

HAS THE RIGHT TO BREACH PATIENT CONFIDENTIALITY CREATED A COMMON LAW DUTY TO WARN GENETIC RELATIVES?

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This paper discusses the conflict between a medical practitioner's duty of care and duty to maintain patient confidentiality, and their statutory right to inform a relative about a possible genetic condition. The statutory right arguably creates a Rogers v Whitaker type duty to provide the same information a patient might require in order to make informed choices about testing and treatment. In the event that reasonable clinical judgment is not applied to disclosure, the genetic relative ought to be offered the opportunity to seek redress through the common law if they suffer harm as a result.

I INTRODUCTION

This paper sets out the current domestic position on disclosure of genetic information by medical practitioners *without patient consent* to do so, and reviews whether that position was altered by the amendments to the *Privacy Act 1988* (Cth) a decade ago. Whilst this involves only the minority of patients (since the majority willingly divulge genetic information to family members),¹ the issue has significant implications for the healthcare provider who 'faces a choice between preserving the confidentiality of one patient and preventing harm to another' as genetic testing becomes more prevalent in the future.²

The author sets out the existing duties to patients of both confidentiality and care and the circumstances in which a breach of patient confidentiality may be legally permissible. Whilst one cannot ignore the ethical ramifications of conflicting duties to patients and third parties, this article affords only a cursory glance at them due to its primary focus on the legal connotations of the question.

The remainder of the paper considers the current statutory *right* of a medical practitioner to disclose genetic information to relatives. In doing so, the author has considered the application of both domestic and international common law precedent (most recently, the UK decision of *ABC v St George's Healthcare NHS Trust*)³ on the duty of care to third parties in a number of different clinical settings to determine whether this right has been, or could be, extended to a positive common law *duty to warn*.

Finally, the paper touches on the issue of foreseeability and its correlation to the causation of harm that might flow from non-disclosure but does not extend to a thorough analysis of the

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¹ Margaret Otlowski, 'Australian Reforms Enabling Disclosure of Genetic Information to Genetic Relatives by Health Practitioners' (2013) 21 *Journal of Law and Medicine* 217.

² Anneke Lucassen and Malcolm Parker, 'Confidentiality and Serious Harm in Genetics: Preserving the Confidentiality of One Patient and Preventing Harm to Relatives' (2004) 12 *European Journal of Human Genetics* 93, 93; Sandi Dheensa, Angela Fenwick and Anneke Lucassen, "'Is This Knowledge Mine and Nobody Else's? I Don't Feel That.'" Patient Views About Consent, Confidentiality and Information-sharing in Genetic Medicine' (2016) 42 *Journal of Medical Ethics* 174.

³ [2015] EWHC 1394 (QB), on appeal.



interrelating issues of breach of duty, factual causation or damage. Overall, the paper concludes that whilst a positive duty is not established, the doorway is certainly open for courts to find such a duty and in the author's view, it would not offend the common law principles of negligence if it was.

II DUTY OF CONFIDENTIALITY

Ingrained not only in their ethical duties towards patients but found in information protection laws,⁴ health statutes (which sometimes create offences for disclosure),⁵ and common law principles,⁶ healthcare providers must keep information about, or provided by their patients confidential, even from family members, unless permitted to do otherwise.

The Hippocratic Oath establishes:

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.⁷

This premise reflects the importance and value of trust in the doctor-patient relationship so as to reinforce the continued role of 'public as well as private health'.⁸ It is based in the ethical principle of autonomy, allowing an individual to have control over decisions affecting their medical treatment and arguably providing choice over what happens to the information they impart.⁹

The author assumes that for most practitioners, if not all, a breach of such an ingrained duty would be difficult to contemplate, let alone justify. The discussion in this paper reflects only the situation where disclosure of information is made absent the consent of the patient. In most cases, particularly in the context of genetic information, patients are willing to divulge information to relevant family members, or at the very least, allow their medical practitioner to do so.¹⁰ Two studies undertaken firstly in a small group of Jewish women in Boston relating to a predisposal to BRCA1/2 mutation and secondly in a small group of students and professors at a university in the UK, both found that whilst patient confidentiality was important to the respondents, 'condition preventability' was the primary factor in determining whether patients would be willing to inform family members or have them informed by their medical practitioner.¹¹

⁴ *Privacy Act 1988* (Cth); *Privacy Amendment (Enhancing Privacy Protection) Act 2012* (Cth); *Privacy Legislation Amendment Act 2006* (Cth); *Health Records (Privacy and Access) Act 1997* (ACT); *Privacy and Personal Information Protection Act 1998* (NSW); *Information Privacy Act 2000* (Vic); *Health Records Act 2001* (Vic); *Information Privacy Act 2009* (Qld); *Health Legislation Amendment Act 2012* (NSW); *Data Protection Act 1998* (UK).

⁵ *Health Act 1911* (WA); *Public Health Act 1997* (Tas); *Public Health Act 2005* (Qld); *Health Care Act 2008* (SA); *Public Health Act 2010* (NSW); *Public Health Act 2011* (SA).

⁶ *Furniss v Fitchett* [1958] NZLR 396; *Hunter v Mann* [1974] QB 767.

⁷ Ludwig Edelstein, *The Hippocratic Oath: Text, Translation, and Interpretation* (Johns Hopkins Press, 1943).

⁸ *X v Y* [1988] 2 All ER 648 [653] (Rose J).

⁹ Lucassen and Parker, above n 2.

¹⁰ Otowski, above n 1.

¹¹ Timothy Heaton and Victoria Chico, 'Attitudes Towards the Sharing of Genetic Information with At-risk Relatives: Results of a Quantitative Survey' (2016) 135 *Human Genetics* 109, 109; Lisa Lehmann et al, 'Disclosure of Familial Genetic Information: Perceptions of the Duty to Inform' (2000) 109 *The American Journal of Medicine* 705, 707.

Has the Right to Breach Patient Confidentiality Created a Common Law Duty to Warn Genetic Relatives?

Some commentators have suggested that:

best practice is represented by striving to avoid the need to use the provisions [of the amended Privacy Act]. With a combination of professionalism and patience, most apparent conflicts can be resolved without recourse to disclosing private information without consent.¹²

Others believe the primary responsibility (or duty) of disclosure of such information falls on the individual patient themselves,¹³ which would negate any duty on the medical practitioner and therefore any liability to family members entirely, although comprehending genetic information without medical assistance could be very difficult for some family members and therefore the medical practitioner would still have a role to play, albeit not a mandated one.¹⁴

However in line with the above, the question becomes whether a similar level of autonomy (or the duty of beneficence) should be extended to family members of patients with genetic conditions, such that they too could make informed decisions about the treatment that they may or may not wish to undergo with the benefit of the information provided.¹⁵ Some suggest that ‘the greater harm in maintaining patient confidentiality is to the relative, and therefore the rights of the relative should predominate’.¹⁶

Given this conflict, it has been suggested that a better approach would be a ‘joint account’ model where all relevant family members hold an equally vested interest to familial information¹⁷ or that a model of ‘comity’ should be preferred over individual rights.¹⁸ In fact, the Australian Medical Association advocated in 2012 for ‘a national approach to raising public awareness of the risks and benefits of genetic testing including ... the shared nature of genetic information’.¹⁹ The reason for this joint approach to information sharing is that irrespective of how sacred the duty of confidentiality to a patient may be, it is recognised that there will always be occasions when harm to the patient (if confidentiality is breached) may be outweighed by the benefit of disclosure to others, particularly where the breach has the potential to protect others from harm.²⁰ This is clearly an intricate balancing exercise which will undoubtedly end

¹² Graeme Suthers, Elizabeth McCusker and Samantha Wake, ‘Alerting Genetic Relatives to a Risk of Serious Inherited Disease Without a Patient’s Consent’ (2011) 194 *Medical Journal of Australia* 385, 386.

¹³ Angus Clarke et al, ‘Genetic Professionals’ Reports of Nondisclosure of Genetic Risk Information Within Families’ (2005) 13 *European Journal of Human Genetics* 556; Pascal Borry and Kris Dierickx, ‘What Are the Limits of the Duty of Care? The Case of Clinical Genetics’ (2008) 5(2) *Personalized Medicine* 101, 101–104; Marni Falk et al, ‘Medical Geneticists’ Duty to Warn At-risk Relatives for Genetic Disease’ (2003) 120A *American Journal of Medical Genetics* 374.

¹⁴ Loane Skene, ‘Patients’ Rights or Family Responsibilities? Two Approaches to Genetic Testing’ (1998) 6 *Medical Law Review* 1.

¹⁵ Roy Gilbar and Charles Foster, ‘Doctors’ Liability to the Patient’s Relatives in Genetic Medicine’ (2015) 24 *Medical Law Review* 112.

¹⁶ Sharon Keeling, ‘Duty to Warn of Genetic Harm in Breach of Patient Confidentiality’ (2004) 12 *Journal of Law and Medicine* 235, 244.

¹⁷ Malcolm Parker and Annette Lucassen, ‘Genetic Information: a Joint Account?’ (2004) 329 *British Medical Journal* 165; Charles Foster et al, ‘Testing the Limits of the “Joint Account” Model of Genetic Information: A Legal Thought Experiment’ (2015) 41 *Journal of Medicine and Ethics* 379; Skene, above n 14.

¹⁸ Angela Davey, Ainsley Newson and Peter O’Leary, ‘Communication of Genetic Information Within Families: The Case for Familial Comity’ (2006) 3 *Bioethical Inquiry* 161.

¹⁹ Australian Medical Association, *Genetic Testing – 2012* (1 April 2012) <<https://ama.com.au/position-statement/genetic-testing-2012>>, [1.5].

²⁰ Australian Law Reform Commission (ALRC) and National Health and Medical Research Council, Australian Health Ethics Committee (AHEC), *Essentially Yours: The Protection of Human Genetic Information in Australia*, Report No 96 (2003).

up resulting in a determination that one party's rights are more significant than another's unless a joint account approach can be adopted.²¹

III PERMISSIBLE BREACHES OF DUTY OF CONFIDENTIALITY

Disclosure in the above context will therefore be based on clinical judgement, an often difficult path to tread, so even in circumstances where the patient expressly prohibits it, the medical practitioner is afforded some legal protection in certain circumstances if they do disclose information to others. For example, a medical practitioner may be required by law to provide information about a patient, either in the context of legal proceedings, in the event of knowledge relating to an offence, child abuse or neglect, or under various public health statutes and regulations relating to notifiable diseases in order that appropriate action may be taken to avoid the spread of disease.²² It has been proposed therefore that a positive common law duty to disclose genetic information would not be inconsistent with these requirements.²³

Perhaps the most difficult to define is what is known as 'the public interest exception' to the duty of confidentiality which is finely balanced between the 'rival interests' of patients to confidentiality and of society to public safety.²⁴ As genetic relatives are arguably representatives of the public when viewed from within the confines of the patient-doctor relationship, this exception could be utilised to permit disclosure of genetic information. However, for many this was 'not regarded as a suitable basis on which to allow for disclosure',²⁵ as the harm would not extend to the community at large, and more carefully constructed regulation on the point was required.

A *Legal Right to Inform*

A decade ago, amendments were made to the *Privacy Act 1988* (Cth) following the *Essentially Yours* report of the Australian Law Reform Commission and the Australian Health Ethics Committee of the National Health and Medical Research Council ('NHMRC').²⁶ The amendments specifically permitted the disclosure of genetic (as opposed to 'health') information without a patient's consent in circumstances where the medical practitioner 'reasonably believes that the use or disclosure is necessary to lessen or prevent a serious threat to the life, health or safety (whether or not the threat is imminent) of another individual who is a genetic relative'²⁷ of their patient. The report suggested that 'developments in genetic medicine have implications for the extent to which the confidentiality of the doctor and patient relationship should be given primacy over other ethical considerations'²⁸ and called for a set of

²¹ Suthers, McCusker and Wake, above n 12.

²² *Health Act 1911* (WA); *Public Health Act 1997* (ACT); *Public Health Regulation 2000* (ACT); *Public Health Act 2005* (Qld); *Public Health Regulation 2005* (Qld); *Public Health and Wellbeing Act 2008* (Vic); *Public Health and Wellbeing Regulations 2009* (Vic); *Public Health Act 2010* (NSW); *Public Health Regulation 2012* (NSW); *Public Health Act 2011* (SA); *Public Health (General) Regulations 2013* (SA). Janine McIlwraith and Bill Madden, *Health Care & The Law* (Thomson Reuters, 5th ed, 2010) 287. Included in a national list of over 70 communicable disease outbreaks of national significance.

²³ Meredith Blake, 'Should Health Professionals Be Under a Legal Duty to Disclose Familial Genetic Information?' (2008) 34 *Commonwealth Law Bulletin* 571.

²⁴ Alister Abadee, 'The Medical Duty of Confidentiality and Prospective Duty of Disclosure: Can They Co-exist?' (1995) 3 *Journal of Law and Medicine* 75.

²⁵ Otowski, above n 1, 222.

²⁶ Amendments were made by the enactment of the *Privacy Legislation Amendment Act 2006* (Cth) and the introduction of section 95AA approving guidelines by the NHMRC. See ALRC and AHEC, above n 20.

²⁷ *Privacy Act 1988* (Cth) Schedule 3 National Privacy Principle 2.1(ea)(ii), since repealed.

²⁸ ALRC and AHEC, above n 20, 548.

guidelines to assist ‘health professionals in providing effective health services to their patients’.²⁹ In more recent times, the legislation was further amended by the enactment of the *Privacy Amendment (Enhancing Privacy Protection) Act 2012* (Cth) which unified public and private sector approaches by repealing the National Privacy Principles and creating the Australian Privacy Principles (‘APPs’).

Currently, APP 6 specifically permits a medical practitioner to disclose a patient’s genetic information if the disclosure is conducted in accordance with guidelines approved under section 95AA of the *Privacy Act 1988* (Cth) and the recipient of the information is a *genetic relative* (author’s emphasis) of the patient, despite recommendations by the NHMRC to cover threats to *any known* individual.³⁰ This suggests that obvious practical issues surrounding disclosure, discussed in more detail below, have helped to shape the scope of the medical practitioners’ right to inform.

The guidelines do not create a legal duty to disclose a patient’s genetic information, rather ‘a framework ... to make disclosure in appropriate circumstances’.³¹ As with all other aspects of the duties of a medical practitioner, clinical judgement will remain the keystone to disclosure of genetic information, particularly in determining whether the threat of a genetic condition is serious and whether disclosure should be made because the genetic condition is capable of being prevented or ameliorated. Whilst this appears to tie in with the study referred to above suggesting ‘condition preventability’ is the primary consideration for disclosure,³² it does beg the question as to whether other ‘non-serious’ genetic conditions ought to be disclosed. Certain guidelines suggest that ‘where genetic information is diagnostic or highly predictive of an illness or relationship, it might carry greater significance than in other situations’³³ which would suggest that predictability, even of a ‘non-serious’ genetic condition, should be the influential factor for disclosure. In the former case, consideration is required of the potential for harm where disclosure is not made whereas in the latter case, any potential for harm caused by the disclosure, should the condition not eventuate, needs to be considered.

The *Essentially Yours* report identified that health professionals ought to be afforded some legal protection when such disclosure was made because ‘the question of whether non-consensual disclosure would be legally defensible butts heads with the legal duty of confidentiality’.³⁴ The legislative amendments, which are an arguable statutory spin-off from the public interest exception to confidentiality, remain the most internationally detailed on point.³⁵ Yet it remains to be seen whether they are being utilised by the Australian medical profession, given the seemingly ad hoc nature of the decision-making process and there being no requirement for central reporting of these decisions.³⁶ Whilst protection from statutory

²⁹ Ibid 544. These guidelines were subsequently established as: National Health and Medical Research Council and Office of the Privacy Commissioner, *Use and Disclosure of Genetic Information to a Patient’s Genetic Relatives Under Section 95AA of the Privacy Act 1988 (Cth): Guidelines for Health Practitioners in the Private Sector* (NHMRC, 2009) and updated in 2014: see <<https://www.nhmrc.gov.au/guidelines-publications/pr3>>.

³⁰ Defined in the *Privacy Act 1988* (Cth) s 6(1) as ‘another individual who is related to the first individual by blood, including but not limited to a sibling, a parent or a descendant of the first individual’.

³¹ Otlowski, above n 1, 224.

³² Heaton and Chico, above n 11, 109.

³³ Royal College of Physicians, Royal College of Pathologists and British Society for Human Genetics, ‘Consent and Confidentiality in Clinical Genetic Practice: Guidance on Genetic Testing and Sharing Genetic Information’ (Report of the Joint Committee on Medical Genetics, 2nd ed, RCPATH, 2011), 2.

³⁴ Mireille Lacroix et al, ‘Should Physicians Warn Patients’ Relatives of Genetic Risks?’ (2008) 178 *Canadian Medical Association Journal* 593, 594.

³⁵ Otlowski, above n 1.

³⁶ Ibid.

liability is offered,³⁷ there is no case law considering the extension of such protection to tortious liability although it is argued that ‘disclosure made in compliance with established guidelines would be evidence that it accorded with accepted standards of professional practice’,³⁸ thus a defence might be established.³⁹

B *The Right Not to Know*

Of equal importance when considering the individual’s right to be fully informed of genetic information, is the individual’s right not to know the information at all (or a medical practitioner’s positive ‘duty not to interfere with my ignorance’).⁴⁰ The decision might be influenced by any number of legal and social implications such as ‘life and health insurance, employment, loans, marriageability, reproductive choices, adoption, school admission and suicide’.⁴¹ One side of the argument equates to an autonomous right premised on self-determination although in fact many will choose not to investigate their risk further, even if informed.⁴² The other, although understood and encompassed in some human rights legislation and raised as a concern in some guidelines,⁴³ has been argued to be incompatible with autonomy because ignorance leads to the individual being unable to make informed choices.⁴⁴

If one considers the right not to know in the context of foreseeable harm, the balancing of the competing rights remains the same. One could envisage circumstances where a family member receiving information against their will suffers psychological harm or alternatively family members who remain uninformed by another’s ignorance suffer physical harm by being unable to take action regarding their own health.⁴⁵ It would appear to the author that the legislative changes seek to balance these competing rights by *not* enforcing a legal duty on medical practitioners and allowing clinical judgement to remain the driving force.

IV DUTY OF CARE

The existence of an established obligation to take care of another, particularly in the setting of healthcare provider and patient, can be demonstrated in many facets of our society. The Hippocratic Oath taken by all medical practitioners, the ethical principle of non-maleficence (doing no harm), the common law tort of negligence, and various statutes and codes of conduct – all provide obligations on healthcare providers to act, treat and address issues of health concern by their patients.⁴⁶ These obligations already extend in certain circumstances beyond

³⁷ Under the *Privacy Act 1988* (Cth).

³⁸ ALRC and AHEC, above n 20, 565.

³⁹ Tortious liability under the various Civil Liability Acts: *Civil Liability Act 1936* (SA) s 41; *Civil Liability Act 2002* (NSW) ss 5P, 5O; *Civil Liability Act 2002* (Tas) ss 21, 22; *Civil Liability Act 2002* (WA) ss 5O, 5PB; *Civil Liability Act 2003* (Qld) ss 21, 22; *Wrongs Act 1958* (Vic) ss 59, 60.

⁴⁰ Philippa Malpas, ‘The Right to Remain in Ignorance About Genetic Information: Can Such a Right Be Defended in the Name of Autonomy?’ (2005) 118 *New Zealand Medical Journal* U1611, 3.

⁴¹ Skene, above n 14, 9.

⁴² Keeling, above n 16.

⁴³ *Universal Declaration on the Human Genome and Human Rights*, GA Res 29 C/17, 29th sess (11 November 1997) Article 5(c) which says ‘the right of each individual to decide whether or not to be informed of the results of genetic examination and the resulting consequences should be respected’; see also NHMRC and Office of the Privacy Commissioner, above n 29.

⁴⁴ Jane Wilson, ‘To Know or Not to Know? Genetic Ignorance, Autonomy and Paternalism’ (2005) 19 *Bioethics* 492.

⁴⁵ *Ibid.*

⁴⁶ Matthew Lynch and David Ranson, ‘Doctors’ Duties and Third Parties’ (2000) 7 *Journal of Law and Medicine* 244.

the doctor-patient relationship, discussed above. However, as can be seen below, the Courts have battled with whether a similar duty of care can be established towards others.

A legal duty of care is one of the three well-founded principles of the tort of negligence, often defined by reference to the position, responsibility, proximity and/or relationship between the parties. The early landmark decision in the UK of *Donaghue v Stevenson*⁴⁷ established that a foreseeable class (in that case, purchasers of ginger beer), were owed a duty (by the manufacturer of the ginger beer) on the basis of what became known as Lord Atkin's 'neighbour test' in which he stated:

You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.⁴⁸

The case established a number of legal principles relating to the duty of care; the standard of the care to be provided (not discussed further in this paper); to whom a duty might be owed; and whether the act or omission of one party to another was one which might foreseeably cause harm. These principles have been cited with approval in many key international decisions, particularly in the UK and Australia; they have become enshrined in modern civil liability legislation, and feature heavily in the context of this issue.

A *What Does the Duty of Care Encompass?*

The content of the legal (and arguably ethical) duty to a patient comes from the requirement for medical practitioners to exercise reasonable care and skill in their practice of medicine to their patients.⁴⁹ It extends not only to positive actions, such as positive diagnosis or surgical technique, but also omissions, such as the failure to refer for specialist opinion or follow up test results.

Of most relevance, here is what is commonly called the 'duty to warn', a concept confirmed in the leading authority of *Rogers v Whitaker*,⁵⁰ in which the High Court was tasked with considering how to measure the failure of the medical practitioner to advise his patient of the risks involved in the medical treatment she was to undergo. Unanimously, the Judges of the High Court agreed that a duty of care should include the provision of information and advice 'if in the circumstances of the particular case, a reasonable person in the plaintiff's position, if warned of the risk [of sympathetic ophthalmia], would be likely to attach significance to it...'.⁵¹ The plaintiff in that case had 'incessantly' questioned the doctor as to possible complications of her surgery. She was particularly concerned that her 'good' left eye would not be affected, although she did not ask specifically whether the surgery to her right eye would affect her left eye. The rare risk of sympathetic ophthalmia eventuated, and the plaintiff was rendered almost totally blind. She alleged the doctor should have given her advice or information regarding this risk. Gaudron J found that:

⁴⁷ [1932] AC 562.

⁴⁸ *Donaghue v Stevenson* [1932] AC 562, 580 (Atkin L).

⁴⁹ *Rogers v Whitaker* (1992) 175 CLR 479.

⁵⁰ *Ibid.*

⁵¹ *Ibid* 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

a patient may have special needs or concerns which, if known to the doctor, will indicate that special or additional information is required. In a case of that kind, the information to be provided will depend on the individual patient concerned. In other cases, where, for example, no specific enquiry is made, the duty is to provide the information that would reasonably be required by a person in the position of the patient.⁵²

In the event that a patient raises specific concerns about their illness or condition in the context of whether it is likely to affect a family member, *Rogers v Whitaker*⁵³ seems to establish clearly that the duty of care would encompass such a discussion. The more difficult assessment is whether, in the knowledge that a genetic condition would affect the patient's family member, the doctor is obliged to provide such information when no such specific enquiry has been made.

The duty to provide information about risks has found significant favour in civil liability legislation across the country and medical codes of conduct.⁵⁴ In the author's view, if the law considers that a 'reasonable person' is entitled to information which would assist their decision about whether to undergo treatment or follow advice, it follows that 'the common law might conceivably impose a duty on a doctor to warn relatives' who might be forced to make the same decisions as the patient (or plaintiff) with a known genetic condition.⁵⁵

B *Scope of Duty*

The author suggests however, that it is the scope of that duty that has caused the most controversy in the various international authorities. The questions regarding to whom the duty is owed and in which circumstances it ought to be applied have been the key features of the cases discussed below.

Given that those within the class of 'purchasers' were not specifically known to the manufacturer of the ginger beer in *Donaghue v Stevenson*, it would seem that the duty of care was always envisaged to extend 'not only to patients but to others whose personal wellbeing ... may be harmed by failure to take reasonable care of a patient'.⁵⁶ However, it took several decades after that case before developments in the law across the globe established a special relationship of proximity between a healthcare provider and a person not previously their patient and even then a cautious approach to the extension of tortious liability has been applied.⁵⁷

⁵² Ibid 493 (Gaudron J).

⁵³ (1992) 175 CLR 479.

⁵⁴ For example, s 21 of the *Civil Liability Act 2003* (Qld) in which it states that a doctor does not breach a duty owed to a patient to warn of risk of personal injury to the patient, unless the doctor at that time fails to give or arrange to be given to the patient (a) information that a reasonable person in the patient's position would, in the circumstances, require to enable the person to make a reasonably informed decision about whether to undergo the treatment or follow the advice; (b) information that the doctor knows or ought reasonably to know the patient wants to be given before making the decision about whether to undergo the treatment or follow the advice. Medical Board of Australia, 'Good Medical Practice: a Code of Conduct for Doctors in Australia' (2014) <<http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>> 3.3.6 promotes 'Ensuring that patients are informed of the material risks associated with any part of the proposed management plan'.

⁵⁵ Skene, above n 14, 21.

⁵⁶ McIlwraith and Madden, above n 22, 186.

⁵⁷ Allison Langford, 'Doctor's Liabilities to Third Parties' (2001) 75(11) *Law Institute Journal* 74.

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In the US, the complexity of the decision to extend the duty of care to a third party first arose in the seminal case of *Tarasoff v Regents of the University of California*,⁵⁸ (*Tarasoff*) in which the Supreme Court:

sought to balance the ... foreseeability of harm to a third party, the degree of certainty that she would suffer injury, the closeness of the connection between the defendant's conduct and the third party's injury; the moral blameworthiness attached to the defendant's conduct and the potential consequences to the community in making its decision.⁵⁹

This case opened the doors for the duty of care to be applied to third parties in other circumstances, although US courts were very careful to only 'develop novel categories of negligence incrementally and by analogy with established categories'.⁶⁰

Some twenty years after *Tarasoff*, the US first considered its application to genetically transmissible conditions in *Pate v Threlkel*,⁶¹ (*Pate*) and *Safer v Estate of Pack*.⁶² In both cases, the Courts established that the medical practitioners involved owed a duty of care to their patients' children to warn of the risk of a genetic condition. However, in *Pate*, the Florida Supreme Court found on appeal that the scope of the duty was too onerous, as 'to require the physician to seek out and warn various members of the patient's family would often be difficult or impracticable and would place too heavy a burden on the physician'.⁶³ It was held that the duty would be sufficiently discharged if the patients themselves were warned of the risk to their relatives, suggesting that practical difficulties have some bearing on whether indeed a duty of care to genetic relatives ought to be imposed at all.

In the UK, the case of *Caparo Industries plc v Dickman*⁶⁴ (*Caparo*), still cited today, established a three-stage test to determine the scope of duty, based on foreseeability, proximity and fairness, justice and reasonableness.⁶⁵ The proximity test has caused most difficulty in cases brought by third parties (it was not adopted by the High Court of Australia in *Sullivan v Moody*,⁶⁶ discussed below) since in many cases the plaintiff had no previous relationship with the defendant and in other cases would not have been within a readily identifiable class. The latter issue is not relevant to the question of genetic information, for which the plaintiffs belong to an 'ascertainable and finite' group at risk.⁶⁷

In Australia, in the case of *BT v Oei*,⁶⁸ the Court held that Oei; a medical practitioner, owed a duty of care to BT, the sexual partner of his patient, AT; and that BT contracted HIV due to the defendant's failure to diagnose and adequately counsel AT in relation to his HIV status.⁶⁹

⁵⁸ 551 P 2d 334 (1976).

⁵⁹ Judith Regan, Ann Alderson and William Regan, 'Health Care Providers' Duty to Warn' (2002) 95(12) *Southern Medical Journal* 1396, 1396.

⁶⁰ Including cases involving contagious and/or communicable diseases or the administration of prescription medication to car drivers who subsequently have accidents. See per Brennan J in *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, [481].

⁶¹ 640 So 2d 183 (1994).

⁶² 677 A 2d 1188 (1996).

⁶³ *Pate v Threlkel*, 661 So 2d 278 (1995) [282].

⁶⁴ [1990] 2 AC 605 (HL).

⁶⁵ Medical Board of Australia, above n 54; Rachael Mulheron, *Medical Negligence: Non-Patient and Third Party Claims* (Ashgate, 2013).

⁶⁶ (2001) 207 CLR 562.

⁶⁷ Keeling, above n 16, 56.

⁶⁸ [1999] NSWSC 1082.

⁶⁹ *Ibid* [14].

The focus of the Court’s decision in this case appears to have been on the foreseeability of the harm caused, while ‘specifically steering clear of any decision to the effect that there is a duty to warn a “non-patient” of the potential risk posed by a patient’,⁷⁰ a finding subsequently followed in *PD v Dr Nicholas Harvey* (and upheld on appeal).⁷¹ Whilst the Court held that the doctors were negligent firstly in their treatment of PD and secondly in their public duty to minimise the risk of the spread of the disease, it held there was no positive duty to inform PD of her sexual partner’s HIV status, and in fact nor could Dr Harvey do so, because the law at the time expressly prohibited such disclosure.⁷²

In *Sullivan v Moody*, the High Court considered whether the defendants owed a duty of care to the plaintiff; a suspect in a criminal investigation of sexual abuse of his daughter, for failure to exercise reasonable care in the conduct of the investigation, thereby causing him psychological injury. The High Court did not follow the proximity part of the three-stage test outlined in *Caparo* and was at pains to point out that the scope of the duty should not be extended where it ‘would give rise to inconsistent obligations’ (in this case, firstly, the statutory obligations of a local authority and secondly, the apparent competing interests of the victim and the plaintiff).⁷³ It was held that finding ‘a duty of care would so cut across other legal principles as to impair their proper application’.⁷⁴

In the more recent group of Australian cases involving those who suffer harm at the hands of a psychiatric patient,⁷⁵ courts held that a public authority with statutory powers under the *Mental Health Act 1990* (NSW) did not owe a duty of care to those into whose care the psychiatric patient was released. Relying heavily on the principles in *Sullivan v Moody*, these cases again highlighted the conflict between the duty of care to the patient and a duty owed to known third parties. It is worth noting that the courts were again not concerned by the fact that there was no previous relationship between the medical practitioners and the plaintiffs in these cases, suggesting that ‘the lack of a previous or current relationship between the health professional and the [third party] is not a bar to the finding of a duty to warn’.⁷⁶

In 2015, the UK High Court heard its first case involving a genetic relative alleging a failure to warn of a genetic condition.⁷⁷ The plaintiff’s father in that case, after killing the plaintiff’s mother, was detained in a mental health hospital where he was subsequently diagnosed with Huntington’s disease. At the time of his diagnosis, the defendant sought permission to disclose it to the plaintiff (she was pregnant at the time) but the patient refused permission. The plaintiff only became aware of the fact some time later, after she had given birth to her daughter. She was diagnosed with the condition but, given her daughter’s age, was unable to have her tested so at the time of the hearing, it was not known whether the plaintiff’s daughter also had the condition. The plaintiff alleged that she should have been advised of the diagnosis at the time of her pregnancy and that, given the result, she would have terminated her pregnancy.

⁷⁰ Lynch and Ranson, above n 46, 245.

⁷¹ [2003] NSWSC 487; *Harvey v PD* (2004) 59 NSWLR 639 (Court of Appeal).

⁷² Bernadette Richards, ‘*PD v Dr Nicholas Harvey*: A Threat to Confidentiality or Straightforward Breach of Duty’ (2003) 7 *University of Western Sydney Law Review* 162.

⁷³ *Sullivan v Moody* (2001) 207 CLR 562, [60] (Gleeson CJ, Gaudron, McHugh, Hayne and Callinan JJ).

⁷⁴ *Ibid* [53].

⁷⁵ *Hunter and New England Area Health Service v McKenna; Hunter and New England Area Health Service v Simon* (2014) 253 CLR 270; *Hunter Area Health Service v Presland* (2005) NSWLR 22.

⁷⁶ Keeling, above n 16, 240.

⁷⁷ *ABC v St George’s Healthcare NHS Trust* [2015] EWHC 1394 (QB).

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Applying the *Caparo* test, the Court held that it would not be fair, just and reasonable to find that the defendant owed a duty of care to the plaintiff stating that ‘it would be a radical departure to impose liability in circumstances such as these’⁷⁸ and that doing so might set a precedent for clinicians to breach confidentiality without justification (the author respectfully disagrees).⁷⁹ The Court also stated that it would ordinarily be troubled by a lack of special relationship between the plaintiff and defendant, although that did not apply to the facts of this case.⁸⁰ The case is currently on appeal but has already been applied in *Smith v University of Leicester NHS Trust*,⁸¹ a case involving the second cousins of a patient with a long-standing, but undiagnosed, genetic disease.

V HAVE THE AMENDMENTS TO THE PRIVACY ACT 1988 CREATED A DUTY TO WARN?

On consideration of the legal test in duty to warn cases, enunciated in *Rogers v Whitaker*, it would appear that any reasonable person ought to be offered the opportunity to consider his or her genetic health issues and treatment options. In the author’s view, it would not be sufficient to rely on patients themselves to disseminate genetic information as a means of discharging a medical practitioner’s duty, since doctors could not be confident that the information was passed on at all, or that it was passed on with the appropriate advice.

The statutory right to inform, and the guidelines which apply to it, have been carefully constructed so as to provide medical practitioners with the tools to exercise clinical judgement before making such disclosure, and a clear process by which that disclosure ought to be carried out. In the event that this is not followed, or indeed reasonable clinical judgment is not applied, the genetic relative ought to be offered the opportunity to seek redress through the common law if they suffer harm as a result.

However, the raft of case law outlined above demonstrates that domestic courts are still not readily amenable to extending a positive duty of care to third parties in general. By inference, this would suggest that in this scenario the law is likely to place higher worth on the patient’s rights than those of the relative, who may in fact suffer an equally serious harm. In cases where the patient and genetic relative share a common interest, i.e., both need to be warned about the same genetic condition and treatment options so as to make informed decisions about their health, there would be little conflict between the rights of each and therefore it follows that a duty to the genetic relative could be imposed.⁸² Where the plaintiff fails to establish a duty of care, as evidenced in the cases above, this tends to be on the basis that the interests of the patient and the plaintiff are very different and the Courts have valued the patient’s (or even society’s) interests first. However, ‘this does not mean that no duty is owed It simply means that the scope of the duty of care does not extend to disclosure’.⁸³

At the time of writing, there is no case law in Australia on the specific issue of disclosure of genetic information to a relative. Given the advances in, and accessibility to genetic testing, the author is surprised there has been no judicial consideration of this point, although one argument might be that this is evidence that the statutory right to inform genetic relatives *is* being exercised by medical practitioners, such that genetic relatives are making informed, and timely,

⁷⁸ Ibid [27].

⁷⁹ *Sullivan v Moody* (2001) 207 CLR 562 [13].

⁸⁰ Ibid [28].

⁸¹ [2016] EWHC 817 (QB).

⁸² Gilbar and Foster, above n 15.

⁸³ Blake, above n 23, 591.

decisions about testing and treatment options. Alternatively, it may be that despite the issue of whether a duty even exists, the other legal hurdles, such as breach, causation and damage cannot be met. It may be for this reason that some believe that the imposition of a duty to genetic relatives is unlikely to be successful here and it was unsupported by the NHMRC in the *'Essentially Yours'* report.⁸⁴

Some commentators are confident, and the author agrees, that '[w]hen the usual principles of negligence, and the legislative reforms of tort law⁸⁵ are applied to genetic harm, a duty to warn unknowing blood relatives of their risk of serious genetic disease should be found in the common law'.⁸⁶ It seems that domestic courts have abandoned the need for a relationship of proximity with the defendant to be established in order for a duty of care to be imposed, unlike the current UK position. That being so, and given that the majority of patients will disclose information to their genetic relatives, the pool of possible plaintiffs will be relatively small but more importantly readily identifiable. This practical hurdle, which has impeded success in other international cases, appears capable of being overcome in our domestic courts. Overall, it is the author's view that considering policy and legal principles, domestic courts could readily determine a duty of care to genetic relatives.

A *Practical Issues of a Duty to Warn*

The literature raises a number of practical issues relating to the imposition of a duty, including identifying the likely plaintiffs (which should not be difficult, given the legislative definition of a genetic relative), tracking them down once identified, the means by which the information is provided to them, whether there should be an ongoing obligation to provide updates on their risk of disease,⁸⁷ the inter-familial consequences of disclosure, the content of the duty for effective discharge of liability (which, in the author's view, should be measured in accordance with professional standards of practice in line with that afforded to patients) and the further cost and workload burden on healthcare providers (which could arguably be addressed by notification to a statutory body for their action).⁸⁸ In some cases discussed above, these practical issues have informed the Courts' views as to whether the scope of the duty of care can be extended to third parties. In the author's view, they should not impede the imposition of a duty to warn relatives of genetic information because they have already been adequately foreshadowed by the relevant statutory guidelines for such disclosure.

B *Foreseeability of Harm*

Finally, in considering foreseeability of harm in the context of disclosure of genetic information, the author briefly raises the question: what is the harm? The harm is not the eventual development of a predisposed genetic condition but the harm that results from 'not being aware of the risk and therefore being unable to take steps to prevent' the condition.⁸⁹

This leads to the next question which is how the risk of harm is categorised, and therefore also quantified, for the purposes of assessing the causative loss to the genetic relative. For example, if a genetic relative commenced a tortious action for the failure to advise of a genetic condition

⁸⁴ Skene, above n 14; ALRC and AHEC, above n 20, 556.

⁸⁵ And also, privacy laws.

⁸⁶ Keeling, above n 16, 252.

⁸⁷ Gary McAbee, Jack Sherman and Barbara Davidoff-Feldman, 'Physician's Duty to Warn Third Parties About the Risk of Genetic Diseases' (1998) 102(1) *Pediatrics* 140.

⁸⁸ Keeling, above n 16.

⁸⁹ *Ibid* 248.

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which may or may not eventuate, the risk of harm might be insignificant if the condition does not eventuate. Does the genetic relative have to wait for a diagnosis of the genetic condition before an action can commence? Should the quantification of risk mirror the statutory requirements for disclosure, in other words, the risk has to be a 'serious threat to health' (which, again, comes back to clinical judgement); and does this suggest that statistical predictability, rather than the balance of probability test, applies?

Finally, if the harm does eventuate, what is the plaintiff's damage? If the genetic condition cannot be cured but can be ameliorated with appropriate treatment, does the plaintiff lose the opportunity to improve their health? Does the leading authority of *Tabet v Gett*⁹⁰ mean that these plaintiffs might not be able to commence a lost opportunity claim in any event, even if there is a positive legal duty owed? It is beyond the scope of this paper to consider these issues in any greater detail but they go some way to illustrate the complexity of the considerations to be applied in a common law duty to warn.

VI CONCLUSION

The recognition that a health professional owes a duty of care to the relatives of a patient who has been diagnosed with a familial genetic condition finds support in medical ethics, and can be accommodated within the existing framework of the law. In particular it is apparent that the ethos of the law of negligence is not opposed to the recognition of such a duty of care.⁹¹

However, as above, we have seen that international and domestic courts have found it difficult to attribute tortious liability to healthcare providers for a failure to directly warn the third-party plaintiff.

Of most significance appears to be the balancing exercise of the duties already owed to a patient against a duty to an individual with whom the doctor does not necessarily have a therapeutic relationship. Yet statutory provision permits disclosure in what is arguably a discrete number of circumstances where appropriate clinical judgement dictates. This would seem to pave the way to a legal *Rogers v Whitaker* type duty to provide genetic relatives with the same level of information that a patient might require in order to make their own informed choices about testing and treatment.

VII ADDENDUM

Since the writing of this article, the appeal decision in the matter of *ABC v St George's Healthcare NSH Foundation Trust*⁹² has been handed down. The original decision of the High Court to strike out the plaintiff's claim was overturned thereby allowing the plaintiff to continue her action to trial. As such, it remains to be seen whether the UK courts will extend the duty of care to this arguably 'novel' situation.

⁹⁰ (2010) 240 CLR 537

⁹¹ Blake, above n 23, 592.

⁹² [2017] EWCA Civ 336.