The BULLETIN

THE • ONTARIO • BOARD • OF • EXAMINERS • IN • PSYCHOLOGY

A NEW REGISTRAR TO JOIN THE STAFF IN JUNE

In its search for a new Registrar the Board was gratified by the number of experienced and well-qualified psychologists who expressed interest in the position. The search is now complete, and the Board is pleased to announce the appointment of Dr. Patrick Wesley, a psychologist registered in Ontario since 1976.

Dr. Wesley will assume the responsibilities of Registrar on June 1, 1991. With a doctorate from the University of Wales, Dr. Wesley came to Canada in 1966 to join the Department of Psychology at Lakehead University where he taught for twelve years. He was also in independent practice for three years in the mid-1970s. Since leaving Lakehead in 1978 he has held administrative positions that have provided extensive experience in relations with branches of government – as Executive Director of the Ontario Confederation of University Faculty Associations, President of Algoma University College, and most recently as Executive Director of the Ontario Chapter, College of Family Physicians of Canada.

The Board and staff look forward to working with Dr. Wesley in continuing to deal with change in the regulation of the profession and in setting objectives for the implementation of the new *Regulated Health Professions Act* and the *Psychology Act*, now before the legislature. These preparations present great challenges for the Board and for its chief executive officer.

HEALTH PROFESSIONS LEGISLATION

The legislation introduced in June, 1990 by then Minister of Health, Mrs. Elinor Caplan, was reintroduced on April 2, 1991 by the Minister appointed in September 1990, Ms. Evelyn Gigantes. The Act setting out the procedures to be followed by each professional regulatory body is now known as Bill 43, the *Regulated Health Professions Act*, and is accompanied by the twenty-one professional Bills, of which the *Psychology Act* is Bill 63. There are few significant changes.

Ms. Gigantes stated that in the forthcoming committee hearings on the Bills she wished to hear mainly from consumers rather than from the professions affected by the legislation. This view may be shared by the new Minister of Health, the Honourable Frances Lankin. In any event, the next four or five months will be busy months for professions that continue to see serious flaws in the legislation as proposed.

Representatives of the Board were fortunate to be able to meet with Ms. Cathy Fooks, Special Assistant to the Minister on matters of policy. Following this meeting, the Board wrote to Ms. Fooks offering suggestions for the resolution of problems that are troubling to a number of groups, including the Board. The Board hopes that its suggestions, if made widely known, can contribute positively to resolving the remaining objections to the wording in some of the Bills. The Ministry had indicated that it wished to see the debate conducted openly. For this reason the Board's letter is being circulated widely to concerned groups and is reproduced here for the information of psychologists.

April 24, 1991

Ms. Cathy Fooks
Special Assistant: Policy
Office of the Minister
Ministry of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario
M7A 2C4

Dear Ms. Fooks:

Mrs. Rothschild, Dr. Quarrington and I would like to thank you for meeting with us on March 20. It was helpful to have your description of the government's intention regarding the health professions legislation, to know that the Board's concerns with the *Psychology Act* are understood, and that the government recognizes that at some point in the process a number of adjustments may be required in the health professions legislation.

Following our meeting with you we met to discuss the problems with the legislation, as you indicated they have been identified by the government and concerned groups, including our own. We thought that it might assist in the resolution of some of these problems if the Board were to set out for you its position on the existing problems, along with some suggestions for modification of the legislation. As well, we thought it would be constructive if we were to make the Board's position known to the other groups that are affected by the legislation and have expressed concerns about various features of it. We are therefore taking the liberty of copying this letter to other groups with whom we have been in touch over the course of the health professions legislation Review.

Diagnosis

The Board is aware that the inclusion of diagnosis as a "controlled act" has aroused alarm among regulated and about-to-be regulated professions that arguably diagnose as part of the practice of their profession at the present time, but whose members will not be authorized to diagnose under the new legislation. We think particularly of speech pathology, physiotherapy and occupational therapy. Similarly concerned are the members of the Coalition of Unregulated Practitioners and the profession of social work, presently not regulated by statute.

The Board can see two possible avenues for resolution of the problem:

1. If the government decides that the restrictions on the act of diagnosis are to be retained, then the Board would recommend:
(a) that diagnosis be authorized in the legislation as a controlled act in the practice of those professions that have argued convincingly that diagnosing within their scope of practice is presently part of the practice of their profession; and
(b) that the Regulated Health Professions Act and/or its Regulations include appropriate distinctions between assessment and diagnosis (as described in Section 26(2), paragraph 1) and make appropriate allowances for assessment.

For example, Section 26(3) of Bill 43, the RHPA, presently states that:

> An act by a person is not a contravention of subsection (1)... if the act is done in the course of an activity exempted by the regulations under this Act.

A regulation could explicitly exempt acts that fit within the meaning of the term "assessment". Such a provision would be consistent with the position taken by Alan Schwartz, the Coordinator of the Review, who said that, in making diagnosis a controlled act, it was "not

intended to impede practitioners not licensed to diagnose from assessing their patients or clients to determine the applicability of a particular range of treatments and from undertaking a course of treatment in appropriate situations" (December 11, 1987).

A stronger alternative would be to add a subsection (4) to Section 26, somewhat as follows:

> An act by a person is not a contravention of subsection (1) or subsection (2), paragraph 1 if, in the course of determining the applicability of a particular range of treatments, the person conducts an assessment of his or her patient or client.

2. A second possibility is to examine the need to include diagnosis as a controlled act. "Diagnosis" as presently defined in subsection 26(2), paragraph 1 of Bill 43, the RHPA, is vague and will resist interpretive consensus. It will offer no protection to the public that is not, or could not be, contained in other provisions of the RHPA. In the case of psychology, the public protection sought would be obtained by a revision of Section 15 of Bill 63, the *Psychology Act*, that would continue restrictions on the terms currently used to identify psychologists and their services. With this proviso, the Board sees no compelling reason why the restrictions on the act of diagnosis should be retained in the RHPA.

The "harm" provision, Section 27.04 in the Schwartz Report

The Board responded to Mrs. Caplan's request, as Minister of Health, for an opinion on the need for this section. Our reply was contained in a letter, dated September 19, 1990, to Mr. Alan Burrows, and a copy is enclosed.

In itself, Section 27.04 does not prevent harm; it merely provides a financial penalty to an unregulated practitioner when it has been established that harm has been caused. In its letter to Mr. Burrows the Board pointed to other mechanisms contained in the legislation for protecting the public against harm. An unregulated practitioner who performs a controlled act exposes him or herself to a heavy fine and/or a prison term; and the regulated professional who performs a controlled act without authorization faces loss or suspension of professional registration. In addition, under the provisions of each professional Act, the regulated professional faces suspension or revocation for harm caused in the legitimate practice of his or her profession. Among the mechanisms protecting the public from harm Mr. Schwartz identified "the strong signal a protected title sends to the public" (December 11, 1987).

For these reasons the Board indicated in its response that, in its view, this section, or a variant, is not required in order to protect the public against harm provided certain other conditions are met. The Board believes it is of great importance that each professional Act contain strong prohibitions against the unauthorized use of professional titles, in order that the public may have adequate means to identify members of regulated professions in their search for services and their exercise of informed choice.

The present wording in the legislation does not provide the means to identify a regulated professional. Those professions whose practice consists mainly in the performance of controlled acts, such as medicine, may not see the need for these provisions. It is, however, of singular importance in the practice of psychology, where the provision of psychological services does not consist mainly of controlled acts, and in many cases will not be judged by the courts to be "health care" – the only area in which the legislation proposes to protect the title, psychologist, or the title of any other regulated professional.

Although we have not been informed of the findings in the survey conducted by Mrs. Caplan as Minister of Health, we have reason to believe that many groups share the views expressed by the Board last September.

Protection of title

In briefs and position papers submitted since 1982 the Board has outlined its reasons why the use of the terms "psychologist", "psychological" and "psychology" must be protected if the public is to be able to identify a psychologist. Moreover, the protection of these terms must not be limited to situations in which "health care" is provided – a limitation contained in the present form of the *Psychology Act*.

The Board has indicated that the practice of psychology has many applications that will not be judged by the courts to be "health care". The practice of industrial or organizational psychology is the most obvious. Less apparent, but also important are the many assessments of families conducted for the purpose of determining custody and access arrangements in the best interest of the child. Under the present wording of the legislation any person offering services in these and other areas may refer to themselves as a "psychologist" whether or not they are registered as a psychologist or even trained in psychology.

We have presented a simple modification of the title protection provision that would meet the needs we have outlined. We trust that the government will perceive that the appeals for uniformity in wording across the professional Acts, while having an abstract legal appeal, are unrelated to the differing circumstances and problems faced by various professions contributing to health care. Elegance in the language of regulatory law surely must bow to the intent of the Regulated Health Professions Act, which is to improve the range and quality of regulated health care services and to allow the public to make effective use of these services.

In respect to the Board's concerns with the wording of the title-protection provisions contained in Section 15 of Bill 63, the *Psychology Act*, the Board canvassed the opinions of over twenty other groups on the following wording:

> 15(1) No person other than a member shall use the title "psychologist", a variation or abbreviation of it or its equivalent in another language in the course of providing or offering to provide services in Ontario.
> 15(2) No person other than a member shall use any designation or description incorporating the words "psychological" or "psychology", a variation or abbreviation of them in the course of providing or offering to provide services in Ontario.
> 15(3) No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a psychologist or in a speciality of psychology.

These provisions retain the restriction contained in the *Psychologists Registration Act*, R.S.O., c.404. None of the groups we contacted in April and May, 1990 objected to the wording the Board is seeking. In fact, supportive letters were received from the Ontario College of Occupational Therapists, the Ontario Society of Occupational Therapists, the Board of Directors of Masseurs, the Board of Directors of Physiotherapy, the Ontario Chiropractic Association, the Governing Board of Denture Therapists, the Ontario Psychological Association and the Ontario Dietetic Association.

In a telephone conversation with the Registrar of the College of Physicians and Surgeons of Ontario, Dr. Dixon stated that he could not imagine any group objecting to the provisions being sought by the Board. In another telephone conversation, Dr. Stephen Semelman of the Canadian Society of Hospital Pharmacists agreed that the issue was important although pharmacists were less affected as their practice consists mainly of the performance of controlled acts. Recently the Board met with representatives of the Coalition of Unregulated Practitioners, Dr. Donald Evans and Mr. Robert MacKay, both of whom indicated that unregulated practitioners, such as pastoral counsellors and persons acting as psychotherapists, have been able to advertise their services without using the presently restricted terms, "psychological" and "psychology". Nor has the Board

found any objection to these provisions raised by members of the Ontario College of Social Workers in the course of frequent discussions of legislation in the early 1980s.

It should be noted here that, in Section 29.03 of his Report, Mr. Schwartz recommended a form of title protection that the Board would not oppose provided this wording was contained in the *Psychology Act*. We are aware that this form of title protection continues to be favoured by some groups, although apparently it was not considered suitable for inclusion in the Bills introduced by the previous government.

In summary, although the practices of many of these professional groups consist mainly in the performance of controlled acts and most of these groups' practices would be considered to be health care, nevertheless most recognize that strong title protection that is not limited to health care is important in the case of the profession of psychology, if the public is to be enabled to make an informed choice of psychological services. And none of these groups has raised objections to the proposal made by the Board for the new *Psychology Act*.

In this letter we have endeavoured to offer constructive suggestions for the resolution of problems with the legislation perceived by other groups that will be affected by it. Although you are aware of the Board's primary concern, we have also included a summary of the Board's recommendations for amending Section 15 of the *Psychology Act*.

We hope that circulation of this statement of the Board's position will be helpful to all concerned. ■

Sincerely yours,

Barbara Wand

Barbara Wand, Ph.D., C.Psych.
Registrar

ETHICAL PROBLEMS IN THE PROVISION OF FORENSIC PSYCHOLOGICAL SERVICES

In response to questions raised by a psychologist concerned with the ethical issues in providing court-ordered assessments Mr. David Porter, a lawyer with the firm of McCarthy Tétrault, was asked to provide an opinion. Mr. Porter's opinion, offered in a letter to the Registrar, is reproduced below in the belief that this opinion will be helpful to psychologists providing similar services.

Dear Dr. Wand:

Re: The Ethics of Forensic Psychological Services

At your request I have considered what psychologists performing court-ordered psychological assessments should do when patients for whom assessments are ordered refuse to consent to the psychologist obtaining information from family, friends or other treating mental health professionals previously seen by the patient. I understand that the patients referred to are those persons charged with criminal offences who are being held in custody either prior to their trial or after conviction. These individuals are assessed by the psychologist, and some are treated as well.

Court-ordered psychological assessments of persons accused of criminal offences occur in essentially four contexts:

1. ***Referral from Bail Hearing***
   When the accused is before the Court for a bail hearing, the Court may order a three day remand to have the accused examined where it appears that a serious mental illness may be contributing to the accused's criminal activity. This may be done without any medical evidence of psychiatric illness being adduced before the Court, and may be done without the consent of the accused.
2. ***Referral from a Preliminary Inquiry, Trial or Appeal***
   Where, as a result of the 3 day examination referred to above, or for any other reason, a judge at a preliminary inquiry, a trial, or an appeal concludes, with the support of the opinion of one physician, that an accused "may be mentally ill" then he can order an accused to be remanded "for observation" for a period of up to 60 days at an appropriate facility. Such an order may be made over the objection of an accused.
3. ***Defence of insanity***
   Where the accused raises the defence of insanity the Crown will usually seek to have a psychiatrist or psychologist chosen by the Crown examine the accused to determine whether the accused was legally insane at the time of the commission of the offence.
4. ***Dangerous Offender Applications***
   Where an accused has been convicted of an offence involving serious violence, and the Crown seeks to have the accused found to be a "dangerous offender" (thereby keeping the offender in jail indefinitely) the Court must hear from at least two psychiatrists, one nominated by the Crown and the other by the defence. A Crown-appointed psychiatrist will, therefore, perform an assessment of the convicted person to prepare his or her opnion as to whether or not the person is a "dangerous offender", as defined in the Criminal Code.

In each case the assessment is being performed for the assistance of the Court. In each case the patient can refuse to co-operate with the psychiatrist or psychologist, thus frustrating the assessment. In such circumstances the Court may draw an inference adverse to the patient as a result of the patient's refusal to co-operate with the psychiatrist or psychologist. In other words, the Court will infer from any unwillingness on the part of the patient to co-operate, or from a refusal to provide information, or to consent to the release of past assessments, that the information kept from the present assessor is evidence that would undermine the patient's present assertions about himself (e.g. that he was insane at the time he committed the murder, or that he is not emotionally ill and not dangerous, and therefore can be released on bail).

As I understand the definitions in the *Standards of Professional Conduct*, when there is a court-ordered assessment, the user of the psychological service performed is the Court, while the accused is the "client" because he or she is the "direct recipient of psychological services" paid for by the user. As you know, principle 7 of the *Standards of Professional Conduct* requires that psychologists ensure that "the privacy of the client is assured". Section 7.3 states that "information will be released only with the permission of the client" and, in section 7.4 the standards state:

> "Subject to interpretation 7.3 above, a psychologist shall not release the name of a client or information regarding a client... except with the informed written consent of the client..."

"Professional Misconduct" is defined in s. 1(p) of Regulation 825 of the *Psychologists Registration Act* to include:

> "giving information concerning a person or any professional services performed for a person to any other person without the consent of the person, unless required to do so by law."

It is my opinion that where a person charged with an offence is sent to a facility for a court-ordered psychiatric or psychological assessment, the psychologist working on the assessment has a duty to keep even the person's name confidential, unless the person gives an informed consent to the disclosure

of that information.

Any attempt by the psychologist to obtain information from either family or friends of that patient or from a treating psychiatrist will invariably lead to at least the disclosure of the patient's name. In my opinion this cannot be done without the consent of the patient.

The purpose of the assessment in each case is to assist the Court in determining what order to make in respect of a patient who is an accused or convicted criminal. If the patient refuses to consent to the psychologist obtaining all necessary information, the Court will draw an adverse inference against the patient. The Court will likely conclude that the patient's present assertions about himself or herself cannot be true if the patient is unwilling to consent to the psychologist obtaining information necessary to conduct the assessment.

Because the court will draw an adverse inference from a failure of the patient to co-operate, such refusal will only rarely occur. When it does, there is no public policy interest that suggests that psychologists should persist in obtaining information from sources against the patient's refusal to consent. In each circumstance the principle of confidentiality would be breached for no material benefit to the public. The patient's refusal to co-operate or to consent to the psychologist obtaining certain information is as likely to undermine the patient's own case in Court as any evidence the psychologist may find. Accordingly, there is no compelling "public policy" reason to sanction a breach of confidentiality in this situation.

In my opinion it is misguided for a psychologist to attempt individually to "protect the community" by breaching ethical principles of confidentiality in order to get more complete information about the patient. The psychologist should, when he or she obtains a refusal from the patient, contact the patient's lawyer and advise the lawyer of the refusal. The psychologist should indicate to the lawyer that the fact of the refusal will be mentioned in the report to the Court, and that the psychologist would appreciate it if the lawyer would draw to the client's attention the potential adverse inference which the Court may draw from the refusal to co-operate. The psychologist should suggest to the lawyer that the lawyer may wish to review the matter with the client to determine whether or not the client will continue to be unco-operative. The likely result will be that, after receiving legal advice on the issue, the client will consent to the psychologist receiving all necessary information about the patient because to fail to do so would greatly damage the patient's case in Court. By proceeding as outlined above, the psychologist will likely obtain complete information about the patient without breaching confidentiality. If the patient persists in refusing, the psychologist can be content that when this is mentioned in the report, it will only serve to cause the Court to protect the public by viewing with scepticism any psychological claims by the patient that the patient refuses to allow the psychologist to fully explore.

You have also asked for advice on what a psychologist should do when, in the face of the patient's refusal to consent to the psychologist contacting the patient's family or friends to obtain information, a friend of the patient calls the psychologist and volunteers extensive clinical information. The question is whether it is unethical for the psychologist to passively receive any information offered by this source.

It appears that the reason the psychologist has to ask the patient for permission to contact others about the patient is because inevitably the psychologist will disclose, at the very least, the patient's name in making such inquiries, and this cannot be done without the patient's consent. Theoretically, this problem does not arise when the patient's friend calls the psychologist because obviously the caller already knows the identity of the patient and, as long as the psychologist does not reveal anything else about the patient, it appears that no specific violation of an ethical principle occurs.

It does seem, however, to be unduly sneaky to passively receive information from a source from whom the patient has stated that information cannot be obtained. The fact that the information has been obtained, and its source, will have to be disclosed in the report to the Court, with the result that the patient will find out, and invariably challenge the psychologist as to how it was obtained. Rather than create such difficulties it would seem preferable for the psychologist to refuse to receive the information from the caller, until the matter has been reviewed with the patient, tell the patient of the call and ask again for permission to discuss the case with the caller, after giving the patient the opportunity to obtain legal advice as discussed above. If the patient persists in refusing to consent to the psychologist discussing the case with the source this should be mentioned in the report to the Court, with the consequences referred to above, that the Court will likely draw an adverse inference against the patient.

I understand that in many circumstances the facility initially performs an assessment of prisoners and then proceeds to treat them. It seems to me that where treatment is involved it is even clearer than it is where only an assessment is involved that the psychologist cannot contact persons about the patient unless the patient consents.

Where the refusal to provide information jeopardizes the psychologist's ability to treat the patient, this should be made clear to the patient, and a signed statement taken in which the patient acknowledges his refusal to consent and the fact that he has been informed of the limitations this has placed on the psychologist in being able to properly assist the patient. ■

Yours very truly,

McCARTHY TÉTRAULT

Per

David M. Porter

DAVID M. PORTER

QUESTIONS MEMBERS RAISE

Over a period of twenty-three weeks from November to this April members of the Board staff, Ms. Susan Brooks, Dr. Bruce Quarrington and Dr. Barbara Wand, have responded to written requests from 80 psychologists for advice or interpretation of the professional standards relating to 104 different issues or problem situations in their practices. In addition, the staff has responded to an equal number of questions raised by consumers and other concerned members of the public. In these letters important questions have been raised and difficult situations psychologists were facing have been described. It is hoped that the responses offered have been helpful.

The interpretation and appropriate application of the *Standards of Professional Conduct* to given practice situations account for the bulk of the questions raised; in particular, the standards related to care of records, the protection of privacy, and informed consent for the release of client information. Some of these questions related to the impact of legislation, such as Ontario's *Freedom of Information and Protection of Privacy Act* or its federal counterparts. Other legislation on which psychologists sought opinion was the provincial *Child and Family Services Act*. Psychologists also sought infor-

mation regarding their obligations when under subpoena to testify in court. Somewhat disturbing were the situations in which the demands of an employing organization conflicted with psychologists' professional judgment or sense of obligation to their clients.

A few psychologists have expressed disappointment that the Board is unable to respond to these inquiries on the telephone. As they are often complex and may require legal opinion or other research, it is believed that these inquiries can only be dealt with in this way. Nonetheless, psychologists should be reassured that the Board office continues to deal with a large portion of its regular business by telephone. Approximately 200 telephone inquiries of other sorts are handled each week from psychologists, applicants, branches of government and members of the public – regarding fees, applications, publications, Board procedures, the process of lodging complaints and many other matters. ■

INFORMED CONSENT

Informed consent is the subject of about one-fourth of the questions psychologists direct to the Board concerning the interpretation of the *Standards of Professional Conduct*. In 1983 the January issue of *The Bulletin* contained this comment:

> Employed psychologists are sometimes asked to provide information to other individuals or agencies on the basis of consent which cannot be considered to have been truly informed. The Board considers many statements designed to obtain formal consent insufficiently specific. Among the common omissions are failure to indicate clearly the purpose for which permission is being sought, the identities of the intended recipients of any information to be released, any limit on the period of time during which the consent will obtain, any limit on the scope of the information being released, or any limit on its form.
>
> While no single form of consent is suitable for all situations, psychologists have an obligation to ensure that consent forms being signed are specific and appropriately phrased.

Although the Board offered this statement of principle in 1983, the *Standards of Professional Conduct* do not contain a set of criteria psychologists can use to ensure that the consent they obtain from their clients is truly informed. In a recent meeting, however, the Board considered the need to provide explicit guidance for psychologists wishing to ensure that consent is informed.

The Board is considering introducing a set of principles, supplementary to Principle 7.4, derived from Recommendation 79 of Mr. Justice Horace Krever's 1980 *Report of the Commission of Inquiry into the Confidentiality of Health Records*. The Board believes these criteria would, if met, protect the interests of psychologists as well as those of their clients – by demonstrating that informed consent has been sought AND obtained.

Even so, the Board is aware that these criteria are more stringent than the requirements for client consent presently used in many institutions in Ontario. Therefore, before they are adopted as an addition to the standards, the Board has decided to publish the proposed criteria here along with an invitation to psychologists to comment.

7.4.1. To ensure that a client's authorization permitting disclosure is informed, psychologists will require that the written authorization:

(a) be in writing and contain the original signature of the subject of the information as well as the original signature of a witness;

(b) be dated;

(c) specify the name or description of the person or institution intended to release the information;

(e) include a description of the information to be disclosed;

(f) specify the purpose for which the information is requested;

(g) include an expiration date or time limit for the validity of the authorization; and

(h) specify that the individual may rescind or amend the authorization in writing at any time prior to the expiration date, except where action has been taken in reliance on the authorization. ■

DISCIPLINARY HEARING

A hearing into allegations of professional misconduct against Dr. Howard Schachter was held before a discipline tribunal of the Ontario Board of Examiners in Psychology on January 14, 1991.

THE ALLEGATIONS

It was alleged that Dr. Schachter was guilty of professional misconduct under the Act in that he failed to maintain the standards of practice of the profession in his conduct toward Ms. A and Ms. B. Further it was alleged that Dr. Schachter was guilty of conduct unbecoming a psychologist.

In particular it was alleged that:

1. He made a series of telephone calls to Ms. A on or about November 9, 1989, on or about November 10, 1989 and on or about November 11, 1989 during the course of which he sexually harassed Ms. A in that he persisted in questioning her and making comments of a personal and sexual nature.
2. He had a meeting with Ms. B on or about September 21, 1989, telephoned her late on that day, and telephoned her again on or about September 23, 1989 during the course of which he sexually harassed Ms. B in that he persisted in questioning her and making comments to her of a personal and sexual nature.

THE PLEA

Dr. Schachter entered a plea of guilty with respect to the charge of professional misconduct. He did not plead guilty to the charge of conduct unbecoming a psychologist and that charge against him was withdrawn.

DECISION OF THE TRIBUNAL

The Tribunal accepted Dr. Schachter's plea of guilty to the charge of professional misconduct.

REASONS FOR THE DECISION

The Tribunal reviewed an Agreed Statement of Facts, submitted to them by legal counsel to the Board and legal counsel to Dr. Schachter, and accepted them.

PENALTY

It was decided by the Tribunal:

1. That Dr. Schachter's certificate of registration be suspended for four months.
2. That the facts of this case and Dr. Schachter's name be published in *The Bulletin* of the Ontario Board of Examiners in Psychology. The names of the complainants shall not be published.

REASONS FOR THE PENALTY

In the opinion of an expert witness who testified at the hearing, Dr. Schachter's behaviour constituted sexual harassment, as indeed had been the opinion of the person

responsible for investigating this matter within the educational institution in which Dr. Schachter worked, who was also a registered psychologist. The expert witness stated that the professor/student relationship involved an imbalance of power and that there must be trust that the professor's power will not be abused. Students view a professor as someone who will be fair, and will not bring sexually oriented remarks into the relationship. Further, in the opinion of the witness, psychologists have an added responsibility as they often teach materials relevant to student's lives and students are more likely to approach them for help with personal problems, and engage in self-disclosure. She informed the Tribunal that in their opinion the area of experiential therapy in which Dr. Schachter engaged in both teaching and clinical practice requires especially strict professional boundaries because of the intimate nature of the material under discussion.

Further, the expert witness stated that she believed that a community standard now exists in universities in Canada regarding the unacceptability of sexual harassment of students by professors. She also informed the Tribunal that in her opinion, a dual relationship still exists after a rebuff by a student of the professor's questioning or remarks, as the power to assess the student's performance still remains in the professor's domain.

Legal counsel for the Board submitted that Dr. Schachter had violated several of the APA Ethical Standards of Psychologists (1977 Revision), citing the following:

1. Preamble of the Standards: Psychologists respect the dignity and worth of the individual and honour the preservation and protection of fundamental human rights ...
2. Principle 1 (d): As teachers, psychologists recognize their primary obligation to help others acquire knowledge and skill. They maintain high standards of scholarship and objectivity by presenting psychological information fully and accurately.
3. Preamble to Principle 3: Regarding their own behaviour, psychologists should be aware of the prevailing community standards and of the possible impact upon the quality of professional services provided by their conformity to or deviation from these standards ...
4. Principle 3 (b): As employees, psychologists refuse to participate in practices inconsistent with legal, moral and ethical standards regarding the treatment of employees or the public ...
5. Preamble to Principle 6: Psychologists respect the integrity and protect the welfare of the people and groups with whom they work ...
6. Principle 6(a): Psychologists are continually cognizant of their own needs and of their inherently powerful position vis a vis clients, in order to avoid exploiting their trust and dependency. Psychologists make every effort to avoid dual relationships with clients and/or relationships which might impair their professional judgement or increase the risk of client exploitation. Examples of such dual relationships include treating employees, supervisors, close friends or relatives. Sexual intimacies with clients are unethical.

The Board's legal counsel held that Dr. Schachter had violated all of these principles.

Counsel for Dr. Schachter submitted that:

1. Dr. Schachter had acknowledged his guilt in this matter and cooperated fully with the Ontario Board of Examiners in Psychology during the investigation and prosecution.
2. Similarly, Dr. Schachter had complied with the requirements of the sexual harassment investigation at the educational institution in which he worked.
3. Dr. Schachter had never before been the subject of a discipline hearing before a Tribunal of the Ontario Board of Examiners in Psychology.
4. Dr. Schachter's admitted behaviour took place over a very short period of time, mainly on the telephone, and consisted of verbal interaction with no physical contact.

However, one of the complainants suffered a disruption of the management of her life at the university so that she could avoid further contact with Dr. Schachter. It is consequences such as this that the Tribunal took into account in determining penalty.

The Tribunal believed that sexual harassment in a university or clinical setting is totally unacceptable conduct however manifested. The power imbalance between teacher/student, therapist/client is implicit and it is the responsibility of the psychologist to maintain professional boundaries. In the opinion of the Tribunal, emotional damage to victims of sexual harassment and the limitations on their lives may often be as serious as that experienced by victims of sexual abuse. Any constraint against full participation in the academic program can have a very serious effect on the academic achievement of the student. ■

ADDITIONS TO THE TEMPORARY REGISTER

October, 1990

Lynette Bauer
Janet Clewes
Daniel Cohen
Heather Davidson
Margaret DeCorte
Pierre Dion
Christina Henninger
Naresh Issar
Mary Klein
Brian Lazowski
Barbara Morrongiello
Randolph Paterson
Coralee Popham Lane

November, 1990

Virginia Bourget
Eleanor Cruise
David Day
David Eccles
Bonnie Gillis
Phyllis Nemers
William Parkinson

December, 1990

Peter Barnett
Carolee Mae Orme

January, 1991

Patricia Cheston
Terry Gall
Gareth Hughes
Anthony Iezzi
John Jordan
Jonathan Mayhew
Wayne Nadler
Helen Radovanovic
Lorna Sandler
Janine Scott
Lynne Sinclair
Karen Terzanno
Moira Tweedale
Michael Vargo
Margaret Weisser

February, 1991

Philip Ritchie

March, 1991

Laurie Gillies
Wendy Henry LeDoux
Marie Kuriychuk
Sandra Nandi
Patricia Rankine
Kathryn Stokes
Jean Szkiba-Day
Jodie Waisberg
Barbara Wilson-Nolan
Warren Zackon

April, 1991

Mario Cappelli
William Colvin
Lynette Eullette
Frederick Schmidt
Brynah Schneider

DECEASED

The Board has learned with regret of the death of Ontario psychologist:
Donald MacTavish, M.A. January 30, 1991

The Bulletin

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