Case No: B3/2015/1816

Neutral Citation Number: [2017] EWCA Civ 336
IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
Mr Justice Nicol
[2015] EWHC 1394 (QB)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/05/2017

Before :

LADY JUSTICE GLOSTER
(Vice President of the Court of Appeal, Civil Division)

LORD JUSTICE UNDERHILL
and
LORD JUSTICE IRWIN

- -

Between :

	ABC	**Appellant**
	- and -	
	(1) ST GEORGE'S HEALTHCARE NHS TRUST **(2) SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST** **(3) SUSSEX PARTNERSHIP NHS FOUNDATION TRUST**	**Respondents**

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Elizabeth-Anne Gumbel QC, Henry Witcomb QC and Jim Duffy (instructed by **Fieldfisher LLP**) for the **Appellant**
Philip Havers QC and Hannah Noyce (instructed by **Capsticks Solicitors LLP**) for the **Respondents**

Hearing dates: 28 and 29 March 2017

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Judgment

Lord Justice Irwin :

Introduction

1. This is an appeal against the decision of Nicol J given on 19 May 2015. The Judge acceded to the Defendant Respondents' application, and struck out the

claim at common law on the ground that there was “no reasonably arguable duty of care” owed by the Respondents to the Appellant. He also struck out a claim formulated under the Human Rights Act 1998 on the basis that the Respondents had breached the Appellant’s rights under Article 8 of the European Convention on Human Rights: “even assuming Article 8 was engaged, any interference would plainly be justified under Article 8(2) for all of the reasons relied upon in answer to the common law claim” (paragraph 35).

2. For the reasons which I will now give, I would allow this appeal and remit the case for trial.

3. For the sake of simplicity, I will refer hereafter simply to the “Claimant” and the “Defendants”.

The Facts

4. As Nicol J rightly observed, the facts of this case are tragic. They can be summarised relatively shortly. In 2007, the Claimant’s father shot and killed her mother. He was convicted of manslaughter on the grounds of diminished responsibility. He was sentenced to a hospital order under Section 37 of the Mental Health Act 1983 and subjected to a Restriction Order under Section 41 of the Act. He was detained at a clinic run by the Second Defendant. He was referred to St George’s Hospital for exploration of his condition, that hospital being the responsibility of the First Defendant. Whilst resident in the clinic he was seen by a social worker for whom the Third Defendant is responsible. As the Judge rightly said, it is not necessary for present purposes to distinguish between the Defendants.

5. In early 2009, it was suspected that the father might be suffering from Huntington’s Disease. This condition is inherited. It is agreed that the child of a parent with Huntington’s Disease has a 50 per cent chance of developing the condition. Huntington’s Disease causes damage to brain cells, giving rise to disruption of movement, cognition and behaviour. It typically brings about personality change, irritability, altered behaviour, and often aggression. It is incurable and the progress of the disease cannot be reversed or slowed. The condition is progressive and fatal.

6. The father’s diagnosis was suspected and then confirmed during 2009. By late August of that year the Claimant’s father had told his brother of the presumed diagnosis, but had not spoken to the Claimant or either of her two sisters.

7. In the course of a multi-disciplinary meeting on 2 September 2009, those concerned with the father’s care considered whether they should override his patient confidentiality and inform his daughters of the diagnosis, because of the implications for them, and because they “may have a right to know”. The father’s wish was that the diagnosis should be “kept confidential” so that his daughters are not additionally distressed. The care team agreed to keep this confidential.

8. On the same day, the Claimant informed her father that she was pregnant.

9. During the latter part of 2009, those responsible for the father's care considered whether they should inform his daughters of the provisional diagnosis and in particular whether they might choose themselves to undergo a predictive test for Huntington's Disease. However, the father remained opposed to that.

10. In November 2009, genetic testing confirmed that the father did indeed have Huntington's Disease. In December the question of informing his family was again explored with the father. A social worker recorded that he "does not want his daughters to know about it, especially the pregnant one until she gives birth some time in 2010".

11. Following further discussion with the father in January 2010, a Dr Olumoroti once more recorded the father's wish that his daughters should not be informed of the diagnosis "as he felt they might get upset, kill themselves, or have an abortion".

12. In April 2010, the Claimant gave birth to a daughter.

13. In June 2010, the father was seen by a forensic social worker, Victor McGill. Mr McGill recorded his view that the father's Huntington's Disease may have been a contributory factor to his mental state at the time of the killing. He went on to record:

> "I do not think that [the father] is able to understand the implications of his illness, the possible speed of his deterioration, or the effects it will have, both on him and his family."

14. On 23 August 2010, the Claimant was accidentally informed by Dr Olumoroti about the father's diagnosis of Huntington's Disease. She subsequently underwent testing, and in January 2013 was herself diagnosed as suffering from Huntington's Disease.

The Claim

15. The Claimant alleges that the particular circumstances of her case mean that the Defendants owed her a duty of care. She says it was critical that she should be informed of her father's diagnosis, firstly presumed and subsequently confirmed, in the light of her pregnancy. This was her first and only child. It was all along known that she would be a single mother with sole responsibility for the upbringing of the child. If informed of her father's diagnosis she would have sought to be tested for Huntington's Disease. If her own diagnosis was confirmed, she would have terminated the pregnancy rather than run the risk that her child might in due course be dependent on a seriously ill single parent or

become an orphan, and the risk that in due course her child might inherit the disease. Her diagnosis would have precluded any subsequent pregnancy. The claim therefore includes a "wrongful birth" claim in respect of the child. The child has an accepted risk of 50 per cent of contracting the disease, but it is not yet possible to reach a diagnosis in her case, one way or another.

16. Part of the Claimant's case turns on the fact that during 2009 she and one of her sisters took part in family therapy, organised and facilitated by the Defendants. In the course of the hearing before this Court draft Re-Amended Particulars of Claim were submitted on behalf of the Claimant. As part of that pleading, the Claimant avers that her attendance at the clinic for family therapy was in the capacity of "a patient of the Defendants" and thus there existed a direct relationship giving rise to a duty of care.

17. The basis of the claimed duty of care is pleaded broadly. It is said that the Defendants knew at all relevant times the Claimant was a daughter of her father, knew of the 50 per cent risk to her, and knew that such a diagnosis would have "a direct effect on the health, welfare and life of the Claimant". The facts gave rise to a special relationship between the Defendants and the Claimant. Alternatively, there was an assumption of responsibility by the Defendants to the Claimant. In either case there arose a duty of care. The Defendants had an obligation to care for the Claimant's "welfare and psychological and/or physical well-being". There was a duty to "take reasonable steps to prevent the Claimant from suffering injury" whilst undergoing the family therapy. The therapy had a "therapeutic objective" to address the facts of her mother's death, "the role that her father played in it, and her future relationship with her father".

18. As a consequence of the duty of care it is said, in summary, that the Defendants should have provided the information as to the father's diagnosis "in a timely manner when it was known, or ought to have been known, that the Claimant was pregnant" and that following the provision of information, the Claimant should have been given the opportunity for "urgent diagnosis and testing" of her own condition, with further advice, support and termination of the pregnancy, if desired.

19. The Claimant also relies on the guidance given by the Royal College of Physicians, the Royal College of Pathologists and the British Society of Human Genetics entitled "*Consent and Confidentiality in Genetic Practice. Guidance on Genetic Testing and Sharing Genetic Information*". The relevant edition was published in April 2006. A central passage relied on by the Claimant reads as follows:

> "2.5.3 Where consent to release information has been refused
>
> The Human Genetics Commission, the Nuffield Council on Bioethics and the GMC have all expressed the view that the rule of confidentiality is not absolute. In special circumstances it may be justified to break confidence where the aversion of harm by the disclosure substantially

> outweighs the patient's claim to confidentiality. Examples may include a person declining to inform relatives of a genetic risk of which they may be unaware, or to allow the release of information to allow specific genetic testing to be undertaken.
>
> Before disclosure is made in such circumstances an attempt should have been made to persuade the patient in question to consent to disclosure; the benefit to those at risk should be so considerable as to outweigh any distress which disclosure would cause the patient; and the information should be anonymised and restricted as far as necessary for the communication of the risk.
>
> We recommend that before disclosure is made when consent has been withheld the situation should be discussed with experienced professional colleagues and the reasons for disclosure documented. Current GMC guidance states that the individual should generally be informed before disclosing the information."

20. As the judge noted, the reference to the "current GMC guidance" was to the GMC report on confidentiality in 2004. Updated guidance was published by the GMC in 2009. Nicol J identified relevant passages from the guidance as follows:

> "Confidentiality is central to the trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to seek medical attention or to give doctors the information they need in order to provide good care. But appropriate information sharing is essential to the efficient provision of safe, effective care, both for the individual patient and for the wider community of patients.
>
> …
>
> Disclosure of personal information about a patient without consent may be justified in the public interest if failure to disclose may expose others to a risk of death or serious harm. You should still seek the patient's consent to disclosure if practicable and consider any reasons given for refusal.
>
> Such a situation might arise, for example, when a disclosure would be likely to assist in the prevention, detection or prosecution of serious crime, especially crimes against the person. When victims of violence refuse police assistance, disclosure may still be justified if others remain at risk, for example from someone who is prepared to use weapons, or from domestic violence when children or others may be at risk.
>
> If a patient's refusal to consent to disclosure leaves others exposed to a risk so serious that it outweighs the patient's

> and the public interest in maintaining confidentiality, or if it is not practicable or safe to seek the patient's consent, you should disclose information promptly to an appropriate person or authority. You should inform the patient before disclosing the information, if practicable and safe, even if you intend to disclose without their consent."

21. The Claimant submits that the professional guidance makes it clear there are professional obligations (to employ a neutral term) towards those who, although not in existing doctor/patient relationships with a clinician, have a vital interest in genetic information which the clinician has obtained. The Claimant submits these obligations are a good foundation for an extension of the legal duty of care to individuals affected in this way, well within the application of the familiar tripartite test laid down in *Caparo v Dickman* [1992] AC 605.

22. The Defendants submit that the Guidance imposes no duty on the clinician. It simply provides:

> "That disclosure may be justified in certain circumstances, and it imposes a duty to conduct a balancing exercise in order to decide whether or not such circumstances arise in each case … as long as he had carried out the requisite balancing exercise, that doctor could not be disciplined or otherwise criticised for failing to disclose on the basis of the Guidance … In other words the Guidance operates as a shield not a sword."

23. With respect, I cannot accept the logic of this submission. Of course there is no simple duty of disclosure. But if the clinician conducts the requisite balancing exercise, and concludes that it falls in favour of disclosure then a professional obligation arises. The question is whether a breach of that obligation is actionable.

24. As the Defendants agreed, before Nicol J and then before us, the first two limbs of the tripartite test can be taken to be established for present purposes. The Claimant would be able to establish at trial that injury to her was reasonably foreseeable from a failure to inform her that her father had Huntington's Disease. Secondly, the Defendants accept for present purposes that there was sufficient proximity between the Claimant and the Defendants for a duty of care to arise. The argument arises from the third limb: is it arguably fair, just and reasonable to impose on the Defendants a duty of care towards the Claimant on the facts alleged.

The Defendants' Submissions on Common Law

25. Mr Havers QC for the Defendants starts from the position that there is no precedent for an extension of the duty of care in these circumstances. The fact that there may be a professional duty, upon occasion, to override patient

confidentiality, does not translate into a legal duty to the persons in need of the information. In making good that distinction, and to support the proposition that it is not fair, just or reasonable to impose such a duty, Mr Havers advanced nine policy reasons why such a duty should not be imposed and also considered such authority as exists from common law countries bearing on the question. Nicol J found the nine policy reasons persuasive. I turn first to them.

26. **"(i) What was put against the public interest in preserving confidence in the present context was not a public interest in disclosure, but the private interest of the Claimant"**.

Here the Defendants suggest there is no public interest to counter-balance the obvious public interest, accepted by all, in preserving confidence in the doctor/patient relationship. I found this argument difficult to follow. The public interest in the preservation of the doctor/patient relationship must inhere in public confidence in the way doctors approach their obligations to patients. For myself I find it difficult to see how public confidence is necessarily improved if private law action is available to enforce only some of the professional obligations laid down in the relevant professional guidance. Where, as here, the professional guidance enjoins a clinician to consider breaching patient confidentiality if the circumstances demand it, I do not myself see that it is necessarily the case that public confidence is increased because the patient could sue but the person who needs the relevant information could not. If and when a decision to override patient confidentiality is taken in line with the relevant professional guidance, it seems to me at least arguable that public confidence will be diminished rather than enhanced by the absence of the duty contended for. It might logically be said that such a situation represents an incentive to the clinician to play safe rather than to take the difficult step of overriding patient confidentiality.

27. In addressing this point I should stress that I have reached no final conclusion on the merits of this argument. As with other points in this case, since the question is whether the strike-out of the case was appropriate on the ground that the case is unarguable and cannot succeed, I confine myself here to a consideration of whether or not the outcome of the argument must be adverse to the Claimant. On this point, my answer is that it is not necessarily adverse to the Claimant.

28. There has been a strong trend in recent authority in the field of clinical negligence, to emphasise the autonomy of the patient. There is no need for an anxious parade of legal learning to make out that proposition. The progress of the common law from *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871 to *Montgomery v Lanarkshire Health Board* [2015] AC 1430 will, in my judgment, demonstrate that trend. Mr Havers would emphasise that the growing emphasis on patient autonomy has developed within the existing ambit of the doctor/patient relationship, and that is correct. However, it is at least arguable that it is irrational to emphasise the need to inform patients so that they may take their own decisions about treatment, whilst at the same time depriving of any legal remedy identified individuals in respect of whom a relevant doctor has specific information which should cause them to become patients. As I have said, I do not think it is obvious that the perpetuation of that position in law will increase public confidence.

29. The Claimant argues additionally that the public interest is engaged more directly in the proper treatment of individuals in her position. Indeed, she argues that there is a public interest in preventing the unwitting conception or birth of a child who may need significant state support because of the parent's potential inability to bring up her child, and where that child itself has such a high chance of growing up only to succumb herself to such a fell disease. Once again, I cannot conclude that the Claimant's position is unarguable.

30. **"(ii) The Law of confidence allowed a doctor to disclose confidential information in certain circumstances – see for instance *Attorney General v Guardian Newspapers (No 2)* [1990] 2 AC 109 (and I would add *W v Egdell* [1990] CA 359). The Claimant was contending for a duty to do so. Consciously or unconsciously, this might encourage doctors to breach confidence where it might not otherwise have been justified."**

The Defendants amplify this argument by submitting that any existing duty does not usually conflict with another duty, particularly another duty owed to a third party. The establishment of a legal duty would place a doctor "in the invidious position of owing conflicting duties to multiple people, one or more of whom may not be his patient".

31. It appears to me that this second policy reason is really duplicated by the third, which reads:

"(iii) Doctors would be subject to conflicting duties, liable to be sued by their patient if they disclose information which should have remained confidential, liable to be sued by a third party, such as the Claimant, if they fail to disclose information which they should have revealed."

There can be no doubt as to the difficulty facing clinicians in the situation we are contemplating. It seems to me the difficulty already arises, and indeed is exemplified and emphasised by the professional guidance I have quoted above. I quite accept that the existence of a legal duty to the "third party" as well as to the patient may add to the pressure on the clinician. It will no longer be clear to the clinician which decision will be protective of legal action against him or her. Is it necessarily and inevitably in the public interest that clinicians should be relieved of that pressure? In my view, it is self-evident that there is a public interest in avoiding excessive litigation and in keeping to a minimum what one can call, in shorthand, defensive medicine. However, it seems not necessarily correct, in a situation where patient confidentiality should be waived or, if necessary breached, that the common law should so clearly incentivise obligations in one direction but not the other. It seems to me at least arguable that that may encourage rather than diminish defensive medicine.

32. The Claimant submits that balancing risks is an inherent part of clinical practice. In such circumstances the imposition of the legal duty advanced here would serve to protect the interests of both parties, and ensure that a proper balancing exercise is performed by the clinician. In my view, this is a properly arguable position. It

also appears to be a matter upon which the Court might well be assisted by expert evidence, preferably of the most senior and authoritative character.

33. The next policy reason advanced by the Defendants is expressed as follows.

"(iv) If a doctor is subject to a duty of care in some situations to disclose information to third parties, it will undermine the trust and confidence which is so important to the doctor/patient relationship. It may lead to patients being less candid with their doctors. The same point had been made by the European Court of Human Rights in the context of Article 8 of the Convention – see *Z v Finland* (1998) 25 EHRR 371 at [95]."

In amplifying this point the Defendants submit that if a patient understands that his or her doctor may disclose confidential information, this is likely to undermine the trust inherent in the relationship even if actual disclosure is rare. The Defendants go on to say:

> "Second, this problem is not currently a feature of work in genetics precisely because there is currently no duty of disclosure. Doctors may in some cases, have to consider whether disclosure would be justified, but that is very different from having a legal duty to disclose."

34. The first part of this submission is clearly correct. It is possible that confidence in the doctor/patient relationship may be reduced if the patient is aware that confidentiality may be breached. However, I question the degree to which such loss of confidence may be affected by the existence of a common law duty of care to the "third party", as opposed to any professional duty to disclose, which already exists. It seems to me unlikely that a patient will be concerned as to the precise legal basis for the duty to override confidentiality: the concern is likely to arise from the fact that confidentiality might be overridden. Perhaps the implicit message behind the Defendants' reasoning is that the existence of a legal duty to the "third party" may cause confidentiality to be overridden more often. However, this does not appear to me to be self-evident. Even if it is true, is that necessarily contrary to the public interest? Once again, this topic might properly be the subject of expert evidence.

35. In my view, it is worth emphasising that it is not implicit in the Claimant's argument that the existence of a duty of care to people in the position of this Claimant should or would lead to greater or more frequent disclosure of information, over and above what should be the outcome of the existing professional obligations. Nor would it necessarily lead to many more successful actions in negligence. Any claimed legal liability to a "third party" would necessarily be tested by reference to the well-known *Bolam* test (see *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582), qualified by the consideration that a professional decision must be a reasonable one (see *Bolitho v City and Hackney Health Authority* [1998] AC 232). Common law liability would be measured against those standards, with the relevant professional practice and guidance very much to the fore. Indeed it seems to me evident, given

the difficulty of such decisions, that the Courts would allow considerable latitude to clinicians faced with such a dilemma. Once again in relation to this policy reason, I reach no decided conclusion save that the matter is to my mind clearly arguable.

36. The next policy reason advanced is as follows.

"(v) If doctors owed a duty of care to third parties, it may result in doctors putting pressure on their patients to agree to disclosure to avoid the risk of being sued by third parties."

The Defendants advance little by way of amplification of this Ground. It may be that the objection would be made out in some cases. However, the premise of this objection is that clinicians will act self-protectively or "defensively". To the extent that that may be true, it does not seem to me obvious that the public interest or the rigour of the common law is served by the maintenance of an incentive to act self-protectively only in one direction. Here again it seems to me this point is arguable and at least potentially susceptible of evidence.

37. The following two policy reasons are linked by the Defendants in their written submissions.

"(vi) Some third parties may not wish to receive information. Yet a doctor may not be able to explore whether this is the case without effectively imparting the information itself",

and

"(vii) It is possible that the third party may suffer psychiatric harm if he or she is told the information in question. The doctor will be in a dilemma as to how to explore whether this is the case when the third party is not or may not be his or her patient".

It seems to me evident that the difficulties outlined in reason (vi) and the first sentence of (vii) are already faced by clinicians. These problems arise in respect of such decisions whether or not legal liability exists towards the "third party".

38. It requires only a small change to the facts of the current case to see how such a situation might arise. If the Claimant had been a psychologically vulnerable woman, clearly beyond child-bearing age, then one could quite see why a geneticist might withhold from her her father's diagnosis. News of the diagnosis must inevitably be very frightening. There is no step which can prevent the onset of this disease if that is what the future holds. The potential patient could be reassured by no suggested cure. In those hypothetical circumstances, one can imagine a proper clinical decision to withhold the news of the paternal diagnosis,

on the ground that the risk of psychological damage outweighed any gain from transmitting the news. There would be reduced value in an argument based on the autonomy of the hypothetical claimant since, by strong contrast to the facts of this case, such a claimant would have no meaningful choices open to her.

39. It seems to me that it is difficult to see how the extension of a legal duty of care affects this problem. I readily concede that expert evidence might alter that view. However, it seems to me this problem arises already, in relation to the transmission of such information with the consent of the diagnosed patient to his or her relative, or when overriding the withholding of such consent, based on the professional guidance.

40. The next policy reason advanced by the defendants is as follows:

"(viii) Doctors receive a very great deal of confidential information. It would be burdensome to place on them a duty to consider whether any of it needs to be disclosed to third parties. The time and resources committed to this will be a distraction from treating patients."

On the face of it, it seems to me this policy reason lacks any bite when applied to geneticists. As will already be clear from the professional guidance to which I have referred, and indeed from the inherent nature of genetic medicine, geneticists frequently acquire definite, reliable and critical facts of clinical significance about their patients' relatives. Included in the material before the Court as part of the guidance from the Joint Committee on Medical Genetics appears the following passage:

> "**Fundamentals of clinical genetic practice**
>
> Whilst genetic information is relevant to an individual, as noted, it may also be relevant to that person's family because much genetic information will be common to both. Indeed, genetic testing may only be requested because of wider knowledge about a condition within a family. The traditional medical approach which focuses on the individual patient to the exclusion of others may be difficult to apply to the use of genetic information. For example, testing one person can reveal information about the chances of a condition occurring in their close relatives and providing the tested person with a right of veto over such risk information in all situations may be legally and ethically unsound. At the same time, respecting confidential information is an important aspect of clinical practice and is vital in securing public trust and confidence in healthcare."

41. It seems plain that this duty already lies on clinical geneticists. There is no basis on the material before us for considering that they are, or will be, distracted from treating their patients by this problem.

42. The Defendants’ real concern here was, it seems to me, not captured by reason (viii). The real concern is a “floodgates” argument. In written submissions to us, the Defendants submit that such problems as these may arise in a variety of medical scenarios aside from those involving genetic conditions. The examples given include a patient suffering from a sexually transmitted disease who refuses to tell his or her previous sexual partners; a patient whose vasectomy has failed but who refuses to tell his sexual partner; a patient who is suffering from a contagious disease who refuses to tell family or friends; a patient dying from a long, distressing illness and who does not wish his family to be told for fear of psychiatric harm; and a terminally ill patient who refuses to allow his pregnant partner to be told, for fear she might choose to terminate the pregnancy. Here, I recognise that there is force in the Defendants’ submissions. The examples given are no more than that, and I readily accept that further problematic examples might be given. As we shall see, some of these situations (or variations upon them) have given rise to some of the few reported authorities from other jurisdictions where the extension of the duty of care has been contemplated.

43. To my way of thinking there is at least one important distinction between the situation of a geneticist and all the other examples given. However problematic, and whatever the implications for “third parties”, the clinician usually only has knowledge of medical facts about the existing patient. It is only in the field of genetics that the clinician acquires definite, reliable and critical medical information about a third party, often meaning that the third party should become a patient.

44. Although parallel duties and difficulties of disclosure arise in other areas of clinical practice, usually to do with risks posed to others by the condition of the existing patient (see below), the clinical geneticist is in a different position. He or she often comes to know of a health problem already present, or potentially present, in the third party, and which means the third party requires advice and, in conditions other than Huntington’s Disease, may require treatment, potentially life saving in its effect. One example would be diagnosis of a strong genetic disposition to breast cancer. In such circumstances the third party is not a patient, but should become a patient. Moreover, in many of the other scenarios envisaged, the practicalities of addressing the implications preclude effective remedy. Some former sexual partners may be known, but they do not constitute a closed class of individuals whose risk is defined by the genetic link to the patient, and who, for the most part, will be contactable.

45. I accept the difficulty presented by the “floodgates” concern. This argument would have to be considered very carefully, particularly given the principle that the common law of negligence should advance by incremental steps. It may be that the distinction I have tentatively suggested as applying to genetic cases might on close consideration be thought insufficiently robust to sequestrate genetic cases from a broad range of other situations. However, it does not seem to me unarguably so, and therefore it does not seem to me the Defendants’ submission justifies a strikeout of the action.

46. The final “policy reason” advanced by the Defendants is in reality a proposition of law:

(ix) "This significant extension of a doctor's duty of care would be contrary to the incremental way in which the law of negligence ought to progress."

In addressing this point it is appropriate to look relatively briefly at existing English authority, and authorities from other common law jurisdictions.

47. Before Nicol J and before us, the Claimant advanced a number of cases which were said to be parallel to this and to support a duty of care in these circumstances. They were successively: *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 (QB); *Angela P v St James and Seacroft University Hospital NHS Trust* [2001] EWCA Civ 560; and *Powell v Boladz* [1998] Lloyds Rep. Med. 116 CA. It seems to me with respect to Ms Gumbel QC for the Claimant, that the farthest that existing law can be stated in any of those cases is that there can arise a duty on the part of the clinician to advise the patient to communicate the relevant information. Nicol J addressed these cases in paragraphs 23 to 25 of his judgment, and I would not dissent from his remarks. However, it is to be noted that neither party submits there is any previous case in this jurisdiction which has considered the obligation to disclose information arising from the practice of clinical genetics. Nor has the professional guidance been considered in the context of common law liability in any English case.

48. Before Nicol J and before us, Mr Havers relies on the well-known decisions of the House of Lords in *X v Bedfordshire County Council* [1995] 2 AC 633 and *D v East Berkshire NHS Trust* [2005] 2 AC 373. It is hardly necessary to rehearse the facts of those cases. The factual matrix was quite distinct from the present case. The decisive considerations in each of those cases were policy considerations affecting, in the first instance, those with responsibility for children in care, and in the second, clinicians with the care of children suspected of being subject to child abuse by their parents. As Nicol J summarised it in paragraph 26 of his judgment, in *D v East Berkshire NHS Trust*:

> "Considerable stress was laid on the danger of creating duties which could potentially conflict, exposing the doctor to a claim from the parent if he acted on his suspicion of abuse and from the child if he did not."

As I have indicated above, the question here is whether the difficulty of the geneticist already faced with such conflicting considerations identified in the relevant professional guidance requires to be protected from such a common law duty of care.

Foreign Authority

49. A number of foreign cases were cited to us. I do not intend to address more than two, both from the United States. Neither represents an exact parallel, although one case concerns clinical genetics.

50. In *Tarasoff v Regents of the University of California* (1976) 551 P.2d 334, the Supreme Court of California considered whether a therapist had a duty of care to warn an identifiable third party, and those capable of warning an identifiable third party, that she was at risk of being murdered, upon being told by a patient during therapy of his intention to do so and upon him being released from police custody. The Superior Court held that the therapist did not. The Supreme Court held that the therapist did.

51. The Supreme Court stated:

> "The Defendant therapists cannot escape liability merely because Tatiana herself was not their patient. When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call upon him to warn the intended victim or others likely to appraise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."

52. The Supreme Court stated that the principle established in *Rowland v Christian* (1968) 69 Cal.2d 108:

> "that whenever one person is by circumstances placed in such a position with regard to another…that if he did not use ordinary care and skill in his own conduct…he would cause danger of injury to the person or property of the other, a duty arises to use ordinary care and skill to avoid such danger"

should be departed from only upon the "balancing of a number of considerations." Major considerations:

> "Are the foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the availability, cost and prevalence of insurance for the risk involved."

53. The Supreme Court went on:

> "The most important of these considerations in establishing duty is foreseeability…. As we shall explain, however, when the avoidance of foreseeable harm requires a defendant to control the conduct of another person, or to warn of such conduct, the common law has traditionally imposed liability only if the defendant bears some special relationship to the dangerous person or to the potential victim. Since the relationship between therapist and his patient satisfies this requirement, we need not here decide whether foreseeability alone is sufficient to create a duty to exercise reasonable care to protect a potential victim of another's conduct."

54. Although under the common law one person owed no duty to control the conduct of another:

> "The courts have carved out an exception to this rule in cases in which the defendant stands in some special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct."

55. The relationship of the therapists to the intended victim created a duty of care which arose between the actor and the other which gives the other a right of protection:

> "Although the Plaintiff's pleadings assert no special relationship between Tatiana and the defendant therapists, they establish as between Poddar and the defendant therapists the special relation that arises between a patient and his doctor or psychotherapist. Such a relationship may support affirmative duties for the benefit of their persons. Thus, for example, a hospital must exercise reasonable care to control the behaviour of a patient which may endanger other persons. A doctor must also warn a patient if the patient's condition or medication renders certain conduct, such as driving a car, dangerous to others.
>
> …
>
> Although the California decisions that recognise this duty have involved cases in which the defendant stood in a special relationship both to the victim and to the person whose conduct created the danger, we do not think that the duty should logically be constricted to such situations. Decisions of other jurisdictions hold that the single relationship of a doctor to his patient is sufficient to support the duty to exercise reasonable care to protect others against dangers emanating from the patient's illness. The courts hold that a doctor is liable to persons infected by his

> patient if he negligently fails to diagnose a contagious disease (*Hofmann v Blackmon*) (Fla. App (1970) 241 So. 2d 752), or having diagnosed the illness, fails to warn the members of the patient's family (*Wojcik v Aluminium Co of America* (1959) 18 Misc. 2d 740 [183 N.Y.S2d 351, 357-358]; *Davis v Rodman* (1921) 147 Ark. 385 [227 S.W. 612, 13, A.L.R 1459]; *Skillings v Allen* (1919) 143 Minn. 323 [173 N.W. 663, 5 A.L.R. 992]; see also *Jones v Stank* (1928) 118 Ohio St. 147 [6 Ohio L.Abs. 77, 160 N.E 456]).
>
> Once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger. While the discharge of this duty of due care will necessarily vary with the facts of each case, in each instance the adequacy of the therapist's conduct must be measured against the traditional negligence standard of the rendition of reasonable care under the circumstances.
>
> The risk that unnecessary warnings may be given is a reasonable price to pay for the lives of possible victims that may be saved. We should hesitate to hold that the therapist who is aware that his patient expects to attempt to assassinate the President of the United States would not be obligated to warn the authorities because the therapist cannot predict with accuracy that his patient will commit the crime.
>
> We recognise the public interest in supporting effective treatment of mental illness and in protecting the rights of patients to privacy…and the consequent public importance of safeguarding the confidential character of psychotherapeutic communication. Against this interest, however, we must weigh the public interest in safety from violent assault.
>
> We conclude that the public policy favouring protection of the confidential character of patient psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins.
>
> If the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we see no sufficient societal interest that would protect and justify concealment."

56. The situation in *Tarasoft* holds parallels with the instant case. One distinction is clear from the California Supreme Court's observations as to the unpredictable nature of the risks to potential victims and the possibility of unnecessary warnings

being given. In the case of clinical genetics the obligation will usually arise from a specific quantifiable risk. Indeed it is one of the clinical functions of the geneticist to calculate the risk. As the science and medical applications of genetics progress, this will become ever more possible.

57. In *Safer v Pack* (291 N.J.Sup. 619, 677 A. 2d 1188) 1996, the New Jersey Superior Court considered the question of whether a physician had a duty to warn the child of his patient of a genetic risk. The Plaintiff contended that the Defendant physician who had treated her father for utile polyposis several decades ago, by virtue of medical standards prevailing at the time when the Defendant treated him, owed a duty of care to warn her of her risk of developing the disease, a hereditary condition, that if undiscovered and left untreated, would lead to metastatic colorectal cancer.

58. The trial court held that the Defendant did not owe the Plaintiff such a duty of care. The New Jersey Superior Court disagreed, approving the reasoning in *Fosgate v Corona*, 66 N.J. 268,274, 330 A.2d 355 (1974) for imposing such a duty, and rejecting the approach of the Supreme Court of Florida in *Pake v Threlkel* 661 So 2d at 282, that in all circumstances, the duty to warn will be satisfied by informing the patient.

59. The Superior Court stated:

> "We see no impediment, legal or otherwise, to recognising a physician's duty to warn those known to be at risk of avoidable harm from a genetically transmissible condition. In terms of foreseeability especially, there is an essential difference between the type of genetic threat at issue here and the menace of infection, contagion or a threat of physical harm….The individual or group at risk is easily identified, and substantial future harm may be averted or minimised by a timely and effective warning….
>
> We need not decide, in the present posture of this case, how, precisely, that duty is to be discharged, especially with respect to young children who may be at risk, except to require that reasonable steps be taken to assure that the information reaches those likely to be affected or is made available for their benefit.
>
> Although an overly broad and general application of the physician's duty to warn might lead to confusion, conflict or unfairness in many types of circumstances, we are confident that the duty to warn of avertable risk from genetic causes, by definition a matter of familial concern, is sufficiently narrow to serve the interests of justice.
>
> It may be necessary, at some stage, to resolve a conflict between the physician's broader duty to warn and his fidelity to an expressed preference of the patient that nothing be said to family members about the details of the

> disease. We cannot know presently, however, where there is any likelihood that such a conflict may be shown to have existed in this matter or, if it did, what its qualities might have been. As the matter is currently constituted, it is as likely as not that no such conflict will be shown to have existed.
>
> This case implicates serious and conflicting medical, social and legal policies, many aptly identified in Sonia M. Suter, Whose Genes Are These Anyway? Familial Conflicts Over Access to Genetic Information, 91 Mich. L.Rev 1854(1993) and in other sources, including some referred to by the motion judge. Some such policy considerations may need to be addressed in ultimately resolving this case. For example, if evidence is produced that will permit the jury to find that Dr Pack received instructions from his patient not to disclose details of the illness or the fact of genetic risk, the court will be required to determine whether, as a matter of law, there are or ought to be any limits on physician-patient confidentiality, especially after the patient's death where a risk of harm survives the patient, as in the case of genetic consequences. See generally Janet A Kobrin, Confidentiality of Genetic Information, 30 UCLA L.Rev 1283(1983)."

60. We were informed by Mr Havers QC that, following the decision in *Safer v Pack*, the duty to warn laid down by the Superior Court was set aside by the State Legislature. That outcome does not affect the quality of reasoning in the decision.

Incremental Development of the Common Law

61. Following from the action of the New Jersey State Legislature, Mr Havers suggested that the extension of the duty of care was not consonant with the incremental development of the common law: if such a change was necessary, it should be for Parliament, not the Courts.

62. I reject that argument. The ambit and content of the duty of care in such cases has long been a matter of common law, developed by judicial decision. If that were to cease to be so, the law would ossify in this area. It has not done so, as demonstrated by the leading authorities in the field, such as *Sidaway* and *Bolitho* have shown. This point was made with characteristic elegance by Lord Bingham in his dissenting judgment in *D v East Berkshire Community Health NHS Trust* [2005] UKHL 23:

> "[50] … But the question does arise whether the law of tort should evolve, analogically and incrementally, so as to fashion appropriate remedies to contemporary problems or whether it should remain essentially static, making only such changes as are forced upon it, leaving difficult and, in human terms, very important problems to be swept up by

> the Convention. I prefer evolution."

63. A similar point was made by Lord Kerr and Lord Reed, with whom Lord Neuberger, Lord Clarke, Lord Wilson and Lord Hodge agreed, in *Montgomery v Lanarkshire Health Board (General Medical Council Intervening)* [2015] 2 All ER 1031:

> "[93] The first of these points has been addressed in para 85 above. In relation to the second, the guidance issued by the General Medical Council has long required a broadly similar approach. It is nevertheless necessary to impose legal obligations, so that even those doctors who have less skill or inclination for communication, or who are more hurried, are obliged to pause and engage in the discussion which the law requires. This may not be welcomed by some healthcare providers; but the reasoning of the House of Lords in *Donoghue v Stevenson* [1932] AC 562, [1932] All ER Rep 1 was no doubt received in a similar way by the manufacturers of bottled drinks."

Assumption of a Duty of Care

64. The Claimant raises this alternative basis of a duty of care, in large measure as a consequence of her participation in the family therapy organised and provided by the Defendants. For my part, I do not yet see a foundation for this part of the claim. I would not have allowed the appeal on this basis. However, if the matter is remitted, I would permit the Claimant to advance this claim if that appears to be justified on a closer consideration of the evidence.

Claims Based on the European Convention

65. The claim has sought to advance an alternative basis for the claim derived from the Claimant's rights under Article 8 of the Convention. I am unconvinced that the Convention adds anything to the common law or can provide a basis for action if the common law does not do so. However, if the matter is remitted, I would not preclude the Claimant from arguing this case, if that is considered proper.

Conclusions

66. For the reasons stated, I am of the view that the Claimant's case is arguable. I would allow the appeal, quash the Order striking out the claim, and remit the case for trial.

Lord Justice Underhill:

67. I agree

Lady Justice Gloster:

68. I also agree.