Access to medical records: *Breen v. Williams*

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1. Introduction

In its decision in *Breen v. Williams*[1] the High Court has unanimously held that, in the absence of a subpoena or order for discovery compelling production, a patient has no legal right to access medical records which have been compiled by a medical practitioner in the course of diagnosing, advising and treating that patient. The decision was eagerly anticipated by the legal profession as it provided the Court with an opportunity to restate, and possibly to reshape, the principles governing fiduciary law. It was also eagerly anticipated by the wider community as there has been increasing concern about the current absence of a legal right in the patient to have access to her medical records. There is, however, little in the decision to excite either group. As predicted by most commentators,[2] the High Court has maintained a conservative approach to the nature and scope of fiduciary law. Further, due to the strictly legalistic nature of the judgments, with only passing references to the competing policy issues involved,[3] the decision is unlikely to provide any significant impetus to the ongoing debate on the broader social question of access to medical records.

2. Factual background

In 1977 the appellant underwent an operation by which silicone implants were inserted into each of her breasts. Some years later a doctor diagnosed that silicone gel had leaked from the implant in the appellant's left breast, requiring a partial mastectomy and further corrective surgery. The appellant became interested in litigation in the United States against Dow Corning, the manufacturer of the breast implants, and was given the opportunity to "opt in" to a

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1 (1996) 138 ALR 259.

2 For example Pizer, J., 'Breen v. Williams' (1995) 20 *MULR* 610; Parkinson, P., 'Fiduciary Law and Access to Medical Records: *Breen v. Williams*' (1995) 17 *Syd LR* 433 at 445.

3 For an assessment of the competing policy considerations, see Parkinson, id at 433-6.

settlement which had been given conditional approval by a United States court.

Before she could opt in to the settlement the appellant was required to file with the United States court copies of medical records in support of her claim. The appellant sought to have access to the medical records of the respondent, who after a number of consultations with the appellant, had in 1978 performed two procedures on the appellant in order to compress the hard capsules which had developed since the implant procedure. The appellant had claimed that she required the records in order to obtain advice about whether she should opt in to the United States settlement and in order to comply with the requirement to file supporting medical records should she decide to do so.[4] The appellant could have obtained a court order to compel the production of the records,[5] however decided not to follow this course as the costs and delays were significant.[6] Instead the appellant asserted that, subject to a qualification based on "therapeutic privilege",[7] patients have a general non-statutory right of access to their medical records to ensure they have at their disposal all information about their health to enable fully informed decisions to be made about future treatment.

At first instance Bryson J rejected the claim,[8] and the Court of Appeal dismissed the appeal by majority.[9] Kirby P, convinced by the reasoning of the Supreme Court of Canada in *McInerney v. MacDonald*,[10] dissented on the basis that a right of access to medical

4 The respondent offered to provide the medical records in question to the appellant, however only on terms which were unacceptable to the appellant. The respondent also offered to provide a written report to the appellant about the contents of her medical records. This offer too was rejected by the appellant.

5 Other Australian litigants had had such orders made by the Supreme Court of New South Wales in response to the Issue of Letters Rogatory by the United States District Court.

6 *Breen v. Williams* (1994) 35 NSWLR 522 at 527, per Kirby P.

7 This privilege could be invoked by a doctor to refuse disclosure where it would be adverse to the interests of the patient.

8 *Breen v. Williams* (Unrept, SC(NSW), 10/10/94, 2363 of 1994).

9 Fn. 6 (Mahoney and Meagher JJA; Kirby P dissenting).

10 (1992) 93 DLR (4th) 415. In this case the Supreme Court of Canada held that the fiduciary obligations of a doctor to a patient include the obligation to give access to a patient to his or her medical records. La Forest J, who wrote the judgment of the Court, thought a doctor owes a duty to patients 'to act with utmost good faith and loyalty.' While the doctor is the owner of the actual documents, those documents are held in a trust-like fashion for the benefit of the

records is an incident of the fiduciary relationship between a doctor and patient. His Honour would have declared that, subject to certain conditions, the appellant had a right of access to the respondent's medical records in order to examine and copy them.[11]

3. Grounds for the claim before the High Court

In the High Court the appellant claimed access as of right to her medical records on three grounds: a patient's proprietary right or interest in the information contained in the records, an implied term of the contract between patient and doctor, and lastly, a fiduciary obligation owed by the doctor to provide access to the medical records. The appellant maintained that the Court should approach each of these grounds from the viewpoint of what she claimed was the law's general acceptance of the principles of personal inviolability and patient autonomy and its rejection of medical paternalism.[12] The Court was unanimous in holding that none of the suggested grounds provided a principled basis on which a right of access to medical records could be granted.[13]

Proprietary right or interest

The appellant conceded that the property in the actual medical documents as chattels lay with the doctor. This concession was appropriate as the general rule is that documents prepared by a professional person during the course of dealings with a client remain the property of the professional.[14] The High Court enthusiastically affirmed this rule.[15]

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patient who retains an interest in, and control over, the information.

11 Fn. 6 at 550.

12 The appellant claimed that these principles imbued the decision in *Rogers v. Whittaker* (1992) 175 CLR 479. The Court rejected this line of reasoning: Fn. 1 at 266, 277-8, 290, 298-9.

13 Gummow J emphasised that the appellant had open to her other sufficient means of securing access to the records by seeking an order for discovery or issuing Letters Rogatory. Fn. 1 at 295, 309.

14 *Leicestershire County Council v. Michael Faraday and Partners Ltd* [1941] 2 KB 205; *Chantrey Martin v. Martin* [1953] 2 QB 286.

15 Fn. 1 at 264, per Brennan CJ; 270, per Dawson and Toohey JJ; 279-80, per Gaudron and McHugh JJ; 299-300, per Gummow J. Though note that Dawson and Toohey JJ suggested that the patient might own any documents on the file which were obtained on behalf of, and paid for by, the patient. X-ray photographs and pathology

The appellant, however, contended that the information contained in the records could be separated from the records themselves and that it is in the *information* that the patient possesses a proprietary interest; that interest taking the form of a right to access the information. This argument raised an important question of principle for Australian law, as there existed conflicting views on the concept of information as property.[16] The High Court in *Breen* rejected the notion of information as property, holding there can be no ownership in information as information. Their Honours[17] recognised that the protection afforded to confidential information in equity provides a level of protection which is analogous to that given to proprietary interests. However, the basis for that equitable protection was not property, but rather the acquisition of the information in circumstances where equity would impose a duty of confidentiality.[18] This amounts to an endorsement of the views of Stuckey who succinctly stated the position as follows:

> Since the action enforces a broad duty of good faith in Equity, the so-called 'property' in confidential information is merely the benefit of the duty enforced in Equity, a benefit which is conferred by a right *in personam*; it is not a proprietary interest, that is, a legal interest enforceable against the whole world, at all. Therefore, it is inaccurate to regard confidential information as a species of equitable property.[19]

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reports provide an example of this class of documents: Fn. 1 at 270. Mahoney JA took a similar approach: Fn. 6 at 560-561.

16 The conflicting authorities and arguments are canvassed in McPherson, B.H., 'Information as Property in Equity' in Cope, M. (ed), 1995, *Equity—Issues and Trends*, Federation Press, Leichhardt, ch. 8.

17 With the exception of Gaudron and McHugh JJ who did not discuss this point.

18 Fn. 1 at 264-5, per Brennan CJ; 271, per Dawson and Toohey JJ; 301-2, per Gummow J. See also *Boardman v. Phipps* [1967] 2 AC 46 at 102, 128-9, cf 107. Further, it was pointed out by Brennan CJ and Gummow J that the appellant's submissions were inconsistent with the operation of copyright law. The notes by the doctor were literary works for copyright purposes, and as such the doctor has the sole right to copy or to permit the copying of the document: Fn. 1 at 264, per Brennan CJ; 300-301, per Gummow J.

19 Stuckey, J., 'The Equitable Action for Breach of Confidence: Is Information Ever Property' (1981) 9 *Syd LR* 402 at 405. Cf McPherson, fn. 16.

Implied contractual term

There was no formal contract between the appellant and the respondent, however the appellant argued that a term conferring a right of access should be implied as a matter of fact in order to give business efficacy to the contract.[20] The Court unanimously refused to imply such a term.

Brennan CJ discussed this question at some length. His Honour stated that, in the absence of special terms agreed between the patient and the doctor, the general obligation of the doctor is to use reasonable skill and care in order to maintain or improve the health of the patient generally.[21] This obligation is not limited to the provision of advice or treatment on the occasion of the particular consultation, but extends generally across the life span of the patient.[22] Accordingly, there will be situations where the doctor must provide to the patient information acquired in connection with advice or treatment of the patient in order to discharge the contractual duty to maintain or improve the patient's health over his or her life. Brennan CJ stated the obligation of doctors to provide information to patients in the following terms:

> When the future medical treatment or physical or mental wellbeing of a patient might be prejudiced by an absence of information about the history or condition or treatment of the patient on an earlier occasion, the doctor who has acquired that information for the benefit of the patient's health must make it available to avoid or diminish that prejudice. Such an obligation is implied by the doctor's acceptance of the patient's authority under the contract to obtain that information. The authority is given in order to benefit the patient's health generally; the authority must be accepted and acted upon for the same purpose. As the obligation is implied, it can be excluded by express provision.
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> The obligation is not unqualified. As it arises from and is conditioned by the doctor's duty to benefit the patient's health generally, the obligation falls to be discharged only when the patient's health would or might be prejudiced by refusing to make the information available. And, as the service of making the information available is not ordinarily covered by the fee paid for advice or treatment,

20 This contractual right was to be subject to therapeutic privilege.
21 Fn. 1 at 262.
22 Ibid.

> the doctor is entitled to a reasonable reward for the service.[23]

Accordingly, in his Honour's view a doctor must disclose information about a patient's history, condition or treatment where failure to disclose the requested information might prejudice the general health of the patient, and where the request for disclosure is reasonable in all the circumstances and a reasonable reward is offered for disclosure.[24] However, an obligation to provide information is to be differentiated from a duty to give a patient a right to access and copy the doctor's records.[25] Where the duty to disclose information to benefit the health of the patient generally can be performed without giving access to the doctor's records, a claim for access should be denied. However, his Honour apparently took the view that a right of access could exceptionally be the subject of an implied term where there is a "therapeutic reason"[26] for permitting access. Rather than laying down an unqualified principle that there can be no implied contractual term of access, his Honour held that the question in each case is whether access to the doctor's records is necessary to avoid or diminish the possibility of prejudice to the patient's health.[27] The appellant had failed to satisfy this test.[28]

The other members of the Court appeared to take the view that a right of access to medical records could never be never be the subject of an implied term in doctor-patient contracts. Dawson and Toohey JJ took the view that it was not necessary for the reasonable or effective performance of the contract to imply the term suggested by the appellant. The contractual obligation of the respondent was to use reasonable skill and care in advising the appellant, and this obligation could be effectively discharged by providing a written report. It did not require giving the appellant a right to inspect her medical records.[29] Further there was no evidence that it was an established professional practice for a medical practitioner to afford a patient

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23 Ibid.

24 Id at 263.

25 Mahoney JA in the Court of Appeal similarly decided that, while a patient does not have a contractual right to inspect a medical file, the patient normally would have the contractual right to be told the information in the file relevant to the patient's ongoing care: fn. 6 at 562, 567.

26 Fn. 1 at 263.

27 Ibid.

28 Id at 263-4, his Honour noting the offer of the respondent to provide a written report of the information on file.

29 Fn. 1 at 272.

access to the patient's medical records.[30] Gummow J took a similar view.[31]

The appellant had further argued that as a matter of legal implication a doctor contracts to act in the "best interests" of the patient. An incident of the "best interests" term, it was argued, was that a doctor must make available medical records concerning a patient when the patient seeks access to them. Gaudron and McHugh JJ rejected the suggestion that a doctor impliedly promises as a matter of law to always act in the "best interests" of the patient.[32] Such a term would impose too onerous an obligation on doctors: it would amount to an absolute obligation to do what was best for the client. However, a doctor is not liable for treatment that goes wrong in the absence of negligence.[33] The only relevant contractual term implied by law is one corresponding with the tortious obligation, namely to exercise reasonable care and skill in the diagnosis, advice and treatment of the patient.[34]

Fiduciary obligation

The doctor-patient relationship is not an accepted category of fiduciary relationship.[35] However, these categories are not closed, and a variety of indicia have been relied upon by the courts in considering whether a relationship outside of these categories is fiduciary in nature. Indicia which have been commonly suggested include: a confidential relationship; inequality of bargaining power; an undertaking by one party to represent another in the performance of a task or duty; the ability of one party to unilaterally affect the rights or interests of another; and a dependency or vulnerability of one on the other resulting in reliance.[36]

There is no clear consensus in the judgments in *Breen* on the critical features of a fiduciary relationship. This is hardly surprising for as Gaudron and McHugh JJ point out 'the term "fiduciary relationship" defies definition.'[37] Brennan CJ states that non-agency

30 Ibid.
31 Id at 297-8.
32 Their Honours also reject the argument that a "best interests" term should be imposed as a matter of fact: id at 283. See also Brennan CJ at 263.
33 Fn. 1 at 282.
34 *Hawkins v. Clayton* (1988) 164 CLR 539.
35 Fn. 1 at 284. See *Hospital Products Ltd v. United States Surgical Corporation* (1984) 156 CLR 41 at 69, 96.
36 Id at 284-5.
37 Fn. 1 at 284.

fiduciary obligations arise from a relationship of ascendancy or influence by one party over another or dependence or trust on the part of that other.[38] On the other hand, Dawson and Toohey JJ consider that the critical feature of a fiduciary relationship is an undertaking by the fiduciary to act as a representative of the beneficiary in the exercise of a power or discretion.[39] Gaudron and McHugh JJ take the view that there is no one critical characteristic of a fiduciary relationship: the Court looks to all the indicia mentioned above to determine this question.[40] Gummow J thought that the basis of a fiduciary relationship was either the vulnerability of one party to the abuse by the other of his or her position, or the undertaking by the doctor to exercise professional skill for the benefit of the patient coupled with specific reliance by the patient. His Honour did not need to choose between these two characteristics as both were satisfied in the doctor-patient relationship.[41]

With the exception of Dawson and Toohey JJ, the Court was willing to characterise the relationship of doctor and patient as a fiduciary one. Brennan CJ considered that the relationship of doctor and patient is one of ascendancy by the doctor and trust by the patient.[42] Gaudron and McHugh JJ considered that the relationship between a doctor and patient is fiduciary as it exhibits dependency and the provision of confidential information by the patient.[43] And Gummow J was prepared to find a fiduciary relationship on one of the two bases mentioned, pointing to the following features of the doctor-patient relationship:

> Advice given by the physician to the patient involves specialised knowledge and matters of skill and judgment, which render the advice difficult, if not impossible, of objective and unassisted assessment by the patient. Hence the particular reliance placed upon the physician. In a real sense, especially if invasive procedures upon the person of the patient are involved, the patient has delegated control to the person providing health care. Further, for the patient to obtain the benefit sought from the relationship the patient often must reveal confidential and intimate information of a personal nature to the medical

38 Id at 265, 266.
39 This was the critical feature of a fiduciary relationship identified by Mason J in *Hospital Products Ltd v. United States Surgical Corporation*, fn. 35 at 96-7.
40 Fn. 1 at 284-5.
41 Id at 305.
42 Id at 266.
43 Id at 285.

> practitioner. Finally, the efforts of the medical practitioner may have a significant impact not merely on the economic but upon the fundamental personal interests of the patient.[44]

However, all of the members of the Court recognised that the fact a relationship is a fiduciary one does not mean that fiduciary duties attach to all aspects of the doctor's activities. It is necessary to define the precise scope of the fiduciary obligations owed by the doctor.[45] Gaudron, McHugh and Gummow JJ held that the central obligations which equity exacts from a fiduciary are to avoid a situation of an actual or potential conflict of duty and interest and to abstain from making an unauthorised profit.[46] Gummow J referred to a doctor who has an undisclosed financial interest in a private hospital to which the patient is referred for treatment, or in a pharmaceutical drug which is prescribed for treatment,[47] as an example of conduct which might amount to a breach of these obligations.[48] Clearly, it would not be a breach of these obligations for a doctor to refuse to allow access to records.

Dawson and Toohey JJ reached a similar result. Their Honours were reluctant to categorise the relationship between a doctor and patient as a fiduciary relationship, holding that when treating and advising a patient, the doctor is not acting in a representative capacity, but is merely discharging the obligations which are enforced in contract and tort.[49] Accordingly, it is the law of contract and negligence which governs the obligations owed by a doctor to a patient, not fiduciary law.[50] However, although there is no fiduciary

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44 Id at 305-6.

45 Id at 265, 273, 285, 306.

46 See Gaudron and McHugh JJ, fn. 1 at 289. This was also the approach taken by Meagher JA, fn. 6 at 570-71. Gummow J formulated the nature of fiduciary obligations as follows (fn. 1 at 306-7):

> The fiduciary will be brought to account for any benefit or gain which (1) has been obtained or received in circumstances where a conflict or significant possibility of conflict existed between the fiduciary duty and personal interest in the pursuit or possible receipt of the benefit or gain or (2) was obtained or received by use or by reason of the fiduciary position or opportunity or knowledge resulting from it.

47 At least where there are other interchangeable drugs.

48 Fn. 1 at 307. Dawson and Toohey JJ give a similar example: fn. 1 at 274.

49 Id at 274.

50 Relying upon *Rogers v. Whittaker*, fn. 12.

relationship between doctor and patient, their Honours recognised that specific obligations of a fiduciary nature might arise in confined circumstances. They held that the only specific obligations of a fiduciary nature conceivably owed by a doctor to a patient are not to make an unauthorised profit, and not to place himself or herself in a position of a conflict of interest and duty.[51] These obligations would be incidental only to the primary duties of the doctor imposed in contract and tort governing the functions of diagnosis, advice and treatment.[52]

Although the judgment of Brennan CJ is not specific on this point,[53] there is a clear majority for the proposition that the central obligations imposed by fiduciary law are not to make an unauthorised profit and to avoid a conflict of duty and interest. The insistence in these judgments that these dual obligations are the core fiduciary obligations is significant for two reasons.

First, the decision amounts to a definitive rejection of the Canadian view—a view which had been approved by Kirby P in the Court of Appeal—that fiduciary obligations 'are capable of protecting not only narrow legal and economic interests, but can also serve to defend fundamental human and personal interests'.[54]

Secondly, the decision confirms for Australian law that fiduciary obligations are proscriptive, not prescriptive, in nature. The members of the Court disapprove of the trend in Canada to view a fiduciary relationship as imposing both proscriptive and prescriptive

51 Fn. 1 at 274.

52 Id at 274-5.

53 Brennan CJ was of the view that duties of two types are imposed on the doctor by virtue of his or her fiduciary status: first, a duty not to take advantage of the doctor's ascendancy over the patient or of the trust the patient places in the doctor, and secondly the onus of proving that any gift received from the patient was given free from the influence which the relationship produces. In the case at hand there was no breach of either of those duties. The respondent had received no gift nor had he taken advantage of his ascendancy over the patient or of her dependence in him. Brennan CJ's formulation of the fiduciary duty as a duty 'not to take advantage' of the patient's trust could potentially disallow a broader range of conduct than is caught within the traditional proscriptions on making an unauthorised profit and avoiding a conflict of interest and duty. However, it is unlikely that Brennan CJ intended such a radical move, and his judgment may be best read as forbidding doctors from taking financial advantage of their patients.

54 *Norberg v. Wynrib* (1992) 92 DLR (4th) 449 at 499, per MacLachlin J.

obligations,[55] stating that the law of fiduciaries in Australia has not developed in that way.[56] Their Honours confirmed that Australian law is not (at least centrally)[57] concerned with the imposition of positive legal duties.[58] Rather, the core of fiduciary obligation consists of the two negative obligations identified above. Accordingly, fiduciary law could not be used to provide a right of access to medical records since this would have the effect of imposing a novel, positive, fiduciary obligation on doctors.[59] Gaudron and McHugh JJ warned against the Canadian trend toward amplifying the scope of fiduciary obligations in order to fill a deficiency in the current law, approving of the following statement by Sopinka J in *Norberg v. Wynrib*:

> Fiduciary duties should not be superimposed on these common law duties simply to improve the nature or extent of the remedy.[60]

It is apparent from the discussion above that the High Court in this case has maintained a conservative approach to fiduciary obligations. An important explanation for this conservatism derives from the Court's recognition of the disruption which would occur if fiduciary obligations were expanded into areas where the conduct has been primarily regulated by tort and contract. Gaudron and McHugh JJ in particular noted the difficulties of imposing fiduciary obligations on a class of relationship which has not traditionally been considered to be

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55 This trend was commented upon by Finn, P. 'The Fiduciary Principle' in Youdan, T.G. (ed), 1989, *Equity, Fiduciaries and Trusts* 1 at 27-30.

56 Fn. 1 at 266, per Brennan CJ; 275, per Dawson and Toohey JJ; 289, per Gaudron and McHugh JJ; 308, per Gummow J.

57 Some positive duties are imposed on trustees. In particular, trustees have a duty to allow beneficiaries to inspect their records, a duty that flows from the trustee's duty to account for the administration of the trust. Such an obligation is one which is derived from the character of the particular fiduciary office, not from fiduciary obligations generally: see fn. 1 at 308, per Gummow J.

58 Fn. 1 at 275, 289, 308.

59 Id at 289.

60 Fn. 54 at 481. In the Court of Appeal Meagher JA had been scathing of this trend (fn. 6 at 570):

> [W]hen analysing the Canadian jurisprudence in this field, one has the uneasy feeling that the courts of that country, wishing to find for a plaintiff, but unable to discover any basis in contract, tort or statute for his success, simply assert that he must bear the victor's laurels because his opponent has committed a breach of some fiduciary duty, even if hitherto undiscovered.

fiduciary and which would radically alter the nature of the pre-existing rights and obligations arising out of that relationship,[61] and which could make available proprietary remedies having the effect of altering priorities on an insolvency.[62] Although some may be disappointed with the Court's conservative approach to fiduciary obligations, it is to be commended for providing a much needed[63] definitive statement about the nature and scope of the fiduciary principle.

4. Conclusion

The Court has placed the onus squarely on the legislature to confer a statutory right of access if such a right is perceived to be necessary.[64] This surely is the correct result. The three legal bases upon which the appellant founded her claimed right could not support such a right without a radical reformulation of the principles involved. Further, the Court is not well placed to fully assess the competing policy considerations in issue. As Mahoney JA recognised, the choice between the parties' competing claims involved 'the making of a general social judgment'.[65] Such judgments should be made by the legislature, not by the courts.

61 Fn. 1 at 287, 289. See also Dawson and Toohey JJ at 274 and Gummow J at 304, affirming *Hospital Products Ltd v. United States Surgical Corporation,* fn. 35 at 98.

62 Id at 289. Their Honours said that if it was otherwise the doctor would be under a duty to inform the patient that the doctor has breached the contract or acted negligently, however that had never been the law.

63 Parkinson, fn. 2 at 443.

64 Fn. 1 at 291. A controlled right of access has been given by statute in the United Kingdom (*Access to Health Records Act 1990*) and New Zealand (*Health Information Privacy Code 1994*).

65 Fn. 6 at 558.