ADMINISTRATIVE APPEALS BOARD

ADMINISTRATIVE APPEAL NO. 32 OF 2008

BETWEEN

x Appellant

and

PRIVACY COMMISSIONER FOR PERSONAL DATA Respondent

Coram: Administrative Appeals Board

Date of Hearing: 27 August 2009

Date of Written Decision with Reasons: 26 July 2010

DECISION

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1. The Appellant consulted a clinical psychologist, Dr Frendi Li ("**Dr Li**"). The purpose was apparently for a psychological report for a personal injury claim.

2. In question are the following documents :-

(a) Registered Form filled on 15 July 2005 before commencing service/interview with Dr Li ("**Item 1**") ;

(b) Questionnaires filled on 15 July 2005 before commencing service/interview with Dr Li ("**Item 2**");

(c) Questionnaires filled on 22 July 2005 (namely, Minnesota Multiphasic Personality Inventory – II in Chinese (CMMPI-II) after finishing service/interview with Dr Li ("**Item 3**");

(d) "Unknown diagrams" ("**Item 4**").

3. We are only concerned with Item 4 at present. As the development of the events leading to this appeal is rather convoluted, we shall endeavour to set out the relevant events in chronological order below.

Events leading to present dispute

4. By letter dated 3 March 2006, the Appellant asked for a copy of "*all the record of my personal data, including filled forms and questionnaires, held by* [*Dr Li*]. *Particularly the record of the interviews dates 15 and 22 July 2005 at your premises*".

5. By letter dated 6 March 2006, Dr Li replied to the Appellant that "*it is our professional practice not to send confidential patient information through the post casually ... Regarding your request for*

copies of the questionnaires you have filled in, due to concerns over misinterpretation and copyright issues, I cannot make copies of them for you, but the interpretation of the results were already in the assessment summary". At that stage the focus was the refusal to provide item 3 to the Appellant.

6. A brief assessment summary dated 20 November 2005 based partly on item 4 was then supplied to the Appellant on about 18 April 2006. It is at appeal bundle pages 234 to 235. In so far as may be relevant, the summary contains certain psychometric assessment and recommendations.

7. On 29 May 2006 the Appellant made a data request pursuant to the Personal Data (Privacy) Ordinance Cap 486 ("the **Ordinance**") for copies of items 1 to 4.

8. At that stage Dr Li provided Item 1 but not others.

9. Dr Li also informed the Appellant that the Appellant could review items 4 in Dr Li's presence so that Dr Li could explain the contents to the Appellant.

10. By letter dated 3 July 2006, Dr Li informed the Appellant that items 2 to 4 are psychological materials. According to the guidelines of the Hong Kong Psychological Society, test materials "*are merely working*

tools and analogous to the MRI machine used by a medical practitioner". They are therefore not considered "*personal data*". Dr Li continued to refuse to make disclosure.

11. By letter dated 8 July 2006, the Appellant made a complaint to the Respondent.

12. By letter dated 2 September 2006, Dr Li enclosed items 2 to 4 to the Respondent.

13. By letter dated 16 September 2006, in response to the Respondent's letters of 24 August and 6 September 2006, Dr Li said among other things

> *"According to the advice of the Honorary Legal Adviser of the Hong Kong Psychological Society ("HKPS"), as set out in the "Ethical and Legal Considerations in Test Use and Record Keeping", the above test materials were in effect working tools for collecting data from the test-taker, and therefore do not form part of the personal data of the test-taker ... [The Appellant] herself, however, has the right to review the relevant test materials under the supervision of the Psychologist, so that the latter could explain the test results to [the Appellant] in an appropriate and accurate manner ..."*

14. By letter dated 19 January 2007, the Respondent sought assistance of the Social Welfare Department. In particular the Respondent sought a copy of a court case referred to in a report on

"*Ethical and Legal Considerations in Test Use and Record Keeping*" in March 2001.

15. In Appendix C of that report a court case was mentioned. The Social Welfare Department had subsequently provided a copy of a judgment and it was apparent that the case concerned a child custody evaluation conducted by a clinical psychologist in March 1999. The clinical psychologist produced a report to the Court and the father applied to the Court for a full set of the test materials in order to challenge the findings.

16. The District Court dismissed the father's application, holding that on the facts of the case it was essential to preserve these test materials as confidential documents, and that the court should endeavour to ensure that these psychological test materials do not fall into the hands of unqualified persons, so as to give effect to the code of professional conduct of the Hong Kong Psychological Society.

17. It is apparent that the applicant (being the father of the data subject, the child) in that case was a third party and an unqualified person. It has no relevance to the present case.

18. By letter dated 18 May 2007, the Respondent informed Dr Li of his intention to carry out an investigation.

19. By letter dated 18 June 2007, Dr Li informed the Respondent that

> *"... Psychologists would not normally follow up individual items or test responses. The global findings would normally be presented in a written summary or report. It is good practice to go through the report with the client if there is reason to believe that the client may not fully understand the report. However, in private sector, more often than not, the clients may not wish to pay for another "discussion session" if they think they can understand (and use) the report. [The Appellant's] case is slightly unusual in that the assessment results did not support her injury claim, but were indicative of mental health problems. I see it as the responsibility of a Psychologist to clearly explain the implications of the results to my client so as to protect her from possible harm (eg brutal challenges by the defense lawyer), and also to recommend treatment as indicated by the assessment. I was ready to provide such consultation without charging her extra fee."*

20. In a later paragraph Dr Li said

> *"... there are indeed grey areas concerning the ownership of psychological test materials. I could only operate according to the ethical code o my profession and try to protect my clients and the general public as far as possible. "*

21. By letter dated 16 August 2007 and 10 September 2007, the Respondent sought the assistance of the Hong Kong Psychological Society.

22. By letter dated 20 September 2007, the Hong Kong Psychological Society informed the Respondent that they do not see major problems for patients to be provided with a summary profile of their test results. Specific test contents and materials, however, are not recommended for disclosure to the "*non-trained general public*" because "*Test materials are copyright protected*". When further clarification was sought no response came forward.

23. By letter dated 17 April 2008, Dr Li informed the Respondent that, among other things, "*My assessment ... releasing Items 2 to 4 to [the Appellant]* ***might cause her grave distress and increase her suicidal risk*** *...*".

24. The Respondent found Dr Li had failed to comply with the data request in respect of items 2 and 3, but not item 4.

25. Enforcement notice was served on Dr Li on 26 August 2008 pursuant Section 50 of the Ordinance. Dr Li had complied with that Enforcement Notice.

26. By another letter dated 26 August 2008, the Respondent informed the Appellant of his decision.

27. By written Grounds of Appeal dated 15 October 2008, the Appellant appealed to this Board.

28. By letter dated 10 November 2008 the Respondent made enquiries of Dr Li Wing Sai, Frendi.

29. By letter dated 24 November 2008 Dr Frendi Li informed the Secretary among other things, that "*It is good practice for a clinical psychologist to explain the assessment results to the patient face to face ... the Appellant was invited for such a meeting, but she did not take up the offer ...*", and that "*The raw data in the assessment process, however, should only be interpreted by trained personnel, and are meaningless outside of the specific clinical context. As such, raw data are usually not released to the patient to avoid misinterpretation*".

30. In the later part of her letter, Dr Frendi Li said *"As a clinician, we always try to be prudent and do our best to reduce possible risk of harm to our patients. Having said that, my last assessment of Ms Ho was now more than 3 years ago. I have no knowledge of what has happened to Ms Ho in the past few years. My risk assessment was based on Ms Ho's previous mental health history as mentioned in paragraphs 2c in the letter dated 17.4.2008. If the Appeal Board has convincing up-to-date evidence that such risks do not exist anymore, I am ready to release the data profile to the Appellant any time."*

31. By setting a condition for up-to-date evidence, Dr Li is now prepared to disclose Item 4.

Discussion

32. We propose to deal with the following questions in considering whether Item 4 is personal data and if so whether an enforcement notice should be issued :-

(a) Whether item 4 is personal data, and whether there is any basis for Dr Li's opinion under Section 59 ;

(b) Whether the views of the Hong Kong Psychological Society should be given any and if so what weight for the purpose of Section 59 of the Ordinance ;

(c) Whether patients rights takes priority when there is a claim by a professional clinical psychologist of his/her right to property rights such as copyright or otherwise reasonable remuneration.

Item 4 is personal data which Section 59 does not apply ?

33. There was some doubt in the evidence as to what part Item 4 played in the provision of professional service by Dr Li but it seems to us the position is as follows :-

(a) It was generated as a result of the questionnaire, namely Item 3.

(b) From Item 4 the brief summary was prepared which was already given to the Appellant.

(c) Item 4 thus represents the intermediate work product of Dr Li who had put in effort.

(d) Section 28 of the Ordinance provides that a fee may be charged in compliance with a data request which fee must not be excessive. However, Section 28 does not appear to cover a reasonable remuneration for professional skills in producing a work such as Item 4. It may or may not have been considered as part of the remuneration in engaging Dr Li.

(e) Section 18 of the Ordinance does not take away property rights that may be claimed.

(f) Dr Li might have claimed but she did not claim a lien on Item 4 for reasonable remuneration. She was absent from the hearing before us.

34. At the hearing we enquired whether we could inspect Item 4. Regrettably we were informed that after inspection by the Respondent, Item 4 was returned to Dr Li, as part of the normal practice of the Respondent.

35. We found such practice to be at odd with the principle of fairness and can work injustice. The Board should not be deprived of relevant materials to make an informed decision. Sensibly the legal representative of the Respondent, Mr Wilson Lee, did not insist that the Respondent was entitled to do this and offered to enquire from Dr Li to disclose the same to us for inspection. Provided a proper system of security is kept and suitable assurance given there is no reason that a copy of Item 4 could not be kept.

36. Further, at the hearing the legal representative of the Respondent, Mr Wilson Lee also disclosed that he had inspected Item 4 and found it was derived from Item 3. He found Item 4 not comprehensive without assistance of an expert. A summary based upon Item 4 had been prepared and disclosed to the Appellant.

37. If Item 4 was incomprehensible to a legally trained representative of the Respondent, we had reasons to be skeptical whether its disclosure "***might cause her grave distress and increase her suicidal risk***".

38. At the hearing we were thus concerned whether Item 4 was not something which can be said would be likely to cause serious harm to the physical or mental health of the Appellant.

39. The burden it seems to us is for Dr Frendi Li to show that disclosure of Item 4 would be likely to cause serious harm to the physical

or mental health of the Appellant. The fact that she did not give reasons why Item 4 would create the risk does not assist her in merely giving her opinion. Dr Frendi Li was not present at the hearing and had apparently waived her right to be heard.

40. Upon inspection we confirmed our view that Item 4 were mere diagrams which were not comprehensible to ordinary people, and probably cannot be easily understood by people other than an expert clinical psychologist. As such prima facie it could not be said that its disclosure would likely cause serious harm to the physical or mental health of the Appellant.

41. Accordingly Item 4 being part of personal data of the Appellant cannot be said that its disclosure would likely to cause serious harm to the physical or mental health of the Appellant.

42. Section 59 plainly therefore does not assist the Respondent.

43. Accordingly, the Respondent's ground of objection on the basis of Section 59 was in error. In the interests of justice we ordered disclosure by Dr Li for this Board to examine Item 4 on a *De Bene Esse* basis.

44. This finding would be sufficient to allow the appeal. However, there are two other matters which arose during the hearing.

Hong Kong Psychological Society (their views)

45. This is an ancillary matter. The Hong Kong Psychological Society was invited by the Respondent to give its views on the matter.

46. We are of the view that it was not appropriate to rely upon the evidence from the Hong Kong Psychological Society to show that the data requested would be likely to cause serious harm to the physical or mental health of the Appellant. We appreciate that resources could be a problem for the Respondent to give evidence which should have been from an independent expert. However, when evaluating the evidence, the Respondent has to be extremely careful and could not simply pass on judgment and unreservedly accepted views of the Hong Kong Psychological Society.

47. It is because that it is doubtful whether the views of the Hong Kong Psychological Society can be given any significant weight :-

(a) The Hong Kong Psychological Society was not under a duty to advise the Respondent.

(b) There was no evidence to show whether indeed the Hong Kong Psychological Society was liable to serve interests of its own members in which case it may be open to problem of conflict of interests when assessing their views. On the evidence it appears to be a society regulating its own members who held themselves out as expert clinical

psychologist and joined the Society out of their own free will. In saying this we do not mean to have any disrespect for the professional standard of the Hong Kong Psychological Society or its members. It is just that the Hong Kong Psychological Society should not be treated as an independent expert. Its views should therefore be viewed with caution.

(c) In its letter dated 20 September 2007, the Society put emphasis on copyright matters and as such was apparently meant to be concerned with at least partly the protection of the financial interests of its members.

(d) In the normal event, and without speculating too much, it may be expected that a professional body had a duty to see whether its members had misconducted himself or herself, but may not be concerned to consider whether the conduct of its members had been open to other criticism such as negligence.

48. For the above reasons, in future cases, if this may serve as a very brief guide, we believe the a respondent (invariably a public or government authority) to the Administrative Appeals Board, and in the present case the Respondent in particular, when giving evidence by drawing on views of a body of professionals or persons claiming to have professional expertise, it would assist and thus advisable to set out the following matters for the assistance of the Board, namely :-

(a) Background for the establishment of the professional body in question,

(b) size and nature of its membership,

(c) whether there is statutory rule(s) or regulation(s) governing that body or its members,

(d) the objects of the body, including any articles of association,

(e) the object of the code of conduct of the professional body that seeks to achieve, particularly whether negligence alone would constitute misconduct, and

(f) the main provisions of the code of conduct that are relevant to the consideration of the issue, for example, the question of data privacy in the present case.

Patients' rights

49. This is a question that had arisen in the course of argument on the true construction of Section 59 on whether disclosure of Item 4 is appropriate.

50. The question, generally speaking, is whether Item 4 forming part of "patient's (or medical) records" are the doctor's aides-mémoire or are they the patient's paper shadow through the health care system. For the purpose of considering this aspect, we do not find there is any or any substantial distinction between medical doctors and clinical psychologists.

51. It should be noted that the Board is only concerned with the question whether if Dr Li does not agree to disclose Item 4, the Respondent should have issued an enforcement notice. Patients' rights are relevant only under this specific context.

52. We believe it is important to first identify the basis why patient's records in general and the records in the present case in particular should or should not be disclosed.

53. The law on disclosure of medical records is not clear as to the basis under which disclosure should be made.

54. There has not been serious dispute that, for the purpose of this appeal, the record sought to be disclosed are writings that formed part of therapeutic process and therefore constituted medical record. See *W. (O.) v. P. (W.)* 2001 Carswell Alta 1166, 2001 ABQB 735, 310 A.R. 294.

55. In this regard, we note that a health record can be recorded in a computerised form or in a manual form or even a mixture of both. They may include such things as, hand-written clinical notes, letters to and from other health professionals, laboratory reports, radiographs and other imaging records e.g. X-rays and not just X-ray reports, printouts from monitoring equipment, photographs, videos and tape-recordings of telephone conversations.

56. The second question is the basis of the right of patients to claim access to medical records is quite different in various jurisdictions. Incorrectly understood or approaching the matter can result in a totally different result in the construction of Section 59.

57. Shortly stated, the Canadian authorities considered a medical doctor is a fiduciary and therefore in the absence of reasons such as that the disclosure would cause harm (physical or psychological) to the patient, the patient's medical record should be disclosed. This is because there would be a breach of fiduciary duties on the part of the doctor.

58. On the other hand, the English and Australian authorities had declined to follow the approach of breach of fiduciary duties. To order disclosure the basis would have to be based upon the contractual relationship or a duty of care between the doctor and the patient.

59. In other words, under the Canadian authorities, the refusal of Dr Li to make disclosure is a breach of fiduciary duties, and this makes her liable for a variety of remedies. On the other hand, unless properly identified on the relationship, either under contract or tort or some other duty, Dr Li would not be so liable to make disclosure.

60. A further matter which we also have to consider before considering whether we should accept and if so the extent of the legal principles adopted in the various jurisdictions on patients' rights, in order

to give a good understanding of the different jurisprudence in different jurisdictions, and arrive at the proper approach, is the proper Hong Kong context and thus we also have to refer ourselves to available materials.

61. We first turn to the different approach adopted by different jurisdictions.

What is Fiduciary Duty ?

62. This is relevant to the question of the relationship between the professional doctor and the patient. Was it a fiduciary relationship between the doctor and the patient, and if so would there be a breach of the fiduciary duty if there was refusal to give information?

63. The relationship between a doctor is capable of being characterized as a fiduciary relationship. *Barclay's Bank v O'Brien* [1994] 1 AC 180, 189 G per Lord Browne Wilkinson.

64. However, the case of *Bristol & West Plc v Mothew* [1998] Ch 1, CA makes it clear that that a claim for breach of fiduciary duty does not arise merely because a defendant who stand in a fiduciary relationship to a claimant has breached a duty of care at common law that he owes to the claimant.

65. In *Bristol & West Plc v Mothew* [1998] Ch 1, the defendant solicitor acted for a husband and wife in the purchase of a house for £73,000 and also for the plaintiff to whom the purchasers had applied for a loan of £59,000 to finance the purchase. The plaintiff offered to advance the money on the express condition that the balance of the purchase price was provided by the purchasers without resort to further borrowing, and it instructed the solicitor to report, prior to completion, any proposal that the purchasers might create a second mortgage or otherwise borrow in order to finance part of the purchase price. The solicitor knew that the purchasers were arranging for an existing bank debt of £3,350 to be secured by a second charge on the new property but, due to an oversight, he stated in his report to the plaintiff that the balance of the purchase price was being provided by the purchasers without resort to further borrowing. The plaintiff advanced the loan and the purchase was completed. When the purchasers defaulted on their mortgage repayments the plaintiff enforced its security and the house was sold at a loss. The plaintiff sought to recover the whole of its loss on the transaction from the solicitor, alleging breach of contract, negligence and breach of trust. The district judge gave the plaintiff summary judgment for damages to be assessed for breach of contract and negligence and for damages of £59,000 less the amount received on the sale of the property for breach of trust. The judge affirmed those decisions.

66. The Court of Appeal allowed the appeal, holding firstly that, where a client sued his solicitor for negligently giving him incorrect advice or information, the client did not have to show that he would not have acted as he did if he had been given the proper advice or correct information but merely that he had relied on the incorrect advice or information; that the evidence showed that the plaintiff had relied on the solicitor's report in advancing the loan and, therefore, the necessary causal link between the solicitor's negligence and the loan was proved; but that the plaintiff had still to establish what, if any, loss was attributable to the solicitor's negligence and, as there was an issue as to what loss was occasioned by the existence of the second charge and the purchasers' indebtedness to the bank, damages remained to be assessed.

67. The Court of Appeal further held that the solicitor's conduct in providing the plaintiff with the wrong information, although a breach of duty, was neither dishonest nor intentional but due to an oversight and was unconnected to the fact that he was also acting for the purchasers; that, accordingly, his conduct and subsequent application of the money advanced by the plaintiff to complete the purchase was not a breach of trust or fiduciary duty; and that the order for damages for breach of trust would therefore be set aside.

68. Millett LJ referred to *Banque Bruxelles Lambert S.A. v. Eagle Star Insurance Co. Ltd.* [1997] A.C. 191 on the distinction between breach of warranty and a duty (contractual or tortious) :-

" It does not, however, follow from the fact that the defendant's negligent statements caused the society to make the mortgage advance that the whole of the society's loss is attributable to his negligence. Having regard to the date of the advance, some part at least of the society's loss may well be attributable to the fall in property values which had occurred by the time that it was able to sell the property.

In Banque Bruxelles Lambert S.A. v. Eagle Star Insurance Co. Ltd. [1997] A.C. 191 the House of Lords ruled definitively on the correct measure of damages for the negligent provision of information on which the plaintiff relied in entering into a transaction from which loss resulted. The only speech was delivered by Lord Hoffmann. He distinguished between the measure of damages for (1) breach of a contractual warranty and (2) breach of a duty (whether contractual or tortious) to take care (i) to give proper advice and (ii) to provide accurate information.

In the case of breach of warranty, the comparison is between the plaintiff's position as a result of entering into the transaction and what it would have been if the facts had been as warranted. The measure of damages is the extent to which the plaintiff would have been better off if the information had been right. In the case of a breach of duty to take care the measure of damages is the extent to which the plaintiff is worse off because the information was wrong. Since he entered into the transaction in reliance on the advice or information given to him by the defendant, the starting point is to compare his position as a result of entering into the transaction with what it would have been if he had not entered into the transaction at all.

But that is only the starting point. Lord Hoffmann distinguished between a duty to advise someone as to what course of action he should take and a duty to provide information for the purpose of enabling someone else to decide upon his course of action. In the former case, the defendant is liable for all the foreseeable consequences of the action being taken. In the latter case, however, he is responsible only for the consequences of the information being wrong. The measure of

damages is not necessarily the full amount of the loss which the plaintiff has suffered by having entered into the transaction but only that part if any of such loss as is properly attributable to the inaccuracy of the information. If the plaintiff would have suffered the same loss even if the facts had actually been as represented the defendant is not liable.

Accordingly, in this class of case the plaintiff must prove two things: first, that he has suffered loss; and, secondly, that the loss fell within the scope of the duty he was owed. In the present case the society must prove what (if any) loss was occasioned by the arrangements which the purchasers had made with the bank.

69. On breach of fiduciary duty, Lord Millet said it is obvious that *not every breach of duty by a fiduciary is a breach of fiduciary duty* :-

*"**Breach of fiduciary duty***

Despite the warning given by Fletcher Moulton L.J. in In re Coomber; Coomber v. Coomber [1911] 1 Ch. 723, 728, this branch of the law has been bedevilled by unthinking resort to verbal formulae. It is therefore necessary to begin by defining one's terms. The expression "fiduciary duty" is properly confined to those duties which are peculiar to fiduciaries and the breach of which attracts legal consequences differing from those consequent upon the breach of other duties. Unless the expression is so limited it is lacking in practical utility. In this sense it is obvious that not every breach of duty by a fiduciary is a breach of fiduciary duty. I would endorse the observations of Southin J. in Girardet v. Crease & Co. (1987) 11 B.C.L.R. (2d) 361, 362:

"The word 'fiduciary' is flung around now as if it applied to all breaches of duty by solicitors, directors of companies and so forth. . . . That a lawyer can commit a breach of the special duty [of a fiduciary] . . . by entering into a contract with the client without full disclosure . . . and so forth is clear. But to say

that simple carelessness in giving advice is such a breach is a perversion of words."

These remarks were approved by La Forest J. in LAC Minerals Ltd. v. International Corona Resources Ltd. (1989) 61 D.L.R. (4th) 14, 28 where he said: "not every legal claim arising out of a relationship with fiduciary incidents will give rise to a claim for breach of fiduciary duty."

It is similarly inappropriate to apply the expression to the obligation of a trustee or other fiduciary to use proper skill and care in the discharge of his duties. If it is confined to cases where the fiduciary nature of the duty has special legal consequences, then the fact that the source of the duty is to be found in equity rather than the common law does not make it a fiduciary duty. The common law and equity each developed the duty of care, but they did so independently of each other and the standard of care required is not always the same. But they influenced each other, and today the substance of the resulting obligations is more significant than their particular historic origin. In Henderson v. Merrett Syndicates Ltd. [1995] 2 A.C. 145, 205 Lord Browne-Wilkinson said:

"The liability of a fiduciary for the negligent transaction of his duties is not a separate head of liability but the paradigm of the general duty to act with care imposed by law on those who take it upon themselves to act for or advise others. Although the historical development of the rules of law and equity have, in the past, caused different labels to be stuck on different manifestations of the duty, in truth the duty of care imposed on bailees, carriers, trustees, directors, agents and others is the same duty: it arises from the circumstances in which the defendants were acting, not from their status or description. It is the fact that they have all assumed responsibility for the property or affairs of others which renders them liable for the careless performance of what they have undertaken to do, not the description of the trade or position which they hold."

I respectfully agree, and endorse the comment of Ipp J. in Permanent Building Society v. Wheeler (1994) 14 A.C.S.R. 109, 157:

"It is essential to bear in mind that the existence of a fiduciary relationship does not mean that every duty owed by a fiduciary to the beneficiary is a fiduciary duty. In particular, a trustee's duty to exercise reasonable care, though equitable, is not specifically a fiduciary duty . . ."

Ipp J. explained, at p. 158:

"The director's duty to exercise care and skill has nothing to do with any position of disadvantage or vulnerability on the part of the company. It is not a duty that stems from the requirements of trust and confidence imposed on a fiduciary. In my opinion, that duty is not a fiduciary duty, although it is a duty actionable in the equitable jurisdiction of this court. . . . I consider that Hamilton owed P.B.S. a duty, both in law and in equity, to exercise reasonable care and skill, and P.B.S. was able to mount a claim against him for breach of the legal duty, and, in the alternative, breach of the equitable duty. For the reasons I have expressed, in my view the equitable duty is not to be equated with or termed a 'fiduciary' duty."

I agree. Historical support for this analysis may be found in Viscount Haldane L.C.'s speech in Nocton v. Lord Ashburton [1914] A.C. 932, 956. Discussing the old bill in Chancery for equitable compensation for breach of fiduciary duty, he said that he thought it probable that a demurrer for want of equity would always have lain to a bill which did no more than seek to enforce a claim for damages for negligence against a solicitor.

In my judgment this is not just a question of semantics. It goes to the very heart of the concept of breach of fiduciary duty and the availability of equitable remedies.

Although the remedy which equity makes available for breach of the equitable duty of skill and care is equitable compensation rather than damages, this is merely the product of history and in this context is in my opinion a distinction without a difference. Equitable compensation for breach of the

duty of skill and care resembles common law damages in that it is awarded by way of compensation to the plaintiff for his loss. There is no reason in principle why the common law rules of causation, remoteness of damage and measure of damages should not be applied by analogy in such a case. It should not be confused with equitable compensation for breach of fiduciary duty, which may be awarded in lieu of rescission or specific restitution."

70. Lord Millet at p.18 giving dicta (which was subsequently approved by *Arklow Investments Ltd v Maclean* [2000] 1 WLR 594) that a fiduciary must prove affirmatively that the transaction is fair and that in the course of the negotiations he made full disclosure of all facts material to the transaction. Even inadvertent failure to disclose will entitle the principal to rescind the transaction :-

" This leaves those duties which are special to fiduciaries and which attract those remedies which are peculiar to the equitable jurisdiction and are primarily restitutionary or restorative rather than compensatory. A fiduciary is someone who has undertaken to act for or on behalf of another in a particular matter in circumstances which give rise to a relationship of trust and confidence. The distinguishing obligation of a fiduciary is the obligation of loyalty. The principal is entitled to the single-minded loyalty of his fiduciary. This core liability has several facets. A fiduciary must act in good faith; he must not make a profit out of his trust; he must not place himself in a position where his duty and his interest may conflict; he may not act for his own benefit or the benefit of a third person without the informed consent of his principal. This is not intended to be an exhaustive list, but it is sufficient to indicate the nature of fiduciary obligations. They are the defining characteristics of the fiduciary. As Dr. Finn pointed out in his classic work Fiduciary Obligations (1977), p. 2, he is

not subject to fiduciary obligations because he is a fiduciary; it is because he is subject to them that he is a fiduciary.

(In this survey I have left out of account the situation where the fiduciary deals with his principal. In such a case he must prove affirmatively that the transaction is fair and that in the course of the negotiations he made full disclosure of all facts material to the transaction. Even inadvertent failure to disclose will entitle the principal to rescind the transaction. The rule is the same whether the fiduciary is acting on his own behalf or on behalf of another. The principle need not be further considered because it does not arise in the present case. The mortgage advance was negotiated directly between the society and the purchasers. The defendant had nothing to do with the negotiations. He was instructed by the society to carry out on its behalf a transaction which had already been agreed.)

The nature of the obligation determines the nature of the breach. The various obligations of a fiduciary merely reflect different aspects of his core duties of loyalty and fidelity. Breach of fiduciary obligation, therefore, connotes disloyalty or infidelity. Mere incompetence is not enough. A servant who loyally does his incompetent best for his master is not unfaithful and is not guilty of a breach of fiduciary duty.

In the present case it is clear that, if the defendant had been acting for the society alone, his admitted negligence would not have exposed him to a charge of breach of fiduciary duty. Before us counsel for the society accepted as much, but insisted that the fact that he also acted for the purchasers made all the difference. So it is necessary to ask: "Why did the fact that the defendant was acting for the purchasers as well as for the society convert the defendant's admitted breach of his duty of skill and care into a breach of fiduciary duty?" To answer this question it is necessary to identify the fiduciary obligation of which he is alleged to have been in breach.

It is at this point, in my judgment, that the society's argument runs into difficulty. A fiduciary who acts for two principals with potentially conflicting interests without the informed consent of both is in breach of the obligation of

undivided loyalty; he puts himself in a position where his duty to one principal may conflict with his duty to the other: see Clark Boyce v. Mouat [1994] 1 A.C. 428 and the cases there cited. This is sometimes described as "the double employment rule." Breach of the rule automatically constitutes a breach of fiduciary duty. But this is not something of which the society can complain. It knew that the defendant was acting for the purchasers when it instructed him. Indeed, that was the very reason why it chose the defendant to act for it. The potential conflict was of the society's own making: see Finn, Fiduciary Obligations, p. 254 and Kelly v. Cooper [1993] A.C. 205

...

Finally, the fiduciary must take care not to find himself in a position where there is an actual conflict of duty so that he cannot fulfil his obligations to one principal without failing in his obligations to the other: see Moody v. Cox and Hatt [1917] 2 Ch. 71; Commonwealth Bank of Australia v. Smith (1991) 102 A.L.R. 453. If he does, he may have no alternative but to cease to act for at least one and preferably both. The fact that he cannot fulfil his obligations to one principal without being in breach of his obligations to the other will not absolve him from liability. I shall call this "the actual conflict rule."

71. It is this aspect that gives us concern when we come back to consider that fiduciary duty should not be easily considered as a basis to ground a duty to a doctor to disclose patient's record to his own patient.

72. In this regard we now look at the authorities on the possible basis of disclosure of patient's records by doctors.

McInerney v MacDonald (Canada)

73. We start off with the Canadian development.

74. In *Mclnerney v MacDonald* [1992] 2 SCR 138, a patient made a request to her doctor for copies of the contents of her complete medical file. The doctor delivered copies of all notes, memoranda and reports she had prepared herself but refused to produce copies of consultants' reports and records she had received from other physicians who had previously treated the patient, stating that they were the property of those physicians and that it would be unethical for her to release them. She suggested to her patient that she should contact the other physicians for release of their records. The patient's application in the Court of Queen's Bench for an order directing her doctor to provide a copy of her entire medical file was granted. A majority of the Court of Appeal affirmed the judgment.

75. The following issues were before the Canadian Supreme Court :-

(1) Are a patient's medical records prepared by a physician the property of that physician or are they the property of the patient?

(2) If a patient's medical records are the property of the physician who prepares them, does a patient nevertheless have the right to examine and obtain copies of all documents

in the physician's medical record, including records that the physician may have received which were prepared by other physicians?

76. Having considered a policy statement of the Canadian Medical Association published in 1985, the Canadian Supreme Court was prepared to accept that the physician, institution or clinic compiling the medical records owns the physical records. This leaves the remaining issue of whether the patient nevertheless has a right to examine and obtain copies of all documents in the physician's medical records.

77. It is important to understand the status that the Canadian Supreme Court put on medical records :-

(1) Medical records continue to grow in importance as the health care field becomes more and more specialized. Reference is made to *L. E. Rozovsky and F. A. Rozovsky in The Canadian Law of Patient Records* (1984), at pp. 73-74.

(2) While a patient may, in the past, have relied primarily upon one personal physician, the trend now tends to favour referrals to a number of professionals.

(3) As the number and use of specialists increase, the more difficult it is for the patient to gain access to a complete picture.

(4) The problem is intensified when one considers the mobility of patients in modern society.

(5) The records consist of information that is highly private and personal to the individual. It is information that goes to the personal integrity and autonomy of the patient. See *Halls v. Mitchell* [1928] S.C.R. 125, at p. 136 per Duff J. that professional secrets acquired from a patient by a physician in the course of his or her practice are the patient's secrets and, normally, are under the patient's control.

(6) As a physician begins compiling a medical file when a patient chooses to share intimate details about his or her life in the course of medical consultation. The patient "entrusts" this personal information to the physician for medical purposes. It is important to keep in mind the nature of the physician-patient relationship within which the information is confided. See *Kenny v. Lockwood* [1932] O.R. 141 (C.A.), Hodgins J.A. stated, at p. 155, that the relationship between physician and patient is one in which "trust and confidence" must be placed in the physician.

78. That the physician-patient relationship is characterised as "*fiduciary*", the Canadian Supreme Court went on to say that certain duties do arise from the special relationship of trust and confidence between doctor and patient. Among these are :-

(1) the duty of the doctor to act with utmost good faith and

loyalty,

(2) to hold information received from or about a patient in confidence,

(3) to make proper disclosure of information to the patient,

(4) to advise the patient about the information concerning his or her health in the physician's medical record,

(5) to grant access to the information the doctor uses in administering treatment.

79. In respect of the fiduciary duty to provide access to medical records the Canadian Supreme Court held that this is ultimately grounded in the nature of the patient's interest in his or her records. While the doctor is the owner of the actual record, the information is to be used by the physician for the benefit of the patient. The confiding of the information to the physician for medical purposes gives rise to an expectation that the patient's interest in and control of the information will continue. The trust-like "beneficial interest" of the patient in the information indicates that, as a general rule, he or she should have a right of access to the information and that the physician should have a corresponding obligation to provide it.

80. The Canadian Supreme Court also noted that if there has been improper conduct in the doctor's dealings with his or her patient, it ought to be revealed. The purpose of keeping the documents secret is to

promote the proper functioning of the relationship, not to facilitate improper conduct.

81. The Canadian Court held that there is a limit to this right of the patient :

(a) If the physician reasonably believes it is not in the patient's best interests to inspect his or her medical records, the physician may consider it necessary to deny access to the information.

(b) But the patient is not left at the mercy of this discretion. When called upon, equity will intervene to protect the patient from an improper exercise of the physician's discretion. It must be exercised on proper principles and not in an arbitrary fashion.

(c) Further, the onus properly lies on the doctor to justify an exception to the general rule of access.

82. A number of arguments for objection to the patient's general right of access were raised but rejected :-

(1) disclosure may facilitate the initiation of unfounded law suits; see Eberle J. in *Strazdins v. Orthopaedic & Arthritic Hospital Toronto* (1978), 7 C.C.L.T. 117 (Ont. H.C.), at pp. 119-20

(2) the medical records may be meaningless, because if the records are, in fact, meaningless, they will not help the patient but neither will they cause harm, and secondly;

(3) the medical records may be misinterpreted, because habitual use of jargon or technical terminology is not a sufficiently sound reason for denying a patient access to health records, and if it is possible that the patient will misconstrue the information in the record (for example, misinterpret the relevance of a particular laboratory test), the doctor may wish to advise the patient that the medical record should be explained and interpreted by a competent health-care professional;

(4) doctors may respond by keeping less thorough notes, as there is an obligation of a physician to keep accurate records

83. The Court only accepted that non-disclosure may be warranted if there is a real potential for harm either to the patient or to a third party. However, even here, the discretion to withhold information should not be exercised readily. Particularly in situations that do not involve the interests of third parties, the court should demand compelling grounds before confirming a decision to deny access.

84. *McInerney* was a case relating to New Brunswick where was no specific regulation on disclosure. The case of *David Grant*[1] was cited by the Respondent where in British Columbia, there were specific legislation on disclosure, *McInerney* should not be applied.

85. In *David Grant*, Mr Justice Curtis held that the common law test used by the Supreme Court requires a higher probability of the harm specified occurring. The common law test is a different one from that in British Columbia which was apparently less stringent.

86. The *McInerney* analysis allowing the imposition of more extensive duties than would arise in contract or tort, was in fact rejected in favour of a more traditional approach to fiduciary duty by McLachlin J in *Smith v Arndt* (1997) 148 DLR (4th) 48 at 63b-d. See *Joanisse v Barker 2003 CarswellOnt 3054*, 5 August 2003 :-

> *"42. The principles that govern a physician's liability in negligence in treating patients - and the extent of the physician's duty of disclosure - have long accommodated, and been affected by, the fiduciary relationship of trust and confidence that exists between them: Halushka v. University of Saskatchewan (1965), 53 D.L.R. (2d) 436 (Sask. C.A.); Hopp v. Lepp (1980), 112 D.L.R. (3d) 67 (S.C.C.), at pages 76 - 78; Zimmer v. Ringrose (1978), 89 D.L.R. (3d) 646 (Alta. T.D.); Arndt v. Smith, [1995] B.C.J. No. 1416 (B.C. C.A.), reversed on other grounds: [1997] 2 S.C.R.. 539. I accept Ms Thomson's submission that the nature of the inquiry is not altered by pleading breach of fiduciary duty rather than*

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[1] *Minister of Health and Minister Responsible for Seniors and the Attorney General of British Columbia v The Information and Privacy Commissioner of the Province of British Columbia and David Grant* A962692, Supreme Court of British Columbia, 9 April 1997

negligence. In Arndt, in the Supreme Court of Canada, McLachlin J. rejected a submission that liability for breach of a fiduciary duty to disclose the likely consequences of a surgical operation called for an application of principles other than those applicable to the torts of battery and negligence. After referring to the comment of Laskin C.J., in Reibl v. Hughes, [1980] 2 S.C.R. 880 (S.C.C.), at pages 891 - 92 that a failure to disclose the risks of treatment "should go to negligence rather than to battery", the learned judge stated:

For the same reasons, I would reject the alternative approach of fiduciary obligation proposed by the respondent. As with battery, the effect would be to replace the factual analysis of standard of care and causation appropriate to negligence actions with a choice-based analysis that makes recovery virtually automatic upon proof of failure to provide relevant information. I see no reason to depart from the approach which considers the failure of a physician to advise of medical risks under the law of negligence relating to duty of care, absent special circumstances like fraud and misrepresentation or abuse of power for an unprofessional end: see Reibl and Norberg v. Wynrib . . . ."

Mid Glamorgan Family Health Services (UK)

87. We notice however that in other overseas jurisdictions there were debates as to the true nature of a patient's relationship with his or her doctor, as to whether the doctor was owed the particular fiduciary duty and hence the nature of his or her right to the doctor's records. In those jurisdictions the Canadian approach in *McInerney* was not followed. Suffice it to say we were not assisted and the present dispute was not put to us primarily on the basis of the relationship.

88. In addition to this right under the Data Protection Act 1998,

(a) Under the Access to Medical Reports Act 1988, a person has specific rights of access to any report relating to himself prepared by a medical practitioner for employment or insurance purposes.

(b) In 1995, the Department of Health published *"The Patient's Charter and You : A charter for England, setting out every patient's "rights" in dealing with the NHS (National Health Service).* This included a statement of a patient's rights to have access to his own health records. This was later replaced by another Department of Health publication *Your Guide to the NHS.* This describes as one of its "core principles" the provision of open access to information about services, treatment and performance. Neither document bestows any rights of access to medical information.

(c) In 1995, the Department of Health also produced a *Code of Practice on Openness in the NHS*, which applied to Regional Health Authorities, Family Health Service Authorities, NHS Trusts, the Mental Health Act Commission and Community Health Councils. Although it spelled out in some detail the procedure that was to be followed, the time within which information was to be provided, a series of nine exemptions, and a complaints procedure, it did not create any enforceable rights.

(d) The Access to Health Records Act 1990 provided a right of access to "manual" health records. This was largely repeated by the Data Protection Act 1998, the scope of

which extended to information caught by the 1990 Act. The Act now applies only to application for access to records by the personal representative of a patient who has died or by a person who might have a claim arising out of the patient's death. See Access to Health Records Act 1990 s.3(1)(f).

89. As far as common law is concerned, in the UK, in *R v Mid Glamorgan Family Health Services Authority ex p Martin* [1994] 5 Med LR 383, the claimant asserted an entitlement at common law to access to his medical records, which were made before the Access to Health Records Act 1990 came into force (on 1 November 1991) and which applied to records made after that date. The claimant argued that the health authority owed him a fiduciary duty to disclose to him all the information contained in his medical records.

90. Ruling that there was no common right to access, Popplewell J specifically rejected the argument that the doctor-patient relationship was to be regarded as giving rise to equitable obligations for these purposes.

91. The Court of Appeal (*R v Mid Glamorgan Family Health Services* [1995] 1 WLR 110) held that the health authorities, as the owners of the medical records of the patient, were obliged to administer their property in accordance with their public purposes. The fulfilment of

this duty meant that the authorities were bound to deal with the records in the same way as a private physician.

92. Proceeding on the footing that the records were the legal property of the health authority (see the authority's contention summarised at p 114H), Nourse LJ after saying the duty of the health authority is the same as a private doctor (at p 116G) :

> *"a public body, as the owner of medical records, can be in a position no different from that of a private doctor whose relationship with his patient is governed by contract. In other words, a public body, in fulfilment of its duty to administer its property in accordance with its public purposes, is bound to deal with medical records in the same way as a private doctor."*

93. He continued at p 117E drawing a distinction of disclosure to a third party and also entitlement of denial of access to a patient of his health records if it was in the best interests, including handing to the patient's other doctors or his legal advisers :

> *"I do not accept that a health authority, any more than a private doctor, has an absolute right to deal with medical records in any way that it chooses. As Lord Templeman makes clear [in Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871 at p 904B], the doctor's general duty, likewise the health authority's, is to act at all times in the best interests of the patient. Those interests*

would usually require that a patient's medical records should not be disclosed to third parties; conversely, that they should usually, for example, be handed on by one doctor to the next or made available to the patient's legal advisers if they are reasonably required for the purposes of legal proceedings in which he is involved. The respondents' position seems to be that no practical difficulty could arise in such circumstances, but that they would act voluntarily and not because they were under a legal duty to do so. If it ever became necessary for the legal position to be tested, it is inconceivable that this extreme position would be vindicated."

94. The health authorities in *Mid Glamorgan* had refused to make voluntary disclosure of any of the records direct to the plaintiff on the footing that to do so would be detrimental to him and not in his best interests. However, the authorities had offered the sight of the records to the applicant's medical adviser. The Court of Appeal held that the taking of that step by the authorities was all that was necessary to comply with their duties to the applicant.

95. It may be noted that the Court of Appeal in *Mid Glamorgan* framed the question as "*whether a doctor or health authority, as the owner of the medical records of a patient, was entitled to deny the patient access to them on the ground that their disclosure would be detrimental to the patient.*"

96. *Sir Roger Parker* observed that the circumstances in which a patient or former patient was entitled to demand access to the medical

history as set out in the records would be infinitely various so that it was neither desirable nor possible to set out the scope of the duty to afford access or the scope of the patient's rights to demand access.

97. The decision of the English Court of Appeal thus does not provide any adequate foundation for the existence of the particular common law right which the appellant propounds in the appeal. There appeared to be an "*absence of solid legal foundations in the judgments for the right to access*".

98. In this regard, consideration must be had to the Human Rights Act 1998 Schedule 1 Part I Article 8(2) which the Appellant referred and submitted (in her submission of 1 March 2010) that [if] any data holder refuses or objects to release personal data to data subject [this] requires a substantial reasonable ground because it violates human right [within] the scope of "protection of health or morals". She submitted that a "may be harmful" excuse obvious(ly) [should] not [be] a good ground [in refusal to disclose the contents of the medical report to the patient in question.

99. The Respondent said the overseas jurisdictions were irrelevant, that the English Human Rights Act 1998 has no application to the present appeal and [hence] interpretation of the Ordinance. It was pointed out that Article 8(2) of the European Convention for the Protection of Human Rights and Fundamental Freedoms only relates to the interference with

the right to private and family life by public authority. Reference was also made to Paragraph 4.23 of the Hong Kong Data Privacy Law, 2nd Ed.

100. As a general observation these submissions must be right that the present appeal does not concern interference of the Appellant's right to private and family life by public authority, but it does not detract from the fact that the Hong Kong courts had from time to time considered human right provisions in other jurisdictions and their applications to different situations. Once it is understood the context in which the human right provisions had been applied, the application of those provisions could and often would be of good and useful guidance.

101. The same observation may be made to the criticism by the Respondent on the Appellant's reference to the Access to Medical Report Act 1988, and the Access to Health Record Act 1990. We note that the Respondent had also submitted that the right to access to medical report or health records are still subject to the limitations set out in s7(1) of the Access to Medical Records Act and s5(1) of the Access to Health Records Act, that if the medical practitioner considers that the disclosure would be *likely to cause* (as opposed to *may cause)* serious harm to the physical or mental health of the patient or any individual, access may or shall be denied.

102. In *A Health Authority v X (No.1) Also known as: A Health Authority v X (Discovery: Medical Conduct) (No.1)* (Fam Div) Family Division, 10 May 2001, the health authority applied for an order that a general practitioner, X, to disclose general practitioner records concerning present or former patients who, as children, had been the subject of care proceedings.

103. The health authority sought disclosure on the basis that it needed to investigate the extent of X's failure to comply with his terms of service. The health authority contended that it was entitled to disclosure of the records under the National Health Service (General Medical Services) Regulations 1992 Sch. 2. Para. 36 as disclosure was necessary to enable it to carry out its public or regulatory functions. X submitted that the health authority was only entitled to demand records where they were needed for bona fide administrative, as distinct from regulatory, purposes.

104. The Court (Munby, J) granted the order for disclosure, holding that the National Health Service (Service Committees and Tribunal) Regulations 1992 Reg. 17(1) together with §36 clearly envisaged that records could be examined for regulatory as well as administrative purposes.

105. However, the Court also held that an order for disclosure would only be granted in circumstances where there was a compelling public interest in disclosure pursuant to the Human Rights Act 1998 Sch. 1 Part I Art. 8(2), and sufficient safeguards existed to prevent any possibility of abuse, *R. v Mid Glamorgan Family Health Services Ex p. Martin* [1995] 1 W.L.R. 110, *Woolgar v Chief Constable of Sussex* [2000] 1 W.L.R. 25, *Norwich Pharmacal Co v Customs and Excise Commissioners* [1974] A.C. 133 and *Entick v Carrington* (1795) 19 St. Tr. 1029 were considered. The matters which the authority wished to investigate were of sufficient gravity to warrant disclosure of the records subject to the condition that the records disclosed remained confidential.

106. Thus the UK authorities apparently did not accept the *McInerney* analysis.

Breen v Williams (Australia)

107. We also note that in the High Court of Australia's case of *Breen v* Williams (1996) 138 ALR 259 the *McInerney* analysis was rejected in the context of a claim for access to medical records.

108. In *Breen*, the appellant in October 1977 underwent a surgical procedure by which a small silicone implant was inserted in her left breast and a larger implant in her right breast. The operation was

performed by another medical practitioner. In August 1978, the appellant consulted the respondent, Dr Williams. Dr Williams has practised in Sydney since 1974 as a consultant surgeon specialising in plastic surgery. The appellant consulted him with respect to both her condition following the surgical procedure of October 1977 and some facial scarring. There were two further consultations concerning both matters in August and September 1978. In November of that year the respondent operated on the appellant under general anaesthetic to perform a bilateral capsulotomy for the compression of hard capsules which had developed since the earlier surgical procedure. The respondent then had no further consultations with the appellant until May 1983. She then wrote to him concerning further plastic surgery, including removal of the breast implants and their replacement with larger implants. Correspondence concerning this possible further treatment continued until September 1983.

109. In 1984 the appellant noticed the development of a lump under her left breast. This was diagnosed as a leakage of silicone gel from the breast implant and an operative procedure was performed by another medical practitioner.

110. It was the practice of the respondent to maintain a file with respect to each patient. Usually this will include handwritten notes containing a variety of information bearing upon such matters as the

description provided by the patient of the patient's medical condition, the circumstances in which the patient was referred to the respondent, the respondent's notes of his observations upon examination of the patient and conclusions in relation thereto (including what the respondent called his "medical musings" about the patient's condition), and communications with other practitioners treating the patient and with the family and friends of the patient. Further, where the respondent has reason to believe or suspect that there may be criticism of his treatment or advice, he keeps short notes of any information or developments which may bear upon any such future dispute. All of these notes are written in an abbreviated fashion which conveys meaning to the respondent but which might be difficult for others to follow.

111. In 1993, the appellant, with many others from Australia, the United States and other countries, became involved in litigation against various parties, including the manufacturer of the breast implants, Dow Corning Corporation.

112. The Federal Council of the Australian Medical Association (the "AMA") resolved at its meeting on 29 and 30 October 1993 that :

> *"That the AMA endorses the following guidelines on patients' access to records concerning their medical treatment: The patient has a 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 or doctors contributing to, or recognised employing hospital or other organisation maintaining the record. Where appropriate, such deductive opinion may be separately recorded. On request, the patient should be informed of any or all content of the following sections of the medical record;

History

Physical Examination Findings

Investigation Results

Diagnosis (Diagnoses)

Proposed Management Plan

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 by hospital administration after consultation with the doctor(s) who completed such section or sections, or as the result of a legal requirement.

Doctors and hospitals are entitled to recoup their costs of providing information contained in a medical record from the patient or other legally authorised requestor [sic] of the information. (Emphasis added.)"

113. Broadly, the respondent's position was to accept that the patient or former patient has a right to be informed of all relevant factual information contained in the medical records of the patient but to deny any entitlement in the patient to examine those records or to obtain copies.

114. On fiduciary duty, Gaudron and McHugh JJ. said there was no basis upon which the doctor had owed to the patient a fiduciary duty to give her access to the medical records :-

> *"Does a doctor owe a fiduciary duty to a patient to give the patient access to that person's medical records?*
>
> ...
>
> *In our view, there is* ***no basis*** *upon which this Court can hold that Dr Williams owed Ms Breen a fiduciary duty to give her access to the medical records. She seeks to impose fiduciary obligations on a class of relationship which has not traditionally been recognised as fiduciary in nature and which would significantly alter the already existing complex of legal doctrines governing the doctor-patient relationship, particularly in the areas of contract and tort. As Sopinka J remarked in Norberg v Wynrib(148): "Fiduciary duties should not be superimposed on these common law duties simply to improve the nature or extent of the remedy."*

Dr Cashman relied strongly on ... McInerney v MacDonald to support ... a fiduciary duty to give her access to the medical records. ...

However, in this country it is not possible to regard the doctor-patient relationship as one in which the doctor is under a general duty "to act with utmost good faith and loyalty" to the patient. When a medical practitioner undertakes to treat or advise a patient on a medical matter, "[t]he law imposes on a medical practitioner a duty to exercise ***reasonable care and skill*** *in the provision of professional advice and treatment", not a general duty "to act with the utmost good faith and loyalty".*

Secondly ... it does not help analysis of the legal issues in the present class of case to say that the information "is held in a fashion somewhat akin to a trust" or that there is an expectation that the patient's "control of the information will continue". The information is not property. Moreover, the only control that a patient has over the information that he or she has given to the doctor is to restrain its improper use. Nor is there any trust of it. Equity does not require the doctor to record, account for or even remember the information. Nor can equity at the suit of the patient prevent the doctor from destroying the records that contain the information. The records are the property of the doctor. He or she may be restrained from using the information in them to make an unauthorised profit or from disclosing that information to unauthorised persons. But otherwise the records are his or hers to save or destroy. The idea that a doctor who shreds the records of treatment of living patients is necessarily in breach of fiduciary duties owed to those patients is untenable.

Furthermore, [McInerney v MacDonald] does not deal with the fact that the medical records of a patient will often, perhaps usually, contain much more than the information that the patient has given to the doctor. In addition to any observations concerning the patient's condition and notes recording treatment and research, the records may contain comments by the doctor about the personality and conduct of the patient. They may also contain information concerning the patient that the doctor has obtained from other sources. The patient has no rights in relation to or control over any information that has not come from him or her. We can think of no legal principle that would give the patient even a faintly arguable case for access to information in the records that is additional to what the patient has given. If the relationship of doctor and patient was a status-based fiduciary relationship in which the doctor was under a general fiduciary duty in relation to all dealings concerning the patient, the patient might be entitled to access to all the information in his or her medical records. But there is no general fiduciary duty.

La Forest J [in McInerney v MacDonald] said that the "fiduciary duty to provide access to medical records is ultimately grounded in the nature of the patient's interest in his or her records". However, the patient has no legal rights in respect of significant parts of the information contained in medical records. If a patient has a legal right of access to medical records merely because he or she has given personal and confidential information to a doctor, it would seem to follow that journalists, accountants, bank officers and anybody else receiving personal and confidential information always

had a fiduciary duty to give access to their records to the person who gave that information.

Thirdly, the Canadian law on fiduciary duties is very different from the law of this country with respect to that subject. One commentator has recently pointed to the "vast differences between Australia and Canada in understanding of the nature of fiduciary obligations". One significant difference is the tendency of Canadian courts to apply fiduciary principles in an expansive manner so as to supplement tort law and provide a basis for the creation of new forms of civil wrongs. The Canadian cases also reveal a tendency to view fiduciary obligations as both proscriptive and prescriptive. However, Australian courts only recognise proscriptive fiduciary duties. This is not the place to explore the differences between the law of Canada and the law of Australia on this topic. With great respect to the Canadian courts, however, many cases in that jurisdiction pay insufficient regard to the effect that the imposition of fiduciary duties on particular relationships has on the law of negligence, contract, agency, trusts and companies in their application to those relationships. Further, many of the Canadian cases pay insufficient, if any, regard to the fact that the imposition of fiduciary duties often gives rise to proprietary remedies that affect the distribution of assets in bankruptcies and insolvencies.

In this country, fiduciary obligations arise because a person has come under an obligation to act in another's interests. As a result, equity imposes on the fiduciary proscriptive obligations - not to obtain any unauthorised benefit from the relationship and not to be in a position of conflict. If these obligations are

breached, the fiduciary must account for any profits and make good any losses arising from the breach. But the law of this country does not otherwise impose positive legal duties on the fiduciary to act in the interests of the person to whom the duty is owed. If there was a general fiduciary duty to act in the best interests of the patient, it would necessarily follow that a doctor has a duty to inform the patient that he or she has breached their contract or has been guilty of negligence in dealings with the patient. That is not the law of this country.

In Australia, therefore, McInerney cannot be regarded as a persuasive authority. In this country a court cannot use the law of fiduciary duty to provide relief to Ms Breen which, if granted, would have the effect of imposing a novel, positive obligation on Dr Williams to maintain and furnish medical records to Ms Breen. It follows that Dr Williams does not owe Ms Breen any fiduciary duty to give Ms Breen access to the medical records that relate to his treatment of her."

115. Gummow J further said if a right to be informed by the respondent, on reasonable request, of relevant factual material contained in her medical records, that might well be accepted by the Court, but rejected an implied term that the patient to have an entitlement to examine her records and to obtain copies :-

"Contract

The relationship between medical practitioner and patient may engage the law in various respects. Traditionally, there has

been a contractual relationship, the medical practitioner performing services in consideration for fees payable by the patient. That established pattern now may require adjustment to accommodate wholly or partly state operated or financed health schemes, established by statute.

...

a right to be informed by the respondent, on reasonable request, of relevant factual material contained in her medical records. If that was all that was in the case, then the Court might well accept the existence of such a term.

But the appellant goes further. She claims an entitlement to examine her records and to obtain copies.

In my view, it cannot be said that a term in that form is necessary for the reasonable or effective operation of the contract. A term in the form urged by the appellant is not to be imported to give effect to a tacit intention of the parties in the circumstances of the case."

116. Gummow J also considered and rejected suggestion of "informed consent" argument, that in fiduciary law "informed consent" is an answer to circumstances which otherwise indicate disloyalty, not a mainspring of equitable liability :-

117.

""Informed consent"

Reference is made in submissions to statements of principle by this Court in Rogers v Whitaker as supportive of a doctrine of "informed consent". That case was an action in negligence ... The particular issue was whether the appellant's failure to advise and warn the respondent of the risks inherent in a particular operation undergone by her constituted a breach of that duty.

...

This formulation of principle was made for the purposes of the tort of negligence, and the elucidation of the overall duty of care owed to the patient by the medical practitioner... nothing was to be gained by reiterating expressions used in American authorities such as "the patient's right of self-determination" or even "the oft-used and somewhat amorphous phrase 'informed consent' The Court pointed out that the phrase "informed consent" is apt to mislead as it suggests a test of the validity of the patient's consent and that, moreover, consent is relevant to actions framed in trespass, not in negligence.".

To this it may be added that in fiduciary law "informed consent" is an answer to circumstances which otherwise indicate disloyalty, not a mainspring of equitable liability. In the United States, the phrase "informed consent" in this area of legal discourse appears to represent some assumed synthesis between the tort of negligence and principles of fiduciary duty law. The Privy Council and House of Lords recently have cautioned against such processes. There is a fundamental principle that it is an answer to a claim against an erring fiduciary that the plaintiff gave an informed consent, after full and frank disclosure of all material facts, to the alleged breach of duty. However, it seems that, in the United States, this is

translated into a "free-standing" action for damages brought against the medical practitioner by the patient for failure to treat the patient only with the "informed consent" of the patient."

118. On the question of property rights, Gummow J said that the documents in question being chattels would have their right to possession being enjoyed by the doctor :-

"The documents in question, including any photographs, are chattels, ownership and the right to exclusive possession of which appear to be enjoyed by the respondent. Access to those records would be an incident of those rights. They would be protected against invasion by the law of tort, in particular by actions for detinue and conversion."

119. On copyright, Gummow J thought that the records might attract copyright, and there was no licence given in the circumstances of that case :-

"material shown on the records may have involved the authorship by him of what, whilst not of literary quality, were nevertheless literary works for the purposes of copyright law. This would vest in him various exclusive proprietary rights, including that to reproduce the work in a material form ... Ownership of the manuscript would not, of itself, carry with it the right to publish it and to reproduce it.

...

However, the circumstances of the present case, as disclosed in the evidence, do not provide support for the existence of any copyright licence or consent given to the appellant either expressly or by implication. Nor does it appear that such a licence is implied in the contract between medical practitioner and patient as a matter of law in the sense I have described earlier in these reasons."

120. On *McInerney*, Gummow J considered the issue was narrower :-

"The decision is McInerney v MacDonald. The decision in that case was :

"In the absence of regulatory legislation, the patient is entitled, upon request, to inspect and copy all information in the patient's medical file which the physician considered in administering advice or treatment. Considering the equitable base of the patient's entitlement, this general rule of access is subject to the superintending jurisdiction of the court. The onus is on the physician to justify a denial of access.

...

However, the precise issue in the case was somewhat narrower and it is to this that one should have regard. The outcome of the litigation was to uphold the order of the primary judge in the Court of Queen's Bench of New Brunswick. This was that Dr McInerney provide to Mrs MacDonald, her patient, copies of all documents which she had received from five other physicians who had previously treated the respondent, together with the written opinions as to the respondent's medical

condition prepared by consultants at the request of the other physicians. Dr McInerney had co-operated with the patient to the extent of providing, for a fee, copies of notes, memoranda and reports prepared by her but she refused to deliver copies of the other documents on the footing that they were the property of the other physicians and it would not be ethical for her to release their reports and records.

By the time the case reached the Supreme Court of Canada, Mrs MacDonald had obtained copies of all the material in question, so that she had no interest in contesting the appeal. Her counsel appeared as amicus curiae only.

...

These passages should be read having in mind the particular issue which had been in dispute, not the provision by Dr McInerney of records prepared by her, but delivery of reports and records prepared by other physicians but which had come into her possession. That, as this appeal was presented, is not the present dispute."

121. In *Pilmer v Duke Group Ltd (In Liq)* (2001) 207 CLR 165 a company, K, made a takeover bid for another company, W. The consideration offered by K for shares in W was either shares in K or a combination of shares in K and cash. Before the takeover, K retained a firm of accountants, N, to prepare the independent report required by the listing rules of the Australian Stock Exchange to be placed before a meeting of shareholders of K. Some members of N had previously had business dealings with K, or directors of K and W. The report expressed

the opinion that the consideration to be offered by K for shares in W was fair and reasonable. If the report had been prepared competently, that opinion would not have been expressed and the takeover would not have proceeded. After the takeover offers were made, the prices of shares in the stock market, including those of K and W, fell considerably but the takeover proceeded. K was later wound up. The liquidators of K sued the members of N, alleging breaches of contractual and common law duties of care and breaches of fiduciary duty.

122. The High Court of Australia, Kirby J, when he examined *Breen*, held that the law does not exclude the existence of a fiduciary obligation although the mere existence of a doctor and patient relationship does not by itself gives rise to such obligation :-

> *"The decision in Breen*
>
> *116. In Breen, this Court upheld a judgment of a majority in the New South Wales Court of Appeal. In that Court I dissented on a point that is here relevant. It was whether a fiduciary duty existed in law in the relationship between the parties or by reason of the other circumstances of that case; whether it had been breached; and, if it had, what equitable relief should be granted.*

117. In that case, I followed the decision of the Supreme Court of Canada in McInerney v MacDonald. That decision was to the effect that a medical practitioner and a patient are involved in a fiduciary relationship for the purpose of the law of fiduciary obligations. On that basis, with certain limitations, a patient was entitled to oblige a medical practitioner to accede to a request to allow access to medical records held by the practitioner in respect of the patient. This Court unanimously disagreed.

118. In ascertaining the ratio of Breen, it is primarily necessary to examine the differing ways in which members of this Court explained their respective conclusions, for within this Court there were differences of opinion. One can perform this task, conscious of the wealth of commentary which the decision has evoked ... Where a judicial decision produces such a wide range of responses, for the most part from knowledgeable writers, it is fair to assume that the law does not speak with total clarity or that its content is uncontested.

119. When one examines what Breen actually stands for, as a matter of legal authority, it clearly negates any entitlement by patients, under the common law, to inspect their medical records, save with the agreement of the medical practitioner concerned or where legislation so provides. In this respect, this Court confirmed the unanimous opinion of the Court of Appeal. But the point upon which a difference of opinion had emerged in the Court of Appeal related to the alternative claim which the patient advanced, based on the suggested equitable category of fiduciary duty. This Court held, affirming the majority in the Court of Appeal (Mahoney JA and Meagher JA), that no such fiduciary duty existed in the circumstances.

120. There were differences of reasoning in this Court's decision in Breen. A majority were clearly of the opinion that the relationship of medical practitioner and patient did not, without more, create fiduciary obligations. Thus, that relationship bore no sufficient analogy to that between a solicitor and client, or trustee and cestui que trust, that traditionally gives rise, without more, to fiduciary obligations. On the other hand, Gummow J concluded that the relationship between a medical practitioner and a patient who seeks skilled and confidential advice and treatment was indeed a fiduciary one. In his Honour's opinion, this conclusion followed, by analogy, from the earlier decision of this Court in Daly. It also followed from an analysis of the formulations of the mainspring of fiduciary duty found in other decisions of this Court, other Australian authority and authority of the Supreme Court of Canada apart from McInerney. The point of Gummow J's analysis was that the answer to the claim advanced by Ms Breen was not to be found, alone, in a classification of her relationship with Dr Williams. The "nature of the relationship" was only one aspect of the two-fold test to be applied for ascertaining the existence and scope of a fiduciary duty. The other aspect considers "the facts of the case".

121. In some established relationships, the relationship itself will be enough to make it clear that a fiduciary obligation is owed by one party to the other in respect of related transactions between them during the relationship. Relationships giving rise to such obligations differ between jurisdictions. In Australia, Gaudron and McHugh JJ in Breen mentioned "trustee and beneficiary, agent and principal, solicitor and client, employee and employer, director and company and partners". However, in other countries, perhaps

reflecting different social circumstances, courts have been willing to add new and different categories. Thus in Canada, the Supreme Court has added (but this Court has not) the category of medical practitioner and patient. That Court has also added the relationships of parent and child and the Crown and indigenous peoples. In the United States of America still further relationships have been added. These include majority and minority shareholders, patients and physicians, or psychiatrists and others.

122. The primary point for which Breen stands in relation to fiduciary duties is that, in Australia, attempts to elevate a relationship between medical practitioner and patient effectively to a special one which, without more, will import fiduciary obligations has, for the moment, failed. Proving that the relationship involves an imbalance of power, and even vulnerability on the part of the patient, was not sufficient.

123. Like that between doctors and their patients, the relationship of chartered accountant and client has not yet been classified as one of the categories which, without more, gives rise to fiduciary obligations. Because such obligations are more onerous (and the legal consequences more drastic) than those arising from common law duties of care or from contractual relationships, it is understandable that the per se categories of fiduciary relationship have been limited in the past and will not be extended except by clear analogy with

those presently accepted. I must comply with this approach.

124. A further point established by Breen is not unconnected. This is that a degree of caution must be observed in relying upon Canadian and United States authorities concerning the expansion of per se fiduciary relationships or factual circumstances in other relationships that are said to combine to impose fiduciary obligations. This difference between the approach of North American courts and those of other common law jurisdictions, particularly the United Kingdom, was also observed by Mason CJ. At least so far as the relationship of medical practitioner and patient was concerned, I suggested in the Court of Appeal that professional paternalism, evident in the decisions on the issue in the United Kingdom, was less in harmony with the social circumstances and law of Australia than was the position prevailing in North America. Similar considerations might inform the approach of Australian law to the obligations of chartered accountants to their clients. Although my approach in this regard in Breen v Williams has been taken to task, I remain of the opinion there stated. But it matters not in this appeal.

125. I do not read Breen as obliging Australian courts to ignore all Canadian and United States authority on fiduciary obligations. ... Nevertheless, in matters of detail, following

Breen, it must be accepted that a view has been taken that North American courts have, to some extent, become engaged in "reshaping the law of obligations in a way which blurs significant distinctions" that are still maintained by the courts of the United Kingdom and Australia. To the extent that there are differences, Australian courts should therefore adhere to "accepted doctrine". They will not uncritically follow judicial authority from North America.

126. Thirdly, Breen illustrates a general disinclination of Australian law to expand fiduciary obligations beyond what might be called proprietary interests into the more nebulous field of personal rights, such as those agitated in Breen itself. There the patient had no proprietary rights of any kind in the notes of the medical practitioner. ... Fiduciary obligations were never limited to disputes about property interests. Nevertheless, Breen stands as a warning that the imposition of fiduciary obligations "gives rise to proprietary remedies that affect the distribution of assets in bankruptcies and insolvencies". This represents a further reason for exercising restraint in expanding the categories of per se relationships or treating new fact situations as attracting fiduciary obligations beyond those accepted in the past.

127. Fourthly, and most importantly, Breen upholds the principle stated in the aphorism that fiduciary obligations are "proscriptive" and not "prescriptive". This, in my view, is the fundamental reason why all members of this Court in Breen rejected Ms Breen's claim of a fiduciary obligation. Whatever the differing views which the justices held concerning the character of the relationship in question ... there was agreement that Ms Breen's claim failed because it would have involved imposing on the suggested fiduciary positive obligations to act. It would have burdened him with an affirmative obligation to grant access to his notes to a patient ("prescriptive" duties). It would thus have gone further than the conventional ("proscriptive") duties of loyalty, of avoiding conflicts of interest or of misusing one's power, such as fiduciary duties have traditionally upheld.

128. Whilst, for my own part, I question the viability of this supposed dichotomy (because omissions quite frequently shade into commissions) I must accept that Breen embraces the distinction. ...

Breen does not exclude a fiduciary obligation

129. When the foregoing considerations are extracted from Breen, as the binding rule established by that decision, it will be seen immediately that none of them decides the present case. Kia Ora did not allege that the relationship of chartered accountant to client was per se of the variety that attracted fiduciary obligations. It did not set out to draw an analogy between that relationship and the closest analogy of a fiduciary kind, namely legal practitioner and client. While there are obvious overlaps between the professions of chartered

accountant and legal practitioner, the history of each has been different and their respective functions are distinct. This is not, therefore, a case (nor was it ever suggested to be) where an established relationship, as such, gave rise to the imposition of fiduciary duties to Kia Ora on the part of the appellants. At all times, Kia Ora addressed itself to the peculiarities of the facts of its relationship with the appellants. This was also how the Full Court dealt with the claim."

Clinical Psychologists in Hong Kong

123. In Hong Kong[2], generally, the basic entry level is earning a Master Degree from a Clinical Psychology programme after the completion of a Bachelor Degree in Psychology (or an equivalent qualification). The programme is offered by the University of Hong Kong and the Chinese University of Hong Kong. Training as a Clinical Psychologist must include a certain amount of clinical placement, as specified by HKPS. All registered Clinical Psychologists of HKPS have qualifications satisfying the above requirements.

124. The main difference between a clinical psychologist and a psychiatrist is that clinical psychologists are not normally regarded as medical practitioners, psychiatrists are. Clinical psychologists have not gone through medical training, and are not qualified for medical prescription; they apply psychological theories, tools and methods to assess and treat psychological problems.

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[2] http://www.dcp.hkps.org.hk/faqs.php

125. To date, there is no legislation governing the licensing of Clinical Psychologists in Hong Kong. Clinical psychologists in Hong Kong can apply for the membership of DCP, HKPS or professional registration on voluntary basis. They are bound by the provisions of the Code of Professional Conduct. According to the record of the DCP on July 2006, there are 23 Qualified Clinical Psychologists in private practice. There are also about 241 Registered Clinical Psychologists in Hong Kong according to the record in March 2007.

126. Assessment in Clinical Psychology integrates standardized psychometric tests, systematic behavioural observation and clinical interviews to evaluate one's cognitive functioning, personality type, mental, behavioural and emotional status; which, in turn, help to throw light on the causes of personal distress and malfunctioning. Examples of psychometric tests include intelligence test (or IQ Test), memory tests, neuropsychological tests, personality and mood tests.

127. Based upon systematic and psychological theories, research results and clinical assessment, Clinical Psychological intervention alleviates and treats physical and emotional distress that sprang from maladjustment to changes in life. Clinical Psychologists draw on information from assessment and observations to select the most suitable treatment modality and procedures that fit the client's problem and psychological conditions. There are a variety of theories and techniques

for psychological treatment, most of which involves verbal communication between the Clinical Psychologist and the client. Examples of interventional techniques include cognitive-behavioural therapy, marital and family therapy, play therapy, biofeedback, psychoanalysis, cognitive retraining and rehabilitation.

128. Noting the general difference between a medical doctor and a clinical psychologist, however, in so far as records of patients are concerned, there appears to be no difference between the two.

129. In Hong Kong there is no legislation dealing with patients rights relating to access to medical records.

130. The fact that medical records are relevant to data privacy is however no stranger to the medical or clinical psychologists profession.

131. The Hong Kong Psychological Society has a code of professional conduct which provides that in providing services to clients, the clients have the right to as complete information as possible about the aims and purposes of the procedures and about their results and outcomes :-

> *"2.1.3 The Clients have the right to as complete information as possible about the aims and purposes of the procedures and about their results and outcomes - information which*

must be conveyed to the Clients in a language and manner which are appropriate to their background and abilities."

132. In addition, the medical doctors have a similar but more direct reference to the Ordinance. See the Code of Professional Conduct of the Medical Council where it is specified that medical doctors should have due regard to their responsibilities and liabilities under the Ordinance 486, in particular, patient's rights of access to and correction of information in the medical record :-

> ***"A. PROFESSIONAL RESPONSIBILITIES TO PATIENTS***
>
> ***1. Medical records and confidentiality***
>
> *1.1 Medical records*
>
> *1.1.1 The medical record is the formal documentation maintained by a doctor on his patients' history, physical findings, investigations, treatment, and clinical progress. It may be handwritten, printed, or electronically generated. Special medical records include audio and visual recording.*
>
> *1.1.2 A medical record documents the basis for the clinical management of a patient. It reflects on the quality of care and is necessary for continuity of care. It protects the legal interest of the patient and the healthcare provider.*
>
> *1.1.3 All doctors have the responsibility to maintain systematic, true, adequate, clear, and contemporaneous medical records. Material alterations to a medical record can only be made with justifiable reason which must be clearly documented.*

1.1.4 All medical records should be kept secure. This includes ensuring that unauthorized persons do not have access to the information contained in the records and that there are adequate procedures to prevent improper disclosure or amendment. Medical records should be kept for such duration as required by the circumstances of the case and other relevant requirements.

1.1.5 Doctors should have due regard to their responsibilities and liabilities under the Personal Data (Privacy) Ordinance (Cap. 486), in particular, patient's rights of access to and correction of information in the medical record and the circumstances under which doctors may refuse to entertain such requests.

The Applicable Principles in Hong Kong

133. Having regard to the legal principles of the different jurisdictions and the Hong Kong context in particular, we believe the following are the principles in governing disclosure of patients' records :-

(a) The Canadian approach that for the purpose of access to medical records (computerized or manual), a doctor is considered to act in breach of his fiduciary duty, appears to be too wide and can work to injustice at least in so far as remedies are concerned. Fiduciary obligations are more onerous (and the legal consequences more drastic) and more facts are required to justify access on the basis of the existence of fiduciary duty. *Breen v Williams* (1996) 138

ALR 259 per Gaudron and McHugh JJ, *Pilmer v Duke Group Ltd (In Liq)* (2001) 207 CLR 165 Kirby J at §120-123.

(b) Medical records are generally property of the doctor but there is a right to the patient to inspect and take copies, subject to a reasonable charge by the doctor for photocopying purpose, unless there are good reasons to depart from such practice. *Mclnerney v MacDonald* [1992] 2 SCR 138, *R v Mid Glamorgan Family Health Services* [1995] 1 WLR 110 both proceeded on the basis that medical records are property owned by the doctors in question. It is right that the patient has no general property right in the medical records.

(c) The circumstances in which a patient or former patient was entitled to demand access to the medical history as set out in the records would be infinitely various so that it was neither desirable nor possible to set out the scope of the duty to afford access or the scope of the patient's rights to demand access. *Sir Roger Parker* in *R v Mid Glamorgan Family Health Services* [1995] 1 WLR 110.

(d) A doctor (and on this particular aspect a doctor is no different from a clinical psychologist) might deny a patient access to medical records if it was in the best interests of the patient to do so.

(e) The Hong Kong situation is rather peculiar. In Hong Kong it is fair to say that there is a relationship of great deal of

trust and confidence between a doctor and a patient. Given the social background, the very limited number of professional medical doctors, and the normally higher social status of a medical doctor vis-à-vis his patient giving rise to certain risks of dominance, although it is insufficient to impose a fiduciary duty in the sense of a doctor being obliged to give access to a patient of his medical records on that basis, we believe the onus will have to be put on the professional medical doctor to justify his decision to deny access, in the event of any dispute. See *Pilmer v Duke Group Ltd (In Liq)* (2001) 207 CLR 165 Kirby J at §120, *Breen v Williams* (1996) 138 ALR 259 *Gummow J* that the relationship between a medical practitioner and a patient who seeks skilled and confidential advice and treatment was indeed a fiduciary one. In terms of the relatively smaller number of professional clinical psychologists, a fortiori, a clinical psychologist should have the burden to show access to his patients is unjustified.

(f) The shifting of burden is in fact consistent the trend of different jurisdictions in allowing patients to access records.

134. We believe if the patient has access to the same information as the clinical psychologist do then they would both be dealing with the same problem. Further, patients may be less demanding and welcome being treated as adults. It helps to overcome patient paranoia if they

know exactly what is going on and know that they have the whole truth. Many doctors in UK said that and we believe the same is in Hong Kong that access would help clear up misunderstandings and misconceptions. Therefore, a great benefit of openness is that it will help improve the accuracy of records.

135. In the UK it has been said that openness will act as a safeguard against possible casual, ill-considered personal comments that are sometimes found on medical records. Such comments may remain on a patient's record for life and may unfavourably affect the way in which subsequent health staff think and regard the patient. The right of access may make those who keep records think rather more carefully about what they write. This is a matter which should equally be of concern in Hong Kong.

136. We would respectfully agree that our finding that Item 4 is personal data does not mean each and every medical record of a patient is personal data but the onus will have to be put on the professional doctor to justify his decision to deny access.

137. We note that Lord Walton of Detchant when speaking on the Data Privacy Bill in 1990 in the House of Lords had cautioned possible problems of disclosure [3] :-

[3] http://hansard.millbanksystems.com/lords/1990/jun/22/access-to-health-records-bill#column_1206

"The opportunity for patients to correct any inaccuracies which might find their way into their medical records would be an obvious gain as would anything which discouraged doctors from recording comments which might be their personal opinion but which did not properly belong in an individual's medical records. However, the proposal might bring some losses as well as very substantial gains.

The introduction of a statutory right of access will inevitably lead to some changes in the essential character of medical record keeping. Many things may improve but there is a risk that if patients can demand access to everything written about them by doctors, whether factual or speculative, some doctors may feel inhibited from keeping full and frank records to the ultimate disadvantage of both. There is a fear that that could encourage a defensive attitude on the part of some doctors not only towards the preparation of written records but towards the practice of medicine itself, with doctors increasingly mindful of the possibility of future litigation. Moreover, anything which affects the comprehensiveness of medical records will have implications for the emerging arrangements to establish, throughout the profession, a system of medical audit by way of peer review which, particularly in general practice, will need to rely heavily upon the scrutiny of full patient case notes."

138. The above legal principles are equally consistent with the true construction of Section 59.

139. Accepting that it is generally true that the decision as to whether patients should have a right of access to their records was one for society as a whole and therefore a question to be decided ultimately by Parliament, we note that the Hong Kong statutory regime on access to medical records is at the moment rather confined to the law of data privacy through which the Ordinance represents.

140. That Section 59 and the legal principles as proposed are consistent on at least two counts. Firstly, the Ordinance brings health service records into line with those of housing, the social services, and education, all of them equally sensitive services and all of them services that need to network their information and to share it with their clients if the most effective counselling and support is to be offered. This is only subject to the condition laid down in Section 59 which provides that personal data relating to the physical or mental health of the data subject are exempt from the provisions of principles 3, 6 and section 18 of the Ordinance, if the data would be likely to cause serious harm to the data subject or any other individual.

141. Secondly, the Ordinance (by section 59) withholds information that a doctor considers would be likely to cause serious harm to the patient, and that means that the Ordinance protects the patient's best interests. The fact that the doctor has to justify his judgment if he refused access does not prevent him from giving his professional opinion that there should be no access at all under Section 59.

142. In our view, the Ordinance on a true construction presumes a patient's rights in his or her own health and therefore in the records of his or her health. It thus assumes that patients are moral adults in the most profound sense, that they are healthy and not insane; adult and not dependants; citizens and not merely passive recipients of care.

143. Our conclusion is therefore that, but for the objection of Section 59 which we have held not applicable, item 4 being part of the medical record is disclosable whether it was in manual or computer form.

Unlimited and Free Access ?

144. But what about protection to the professional doctor, as he owned the records ? We are of the view that the patient should normally not be allowed for complete free access as the professional doctor had put in his skill and effort and time, even if they are personal data. The Ordinance is silent on this aspect.

145. We believe it is fair to say, that a patient under psychological care should be given his/her rights to have access of records contain his/her personal data, conditional upon payment of a reasonable sum, unless it can be satisfied that Section 59 of the Ordinance can apply. We note that in the UK this was subject to the ceiling to cover photocopying and connected administrative charges for retrieval. In our view this is normally not unreasonable although there may be circumstances to justify more, and should not go so far as requiring the

clinical psychologist to become an expert witness in Court, which reasonable remuneration should be separately awarded.

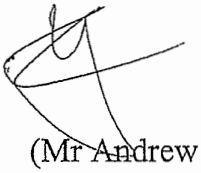
146. We would add that if the patient is not willing to pay the reasonable sum, the clinical psychologist is entitled to claim a lien and refuses to give access.

147. In the present case we believe sufficient protection has been granted to Dr Li, as being a patient the Appellant should not have Item 4 free of charge, under the disguise of a personal data request. That protection was the existence of a lien over the work of Dr Li in Item 4. Dr Li had so far not exercised her right to claim the lien.

148. The Respondent submitted that *McInerney* is distinguishable. As a result of the above analysis, we are of the view that the Respondent, even if he is right in submitting that *McInerney* should not apply, had failed to consider the reason the true basis why *McInerney* should not be followed, and further failed to consider the rights of patients from a true construction of the Ordinance, in the light of the wider context of its legislative and the common law background.

149. Our view is therefore that in the present case, Dr Li should disclose Item 4 to the Appellant. If indeed Dr Li should claim such a lien in future, she has to justify her rates are reasonable.

150. We would express our thanks to the Appellant and the Respondent's legal representative for their helpful submissions and assistance to look into this rather complicated and controversial aspect of the data privacy law against the background of patients' medical and health records.



(Mr Andrew Mak)
Deputy Chairman
Administrative Appeals Board