A Duty To Warn Relatives in Clinical Genetics: Arguably ‘Fair just and reasonable’ in English Law?

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ABSTRACT

The use of ‘next-generation’ genetic sequencing technology that allows the sequencing of large parts, or even the entirety, of a patient’s genome is advancing rapidly in the UK and around the world. This is set to greatly increase the level of health information that will be of relevance to relatives and the latest medical guidance advises that there is a professional duty to consider warning a patient’s relatives of a serious genetic risk in limited circumstances. However, the High Court in *ABC v St George’s Healthcare NHS Trust* [2015] EWHC 1394 (QB), recently found that a legal duty on the part of doctors to warn a patient’s daughter of a genetic risk of Huntington’s Disease without the patient’s consent, was not even ‘reasonably arguable’ and would not be ‘fair, just and reasonable’. This article considers the courts’ approach to a duty of care towards ‘third parties’ in this context and concludes that some form of a duty of care to genetic relatives in clinical genetics is at very least arguably ‘fair, just and reasonable’.

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I. INTRODUCTION

The question of the existence of a legal duty towards relatives of the patient, or proband,[6] has been pertinent to clinical genetics for many years. The 'shared nature'[7] of genetic information means that a clinician is often able to identify results that are relevant for close relatives and family members. The level of results that are relevant to relatives as well as the patient is set to increase with the clinical application of next generation sequencing (NGS) technologies that allow the sequencing of large parts, or even the entirety of the human genome.[8] These techniques are able to generate a massive amount of potentially relevant health data for an individual, some of which are directly relevant to the immediate presentation or diagnosis, but many of which are revealed as secondary or 'incidental' findings.[9] Although at the moment much of this information is uncertain in its' meaning for health, understanding of genetic variants is increasing all the time. However, NGS technologies are likely to greatly increase the amount of information that is potentially valuable to genetic relatives of a patient[10] and this is set to be tested now that the UK Government has begun a project to sequence 100,000 genomes as part of NHS care in England by 2017.[11] Against this background, clinicians may be uncertain of where their obligations lie and to whom they owe a legal duty of care, equally, relatives may be unsure if their interests and health are being considered.[12] The question of whether a duty of care can be owed to a relative in clinical genetics has now been given its first judicial consideration in English law and it has not been favourable to the finding of a duty.

In *ABC v St George's Healthcare NHS Trust & Others,* reported May 2015, Nicol J struck out a claim in negligence against the Defendant health Trusts by the daughter of a man suffering from Huntington's Disease, who claimed a duty of care was owed to warn her of the genetic risk that she would inherit the condition, even against the wishes of her father.[13] The Claimant was not party to a doctor-patient relationship in this regard and this potential duty of care to a 'third party' was recognised by Nicol J as 'entirely novel'.[14] Following submissions from both sides where some elements of the case had been agreed for the purposes of that application but before a full hearing,

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[6] The proband is the person who is the starting point for genetic study of a family, usually as the first family member in whom a genetic condition is identified.

[7] Michael Parker and Anneke M Lucassen, 'Genetic Information: A Joint Account?' (2004) 329 BMJ 165.

[8] Examples include whole exome sequencing (WES) and whole genome sequencing (WGS) which promise faster diagnosis of disease 'particularly where simultaneous investigation of multiple genes replaces sequential investigation, resulting in lower sequencing costs per gene'; Realising Genomics in Clinical Practice. Hall A, Finnegan T, Alberg C. PHG Foundation (2014). ISBN 978-1-907198-15-1. p1.

[9] Lisa Eckstein, Jeremy R Garrett and Benjamin E Berkman, 'A Framework for Analyzing the Ethics of Disclosing Genetic Research Findings' (2014) 42 The Journal of Law, Medicine & Ethics 190; Corrette Ploem, 'Handling Unsolicited Findings in Clinical Care: A Legal Perspective' (2014) 21 European Journal of Health Law 489.

[10] Anneke Lucassen and Richard S Houlston, 'The Challenges of Genome Analysis in the Health Care Setting' (2014) 5 Genes 576.

[11] http://www.genomicsengland.co.uk/the-100000-genomes-project/ .

[12] Sandi Dheensa and others, 'Health-Care Professionals' Responsibility to Patients' Relatives in Genetic Medicine: A Systematic Review and Synthesis of Empirical Research' [2015] Genetics in Medicine <http://www.nature.com/gim/journal/vaop/ncurrent/full/gim201572a.html> accessed 29 June 2015.

[13] *ABC v St George's Healthcare NHS Trust & Ors* [2015] EWHC 1394 (QB) (EWHC (QB)).

[14] ibid 23.

Nicol J concluded that there was no reasonable cause of action in negligence and 'no reasonably arguable duty of care'[15] and the claim was struck out. This was largely on the basis that such a duty could not be fair, just and reasonable, a requirement we explore further below. While there is strength in the case against a duty of care towards relatives in clinical genetics, in particular, the importance of maintaining trust in patient confidentiality and some practical implications of a duty to warn,, we suggest in this article that such a duty is—at very least— reasonably arguable in certain circumstances, on the basis of case law, developing medical practice and ethical proposals for clinical genetics in the era of NGS. This article critiques the objections made in *ABC* and sets out further arguments in favour of a duty of care towards relatives in English law. First, we consider the approach that has been taken by the courts in determining whether a duty of care applies in cases of 'third party' negligence.

II. DETERMINING A DUTY OF CARE

To proceed with an action in negligence, it must first be established that there was a legal duty of care owed by the person who is responsible for the harm. Over the years, the courts have used a 'battery of tests' to determine whether a duty of care exists in a new area[16] and the three-pronged *Caparo* test has been approved as the favoured test for a novel duty of care.[17] This test requires that three things are established before a duty of care is imposed: foreseeability of the damage, proximity and that it is 'just, fair and reasonable' to impose a duty.[18]

Forseeability

The need for a foreseeable harm—the first limb of the *Caparo* test—is an essential pre-requisite for a duty of care; there are perhaps a number of potential harms that may result from negligence in clinical NGS towards relatives of the proband. An example might be a failure to identify and communicate a known pathogenic genetic variant which develops into disease, where action could have been taken to avoid or mitigate the illness at an early stage. Another harm that may be foreseeable is the cost of raising a disabled child, as a result of a failure to disclose a genetic risk to a relative, or an action for 'wrongful birth'.[19] This paper will not focus on the potential harms that could be claimed by relatives in clinical genetics, such as an infringement of autonomy[20] as they may be more problematic in terms of foreseeability.

Proximity

A potential hurdle in the case of relatives and third parties is the second requirement of the *Caparo* test: the need for 'proximity'. A duty of care will exist if there is a relationship of proximity between

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[15] ibid 31.

[16] Brooke LJ in *McLouglin v Jones* [2002] 2WLR 1279 at 1288; *AB v Leeds Teaching Hospital NHS Trust* [2004] EWHC 644 (QB) [207].

[17] See, for example, Lord Bingham in *Hertfordshire Police v Van Colle [2008] UKHL 50* (UKHL (2008)) [42].

[18] *Caparo Industries plc v Dickman* [1990] 2 AC 605.

[19] The possibility left open by the House of Lords in Macfarlane and Another v Tayside Health Board (Scotland) [1999] UKHL 50; [2000] 2 AC 59; [1999] 4 All ER 961 (25th November, 1999) (UKHL (1999)). This form of harm was upheld in *Rand v East Dorset Health Authority* [2000] Lloyd's Med Rep 181; *Hardman v Amin* [2000] Lloyd's Med Rep 498; *Lee v Taunton and Somerset NHS Trust* (October 2000, unreported).

[20] Victoria Chico, 'Known Unknowns and Unknown Unknowns: The Potential and the Limits of Autonomy in Disclosure of Genetic Risk' (2012) 28 Professional Negligence 162.

the person who owes the duty (such as a doctor) and the subject of the duty (the patient). The concept of proximity involves the notion of nearness or closeness and includes physical proximity (in the sense of space and time), circumstantial proximity, causal proximity and assumption of responsibility.[21] The issue of proximity in relation to third parties stems from the principle that the law does not give a remedy to all people who have been affected by a negligent act. For example, as Lord Rodger of Earlsferry put it, when someone is maimed because of a negligent act during surgery:

'To varying degrees, these others can plausibly claim to have suffered real harm as a result of the Defendant's act. For the most part, however, the policy of the law is to concentrate on compensating the victim for the effects of his injuries while doing little or nothing for the others. In technical language, the Defendants owe a duty of care to the victim but not to the third parties, who therefore suffer no legal wrong.'[22]

The purpose of requiring sufficient proximity between the doctor and the Claimant is generally to limit the extent of the liability of doctors so that they do not owe the duty of care to 'the world at large'. It is in this regard that the position of close genetic relatives (at least for first degree relatives) may be somewhat different from the positions of third parties in general since they could constitute a much smaller pool of potential Claimants.

Fair, just and reasonable

As well as establishing a reasonable degree of proximity, the court must consider 'it fair, just and reasonable that the law should impose a duty of a given scope upon the one party for the benefit of the other.'[23] If the courts were to establish a new duty of care, they would have to justify this on policy grounds.[24] It is this requirement that provides the greatest room for argument over the potential duty of care towards genetic relatives, with many points made in either direction. As Claire McIvor described it, the law in this area is 'unstructured, unprincipled and incoherent'[25] and, as Rachael Mulheron suggests, moving forward into novel areas of legal liability involves understanding a 'matrix of pointers'[26] that may help to predict the Courts' approach to the question of how widely a duty of care is owed in the case of genetic testing.

A duty of care to 'third parties'

In the past, the Courts' analysis has not always fitted neatly in the *Caparo* formulation. The precise status of other approaches is uncertain. In the area of duties owed to a 'third party'(as is the case with relatives in genetics), the House of Lords in *Mitchell v Glasgow City Council* was in agreement that foreseeability alone would be insufficient to impose a duty of care towards a third party and that something more, such as an assumption of responsibility, was necessary.[27] The Court of Appeal's approach in a medical negligence 'third party' claim suggests such extra factors will, in fact, be strong

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[21] *Sutherland Shire Council v Heyman* (1985) 60 A.L.R. 1.

[22] *JD v. East Berkshire Community Health NHS Trust and others* [2005] UKHL 23, per Lord Rodger of Earlsferry at [101].

[23] *Caparo Industries plc v Dickman* [1990] 2 AC 605, at 618.

[24] See for example, *JD v. East Berkshire Community Health NHS Trust and others* [2005] UKHL 23.

[25] C McIvor, *Third Party Liability in Tort.* (Hart Publishing 2006) <http://www.hartpub.co.uk/books/details.asp?isbn=9781841135526> accessed 20 October 2014.

[26] Rachael Mulheron, *Medical Negligence: Non-Patient and Third Party Claims: Non-Patient and Third Party Claims* (Ashgate Publishing, Ltd 2010) 3.

[27] *Mitchell & Anor v Glasgow City Council (Scotland)* [2009] UKHL 11 (UKHL (2009)).

indications that the case falls within the *Caparo* requirements.[28] The general tenor of these cases is that some compelling factor, such as a form of special relationship will be a strong indication that a duty of care is owed in third party cases. Whether this is considered as part of a *Caparo* type assessment or as a separate issue is perhaps mainly a matter of terminology. The *Caparo* formula was indeed the test used in the only case to date on the question of a duty of care to relatives in clinical genetics.

III. A CASE IN ENGLISH LAW FOR A DUTY OF CARE TO RELATIVES?

A. ABC v St George's Healthcare NHS Trust

In the case of *ABC v St George's Healthcare NHS Trust & Others*, reported May 2015, English law now has some authority on the position of genetic relatives of the proband in clinical medicine, and it has not been favourable to the finding of a duty towards them. In this case, the Claimant's father (F) shot and killed the Claimant's mother in 2007. He was convicted of manslaughter on the grounds of diminished responsibility and sentenced to a Hospital Order under the Mental Health Act 1983. In 2009 it was suspected that he was suffering from Huntington's Disease and a referral was made to St George's Hospital. It was confirmed that the Claimant's father was indeed suffering from the disease. Huntington's Disease is a serious hereditary disorder of the central nervous system that gets progressively worse over time and has no cure. The genetic origin of the disease means that if a parent has it, there is a 50% chance that their child will inherit it as well.

Due to the severe consequences of the disease and, therefore, the importance of informing the patient's offspring, health professionals made several attempts to seek F's consent to disclose the diagnosis to his daughter, who was pregnant at the time. However, F refused consent to inform his daughter. Although Huntington's Disease can lead to a change in personality and even ability to evaluate issues, there was no allegation that he lacked capacity to make this decision;[29] it was recorded that he was concerned his daughters 'might get upset, kill themselves or have an abortion'.[30]

The Claim

The Claimant pleaded that had she been informed of her father's condition, she would have undergone testing and, if positive, would have terminated her pregnancy. She alleged that the failure of health professionals to inform her of her father's condition was negligent and that she had suffered psychiatric harm as a result of this failure, and, if her daughter does have the disease (this won't be known until adulthood), she will incur additional expense which would otherwise have been avoided. The Defendant NHS Trusts applied for the claim to be struck out because it disclosed 'no reasonable cause of action',[31] and that the Claimant would not be able to establish a relevant duty of care even if all the alleged facts were proved.

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[28] *London Borough of Islington v University College London Hospital NHS Trust* [2005] EWCA Civ 596 (EWCA (Civ)).

[29] In accordance with the Mental Capacity Act 2005, F was presumed to have capacity to take decisions about his care and his right to confidentiality unless the contrary were established.

[30] *ABC v St George's Healthcare NHS Trust & Ors* [2015] EWHC 1394 (QB) (n 8) [5].

[31] ibid 3.

This application was considered by Mr Justice Nicol, who, after considering all the facts and arguments, agreed with the Defendants that there was no comparable situation in which a duty of care had been recognised to exist and that the duty of care the Claimant was trying to construct was 'entirely novel'.[32] No useful comparison could be made with other genetic negligence cases because they were entirely conventional cases of doctor—patient relationships between Defendant and Claimant;[33] it was the third party position of the Claimant that made for a novel claim.[34] Nicol J also agreed with the Defendants that this was an allegation of omission rather than negligence in positive action on the part of the clinicians.[35] In his consideration of this point, Nicol J concluded that there was no 'special relationship' or assumption of responsibility that would ordinarily be required to establish a duty of care for an omission. However, the judge made clear that, regardless of this conclusion,[36] a duty of care in these circumstances would not be 'fair, just and reasonable' and that a 'formidable argument' had been made against a duty by the Defendants.[37]

In conclusion, the common law application in *ABC* was struck out because the Defendants' submissions 'cumulatively' provided a 'formidable argument as to why it would not be fair, just or reasonable' to find a duty of care to warn the daughter of genetic risk against her father's wishes.[38,39] As the only case to date on this issue in English law and because of the possible importance of this case for other jurisdictions, we carefully consider each of those arguments against a duty of care in turn in our analysis below. In response we make the counter-argument that a limited duty to relatives would be fair, just and reasonable and, moreover, consistent with the incremental development of this area of law.

B. *A limited duty to warn genetic relatives*

As Rachael Mulheron has written, healthcare professionals could owe different forms of legal duties to relatives in medical genetics. This could be either a duty to warn the patient of the genetic nature of the risk (a 'weaker' form of the duty) or a duty to warn non-patient third parties directly (a 'robust' form of the duty).[40] The weak form of a duty simply to inform the patient would preserve patient confidentiality because they are in the position to make the choice whether to disclose their diagnosis. The problem with this form of a duty is that whether a relative is protected from harm depends on the patient's willingness; the patient may not want to disclose information for any number of reasons, from embarrassment to malice. In this situation, the relatives are not in the position to make a fully informed

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[32] ibid 23.
[33] ibid 23–26.
[34] ibid.
[35] ibid 22.
[36] ibid 29. The Claimant argued that consideration of the relationship between the parties should not determine this decision because they often formed part of the analysis of proximity, which had been conceded by the Defendants for the purposes of this application.
[37] ibid 30.
[38] ibid.
[39] Nicol J was also concerned that there had been no 'limiting principle' put forward by the Claimant against the undesirably wide implications suggested by the Defendants of such a duty.
[40] Mulheron (n 21) 127. It is also possible that a duty could be owed to warn another party such, as a general practitioner, who in turn would inform the relative.

decision about their health or reproduction. In *ABC*, the daughter claimed that failure to tell her of her father's condition was actionable negligence. It would appear that the healthcare professionals had in fact complied with a 'weak' form of the duty: the doctors only warned the father of the implications of his diagnosis for his daughter and, when he refused to warn his daughter himself or to consent for the medical professionals to inform her directly, did not take action. The daughter argued for a 'robust' form of the duty to warn her directly without consent.[41]

In this paper we argue for a duty to consider warning at risk-family members directly, without consent. We do not want to suggest that a duty of care to at-risk family members would automatically involve a direct disclosure policy. However, warning family members at-risk could be required if the patient refuses to do so himself or when he does not provide consent to disclosure by his doctors.[42] This is also in line with guidance from the General Medical Council (GMC) on confidentiality which suggests that disclosure without consent should only occur in exceptional circumstances;[43] if consent is refused a clinician should balance their duty to care to the patient with a 'duty to help protect the other person from serious harm.'[44]

We would like to stress that a duty as defined above is limited in a number of ways. First: it is not a duty to disclose a genetic diagnosis to relatives without consent in *all* circumstances; it only applies if a close blood relative is at imminent risk of serious harm and the harm is avoidable (or may be mitigated) through disclosure. The latter implies a process of carefully balancing the rights and interests of the at-risk family member against the patient's right to privacy and confidentiality. The duty would be limited when it is clear that a relative would not want to know their risk, even if serious and avoidable;[45] Altogether, very often the balance would fall in favour of non-disclosure. Moreover, the duty would only be owed to a small number of identifiable people in quite exceptional circumstances. Last, a duty to warn relatives will not apply if the healthcare professional does not know who the at-risk relatives are.

C. *Professional obligations and legal duties*

Healthcare professionals are subject to a large number of professional obligations. They are registered professionals who must meet standards set by their governing authorities. For doctors, who are licensed by the General Medical Council, they must meet the standards set by the GMC in their practice. As noted above, the GMC's confidentiality guidance on genetic and other shared information

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[41] The Claimant also suggested in the particulars of claim that the Defendants had failed to meet the weak form of the duty but this was rejected by Nicol J because there had been no suggestion that proper advice to the patient would have led him to consent to disclosure; *ABC v St George's* [20].

[42] As we discuss below, it can be argued that the duty of medical confidentiality towards the patient may be discharged if the relatives have a serious and imminent risk that their health is being threatened.

[43] General Medical Council, 'Confidentiality' (2009) para 37 <http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp> accessed 2 June 2015.

[44] ibid 69.

[45] It is important to note that it could be also in the relatives' interest not to be warned by a health care professional; some individuals may prefer not to know their health risks, for instance because they fear psychological burden or difficulties with access to work or insurance. Determining this may not be easy and current GMC guidance advises warning directly only where risks are serious and actionable.

acknowledges that genetic information may be important to the patient's relatives and that patients should be informed of this. The guidance makes clear that disclosure without consent may be justified in the public interest in cases where there is a serious risk of serious harm to a genetic relative.[46] Not all professional obligations also attract liability within the law of negligence because there are further legal requirements that must be met to establish a duty of care. However, there are instances where it has been felt necessary to impose a legal duty of care as well as the professional obligation as a means of reinforcing that obligation and emphasising its importance.

The Supreme Court recently considered the relationship between professional obligations (as set out in GMC guidance) and a legal duty of care in the law of negligence. Imposing a duty of care to ensure informed consent to medical treatment where the '[g]uidance issued by the General Medical Council has long required a broadly similar approach,'[47] the Supreme Court concluded that '[i]t is nevertheless necessary to impose legal obligations, so that even those doctors who have less skill or inclination for communication, or who are more hurried, are obliged to pause and engage in the discussion that the law requires.'[48]

Supplementing a clinician's existing professional duty to consider warning genetic relatives of serious risk with a legal duty would equally ensure a 'pause' and the balancing of the patient's and relative's interests. Many of the same interests are at stake as were forefront in the mind for the Supreme Court in *Montgomery*. Autonomy and freedom to make informed choices about health and reproduction were recognised as important values in *Montgomery*[49] and they have been increasingly emphasised in recent years.[50] Parallel to this, the autonomy of the patient's relatives and their ability to make informed decisions about treatment and reproduction would be enhanced by being warned of their risk of developing a serious disorder in the near future or passing this on to offspring.

In *ABC*, the GMC guidance that, in certain circumstances, doctors would be under a positive (professional) obligation to inform relatives was advanced by the Claimant as an important factor in favour of a duty of care.[51] However, the Judge found favour with the Defendants' argument that, despite this professional obligation, it would not be fair, just and reasonable to impose a duty of care on the Defendants to the Claimant.[52] As remarked earlier, we disagree with this conclusion and want to explain why a limited duty of care would be fair, just and reasonable.

D. *Proximity and actionable harm*

We acknowledge that there are other requirements that a successful claim would need to meet. One of

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[46] General Medical Council (n 38) 36–39, 67–69.
[47] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 (UKSC (2015)) [93].
[48] ibid 93.
[49] Powerfully expressed in *Montgomery* by Lady Hale at [107-108].
[50] e.g. Chester v Afshar [2004] UKHL 41 (UKHL (2004)).
[51] The Claimant relied on the GMC guidance and a related report from the Joint Committee of the Royal College of Physicians, the Royal College of Pathologists and the British Society for Human Genetics; *ABC v St George's Healthcare NHS Trust & Ors* [2015] EWHC 1394 (QB) (n 8) [7–9, 16].
[52] ibid 13, 30.

these is establishing proximity. It is likely that establishing sufficient proximity between the parties will be challenging for relative-claimants who are not part of a standard doctor—patient relationship. However, there are strong arguments that healthcare professionals providing care to patients that seek clinical genetic testing not merely have responsibilities towards their patients, but also, although to a lesser extent, towards their patients' relatives. We point also to the fact that in clinical genetics, there has long been cognisance that 'the fundamental unit of responsibility is the 'family' and includes not only the 'sick' individual who presents for diagnosis and treatment but also the family members who are identified as being at-risk.'[53] As noted above, the same factors assessed in the courts' proximity analysis may be considered as part of the question of whether a duty of care is fair, just and reasonable and we discuss some of these further below.[54]

Another requirement for a successful claim is that the claimant can establish harm of a type that is legally recoverable, such as physical injury or psychiatric harm, and prove that the harm was caused, on the balance of probabilities, by the negligence of the claimant. Although we do not focus on this issue in this article, in general the duty to disclose information to relatives will be to protect them from physical harm. However, we note that establishing this may prove problematic in the circumstances of *ABC*.[55]

E. *Is a duty to warn genetic relatives 'fair, just and Reasonable'?*

As a novel duty in negligence, the question of whether a duty to warn genetic relatives is owed by clinicians will depend heavily on whether it is found to be fair, just and reasonable. This was the case in *ABC v St George's Healthcare NHS Trust* where the Defendants' arguments were so persuasive that a duty was not even considered to be 'arguable'.[56] Many of these centred on a potential conflict between the proposed duty of care and the well-established duty of confidence owed by doctors to their patients. Of considerable weight for the judge was the Defendants' final argument that such a duty would not be consistent with the 'incremental development' of the law of negligence. In the following analysis we suggest that a duty to warn relatives would not be such a 'giant leap' for the duty of care in the context of clinical genetics.

A private, not public, interest in breach of confidence?

An initial argument raised in *ABC* was that it is not in the public interest that a breach of confidence

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[53] Karen Temple & Greta Westwood, 'Do Once and Share: Clinical Genetics Project Report' (British Society for Genetic Medicine, 5th May 2006) <http://www.bsgm.org.uk/media/17225/doas_clinical_genetics_project_report_may_2006_1_.pdf> 1.2

[54] Although in *ABC* the question of proximity was left out of the application to strike out by agreement, the Claimant daughter was known to the Defendant clinicians and there was sufficient connection between them for her to be accidentally told that her father had Huntington's Disease.

[55] The Claimant is seeking recovery for psychiatric harm and potential additional costs of caring for her daughter if she develops Huntingdon's Disease. However, Huntington's Disease is an adult-onset condition and English Courts have generally been reluctant to award damages for the birth of a healthy child (see *Macfarlane and Another v Tayside Health Board* [1999] UKHL 50).

[56] *ABC v St George's Healthcare NHS Trust & Ors* [2015] EWHC 1394 (QB) (n 8) [31].

would be justified[57] but that it is, in fact, a 'private interest' of the Claimant. It is clear in law that the 'public interest' justification for breach of confidence can extend to the avoidance of danger to the health or safety of others, [58] and this includes those who may suffer risk of infection. However, given the non-transferable nature of genetic risk it is perhaps a valid question of whether it could be termed a 'public' interest in disclosure if it only benefits limited others. The breadth of the justification for breach of confidence at common law is not certain. As Laurie notes, the categories are certainly not closed but it may be difficult to conceptualise the prevention or diminution of harm to genetic relatives as a 'public' interest;[59] it could be argued that the prevention of harm to others and even 'the reduction of the incidence of genetic disease are legitimate public interests that can be furthered through the disclosure of genetic information.'[60] The General Medical Council's Guidance on Confidentiality interprets the public interest in disclosure as capable of extending to the avoidance of harm to genetic relatives.[61]

While it may be difficult to define this situation as a public interest justification for a breach of confidence, the protection of another's human rights— clearly private interests—must justify a breach of confidence in certain circumstances: The rights which the duty of confidence help to protect—right to a private and family life—under Article 8 of the European Convention on Human Rights, and incorporated within UK law in the Human Rights Act, allow interference by a public authority (this includes the NHS) if justified to protect the rights and freedoms of others.[62] To be compatible with human rights law, the common law must allow a breach of the duty of confidence in some circumstances to protect private interests. To conclude: the wording of 'public' interest is problematic, but the substance of the public interest justification for breach of confidence is clearly broader than a superficial reading might imply.

A duty might encourage unjustifiable breach of confidence?

A second argument based on the importance of the doctor's duty of confidence is that, although the law allows a disclosure of confidential information in certain circumstances, a duty to do so might 'consciously or unconsciously' encourage doctors to breach confidence where it would not be justified.[63] This is an argument that the existence of a legal duty might encourage over-cautious behaviour or behaviour that seeks to avoid liability, regardless of the fact that the duty itself would not require the undesirable behaviour. It is an argument against legal duties in general, not due to their content but for potential mistaken beliefs that may arise in relation to them. Problem of this argumentation is that it leaves out of account that professionals would have two conflicting legal duties

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[57] For an example of the public interest justification see *Attorney-General v Guardian Newspapers (No.2)* [1990] 2 AC 109.

[58] *W v Egdell* [1990] Ch 359.

[59] Graeme Laurie, *Genetic Privacy: A Challenge to Medico-Legal Norms* (Cambridge University Press 2002) 229.

[60] ibid 231.

[61] General Medical Council, 'Confidentiality Guidance: Genetic and Other Shared Information' para 69 <http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality_67_69_genetic_and_other_shared_information.asp> accessed 20 November 2014.

[62] Human Rights Act 1998, s 8(2).

[63] *ABC v St George's Healthcare NHS Trust & Ors* [2015] EWHC 1394 (QB) (n 8) [13].

in this situation: a duty to keep patient information confidential and a duty to warn relatives for significant health risks. It is no more likely that one duty would encourage mistaken behaviour than the other. Indeed, following this argument it could be argued that the *status quo* of only the duty of medical confidentiality without the duty to warn relatives means that professionals will consciously or unconsciously fail to disclose important health information to family members where it would in fact be legally justified and morally desirable to warn them.

Moreover, both duties and forms of legal liability might actually be required in order to properly balance rights to confidentiality and relative's rights: As Chan has highlighted in the context of HIV infection,[64] under the European Convention on Human Rights, a state's positive obligations to protect a citizen's right to life (Art. 2 of the Convention) extend to the affording of remedies to victims of medical negligence. The European Court of Human Rights, in *Colak & Tsakiridis v Germany,* confirmed that this extends to providing a 'general legal framework for resolving the conflict of interests between a physician's duty of confidence owed towards one patient and another patient's right to physical integrity'.[65] It is arguable (although this was not raised in *ABC v St George's*) that the UK's obligation to protect an individual's rights to life and private and family life (arts. 2 & 8) should extend to the provision of a remedy to affected relatives in cases where a serious, actionable genetic risk has not been disclosed; the state should ensure that the legal framework allows the resolution of the conflict between the duty of confidence and another person's rights, not deny the possibility of such a claim. Moreover, in his separate opinion in that case, Judge Maruste suggested that an individual's right to determine her private life under Article 8 was more centrally affected in these cases than her right to life. Based on these rights, it could be argued the State has an obligation to protect its citizens through a legal framework that allows balancing between confidentiality and protecting the rights of others, e.g. their right to life or even their own right to a private life.[66] Since there was found to be no such duty of care in *ABC v St George's*, it could be argued that there is a deficit in the current legal framework.

Doctors will be subject to conflicting duties?

Another similar argument advanced by the Defendants was that doctors would be subject to 'conflicting duties';[67] of confidence towards the patient and towards the non-patient if they fail to disclose information which they should have revealed. However, all this really reiterates that a balance has to be struck between confidentiality and the 'duty to help protect the other person from serious harm', in the words of the current GMC Guidance's section on 'Genetic and other shared

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[64] Tak Kwong Chan, 'Doctors Have a Duty to Breach Patient Confidentiality to Protect Others at Risk of HIV Infection' (2013) 346 BMJ f1471.

[65] *Colak & Tsakiridis v Germany-* 77144/01 [2009] ECHR 404 (ECHR (2009)) [31–32].

[66] As an indication that the right to a private life incorporates a right to this information, the Council of Europe's Convention on Human Rights and Biomedicine sets out an individual's right to know (and a right not to know) information collected about their health, including from clinical genetic tests as part of an additional protocol: Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (opened for signature 4 March 1997, entered into force 1 December 1999) CETS No. 164; Additional Protocol to the Convention on Human Rights and Biomedicine, concerning Genetic Testing for Health Purposes (2008).

[67] *ABC v St George's Healthcare NHS Trust & Ors* [2015] EWHC 1394 (QB) (n 8) [13].

information'.[68] If there is a pressing need to protect others, the duty of confidence will be legitimately outweighed and that claim will fail. This does not deny that there would be a new line of liability for the health care professional (although, as above, there may be a rights based argument that such a remedy must be available to allow this proper balancing) but the balancing of the interests and rights involved as part of practice would not change from the position already advocated in the professional guidance.

This situation can be distinguished from cases such as *JD v East Berkshire NHS Trust,* put forward by the Defendants as a case where the establishment of a potentially conflicting duty of care was inappropriate.[69] In *JD* doctors acted on a suspicion of child abuse which turned out to be ill-founded. The claimed duty of care for ensuing psychiatric harm on the part of parents wrongfully suspected of abuse was denied. The case of suspected child abuse is in many ways very different to that of relatives in clinical genetics; any duty to consider parents' interests could be objected to as putting the children at further risk, and exposing them to further harm. It is a sensible matter of policy that the duty towards the children should be prioritised here and that consideration of the parents' role and interests should be carried out as part of wider local authority and police investigation. The balancing of interests should not be carried out by doctors. By contrast, in the case of shared genetic information, consideration of disclosure does not expose the patient to the same sort of harm or risk the perpetuation of crime. It is an area where a balancing of interests is accepted as necessary to avoid serious harm to relatives as part of best practice.

A duty to disclose confidential information to a 'third party' would undermine the trust and confidence that is so important to the doctor/patient relationship?

As part of this the Defendants argued that a duty to disclose might even lead to some patients being less candid with their doctors, a point made by the European Court of Human Rights in *Z v Finland.*[70] In that case, as in the more pertinent case of *Colak & Tsakiridis v Germany* (considered above), the ECtHR emphasised the importance of respecting the confidentiality of medical data as part of respect for rights guaranteed by Art. 8 of the Convention. However, these rights are not absolute and may be outweighed by the need to protect other parties' rights. Within this framework, professional guidelines already advise on the disclosure of confidential information to prevent serious harm to others, for example in the interests of criminal justice and also in cases of a serious genetic risk. A patient cannot expect their information to remain confidential in all circumstances. A very narrow duty to disclose in exceptional circumstances would avoid widespread disclosure and maintain trust and confidence as far as possible within a framework that respects fundamental rights. This objection falls away if the duty is limited to the serious and actionable risks as the professional guidance anticipates.

A duty towards relatives would result in pressure on patients to agree to disclosure?

Another argument made by the Defendants was that if doctors owed a duty of care to relatives, it may result in doctors putting pressure on their patients to agree to disclosure to avoid the risk of being sued by family members. This is another argument that is not against a duty itself but a potential undesirable

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[68] General Medical Council (n 38) 69.

[69] *ABC v St George's Healthcare NHS Trust & Ors* [2015] EWHC 1394 (QB) (n 8) [26].

[70] *Z v Finland* - 22009/93 - Chamber Judgment [1997] ECHR 10 (ECHR (1997)) [95].

response, differing with the mistaken behaviour feared in unjustified disclosure because this anticipates pressurising that would be clearly against all professional standards. The GMC guidance already encourages doctors to advise patients of the potential benefits of sharing this genetic information for relatives but if that fails, to consider disclosure without consent—in the public interest. To avoid being sued by a relative they would only need to make such a disclosure if they felt it might be serious and justified. It is more likely that the pressure felt by doctors would result in disclosure without consent, which is legitimate in extreme circumstances, than undue pressure on patients to provide consent, which is never legitimate or acceptable.

Some relatives might not want to know or may even suffer harm from knowledge of risk?
Another more fundamental objection is that some third parties may not wish to receive information of genetic risk and the doctor would not be able to explore whether this is the case without effectively imparting the information itself. As an addendum to this it was also argued that some third parties may even suffer psychiatric harm if they are told the information in question. This is a much debated ethical problem in the genetic context, often referred to as the 'right not to know'. It is a case where privacy or the private sphere of an individual is at stake, and a difficult analysis must take place to decide whether it is justified to step into the private sphere.[71] There are a number of clinical reasons that may justify stepping into that sphere without knowledge of the individual's preferences about disclosure and, as Laurie notes, and the Supreme Court of Minnesota suggested in *Molloy v Meier*; 'it is unlikely that the medical community will adopt a standard of care that is either unduly burdensome or unbeneficial to patients'.[72] We realise that there may be some cases where the individual would not want to know of their genetic risk. However, the analysis must begin with the position of that individual's privacy and only make encroachments if a risk is serious and in some way actionable. This is a matter for sensitive assessment according to professional guidelines and clinical judgement of the circumstances. If the law does nothing more than respect existing professional guidance and best practice in making that assessment, the law is not powerfully changing standards, it is reinforcing them.

A duty of care to relatives would be a burden on doctors and health care?
A further argument made by the Defendants in *ABC* is a version of a more common objection to the establishment of duties of care in negligence; that such a duty would constitute a burden. It is similar to the influential argument against the imposition of a duty of care on a public authority acting in the public good.[73] The Defendants argued that; '[D]octors receive a very great deal of confidential information. It would be burdensome to place on them a duty to consider whether any of it needs to be disclosed to third parties. The time and resources committed to this will be a distraction from treating patients.'[74] However, such a duty would only apply to genetic information that is shared with a very small number of people and would only apply in circumstances where serious and actionable results have been found. It could even be restricted to circumstances where the relative is known to the doctor, as in *ABC*. Rather than expand a general duty to consider disclosure of *all* confidential information,

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[71] Graeme Laurie, 'Recognizing the Right Not to Know: Conceptual, Professional, and Legal Implications' (2014) 42 The Journal of Law, Medicine & Ethics 53.

[72] ibid 61. citing *Molloy v Meier* (2004) 679 NW 2d 711 (Supreme Court) 685.

[73] Such an argument was influential in the third party case of *Mitchell & Anor v Glasgow City Council (Scotland)* [2009] UKHL 11 (n 22).

[74] *ABC v St George's Healthcare NHS Trust & Ors* [2015] EWHC 1394 (QB) (n 8) [13].

this would simply apply a legal duty in line with the current professional standards that require a consideration of whether to disclose, and a discussion with the patient about this, in very exceptional circumstances. This is already part of the practice of modern genetic medicine and would be reinforced with a legal duty to balance patients' interests and those of family members.

Would a duty to genetic relatives be contrary to the incremental development of the law of negligence?

The final argument made by the Defendants was that the claimed duty of care 'would be contrary to the incremental way in which the law of negligence ought to progress.'[75] The Judge agreed and found that it would not be fair, just and reasonable to recognise such a novel duty. We disagree that a limited duty to genetic relatives in clinical genetics is more than an incremental development of clinical duties in this particular area. The Defendants argued that '[T]his is significant extension of a doctor's duty of care would be contrary to the incremental way in which the law of negligence ought to progress.'[76] In striking out the claim, Nicol J found favour with this argument, concluding;

'…this is not a case where the Claimant can show that a novel duty of care would be but an incremental development from some well established duty. It would, on the contrary, be a radical departure to impose liability in circumstances such as these. It would be an example of the "giant step" which Lord Toulson in *Michael v Chief Constable of the South Wales Police* [2015] UKSC 2 at [102] contrasted with the proper development of the common law of negligence by incremental steps.'[77]

But the question is: is a narrow, limited duty of care towards relatives in the case of shared genetic information really such a giant step? In this respect it is worth paying a little more attention to the judgment in *Michael*. Lord Toulson (with whom all his colleagues agreed) did indeed recognise that 'the development law of negligence has been by an incremental process rather than giant steps' and added that the method of the court 'involves examining the decided cases to see how far the law has gone and where it has refrained from going';

'From that analysis it looks to see whether there is an argument by analogy for extending liability to a new situation, or whether an earlier limitation is no longer logically or socially justifiable. In doing so it pays regard to the need for overall coherence. Often there will be a mixture of policy considerations to take into account.'[78]

There are some indications from case law not considered in *ABC* that the courts are capable of thinking of duties to families in certain clinical contexts, and that the incremental extension of duties to those who ordinarily receive advice and care as part of clinical genetics—albeit not as the proband or immediate patient—would not be such a great leap. Where family members are given advice or counselling, they will indeed form a doctor-patient relationship and duties will arise in relation to this care.[79] This has extended to a duty of care in regard to advice given about future pregnancies, notwithstanding the fact that the doctor was a paediatrician and that his patient in the first instance was

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[75] ibid. *ABC v St George's Healthcare NHS Trust & Ors* [2015] EWHC 1394 (QB) (n 8) [13].

[76] ibid.

[77] ibid 27.

[78] *Michael & Ors v The Chief Constable of South Wales Police & Anor* [2015] UKSC 2 (UKSC (2015)) [102].

[79] *Powell v Bolaz* (1997) 39 BMLR 35(CA); *X (Minors) v Bedfordshire County Council* [1995] 2 AC 633, 665G – H; *B and others v Attorney General of New Zealand*[2003] 4 All ER 833; *Sullivan v Moody* (2001) 207 CLR 562; *Attorney-General v Prince and Gardner* [1998] 1 NZLR 262; *B and others v A-G of New Zealand* [2003] UKPC 61, [2003] 4 All ER 833.

the baby.[80] In the Scottish case of *Anderson v. Forth Valley Health Board*,[81] a duty of care was also found towards a father for the anxiety and distress caused by negligent omission of pre-natal genetic testing for the mother.[82] In such cases the courts are acknowledging the difficulty of making a distinction between parents and children or between the patient mother and the father; the care provided affects the family more generally and the courts have recognised this. Current medical genetics is acutely aware of the shared implications of information for family members and, in many cases, will treat a whole family as patients.[83] Indeed, it has been suggested that the family is the 'fundamental unit of responsibility', not only the sick individual who presents for diagnosis and treatment.[84]

In *ABC*, the Claimant argued that she was not just any third party but the patient's daughter and moreover, that she was in a sense a patient herself because she had been undergoing family therapy with the Defendants.[85] The Judge rejected the notion that family therapy created a special relationship that would lead to a duty of care in relation to her father's diagnosis; the claim could not be characterised as 'badly performed family therapy'.[86] However, the Claimant did not raise the potentially stronger argument that the Defendants were, to an extent, responsible for her welfare as a known at-risk family member of their patient who had been given a genetic diagnosis. It is simplistic to see the responsibility that healthcare professionals bear in genetic medicine as relating only to an individual patient. It does not accurately reflect the responsibility that healthcare professionals feel towards at risk relatives in medical genetics.[87] Nicol J made some assessment of whether there was a 'special relationship between the Defendants and the Claimant' of a type that would 'ordinarily' suffice to establish a duty of care for omission.[88] This included whether there could be said to have been an assumption of responsibility towards the daughter. The Judge's conclusion was that this was not the case because there was nothing analogous to situations where a special relationship had been found to exist—'such as an occupier of land to neighbours, an employer to his employees, a parent or a school to a child'—and she was not entitled to reliance, express or implied in the relationship, that the clinicians would make provision for her safety.[89,90] Rather than looking for an analogy outside the medical context, it could be accepted that there is a very limited assumption of responsibility by healthcare professionals in medical genetics to consider the interests of known, at-risk family members. This is already part of practice when discussing the familial relevance of results with patients and, the GMC guidance suggests, in very extreme circumstances in informing relatives

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[80] *AB v Leeds Teaching Hospital NHS Trust* [2004] EWHC 644 (QB), at 201

[81] 1998 S.L.T. 588

[82] *Anderson v. Forth Valley Health Board* **(**1998) S.L.T. 588

[83] Anneke Lucassen and Alison Hall, 'Consent and Confidentiality in Clinical Genetic Practice: Guidance on Genetic Testing and Sharing Genetic Information' (2012) 12 Clinical Medicine 5.

[84] Karen Temple & Greta Westwood, 'Do Once and Share: Clinical Genetics Project Report' (British Society for Genetic Medicine, 5th May 2006) <http://www.bsgm.org.uk/media/17225/doas_clinical_genetics_project_report_may_2006_1_.pdf> 1.2

[85] *ABC v St George's Healthcare NHS Trust & Ors* [2015] EWHC 1394 (QB) (n 8) [15] & [5].

[86] *ABC v St George's Healthcare NHS Trust & Ors* [2015] EWHC 1394 (QB) (EWHC (QB)) [22].

[87] Dheensa and others (n 7) 7.

[88] *ABC v St George's Healthcare NHS Trust & Ors* [2015] EWHC 1394 (QB) (n 8) [12].

[89] ibid 28.

[90] Although Nicol J agreed that an assumption of responsibility was not necessarily essential to establish a duty of care, particularly since proximity had been agreed.

directly of a serious risk of serious harm. Very limited professional duties have already been incrementally extended beyond the patient to at-risk family members in medical genetics, it would be no great leap for the legal duty to follow suit.

We propose that the Defendants' objections to the duty of care in *ABC* are far from formidable. Cumulatively they amount to a prioritisation of confidentiality that a duty to relatives would alter little save to ensure that a balance takes place in line with professional best practice and the protection of fundamental human rights, and, an account of the law that is arguably out of step with developments in clinical genetics and the increasing legal concern for autonomy and a right to information governing personal decisions.[91] On these points alone we submit it is certainly arguably fair, just and reasonable that a duty of care is found to warn genetic relatives in certain circumstances, and there are further arguments in favour of a duty that were not considered in *ABC*.

F. Further factors in favour of a duty to relatives

There are a number of further arguments that can be made to support the extension of clinician's duty of care in the context of clinical genetics and a (limited) duty of care to warn genetic relatives. A major factor in favour of a duty to warn those related to the proband is that they are of a small and defined group of people. This distinguishes the context of clinical genetics from previous third party cases where powerful arguments of policy were made that a duty to a wide class of potential Claimants would place considerable burden on public body (such as the police) acting for the general good.[92] Firstly, genetic relatives are generally easily identifiable and although actual knowledge of the Claimant is often helpful in establishing proximity, it is not always essential; For example, in the case of *Home Office v Dorset Yacht*, the House of Lords found that a class of Claimants are capable of being owed a duty of care if sufficiently identifiable as distinct from the general population—albeit in this case based on geographical proximity as the primary form of identifiability.[93] The easy identifiability of close relatives was also a significant support in the finding of a duty of care in the US cases of *Pate v Threlkel* and *Safer v Pack*.[94] Second, and perhaps even more important for the courts is the very limited nature of genetic relatives (in terms of the significance of shared genetics at least) and the fact that they are a narrow and limited group. This is a rebuttal to the common argument that a duty will be too broad and owed to the world at large—the extent of a duty also concerned Nicol J in *ABC*.[95] Moreover, in *Selwood v Durham*, the Court of Appeal found the difference between a potential duty to the 'world at large' and a duty to a small, defined group was of such significance that the case was accepted for trial largely on that point.[96]

Another strong indication in favour of a limited legal duty towards relatives within the assessment

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[91] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 (n 43).

[92] *Mitchell & Anor v Glasgow City Council (Scotland)* [2009] UKHL 11 (n 22); *Selwood v Durham County Council & Ors* [2012] EWCA Civ 979 (18th July 2012) (EWCA (Civ)).

[93] *Home Office v Dorset Yacht Co Ltd* [1970] UKHL 2 (UKHL (1970)).

[94] *Pate v Threlkel* (1995) 661 2d 278 (Supreme Court); *Safer v Estate of Pack* (1998) 314 NJ Super 496 (Appellate Div).

[95] *ABC v St George's Healthcare NHS Trust & Ors* [2015] EWHC 1394 (QB) (n 8) [30].

[96] *Selwood v Durham County Council & Ors* [2012] EWCA Civ 979 (18th July 2012) (n 88) [55].

whether a duty is just, fair and reasonable is the nature of best practice and authoritative guidance on genetic risk and relatives. As we have emphasised, the guidance issued by the doctors regulatory body already advises that genetic information may be relevant to the patient's relatives and acknowledges that informing relatives against the express wishes of a patient could be, under very specific circumstances, a justified breach of confidence in certain circumstances where another person is at risk of 'serious harm'.[97] A very limited duty of care towards close, identifiable genetic relatives in cases where there is a serious risk of serious harm, in line with this guidance would reinforce the professional duty with a legal one. The Supreme Court recently favoured the reinforcement of a medical professional obligation in *Montgomery v Lanarkshire Health Board* 'so that even those doctors who have less skill or inclination for communication, or who are more hurried, are obliged to pause and engage in the discussion'.[98] Supplementing a clinician's existing professional duty to consider warning genetic relatives of serious risk with a legal duty would equally require a pause and balancing of patients and family members' rights and interests. The right to confidentiality would only be outweighed in cases of serious risks to relatives.

IV. CONCLUSION

In this article we have set out reasons why it is—at the very least—arguable that a duty of care is owed to relatives of the patient in clinical genetics. We have responded to objections made in *ABC v St George's Healthcare NHS Trust*, that a duty of care towards a daughter would not be fair, just and reasonable. We underline that within the practice of medicine it is since long accepted that the patient's right to confidentiality is not absolute and under specific circumstances it may be put aside to protect others from harm. The legal construction underlying this practice is acknowledging a duty towards known, at-risk family members to disclose risk-information in exceptional circumstances, when action could be taken to prevent or reduce significant harm and the patient is unwilling to inform the relatives themselves. Contrary to the decision in *ABC,* this would not be a giant leap for the medical profession or the law of medical negligence. GMC guidance acknowledges some responsibility for family members if they are aware they may be at risk of harm. A limited extension of the duty of care to this small and identifiable group would reflect the shared nature of genetic information and practice in genetic medicine. For a professional, all a legal duty would require is that they *consider* the interests of affected relatives—not all relatives—and balance the seriousness of the risk against the interests of the patient. Following guidelines, the conclusion will often be that the risk of harm does not outweigh a patient's right to confidentiality. Such a duty has been supported by commentators[99] and recognised by courts in the USA.[100]

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[97] 'Confidentiality Guidance: Genetic and Other Shared Information' (n 57) 67–69. This approach is taken around the world, for example see the Dutch Society for Clinical Genetics Guidelines on informing relatives of patients with hereditary cancer; Richtlijn VKGN, 'Het informeren van familieleden bij erfelijke aanleg voor kanker' (VKGN 2012) < www.vkgn.org/index.php/vakinformatie/richtlijnen-en-protocollen/erfelijke-tumoren> accessed 05th April 2016.

[98] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 (n 43) [93].

[99] Michael Fay, 'Informing the Family: A Geneticist's Duty of Care to Disclose Genetic Risks to Relatives of the Proband' (2011) 27 Journal of Professional Negligence 97; Dean Bell and Belinda Bennett, 'Genetic Secrets and the Family' (2001) 9 Medical Law Review 130.

[100] *Safer v Estate of Pack* (1996) 677 2d 1188 (Appellate Div).

The circumstances of *ABC* may have provided a more difficult test for the duty to relatives in clinical genetics than a case where a failure to communicate genetic risk disclosure resulted in avoidable physical harm. Equally, a claim based on a failure to warn *the patient* of the risk to family members from a genetic diagnosis would have avoided the clash with patient confidentiality and therefore would have been more likely to succeed. However, as medical genetics continues to grow, it is probable that the question of a duty of care towards relatives will be revisited in the courts and it is submitted that the case is likely to be more finely balanced than *ABC v St George's Healthcare NHS Trust* suggests.

The approach taken in medical practice, supported by the GMC's guidance on confidentiality and genetics, has out-paced developments in the law and could suggest that practice will develop more rapidly in favour of a direct duty to warn relatives in limited circumstances. As the 100,000 Genomes Project progresses in England, a proportion of results will be relevant to relatives and there is likely to remain pressure on practice and guidelines that are developed for genetic testing in the clinic and new approaches like whole genome or exome sequencing for diagnostics. Guidelines that balance the rights and interests of patients and relatives in exceptional circumstances are certainly legally sound. In the future, in the same manner as the Supreme Court found a duty to inform patients of risks in relation to their treatment,[101] these professional standards could well be reinforced with a narrowly defined legal duty of care.

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[101] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 (n 43) [93].