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4H Shapley, A Treasury of Science (Angus& Robertson, London 1954) 510.

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6A H. Ferguson, ‘ The Evolution of Confidentiality in theUnited Kingdom and the West’ (2012) 14(9) Virtual Mentor 738. 7ibid. 8ibid.

9J McHale and M Fox, HealthCare Law (2nd edn, Sweet & Maxwell 2007) 565.

10 General Medical Council, Confidentiality: good practice in handlingpatient information (2017). 11Nuffield Council on Bioethics, Thecollection, linking and use of data in biomedical research and healthcare: ethical issues (2015), para 4. 49.

12GMC (n 10) 37. 13ibid 36. 14M Taylor, Genetic Data and the Law: ACritical Perspective on Privacy Protection (Cambridge, 2012) 7. 15S Pattinson, MedicalLaw and Ethics (3rd edn, Sweet and Maxwell 2011) 203. 16C Jones, ‘ The utilitarian argument for medicalconfidentiality: a pilot study of patients’ views’ (2003) 29 J Med Ethics 348. 17Pattinson (n 15) 202. 18GMC (n 10). 19G Laurie, GeneticPrivacy: A Challenge to Medico-Legal Norms (CUP, 2002) 232.

20ibid. 21ibid 233. 22J Mandal, DK Ponnambath and SC Parija, ‘ Utilitarian anddeontological ethics in medicine’ (2016) 6(1) Trop Parasitol 5. 23Pattinson (n 15) 202. 24ibid. 25ibid.

262004 UKHL 22. 27Council of Europe, Convention for the Protection ofHuman Rights and Fundamental Freedoms (European Convention on Human Rights, asAmended) (ECHR) art 8, 1950. 28Human Rights Act 1998.

29Campbell (n 26) 11. 30ibid 14. 31ibid 17. 322014 EWHC 13 (QB).

33ibid 67. 342015 EWCACiv 311. 352014 EWCA Civ 1277. 36K Horsey and E Rackley, Tort Law (5th edn, OUP 2017) 450. 37McHale and Fox (n 9) 572. 382003 EWHC 1670 (QB).

392001 68 BMR 62. 40The Times, May25, 1999. 41GMC (n 10). 421988 UKHL 6.

43GMC (n 10) 32-36. 441990 1 ALL ER 835 (CA). 45131 Cal Rptr 14 (Cal 1976) (SC). 462003 4 All E. R. 969.

47National Health Service Venereal Disease Regulations 1974, SI 1968/1624. 48Human Fertilisation and Embryology Act 2008, s25. 49Abortion Regulations 1991, SI 1991/499.

50Data Protection Act 1998. 51Health and Social Care Act 2001, s. 60.

52Health Service (Control of Patient Information)Regulations 2002, SI 2002/1438. 53P Case, ‘ Confidence Matters: the Rise and Fall ofInformational Autonomy in Medical Law’ (2003) Medical Law Review 208, 231. 54ibid. 55ABC (n 3) 31. 56ABC v St George’s Healthcare NHS Trustand Others 2017 EWCA Civ 336.

Although patient confidentiality is central to the trust between doctorand patient, it is far from absolute: the caselaw discussed addresses thebalance

of competing interests for lawful breach of confidentiality. Likewise, professional ethical guidance and some legislation permits a breach ofconfidentiality where it can be outweighed by a legitimate interest. Furthermore, the GMC's guidance requires doctorsto balance disclosure of information to the patient's relatives against their dutyto preserve confidence; however, there is no legal duty to do so. This was atissue in ABC, where in the HC Nicol Jstruck out the claim on the basis that there was ' no reasonably arguable DOC'. 55However, the CA remitted the case for trial, stating that such imposition of a DOCis ' arguable'. 56 2.

5 Conclusions In contrast, there is legislation which permits disclosure of information considered confidential. Section 60 of the Health and Social Care Act 200151and the Health Service (Control of Patient Information) Regulations 200252 arguablyundermine the equitable remedy of breach of confidence. Case maintains that the2001 Act 'empowers the Secretary of State to make broadly two types ofregulations which enable bypassing of the general rule requiring consent to thedisclosure of patient information'. 53 Moreover, the 2002 Regulations ' authorises the procurement of otherwise confidentialpatient information'. 54 Thislegislation highlights the non-absolute nature of confidentiality, and thatthere are exceptions which mandate disclosure without legal penalty. Legislation in English lawboth mandates patient confidentiality and requires a breach of confidence inexceptional circumstances. The mandating legislation enshrines the duty ofconfidentiality recognised in English common law.

There is no specificstatutory protection afforded to medical information in English law (Wainwright v HomeOffice); 46 however, there are

statutoryprovisions which protect sensitive areas of healthcare. The National HealthService Venereal Disease Regulations 1974/29, 47 section25 (33A) of the Human Fertilisation and Embryology Act 200848and the Abortion Regulations 1991/49949are examples of statutory provisions protecting the disclosure of medicalinformation. Furthermore, the Data Protection Act 1998 regulates the processingof personal data about living individuals by setting out the responsibilitiesof data controllers and individual rights. 50 2. 4. 3 Legislation The duty of confidentiality is not absolute, as recognised by the GMC's guidance, 41legislation and the caselaw.

The leading case Attorney General v Observer Ltd and Others heldthat a duty of confidence precludes disclosure of information to others unless confidentialityis outweighed by a countervailing public interest. 42 Thus, recognising that confidence may not always prevail where other legitimateinterests are engaged. However, whilst a doctor can breach their duty ofconfidence, it is unsettled as to whether they will be held liable for failingto do so. The GMC sets out a further exception, where disclosure is necessaryto protect another individual's welfare. 43Both the United States and UK courts have recognised this exception to the dutyof confidence: W v Egdell held that abreach was justified in the public interest, to protect the public fromdangerous criminal acts. 44In Tarasoff v Regents of the Universityof California, the Supreme Court (SC) imposed a duty on a doctor todisclose information to third parties who may suffer foreseeable harm.

45Although Egdell recognised a breachin the public interest, it appears unlikely that the Tarasoff duty would be recognised by the English courts. 2. 4. 2 Exceptions Recognised in Law If the test is satisfied, there is a potential

civil claim for an injunction to preventpublication of the information or an action for damages.

There are alternativegrounds for legal proceedings: actions may be brought in contract andnegligence. 37 In Archer v Williams, an injunction was granted in relationto information disclosed in breach of an employment contract. 38In Cornelius vTaranto, the Claimant broughta civil claim in negligence and damages were awarded on the basis that theDefendant breached confidence by revealing medical information without consent.

39 Thereis no clear authority on this point in English law, although such action isanalogous to an action for breach of disclosure of a police informers identityin Swinney vChief Constable of the Northumbria Police. 40These alternative proceedings are rare: today it is generally recognisedthat the doctor-patient relationship is a relationship category protected bythe equitable remedy of breach of confidence. Since Campbell, the existenceof a misuse of private information tort was confirmed by the HC in Vidal-Hall and Others v Google Inc. 32 Tugendhat J citedLord Nicholls in Douglas and Others vHello! Ltd and Others: ‘ breach of confidence, or misuse of confidentialinformation, now covers two distinct causes of action, protecting two differentinterests: privacy, and secret (“ confidential”) information’, leading him toconclude that a distinct ‘ tort of misuse of private information’ exists.

33This was upheld by the CA in Vidal-Hall. 34 In OPOv MLA, it was considered a tort by the CA. 35 Anew two-stage test has been used to determine whether a breach of confidence or’misuse of private information’

has occurred since Campbell: (1) Did the claimant have a ‘ reasonable expectation ofprivacy’ with regard to the information? If so, (2) Does the claimant’sinterest in maintaining their right to privacy outweigh the defendant’sinterest in freedom of expression? 36 Their Lordships clarified the relationship between breach of confidenceand privacy. Lord Nicholls maintained that ‘ there is no over-arching, all-embracing cause of action for “ invasion of privacy”‘. 29 Heacknowledged that the HRA prompted developments in the law of confidence andthat because the duty of confidence now arose where ‘…a person receives information he knows or ought toknow is fairly and reasonably to be regarded as confidential’ this hadcreated a tort of ‘ misuse of private information’.

30 He acknowledged that ‘ the values in Articles8 and 10 are now part of the cause of action for breach of confidence’ in lightof the HRA plus European Court of Human Rights (ECtHR) jurisprudence. 31Thus, future cases would need to concentrate on confidential information andthe balance of the claimant’s Article 8 and the defendant’s Article 10 rights. Although patientconfidentiality is not absolute, English law adopts a strong presumption infavour of confidentiality. This duty is governed by legal principles in equity, and is based on a relationship of trust between doctor and patient. Disclosureof information outside the legitimate exceptions thus gives rise to anequitable claim for a breach of confidence. This has developed through thecaselaw to protect privacy interests. In the years preceding the leading case Campbell v MGN Limited, 26 actions for breach of confidence forunauthorised publication of personal information increased. In

Campbell, an action for damages was brought regarding publicationof an article in the Daily Mirror allegingCampbell's treatment for drug addiction.

She argued that this constituted abreach of confidence, leading the House of Lords to confirm that Article8 of the European Convention on Human Rights (ECHR)27underpins domestic law protection of the confidentiality of medicalinformation. This is given effect by the Human Rights Act 1998 (HRA). 28 2. 4. 1 TheLaw of Equity 2. 4 English Law on Patient Confidentiality Mandal et.

al note ' deontology is ethics of duty where the morality of anaction depends on the nature of the action'. 22 Advocatesadvance that confidentiality should be upheld, because the patient's right toprivacy is at stake. 23Deontological ethics therefore strengthens the doctor-patient bond underpinningpatient confidentiality. Whilst utilitarianism is not concerned withfundamental human rights, deontological ethics is receptive to these: theindividual's interests cannot be aggregated where the moral need to protectinformation should be overridden in favour of other moral interests. 24 Pattinsonnotes deontological-based theories ' will only allow a patient's right to havemedical information kept private and confidential to be outweighed by another'smore important individual right'.

25 Disclosureof risk of harm to a relative is thus outweighed by the patient's right to confidentiality. However, this viewpoint is challenging considering the non-absolute nature ofconfidentiality. Not only is this reflected in the professional ethicalguidance, but also in the relevant caselaw and statutory provisions. 2. 3.

2 Deontology Utilitarianism is the belief that actions are morally correct if theymaximise the majority’s benefit. Jones comments: ‘ the utilitarian justificationfor maintaining medical confidentiality rests ultimately on a calculation ofthe effects of confidentiality or disclosure on the behaviour of current andpotential future patients’. 16 Inthe medical context, confidentiality should thus be maintained if it upholdspatient welfare; however, Pattinson argues that ‘ act-utilitarian reasoning mayfavour a breach of confidence to prevent the harm or death of a patient’s relative’. 17 TheGMC requires doctors to balance their duty toward their patient againstpreventing harm to others, 18 placingan emphasis on the maximisation of utility. Contrarily, Laurie notes that whetherutility is maximised turns on whether disclosure prevents harm. 19He states ‘ it would be foolhardy not to inform relatives of a highly predictivepredisposition to such a condition, especially if pre-emptive treatment couldprevent the onset of disease’. 20He questions what harm will be avoided through disclosure – if the risk is tolifestyle rather than life, the public interest argument is weakened. 21 Theutility argument’s strength thus depends on the harm to be avoided throughdisclosure.

2. 3. 1 Utilitarianism The debate over whether a breach of confidence is justified in theclinical genetics context requires considerations of the ethical justificationsfor maintaining confidence. There are moral theories which claim to underpinthe obligation, with each attaching different weight to legitimate interestswhich may override confidentiality. Pattinson thus argues that ‘ interpretingEnglish law by reference to a coherent underlying ethical framework… presents achallenge.

What is clear is that it adopts a strong presumption in favour ofconfidentiality with exceptions involving a balancing exercise.’15 2. 3 The Ethical Debate An obligation touphold confidentiality has long been included in the ethical codes of healthcareprofessionals, 9which enshrine the moral code of the Oath. The General Medical Council (GMC) providesguidance which sets out confidentialityprinciples that all doctors must follow.

10Failure to respect these principles will be a serious matter, exposing thedoctor to potential professional penalties. 11However, there are exceptions provided by the GMC’s guidance: disclosureswith consent, disclosures required by law, and disclosures in the publicinterest. 12In such circumstances, breaches are lawful and doctors will not be exposed toprofessional penalties. The non-absolute nature of confidentiality thusinvolves a balancing test between public interests: the GMC states that doctorsare required ‘ to balance their duty to make the care of their patienttheir first concern against their duty to help protect the other personfrom serious harm’.

13 This is at issue in thecontext of clinical genetics. Taylor comments: ‘ personal data… tends to assumethat there will be a single identifiable individual to whom personal data will ‘ relate”. 14 The shared nature of DNA thusraises the debate of whether this warrants a breach of confidence to discloseinformation to the patient’s relatives. 2. 2 Professional Ethical Guidance Patientconfidentiality has historical roots, beginning with the Hippocratic Oath whichplaced an absolute duty on doctors to maintain patient confidentiality: ‘ Andwhatsoever I shall see or hear in the course of my profession, as well asoutside my profession in my intercourse with men,

if it be what should not bepublished abroad, I will never divulge, holding such things to be holysecrets'.

4 The Declaration of Genevaimposes the same duty on doctors, requiring them to ' respect the secrets thatare confided in them, even after the patient has died.'5 The notion ofconfidentiality thus encourages trust in the doctor-patient relationship: patients are likely to disclose their symptoms, which facilitates diagnosis andtreatment of illness. Ferguson notes that it is thus '… an integral element ofthe patient-doctor relationship, playing a vital role in the primary healingpurpose of the profession.'6 He states that although theOath recognises the importance of medical confidentiality, the qualificationthat confidentiality covered those things that ought ' not be published abroad'suggests that the obligation of confidentiality was not considered absolute. 7 These exceptions developedin modern codes of conduct. 8 2. 1 The Nature of Patient Confidentiality 2. PATIENTCONFIDENTIALITY Section two examines the natureof patient confidentiality, its regulation by professional ethical guidance, theethical debates surrounding this and the law in this area.

Section threeexamines the High Court (HC) and CA judgments in the ABC case. Finally, section four presents policy arguments againstextending the DOC raised in ABC, critiquesthem and sets out further arguments for imposing such DOC on doctors. Although the debate is long-established, it must be revisited considering ABC v St George's Healthcare NHS Trust andOthers3 (ABC), which reignited the discussionwhen it came before the courts in May 2015. It was the first casein English law to consider whether the doctor's duty should extend to warning thepatient's relatives. The

Claimant alleged that, because of her pregnancy, the Defendantsowed her a DOC to inform her of her father's Huntington's Disease (HD)diagnosis. Nicol J addressed policy concerns against extending the DOC beforestriking out the claim for trial as it would not be ' fair, just and reasonable'to impose such duty. In March 2017, the Court of Appeal (CA) quashed the Orderstriking out the claim.

The remittal for trial indicates that patientconfidentiality may not prevail against legitimate interests of at-risk relatives. Following consideration of an extension to the DOC in ABC, this dissertationexamines the implications of imposing a duty on doctors to warn the patient'srelatives and argues for adoption of such a DOC. This duty is limited tosituations where the doctor acquires critical medical information about thepatient's relative, thus where disclosure could mitigate serious harm or death. Traditionally, English law onthe duty of care (DOC) owed by doctors has assumed that there are two partiesto the relationship: the doctor and the patient. This is underpinned by patientconfidentiality, the moral basis of which is to instil trust in the public thatthey have control over their medical records and to encourage willingness toseek healthcare. Yet as genetic testing gained prominence in secondary care, sodid the debate over whether a doctor should owe a DOC to disclose a geneticrisk to a patient's relative. This has troubled doctors and legal scholars fordecades.

In 1993, the Nuffield Council on Bioethics reported on the ethicaldilemmas surrounding genetic screening. 1 The Council acknowledged that the tensionbetween the preservation of confidentiality and disclosure increases in theclinical genetics context, 2 because extending a doctor's DOC to

includethe patient’s relatives impinges upon patient confidentiality. This intrusionof genetic medicine into the moral basis of the doctor-patient relationshipraises questions which have been debated in the literature. 1. INTRODUCTION