sun shall be darkened, and the moon shall not give her light, And the stars of heaven shall fall, and the powers that are in heaven shall be shaken. And then shall they see the Son of man coming in the clouds with great power and glory. And then shall he send his angels, and shall gather together his elect from the four winds, from the uttermost part of the earth to the uttermost part of heaven’ (Mark 13: 24-27).

¹⁵ For a historical review, which locates the origin of the liberal doctrine of toleration in the centrality of authentic, subjective experience to the religious life of Quakers and other sectarians, see Troeltsch (1912/ 1986).

¹⁶ This view of the uses of free speech was also adopted into the First Amendment jurisprudence of the US Supreme Court under the influence of Oliver Wendell Holmes, see Cohen (1989).

¹⁷ As has been argued of a related context: ‘[t]he petty proprietors of a commodity known as “opinion” assemble together for its regulated interchange, at once miming in purer non-dominative form the exchanges of bourgeois economy, and contributing to the political apparatus which sustains it’ (Eagleton 1984: 26).

¹⁸ According to Steve Fuller, while Popper's science can be understood as part of the Enlightenment tradition, Kuhn's is arcane and closed, its practitioners maintain their autonomy through uniform displays of their authority (1997: 5, 26).

¹⁹ For a philosophical consideration of the 'limits to medicine', see Jonas (1984).

²⁰ The medicalization of life' thesis was first developed by Zola (1972).

²¹ Illich borrows the legal term 'dissezin' to describe this 'wrongful putting out' of people from their capacity to cope and care for each other (1976: 70).

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