In the Matter Of:

Barbara Wand Seminar

DR. MARGARET WEISER

June 14, 2018

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3 BARBARA WAND SEMINAR IN PROFESSIONAL ETHICS,
4 STANDARDS AND CONDUCT
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7 PRESENTATION OF DR. MARGARET WEISER and Q & A
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1 DR. MARGARET WEISER: (Beginning of
2 presentation not captured on recording) ....As
3 indicated, say no if you're not comfortable if you
4 don't know what to expect. It's very crucial to be
5 mindful of your key role as a clinician. If, in fact,
6 you are a clinician and you have a sense of your own
7 competence and your own area of practice, that is your
8 area, your domain that you have within your own
9 control, and you should also start reaching out for
10 advice and for consultation when you're entering a new
11 area. This is actually a really interesting
12 opportunity to learn more about the areas of forensic
13 psychology and to make friends with a forensic
14 psychologist who can actually cast light on the
15 complexities of that domain.
16 Here is an example of how you might drift
17 into something fully unprepared, and this is an
18 example of a situation that I encountered several
19 years ago in which my clinical opinion was initially
20 sought as a client was recovering from a serious
21 injury, but it soon became a question of preparing for
22 the future and preparing a lawsuit. And so this was a
23 situation where what was initially in my mind, when I
24 was meeting with the client and preparing a detailed
25 assessment, was going to be used in court to plan for

1 the client's future. And these were not questions
2 that were in the clinical situation when we were
3 working together, and so these were not questions I
4 could answer now as an independent expert, not the
5 least the fact that I was not really truly an
6 independent expert because I was well aware of the
7 client's needs and had established a therapeutic
8 relationship.
9 So these are difficult situations where,
10 in fact, it may be still possible to provide a status
11 report to clearly delineate the client's strengths and
12 areas of difficulty, but to offer the opportunity for
13 the legal consultation, to consider talking to another
14 psychologist and to consider widening their scope in
15 terms of looking at vocational assessment, looking at
16 the role of clinical psychology to understand the
17 nature of the client's injury on their family and on
18 children who are under the client's care as well. So
19 again, what seems to be a very brief and simple
20 question at the beginning is one that really needs to
21 be opened up and others may be brought into the
22 equation.
23 It's always important to be mindful that
24 you're writing for a very much broader audience, and
25 what I think sometimes I was not sufficiently aware of

1 when I began writing reports is how many of these
2 reports are actually read by the client and by the
3 client's family, and it's absolutely necessary to try
4 to describe the client's issues in ways that are
5 certainly consistent with our clinical training and
6 with our standards, but at the same time reflect the
7 impact that our words can have on the individual.
8 And when you're working with someone who
9 you're seeing over a period of time, it is useful to
10 capture their own words. This can be quite useful and
11 legitimate when your reports are used to fully
12 describe their challenges in other situations. I have
13 also found it quite interesting when doing independent
14 assessments when the client tends to have a rehearsed
15 narrative of a particular series of events, and this
16 is very telling sometimes that, in fact, you're not
17 really getting to all of the stories about a
18 particular event.
19 You are being given a version that the
20 client is comfortable with, and they may be
21 comfortable with it because they are accustomed to it
22 and it is familiar, but it may only be one of several
23 stories that could be told about that event. So
24 again, as an assessor, you are able to and must be
25 able to consider collateral interviews and challenging

1 the client to some degree, and sometimes to a great
2 degree, with regard to information that would fully
3 help you to understand their presentation.
4 Again, thinking about preparations here
5 for a possible appearance in court, try not to do
6 anything hastily. These are all fairly
7 straightforward suggestions which I'm sure you're
8 familiar with, but I'm continuing to repeat them
9 because it's easy to lose track of your limitations
10 and your own boundaries when you are working on
11 someone else's schedule.
12 And unfortunately, sometimes working with
13 lawyers has a tendency for that to happen in that they
14 may hijack your schedule, they may change the nature
15 of the questions. As you get closer to a deadline,
16 they have a habit of suddenly sending you hundreds and
17 hundreds of pages of new reports to review just before
18 some deadline has arrived. Don't get hijacked by
19 that. Take the time to insist on what you know is
20 necessary for your own good work, as well as for the
21 well-being of the client.
22 To mitigate perception of personal bias
23 is something which we must adhere and strive to and
24 also be open about any potential that it might look as
25 if you are taking a particular side, or that you're

1 acting as a hired gun, or that you only have one
2 particular opinion about a complex issue. Sometimes,
3 it is necessary to actually take a break from work
4 which is painting you into a corner.
5 Sometimes, it's a good idea not to take
6 several referrals in a row from one particular source.
7 If you're getting a sense that they're trying to give
8 you only one particular opinion, and they are, in fact
9 trying to nudge you towards a certain kind of opinion,
10 it's a good opportunity to kind of reflect on your own
11 work and consult with a client -- consult with a
12 colleague to see if your work for clients is not fully
13 -- does not show the full range you're capable of.
14 One tricky issue here that I'm hoping we
15 can explore in the future in greater detail is dealing
16 with the ways in which third party brokers and
17 individuals who are not psychologists try to influence
18 the work that we do, both in terms of how they set up
19 contracts and how they control information flow and
20 how they sometimes actually can place both clinicians,
21 including psychologists, as well as clients under
22 significant pressure, and I think this is an area of
23 great concern.
24 I'll mention parenthetically here that it
25 is -- unfortunately, at this point, it's not clear to

1 what degree psychologists actually are initiating work
2 of this kind on their own. Sometimes, the referrals
3 are coming from agencies that seem to specialize in
4 this kind of referral work and they don't fully
5 understand what we do and they expect us to respond in
6 ways that are in conflict with our standards. So you
7 have to be very, very firm about declining their
8 business approaches when they are actually at great
9 risk to ourselves and others.
10 This is my very simplified venn diagram
11 of the ideal sweet spot of where I would like to be
12 when I'm accepting an independent evaluation referral.
13 It should be one that fully satisfies all the needs.
14 It should be one that is with the full consent of the
15 client which adequately maps onto my clinical practice
16 and which is going to be able to answer the referral
17 question.
18 But I would say from experience there are
19 many times when the referral questions just do not
20 remotely hit the mark with regard to what I am
21 prepared or actually capable of doing; or in other
22 situations, the client has not been fully briefed or
23 is able to give informed consent because they have not
24 been in any way involved in the process, and it really
25 does hit them sometimes like a bolt out of the blue.

1 They can be very, very distraught and very upset, and
2 these are situations where it really is inappropriate
3 to proceed and, in some case, again, there may be
4 necessity to follow up and to give some follow-up to
5 the referral source that this was not an appropriate
6 referral.
7 I'm acknowledging our standards here and
8 just added this link in case if you're looking at this
9 electronically, you can just pop right into it, but
10 being aware that, of course, we do have ethical
11 guidelines that are in our possession and that we
12 should all be familiarizing ourselves with regularly
13 that actually assist us. But when we get to the point
14 of actually working through a dilemma, it is very
15 helpful to reach out to the College, and in fact, the
16 email there that I've given I'm hoping is the right
17 one, Barry, for the professional practice inquiries so
18 that they will get to a very small pool of highly
19 competent and capable individuals who will respond
20 quickly to you, and I can attest on personal
21 experience that they really do. It really makes a
22 difference.
23 I'm not going to read this out loud, but
24 I do want to give you this as an example from our most
25 recent standards that have been revised. And I really

1 like those little pop-down screens that come out with
2 the practical applications, and this one really
3 resonated with me about the need to clarify who is the
4 client, who is the claimant, who is the payor.
5 And so the language that we use here is
6 basically to differentiate between individual clients
7 and organizational clients. So an example would be
8 that I may have an individual client but they are also
9 -- their case is being funded, or the intervention or
10 the assessment is being funded by an organization who
11 is the payor, but the payor's needs and the payor's
12 questions do not supersede the rights of the client,
13 of the individual person who I am actually doing the
14 assessment on, and sometimes I have to explain that as
15 the psychologist to the payor because the payor is not
16 always aware of that.
17 When I say "payor", I may be referring to
18 an individual automobile adjuster, I may be referring
19 to someone at the WSIB, I may be referring to somebody
20 at Veterans Affairs, Manulife, Blue Cross, the various
21 clerks and nurse case managers or new roles that I
22 have no names for, individuals who are not
23 psychologists, if you approach them at the right time,
24 sometimes they will listen to what we have to say.
25 But even if they don't, we do set the limits and we

1 have to keep those boundaries.
2 I would also at this point love to flag a
3 document that I find very helpful that was written
4 some years ago in a joint collaboration between OPA
5 and CAPDA, and this is very, very strong advocacy with
6 regard to the roles that those of us play when we
7 engage with third party providers, and this has been
8 very, very useful to help remind us how we can go
9 about this. There are again mentors, there are
10 individuals that we can reach out to, who are helpful
11 in actually having those discussions and getting those
12 discussions on the go.
13 An example here again would be that you
14 have to establish the terms of engagement yourself.
15 There isn't really a standard template for that, but
16 there is the need to actually explicitly define what
17 is the question that you want me to answer or
18 questions, and they may have five or six or 15 or 20.
19 And if they are saying we would like you to answer all
20 these questions and we are going to pay you a set
21 number of dollars and we want you to deliver this
22 report in two days after seeing the client, you need
23 to be very realistic about your ability to provide
24 that and the value of that report. Is it possible to
25 actually produce a product that will be useful and

1 relevant and necessary and when is it important to
2 actually reveal some of these practices as being
3 deleterious to professional work and also of potential
4 problems and damage to the client. So it's a
5 difficult situation to be in, I think at this point,
6 when more money is being spent on deciding whether or
7 not a client should have care than on actually
8 providing the care.
9 And of course, again, being aware of
10 these guidelines and seeing how they synchronize with
11 our standards, and reviewing this from time to time,
12 the OPA CAPDA guidelines were actually produced by our
13 colleagues volunteering their time and effort and
14 significant brainpower and lots of effort went into
15 this. And unfortunately, the guidelines will at some
16 point need to be refreshed because legislation is
17 changing, it probably will change again rapidly, and
18 our standards also are changing. So it's an ongoing
19 dialogue, and I would invite you to become part of it
20 if you haven't already done so.
21 I'm highlighting here two documents that
22 CPA has provided which are again very, very valuable,
23 indispensible to regularly around this time of year
24 when we all find ourselves looking over our scope of
25 competence and reviewing our goals for our ongoing

1 lifelong learning, looking at what the CPA Code of
2 Ethics looks like right now in 2018, and looking back
3 at Jean Pettifor's guide which was actually compiled
4 several decades ago but still has really strong truths
5 about private practice that I'll be mentioning in the
6 remainder of my presentation.
7 When I'm talking about controversy here,
8 I'm talking about the importance of being mindful of
9 what is going on in your little community and the way
10 in which client's needs are actually being addressed
11 when they are referred for third party assessment. It
12 is important that you separate issues having to do
13 with the business of private practice and the business
14 of being a psychologist and providing clinical care,
15 because there may be times that you will be asked to
16 do something that you must refuse, and there may be
17 times when you must complete work with the client,
18 knowing full well that the payment is not going to
19 arrive, and you may have to reconcile this in terms of
20 future decisions.
21 You may be in a position where you will
22 be going through Small Claims Court to try to retrieve
23 some partial payment, but you may also have to look at
24 partnering with others in your community who can pick
25 up the necessary care for your client if you are

1 unable to provide indefinite pro bono services. So
2 again, that's something to be very keenly aware of is
3 that, although promises may be made at the onset as to
4 how a service may be eventually able to be paid, you
5 cannot rely on that when you're accepting a treatment
6 referral and when you are being asked to provide an
7 opinion that may be highly litigious.
8 And the example that Peter gave earlier
9 where someone might tell you this is very simple and
10 straightforward and we're anticipating a settlement
11 that's going to happen any day now, all we need you to
12 do is just write this short little report that will
13 seal the deal, be very suspicious of that because even
14 if it was true, that may not be the only settlement at
15 issue, and there may be several other suits and there
16 may be other claims that will hinge upon what you
17 write right now. So, it can be very difficult both to
18 actually wrap it up that quickly and to be prepared
19 for what might happen in the future.
20 Legal advice and the ability to actually
21 retain that through the CPA insurer or through any
22 other insurer that you have your professional
23 liability insurances with, I would again suggest you
24 try that out before you actually need it. So, make an
25 actual call to the number that is identified and talk

1 to them, get a sense of how they work, get a sense of
2 what they need from you in order to become involved
3 and to intercede on your behalf. You have a far
4 better sense of how the system works that way.
5 This is certainly also the case anyone
6 who has been in a situation where they had to make a
7 report to the CAS, it's a good thing to practice that
8 as well, to inquire what is the process hypothetically
9 if I had such-and-such an issue, how long would it
10 take for you to respond, what would you need from me,
11 what do you need me to prepare, and that way you have
12 more of a sense of being informed and being prepared
13 instead of running through it and basically having to
14 do it all very quickly when you're under the gun
15 already, and these are the points that I've
16 highlighted on this slide already.
17 Preparing yourself for the person or
18 persons, the other side who will not be accepting your
19 opinion, be aware of how it may have a waterfall
20 effect or an avalanche effect on the others who are
21 providing care to the client, and be aware of the
22 effect it may have on you. If you're feeling that
23 your work and your opinions are going to actually
24 place you in the crosshairs and that you will be
25 targeted in a way that you're not comfortable to

1 actually adhere to, then that would be something to
2 bear in mind before you take on this work.
3 But if you are clear about what needs to
4 be done, don't let your anxiety hold you back from
5 actually making clear statements that can be
6 defensible and are necessary. So it would be very,
7 very important to at that stage, if you feel you're
8 being threatened in any way, either directly or
9 indirectly, to speak to others who have been through
10 the same situation and to reach out to your liability
11 insurer because they want to know first whether
12 there's a possibility of the claim against you, and
13 that is something they can advise on. I again have
14 tried this. I have gone through this process. They
15 are very respectful, they are very helpful, they are
16 very direct, and they can intervene very, very
17 quickly.
18 Watching your own behaviour, remembering
19 that for myself I am first and foremost a clinician,
20 and so I need to be aware of the effect of this kind
21 of work on myself and my tendency to perhaps drift
22 into my own comfort zone and stay there. It's
23 important not to get too comfortable, not to look for
24 shortcuts. It's important to challenge yourself, and
25 the best way to do that is to seek the feedback of

1 someone you trust who has more expertise than you in
2 that area. And so that's why really, as we all know,
3 it gets actually over time both more rewarding but
4 also harder to work in a particular area because you
5 have a sense that things are shifting constantly and
6 you have a sense that you need to be prepared for the
7 unexpected.
8 At the same time, though, I'm currently
9 reading the book by Brian Goldman of White Coat, Black
10 Art, "The Power of Kindness", and I do find that this
11 is something that really inspires me at this time to
12 try to always be uppermost be kind and compassionate
13 in your interactions with others, not just with your
14 clients, of course, but also with people who are
15 feeling downtrodden when you talk to them on the
16 phone. You're talking to the folks answering the
17 phone in the insurance companies, you're talking to
18 people who are trying to get quick decisions very
19 quickly. They may be out of their depth and they are
20 not able to understand that.
21 As psychologists, we do have the ability
22 to moderate our own emotions and to regulate our own
23 reactions, and when you're finding it's hard to do so,
24 that's a good time to take the time to take care of
25 yourself as well and reach out to colleagues and to

1 friends. But first of all, establish your area of
2 work and your area of expertise and stay within it,
3 mindful of the fact that your expertise grows with the
4 work you do, and the work you do is related to the
5 referrals you get and the familiarity that others have
6 with your work and your reports and your client
7 interactions, and your life as it is as a professional
8 is sometimes under the microscope.
9 And in fact, it's not really possible to
10 guarantee the same degree of privacy that we adhere to
11 for our clients. We cannot expect for ourselves once
12 you've entered the public realm and thus essentially
13 set up the opportunity for people to reach you
14 directly through email, through social media, and so
15 be aware of that and be aware, of course, as we've
16 already heard, that correspondence with legal counsel,
17 correspondence with anyone else related on a file will
18 probably end up before the court.
19 I've had that experience, when actually
20 testifying as a witness of fact, of having to read
21 through reams and reams of progress notes in a
22 hospital chart, most of which were not written by me,
23 but I was the person on the stand. And that is not an
24 enjoyable situation but it is one that may occur
25 because all correspondence and all clinical notes are

1 open to review to the court in certain situations.
2 So, again, there is really, when it comes to the
3 review of issues and interactions, we cannot expect
4 that anything we say, write or communicate will in
5 fact remain private.
6 Communication gaps are very common in the
7 work that we do, and it's very important to remember
8 that the acronyms and the shortcuts and the way that
9 we refer to particular interactions and behaviours and
10 diagnoses are not familiar to many in the court. It
11 is really necessary to learn to speak about what we do
12 to people who are not psychologists. So I think
13 that's something that is worth doing in different
14 situations, and it's also worth doing abundantly
15 before you appear in court.
16 I'll give you an example of a situation I
17 still think of from time to time where I would like to
18 have the opportunity to redress something that I
19 obviously cannot do. I cannot go back, but I'm
20 sharing this with you as an example.
21 I worked with an individual who had
22 sustained injuries in a motor vehicle collision. This
23 was some 20 years ago, and that individual, during
24 that interaction with me when I was providing
25 intervention, recalled an incident of abuse that

1 occurred when they were much younger, not a child, but
2 a much younger person, and they disclosed this to me
3 ostensibly for the first time and wanted to know how
4 they could go forward to actually address this issue.
5 And that was not something that I was prepared or
6 capable of doing within my scope of competence, so I
7 made a referral to a colleague who was able to take
8 the client into their practice to address the issues
9 with regard to sexuality and identity and the concerns
10 about communication and abuse.
11 And eventually, as in the example that
12 Peter mentioned, this individual chose to actually
13 speak to the police and charges were laid and the
14 abuser was brought to court and at that time I was
15 also subpoenaed. And my regret is that I did not
16 sufficiently capture verbatim the exact statements
17 that the client made to me when the disclosure was
18 made. I described it at the time what I thought was
19 the most sufficient language, describing more
20 generally, but I did not actually capture the verbatim
21 statements, which would have been very helpful at the
22 time when the decision was made to lay charges.
23 So I'm just giving that as an example
24 that, even though that was not my domain, not my area,
25 that lack of detail was pivotal when the case came to

1 court. So, I try now to capture almost as vividly as
2 I can when individuals are describing something in a
3 first person perspective, particularly anything like
4 that, which obviously the colleague who took on the
5 care for this individual was able to provide much
6 greater detail afterwards, but it was something that
7 the court wanted from the firsthand description.
8 Thinking about what it's like to be in
9 court, and I've been in court on several occasions,
10 and I find every time it is daunting and it is a very
11 different culture, and I would certainly
12 enthusiastically recommend that you take any
13 opportunity that you can to enter the court well
14 before you have to. And of course, all things being
15 equal, if you expect you never will, you probably
16 certainly do. But if you have the chance to either be
17 prepared to just observe an ongoing case, which many
18 cases are open and you can go down to the courtroom
19 and actually walk in and see the whole dynamic and see
20 what it's like to be there, I would certainly
21 recommend that.
22 If you're called to serve on the jury,
23 try not to get out of it. I know I always see these
24 discussions where people say, oh, I don't want to have
25 to do this, what a waste of time. I would say it's

1 the best investment you can make in understanding how
2 the courts work, and it is well worth it even if the
3 case may not be all that exciting, it may be pretty
4 mundane.
5 The one I was asked to serve on the jury
6 was actually very, very exhausting and was difficult
7 for many members of the jury, and it was one I still
8 can't speak about because of the rules as they exist,
9 apart from saying that it was a case of manslaughter.
10 And this was one where the jury was not sequestered,
11 so every day at the end of the day, we would have to
12 go home and not say anything about it to anybody. So
13 these are difficult situations, and I'm very pleased
14 to see that there is movement afoot to address the
15 needs of a jury, but I think as psychologists we need
16 to understand the various perspectives involved.
17 If you are called to testify and you are
18 invited -- well, invited, you have the opportunity to
19 actually serve as an expert, you will be vetted. Your
20 credentials will be examined, not necessarily with a
21 fine tooth comb. There may be some surprising things,
22 like maybe some really unusual questions that you're
23 not expecting, and again, don't take it personally.
24 This is -- to a great degree, it is a process where it
25 must happen, but it may feel uncomfortable. And

1 again, they are not really questioning your training
2 and your background; they are questioning whether they
3 would like to have you speak on this particular case
4 and whether your opinion will be of merit and will be
5 valuable to the court.
6 So again, when you're answering, you're
7 answering to the judge and with the jury in mind. So
8 again, many other people have explained this far
9 better than I can, try not to get caught into the
10 back-and-forth of seeing the lawyer who has called you
11 as the person who is retaining you. Don't see one
12 lawyer as a friend and the other as an enemy. That's
13 not a good way to look at it. They are both
14 representing different points of view and different
15 aspects of the full case, but you are addressing the
16 judge and the jury, you're addressing the court in its
17 full authority.
18 Just highlighting again the same issues
19 that Peter has explained in greater detail, so I will
20 move on. I would say, when I was sitting on the jury,
21 one of the things that I noticed was discussed in a
22 more general sense is how experts can be boring and
23 experts really don't use their time wisely. And I
24 think, unfortunately, sometimes lawyers are good at
25 setting experts up to be boring by asking them to

1 explain minutiae that the jury cannot process, so that
2 you don't really have a choice when you're asked to
3 explain something in greater detail, but be aware that
4 adding any extra detail is not helpful.
5 You may stray from your mandate and you
6 may provide something that you're unable to back up,
7 so you have to be very cautious in terms of sharing
8 only what is directly relevant to the questions at
9 hand, and at the same time also being aware of the way
10 in which your presentation is being read, not just for
11 the words you say, but for your body language and your
12 interaction. Even such things as whether or not you
13 look at the accused, these are things that the jury is
14 affected by, and they will notice if, in their
15 opinion, an expert witness never looks at the person
16 who is accused and whose case is being tried. That
17 will be noticed.
18 I'm again going to share at this point an
19 example of how mistakes can elevate risk for the
20 client and for yourself, and again this is several
21 years back, thinking of a report that I tried to
22 rewrite for a client to appease their sense of not
23 being adequately described. And my concern here is
24 that, in my efforts as a clinician to try to make the
25 report palatable and acceptable, I took too long in

1 trying to refine it and gave too much opportunity for
2 my authority as a clinician to be watered down by
3 trying to make the words more appealing and more
4 acceptable.
5 And keeping in mind that that happens
6 often if there is a sense of indecision or there's a
7 sense of indeterminacy, and so by trying to be
8 appeasing, we can actually contradict ourselves and it
9 can lead to a situation where the client is actually
10 more uncertain. So again, I give this as an example
11 of being aware of your role both as a clinician and as
12 an assessor when you're coming to a determination.
13 These sometimes may not always feel
14 easily reconcilable. They may feel like you're having
15 to straddle two sides of the fence. I don't have a
16 good solution here for this, but I'm saying we need to
17 be aware of this as clinicians. It is difficult.
18 I would also at this point, now that I am
19 in private practice, nod and acknowledge the
20 leadership and the mentorship of many of my colleagues
21 in private practice who have been doing this for far
22 longer than I have. I worked in a hospital for more
23 than 25 years, and working within a hospital
24 environment gives you an added level of oversight and
25 security because you have an employer who is the

1 custodian of care, and that means that even if there
2 is a very serious problem, there is an immediate level
3 of oversight and intervention that can be provided
4 both for the client, the patients in those situations
5 -- usually in hospital we still refer to them as
6 patients -- but also for the staff who work in a
7 hospital setting.
8 But for individuals working in private
9 practice, you do not have that invisible cloak, and
10 you're it; right? You are your own privacy officer,
11 you are your own person responsible to make sure that
12 you take on work that can be done, and you don't
13 necessarily have the time to turn to somebody in the
14 moment. You have to make much more quick decisions at
15 times when you are being asked to do so. So again,
16 conflict is sometimes inevitable and you need to be
17 ready to take action when it is necessary to do so.
18 Sometimes, holding back and waiting, as
19 an example that came up when Rick was doing his
20 reporting obligations questions, waiting for more
21 evidence to present itself before you choose to act
22 can be a problem. Sometimes, you have to recognize a
23 possible danger, a possible red flag, and just go
24 ahead and act on that.
25 It may be that that at times will lead to

1 a situation which will have to be resolved in a
2 different way. It may turn out that some of these
3 situations are not a problem, but it's not worth the
4 risk of just sitting on it, so be prepared to act when
5 you see an obvious difficulty.
6 I'm thinking here of situations, for
7 example, where it becomes obvious that a client has
8 been told that they have no choice, that they must
9 participate in an assessment, and that their monies
10 will be cut off if they don't, that they will be
11 losing benefits and their family's well-being is at
12 stake. These are reprehensible threats that sometimes
13 are made to clients and they are forced to do things
14 that they are not comfortable to do.
15 My role as a clinician is to have the
16 ability to actually notice if there is a difficulty of
17 that kind and to, if need be, seek advice and counsel
18 myself to help redirect the client and find better
19 alternatives and not to take advantage of them at that
20 moment when they are not capable of actually truly
21 informed consent. I'm giving an example of a client
22 who is told you must complete this assessment right
23 now, and they show up to my office in grave distress
24 and obviously very, very troubled, and I will turn
25 them away and I will talk to the referral source and

1 say you must do this differently, this is not the way
2 we can treat individuals in this situation.
3 And having said that, again, it's very
4 important, particularly if you're in private practice,
5 to let others know when you are working and where you
6 are working and to either have an alarm system or to
7 have a colleague nearby. Don't set yourself up in a
8 situation where someone who is upset and angry at you
9 might turn up afterhours when you're quietly writing
10 reports and demand a rewrite or demand a decision that
11 you're unable to give.
12 Be aware of risk management, be aware of
13 de-escalation techniques, and be aware of how to call
14 911 if you have to. But above all, look at this as an
15 opportunity to grow, and I'm trying to end on a really
16 positive note here because in fact it's actually part
17 of what we do all the time is to be mindful of how we
18 can be helpful to the client and to the community at
19 large in terms of educating people what psychology
20 really does.
21 And sometimes that means being aware that
22 what I am doing in my practice is not necessarily
23 exactly the same what I was doing five years ago or
24 ten years ago, and in fact, it gets to the point where
25 I realize I need to actually seek out a mentor and go

1 through the College's process for expanding my scope
2 of practice because I would like to start working with
3 Peter in custody and access, for example. What would
4 it take for me to be able to do that? What would it
5 take for me to actually define a program that would
6 allow me to expand my scope?
7 So I would encourage you to kind of look
8 at your practice and see where your practice is going
9 now, where you would like to see it in five years.
10 Consult with your legal counsel when you have a
11 specific situation, but also consult with your
12 colleagues when you're just generally looking at your
13 ability to thrive. And there should always be
14 challenge in life, I do believe in that, but challenge
15 should not be at the risk for yourself or others or
16 for your clients. We protect our clients. Thank you
17 very much for your time.
18 BARRY GANG: So we have about a half hour
19 for questions. I'm going to ask Margaret and Peter if
20 they wouldn't both mind coming up and taking
21 questions. I'd also like, though, to ask anybody who
22 has questions to just raise their hands and wait for
23 Stephanie, who is in the back, or Katelyn to give you
24 a microphone so that everybody can hear the questions
25 clearly.

1 DR. PETER JAFFE: Rick, you're taking
2 questions, too.
3 PARTICIPANT: Hi. I heard -- I guess the
4 question is about giving detail in reports. As we
5 increasingly move towards electronic documentation,
6 and there is sometimes discussions about how much
7 detail to put, and the comment that we should be very
8 detailed in quoting things like sexual or allegations
9 of sexual abuse. So I was just wondering if people
10 could comment on that? So for example, on a health
11 record, if a number of professionals will be looking
12 through that health record, weighing how much is too
13 much versus the need for detail.
14 DR. PETER JAFFE: There may be many
15 different opinions about this issue. My advice is to
16 make note that the issue was raised because sometimes
17 when you're looking through historical records, the
18 issue was, you know, was the issue of sexual abuse
19 raised previously with a therapist, you know, five
20 years ago or ten years ago, depending on the nature of
21 the litigation. So my advice in general -- and
22 Margaret may disagree and we may have divided opinions
23 here -- acknowledging is important.
24 I always worry about giving too much
25 detail, and the worry about putting in too much detail

1 is you might make a mistake in reporting those details
2 and that gets used against a potential victim later
3 on. So I'm always very reluctant to add a lot of
4 information. Let's say in transcribing notes or doing
5 something you misstate something and it's your fault,
6 not the client's fault, you didn't hear right, or the
7 client was mumbling, then later on that's going to be
8 used against the client in litigation saying, "Well,
9 you told Dr. Smith this and now you're saying that.
10 You know, were you lying then?"
11 So I'm especially cautious with abuse
12 survivors to have information used against them, so I
13 think it's more important to note that it's been
14 reported to you, but depending on your mandate, so I
15 err on the side of less, but there may be other cases,
16 and obviously Margaret might have a different point of
17 view where it may be important to put more details
18 about who it was, for how long. I get more -- I've
19 had bad experiences where I've put too much in my
20 notes and it gets used against the client unfairly, so
21 I'm cautious from that.
22 DR. MARGARET WEISER: I like that answer,
23 and it alleviates my sense of regret about not having
24 provided quite as much information as was being asked
25 for in court, but I think part of -- just to put it in

1 perspective, I was referring to a private practice
2 client who only I saw and who only I read the notes
3 of. So I would add that the comments raised about
4 what if your notes are being read by many people, that
5 adds a whole new level of concern, so you have to keep
6 that in mind, so I think your answer is the right one.
7 PARTICIPANT: I'm a nurse, rather than a
8 psychologist, and I had the privilege of transcribing
9 psychiatric nursing notes into electronic format, and
10 we tried a checklist at first for, you know, the
11 mental status, et cetera, and what we found was that
12 it didn't tell the patient's story, and so I would
13 only encourage that we give enough information that we
14 can tell the patient's story and get the picture in
15 our brain.
16 DR. PETER JAFFE: I think that's a good
17 reflection. The only thing is that, for many of our
18 clients or patients, a story unfolds over time.
19 Somebody on day one may be comfortable to tell you
20 part of the story or the reason that they're coming to
21 see you, but over time it unfolds. So it's also, in
22 fairness to some clients, they may not be ready to
23 tell you something because there's obviously an
24 interaction effect.
25 The client has to trust you enough to

1 tell you something. They also have to understand what
2 they've been through, especially if it's dealing with
3 historical incidents that they're just getting in
4 touch with, so there could be unfolding over time.
5 Just because someone didn't tell you something in
6 1995, it didn't mean it didn't happen, just it took
7 time so there is a gradual unfolding.
8 But I agree with the general comment, you
9 want to get people's accounts, but their accounts may
10 change over time. It doesn't mean that they're lying
11 or minimizing necessarily. It's just that it took
12 time for everything to unfold.
13 PARTICIPANT: Just to make a quick
14 comment, sometimes what I've done with a particularly
15 contentious issue would be to take the note right then
16 and there with the client in the room, read it back to
17 them, ask them if they're okay with what I'm writing.
18 DR. PETER JAFFE: I think that's
19 important to really verify. I'm always -- I have a
20 list of top ten things that make me anxious, and one
21 of them is not getting my notes right and doing
22 something that harms the client when, in fact, it's my
23 fault.
24 PARTICIPANT: Okay. On a totally
25 different note, I'd like to take this opportunity to

1 get some clarification about the difference between
2 being a fact and an expert witness in Ontario, because
3 this issue never seems to go away. In fact, one time
4 I was on the stand, I asked the judge for
5 clarification and they asked me what my opinion was,
6 which I of course gave him, but that just indicates
7 how difficult a question it is.
8 One of the issues that keeps coming up in
9 the context of my private practice is in
10 rehabilitation, well, neuropsychological assessment of
11 children and adults with brain injuries. I will apply
12 through the auto insurer to have funding for my
13 assessment, and then down the road the lawyer will
14 send me a Form 53 to say that I did the assessment at
15 their request and blah, blah, blah. Now, I refuse to
16 sign the Form 53 because, in my opinion, this is not
17 an expert legal opinion. This is actually a
18 rehabilitation assessment or neuropsychological
19 assessment that was done within certain time
20 constraints and was funded by an insurance company.
21 So, but I can only assume that other
22 people must be signing the Form 53 since I keep
23 getting the same request over and over again and, in
24 fact, I've had some very let's say heated discussions
25 with lawyers about this issue. So I was just

1 wondering how other people think about this and maybe
2 get some clarification in my own thinking.
3 DR. MARGARET WEISER: I will make a
4 preliminary comment, but I would really love to hear
5 from other people in the room as to whether they have
6 similar experiences and how they respond to this, and
7 from my own practice, I can see the commonsense
8 approach to what you're saying. I think that does --
9 it sits well at one level in that, if the insurer is
10 paying, they're paying for a clinical assessment and a
11 clinical plan of care, and it is not really an arm's
12 length legal question.
13 However, I think what happens is that, as
14 time goes on, the lawyers then plan to use that in
15 their determination of the outcome of a legal suit,
16 and so what would be interesting to know is whether
17 those Form 53s are only sent to individuals when the
18 lawyers see the report as being congruent with the
19 terms of the suit. So that would be -- that would
20 make it a little awkward if, you know, they're
21 basically trying to very gently control the outcome in
22 that way. Does anybody else want to comment or weigh
23 in on this, on this process?
24 PARTICIPANT: I would think that one way
25 to sort of boil down the issue is Form 53 is really

1 meant to acknowledge your independence, non-bias and
2 expertise. So if you've done a sufficient assessment
3 that would allow you to feel confident to offer
4 opinions, then to me the Form 53 would be relevant.
5 But if you've done a briefer assessment or assessment
6 for different purposes, then that's not really the
7 same as doing an independent assessment for the
8 purposes of opinion.
9 Let me add one more thing. I've had
10 situations where I've done briefer versions or
11 versions of reports for different purposes, and if a
12 lawyer writes and asks for certain opinions, I would
13 say that that requires a fuller assessment. If you
14 want me to review all the documents, reassess the
15 person, test them, do another report, then we'll see
16 whether a Form 53 is relevant, but not just based on
17 my initial work which might be....
18 PARTICIPANT: And I often do that. What
19 I have problems with is when I do a neuropysch
20 assessment for rehabilitation purposes and then I get
21 the request to sign a Form 53 down the road, and I'm
22 like, this was not a legal assessment, I didn't go
23 into that level of detail, I addressed specific
24 questions, developed some treatment goals, and I will
25 not sign this. And there appears to be sometimes an

1 expectation, but what you suggest is exactly what I
2 do, and I guess the line that really concerns me on
3 the Form 53 is not the "this is an unbiased
4 assessment" blah, blah, blah; it's "this was done on
5 behalf of". And sometimes the lawyers want you to say
6 that you did it for them, rather than for...
7 PARTICIPANT: That undermines your
8 credibility, too.
9 PARTICIPANT: Well, that's what I said, I
10 didn't do it for you, and in fact did it at the
11 request of the case manager, I find that that is in
12 fact saying something that is not, in fact, true to
13 the court system.
14 PARTICIPANT: I think Peter gave an
15 example of the actual standard.
16 DR. PETER JAFFE: Sorry, just if I can
17 jump in on that, I agree with the basic point, but my
18 preference would be to always sign the Form 53,
19 especially you do amazing reports, so I think you
20 should always sign them. But I think, I mean, there's
21 two things. One, in every report I have sort of a
22 standard paragraph about the limitations at the end.
23 I mean, you usually have at the beginning like who the
24 report was done for.
25 If a lawyer is asking you to sign a Form

1 53, usually, there's an affidavit form. You can also
2 get them to amend it. So for example, I had one last
3 week where a lawyer wanted me to sign a Form 53 but it
4 was related to an old report I had done for a Crown
5 Attorney with multiple abuse victims involving the
6 church. So I asked the lawyer to change the affidavit
7 to say this was prepared for a Crown Attorney, I'm
8 prepared to come and testify about that, but I wasn't
9 retained by that lawyer for that.
10 So the lawyers can change that, and that
11 can be the first thing you say on the stand. You can
12 say to the lawyer, after you ask me to spell my name,
13 let me clarify who I did the report for, because I
14 think a Form 53 is a bit like motherhood or
15 fatherhood. It's really you're saying it doesn't
16 matter who hired you, you're going to be fair and
17 impartial, so it's really -- I don't think it limits
18 you as long as you can explain that part of it or ask
19 the lawyer to amend that.
20 PARTICIPANT: I think that's a good
21 suggestion because I could say I did this on behalf of
22 a case manager, but it reflects, you know, my true
23 opinion.
24 DR. PETER JAFFE: Right.
25 PARTICIPANT: Thank you.

1 DR. PETER JAFFE: You're very fair.
2 PARTICIPANT: So I have a fairly busy
3 treatment practice and assessment practice in
4 Thornhill, and I get asked to sign Form 53s by lawyers
5 on a regular basis when the person was sent to me for
6 treatment planning and for treatment, and this has
7 come up time and time again, and I started signing
8 them. My recollection, and I wish I could give the
9 details, but my recollection is that there is a
10 judicial decision that came out where the judge spoke
11 to the importance of having treatment provider's
12 opinions and as opinion evidence.
13 And if we consider just by extrapolation
14 that you cannot give opinion evidence without signing
15 a Form 53, by extension, we would have to sign the
16 Form 53, and so there's at least one judicial opinion
17 in Ontario where the judge essentially said it makes
18 no sense to say just because you're the treatment
19 provider that you shouldn't be able to provide
20 evidence to the court that would assist the court in
21 coming up with an ultimate opinion. And so from that,
22 it seems to me that it's a less than perfect solution
23 because it's true the Form 53 does speak to being
24 entirely impartial and, as a treatment provider, it's
25 hard to say you're entirely impartial when of course

1 you have a treating relationship with the person.
2 But that said, I think it's the lesser of
3 two evils is to go there and say I'm doing the very
4 best I can to provide an unbiased and impartial
5 opinion to the court, even though I had a relationship
6 or I have a relationship that's a treatment
7 relationship. And the gist of it is that that seems
8 to be what I hear from lawyers in Toronto anyway on a
9 regular basis.
10 DR. PETER JAFFE: I think a lot depends
11 on what question you're being asked. If you're in
12 court to say I've treated somebody for the last five
13 years, in my opinion, you know, this is their
14 diagnosis, and they need five more years of treatment,
15 so if there is sort of a limited scope, I think it's
16 totally fair. You are offering, you know, your
17 psychological opinion.
18 I think the challenge is when you get
19 into other areas if that leads to what extent the
20 damages are, you know, from the accident, or if it
21 gets into somebody being a better parent. I think the
22 challenge, if you get into other areas that are part
23 of other questions the court may have, I think that's
24 the difficulty.
25 But I think you're totally fair, and as

1 long as when you go to court, as long as you
2 acknowledge what your role is -- and you can expect
3 any therapist going to court, the other side is going
4 to cross-examine you about therapy and what you did
5 and the perceived bias. Even though you may not have
6 any bias, you will be still perceived to be biased and
7 you could face a difficult cross-examination and
8 withstand it, and just explain what you did and what
9 cautions you're offering in your opinion.
10 PARTICIPANT: Yes, my question is
11 probably best addressed to Dr. Morris. The question I
12 have goes beyond College regulations when you end up
13 having a case -- and I've had a couple, one was
14 clinical, one was medical/legal -- where the question
15 is whether there were regulations regarding duty to
16 warn that again fall outside the College boundaries
17 and what to do about it.
18 The one particular case, it was a couple
19 of years ago, I actually called Dr. Morris. You
20 probably don't remember, but it was a medical/legal
21 case where someone had very significant residual
22 neuro-cognitive impairment from a very bad brain
23 injury. It was a severe TBI.
24 Anyway, doing my reporting, going through
25 the medical records, I came across one of these forms

1 to be recertified as a pilot because the individual
2 patient was a pilot and you have to get medically
3 certified every year by GPs who are authorized to do
4 that. On this particular recertification form, which
5 was dated after the severe TBI, there's a question on
6 it that said have you ever experienced a head injury
7 with loss of consciousness, and you either had to
8 check yes or no, and this individual checked the "no"
9 box which was clearly incorrect.
10 The patient actually signed this, the GP
11 assessor signed off on it. And you know, I was
12 working on my report and I was very concerned because
13 this person indicated to me in the interview that they
14 were still flying an airplane from time to time, and I
15 said to myself there was no way in the world I would
16 want to be in an airplane with this guy behind the
17 pilot wheel or whatever.
18 Now, I know because of the Highway
19 Traffic Act we're not allowed to report somebody
20 unless we have their permission. Physicians are
21 indemnified for that, we are not, but this goes to the
22 issue about, you know what do I do about this pilot.
23 Okay. I ended up actually calling and speaking to the
24 head physician for the Canadian Aviation Association
25 or the federal aviation, whatever they're called, and

1 I was informed that the only people that could report
2 or have a duty to report legally are physicians and
3 optometrists.
4 DR. RICK MORRIS: Okay. That...
5 PARTICIPANT: And I think I spoke to you
6 a number of years ago about this, and I actually spoke
7 to the guy that I talk to to help me with these
8 things.
9 DR. RICK MORRIS: Hopefully, I'll tell
10 you the same thing now as I told you then, unless it
11 was before 2004, and then my answer might have
12 changed. In Ontario, without getting into a lot of
13 detail, in Ontario we don't have a thing called duty
14 to warn. California does. For example, California
15 has Tarasoff legislation, very clear. We all know the
16 Tarasoff case, very clear that if you have certain
17 information you are obligated, no questions asked,
18 like child abuse reporting information, where you have
19 no questions asked, you have to do something about it.
20 That's a duty.
21 The legislation in Ontario, section 40 of
22 the Personal Health Information and Protection Act,
23 doesn't describe providing information that you get,
24 as you were just talking about, as a duty to tell
25 people, but it makes it very clear that you have the

1 permission of the legislation to take some steps with
2 that information if you feel it's necessary.
3 So the purpose of "duty to warn"
4 legislation is it does indemnify you. So the child
5 abuse legislation, whether the client likes it or not,
6 you have to report, the law says so. Well, PHIPA
7 doesn't say that, but PHIPA says as the health
8 information custodian you may report or you may
9 disclose personal health information in order to
10 reduce or eliminate a significant risk of serious
11 bodily harm.
12 So the legislation gives you that
13 permission. It doesn't require you to do it, the way
14 child abuse legislation reports it, but since it
15 authorizes you or allows you to do it, then you get to
16 decide and make a decision. So if you decided in the
17 case that you had that you were going to notify
18 somebody, even though the client said don't breach my
19 confidentiality no matter what, the legislation would
20 have been supportive of you being able to say whether
21 it's Nav Can or whether it's their family physician or
22 somebody that you feel is in a position to take some
23 action.
24 That would be the idea, because it also
25 doesn't say that you have to report to A or B or C or

1 D, the Department of Transportation or the police or
2 whoever. What it says is you get to report if this is
3 your concern, and I believe the intent behind that is
4 you can report to someone who has the capacity to do
5 something about it.
6 So if it's an elderly person who is
7 driving and you have a concern, you might decide,
8 well, I could tell the Ministry of Transportation.
9 And I know from personal experience with my father,
10 six months later he'll get a letter saying don't
11 drive, which doesn't do very much to stop him from
12 driving, or it didn't do very much to stop him from
13 driving. But if there is a child of that elderly
14 person or a spouse who is in a position to just take
15 the keys away, then that may be the better route to
16 go, but there is nothing in the legislation that tells
17 you who that you're supposed to.
18 PARTICIPANT: But does the legislation
19 protect...
20 DR. RICK MORRIS: Yes.
21 PARTICIPANT: It does.
22 DR. RICK MORRIS: If there was going to
23 be -- I mean, now we're getting into legal stuff, and
24 this is why I always say talk to a lawyer. But if you
25 were to be -- if it was a case against you, a civil

1 case against you for breaching this individual's
2 confidentiality, you have to pull out the legislation
3 and say, yes, I did breach his confidentiality, here
4 was the reason and this is my authority. And what you
5 would have to be able to do is show that it was
6 reasonable, that there was a reasonable belief that
7 someone might be in danger, and you acted on that
8 reasonable belief.
9 PARTICIPANT: Okay.
10 DR. PETER JAFFE: Just on that question,
11 one other rule of thumb. We get into a lot of grey
12 areas where obviously calling Rick or emailing Rick,
13 I've contacted him many times over the years, he gives
14 great advice, and also calling a lawyer, at the end of
15 the day, there's some cases that you're on the horns
16 of a dilemma and this is my test.
17 When it shows up in the front page of the
18 paper, which side would you rather have been on?
19 Because as long as there's, you know, a lawyer living
20 and breathing somewhere, you're going to be sued for
21 doing one thing or the other. So the question you
22 have to ask yourself, when you're reading a public
23 inquiry, you have to say to yourself, if my name is in
24 the paper, is it because I did something in good
25 conscience because I was worried about somebody's

1 personal safety and health, or didn't I.
2 So I mean, I think it's tricky.
3 Obviously, you want to get legal advice but sometimes
4 you'll end up with sort of pros and cons, but you have
5 to decide, you know, what part of the lawsuit do you
6 want to appear in, what side do you want. That's what
7 I end up often asking myself when there is no clear
8 answer but you have sought the best advice you can
9 get.
10 And coming back to some of the issues we
11 talked about earlier about mandatory reporting, and I
12 think a comment that Jeff made, I mean, there's
13 mandated reporting, there's also policies in all our
14 workplaces, but there is also doing the right thing
15 from a moral perspective and there's legal, things you
16 have to do, and if you don't do it, you're in big
17 trouble.
18 But sometimes, you may want to do
19 something because it's the right thing to do and
20 you've got a legal opinion to support you, or your
21 workplace tells you you have to do it. So just
22 because something isn't mandated, it doesn't mean you
23 can't do what's right to protect clients or other
24 people who may be in danger of the client.
25 BARRY GANG: I guess we finished on time.

1 That's great. I want to thank the presenters, all
2 three of them. I actually thought, you know, Peter
3 and Margaret, but Rick, too. I think the engagement
4 of the audience is an attestation to how effective you
5 are at taking, you know, situations which, you know,
6 throw people into things you're not really trained to
7 deal with sort of entering, you know, the foray when
8 you go to graduate school.
9 But I think, you know, what you can take
10 from this and hopefully carry on your shoulders, there
11 are calm, reasoned, measured voices to do the right
12 thing and to find your centre as a professional. You
13 may have people advocating for all kinds of different
14 things, but you are experts at what you do, and I
15 think that our three presenters have really done a
16 great job of reminding you of that.
17 I would also like to thank Angela and
18 Rosalie for being our sign language interpreters,
19 Stephanie and Katelyn on the College staff who have
20 made things as seamless as I think they possibly can
21 be. I think, you know, you probably could leap,
22 whatever Superman's expression is, tall buildings at a
23 single bound if we ever asked you to, and thank you
24 for that, and the staff of the London conference
25 centre.

1 You should all be receiving evaluations
2 very soon by email. Those of you who have arranged
3 for people to be joining you on your registration
4 online, please forward those to whoever is involved
5 because the more information we get, the better we can
6 prepare for the next Barbara Wand Seminar. So thank
7 you very much, and safe journeys home.
8 **********
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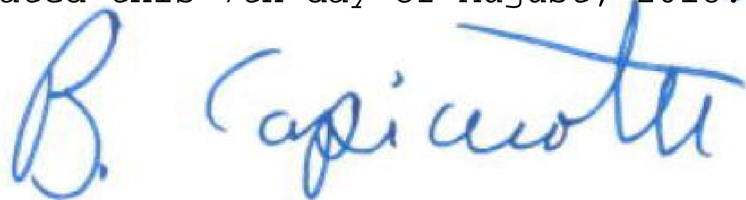
21 
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