

Fordham International Law Journal

Volume 21, Issue 4

1997

Article 7

Patients' Rights to Access their Medical Records: An Argument for Uniform Recognition of a Right of Access in the United States and Australia

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Abstract

This Note addresses the issue of a patient's right to access her own medical records in the United States and Australia. Part I discusses the background of a right of patient access to medical records through case law in the United States. Part I gives a historical perspective on US and Australian legislation regarding access to medical records. Part II reviews commentary both for and against access in the United States and in Australia. Part II focuses on legal arguments from the recent decision concerning patient access to medical records by the Australian courts in *Breen v. Williams*. Further, Part II also briefly examines jurisprudence with respect to access rights in Canada and the United Kingdom. Part III argues that the United States and Australia should follow the international trend and grant access to medical records through legislation. Finally, this Note concludes that a right of access would not only be fairer to patients and improve the physician-patient relationship, but also would facilitate transnational legal actions where medical records are required but the countries' laws differ on the right of access. Australia and the United States, either on the federal level or uniformly on the state level, should adopt legislation providing for a right of patient access to medical records.

NOTES

PATIENTS' RIGHTS TO ACCESS THEIR MEDICAL RECORDS: AN ARGUMENT FOR UNIFORM RECOGNITION OF A RIGHT OF ACCESS IN THE UNITED STATES AND AUSTRALIA

Hayley Rosenman*

INTRODUCTION

The United States and Australia share a common law tradition¹ that transcends geographical boundaries and cultural differences.² Both countries originated as British colonies³ and,

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1. See PATRICK PARKINSON, TRADITION AND CHANGE IN AUSTRALIAN LAW 4 (1994) (characterizing Australian legal tradition as received, rather than indigenous, tradition). Legal precedent guides the development of the common law. See JAMES G. APPLE & ROBERT P. DEYLING, FEDERAL JUDICIAL CENTER, A PRIMER ON THE CIVIL-LAW SYSTEM 35 (1995) (discussing role of jurists in common law systems). Jurists in common-law countries are relatively unimportant when compared with prior decisions of the courts. *Id.* In common law countries, an *ad hoc* process over many years has produced statutes and codes that often reflect rules of law enunciated in judicial decisions. *Id.* at 36. On the other hand, civil law countries have comprehensive and integrated codes that are often developed from a single drafting event. *Id.* This codification dichotomy has given rise to other distinctions between the civil and common law systems. *Id.* at 36-38. Common law countries have elevated precedent to a position of utmost prominence. *Id.* at 37. In civil law systems, the role and influence of judicial precedent, at least until more recent times, has been negligible because judges initially look to code provisions to resolve a case. *Id.* at 36. See also JOHN HENRY MERRYMAN, THE CIVIL LAW TRADITION 47 (2nd ed. 1985) (stating, however, that civil law courts do use precedents and common law courts distinguish cases they do not want to follow, and sometimes overrule their own decisions). In addition, in the common law tradition, judges apply inductive reasoning, deriving general principles or rules of law from precedent and extracting an applicable rule that they then apply to the case. APPLE & DEYLING, *supra*, at 37. In the civil law system, the reasoning process is deductive, proceeding from stated general principles or rules of law contained in the legal codes to a specific solution. *Id.*

2. PARKINSON; *supra* note 1, at 4.

3. *Id.* at 5. In 1776, the U.S. Colonists severed their ties to Britain by passing the Declaration of Independence. *Id.* at 126. After the Declaration of Independence, the British could no longer transport criminals to the United States so they decided to develop a new penal settlement in New South Wales. *Id.* at 125-26. In 1787, the first British convicts began to settle in Australia, and in 1788 the Act of Parliament established the new colony of New South Wales. *Id.* at 126. With the concurrence of the British Parliament, the Commonwealth of Australia came into being as a federation in 1901, through the Commonwealth of Australia Constitution Act. *Id.* at 155.

even today, the U.S. and Australian laws share a resemblance to each other as well as to British law.⁴ Like the United States, Australia's judiciary consists of both a federal court system that operates throughout Australia and a state court system operating within each state.⁵

The American colonies rebelled against England to create the United States.⁶ Over time, the U.S. citizens developed their own case law and precedents.⁷ Australia, however, did not experience any revolution and, therefore, did not adopt a distinct legal tradition from Britain.⁸ Thus, although both the United States and Australia have similar legal origins, there are differences in their laws today.⁹ Specifically, the countries' laws diverge with respect to a patient's right to access her medical

4. *Id.* at 4-6.

5. JOHN CARVAN, UNDERSTANDING THE AUSTRALIAN LEGAL SYSTEM 53 (2nd ed. 1994). One concern of the framers of Australia's Constitution was to work out a suitable balance between government by a majority of the people and government by a majority of the states. See PARKINSON, *supra* note 1, at 161 (addressing framers' concern with federal-state balance of powers). Another concern was to ensure that the states only surrendered such powers to the Commonwealth as were necessary for the Commonwealth's effective functioning. See *id.* (stating that convention of delegates did not want to surrender much of their power to Australian federal government); AUSTL. CONST. Ch. I, pt. V, § 51 (enumerating areas in which Parliament has power to make laws for Commonwealth). In the first few years of federation, judges interpreted the Australian Constitution to reserve powers for the states unless specifically allocated to the Commonwealth. See PARKINSON, *supra* note 1, at 161 (discussing Australian High Court's interpretation of Australian Constitution). According to one scholar, this interpretation has proved to be a relatively ineffective means of preserving states' rights and federal power in Australia has expanded since federation. See *id.* at 161-64 (explaining factors in expansion of federal power in Australia, including literal and broad interpretations of Australian Constitution). The Australian Constitution vests the legislative power of the Commonwealth in a federal Parliament. See AUSTL. CONST. Ch. I, pt. I, § 1 (vesting power in Australian federal Parliament, which is comprised of Queen, Senate, and House of Representatives).

6. PARKINSON, *supra* note 1, at 5.

7. *Id.* at 6. One scholar wrote that

[d]uring the Colonial period, English common law applied uniformly. After the American Revolution, each state provided for the adoption of part or all of the then existing English common law. All subsequent common law in the United States has been developed on a state basis, so common law may differ from state to state.

WILLIAM H. ROACH, JR. & THE ASPEN HEALTH LAW CENTER, MEDICAL RECORDS AND THE LAW 257 (2nd ed. 1994).

8. See PARKINSON, *supra* note 1, at 5-6 (noting that there was no revolution in Australia's government that brought birth to new legal or political system).

9. See *id.* at 4 (stating that despite manifold differences between laws of common law countries, common law tradition allows each country to draw upon experience of others).

records.¹⁰

The U.S. health system is a privately financed,¹¹ privately organized¹² system with multiple payers.¹³ Taxes and third-party insurance cover three quarters of the health care expenditures.¹⁴ The organization of health care in the United States is on the private end of the public-private spectrum.¹⁵ In Australia, the revenue raised by taxation or by mandatory contributions provides at least three quarters of the cost of health care.¹⁶

The keeping of accurate medical records predates case law.¹⁷ The requirements of medical records in all jurisdictions may differ slightly, but all carry the same basic message that

10. Compare *Hutchins v. Texas Rehabilitation Comm'n*, 544 S.W.2d 802 (Tex. Ct. App. 1976) (granting patient right to access own records based on common law) with *Breen v. Williams* (1996) Aust. High Ct. LEXIS 54 (Sept. 6, 1996) (denying patient right to examine and copy her own medical records). The medical record should be a complete, accurate, and current account of the history, condition, and treatment of the patient and the results of the patient's care. See ROACH, JR., *supra* note 7, at 2 (discussing patient record requirements).

11. Victor G. Rodwin, *Comparative Health Systems*, in *HEALTH CARE DELIVERY IN THE UNITED STATES* 456, 469 (Anthony R. Kovner ed., 5th ed. 1995).

12. *Id.*

13. See *id.* (discussing structure of health care financing and organization in United States).

14. See WILLIAM L. KISSICK, *MEDICINE'S DILEMMAS* 48-49 (1994) (stating that in United States, health care is mainly mix of Social Security entitlement, public welfare, and prerogative of employment).

15. See Rodwin, *supra* note 11, at 470 (comparing U.S. health care with that of Western Europe). U.S. health care is considered more private than public because the United States has one of the smallest public hospital sectors. *Id.* The author states, however, that

[t]he absence of an NHI [national health insurance] program in the United States has resulted in a system of multiple payers and has encouraged a more pluralistic pattern of medical care organization and more innovative forms of medical practice—for example, multispecialty group practices, HMOs [health maintenance organizations], ambulatory surgery centers, and preferred provider organizations (PPOs).

Id. at 470.

16. See KISSICK, *supra* note 14, at 48-49 (analyzing resource allocation in nine economically advanced countries, namely, United Kingdom, Italy, Japan, Germany, Australia, Canada, France, Sweden, and United States).

17. Interview with Dr. Allan Gibofsky, Hospital for Special Surgery, New York (Jan. 9, 1998). Dr. Gibofsky noted that "[t]he keeping of records goes back to the Ancient Egyptians. The keeping of records may have resulted in case law. Medicine has influenced law, not the other way around." *Id.*; see David McQuoid-Mason, *Medical Records and Access Thereto*, *MEDICINE AND LAW* 499, 509 (1996) (stating that international case law indicates that practitioners should keep medical records on all patients); DIETER GIESEN, *INTERNATIONAL MEDICAL MALPRACTICE LAW* 416-24 (1988) (discussing importance of adequate medical records in various countries).

every record must give the patient's and doctor's identities,¹⁸ contain relevant legal documents,¹⁹ contain necessary patient information,²⁰ as well as information concerning therapy,²¹ discharge,²² and follow-up²³ as appropriate.²⁴ The reasons why patients may want to see their records vary.²⁵ Differences in the laws concerning patient access to medical records present conflicts for transnational legal actions.²⁶ Scholars contend that it is a restriction of legal rights,²⁷ and is contrary to social policy,²⁸ to

18. See GIESEN, *supra* note 17, ¶ 866 at 422 (discussing acceptable medical records).

19. *Id.*

20. See *id.* (mentioning patient's prior medical history, reports of diagnostic tests and procedures, consultations, and final diagnosis).

21. See *id.* (including orders for treatment and medication, treatment reports and protocols, and progress and other health care notes).

22. *Id.*

23. *Id.*

24. See *id.* (setting out requirements of medical record).

25. McQuoid-Mason, *supra* note 17, at 512. Some of the reasons for patients wanting to see their records are to check the accuracy of personal data, to learn what the record contains before authorizing its release to a third party, to assist them in making informed treatment decisions, and to be able to participate more fully in their health care. *Id.* In addition, people may seek access to their medical records whenever a record is needed for litigation. See JO ANNE CZECOWSKI BRUCE, *PRIVACY AND CONFIDENTIALITY OF HEALTH CARE INFORMATION* 9 (2nd ed. 1988) (noting that attorneys are interested in health records because of malpractice cases).

26. See, e.g., *Breen* (1996) Aust. High Ct. LEXIS 54 (stating that plaintiff could not enter lawsuit in United States due to Australia's lack of right of access to patient's medical record).

27. See ROACH, JR., *supra* note 7, at 95-102, 115-21 (reviewing common law cases, state access statutes, state open records statutes, Privacy Act, and Freedom of Information Act, all of which may enable access to patient medical records). These legal rights include a fiduciary duty, property rights, the right to privacy, and the right to know. See, e.g., *Cannell v. Medical and Surgical Clinic*, 315 N.E.2d 278, 280 (Ill. App. Ct. 1974) (discussing fiduciary duty as requiring disclosure of medical data); *Pyramid Life Ins. Co. v. Masonic Hosp. Ass'n of Payne County*, 191 F. Supp. 51, 54 (addressing patient's property right in information on record); *Whalen v. Roe*, 429 U.S. 589, 598-600 (1977) (recognizing right to privacy in information); Ellen Klugman, *Toward a Uniform Right to Medical Records: A Proposal for a Model Patient Access and Information Practices Statute*, 30 UCLA L. REV. 1349, 1349 (1983) (addressing right to know contents of medical record). The fiduciary relationship between a physician and patient requires the disclosure of medical information to the patient upon request. See *Emmett v. Eastern Dispensary and Casualty Hosp.*, 396 F.2d 931, 935 (D.C. Cir. 1967) (holding that physician has duty to reveal to patient information that is in her best interests to know). The hospital or doctor owns the medical record itself, but the patient has a limited property interest in information the record contains. See *Wallace v. University Hosps. of Cleveland*, 164 N.E.2d 917, 918 (Ohio Ct. Com. Pleas 1959), *modified and aff'd*, 170 N.E.2d 261, 261-62 (Ohio Ct. App. 1960), *appeal dismissed*, 172 N.E.2d 459 (Ohio 1961) (holding that patient has property right to information in medical record). In 1890, legal scholars War-

deny a person access to her medical records.²⁹

This Note addresses the issue of a patient's right to access her own medical records in the United States and Australia. Part I discusses the background of a right of patient access to medical records through case law in the United States. Part I gives an historical perspective on U.S. and Australian legislation regarding access to medical records. Part II reviews commentary both for and against access in the United States and in Australia. Part II focuses on legal arguments from the recent decision concerning patient access to medical records by the Australian courts in *Breen v. Williams*.³⁰ Further, Part II also briefly examines jurisprudence with respect to access rights in Canada and the United

ren and Brandeis argued that the common law implicitly recognized the right to privacy. See Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193, 198, 207-12 (1890) (pointing to English cases of intellectual and artistic property as instances and applications of general right to privacy). The U.S. Supreme Court recognized a constitutional right of privacy in *Griswold v. Connecticut*. See *Griswold v. Connecticut*, 381 U.S. 479, 483-85 (1965) (finding that guarantees in U.S. Bill of Rights create penumbras, or zones, of privacy). In *Whalen*, a case involving medical data, the Court recognized a right to information privacy for the first time. See 429 U.S. at 598-600 (noting that U.S. constitutionally protected zones of privacy involved at least two different kinds of interests). One is the individual interest in avoiding disclosure of personal matters, and another is the interest in independence in making certain important decisions. *Id.* The right to know is a difficult concept because it is not found in the Constitution and it is impossible to define. See Loren P. Beth, *The Public's Right to Know: The Supreme Court as Pandora?*, 81 MICH. L. REV. 880, 881-82 (1983) (discussing problems of right to know). A combination of agency discretion, press surveillance, an occasional court decision, and some rights legislatively-granted to the general public secure a public's right to know. *Id.* at 888. The Freedom of Information Act provides an example of legislation in this area. 5 U.S.C. § 552 (West 1997).

28. See Beth, *supra* note 27, at 882 (noting that "[m]ost advocacy of the right to know seems to ground it in the necessities of democracy.") The philosophical justification for privacy rests largely on its importance to the individual as an individual. See PRISCILLA M. REGAN, *LEGISLATING PRIVACY* 24 (1995) (discussing privacy as philosophical and legal concept). The Western notion of autonomy favors the individual over the community. See Elysa Gordon, Note, *Multiculturalism in Medical Decisionmaking: the Notion of Informed Waiver*, 23 *FORDHAM URB. L.J.* 1321, 1321 (1996) (arguing that lawyers and health care providers must reform law regarding patient autonomy to accommodate patients holding non-Western beliefs regarding medical decisionmaking). Access to medical records allows patients to play a greater role in their own medical care. Cf. BRUCE, *supra* note 25, at 7 (noting that recipients of health care services have access to data that allow them to make more informed choices on health care). One scholar argues that although U.S. law recognizes the importance of informational self-determination, it fails to protect this value in the context of health care. Paul M. Schwartz, *The Protection of Privacy in Health Care Reform*, 48 *VAND. L. REV.* 295, 309 (1995).

29. See Klugman, *supra* note 27, at 1349-363 (addressing issue of patient's right to know contents of own medical record in United States).

30. *Breen* (1996) Aust. High Ct. LEXIS 54.

Kingdom. Part III argues that the United States and Australia should follow the international trend³¹ and grant access to medical records through legislation. Finally, this Note concludes that a right of access would not only be fairer to patients and improve the physician-patient relationship, but also would facilitate transnational legal actions where medical records are required but the countries' laws differ on the right of access. Australia and the United States, either on the federal level or uniformly on the state level, should adopt legislation providing for a right of patient access to medical records.

I. RIGHT OF ACCESS UNDER U.S. AND AUSTRALIAN LEGAL SYSTEMS

As a general rule, the medical record is a confidential document and access to it is limited.³² In the United States, there is a growing trend towards recognizing patients' rights to access their own medical records.³³ In Australia, however, the High Court³⁴ has held that a patient's right of access to medical records does not exist in Australian law,³⁵ other than the right to access publicly held records.³⁶

A. Right of Access

Every health care provider is ethically³⁷ and legally³⁸ re-

31. See McQuoid-Mason, *supra* note 17, at 511 (noting that trend in many countries is to allow patient access to medical records).

32. See ROACH, JR., *supra* note 7, at 95 (stating that access to medical record should be limited to patient or authorized representative, attending physician, and other hospital staff members possessing legitimate interests in record); Giesen, *supra* note 17, ¶ 871 at 424 (noting that, on international level, generally no one can access medical record without patient's consent).

33. See SIDNEY M. WOLFE, *preface* to DIANN JOHNSON & SIDNEY M. WOLFE, Public Citizen's Health Research Group, *MEDICAL RECORDS: GETTING YOURS* at vii (5th ed. 1995) (stating that growing movement is part of right to know movement).

34. *Breen* (1996) Aust. High Ct. LEXIS 54.

35. See *id.* (holding that plaintiff could not secure access to her medical records in hands of private physician).

36. See Freedom of Information Act, 1982 (Austl.) (granting individuals right to access information held in government files); Privacy Act, 1988 (Austl.) (protecting personal information privacy).

37. See RONALD W. SCOTT, *LEGAL ASPECTS OF DOCUMENTING PATIENT CARE* 31 (1994) (mentioning health care provider's ethical requirement to record pertinent medical information in patient records).

38. See, e.g., 305 ILL. COMP. STAT. ANN. 5/5-5 (West 1997) (stating that Illinois Department of Public Aid shall require health care providers to maintain records that

quired to maintain patient treatment records.³⁹ Although patient treatment records are guided primarily by patient welfare-oriented health care principles,⁴⁰ the record is also a legal document.⁴¹ It serves to protect the legal interests of all participants in the health care delivery system worldwide.⁴²

Although the medical record is a confidential document,⁴³ the United States allows patients to access medical records that are held by public institutions under the Freedom of Information Act⁴⁴ ("FOIA") and the Privacy Act ("Privacy Act").⁴⁵ In addition, most states grant statutory recognition to a patient's right of access to hospital records.⁴⁶ U.S. courts have also relied upon the common law to grant a patient a right of access to her medical records.⁴⁷ Similarly, Australia has a Commonwealth Freedom

document medical care and services provided to recipients of Medical Assistance). Regarding hospices, an Oklahoma statute states that "[a]n up-to-date record of the services given to the patient and family shall be kept by the hospice team. Records shall contain pertinent past and current medical, nursing, social, and other such information that is necessary for the safe and adequate care of the patient and the family." OKLA. STAT. ANN. tit. 63, § 1-860.4 (C) (West 1997).

39. See SCOTT, *supra* note 37, at 31 (stating that as part of legal duty owed to patients, every primary health care provider is ethically and legally required to record pertinent information about their patients and to maintain that information in form of patient treatment records).

40. *Id.* at 84. All health care professions and almost all health care providers have as their altruistic, narrow focus the welfare of the patients. *Id.* During routine health care delivery providers generally are focused on their patients and on recording in an objective manner that will create a basis for efficacious continuity of care. *Id.* Providers are not primarily focused on self-protection from legal action. *Id.*

41. *Id.* at 83-84.

42. *Id.* For example, in malpractice litigation, a medical record can be used as a sword by a patient-plaintiff and as a shield by the patient's health care provider-defendant. *Id.* at 84. See Giesen, *supra* note 17, ¶ 854 at 417 (noting that, on international level, good medical records are not only indispensable on medical grounds, but also are desirable on legal grounds).

43. See ROACH, JR., *supra* note 7, at 95 (mentioning exceptions to general rule of confidentiality regarding medical records).

44. 5 U.S.C.A. § 552 (West 1997).

45. 5 U.S.C.A. § 552a (West 1997).

46. See ROACH, JR., *supra* note 7, at 97-102 (giving overview of state access statutes). See, e.g., N.Y. PUB. HEALTH LAW § 18 (McKinney 1997) (granting right of access to patient).

47. See, e.g., *Emmett*, 396 F.2d at 935 (stating that physician has duty of disclosure based upon fiduciary relationship between physician and patient); *Wallace*, 164 N.E.2d at 918 (holding that patient is entitled to copy of medical record based on patient's property right in information in record).

of Information Act⁴⁸ ("FOI Act") that provides individuals with access to records in the public sector, as well as a Privacy Act ("APA").⁴⁹ Australian courts, however, do not recognize a patient's right to access privately held records.⁵⁰

B. U.S. Law

In the United States, there is a growing trend of recognizing patients' accessibility to their own medical records.⁵¹ There are various ways of creating a right of patient access to medical records in the United States.⁵² Courts have relied upon common law rights to develop a patient's right to access medical records.⁵³ Federal statutes allow access to medical records held by federal agencies.⁵⁴ In addition, courts may also imply a right of access based on state legislation.⁵⁵ Finally, legislatures have passed state statutes granting express rights of access.⁵⁶

1. Background

In the 1970s, the U.S. health care system maintained a restrictive position⁵⁷ on patient access issues because physicians assumed that direct patient access would harm the patient, the physician-patient relationship, and the integrity of the record.⁵⁸

48. See Freedom of Information Act, 1982 (Austl.) (enabling individuals to have access to information about them held in government files).

49. See Privacy Act, 1988 (Austl.) (protecting privacy in personal information).

50. *Breen* (1996) Aust. High Ct. LEXIS 54.

51. See WOLFE, *supra* note 33, at vii (discussing courts' recent recognition of patients' right to access).

52. See Klugman, *supra* note 27, at 1363 (discussing inadequacy of current patient access law in United States).

53. See *Hutchins*, 544 S.W.2d at 804 (stating that patient had common law right to inspect her own medical records).

54. 5 U.S.C. § 552a; 5 U.S.C. § 552.

55. See Andrea G. Nadel, Annotation, *What are "Records" of Agency Which Must Be Made Available Under State Freedom of Information Act*, 27 A.L.R. 4th 680 (1981) [hereinafter Nadel, *What are "Records"*] (analyzing U.S. state cases that discuss what constitutes public record under state freedom of information acts); Andrea G. Nadel, Annotation, *Patient's Right to Disclosure of His or Her Own Medical Records Under State Freedom of Information Act*, 26 A.L.R. 4th 701 (1981) [hereinafter Nadel, *Patient's Right to Disclosure*] (reviewing U.S. state cases that discuss whether medical or hospital records are subject to disclosure to patient under state freedom of information acts).

56. See, e.g., 735 ILL. COMP. STAT. ANN. 5/8-2001 (West 1997); N.Y. PUB. HEALTH LAW § 18 (McKinney 1997).

57. BRUCE, *supra* note 25, at 162. The health care system continually denied patient access in the 1970s. *Id.*

58. *Id.*

At the end of the decade, the American Medical Association⁵⁹ ("AMA") cited the need to protect patients from misconstruing information in the record or from trying to treat themselves as reasons for opposing patient access.⁶⁰ In the 1980s, however, a trend towards accessibility emerged.⁶¹ In 1984, the AMA changed its opinion from its 1970s restrictive stance, expressing the view that doctors should provide a copy or summary of the record to the patient upon the patient's request.⁶²

The growing movement toward patients' access to their medical records is part of the larger right-to-know movement.⁶³ A tendency towards disclosure has replaced the United States' traditional position of secrecy.⁶⁴ This has marked a recognition of the right of patients to play a meaningful role in their own health care management.⁶⁵ Currently, all patients in the United States have at least a limited right to access their own medical records.⁶⁶ Legal scholars, health care providers, and patients have debated the rights of patients to access their medical

59. AMERICAN MEDICAL ASSOCIATION, MEMBERSHIP FACTS (on file with the *Fordham International Law Journal*). The American Medical Association ("AMA") was founded in 1847 and is the "primary voice for the Medical Profession. The AMA represents physicians who are dedicated to the health of the American people, serving as a forum for national health policy and development." *Id.*

60. WOLFE, *supra* note 33, at vii.

61. BRUCE, *supra* note 25, at 162. Some reasons for the departure from prior restrictions on patient access included fairness to patients, a positive effect on patient trust in the doctor-patient relationship, a positive effect on patient recovery, and a positive effect on the quality of care and record-keeping. *Id.* at 162-163. Furthermore, studies suggested that original concerns about the effects of access might not have been valid. *See id.* at 163 (discussing findings of various studies affecting patient access to records). For example, one study concluded that access does not disrupt physician-patient communication, but rather access will be sought where the physician fails to communicate. *Id.*

62. *See* WOLFE, *supra* note 33, at viii (contributing reversal in trend to patients' continued demand for release of medical records and to debunking of myths about harm to patients caused by access).

63. *See id.* at vii (noting that "[t]his movement is based on a very old, very American Jeffersonian principle: that information is power."). The larger right-to-know movement includes citizens demanding to know the names and hazards of chemicals in their communities, workers demanding the right to know the names or hazards of the chemicals to which they are exposed, battles to require warnings on products about health problems, and battles to list ingredients and additives on food. *Id.*

64. *See id.* at vii-viii (noting that before mid-1980s AMA opposed giving patients access to their own records, espousing "doctor knows best" philosophy). *See also* BRUCE, *supra* note 25, at 161 (analyzing trend toward disclosure of health records to patients on demand).

65. BRUCE, *supra* note 25, at 161.

66. ROACH, JR., *supra* note 7, at 82.

records⁶⁷ and the rules governing access in the United States are not uniform from state to state.⁶⁸

2. Right of Access Based Upon Common Law

In the absence of a statute or regulation, some courts have held that a patient has a common law right to inspect her own records.⁶⁹ At least one judge has recognized the right without reference to any specific legal theory.⁷⁰ Usually, however, the common law duty to allow a patient limited access to records is based upon either property notions regarding the ownership of the record⁷¹ or upon the fiduciary qualities of the physician-patient relationship.⁷²

67. See UNIFORM HEALTH-CARE INFORMATION ACT, at 6 (Proposed Official Draft 1985, Approved 1986) (stating that entire National Conference of Commissioners on Uniform State Laws ("Conference") debated Uniform Health-Care Information Act ("Model Act") in two separate years). U.S. medical practitioners traditionally believed that personal access to medical records would have an adverse effect on the patient's health and peace of mind. See, e.g., Klugman, *supra* note 27, at 1349-374 (naming medical paternalism, when doctors make decisions for patients, as one traditional medical rationale for withholding patient information and arguing that individual freedom and self-determination favor access to medical records). Judge Cardozo stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body," thereby advocating self-determination. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125 (N.Y. 1914). Congress addressed the issue of patient access rights for institutional health care facilities when it considered The Federal Privacy of Medical Information Act, which ultimately failed because of the restrictive provisions on confidentiality and disclosure. Klugman, *supra* note 27, at 1374-75.

68. Compare 735 ILL. COMP. STAT. ANN. 5/8-2001 (West 1997) (requiring private and public hospitals to permit patients to examine hospital records upon request) with ARK. CODE 16-46-106 (Michie 1995) (stating that doctors or hospitals must furnish patients with copies of medical records if in preparation for legal proceeding). See also Paula F. Henry, *Legal Issues Relating to Access to Medical Records*, NURSE PRACTITIONER FORUM, Sept. 1993, at 120, 120 (discussing legal issues of access from U.S. nurse practitioner's point of view).

69. See *Hutchins*, 544 S.W.2d at 804 (Tex. Ct. App. 1976) (holding that former patient had common law right to inspect her own records); *Pyramid Life Ins. Co.*, 191 F. Supp. at 54 (finding right of access in patient's property right in information appearing on records).

70. See *Hutchins*, 544 S.W.2d at 804 (upholding patient's right of access without referring to specific theory for right). A former patient of the Texas Rehabilitation Commission sought by mandamus to compel disclosure of her records under the Texas Open Records Act. *Id.* at 802. The Court of Civil Appeals held that the former patient could not gain access under authority of the Open Records Act, but had a common law right to inspect her own records. *Id.* at 804.

71. See, e.g., *Wallace*, 164 N.E.2d at 918 (holding that patient has property right in information contained in medical record).

72. See, e.g., *Cannell*, 315 N.E.2d at 280 (holding that fiducial qualities of patient-

a. Ownership of the Medical Record

Under early common law the physician had absolute ownership rights to the records of her patients.⁷³ The traditional school of thought held that physicians viewed their patients' medical records as a personal diary and, therefore, the physician owned the record and could do with it as she pleased.⁷⁴ As patients' autonomy emerged, however, a legal recognition that patients had a property right to the information within the record developed.⁷⁵ Today, the generally accepted notion is that the hospital owns the hospital medical record,⁷⁶ subject to the patient's interest in the information it contains.⁷⁷

In 1959, the court in *Wallace v. University Hospitals of Cleveland*⁷⁸ first recognized a patient's right to access her own medical records.⁷⁹ In *Wallace*, the Court of Common Pleas of Ohio reaffirmed the axiom that hospital records are the property of the hospital.⁸⁰ Nevertheless, the court held that the patient has a property right to the information contained in the record and is, therefore, entitled to a copy of the record.⁸¹ In *Pyramid Life*

physician relationship require disclosure of medical information to patient upon request).

73. SCOTT, *supra* note 37, at 93. See *McGarry v. J.A. Mercier Co*, 272 Mich. 501 (Mich. 1935) (holding that in absence of agreement to contrary, X-ray negatives, which are part of clinical record, are property of physician or surgeon rather than of patient).

74. Henry, *supra* note 68, at 120.

75. *Id.*

76. ROACH, JR., *supra* note 7, at 96. A hospital record may be different from a physician's private office records, although the purpose and function for both types of records are the same. See AMERICAN COLLEGE OF LEGAL MEDICINE, *LEGAL MEDICINE: LEGAL DYNAMICS OF MEDICAL ENCOUNTERS* 246 (2nd ed. 1991) (comparing private office records with hospital records). A physician owns her private office records, subject to an ethical obligation to furnish them to another physician who assumes responsibility for the patient's care. *Id.* Patients do not have an absolute right to inspect private office medical records in the absence of statutory authority or an applicable court decision. *Id.*

77. ROACH, JR., *supra* note 7, at 96.

78. 164 N.E.2d 917.

79. *Id.* at 918.

80. *Id.* The court held that a patient's medical records are the property of the hospital stating that "their maintenance and custody is essential to the proper administration of the Hospital." *Id.*

81. *Id.* On appeal, the court limited the right of access to those records which, when left to the hospital's discretion, were proper to copy under the circumstances of the case, keeping in mind "the beneficial interest of the plaintiff and the general purpose for which such records or any part thereof were kept and maintained . . ." *Wallace*, 170 N.E.2d at 261.

Ins. Co. v. Masonic Hosp. Ass'n. of Payne County,⁸² the court declared that the keeper of the records does not have the right to possess and use the information contained therein to the exclusion of the patient, her representative, or those standing in her shoes.⁸³ Under this theory the physician is regarded as the custodian, rather than the owner, of the information constituting the records.⁸⁴ Because the keeper of the records is only the custodian of the information,⁸⁵ the patient can inspect and/or copy the records without resorting to litigation.⁸⁶ While courts generally accept this theory, the basic rule of record ownership is established by statute in many cases.⁸⁷

There is no constitutional right, however, to obtain the information contained in medical records.⁸⁸ In *Gotkin v. Miller*,⁸⁹ a former mental patient, who was writing a book, requested copies of her records in order to verify her recollections of the experience at the hospitals.⁹⁰ The hospitals denied the requests and at trial the patient argued that the hospitals had violated her federal constitutional rights.⁹¹ In affirming the district court's opin-

82. 191 F. Supp. 51, 54 (W.D. Okla. 1961). In *Pyramid*, the patient's health insurer sought access to the hospital records in order to settle an insurance claim. *Id.* The court granted access to the insurer because the patient had authorized disclosure. *Id.*

83. *Id.*

84. *Id.*

85. *See id.* (holding that keeper of records is not owner of information constituting patient's medical records).

86. *See id.* (stating that patient's property interest in information in medical records entitles patient to inspect and copy records).

87. *See* ROACH, JR., *supra* note 7, at 96 (discussing issue of ownership of medical records). *See, e.g.*, TENN. CODE ANN. § 68-11-304 (1997) (stating that hospital records are and shall remain property of hospital).

88. *See* *Gotkin v. Miller*, 379 F. Supp. 859, 868 (E.D.N.Y. 1974) (concluding that plaintiff could not show sufficient property interest in hospital's medical records to entitle records to constitutional protection), *aff'd*, 514 F.2d 125, 128 (2d Cir. 1975).

89. *Id.*

90. *Gotkin*, 514 F.2d at 127.

91. *Id.* In *Gotkin*, plaintiff alleged that the policies of the hospitals against granting requests for copies of patient records violated the rights of former mental patients under the First, Fourth, Ninth, and Fourteenth Amendments of the U.S. Constitution. *Id.* at 127. The district court believed that while the right to receive information is a necessary corollary to the First Amendment's right to free speech, the Amendment's tenets were inapplicable to the facts of *Gotkin*. 379 F. Supp. at 862-63. Similarly, the district court held that the Fourth Amendment prohibition of unreasonable searches and seizures was inapplicable. *Id.* at 863. The district court failed to see how the right to privacy under the Ninth Amendment was germane to the facts of the case. *Id.* at 863-64. Finally, plaintiffs had not been deprived of liberty or property protected by the due process clause of the Fourteenth Amendment. *Id.* at 864.

ion, the Second Circuit Court of Appeals⁹² found no basis for recognizing that patients have a constitutionally protected property interest in direct and unrestricted access to their records.⁹³

b. Fiduciary Duty

A fiduciary duty is the duty to act for someone else's benefit, while subordinating one's personal interests to that of the other person.⁹⁴ Trust or confidence reposed by one person in the integrity and fidelity of another establishes a fiduciary relationship.⁹⁵ The relation can be legal, social, domestic, or merely personal.⁹⁶ Typical examples of fiduciary relationships include those existing between attorney and client,⁹⁷ principal and agent,⁹⁸ trustee and beneficiary,⁹⁹ and landlord and tenant.¹⁰⁰

The fiducial quality of the physician-patient relationship has created a different basis for common law patient access rights.¹⁰¹ This theory was established in 1967 in *Emmett v. Eastern Dispensary and Casualty Hospital*,¹⁰² where the court held that the fiduciary relationship between the physician and the patient imposes

92. *Gotkin*, 514 F.2d 125.

93. *See id.* at 128 (stating that U.S. Fourteenth Amendment is not independent source of property rights and does not support appellants' claim that former mental patients have constitutionally protected, unrestricted property right directly to inspect and copy their hospital records). The *Gotkin* court noted that prior cases indicate that "patients have certain rights in their records short of the absolute property right to unrestricted access" that the plaintiff was claiming. *Id.* at 129. The court, however, did not address the limits on indirect or restricted access. *See id.* at 127-30 (discussing only issue of constitutional interest in direct and unrestricted access to mental health records).

94. *See* BLACK'S LAW DICTIONARY 625 (6th ed. 1990) (defining fiduciary duty as highest standard of duty implied by law).

95. *See id.* at 626 (defining fiduciary relation as broad term embracing both technical fiduciary relations and informal relations that exist wherever one person trusts in or relies upon another).

96. *See* Estate of Heilman v. Burson, 345 N.E.2d 536, 540 (Ill. App. Ct. 1976) (finding fiduciary relationship between owner of estate and defendant because estate owner relied upon defendant and looked to him for advice and help in managing business affairs).

97. BLACK'S LAW DICTIONARY, *supra* note 94, at 626.

98. *Id.*

99. *Id.*

100. *Id.*

101. *See Cannell*, 315 N.E.2d at 280 (holding that fiducial qualities of patient-physician relationship require disclosure of medical data).

102. 396 F.2d 931 (D.C. Cir. 1967).

upon the physician a duty of disclosure.¹⁰³ While the *Emmett* court relied on a best interest test,¹⁰⁴ the Illinois court in *Cannell v. Medical and Surgical Clinic*¹⁰⁵ upheld patient access without expressly relying on the best interest test.¹⁰⁶ The *Cannell* court, however, did express its belief that the *Emmett* case should be considered descriptive of Illinois law as well.¹⁰⁷ The court found that the fiduciary qualities of the physician-patient relationship required the provider to disclose medical information to the patient upon request and that the patient need not engage in legal proceedings in order to receive the information.¹⁰⁸

3. Federal Statutes

Federal statutes exist in the United States that give patients a right to access their medical records.¹⁰⁹ The two statutes that confer a right of access on patients are the federal FOIA,¹¹⁰ which was enacted in 1966,¹¹¹ and the Privacy Act of 1974.¹¹² These acts apply to federal agencies only.¹¹³ Therefore, the only medical records that patients can obtain under these statutes are those that a federal medical care facility¹¹⁴ maintains or those records that are maintained in a records system operated under a contract with a federal government agency.¹¹⁵ Federal funding

103. See *id.* at 935 (holding that duty of disclosure extends after patient's death to next of kin).

104. See *id.* (stating that "[w]e find in the fiducial qualities of that relationship the physician's duty to reveal to the patient that which in his best interests it is important that he should know.").

105. 315 N.E.2d 278.

106. See *id.* at 280 (considering *Emmett* descriptive of Illinois law without referring to *Emmett's* best interest test).

107. See *id.* (discussing *Emmett* where District of Columbia court held that both hospital and doctor had duty of disclosure).

108. See *id.* (holding that defendant should have produced information sought by plaintiff).

109. 5 U.S.C. § 552a; 5 U.S.C. § 552.

110. See 5 U.S.C. § 552 (making agency information available for public inspection and copying).

111. *Id.*

112. See 5 U.S.C. § 552a (requiring agency to permit individual to gain access to record or information pertaining to such individual).

113. *Id.*; 5 U.S.C. § 552.

114. JOHNSON & WOLFE, *supra* note 33, at 57. Examples of federal medical care facilities include Veterans Administration hospitals, Public Health Service facilities, and military hospitals. *Id.*

115. See ROACH, JR., *supra* note 7, at 116-17 (emphasizing that Privacy Act applies only to federal agencies).

or federal regulation, however, does not automatically subject a hospital or other health care facility to the Privacy Act or FOIA.¹¹⁶ Because these statutory measures apply only to federal agencies, most medical data is left entirely outside of their protections.¹¹⁷

a. Freedom of Information Act

The FOIA also gives individuals rights to access records held by federal agencies, independently of the Privacy Act.¹¹⁸ Yet the framers of the FOIA did not have disclosure of records concerning private citizens in mind when they created the statute.¹¹⁹ The FOIA is concerned with what types of information must be made public, regardless of the purposes for which the request for information is made and regardless of the identity of the requesting party.¹²⁰ The basic purpose of the FOIA is to open agency action up to public scrutiny.¹²¹ Under the FOIA the agency records must be available for inspecting and copying.¹²² The policy underlying the FOIA is one of full agency disclosure unless the information falls within one of the statutory exemptions.¹²³

116. *See id.* at 117 (discussing which types of hospitals are bound by Privacy Act's requirements).

117. *See* PAUL M. SCHWARTZ & JOEL R. REIDENBERG, *DATA PRIVACY LAW: A STUDY OF UNITED STATES DATA PROTECTION* 172-73 (1996) (stating that notable weaknesses exist in federal measures that regulate medical data). In the United States, most of the hospital system is in private hands. Dieter Giesen, *Vindicating the Patient's Rights: A Comparative Perspective*, 9 J. CONTEMP. HEALTH L. POL'Y 273, 280 (1993) (noting expansionist trends of hospital liability in negligence claims).

118. JOHNSON AND WOLFE, *supra* note 33, at 57. *See* 5 U.S.C. § 552 (making official information available for public inspection).

119. *United States Dep't of Justice v. Reporters Comm. for Freedom of the Press*, 489 U.S. 749, 765 (1989). The Freedom of Information Act ("FOIA") reads in pertinent part: "To the extent required to prevent a clearly unwarranted invasion of personal privacy, an agency may delete identifying details when it makes available or publishes an opinion, statement of policy, interpretation, staff manual, instruction, or copies of records referred to in subparagraph (D)." 5 U.S.C. § 552(a)(2)(E).

120. *See Reporters Comm. for Freedom of the Press*, 489 U.S. at 771-72 (stating that identity of requesting party has no bearing on merits of FOIA request except for cases in which objection to disclosure is based on claim of privilege and person requesting disclosure is party protected by privilege).

121. *See Department of Air Force v. Rose*, 425 U.S. 352, 372 (1976) (finding no support for claim that Congress created blanket exemption for personnel files).

122. 5 U.S.C. § 552(a)(2).

123. *See Rose*, 425 U.S. at 360-61 (reflecting Congress' general philosophy of full agency disclosure unless information is exempted under statutory language). The FOIA does not apply to matters that are: 1) specifically authorized to be kept secret in

An exemption of the FOIA excludes from disclosure personnel and medical files under specific circumstances.¹²⁴ The inquiry under this exemption is whether disclosure of the files would be an invasion of privacy that is clearly unwarranted.¹²⁵ This inquiry involves balancing the public interest¹²⁶ against the personal harm resulting from a privacy invasion,¹²⁷ keeping in mind that the presumption is in favor of disclosure.¹²⁸ An agency seeking to withhold information has the burden of showing that the requested material satisfies the elements of the exemption.¹²⁹ Scholars assert that if a patient is requesting her own records, however, a restriction on access should not apply because the disclosure would not be an unwarranted invasion of privacy.¹³⁰ Nevertheless, both the Privacy Act and the FOIA require U.S. federal agencies that maintain, or have obtained, medical records to withhold disclosure of the records unless a court conducts the balancing test and orders disclosure¹³¹ or unless U.S. Congress requests the records.¹³²

the interest of national defense or foreign policy; 2) related only to internal personnel rules and practices of an agency; 3) specifically exempted by statute; 4) privileged or confidential trade secrets and commercial or financial information; 5) inter- or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency; 6) personnel, medical, and similar files that would constitute a clearly unwarranted invasion of personal privacy; 7) compiled for law enforcement purposes; 8) related to regulation or supervision of financial institutions; and 9) geological and geophysical information and data. 5 U.S.C. § 552(b).

124. See 5 U.S.C. § 552(b)(6) (specifying exemptions under FOIA). This section does not apply to matters that are "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of privacy." *Id.*

125. *Id.*

126. See *International Bhd. of Elec. Workers Local Union No. 5 v. Dep't of Hous. & Urban Dev.*, 852 F.2d 87, 89 (3d Cir. 1988) (holding that exemptions under FOIA are to be narrowly construed).

127. See *id.* (summarizing exemption 6 analysis governing personnel, medical, and similar files).

128. See *Rose*, 425 U.S. at 360-61 (expressing view that disclosure is dominant objective of FOIA).

129. See 5 U.S.C. § 552(a)(4)(B) (stating that on complaint, court shall determine matter *de novo* and burden is on agency to sustain its action of withholding information).

130. JOHNSON & WOLFE, *supra* note 33, at 57.

131. See 5 U.S.C. § 552(b)(6) (exempting from disclosure medical records that would constitute clearly unwarranted invasion of personal privacy); 5 U.S.C. § 552a(g)(3)(A) (giving court authority to order production to complainant of any agency records improperly withheld).

132. See 5 U.S.C. § 552(c)(3)(d) (stating that this section does not provide authority to withhold information from Congress); 5 U.S.C. § 552a(b)(9) (stating that no

b. Privacy Act

The Privacy Act was designed to give private citizens control over information collected by the federal government.¹³³ The U.S. Congress passed it largely out of concern with the impact of computer data banks on individual privacy.¹³⁴ The Privacy Act restricts the type of information that a federal agency may collect on individual citizens and it limits the uses of such information.¹³⁵ The Privacy Act requires the federal government to grant patients direct access to their own medical records.¹³⁶ The Privacy Act also requires each federal agency to make copies of the records available for copying.¹³⁷

4. State Statutes

State statutes are often the basis for a right of patient access

agency shall disclose any record unless disclosure would be to either House of Congress).

133. See ROACH, JR., *supra* note 7, at 115 (stating purposes of Privacy Act).

134. *Reporters Comm. for Freedom of the Press*, 489 U.S. 749, 766 (1989). The Privacy Act promotes accountability, responsibility, legislative oversight, and open government with respect to the use of computer technology in the Federal Government's personal information systems and data banks and with respect to all of the Federal Government's other files. S. REP. NO. 93-1183 (1974).

135. See ROACH, JR., *supra* note 7, at 115-16 (discussing Privacy Act). The Privacy Act provides that an agency may maintain only such information about an individual that is relevant and necessary to accomplish an authorized purpose of the agency. See 5 U.S.C. § 552a (e)(1) (setting out agency requirements). It limits the use of such information by requiring written consent of the individual to whom the record pertains or under specified circumstances. See 5 U.S.C. § 552a (b) (stating conditions of disclosure).

136. 5 U.S.C. § 552a. Section 552a (f)(3) allows for special procedures when the release of the information pertaining to the individual could have an adverse effect on her physical or mental health. 5 U.S.C. § 552a (f)(3). This section provides:

(f) Agency rules.—In order to carry out the provisions of this section, each agency that maintains a system of records shall promulgate rules, in accordance with the requirements (including general notice) of section 553 of this title, which shall—

(3) establish procedures for the disclosure to an individual upon his request of his record or information pertaining to him, including special procedure, if deemed necessary, for the disclosure to an individual of medical records, including psychological records, pertaining to him.

Id.; see SCOTT, *supra* note 37, at 104 (stating that when exception is applicable, disclosure is still accomplished by releasing information to designated physician).

137. See 5 U.S.C. § 552a (d) (requiring agency to permit individual to review record pertaining to her and obtain copy in comprehensible form).

to medical records.¹³⁸ U.S. state courts have viewed state public records or freedom of information acts as implying a right of access to medical records in public hospitals.¹³⁹ In addition, the majority of U.S. states have access statutes that recognize a patient's direct or indirect¹⁴⁰ right of access.¹⁴¹

a. Acts

U.S. Courts have implied a right of access to medical records in public hospitals based on state public records or freedom of information acts.¹⁴² Similar to the federal FOIA, the U.S. state statutes typically contain exceptions for medical records where disclosure would be an unwarranted invasion of personal privacy.¹⁴³ Some U.S. state freedom of information laws exempt from disclosure personal information in files maintained for patients of public institutions¹⁴⁴ as well as files of public agencies to the extent that disclosure would violate a privacy

138. See James M. Madden, Comment, *Patient Access to Medical Records in Washington*, 57 WASH. L. REV. 697, 704 (1982) (examining basic ways in which jurisdictions have created right of patient access to medical records).

139. See *Oliver v. Harborview Med. Ctr.*, 94 Wash. 2d 559, 566-67 (Wash. 1980) (finding that patient's public hospital medical records are public records under Washington's Public Disclosure Act); *Sullivan v. State*, 352 So. 2d 1212, 1213 (Fla. Dist. Ct. App. 1977) (stating that legislature intended that patient have access to record).

140. See ROACH, JR., *supra* note 7, at 98 (describing access by or on behalf of patient).

141. See *id.* at 97-102 (canvassing U.S. state access laws); see also JOHNSON & WOLFE, *supra* note 33, at 38-56 (analyzing access rights in United States on state-by-state basis).

142. See *Oliver*, 94 Wash. 2d at 566-67 (concluding that medical records were not necessarily exempted from disclosure under Washington's Public Disclosure Act); *Sullivan*, 352 So. 2d at 1212 (stating that legislature intended patient to be able to access record); Madden, *supra* note 138, at 704 (discussing courts deriving access rights from statutes).

143. See, e.g., 5 ILL. COMP. STAT. ANN. 140/7 (West 1997) (exempting information that, if disclosed, would constitute clearly unwarranted invasion of personal privacy unless disclosure is consented to in writing by subjects of information); N.Y. PUB. OFF. § 89 (McKinney 1997) (stating that committee on public access to records may promulgate guidelines regarding deletion of identifying details or withholding of records to prevent unwarranted invasions of personal privacy). See also ROACH, JR., *supra* note 7, at 120 (discussing state open records laws and stating that most case law arising under state acts deals with balancing public interest in disclosure with private interest in confidentiality).

144. See, e.g., WASH. REV. CODE ANN. § 42.17.310(1)(a) (stating that personal information in files maintained for patients or clients of public institutions or public health agencies are exempt from public inspection and copying). See also Nadel, *Patient's Right to Disclosure*, *supra* note 55 (analyzing state cases which have discussed whether medical records are subject to disclosure under state freedom of information acts).

right.¹⁴⁵ Despite the exceptions, courts have held that medical records were not necessarily exempt from disclosure under the state acts.¹⁴⁶ Most case law concerning the state acts deals with determining whether the private interest in confidentiality outweighs the public interest in disclosure.¹⁴⁷

U.S. state courts disagree, however, on whether patient medical records are public records within the meaning of the state laws.¹⁴⁸ The Kentucky Court of Appeals¹⁴⁹ held that a patient's medical records were not public records subject to the Kentucky Open Records Act¹⁵⁰ because they were not related to the functioning of the hospital or the hospital's activities and programs.¹⁵¹ Yet the Supreme Court of Washington, in *Oliver v.*

145. See, e.g., WASH. REV. CODE ANN. § 42.17.310(1)(b) (exempting personal information in files maintained for employees, appointees, or elected officials of any public agency to extent that disclosure would violate right to privacy).

146. See *Oliver*, 94 Wash. 2d 559, 567 (writing that "[r]espondents contend that . . . appellant's medical records . . . are exempted from disclosure We do not agree."); *State v. Fears*, 659 S.W.2d 370, 376 (Tenn. Crim. App. 1983), cert. denied, 465 U.S. 1082 (1984) (allowing disclosure of defendant's medical records under state Freedom of Information Act to District Attorney General).

147. See *Child Protection Group v. Cline*, 350 S.E.2d 541, 543 (W. Va. 1986) (stating that court, in deciding whether to release medical records, must balance public's need to know against individual's right to privacy and adopting five factor test for deciding whether disclosure of personal information, such as that kept in medical file, would constitute unreasonable invasion of privacy). The *Cline* court's five-factor test is: 1) whether disclosure would result in a substantial invasion of privacy, and if so, how serious invasion would be; 2) the extent of the public interest and the purpose of the individuals seeking disclosure; 3) whether the information is available from other sources; 4) whether the information was given with an expectation of confidentiality; and 5) whether it is possible to mould relief so as to limit the individual's privacy invasion. *Id.* See also ROACH, JR., *supra* note 7, at 120 (discussing state open records statutes).

148. See Nadel, *What are "Records"*, *supra* note 55, at § 8 (analyzing cases that discuss hospital and medical reports as public records under state freedom of information acts). For example, the court in *Wooster Republican Printing Co. v. Wooster*, held that admission and discharge records of a community hospital were public records and, therefore, subject to disclosure. 56 Ohio St. 2d 126, 135 (Ohio 1978). In *Patients of Philadelphia State Hospital v. Commonwealth Dept. of Welfare*, the court held that a report prepared by the hospital accreditation commission for the state department of welfare was a public record within meaning of the state right to know law and thus subject to disclosure to patients about whom report was prepared. 53 Pa. Commw. 126, 133-34 (Pa. Commw. Ct. 1980). See, e.g., TENN. CODE ANN. § 68-11-304 (1997) (specifying that hospital records shall not constitute public records).

149. *Hardin County v. Valentine*, 894 S.W.2d 151 (Ky. Ct. App. 1995).

150. KY. REV. STAT. ANN. § 61.780 (Banks-Baldwin 1997).

151. See *Valentine*, 894 S.W.2d at 152 (determining that medical records are not public records).

Harborview Medical Center,¹⁵² stated that a patient's hospital records were public records within the meaning of the state's Public Disclosure Act.¹⁵³ While the court acknowledged that the medical record of a patient at a public hospital contains personal data,¹⁵⁴ it asserted that the record also contains information of a more public nature that carries out or relates to the performance of a governmental or proprietary function.¹⁵⁵

U.S. courts have implied a right of access based on state laws that require release of records upon the patient's authorization.¹⁵⁶ While these laws do not expressly grant a direct right of access, the court in *Sullivan v. State*,¹⁵⁷ for example, believed that the state legislature correctly gave the patient the right to release her records to others.¹⁵⁸ It should therefore follow that the patient herself may have access to the record in order to properly exercise the release right.¹⁵⁹

b. Access Statutes

All U.S. states allow patients, or at least their attorneys,¹⁶⁰ to obtain their medical records in the context of a lawsuit.¹⁶¹ Every state has a statute defining the patient's rights to have an attorney receive a copy of her records for malpractice litigation¹⁶² by written authorization from the patient.¹⁶³ Some statutes declare

152. *Oliver*, 94 Wash. 2d 559.

153. *Id.* at 566.

154. *See id.* (recognizing that private data is contained in patient's record).

155. *See id.* (stating that fact that some personal data is contained in patient's record does not impress thereon character of nonpublic document).

156. *See, e.g., Sullivan*, 352 So. 2d at 1212 (reversing lower court's denial of Sullivan's right to receive copy of most recent clinical summary of his mental conditions as prepared by staff of state hospital).

157. *Id.*

158. *See id.* (stating that any ambiguity in statute regarding patient access should be resolved in favor of patient).

159. *See id.* (declaring that legislature clearly intended that patient have access to record in order to determine whether and to whom patient wished report to be released).

160. *See JOHNSON & WOLFE, supra* note 33, at 38 (reporting results of fifty-state survey on access rights).

161. *Id.*

162. *See BLACK'S LAW DICTIONARY, supra* note 94, at 959 (defining malpractice as professional misconduct or unreasonable lack of skill). In medical malpractice litigation in the United States, negligence is the predominant theory of liability. *Id.*

163. *See Henry, supra* note 68, at 120 (noting that it is important for nurse practitioners to be aware that every state has statutes that define patient rights to have attorney receive copy of records for malpractice litigation). *See, e.g., 735 ILL. COMP. STAT.*

that failure to provide copies of medical records relevant to litigation shall constitute evidence of failure to comply with good faith discovery.¹⁶⁴

The patient record statutes usually establish that the health care providers creating the records own the physical records.¹⁶⁵ Yet, the majority of states now grant statutory recognition to a patient's direct or indirect¹⁶⁶ right of access.¹⁶⁷ But even where a patient has statutory access, the nature of the right varies from state to state.¹⁶⁸

Half of the U.S. states have statutes providing for access to

ANN. 5/8-802 (West 1997) (stating that healthcare practitioner shall be permitted to disclose any information she acquired while attending to any patient in professional character in civil or criminal actions against healthcare practitioner for malpractice); CAL. EVID. CODE § 1158 (West 1998) (providing that whenever, prior to filing of any action or appearance of defendant in action, attorney presents written authorization signed by patient, healthcare practitioner shall make all of patient's records under her or its control available for inspection and copying by attorney); FLA. STAT. ANN. § 766.204(1) (West 1997) (stating that copies of any medical record relevant to any litigation of medical negligence claim or defense shall be provided to claimant or defendant, or to attorney thereof).

164. *See, e.g.*, FLA. STAT. ANN. § 766.204(2) (West 1997) (declaring that failure to provide copies of medical record or failure to make charge for copies reasonable shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive requirement of written medical corroboration by requesting party).

165. *See, e.g.*, TENN. CODE ANN. § 68-11-304 (1997) (stating that hospital records are property of hospital, subject to court order to produce); MISS. CODE ANN. § 41-9-65 (1996) (providing that hospital records are property of various hospitals, subject to reasonable access to information contained therein). *See also*, SCOTT, *supra* note 37, at 93 (discussing ownership of record and patient access); ROACH, JR., *supra* note 7, at 96 (discussing statutes and cases addressing ownership of medical records).

166. *See* ROACH, JR., *supra* note 7, at 98 (addressing issue of access by or on behalf of patient). Most state laws allow a patient or her authorized representative to access the records. *See id.* (stating that most jurisdictions expressly grant patient or patient's representative right to examine and copy patient's hospital record). *See, e.g.*, 735 ILL. COMP. STAT. ANN. 5/8-2001 (West 1997) (permitting patient, patient's physician, authorized attorney, or holder of consent to examine hospital records); ME. REV. STAT. ANN. tit. 22 § 1711 (West 1996) (stating that if patient or authorized representative for patient requests copies of medical records hospital shall make records available).

167. *See* ROACH, JR., *supra* note 7, at 97-102 (discussing U.S. state access laws). *See also* JOHNSON & WOLFE, *supra* note 33, at 38-56 (analyzing access rights in United States on state-by-state basis).

168. *Compare* MINN. STAT. § 144.335 (1996) (allowing patient to review records during course of hospitalization) *with* 735 ILL. COMP. STAT. ANN. 5/8-2001 (West 1997) (restricting access to hospital records to patients who have already been discharged from hospital). *See* Klugman, *supra* note 27, at 1365 (advocating uniform access statute).

records held by doctors and hospitals.¹⁶⁹ Six other states provide access to hospital records only.¹⁷⁰ Some states place restrictions or qualifications on release of health care patients.¹⁷¹ Examples of these prerequisites to access include the requirement of a court order before release of records,¹⁷² release to a patient only if in contemplation of a lawsuit,¹⁷³ provision of a summary¹⁷⁴ in lieu of the record if the doctor prefers, and release to the patient only after a demonstration of good cause.¹⁷⁵

Procedural details of the right of access also differ between states.¹⁷⁶ Some states allow patients to access their records dur-

169. See JOHNSON & WOLFE, *supra* note 33, at 39 (presenting chart of existing law on patient access to medical records in each of U.S. states and District of Columbia). Those states providing for access to records held by both doctors and hospitals are Alaska, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Louisiana, Maryland, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New York, Oklahoma, South Dakota, Virginia, Washington, West Virginia, and Wisconsin. *Id.* See, e.g., ARK. CODE § 16-46-106 (Michie 1995) (stating that any patient who is or has been patient of doctor, hospital, or other medical institution shall be entitled to obtain access to information in records); MINN. STAT. § 144.335 (1996) (stating that provider shall supply medical information to patient and defining provider to include health care facility or any person who furnishes health care services).

170. See JOHNSON & WOLFE, *supra* note 33, at 1-3, 38-56 (analyzing each state's access provisions). Those states providing access to hospital records only are Maine, Massachusetts, Nebraska, Ohio, Pennsylvania, and Wyoming. *Id.* See, e.g., ME. REV. STAT. ANN. tit. 22 § 1711 (West 1996) (limiting access to patients of institutions licensed as hospital by state).

171. See SCOTT, *supra* note 37, at 93-94 (noting restrictions in access laws). See also JOHNSON & WOLFE, *supra* note 33, at 38-56 (summarizing each of U.S. state's access laws).

172. See ALA. CODE § 22-50-62 (1996) (providing that no employee of any facilities affiliated with Alabama department of mental health and mental retardation shall be required to disclose any record unless a court orders disclosure for promotion of justice).

173. See ARK. CODE 16-46-106 (Michie 1995) (entitling past and present patients to obtain access to information in own medical records for preparation or use in legal proceeding).

174. See ME. REV. STAT. ANN. tit. 22 § 1711-B (West 1996) (stating that health care practitioner shall release copies of all treatment records of patient or narrative containing all relevant information in treatment records).

175. See MISS. CODE ANN. § 41-9-65 (1996) (subjecting hospital records to reasonable access to information contained therein upon showing of good cause).

176. See, e.g., MONT. CODE ANN. § 50-16-541 (1995) (limiting time health care provider must make records available to regular business hours); N.Y. PUB. HEALTH LAW § 18(2)(e) (setting limits on charge for paper copies of record at seventy-five cents per page); ARK. CODE 16-46-106 (Michie 1995) (limiting cost of each photocopy to one dollar per page for first five pages and twenty-five cents for each additional page, except that minimum charge shall be five dollars). See generally JOHNSON & WOLFE, *supra* note 33, at 38-56 (giving state-by-state analysis of access provisions).

ing the course of hospitalization,¹⁷⁷ while others give a right of access only after discharge from the hospital.¹⁷⁸ Some statutes declare that the health care practitioner or physician must make the records available at reasonable times and places and at reasonable costs.¹⁷⁹ Still other statutes specify the maximum time limits and fees for inspecting and copying the records.¹⁸⁰

Many states grant the physicians a therapeutic privilege¹⁸¹ to deny a patient access to the records where the release of the information would adversely affect the patient's mental or physical well-being.¹⁸² Some states reserve this privilege for mental health records only.¹⁸³ In most states, when this exception denies the patient access to her records, the hospital may still be

177. See, e.g., MINN. STAT. § 144.335 (1996) (granting patient right of access to complete and current information); ARK. CODE 16-46-106 (Michie 1995) (allowing any person who is or has been patient of doctor, hospital, or other medical institution to access medical records for use in legal proceeding).

178. See, e.g., 735 ILL. COMP. STAT. ANN. 5/8-2001 (West 1997) (specifying that patients can access their records only after discharge from hospital); ME. REV. STAT. ANN. tit. 22 § 1711 (West 1996) (making copies of medical records available to patient after discharge from state hospital).

179. See, e.g., 735 ILL. COMP. STAT. ANN. 5/8-2003 (West 1997) (stating that physician or practitioner shall comply with written request for medical records within reasonable time after receipt and physician or practitioner shall be reimbursed by person requesting records for all reasonable expenses incurred in connection with such examination or copying).

180. See, e.g., N.Y. PUB. HEALTH LAW § 18(2) (McKinney 1997). This statute provides, in pertinent part, that:

(a) [A] health care provider shall provide an opportunity, within ten days, for such subject to inspect any patient information concerning or relating to the examination or treatment of such subject in the possession of such health care provider.

...

(e) The provider may impose a reasonable charge for all inspections and copies, not exceeding the costs incurred by such provider. However, the reasonable charge for paper copies shall not exceed seventy-five cents per page.

Id.

181. See SCOTT, *supra* note 37, at 221 (defining therapeutic privilege as "an exception to the requirement to obtain patient informed consent before treatment for a situation in which an attending physician reasonably believes that the patient could not psychologically cope with the information disclosed.").

182. See, e.g., ARK. CODE 16-46-106 (Michie 1995) (stating that doctor may deny request to review records if disclosure would be detrimental to individual's health or well-being). See also ROACH, JR., *supra* note 7, at 100 (discussing therapeutic privilege with respect to psychiatric or any medical information).

183. See, e.g., OR. REV. STAT. § 179.505 (1996) (stating that mental health records may be withheld if release will result in immediate and grave detriment to treatment of patient); COLO. REV. STAT. ANN. § 25-1-801 (West 1997) (excepting from disclosure records pertaining to mental health problems if independent third party psychiatrist

required to grant the patient's representative or attorney access.¹⁸⁴

Recognizing the need for consistency in the laws, the National Conference of Commissioners on Uniform State Laws¹⁸⁵ ("Conference") has created a model uniform statute.¹⁸⁶ In 1985, the Conference drafted and approved a Uniform Health-Care Information Act¹⁸⁷ ("Model Act"), which it recommended for enactment in all U.S. states.¹⁸⁸ The American Bar Association¹⁸⁹

feels that inspection of records would have significant negative psychological impact upon patient).

184. *See, e.g.*, MINN. STAT. ANN. § 144.335 (West 1996) (stating that if information contained in records is determined to be detrimental to physical or mental health of patient, or is likely to cause patient to harm herself or another, provider may withhold information from patient and may supply information to appropriate third party or to another provider and that person may then release information to patient). The provider, however, may be required to grant access, but the provider can redact sensitive information from the record before disclosure. *See, e.g.*, ARK. CODE 16-46-106 (Michie 1995) (stating that "if the determination is that disclosure of such information would be detrimental, then it either will not be released or the objectionable material will be obscured before release."). A provider may not disclose HIV related information to a third party unless the patient has authorized a release of that confidential HIV related information. *See* N.Y. PUB. HEALTH LAW § 2782 (West 1997) (setting forth terms for confidentiality and disclosure of HIV and AIDS related information); 410 ILL. COMP. STAT. ANN. 305/9 (West 1997) (providing that person may disclose results of AIDS test to subject of test or any person designated in legally effective release of test results executed by subject of test or subject's legally authorized representative).

185. UNIFORM HEALTH-CARE INFORMATION ACT, *supra* note 67. The Conference drafts statutes on a variety of topics to encourage uniformity in state laws. JOHNSON & WOLFE, *supra* note 33, at 65. Organizations with a direct interest in the subject of a health-care act participated in the Conference's drafting process, including the American Medical Association, the American Bar Association, and the United States Department of Justice. UNIFORM HEALTH-CARE INFORMATION ACT, *supra* note 67, at 6 (1985). As of 1995, however, only Montana and Washington had enacted the Conference's Model Act. *See* Lawrence O. Gostin, *Health Information Privacy*, 80 CORNELL L. REV. 451, 516-17 (1995) (stating that variability of state rules does not reflect realities of modern health care finance and delivery). "A state-by-state approach to regulation of medical information is rarely restricted to the state in which it is generated. . . . Further, the physical location of health information is no longer relevant." *Id.* at 516. "For example, a patient may be treated in an emergency room in one state, return to his or her home state for continuing treatment, and fly to yet another state for specialist care." *Id.* at 517.

186. UNIFORM HEALTH-CARE INFORMATION ACT, *supra* note 67.

187. *Id.*

188. *Id.* *See also* Klugman, *supra* note 27, at 1375-77 (discussing advantages and recommending adoption of uniform patient access law enacted at state level in United States). One scholar, however, asserts that a preemptive federal statute is needed because the prospect for resolving problems through enactment of uniform laws in every state is exceedingly small. *See* Gostin, *supra* note 185, at 516-17 (advocating preemptive uniform federal health information statute in United States).

approved the Model Act in 1986.¹⁹⁰ The Model Act requires disclosure of a medical record for examination and copying upon request from a patient, and provides exceptions for denial of access.¹⁹¹

189. DIVISION FOR MEDIA RELATIONS & PUBLIC AFFAIRS, A.B.A., ABA PROFILE I (1997). The stated mission of the American Bar Association ("ABA") is "to be the national representative of the legal profession, serving the public and the profession by promoting justice, professional excellence and respect for the law." *Id.* The ABA, founded in 1878, leads by developing model rules and guidelines. *Id.*

190. UNIFORM HEALTH-CARE INFORMATION ACT, *supra* note 67.

191. *Id.* The Model Act provides, in pertinent part:

Article III—Examination and Copying of Record

Section 3-101. Requirements and Procedures for Patient's

Examination and Copying

Upon receipt of a written request from a patient to examine or copy all or part of the patient's recorded health-care information, a health-care provider, as promptly as required under the circumstances, but no later than ten days after receiving the request shall:

make the information available for examination during regular business hours and provide a copy, if requested, to the patient;

deny the request, in whole or in part, under Section 3-102 and inform the patient.

Upon request, the health-care provider shall provide an explanation of any code or abbreviation used in the health care information. If a record of the particular health-care information is not maintained by the health-care provider in the requested form, the health-care provider is not required to create a new record or reformulate an existing record to make the health-care information available in the requested form. The health-care provider may charge a reasonable fee, not to exceed the health-care provider's actual cost, for providing the health-care information and is not required to permit examination or copying until the fee is paid.

Section 3-102. Denial of Examination and Copying

A health-care provider may deny access to health-care information by a patient if the health-care provider reasonably concludes that:

knowledge of the health-care information would be injurious to the health of the patient;

knowledge of the health-care information could reasonably be expected to lead to the patient's identification of an individual who provided the information in confidence and under circumstances in which confidentiality was appropriate;

knowledge of the health-care information could reasonably be expected to cause danger to the life or safety of any individual;

the health-care information was compiled and is used solely for litigation, quality assurance, peer review, or administrative purposes; or
access to the health-care information is otherwise prohibited by law.

If a health-care provider denies a request for examination and copying under this section, the provider, to the extent possible, shall segregate health-care information for which access has been denied under subsection (a) from

C. Australian Law

In 1996, the Australian High Court held that patients do not have a right of access to medical records held by their private doctors.¹⁹² Similar to the United States, however, legislative developments in Australia have afforded patients a right of access to records held in a public hospital.¹⁹³ These statutes exist at both the federal¹⁹⁴ and state levels.¹⁹⁵

1. Background

Australia has a common law system based on the English system of law,¹⁹⁶ which is a mixture of customary law, judge-made law, and parliamentary law.¹⁹⁷ In the past, Australian courts had followed the decisions of English superior courts.¹⁹⁸ In 1986, a decision of the Australian High Court¹⁹⁹ confirmed the principle that the House of Lords did not bind Australian

information for which access cannot be denied and permit the patient to examine or copy the disclosable information.

Id.

192. See *Breen* (1996) Aust. High Ct. LEXIS 54, at *160 (holding that no right of access existed in Australian law).

193. See Michael D. Kirby, International Commentary, *A Patient's Right of Access to Medical Records*, 12 J. CONTEMP. HEALTH L. POL'Y 93, 109 (1995) (citing factors that support recognition of access right).

194. See, e.g., Freedom of Information Act, 1982 (Austl.) (promoting disclosure of information held by Australian government).

195. See, e.g., NSW Consolidated Acts, *Freedom of Information Act 1989* (updated Dec. 19, 1997) <http://www.austlii.edu.au/au/legis/nsw/consol_act/foia1989222/> (also on file with the *Fordham International Law Journal*) [hereinafter *NSW Freedom of Information Act*].

196. CARVAN, *supra* note 5, at 9.

197. *Id.*

198. See *id.* at 62-64 (describing structure of English court system). The system of superior courts in England consists of a High Court of Justice and a Court of Appeal. *Id.* at 63.

199. *Cook v. Cook* (1986) 68 A.L.R. 353. The highest federal court of Australia, known as the High Court, has original jurisdiction and is the final court of appeal. See PARKINSON, *supra* note 1, at 186-87 (discussing necessity of limiting court's original jurisdiction). Much of the High Court's work falls within its appellate jurisdiction, where five judges usually sit on appeals regarding non-constitutional cases. See *id.* at 189 (noting High Court's policy on limiting appeals in order for court to maintain manageable workload and to ensure that court concentrates on important legal matters). In constitutional cases, all seven judges sit, and on other important issues of law the Chief Judge may decide that a seven-member court should determine the matter. See *id.* (stating that seven-member court does not always result in clear determination of legal principle involved because judges leave law in confusion when each judge insists on offering individual opinion).

courts, although the United Kingdom's decisions might still be helpful in their reasoning.²⁰⁰ A distinctive Australian version of the common law has since been emerging.²⁰¹

In 1996, the Australian High Court decided the issue of a patient's right of access to medical records in *Breen v. Williams*.²⁰² In *Breen*,²⁰³ the plaintiff sought access to her medical records and decided to start a test case²⁰⁴ in the New South Wales Supreme Court Equity Division²⁰⁵ asserting a right of access.²⁰⁶ The plaintiff modified her claim slightly as the case moved on from the Supreme Court²⁰⁷ to the Court of Appeal²⁰⁸ and even-

200. See *Cook* (1986) 68 A.L.R. 353 (stating that "precedents of other legal systems are not binding and are useful only to the degree of the persuasiveness of their reasoning").

201. See PARKINSON, *supra* note 1, at 168-71 (discussing Australia's gradual legal independence from English precedent).

202. *Breen* (1996) Aust. High Ct. LEXIS 54.

203. *Breen v. Williams* (1994) N.S.W. LEXIS 13365 (Oct. 10, 1994); *Breen v. Williams* (1994) N.S.W. LEXIS 13703 (Dec. 23, 1994); *Breen* (1996) Aust. High Ct. LEXIS 54. Ms. Breen, an Australian patient and the plaintiff in *Breen*, underwent augmentation mammoplasty in 1977. See *Breen* (1994) N.S.W. LEXIS 13703, at *7 (recounting plaintiff's relevant medical history). See also Kirby, *supra* note 193, at 94-97 (summarizing facts of *Breen*). In the augmentation mammoplasty operation, a doctor inserted silicone implants into the plaintiff's breasts to increase their size. See *Breen* (1994) N.S.W. LEXIS 13703, at *8. In 1978, Dr. Cholmondeley Williams, the defendant, treated the plaintiff with respect to complications resulting from the original surgery. See *id.* (concerning defendant's medical treatment of plaintiff). See also Jane Swanton & Barbara McDonald, *Common Law: Patients' Right of Access to Medical Records—a "Test Case"*, AUSTRALIAN L.J. 332, 332 (1997) (stating facts behind *Breen* litigation). The defendant operated on the plaintiff that year and over subsequent years the plaintiff had corresponded with the defendant concerning the removal of the silicone implants. *Breen* (1994) N.S.W. LEXIS 13703, at *8. In 1984, another doctor performed an operative procedure due to leakage of silicone gel from the breast implant. *Id.*

204. See *Breen* (1994) N.S.W. LEXIS 13703, at *11 (stating that plaintiff's advisors decided to launch test case for access to records). The plaintiff wished to treat the litigation as an opportunity to test whether a patient has a right of access to all information in medical records maintained by the patient's treating doctor. See *Breen* (1994) N.S.W. LEXIS 13365, at *2-3 (stating that plaintiff accepted that doctor may withhold information where disclosure would be adverse to patient's interests).

205. *Breen* (1994) N.S.W. LEXIS 13365.

206. See *id.* at *2-3 (deciding issue of patient entitlement to access and copy medical records).

207. See *Breen* (1994) N.S.W. LEXIS 13365, at *30-45, *46-50, *89-98, *102-03 (arguing for right of access based on common law, right to self-determination, fiduciary duty, and right to know).

208. See *Breen* (1994) N.S.W. LEXIS 13703, at *28, *36-37 (modifying claims slightly by softening terms and acknowledging limitations on right of access).

tually to the High Court of Australia.²⁰⁹ The High Court of Australia decided the access issue relying on property notions,²¹⁰ contractual principles,²¹¹ a fiduciary duty,²¹² and an asserted right to know.²¹³

The plaintiff sought access to her records to secure the basis for advice on whether she should opt in to a U.S. class action settlement²¹⁴ and, if she decided to opt in, to comply with the procedure.²¹⁵ To opt in, each claimant had to file copies of

209. See *Breen* (1996) Aust. High Ct. LEXIS 54 (basing argument on contract, property, equity, and right to know).

210. See *id.* at *8-12, *28-34, *60-63, *126-35 (focusing on property issue and stating that defendant's written notes belong to defendant).

211. See *id.* at *1-7, *34-34, *63-72, *119-22 (addressing and rejecting contract basis of claim).

212. See *id.* at *12-16, *37-53, *75-96, *135-58 (analyzing principles of fiduciary duty and finding no fiduciary duty between plaintiff and defendant).

213. See *id.* at *17, *53-55, *96-98 (discussing right to know contents of medical records).

214. *Lindsey v. Dow Corning Corp.* (In re Silicone Gel Breast Implant Products Liability Litigation), No. CIV.A. 94-P-11558-S, 1994 WL 578353 (N.D. Ala. Sept. 1, 1994). In 1993, the plaintiff became involved in litigation against the manufacturer of the breast implants, contending that the breast implants were defective. See *Breen* (1994) N.S.W. LEXIS 13703, at *8-9 (referring to class action suit in United States). U.S. corporations manufactured almost all of the breast implants sold in Australia. Kathleen Carter-Stein, *In Search of Justice: Foreign Victims of Silicone Breast Implants and the Doctrine of Forum Non Conveniens*, 18 SUFFOLK TRANSNAT'L L. REV. 167, 186 (1995). Thousands of women worldwide experienced similar problems with the implants, resulting in a class action in the United States. See BLACK'S LAW DICTIONARY, *supra* note 94, at 249 (defining "class or representative action" as means by which, where large group of persons are interested in matter, one or more may sue or be sued as representatives of class without needing to join every member of class). The principle vehicle for the litigation was the class action *Lindsey v. Dow Corning Corp.*, known as the Silicone Gel Breast Implant Products Liability Litigation, which began in the U.S. District Court for the Northern District of Alabama. *Lindsey*, No. CIV.A. 94-P-11558-S. The plaintiff and 2000 other Australian women wanted to participate in the class action. See *Breen* (1994) N.S.W. LEXIS 13703, at *8-9 (stating that at least 2000 women, out of 50,000 to 80,000 who had received such implants in Australia, were engaged in litigation). Dow Corning eventually conceded liability and agreed to settle. See *Lindsey*, No. CIV.A. 94-P-11558-S, at *24 (concluding that settlement agreement was reasonable, fair, and adequate). Because overseas litigants were originally thought to be an opt out class, the Australian litigants would share in the settlement class unless they chose to opt out. See Kirby, *supra* note 193, at 95 (explaining that Australian litigants were entitled to share in settlement fund unless they specifically chose not to in order to pursue alternative remedies); *Lindsey*, No. CIV.A. 94-P-11558-S, at *25 (naming Australian litigants voluntary Foreign Claimant members of settlement class). But the Alabama Judge excluded the Australian litigants from the settlement and gave them an opportunity to opt in to the litigation before December 1, 1994. See *id.* at *10, *25 (setting deadline for foreign claimants to opt in to litigation).

215. *Breen* (1994) N.S.W. LEXIS 13703, at *10. While a right to access medical

medical records with the U.S. court in support of their claims.²¹⁶ The plaintiff's attorneys wrote to the defendant requesting copies of all primary medical records that he held concerning her case.²¹⁷ The defendant refused to provide copies of the records, saying that the records were his property and he would release them only on production of a subpoena.²¹⁸ He was, however, willing to release the records to the plaintiff if she would release the defendant from any claim that might arise in relation to her treatment.²¹⁹ The defendant was also willing to provide the plaintiff with a report setting out what was done in relation to the implants.²²⁰ The plaintiff did not accept either offer.²²¹

Compulsory court process in Australia could have secured access to the records.²²² The U.S. Judge secured letters rogatory²²³ for this purpose.²²⁴ But the costs, delays, and complications of the compulsory production procedure were signifi-

records, however, does not necessarily mean a right to copy records, almost everywhere that access to a record is allowed, copying the record is an option. *See, e.g.*, Freedom of Information Act, 1982, § 20 (Austl.) (setting out forms of access and including copy of document as one type of access). Thus, arguing for merely a right of access would most likely satisfy the plaintiff's need for a copy of the actual record. *But see Breen* (1996) Aust. High Ct. LEXIS 54, at *33-34 (raising issue of potential copyright problem if plaintiff were to succeed in obtaining right of access, although it was unnecessary to reach any conclusion concerning copyright in *Breen*).

216. *See Lindsey*, No. CIV.A. 94-p-11558-S, at *10 (extending deadline to December 1, 1994 for foreign class members to submit medical documentation required for current claims).

217. *See Breen* (1994) N.S.W. LEXIS 13703, at *12 (stating that plaintiff emphasized to defendant that she was seeking all primary records, not medical report).

218. *See id.* at *12-13 (providing defendant's statement that it was "longstanding legal tradition" that medical records were property of medical practitioner).

219. *See Breen* (1994) N.S.W. LEXIS 13365, at *10-11 (supplying copy of defendant's letter to plaintiff).

220. *See id.* at *11-12 (stating that defendant would compile report and plaintiff would still not be able to see actual medical record).

221. *See id.* at *12-13 (stating that offer to provide report of contents of medical file was not accepted nor withdrawn).

222. *See Kirby*, *supra* note 193, at 96 (stating that throughout Australia, compulsory court process could secure access to medical records).

223. *See Breen* (1994) N.S.W. LEXIS 13703, at *11 (mentioning that U.S. judge secured letters rogatory for case of several litigants). Letters rogatory are the "medium whereby one country, speaking through one of its courts, requests another country, acting through its own courts and by methods of court procedure peculiar thereto and entirely within the latter's control, to assist the administration of justice in the former country." BLACK'S LAW DICTIONARY, *supra* note 94, at 905.

224. *See Breen* (1994) N.S.W. LEXIS 13703, at *11 (discussing plaintiff's alternative ways of accessing her medical records).

cant.²²⁵ Thus, the plaintiff decided to launch a test case in the Australian courts to decide whether patients had a right to their medical records without court orders.²²⁶ What the plaintiff was asking the Australian courts to decide was not whether there should be a right of access in Australia, but whether there was such a right.²²⁷

The courts held that there was no enforceable common law right of access to private records that would provide the plaintiff in *Breen* with a remedy.²²⁸ The case made its way through the Australian court system to the High Court where six judges²²⁹ decided this question of great social importance.²³⁰ The judges unanimously held that patients do not have a right of access to medical records held by their private doctors.²³¹

2. Federal Statutes

Federal legislation in Australia that concerns access to personal information applies to Commonwealth agencies.²³² The object of the FOI Act was to enable individuals in Australia to have access to the information that the federal government held on them.²³³ The APA provides protection for privacy interests of individuals.²³⁴

225. *See id.* at *11 (stating that delays of compulsory production are significant and time available was short).

226. *Id.*

227. *See id.* at *6 (contending that *Breen* does not concern hypothetical question).

228. *See Breen* (1994) N.S.W. LEXIS 13703, at *4-5 (stating that legislation in Australia that provides access to health records generally is restricted to records held by public authorities); *Breen* (1996) Aust. High Ct. LEXIS 54, at *99 (concluding that absent contractual right, Australian common law does not give patient right to access medical practitioner's records).

229. *See Breen* (1996) Aust. High Ct. LEXIS 54, at *1 (listing judges who participated in High Court's decision). Justice Kirby did not sit because he decided the case when he sat as a member of the New South Wales Court of Appeal. *See Breen* (1994) N.S.W. LEXIS 13703, at *4-76 (providing Justice Kirby's opinion in Court of Appeal).

230. *See Breen* (1996) Aust. High Ct. LEXIS 54, at *59 (recognizing importance of claim that patient has right of access to medical records).

231. *See id.* at *1-161 (holding that no right of access existed in each opinion).

232. *See* Freedom of Information Act, 1982 (Austl.) at § 4 (interpreting terms in Freedom of Information Act ("FOI Act")); Privacy Act 1988 (Austl.) at Part II (defining terms used in the Privacy Act ("APA")).

233. *See* Freedom of Information Act, 1982, § 3 (Austl.) (stating object of FOI Act).

234. *See* Privacy Act 1988 (Austl.) at Part III (describing interferences with privacy of individuals).

a. Freedom of Information Act

The Australian government intended the Commonwealth's FOI Act²³⁵ to increase government accountability, to improve the quality of government agencies' decision making, and to enable individuals to have access to government-held information about them.²³⁶ The object of the FOI Act is to extend as far as possible the right of the Australian public to access to information in the possession of the government of the Commonwealth.²³⁷ Similar to the United States' FOIA, the right of access under the FOI Act is not affected by the purpose for which the individual seeks access.²³⁸ The FOI Act exempts a document if its disclosure would involve the unreasonable disclosure of personal information.²³⁹ The FOI Act also contains a provision similar to a therapeutic privilege.²⁴⁰ The legislation applies only to Commonwealth agencies²⁴¹ and, therefore, exhibits limitations.²⁴²

b. Privacy Act

Australia's Privacy Act,²⁴³ which applies principally to the acts and practices of Commonwealth agencies, establishes Information Privacy Principles²⁴⁴ that provide protection for privacy

235. Freedom of Information Act, 1982 (Austl.).

236. *Commonwealth of Australia* (visited Dec. 17, 1997) <http://www.comlaw.utas.edu.au/law/foi/aus_comm.html> (also on file with the *Fordham International Law Journal*).

237. *See* Freedom of Information Act, 1982, § 3 (Austl.) (creating general right of access and promoting disclosure of government information).

238. *See id.* at § 11 (providing that person's right of access is not affected by "any reasons the person gives for seeking access").

239. *See id.* at § 41 (discussing documents affecting personal privacy).

240. *See id.* (stating that instead of giving access to applicant, qualified person will have access to document when it appears to principal officer of agency or to Minister that disclosure to applicant might be detrimental to applicant's physical or mental health or well-being).

241. *See id.* at § 4 (defining agency to mean Department, prescribed authority, or eligible case manager).

242. *See* GORDON HUGHES, *DATA PROTECTION IN AUSTRALIA* 168 (1991) (giving background information on FOI Act and stating that "the [APA] is incapable of providing an adequate basis for the regulation of computer databanks containing personal information, even in the limited context of freedom of information.").

243. Privacy Act, 1988 (Austl.).

244. *See id.* at pt. III (listing information privacy principles that agencies shall not breach).

interests.²⁴⁵ Principle Six of the APA entitles individuals to have access to records containing their personal information.²⁴⁶ The APA does not affect personal information in the private sector.²⁴⁷

3. State Statutes

State legislation in Australia has also afforded patients a right of access to medical records held in a public hospital.²⁴⁸ For example, the New South Wales Freedom of Information Act's²⁴⁹ ("NSW FOI Act") purpose is to extend the public's right to access Government-held information and to ensure that the records are complete and accurate.²⁵⁰ Documents containing matter that would involve the unreasonable disclosure of information concerning personal affairs are exempt from disclosure under the NSW FOI Act.²⁵¹ Thus, a patient's application for access to her own publicly held record would not be an unreasonable disclosure of information and she could access the record.²⁵²

II. ARGUMENTS FOR AND AGAINST A RIGHT OF ACCESS

Patients' rights to access their medical records has been an

245. *See id.* (describing interferences with privacy of individuals).

246. *See id.* at Principle 6 (discussing access to records containing personal information). Principle 6, entitled "Access to records containing personal information," states that

[w]here a record-keeper has possession or control of a record that contains personal information, the individual concerned shall be entitled to have access to that record, except to the extent that the record-keeper is required or authorised to refuse to provide the individual with access to that record under the applicable provisions of any law of the Commonwealth that provides for access by persons to documents.

Id.

247. *See HUGHES, supra* note 242, at 83 (examining Information Privacy Principles of Privacy Act ("APA") and noting APA's imperative language). The APA does affect personal information in the private sector only to the extent that tax file number information or credit information falls within that category. *Id.*

248. *See id.* at 165 (stating that rights of access to, and amendment of, personal information are addressed by state legislation in Victoria and New South Wales); Kirby, *supra* note 192, at 109 (arguing that Australian common law should develop in harmony with Australian legislative provisions).

249. NSW *Freedom of Information Act, supra* note 195.

250. *See id.* at § 5 (stating objects of New South Wales Freedom of Information Act).

251. *Id.* at Schedule 1, § 6.

252. *See id.* (providing that document is not exempt merely because it contains information concerning person making application for access).

issue for years.²⁵³ Scholars have used legal and policy principles to support recognition of a right of access.²⁵⁴ On the other hand, however, scholars have used legal and policy theories to argue against and show the disadvantages of such a right.²⁵⁵

A. Arguments for a Right of Access

Numerous scholars have argued in favor of a patient's right of access to medical records.²⁵⁶ Legal reasoning has supplied support for recognition of such a right of access.²⁵⁷ Individuals have relied on jurisprudence from other countries, as well, to bolster their arguments for a right of access to medical records.²⁵⁸ Scholars have also based arguments for a right of access on policy considerations.²⁵⁹

1. Legal Arguments

The legal debate concerning patients' rights to their medical records is illustrated in the *Breen* litigation.²⁶⁰ Because the plaintiff in *Breen* sought records that were held by a private practitioner, she could not rely on any Australian statutes to secure

253. See WOLFE, *supra* note 33, at vii (explaining that American Medical Association opposed giving patients access to their own records in late 1970s, but moderated its view to allow for access in mid 1980s).

254. See JOHNSON & WOLFE, *supra* note 33, at 22-27 (pointing out advantages of right of access); Klugman, *supra* note 27, at 1357-71 (analyzing adequacy of patient access law).

255. See *Breen* (1996) Aust. High Ct. LEXIS 54 (finding no right of access based in legal principles); JOHNSON & WOLFE, *supra* note 33, at 27-31 (critiquing objections to right of patient access).

256. See, e.g., Madden, *supra* note 138, at 713 (arguing that patient access is desirable because benefits of patient access outweigh risk of harm to patient); Klugman, *supra* note 27, at 1376 (asserting that patients need access to their medical data).

257. See, e.g., Wallace, 164 N.E.2d at 918 (holding that patient has property right in information in medical record and, therefore, is entitled to copy of record); Cannell, 315 N.E.2d at 280 (finding that fiducial qualities of physician-patient relationship require disclosure of medical information to patient).

258. See *Breen* (1994) N.S.W LEXIS 13365, at *50-74 (referring to plaintiff's reliance on judicial decisions in North America and Canada, including *Emmett*, *Cannell*, and *McInerney v. MacDonald*); McQuoid-Mason, *supra* note 17, at 511-13 (examining laws of other countries and concluding that South Africa should adopt legislation allowing patients to inspect and copy their medical records).

259. See JOHNSON & WOLFE, *supra* note 33, at 22-27 (presenting advantages of patient access to medical records); Anton de Klerk, *The Right of Patients to Have Access to Their Medical Records: The Position in South African Law*, *MEDICINE AND LAW* 77, 78-79 (1993) [hereinafter de Klerk, *The Right of Patients*] (giving arguments in favor of access to medical records).

260. *Breen* (1996) Aust. High Ct. LEXIS 54.

access to the records.²⁶¹ Thus, she argued that such a right already existed in the law.²⁶² The plaintiff based her claims on principles of contract, property, equity, and a right to know.²⁶³

a. Right in Contract

In *Breen*, the plaintiff argued for a more specific implied term than a duty of reasonable care.²⁶⁴ The plaintiff asserted that, by implication of law, a doctor always contracts with a patient to act in the patient's best interests.²⁶⁵ Therefore, as a result of the best interest term, the doctor must allow access to a patient's medical records.²⁶⁶

b. Right in Property

The plaintiff did not claim ownership of the actual medical records.²⁶⁷ The plaintiff's contention was that she has a property right in the information within the records.²⁶⁸ She asserted that this proprietary interest in the information entitled her to access the medical records.²⁶⁹

c. Right in Equity

The plaintiff claimed that the fiduciary duty that a doctor owes her patients creates a patient's right to reasonable access of

261. See *Breen* (1994) N.S.W. LEXIS 13703, at *4 (stating that Australian legislation is generally restricted to health records held by public authorities).

262. See *id.* at *6 (presenting question of case as being whether doctor must provide patient with access to information in medical record).

263. See *Breen* (1996) Aust. High Ct. LEXIS 54, at *27-28 (putting forth bases for plaintiff's argument).

264. See *Swanton & McDonald, supra* note 203, at 335 (analyzing High Court's decision in *Breen* with respect to implied terms in contracts between doctor and patient).

265. See *Breen* (1996) Aust. High Ct. LEXIS 54, at *66 (reciting plaintiff's contract argument).

266. See *id.* at *67 (disagreeing with plaintiff that doctor impliedly promises to act in patient's best interests).

267. See *id.* at *28, *60 (opining that it is understandable that plaintiff did not claim ownership of actual records because records did not include any documents that plaintiff paid for, such as x-ray photographs, which plaintiff may have been able to claim).

268. See *id.* at *32, *62 (stating that premise of plaintiff's argument was that records were not owned by anybody).

269. See *id.* (restating plaintiff's claim regarding proprietary interest in records).

her medical records.²⁷⁰ Australian authors have called the issue of a fiduciary relationship the most important aspect of *Breen*.²⁷¹ While the High Court unanimously rejected finding such a fiduciary relationship,²⁷² this claim was the basis for Justice Kirby's dissent in the Court of Appeal.²⁷³

In the Court of Appeal decision in *Breen*, Justice Kirby found a right of access based on a fiduciary relationship between a doctor and her patients.²⁷⁴ He began his analysis of the issue by reviewing the law of fiduciary relationships in Australia.²⁷⁵ Some of the propositions stated to evaluate the assertion that a fiduciary relationship existed included the developing complexity of society necessitating an expansion of fiduciary obligations,²⁷⁶ a fiduciary principle not being limited to commercial relationships,²⁷⁷ and a person being in a fiduciary position in some aspects of her activities but not in others.²⁷⁸

270. *See id.* at *12-17, *37-54, *75-96, *144-158 (addressing plaintiff's claim of access to records based on alleged fiduciary duty).

271. *See Swanton & McDonald, supra* note 203, at 333 (stating that fiduciary duty is most important aspect of case from doctrinal point of view).

272. *See Breen* (1996) Aust. High Ct. LEXIS 54, at *12-17, *37-54, *75-96, *144-58 (analyzing aspects of fiduciary duty and concluding that none existed in *Breen* that would allow for plaintiff to access records in defendant's possession).

273. *See Breen* (1994) N.S.W. LEXIS 13703, at *52-73 (finding in favor of plaintiff based on defendant's fiduciary obligation).

274. *See Breen* (1994) N.S.W. LEXIS 13703, at *4-76 (giving Justice Kirby's opinion). The three justices in the Court of Appeal reached different conclusions on the issue of a fiduciary relationship. *See id.* at *52-135 (determining whether fiduciary relationship existed between plaintiff and defendant). Justice Mahoney rejected the idea that a fiduciary relationship exists between a doctor and her patients. *See id.* at *119-20 (stating that doctor-patient relationship is not trust relationship). Justice Meagher believed that a doctor owes her patients a fiduciary duty, but that the relationship does not generate a right of access. *See id.* at *133 (conceding that doctor owes patient fiduciary duties in certain circumstances, but this does not amount to demonstration that patient has right to inspect doctor's notes and records). The third justice, Justice Kirby, also concluded that the doctor-patient relationship was fiduciary in nature, but he dissented and held that the relationship did create a right of patient access. *See id.* at *51-76 (addressing policy considerations for recognizing right of access to records).

275. *See id.* at *52-63 (finding that fiduciary relationship existed between plaintiff and defendant).

276. *See id.* at *54-56 (stating that as society becomes more complex, it is necessary and appropriate for courts of equity to recognize new fiduciary duties and to protect incidents of new or changing relationships).

277. *See id.* at *56-57 (contending that commercial relationships cannot possibly define and limit fiduciary relationship).

278. *See id.* at *58 (asserting that even after fiduciary relationship has been established, it is still necessary to examine facts and circumstances of transaction to see if fiduciary relationship applies to particular transactions in question).

The dissenting justice then examined the duties that arose from the existing fiduciary relationship, specifically addressing the question of whether a right of access was an incident of the relationship.²⁷⁹ He concluded that the Court of Appeal should recognize a right of patient access based on policy considerations.²⁸⁰ Once Justice Kirby established the duty to grant access, he stated that the defendant had breached his fiduciary duty by failing to provide the plaintiff with access to the medical records.²⁸¹ Justice Kirby felt that instead of acting with loyalty and care, as defendant's duty required, the doctor was only protecting his own interests.²⁸²

Other justices involved in this case noted that absent any established legal principle that would allow derivation of a right of access, they were not in the position to create such a right.²⁸³ The other justices were of the view that this change should be left to the legislature.²⁸⁴ Justice Kirby, however, felt that it was unrealistic to wait for the Australian Parliament to act and he would have had the court recognize the right of access to a patient's medical records based on a fiduciary duty.²⁸⁵

279. *See id.* at *62-72 (refuting reasons for not imposing obligation to provide access to records as incident of fiduciary relationship and concluding that law should uphold patient's right of access to information in medical records held by medical practitioner).

280. *See id.* (mentioning policy considerations in favor of right of access). Justice Kirby noted that society is more mobile today; that patients today are less blindly trustful and more assertive of their entitlements to information about themselves; and that patients should not have to be put to the inconvenience and expense of having to invoke court procedures to secure access to records. *Id.*

281. *See id.* at *72-73 (maintaining that defendant places protection of his own position before his duty of loyalty and care to plaintiff).

282. *See id.* (explaining that defendant made this clear by stating that he would provide plaintiff with access to her records only if she would release him from any claims that might arise in relation to treatment).

283. *See, e.g., Breen* (1996) Aust. High Ct. LEXIS 54, at *98-100 (stating that changes in law that cannot logically or analogically be related to existing common law rules and principles are in legislature's domain).

284. *See id.* at *56, *98-100 (asserting that if there is choice between views, choice is appropriate for legislature, not courts). Justices Gaudron and McHugh wrote that

[t]he judges of Australia cannot, so to speak, 'make it up' as they go along. It is a serious constitutional mistake to think that the common law courts have authority to 'provide a solvent' for every social, political or economic problem. The role of the common law courts is a far more modest one.

Id. at *99.

285. *See Breen* (1994) N.S.W. LEXIS 13703, at *65 (arguing that courts should recognize physician-patient fiduciary duty and right of access). Justice Kirby stated that

[t]his country has no tribunal equivalent to the European Court nor any inter-

d. Right to Know

The plaintiff did not submit the claim of a right to know as an independent ground for a right of access to her records, but rather submitted the argument in furtherance of her other claims.²⁸⁶ In this regard, the plaintiff sought to rely on the High Court decision of *Rogers v. Whitaker*²⁸⁷ to introduce a movement in Australian law towards personal inviolability and patient autonomy and away from medical paternalism.²⁸⁸ The plaintiff did not contend that this movement itself granted a right of access, but instead that it advanced the validity of the other arguments and demonstrated a trend towards a recognition of the patient's right to know.²⁸⁹

2. Legal Arguments from the United Kingdom and Canada

While the precedents of other legal systems are not binding,²⁹⁰ the plaintiff in *Breen* relied on cases from other common

national obligation that would give the impetus to the passage of legislation equivalent to that which has now been enacted in the United Kingdom. In this matter of detail of the law's operation, it is unrealistic to wait for Parliament to act.

Id. See also Roger S. Magnusson, *Case Notes: A Triumph for Medical Paternalism: Breen v. Williams, Fiduciaries, and Patient Access to Medical Records*, 1995 TLJ LEXIS 12, at *6 (1995) (stating that to ignore social or policy considerations where socially significant human relationships are concerned and to intimate that if they were really that important legislature would deal with the relationships is overly timid and unrealistic).

286. See *Breen* (1996) Aust. High Ct. LEXIS 54, at *53 (addressing right to know although plaintiff did not submit argument as independent ground before High Court).

287. See *Rogers v. Whitaker* (1992) 175 C.L.R. 479 (holding that amount of information to be provided to patient cannot be determined from perspective of practitioner alone). The patient-based disclosure standard used in *Rogers* gives priority to the patient's right to self-determination. Giesen, *supra* note 117, at 298.

288. See *Breen* (1996) Aust. High Ct. LEXIS 54, at *53-56, *97 (addressing movement in law governing doctor-patient relationship). "*Rogers v. Whitaker* represents an important assault on medical paternalism, and embodies a model of the doctor/patient relationship which grants individual autonomy to the patient." Magnusson, *supra* note 285, at 25.

289. See *Breen* (1996) Aust. High Ct. LEXIS 54, at *97 (restating plaintiff's argument regarding right to know). The plaintiff argued that the movement towards patient's right to know is recognizable in five ways: acceptance of the principle of personal inviolability; rejection of the paternalistic approach which had previously been accepted; rejection of the notion that patient's interests are to be determined by standards exclusively fixed by the medical profession; imposition of judicially imposed standards; and acceptance of patient autonomy. *Id.*

290. See *Cook*, 68 A.L.R. 353 (holding that precedents of other legal systems are useful only for reasoning).

law countries to support her argument for a right of access to her medical records.²⁹¹ She relied on cases and legislation from the United Kingdom where patients have a right of access.²⁹² In addition, the plaintiff sought to rely on legal precedent from Canada, where courts have found that doctors have a fiduciary duty to provide patients with access to their medical records.²⁹³

a. British Authority

In the United Kingdom, legislation now addresses the issue of a patient's right to access her medical records.²⁹⁴ England enacted the Access to Health Records Act of 1990,²⁹⁵ ("Records Act") which gives a prima facie right of access to health records by the individuals to whom the records pertain.²⁹⁶ The Records Act, however, contains several exceptions to the right of access, one of which is that access to records made before the commencement of the Records Act shall not be given.²⁹⁷ As per this exception, the English Court of Appeal determined the right of access based on the common law in *Regina v. Mid Glamorgan Family Health Services*,²⁹⁸ where a patient sought access to his medical

291. See *Breen* (1994) N.S.W LEXIS 13365, at *50-74 (referring to judicial decisions that recognize right of access in North America and Canada, including *Emmett, Cannell, and McInerney v. MacDonald*).

292. See *Breen* (1996) Aust. High Ct. LEXIS 54, at *46-53 (discussing England's Access to Health Records Act and *Regina v. Mid Glamorgan Family Health Services*, which gives patient in England right to access own medical records).

293. See *id.* at *44-46 (discussing Canadian and U.S. law which recognize right of access based on fiduciary duty).

294. See Access to Health Records Act, 1990 (Eng.) (giving right of access to individuals to whom health records relate).

295. *Id.*

296. See *id.* (establishing right of access to health records and providing for correction of inaccurate health records). The text of the statute provides that "(1) An application for access to a health record, or to any part of a health record, may be made to the holder of the record by any of the following, namely—(a) the patient; . . ." *Id.* at § 3. The Health Records Act ("Records Act") was passed as a result of the European Court of Human Rights' decision in *Gaskin v. United Kingdom*. See *Breen* (1996) Aust. High Ct. LEXIS 54, at *47 (discussing Records Act). *Gaskin* held that the refusal to allow access by the applicant to certain health records was in breach of his right to respect for his private and family life under Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950. *Id.*

297. See Access to Health Records Act, 1990, § 12(2) (Eng.) (declaring that Records Act comes into effect on November 1, 1991).

298. *Regina v. Mid Glamorgan Family Health Services Authority* (ex parte Martin), 1 W.L.R. 110 (Eng. C.A. 1995).

records that were created before the Record Act's enactment.²⁹⁹

Although the English Court of Appeal upheld the lower court's decision dismissing an application by a patient for access to his medical records based on the common law, some of the judges made remarks that seemed favorable to a patient's right of access.³⁰⁰ Lord Justice Evans, for example, stated that not having a duty to disclose the records to the patient himself would frustrate the purposes for which the medical records are made.³⁰¹ Based on the specific facts of the case, however, the court unanimously agreed that there were no reasons for holding that there was a common law right of access.³⁰²

b. Canadian Authority

The plaintiff relied heavily on the Canadian decision in *McInerney v. MacDonald*³⁰³ to support the contention that she had a right to access her medical records.³⁰⁴ In *McInerney*, the Canadian Supreme Court held that the doctor-patient relationship casts on the doctor a fiduciary duty to provide a patient with access to her medical records.³⁰⁵ The Canadian court relied on a line of U.S. cases to reach this conclusion.³⁰⁶

The Canadian court likened the doctor-patient relationship

299. *See id.* (indicating that appellant's medical records were made in late 1960s and, therefore, not subject to Records Act).

300. *See id.* (expressing view that there is no good reason for doubting that right of access exists).

301. *See id.* (noting that purposes of medical record are first, to provide part of medical history of patient, for benefit of doctor or future doctors, and secondly, to provide record of diagnosis and treatment in case of future inquiry or dispute).

302. *See id.* (concluding that plaintiff seeks disclosure simply to have greater knowledge of his childhood development and believing that releasing the records to plaintiff might cause harm to plaintiff's mental health). The purposes for making the record would not be frustrated because "the present case is not one where the records are required for medical purposes, or in connection with any dispute or projected litigation." *Id.*

303. [1992] D.L.R. 4th 415.

304. *See Breen* (1996) Aust. High Ct. LEXIS 54, at *16, *44-46, *87-96, *135-140 (discussing *McInerney* as support for plaintiff's claim in *Breen*).

305. *See* [1992] D.L.R. 4th at 9 (holding that fiduciary qualities of physician-patient relationship extend physician's duty to make proper disclosure of information to include obligation to grant access to information doctor uses in treating patient).

306. *See id.* at 8-11. (referring to *Emmett v. Eastern Dispensary and Casualty Hospital* and *Cannell v. Medical and Surgical Clinic*); *Emmett*, 396 F.2d at 935 (holding that fiduciary relationship between doctor and patient requires disclosure of medical record); *Cannell*, 315 N.E.2d at 280 (requiring doctor to provide patient with access to record based on fiduciary duty).

to a trust and characterized the relationship as fiduciary in nature.³⁰⁷ The court found it unnecessary to go so far as to call the doctor a mere custodian of information.³⁰⁸ The court found that the trust-like beneficial interest of the patient in the information was sufficient to guarantee that the patient has a right of access.³⁰⁹

The Canadian court ruled that the duty of a doctor to act with utmost good faith and loyalty provided further support for a right of access.³¹⁰ That duty would not be fulfilled if the doctor were to deny a patient access to her records.³¹¹ The court noted that access to the records is important to ensure the proper functioning of the doctor-patient relationship, as well as to protect the patient's well-being.³¹²

3. Policy Arguments

Looking to the law of other jurisdictions can provide legislatures and judges with useful solutions that guide them in their treatment of legal questions.³¹³ The social policy considerations behind patient accessibility to medical records are likely to be similar throughout various legal systems.³¹⁴ Policy considerations in favor of a right of access include a positive effect on patient trust in the doctor-patient relationship and a beneficial effect on patient recovery.³¹⁵

307. See [1992] D.L.R. 4th at 9-10 (stating that doctor is in position of trust and confidence and information conveyed is held in trust-like fashion). "While the doctor is the owner of the actual record, the information is to be used by the physician for the benefit of the patient." *Id.* at 10.

308. See *id.* at 10 (finding it needless to state that patient has proprietary interest in records).

309. See *id.* (stating that trust-like beneficial interest of patient in information indicates that "as a general rule, he or she should have a right of access to the information and that the physician should have a corresponding obligation to provide it").

310. See *id.* at 11 (noting that physician's standard of care militates in favor of disclosure).

311. See *id.* (asserting that it may not be possible for patient to establish that physician fulfilled duty to act with utmost good faith and loyalty if patient cannot access records).

312. See *id.* (contending that disclosure serves to reinforce faith of patient in her treatment).

313. See Giesen, *supra* note 117, at 274 (identifying importance of looking at foreign law).

314. See *id.* at 275 (stating that application of medical skills is universal activity that shows little variance from country to country).

315. See BRUCE, *supra* note 25, at 162-63 (providing reasons for supporting patient access to records).

a. The International Trend

The law of other countries provides useful analogies to the general principles that should control the rights and duties of physicians.³¹⁶ The trend in many countries is to allow patient access to medical records prior to formal institution of a legal action.³¹⁷ Canada and England permit access.³¹⁸ The tendency in the Netherlands is also to grant patients access to their records.³¹⁹ In Germany, the Supreme Court has acknowledged the patient's right to access her medical records as part of a right to self-determination.³²⁰ The Austrian Supreme Court has adopted rules similar to those of Germany.³²¹ Patients in China, Norway, and parts of Africa also routinely have access to their medical records.³²²

b. Policy Considerations in Favor of a Right of Access

There are many benefits to allowing a patient access to her medical records.³²³ Some reasons for supporting patient access include a positive effect on patient trust in the doctor-patient relationship, a beneficial effect on patient recovery, and a positive effect on the quality of care.³²⁴ With access to the actual medical record, a patient will be in a better position to under-

316. See Kirby, *supra* note 193, at 111 (stating that willingness of judges to derive lessons from other legal traditions depends on open-mindedness to learn from approaches of others).

317. See McQuoid-Mason, *supra* note 17, at 511 (arguing that South Africa should follow trend in various countries of allowing patients to access records).

318. See Access to Health Records Act, 1990 (Eng.) (giving individuals to whom record pertains right of access); *McInerney* [1992] D.L.R. 4th 415, at 9 (characterizing physician-patient relationship as fiduciary in nature and holding that relationship creates duty to provide patients with access to their medical records).

319. See McQuoid-Mason, *supra* note 17, at 511 (mentioning countries that allow patients to access their medical records).

320. See GIESEN, *supra* note 17, at 427 n.96 (stating that "access to one's medical records is an incident of human dignity, which forbids the patient to be degraded to a mere object or tool in the hands of others . . .").

321. *Id.*

322. JOHNSON & WOLFE, *supra* note 33, at 1.

323. See Klugman, *supra* note 27, at 1371-74 (evaluating arguments against patient access to records); Anton de Klerk, *Should a Patient Have Access to His Medical Records*, MEDICINE AND LAW 475, 477-78 (1989) [hereinafter de Klerk, *A Patient's Access*] (examining arguments in favor of medical records accessibility); JOHNSON & WOLFE, *supra* note 33, at 22-27 (discussing advantages of patient access).

324. See BRUCE, *supra* note 25, at 162-63 (giving reasons for supporting patient access to records).

stand her illness.³²⁵ Studies indicate that a patient who comprehends her medical problem and treatment is more likely to comply with the doctor's orders.³²⁶ In addition, most patients today see various doctors in the course of their lives³²⁷ and access to the records can help avoid repetitive treatment.³²⁸

Scholars maintain that policy considerations also support the recognition of a right of access incidental to the fiduciary duty owed by a physician to a patient.³²⁹ The duty of the doctor to act in the patient's best interests would control unnecessary collection of harmful information.³³⁰ Even with a right of access, the doctor could retain a therapeutic privilege,³³¹ so as to ensure that the patient does not suffer harm from the information.

One scholar asserts that access to medical records will lead to better medical care and will protect patients against the indiscretion of physicians.³³² The right to one's own medical record is an extension to the right of privacy and autonomy and the right to know.³³³ Scholars argue that these factors outweigh policy considerations against a right of access.³³⁴ This is true especially because in various cases, a medical professional's concerns with access have proven to be unsubstantiated.³³⁵ In federal gov-

325. See de Klerk, *A Patient's Access*, *supra* note 323, at 477 (presenting arguments in favor of right to access records).

326. See JOHNSON & WOLFE, *supra* note 33, at 24 (finding that improved patient education will lead to better health care).

327. See *id.* at 26 (explaining that patients today see numerous doctors due to specialization of medicine and population mobility).

328. See de Klerk, *The Right of Patients*, *supra* note 259, at 79 (stating that record accessibility ensures continuity of medical records).

329. See Kirby, *supra* note 193, at 108-09 (comparing policy considerations that reject and support right of access to medical practitioner's files).

330. See *id.* (asserting that doctor's duty to act in patient's best interests would limit and control unnecessary collection of information that would be harmful or prejudicial to patient).

331. See *id.* (noting that physician's retention of therapeutic privilege provides support for recognizing right of access to records).

332. See de Klerk, *The Right of Patients*, *supra* note 259, at 78-79 (providing arguments for right of access).

333. See generally Kirby, *supra* note 193, at 109 (stating that patients' interest in information that concerns their personal integrity and autonomy supports recognition of right of access to medical records).

334. See JOHNSON & WOLFE, *supra* note 33, at 1-2, 22-31 (advocating patient access and demonstrating flaws in medical profession's objections to access).

335. See *id.* at 27 (stating that problems that doctors associate with patient access have not occurred in U.S. federal government hospitals where patients have right to access medical records for both physical and mental conditions).

ernment hospitals, where federal legislation³³⁶ gives patients access to their medical records, administrators have found few problems.³³⁷ Scholars declare that the calamities that doctors link to patient access have not occurred.³³⁸

B. Arguments Against a Right of Access

While courts in the United States have been willing to create a right of access based on legal principles,³³⁹ Australian courts have not.³⁴⁰ In this regard Australia has refused to follow the legal precedents of the United Kingdom and Canada.³⁴¹ Australian justices have found no legal argument that would support this right³⁴² and have, therefore, said that this right of access, which would be based on policy considerations, is best for legislature to deal with.³⁴³

I. Legal Arguments

The *Breen* litigation began in the Supreme Court of New South Wales Equity Division.³⁴⁴ The plaintiff submitted that a right of access to her medical records could be found upon four bases, each of which the court rejected.³⁴⁵ The court stated that

336. See 5 U.S.C. § 552 (granting individuals in United States right to access government-held records); 5 U.S.C. § 552a (requiring U.S. federal government to grant patients access to their own medical records).

337. See JOHNSON & WOLFE, *supra* note 33, at 27 (rebutting doctors' arguments against free access).

338. See *id.* (finding that evidence does not corroborate doctors' objections to patient access to medical records).

339. See, e.g., *Emmett*, 396 F.2d at 935 (holding that physician must reveal information to patient based on fiduciary duty); *Hutchins*, 544 S.W.2d 802 (finding patient right of access based on common law).

340. See *Breen* (1996) Aust. High Ct. LEXIS 54, at *100 (concluding that patient's right to access privately held medical records does not exist under Australian law).

341. See, e.g., *Breen* (1994) N.S.W. LEXIS 13365 at *108-09 (finding the views of Canadian and English courts unpersuasive).

342. See *Breen* (1996) Aust. High Ct. LEXIS 54 at *160-61 (dismissing plaintiff's appeal and stating that right of access does not exist).

343. See *id.* at *98-100 (stating that it is serious constitutional mistake to think that common law courts have authority to provide solution for every social problem).

344. *Breen* (1994) N.S.W. LEXIS 13365.

345. *Id.* The first basis the plaintiff relied on to secure access to her medical records was a right of access under the common law of Australia. *Id.* at *30-45. The second argument in favor of access was the peoples' right to self-determination mentioned in Article I of the International Covenant on Civil and Political Rights and the European Convention on Human Rights. *Id.* at *45-50. The court noted that neither of these conventions was in force under Australian law. *Id.* at *46. The third argument

the doctor's ownership of the medical records entitled the defendant to control access to the records.³⁴⁶ The court did not find the right of self-determination,³⁴⁷ as used in international protection of human rights,³⁴⁸ to relate to the rights of an individual to bodily integrity, and thus refused to grant a right of access on this basis.³⁴⁹ The court also rejected the notion of a fiduciary duty providing a right of access, noting that the universal responsibility of a doctor for the patient's well-being, which is attributed to fiduciary duty, is not part of Australia's law.³⁵⁰ Finally, the court found no support for a right to know and was, therefore, unwilling to adopt the terminology and base a right of access upon the right to know.³⁵¹

The court denied the right of access, finding England's and Canada's views,³⁵² which allow for a right of patient access, unpersuasive.³⁵³ The court was not prepared to change Australia's

for access was based on an alleged fiduciary duty. *Id.* at *50-98. The final basis the plaintiff offered to secure access to the records rested on a patient's implied right to know any relevant information concerning her treatment. *Id.* at *102-03.

346. *See id.* at *26-31 (stating that "a person who brings into existence a document by writing on a piece of paper which he owns continues to be its owner [D]ocuments prepared by the professional person for his own benefit and protection while doing the work are usually held to be the property of the professional person."). Ownership also depends on the intention of the person who created the document and the court did "not find that the defendant . . . has ever intended that ownership of any of the documents in the defendant's possession should pass to the plaintiff." *Id.* at *29.

347. *See id.* at *46-48 (understanding plaintiff's claim of right of self-determination to mean right to bodily integrity).

348. *See id.* (stating that right of self-determination as used in International Covenant on Civil and Political Rights "refers to civil and political rights enjoyed by peoples in their relationships with governments.").

349. *Id.* at *45-50 (concluding that there is no interference with plaintiff's privacy, family, or home while correspondence involved is defendant's private correspondence).

350. *See id.* at *50-98 (differentiating North America and Canada's perception of fiduciary duty from that of Australia's).

351. *See id.* at *102-03 (holding that prior cases that plaintiff relied upon in *Breen* did not support entitlement of patient to all knowledge available to medical practitioner).

352. *See id.* at *58-75 (examining Canadian judicial decision that supports plaintiff's case). England has enacted legislation that gives individuals to whom the health record pertains a right of access. Access to Health Records Act, 1990 (Eng.). Canada recognizes a right of access based on a fiduciary duty. *See McInerney* [1992] D.L.R. 4th 415 (holding that doctor-patient relationship creates fiduciary duty to provide patient with access to her own medical records).

353. *See Breen* (1994) N.S.W. LEXIS 13365, at *58-75, *108 (refusing to rely on England and Canada's cases).

common law.³⁵⁴ In addition, the court felt that the existing legal process for compelling documents for litigation was adequate.³⁵⁵

Plaintiff altered her arguments slightly in the case before the Supreme Court of New South Wales Court of Appeal.³⁵⁶ The absolute terms the plaintiff used in the first case were softened,³⁵⁷ and, in this claim, the plaintiff acknowledged exceptions and limitations on the right of access.³⁵⁸ All three judges in the Court of Appeal rejected each of the plaintiff's common law claims³⁵⁹ and dismissed the plaintiff's claim by a majority ruling.³⁶⁰

After the New South Wales Court of Appeal dismissed the plaintiff's appeal,³⁶¹ the plaintiff sought special leave to appeal to the High Court of Australia, which the High Court granted in

354. *Id.* at *108 (refusing to enunciate significant development in common law rights of plaintiff and defendant or to recognize extension of equitable remedies).

355. *See id.* (entitling defendant to control access to records).

356. *Breen* (1994) N.S.W. LEXIS 13703.

357. *See id.* at *36-37 (stating that plaintiff's original absolute terms did not represent what she actually sought in Court of Appeal).

358. *See id.* (discussing plaintiff's reformulated claim). Plaintiff urged the Court to declare a right of access except:

(a) Where the information had been created or obtained solely for [Dr. Williams's] benefit (e.g., fees and administrative records); (b) Where the disclosure would, in the reasonable belief of Dr. Williams, be likely to cause serious harm to the physical or mental health of Ms. Breen; or (c) Where the disclosure would found an action for breach of confidence, i.e., by a third person.

Id. at *37.

359. *See id.* at *40-135 (providing discussion of plaintiff's common law claims). The common law claims asserted in the Court of Appeal were the contractual right, the claim of proprietary right, reliance on fundamental human rights, an asserted innominate common law right, and a claim of the right to know. *Id.* The court dismissed the contract claim because an implied term of access was not necessary to give efficacy to the arrangement between the parties. *Id.* at *40-41. The medical record belonged exclusively to Dr. Williams and at common law the owner of a record has a full right to control access to it and the information contained in it. *See id.* at *41-42 (dismissing plaintiff's argument as to proprietary right). The court dismissed the plaintiff's claim based on fundamental human rights because the instrument that the plaintiff relied on was not incorporated into local law. *Id.* at *42. The court could not find convincing terms of legal principle that would support a general common law right of access. *See id.* at *42-48 (discussing innominate, or general, common law right). The court could not derive a general right to know from past cases. *See id.* at *48-52 (stating that case plaintiff relied on dealt with negligence and in *Breen* plaintiff was not asserting that defendant fell short of his professional duty to plaintiff).

360. *See id.* at *135 (dismissing plaintiff's appeal).

361. *See id.* (dismissing appeal with costs).

May 1995.³⁶² In unanimous opinions, the High Court dismissed the appeal, holding that a patient has no right of access to information or medical records in the hands of a private physician.³⁶³ The Court rejected the plaintiff's arguments for a right of access that were based on contract principles, property notions, a fiduciary duty, and an asserted right to know.³⁶⁴

a. Right in Contract

The justices who addressed the plaintiff's contract argument rejected it.³⁶⁵ All of the justices recognized that in the absence of a special contract, as was the case in *Breen*, the doctor undertakes to advise and to treat her patients with reasonable skill and care.³⁶⁶ The justices did acknowledge that there might be a duty to provide the patient with information that the doctor has acquired in the course of treatment.³⁶⁷ This did not mean, however, that there was an obligation to provide access to the records.³⁶⁸ The justices pointed out that a term is not implied in a contract if the contract is effective without it or if the term is so

362. See Kirby, *supra* note 183, at 110 (stating that special leave to appeal is first step on way to appellate review).

363. See *Breen* (1996) Aust. High Ct. LEXIS 54, at *161 (dismissing appeal with costs).

364. See *id.* at *160 (concluding that no right of access to medical records exists in Australian law).

365. See *id.* at *6, *67 (concluding that right of access could not be based on principles of contract law). The three justices rejecting this argument noted that a doctor does not impliedly promise that she will always act in the best interests of her patients. *Id.* The term in the ordinary contract does not extend that far. *Id.* at *6. "Such a duty would be inconsistent with the existing contractual and tortious duty to exercise reasonable care and skill in the provision of professional advice and treatment." *Id.* at *68-69.

366. See *id.* at *2, *35, *67-68 (noting similar duty of reasonable skill and care in tort law).

367. See *id.* at *3 (discussing situations where doctor may have duty to provide patient with information that doctor has acquired in course of treatment). Chief Justice Brennan held that

information with respect to a patient's history, condition or treatment obtained by a doctor in the course or for the purpose of giving advice or treatment to the patient must be disclosed by the doctor to the patient or the patient's nominee on request when (1) refusal to make the disclosure requested might prejudice the general health of the patient, (2) the request for disclosure is reasonable having regard to all the circumstances and (3) reasonable reward for the service of disclosure is tendered or assured.

Id. at *5.

368. See *id.* at *5-6 (stating that there is no foundation for implying obligation to give access where duty to provide information can be performed without giving patient access to records).

obvious that it is understood between the parties.³⁶⁹ In the plaintiff's case, the contract between the defendant and the plaintiff was effective without any term entitling the plaintiff to access her records and requiring the defendant to grant access.³⁷⁰ Thus, there was no basis for implying a term of access and the claim failed on a contract theory.³⁷¹

b. Right in Property

The justices noted that while documents prepared by an agent are ordinarily the property of the principal, documents prepared by a professional to assist her to do her work for a client are the property of the professional.³⁷² Justices Dawson and Toohey asserted that the defendant compiled the records in carrying out his duty of reasonable care and the documents were, therefore, his property alone.³⁷³ Absent a right to require production of the document for inspection, the justices held that the owner is entitled to refuse to produce the document.³⁷⁴

The justices also rejected the plaintiff's argument that a patient has a proprietary interest in the information contained in the records.³⁷⁵ Justices Dawson and Toohey declared that information cannot be property because once it passes from one person to another it belongs to both individuals.³⁷⁶ Although, in

369. *See id.* at *6, *72 (stating that best interests term was not so obvious that "it goes without saying").

370. *See id.* at *6-7 (stating that defendant's offer to provide medical report would have discharged defendant's obligation that might have arisen by implication from contract between plaintiff and defendant).

371. *See id.* (rejecting plaintiff's contract argument).

372. *See id.* at *60 (dismissing notion that professional's documents are property of lay client). The Australian Medical Association endorses a patient right to be informed of all relevant factual information contained in the medical record, but all deductive opinion therein recorded remains the intellectual property of the doctor The patient should be allowed access to any other contents of the medical record (such as reports by specialists) beyond the materials above specified only at the discretion of the doctor or doctors who completed such additional section or sections, . . . or as the result of a legal requirement.

Breen (1994) N.S.W. LEXIS 13365, at *23-24.

373. *See Breen* (1996) Aust. High Ct. LEXIS 54, at *29 (stating that defendant's written notes comprise medical record plaintiff was seeking).

374. *Id.* at *8.

375. *See id.* at *9, *32 (finding that right to access and copy information in records cannot be based on notions of property).

376. *See id.* at *32 (contending that there is no property in information plaintiff

general, information is not considered to be property in Australia, equity will restrain the information's transmission to another if it would be in breach of confidence.³⁷⁷ Chief Justice Brennan stated that the defendant did not breach any moral obligation, and hence, no remedy in equity was available.³⁷⁸ Thus, the law of property also failed to provide any basis for the plaintiff's claim of a right to access her medical records.³⁷⁹

c. Right in Equity

Justices Gaudron and McHugh asserted that the law in Australia does not provide that the doctor-patient relationship is an accepted fiduciary relationship.³⁸⁰ The categories of fiduciary relationships, however, are not fixed.³⁸¹ The Australian courts have not provided a general test for determining when persons or classes of persons stand in fiduciary relationships with one another.³⁸² Justices Gaudron and McHugh stated that fiduciary obligations arise where a person has come under an obligation to act in another's interests.³⁸³ Chief Justice Brennan wrote that fiduciary duties arise from either a source of agency or from a relationship of influence by one party over another, or depen-

provided defendant). There can be no ownership in information as information, because once imparted by one person to another, it belongs equally to both of them. *Id.*

377. *See id.* at *10 (quoting passage from prior case that says if information has been acquired in circumstances that it would be breach of confidentiality to disclose information to another person, then courts of equity will restrain recipient of information from communicating it to another).

378. *See id.* at *12 (stating that defendant's mere possession of records relating to plaintiff breaches no obligation of conscience and thus attracts no equitable remedy).

379. *See id.* (rejecting claim to right of access based on property rights).

380. *See id.* at *76 (naming trustee and beneficiary, agent and principal, solicitor and client, employee and employer, and director and company and partners as recognized fiduciary relationships in Australia). Not all members of the High Court agreed on the issue of whether the doctor-patient relationship is a fiduciary relationship. *Compare id.* (stating that "[a]s the law stands, the doctor-patient relationship is not an accepted fiduciary relationship . . .") *with id.* at *148-49 (stating that "the relationship between medical practitioner and patient who seeks skilled and confidential advice and treatment is a fiduciary one").

381. *See id.* at *77 (noting that courts have identified various circumstances that point towards, but not do determine, existence of fiduciary relationship).

382. *See id.* at *75 (stating that Australian courts have consciously refrained from providing general test for determining whether fiduciary relationship exists because term fiduciary relationship defies definition).

383. *See id.* at *95 (stating when fiduciary obligations arise in Australia).

dence, or trust.³⁸⁴ Although a doctor does acquire an ascendancy over a patient and a patient does place trust and confidence in the doctor,³⁸⁵ Justices Dawson and Toohey wrote that the trust is not due to the doctor acting on behalf of the patient.³⁸⁶ They asserted that a patient places trust and confidence in a doctor because a patient expects a doctor to observe professional standards in matters of treatment and advice and because a patient is afforded a remedy if the professional standards are not adhered to.³⁸⁷ A doctor is not acting as a representative of the patient, but simply carrying out her professional responsibilities.³⁸⁸

Even in situations where a fiduciary relationship exists, the scope of the duty owed by the fiduciary to his beneficiary does not extend to every aspect of the fiduciary's conduct.³⁸⁹ Justices Gaudron and McHugh pointed out that courts have used some aspects of the doctor-patient relationship to find a fiduciary relationship, such as the patient's dependence upon the advice and treatment of her doctor.³⁹⁰ The justices seemed to agree that doctors have obligations of a fiduciary nature in respect of certain matters, such as confidentiality of medical information.³⁹¹ For the purposes of *Breen*, however, the court declared that no fiduciary relationship existed that would give rise to a duty to give the plaintiff access to her medical records.³⁹²

384. *See id.* at *12-13 (explaining that fiduciary duty does not attach to every aspect of fiduciary's conduct).

385. *See id.* at *15, *40-41 (maintaining that refusal to give plaintiff access to records does not deny plaintiff benefit to which plaintiff was entitled by reason of trust plaintiff placed in defendant).

386. *See id.* at *40-41 (asserting that trust lies in doctor's duty to exercise reasonable skill and care in treating patient).

387. *See id.* at *41 (explaining that tort and contract law entitles patient to remedy if doctor does not observe professional standards).

388. *See id.* at *40 (noting that it is of significance that fiduciary acts in representative character in exercise of responsibility).

389. *See id.* at *13-14 (quoting Justice Mason in *Hospital Products Ltd. v. United States Surgical Corp.* that "the scope of the fiduciary duty must be moulded according to the nature of the relationship and the facts of the case.").

390. *See id.* at *78 (stating that this does not mean that relationship would be considered fiduciary for all purposes).

391. *See id.* at *31, *150 (recognizing that for certain purposes courts may impose duties of fiduciary nature upon doctor).

392. *See id.* at *12-17, *37-54, *75-96, *144-58 (rejecting plaintiff's fiduciary argument).

d. Right to Know

The Court did not find a movement in the law that would support the plaintiff's claims.³⁹³ While the Australian High Court rejected the paternalistic approach in *Rogers v. Whitaker*,³⁹⁴ there was no justification for a right of access in *Breen*.³⁹⁵ Finding no support for a right to access her medical records, the High Court unanimously dismissed the plaintiff's claim.³⁹⁶

2. Australia's Rebuttal of Legal Arguments from the United Kingdom and Canada

Although the English Court of Appeal found that it is the doctor's general duty to act in the best interests of the patient at all times,³⁹⁷ the Australian High Court felt that it was difficult to gauge the intended effect of this statement, and thus, refused to use the English case as a basis for recognizing a right of access in Australia.³⁹⁸ The Australian justices in *Breen* also refused to follow Canada's recognition of a right of access based on a fiduciary duty.³⁹⁹ The Australian court contended that the Canadian duty of doctors to act with good faith and loyalty does not fit with the Australian duty to exercise reasonable skill in care and giving treatment and advice.⁴⁰⁰

a. British Authority

Justice Evans of the English Court of Appeal acknowledged that a right of access to medical records exists in *Regina v. Mid Glamorgan Family Health Services*.⁴⁰¹ Based on the specific facts of

393. See *id.* at *55 (concluding that even if movement in law were to exist it could have no significance where established principle points to clear conclusion).

394. 175 C.L.R. 479.

395. See *Breen* (1996) Aust. High Ct. LEXIS 54, at *97-98 (stating it would require "a quantum leap in legal doctrine" to justify relief for which plaintiff contends).

396. See *id.* at *161 (dismissing plaintiff's appeal).

397. See *Mid Glamorgan Family Health Servs.*, 1 W.L.R. 110 (concluding that health authority and private doctor do not have absolute right to deal with medical records in any way they choose).

398. See *Breen* (1996) Aust. High Ct. LEXIS 54 at *50-51 (stating that patient right of access to records serves no point if doctor is to judge what information is to be provided in interests of patient).

399. See *id.* at *16 (maintaining that Canadian notion of fiduciary duty does not accord with Australian notion of fiduciary duty).

400. See *id.* at *44-45, *89 (stating that Australian law does not impose on medical practitioner duty to act with utmost good faith and loyalty).

401. 1 W.L.R. 110.

the case, however, the court found that there were no reasons for holding that there was a common law right of access.⁴⁰² Thus, the Australian justices in *Breen* felt that the English decision in *Mid Glamorgan Family Health Services* did not provide an adequate basis for the existence of the common law right that the plaintiff asserted.⁴⁰³

b. Canadian Authority

The High Court of Australia noted that the conception of fiduciary duty in Canada and the United States does not accord with the conception of fiduciary duty in Australia.⁴⁰⁴ Justices Gaudron and McHugh stated that, contrary to Australian courts, Canadian courts tend to apply fiduciary principles in an expansive manner and to view fiduciary duties as both proscriptive and prescriptive.⁴⁰⁵ Australian courts, however, recognize only proscriptive duties.⁴⁰⁶

The Australian justices also rejected the principle favored in *McInerney* that the doctor's role was to act with utmost good faith and loyalty.⁴⁰⁷ The justices contended that this duty of good faith and loyalty does not fit with the Australian duty of the doctor to exercise reasonable skill in care and giving treatment and advice.⁴⁰⁸ Therefore, the Australian High Court found no foundation in Australian law for the conclusion that patients enjoy a

402. *See id.* (limiting common law right of access because to release records to applicant would risk causing harm to applicant's mental or physical health).

403. *See Breen* (1996) Aust. High Ct. LEXIS 54, at *142 (finding that, while neither desirable nor possible, decision in *Mid Glamorgan Family Health Services Authority* did not set out scope of duty to afford patients access to records).

404. *See id.* at *44-45, *93-94 (distinguishing Canadian and U.S. doctors' duty to act with utmost good faith and loyalty from Australian duty of doctor to act with reasonable skill and care).

405. *See id.* at *94-95 (mentioning Canadian courts' tendency to apply fiduciary principles in expansive manner so as to supplement tort law and provide basis for creation of new forms of civil wrongs). In Australia, fiduciary duties are the consequence of a duty to act in the interests of another, not the source of those duties. *See Swanton and McDonald, supra* note 203, at 335 (analyzing fiduciary discussion in *Breen*).

406. *See Breen* (1996) Aust. High Ct. LEXIS 54, at *94-95 (stating that in Australia, equity imposes on fiduciary obligations not to obtain unauthorized benefit from relationship and not to be in position of conflict).

407. *See id.* at *44-45, *89 (asserting that duty of good faith and loyalty is not part of Australian law).

408. *See id.* at *45, *89 (concluding that duty of reasonable skill and care in Australia is "undoubted").

right of access to their medical records.⁴⁰⁹

3. Policy Arguments

One justification for allowing physicians to withhold medical records is to protect patients from information that would be detrimental to their health or peace of mind.⁴¹⁰ A fatal prognosis or a diagnosis of a malignant disease is a common example of such detrimental information.⁴¹¹ Scholars contend, however, that this information will not harm many patients and, indeed, these individuals may find their final months more meaningful if they have this knowledge.⁴¹² A study of cancer patients found that patients generally benefited from being given access to their medical records, even when the records contained bad news.⁴¹³ Studies have also shown that open access to mental health records involves the same benefits and advantages as open access to general health records.⁴¹⁴

Another reason for denying patient access is that patients might not be able to understand the technical language or poor handwriting of the medical record.⁴¹⁵ This may lead to misinterpretation of the record.⁴¹⁶ Scholars refute this argument by stat-

409. *See id.* at *45, *96 (refusing to follow Canadian law in order to recognize right of access to medical records).

410. *See* Madden, *supra* note 138, at 701 (addressing reasons for denying patients access to mental health and general medical records); de Klerk, *A Patient's Access*, *supra* note 323, at 478 (summarizing arguments against medical record accessibility); de Klerk, *The Right of Patients*, *supra*, note 259, at 79-80 (giving reasons for patients not having right of access to medical records and favoring accessibility); BRUCE, *supra* note 25, at 163 (citing one study finding that 75% and another study finding that 85% of physicians felt that patients would be harmed by reading their health records).

411. Madden, *supra* note 138, at 701.

412. *See id.* (discussing physician discretion to withhold general medical records); JOHNSON & WOLFE, *supra* note 33, at 29-31 (addressing issue of patient harm arising from access to complete record).

413. *See* JOHNSON & WOLFE, *supra* note 33, at 29 (explaining that British study found that information helped patients understand their condition and participate more actively in their treatment, in addition to permitting patients to plan for future). Doctors also benefited from the patients having access to their medical records. *Id.*

414. *See id.* at 29-30 (finding that positive benefits, including improved treatment, patients' rights, and patient-staff relationships seem to outweigh costs of patient access to mental health records).

415. *See id.* at 27-28 (attributing patients' misunderstanding to fact that physicians keep medical records in sloppy disarray and that doctors write medical records in technical language); de Klerk, *The Right of Patients*, *supra* note 259, at 79-80 (presenting arguments against medical record accessibility).

416. De Klerk, *The Right of Patients*, *supra* note 259, at 79-80.

ing that although the record may contain technical language, today's informed and sophisticated patients should still be able to comprehend it.⁴¹⁷ Furthermore, scholars assert that the arguments about misunderstanding simply point out a need for doctors to find better ways of explaining their findings to patients.⁴¹⁸

An additional argument against patient access to medical records is that having to search for, copy, and explain the records are very time-consuming activities and administrative costs will increase.⁴¹⁹ Furthermore, if access were allowed doctors might use general, instead of clear, language, which would lead to a decline in the quality and value of the records.⁴²⁰ Doctors also fear that patient access to their records might expose them to potential malpractice suits.⁴²¹

III. *THE COUNTRIES' ACCESS LAWS MUST BE IMPROVED*

Neither the United States nor Australia has recognized patients' rights to access their own medical records to the extent necessary.⁴²² In light of the international trend towards allowing patients to access their medical records, Australia and the United States should also guarantee their citizens this right.⁴²³ Legislation should address this issue and create laws that will ensure a uniform right of access in order to guarantee consistent justice within both countries.

417. See JOHNSON & WOLFE, *supra* note 33, at 27-28 (stating that understanding records may be difficult, but will improve patient's understanding of health care).

418. See *id.* at 27 (quoting physician who commented that arguments about failure of understanding are largely without foundation).

419. See *id.* at 28 (rebutting time and cost concern by insisting that time spent in explaining records would be more than compensated for in time saved in repeat questioning and testing); de Klerk, *The Right of Patients*, *supra* note 259, at 79 (arguing that increase in administrative costs cuts against patient accessibility to records).

420. See de Klerk, *The Right of Patients*, *supra* note 259, at 80 (citing ambiguous language as one argument against patient access to medical records). *But see* JOHNSON & WOLFE, *supra* note 33, at 28 (speculating that records will improve rather than deteriorate as doctors attempt to write records more clearly and carefully while avoiding recording irrelevant or pejorative information).

421. See Kirby, *supra* note 193, at 108 (summarizing policy considerations that favor rejection of right of access).

422. See *supra* notes 51-191 and 192-252 and accompanying text (discussing right of access in United States and Australia).

423. See *supra* notes 290-322 and accompanying text (addressing trend in various countries towards allowing patients to access their medical records).

A. *Current Rights of Access in the United States and Australia are Insufficient*

As a whole, U.S. law is more fully developed than Australian law on the issue of a patient's right to access her medical records.⁴²⁴ Both countries allow access to records held by public institutions through federal statutes.⁴²⁵ Nevertheless, these statutes are not sufficient to grant patients a right of access because patients often seek medical care from private hospitals or physicians.⁴²⁶ The United States has gone a step further than Australia in that some state courts have recognized a common right of access and more than half the states have adopted legislation expressly granting the right to access even privately held records.⁴²⁷ But, even where a patient has an access right, the nature of the right varies from state to state.⁴²⁸ Australia does not recognize the right of a patient to access privately held medical records at all.⁴²⁹ Thus, Australian legislation should provide for such a right and the United States should expand the current right of access in order to give all patients in both countries the right of access that they deserve. All states within both countries should uniformly recognize a right to access a patient's own medical records to achieve this goal.

B. *U.S. and Australian Law Should Change to Keep Up with the International Trend*

In light of the international trend towards allowing patients

424. See *supra* notes 51-191 and 192-252 and accompanying text (discussing present laws in United States and Australia regarding patient's right to access her own medical records).

425. See *supra* notes 109-37 and 232-47 and accompanying text (discussing Freedom of Information and Privacy statutes in United States and Australia, which allow individual to access records held by federal agencies).

426. See Anthony R. Kovner, *Hospitals, in Health Care Delivery in the United States*, *supra* note 11, at 162, 169 (stating that federal hospitals typically have provided for special beneficiaries, such as veterans and Native Americans, and state hospitals typically have provided long-term psychiatric and chronic care).

427. See *supra* notes 69-191 and accompanying text (discussing cases recognizing right of access, federal statutes allowing for access, and state statutes delineating right of access in United States).

428. See *supra* notes 160-91 and accompanying text (discussing U.S. state access statutes).

429. See *supra* notes 202-31, 260-89, and 344-99 and accompanying text (examining the Australian High Court's decision in *Breen* refusing to recognize right of patient access to medical records).

to access their medical records, Australia and the United States should adopt legislation that would guarantee a right of access in order to be fair to patients who seek their records for any reason, be it legal or medical.⁴³⁰ Lack of uniformity among countries may be critical in cases such as *Breen v. Williams*,⁴³¹ where patients seeking their medical records for litigation in foreign countries are blocked from using simple and efficient avenues of redress for their injuries. Patients who are nationals of foreign countries that do not grant statutory access may be faced with an insufficient remedy or, eventually, no remedy at all if the court procedures for securing access are too time-consuming and expensive.

C. *The Two Systems Should Be Improved Through Legislation*

Broadening patients' rights to access their medical records is best left to the legislature because legislature can create laws based on social policy when legal policy is unclear.⁴³² The U.S. states should all adopt the same access laws, to ensure uniformity throughout the nation.⁴³³ The Australian Commonwealth Parliament, or the individual state Parliaments, should adopt a binding legislative measure similar to the access statutes currently in force in some U.S. states in order to guarantee a uniform right.⁴³⁴ A law creating a uniform right of access would be the ideal solution for protecting patients' rights in both countries.

Patients and health care providers in the United States should not have to speculate as to which state's access laws apply.⁴³⁵ While some U.S. courts have been willing to recognize a right based on common law principles, in many states, statutes

430. See *supra* note 25 (addressing reasons patients might want to see their records).

431. See *Breen* (1996) Aust. High Ct. LEXIS 54 (deciding issue of patient's right to access medical records).

432. See *supra* note 284 and accompanying text (discussing opinion of some Australian justices that right of access is choice for legislature to make); Madden, *supra* note 138, at 710-11 (calling for new statute in Washington to properly balance patient, physician, and third-party rights concerning patients' medical records).

433. See *supra* notes 185-91 and accompanying text (reviewing uniform model statute in United States).

434. See *supra* notes 160-91 and accompanying text (discussing state access statutes in United States); note 5 and accompanying text (discussing federal-state balance of powers in Australia).

435. See *supra* notes 185-91 and accompanying text (examining uniform statute in United States).

or regulations establish the basic rules of access to medical records.⁴³⁶ Not all states, however, have established a right of access.⁴³⁷ This could potentially create a problem if a person who resides in a state with access statutes is travelling to a state that does not allow access to medical records falls ill in the foreign state and receives treatment there.⁴³⁸ Had the patient been treated in her home state, she could have easily been able to access her records.⁴³⁹ Now, however, in order to secure access to her files, she must incur the costs and inconveniences of litigation in the distant state and must worry about which state law will apply.⁴⁴⁰ In addition to unplanned treatment in foreign states, situations like this also arise when people knowingly travel across state lines for a course of treatment.⁴⁴¹

Identical state laws across the United States are clearly needed to end the inconsistency and inconveniences associated with the differing state laws.⁴⁴² A law at the federal level could achieve this goal.⁴⁴³ Adoption of a uniform access act at the state level, however, would satisfy the same needs as would a law enacted at the federal level.⁴⁴⁴ Currently, state statutes cover the right of access,⁴⁴⁵ thus keeping the regulation at the state level would defeat any concerns with federalism.⁴⁴⁶ All states should, therefore, enact uniform legislation, which would resolve any interstate differences.⁴⁴⁷

436. See *supra* notes 69-108 and 142-84 and accompanying text (reviewing bases on which patients have right of access in United States).

437. See *supra* notes 160-91 and accompanying text (analyzing current and proposed U.S. state statutes).

438. See Klugman, *supra* note 27, at 1375-76 (giving hypothetical problem due to lack of uniformity between states in United States).

439. See *supra* notes 160-84 and accompanying text (discussing right of access under U.S. state statutes).

440. See *supra* notes 168-84 and accompanying text (presenting differences among U.S. state access laws).

441. See *supra* note 185 (giving reasons for eliminating variability of state access laws).

442. See *supra* notes 168-91 and accompanying text (examining differences in current U.S. state laws and considering potential uniform law which would eliminate differences between states).

443. See *supra* note 188 (considering preemptive federal statute).

444. See *supra* notes 185-91 and accompanying text (discussing creation of Uniform Health-Care Information Act).

445. See *supra* notes 160-91 and accompanying text (discussing state access statutes).

446. See *supra* note 188 (giving argument against preemption).

447. See *supra* notes 185-91 and accompanying text (discussing uniform state law).

The same problem that could easily occur between states within one nation could occur on a transnational level as well, as the *Breen* litigation has made clear. U.S. corporations manufactured almost all of the breast implants sold in Australia.⁴⁴⁸ Similar situations could potentially arise where someone would need access to her medical records in order to participate in litigation against a foreign company. In today's society where countless products are sold in foreign lands, either state or federal legislatures should enact access laws that would apply to both public and private medical records, making the compensation process for victims of medical injuries fair and just.

Australia, too, should enact legislation to resolve the issue. As numerous justices in the *Breen v. Williams* decisions pointed out, change is best left to the legislature.⁴⁴⁹ The *Breen* case was not about whether there should be a right of access to medical records, but rather whether there was one already existing in the laws of Australia.⁴⁵⁰ The justices involved in the case found no common law right in Australia that could be extended to include the right of access.⁴⁵¹ Although the court was unwilling to acknowledge a right of access, that does not mean that a patient should not have that right. While judges are not in the position to change legal doctrine,⁴⁵² Parliament is in this position.⁴⁵³ Parliament, therefore, should enact legislation recognizing a right of access in order to take account of current conditions necessitating a uniform right of access. With the expansion of federal power in Australia,⁴⁵⁴ it would be ideal for the Commonwealth Parliament to adopt legislation recognizing the right of access.

448. See *supra* note 214 (discussing U.S. class action suit).

449. See *supra* notes 344-64 and accompanying text (tracing *Breen* litigation); *Breen* (1994) N.S.W. LEXIS 13703, at *31-32 (considering earlier Canadian decision where dissenting justice stated that there is long-established principle that in constitutional democracy it is legislature, as elected branch of government, which should assume major responsibility for law reform); *Breen* (1996) Aust. High Ct. LEXIS 54, at *98-100 (declaring that change is for legislature, not courts, to make).

450. See *supra* notes 202-27 and accompanying text (giving background on *Breen*).

451. See *supra* notes 362-95 and accompanying text (discussing High Court's opinion rejecting recognition of right to access medical records).

452. See *supra* note 284 and accompanying text (pointing out judges' views that change in law is best left up to legislature).

453. See *Breen* (1996) Aust. High Ct. LEXIS 54, at *98-100 (stating that social judgments should be for legislature).

454. See *supra* note 5 and accompanying text (discussing Australia's federal-state balance of powers).

If, however, there are federalism concerns, the regulation can be kept at the state level, as long as it is consistent from state to state.⁴⁵⁵

CONCLUSION

Neither the U.S. nor Australian legal system has protected a patient's right of access to the extent necessary. Patients in all states of the United States and of Australia should have a right to access their own medical records because legal and social policies favor such a right. There may be situations, of course, where common sense suggests that the patient should not have access to the records. In these situations patients should have the opportunity to appoint another person to receive the information for them. Access laws would satisfy the patient's right to know and the physician's fiduciary duty, as well as improve the quality of health care and the physician-patient relationship. In addition to improving the health-care system, access to records will be beneficial from a legal standpoint. A right of access would facilitate the resolution of disputes arising either out of care rendered or out of events that necessitate medical care. The introduction of either a federal law or a uniform system of state law within the United States and Australia would allow for patient access to medical records. Such laws would help promote a more efficient, less costly, and less time-consuming process than the current system of having to resort to court procedures to secure access. Denial of access to patients who do not utilize the court system should not stand as a legal barrier to patients' rights. Legal principles, as well as policy considerations, clearly point in favor of disclosure. Access statutes must be enacted in both countries in the interest of the justice that patients deserve.

455. See *supra* note 188 (mentioning preemptive federal health information statute in United States).