BREEN v WILLIAMS*

The New South Wales Court of Appeal decision in *Breen v Williams* has been described as 'spectacularly regressive' and a 'triumph for medical paternalism'.[1] Whilst some may question the fairness of this description, there can be no doubt that the decision reflects a cautious approach to judicial law-making and a conservative characterisation of the doctor-patient relationship.

The specific question before the Court of Appeal was whether a patient has a (non-statutory) right to have access to his or her medical file when that file is in his or her doctor's possession. More general questions relating to the existence, nature and scope of fiduciary duties in the medical context also fell for consideration.

The High Court, which has granted special leave to appeal in this case, has the opportunity to explore these issues further. It would be most disappointing indeed if the Court let this opportunity pass without restating (if not reshaping and redefining) the nature and scope of fiduciary duties in Australia.

Factual Background

The appellant, Ms Breen, had silicone gel breast implants surgically implanted in 1977. A short time after the operation, she noticed that she had developed breast capsules. This led her to consult the respondent, Dr Williams, for the first time. Dr Williams performed an operation to compress these capsules but, with one immaterial exception, was not called upon to advise Ms Breen after that time.

In 1993, Ms Breen became involved in a large American-based class action against the manufacturer of the breast implants. Soon after, the litigation proceeded towards settlement. Under the terms of this settlement, the manufacturer proposed to make $US 4.2 billion available as settlement money. Originally, the Australian litigants (including Ms Breen) would have been entitled to a share of this settlement money unless they chose to 'opt-out'. But, after an order by the presiding United States District Judge dated 1 September 1994, the Australian litigants would not be so entitled unless they chose to 'opt-in' before 1 December 1994. The terms of the order were such that a litigant could 'opt-in' only if she filed copies of medical records in support of her claim with the United States court.

Thus, Ms Breen required access to her medical files, including the file in Dr Williams' possession. Such access could have been achieved through official channels: she could have obtained a court order to force Dr Williams to hand

* (1994) 35 NSWLR 522. New South Wales Court of Appeal, 23 December 1994, Kirby P, Mahoney and Meagher JJA ('*Breen*').

[1] Roger Magnusson, 'A Triumph for Medical Paternalism: *Breen v Williams*, Fiduciaries, and Patient Access to Medical Records' (1995) 1 *Torts Law Journal* 27.

over the file.[2] But since the costs, delays and complications of such a procedure were significant, Ms Breen's solicitors decided to adopt a different route.

The solicitors wrote to Dr Williams requesting copies of all primary records in Ms Breen's file.[3] Dr Williams wrote back to Ms Breen directly, stating that the file was his 'property' and that it could only be released on production of a court subpoena. He did add, however, that he would be happy to hand over her file if she sent him a document releasing him from any claim that might arise out of his treatment of her. Ms Breen rejected this offer. Instead, she brought an action against Dr Williams seeking a declaration that she had a right to have access to her file. At the hearing before Bryson J, Dr Williams offered to provide a summary of what the file contained. Ms Breen also rejected this offer, preferring instead to assert her right of access.

The Decision at First Instance

Bryson J rejected Ms Breen's claimed right of access. His Honour held that Dr Williams was the legal owner of the file and that such ownership entitled him to control access to that file. According to His Honour, there was no need for the claimed right because the existing legal process for compelling production of documents was 'not inadequate'.[4]

The Decision on Appeal

The New South Wales Court of Appeal, by majority,[5] dismissed the appeal. All three judges confirmed that Dr Williams was the legal owner of the file. Thus, at common law the doctor ordinarily enjoyed a full right to control access to the file and the information contained within it. The Court noted that this position could have been altered by the express or implied contractual arrangements between the parties. But no express arrangements had been made in this case. Nor could it be said that a term requiring access should be implied. The three judges also held that the claimed right of access could not be based on some innominate common law right.[6] Nor could it be based on a patient's general 'right to know', a right that was allegedly spawned by the High Court in *Rogers v Whitaker*.[7]

Thus, the Court unanimously held that Ms Breen had no right at common law to access her medical file. But the Court was divided on the question as to whether such a right existed in equity.

2 Several Australian litigants, after obtaining letters rogatory from the presiding United States Judge, successfully applied to the NSW Supreme Court for such an order.

3 It subsequently transpired that this file probably contained handwritten notes, copies of letters reporting to referral doctors, hospital advice slips, correspondence with the patient, reports from other doctors, communications with the NSW Medical Defence Union, photographs, and account cards with information relevant to charges and payments.

4 *Breen v Williams*, Supreme Court of New South Wales, Bryson J, 10 October 1994, 77.

5 Mahoney and Meagher JJA; Kirby P dissenting.

6 The Court refused to follow *R v Mid Glamorgan Family Health Services Authority; ex parte Martin* [1995] 1 WLR 110.

7 (1992) 175 CLR 479.

Mahoney JA answered this question in the negative. His Honour accepted that a doctor owes a duty to his or her patients to act with the utmost good faith and loyalty.[8] His Honour also accepted that a doctor must hold information provided by the patient in confidence. But his Honour did not accept that the existence of these two duties meant that the relationship between a doctor and a patient is fiduciary in nature. It may be that a doctor owes fiduciary duties to a current or former patient in relation to particular items of property. In general, however, it is incorrect to state that a doctor owes a fiduciary duty to his or her patients. Accordingly, his Honour concluded that the claimed right of access did not exist in equity.[9]

Meagher JA also rejected the argument that the alleged right of access existed in equity, but for different reasons. Unlike Mahoney JA, his Honour accepted that a doctor owes a fiduciary duty to his or her patients. According to his Honour, this means that a doctor must not profit at a patient's expense (beyond the agreed fees) and that a doctor must avoid situations that give rise to a conflict of interest. But his Honour did not accept that the scope of this duty was such that a patient enjoys a right to inspect the doctor's files.[10]

Kirby P disagreed. After canvassing the relevant authorities from other jurisdictions, his Honour concluded that there was 'no reason of legal principle or policy'[11] that suggested that a doctor-patient relationship is not fiduciary in nature. His Honour also concluded that, as an incident of this relationship, a patient has a right to have access to his or her medical file.[12] His Honour stressed, and Ms Breen conceded, that this right of access is not absolute; it is subject to exceptions. Thus, a doctor may lawfully refuse to provide his or her patient with information:

1 that attracts legal professional privilege ('the privilege exception');
2 the disclosure of which the doctor reasonably believes is likely to cause serious harm to the patient ('the therapeutic exception'); or
3 the disclosure of which would found a breach of confidence action ('the confidentiality exception').[13]

On the facts of the present case, Kirby P had no difficulty in finding that Dr Williams had breached his fiduciary duty by refusing Ms Breen's request for access. Thus, his Honour would have declared that, subject to the exceptions outlined above, Ms Breen had a right, upon request, to be given reasonable access by Dr Williams 'to examine, copy and/or at reasonable cost, to obtain [a] copy of records or information concerning her,'[14] where the information was

[8] This duty, according to his Honour, ordinarily requires a doctor to make proper disclosure of information to his or her patients; but it does not require a doctor to give his or her patients access to their files. Thus, Mahoney JA drew a distinction between the right to be *informed* about the contents of a medical file and the right to have *physical access* to that file: *Breen* (1994) 35 NSWLR 522, 566-7.

[9] *Breen* (1994) 35 NSWLR 522, 563-9 (Mahoney JA).

[10] Ibid 569-71 (Meagher JA).

[11] Ibid 549 (Kirby P).

[12] Ibid 550.

[13] Ibid 546.

[14] Ibid 550.

created or obtained by Dr Williams in the course of his treating or advising her, and where it was in his possession, 'being recorded in the medical records or in other tangible form.'[15] In addition, his Honour would have ordered Dr Williams to provide Ms Breen with reasonable access to such records or information.

The Application for Special Leave to Appeal

On 12 May 1995, the High Court heard Ms Breen's application for special leave to appeal. The Court granted special leave, but cautioned that, 'in view of the manner in which these proceedings have been framed and the absence of any appropriate concrete question',[16] there was a real risk that such leave would be revoked during the appeal.

The Issues Before the High Court

On 21 November 1995, the High Court heard the appeal. The Court did not revoke special leave, although some members of the Court expressed concern about the manner in which the case had been framed. Importantly, the precise question before the Court was gradually refined during argument.[17] That question may be summarised in the following way:

> Subject to the exceptions outlined by the Court of Appeal and irrespective of the purpose of the request, does a patient have a legal right to:
>
> - be provided with a copy of; or
> - make a copy of and/or inspect,
>
> all medical records in the Doctor's possession that were created or obtained:
>
> - for the patient's benefit; and
> - during the course of the Doctor's provision of treatment or advice?

Ms Breen sought a declaration that she was entitled to such a right and an order that Dr Williams provide reasonable access to her file. The major difficulty in this case is identifying the legal origin of the claimed right of access. The most likely source of such a right lies in the realm of the law relating to fiduciary relationships. Accordingly, the two main issues before the Court are as follows:

- Is the relationship between a doctor and a patient necessarily fiduciary in nature?; and if so
- Does a patient enjoy a right to have access to his or her medical file as an incident of that relationship?

These issues will be examined in turn.

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[15] Ibid.

[16] *Breen v Williams*, Transcript of High Court special leave application, Deane, Toohey and McHugh JJ, 12 May 1995, 22.

[17] *Breen v Williams*, Transcript of High Court hearing, Brennan CJ, Dawson, Toohey, Gaudron, McHugh and Gummow JJ, 21 November 1995, 12-26, 74, 94.

1 *The Doctor-Patient Relationship*

The courts have recognised that certain categories of relationship are normally fiduciary in nature. These 'traditional' relationships include trustee and beneficiary, partners, principal and agent, director and company, master and servant, and solicitor and client. Historically, the doctor-patient relationship has fallen outside this list.[18]

In recent times, the courts have been more willing to develop a general test for determining whether, in the specific circumstances, a relationship falling outside the traditional categories may be characterised as fiduciary. In *Hospital Products,* Mason J identified the necessary elements of such a test by analysing the traditional categories.[19] According to his Honour, the defining characteristic of a fiduciary relationship is its 'representative' nature. In other words, a fiduciary relationship will exist where one person (the 'representor') undertakes to act 'for or on behalf of' another (the 'representee') in a manner that will affect the representee's interests in a legal or practical sense. Dawson J stated that 'inherent in the nature of the relationship itself is a position of *disadvantage* or *vulnerability* on the part of one of the parties which causes him to place *reliance* on the other.'[20] And in *Mabo v The State of Queensland [No 2]*[21] Toohey J also emphasised that the representee must be reliant and vulnerable, and that the representor must have a 'special opportunity' to exercise a discretion to the representee's detriment.[22]

In the present case, Ms Breen sought to establish that a fiduciary relationship normally exists between every doctor and every patient. In other words, she sought to add the doctor-patient relationship to the traditional list of fiduciary relationships. This, of course, is not an impossible task. The courts have consistently stressed that the categories of fiduciary relationships are not closed.[23]

The courts have rarely articulated why the doctor-patient relationship has been excluded from the list of traditional fiduciary relationships. In *Sidaway*,[24] for example, Lord Scarman bluntly rejected the argument that the relationship is of a fiduciary character, whilst conceding that it is a 'very special one, the patient putting his health and his life in the doctor's hands.'[25] Perhaps the most likely reason for the exclusion is the fact that the law relating to fiduciaries has been developed in a commercial context. The fiduciary principles have been designed to protect the financial and other proprietary interests of the relevant vulnerable

[18] See *Hospital Products Ltd v United States Surgical Corporation* (1984) 156 CLR 41, 68 (Gibbs CJ), 96 (Mason J), 141 (Dawson J) ('*Hospital Products*'); *Sidaway v Bethlem Royal Hospital* [1985] AC 871, 884 (Lord Scarman) ('*Sidaway*'). The doctor-patient relationship falls within the traditional list of relationships of presumed undue influence, but it is important to maintain the distinction between fiduciary relationships of influence, and fiduciary relationships of trust and confidence: John Glover, *Commercial Equity Fiduciary Relationships* (1995) 10.

[19] *Hospital Products* (1984) 156 CLR 41, 96-7.

[20] Ibid 142 (emphasis added).

[21] (1992) 175 CLR 1 ('*Mabo [No 2]*').

[22] Ibid 200-1.

[23] See, eg, *Hospital Products* (1984) 156 CLR 41, 68.

[24] [1985] AC 871, 884.

[25] Ibid.

party. Since doctors rarely undertake to act in a 'representative' capacity in relation to the patient's money or other property, the doctor-patient relationship has been excluded from the traditional list.

Nevertheless, a doctor undertakes to act in a 'representative' capacity in relation to the patient's health. And, given the (usual) gulf in knowledge between the two parties, the doctor holds the potential, the 'special opportunity', to exert considerable influence over the patient, who is correspondingly 'reliant' and 'vulnerable'. Thus, the only barrier standing in the way of the conclusion that the doctor-patient relationship should be added to the list is the argument that the law relating to fiduciaries is not designed to protect fundamental personal interests, such as an individual's health.

This argument is not compelling. There is simply no reason in logic or principle for retaining the distinction between fundamental personal interests and proprietary interests.[26] As Kirby P noted:

> [T]he unifying concept behind the imposition of fiduciary obligations appears to be the secure observance of [the] fundamental duties [of honesty, care and loyalty] in relationships in which it is the role of one party to act in the service and interests of the other who is specially liable to harm if that party does not conform to such duties.[27]

This unifying concept applies with equal force to cases where the weaker party is specially liable to sustain harm to his or her *fundamental human* interests as it does to cases where that party is specially liable to sustain harm to his or her *financial* interests.

Accordingly, there is much to be said for the view that the doctor-patient relationship should be added to the list of 'accepted' categories of fiduciary relationships. The scope of a particular doctor's duty will, of course, depend upon the circumstances of the case. As noted above, in the present case, Kirby P held that the scope of the duty was such that Dr Williams had to provide Ms Breen with access to her file, whereas Meagher JA held that the duty was more limited. This leads to the second main issue before the High Court: assuming that the relationship is fiduciary in nature, is the scope of the duty broad enough to confer upon the patient a right to have access to his or her medical file?

2 *The Scope of the Doctor's Fiduciary Duty*

In *McInerney*,[28] the Canadian Supreme Court held that, subject to exceptions, a patient has a right to have access to his or her medical records. It did so for the following reasons:

> The fiduciary duty to provide access to medical records is ultimately grounded in the nature of the patient's interest in his or her records. As discussed earlier, information about oneself revealed to a doctor acting in a professional capacity

[26] This distinction is no longer maintained in Canada: see, eg, *McInerney v MacDonald* [1992] 2 SCR 138 ('*McInerney*'); *Norberg v Wynrib* (1992) 92 DLR (4th) 449; *Taylor v McGillivray* (1994) 110 DLR (4th) 64.

[27] Paul Finn, 'The Fiduciary Principle' in Timothy Youdan (ed), *Equity, Fiduciaries and Trusts* (1989) 1, 27 cited in *Breen* (1994) 35 NSWLR 522, 543 (Kirby P).

[28] [1992] 2 SCR 138.

> 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 .... [Accordingly], as a general rule, [the patient] should have a right of access to the information and ... the physician should have a corresponding obligation to provide it.[29]

Although the Court specifically refused to reify the patient's 'trust-like beneficial interest' in the information,[30] there is much force in Bryson J's observation that, in substance, that is exactly what the Court did.[31] The Canadian approach is conceptually inelegant for two reasons. First, the reification of the patient's interest does not sit comfortably with the existence of exceptions to the right of access.[32] And second, if information given in confidence is not proprietary in nature,[33] it can hardly be said that a patient has a proprietary interest in information contained in medical records. Accordingly, an alternative doctrinal source must be found for the claimed right of access.

The Canadian Supreme Court also justified the patient's general right of access on the ground that such a right ensured the proper functioning of the doctor-patient relationship and promoted the well-being of the patient.[34] According to the Court, the proper functioning of the relationship was ensured because the patient could be better equipped to determine whether the doctor was acting with 'utmost good faith and loyalty'. And the patient's well-being was promoted because the right of access strengthened the bond of trust between the doctor and the patient.

This reasoning identifies two underlying policy rationales for the right of access but does not explain its legal origin.[35] Interestingly, the Court subsequently noted that the doctor's duty to act in the best interests of his or her patients may allow the doctor to rely on the therapeutic exception to access,[36] but did not invoke this duty to justify the existence of the right itself.

This is a curious omission. If it were to be accepted that a doctor owes a fiduciary duty to act in the best interests of his or her patients, then surely it can be argued that, as an incident of this duty, the doctor must generally allow his or her patients to have access to their files. As will be seen, the success or otherwise of this argument (assuming the initial premise to be valid) depends upon how the court characterises the doctor-patient relationship.

29 Ibid 150-2 (La Forest J).

30 Ibid 152.

31 *Breen v Williams*, Supreme Court of New South Wales, Bryson J, 10 October 1994, 48. For example, the Supreme Court described the patient's interests as 'an *equitable* interest arising from the physician's obligation to disclose the records upon request': *McInerney* [1992] 2 SCR 138, 154.

32 Ibid.

33 See *Moorgate Tobacco Co Ltd v Philip Morris Ltd [No 2]* (1984) 156 CLR 414, 438.

34 *McInerney* [1992] 2 SCR 138, 152-3.

35 See *Breen* (1994) 35 NSWLR 522, 570 (Meagher JA).

36 *McInerney* [1992] 2 SCR 138, 154.

(a) The Paternalistic Model

If the court embraced the paternalistic model, where the doctor 'can discern what is in the patient's best interest with limited patient participation',[37] then there would seem to be little justification for a right of patient access. Under this model, the doctor will usually act in the best interests of his or her patients by simply offering to give a verbal summary of the relevant file.

Indeed, with this model in mind, it may be argued that a doctor would not be acting in his or her patients' best interests if access were generally granted. This argument has two limbs. The first limb is that the information in the file may actually harm the patient in question. For example, a patient's misconceptions about material in the file may lead to feelings of hopelessness, which could impair treatment.[38] Thus, the doctor must, with paternalistic fervour, protect each patient by filtering out potentially harmful information.

The second limb of the argument is that a right of access would change the way that doctors wrote down their medical opinions. If doctors prepared their written notes with a cautious eye on the possibility of future patient access, the notes would almost certainly be less candid and less complete. Moreover, outside consultants may be less willing to commit opinions to writing if they knew that anything they wrote would, in effect, be communicated to the patient.[39] As a result, important pieces of a patient's medical history would be left out of the file. This may make it harder for other practitioners, who may see the patient at some future time, to advise that patient in an adequate fashion.

Drawing the two limbs of the argument together, an important question arises: how can it be said that a doctor who grants access will be acting in the best (present and future) interests of his or her patients?

(b) A Model More Respectful of Patient Autonomy

If the court embraced a model of the doctor-patient relationship that was more respectful of patient autonomy, where the patient has more control and choice over medical decisions, then this question may be answered in two parts. In the first part, it must be conceded that information in a particular patient's file may actually harm that patient. But this concession does not mean that there cannot be a general right of access. On the contrary, there may be such a right, but that right must be subject to certain exceptions, such as the therapeutic exception. In other words, the doctor must have a discretion to refuse access on the basis that such access would seriously harm the patient. Importantly, however, such a discretion should be exercised sparingly in order to remain consistent with the model's underlying philosophy of maximising patient participation in medical decision-making.

In the second part, it must be questioned whether doctors and outside consultants would actually censor what they wrote if a right of access existed. Some

[37] Ezekiel Emanuel and Linda Emanuel, 'Four Models of the Physician-Patient Relationship' (1992) 267 *Journal of the American Medical Association* 2221.

[38] See James Madden, 'Patient Access to Medical Records in Washington' (1982) 57 *Washington Law Review* 697, 700.

[39] *Breen v Williams*, Supreme Court of New South Wales, Bryson J, 10 October 1994, 48, 51.

studies have shown that such censoring does not occur.[40] As Krever J put it in the *Krever Report*:

> I say, at once, that I do not believe that any responsible and ethical physician would omit from a medical record any information that, in the interests of proper medical care, belongs in it because of the possibility that the patient may ask to inspect it.[41]

Thus, drawing the two parts of this answer together, it may be argued that a doctor will be acting in his or her patient's best (present and future) interests by granting access to the patient's file. Indeed, under the model of the relationship more respectful of patient autonomy, it may even be argued that a doctor will generally not be acting in his or her patient's best interests unless such access were granted.[42]

There are several policy reasons underpinning this argument. One such reason is that 'sharing' medical files would tend to improve the communication between a doctor and his or her patients. This improved communication would not only help each patient deal with his or her condition,[43] but would also inject a greater amount of trust into the relationship.[44] In addition, access may lead to corrections of inaccurate or incomplete records.[45] It would seem clear that each of these results is in the patient's best interests.

If this reasoning were to be adopted (ie, if the court accepted that a doctor has a fiduciary duty to act in the best interests of his or her patients, and if the court embraced a model of the doctor-patient relationship more respectful of patient autonomy),[46] then it may be said that the right of access is both doctrinally and conceptually sound. However, there are some real doubts as to whether a doctor has a *fiduciary* (as opposed to *ethical*) duty to act in the best interests of his or her patients.

(c) The Duty to Act in the Best Interests of a Patient

The traditional view is that a fiduciary duty arises because one party undertakes to act in the best interests of another and that, as a result of this undertaking, the fiduciary must not allow a conflict of interest to arise or make an unauthorised profit at the beneficiary's expense. These prophylactic prohibitions are the two central themes of the fiduciary obligation.[47] Indeed, these themes are

40 See *McInerney* [1992] 2 SCR 138, 157; Mary Gilhooly and Sarah McGhee, 'Medical Records: Practicalities and Principles of Patient Possession' (1991) 17 *Journal of Medical Ethics* 138, 140. But cf Michael King and Judith Trowell, *Children's Welfare and the Law* (1992) 40-1.

41 Ontario, *Report of the Commission of Inquiry into the Confidentiality of Health Information* (1980) vol 2, 487 ('*Krever Report*').

42 Under this model, it is arguable that patients should be allowed to *keep* their files. For a discussion of this possibility see Gilhooly and McGhee, above n 40, 140-1.

43 Ibid 141.

44 Ibid.

45 *Breen* (1994) 35 NSWLR 522, 548 (Kirby P).

46 As the High Court did in *Rogers v Whitaker* (1992) 175 CLR 479.

47 *Chan v Zacharia* (1984) 154 CLR 178, 199 (Deane J).

responsible for most fiduciary duties.[48]

As Parkinson notes, the Canadian courts are in danger of standing this traditional reasoning 'on its head'.[49] Those courts have held that fiduciaries have a legal duty to act in the best interests of the relevant beneficiary.[50] In other words, the undertaking to act in the interests of another is not simply the *source* of the fiduciary duties to avoid conflicts and to avoid making unauthorised profits (as has traditionally been the case); rather, such an undertaking has been transformed into the *content* of the fiduciary duty itself.

This subtle transformation has allowed the Canadian courts to steer the fiduciary concept into previously unchartered territory. Although at least two Australian judges have flirted with the idea of adopting the Canadian approach,[51] it is highly likely that such 'well-meaning sloppiness of thought'[52] will not be perpetuated by the current High Court.

If this prediction turns out to be true, then the High Court will almost certainly reject the existence of the claimed right of access. This is because, in the absence of a doctor's fiduciary duty to act in the best interests of his or her patients, it is difficult to identify a sound doctrinal base that supports the existence of such a right.[53]

Conclusion

Patient access to medical records is a contentious issue. Freedom of Information legislation gives patients a 'legally enforceable right' to access their medical records held by Federal and State government health organisations.[54] By contrast, the majority of the Court of Appeal concluded that Ms Breen did not have a right to access records held by Dr Williams, a private practitioner.

The alarming incongruity of this position is self-evident. But the question of whether Ms Breen *should* have had a right of access is very different from the question of whether she did in fact *have* such a right. Upon close inspection, such a right could exist (apart from statute) only if the Court revolutionised the traditional law of fiduciary relationships in this country.

[48] Some duties, however, may arise by virtue of the nature of the particular fiduciary relationship. For example, as Meagher JA noted in the Court of Appeal, trustees have a duty to allow beneficiaries to inspect their records, a duty that flows from the trustee's duty to account for the administration of the trust: *Breen* (1994) 35 NSWLR 522, 548.

[49] Patrick Parkinson, 'Fiduciary Law and Access to Medical Records: *Breen v Williams*' (1995) 17 *Sydney Law Review* 433, 441.

[50] See, eg, *J(LA) v J(H)* (1993) 102 DLR (4th) 177, 182 (Rutherford J). For an American example, see *Emmett v Eastern Dispensary and Casualty Hospital* 396 F 2d 931 (1967), 935.

[51] See *Breen* (1994) 35 NSWLR 522, 547 (Kirby P); *Williams v Minister, Aboriginal Land Rights Act 1983* (1994) 35 NSWLR 497, 511 (Kirby P); *Mabo [No 2]* (1992) 175 CLR 1, 203 (Toohey J). In addition, it is at least arguable that in *Marion's Case*, McHugh J implicitly endorsed the view that a parent has a fiduciary duty to act in the best interests of his or her children: *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, 317.

[52] This phrase is borrowed from Scrutton LJ's judgment in *Holt v Markham* [1923] 1 KB 504, 513.

[53] In the absence of a sound doctrinal base supporting the existence of such a right, there is no need to consider the complex arguments about the relationship between such a right and the Doctor's copyright in the medical records.

[54] See, eg, Freedom of Information Act 1982 (Cth) ss 11, 41; Freedom of Information Act 1989 (NSW) ss 16, 31; Freedom of Information Act 1982 (Vic) ss 13, 33.

If, as predicted, the High Court refrains from taking this revolutionary step, it can only be hoped that the ensuing public outcry triggers the type of legislative reform that has been promised,[55] but that has, at least until now, been pushed off the Federal Government's agenda by more 'pressing' political concerns.

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[55] See 'Federal Push to Free Medical Records', *Age* (Melbourne), 17 February 1995; 'Move for full access to medical records', *Age* (Melbourne), 3 June 1995. Such legislation exists in other countries: Access to Health Records Act 1990 (UK); Health Information Privacy Code 1994 (NZ).

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