[1989] EWCA Civ 13; [1990] 2 WLR 471; [1990] Ch 359; [1990] 1 All ER 835

IN THE SUPREME COURT OF JUDICATURE
COURT OF APPEAL
(CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
CHANCERY DIVISION
(MR. JUSTICE SCOTT)

Royal Courts of Justice.
9th November 1989

Before:

THE PRESIDENT (Sir Stephen Brown)
LORD JUSTICE BINGHAM
SIR JOHN MAY

W
Appellant

v.

Egdell
Respondent

MR. G. ROBERTSON, Q.C. and MR. N.G. ORR (instructed by Messrs. Irwin Mitchell of Sheffield) appeared on behalf of the (Plaintiff) Appellant.
MR. A. WHITFIELD, Q.C. and MR. K. COONAN (instructed by Messrs. Hempsons) appeared on behalf of the (Defendant) Respondent.

THE PRESIDENT: This appeal raises in an unusually stark form the question of the nature and quality of the duty of confidence owed to a patient detained in a special hospital pursuant to a hospital order coupled with a restriction order by an independent consultant psychiatrist engaged on behalf of the patient to report on the state of his mental health in connection with a forthcoming application to a Mental Health Review Tribunal for his discharge.

The plaintiff, W, appeals to this court against the dismissal by Mr. Justice Scott of his claim for damages and other relief against Dr. Egdell for alleged breach of confidence. The circumstances which led to his conviction and the making of the hospital order are summarised in the judgment of Mr. Justice Scott which is reported in [1989] 2 W.L.R. 689. At page 693 the judge described the circumstances:

> "About ten years ago W shot the four members of a neighbouring family. He shot another neighbour who had come to investigate the shooting. He then drove off in his car, throwing hand-made bombs as he did so. Later the same day he shot two more people, not neighbours, but strangers to him. Five of his victims died of their injuries. The other two needed major surgery for serious bullet wounds. W was diagnosed as suffering from paranoid schizophrenia. It was believed by the doctors who examined him that he had been suffering from this illness for about two years before the

> offences. The illness involved delusions that he was being persecuted by his neighbours. In the circumstances W's plea of guilty to manslaughter on the grounds of diminished responsibility was accepted by the Crown and he was convicted accordingly. Orders were made under sections 60 and 65 of the Mental Health Act 1959, now sections 37 and 41 of the Mental Health Act 1983, providing for his detention without limit of time. He was at first detained at Broadmoor Hospital. In 1981 he was transferred, in accordance with a transfer direction given by the Home Secretary, to a secure hospital in the North of England. Reference hereafter in this judgment to 'the Hospital' will be references to this hospital where W is still detained."

In 1984 a Mental Health Review Tribunal recommended W's transfer to a regional secure unit. This was intended to be a first stage in a rehabilitation programme leading to discharge into the community. The Secretary of State, however, refused to approve the transfer. The plaintiff's responsible medical officer, Dr. Chandra Ghosh, however, recommended to the Secretary of State that W should be transferred to a regional secure unit. The Secretary of State refused to consent to a transfer by a letter of the 20th May, 1987 in which he set out his reasons. Shortly before that date W had consulted solicitors with a view to making an application to a Mental Health Review Tribunal for his conditional discharge. He was granted legal aid for the purpose of his application and the certificate included an authorisation to obtain an independent psychiatric report. On the 19th May, 1987 Dr. Ghosh as the responsible medical officer for W made a statement pursuant to the Mental Health Review Tribunal Rules 1983 for the purposes of the forthcoming tribunal hearing. Her report under the heading "Present Mental State" stated:

> [W] has been diagnosed as suffering from Schizophrenia. His mental illness is now controlled by medication and he has been stable for the past 2 years. He has considerable insight into his mental state and accepts the need for continuing on medication. He also realises that he requires close and careful monitoring of his mental state.
>
> It is my opinion that [W] requires to move gradually through graded security with maximum and immediate supervision being available in the early stages. [W] was recommended for transfer on 20 March 1985. He has been accepted by Doctor R Cope for ... Regional Secure Unit at ... Hospital on 20 June 1986, his previous Mental Health Review Tribunal supported a recommendation of transfer to a Regional Secure Unit.
>
> We are still awaiting Home Office permission for such a move."

A copy of that statement was sent to W's advisers. A statement by the Secretary of State for consideration by the tribunal followed in June 1987. That statement which is to be found at pages 168 and 169 of the bundle before the court set out the circumstances of the offences leading to W's admission to hospital and concluded with the Secretary of State's observations on the patient's suitability for discharge. It stated: "The Home Secretary has noted Dr Ghosh's report of 19 May but, having given the most careful consideration to all the circumstances of the case, he is unable to consent to her recommendation to move [W] to the [Regional Secure] Unit at this time. He feels that there is a need for the utmost caution to be exercised in this case and he would expect [W] to show a very long period of stable behaviour before commencing on a programme of rehabilitation, bearing in mind his indiscriminate violence

towards his victims in the index offence. Furthermore, he would feel more confident towards [W's] removal from conditions of maximum security when his interest in weapons has been more fully explored and explained and he would be prepared to consider the case for [W] to move to a secure unit in perhaps 18 months' time in the light of these findings. He will in all probability wish to refer any future proposals to the Advisory Board on Restricted Patients." In late 1985 and early 1986 at the instance of Dr. Ghosh, W underwent an assessment of his personality by a clinical psychologist, Mr. Tulloch. In his report of the 18th April, 1986 Mr. Tulloch said:

> "It is not possible to shed much light on [W's] pre-morbid personality from this assessment."

Further:

> "It should also be borne in mind that [W] is not an 'immediate' danger. He was clearly mentally ill at the time of his offences, this process having built up over a prolonged period. Given that he is now stabilised on medication his dangerousness is significantly reduced. A [regional secure unit] would , therefore, seem to be an appropriate placement. Exploration of his personality at a more detailed level would be useful in terms of preparation for future community survival and this can probably be achieved more readily within an RSU context."

It concluded with a "Summary":

> "This brief assessment of [W's] personality does not reveal any significant disturbance. Two main areas of dynamic tension, emotional dependence and self-concept, were noted although it is not possible to do more than speculate on their pre-morbid significance. Exploratory psychotherapy may be more helpful in this situation and it is suggested that this would be more appropriate in an RSU setting."

On the 2nd July, 1987 solicitors acting on behalf of the plaintiff instructed Dr. Egdell to report on W's mental state. Dr. Egdell is a distinguished consultant psychiatrist. He is also a clinical lecturer at a university and a member of a Mental Health Review Tribunal- His instructions were "to attend upon our client and complete a report for use at his forthcoming Mental Health Review Tribunal." Dr. Egdell submitted a report on the 29th July, 1987. It is a detailed psychiatric report. Under the heading "Interest in Fireworks", Dr. Egdell said:

> "At the age of about ten or twelve he began to make fireworks to let them off in the back yard. As an adult he continued to make them regularly over a number of years. He would buy the ingredients from 'any chemist' and 'make them in the garage' 'for something to do'. He says that about once a month he would go off into the country to let them off and said he would perhaps explode a couple at a time. They would consist of a steel piping packed with chemicals and a fuse which he lit. He reports that on at least one occasion he let them off in a canal bank near home. He reports that he ' always' carried some made up explosives in his car. When asked if there was a potential danger he confidently replied 'there was no danger if you threw them far enough away'.
>
> [W] told me that immediately after the first shooting in the index offence he threw, he thinks, two or three of them out of the car and thinks two of them went off. When

> questioned further about this [W] became very tense and said: 'I can't remember any more of that' and was unwilling to discuss this further. One opinion recorded in the report of the index offence was that the home made bombs were 'sophisticated'".

Dr. Egdell then gave his "Psychiatric Opinion and Recommendation". Under the heading "Illness" he said:

> "I was not convinced that he really had insight into his illness. He verbally stated that he accepted medication but this appeared to be to avoid being labelled as a 'psychopath' and secondly the illness was used as an excuse to avoid considering the motivation behind the killings. He may not even have faced up to this himself."

Under the heading "Personality at page 60 Dr. Edgell said:

> "There was striking lack of remorse even at a simple verbal level. For example the wife at the garage 'made a fuss' so she was shot. He showed no concern for those who were wounded, their relatives or even the effects of his offence on his own family.
>
> My overall opinion would be that [W] has a clearly abnormal personality, particularly in regard to his relationships, to the management of his feelings and dealing with frustration and an unwillingness to look at his own personal problems in the past and in the future and to review the motivation lying behind the killings. I am reluctant at this stage to say that [W] suffers from a psychopathic personality, as my contacts with him were confined to one interview, and also the report of the clinical psychologist, Mr. R. Tulloch of 18th April 1986. There does seem to be a serious conflict between the findings of Mr. Tulloch and my overall impression culled from various sources. I think that it would be important for this conflict to be resolved before a decision is made on [W's] departure from [the secure] Hospital."

Under the heading "Home made bombs" Dr. Egdell said:

> "Again this interest goes back, to his school days. There is also the important record in the 1982 occupational reports stating that he said he was keen on bombs and there was the hint of a plan to bomb Windscale. He describes a life-long interest in making home made bombs and exploding them. He has done this on a very regular basis over very many years. There are also reports that he always carried some bombs in his car which illustrates how much they were a regular part of his life. He was clearly very aware of the precautions necessary to avoid injury to himself over the years. In the index offence he was prepared to use these to 'scare people off' with no apparent regard for the risk of injury to others. I would link his interest in home made bombs to his major interest in hospital in watching science documentaries and reading science fiction.
>
> My view would be that this all points to a seriously abnormal interest in the making of home made bombs. He euphemistically calls them 'fireworks'. They are clearly much more dangerous than that."

Under the heading "Fitness for transfer to a Regional Secure Unit" (page 62) Dr. Egdell said in summary:

> "... I would strongly recommend that [W] is not considered for transfer to an RSU until the above recommendations are fulfilled. Even when these are completed there may be indications for further prolonged stay under the present secure conditions."
> Dr. Egdell added:
>
> "I have no objection to [W] seeing this report."

It is clear that the report did not support the plaintiff's case for discharge or alternatively for transfer to a regional secure unit. It was seriously at variance with the reports and recommendations made by Dr. Ghosh and the report made by Dr. Cope, the consultant psychiatrist at the regional secure unit. In particular Dr. Egdell's report contained new information which he stated came from the plaintiff himself concerning his long-standing interest in "fireworks" which in fact, according to the information recorded by Dr. Egdell, were bombs of a somewhat sophisticated nature.

After consideration of the report, the plaintiff through his solicitors withdrew his application to the tribunal by a letter dated the 18th August, 1987.

As a result of a telephone conversation which he had had with Dr. Ghosh at the end of July 1987, Dr. Edgell knew that his views about W did not agree with hers. On the 19th August, 1987, not knowing that W's solicitors had withdrawn the application, Dr. Egdell telephoned the tribunal and asked whether it had received a copy of his report. He was told that a copy of his report had not been received and that W's application had been withdrawn.

In paragraph 4 of his affidavit, sworn on the 13th October, 1988, Dr. Egdell said:

> "On learning that my report was not available to the Mental Health Review Tribunal I telephoned Dr Hunter [Assistant Medical Director] at [the Hospital] for advice in this matter. This was the first occasion on which I spoke to Dr Hunter about this patient. I explained my concern that my views were so different from those expressed by Dr Ghosh (W's Responsible Medical Officer) and also my belief that two important matters relating to W's interest in firearms and explosives had not been properly explored or even appreciated. Dr Hunter indicated that additional information about his patient was always helpful and indeed welcome. He asked me to contact W's solicitors as a matter of courtesy to see if they would agree to disclosure of my report of 29th July to Dr Hunter.
>
> They declined to agree.

Dr. Hunter, the acting medical director of the hospital, is himself a consultant forensic psychiatrist. In his judgment Mr. Justice Scott said:

> "Dr Egdell's terse 'They declined to agree' is amplified by paragraph 9 of the affidavit of Mr. Ronald, W's solicitor, sworn on 5 th September 1988. Mr. Ronald says this:
> 'Following the 19th August and prior to 24th August the first defendant' — that is Dr. Egdell -- 'telephoned to Mr. Brian Canavan to discuss the plaintiff's case. In the course of this conversation he was advised that the tribunal application had been withdrawn and he queried what would happen to his report. It was explained to him by Mr. Canavan that his reports would be on their files and would not be drawn to anyone's attention. The first defendant expressed a wish that the reports be forwarded

> to [the Hospital] so that they were aware of his findings. However, Mr. Canavan declined to do this in view of the clear instructions that he had received from the plaintiff."

Mr. Justice Scott continued:

> "What passed between Dr. Egdell and Dr. Hunter in their telephone conversation on 24th August 1987 is set out in a letter dated 25th April 1988, written by Dr. Hunter to [W's present solicitors]. The letter says this: 'Dr. Egdell expressed the view that the material which he felt had been revealed from his examination cast a new light upon the patient's dangerousness and ought to be known to those responsible for his care and for the formulation of any recommendations for discharge. During this conversation I asked Dr. Egdell to forward to me a report in writing of his concerns about the patient and this report, dated 25th August 1987, was received in the hospital shortly thereafter.' "

Mr. Justice Scott continued at page 705C:

> "Following that telephone conversation and in accordance with Dr. Hunter's request, recorded by Dr. Hunter in his letter, Dr. Egdell sent Dr. Hunter a report dated 25th August 1987. Dr. Egdell substituted the name and address of Dr. Hunter for the name and address of [the solicitors], and he altered the opening paragraph so as to read: 'The following report is provided at your formal verbal request to me on 24th August 1987'".

The report sent to Dr. Hunter was identical with that dated 29th July, 1987 that had been sent to W's solicitors. The judge added:

> "It was Dr. Egdell's opinion that a copy of his report ought also to be supplied to the Home Office. Dr. Egdell pressed this opinion on Dr. Hunter and on 18th November 1987 wrote to Dr. Hunter in these terms: 'I am sorry I have not yet received formal confirmation from you that the report prepared on W dated 29th July 1987 has been made available in his case notes. I regret to have to say this, but without this I shall feel obliged to send a copy directly to the Home Office. I would prefer to avoid this'".

By a letter dated the 20th November, 1987 signed by Dr. Ghosh, Dr. Egdell was informed that:

> "A copy of your report on the above patient was forwarded to the Home Office and a further copy is on our case notes."

On the 25th November, 1987 the Home Secretary referred W's case to the Mental Health Review Tribunal under section 72(2) of the Act, which he was obliged to do because W's case had not been before the Tribunal within the last three years.

On learning, apparently from Dr. Ghosh, that Dr. Egdell's report was held by the hospital and that Dr. Egdell was pressing for a copy to be sent to the Home Office, the plaintiff's solicitors commenced these proceedings against Dr. Egdell. Subsequently they also commenced separate proceedings against the Secretary of State for Health, the Home Secretary, the Hospital Board and the Mental Health Review Tribunal which were consolidated with the

action against Dr. Egdell. The judge also dismissed those claims. They are not the subject of an appeal to this court.

The evidence in this case, by agreement, was given on affidavit. No witness was called for cross-examination. Dr. Egdell swore three affidavits. In an affidavit sworn on the 15th February, 1988 he said in paragraph 4:

> "Following perusal of the notes I am now satisfied that there is adequate material in the case notes to suggest that [W's] interest in guns was long standing and pre-dated his illness."

In paragraph 6 he said:

> "The existence of a long standing interest in explosives as well as guns is a pointer to a psychopathic disorder. So far Dr Ghosh has rejected the question of psychopathic behaviour and has sought to explain [W's] bizarre behaviour on the basis of transient mental illness albeit now controlled by medication."

In paragraph 7 he said:

> "I do not see it as part of my duty in the public interest to proffer an alternative diagnosis but I do think it necessary in the public interest that [W's] confession to me about his long standing interest in explosives be made available to the Home Office and that I be released from my duty of confidentiality."

In an affidavit sworn on the 13th October, 1988 he said in paragraph 10:

> "Throughout this matter I have acted in good faith."

In the course of his judgment at page 709E Mr. Justice Scott said:

> "The basis of W's case is that his interview with Dr. Egdell on 23rd July 1987 and the report written by Dr. Egdell on the basis of that interview are, or ought to have been, protected from disclosure by the duty of confidence resting on Dr. Egdell as W's doctor. It is claimed that Dr. Egdell was in breach of his duty of confidence in telling Dr. Hunter about the report, in sending a copy of the report to Dr. Hunter and in urging the despatch of a copy to the Home Office."

He continued at page 710D:

> "It is convenient for me first to ask myself what duty of confidence a court of equity ought to regard as imposed on Dr. Egdell by the circumstances in which he obtained information from and about W and prepared his report. It is in my judgment plain, and the contrary has not been suggested, that the circumstances did impose on Dr. Egdell a duty of confidence. If, for instance, Dr. Egdell had sold the contents of his report to a newspaper, I do not think any court of equity would hesitate for a moment before concluding that his conduct had been a breach of his duty of confidence. The question in the present case is not whether Dr. Egdell was under a duty of confidence; he plainly was. The question is as to the breadth of that duty. Did the duty extend so as to bar disclosure of the report to the medical director of the Hospital? Did it bar

> disclosure to the Home Office? In the 'Spycatcher' case in the House of Lords (1988 3 W.L.R. 766) Lord Goff of Chieveley after accepting 'the broad general principle ... that a duty of confidence arises when confidential information comes to the knowledge of a person (the confidant) in circumstances where he has notice, or is held to have agreed, that the information is confidential, with the effect that it would be just in all the circumstances that he should be precluded from disclosing the information to others' (p. 805) formulated three limiting principles. He said (p. 807): "The third limiting principle is of far greater importance. It is that, although the basis of the law's protection of confidence is that there is a public interest that confidence should be preserved and protected by the law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure. This limitation may apply, as the learned judge pointed out, to all types of confidential information. It is this limiting principle which may require a court to carry out a balancing operation, weighing the public interest in maintaining confidence against a countervailing public interest favouring disclosure'.
>
> In X v. Y [1988] 1 All ER 648, a case which concerned doctors who were believed to be continuing to practice despite having contacted AIDS, Mr. Justice Rose said this: 'In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients will not come forward if doctors are going to squeal on them. Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self-treatment does not provide the best care' (p. 653).
>
> The question in a particular case whether a duty of confidentiality extends to bar particular disclosures that the confidant has made or wants to make requires the court to balance the interest to be served by nondisclosure against the interest served by disclosure.
>
> Mr. Justice Rose struck that balance. It came down, he held, in favour of non-disclosure. In the 'Spycatcher' case that balance too was struck. In that case the balance did not come down in favour of non-disclosure. I must endeavour to strike the balance in the present case."

Mr. Robertson on behalf of the appellant, W, agreed that the judge was required to carry out a balancing exercise. He said that it is a question of degree.

As a starting point Mr. Justice Scott turned to Advice on Standards of Professional' Conduct and on medical ethics contained in the General Medical Council's "Blue Book" on professional conduct and discipline. The judge said:

> "These rules do not provide a definitive answer to the question raised in the present case as to the breadth of the duty of confidence owed by Dr. Egdell. They seem to me valuable, however, in showing the approach of the General Medical Council to the breadth of the doctor/patient duty of confidence."

These rules do not themselves have statutory authority. Nevertheless, the General Medical Council in exercising its disciplinary jurisdiction does so in pursuance of the provisions of the

Medical Act 1983. Under the heading "Professional Confidence", rules 79 to 82 provide as follows:

> "79. The following guidance is given on the principles which should govern the confidentiality of information relating to patients.
> 80. It is a doctor's duty, except in the cases mentioned below, strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information about a patient which he has learnt directly or indirectly in his professional capacity as a registered medical practitioner. The death of the patient does not absolve the doctor from this obligation.
> 81. The circumstances where exceptions to the rule may be permitted are as follows:
> (a) If the patient or his legal adviser gives written and valid consent, information to which the consent refers may be disclosed.
> (b) Confidential information may be shared with other registered medical practitioners who participate in or assume responsibility for clinical management of the patient. To the extent that the doctor deems it necessary for the performance of their particular duties, confidential information may also be shared with other persons (nurses and other health care professionals) who are assisting and collaborating with the doctor in his professional relationship with the patient. It is the doctor's responsibility to ensure that such individuals appreciate that the information is being imparted in strict professional confidence.
> (c) If in particular circumstances the doctor believes it undesirable on medical grounds to seek the patient's consent, information regarding the patient's health may sometimes be given in confidence to a close relative or person in a similar relationship to the patient. However, this guidance is qualified in paragraphs 83-85 below.
> (d) If in the doctor's opinion disclosure of information to a third party other than a relative would be in the best interests of the patient, it is the doctor's duty to make every reasonable effort to persuade the patient to allow the information to be given. If the patient still refuses then only in exceptional cases should the doctor feel entitled to disregard his refusal.
> (e) Information may be disclosed to the appropriate authority in order to satisfy a specific statutory requirement, such as notification of an infectious disease.
> (f) If the doctor is directed to disclose information by a judge or other presiding officer of a court before whom he is appearing to give evidence, information may at that stage be disclosed. Similarly, a doctor may disclose information when he has been summoned by authority of a court in Scotland, or under the powers of a Procurator-Fiscal in Scotland to investigate sudden, suspicious or unexplained deaths, and appears to give evidence before a Procurator-Fiscal. Information may also be disclosed to a coroner or his nominated representative to the extent necessary to enable the coroner to determine whether an inquest should be held. But where litigation is in prospect, unless the patient has consented to disclosure or a formal court order has been made for disclosure, information should not be disclosed merely in response to demands from other persons such as another party's solicitor or an official of the court.
> (g) Rarely, disclosure may be justified on the ground that it is in the public interest which, in certain circumstances such as, for example, investigation by the police of a grave or very serious crime, might override the doctor's duty to maintain his patient's confidence.
> (h) Information may also be disclosed if necessary for the purpose of a medical research project which has been approved by a recognised ethical committee.

82. Whatever the circumstances, a doctor must always be prepared to justify his action if he has disclosed confidential information. If a doctor is in doubt whether any of the exceptions mentioned above would justify him in disclosing information in a particular situation he will be wise to seek advice from a medical defence society or professional association."

The judge said that sub-paragraphs (b) and (g) of rule 81 seemed to him to be particularly relevant. He then rehearsed the circumstances of the disclosure by Dr. Egdell of his report and at page 713A asked the question:

> "Did these circumstances impose on Dr. Egdell a duty not to disclose his opinions and his report to Dr. Hunter, the medical director at the hospital? In my judgment they did not. Dr. Egdell was expressing opinions which were relevant to the nature of the treatment and care to be accorded to W at the Hospital. Dr. Egdell was, in effect, recommending a change from the approach to treatment and care that Dr. Ghosh was following. He was expressing reservations about Dr. Ghosh's diagnosis. The case seems to me to fall squarely within sub-paragraph (b) of rule 81.
>
> But I would base my conclusion on broader considerations than that. I decline to overlook the background to Dr. Egdell's examination of W. True it is that Dr. Egdell was engaged by W. He was the doctor of W's choice. Nonetheless, in my opinion, the duty he owed to W was not his only duty. W was not an ordinary member of the public. He was, consequent upon the killings he had perpetrated, held in a secure hospital subject to a regime whereby decisions concerning his future were to be taken by public authorities, the Home Secretary or the tribunal- W's own interests would not be the only nor the main criterion in the taking of those decisions. The safety of the public would be the main criterion. In my view, a doctor called upon, as Dr. Egdell was, to examine a patient such as W owes a duty not only to his patient but also a duty to the public. His duty to the public would require him, in my opinion, to place before the proper authorities the result of his examination if, in his opinion, the public interest so required. This would be so, in my opinion, whether or not the patient instructed him not to do so."

The learned judge then referred to Mr. Robertson's submission that the dominant public interest in the case was the public interest in patients being able to make full and frank disclosure to their doctors, and in particular to their psychiatrist, without fear that the doctor would disclose the information to others. The judge said:

> "I accept the general importance in the public interest that this should be so. It justifies the General Medical Council's rule 80."

At page 714D he said:

> "In truth, as it seems to me, the interest to be served by the duty of confidence for which Mr.Robertson contends is the private interest of W and not any broader public interest. If I set the private interest of W in the balance against the public interest served by disclosure of the report to Dr. Hunter and the Home Office, I find the weight of the public interest prevails."

At page 714H he said:

> "In my judgment, therefore, the circumstances of this case did not impose on Dr. Egdell an obligation of conscience, an equitable obligation, to refrain from disclosing his report to Dr. Hunter, or to refrain from encouraging its disclosure to the Home Office."

In this court Mr. Robertson acknowledges that in addition to the duty of confidence admittedly owed by Dr. Egdell to W, it was necessary for the judge to consider the public interest in the disclosure by Dr. Egdell of his report to the authorities. There are two competing public interest considerations. However, he submitted that the dominant public interest was the duty of confidence owed by Dr. Egdell to W. The burden of proving that that duty was overridden by public interest considerations in disclosing his opinion to the public authorities rested fairly and squarely upon Dr. Egdell. He contended that where the public interest relied upon to justify a breach of confidence is alleged to be the reduction or elimination of a risk to public safety, it must be shown: (a) that such a risk is real, immediate and serious; (b) that it will be substantially reduced by disclosure; (c) that the disclosure is no greater than is reasonably necessary to minimise the risk; and (d) that the consequent damage to the public interest protected by the duty of confidentiality is outweighed by the public interest in minimising the risk. He relied upon the decision of Mr. Justice Rose in X v. Y [1988] 2 All E.R. 648. He also cited a passage from the judgment of Mr. Justice Boreham in Hunter v. Mann [1974] Q.B. 767. The passage in question is to be found at page 772F:

> "The second proposition is this: that in common with other professional men, for instance a priest and there are of course others, the doctor is under a duty not to disclose, without the consent of his patient, information which he, the doctor, has gained in his professional capacity, save, says Mr. Bingham, in very exceptional circumstances. He quoted the example of the murderer still manic, who would be a menace to society. But, as Mr. Bingham says, save in such exceptional circumstances, the general rule applies. He adds that the law will enforce that duty."

He referred to the American case of Tarasoff v. University of California 17 Cal. 3(d) 358 as an example of extreme circumstances and submitted that only in the most extreme circumstances could a doctor be relieved from observing the strict duty of confidence imposed upon him by reason of his relationship with his patient. In this instance, said Mr. Robertson, there was no immediate prospect of W being released or of being detained other than under secure conditions and furthermore any change in his circumstances would be conditional upon further expert analysis and recommendation.

The two interests which had to be balanced in this case were both public interests. The judge was wrong to refer to W's "private" interest. The judge was also in error, said Mr. Robertson in saying: "The case seems to me to fall squarely within sub-paragraph (b) of rule 81" (of the General Medical Council's rules). Dr. Egdell did not have any clinical responsibility for W and accordingly that particular rule could not be relied upon by Dr. Egdell in the present circumstances.

With reference to "legal privilege", Mr. Robertson submitted that in the context of this case it was highly relevant that the report was commissioned by solicitors acting on behalf of W in the matter of his application to the tribunal. He argued that if legal privilege did not strictly apply to the report of Dr. Egdell as distinct from his instructions, nevertheless the context in which it was prepared added strength to the duty of confidence. He used the phrase "a cumulative effect".

Mr. Whitfield on behalf of the respondent argued that Dr. Egdell is acknowledged to be a responsible and experienced consultant psychiatrist having particular knowledge of the procedures relating to the management and treatment of restricted patients detained in secure conditions under the provisions of the Mental Health Act. His evidence on matters of fact was not challenged. It must be accepted that he was genuinely seriously concerned by the revelation of what seemed to him to be entirely new facts relating to W's long standing interest in guns and explosives. It is not challenged, he said, that he acted in good faith in disclosing his report to Dr. Hunter and in urging its disclosure to the Home Secretary. He plainly believed that he was acting in the public interest.

The balance of public interest clearly lay in the restricted disclosure of vital information to the Director of the Hospital and to the Secretary of State who had the onerous duty of safeguarding public safety.

In this case the number and nature of the killings by W must inevitably give rise to the gravest concern for the safety of the public. The authorities responsible for W's treatment and management must be entitled to the fullest relevant information concerning his condition. It is clear that Dr. Egdell did have highly relevant information about W's condition which reflected upon his dangerousness. In my judgment the position came within the terms of rule 81, subparagraph (g) of the General Medical Council's Rules. Furthermore, Dr. Egdell amply justified his action within the terms of rule 82. The suppression of the material contained in his report would have deprived both the hospital and the Secretary of State of vital information, directly relevant to questions of public safety. Although it may be said that Dr. Egdell's action in disclosing his report to Dr. Hunter fell within the letter of rule 8Kb), the judge in fact based his conclusion on what he termed "broader considerations" - that is to say, the safety of the public. I agree with him.

In so far as the judge referred to the "private interest" of W, I do not consider that the passage in his judgment at page 714D accurately stated the position. There are two competing public interests and it is clear that by his reference to the case of X v. Y the judge was fully seized of this point. Of course W has a private interest, but the duty of confidence owed to him is based on the broader ground of public interest described by Mr. Justice Rose in X v. Y.

I do not consider that this is a case of legal professional privilege, although it is, however, relevant as part of the background which gave rise to the issue of confidentiality.

Accordingly I agree with the judge's decision to dismiss the plaintiff's claim. Dr. Egdell was clearly justified in taking the course that he did.

LORD JUSTICE BINGHAM: W, the plaintiff in this action, appeals against a decision of Mr. Justice Scott made on the 9th December, 1988. The main issue in the appeal is an important one: what is the scope of the duty of confidence owed to a restricted mental patient by a psychiatrist engaged by the patient to report on his mental health for purposes of his forthcoming application to a Mental Health Review Tribunal?

The statutory provisions relevant to this appeal and the detailed facts giving rise to this action are set out clearly and comprehensively in the judgment of Mr. Justice Scott which is reported at [1989] 2 W.L.R. 689. I shall not repeat that summary, which should be treated as

incorporated in this judgment. I give only the barest summary of the fact needed to show how the appeal arises.

Some years ago W shot and killed five people and serious wounded two others. He was. charged with murder but pleaded guilty to manslaughter on the ground of diminished responsibility . He was agreed to be suffering from mental illness when the offences were committed. In the Crown Court a hospital order was made with a restriction on his discharge without limit of time. He was detained in Broadmoor Hospital for a time, and then in the special hospital where he remains. In 1984 a tribunal recommended W's transfer to a regional secure unit (RSU) as the first trial step towards W's eventual rehabilitation and release. After further psychological test and psychiatric assessments Dr. Ghosh, as W's responsible medical officer (RMO), advised the Home Secretary that W should be transferred to a named RSU. For reasons given at length in a letter of the 20th May, 1987 the Home Secretary did not then accept that advice. By then W had already instructed solicitors to apply to a tribunal for a review of his case. His legal aid certificate covered an independent psychiatric report. Dr. Egdell, a consultant psychiatrist of repute, was accordingly instructed to attend upon W and complete a report for use at the forthcoming tribunal. The tribunal was to sit on the 25th August and Dr. Egdell was asked to deliver his report not less than two weeks before.

Having discussed the case with others and interviewed W, Dr. Egdell was of opinion that certain potentially dangerous features of W's personality (in particular, a long-standing interest in explosives, dating from a period well before W's acute mental illness) had previously been insufficiently appreciated and explored. He did not favour W's transfer at that stage. He expressed this opinion in a long report dated the 29th July, 1987 which he sent to W's solicitors. The solicitors discussed the report with W who instructed them that his application to the tribunal should be withdrawn and that he did not wish anyone to see the report. The application was withdrawn. Dr. Egdell (who did not then know of W's instructions) was concerned that his report might not be placed before the tribunal and on the 19th August telephoned the tribunal to find out if it had or not. He learned that it had not, and that the application had been withdrawn. He knew his opinion differed from that of W's RMO, to whom he had spoken before completing his report, and accordingly spoke to the acting medical director (Dr. Hunter) at W's hospital who should, Dr. Egdell felt, know of his findings and opinion. Dr. Hunter suggested that Dr. Egdell obtain the solicitors ' consent to disclosure of the report. Dr. Egdell therefore telephoned the solicitors and was told that his report would be kept on the solicitors' files and not shown to anyone. Dr. Egdell made clear his wish that his report be forwarded to the hospital. The solicitors declined to do this in view of W's clear instructions.

On the 24th August, 1987 Dr. Egdell spoke to Dr. Hunter on the telephone again. Dr. Egdell expressed the view that the material which he felt had been revealed on his examination cast a new light on the patient's dangerousness and ought to be known to those responsible for his care and discharge. Dr. Hunter asked Dr. Egdell to forward a report in writing of his concerns. Dr. Egdell accordingly altered the introductory sentence in his report of the 29th July, re-addressed it, dated it the 25th August and sent it to Dr. Hunter. At Dr. Egdell's urging a copy was later sent to the Home Office and placed with W's clinical case notes. On the 22nd December, 1987 W issued a writ against Dr. Egdell and an injunction was granted restraining Dr. Egdell from communicating the contents of the report save to W or with W's authority. W did not know that the report had already been sent to the Home Office, but the matter was of concern to W in particular because a periodic 3-year review of his case was in train. The ex parte injunction was by consent continued until trial. In the meantime a second

writ had been issued by W against a number of public authorities (the DHSS, the Home Office, the hospital board and the tribunal). That action was consolidated with W's action against Dr. Egdell but there is no appeal against the judge's decision in favour of those authorities.

The action was tried on affidavit. There was no cross-examination . On the 9th December, 1986 the judge held that Dr. Egdell, although owing W a duty of confidence, had not acted in breach of it in sending a copy of his report to Dr. Hunter. It is that conclusion which W now challenges.

The philosophy underlying the statutory regime which the judge described is in my view clear. A man who commits crimes, however serious, when subject to severe mental illness is not to be treated as if he were of sound mind. He requires treatment in hospital, not punishment in prison. So an order may be made committing him to hospital. He may, however, represent a great and continuing danger to the public. So his confinement in hospital may be ordered to continue until the Home Secretary, as guardian of the public safety, adjudges it safe to release him or relax the conditions of his confinement. But a decision by the Home Secretary adverse to the patient is not conclusive. The patient may have recourse to an independent tribunal which, if certain conditions are satisfied, must order his discharge either conditionally or absolutely and which may make non-binding recommendations. Lest an inactive patient be forgotten, his case must be reviewed by the tribunal at three-yearly intervals. These provisions represent a careful balance between the legitimate desire of the patient to regain his freedom and the legitimate desire of the public to be protected against violence. The heavy responsibility of deciding how the balance should be struck in any given case at any given time rests in the first instance on the Home Secretary and in the second on the tribunal. It is only by making a careful and informed assessment of the individual case that the potentially conflicting claims of humanity to the patient and protection of the public may be fairly and responsibly reconciled.

It has never been doubted that the circumstances here were such as to impose on Dr. Egdell a duty of confidence owed to W. He could not lawfully sell the contents of his report to a newspaper, as the judge held (710E). Nor could he, without a breach of the law as well as professional etiquette discuss the case in a learned article or in his memoirs or in gossiping with friends, unless he took appropriate steps to conceal the identity of W. It is not in issue here that a duty of confidence existed.

The breadth of such a duty in any case is, however, dependent on circumstances. Where a prison doctor examines a remand prisoner to determine his fitness to plead or a proposer for life insurance is examined by a doctor nominated by the insurance company or a personal injury plaintiff attends on the defendant's medical adviser or a prospective bidder instructs accountants to investigate (with its consent) the books of a target company, the professional man's duty of confidence towards the subject of his examination plainly does not bar disclosure of his findings to the party at whose instance he was appointed to make his examination. Here, however, Dr. Egdell was engaged by W, not by the tribunal or the hospital authorities. He assumed at first that his report would be communicated to the tribunal and thus become known to the authorities but he must, I think, have appreciated that W and his legal advisers could decide not to adduce his report in evidence before the tribunal.

The decided cases very clearly establish:

(1) that the law recognises an important public interest in maintaining professional duties of confidence; but
(2) that the law treats such duties not as absolute but as liable to be overridden where there is held to be a stronger public interest in disclosure.

Thus the public interest in the administration of justice may require a clergyman, a banker, a medical man, a journalist or an accountant to breach his professional duty of confidence (Attorney-General v. Mulholland and Foster [1963] 2 Q.B. 477 at 489-490; Chantrey Martin v. Martin [1953] 2 Q.B. 286). In Parry-Jones v. Law Society [1969] 1 Ch. 1 a solicitor's duty of confidence towards his clients was held to be overridden by his duty to comply with the law of the land which required him to produce documents for inspection under the Solicitors' Accounts Rules. A doctor's duty of confidence to his patient may be overridden by clear statutory language (as in Hunter v. Mann [1974] Q.B. 767). A banker owes his customer an undoubted duty of confidence, but he may become subject to a duty to the public to disclose, as where danger to the state or public duty supersede the duty of agent to principal (Tournier v. National Provincial and Union Bank of England [1924] 1 K.B. 461 at 473, 486). An employee may justify breach of a duty of confidence towards his employer otherwise binding upon him when there is a public interest in the subject matter of his disclosure (Initial Services Ltd. v.. Putterill [1968] 1 Q.B. 396; Lion Laboratories v. Evans [1985] Q.B. 526). These qualifications of the duty of confidence arise not because that duty is not accorded legal recognition but for the reason clearly given by Lord Goff in his Spycatcher speech ([1988] 3 W.L.R. 776 at 807), quoted by Mr. Justice Scott at 710G:

> "The third limiting principle is of far greater importance. It is that, although the basis of the law's protection of confidence is that there is a public interest that confidences should be preserved and protected by the law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure. This limitation may apply, as the learned judge pointed out, to all types of confidential information. It is this limiting principle which may require a court to carry out a balancing operation, weighing the public interest in maintaining confidence against a countervailing public interest favouring disclosure."

These principles were not in issue between the parties to this appeal. Mr. Robertson accepted that W's right to confidence was qualified and not absolute. But it is important to insist on the public interest in preserving W's right to confidence because the learned judge at pages 713E-714D of his judgment concluded that while W had a strong private interest in barring disclosure of Dr. Egdell's report he could not rest his case on any broader public interest. Here, as I think, the judge fell into error. W of course had a strong personal interest in regaining his freedom and no doubt regarded Dr. Egdell's report as an obstacle to that end. So he had a personal interest in restricting the report's circulation. But these private considerations should not be allowed to obscure the public interest in maintaining professional confidences. The fact that Dr. Egdell as an independent psychiatrist examined and reported on W as a restricted mental patient under section 76 of the Act does not deprive W of his ordinary right to confidence underpinned, as such rights are, by the public interest. But it does mean that the balancing operation of which Lord Goff spoke falls to be carried out in circumstances of unusual difficulty and importance.

We were referred, as the judge was, to the current advice given by the General Medical Council to the medical profession pursuant to section 35 of the Medical Act 1983. Paragraph 80 provides:

> "It is a doctor's duty, except in the cases mentioned below, strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information about a patient which he has learnt directly or indirectly in his professional capacity as a registered medical practitioner ..."

I do not doubt that this accurately states the general rule as the law now stands, and the contrary was not suggested. A disclosure compelled by statute or court order is not voluntary.

Paragraph 81 of the GMC advice lists the exceptions. Our attention was drawn to (b) and (d):

> "(b) Confidential information may be shared with other registered medical practitioners who participate in or assume responsibility for clinical management of the patient. To the extent that the doctor deems it necessary for the performance of their particular duties, confidential information may also be shared with other persons (nurses and other health care professionals) who are assisting and collaborating with the doctor in his professional relationship with the patient. It is the doctor's responsibility to ensure that such individuals appreciate that the information is being imparted in strict professional confidence.
> ...
> (d) If in the doctor's opinion disclosure of information to a third party other than a relative would be in the best interests of the patient, it is the doctor's duty to make every reasonable effort to persuade the patient to allow the information to be given. If the patient still refuses then only in exceptional cases should the doctor feel entitled to disregard his refusal."

The learned judge regarded sub-paragraph 8Kb) as accurately stating the law and held that Dr. Egdell's disclosure in the present case fell squarely within it (713B). I have some reservations about this conclusion. It is true that the disclosure here may be said to fall within the letter of the first sentence of (b). But I think the sub-paragraph is directed towards the familiar situation in which consultants or other specialised experts report to the doctor with clinical responsibility for treating or advising the patient, and the second sentence shows that the doctor whose duty is in question is regarded as having a continuing professional relationship with the patient. I rather doubt if the draftsman of subparagraph (b) had in mind a consultant psychiatrist consulted on a single occasion "for the purpose of advising whether an application to a Mental Health Review Tribunal should be made by or in respect of a patient who is liable to be detained or subject to guardianship under Part II of this Act or of furnishing information as to the condition of a patient for the purpose of such an application" (section 76(1) of the Act.) Nor do I think that Dr. Egdell, in making disclosure, was primarily motivated by the ordinary concern of any doctor that a patient should receive the most efficacious treatment. Had that been his primary object, I think he would, consistently with the spirit of sub-paragraph (d), have tried to reason with W to obtain his consent to disclosure in W's own interest. I need not, however, reach a final view. The judge preferred to rest his conclusion on a broader ground (713B) which was in effect the exception set out in sub-paragraph 81(g) of the GMC advice, and I think that if the disclosure cannot be justified under that exception it would be unsafe to justify it under any other.

Sub-paragraph 81(g) provides:

> "Rarely, disclosure may be justified on the ground that it is in the public interest which, in certain circumstances such as, for example, investigation by the police of a grave or very serious crime, might override the doctor's duty to maintain his patient's confidence."

It was this exception which, as I understand, the judge upheld and applied when he held, in what is perhaps the crucial passage in his judgment (at 713D):

> "In my view, a doctor called upon, as Dr. Egdell was, to examine a patient such as W owes a duty not only to his patient but also a duty to the public. His duty to the public would require him, in my opinion, to place before the proper authorities the result of his examination if, in his opinion, the public interest so required. This would be so, in my opinion, whether or not the patient instructed him not to do so."
> Mr. Robertson criticised this passage as wrongly leaving the question whether disclosure was justified or not to the subjective decision of the doctor. He made the same criticism of a passage at 714E where the judge said:
>
> "If a patient in the position of W commissions an independent psychiatrist's report, the duty of confidence that undoubtedly lies on the doctor who makes the report does not, in my judgment, bar the doctor from disclosing the report to the hospital that is charged with the care of the patient if the doctor judges the report to be relevant to the care and treatment of the patient, nor from disclosing the report to the Home Secretary if the doctor judges the report to be relevant to "the exercise of the Home Secretary's discretionary powers in relation to that patient."

In my opinion these criticisms are just. Where, as here, the relationship between doctor and patient is contractual, the question is whether the doctor's disclosure is or is not a breach of contract. The answer to that question must turn not on what the doctor thinks but on what the court rules. But it does not follow that the doctor's conclusion is irrelevant. In making its ruling the court will give such weight to the considered judgment of a professional man as seems in all the circumstances to be appropriate.

The parties were agreed, as I think rightly, that the crucial question in the present case was how, on the special facts of the case, the balance should be struck between the public interest in maintaining professional confidences and the public interest in protecting the public against possible violence. Mr. Robertson submitted that on the facts here the public interest in maintaining confidences was shown to be clearly preponderant. In support of that submission he drew our attention to a number of features of the case of which the most weighty were perhaps these:

(1) Section 76 of the Act shows a clear parliamentary intention that a restricted patient should be free to seek advice and evidence for the specified purposes from a medical source outside the prison and secure hospital system. Section 129 ensures that the independent doctor may make a full examination and see all relevant documents. The examination may be in private, so that the authorities do not learn what passes between doctor and patient.

(2) The proper functioning of section 76 requires that a patient should feel free to bare his soul and open his mind without reserve to the independent doctor he has retained. This he will not do if a doctor is free, on forming an adverse opinion, to communicate it to those empowered to prevent the patient's release from hospital.

(3) Although the present situation is not one in which W can assert legal professional privilege, and although tribunal proceedings are not strictly adversarial, the considerations which have given rise to legal professional privilege underpin the public interest in preserving confidence in a situation such as the present. A party to a forthcoming application to a tribunal should be free to unburden himself to an adviser he has retained without fearing that any material damaging to his application will find its way without his consent into the hands of a party with interests adverse to his.

(4) Preservation of confidence would be conducive to the public safety: patients would be candid, so that problems such as those highlighted by Dr. Egdell would become known; and steps could be taken to explore and if necessary treat the problems without disclosing the report.

(5) It is contrary to the public interest that patients such as W should enjoy rights less extensive than those enjoyed by other members of the public, a result of his judgment which the judge expressly accepted (at 714F).

Of these considerations, I accept (1) as a powerful consideration in W's favour. A restricted patient who believes himself unnecessarily confined has, of all members of society, perhaps the greatest need for a professional adviser who is truly independent and reliably discreet. (2) also I, in some measure, accept, subject to the comment that if the patient is unforthcoming the doctor is bound to-be guarded in his opinion. If the patient wishes to enlist the doctor's wholehearted support for his application, he has little choice but to be (or at least convince an expert interviewer that he is being) frank. I see great force in (3). Only the most compelling circumstances could justify a doctor in acting in a way which would injure the immediate interests of his patient, as the patient perceived them, without obtaining his consent. Point (4), if I correctly understand it, did not impress me. Counsel's submissions appeared to suggest that the problems highlighted by Dr. Egdell could be explored and if necessary treated without the hospital authorities being told what the problems were thought to be. I do not think this would be very satisfactory. As to (5), I agree that restricted patients should not enjoy rights of confidence less valuable than those enjoyed by other patients save in so far as any breach of confidence can be justified under the stringent terms of sub-paragraph 81(g).

Mr. Whitfield, Q.C. for Dr. Egdell justified his client's disclosure of his report by relying on the risk to the safety of the public if the report were not disclosed. The steps of his argument, briefly summarised, were these:

(1) As a result of his examination Dr. Egdell believed that W had had a long-standing and abnormal interest in dangerous explosives dating from well before his period of acute illness.

(2) Dr. Egdell believed that this interest had been overlooked or insufficiently appreciated by those with clinical responsibility for W.

(3) Dr. Egdell believed that this interest could throw additional light on W's interest, also long-standing' and in this instance well documented, in guns and shooting.

(4) Dr. Egdell believed that exploration of W's interest in explosives and further exploration of W's interest in guns and shooting might lead to a different and more sinister diagnosis of W's mental condition.

(5) Dr. Egdell believed that these explorations could best be conducted in the secure hospital where W was.

(6) Dr. Egdell believed that W might possibly be a future danger to members of the public if his interest in firearms and explosives continued after his discharge.

(7) Dr. Egdell believed that these matters should be brought to the attention of those responsible for W's care and treatment and for making decisions concerning his transfer and release.

Dr. Egdell's good faith was not in issue. Nor were his professional standing and competence. His opinions summarised in CD, (2), (3) and (4) (although not accepted) were not criticised as ill-founded or irrational. Dr. Egdell deferred to the greater knowledge of another medical expert relied on by W concerning the regime in an RSU but did not (as I understood) modify his view that the explorations he favoured should take place before transfer.

Mr. Robertson contended that Dr. Egdell's belief summarised in (6) did not in all the circumstances justify disclosure of the report. There was, he said, no question of W's release, whether absolutely or conditionally, in the then foreseeable future. The Home Office had made plain that it would not sanction transfer to an RSU for about 18 months. Even if he were transferred he would remain a patient of the special hospital for the first six months and the high staff ratio in such units would ensure a very high level of security thereafter. Much further testing would in any event be done before W was again at large. Disclosure of the report would do nothing to protect the public.

I do not find these points persuasive. When Dr. Egdell made his decision to disclose, one tribunal had already recommended W's transfer to an RSU and the hospital authorities had urged that course. The Home Office had resisted transfer in a qualified manner but on a basis of inadequate information. It appeared to be only a matter of time, and probably not a very long time, before W was transferred. The RSU was to act as a staging post on W's journey back into the community. While W would no doubt be further tested, such tests would not be focused on the source of Dr. Egdell's concern, which he quite rightly considered to have received inadequate attention up to then. Dr. Egdell had to act when he did or not at all.

There is one consideration which in my judgment, as in that of the judge, weighs the balance of public interest decisively in favour of disclosure. It may be shortly put. Where a man has committed multiple killings under the disability of serious mental illness, decisions which may lead directly or indirectly to his release from hospital should not be made unless a responsible authority is properly able to make an informed judgment that the risk of repetition is so small as to be acceptable. A consultant psychiatrist who becomes aware, even in the course of a confidential relationship, of information which leads him, in the exercise of what the court considers a sound professional judgment, to fear that such decisions may be made on the basis of inadequate information and with a real risk of consequent danger to the public is entitled to take such steps as are reasonable in all the circumstances to communicate the grounds of his concern to the responsible authorities. I have no doubt that the judge's decision in favour of Dr. Egdell was right on the facts of this case.

Mr. Robertson argued that even if Dr. Egdell was entitled to make some disclosure he should have disclosed only the crucial paragraph of his report and (I think) his opinion. I do not agree. An opinion, even from an eminent source, cannot be evaluated unless its factual

premise is known, and a detailed 10-page report cannot be reliably assessed by perusing a brief extract.

No reference was made in argument before us (nor, so far as I know, before the judge J to the European Convention of Human Rights, but I believe this decision to be in accordance with it. I would accept that Article 8(1) of the Convention may protect an individual against the disclosure of information protected by the duty of professional secrecy. But Article 8(2) envisages that circumstances may arise in which a public authority may legitimately interfere with exercise of that right in accordance with the law and where necessary in a democratic society in the interests of public safety or the prevention of crime. Here there was no interference by a public authority. Dr. Egdell did, as I conclude, act in accordance with the law. And his conduct was in my judgment necessary in the interests of public safety and the prevention of crime.

I would dismiss the appeal. Having reached that conclusion I do not think it necessary to consider whether, had W succeeded, he could have recovered damages in contract for shock and distress.

SIR JOHN MAY: I have had the advantage of reading the judgments prepared by my Lords. I respectfully agree with them. In the circumstances there is nothing I wish to add on my own account. I too would dismiss this appeal.

(Order: Appeal dismissed. No order for costs save legal aid taxation of appellant's costs. Application for leave to appeal to the House of Lords refused)