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Analysis of *Breen v Williams*: A Critical Examination of the Doctor-Patient Fiduciary Relationship

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Abstract

This paper critically examines *Breen v Williams*, where the High Court of Australia rejected the view that doctors owe fiduciary duties to grant patients access to medical records. By restricting fiduciary obligations to negative duties, the Court overlooked patient vulnerability, trust, and the therapeutic realities of healthcare. Drawing on Canadian jurisprudence, particularly *McInerney v MacDonald*, the paper highlights the divergence from international approaches that affirm positive disclosure duties. It argues for a reformed fiduciary framework aligned with patient autonomy, while noting that legislative reforms, such as the Health Records and Information Privacy Act 2002 (NSW), have partially addressed these gaps.

Keywords: *Breen v Williams*, doctor-patient relationship, fiduciary duty, access to medical records, patient rights, information privacy

1. Introduction

The landmark case of *Breen v Williams* represents a vital moment in Australian medical law with regard to the nature of the doctor-patient relationship. However, the decision has been criticised for failing to acknowledge the full complexity of the doctor-patient relationship. In this case, the High Court unanimously rejected the argument that a doctor undertakes a fiduciary duty to grant patients access to their medical records. While this approach may reflect a traditional understanding of fiduciary law, it fails to capture the relational, informational, and moral dimensions that define modern healthcare.

In light of this criticism, this paper analyses the High Court's reasoning in *Breen*, highlighting its doctrinal limitations and practical consequences. It examines relevant case law and academic commentary, including Canadian jurisprudence and post-*Breen* Australian developments. It also considers reform proposals such as the Appointed Fiduciary Model and Fiduciary Informed Consent. This paper agrees that a reformed, context-sensitive fiduciary framework is essential to better protect patient rights and reflect the relational realities of modern healthcare.

2. The High Court's Reasoning

In *Breen v Williams*, Ms Breen was a former patient of Dr. Williams. She requested permission to review and copy all the medical

records of her diagnosis and treatment for another class action in the United States. The High Court rejected her claim based on five grounds, including that no fiduciary duty obliged Dr. Williams to provide such access.

The majority, particularly Brennan CJ and Gaudron and McHugh JJ, held that the fiduciary relationship between doctors and patients occurs in limited circumstances. Brennan CJ stated that fiduciary duties do not impose positive obligations to act in another's interests, but rather restrain a fiduciary from acting against the interests of the principal.[1] Gaudron and McHugh JJ asserted that where the doctor-patient relationship is characterised by trust, confidence and the patient's inherent vulnerability, fiduciary obligations arise.[2] It mainly relates to the doctor's conduct in providing diagnosis, advice, and treatment.[3] Although the judges acknowledged aspects of trust and vulnerability in the doctor-patient relationship in this case, they found that these were insufficient to ground a fiduciary duty of disclosure.[4] What's more, they also mentioned the Canadian case of *McInerney v MacDonald*, where a fiduciary duty to disclose medical records was recognised. However, the High Court distinguished it on legal grounds and ultimately declined to follow its reasoning.[5]

Furthermore, the High Court also distinguished between proscriptive (negative) and prescriptive (positive) duties within the doctor-patient relationship. The court held that doctors owe proscriptive fiduciary duties such as the duty to avoid conflicts of interest and to maintain patient confidentiality.[6] But the Court firmly rejected the notion that fiduciary nature of the doctor-patient relationship gives rise to prescriptive duties. In particular, it held that there is no enforceable obligation requiring doctors to grant patients access to their medical records. Brennan CJ stated that while a doctor may be required to provide medical information in certain circumstances—such as where refusal may prejudice the patient's health—this obligation does not extend to granting direct access to or copies of medical records.[7] Arguably, the Court's reasoning affirms that fiduciary duties in the medical context are essentially proscriptive, and any prescriptive duties must be established through legislative reform rather than judicial implication.[8]

3. Criticisms

3.1 Narrow View of Medical Relationships

Legal scholars have argued that the ruling of *Breen v Williams* reflects a misunderstanding of the doctor-patient relationship in the therapeutic reality. Zara J Bending asserts that the High Court's adherence to a narrow contractual model ignores the significance of trust in this relationship.[9] She points out an insufficient recognition of power imbalance in this case. While Brennan CT acknowledged that 'the doctor-patient relationship is one in which the doctor has an ascendancy over the patient and the patient places trust in the doctor,'[10] the court failed to translate this recognition into a comprehensive legal acknowledgment of the doctor-patient relationship's nature.[11]

Some legal scholars also criticised this ruling as overly formalistic. Diana Nestorovska argues that the High Court's rigid application of fiduciary categories ignored the reality that patients entrust their wellbeing, bodies, and personal information to physicians.[12] She observes that although fiduciary law is intended to protect against the abuse of power and dependence, the Court's refusal to recognise any affirmative obligations in *Breen* ultimately undermines equity's protective purpose.[13] She also notes that the judgment reinforces a view of fiduciary obligations as purely proscriptive, which differs from modern ethical and relational approaches to healthcare.[14]

In contrast, the Canadian Supreme Court has taken a more expansive view. In *McInerney v*

[1] *Breen v Williams* (1996) 186 CLR 71, 83 (Brennan CJ).

[2] Ibid 107 (Gaudron and McHugh JJ).

[3] Ibid 107 (Gaudron and McHugh JJ).

[4] Ibid 108 (Gaudron and McHugh JJ).

[5] *McInerney v MacDonald* [1992] 2 SCR 138, 148-9.

[6] *Breen v Williams* (1996) 186 CLR 71, 83 (Brennan CJ), 92-93 (Dawson and Toohey JJ).

[7] Ibid 79 (Brennan CJ).

[8] Ibid 83 (Brennan CJ), 92–94 (Dawson and Toohey JJ).

[9] Zara J Bending. (2015). Reconceptualising the Doctor-Patient Relationship: Recognising the Role of Trust in Contemporary Health Care. *Journal of Bioethical Inquiry*, *12*(2), 189, 190.

[10] *Breen v Williams* (1996) 186 CLR 71, 83 (Breena CJ).

[11] Bending (n 9) 190.

[12] Diana Nestorovska. (2018). Revisiting Breen v Williams: Breathing Life into a Doctor-Patient Fiduciary Relationship. *Journal of Law and Medicine*, *25*(4), 692, 695-6.

[13] Ibid 696.

[14] Ibid 695.

MacDonald, La Forest J held that while medical records may be physically owned by the physician, their contents belong to the patient, and must be disclosed unless disclosure would be harmful.[1] This contrasts starkly with the High Court's property-based rationale in *Breen*. Moreover, in *Norberg v Wynrib*, the Canadian Court found that fiduciary duties applied to a doctor who took advantage of a patient's drug dependency. Therefore, the Court reasoned that the trust and power imbalance in the medical relationship created obligations that went beyond those found in contract or tort law.[2]

3.2 Overly Rigid Distinction of Proscriptive and Prescriptive

The High Court's commitment to the proscriptive/prescriptive distinction has been challenged. In *Breen v Williams*, the Court held that fiduciary duties are limited to proscriptive obligations, obliging the fiduciary only to refrain from obtaining unauthorised benefits or acting in conflict with the interests of the beneficiary.[3] This rigid approach has been criticized for being unrealistic and inadequate in situations where protecting vulnerable individuals calls for affirmative action.[4] Justice Fabian Gleeson points out that although fiduciary duties are said to be purely proscriptive in Australia, courts have often recognised positive obligations (such as disclosure, candour, and loyalty).[5] Importantly, this recognition is not limited to interpersonal contexts; it also extends to duties owed by corporate fiduciaries. In such cases, courts have enforced these obligations even where they require affirmative conduct—for example, taking steps to avoid conflicts of interest through proactive disclosure.[6]

Furthermore, the doctrinal tension is evident in decisions such as *Duncan v Independent Commission Against Corruption*, Justice McDougall acknowledged that proactive measures may be required to fulfil fiduciary duty to avoid conflicts.[7] The *Duncan* expose the limitations of a strict proscriptive model and suggests that functional needs, rather than rigid legal formalism, should guide the identification of fiduciary duties.

3.3 Failure to Recongnise the Therapeutic Reality

Beyond its rigid legal framework, some scholars have challenged *Breen* for failing to reflect the substantive realities faced by patients. Diana Nestorovska argues that the Court obscures the inherently unequal and trust-based nature of medical care.[8] She also emphasises that equity is designed to respond to such vulnerability, and its retreat in *Breen* represents a failure to protect patients' right in the face of informational imbalance.[9]

Zara J Bending similarly criticises the Court for relying on a commercial contract model, which treats the doctor-patient relationship as a transaction between equals.[10] In doing so, the High Court imposed an inappropriate "market logic" that does not suit the healthcare context.[11] By comparison, Bending proposes a "Trust Model" that acknowledges the ethical and relational dimensions of medical care. She argues that patients expect not merely technical competence but also good faith, disclosure of conflicts, and the prioritisation of their interests.[12]

3.4 Inconsistency with International Approach

In addition to domestic scholarly criticism, the High Court's reasoning in *Breen v Williams* places Australian fiduciary jurisprudence at odds with the evolving international trends that favour a more expansive and protective conception of the doctor-patient relationship. In *McInerney v MacDonald*, it demonstrates that Canadian courts have increasingly embraced a functional and ethically grounded fiduciary model. In particular, doctors are under affirmative duties to disclose, inform, and prioritise their patients' interest. As mentioned above, the Supreme Court of Canada held that doctors may retain physical ownership of medical records. However, the informational

[1] *McInerney v MacDonald* [1992] 2 SCR 138, 148-9 (La Forest J).

[2] *Norberg v Wynrib* [1992] 2 SCR 226, 272 (McLachlin J).

[3] *Breen v Williams* (1996) 186 CLR 71, 113 (Gaudron and McHugh JJ).

[4] The Honourable Justice Fabian Gleeson. (2018). Proscriptive and Prescriptive Duties: Is the Distinction Helpful and Sustainable, and If So, What Are the Practical Consequences? *Judicial Review*, *14*, 70, 73-4.

[5] Ibid 74.

[6] Ibid 75-6.

[7] *Duncan v Independent Commission Against Corruption* [2014] NSWSC 1018, [205] (McDougall J).

[8] Nestorovska (n 12) 694-6.

[9] Ibid 697.

[10] Bending (n 11) 190-1.

[11] Ibid 193.

[12] Ibid 194-6.

content belongs to the patient, giving rise to a fiduciary duty of disclosure.[1] La Forest J observed that "the trust reposed in the physician by the patient mandates that the flow of information operate both ways" and that disclosure of medical records is essential to preserving that trust.[2] The judgment clearly rejected the idea that fiduciary duties must be passive or solely restrictive. Instead, it viewed access to information as a fundamental aspect of fiduciary loyalty and a key element in respecting patient autonomy.

By contrast, the High Court in *Breen* declined to adopt these protections, dismissing *McInerney* as inconsistent with Australian law.[3] This divergence raises broader questions about Australia's intolerance in fiduciary reasoning. The aim of fiduciary law is to protect individuals who are vulnerable to the discretion of others. Australia's rejection of prescriptive duties therefore risks undermining the fundamental purpose of fiduciary protection in the medical context.

4. Doctrinal and Practical Consequences

4.1 Inadequate Protection of Patient Rights

As a result of the restrictive approach adopted in *Breen v Williams*, a doctrinal gap has emerged in the protection of patient rights. By refusing to recognise affirmative fiduciary duties, the decision offers no legal mechanism. Arguably, there is no legal mechanism to ensure that doctors provide patients with access to information, support their decision-making, or prioritise their best interests. As Diana Nestorovska observes, the Court's narrow view of fiduciary law overlooks the trust, dependency, and informational asymmetry that define modern health care.[4] Patients entrust their well-being, bodies, and confidential information to doctors—yet *Breen* provides no positive obligations to match that trust.[5]

4.2 Regressive Effect on the Doctor-Patient Relationship

The ruling also risks undermining the development of ethical and relational models of care. Zara J Bending critiques the Court for applying a "market logic" to the therapeutic context, treating the relationship as a transaction between equals.[6] This framing ignores the emotional, ethical, and informational dimensions of medical care, where patients often seek support, reassurance, and shared decision-making. Without a legal duty to disclose or guide, the doctor-patient relationship may default to formality and detachment, leaving patients without the relational support they need.[7]

4.3 Doctrinal Rigidity and Erosion of Fiduciary Law

Finally, *Breen* imposes a rigid proscriptive model on fiduciary law that undermines its broader protective purpose. Fiduciary doctrine is designed to evolve across contexts, protecting beneficiaries wherever there is vulnerability and power imbalance.[8] Yet by declaring fiduciary duties to be inherently proscriptive, the High Court restricts this flexibility and risks causing fiduciary law to become rigid and outdated.[9] Moreover, Gleeson J has criticised *Breen*'s formulation as being more formalistic than substantive. He points out that in many real-world scenarios, a failure to act—such as a failure to inform or guide—may have the same practical consequences as disloyal or self-interested conduct.[10] He argues that a rule which denies fiduciary liability for omissions, even when they amount to betrayal of trust, undermines the very purpose of fiduciary law.

By locking fiduciary doctrine into a formalistic and static framework, *Breen* weakens its capacity to respond to contemporary ethical and relational challenges. A failure to update this approach may erode public confidence in fiduciary protections, and diminish the law's normative force in contexts where it is most needed.

5. Recommendations for Reform

In light of the doctrinal shortcomings exposed by *Breen v Williams*, several models of reform should be considered to protect patients' rights. These reforms aim to re-align fiduciary law in medical settings to recognise patients' inherent dependence and vulnerability. Besides, they also

[1] *McInerney v MacDonald* [1992] 2 SCR 138, 148-9.

[2] Ibid 149 (La Forest J).

[3] *Breen v Williams* (1996) 186 CLR 71, 112-13 (Gaudron and McHugh JJ).

[4] Nestorovska (n 12) 696-7.

[5] Ibid 695-6.

[6] Bending (n 9) 193-4.

[7] Ibid 194-6.

[8] *Hospital Products Ltd v United States Surgical Corporation* (1984) 156 CLR 41, 97 (Mason J).

[9] *Breen v Williams* (1996) 186 CLR 71, 113 (Gaudron and McHugh JJ); see also Gleeson (n 18) 74.

[10] Gleeson (n 18) 75-6.

acknowledge that doctors possess both the specialised expertise and the ethical duty to guide patients in making informed treatment decisions.

The first one is the appointed fiduciary model developed by Davies and Parker. In their opinions, patients can choose to formally allow their doctor to help make decisions on their behalf.[1] This approach does not assume that every doctor-patient relationship works the same way. Instead, the doctor may act mainly as an adviser, or may take a more active role if the patient requests it.[2] This model agrees that not all patients want to make decisions alone especially those feel overwhelmed or uncertain. Moreover, it provides a respectful and structured way for doctors to help without taking away the patient's freedom to decide.

Another recommendation comes from Ludewig and colleagues. They propose a more ethical and patient-centred approach to medical decision-making. They suggest that the doctor-patient relationship should be based on mutual trust and shared responsibility, not just on legal duties.[3] In consequence, they introduce the idea of fiduciary informed consent. Under this model, doctors should not only provide information but also take time to understand the patient's values, needs and preferences. What's more, doctors should take the responsibility to help the patients make decision that reflect what matters most of them.[4] This does not mean doctors should make decisions for patients, but rather that they should work with patients to guide them in a respectful and supportive way.

Both models challenge the rigid legal rule in *Breen*, which says doctors only need to avoid conflicts of interest or personal gain. Instead, it is suggested that doctors sometimes have a positive duty to assist, inform, and guide, especially when patients ask for help. This would bring fiduciary law closer to modern expectations in healthcare, where patients are treated as partners, not just as recipients of care.

[1] Ben Davies and Joshua Parker. (2022). Doctors as Appointed Fiduciaries: A Supplemental Model for Medical Decision-Making. *Cambridge Quarterly of Healthcare Ethics*, *31*(1), 23, 24.

[2] Ibid 25-6.

[3] Sophie Ludewigs et al. (2025). Ethics of the Fiduciary Relationship Between Patient and Physician: The Case of Informed Consent. *Journal of Medical Ethics*, *51*(1), 59, 60-1.

[4] Ibid 62-3.

6. Legislative and Policy Development

6.1 Legislation

After the High Court declined to recognise a fiduciary right of access to medical records in *Breen v Williams*, legislative measures soon became the dominant approach to advancing reform. In New South Wales, the *Health Records and Information Privacy Act 2002* (NSW) grants patients a legally enforceable right to access their personal health information. These include situations where access would pose a serious threat to life or health, unreasonably impact the privacy of others, prejudice legal proceedings or investigations, reveal sensitive negotiation intentions, or where access is prohibited or required to be denied by law.[5] Similarly, the *Privacy Act 1988* (Cth), through the *Australian Privacy Principles* (APPs), provides comprehensive access and correction rights about health information held by Commonwealth-regulated entities.[6] All of these provide strong safeguards for protecting the legitimate rights and interests of patients in the medical-patient relationship. These statutory developments have filled the normative gap left by *Breen*, establishing patient access rights as a matter of privacy and administrative fairness rather than equity.

6.2 Case

Subsequent case law demonstrates a judicial trend toward strengthening the obligations owed by medical professionals to patients. It is with regret that this evolution has primarily occurred within the boundaries of negligence law, rather than through a direct expansion of fiduciary duties as recognised at common law.

In *Cattanach v Melchior*, the Court examined a situation where a doctor failed to inform a patient about an undiscovered fallopian tube before a sterilisation procedure.[7] The judges considered the issue whether the doctor could be held liable for the financial costs of raising a healthy child as a result. The majority held that a doctor could be found liable in negligence for failing to provide material information that might affect a patient's reproductive choices. While the judgment underscored the importance of disclosure in sensitive medical contexts, the

[5] *Health Records and Information Privacy Act 2002* (NSW) pt 4, div 1.

[6] *Privacy Act 1988* (Cth) sch 1.

[7] *Cattanach v Melchior* (2003) 215 CLR 1, 41-42 (Gummow and Kirby JJ), 95 (Callinan J).

Court did not identified this duty as fiduciary in nature. Instead, the obligation was based on the tortious duty of care. This principle requires doctors to exercise reasonable skill and to disclose information that a reasonable person in the patient's position would want to know.[1]

In *Hunter Area Health Service v Presland*, the NSW Court of Appeal rejected a psychiatric patient's claim in negligence after he committed a violent act following hospital discharge.[2] The Court declined to impose a duty of care in the circumstances and made no attempt to frame the medical professionals' obligations as fiduciary. Rather than extending fiduciary doctrines, the case shows that judges are reluctant to broaden liability in mental health situations. This is especially apparent in cases involving complex clinical decisions and matters of public interest.

By contrast, *Rogers v Whitaker* marked a significant shift in how courts view doctors' disclosure obligations. The High Court held that a doctor's failure to warn a patient of a rare risk of blindness amounted to negligence, even where the risk was less than one percent.[3] The Court affirmed that patients have the right to make informed decisions about their medical treatment. It also held that a doctor's duty to warn is not governed by medical custom, but by whether the information is materially significant to the individual patient.[4] Although the case was decided in negligence, scholars have interpreted it as laying the foundation for a more relational and patient-centred approach. This interpretation aligns with the underlying rationale of fiduciary obligations.[5]

Thus, while Australian courts have been reluctant to formally expand fiduciary duties in the medical context beyond their traditional proscriptive scope, cases such as *Rogers v Whitaker* reflect a growing judicial emphasis on affirmative duties. This shift aligns with ethical principles that support patient autonomy, trust, and recognition of vulnerability.

7. Conclusion

The High Court's decision in *Breen v Williams* marks a pivotal moment in Australian medical law. However, its restrictive interpretation of fiduciary obligations in the doctor-patient relationship remains deeply problematic. By maintaining a rigid distinction between proscriptive and prescriptive duties, the Court overlooked the nuanced realities of patient vulnerability and the dynamics of trust inherent in contemporary healthcare. This has left significant gaps in legal protection for patients, particularly where breaches of trust do not involve personal interests.

This position diverges sharply from international jurisprudence. Canada Courts there have recognised that fiduciary duties in healthcare may require affirmative action, such as disclosure, guidance, and prioritisation of patient interests. While subsequent Australian case law has shown a growing judicial appreciation of patient autonomy and trust, this has occurred mainly in areas such as informed consent and medical disclosure. What's more, this evolution remains limited in its reach. These developments have generally taken place within the boundaries of negligence law, rather than through a direct expansion of fiduciary doctrine.

The ongoing reliance on legislative intervention, such as the *Health Records and Information Privacy Act 2002* (NSW) and the *Privacy Act 1988* (Cth), has begun to address the gaps left by *Breen*. However, statutory reforms alone cannot resolve the doctrinal and relational shortcomings of the High Court's approach. Reform models—such as the Appointed Fiduciary framework and Fiduciary Informed Consent—provide a blueprint for recalibrating fiduciary law to better reflect patient dependence, autonomy, and the ethical responsibilities of doctors.

In sum, a broader, context-sensitive reframing of fiduciary duties in the medical sphere is both possible and necessary. Fiduciary law can fulfil its purpose only by moving beyond formalistic limitations. It would benefit from adopting a more relational and protective approach. This approach ensures that people who place their trust and wellbeing in the hands of medical professionals are meaningfully protected in both law and practice.

References

Ben Davies and Joshua Parker. (2022). Doctors as Appointed Fiduciaries: A Supplemental Model for Medical Decision-Making.

[1] Ibid 16-17 (Gleeson CJ).

[2] *Hunter Area Health Service v Presland* [2005] NSWCA 33, [100]-[110] (Spigelman CJ); see also [21]-[22], [142]-[144] (Ipp JA).

[3] *Rogers v Whitaker* (1992) 175 CLR 479, 489-490 (Brennan J).

[4] Ibid 490-491.

[5] McLean, Sheila. (2002). What Do We Mean by "Fiduciary Duty" in Medical Law? *Medical Law Review*, *20*(2), 129, 136-138.

Cambridge Quarterly of Healthcare Ethics, *31*(1), 23, 24.

Diana Nestorovska. (2018). Revisiting Breen v Williams: Breathing Life into a Doctor-Patient Fiduciary Relationship. *Journal of Law and Medicine*, *25*(4), 692, 695-6.

McLean, Sheila. (2002). What Do We Mean by "Fiduciary Duty" in Medical Law? *Medical Law Review*, *20*(2), 129, 136-138.

Sophie Ludewigs et al. (2025). Ethics of the Fiduciary Relationship Between Patient and Physician: The Case of Informed Consent. *Journal of Medical Ethics*, *51*(1), 59, 60-1.

The Honourable Justice Fabian Gleeson. (2018). Proscriptive and Prescriptive Duties: Is the Distinction Helpful and Sustainable, and If So, What Are the Practical Consequences? *Judicial Review*, *14*, 70, 73-4.

Zara J Bending. (2015). Reconceptualising the Doctor-Patient Relationship: Recognising the Role of Trust in Contemporary Health Care. *Journal of Bioethical Inquiry*, *12*(2), 189, 190.