McInerney *v.* MacDonald, [1992] 2 S.C.R. 138

Elizabeth A. McInerney *Appellant*

v.

Margaret R. MacDonald *Respondent*

Indexed as: McInerney *v.* MacDonald

File No.: 21899.

1992: February 5; 1992: June 11.

Present: La Forest, L'Heureux-Dubé, Gonthier, Stevenson[*] and Iacobucci JJ.

on appeal from the court of appeal for new brunswick

Physicians and surgeons -- Medical records -- Patient's right of access -- Patient requesting copies of her complete medical records -- Patient's physician delivering copies of her notes but refusing to produce copies of reports and records received from other physicians -- No legislation in province regulating patient's access to information contained in medical records -- Whether patient entitled to inspect and obtain copies of her medical records upon request.

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 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.

Held: The appeal should be dismissed.

In the absence of legislation, a patient is entitled, upon request, to examine and copy all information in her medical records which the physician considered in administering advice or treatment, including records prepared by other doctors that the physician may have received. Access does not extend to information arising outside the doctor-patient relationship. The patient is not entitled to the records themselves. The physical medical records of the patient belong to the physician.

The physician-patient relationship is fiduciary in nature and certain duties arise from that special relationship of trust and confidence. These include the duties of the doctor to act with utmost good faith and loyalty, to hold information received from or about a patient in confidence, and to make proper disclosure of information to the patient. The doctor also has an obligation to

grant access to the information used in administering treatment. This fiduciary duty is ultimately grounded in the nature of the patient's interest in the medical records. Information about oneself revealed to a doctor acting in a professional capacity remains, in a fundamental sense, one's own. While the doctor is the owner of the actual record, the information is held in a fashion somewhat akin to a trust and 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, she should have a right of access to the information and that the physician should have a corresponding obligation to provide it. The patient's interest being in the information, it follows that the interest continues when that information is conveyed to another doctor who then becomes subject to the duty to afford the patient access to that information. Further, since the doctor has a duty to act with utmost good faith and loyalty, it is also important that the patient have access to the records to ensure the proper functioning of the doctor-patient relationship and to protect the well-being of the patient. Disclosure serves to reinforce the patient's faith in her treatment and to enhance the trust inherent in the doctor-patient relationship. As well, the duty of confidentiality that arises from the doctor-patient relationship is meant to encourage disclosure of information and communication between doctor and patient. The trust reposed in the physician by the patient mandates that the flow of information operate both ways.

The patient's general right of access to medical records is not absolute. If the physician reasonably believes it is not in the patient's best

interests to inspect the medical records, the physician may consider it necessary to deny access to the information. Considering the equitable base of the patient's entitlement, when a physician refuses a request for access, the patient may apply to the court for protection against an improper exercise of the physician's discretion. The court will then exercise its superintending jurisdiction and may order access to the records in whole or in part. The onus lies on the physician to justify a denial of access. Patients should have access to their medical records in all but a small number of circumstances. In the ordinary case, these records should be disclosed upon the patient's request unless there is a significant likelihood of a substantial adverse effect on her physical, mental or emotional health or harm to a third party.

Here, there is no evidence that access to the records would cause harm to the patient or a third party; nor does the doctor offer other compelling reasons for non-disclosure. Accordingly, the patient is entitled to her medical records.

Cases Cited

Referred to: *R. v. Dyment*, [1988] 2 S.C.R. 417; *Halls v. Mitchell*, [1928] S.C.R. 125; *Kenny v. Lockwood*, [1932] O.R. 141; *Henderson v. Johnston*, [1956] O.R. 789; *Canson Enterprises Ltd. v. Boughton & Co.*, [1991] 3 S.C.R. 534; *Reibl v. Hughes*, [1980] 2 S.C.R. 880; *Emmett v. Eastern Dispensary and Casualty Hospital*, 396 F.2d 931 (1967); *Cannell v. Medical and Surgical Clinic*, 315 N.E.2d 278 (1974); *Re Mitchell and St. Michael's Hospital* (1980), 112 D.L.R. (3d) 360; *Guerin v. The Queen*, [1984] 2 S.C.R. 335; *Strazdins v. Orthopaedic & Arthritic Hospital Toronto* (1978), 7 C.C.L.T. 117.

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APPEAL from a judgment of the New Brunswick Court of Appeal (1990), 103 N.B.R. (2d) 423, 259 A.P.R. 423, 66 D.L.R. (4th) 736, affirming a judgment of Turnbull J., ordering a physician to provide copies of medical records to a patient. Appeal dismissed.

B. A. Crane, *Q.C.*, and *Wayne Brynaert*, for the appellant.

J. George Byrne and *Barry R. Morrison*, as *amici curiae*, for the respondent.

//*La Forest J.*//

The judgment of the Court was delivered by

LA FOREST J. -- The central issue in this case is whether in the absence of legislation a patient is entitled to inspect and obtain copies of his or her medical records upon request.

Facts

The facts are simple. The appellant, Dr. Elizabeth McInerney, is a medical doctor who is licensed to practise in New Brunswick. The respondent,

Mrs. Margaret MacDonald, was her patient. Before her consultations with Dr. McInerney, Mrs. MacDonald was treated by various physicians over a period of years. On Dr. McInerney's advice, Mrs. MacDonald ceased taking thyroid pills previously prescribed by other physicians. She then became concerned about her medical care before consulting Dr. McInerney, and wrote the latter requesting 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, stating that they were the property of those physicians and that it would be unethical for her to release them. She suggested that Mrs. MacDonald contact the other physicians for release of their records.

An application was then made on behalf of Mrs. MacDonald to the New Brunswick Court of Queen's Bench for an order directing Dr. McInerney to provide a copy of her entire medical file relating to Mrs. MacDonald. Turnbull J. granted the application. The appeal to the Court of Appeal of New Brunswick was dismissed, Rice J.A. dissenting: (1990), 103 N.B.R. (2d) 423, 259 A.P.R. 423, 66 D.L.R. (4th) 736. Dr. McInerney then sought and was granted leave to appeal to this Court, [1990] 2 S.C.R. viii.

Following the judgment of Turnbull J., copies of the requested records were filed with the court, and at some point Mrs. MacDonald obtained a copy of the filed material. That being so, she had no interest in contesting the appeal. Given the importance of the issues, however, her counsel appeared before the Court as*amici curiae*.

The Courts Below

Court of Queen's Bench (Trial Division)

Turnbull J. equated the law respecting physicians with that relating to the legal profession. He stated:

> Ownership of documents prepared by a lawyer on behalf of a client rests with the client in a solicitor-client relationship and with the patient in a physician-patient relationship. To me it is akin to a person engaging an artist to paint a portrait. When paid for it belongs to that person, and not the artist. The Government pays the doctor in the physician-patient relationship and the patient pays the Government. To me anything further is complicating what should be clear. In our mobile society many people prefer to keep complete dossiers on their medical records, not only for themselves, but their children.

Consequently, Turnbull J. concluded, the patient has a sufficient property interest in the photocopy of documents prepared by other physicians to request an additional photocopy from his or her physician without having to go back to the other physicians to obtain a photocopy of the original.

Court of Appeal (1990), 103 N.B.R. (2d) 423

Ryan J.A., Hoyt J.A. concurring, noted that, unlike some provinces, there was no legislation in New Brunswick regulating a patient's access to the information contained in his or her medical record. He also observed that a noticeable trend has developed favouring an individual's right of access to personal information.

Ryan J.A. stated that the issue was not ownership but the right of the patient to have access to his or her medical record. He focused on the contractual relationship between the parties. In his view, Mrs. MacDonald's contract for treatment included an implied contract for information relating to the treatment. He stated, at p. 439:

> I imply a right in the patient of access to all the information in her chart which the physician considered in providing professional services to the patient subject only to regulatory legislation and any superintending role which a court may assume. To my mind, the supervisory responsibility must rest with the courts as guided by the common law or regulations adopted by the state. People must generally have access to all the information in their charts. We live in a mobile society with a growing emphasis on access to information. This claim to information is simply one facet of a many sided repository of rights aimed at self-determination insisted upon by Canadians today. To hold otherwise would plunge the judgment making power of whether or not to grant access into a sea of subjective decisions.

Ryan J.A. concluded that, subject to the court's supervisory role, a patient has a right of access to material in his or her record if it relates to the treatment or advice provided by the physician to the patient. Since Mrs. MacDonald had a right to copies of documentation in her record, there was no purpose in forcing her to make individual demands upon the other five doctors or to commence similar lawsuits against them. He, therefore, dismissed the appeal.

Rice J.A., dissenting, observed that even in a solicitor-client relationship, a client does not enjoy a right to the notes made by a solicitor for the benefit of the solicitor in rendering services for a client. He pointed out that the

court has ruled in several decisions that the solicitor is the owner of such notes and need not transmit them to the client. Since the contents of the records sought were unknown, it was impossible to ascertain their ownership.

If the question was not one of ownership but one of a right to information, it was not clear to Rice J.A. on what legal basis this right rested. In the absence of legislation, the only possible applicable principle would be that of an implied term to the contract of service between the physician and the patient. Rice J.A. noted that courts, in certain circumstances, have imposed a term to a contract by implying that the parties had intended to agree to what was fair and reasonable having regard to the interest of both parties and the object of the contract. However, he held, at p. 430:

> Taking into account the guidelines of the Canadian Medical Association which restrict a physician to disclose the information contained in a physician's record, I cannot conclude that the appellant would have agreed to such a term had the matter been discussed with the respondent.
>
> Notwithstanding, to imply such a term in this contract of service between the appellant and respondent would unduly extend the existing principles of contract law. Essentially, the physician (appellant) undertook to provide a service, and the respondent to pay for it through the Medicare provisions of the related legislation in this province. To imply a term in that relationship as suggested would, in my view, go beyond an ordinary and incremental evolution of the law of contract established through precedents, and to transcend the power of the judiciary to change that law.

Although legislation could provide patients with a right of access to their records, in its absence, Rice J.A. did not see fit to alter established rules of law. He would have allowed the appeal and set aside the order of Turnbull J.

Issues

The appellant raises two issues in this appeal:

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?

Analysis

The current position of the medical profession with respect to the right of patients to information in their medical records is reflected in the policy statement of the Canadian Medical Association published in 1985:

CONFIDENTIALITY, OWNERSHIP AND TRANSFER OF MEDICAL RECORDS

The Canadian Medical Association (CMA) regards medical records as confidential documents, owned by the physician/institution/clinic that compiled them or had them compiled. Patients have a right to medical information contained in their records but not to the documents themselves. The first consideration of the physician is the well-being of the patient, and discretion must be used when conveying information contained in a medical record to a patient. This medical information often requires interpretation by a physician or other health care professional. Other disclosures of information contained in medical records to third parties (eg. physician-to-physician transfer for administrative purposes, lawyer, insurance adjuster) require written

> patient consent or a court order. CMA is opposed to legislation at any level which threatens the confidentiality of medical records.

I am 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. The majority of the Court of Appeal based the patient's right of access on an implied contractual term. While it may be possible to pursue the contractual route in the civil law system, I do not find it particularly helpful in the common law context. Accordingly, I am not entirely comfortable with the approach taken by the Court of Appeal. However, I do agree that a patient has a vital interest in the information contained in his or her medical records.

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

> The twentieth century has seen a vast expansion of the health care services. Rather than relying on one individual, a physician, the patient now looks directly and indirectly to dozens and sometimes hundreds of individuals to provide him with the services he requires. He is cared for not simply by his own physician but by a veritable army of nurses, numerous consulting physicians, technologists and technicians, other allied health personnel and administrative personnel.

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. Each of the pieces of information provided by this "army" of

health care workers joins with the other pieces to form the complete picture. As the number and use of specialists increase, the more difficult it is for the patient to gain access to that picture. If the patient is only entitled to obtain particular information from each health care provider, the number of contacts he or she may be required to make may become enormous. The problem is intensified when one considers the mobility of patients in modern society.

Medical records are also used for an increasing number of purposes. This point is well made by A. F. Westin, *Computers, Health Records, and Citizen Rights* (1976), at p. 27:

> As to medical records, when these were in fact used only by the physician or the hospital, it may have been only curiosity when patients asked to know their contents. But now that medical records are widely shared with health insurance companies, government payers, law enforcement agencies, welfare departments, schools, researchers, credit grantors, and employers, it is often crucial for the patient to know what is being recorded, and to correct inaccuracies that may affect education, career advancement or government benefits.

This then is the general context in which medical records are compiled and the broad purposes they serve in our day. The nature of the information contained in medical records must now be examined.

When a patient approaches a physician for health care, he or she discloses sensitive information concerning personal aspects of his or her life. The patient may also bring into the relationship information relating to work done by other medical professionals. The policy statement of the Canadian Medical Association cited earlier indicates that a physician cannot obtain access to this

information without the patient's consent or a court order. Thus, at least in part, medical records contain information about the patient revealed by the patient, and information that is acquired and recorded on behalf of the patient. Of primary significance is the fact that 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. As counsel for the respondent put it in oral argument: "[The respondent] wanted access to information on her body, the body of Mrs. MacDonald." In *R. v. Dyment*, [1988] 2 S.C.R. 417, at p. 429, I noted that such information remains in a fundamental sense one's own, for the individual to communicate or retain as he or she sees fit. Support for this view can be found in *Halls v. Mitchell*, [1928] S.C.R. 125, at p. 136. There Duff J. held 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. In sum, an individual may decide to make personal information available to others to obtain certain benefits such as medical advice and treatment. Nevertheless, as stated in the report of the Task Force on *Privacy and Computers* (1972), at p. 14, he or she has a "basic and continuing interest in what happens to this information, and in controlling access to it".

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. In *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. This statement was referred to with approval by LeBel J. in *Henderson v. Johnston*, [1956] O.R. 789, who himself characterized the physician-patient relationship as "fiduciary and confidential", and went on to say: "It is the same relationship as that which exists in equity between a parent and his child, a man and his wife, an attorney and his client, a confessor and his penitent, and a guardian and his ward" (p. 799). Several academic writers have similarly defined the physician-patient relationship as a fiduciary or trust relationship; see, for example, E. I. Picard, *Legal Liability of Doctors and Hospitals in Canada* (2nd ed. 1984), at p. 3; A. Hopper, "The Medical Man's Fiduciary Duty" (1973), 7 *Law Teacher* 73; A. J. Meagher, P. J. Marr and R. A. Meagher, *Doctors and Hospitals: Legal Duties* (1991), at p. 2; M. V. Ellis, *Fiduciary Duties in Canada* (1988), at p. 10-1. I agree with this characterization.

In characterizing the physician-patient relationship as "fiduciary", I would not wish it to be thought that a fixed set of rules and principles apply in all circumstances or to all obligations arising out of the doctor-patient relationship. As I noted in *Canson Enterprises Ltd. v. Boughton & Co.*, [1991] 3 S.C.R. 534, not all fiduciary relationships and not all fiduciary obligations are the same; these are shaped by the demands of the situation. A relationship may properly be described as "fiduciary" for some purposes, but not for others. That being said, certain duties do arise from the special relationship of trust and confidence between doctor and patient. Among these are the duty of the doctor to act with utmost good faith and loyalty, and to hold information received from or about a patient in confidence. (Picard, *supra*, at pp. 3 and 8; Ellis, *supra*, at pp. 10-1 and 10-12, and Hopper, *supra*, at pp. 73-74.) When a patient releases

personal information in the context of the doctor-patient relationship, he or she does so with the legitimate expectation that these duties will be respected.

The physician-patient relationship also gives rise to the physician's duty to make proper disclosure of information to the patient; see *Reibl v. Hughes*, [1980] 2 S.C.R. 880, at p. 884; and *Kenny v. Lockwood*,*supra*, at p. 155. The appellant concedes that a patient has a right to be advised about the information concerning his or her health in the physician's medical record. In my view, however, the fiducial qualities of the relationship extend the physician's duty beyond this to include the obligation to grant access to the information the doctor uses in administering treatment. This approach has been taken by one stream of American cases. In *Emmett v. Eastern Dispensary and Casualty Hospital*, 396 F.2d 931 (D.C. Cir. 1967), Robinson J. held, at p. 935, that the fiducial qualities of the physician-patient relationship impose a duty on the physician "to reveal to the patient that which in his best interests it is important that he should know". Thus, in that case, the decedent patient's son was entitled to inspect the decedent's medical records. Similarly, in*Cannell v. Medical and Surgical Clinic*, 315 N.E.2d 278 (Ill. App. Ct. 1974), the court, having referred to the decision in *Emmett*, held that the fiducial qualities of the physician-patient relationship require the disclosure of medical data to a patient or his agent upon request, and that the patient need not engage in legal proceedings to obtain the information.

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

of trust and confidence. The information conveyed is held in a fashion somewhat akin to a trust. 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.

Certain textbooks and case law go further and assert that the patient has a "proprietary" or "property" interest in the medical records. For example, Meagher et al., *supra*, write, at p. 289:

> In the absence of an agreement, a doctor or hospital owns the records of the patient, but the patient is considered to have a property interest in the medical information contained in the record, with a right of access to it, but not to its possession.

Judicial support for the "proprietary interest" of the patient can be found in *Re Mitchell and St. Michael's Hospital* (1980), 112 D.L.R. (3d) 360 (Ont. H.C.). Although Maloney J. there held that he did not have jurisdiction to order the release of hospital records on an originating notice of motion, he had this to say, at p. 364:

> By virtue of s. 11 of the [*Public Hospitals Act*, R.S.O. 1970, c. 378], medical records are "the property of the hospital and shall be kept in the custody of the administrator", but it seems to me that a patient, or the personal representative of a deceased patient, has something akin to a proprietary interest in the contents of those records and s. 11 should in no way operate to prevent appropriate inspection or provision of copies.

A similar sentiment is expressed in the American text by R. D. Miller, *Problems in Hospital Law*(4th ed. 1983). The author has this to say, at pp. 276-77:

> The medical record is an unusual type of property because physically it belongs to the hospital and the hospital must exercise considerable control over access, but the patient and others have an interest in the information in the record. One way of viewing this is that the hospital owns the paper or other material on which the information is recorded, but it is just a custodian of the information. Thus, as stated in *Cannell v. Medical and Surgical Clinic*, 21 Ill.App.3d 383, 315 N.E.2d 278 (1974), the patient and others have a right of access to the information in many circumstances, but they do not have a right to possession of the original records.

I find it unnecessary to reify the patient's interest in his or her medical records and, in particular, I am not inclined to go so far as to say that a doctor is merely a "custodian" of medical information. The fiduciary duty I have described is sufficient to protect the interest of the patient. 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. The patient's interest being in the information, it follows that the interest continues when that information is conveyed to another doctor who then becomes subject to the duty to afford the patient access to that information.

There is a further matter that militates in favour of disclosure of patient records. As mentioned earlier, one of the duties arising from the doctor-patient relationship is the duty of the doctor to act with utmost good faith and loyalty. If the patient is denied access to his or her records, it may not be possible

for the patient to establish that this duty has been fulfilled. As I see it, it is important that the patient have access to the records for the very purposes for which it is sought to withhold the documents, namely, to ensure the proper functioning of the doctor-patient relationship and to protect the well-being of the patient. 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.

Disclosure is all the more important in our day when individuals are seeking more information about themselves. It serves to reinforce the faith of the individual in his or her treatment. The ability of a doctor to provide effective treatment is closely related to the level of trust in the relationship. A doctor is in a better position to diagnose a medical problem if the patient freely imparts personal information. The duty of confidentiality that arises from the doctor-patient relationship is meant to encourage disclosure of information and communication between doctor and patient. In my view, the trust reposed in the physician by the patient mandates that the flow of information operate both ways. As B. Knoppers puts it in "Confidentiality and Accessibility of Medical Information: A Comparative Analysis" (1982), 12 *R.D.U.S.* 395, at p. 431:

> In a relationship often characterized as fiduciary, that is, based on mutual trust and confidence, reciprocity implies an exchange. The personal privacy of the patient which he entrusts to a certain extent to the physician must be met with a corresponding openness and full disclosure. . . . Personal privacy and access to medical information are not incompatible partners but interchangeable rights.

Robinson J., in *Emmett*, *supra*, at p. 935, note 19, also notes the link between disclosure of medical records and doctor-patient trust: "The duty of disclosure is a concomitant of the patient's inescapable reliance upon the unadulterated good faith as well as the professional skill of those to whom he has entrusted his treatment." Rather than undermining the trust inherent in the doctor-patient relationship, access to medical records should enhance it. Indeed, H. E. Emson observes that the practice of giving patients their own records "has been said to improve patient understanding, cooperation and compliance"; see *The Doctor and the Law: A Practical Guide for the Canadian Physician* (2nd ed. 1989), at p. 214. In this sense, reciprocity of information between the patient and physician is *prima facie* in the patient's best interests. It strengthens the bond of trust between physician and patient which, in turn, promotes the well-being of the patient.

While patients should, as a general rule, have access to their medical records, this policy need not and, in my mind, should not be pursued blindly. The related duty of confidentiality is not absolute. In *Halls v. Mitchell*, *supra*, at p. 136, Duff J. stated that, *prima facie*, the patient has a right to require that professional secrets acquired by the practitioner shall not be divulged. This right is absolute unless there is some paramount reason that overrides it. For example, "there may be cases in which reasons connected with the safety of individuals or of the public, physical or moral, would be sufficiently cogent to supersede or qualify the obligations *prima facie* imposed by the confidential relation". Similarly, the patient's general right of access to his or her records is not absolute. The patient's interest in his or her records is an equitable interest arising from the physician's fiduciary obligation to disclose the records upon

request. As part of the relationship of trust and confidence, the physician must act in the best interests of the patient. 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. 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. In other words, the physician has a discretion to deny access, but it is circumscribed. It must be exercised on proper principles and not in an arbitrary fashion. Where a person, in this case a doctor, is under a fiduciary duty to inform another, equity acts *in personam* to prevent that person from acting in a manner inconsistent with the interests of the person to whom the duty is owed. As stated by Dickson J. (as he then was) in *Guerin v. The Queen*, [1984] 2 S.C.R. 335, at p. 384:

> . . . where by statute, agreement, or perhaps by unilateral undertaking*, one party has an obligation to act for the benefit of another, and that obligation carries with it a discretionary power, the party thus empowered becomes a fiduciary. Equity will then supervise the relationship by holding him to the fiduciary's strict standard of conduct.

I hasten to add that, just as a relationship may be fiduciary for some purposes and not for others, this characterization of the doctor's obligation as "fiduciary" and the patient's interest in the records as an "equitable interest" does not imply a particular remedy. Equity works in the circumstances to enforce the duty. This foundation in equity gives the court considerable discretion to refuse access to the records where non-disclosure is appropriate.

In my view, the onus properly lies on the doctor to justify an exception to the general rule of access. Not only is the information in some

fundamental sense that of the patient; the doctor has primary access to it. In comparison, the records are unavailable to the patient. To some extent, what the documents contain is a matter of speculation for the patient. Consequently, there is a marked disparity in the ability of each party to prove its case. The burden of proof should fall on the party who is in the best position to obtain the facts.

If a physician objects to the patient's general right of access, he or she must have reasonable grounds for doing so. Although I do not intend to provide an exhaustive analysis of the circumstances in which access to medical records may be denied, some general observations may be useful. I shall make these in a response to a number of arguments that have been advanced by the appellant and in the literature for denying a patient access to medical records. These include: (1) disclosure may facilitate the initiation of unfounded law suits; (2) the medical records may be meaningless; (3) the medical records may be misinterpreted; (4) doctors may respond by keeping less thorough notes; and (5) disclosure of the contents of the records may be harmful to the patient or a third party.

The argument that patients may commence unfounded litigation if they are permitted to examine their medical records is not a sufficient ground for withholding them. The comments of Eberle J. in *Strazdins v. Orthopaedic & Arthritic Hospital Toronto* (1978), 7 C.C.L.T. 117 (Ont. H.C.), at pp. 119-20, are helpful in this regard. He states:

> . . . I believe that it is part of our system of government and of the administration of justice that persons are entitled to start law suits against persons whom they feel have wronged them. The persons who start such actions do so at the risk of costs, the risk of having the action

> dismissed at some stage if it turns out that it is groundless or even if not groundless turns out to be unsuccessful, and that right of any person to start a law suit does carry with it a correlative obligation on the part of every person in our society; that is, that any one of us may be subject to groundless law suits and it may be that our only weapon to fight them is the penalty in costs. . . . I am not forgetting that if any particular person makes a habit of starting groundless law suits or repetitive law suits against a particular person or persons, there are controls which may be exercised to prevent such matters from occurring.

Denial of access may actually encourage unfounded law suits. If a law suit is started, a patient can generally obtain access to his or her records under rules of civil procedure relating to discovery of documents. Thus, if a patient strongly wishes to see his or her records, one way of achieving this result is to commence an action before ascertaining whether or not there is a valid basis for the action.

The arguments that the records may be meaningless or that they may be misinterpreted do not justify non-disclosure in the ordinary case. If the records are, in fact, meaningless, they will not help the patient but neither will they cause harm. It is always open to the patient to obtain assistance in understanding the file. In the *Report of the Commission of Inquiry into the Confidentiality of Health Information* (Ontario, 1980) (the "Krever Report"), vol. 2, at p. 469, Krever J. expressed the opinion that habitual use of jargon or technical terminology is not a sufficiently sound reason for denying a patient access to health records. He did note, however, that a re-evaluation of record keeping methodology may be necessary if a general rule of access is established. 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.

The concern that disclosure will lead to a decrease in the completeness, candour and frankness of medical records, can be answered by reference to the obligation of a physician to keep accurate records. A failure to do so may expose the physician to liability for professional misconduct or negligence. It is also easy to exaggerate the importance of this argument. Certainly physicians may become more cautious in what they record, but it cannot be assumed as a natural consequence that this will detrimentally affect the standard of care given to the patient. Generally I doubt that the quality of medical records will be measurably affected by a general rule allowing access to the patient. As Krever J. put it in the "Krever Report", *supra*, at p. 487: "I say, at once, that I do not believe that any responsible and ethical physician would omit from a medical record any information that, in the interests of proper medical care, belongs in it because of the possibility that the patient may ask to inspect it."

Non-disclosure may be warranted if there is a real potential for harm either to the patient or to a third party. This is the most persuasive ground for refusing access to medical records. 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. As H. Beatty observes in "The Consumer's Right of Access to Health Care Records" (1986), 3:4 *Just Cause* 3, at p. 3, paternalistic assumptions such as the "best interests of

the patient" may have carried more weight in an era where patients had little education or information with respect to health care and relied upon the trusted family doctor. However, these assumptions "do not apply today, where consumers typically have brief contacts with many health care providers and institutions, none of which knows the person well enough to determine his or her `best interests'". Assessing the "best interests of the patient" is a complex task. Non-disclosure can itself affect the patient's well-being. If access is denied, the patient may speculate as to what is in the records and imagine difficulties greater than those that actually exist. In addition, the physical well-being of the patient must be balanced with the patient's right to self-determination. Both are worthy of protection. In short, patients should have access to their medical records in all but a small number of circumstances. In the ordinary case, these records should be disclosed upon the request of the patient unless there is a significant likelihood of a substantial adverse effect on the physical, mental or emotional health of the patient or harm to a third party.

If a physician refuses a request for access to a patient's medical records, the patient may apply to the court for a remedy. The court will then exercise its superintending jurisdiction and may order access to the records in whole or in part notwithstanding the physician's refusal. Even though the court may ultimately disagree with the physician's view that access should be denied, I have no doubt that in many cases it will be satisfied that the physician acted in good faith in the performance of his or her fiduciary duties. However, if the court is not satisfied that the physician acted in good faith, it should not hesitate to exercise its discretion to grant appropriate relief by way of costs. The general

rule of access should not be frustrated by the patient's fear of incurring costs in the pursuit of what is fundamentally his or her right.

Since I have held that the tangible records belong to the physician, the patient is not entitled to the records themselves. Medical records play an important role in helping the physician to remember details about the patient's medical history. The physician must have continued access to the records to provide proper diagnosis and treatment. Such access will be disrupted if the patient is able to remove the records from the premises. Accordingly, the patient is entitled to reasonable access to examine and copy the records, provided the patient pays a legitimate fee for the preparation and reproduction of the information. Access is limited to the information the physician obtained in providing treatment. It does not extend to information arising outside the doctor-patient relationship.

Conclusion

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. The majority of the Court of Appeal came to essentially the same conclusion, although, as is evident from the above discussion, for different reasons.

In this case, there is no evidence that access to the records would cause harm to the patient or a third party; nor does the appellant offer other compelling reasons for non-disclosure. Accordingly, in my opinion, the lower courts quite properly held that the respondent was entitled to copies of the documentation in her medical chart.

Disposition

I would dismiss the appeal. There should be no order as to costs.

Appeal dismissed.

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