Julie Breen v Cholmondeley Williams (1996) 186 CLR 71
Brennan CJ, Dawson, Toohey, Gaudron, McHugh and Gummow JJ

I) Introduction

The clinical records of private medical practitioners may be the last surviving category of information generated within the health system which is truly inaccessible. Freedom of information legislation[1] makes it possible for patients to access and inspect information contained in their medical records irrespective of whether the holding institution is public or private. An apparent anomaly arises if the treatment is carried out by the patient's private physician, and it appears to be immaterial whether the treatment is delivered in the confines of a private surgery and then continued within an external health institution. Whilst the records of the physician which are deposited with an institution may be accessed by the patient, records which are held at the physician's rooms or private surgery remain inaccessible. It was this apparent anomaly which triggered a dispute between the appellant, Julie Breen, and the respondent, Dr Cholmondeley Williams.

II) The Facts[2]

In October 1977 Breen underwent plastic surgery, described as bilateral augmentation mammaplasty, that is, breast implants. Silicone prosthetics, now known to be hazardous but at the time a popular cosmetic surgery

[1] *Freedom of Information Act 1982 (Cth)* and quasi freedom of information legislation specific to private hospitals which grant a right of inspection.

[2] See Dawson and Toohey JJ at pp84-88; Gaudron and McHugh JJ at pp99-100; and Gummow J at pp115-119.

product, were used. A plastic surgeon other than the respondent inserted a small silicone implant into Breen's left breast and a larger one into her right breast. Some time later she developed what was diagnosed as bilateral breast capsules, an abnormality caused by leakage of silicone from the implants. In November of 1978 Breen consulted, for the first time, the respondent Williams. Also a plastic surgeon, Williams advised that the *capsules* should be compressed. Breen accepted that advice and the respondent conducted the operation. However, the appellant continued to suffer from pain and the respondent advised and performed a bilateral capsulotomy, that is, surgical removal of the capsules. Since that time the appellant had not consulted the respondent in relation to matters arising from her breast implants but has consulted him on other plastic surgery matters.

In 1984, the appellant discovered another abnormal lump in her left breast and consulted a Dr McDougall who identified the cause of the lump as the silicone gel which had leaked from the 1977 implants. With the consent of the appellant, Dr McDougall performed a left breast mastectomy. Since that time the appellant has undergone further corrective surgery to her left breast and has had the right silicone implant replaced. Neither of these procedures were performed by the respondent. The appellant later became aware of a class action before courts in the United States in which manufacturers of silicone implants, including Dow Corning Corporation, faced claims that the silicone implants were defective and had caused injuries of the type suffered by Ms Breen. The lawyer representing Australian claimants was Mr Peter Cashman, and the matter become one of some public notoriety. After a time, the Australian claimants received an offer to share in a settlement negotiated with the manufacturers. However, copies of medical records supporting the claim of each participant had to be filed in a United States court before 1 December 1994.

In August 1993 legal representatives of the appellant wrote to Dr Williams seeking access to medical records created whilst Breen was under his care. The respondent contacted the Medical Defence Union for advice on whether he should release the records. The advice of the Medical Defence Union relied upon an assumption that private medical records are the property of the treating doctor and, accordingly, there is no obligation to release any such record other than as ordered to produce by subpoena. Notwithstanding all of that, the MDU advised Dr Williams that he should agree to hand over the records if Breen would supply him with a written release from any claim which might arise from his treatment of Breen. The appellant declined to give the undertaking and decided to pursue access to the records as a matter of legal right. Before proceeding it should be noted that Williams also offered to provide the appellant with a detailed written summary of relevant information held in the patient's records, including the following: the medical history of the appellant as it had been taken by the respondent, the findings of

physical examinations, the results of other investigations, a rationale for diagnosis and management plan, details of all treatment and advice. To be excluded was correspondence with the Medical Defence Union and with the appellant's legal representatives. The offer of a written report based upon the records did not satisfy the appellant, who gave three reasons for rejecting the offer. First, the report, as opposed to the primary records, would not be an adequate basis upon which the appellant could make a fully informed decision as to the terms of the manufacturer's offer to settle. Second, it would be unacceptable to file a report in aid of her claim to join the United States settlement. Third, the appellant stated that denial of access to the medical records was an offence against her putative right to access the record directly. Although the offers of the respondent were rejected by the appellant, at no stage were they withdrawn by the respondent.

III) Access to private practice records

The appellant sought to establish and enforce a legal right to have direct access to all of the medical records of the respondent which contained information relating to treatment or advice given to her. On the appellant's view of what her rights consisted of, access to the records should have been in no way dependant upon the purpose for which access was sought. Breen professed the existence of a legal entitlement which, subsequent to a reasonable request for delivery of the records, enabled her to assert free access, to examine the relevant records and to have copies of whatever particular parts of the record she nominated. The respondent countered by accepting the existence of a right of a patient to be informed about relevant information contained in the medical record, but denied that there was any right by which a patient could insist that they be allowed to unconditionally examine the records or to have copies of any part of the record.[3]

Proceedings commenced in the New South Wales Supreme Court and the matter came before Bryson J His Honour saw the matter in terms of whether a patient has a right of general access to information in medical records maintained within the private practice of the treating doctor. The contrary proposition was that a treating doctor has a discretion to either grant or deny access as may be seen fit. Bryson J refused the relief sought by Breen on the basis that:

> "...The [respondent] was not made the [appellant's] medical adviser for the purpose of making him a collector or repository of information for the [appellant] to have available to her for whatever purpose she chose. Collecting and

[3] Gummow J at p 115.

> retaining information by him was a purpose of the relationship, but it was a subsidiary purpose, to lead only to medical advice and treatment to be administered by him or on his referral. It is not in my judgment unconscionable for the [respondent] to retain his information and keep it to himself except when and insofar as it is required for the purpose of treatment by him. A doctor is not put in a position to receive, compile and retain information for the very purpose of having it available when it is required and for whatever purpose it is required..."[4]

In the Court of Appeal,[5] Ms Breen's arguments were dismissed by Mahoney and Meagher JJA with Kirby P dissenting on the grounds that there was an aspect of fiduciary duty by which a medical practitioner falls under an obligation of disclosure in respect of patient information[6] Breen, in the hands of the Sydney firm Cashman and Partners sought special leave to appeal to the High Court. By that stage the case had the profile of a public interest test case and the outcome of the special leave application was a matter of public anticipation. Medical professionals and their indemnity insurers were obvious stakeholders in the outcome, but interest in the decision extended to the Commonwealth Attorney General who advocated a position articulated from freedom of information values. Special leave was granted and the matter came before a full court which had recently lost Mason CJ and Deane J. A very recent appointment at the time, Kirby J did not sit, having presided over the matter in the Court of Appeal.

IV) Patients' right of access?

By unanimous decision expressed across four separate judgments, the High Court appeal was dismissed. Overall, the reasoning of the Court differs only by subtlety, although there was some basic disagreement as to the precise grounds upon which the appellant had based her application. In general, it was accepted that the argument of the appellant rested upon broad heads of contract, property and fiduciary duty. In addition to these grounds, Dawson and Toohey JJ addressed what was loosely described as a *right to know* argument,[7] an approach which was emphatically rejected by Brennan CJ.[8] Gaudron and McHugh JJ were somewhat more thorough and analytical in their interpretation of how the appellant's argument was based, and wrote a joint judgment on the premise that Breen was arguing for an overriding general right of access which

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4 Gummow J at p 117.
5 *Breen v Williams* (1994) 35 NSWLR 522.
6 (1994) 35 NSWLR 522 at 542-545 and the terms of relief as formulated by Kirby P at 550.
7 At pp 98-99.
8 At p 83.

was said to be supported by five distinct points:[9] First, a notion of proprietary rights and interests in specific information; Second, an implied contractual term which affects the right of access; Third, an innominate common law right of access; Fourth, that a patient has a common law *right to know* all of the available information which relates to their personal medical treatment; Fifth a fiduciary duty by which a doctor is obliged to provide access to patient records. Why were the arguments of Breen rejected? We will look at the decision in terms of property, contract, fiduciary duty and the suggested *right to know*.

a) Proprietary rights and interests

Each of the judgments mentioned proprietary rights and the *interest* argument of the appellant.[10] All agreed that it was correct of Breen to concede that Williams was the legal owner of the medical records and not to mount a case such as that Breen fell into some category of obscure but 'true' owner of the physical documents. Dawson and Toohey JJ refer with some light ridicule to the shallow irony of the phrase, *the appellant's medical records*,[11] which was used throughout to describe the documents in question. It was also agreed by the Court that Williams had prepared the records for his own reference and had done so in the course of his profesional duties.

Although not contesting chattel ownership of the medical records, the appellant nevertheless submitted that she retained some proprietary right or interest in the documents which entitled her to direct and full access. On this point a distinction was drawn between the physical documents and the information contained within them. The response of Brennan CJ to this was blunt; absent a proprietary right to acquire or some power to compel, a patient may not force access to records for inspection or for copying.[12] Furthermore, Brennan CJ stated that information itself cannot be thought of as property and that there was, accordingly, no foundation for the suggested right of access.[13] Gaudron and McHugh JJ stated simply that documents prepared by a professional person to assist in delivering professional work to a client are in no sense the property of the client.[14] Dawson and Toohey JJ agreed that information does not form a species of property and suggested that some confusion may arise where information seems to take on a proprietary nature under the equitable

9 At pp 100-101.
10 Brennan CJ at pp 80-82; Dawson and Toohey JJ at pp 88-90; Gaudron and McHugh JJ at pp 101-102; and Gummow J at pp 126-132.
11 At pp 84-85.
12 At pp 80-81.
13 At p 81.
14 At p 101.

doctrine of confidential information. Their Honours responded to this by saying that the proprietary characteristics of information in an action for breach of confidence appears merely as an effect of the remedies which are available under that doctrine, and is not a basis of any action in itself.[15] Moreover, there was no suggestion that confidential information had been abused.

Gummow J[16] made rather more detailed comments on the property aspect of the case and best dealt with the suggestion that information and records may be separate things at law. His conclusion was that information is not to be defined as property, but that it may be protected by equity under the doctrine of confidential information. Distinguishing the Canadian decision, *McInerney v MacDonald*,[18] upon which the appellant placed reliance, Gummow J discussed the notion of a patient who confides information to a physician in the expectation of an ongoing interest in and control of the information. Even if accepted as law in Australia, the analysis of equitable obligations of confidence was, in Gummow J's view, of no assistance unless an allegation of abuse of confidence was first pursued. Likewise, the English decision in *R v Mid Glamorgan Family Health Services*[18] was distinguished by his Honour on the basis that UK legislation explained an outcome which the common law itself did not provide for.

b) Implied contractual term

The argument that the appellant could access the records under a term implied into the contract between her and Dr Williams was treated almost uniformly by the Court. It was agreed that the doctor patient relationship is primarily contractual in origin,[19] but it would be rare that a formal contract would come into existence. The Court further agreed that terms are implied into contracts either to give proper effect to the presumed or imputed intentions of the parties[20] or to provide the agreement with efficacy, or on narrow grounds of necessity. It was also agreed that the gist of the medical contract was that it obliged Dr Williams to use professional care and skill in treating and advising the appellant. In other words, it was an agreement to provide treatment and as this was the real subject matter of the contract, the Court could find no basis upon which

[15] At p 90.
[16] At pp 126-132.
[17] [1992] 2 SCR 138; (1992) 93 DLR (4th) 415.
[18] [1995] 1 WLR 110; [1995] 1 All ER 356.
[19] Brennan CJ at pp 78-80 and Gaudron and McHugh JJ, at pp 102-103 suggest that the doctor offers a patient diagnosis, advice and treatment the objectives of which are the prolongation of life, the restoration of the patient to full physical and mental health and the alleviation of pain.
[20] Per Deane J in *Hawkins v Clayton* (1988) 164 CLR 539.

it could then be said necessary to imply a term which would entitle the appellant to force access to the records. Such a term was neither necessary nor would it add to the efficacy of the treatment for which the contract was formed. Gaudron and McHugh JJ dismissed an additional point by which it was argued that, as such a term would be in the *best interests* of the appellant, it ought to be implied.[21] The implication of terms on general grounds such as this was identified by their Honours as a floodgate through which the certainty of general contractual duties would be dissipated.

c) Fiduciary duty

With the exception of Gummow J,[22] all other five justices agreed that fiduciary relationships arise from one of two sources: a relationship of agency, or a relationship of ascendancy, undue influence, trust or dependence. Both categories of relationship hold a potential for conflict of interest, but neither apply to the doctor-patient relationship as a general matter and were otherwise inapplicable to the circumstances of the relationship between Breen and Williams.[23] Most obviously, the Court pointed out that there had been no suggestion of conflict of interest whilst the appellant was in the care of Dr Williams, that there was no unauthorised profit and no other loss suffered by the appellant.

It was generally agreed that no element of agency is found in the doctor-patient relationship, although there may be a situation of ascendancy or undue influence. If the latter was shown, the onus of proving otherwise or that no advantage was taken of the patient, would transfer to the doctor. So, the doctor patient relationship may be fiduciary, but the relevance of the point depends upon the circumstances of each case and, in the absence of any allegation of advantage or ascendancy, there were no grounds from which to argue for the existence of a fiduciary relationship in the instant case. Dawson and Toohey JJ[24] made the point that, and although it is not an absolute point, as the doctor-patient relationship is already structured by contract and tort, there is little warrant for easily adding the additional protections of fiduciary duties. This conclusion was in direct contrast with Canadian authority,[25] which relies heavily on the assumed fiduciary nature of the doctor-patient relationship whereby doctors are under a duty to act with utmost good faith and loyalty to the patient, including a right of access to medical records. All members of the

[21] At pp 103-105.
[22] At pp 133-135.
[23] Brennan CJ at pp82-83; Dawson and Toohey JJ at 92-98; Gaudron and McHugh JJ at pp 106-114.
[24] At pp 92-94.
[25] *McInerney v MacDonald* (1992) 93 DLR (4th) 415.

Court distinguished the Canadian authority with the rather dismissive observation that views differ substantially between the two jurisdictions.

The most significant departure in the judgments on the fiduciary analysis was taken by Gummow J, who said that the relationship between a medical practitioner and a patient who seeks skilled and confidential advice and treatment is by type, fiduciary in character.[26] His Honour based that view on the reasoning of Gibbs CJ and Brennan J in *Daly v Sydney Stock Exchange Ltd*,[27] and the particular high level of reliance which a patient places upon the medical practitioner. But Gummow J went on to state that identifying the relationship as fiduciary is not to make the leap that a patient therefore has a right of access.[28] Harking back to what was said about the subject matter of the contract, Gummow J was of the opinion that the subject matter of the fiduciary duty relates to matters of treatment and advice, and is not a general duty at large to act in the best interests of a patient. As such, the fiduciary duty does not extend to a right of access to medical records.

d) The right of access

The right of access was the most contentious of the submissions argued by the appellant. Gaudron and McHugh JJ stated at the outset that the notion of a right of access is of great social significance.[29] However, after appearing to be quite sympathetic to the appellant, their Honour's proceeded to undercut the argument in three ways: First, by distinguishing a right of access from a *right to know*;[30] Second, by concluding that the common law recognises no right of access in Australia[31]; Third, that a large legal step would be required to move from the apparent paternalism of the current law, by which a medical practitioner may withhold records, to a very different system in which the patient's right to know is paramount.[32] Similarly, Gummow J discussed the right of access as it appeared in British authorities, and rejected the idea as insufficiently based in binding authority.[33]

In the alternative, Brennan CJ was emphatic when he pointed out that the appellant did not rely on a right to know as opposed to access when formulating her claim in the High Court.[34] With great respect, it is not

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[26] At p 134
[27] (1986) 160 CLR 371, at 377, 384-385.
[28] At pp 134-135.
[29] At p 100.
[30] At p 114.
[31] At pp 105-106.
[32] At p 114.
[33] At pp 131-132.
[34] At p 83.

obvious that Brennan CJ was entirely correct on the point. In any case, the issue was addressed by Dawson and Toohey JJ, even though it was conceded that the appellant did not submit it as a separate ground, independent of her other points. In the view of Dawson and Toohey JJ, the right to know was so much a theme of the appellant's case that it could be treated as a point in aid of the independently submitted grounds.[35] Also relevant was that the right to know tied into a more general proposition that there had been significant movement in the law governing the doctor-patient relationship as norms of patient autonomy and personal right have challenged the traditional paternalism which characterises medical practice. In the result, neither judge gave much hint of being inclined to accept such broad brush propositions as sufficient to justify a change in the law.

V) Comments

It is surprising that the High Court decided to grant special leave in this case, and the observation can be defended on a number of grounds. First, the weight and tide of judicial opinion which ran against *Breen's case* was formidable. The issues had been canvassed extensively in the Supreme Court and the NSW Court of Appeal. What motivated the Court to take the matter on is even less transparent in light of the unanimous rejection of the appeal. Can the reasons for the case coming forward be so straightforward as Gummow J suggested:

> "...the appellant asserts a right given to her by the law and the respondent denies the existence of that right. We should, therefore, determine the controversy..."[36]

If the appeal was affected by a view that the High Court should have been pushed into a test case on the point, the question which must be asked is: why was it thought that the facts of Breen's case were the appropriate vehicle for such a case? There are several reasons for which Breen's matter was not a suitable context in which to raise the issue of access to private practice medical records. First, it is not clear that Breen had any real need to pursue direct access to the records for the purpose of filing in the United States settlement. Second, was it so unreasonable for Williams to have asked for a release in exchange for the records? Third, within the procedural law there are several other options which may have been pursued and so it was not as if the right of access was Breen's last or only chance of obtaining information which she genuinely needed. In addition

[35] At p 98.
[36] At p 123.

to the (perhaps) vacuous nature of the action, the request made to the High Court was clearly that new law should be made and that public opinion wished for it be changed.[37] That Parliament is the appropriate forum to change such basic matters is the general reply which threads itself through all four judgments.

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LLB (Hons)

[37] Gaudron and McHugh JJ at pp 114-115.