Patient Access to Medical Records: Fiduciary Duties and Other Issues – A Classroom Interactive

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In *Breen v Williams*[1] the High Court of Australia considered the delicate and important issue of a patient's right of access to medical records. The Court held unanimously[2] that a patient has no general right to inspect or to copy medical records documenting the patient's medical history and relevant relationship with a health care provider. The High Court upheld the New South Wales Court of Appeal ruling[3] that neither contract, property, tort nor fiduciary law supported a general right of patient access. The absence of dissent in the High Court judgments, and the consistency in the reasoning, makes *Breen* a very powerful authority.[4] This comment is not intended to systematically explore the doctrinal basis of the decision in the manner of a case note. Rather, through the medium of an imagined 'classroom interactive', it critically assesses the Court's reasoning on both doctrinal and policy grounds, and in doing so, seeks to draw out some of the tensions inherent in appellate judicial method.

Disagreeing with the High Court

The decisions in the *Breen* litigation from trial-court level through to the High Court have been controversial and have attracted considerable aca-

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1 (1996) 186 CLR 71.

2 The case was heard by six Justices: Brennan CJ, Dawson, Toohey, Gaudron, McHugh, and Gummow JJ. Kirby J did not hear the case, as he had previously delivered judgment in the case as President of the New South Wales Court of Appeal: *Breen v Williams* [1994] 35 NSWLR 522.

3 See note 2 above. The NSW Court of Appeal, in turn, had upheld the trial court's decision: *Breen v Williams*, unreported, Supreme Court of NSW, 10 October 1994, Bryson J.

4 Furthermore, of the 10 judges who heard the case at all three levels, only Kirby P, then in the NSW Court of Appeal, found in favour of the plaintiff.

demic comment.[5] Given the opportunity to be 'activist', the High Court adopted what we would argue was a narrow and rather doctrinaire approach, despite previous 'activism' which elevated patients' interests as 'consumers' of medical services.[6] This more conservative approach was greeted with relief by a medical profession already concerned about increasing legal regulation and malpractice litigation. Also, the decision preserved the status quo and the Court thus avoided, on this occasion, the criticisms of those politicians and commentators who have charged the court with over-reaching its proper role.

Nevertheless, in our opinion, the decision in *Breen* is overly conservative. In essence, the High Court held that patients do not now have a right of access to 'their' medical records because such a right never existed in the past. In traditional style, the judges of the Court set out their searches through the nooks and crannies of tort, contract, property and fiduciary law in unsuccessful pursuit of the existence of the claimed right. We would argue that the Court had a choice: it was open to develop existing doctrine, particularly fiduciary doctrine, to accommodate on-going changes in the nature of medical practice and community expectations regarding control of sensitive personal information. As Gaudron and McHugh JJ recognised:

> Many [people], Ms Breen among them, no doubt think that a patient should have access to [the medical records that concern them], subject to limited exceptions. Perhaps only a very small minority of persons in Australia would think that in no circumstances should patients have access to information contained in their medical records.[7]

Even so, the Court chose to apply legal doctrine in an unnecessarily narrow manner, reaching a result based upon an outdated perception of medical record-keeping.

5 Comment on the High Court decision includes: Hepburn S, '*Breen v Williams*' (1996) 20 *Melbourne University Law Review* 1201. Comment on the Court of Appeal decision includes: Magnusson R, 'A Triumph for Medical Paternalism: *Breen v Williams*, Fiduciaries and Patient Access to Medical Records' (1995) 3*Torts Law Journal* 27; Parkinson P, 'Fiduciary Law and Access to Medical Records: *Breen v Williams*' (1995) 17 *Sydney Law Review* 433; The Honourable Justice Michael Kirby, 'A Patient's Right of Access to Medical Records' (1995) 12 *Journal of Contemporary Health and Law Policy* 93. Comment on the trial court's decision includes Hamblin J, '*Breen v Williams*: Right of Access to Medical Records Denied' (1994) 1 *Privacy Law & Policy Reporter* 141; Culkoff V, 'Patient Access to Medical Records: A Step Backwards' (1994) 3 *Australian Health Law Bulletin* 21.

6 *Rogers v Whitaker* (1992) 175 CLR 479; see also Darvall L, *Medicine, Law and Social Change: The Impact of Bioethics, Feminism and Rights Movements on Medical Decision-Making*, Dartmouth Publishing Company, 1993, pp 8-9.

7 *Breen v Williams*, note 1 above, at 114.

What model of patient access might have informed the Court's deliberations, had it been prepared to develop legal principles to account for developments in health informatics?[8] Increasingly, medical records are becoming computerised, containing computer-generated records of pathology tests obtained from third parties, as well as details of diagnosis, suggested treatment options and treatment rendered keyed in by the doctor or by support staff. Access to this computer record, perhaps by a printout, would have satisfied Ms Breen's needs. No doubt, files accessible solely by the doctor could store information obtained confidentially from third parties,[9] or comments which might come within the scope of 'therapeutic privilege'.[10] However, by recognising the doctor's right to exclude their records from patient scrutiny, the High Court delivered a setback to patient's rights and missed an opportunity to put in place an incentive for orderly and accurate record-keeping that would lead to greater efficiency.

In the classroom interactive which follows, participants vigorously set out their arguments for and against the High Court's decision. We have set out our personal views of the decision in general terms because they have coloured out construction of the interactive. We do not pretend to be neutral, nor does the interactive itself embody every available perspective on the underlying social issues. While we do not subscribe to all the arguments against the decision which feature in the interactive, we do believe they assist in providing a broad-based critique of the decision.

8 Health informatics has been defined as 'an evolving scientific discipline thatdeals with the collection, storage, retrieval, communication and optimal use of health-related data, information and knowledge.' House of Representatives Standing Committee on Family and Community Affairs, *Health on Line: Report on Health Information, Management and Telemedicine*, October 1997, p 5. Hereafter '*Telemedicine Inquiry Report*'.

9 *Breen v Williams*, note 1 above, at 114.

10 'Therapeutic privilege' may excuse a doctor from a legal obligation otherwise owed. In *Rogers v Whitaker* (see above note 6, at 490, approving *F v R*(1983) 33 SASR 189 at 193), the High Court accepted that a doctor may not be legally required to disclose to the patient any 'material risks' of misadventure associated with the proposed treatment when the doctor judges on reasonable grounds that the patient's physical or mental health would be seriously harmed by the information, or where the patient's temperament or emotional state renders the patient unable to rationally process the information. Therapeutic privilege could also justify the non-disclosure of a patient's medical record. It was accepted by Ms Breen's barrister, Dr Cashman, before the NSW Court of Appeal, that non-production of a patient's records could be justified on the basis of therapeutic privilege, or additionally if it would found an action for breach of confidence: *Breen v Williams*, above note 2, at 556 per Mahoney JA.

Two 'Readings' of the High Court Decision

In *Breen* we see an intriguing example of the courts at work. In addition to being an important decision on a topic of health law, as a *case study* it provides insights into some aspects of the nature of legal reasoning, in particular the use of precedent and the question of doctrinal coherence. It is beyond the scope of this article to review critiques of the judicial method generally or of the High Court's in particular. Rather, we will attempt to explore the issues and the process of reasoning in *Breen* through two opposing 'readings' of the case.

The first 'reading' is positivist in tradition, confining itself to matters of internal doctrinal coherence. This 'reading' criticises some aspects of the Court's reasoning, although it concludes that the ultimate outcome was justified in terms of existing principle, any change being a matter for Parliament. By contrast, the second 'reading' speculates about some themes and policy issues which were largely ignored in the judgments. It is strongly critical of the Court's decision, and suggests that a more flexible approach to doctrinal matters, informed by policy issues, might have led the Court to a different conclusion. It is worth stressing that each 'reading' does not strictly equate with a 'defence' or a 'critique' of the case. The two 'readings' provide a basis for exploring the one decision from different perspectives: whichever reading is preferred, the decision in *Breen* (or aspects of it) is less than satisfactory.

In this comment we identify each 'reading' of the case with a hypothetical law teacher, both of whom are collaborating in teaching a class of gifted students. The fresh and uninhibited approach of students in questioning the consequences and logic of the High Court judgment throws into stark relief some issues of the case, which have been underrepresented in the literature. We also chose two law teachers with different perspectives in order to suggest some possibilities for legal teaching; in particular, the option of exploring important decisions in class using different (and even theoretically incompatible) perspectives. As teachers of the law our aim is to encourage students not only to think rigorously within a positivist framework, but also to critically evaluate the impact of law on society. Of course, while a Socratic teaching method, as employed by the two teachers in the interactive, is only one of several models available to law lecturers, it does provide a convenient mechanism in this interactive for drawing out salient issues.

Facts and Context

Breen was litigated as a test case on behalf of a class of some 2,000 Australian women involved in litigation against, *inter alia*, Dow Corning

Corporation, as a result of leakage and other problems associated with silicon breast implants manufactured by Dow Corning. The Australian women were interested in 'opting in' to a US court-approved agreement distributing a fund of US $4.2 billion in settlement of worldwide litigation against Dow Corning and its subsidiaries. The United States litigation had previously been consolidated and was under the control of the United States District Court for the Northern District of Alabama.

Ms Breen had been surgically implanted with silicon breast implants in 1977. In 1978, the defendant specialist had performed a bilateral capsulotomy of compressed hard capsules which had developed within the silicon implants. In 1984 she underwent a partial mastectomy, following diagnosis of leakage of silicon gel from her left breast implant. In 1993, Mrs Breen became involved in the class action against Dow Corning. As a result of a US District Court order on 1 September 1994, however, Ms Breen and the other Australian claimants wishing to share in the settlement monies were required to file copies of their medical records with the District Court in Alabama within three months.

Production of the medical records to the Supreme Court of New South Wales in aid of the United States proceedings was available by way of Letters Rogatory issued by the US District Court. Alternatively, an order for discovery of the Plaintiff's records could have been sought and obtained from the Supreme Court in its equitable jurisdiction.[11] The plaintiff's action claiming a right to inspect and copy her medical records was intended, however, to circumvent the delays and costs associated with these procedures. Since Ms Breen was not alleging any breach of duty on the part of the defendant, her's was a test case for a right of access arising simply because she was a patient.[12]

Part 1

Professor Rupert Cautious and Ms Tamara Skeptic are co-teaching a final-year health law class at the University of Sydbourne. They each bring to class competing approaches to law and interpretations of the case. The following exchanges reflect the tension between these approaches, and require some signposting of their respective frameworks for analysis of the case.

In Part 1, Professor Cautious wishes to move straight into a doctrinal analysis. Ms Skeptic, however, is concerned to ensure students under-

11 *Breen v Williams*, note 1 above, at 84 per Dawson and Toohey JJ, at 120-1, 138 per Gummow J.

12 Ibid., at 86-7 per Dawson and Toohey JJ.

stand the broader nature of medical-record keeping. She considers this essential to assessing the doctrinal and policy underpinnings of the case. This leads to discussion about the availability of health information, and ultimately, a number of exchanges about the nature of the judicial role.

...

Professor Cautious: To analyse this case we need to consider the different grounds upon which Ms Breen argued the right to access her medical records. It was a novel claim, and it was up to her to demonstrate a doctrinal basis for it. But she failed to do so. The High Court considered contract, property, tort and fiduciary law as a basis for access, and rejected them all. Let's examine each of these in turn, beginning with contract.

Ms Skeptic: Professor, may I interrupt for a moment? We cannot adequately appreciate how the court reached its decision and assess its implications without some understanding of the broader social context. I suggest we begin by briefly considering what medical records contain, the kinds of information they can disclose, changes in information technology and their impact upon record-keeping practices, and patient expectations about access to information from health care providers.

Professor Cautious: Well, yes, some information on medical systems might provide a useful background, although we need to focus on the legal issues which emerged from the judgments.

Ms Skeptic: What I was referring to was more than just background; it is central to understanding the significance of this decision. An introspective doctrinal analysis can only obscure the policy choices the court has made in this case. The decision reverses the trend towards a patient-centred approach to health care service delivery as reflected through decisions such as *Rogers v Whitaker*.[13]

Professor Cautious: Well, in any event, what do you want to say about medical records?

Ms Skeptic: To start with, most people wouldn't realise the volume and nature of information which can be held in a hospital patient's record. A 1994 study of medical privacy issues, for example, took note of the typical contents of the medical files of inpatients and regular outpatients with human immunodeficiency virus (HIV) at a metropolitan public hospital. The study found that HIV records typically contain any or all of the following:

13 See note 6 above.

> 'HIV test results, T4 cell counts, other pathology [tests], details of sexual orientation, sexual practices and drug use, a full medical history, including family histories and biographical details, correspondence from specialists, copies of scripts and information concerning prescribed medication, details of clinical symptoms and progress notes, as well as (on occasion) counsellor's notes and details of the patient's economic, social and housing problems.'[14]

Although hospital records are confidential, in a hospital environment a wide range of information will nevertheless be available to all members of the health care team on a 'need to know' basis. In a well-known article published in the *New England Journal of Medicine* in 1982, a hospital physician whose patient had threatened to discharge himself unless the confidentiality of his medical record could be guaranteed, decided to check how many medical functionaries had a right to access a patient's records. He concluded:

> 'I was amazed to learn that at least 25 and possibly as many as 100 health professionals and administrative personnel at our university hospital had access to the patient's record and that all of them had a legitimate need, indeed a professional responsibility, to open and use that chart.'[15]

This state of affairs was confirmed in the Australian HIV study referred to above.

Student A (Anna): Doesn't this mean, therefore, that dozens of health professionals will be able to access a patient's record, and will be able to see what every other health professional has written in the record? And yet the patient, alone, is excluded from looking at the record. That seems absurd. One of the reasons given by Dr Williams in this case for denying access to handwritten notes in the medical record was that they were sensitive and would have been written differently if the doctor knew the patient would be able to read them.[16] However the fact that so many people

14 Magnusson R, 'Privacy, Confidentiality and HIV/AIDS Health Care,' (1994) 18 *Australian Journal of Public Health* 51, p 54.

15 Siegler M, 'Confidentiality in Medicine – A Decrepit Concept' (1982) 307 *The New England Journal of Medicine* 1518, p 1519. These persons included:

> '6 attending physicians (the primary physician, the surgeon, the pulmonary consultant, and others); 12 house officers (medical, surgical, intensive care unit, and covering house staff); 20 nursing personnel (on three shifts); 6 respiratory therapists; 3 nutritionists; 2 clinical pharmacists; 15 students (from medicine, nursing, respiratory therapy and clinical pharmacy); 4 unit secretaries; 4 hospital finance officers; and 4 chart reviewers (utilisation review, quality assurance review, tissue review, and insurance auditor). It is of interest that this patient's problem was straightforward and he therefore did not require many other technical and support services that the modern hospital provides.'

16 *Breen v Williams*, note 1 above, at 85-6.

have access to – for example – a hospital file, tends to undermine Dr Williams' argument.

Student B (Boris): We're not only talking about hundreds of people accessing the record. The networking of electronic and medical records and the development of telemedicine[17] can potentially result in thousands of health professionals having access.

Ms Skeptic: That's a good point. As the Chairman of the New South Wales Privacy Committee told the Senate Community Affairs References Committee inquiry into access to medical records:

> 'We are talking about tens of thousands of people who have access to the information, yet there are some people quibbling about whether the person about whom the information is held should be the last in the queue to actually find out that information ...'[18]

Professor Cautious: This was a point raised by Kirby P, in his minority judgment in the NSW Court of Appeal.[19] You need to remember, however, that the High Court unanimously affirmed the majority decision.

In any event, as Ms Skeptic is no doubt aware, hospital treatment involves the collaboration of many professional and administrative people in the patient's interests. This 'team approach' necessitates the collection of information within a central repository. Access in a suburban general practice, however, might be limited to the doctor and the medical receptionist, although in a group practice, it might be more extensive. In both cases, however, the legal approach to patient access is not affected by the nature of the treatment environment. The patient would need to demonstrate a legal foundation for a right of access.

Your concern about patient exclusion from hospital records is also, in many cases, groundless. Freedom of information legislation gives patients

17 The American Telemedicine Association has defined 'telemedicine' as including:

> 'the transfer of medical information (graphic, video, voice, etc.) between distant locations with patients, physicians, other health care providers, and medical institutions. It includes using telecommunications to link health care specialists with clinics, hospitals, primary physicians and patients in distant locations for diagnosis, treatment, consultation and continuing education.'

Sourced from the House of Representatives Standing Committee on Family and Community Affairs, *Inquiry into Health Information Management and Telemedicine*, Submissions, Volume 1, September 1996, p 84. Submission by PictureTel Australia Pty Ltd, Submission No. 70.

18 Senate Community Affairs References Committee, *Report on Access to Medical Records*, June 1997, para 4.77.

19 *Breen v Williams*, note 2 above, at 548 per Kirby P.

a right to access their medical records within the public health sector,[20] except where such access would seriously harm the patient's physical or mental health (the so-called 'therapeutic privilege' exception).[21] Some States have enacted legislation which also grants patients access rights within private hospitals.[22] So patients are not necessarily excluded from accessing hospital records.

Anna: But doesn't this make the exclusion of patients from inspecting the records of a practitioner such as Dr Williams look all the more anomalous?

Boris: It makes the access issue turn on the apparently irrelevant consideration or whether the patient is in a hospital or not, or in some States, whether the patient is accessing private as against public health care services.

Professor Cautious: Perhaps. But that is an irrelevant consideration for a court, which is not concerned with remedying legal inconsistencies, but with applying the law. Ms Breen could only have won her case by demonstrating a legal basis for her claimed right of access in contract, property, equity or on some other basis. This is an important point. When you look at the judgments in *Breen* you will see that it was the doctrinal basis of the claimed right of access with which the judges were (rightly) concerned. It is irrelevant whether the judges thought patient access was a good idea. Gaudron and McHugh JJ spelled this out when they said:

> 'Advances in the common law must begin from a baseline of accepted principle and proceed by conventional methods of legal reasoning ... Any changes in legal doctrine, brought about by judicial creativity, must "fit" within the body of accepted rules and principles. The judges of Australia cannot, so to speak, "make it up" as they go along. It is a serious constitutional mistake to think that the common law courts have authority to "provide a solvent" for every social, political, or economic problem.'[23]

But let's get away from the nature of the judicial role to deal with what I detect is the underlying concern of your questions: that patients are being denied medical information about themselves. This is not true. In fact, the

20 At the Commonwealth level, see: *Freedom of Information Act* 1982 (Cth) ss 11, 41 (subject to therapeutic privilege). At the State level, see, for example: *Freedom of Information Act* 1989 (NSW) ss 16, 31 (subject to therapeutic privilege); *Freedom of Information Act* 1982 (Vic) ss 13, 33 (subject to therapeutic privilege).

21 See note 10 above.

22 E.g.: *Private Hospitals Regulation* 1996 (NSW Schedule 1, Clauses 42-4 (access subject to therapeutic privilege, but reviewable by the Director-General of the Health Department); see also *Health Records (Privacy and Access) Act* 1997 (ACT).

23 *Breen v Williams*, note 1 above, at 115 per Gaudron and McHugh JJ.

law supports patients' rights to information about their health. Apart from Freedom of Information, and the other legislative rights to medical information to which I have alluded, what other avenues are open to a patient who desires to obtain medical information about themselves?

Student C (Carla): Brennan CJ recognised that a doctor has an implied contractual duty to provide the patient with medical information 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 on an earlier occasion.'[24]

Professor Cautious: Correct. A right to receive information from the medical history when the patient's health would suffer in the absence of such information does not extend, however, to a right of physical access to the medical record. Anything else?

Boris: In practice, patients are frequently given their X-rays and pathology reports to keep. For example, some X-rays were recently taken of me. I had to carry them to my doctor's surgery and she gave them back to me after the consultation. On the envelope containing the X-rays, there was a printed statement from the radiologist which said the X-rays belonged to me and I should store them in a dry, dark and safe place for future reference. Also, in terms of underlying principle, in *Breen*, Dawson and Toohey JJ considered that a patient might well have a proprietary right in these records.[25]

Carla: A doctor may be required by subpoena to produce medical files in court or to a patient's legal representative if the patient is suing the doctor or if those records are otherwise relevant to litigation.[26]

Professor Cautious: These are good points. To sum up, the law recognises no general right of physical access to the medical file. However, as you have pointed out, the law nevertheless makes a patient's health information available to the patient when the patient has a specific and legitimate need for it. Access may also occur if a particular doctor or clinic has a policy of providing access, although that does not affect the basic legal principle that there is no duty to provide access.

Student D (Douglas): Just to return to an earlier point about FoI legislation, I have the following question. If my doctor, a general practitioner, referred me to a specialist at a public hospital, could I obtain – through FoI legislation – access to any file the specialist created as a result of

24 Ibid., at 78 per Brennan CJ; see also at 91 per Dawson and Toohey JJ.

25 Ibid., at 88 per Dawson and Toohey JJ; cf at 126 per Gummow J.

26 Ibid., at 86 per Dawson and Toohey JJ; at 138 per Gummow J.

treating me? If I could, then presumably I could also access any letters exchanged between my doctor and the specialist *from the specialist's hospital file*, although I could not access the same letters from my doctor's file.

Ms Skeptic: Presumably the answer to your question is 'yes'. While you could not access the correspondence from your private doctor's file you could access the same correspondence from the public hospital file, unless the information in the particular document was subject to therapeutic privilege, or was received by the specialist on a confidential basis.[27] From the patient's point of view, however, that distinction is completely arbitrary and incomprehensible.

Professor Cautious: Yes, OK, but you need to remember that these inconsistencies arise form the operation of Freedom of Information legislation rather than from the underlying common law principle.

Douglas: In any event, this seems bizarre to me. On the one hand the High Court is saying that there is a general principle that a patient cannot look at his or her doctor's file. On the other hand, this principle has been undermined by quite a few exceptions. There are statutory provisions which enable the patient to see the hospital file and to access letters from a private doctor to a hospital which could not be accessed directly from the private doctor's file, to obtain court orders requiring presentation in open court of the doctor's file, and, as well, a doctor is obliged to tell a patient the substantive contents of the file if health circumstances warrant it. Also, some parts of the file such as X-rays may even be owned by the patient. Given all of this, what purpose is served by protecting the doctor's file? Would it not be more logical to have a general right to access the file, rather than the High Court's rule which is undermined by myriad qualifications?

Professor Cautious: No, I don't think so. There must be a doctrinal basis on which to rest such a general right of access. The High Court's task is to apply existing legal principle. And putting unusual circumstances such as those involving Ms Breen to one side, the width of the qualifications means that in most circumstances where isn't any practical need for a general right of access.

Ms Skeptic: I disagree. I would say that what Douglas seems to be struggling with are the seemingly illogical consequences of the decision. The approach adopted by the High Court appears to rest on a model that doctors do not have to make their files available unless there is a recognised

27 See note 10 above.

need on the part of a patient. This necessarily places the patient in a position of inferiority. I prefer a model which recognises that the doctor is engaged by the patient to provide medical care and to obtain sensitive information about the patient. Such a model demands that the patient retain ultimate control over that information, unless the provision of that information itself undermines the purpose of the relationship by harming the patient's physical or psychiatric health. Decisions such as *Rogers v Whitaker* provide implicit support for such a model, and indeed, raised expectations that at last patients might be treated as independent moral agents and be given an unfettered right to access the information which would enable them to make free and independent choices. In my view, however, the *Breen* decision turns the clock back and permits doctors to 'filter' the information provided to the patient, even though it is intensely personal information related to the patient's life and health.

I think the High Court was wrong because it embraced an old-fashioned model of medical decision-making. I think the factors the judges took into account in arriving at their decisions were too narrow. Since the law governs people in their day-to-day lives, why shouldn't the Court have considered whether patient access to their medical records was, in practical or policy terms, a good idea? The issue of patient access has been considered in the literature.[28] I am aware of the warnings that judges should not 'invent' law, but it is just as unsatisfactory for judges to blindly 'apply' the law without caring how that law will impact upon society. Law isn't just some sterile, hypothetical process which is hermetically sealed off from real life. This is why I prefer the dissenting judgment of Kirby P in the New South Wales Court of Appeal, who singled out issues such as the impact of the consumer movement upon patient expectations in health care, the increased mobility of patients, changes in technology, and the attitudes of doctors towards patient access.[29]

Professor Cautious: Well, that's all very interesting, but rather off the point, I feel. We've digressed. In fact, we haven't even started to consider the issues raised by this case.

Part Two

Professor Cautious and Ms Skeptic narrow their discussion to the juridical bases on which the plaintiff claimed her legal right of access to medical records.

28 For example, Gilhooly M and McGhee S, 'Medical Records: Practicalities and Principles of Patient Possession' (1991) 17 *Journal of Medical Ethics* 138.

29 *Breen v Williams*, note 2 above, at 547-9.

...

A: Contract

Professor Cautious: The first basis on which Ms Breen claimed a right to access 'her' medical records was contract.

Although the foundation of the relationship between a doctor and a patient is in contract, as Gaudron and McHugh JJ point out, '[g]iven the informal nature of the relationship ... a contract between ... [them] ... rarely contains many express terms.'[30] As might be expected, there was nothing in the relationship between Dr Williams and Ms Breen which expressly provided for her to have access to the medical records.

Ms Breen, however, argued that a right to access arose by implication. She was unsuccessful in this argument.[31] It was neither standard practice for contracts between doctors and patients to contain a term providing for access, nor was such a term necessary to give reasonable or effective operation to the contract. Ms Breen also argued that the doctor had a duty to act in her best interests and that this necessitated giving her access to the medical file. However, as Gaudron and McHugh JJ pointed out, this duty is too vaguely defined, and goes well beyond the recognised duty to act with reasonable care, which is imposed in tort and implied, where applicable, in contract.[32]

Anna: Professor, I know that Brennan CJ and some other judges[33] recognised that the doctor would be under a contractual obligation to pass on medical information to other medical people; for example, when the patient moved to another locality or was referred to a specialist. What I do not understand is how the judges can imply a term of this sort, and yet refuse to imply a term granting a general right of access. After all, whichever term is to be implied, the contracting parties have not said anything expressly about either. Isn't the Court being arbitrary by implying one term, but not the other?

Professor Cautious: That is a good question, Anna. The answer is to be found in the restricted nature of the terms which a court will imply into a contract. As I indicated, a term will be implied if it is necessary to give reasonable or effective operation to the contract. Sometimes the terminol-

30 *Breen v Williams*, note 1 above, at 102.

31 Ibid., at 78-80 per Brennan CJ; at 91-2 per Dawson and Toohey JJ; at 102-5 per Gaudron and McHugh JJ; at 123-4 per Gummow J.

32 Ibid., at 104. See also at 78-80 per Brennan CJ.

33 Ibid., at 78-9 per Brennan CJ; at 91 per Dawson and Toohey JJ; and, probably, at 124 per Gummow J.

ogy 'to give business efficacy to the contract' is used to describe situations where terms are to be implied. It is accepted that the primary obligation of the doctor under the doctor-patient contract is the duty to 'use reasonable skill and care in treating and advising the [patient]'.[34] In order to comply with this obligation, in certain circumstances it will be necessary to pass on information from the doctor's file to other medical personnel. However, granting a patient a general right of access to the doctor's file is not necessary in order to give business efficacy to the doctor/patient contract. So the court is not acting arbitrarily here, but according to established principles underlying the implication of contractual terms.

Having said that, it seems to me that there is nevertheless one argument which might have enabled Ms Breen to succeed, which is consistent with the proper approach to the implication of terms into a contract. In my opinion, the speedy and accurate investigation and resolution of disputes about the delivery of medical care to a patient are clearly necessary accompaniments to the reasonable medical care of a patient. Indeed, in some cases the health of the patient may be materially advanced by doing so. Thus, I believe it was open to the Court to have granted a limited right of access which could be justified on the cost-savings involved in avoiding other, more cumbersome court procedures available to Ms Breen. This would not have disturbed the established balance of interests in the doctor/patient contractual relationship.

Ms Skeptic: Rupert, I think your comments betray the fact that the 'established principles' governing the implication of contractual terms, as you refer to them, are open to manipulation, or at least do not clearly dictate any particular result in a case such as this.

Quite apart from this, however, I think contract is a poor basis on which to decide the issue of access, given that a doctor/patient relationship may exist in the absence of contract. It doesn't make sense to decide the access issue on the basis of contract when the patient's interest in obtaining access remains, regardless of whether there is privity of contract between the patient and the particular doctor.

B: Property

Professor Cautious: Oh, well, let us leave contract aside then, and go on to consider property. The second basis on which Ms Breen claimed a right to access 'her' medical records was by claiming a direct, proprietary

34 Ibid., at 91 per Dawson and Toohey JJ.

interest in them. In my view, this argument was doomed from the start. Tamara, perhaps you will argue with me on this point.

Ms Skeptic: I'm not sure that property gets us any further than contract, Rupert, but please go on.

Professor Cautious: Courts have determined the ownership of documents generated within the context of a professional relationship by distinguishing between two situations. On the one hand, if the documents were prepared for the benefit of the client or were received by the professional as an agent for the client, then they belong to the client. On the other hand, if the documents were prepared by the professional for his or her own benefit in delivering services to the client, then they belong to the professional.[35] Since the purpose of the medical record, when created, is to assist the health care provider in managing the patient,[36] medical records have traditionally been regarded as a doctor's property.

In *Breen*, the plaintiff conceded before the High Court, to the unanimous satisfaction of the Court, that Ms Breen's medical records were chattels owned by Dr Williams.[37] Even so, Dawson and Toohey JJ intimated that a patient might own X-ray films and pathology reports.[38] This troubles me. I do not think that Dawson and Toohey JJ were applying the distinction correctly. In some cases, an X-ray will merely report a bare scientific fact: for example 'the bone is broken'. But in many instances it will require a doctor's interpretation in order to make sense to the patient. It is better to regard the pathologist as an agent of the doctor, rather than as an agent of the patient. Regardless of whether the X-ray films or pathology report are given to the patient to take back to the doctor, or are sent directly to the doctor, the fact remains that they will have initially been requested by, and will require interpretation by, the doctor. And the doctor will use the information in the reports or films to assist in managing the patient. Thus, Dawson and Toohey JJ wrongly classify externally generated documents as the property of the patient. The convention that X-rays and pathology reports tend to finish up in the hands of patients can be explained by either an express contractual arrangement at the beginning to that effect, or by the doctor gifting them to the patient once they are no longer needed by the doctor. There may be sound practical reasons for this, such as a lack of storage space.

35 *Leicestershire County Council v Michael Faraday & Partners Ltd.* [1941] 2 KB 205, at 216.

36 *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542, at 548-9 per Hope JA.

37 *Breen v Williams*, note 1 above, at 80, 88, 101 and 126.

38 Ibid., at 88.

Anna: Perhaps the distinction you refer to above, for determining who owns documents, isn't relevant in this case. Perhaps the criterion for ownership in this case is *who pays* for the X-rays and pathology reports. If the patient pays for them, then the patient owns them.

Boris: Yes, but if payment is the issue, couldn't you also argue that the patient pays for the medical record which the doctor creates, at least where a contract exists between doctor and patient?

Professor Cautious: Alternatively, you might argue that when a patient obtains a pathology report, all the patient pays for is the provision of information to the doctor, who is the only one in a position to interpret the results, and who will add those results to the mix of relevant information used to manage the patient!

Carla: Can I make a comment? Let's assume, as you suggest, Professor, that the treating doctor does own the pathology reports. Let's also assume that the pathologist makes a technical mistake in the analysis, and reports the wrong result to the patient (or doctor)! Is the doctor liable for the error which harms me, the patient? Presumably not, because she has not been personally negligent and is not responsible for the acts of a third party (the pathologist) who is carrying out that party's professional responsibilities.[39] Yet isn't it curious that the doctor is not liable for the injury caused by reliance upon a document which she owns, which embodies the results of a test which she requested and alone has power to interpret, which causes me harm, which is paid for by me, and which you argue the doctor has a right to exclude me from accessing, thereby ensuring that I cannot protect myself from harm?

Professor Cautious: Er ...

Carla: Or take another example. I undergo some expensive medical tests which take a long time to complete and are physically taxing. My specialist misinterprets the tests. My condition deteriorates. In desperation, I seek out another specialist. My new specialist asks for copies of the test results from my first specialist. But my first specialist, who, as you point out, Professor, owns the test results, refuses. Can I compel the first specialist to comply with the request? If I can do so (and surely no other conclusion is justified), how is that legal right consistent with the first specialist being the owner of the records? The same principle would apply (but less dramatically) when a patient moves interstate and changes

39 This broad statement needs some qualification. In some circumstances it may be negligent for a medical practitioner to rely on (incorrect) pathology results without further investigation: *O'Shea v Sullivan* (1994) Australian Torts Reports 81-273, at 61,299-301.

their doctor. People are increasingly mobile. It is interesting that one of the policy reasons Kirby P gave for upholding a patient's right of access was the fact that:

> '[p]atients moving from one place to another should not be obliged to depend upon the willingness of a medical practitioner to provide access or to offer a summary'.[40]

Professor Cautious: It seems to me that you are failing to distinguish proprietary from contractual rights. The fact that the doctor owns the file is quite consistent with a contractual obligation upon the doctor to disclose information from the file in certain circumstances. By the way, it is reassuring to observe that this contractual obligation is economically efficient. The patient does not need to undergo the expense and inconvenience of further tests. The contractual right implied by Brennan CJ ensures that relevant information is supplied to other doctors who may treat the patient.

Ms Skeptic: Let's return to Dawson and Toohey JJ's dicta about the ownership of pathology and X-ray reports. Another strange consequence of their comments is that pathology and X-ray records are treated differently to the records of a treating doctor. The pathologist's files are transparent: the report generated as a result of the pathologist carrying out his or her function belongs to the patient, while the treating doctor's files are protected from patient inspection. As I said before, from a patient's perspective, this is ludicrous.

Professor Cautious: Hang on a minute. I agree with you that Dawson and Toohey's distinction is problematic. However, if property laws were applied coherently, the patient would have property rights in *neither* the doctor's records, *nor* the pathologist's records. That is simply the result of applying principles of personal property law to this case. What other proprietary rights did the plaintiff assert in this case?

Carla: The plaintiff also argued that she had a proprietary right in the *information* contained in the medical files, and that this permitted her to access those files.

Professor Cautious: Quite right. Australian courts have traditionally rejected the argument that there is property in information itself, particularly in cases involving breaches of confidence.[41] The problem, as Dawson and Toohey JJ rightly pointed out, is that 'there can be no proprietorship in information as information, because once imparted by one

40 *Breen v Williams*, note 2 above, at 547.

41 See Magnusson R, note 5 above, pp 32-3.

person to another, it belongs equally to them both'.[42] Equity may restrain the disclosure of confidential information, but that does not mean that a person can 'own' information, either for the purposes of restraining others from using it, or obtaining a right to access it oneself.

Ms Skeptic: I think this obsession with the application of 'settled principles' is leading us astray here. To my mind, the fact that information can become separated from the physical medium used to store it suggests that personal property is a poor basis on which to argue about access rights. Increasingly, medical files are going on-line. There may be no physical medium, no 'hard copy' record. There is a revolution in information technology under way within the health sector. Medical networks linking health providers from a variety of contexts (including hospitals, general practice, pathology laboratories and State Health Departments) are under active planning in order to improve continuity of care, to facilitate electronic collaboration between treating doctors and specialists, and to reduce duplication and inefficiency. The aim of the Health Commission's Network, for example, which has been under development for several years in Australia, is to:

> 'link doctors, hospitals, allied health practitioners, pharmacies, nursing homes and community health centres in Australia through computer modem connections and telephone lines. The network would not store information, but would allow the exchange of appropriate information by authorised users.'[43]

For example, tele-reporting of pathology results may involve a pathologist downloading the results of a pathology test into a treating doctor's computer, automatically updating the patient's computerised file.[44] There may be no piece of paper which constitutes the report. Or, to take a second example, under amendments to the *National Health Act* 1953 (Cth), private health funds can purchase health care services from hospitals for their members.[45] Patients who are contributors to private insurance funds

42 *Breen v Williams*, note 1 above, at 90.

43 Health Issues Centre, *The Power of Information: Health Providers, Consumers and Treatment Records*, May 1993, p 22; 'Meaningful and Confidential: The New Health Communications Network' (1994) 6(2) *Circuit Newsletter* 9; see further the submission by the Health Communications Network to the 'Telemedicine Inquiry', note 17 above, Volume 2, pp 461-93. For a review of pilot trials involving telemedicine, see the 'Telemedicine Inquiry Report', note 8 above, p 27 ff.

44 Crowe B, *Telemedicine in Australia: A Discussion Paper*, Australian Institute of Health and Welfare, February 1993, pp 27-8.

45 *National Health Act* 1953 (Cth) s 73BD; See further Mendelson D, 'Health Legislation (Private Insurance Reform) Amendment Act 1995 (Cth) and the Question of Medical Confidentiality' (1996) 4 *Journal of Law and Medicine* 107; Devereux J, 'New Health Insurance Legislation' (1995) 3 *Journal of Law and Medicine* 11.

contract with their funds to provide the care they require when admitted to hospital. A patient in a private hospital might reasonably desire access to information from a medical provider with whom he or she has no direct contractual relationship,[46] and in circumstances where the medical file exists only in computerised form. These examples simply underscore how unhelpful a discussion of personal property and contract is, and how important a thorough understanding of the wider social context of medical practice is to legal questions, including the question of access to records. In my view, the law should consider the access issue according to principles which apply consistently where the issue is raised.

C: Fiduciary Law

Professor Cautious and Ms Skeptic move on to discuss fiduciary law.

...

Professor Cautious: The third basis on which Ms Breen argued her right of access was through fiduciary law. Before we can discuss the proposed connection between fiduciary principles and Ms Breen's claim, we need to be clear on some fundamental principles of fiduciary law. Now, fiduciary duties are stringent duties of loyalty imposed by the courts in their equitable jurisdiction upon a person who 'has come under an obligation to act in another's interests'.[47]

Secondly, as Brennan CJ pointed out, a fiduciary relationship may arise where there is 'a relationship of ascendancy or influence by one party over another, or dependence, or trust on the part of that other'.[48] Such a relationship is presumed in the case of trustee and beneficiary, solicitor and client, agent and principal and some other relationships. Outside of these 'core' relationships, the specific circumstances of a particular relationship may also give rise to fiduciary duties.[49]

46 The health care provider (the hospital, and its contracted medical staff) is paid by the private insurer, not the patient.

47 *Breen v Williams*, note 1 above, at 113 per Gaudron and McHugh JJ. They state, at 108:

> '[t]he law of fiduciary duty rests not so much on morality or conscience as on the acceptance of the biblical injunction that 'no man can serve two masters'. Duty and self-interest, like God and Mammon, make inconsistent calls on the faithful. Equity solves this problem in a practical way by insisting that fiduciaries give undivided loyalty to the persons whom they serve.'

48 Ibid., at 82.

49 Dawson and Toohey JJ note that apart from this:

Thirdly, the core fiduciary duties imposed by equity are the duties to avoid a conflict between personal interest and the interests of the dependent party, and secondly, the duty not to make a profit from using one's fiduciary position.[50]

Against this background, please tell me, why did the High Court unanimously hold that Ms Breen failed in her attempt to show that it was a breach of fiduciary duty for Dr Williams to refuse Ms Breen access to 'her' medical file?

Anna: Well, the first problem was whether the doctor/patient relationship is a 'fiduciary relationship'. Even if the doctor was a 'fiduciary', the second problem was whether the failure to provide access to medical records breached any relevant fiduciary duty. Fiduciary duties do not attach to all aspects of a fiduciary's conduct.

Professor Cautious: Quite right. Some members of the High Court accepted that the doctor/patient relationship displays some of the same characteristics of ascendancy/vulnerability which courts have identified in fiduciary relationships, while denying that this implied a specific duty to provide patients with access to their medical records.[51] Secondly, some of the Court also accepted that the doctor/patient relationship may be one of 'undue influence', in the sense that a doctor might bear the onus of proving that a gift received from the patient was given free from the influence which the relationship produced. Of course, undue influence can well be regarded as a separate equitable doctrine independent of fiduciary law.[52] Thirdly, some members of the Court did, in fact, concede that doctors can owe fiduciary duties in limited circumstances.[53] Dawson and Toohey JJ, for example, accepted that it was conceivable that a doctor might place himself or herself in a position of conflict of interest giving rise to a fiduciary obligation; for example, where a doctor referred a patient to a private hospital or pathology service in which the doctor had an

'the law has not yet been able to formulate any precise or comprehensive definition of the circumstances in which a person is constituted a fiduciary in his or her relations with another'.

Ibid., at 92.

50 Ibid., at 93 per Dawson and Toohey JJ; see also at 135 per Gummow J.

51 Ibid., at 83 per Brennan CJ; at 107-8 per Gaudron and McHugh JJ; at 134-5 per Gummow J; cf at 93 per Dawson and Toohey JJ.

52 Ibid., at 83 per Brennan CJ; at 92 per Dawson and Toohey JJ; see also Parkinson P, note 5 above, p 445.

53 Ibid., at 93-4 per Dawson and Toohey JJ; at 107-8 per Gaudron and McHugh JJ; at 134-5 per Gummow J.

undisclosed financial interest.[54] However, there was no evidence in this case that Dr Williams had profited from the relationship beyond his standard fee.[55] Failing to provide access to medical records did not break any duty hitherto recognised by the courts as 'fiduciary' in nature. The underlying principle is this: you can't just invent a new duty called 'the duty to provide patients with access to their medical records' and label it a 'fiduciary duty' merely because the doctor/patient relationship is a relationship which supports, in rare circumstances, recognised fiduciary duties.[56]

Anna: I don't understand. It seems clear to me that ultimately Dr Williams was motivated to refuse access to the file by a desire to protect his own interests ahead of those of his patient. He was prepared to provide Ms Breen with access to her records, but only on condition that she release him from *any claim* that might arise from his treatment of her.[57] In the New South Wales Court of Appeal, Kirby P found that for this reason, Dr Williams had placed his own legal interests into conflict with those of his patient.[58] Dr Williams did, arguably, breach a 'recognised' fiduciary duty; ie, the 'no conflict' rule.

Boris: Perhaps, Anna, the 'no conflict of interest/no profit' rules apply specifically only to *financial or property* interests. You might argue that the refusal to provide access to medical records had nothing to do with the patient's financial or property interests. On the other hand, this was a

54 Ibid., at 93-4 per Dawson and Toohey JJ. Note that criminal provisions also sanction 'sweetheart' arrangements between doctors and pathologists: *Health Insurance Act* 1973 (Cth) ss 129AA-129AAA. As another example, Gummow J (at 136) mentioned the well-known American case of *Moore v Regents of the University of California* 794 P 2d 479 (1990), where a physician treating a patient with hairy-cell leukaemia took numerous samples of body fluids from the patient, following a splenectomy, to assist in growing a commercial cell line established with cells from the patient's spleen; see, further, Magnusson R, 'Specific Consent, Fiduciary Standards and the Use of Human Tissue for Sensitive Diagnostic Tests and in Research' (1995) 3 *Journal of Law and Medicine* 206, pp 216-7, 226-9.

55 *Breen v Williams*, note 1 above, at 109 per Gaudron and McHugh JJ; similarly, at 136-7 per Gummow J.

56 Ibid., especially at 83 per Brennan CJ; at 136-7 per Gummow J.

57 According to the Australian solicitors for the plaintiffs in the breast implants litigation, at a meeting held between them and representatives of the AMA and medical defence unions, the unions required the plaintiffs to indemnify the treating doctors against *any proceedings* which *third parties* might take against the doctors as a precondition to providing the patients with their medical records. The plaintiffs thought this went too far, particularly in view of the possibility that Dow Corning, the manufacturer of the breast implants, might counter-claim against individual doctors. It was the defence union's insistence that Ms Breen effectively insure Dr Williams against suit, and her refusal to go this far, which led to the test case. Source: discussion with Mr David Hirsch, Partner, Messrs Cashman & Partners, Sydney, 25 September 1997.

58 *Breen v Williams*, note 2 above, at 547 per Kirby P.

case where a woman – whose leaking breast implants had already resulted in a partial mastectomy – was contemplating litigation against the manufacturer. In the absence of an indemnity to protect his legal position, Dr Williams was forcing her to go to the trouble and expense of obtaining a court order from the relevant United States court, and to have it enforced in New South Wales. Surely Dr Williams' refusal was in conflict with his patient's *financial* interests? Surely Dr Williams did, therefore, breach the narrow 'conflict of interest' duty which three members of the High Court accepted may apply to doctors?[59]

Professor Cautious: I don't think you can argue that Dr Williams breached the 'no conflict of interest' rule which applies to fiduciaries. Any fiduciary duty owed by Dr Williams could only have arisen with respect to the performance of the services which Dr Williams had undertaken to perform for Ms Breen. In addition, it could only have attached to those aspects of the undertaking 'which exhibited the characteristics of trust, confidence and vulnerability that typify the fiduciary relationship'.[60] In this case, as Gaudron, McHugh and Gummow JJ point out, any fiduciary duty owed by Dr Williams could only have attached to matters relating to diagnosis, advice and treatment.[61] Dr Williams did not owe, at any time, a generalised duty to act in Ms Breen's best interests – such a hypothetical fiduciary duty could only have arisen with respect to his provision of advice and treatment to her. Yet nothing which Dr Williams did in the provision of that advice and treatment brought him into a conflict of interest with Ms Breen's interests. She relied upon him when he gave her treatment and advice. But how has he profited at her expense? How did he – in the course of his consultations with her – pursue his own interests at the expense of hers? As Gaudron and McHugh JJ concluded, 'it is impossible to identify any conflict of interest, unauthorised profit or any loss resulting from any breach of duty.'[62]

Boris: It does seem to me that the only breaches of fiduciary duty their Honours were prepared to recognise were those which disadvantaged Ms Breen financially. That is one point. And there is no argument over the fact that a doctor might fairly ask a fee for time and expense incurred in granting access. However, I do think that Dr Williams' refusal to grant access involved a conflict of interest which related directly to the services of treatment and advice which he had undertaken to provide to Ms Breen.

59 Cf *Breen v Williams*, note 1 above, at 93-4 per Dawson and Toohey JJ; at 136 per Gummow J.

60 Ibid., at 108 per Gaudron and McHugh JJ.

61 Ibid., at 108 per Gaudron and McHugh JJ; at 135, 138 per Gummow J.

62 Ibid., at 108.

If, for example, the refusal to grant access was motivated by a desire to avoid potential litigation relating to the doctor's past provision of treatment and advice to the patient, then surely there is a direct conflict, and more than this, the doctor would arguably be profiting from it – legally, if not financially – by reducing exposure to a potential liability?

Professor Cautious: You are overlooking, aren't you, Gaudron and Toohey JJ's comment that the conditional denial of access ('if you release me from legal claims') could not have been a breach because it would lead to the strange result that an unconditional refusal was OK, but a conditional refusal (a refusal in the absence of an indemnity) was a breach.[63]

Anna: Why does it matter whether the refusal is conditional or unconditional? Surely the real issue was whether the refusal, however expressed or qualified, and relating as it did to the past provision of treatment and advice to Ms Breen, was motivated by a desire to protect the doctor's own financial or legal interests, to the detriment of Ms Breen.

Boris: Perhaps the issue is not what *motivated* Dr Williams' refusal, but what Dr Williams did after being made aware that his patient did have, in fact, a legal and financial interest in accessing the records which related to his previous provision of treatment and advice.

Professor Cautious: I understand the arguments you are both making. They are very inventive. But the circumstances of the relationship here, I think you'll admit, are a long way from the trustee/beneficiary relationship, which is the paradigm context within which the 'no conflict of interest' principle operates. In your case, you're arguing that while no breach was involved at the time of the original consultations, Ms Breen's subsequent personal circumstances retrospectively taint the nature of the treatment and advice that Dr Williams gave. I don't think you can argue this.

Douglas: It was open to the court to adopt the more liberal Canadian approach to fiduciaries though, wasn't it?

Professor Cautious: I suppose it was, although the Court didn't, and with good reason. Like Anglo-Australian courts, the Canadian Supreme Court uses the language of 'fiduciary duties' but the concepts are actually very different. In *McInerny v MacDonald*,[64] the Court focussed on the fact that patients entrust doctors with highly personal information, in the expectation that it will be used for the patient's benefit. Emerging from this model of the doctor/patient relationship are a category of duties which the

63 Ibid., at 108-9.

64 (1992) 93 DLR(4th) 415.

Canadian courts also call 'fiduciary duties' However, unlike the *prospective or negative* duties which exist under Anglo-Australian law (the duties to avoid a conflict of interest and not to profit from one's fiduciary position), the Canadian courts have recognised the existence of *prescriptive or positive* 'fiduciary' duties. These duties have no foundation in precedent.[65] They are judicial inventions. They are, if you like, no more than the products of judicial musings upon this theme of 'trust and confidence' between doctor and patient. Let's look at one of the key passages in the judgment:

> '[I]nformation about oneself revealed to a doctor acting in a professional capacity remains, in a fundamental sense, one's own. The doctor's position is one of trust and confidence, The information conveyed is held in a fashion somewhat akin to a trust. While the doctor is the owner of the actual record, the information is to be used by the physician for the benefit of the patient ... the trust-like "beneficial interest" of the patient in the information indicates that, as a general rule, he or she should have a right of access to the information and that the physician should have a corresponding obligation to provide it.'[66]

In *Breen*, Gaudron and McHugh JJ warned that Canadian courts 'apply fiduciary principles in an expansive manner so as to supplement tort law and provide a basis for the creation of new forms of civil wrongs'.[67] The fact is, of course, the doctor/patient relationship is primarily regulated by the law of tort and contract, and only extremely rarely by fiduciary law.[68]

Boris: Can I make a comment here? Gaudron and McHugh JJ rather vigorously denied that doctors have any duty to act in their patients' best interests.[69] In whose interests, then, should they act? Their own?

Professor Cautious: The point of that statement was that doctors' practices are regulated primarily by tort and contract, with fiduciary law only becoming relevant in rare situations where there is a conflict of interest or unauthorised profit. There is no general fiduciary duty 'to act in the patient's best interests' which becomes the springboard for a clutch of new, judicially-invented duties owed by doctors.

65 As Dawson and Toohey JJ stated in *Breen v Williams*, the Canadian approach to fiduciary duties 'may effectuate a preference for a particular result, [but] does not involve the development or elucidation of any accepted doctrine': (1996) 186 CLR 71, at 95.

66 *McInerny v MacDonald* (1992) 93 DLR(4th) 415, at 424-5 per La Forest J (for the Court).

67 *Breen v Williams*, note 1 above, at 113.

68 Ibid., at 93 per Dawson and Toohey JJ; at 102 per Gaudron and McHugh JJ.

69 Ibid., at 103-5, 110.

Student E (Edward): Professor, I am a bit worried by the possibilities which would confront doctors if some general fiduciary duty to act in a patient's best interests was to be imposed on them. For instance, is a doctor who knows or even suspects that he or she has been negligent in the treatment of a patient under a fiduciary duty to inform the patient of those matters because it is in the best interests of the patient to know?

Anna: Edward, he would have a duty of care to tell if there was some danger to the patient of future harm from the negligence such as where the doctor knew that he had carelessly failed to remove all of a cancer.

Edward: Yes, however, that is in negligence, not in fiduciary law. But what if the pain a patient suffers is more prolonged or the scarring greater than it need have been and the patient does not realise? There is no risk of future harm in these cases. Must the doctor 'dob herself in' because of some fiduciary obligation to act in the patient's best interests, namely, to alert the patient to the circumstance that the patient may have a legal claim against the doctor?

Professor Cautious: That is clearly not the position under fiduciary law. In fact, Gaudron and McHugh JJ expressly reject that very concern.[70] But Edward has hinted at a very important general point. If a court is to assume the role of developing a major new doctrine, it must be very aware of the possible implications. Courts are notoriously ill-equipped for this role because they lack the resources to consult and receive submissions in the manner of our Parliaments.

Edward: Another possible negative implication of some nebulous fiduciary duty owed to patients is that doctors might not be able to destroy their records without consent from patients. That would be very impractical.

Professor Cautious: Yes, and this is also dealt with by Gaudron and McHugh JJ where they cite the doctor's ownership of the records as the prevailing consideration in allowing destruction without patient permission.[71] By confining itself to interpretation and clarification, rather than embarking upon invention, the Court has fulfilled its proper role.

Ms Skeptic: I am not so sure that these 'negative implications' are all that significant. Why shouldn't people in positions of trust and responsibility, such as doctors, be required to own up to their wrongs? While no-one wants to be sued, at least doctors are insured. Also, the destruction of records issue can be practically managed by routinely obtaining patient consent to their destruction after a certain and reasonable period of time. In

70 Ibid., at 113.

71 Ibid., at 112.

any event, computer technology does away with record space and access problems.

But returning to the Professor's point about clarification and interpretation, I agree that in this case the High Court judgments appear to clarify the nature of fiduciary duties in Australian law. For example, the Court emphasised the 'representative' nature of those relationships within which fiduciary duties *may* arise[72] (in order to point out that doctors do not generally act in a representative capacity for patients),[73] whereas previously there was some uncertainty over the essential features of those relationships capable of supporting fiduciary duties.[74] However, I think the formalist interpretation of *Breen v Williams* – that the High Court was 'restrained by principle' from accepting Ms Breen's fiduciary argument – is quite misleading. The High Court had a choice. It chose to adopt a view which was doctrinally conservative and, in my view, rather regressive. Courts in England,[75] Canada,[76] and the United States[77] have decided differently. Prior to the High Court's decision, bodies such as the Royal Australian College of General Practitioners,[78] and the Privacy of Information Committee of the New South Wales Health Department,[79] had recommended that patients be granted a right of access. In fact, the High Court's decision precipitated an inquiry by the Senate Community Affairs References Committee which recommended the enactment of:

> 'comprehensive national legislation enshrining the right of access to medical and other health records in the public and private sectors ... without delay'.[80]

72 Approving Mason J's approach in *Hospital Products Ltd. v United States Surgical Corporation* (1984) 156 CLR 41 at 96-7.

73 *Breen v Williams*, note 1 above, at 93 per Dawson and Toohey JJ; at 107 per Gaudron and McHugh JJ.

74 For example, in *Hospital Products Ltd. v United States Surgical Corporation*, note 72 above, at 68-70 per Gibbs J (declining to characterise the nature of fiduciary relationships); at 142, 147 per Dawson J (relative inequality of bargaining power, special vulnerability of one party); at 96-7 per Mason J (representative nature of the relationship).

75 *R v Mid Glamorgan Family Health Services Authority; ex parte Martin* [1995] 1 WLR 110 (CA).

76 *McInerny v MacDonald* (1992) 93 DLR(4th) 415.

77 *Cannell v Medical and Surgical Clinic* 315 NE 2d 278, at 280 (1978); *Emmett v Eastern Dispensary and Casualty Hospital* 196 F 2d 931 (1967).

78 The Royal Australian College of General Practitioners, *Code of Practice for Medical Records in General Practice*, January 1996 (draft), p 9.

79 Privacy of Information Committee, NSW Health, *Information Privacy: Code of Practice*, 1st ed., May 1996, pp 30-1.

80 Senate Community Affairs References Committee, *Report on Access to Medical Records*, June 1997, Recommendation 3.

And yet the High Court, like the majority judges in the New South Wales Court of Appeal ignored completely the central policy issue: whether patient access would be a good idea.

Professor Cautious: They ignored it, Tamara, because it was irrelevant! As Gaudron and McHugh JJ said:

> '[I]n a democratic society, changes in the law that cannot logically or analogically be related to existing common law rules and principles are the province of the legislature'.[81]

Courts are not democratically elected. They have no right to impose their own policy preferences or their own versions of 'what is a good idea' upon society at large.

Ms Skeptic: Oh, but they do, Rupert, all the time. Take the medical law area, for example. Contrast the judgments of Kirby A-CJ and Meagher JA in *CES v Superclinics (Aust.) Pty. Ltd.*, recognising and repudiating, respectively, a claim for wrongful birth.[82] I challenge you to argue that either judgment is the product of neutral reflection and interpretation of existing legal principle. In *Re Marion*, Mason CJ, Dawson, Toohey and Gaudron JJ were perfectly happy to discuss policy issues, concluding that court authorisation was necessary as a procedural safeguard prior to sterilisation of an intellectually handicapped child.[83] Nor did Brennan J's commitment to the rule of law prevent him from discussing at length the notion of human dignity and personal inviolability; indeed, his Honour's highly original judgment introduced a novel distinction into Australian law – adapted, as it happens, from the Canadian Supreme Court – between therapeutic and non-therapeutic medical treatment.[84]

Having said that, I am not arguing that the High Court should have arbitrarily 'legislated' the policy preference which happens to persuade me. But I do think the Court could have recognised a patient's right to access records within the broad bounds of fiduciary principle. Consider the notion of 'loyalty to another's interests' which is, as the High Court states, the basis for Anglo-Australian fiduciary duties.[85] What is to stop courts

81 *Breen v Williams*, note 1 above, at 115.

82 (1995) 38 NSWLR 47, at 49 ff, 85 ff. In a 'wrongful birth' claim, the plaintiff claims damages to compensate for the birth of an unwanted child. Wrongful birth claims variously arise from unsuccessful sterilisations, negligent contraceptive advice, the failure to detect birth defects, or, in the *CES* case, the failure to detect a pregnancy until it was too late to have an abortion safely.

83 *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, at 249-54.

84 Ibid., at 269-77.

85 See note 47 above.

from acknowledging that fiduciaries should show loyalty, not only to the financial or proprietary interests of their patients, but also to their vital non-economic, personal interests, such as the interest in having access to the information upon which decisions are made which relate to the patient's life and health?[86] Is that such a big step? What interest could be more fundamental than one's interest in participating in decisions affecting one's life and health? Does the notion of loyalty to the interests of a dependent and trusting party make any less sense in the patient's context than in that of the beneficiary of a trust? And yet the High Court seems to be limiting fiduciary duties to contexts in which the wrong committed, or the remedy given, relates to money or some proprietary interest. Fiduciary laws protect partners, beneficiaries, and solicitor's clients, but not patients, whose life or health, rather than bank balance is at stake. If the Court had regarded a fiduciary's duty of loyalty as encompassing a person's non-economic (health) interests, then Ms Breen's claim might have been supported as an incremental development of the law, while remaining within the bounds of established legal principles.

Professor Cautious: Actually, Tamara, I don't think there is much in *Breen* on which to offer an opinion one way or another over whether the only interests fiduciary law protects are financial or proprietary in nature. As I explained before, Ms Breen failed not because Ms Breen's interest were non-financial, but because Dr Williams was found not to have engaged in conduct, in the course of providing treatment and advice, which involved a conflict of interest.

But coming back to your specific point about the development of fiduciary law. The fiduciary obligation is a powerful legal tool developed for a specific purpose: to remedy conflicts of interest, the receipt of unauthorised profits by fiduciaries, and other wrongs falling within these categories. Its remedial value lies in the fact that it is used sparingly. It should not be watered down as a 'remedy-at-large' for every gap in contractual or tortious principles.[87]

Ms Skeptic: What I'm saying, Professor Cautious, is that Ms Breen's fiduciary remedy might not be explicitly within the boundaries of the 'no profit/conflict of interest rule' as it applied to treatment and advice, but it is not clearly outside the notion of loyalty which is the unifying principle of Anglo-Australian courts' development of fiduciary obligations. What

86 Cf *Norberg v Wynrib* (1992) 92 DLR (4th) 449, at 489 per McLachlin J.

87 Sir John Balcome, formerly a Lord Justice of Appeal of England, encapsulated this view in a recent extra-judicial statement: 'If the law is deficient reform it; do not stretch the doctrine of fiduciary relationships beyond what it can properly bear.' *New Zealand Law Journal*, November 1996, 402, p 404.

we have here is a conservative decision, made at a time when the High Court was under sustained criticism for its 'activism', and the probable effect of which is to continue to limit fiduciary law to the economic/proprietary area. Class, what implications does this decision have for the doctor/patient relationship?

Professor Cautious: None at all! I know what you're trying to do! You're trying to suggest that the decision embodies a paternalistic model of the doctor/patient relationship, merely because no existing legal principle gave Ms Breen the novel right she claimed.

Ms Skeptic: What the law doesn't do with respect to the rights and duties which it confers or imposes upon patients and doctors *does embody*, and *does construct* a model of that relationship. In *Breen v Williams*, the High Court upheld a model of decision-making which permits the doctor to filter the information which patients are allowed to know. I prefer a model which views the relationship in terms of 'mutual participation', in which the doctor collaborates with the patient in maximising the patient's health and wellbeing, recognises the patient as an independent moral agent, and incorporates the patient's perspective and expressed concerns when choosing a course of action.[88] While the doctor brings professional expertise and knowledge into the relationship, this model nevertheless facilitates the patient in making his or her own decisions with fullest access to the information he or she considers necessary to do so.

Anna: Your model of decision-making would put patients in the 'driver's seat'. The role of the doctor would be rather like that of a driving instructor, to explain the controls and buttons, and to advise certain courses of action. But the patient is driving the vehicle.

Edward: But isn't it curious, Ms Skeptic, that your preferred model of the doctor/patient relationship, which can only be achieved by so-called 'fiduciary duty' to provide access to medical records, also has the effect of *reducing* the power differentials between the doctor and the patient, which must be the basis for any fiduciary duty in the first place?

Ms Skeptic: Of course, without access there is the power differential, whereas access permits a more equal relationship. Acting in a manner which discharges the duty arising under the fiduciary relationship (thereby avoiding potential harm to the patient's vital, albeit non-economic, interests) doesn't mean the duty didn't exist in the first place. The duty to provide access exists to reduce the risks of harm inherent in relationships of ascendancy/vulnerability.

88 See Laine C and Davidoff F, 'Patient-Centered Medicine: A Professional Evolution', (1996) 275 *Journal of the American Medical Association*, 152, p 153.

Professor Cautious: I'm afraid you haven't convinced me. All of us wish we could achieve noble ends by using the law, but the coherency of law depends upon judicial respect for precedent and established principles. Whilst a right of patient access has popular appeal, such issues must be examined in a detached fashion.

Ms Skeptic: This is not merely a populist or emotional issue, although those elements are present to some degree. Interestingly, one might argue that the rhetoric heard about the importance of following precedent merely reflects a disposition not to depart form an entrenched position. A judge who favours a more flexible view in a particular case, on the other hand, might remark, as Kirby P did in his dissent:

> 'The fiduciary principle is in a state of development whose impetus has not been spent to the present day ... As society becomes more complex, it is both necessary and appropriate for courts of equity to recognise new fiduciary obligations and to protect incidents of new or changing relationships.'[89]

Or, as Justice Thomas, of the New Zealand High Court, has stated extra judicially:

> '[t]he [fiduciary] concept can be advanced, and with it the equitable remedies, under the rubric of public policy to meet the reasonable expectations of the community.'[90]

Flexibility has, in fact, been an accepted feature of equity for a long, long time.[91]

Perhaps a better approach to decision-making in this case would have been to ask, explicitly, whether there were good reasons for recognising an incremental development of fiduciary principles into a new area. Judges should be clear about what is motivating new developments in the law. Who benefits? And who loses if patients' interests are judicially defined as outside the scope of legal principle? And who will be honest about this whole judicial game which the judges are playing? We should ask all these questions, but most of all we shouldn't hide behind the veneer of formal neutrality. Law isn't neutral. It must be judged as well.

Part 3

Professor Cautious and Ms Skeptic share very little common ground and they present their conclusions to the class separately.

89 *Breen v Williams*, note 2 above, at 543 per Kirby P.

90 Justice E W Thomas, 'An Affirmation of the Fiduciary Principle', *New Zealand Law Journal*, November 1996, 405, p 406.

91 See, for example, *In re Hallet's Estate* (1879) 13 Ch. D 696, at 710 per Jessel MR.

...

Ms Skeptic: *Breen v Williams* is a disappointingly timid decision. The Court, and this class, spent a lot of time discussing contract and property, although these are odd doctrinal bases on which to decide issues of access, because they are only contingently relevant to the context in which patients might reasonably seek access. I had hoped the Court might have developed the notion of fiduciary duties further than it did. Equity is after all, the embodiment of judicial invention to meet changing social conditions. We have seen that there are significant circumstances in which a patient can obtain direct access to medical records and have questioned why the Court did not show judicial leadership and draw together the multifarious means of access into a single principle recognising a right of access which is inspired by modern values of patient self-determination and transparency in professional, business and administrative practice. In other words, in view of compelling policy reasons, the Court should have been prepared to incrementally expand fiduciary principles.

In Ms Breen's case, the Court might have recognised that Dr Williams' refusal to provide access brought him into conflict with his patient's interest in having medical information gathered for the specific purpose of providing advice and treatment to the patient. The doctor/patient relationship is a special relationship of honesty and trust, and any personal information acquired by the doctor should be held by the doctor for the benefit of the patient. Subject to therapeutic privilege, patients ought not to be reliant upon the doctor to reveal, and perhaps filter, that information. For personal and legal reasons, Dr Williams refused Ms Breen access to that information. In addition, he prejudiced Ms Breen's legal interests by forcing her to the trouble and expense of seeking court orders for release of the records. I admit that the interest in accessing personal information represents an expansion of the 'no profit/conflict of interest' principle beyond its usual economic context and bears some resemblance to the reasoning in *McInerny v MacDonald*,[92] but an incremental development on good policy grounds is nothing new to the law.[93]

I am disappointed in the Court's failure to explicitly consider the policy aspects of this case. The Court's decision does, of course have a social impact. Although the Senate Committee recommended national legislation granting patients a right of access, it recommended it as part of the

92 (1992) 93 DLR (4th) 415.

93 *Caparo Industries Plc v Dickman* [1990] 2 AC 605, at 618,628, 633-4; *Murphy v Brentwood District Council* [1991] 1 AC 398, at 461, 482, 487, referring to well-known views of Brennan J in the High Court.

envisaged extension of federal privacy legislation to the private sector,[94] which the federal Government has since repudiated.[95] It is not clear whether the government will proceed with access to records legislation, applicable to the private sector, on some other basis.

Professor Cautious: You shouldn't neglect to mention, Tamara, that since the High Court decision, the ACT government has, in fact, introduced specific legislation granting patients a right of access.[96] The Privacy Commissioner has also introduced voluntary, private sector privacy principles, which private sector health providers are free to commit to, and which would give patients a right to access their health information.[97]

Ms Skeptic: We may still be quite some way, however, from an enforceable, Australia-wide, right of access to health records.

Perhaps we should conclude, then, by doing what the High Court didn't do; that is, ask ourselves whether giving patients access to 'their' medical records is a good policy?

Anna: One policy reason which might support the High Court's decision would be the fear that doctors might be subjected to a flood of requests by patients to examine their files.

Ms Skeptic: Is this a realistic fear?

Boris: I don't think so. Most people would not want to look at their files if the doctor was explaining the issues clearly and providing good care. A patient is only likely to want to look at their record when the doctor loses the patient's confidence and that would be rare given the overall volume of consultations.

Anna: But what about those patients who might be regarded as 'troublemakers'. By that I mean a patient who might be a 'sticky-beak' or is obsessively concerned either with their medical condition or with what the doctor is taking down in the clinical notes? These people could waste the doctor's time or become very confused and upset by what is in the notes if they were allowed to read them.

94 Senate Community Affairs References Committee, *Report on Access to Medical Records*, June 1997 (Recommendation 6).

95 'Another Key Election Promise Bites the Dust', *The Sydney Morning Herald*, 31 March 1997, p 11.

96 *Health Records (Privacy and Access) Act* 1997 (ACT).

97 Office of the Privacy Commissioner, *National Principles for the Fair Handling of Personal Information*, February 1998. The 'Access and Correction' principle refers to access to personal information about the individual, rather than access to the records (if they exist in hard copy) embodying that information.

Boris: Well, if something in the file is medically damaging to the patient it could be withheld under the medical privileges qualification which has been accepted by the Canadian Supreme Court and was conceded by Ms Breen.[98] In any event, leaving aside those situations where therapeutic privilege might arise, studies suggest that patient access, supervised where necessary, is a positive experience which benefits patients.[99] Furthermore, the doctor might justifiably charge a reasonable fee for access and that would have the effect of discouraging frivolous inquiries.

Carla: I asked my father, who is a plastic surgeon, about the wisdom of patients accessing their records. He says doctors' medical files are not complete. They don't write everything down; they sometimes rely on memory. Also, they use shorthand expressions and medical jargon. If the patient comes to the medical file wanting a comprehensive description of their relationship with the health provider, they're going to be disappointed. If doctors documented everything relevant to the case, they'd see two patients a day instead of twenty.

Boris: These are not insurmountable problems. I don't see why doctors cannot continue to use shorthand expressions and medical jargon. All that is needed is for the doctor to be available, for a reasonable fee, to explain those terms to the patient if necessary. Increasingly, medical files are going to be maintained on-line using standardised clinical terms and corresponding codes.[100] These developments will at least go some way towards satisfying your concerns about the time-costs of record keeping.

Carla: According to my father, a more serious consequence of patients having access to their records is that doctors won't write their initial thoughts down anymore. They certainly won't write a tentative diagnosis down in the notes when tests are still ongoing. Rather, they will protect themselves by writing nothing down until they are absolutely sure: who wants to get sued for not acting earlier on a 'diagnosis' written in the notes?

Boris: But why couldn't a doctor simply record the fact that the diagnosis is tentative? Wouldn't it be good professional practice for the doctor to record such suspicions and theories – identified as such – so that a full re-

98 *McInery v MacDonald* (1992) 93 DLR(4th) 415 at 430; *Breen v Williams*, note 2 above, at 546; *Breen v Williams*, note 1 above, at 87.

99 See studies reviewed and referred to in Bloch S, Riddell C and Sleep T, 'Can Patients Safely Read their Psychiatric Records?' (1994) 161*The Medical Journal of Australia* 665; Gilhooly M and McGhee S, 'Medical Records: Practicalities and Principles of Patient Possession' (1991) 17 *Journal of Medical Ethics* 138.

100 See, for example, Submission of the Computer ServicesCorporation Australia to the 'Telemedicine Inquiry', note 17 above, Volume 4, pp 897-9.

cord can exist to guide any other medical practitioners who may need to look at the file? In any event, if litigation does arise, the file will be accessible anyway in the discovery.

Edward: There is, of course, another issue which nobody has mentioned: retrospectivity. For years doctors have maintained patient records on the basis that they weren't open to patient inspection. It seems rather unfair to the doctors if the law were suddenly to make these records available. A legislature could take these matters into consideration and perhaps create a prospective right of access to all records created after a certain date. That's why I think the legislature is better placed than the courts to consider the issue of access to medical records.

Ms Skeptic: I acknowledge that retrospectivity is one argument which perhaps weighs against the introduction of a right of access. However, this is always the case when courts recognise a new legal right. The disadvantage of having courts declare a new right which challenges settled perceptions must be balanced against the benefits of having a common law which responds to changing social circumstances.

Let's turn, then, from considering the negative implications of allowing patients access to their files, to any positive effects which providing access may have. Do you have any suggestions?

Anna: I think doctors would be discouraged from making disparaging or 'boysey' remarks about their patients if the comments were open to inspection. Also, patient access to medical records is a form of accountability which builds into the system transparency and an incentive to good record-keeping.

Ms Skeptic: Personally, I must admit I agree with you. Those doctors who cannot keep their records in a professional manner should be open to being exposed for what they are. In a recent study of psychiatric patients' records, for example, Bloch, Riddell and Sleep noted that:

> '[i]t was disconcerting to encounter so many carelessly written comments, which could be interpreted by patients as reflecting a lack of professionalism.'[101]

Professor Cautious: If I might also sum up at this point? We have seen that neither contract, property, tort nor fiduciary law granted Ms Breen a right of access to her medical records. Even so, access rights exist in legislation, by discovery, and under doctors' duties to provide information to clients as part of their contractual and tortious obligations. Beyond this, however, it may very well be that our law lacks a theoretical infrastruc-

101 See note 99 above, p 665.

ture for theorising the kind of liberal, patient-centred model of the doctor/patient relationship my colleague Ms Skeptic so passionately advocates.

In recognising the absence of that theoretical structure, I return to my earlier comments directed to the proper role of an appellate court and remind you of the remarks of Gaudron and McHugh JJ in that regard. The court cannot and must not '"make it up" as they go along'.[102] The legal solution which Ms Skeptic embraces has grave and uncertain implications for the practice of health care. Furthermore, for decades doctors and others in health care professions have been proceeding on the basis that patients are not permitted to view their files. To overturn this applecart with retrospective application as Ms Skeptic would have us do seems quite inappropriate.

The vigorous exchanges between my colleague and I may have given the impression that I do not support patient access to medical records. The truth is, I hope that the Commonwealth will pass legislation creating such a right, as the ACT government has already done. I also accept that there are 'policy' arguments either way, as you have just been discussing. But courts cannot legislate. If they could, the rights and liberties the law grants us would be constantly under threat from judges with the power to impose their own values and preferences upon a populace which did not elect them.

102 *Breen v Williams*, note 1 above, at 115.