

***Breen v. Williams:* A lost opportunity or a welcome conservatism?**

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1. Introduction

The recent case of *Breen v. Williams*¹ provided the High Court with an opportunity to re-evaluate the fiduciary law of this country to bring it into line with that of the Canadian jurisdiction. Canadian courts have a history of imposing positive obligations on fiduciaries in novel situations, most recently in respect of doctor-patient relationships. Such relationships, it held, were fiduciary in nature and, by virtue of this, the doctor was said to be burdened with a positive obligation to act with 'utmost good faith and loyalty'² towards the patient, an incident of which was to allow patients access to their medical records. However, in a clear rejection of Canadian developments, the High Court unanimously refused to expand the nature and scope of Australian fiduciary law in such a way as to impose upon doctors such an obligation.

2. Background: *Breen v. Williams*

In 1977 the appellant, Ms Breen, underwent plastic surgery during which silicon implants were inserted into each of her breasts. Subsequently, as a result of severe pain, the appellant consulted the respondent, Dr Williams, who performed an operative procedure in which he neither inserted implants nor removed the existing ones. Subsequently Ms Breen corresponded with Dr Williams about the possibility of having the implants removed, but no such surgery was performed by him. It was subsequently discovered that silicon gel had leaked from the implant in Ms Breen's left breast, which required corrective surgery.

Ms Breen later became involved in litigation against the manufacturers of the implants in the United States. However, in order to 'opt in' to a proposed settlement, Ms Breen was required to file copies of her medical

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¹ (1996) 186 CLR 71 (*Breen*).

² *McInerney v. MacDonald* (1992) 93 DLR (4th) 415 at 423.

records with the United States court. Thus, she sought to obtain medical records from Dr Williams who refused to provide them on terms which were acceptable to her.³ Although Ms Breen could have obtained the records by compulsory court process⁴ she chose not to follow this course because of the associated delays and expense.⁵ Instead she initiated proceedings claiming a qualified right⁶ to have access to her medical records.

At first instance Bryson J rejected the appellant's claim,⁷ and an appeal to the Court of Appeal was dismissed by majority. Kirby P, dissenting, was 'wholly convinced' by Canadian authority suggesting such a right of access.⁸ Basing his decision primarily on policy, he would have been prepared to allow the appellant access in this case. Leave to appeal to the High Court was granted.

3. Claims Before the High Court

When the matter reached the High Court there were three primary grounds for the appellant's claim that she had a right to access her medical records.⁹ These were (i) that there is an implied term in doctor-patient contractual relationships which would enable patients to have access to their medical records; (ii) that patients have a proprietary interest in the information contained within their medical records; and (iii) that a fiduciary relationship exists between doctors and patients which requires doctors to provide patients with access to their medical records.

³ Dr Williams offered to provide Ms Breen with a report of her medical records, or the medical records themselves, provided that she would exempt him from any liability in negligence that may arise from them.

⁴ Ms Breen could have obtained the records through the issue of Letters Rogatory, which had been obtained by several other litigants in her position, or through a court order for discovery: *Breen*, fn. 1 at 84.

⁵ *Breen v. Williams* (1994) 35 NSWLR 552 at 527 per Kirby J.

⁶ Qualifications based on 'therapeutic privilege' where disclosure would be injurious to the welfare of the patient, were acknowledged: *Breen*, fn. 1 at 87.

⁷ *Breen v. Williams* (Unrept, SC(NSW), 10/10/94).

⁸ *Breen* (1994), fn. 5 at 545.

⁹ Grounds which were previously submitted as forming the basis of a right of access, but not pursued in the High Court, or abandoned during the course of the appeal included: (i) fundamental human rights; (ii) an innominate common law right; and (iii) the right to know: *Breen* (1994), fn. 5 at 538-541.

The focus of this note is on the third ground and, in particular, the Court's unanimous dismissal of Canadian authority in this area as persuasive precedent in this Country. However before proceeding to do this I will deal briefly with the Court's treatment of the first two claims.

An implied contractual right

The Court was in agreement that the primary duties of a doctor are regulated by contract, and that absent a special contract, a doctor undertakes 'to advise and treat the patient with reasonable skill and care'.¹⁰ This duty does not extend to providing a patient with a general access to their medical records, however necessity may require the doctor to provide such access where to do otherwise would prejudice the health of the patient.¹¹ There was, however, no evidence to suggest that this was the case here.¹²

In addition, the Court unanimously refused to imply a term that doctors contract to act in the 'best interests' of the patient, as claimed by the appellant, noting the general rule that an implied term is based upon the presumed or imputed intention of the parties,¹³ meaning that had they put their minds to it they would have expressly agreed to it.¹⁴ It would be a far stretch of this proposition to suggest that a doctor would voluntarily submit himself to a duty to always act in the 'best interests' of the patient.¹⁵

¹⁰ *Breen*, fn. 1 at 78 per Brennan CJ.

¹¹ *Ibid.* The 'question in each case is whether access to the doctor's records is necessary to avoid or diminish the possibility of prejudice to the patient's health': Erbacher, S., 'Access to Medical Records: *Breen v. Williams*' (1996) 3 *Deakin LR* 67 at 72. See also the opinion of Mahoney J in the Court of Appeal that a 'doctor is contractually bound to make available information in relation to the patient's ongoing medical care': Scott, R., 'Breen v Williams and Patient Access to Medical Records' (August 1995) *Queensland Law Society Journal* 315 at 323.

¹² *Breen*, fn. 1 at 79 per Brennan CJ.

¹³ *Id* at 90 per Dawson & Toohey JJ.

¹⁴ Clarke, P.H., 1993, *Contract Law*, Butterworths, Sydney, 179.

¹⁵ 'No doctor in his senses would impliedly contract at the same time to give to the patient all the information available to the doctor as a result of the doctor's training and experience and as a result of the doctor's diagnosis of the patient': *Sidaway v. Board of Governors of the Bethlam Royal Hospital and the Maudsley Hospital* (1985) AC 871 at 904. The concept of 'best interest' and the effect such a duty would have on the generally accepted contractual duties is explored further in the context of fiduciary duties.

Further, the implication of such a term is not necessary to give effect to the contract¹⁶ given the existing duties to exercise reasonable care in their dealings with the patient. The uncertainty of the 'best interest' term also militated against its implication into the contract.¹⁷ This ground of the appellant's claim therefore failed.

Proprietary interest

Although the appellant conceded that the physical property of the medical files belonged to the doctor, she claimed that she had a proprietary interest in the *information* contained within the files, and that this carried with it a right to access the information. However the Court unanimously refused to recognise such a right,¹⁸ providing that there can be 'no proprietorship in information as information'¹⁹ in Australian law.

Fiduciary relationship

The most compelling basis for the appellant's claim lay in the assertion that a doctor-patient relationship is fiduciary in nature, and that as a corollary to that a doctor is under an obligation to act in the 'best interests' of his or her patient. The discharge of such an obligation, it was claimed, would require a doctor to provide patients with access to their medical records.²⁰ The High Court, however, in a controversial decision, unanimously refused to expand the notion of fiduciary obligations in Australia to accommodate such a duty.

Australian fiduciary relationships have traditionally fallen into a number of specified categories including trustee-beneficiary, solicitor-client, principal-agent and director-company, but traditionally have not included doctor-patient relationships. Although the categories of relationship which may be

¹⁶ *Breen*, fn. 1 at 80; *BP Refinery (Westernport) Pty Ltd v. Shire of Hastings* (1977) 180 CLR 266 at 283.

¹⁷ *Breen*, fn. 1 at 103-104 per Gaudron & McHugh JJ.

¹⁸ *Breen*, fn. 1 at 80-82 per Brennan; 88-90 per Dawson & Toohey JJ; 101-102 per Gaudron & McHugh; 126-129 per Gummow J. Kirby P in the Court of Appeal stated that: 'The information cannot in this case be disembodied from the medium in which it is contained': *Breen* (1994), fn. 5 at 538.

¹⁹ *Id* at 90 per Dawson & Toohey JJ. Their Honours referred to a number of authorities to support this statement, including: *Federal Commissioner of Taxation v. United Aircraft Corporation* (1943) 68 CLR 525; *Phipps v. Boardman* [1967] 2 AC 46; and *Moorgate Tobacco Co Ltd v. Philip Morris Ltd* (1982) 64 FLR 387.

²⁰ *Breen*, fn. 1 at 106 per Gaudron & McHugh JJ.

classed as fiduciary are not closed,²¹ and may encompass potentially any relationship in which trust and confidence exists between the parties that enables the dominant party to adversely affect the interests of the weaker party,²² it is rare that fiduciary relationships are determined to exist beyond the accepted categories.

If a fiduciary relationship is established, equity attaches certain obligations to the fiduciary, by virtue of her or his position of power and dominance, in order to protect the 'weaker' party. In Australia these have traditionally been proscriptive, or negative, in nature and have fallen into two categories:

- the duty to avoid a conflict of interest; and
- the obligation to account for any profits obtained by virtue of his/her position as a fiduciary.²³

In a 'trust' relationship, which has always been considered the strongest of all fiduciary obligations, these duties have extended to include the imposition of prescriptive obligations.²⁴ This is so by virtue of the fact that the fiduciary actually has a legal proprietary interest in the trust property, and therefore a greater potential to abuse the fiduciary position. The obligations imposed upon a trustee, however, provide an exception to the norm, and in other relationships Australian courts have not been prepared to impose obligations which extend beyond the two traditional proscriptive duties.

²¹ *Hospital Products Pty Ltd v. United States Surgical Corporation* (1984) 156 CLR 41 at 96. Courts may establish new categories where the main features of a fiduciary relationship are in existence.

²² Although determining what constitute the critical features of a fiduciary relationship is a near impossible task, given that the term fiduciary relationship 'defies definition' (*Breen*, fn. 1 at 106), the requirement of a relationship of ascendancy or trust by one party over another appear common to all fiduciary relationships: *Breen*, fn. 1 at 82-83. See also *Hospital Products*, fn. 21, where the Court of Appeal defined a fiduciary as 'a person who undertakes to act in the interests of another person'.

²³ *Breen*, fn. 1 at 113 per Gaudron and McHugh JJ. See also *Breen* (1994), fn. 5 at 570-71 per Meagher JA.

²⁴ These include a duty to act with reasonable prudence, a duty to act in the interests of beneficiaries, a duty to act impartially, a duty to keep trust funds separate, a duty to keep proper accounts and a duty to allow beneficiaries access to trust documents: Hepburn, S. 1997, *Principles of Equity and Trusts*, Cavendish Publishing, Sydney, 289-301.

In contrast to this Australian conservatism with respect to the development of fiduciary obligations, the Canadian jurisdiction appears to have developed this area of law much more radically. Canadian courts have been both more willing to recognise fiduciary relationships in novel situations, and then once such relationships are established, have been prepared to impose prescriptive fiduciary obligations in addition to the traditional proscriptive obligations. One recent example of these Canadian developments has seen the extension of the categories of fiduciary relationship to include that of doctor-patient, and has imposed upon doctors, as an incident of this relationship, a duty to provide their patients with access to their medical records.²⁵

The specific case relied upon in *Breen* as authority for the establishment of such a duty was *McInerney v. McDonald*.²⁶ This case concerned a doctor's refusal to provide a patient with medical reports and records that were in her hands, though had not been prepared by her.²⁷ In reaching the conclusion that there was an obligation to provide the patient with access to the medical records La Forest J, delivering the judgment of the Court, held that the relationship itself was fiduciary because of the trust and confidence reposed in the doctor.²⁸ Flowing from this relationship was, his Honour concluded, an obligation upon a doctor to act toward patients with 'utmost good faith and loyalty'.²⁹ The duty to provide the patient with an opportunity to view his or her medical records was considered by his Honour to be an incident of the duty to act with 'utmost good faith and loyalty'.³⁰ This duty was not, however, unqualified,³¹ an exception to full disclosure being available where

²⁵ *McInerney v. MacDonald* (1992) 93 DLR (4th) 415; *Norberg v. Wynrib* (1992) 92 DLR (4th) 449 (*Norberg*).

²⁶ (1992) 93 DLR (4th) 415 (*McInerney*).

²⁷ Mrs MacDonald had seen many doctors, and Dr McInerney was prepared to, and did in fact, provide Mrs MacDonald with copies of his medical records. However he also had in his possession medical records of Mrs MacDonald prepared by other physicians, which he refused to give to Mrs MacDonald upon her request.

²⁸ *McInerney*, fn. 26 at 423.

²⁹ *Ibid*.

³⁰ Dickens, B., 'Medical Records – Patient's Right to Receive Copies – Physician's Fiduciary Duty of Disclosure: *McInerney v. McDonald*' (1994) 73 *Canadian Bar Review* 234 at 237.

³¹ *McInerney*, fn. 26 at 427.

'there is a significant likelihood of a substantial adverse effect on the physical, mental or emotional health of the patient.'³²

Although considering the Canadian authority at length, the High Court expressly disapproved the application of its principles to Australian fiduciary law. A majority³³ of the High Court was prepared to recognise that the doctor-patient relationship is a fiduciary one. In this respect Brennan CJ considered that the fiduciary nature of the relationship came about because of a doctor's position of 'ascendancy over the patient' and the patients position of 'reposing trust in the doctor'.³⁴ Gaudron & McHugh JJ pointed to 'the dependency of the patient on the provision of confidential information'³⁵ and Gummow J pointed to several factors, including the reliance placed by a patient upon a doctor's specialised knowledge, skill and judgment,³⁶ the provision of confidential and intimate personal information and the impact the efforts of the doctor may have on the 'fundamental personal interests of the patient'.³⁷

However, despite acknowledging the fiduciary characteristics of a doctor-patient relationship their Honours were not prepared to extend the obligations imposed by a fiduciary relationship beyond the negative, traditional duties previously outlined.³⁸ They reinforced that Australian courts recognise only proscriptive fiduciary duties.³⁹ Recognition of a fiduciary relationship did not, however, mean that fiduciary obligations

³² Id at 427, 429-430.

³³ With the exception of Dawson and Toohey JJ who state; '... it is the law of negligence and contract which governs the duty of a doctor towards a patient. This leaves no need, or even room, for the imposition of fiduciary obligations': *Breen*, fn. 1 at 93. However, their Honours did recognise that 'duties of a fiduciary nature may be imposed upon a doctor': *Breen*, fn. 1 at 92.

³⁴ Fn. 1 at 83.

³⁵ Id at 107.

³⁶ Id at 134-135.

³⁷ Id at 135.

³⁸ Dawson and Toohey JJ did not characterise the doctor-patient relationship as a fiduciary one. However they were willing to recognise that fiduciary obligations may attach to some aspects of the relationship. These would include the traditional duties to avoid a conflict of interest and account for unauthorised profit: *Breen*, fn. 1 at 93.

³⁹ *Breen*, fn. 1 at 113 per Gaudron and McHugh JJ. See also Parkinson, P., 'Fiduciary Law and Access to Medical Records: *Breen v. Williams*' (1995) 17 *Sydney Law Review* 433 at 441-442.

attached to every aspect of the doctor-patient relationship, but only those aspects which exhibited the characteristics of a fiduciary relationship.⁴⁰

In unanimously refusing to follow the *McInerney* decision, the Court held that the Canadian notion of fiduciary duties does not 'accord with the law of fiduciary duty as understood in this country',⁴¹ noting the 'vast differences between Australia and Canada in understanding of the nature of fiduciary obligations'.⁴² Therefore any change to Australian fiduciary law to accommodate such duties as were determined to exist in *McInerney* would not simply constitute a progressive development of Australian fiduciary law, based on existing understanding of what characterises a fiduciary relationship and the obligations inherent in such relationships, but would involve a fundamental re-writing of fiduciary law as understood in Australia:

it would be to stand established principle on its head to reason that because equity considers the defendant to be a fiduciary, therefore the defendant has a legal obligation to act in the interest of the plaintiff so that failure to fulfill that positive obligation represents a breach of fiduciary duty.⁴³

In particular, the High Court considered that the Canadian decision was lacking in any sound doctrinal basis.⁴⁴ Meagher JA in the Court of Appeal alluded to this absence when he stated that the Canadian decisions:

do not explain either the origins or the boundaries of the supposed right, or even provide a description (much less a definition) of it. They merely assert it exists.⁴⁵

⁴⁰ Id at 107-108. Mason J in *Hospital Products*, fn. 21 at 98 noted that 'a person may stand in a fiduciary relationship to another for one purpose but not for others'.

⁴¹ Id at 83 per Brennan CJ.

⁴² Parkinson, fn. 35 at 439-40. This passage was adopted by Gaudron and McHugh JJ in *Breen*, fn. 1 at 112-113.

⁴³ *Breen*, fn. 1 at 137-138, per Gummow J.

⁴⁴ Id at 83 per Brennan: 'There is no relevant subject matter over which the respondent's fiduciary duty extended'; 98 per Dawson and Toohey JJ; 113 per Gaudron and McHugh; 138 per Gummow J.

⁴⁵ *Breen* (1994), fn. 5 at 570.

In this respect the High Court pointed to the tendency of the United States and Canadian courts to impose fiduciary obligations as 'an independent source of positive obligations' which create 'new forms of civil wrongs'.⁴⁶ While this 'may effectuate a preference for a particular result, it does not involve the development or elucidation of any accepted doctrine'.⁴⁷ Again, Meagher JA highlights this, referring to the tendency of the Canadian courts:

to widen the equitable concept of a fiduciary relationship to a point where it is devoid of all reasoning [so that] one has the uneasy feeling that the courts of that country, wishing to find for the plaintiff, but unable to discover any basis in contract, tort or statute for his success, simply assert that he must bear the victor's laurels because his opponent has committed a breach of some fiduciary duty, even if hitherto undiscovered.⁴⁸

The only apparent juridical basis for the decision in *McInerney* appears to have been founded on an analogy between the doctor-patient relationship and that of a trustee and beneficiary, with La Forest J referring to the patient's interest in the information as 'trust-like' and 'beneficial'.⁴⁹ With respect, such an analogy is inappropriate in the circumstances of the case. As noted earlier, trustee duties are justifiably more onerous than those arising in other fiduciary relationships by virtue of the fact that trustees hold legal title in trust property⁵⁰ and therefore exhibit a greater potential for abuse of their position. However the analogy breaks down and fails to provide a compelling doctrinal ground for the imposition of novel, prescriptive obligations when it is recognised that the High Court clearly established that a patient holds no proprietary interest in either the medical files prepared by a doctor, or the *information* contained within them.⁵¹

⁴⁶ *Breen*, fn. 1 at 95 per Dawson and Toohey JJ; 113 per Gaudron and McHugh. See also Parkinson, fn. 39 at 442.

⁴⁷ *Id* at 95.

⁴⁸ *Breen* (1994), fn. 5 at 570.

⁴⁹ *McInerney*, fn. 26 at 425.

⁵⁰ *Breen* (1994), fn. 5 at 563.

⁵¹ Gaudron and McHugh JJ noted in support of this view that the 'idea that a doctor who shreds the records of treatment of living patients is necessarily in breach of fiduciary duties owed to those patients is untenable' at 112. See also Mahoney JA: 'A doctor is plainly not a trustee vis-à-vis his patient': *Breen* (1994), fn. 5 at 566.

The High Court was also wary of the floodgate effect the imposition of such positive rights may have on other fiduciary relationships.⁵² If positive obligations were to be imposed in a doctor-patient relationship it would follow that in many situations where personal and confidential information is conveyed, such as 'journalists, accountants [and] bank officers', such persons would come under a fiduciary duty to 'give access to their records to the person who gave that information' and such a broad ranging obligation would simply be untenable.⁵³

The Court further considered that the recognition that the imposition of such a positive duty would be inconsistent with the existing doctor-patient duties at common law in both negligence and tort, and in equity.⁵⁴ The High Court felt that the Canadian jurisdiction paid insufficient regard to the effect such a broad fiduciary obligation would have on existing common law duties. Although fiduciary obligations may co-exist with contractual obligations, the 'fiduciary relationship will not be superimposed on the contract so as to distort the latter'.⁵⁵ It was said that a duty to always act in the best interests of the patient would often conflict with the common law duties of a doctor to exercise reasonable care and skill in the treatment of patients.⁵⁶

⁵² *Breen*, fn. 1 at 112 per Gaudron and McHugh JJ.

⁵³ *Id.* Note also in this context Rice JA's dissent at the Court of Appeal in *McInerney* (66 DLR (4th) 736) where his Honour 'observed that even in a solicitor-client relationship, a client does not enjoy a right to the notes made by a solicitor for the benefit of the solicitor in rendering services for a client': *McInerney*, fn. 26 at 419.

⁵⁴ Mahoney J in *Breen* (1994), fn. 5 approved Lord Templeman's judgment in *Sidaway*, fn. 14 at 904, where he said: 'An obligation to give a patient all the information available to the doctor would often be inconsistent with the doctor's contractual obligation to have regard to the patient's best interests. Some information might confuse, other information might alarm a particular patient ...'. Cf *Breen*, fn. 1 at 104 per Gaudron and McHugh, who stated that implication of a 'best interests' term 'would be inconsistent with the existing contractual and tortious duty to exercise reasonable care and skill in the provision of professional advice and treatment'. Although they were there speaking in terms of implying a term into a contract, this reasoning would have equal application in the context of fiduciary duties.

⁵⁵ *Breen* (1994), fn. 5 at 544 per Kirby.

⁵⁶ *Breen*, fn. 1 at 93 per Dawson and Toohey JJ.

Because of common law duties inherent in a doctor-patient relationship, there is 'no need, or even room, for the imposition of fiduciary obligations'⁵⁷ to protect a patient's perceived interest. If equity's true function is to embellish the common law where it is deficient,⁵⁸ it is far from certain that such a deficiency exists here. Access to medical records must be provided where failure to do so would prejudice the health of the patient,⁵⁹ which would appear sufficient to protect the patient's interest. In the present case there was no suggestion that it was the health of Ms Breen which rendered access to medical records necessary.⁶⁰

Given these considerations militating against the imposition of positive fiduciary obligations, the High Court concluded that any such duty could only be imposed where issues of public policy necessitated such imposition, and that in the circumstances of this case, the competing policy concerns rendered this decision a matter for the legislature, not for the courts of equity.

4. Public Policy: A matter for the legislature?

It was argued for Dr Williams that the creation of a new legal right enabling patients to access their medical records was too substantial to be made by the courts, and therefore 'should be left to the legislature.'⁶¹ It is that body of government which is better positioned to examine all the policy concerns which arise, and would enable the imposition of such rights to be regulated by 'appropriate conditions, with appropriate exceptions'.⁶²

The High Court agreed. There were clearly compelling arguments for and against the existence of a right to access medical records.⁶³ It would first require that novel, prescriptive duties be imposed upon doctor fiduciaries to act in the best interests of their clients, and it would further require that access to medical records be determined as being in the 'best interests' of the

⁵⁷ *Id.*

⁵⁸ Hepburn, fn. 24 at 7.

⁵⁹ See fn. 11.

⁶⁰ *Breen*, fn. 1 at 80 per Brennan CJ.

⁶¹ Scott, fn. 11 at 321.

⁶² *Breen* (1994), fn. 5 at 537.

patient. That was presumed to be the case in *McInerney*, however it is far from clear whether this is the case in reality.⁶⁴

The Court, therefore, was reluctant to focus too much attention on policy, and a detailed discussion of the competing policy concerns is notably absent from the High Court judgments. This was clearly the correct approach for their Honours to take. Given the strong social digression on this issue, which would involve the imposition of a new 'right' and corresponding obligation, such a decision is, in a democratic society, a matter for the legislature.⁶⁵ Mahoney JA accurately described the court's function when he stated:

the courts may develop the common law and in the course of doing so may change the existing law; but, in my opinion, it is not the function of the courts to change the law by processes which are legislative rather than judicial.⁶⁶

5. Conclusion

The determination to be made in this case was not simply whether to extend existing fiduciary obligations to encompass doctor-patient relationships. A determination that a doctor is under a positive obligation to act in the best interests of his or her patients would have necessitated a complete

⁶³ For some insight into the numerous policy issues involved see: *Breen* (1994), fn. 5 at 546-549 per Kirby P, although the policy considerations his Honour makes reference to are by no means exhaustive.

⁶⁴ It has been commented that: 'Some information in case notes, for example, "suspected child abuse", falls in between personal comments and medically relevant "fact". It is argued that this type of information is essential for doctor-doctor communication.' It is also argued that patient access to medical records would 'do away with the benefits of placebo effects': Gilhooly, M. & McGhee, S., 'Medical records: practicalities and principles of patient possession' (1991) 17 *Journal of Medical Ethics* 138 at 140. Another complaint against providing patient access to medical records has come from Dr Nelson, former Federal President of the Australian Medical Association, who noted that he has 'recorded things in my notes that could destroy marriages and possibly lead to suicides if seen by the wrong person': Davies, J., 'Move to free up access to medi-records' (19 March 1995) *The Sunday Age* 6. These are only a few of the policy arguments, which may, or may not, constitute valid reasons for restricting patient access to medical records.

⁶⁵ *Breen* (1994), fn. 5 at 557-8 per Mahoney JA: *Breen*, fn. 1 at 114-115.

⁶⁶ *Breen* (1994), fn. 5 at 557.

revolution of fiduciary obligations as understood in Australia.⁶⁷ This in turn would no doubt have had a major impact on numerous other, well established, fiduciary relationships.

The High Court's decision not to follow the Canadian decision, and to leave matters of competing social interests to the legislature, must surely be correct. Though many will be disappointed with the decision, and perceive it as a 'lost opportunity' to develop fiduciary law, the strong policy arguments which govern the opinions of both parties to the patient access debate necessitate that it be the legislature, and not the courts, which prescribe the law in this area.

The Court is to be commended for not falling into the trap that the Canadian jurisdiction has, whereby claims with no apparent doctrinal basis have found relief in equity purely because the result is viewed by the judiciary as desirable in a particular case. Such 'highly activist law-making' has the potential to undermine judicial legitimacy.⁶⁸ The decision in *Breen* provided a welcome conservatism to Australian fiduciary law, and a clear statement that the High Court will not blindly extend fiduciary law to accommodate 'idiosyncratic notions of what is fair and just'.⁶⁹

⁶⁷ Pizer, J., 'Breen v Williams' (1995) 20 *MULR* 611 at 619.

⁶⁸ French, R., 'Parliament, the Executive, the Courts and the People' (1996) 3 *Deakin LR* 1 at 16.

⁶⁹ *Pavey & Matthews Pty Ltd v. Paul* (1986-1987) 162 CLR 221 at 256 per Deane J.