BREEN v WILLIAMS*

I INTRODUCTION

The High Court decision in *Breen v Williams* upheld the decision of the majority in the New South Wales Court of Appeal[1] in refusing to recognise any common law or equitable right in a patient to access medical files held in the possession of that patient's doctor. The High Court held that a patient has no proprietary, contractual or equitable right to obtain a medical file held by a doctor. Ultimately, the decision of the High Court reinforces the primacy of the doctor's common law and equitable right to retain medical records and in this respect represents a victory for medical expedience and discretion. Nevertheless, the court did not rule out the possibility of a statutory right being introduced. Specific reference was made to s 3 of the Access to Health Records Act 1990 (UK) which confers a prima facie right of access to health records by the individuals to whom they relate. This right is, however, qualified by s 5 which sets out that access will not be conferred where, in the opinion of the holder, the information would be likely to cause serious harm to the physical or mental health of the patient or any other individual or alternatively, a third party could be identified from that information.[2] Gaudron and McHugh JJ stressed the fact that changes in the law which are beyond the scope of the existing common law are properly to be addressed by the legislature:

> In 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.[3]

The right to medical files claimed by the plaintiff in *Breen* was qualified in a similar way to the English legislation; she claimed a right to all material which was not harmful to herself and which did not identify third parties. The High Court did not explore in depth the various policy arguments arising from such a right, reaching their conclusions on purely legal grounds. As Gaudron and McHugh JJ clearly noted, it may well be that people believe a right — or at least a qualified right — to access should be conferred by the court, but in the absence of a contractual duty, there is simply no existing common law principle that would countenance such a right.[4] Furthermore, the court was not prepared to extend the application of fiduciary obligations in equity to cover such a right. Effectively, this leaves the creation of such a right up to the legislature. A

* (1996) 138 ALR 259. High Court of Australia, Brennan CJ, Dawson, Toohey, Gaudron, McHugh and Gummow JJ, 6 September 1996 ('*Breen*').

1 *Breen v Williams* (1994) 35 NSWLR 522 (Mahoney and Meagher JJ, Kirby P dissenting).

2 *Breen* (1996) 138 ALR 259, 275-6.

3 Ibid 290.

4 Ibid.

statutory right to access may well be more appropriate given the obvious importance of qualifying the right in certain circumstances: legislation could circumscribe more accurately the scope and application of the right, thereby enabling important policy considerations to be reflected more accurately.

One of the most disturbing consequences of *Breen v Williams*, however, was the Court's refusal to recognise the significance of the equitable jurisdiction — in particular the ambit of fiduciary obligations. This problem becomes more obvious when the Canadian developments are considered. Most of the judges in *Breen* either refused or were cautious about imposing fiduciary obligations that resulted in patients acquiring medical files. The majority concluded that this was beyond the scope of equity and expressly disapproved of developments in the Canadian equity jurisdiction in this respect. It is unfortunate that the High Court did not seize upon the opportunity to develop the equitable jurisdiction in accordance with changing social relationships. Kirby P (in dissent) in the Court of Appeal stated:

> 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 .... The courts of equity began their development of the obligations of fiduciaries in the context of many commercial relationships, such as partners, principal and agent, director and company, and solicitor and client. But, clearly, these are mere species of the genus. They cannot possibly define and limit the fiduciary relationship.[5]

Fiduciary obligations have become a vitally important method of safeguarding a wide variety of different relationships that display characteristics such as ascendancy, influence, vulnerability, trust, confidence and dependence. With respect, there is no reason why such obligations should not be extended to provide greater protection to the changing dynamic of the doctor-patient relationship, particularly in cases where a patient is vulnerable, heavily reliant upon a doctor and in particular need of information contained within the medical file. Nevertheless, the High Court has not developed the equity jurisdiction in this way, leaving the legislature with the full responsibility of determining what level of protection, if any, should be introduced.

II THE HISTORY OF *BREEN V WILLIAMS*

In 1977 the appellant, Ms Breen, had an operation referred to as a bilateral augmentation mammaplasty. This involved the insertion of breast implants made of silicon gel. In 1978, Ms Breen consulted the respondent, Dr Williams, who performed an operation to compress the breast capsules. Dr Williams was not the doctor who performed the initial breast implant surgery. After this operation Ms Breen had limited correspondence with Dr Williams, apart from discussing the possibility of removing the implants and considering other unrelated medical conditions. In 1984, another plastic surgeon, Dr McDougall, performed surgery to remove silicone gel leakage in the left breast and corrective surgery to the right

[5] *Breen v Williams* (1994) 35 NSWLR 522, 543.

breast. In 1993, Ms Breen decided to join a class action in the United States against the manufacturer of the breast implants, alleging that they were defective and seeking damages. In order for Ms Breen to join this litigation, she had to file medical records with the United States court before 1 December 1994. She sought access to the medical file held by Dr Williams. He refused to supply the file unless Ms Breen gave an undertaking releasing him from any legal claim that might arise in relation to his treatment. Ms Breen refused to give such an undertaking.

It would have been possible for Ms Breen to obtain the file through discovery or through the issuing of Letters Rogatory by the United States District Court that was hearing the pre-trial proceedings, forcing Dr Williams to hand over the file for the purposes of litigation. This was the procedure adopted by most of the other Australian litigants joining in the action, but Ms Breen chose not to do so because costs, delays and complications associated with that procedure were significant. Instead, Ms Breen chose to rely on a range of common law and equitable rights that she argued supported her right to access the file. She brought an action against Dr Williams in the Equity Division of the Supreme Court of New South Wales for a declaration that she was entitled to access her medical records.

The actual contents of the file were not in issue during the trial, but the trial judge, Bryson J, concluded that it probably contained handwritten notes by Dr Williams, possibly referral letters and hospital advice slips, correspondence with the patient, possibly reports from the other plastic surgeon, Dr McDougall, photographs and communications with the New South Wales Medical Defence Union.[6] During the trial, Dr Williams offered to provide a written report to Ms Breen outlining the contents of her medical records but excluding his correspondence with the Medical Defence Union. Ms Breen did not accept this offer.

The trial judge concluded that Ms Breen had no right of access to the medical file because the file belonged to Dr Williams.[7] Bryson J further held that there was no need to extend the common law to include a right to access because Ms Breen could have adequately made use of the existing legal process relating to the production of documents relevant to pending litigation.[8]

In the New South Wales Court of Appeal, a majority consisting of Mahoney and Meagher JJA dismissed the appeal, with Kirby P dissenting.[9] The Court of Appeal unanimously rejected any common law right to access the documents, but the judges assumed differing positions with respect to the imposition of equitable obligations. Mahoney JA felt that a doctor would be unlikely to owe a general fiduciary duty to patients although special areas may attract the application of such obligations.[10] Meagher JA was prepared to accept that a relationship between doctor and patient may be fiduciary in nature, but felt that the scope of

6 *Breen v Williams* (Supreme Court of NSW, Bryson J, 10 October 1994) 19.
7 Ibid 32.
8 Ibid 77.
9 *Breen v Williams* (1994) 35 NSWLR 522.
10 Ibid 568-9.

the duties imposed by such a relationship did not include a duty to allow a patient access to his or her medical file.[11]

III THE JUDGMENTS OF THE HIGH COURT

The primary issue before the High Court was whether or not a patient has a legal or equitable right to inspect or be provided with a copy of all medical records in the possession of his or her doctor which were created by that doctor during the course of treating the patient. The unanimous decision of the High Court was that no such right exists, either at law or in equity. Some of the important issues considered during the course of reaching this determination were:

- Who owns a medical file: the doctor or the patient?
- Can a patient argue that the contract he or she entered into with the doctor contained an implied term that the doctor will provide the patient with access to information contained in his or her medical file?
- Does the common law recognise any general right, whether contractual, proprietary or tortious in nature, of a patient to access his or her medical files?
- Is the relationship between doctor and patient of a sufficiently mutual and confidential nature to attract fiduciary obligations and, if so, do the duties imposed by such a relationship include a duty to provide a patient with access to his or her medical files? To what extent should Australian courts be prepared to follow Canadian developments in this regard? Further, to what extent do the equitable obligations overlap or conflict with the tortious duty of a doctor to exercise reasonable care towards a patient?

The approach of the High Court to each of these issues is discussed in turn.

IV OWNERSHIP OF THE MEDICAL FILES

The Court unanimously rejected the notion that Ms Breen had any proprietary right to the medical file. Importantly, Ms Breen did not claim that she owned the actual documents; rather, she claimed that she owned the information contained within the documents. In order for this argument to succeed, it was suggested that the actual documents were not 'owned' by anybody. This argument was categorically rejected by the High Court.

According to Gaudron and McHugh JJ, this was because the relationship between doctor and patient is not one of principal and agent; documents prepared by a doctor to assist him or her in fulfilling professional duties belonged to the doctor and, having the right of ownership, he or she was entitled to exclude any person from having access to them.[12] Brennan CJ came to a similar conclusion noting that

[11] Ibid 570. See, generally, Jason Pizer, 'Case Note: *Breen v Williams*' (1995) 20 *Melbourne University Law Review* 610.

[12] *Breen* (1996) 138 ALR 259, 279-80.

> documents prepared by a professional person to assist the professional in performing his or her professional duties are not the property of the lay client; they remain the property of the professional.[13]

Gummow J noted that a doctor may not only own the documents as chattels, but may also own the copyright in any materials produced for the purposes of treating a patient. As such, he or she had the sole right to determine whether or not to permit any copying of the documents.[14] Gummow J went on to note that the mere fact that a patient may be able to claim that a doctor is under an obligation of confidence with respect to information given over by the patient does not necessarily mean that the patient has any proprietary rights over the information itself.[15] His Honour distinguished the Canadian decision of *McInerney v MacDonald*,[16] in which La Forest J concluded that the information conveyed from patient to doctor is held by the doctor 'in a fashion somewhat akin to a trust'. The doctor owns the actual record that is prepared, but the information is to be used for the benefit of the patient; when the patient confides the information to the physician, that patient immediately gains an expectation that he or she will hold a continuing interest in the information.[17]

Gummow J disagreed with the analysis by La Forest J and noted that the proprietary analysis of the equitable obligation of confidence was inappropriate. Furthermore, Gummow J felt that the facts in *McInerney* could be distinguished to the facts at hand because the dispute related to the delivery of records and reports prepared by other doctors that had come into the possession of Dr McInerney, rather than any documents she had prepared herself.[18] Similarly, Dawson and Toohey JJ also rejected any trust analogy concluding that the relationship between doctor and patient is not that of trustee and beneficiary, being contractual rather than proprietary in nature.[19]

The decision in *McInerney* is an interesting one. The idea that a patient may own the information which he or she conveys to a doctor during the course of a consultation is certainly novel, as is the trust analogy. It seems that La Forest J was attempting to illustrate the rights that a patient has when conveying confidential, personal information by comparing the status of a doctor with that of a trustee: at no stage did La Forest J actually conclude that a doctor was a trustee or that a patient owned an equitable proprietary interest in the information. The analogy does serve to illustrate the degree of confidentiality attached to such information, however. In this regard, despite the protests of Gummow J, it may be possible to conclude that a patient holds an equitable right in the form of a chose in action over any documents prepared with such information. This is not to say that the patient owns the documents, nor that the patient owns the informa-

[13] Ibid 264.
[14] Ibid 299-300.
[15] Ibid 301-2.
[16] (1992) 93 DLR (4th) 415 ('*McInerney*').
[17] Ibid 424-5.
[18] *Breen* (1996) 138 ALR 259, 303.
[19] Ibid 273-4.

tion; rather, the patient holds a right, enforceable in equity, in respect of those documents which may be exercised to ensure that the information is used properly and for the benefit of the patient.

While Canadian courts may be prepared to recognise such a right, the Australian High Court, at least for the time being, appears unlikely to endorse it. Nevertheless, the trust analogy outlined by La Forest J in *McInerney* at least may have influenced Gummow J in his determination that, in light of the significant degree of confidentiality and trust between doctor and patient, the general relationship between doctor and patient is fiduciary in nature.

V CONTRACTUAL ARGUMENTS

The High Court also concluded unanimously that the contractual relationship between doctor and patient did not include an implied term to grant that patient a right of access to his or her medical files. Gaudron and McHugh JJ emphasised the contractual nature of the relationship between doctor and patient, though they also noted that the circumstances of such a relationship mean that such contracts rarely contains many express terms. As such, courts are required to determine the rights and obligations of the parties.[20]

Ms Breen argued that one of the essential terms that should be implied in every contract between doctor and patient is that the doctor should act in the best interests of the patient, and that an incident of this obligation is that a doctor should give a patient access to all medical files. Their Honours categorically rejected the imputation of such a term, holding that it would place doctors under an impossible burden; it would mean that whenever a doctor made a decision that turned out to be inappropriate, he or she could be liable for breach of contract. Their Honours also felt that such a term would contradict the tortious duties of a doctor to act with reasonable care and skill when providing professional advice and treatment. Finally, such a term would be too uncertain in scope: it would be difficult to work out whether or not a doctor had breached an implied contractual duty to act in the best interests of the patient. It may well be that where a doctor decided not to grant a patient access to medical records to ensure the psychological and therapeutic well-being of a patient, the doctor would not be in breach.

Brennan CJ concluded that in the absence of an express term conferring such a right, a term would only be implied where the contract would not be effective without it. His Honour felt that as the contract would be wholly effective without such a term, there was no foundation for implying it.[21] Gummow J came to a similar conclusion. His Honour noted that it may have been possible to imply a term giving Ms Breen a right to be informed, upon a reasonable request, of relevant factual material contained in her medical records, but it was going too far to imply a term granting her full rights to access such files.[22]

[20] Ibid 280-1.
[21] Ibid 263-4.
[22] Ibid 297-8.

Dawson and Toohey JJ also concluded that no implied term could arise unless it was necessary for the reasonable operation and efficacy of the contract. This could not be established on the facts. Their Honours held that the only terms that should be implied were those necessary for the doctor to properly exercise his duty of care towards the patient. Whilst it may be necessary for the ongoing health of a patient for a doctor to provide information in the form of a report to either a patient or an interested third party, it would be going too far to hold that the duty of care could only be properly exercised by implying an obligation to provide a patient with access.[23]

None of the judges was prepared to imply broad, protective terms favouring a patient. This is not surprising given that implied contractual terms are concerned with transactional efficacy rather than protection. If a contract can be properly performed without a particular term being implied, there will be no need for it. Hence the argument raised by Ms Breen (that it was necessary to imply a term to the effect that a doctor was obliged to act in the best interests of his or her patient) was clearly exceeding contractual boundaries. Doctors, like other professionals, are obliged to exercise reasonable care when dealing with patients, but they still have a right to take their own interests into account. A duty to act in the best interests of a patient may well require a practitioner to ignore his or her own financial or ethical considerations in favour of a patient's health. Such philanthropic behaviour could really only be expected in circumstances where it has been expressly agreed to.

Even if a duty to act in the best interests of a patient could be implied, there is nothing to suggest that this would necessarily mean that a doctor is under an obligation to provide a patient with access to medical records. The Court emphasised the importance of ensuring that implied contractual terms do not unduly interfere with the tortious obligation of a doctor to act with reasonable care.[24] The only circumstance in which a duty to provide access to information contained in medical files may be truly implied is where, as Brennan CJ notes, 'the future medical treatment or physical or mental wellbeing of a patient might be prejudiced by an absence of information about the history or condition or treatment of the patient on an earlier occasion'.[25] Such an obligation cannot, however, be unqualified. The obligation would only arise if and when a failure to provide information would prejudice the health of the patient.[26]

VI Common Law Right to Access Medical Files

One of the arguments raised by Ms Breen was that the law was moving towards the recognition of a general right allowing a patient to access his or her medical files. This right existed independently of proprietary and contractual arguments and was primarily based on policy arguments. Ms Breen argued that the law

[23] Ibid 271-2.
[24] Ibid 262 (Brennan CJ), 272 (Dawson and Toohey JJ), 282 (Gaudron and McHugh JJ).
[25] Ibid 262.
[26] Ibid.

should not promote medical paternalism and that it was in fact moving towards an acceptance of the principle of personal inviolability and patient autonomy. In this regard, Ms Breen noted the decision in *Rogers v Whitaker*.[27] This case concerned an action for medical negligence and, in particular, whether the failure of a doctor to advise a patient of the inherent risks associated with a particular operation constituted a breach of the duty of care. The Court held that except in cases of emergency, a medical practitioner has a duty to warn a patient of a material risk inherent in a proposed treatment. Whilst this case clearly advances the tortious obligations of doctors, it does not suggest that doctors are subject to a right of access to medical files. Certainly, the change in medical perspective can be detected from this decision. A patient has a right to be fully and freely informed of all the material risks and possibilities associated with treatment and it is not up to a doctor to determine whether or not such risks should be stated. Nevertheless, it is, as Gaudron and McHugh JJ noted, a 'quantum leap' to conclude that this now means doctors must give patients access to their medical files.[28] Indeed, none of the judges accepted the existence of an innominate common law right to access medical files.[29]

It is clear that in modern times, medical practitioners should no longer have a right to determine when patients should be protected from themselves. Nevertheless, this does not mean that doctors should lose all discretion. Doctors are obliged to act with reasonable care when dealing with a patient and reasonable care must include a full and accurate description of treatment procedures and consequences. Yet reasonable care means that a doctor must still consider the health of a patient and, as all the members of the High Court noted, full and absolute candour may not necessarily be in the best interests of a patient. Changing social standards demand that doctors act with greater openness when treating patients, but this does not necessarily include the revelation of private notes and comments — particularly where such notes would provide the patient with no greater insight into their ailment and may, in the circumstances, have a deleterious effect.

VII FIDUCIARY OBLIGATIONS

Most members of the High Court accepted that a doctor-patient relationship, or at least some aspects of the relationship, may raise fiduciary obligations. As Gummow J pointed out:

> [T]he relationship between medical practitioner and patient who seeks skilled and confidential advice and treatment is a fiduciary one. That will be so regardless of whether it is because the relationship between the parties is one which gives the medical practitioner a special opportunity to affect the interests of the patient who is vulnerable to abuse by the fiduciary of his position, or because the medical practitioner undertakes to exercise professional skill for the

[27] (1992) 175 CLR 479.

[28] *Breen* (1996) 138 ALR 259, 290.

[29] Ibid 266 (Brennan CJ), 277-8 (Dawson and Toohey JJ), 290 (Gaudron and McHugh JJ), 299 (Gummow J).

> benefit of the patient, and particular reliance is placed upon the medical practitioner by the patient.[30]

Some members of the Court felt that particular aspects, rather than the relationship itself, could be fiduciary in nature. Gaudron and McHugh JJ, for example, noted that in circumstances where a patient provides confidential information to a doctor and relies upon the doctor to keep such information private, the doctor may become a fiduciary of that information.[31] Similarly, Dawson and Toohey JJ concluded that fiduciary duties may be imposed on some aspects of the doctor-patient relationship, but they are confined and do not cover the entire relationship.[32]

The application of fiduciary obligations to the relationship between doctor and patient would enhance the protection of the patient: in such circumstances, a doctor would be obliged to avoid a conflict of interest and to account for any profit he or she might make. Not all of the judges felt that such duties were entirely consistent with the character of the relationship. Dawson and Toohey JJ were prepared to recognise that fiduciary obligations can co-exist with contract and tort. They felt, however, that such duties are often unnecessary because the focus of the doctor-patient relationship is positive rather than negative; the obligations which arise are more appropriately defined in terms of a positive observance of a duty of care rather than the negative avoidance of a conflict of interest.[33]

Similarly, Gaudron and McHugh JJ felt that the application of fiduciary duties could not alter the operation that the contract was intended to have according to its true construction. If the contract did not create any obligation to act in the best interests of the patient or any corresponding right to access medical files, such a right could not be applied through equity.[34] Their Honours note that

> a fiduciary duty that Dr Williams would always act in Ms Breen's best interests, which is the foundation of the claim of fiduciary obligation to provide access to the records, would conflict with the narrower contractual and tortious duty to exercise reasonable care and skill in the provision of professional advice and treatment that Dr Williams undertook.[35]

Both Dawson and Toohey JJ and Gaudron and McHugh JJ noted with disapproval the Canadian developments in this regard. In *McInerney*,[36] La Forest J held that one of the fiduciary qualities of the relationship between a medical practitioner and patient included the obligation to act with utmost good faith and loyalty to a patient and to grant access to the information the doctor uses in administering treatment. Dawson and Toohey JJ concluded that such obligations went too far and effectively 'displaced the role hitherto played by the law of

[30] Ibid 305.
[31] Ibid 285.
[32] Ibid 273.
[33] Ibid 274.
[34] Ibid 286-7.
[35] Ibid.
[36] (1992) 93 DLR (4th) 415.

contract and tort by becoming an independent source of positive obligations and creating new forms of civil wrong'.[37] Gaudron and McHugh JJ came to a similar conclusion, noting that Australian courts take a proscriptive rather than prescriptive approach to fiduciary duties. In this regard, their Honours felt that the Australian approach to fiduciary obligations is less intrusive on the law of negligence and contract than Canada. Further, their Honours seemed to indicate that if fiduciary duties were restricted to a greater extent, the problems associated with the unfair application of proprietary relief would be reduced.[38]

With respect, these comments seem to overlook the fundamental objectives of equity. Equity exists as a supplement to the law and its aim is to follow the law rather than overwhelm it. Fiduciary obligations are superimposed upon contractual or tortious duties where the circumstances are such that greater protection is needed. If fiduciary obligations co-existed with contractual or tortious duties, there would be no need for them in the first place. Hence, where fiduciary obligations are imposed, it is to be expected that they will add to the existing common law duties. This does not necessarily mean that the common law duties are destroyed. Fiduciary obligations must accommodate and be consistent with existing contractual duties; they cannot be superimposed so as to alter the operation that the contract was intended to have. This does not mean that fiduciary obligations are inapplicable, however. In some cases, the protection conferred by contractual duties is inadequate or the nature and ambit of the contractual duties is unclear. In such circumstances, fiduciary duties may provide supplementary protection against a vulnerable party. As Mason J noted in *Hospital Products Ltd v United States Surgical Corporation*,[39] the fact that a contract is unclear is not in itself a ground for rejecting the application of fiduciary obligations.[40] Indeed, it could be argued that the lack of clarity as to the terms of the contract in *Breen* provided a sufficient justification for the application of fiduciary obligations.[41]

In a doctor-patient relationship that contains few express terms and does not clearly indicate what the parties intended, the additional protection resulting from the imposition of fiduciary obligations may be desirable; such protection is aimed at alleviating the existing deficiencies in the contract rather than overwhelming the intentions of the parties or the fundamental objectives of the transaction.

VIII CONCLUSION

The decision in *Breen* illustrates a clear reluctance on the part of the High Court to develop contractual, proprietary or equitable obligations in order to allow a patient a right of access to his or her file. It would seem that if such rights are to be conferred, it will now be up to Parliament. This is a particularly

[37] *Breen* (1996) 138 ALR 259, 275.
[38] Ibid 289.
[39] (1984) 156 CLR 41.
[40] Ibid 97-9.
[41] See Patrick Parkinson, 'Fiduciary Law and Access to Medical Records: *Breen v Williams*' (1995) 17 *Sydney Law Review* 433, 442-3.

disappointing decision for the equitable jurisdiction. Whilst we may accept the proprietary and contractual conclusions of the court, it is hard to understand why the court was not prepared to recognise fiduciary obligations to act in the best interests of a patient, particularly in light of Canadian developments. If, as most judges noted, a patient is in a position of vulnerability and dependency, with the potential for abuse, why shouldn't a doctor be obliged to act in the best interests of a patient? This would not necessarily mean that a patient had an automatic right to access files, but surely, where such information is relevant to the ongoing care of a patient, both equity and common law should recognise a right to access. The refusal to recognise such a right undermines the whole purpose of the equitable jurisdiction and impedes its ongoing ability to 'temper the rigours' of the law. In this regard, perhaps the most progressive judgement in the case was that of Gummow J who, despite being stereotyped as an equity conservative,[42] emphasised the importance of mutuality between the inter-related doctrines of tort, contract and equity:

> The principles of tort, contract and equity interact to protect the concerns of the appellant in receiving confidential advice and skilful treatment from the respondent, without the abuse by him of the special position he occupies.[43]

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[42] See, eg, Gino Dal Pont and Don Chalmers, *Equity and Trusts in Australia and New Zealand* (1996) cxxx.

[43] *Breen* (1996) 138 ALR 259, 309.

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