Cousins, Genetic Diagnosis and Liability of Clinicians:

Smith & Another v University of Leicester NHS Trust [2016] EWHC 817 (QB)

**Abstract**

This comment analyses the recent High Court decision in *Smith & Another v University of Leicester NHS Trust*. In this case, the court struck out a claim brought by a patient’s second cousins regarding their failure to provide the patient with an accurate diagnosis, which would have resulted in the claimants being diagnosed with hereditary disease earlier than they in fact were. The claimants argued that the doctors’ failure to conduct the test caused harm and a duty of care was owed in respect of the patient’s relatives. The defendant conceded the issue of foreseeable harm but argued a duty was not fair, just and reasonable when treating the patient and no other, or, alternately, if the duty was to inform then the cousins was insufficiently proximate. It is argued in this comment that the judge was correct to reject the claim but that aspects of the judgment demanded greater analysis.

**Introduction**

Genes are the fundamental unit of hereditary, passing on traits from parents to offspring. Thus genetic information can reveal data relevant to both a patient and their family. This familial dimension to genetic information has been a subject of academic commentary for years,[[1]](#footnote-1) but how overlapping interests in a person’s genetic data should be managed has only become a question for the courts comparatively recently, with the decisions of the High Court in *ABC v St George’s Healthcare NHS Trust*[[2]](#footnote-2) and *Smith & Anor v University of Leicester NHS Trust*.[[3]](#footnote-3) The diminishing cost of testing means information about genetic heritage, and particularly risks of disease, is becoming more readily available; and for this reason it is foreseeable the courts will face an increasing volume of litigation concerning hereditary conditions.[[4]](#footnote-4) The crux of both *ABC*[[5]](#footnote-5) and *Smith* is nondisclosure of a genetic diagnosis, but while *ABC* closely resembled the doctor-relatives scenario envisaged by commentators,[[6]](#footnote-6) *Smith* deviates somewhat from that anticipated form of litigation. Firstly, *Smith* concerned a relationship beyond the nuclear family, namely that of cousins, a degree of consanguinity where proximity between a patient’s clinician and blood relations has been posited as more difficult to establish.[[7]](#footnote-7) Secondly, the alleged negligence was not failing to disclose information in a clinician’s possession – which was the crux of the matter in *ABC* – but failing to conduct a test ordered by a consultant neurologist. These particular facts gave rise to issues regarding proximity for the purposes of establishing a duty (as highlighted above) and the appropriate scope of a duty to blood relations in the context of genetic disease. The claimants argued that the scope of that duty was ‘to take reasonable steps to provide the patient with an accurate diagnosis that would enable relatives to seek genetic testing’.[[8]](#footnote-8) This is a step beyond disclosing a diagnosis already known, which has traditionally been the argument advanced in respect of genetic information.[[9]](#footnote-9) The defendants argued that it was not fair, just and reasonable to impose a duty when treating a patient and not the wider family, or that if there were a duty to inform a third party of a diagnosis reached there was insufficient proximity.[[10]](#footnote-10) The case was struck out as disclosing no reasonable grounds for bringing a claim. This conclusion is not surprising, given the claimant’s submission of negligence related to conduct in the treatment of another, but the defendant’s construction of duty (in reference to disclosure) and the issue of proximity is nevertheless worthy of greater analysis.

**The Facts:**

The case concerned diagnosis and treatment of brothers Callum and Connor Smith and their second cousin, Neil Caven. Callum and Connor both suffered from Adrenoleukodystrophy (ALD). ALD is a rare, genetic disorder characterized by the breakdown or loss of myelin – the fatty covering surrounding nerve cells in the brain – and progressive dysfunction of the adrenal gland.[[11]](#footnote-11) Callum was diagnosed on 23rd March 2006, when he was six, following an admission to hospital for high temperature, vomiting, loss of vision and being unsteady on his feet. Once Callum was diagnosed, Connor underwent testing for ALD and was also found to be suffering from the condition. By the time a diagnosis was made, Callum’s ‘symptomology … was too far advanced’,[[12]](#footnote-12) and he was unable to benefit from haematopoietic stem cell transplant,[[13]](#footnote-13) instead being treated with Lorenzo’s oil.[[14]](#footnote-14) His neurological condition deteriorated rapidly and he died on the 26th April 2012 following cardio-respiratory arrest consequent upon his condition. Connor was not demonstrating clinical signs or symptoms of ALD like his brother and, as the disease was not so advanced in him, was able to undergo a bone marrow transplant in September 2006. In February and June 2007, he underwent two further leukocyte infusions and also received hydrocortisone and Lorenzo’s oil. When the case reached court, his general health was described as ‘satisfactory’, and it was noted that his ‘[n]eurological function is reasonably normal although there are significant intellectual and neuropsychological problems’, his ‘adrenal impairment is managed’ and there had been ‘no material deterioration since 2007.’[[15]](#footnote-15)

Neil Caven suffered from Adrenomyeloneuropathy (AMN), a ‘complex and relatively longstanding genetic disease which adversely impacts upon the myelin or white matter of the brain.’[[16]](#footnote-16) AMN is the adult version of ALD. In March 2003, Mr Caven was seen by Dr Rajabally, a Consultant Neurologist at Leicester Royal Infirmary. As part of a diagnostic package, Dr Rajabally requested testing of very long chain fatty acids (VLCFA). The test was not completed at the time. In 2006, following Callum and Connor’s ALD diagnosis, Mr Caven was seen again by Dr Rajabally, who explained that his first cousin (Callum and Connor’s mother) had been identified as an asymptomatic carrier of ALD and that her sons had all been diagnosed with the condition. It was then that the non-performance of the VLCFA test was noted by Dr Rajabally, who then ordered it to be performed. In August 2006, Mr Caven was informed that his VLCFA result was abnormal and ‘consistent with a diagnosis of the adult from of ALD.’[[17]](#footnote-17) A genetic test was ordered, confirming the diagnosis in September 2006. The report acknowledged the familial risks of the condition:

‘other members of his family are at a high risk of this disorder. We strongly recommend referral to the genetic counselling services where the implications of this report and the testing of other family members if required can be discussed.’[[18]](#footnote-18)

The claimants alleged that the defendant was negligent and in breach of its duty of care in failing to perform the VLCFA test on Mr Caven when it was first ordered in 2003. They argued that, had the test been performed when originally requested, a positive result would have been returned (as occurred in 2006), and a positive result for AMN would have led to testing of the wider family as recommended by the genetic report. Wider testing would have included Callum and Connor. The boys would then have been diagnosed ‘some two and a half to three years earlier than was in fact the case’,[[19]](#footnote-19) and earlier diagnosis of ALD would ‘have led to a materially improved outcome’ for the brothers.[[20]](#footnote-20) The defendant applied to strike out the claim.

Analysis:

The strike out application proceeded on the basis that no reasonable grounds for bringing the claim were disclosed or, alternately, that the claimant had no real prospect of succeeding.[[21]](#footnote-21) It was argued that a duty was not fair, just and reasonable to impose when the defendant ‘was treating Mr Caven and not his wider family’,[[22]](#footnote-22) and further that where the scope of a duty was to inform a third party of a patient’s diagnosis ‘there is insufficient proximity between parties for such a duty to be imposed.’[[23]](#footnote-23) It is notable that the defendant articulated the alleged duty as one of disclosure, whereas the claimant contended it was to take reasonable steps to reach an accurate diagnosis.[[24]](#footnote-24) The defendant relied on numerous authorities, including the first instance decision in *ABC v St George’s Healthcare*, where Nicol J upheld a strike out application on grounds a duty to disclose a patient’s diagnosis to his daughter was not fair, just and reasonable.[[25]](#footnote-25) In *ABC*, the court focused exclusively on this point, eschewing the other limbs of the *Caparo* test[[26]](#footnote-26): foreseeable harm and proximity.[[27]](#footnote-27) The defendants in *Smith* also argued a duty was not fair, just and reasonable but, in addition, contended the parties were insufficiently proximate.[[28]](#footnote-28) The efficacy of these two arguments, and the claimants’ rejoinder, will be considered separately below.

*The Defendant’s Argument*

*ABC* and *Smith* re-emphasise the importance of policy considerations in the development of duty. The law of negligence is ‘currently experiencing a restrictive period’,[[29]](#footnote-29) with the judiciary preferring to ‘hug the coastline’ of existing duties,[[30]](#footnote-30) developing negligence incrementally as opposed to trail blazing. A significant hurdle to claimants bringing ‘novel’ claims is therefore the need to prove a duty of care is fair, just and reasonable in the circumstances. This is essentially an exercise of judicial policy making and its relevance in the genetic context is clearly illustrated by *ABC*, where policy issues such as confidentiality and trust within the doctor-patient relationship influenced the court. In *Smith*, the defence referred McKenna J to numerous authorities said to support a finding that the alleged duty was not, in fact, fair, just and reasonable.

The first of these authorities was *Powell v Boladz*,[[31]](#footnote-31) a Court of Appeal decision wherein it was held that no duty of care was owed to the parents of a patient who died from a rare disease. The patient had been examined on a number of occasions by the defendants, but his condition was not correctly diagnosed. The defendant admitted liability and agreed to compensation, but the claimants started additional proceedings regarding psychiatric injuries, allegedly suffered as a result of removal and falsification of medical records pertaining to the patient’s death. Delivering the judgment of the court, Stuart-Smith LJ quoted with approval Lord Diplock in *Sidaway v Governors of Bethlem Royal Hospital* who said that a ‘doctor’s duty of care … is owed to that patient and none other’.[[32]](#footnote-32) The decision in *Boladz* affirmed the scope of a doctor’s duty of care when providing treatment, namely that claimants are only owed a duty of care in respect of *their* treatment and not treatment given to another. Stuart-Smith LJ acknowledged that when counselling or medical intervention is required by a relative, and is given or sought, ‘the doctor-patient relationship will exist *in relation to the advice and treatment given* and the duty of care will arise.’[[33]](#footnote-33)

The scope and efficacy of this paradigm is doubted in respect of genetic information,[[34]](#footnote-34) but *Boladz* was problematic for the claimants in *Smith*. Non-performance of the VLCFA test was potentially negligent, but, even if it were, it was negligence against Neil Caven, not against Callum or Connor. The claimants attempted to circumvent this issue by arguing a voluntary assumption of responsibility by the clinical genetics service (a point which is discussed below). *Boladz* therefore appears to be a bulwark against the claimant’s articulation of duty, but if we frame the duty as being to ‘inform a third party of a diagnosis reached in respect of a patient’,[[35]](#footnote-35) it is perhaps not such clear ground for rejection. First, matters of disclosure are arguably separate to treatment, a fact suggested by the divergence between such affirmed in *Montgomery v Lanarkshire NHS Trust*.[[36]](#footnote-36) It is not therefore clear that *Boladz* applies to matters of disclosure. Furthermore, it is arguable that blood relations ought to be held in contemplation as foreseeably affected by a defendant’s acts or omissions, herein nondisclosure,[[37]](#footnote-37) thus it is not immediately apparent that a duty is not fair, just and reasonable. Second, the cases diverge in terms of the harm at the crux of the action. *Boladz* concerned psychiatric injury, where the courts are traditionally reluctant to grant recovery,[[38]](#footnote-38) while in *Smith* (wherein harm was conceded as foreseeable for the purposes of the hearing) the injury was to the claimants’ bodily integrity. The lack of parity between recovery for physical and mental injuries in tort – though not sufficient grounds to discount *Boladz* outright – certainly meritsa cautious approach. It is trite that both cases involve third parties ancillary to the doctor-patient relationship, however, the ‘factual matrix’ in *Boladz* is arguably distinguishable from that in *Smith*.[[39]](#footnote-39) The substitution of documents after the patient’s death is not commensurate with the failure to conduct the VLCFA test, but it is certainly not comparable to disclosure of a diagnosis. The broader definition of duty supplied by the defence does not, therefore, immediately preclude a tortious obligation.

The defendants also referenced *X v Bedfordshire County Council*[[40]](#footnote-40) and *D v East Berkshire NHS Trust*[[41]](#footnote-41) – cases also cited in *ABC v St George’s Healthcare*. These involved claims for psychiatric injury by parents wrongfully suspected of child abuse, which ultimately failed, ‘the courts accepting the contention that clinicians should not face conflicting duties’.[[42]](#footnote-42) The House of Lords in *D* identified that when abuse is suspected,

‘a doctor must be able to act single-mindedly in the interests of the child … [not] have at the back of his mind an awareness … he may be exposed to claims by a distressed parent.’[[43]](#footnote-43)

*X* and *D* were ostensibly used to reinforce the limitation in *Boladz*, since both cases found no duty was owed to parents suspected of child abuse. But *Smith* does not sit easily with the factual matrix of *X* and *D*. In these cases, the purpose of the assessments contended as negligent was to ‘protect weaker members of society (children) from harm done to them by others’.[[44]](#footnote-44) To allow claims by parents wrongly suspected of abuse would have created a duty in direct conflict with the defendants’ duty to suspected victims of child abuse, and their obligations under the relevant statutory social welfare scheme. In *Smith*, the duty articulated by the claimants arguably coincided with the duty to the patient, since it is in the patient’s interest to receive an accurate diagnosis.

Reliance on *X* and *D* is therefore problematic. While these cases are evidence of no duty being owed to third parties, this analysis ignores the fact that parents were not owed a duty only when they were the suspected abuser. A duty has been imposed when the interests of parents and children are similar, such as when the abuser is a third party.[[45]](#footnote-45) A comparable oversight has been highlighted in *ABC*,[[46]](#footnote-46) wherein *X* and *D* were relied upon to stress the danger of creating conflicting duties, implying an analogy between the position of the local authorities in the child abuse scenario with the medical profession in circumstances involving confidentiality and disclosure to non-patients.[[47]](#footnote-47) *X* and *D* are authority for denying a duty of care where the interests of patients and third parties conflict. In *Smith*, it is strongly contestable that the interests of patient and blood relations aligned, since both parties were interested in ‘reducing the risk of developing hereditary diseases, [and] ensuring early diagnosis’.[[48]](#footnote-48) Thus *X* and *D* do not necessarily support outright rejection of the claimant’s articulation of duty in *Smith*. It is even less clear that these cases support a negative finding in respect of duty if said duty is ‘to inform a third party of a diagnosis’, as the defendants suggested.[[49]](#footnote-49) Commentary on *ABC* noted a ‘better parallel’ to this latter formulation of duty might be found in cases concerning disclosure of information about foster children;[[50]](#footnote-50) the point applies equally to the defendant’s articulation of duty in *Smith*. Restricting a foster child’s confidentiality is justified on grounds of mitigating harm, and an analogy can be drawn with qualifying doctor-patient confidentiality. A doctor would owe a duty to blood relations because she is aware that non-disclosure ‘exposes the relatives to a risk of physical or psychiatric harm’.[[51]](#footnote-51) Two critical points require emphasis here. First, the defendants’ articulation of duty would only arise in respect of information already known, not in respect of incomplete diagnostic examinations, thus the claim would still not have succeeded; second, a confidentiality-disclosure conflict did not arise in *Smith*, whereas it was arguably central in *ABC*, so reliance on case law involving conflicting duties is questionable, because the interests of patient and blood relations ostensibly aligned.

The defendants also relied on the judgment of Nicol J in *ABC*. This case concerned nondisclosure of a diagnosis of Huntington’s disease to a patient’s pregnant daughter.[[52]](#footnote-52) Subsequent to learning about the diagnosis by chance, the woman brought a claim in negligence for psychiatric injury and wrongful birth. Nicol J rejected her claim, concluding a duty to disclose was entirely novel and an example of the ‘giant steps’ Lord Toulson contrasted with ‘the proper development of the common law of negligence’ in *Michael v Chief Constable of South Wales Police*.[[53]](#footnote-53) McKenna J in *Smith* also referred to *Michael*, explaining the duty contended would go ‘well beyond the existing law’.[[54]](#footnote-54) But Lord Toulson’s statement should not be read as absolute;[[55]](#footnote-55) though he greatly emphasised incremental development, his lordship also explained giant steps are permissible when an ‘earlier limitation is no longer logically or socially justifiable’.[[56]](#footnote-56)

Labelling a duty to disclose a genetic diagnosis as a ‘giant step’ is subject to criticism;[[57]](#footnote-57) rejection of the defendants’ formulation of duty on such grounds is therefore contestable. However, a duty to accurately diagnose a patient for the benefit of their family is quite possibly a bridge too far. Whether it is truly a ‘giant step’ is debatable, since the law does provide for liability to third parties arising from conduct against another. This provision is, however, restrictive, and becoming more so.[[58]](#footnote-58) Coupled with the decision in *ABC*, little room for doubt is left about how the judiciary find a duty to third parties in respect of diagnoses legally unpalatable.

*The Claimants’ Arguments*

The defendants argued a duty was not fair, just and reasonable when ‘treating Mr Caven and not his wider family’,[[59]](#footnote-59) and, further, that where the scope of a duty was to inform a third party of a patient’s diagnosis ‘there is insufficient proximity between parties for such a duty to be imposed.’[[60]](#footnote-60) The authorities used to justify this position were critiqued above and doubt certainly raised as to whether cases such as *Boladz*, *X* and *D* supported a rejection of a duty as articulated by the defendants. The application of the cited case law to the claimants’ formulation of duty is recognised as considerably more robust, yet the claimants offered a somewhat ineffectual rejoinder. No effort was made to distinguish *Boladz*, *X* and *D*; in respect of *ABC*, it was argued that it was ‘of crucial importance in that case that the patient had refused the defendant’s permission to alert his daughter’ about his diagnosis.[[61]](#footnote-61) The existence of a duty of confidentiality meant it was not fair, just and reasonable to impose a duty to disclose – although, as previously noted, the case law underpinning Nicol J’s reticence towards creation of conflicting duties is problematic.

By contrast, in *Smith* there existed ‘no evidence to suggest Mr Caven would have refused to allow … his AMN to be communicated to his wider family’,[[62]](#footnote-62) so it was contended Nicol J’s reasoning in *ABC* relating to confidentiality was inapplicable.[[63]](#footnote-63) It was also argued that Neil Caven’s evidence meant that the claimant did not need to prove the defendants owed a duty to inform blood relations of his diagnosis. McKenna J acknowledged there were issues of confidentiality in *ABC* which did not apply to *Smith*, but did not find Nicol J’s judgment to be dependent on those issues.[[64]](#footnote-64) He concluded *ABC* was struck out because there was no duty between a doctor/hospital and a non-patient.[[65]](#footnote-65) He went on to say that ‘a third party cannot recover damages for a personal injury suffered because of an omission in the treatment of another’,[[66]](#footnote-66) but this is a misunderstanding of the issue in *ABC*, which concerned non-disclosure of a known diagnosis, and did not hinge upon an omission in the treatment of another – the nub of the issue in *Smith*. *ABC* instead coincides broadly with the defendants’ articulation of duty.

In support of their case, and to open further distance with *ABC*, the claimants pleaded a voluntary assumption of responsibility because, in the circumstances, the defendant’s ‘clinical genetics services would investigate pedigrees’.[[67]](#footnote-67) This assumption of responsibility, it was submitted, did not need to be express and could be inferred. The issue was given cursory consideration by McKenna J, who stated that ‘it would be impossible for the court to determine, at this stage of proceedings’.[[68]](#footnote-68) The sense (rightly or wrongly) is that by this point in the judgment, the die had already been cast.

The suggestion that an assumption of responsibility can be inferred, because the defendant’s clinical genetics services investigate pedigrees, is not wholly outwith the English Law doctrine. In *Phelps v Hillingdon LBC*, Lord Slynn explained that the phrase ‘assumed responsibility’ does not necessarily mean ‘the professional person knowingly and deliberately accepts responsibly’, but instead ‘that the law recognises that there is a duty of care.’[[69]](#footnote-69) Thus it is possible for defendants to assume responsibility even when there is not a conscious intention to do so, however, an assumption of responsibility is most likely when the parties are in a relationship akin to a contract.[[70]](#footnote-70) Case law suggests the typical hallmarks of assuming responsibility include the exercise of an element of power or control on the part of the defendant,[[71]](#footnote-71) or vulnerability of the claimant.[[72]](#footnote-72) Arguably both an exercise of power and vulnerability are present in the context of clinical genetic services, and assumptions of responsibility can arise in respect of a class of persons, which blood relations could certainly constitute. The question is whether a defendant assumes responsibility because they ‘take reasonable steps to provide the patient with an accurate diagnosis’ and ‘investigate pedigrees’.[[73]](#footnote-73) Greater evidence of the practices of clinical genetics services was necessary to reach a finite conclusion, but it is not beyond the realms of possibility that an assumption of responsibility could occur in respect of a positive undertaking to investigate pedigrees. But even if it were found the defendant did assume responsibility, it still remains for the claimant to demonstrate reasonable reliance. The facts in *Smith* do not readily suggest the claimants could overcome this hurdle. When no reasonable reliance is found, assessment of duty defaults back to the *Caparo* test.[[74]](#footnote-74)

The claimants also relied on *Selwood v Durham County Council*,[[75]](#footnote-75) which involved a social worker who was attacked by a patient with mental health issues after being assigned to the patient’s daughter. McKenna J dismissed it as being a very different factual matrix,[[76]](#footnote-76) but this is arguably a narrow view to adopt. *Selwood* and *Smith* are certainly distinguishable factually, but arguably so is *Boladz*. Further, *Selwood* involves a duty to third party, and is particularly apt in respect of the defendants’ articulation of duty. If the duty of care is to disclose a diagnosis (and therefore risks to blood relations) American case law suggests disclosure is not capable of being compartmentalized and core principles in the context of a risk of physical violence apply equally to genetic diseases.[[77]](#footnote-77) These cases were given due consideration by the Court of Appeal in *ABC*.[[78]](#footnote-78) *Selwood* therefore warranted deeper consideration, especially in relation to the duty expressed by the defendants; recall it was argued in this respect the parties were insufficiently proximate if the duty was to inform.

In *Selwood*, the claimant was an employee of Durham County Council; the council was collaborating with two mental health authorities to provide integrated mental health and social care. The patient made repeated threats during treatment to harm the claimant, going as far as to state he would ‘kill her on the spot’ if he saw her. Despite the severity of the threat, the risk was not disclosed to either the claimant or her employer. When the patient was temporarily discharged from hospital, he attacked her with a knife, causing serious injuries. She sued her employer and the NHS trusts in negligence, but at first instance it was held neither trust owed her a duty of care. On appeal to the Court of Appeal, Dame Smith sent the matter to trial, concluding the judge at first instance had erred. She explained the ‘appellant was not one of the world at large; she was one of a small group … working in close proximity and cooperation with the second and third defendants’ own employees.’[[79]](#footnote-79) The claimant’s membership of a finite group meant she occupied a ‘special position’,[[80]](#footnote-80) and Dame Smith concluded it was open to a trial judge to decide whether a duty was fair, just and reasonable, noting ‘the point is arguable’.[[81]](#footnote-81)

The claimant in *Selwood* argued a duty on the basis of quasi-employment with the NHS because of its collaborations with Durham County Council. However, as the specific target of the threats, it is possible to draw an analogy with the earlier American case of *Tarasoff v Regents of the University of California*.[[82]](#footnote-82) Similar facts were at issue here. A young woman was murdered by an ex-boyfriend, who was a former patient of the defendants. During psychotherapy, the man had repeatedly stated his intentions to kill his ex-girlfriend, but no disclosure of that risk was made. A relationship of sufficient proximity was found because the ex-girlfriend was an identifiable victim of the negligence. In *ABC*, the Court of Appeal opined that *Tarasoff* ‘holds parallels with the instant case’,[[83]](#footnote-83) but identified one distinction as ‘the unpredictable nature of the risks to potential victims’ and ‘the possibility of unnecessary warnings’.[[84]](#footnote-84) The Court ostensibly suggests a stronger justification for an obligation exists in the case of clinical genetics because it concerns ‘specific quantifiable risk.’[[85]](#footnote-85)

This reasoning in *Tarasoff* was subsequently applied to genetic risks in *Safer v Estate of Pack*,[[86]](#footnote-86) where the court held a doctor owed a duty to disclose risks of genetic diseases to blood relations, so they might mitigate or ‘avoid the most baneful consequences of the condition.’[[87]](#footnote-87) *Safer* was also considered by the Court of Appeal in *ABC*[[88]](#footnote-88), wherein it was noted the decision has been superseded by the New Jersey Genetic Privacy Act, which prohibits disclosure of genetic information without consent of the individual. The Genetic Privacy Act only prohibits disclosure of the identity of the patient undergoing a test, or disclosure of information in a manner that permits identification.[[89]](#footnote-89) Thus *Safer* may continue to have a role where genetic information is disclosed in a manner that does not permit identification.[[90]](#footnote-90) The Court of Appeal held that the fact *Safer* has been largely set aside by the State Legislature did ‘not affect the quality of reasoning in the decision.’[[91]](#footnote-91) This is an indication the content of the judgment in *Safer* is by no means defunct and remains a persuasive influence on the domestic courts.

Furthermore, the scope of the duty articulated in *Safer* is comparable to that put forward by the defendant in *Smith*, and, since the court in *Safer* held genetic conditions as comparable to infection, contagion and threats of physical harm,[[92]](#footnote-92) it casts doubt on the correctness of excluding discussion of *Selwood* solely by reference to its ‘factual matrix’. A more compelling basis upon which to distinguish *Selwood* from the claimant’s argument in *Smith* is that *Selwood* concerns the nondisclosure of a known risk, whereas *Smith* concerns reasonable care in the treatment of another so as to uncover risk. If the duty is one of informing of a diagnosis (thus a risk of genetic disease), then *Selwood* is an important case, but it does not provide authority for a third party claim due to an omission in the treatment of another. In such a case, *Boladz* would ostensibly apply. Thus, although *Selwood* warranted greater discussion, it supports the defendants’ articulation of duty as a duty to disclose a known diagnosis, not the claimants’ contention regarding reaching an accurate diagnosis for the benefit of third parties. However, even if a duty to disclose is held to be appropriate (and in *Smith*, it is not readily applicable), a relationship of second cousins is arguably too remote to fall within the scope of those whom ought to be in reasonable contemplation as proximate to a doctor’s acts or omissions.[[93]](#footnote-93)

*Conclusion*

The decision in *Smith* is a second, tentative step into the difficult area of genetics and family, but the duty contended by the claimants was a bridge too far in terms of developing a duty of care. The judiciary has historically been reticent to extend liability to third parties and those categories of claim that exist are hard fought, grudgingly conceded enclaves within tort.[[94]](#footnote-94) McKenna J’s reluctance to permit *Smith* to progress to full trial is not surprising, particularly given the scope of duty the claimant attempted to advance. The defendant relied heavily upon Nicol J’s judgment in *ABC*, and its allure to court and defendant is clear: *ABC* likewise concerned liability of medical practitioners to third parties, contention of a (supposedly) ‘novel’ duty, and a finding on policy grounds a duty was not fair, just and reasonable. Nicol J’s decision has subsequently been overturned by the Court of Appeal, who considered the claimant’s case arguable and remitted it for trial. Irwin LJ (with whom Underhill and Gloster LJJ agreed) sought to distinguish *X* and *D* because the ‘decisive considerations’ in those cases were matters of policy in respect of vulnerable children.[[95]](#footnote-95) He further rejected that a duty to disclose is inconsistent with the incremental development of the common law, stating the ‘ambit and content of the duty of care … has long been a matter of common law, developed by judicial decision.’[[96]](#footnote-96) Therefore McKenna J’s view in *Smith* that there is ‘no duty between a doctor/hospital and someone who is not a patient’ because it is a giant step that goes well beyond the current law does not appear sound.[[97]](#footnote-97) The Court of Appeal have clearly suggested such duties are arguable. It cannot therefore be said the claimant had no clear prospect of success in *Smith*. The striking out of the claim does not appear sustainable in the event of an appeal.

However, it is important to note these cases must not be equated lightly. Critical distinctions between *Smith* and *ABC* must be reiterated. *Smith* concerned an omission in the treatment of the claimant’s second cousin: failure to conduct a VLCFA test. The duty contended by the claimants ran afoul of the scope of a doctor’s duty in respect of diagnosis and treatment affirmed in *Boladz*. However, the defendants’ articulation of duty as being to disclose a diagnosis is not as straightforward to reject and, although it is questionable whether it is engaged on the facts, it is worthy of further analysis.

1. For example, see M. Fay, ‘Negligence, Genetics and Families: a duty to disclose actionable risks’ (2016) 16(3) *Medical Law International* 115; V. Chico, *Genomic Negligence: An Interest in Autonomy as the Basis for Novel Negligence Claims Generated by Genetic Technology* (London: Routledge-Cavendish, 2011); G. Laurie, ‘Obligations Arising from Genetic Information – Negligence and the Protection of Familial Interests’, (1999) 11(2) Child and Family Law Quarterly 109. [↑](#footnote-ref-1)
2. [2017] EWCA Civ 336 (hereinafter *ABC*). [↑](#footnote-ref-2)
3. [2016] EWHC 817 (QB) (Hereinafter *Smith*). [↑](#footnote-ref-3)
4. The cost of the Human Genome Project is estimated as between US$2 billion and US$3 billion; the cost of sequencing James Watson’s genome in 2007 was $1 million; routine sequencing of cancer genomes has been estimated as costing US$30,000; and, in 2009, a company stated it would be capable of sequencing entire genomes for US$5000; see P. Aldhous, ‘Genome Sequencing Falls to US$5000’ New Scientist (6 February 2009). The US National Library of Medicine presently identifies the cost of genetic testing as ranging from under US$100 to in excess of US$2000; see US National Library of Medicine, Genetic Home Reference, ‘What is the Cost of Genetic Testing and How Long Does it Take to Get the Results’, Available at: <https://ghr.nlm.nih.gov/primer/testing/costresults> (accessed 27 April 2017). In the United Kingdom, private companies offer a range of genetic test costing from £720 to £2150; see GeneHealth UK, available at: <https://www.genehealthuk.com/cancer-genetic-testing-prices> (accessed 27 April 2017). [↑](#footnote-ref-4)
5. R. Gilbar and C. Foster, ‘Doctors’ liability to the patient’s relatives in genetic medicine: *ABC v St George's Healthcare NHS Trust* [2015] EWHC 1394 (QB)’ (2016) (24(1) Med Law Rev 112 [↑](#footnote-ref-5)
6. For example, see Fay, n1, and Chico, n1. [↑](#footnote-ref-6)
7. See Fay, n1. [↑](#footnote-ref-7)
8. *Smith*, n3, [28]. [↑](#footnote-ref-8)
9. See Fay, n1; Gilbar, Foster, n5; R. Gilbar, ‘The passive patient and disclosure of genetic information: can English tort law protect the relatives’ right to know?’ (2016) 30(1) International Journal of Law, Policy & the Family 79; Chico, n1; Laurie, n1. [↑](#footnote-ref-9)
10. *Smith*, n3, [19]. [↑](#footnote-ref-10)
11. See: <http://myelin.org/lorenzos-oil/> (accessed 27 April 2017). [↑](#footnote-ref-11)
12. *Smith*, n3, [7]. [↑](#footnote-ref-12)
13. The intravenous infusion of autologous or allogeneic stem cells collected from bone marrow, peripheral blood, or umbilical cord blood to reestablish hematopoietic function in patients whose bone marrow or immune system is damaged or defective. See: <http://emedicine.medscape.com/article/208954-overview> (accessed 27 April 2017). [↑](#footnote-ref-13)
14. Lorenzo’s Oil is a combination of a 4:1 mix of oleic acid and erucic acid, extracted from rapeseed oil and olive oil designed to normalize the accumulation of the very long chain fatty acids in the brain thereby slowing the progression of adrenoleukodystrophy (ALD). It is specific to ALD. See: <http://myelin.org/lorenzos-oil/> (accessed 27 April 2017). [↑](#footnote-ref-14)
15. *Smith*, n3, [13]. [↑](#footnote-ref-15)
16. Ibid, [1]. [↑](#footnote-ref-16)
17. Ibid, [9]. [↑](#footnote-ref-17)
18. Ibid, [10]. [↑](#footnote-ref-18)
19. Ibid, [14]. [↑](#footnote-ref-19)
20. Ibid. [↑](#footnote-ref-20)
21. CPR Part 3.4 and 24.2. [↑](#footnote-ref-21)
22. *Smith*, n3, [19]. [↑](#footnote-ref-22)
23. Ibid. [↑](#footnote-ref-23)
24. Ibid, [28]. [↑](#footnote-ref-24)
25. *ABC* *v St George’s Healthcare NHS Trust* [2015] EWHC 1394 (QB), [30]. [↑](#footnote-ref-25)
26. *Caparo v. Dickman* [1990] 2AC 605, HL (hereinafter *Caparo*). [↑](#footnote-ref-26)
27. The defendants accepted such could be established for purposes of the strike out application; see *ABC*, n2, [11]. [↑](#footnote-ref-27)
28. For the purposes of the strike out application, the defendants were prepared to concede that the claimants ‘would be able to establish at trial that injury would have been reasonably foreseeable’. See *Smith*, n3, [20]. [↑](#footnote-ref-28)
29. Chico, n1, p2. [↑](#footnote-ref-29)
30. *Caparo*, n26, per Lord Bridge, 618. [↑](#footnote-ref-30)
31. [1998] Lloyd’s Rep Med 116 (hereinafter *Boladz*). [↑](#footnote-ref-31)
32. [1985] AC 871, 890. [↑](#footnote-ref-32)
33. [1998] 39 BMLR 35, 46. [↑](#footnote-ref-33)
34. Fay, n1. [↑](#footnote-ref-34)
35. *Smith*, n3, [19]. [↑](#footnote-ref-35)
36. [2015] UKSC 11. [↑](#footnote-ref-36)
37. *Donoghue v Stevenson* [1932] AC 562. [↑](#footnote-ref-37)
38. An attitude typified by *Alcock v Chief Constable of South Yorkshire* [1990], *White v Chief Constable of South Yorkshire* [1999] and, most recently, *Liverpool Women’s Hospital v Ronayne* [2015] EWCA 588. [↑](#footnote-ref-38)
39. *Smith*, n3, [27]. [↑](#footnote-ref-39)
40. [1995] 2 AC 663 (hereinafter *X*). [↑](#footnote-ref-40)
41. [2005] 2 AC 373 (hereinafter *D*). [↑](#footnote-ref-41)
42. Gilbar, Foster, n5, p116. [↑](#footnote-ref-42)
43. *D*, n41, per Lord Nicholls, 85. [↑](#footnote-ref-43)
44. *X*, n40, per Lord Browne-Wilkinson, 751. [↑](#footnote-ref-44)
45. Gilbar, Foster, n5, p117. See also *Merthyr v Tydfil CBC v C* [2010] EWHC 869, QB. [↑](#footnote-ref-45)
46. Ibid. [↑](#footnote-ref-46)
47. But it is an imperfect analogy. Confidentiality is not absolute and doctors can be subject to conflicting duties regarding patient information: i.e. *W v Egdell* [1990] Ch 359, CA. [↑](#footnote-ref-47)
48. Gilber, Foster, n5, p117. [↑](#footnote-ref-48)
49. *Smith*, n3, [19]. [↑](#footnote-ref-49)
50. Gilbar, Foster, n5, p116. See *A v Essex CC* [2003] EWCA Civ 1848; *W v Essex CC* [2001] 2 AC 592, HL. [↑](#footnote-ref-50)
51. Ibid. [↑](#footnote-ref-51)
52. Huntington’s disease is a genetic condition which has a 50 per cent chance of being inherited by patients’ children. [↑](#footnote-ref-52)
53. [2015] UKSC 2, [102] (hereafter *Michael*); see also *ABC*, n25, [27]. [↑](#footnote-ref-53)
54. *Smith*, n3, 29. [↑](#footnote-ref-54)
55. *Michael*, n53, [102]. [↑](#footnote-ref-55)
56. Ibid. [↑](#footnote-ref-56)
57. Gilbar, Foster, n5; Fay, n1. [↑](#footnote-ref-57)
58. See n38. [↑](#footnote-ref-58)
59. *Smith*, n3, [19]. [↑](#footnote-ref-59)
60. Ibid. [↑](#footnote-ref-60)
61. Ibid, [24]. [↑](#footnote-ref-61)
62. Ibid, [25]. [↑](#footnote-ref-62)
63. Ibid. [↑](#footnote-ref-63)
64. Ibid, [29]. [↑](#footnote-ref-64)
65. Ibid. [↑](#footnote-ref-65)
66. Ibid. [↑](#footnote-ref-66)
67. Ibid, [26]. [↑](#footnote-ref-67)
68. Ibid. [↑](#footnote-ref-68)
69. [2001] 2 AC 619 (HL), 654. [↑](#footnote-ref-69)
70. *Commissioner of Customs & Excise v Barclays Bank* [2006] UKHL 28, per Lord Bingham, 4. [↑](#footnote-ref-70)
71. Such as expertise, or a capacity to enforce rules: i.e. *Hedley Byrne* [1964] AC 465 (HL); *Perrett v Collins* [1998] 2 Lloyd’s Law Rep 255 (CA). [↑](#footnote-ref-71)
72. *Barrett v MOD* [1995] 1 WLR 1217 (CA). [↑](#footnote-ref-72)
73. Smith, n3, [26]. [↑](#footnote-ref-73)
74. *Biddick v Morcom* [2014] EWCA Civ 182. [↑](#footnote-ref-74)
75. [2012] EWCA Civ 979 (hereinafter *Selwood*). [↑](#footnote-ref-75)
76. *Smith*, n3, [27]. [↑](#footnote-ref-76)
77. For example, *Tarasoff v The Regents of the University of California* 529 P 2d 55 (Cal. 1974), 551 P 2d 334 (Cal. 1976) concerned the actions of a violent patient (like *Selwood*), while *Safer v Estate of Pack* 677 A 2d 1188 (New Jersey Superior Court Appellate Division 1996) applied the principles espoused in *Tarasoff* to genetic risks. *Safer* has since been legislatively overruled but may retain relevance in respect of legislative exceptions. [↑](#footnote-ref-77)
78. *ABC*, n2, [49]-[60]. [↑](#footnote-ref-78)
79. *Selwood*, n75, 456. [↑](#footnote-ref-79)
80. Ibid. [↑](#footnote-ref-80)
81. Ibid. [↑](#footnote-ref-81)
82. 529 P 2d 55 (Cal. 1974), 551 P 2d 334 (Cal. 1976) (hereinafter *Tarasoff*). [↑](#footnote-ref-82)
83. *ABC*, n2, [56]. [↑](#footnote-ref-83)
84. Ibid. [↑](#footnote-ref-84)
85. Ibid. [↑](#footnote-ref-85)
86. 677 A 2d 1188 (New Jersey Superior Court Appellate Division 1996) (hereinafter *Safer*). [↑](#footnote-ref-86)
87. Ibid, 623. [↑](#footnote-ref-87)
88. *ABC*, n2, [57]-[60]. [↑](#footnote-ref-88)
89. New Jersey Genetic Privacy Act, C10:5-47. [↑](#footnote-ref-89)
90. See G. Suthers, *et al*, ‘Letting the family know: balancing ethics and effectiveness when notifying relatives about genetic testing for a familial disorder’ (2006) 43 *J Med Genet* 665.

    [↑](#footnote-ref-90)
91. *ABC*, n2, [60]. [↑](#footnote-ref-91)
92. *Safer*, n86, 1192. [↑](#footnote-ref-92)
93. Fay, n1. [↑](#footnote-ref-93)
94. For example, psychiatric injury, see n38. [↑](#footnote-ref-94)
95. *ABC*, n2, [48]. [↑](#footnote-ref-95)
96. *ABC*, n2, [62]. [↑](#footnote-ref-96)
97. *Smith*, n3, [29]. [↑](#footnote-ref-97)