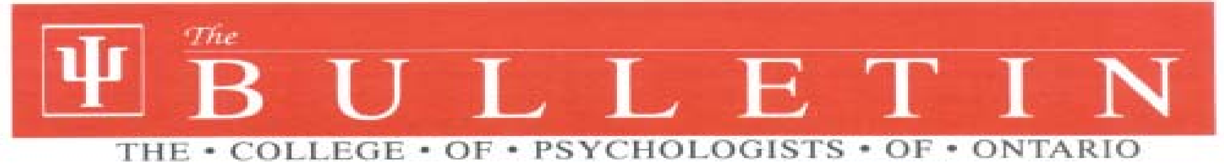

Consent to Treatment

Capacity, Children, Custody

Since passage of the Consent to Treatment Act, 1992 and its successor, the Health Care Consent Act, 1996, members have sought guidance respecting appropriate consent for providing services to minors. Even before either of these statutes was passed, it had become an established principle in common law that an individual who had the capacity to understand the nature of a treatment being proposed and the expected benefits and possible risks of that treatment could consent on his or her own behalf.

Members were concerned about providing treatment to a minor without involving the parent of the minor to obtain consent. They were confused in light of provisions in the Education Act which require parental consent for intellectual or personality assessment of a child; they wondered if the same requirement applied to the provision of therapeutic services to a child. In contrast, the Child and Family Services Act allowed for a child aged 12 or over and under the auspices of a Ministry of Community and Social Services agency to consent for him or herself to counselling services.

Health Care Consent Act, 1996

The Health Care Consent Act provides that anyone "capable with respect to treatment" may give consent to treatment on his or her own behalf. There is no discussion of a minimum age. Rather, the Act states that the health practitioner should assume that the person is capable of consenting on his or her own behalf unless there are reasonable grounds to believe otherwise. The Substitute Decisions Act, 1992 provides that a person who is aged sixteen years or more is presumed to be capable of giving or refusing consent in connection with his or her personal care. This does not preclude a practitioner from determining that a younger person is capable of consenting to treatment, but does imply that greater care should be taken in making that determination. The determination of capacity to consent to the particular treatment relies on the judgement of the health practitioner.

No treatment without consent

The Act further provides that a health care practitioner who proposes a treatment for a person shall not administer the

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treatment unless the person is capable with respect to the treatment and has given consent. If the practitioner is of the opinion that the person is incapable with respect to consenting to the treatment, the consent of the person's substitute decision maker (as specified in the Act) must be obtained before treatment can be provided.

What is appropriate consent?

The consent must be related to the treatment, it must be informed, it must be given voluntarily and it must not be obtained through misrepresentation or fraud.

What is informed consent?

A consent to treatment is informed if, before giving it, the person received information about the nature of the treatment, the expected benefits of the treatment, the material risks of the treatment, the material side effects of the treatment, alternative courses of action and the likely consequences of not having the treatment. The information should be of the sort that a reasonable person in the same circumstances would require in order to make a decision about the treatment. The person must also have received responses to his or her requests for additional information about those matters.

...There is no discussion of minimum age...

Members should make reasonable efforts to ensure that the information provided to the person is in a form appropriate to the understanding, language and needs of the person while communicating accurately the nature and expected outcomes of the proposed treatment.

Consent may be express or implied and may be withdrawn at any time by the person, or by the person's substitute decision maker if the person is incapable with respect to the particular treatment. Members are encouraged to record the nature of the discussion with the client, any clarification provided and the manner in which consent was given.

What is treatment?

The Health Care Consent Act defines "treatment" as anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment or a plan of treatment. It does not include the taking of a person's health history, the assessment or examination of a person to determine the general nature of a person's condition, a treatment that in the circumstances poses little or no risk of harm to the person, or the assessment for the purpose of the Health Care Consent Act of a person's capacity with respect to treatment.

This means that a member can conduct an intake interview to determine whether a more formal assessment is required, to propose a preliminary treatment plan and to evaluate the person's capacity to understand and give consent to the proposed treatment. If the member is conducting a formal capacity assessment under the Substitute Decisions Act, this is not considered "treatment" within the meaning of the Health Care Consent Act and may be carried out without meeting the full requirements for consent under the Health Care Consent Act.

How old must a child be in order to consent to his or her own treatment?

The child's consent to treatment is sufficient so long as the child is capable with respect to treatment, that is, so long as the child understands the proposed treatment and the possible risks and benefits of having or not having the treatment. Members are advised to use their professional judgement and to exercise appropriate care in determining whether a child is capable of consenting to treatment.

Where the member determines that a child is incapable with respect to treatment, treatment may not be carried out unless consent has been obtained from the parent of the child (this does not apply to a parent who has only a right of access except in certain circumstances discussed below) or a children's aid society having custody of the child or other person who is lawfully entitled to give consent or refuse consent in the place of the parent.

The person described above may give or refuse consent only if he or she:

* is capable with respect to the treatment,
* is at least 16 years old (unless he or she is the incapable person's parent),
* is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf,
* is available, and is willing to assume the responsibility of giving or refusing consent.

A parent who has only a right of access to a child may give

consent only if the custodial parent is incapable, unavailable or unwilling to assume the responsibility of giving or refusing consent. (A person is considered to be available if it is possible within a time that is reasonable in the circumstances to communicate with the person and to obtain a consent or refusal.) Even so, the access parent may give or refuse consent only if he or she is capable with respect to treatment and is not prohibited by a court order or separation agreement from giving or refusing consent on behalf of the child.

A person giving or refusing consent to treatment on behalf of a child must act in the child's best interests after receiving all of the information necessary for an informed consent.

What is the effect of the Education Act?

Other than requiring prior written permission from the pupil, or from the parent of the pupil if the pupil is a minor, before administering a proposed test of intelligence or personality, neither the Education Act nor the regulations made under it appear to affect the law of consent to psychological treatment now set out in the Health Care Consent Act. This means that if a member is planning to give a pupil an intelligence test or a personality test, the member must first obtain the written consent of the pupil if the pupil is 18 years of age or older; if the person is under the age of 18, the consent of the parent or guardian is required. For any other treatment, the pupil's consent is adequate provided that the pupil is capable with respect to the proposed treatment.

> *...anyone "capable with respect to treatment" may give consent to treatment on his or her own behalf...*

How do I determine whether the child (or parent) is capable with respect to the treatment?

A person is considered capable with respect to treatment if the person is able to understand the information that is relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision. A practitioner may presume that a person is capable with respect to treatment unless the practitioner has reasonable grounds to believe otherwise. A practitioner should take greater care, however, in relying on a presumption of capacity for a person under the age of 16.

What do I do if the child cannot consent, that is, if the child is incapable?

If the child is incapable of consenting to treatment within the meaning of the Health Care Consent Act, 1996, the member is expected to inquire whether the person accompanying the child has custody or joint custody of the child. This inquiry and the response to the inquiry should be documented.

Where the parents are not separated, the member may rely upon the consent to treatment of the child from either parent.

Where the parents are living separate and apart and the child resides with one parent with the consent of the other, unless or until a separation agreement between the parents or a court order provides otherwise, the parent with whom the child resides has the right to consent to treatment on behalf of the child. Once the final custody arrangement has been determined by agreement or by court order the parent with custody may consent to treatment on behalf of the child. In a joint custody arrangement, it is rare for the consent of both parents to be required. However, where this is the case this provision must be observed.

If the person accompanying the child denies having custody of the child and the custodial parent has not provided consent, the member may not proceed to treat the child. If the person reports having joint custody of the child, the member should inquire whether the consent of both parents is required. In the rare case where both parents must consent to treatment, the member may not proceed to treat without the consent of both parents.

If the person accompanying the child reports having custody or being able to consent to treatment on his or her own in a joint custody arrangement, the member may rely upon the consent of that person, unless the member has reasonable grounds to doubt the word of the person.

Doubt respecting the authority of the person to consent could be based on the member's judgement regarding questionable behaviour of the person or on available information contradicting the person's claim respecting custody.

Summary

Where a child is incapable of consenting to treatment, the member is advised to inquire whether the accompanying adult has custody of the child and whether, in the case of a joint custody arrangement, the person may consent on his or her own to treatment for the child. If in the member's judgement, there is no reason to doubt the person's assertion of custody and the right to consent, the member may rely upon that consent in providing treatment. The member's inquiry and the resulting response should be documented in all cases.§

PRESIDENT'S REPORT

The first months of the fiscal year have proven to be very busy ones for the College. As President, it has been my goal to foster better communication with government respecting regulatory issues. To that end, I met with John Baird, MPP on August 12, 1996 to discuss the College's concerns about the loss of public access to psychological services in public hospitals and the continuing delay of the government in passing regulations submitted two and one half years ago. On October 8, 1996, representatives of the College met with Jim Wilson, MPP, Minister of Health, Jessica Hill, Assistant Deputy Minister: Mental Health Services, and other Ministry representatives to discuss the delay in passing the College's proposed regulations, the reduction of psychological services available in public hospitals and the promotion of regular communication with the Minister's office.

Over the summer, the College participated in consultation sessions on the proposed legislation on health information. A formal submission was made in response to the Ministry's consultation paper and the College has applied to make oral and written submissions on the draft legislation itself when it becomes available. This legislation is particularly important to clients of psychological professionals as confidentiality is central to the client professional relationship. The Executive Summary of the College's submission may be obtained upon request from the College.

The Registrar met with Barry Campbell, MP, Parliamentary Secretary to the Minister of Finance and the College wrote to the Honourable Paul Martin, Minister of Finance to express concern over a proposal to remove the exemption for non-profit organizations respecting mandatory collection of the GST on annual fees. Following the intervention of a number of organizations, the Ministry of Finance recanted on this proposal.

More recently, the College has participated in written and oral consultations for the Red Tape Review Commission established by the government. Specifically, the College commented on proposals from the Ministry for amending the RHPA to reduce administrative requirements by shifting some of the regulation making authority of the Colleges to by-laws and amending some of the provisions for the complaints process. It is expected that the Commission will make its report to the legislature near the end of the calendar year.

The College continues to participate actively in the Federation of Regulated Health Colleges. At the October 31, 1996 general meeting, the Health Professions Regulatory Advisory Council will be conducting a workshop to assist in preparation for a formal review of the RHPA anticipated by December 1998.

Both the President and the Registrar attended meetings of the Council of Provincial Associations of Psychologists and the Association of State and Provincial Psychology Boards where one topic of discussion has been the regulatory role in the mobility of psychological professionals and the expected impact of the North American Free Trade Agreement and the Agreement on Internal Trade. Canadian jurisdictions will be considering the possibility of establishing bilateral or multilateral Memoranda of Mutual Recognition to facilitate the mobility and regulation of qualified psychological professionals.

The President, the Registrar and Mr. Giffen, a public member of the Council have also been involved in ongoing meetings with executive representatives of the Ontairo Psychological Association to discuss areas of mutual concern.

I shall be reporting further developments on these and other matters in this space in future issues.

Dr. John Goodman, C.Psych.
President

Health Care Consent Act: Information to Incapable Persons

The Health Care Consent Act, 1996 which replaced the Consent to treatment Act, 1992, does not have any requirements for advising incapable persons of a finding of incapacity or of the option of applying to the Consent and Capacity Review Board for a review of a finding of incapacity.

The removal of such requirements which were found in the Consent to Treatment Act acknowledges the likelihood that many incapable persons would have been unable to understand such information and therefore to benefit from it.

In his correspondence of February 22, 1996, the Minister requested that Colleges develop guidelines for members for informing incapable persons of their rights. The following are the guidelines approved by the Executive Committee in July and provided for information to the Minister. Please retain these guidelines for your reference when you determine that a client is incapable with respect to consent to treatment.

Guidelines for Providing Information to Incapable Persons

The member uses professional judgement to determine whether the client is capable of understanding information regarding a substitute decision maker. It is possible that in some cases, for example a very young child or a client with advanced dementia, the member may conclude that the client is incapable of understanding information respecting a substitute decision maker.

When a member finds a client incapable with respect to consent to treatment but capable of understanding information relating to a substitute decision maker, and the emergency provisions of the Act do not apply, the following guidelines are to be followed:

1. The member must advise the incapable client that a substitute decision maker will assist the client in understanding the proposed treatment and will make a final decision. This is communicated in a manner that takes into account the client's capability of understanding the information.

2. The member should involve the client to the extent possible in discussions with the substitute decision maker.

3. If the client disagrees with the need for a substitute decision maker because of the finding of incapacity, or because of the involvement of the present substitute, the member must advise the client of his or her options. These include finding another substitute decision maker of the same or more senior rank, and/or applying to the Consent and Capacity Review Board for a review of the finding of incapacity and/or for the appointment of a representative of the client's choice.

4. Members are expected to provide reasonable assistance to clients if they wish to exercise these options. §

Client Relations Committee Update

The role of the Client Relations Committee is to enhance relations between members of the College of Psychologists and the public. In fulfilling this mandate, the Committee is concerned with client best interests, professional and public education, and issues which may arise in the relationships between members and their clients.

To date, the Committee has been working in a number of areas including: the RHPA mandated Sexual Abuse Prevention Plan; provisions for funding and additional eligibility criteria for therapy and counselling for clients who were sexually abused by members; professional liability insurance; dual relationships; boundary issues; and evaluation of the Alternate Dispute Resolution process in resolving client complaints.

Currently, a number of projects are on the work plan. The Committee is developing a public information brochure to describe the role of the College, to identify the two profes-

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sional titles of members, and to explain the benefits and protection inherent in obtaining services from a regulated health professional. This publication would be available for wide distribution to current clients as well to others who may need to seek psychological services. More detailed information on the workings of the College, its regulatory functions and structure as well as a description of the Committees and their roles would be available upon request.

As part of their Sexual Abuse Prevention Plans, a number of other Colleges have developed extensive guidelines for their members pertaining to boundary violations and sexual abuse prevention. The Client Relations Committee is reviewing the work of the other Colleges with a view to developing guidelines applicable to the practice of psychology.

The Complaints and Discipline processes of the College are, understandably, very demanding and stressful for both the complainant and member. The Client Relations Committee has undertaken to evaluate these processes, from both client and member perspective, and, where possible, incorporate their suggestions and experiences into these regulatory functions.

To meet its mandate most constructively, the Client Relations Committee requires ongoing awareness of potential client/member issues and draws upon many sources for this. The primary source of information is the Committee's review of questions or concerns received by the College from both members and the public. This information is invaluable in understanding potential dilemmas that can arise in the client/professional relationship. In addition, the Committee identifies relevant issues through contact with parallel committees of other Colleges and by reviewing current literature on professional practice and ethical matters.

If you are interested in reviewing and commenting upon drafts of the materials being developed, please let us know. As well, as the best source of information about client relationship issues, the Committee welcomes any suggestions you may have in helping us to further enhance relations between members of the College and the public.§

Quality Assurance Committee Update

The development of the Quality Assurance Program steadily continues as we move toward the January 1997 implementation date required by the RHPA. The Regulation describing the program, first distributed with the consultation paper in the Bulletin last April, has undergone revision and improvement reflecting the input and suggestions from members. Council will consider the revised draft at its meeting on November 29 and 30, 1996.

In response to the article in the last Bulletin, many members requested the opportunity to review the Self-Assessment Guide and feedback has been both positive and constructive. With some further minor modifications, the Self-Assessment Guide will be ready for use early in the new year.

Quality Assurance presentations are taking place in a number of communities across the province to afford members the opportunity to hear more about the Program. The purpose of these evenings is to present the current status of the Quality Assurance Program and those held to date have been well received. The Program continues to be "work in progress" and these presentations provide the opportunity for further member consultation, discussion and input. In addition, there is a discussion of members' most pressing concerns and most frequently asked questions about the program and the chance to add to this list. It is a credit to our membership that concern about client confidentiality leads the list of concerns over any questions regarding the implications of the Program for members themselves. The 'roadshow' has been to Sudbury and through teleconferencing other communities in the north, as well as to Ottawa and Toronto. Future meetings are being planned for London, Hamilton-Niagara and Kingston.

The goal of the Quality Assurance Program is to motivate members to maintain a high level of quality in their delivery of psychological services. It is hoped members will take advantage of the Program, viewing it not only as a process by which the College assures the public of quality within the profession, but as an opportunity for each individual practitioner to assure themselves of the quality of the services they offer their clients.§

Registration Developments: Jurisprudence Examination

Oral/Jurisprudence Examination: Distinct Components

As anyone who has gone through the registration process over the past year and one half can tell you, the oral examination has been split into two distinct components, the regular oral examination and the jurisprudence examination.

At its meeting of December 1994, the Council of the College approved separating the legislation and ethics portion of the oral examination from the practice aspects of the examination.

In doing so, the Council endorsed the importance of ensuring that individuals registered in Ontario demonstrate knowledge of legislation and standards relevant to the practice of psychology. In addition, the Council noted that while both the North American Free Trade Agreement and the Agreement on Internal Trade require individual jurisdictions to facilitate mobility of qualified professionals, both agreements recognize that it is in the public interest for professionals to satisfy the regulatory body respecting their knowledge of local legislation and standards.

The jurisprudence component and the practice component of the oral examination are currently administered during the same examination time slot, with the practice component preceding the jurisprudence component. The demonstration of jurisprudence knowledge appropriate for autonomous practice is a necessary dimension for passing the oral examination.

Written Jurisprudence Examination under Development

Having established the oral jurisprudence examination, the College approved the development of a standardized written mastery examination for jurisprudence. While the written examination will evaluate knowledge of jurisprudence, the Council affirmed that the application of knowledge of jurisprudence and standards to practice would still be evaluated during the oral examination.

Work on the written jurisprudence examination will commence over the next few months and examination items are expected to be ready for field testing in the autumn of 1997 and spring of 1998. In the autumn of 1998, it is anticipated that the first formal administration of the written jurisprudence examination will occur. Until then, registration candidates will continue to be required to take the oral jurisprudence examination.

Each year the Directory of Members contains a list of documents relevant to the practice of psychology. All members and registration candidates are encouraged to review this list and to ensure familiarity with the legislation, regulations, standards, guidelines and ethical codes which bear on the practice of the profession. §

Registration: Transitional Entry for Psychological Associates to End December 1998; Regular Entry Continues

If you or anyone you know is considering registration as a Psychological Associate, it would be a good idea to obtain a copy of the academic requirements and the experience requirements soon.

While regular entry registration will continue, the opportunity to have your registration application reviewed under the transition stream requirements will soon end. In fact, as the required five years of post-graduate experience as well as the required examinations (Examination for Professional Practice, jurisprudence and oral) must all have been successfully completed by December 31, 1998, you should be submitting your application as soon as possible.

If you have reviewed the requirements for regular entry and believe that your Masters Degree in Psychology meets those requirements, then you may be eligible to apply for registration as a psychological associate under regular entry, in which case the December 31, 1998 deadline for completing all of the requirements does not apply.

In order to assist potential applicants in determining whether their academic training meets either the regular entry requirements or the transition stream requirements, the Registration Committee is prepared, for a fee, to carry out an academic credential review.

If you are in any doubt that your academic training and experience meet the regular entry requirements and want to know if you may be eligible under the time-limited transition requirements, act now to determine if professional registration is a possible career goal for you.

For further information on regular and transition stream entry and how to obtain an application package, please contact the College by telephone, facsimile or *e-mail*. §

CONFLICT OF INTEREST

Draft Regulation

Following in this issue of the Bulletin, you will find the annotated text of a draft regulation on conflict of interest for members. Council and Executive have approved the text for circulation to members for consultation. The draft is not College policy; it reflects Council's proposal for this regulation. The views of the members are being sought before a revised version is prepared and approved for submission to the Ministry for review.

In preparing the draft regulation, Council consulted guidelines provided by the Professional Relations Branch of the Ministry of Health and by the Health Professions Regulatory Advisory Council. The regulations drafted by other Colleges were also considered. Council debated the particular conflicts likely to arise in psychological practice and considered the circumstances in which the provision of service to the public might be compromised.

Please read the draft regulation carefully, discuss it with your colleagues and provide your feedback to the College. All written submissions will be forwarded to the Council for review prior to approval of a revised draft to go to the Ministry.

Draft Regulation

Conflict of Interest: Members of the College

Revised October 15, 1996

1 Introduction

1.1 This Regulation is made under the authority of the Psychology Act, 1991, and the Regulated Health Professions Act (Code), 1991, 95.- (1) 21.

Establishes the legal basis for the regulation, and provides a specific pointer to the relevant sections of the Code.

1.2 The purpose of this regulation is to identify what constitutes a conflict of interest in the practice of the profession, and to regulate and/or prohibit the practice of the profession in cases were there is a conflict of interest. In addition, this regulation defines conflict of interest for the purpose of Ontario Regulation 801/93 (Professional Misconduct).

Provides a clear statement about the purpose of the regulation, and establishes the regulation's connection to the Professional Misconduct regulation.

2 Definitions

2.1 *Conflict of Interest.* In the context of a professional relationship in which psychological services are being provided, conflict of interest refers to a situation in which a Member's material, personal or moral interest influences the exercise of the Member's professional duty with respect to the Member's client(s).

Adapted from the HPRAC definition. Defines conflict of interest narrowly, to include only instances where the Member's behaviour is actually affected by the conflict, as has been done in the HPRAC definition and by the Courts. Distinguishes the three kinds of interest addressed below.

2.2 *Material interest.* Financial or other material circumstances favourable to a Member.

2.3 *Personal interest.* Personal circumstances of a Member, including but not limited to, family and personal relationships.

Identifies personal circumstances that might influence a Member's conduct in the course of professional work. Provides the basis for definition of dual relationship as a conflict of interest.

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2.4 *Moral interest.* A Member's religious beliefs or other personal convictions.

Identifies personal convictions as a source of conflicts.

2.5 *Relative.* A family member by virtue of blood relationship, adoption, marriage, common-law or life partner relationship.

2.6 *Self-referral.* When a Member refers a client to himself/herself or to a relative, or to an organization or agency in which the Member or a relative has a material interest, for treatment, services or acquisition of materials.

3 Professional Misconduct

3.1 It is professional misconduct for a Member to practise the profession while in a conflict of interest, except as otherwise provided for in this regulation.

Professional Misconduct Regulation, Section 10.

4 Material Conflicts of Interest

4.1 Without limiting the generality of paragraph 2.1, a material conflict of interest occurs in the following circumstances:

4.1.1 A member refers a client to himself or herself, or to a relative;

4.1.2 A member or a relative receives or provides a material benefit in exchange for a referral to or from the Member, or in exchange for a promise to refer;

4.1.3 A member advises a client on a course of action that will likely result in a material benefit for the Member or a relative, except when the advice relates directly to the course of treatment, assessment or other professional intervention appropriate to the needs of the client;

4.1.4 A member engages in any other form of self-referral.

5 Personal Conflicts of Interest

5.1 Without limiting the generality of paragraph 2.1, a personal conflict of interest occurs when a Member has a family, personal, business or other non-client relationship which reduces the capacity of the Member to act in the best interests of his or her client.

Addresses the issue of dual relationships. A general statement that is limited to the effect of the second relationship, without attempting to define it completely.

6 Moral Conflicts of Interest

6.1 Without limiting the generality of paragraph 2.1, a moral conflict of interest occurs in the following circumstances:

6.1.1 A member has a religious or personal conviction that prescribes a course of action with respect to client circumstances, or that otherwise limits the advice or treatment provided to a client, and

Intended to address instances where a moral conviction prevents a practitioner from recommending a course of action that might otherwise be desirable.

6.1.2 the prescription or limitation goes beyond those provided in law.

Limits application to those instances that go beyond the law. For instance, if abortion were prohibited by law, it would not be a conflict of interest for a practitioner with strong anti- abortion sentiments to treat a client considering abortion.

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7 A material, personal or moral conflict of interest is permissible under the following circumstances:

Provides that a treatment within a conflict of interest situation is permissible, if the client fully understands the situation, is offered alternatives, and still agrees to continue. It must be demonstrable however, that the client was not unduly influenced by the practitioner. Current wording should also govern instances where the client is incapable of reasonably determining their own course of action.

7.1 the conflict of interest is accurately and clearly explained to the client, and the client demonstrates an understanding of the issues; and,

7.2 alternative courses of action for the client are identified, including referral to another practitioner, and the Member undertakes to facilitate implementation of these options if they are chosen by the client; and,

7.3 the client chooses to continue with the course of action giving rise to the conflict of interest; and,

7.4 the client's interests are not compromised as a consequence of the client's trust relationship with the Member.

8 Section 7 does not apply when:

Identifies circumstances where a conflict of interest cannot be allowed, even with the apparently informed consent of the client.

8.1 the Member has a romantic or sexual relationship with the client;

8.2 the Member is in a position of authority or in an evaluative or supervisory relationship with respect to the client;

8.3 the client is incapable of appreciating the significance of the conflict of interest; or,

8.4 continuing to provide a service to the client would violate other applicable Regulations or Standards of practice of the profession or any Statute relevant to the practice of the profession.§

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Member Feedback

Council needs to know your views.

After reviewing the draft regulation on conflict of interest and discussing it with your colleagues, please send the College a note, letter, or copy of the regulation with your comments and suggested changes by mail, facsimile or *e-mail*.

In addition to outlining your specific concerns and suggestions, please provide general comments on whether you think the regulation is complete and appropriate, whether it is clear and understandable, and whether it can be applied by members in their professional practices.

Although Council had originally hoped to put reconsideration of the regulation on its agenda for November 29, 1996, the delayed publication of this issue of the Bulletin does not leave sufficient time for consultation before the November meeting of Council. Instead would you please ensure that your comments are received by the College by **January 18, 1997** so that Council can approve a revised version of the proposed regulation at its March 1997 meeting for submission to the Ministry.

Tricky Issues Feature I

Requests for Release of Clinical Reports, Notes and Records, Including Raw Test Data and Results

The Issue:

Members have sought direction from the College regarding the appropriate response to requests from individuals or others authorized by the individual for the disclosure of clinical reports, notes and records, including raw test results or data.

The College's Advice:

The psychological associate or psychologist should make reasonable efforts to protect test data from misuse or misinterpretation by unqualified users and to maintain the integrity and security of test materials. These efforts having been made, a member may release his or her clinical reports, notes and records, including raw test results or data when provided with appropriate client consent, after a consideration of the issues discussed below.

Discussion:

Principle 7.5(2) of the Standards of Professional Conduct speaks to this issue and outlines the conditions a member should consider before releasing any client record, in whole or in part. These include considerations of informed consent, removal of confidential information about third parties and the likelihood the release may have a substantial adverse effect on the physical, mental or emotional health of the individual or a third party.

Based on the decision of the Supreme Court of Canada (McInerey v. MacDonald, 1992), patients are entitled to examine and copy all information in their record used in administering advice or treatment. This would include the member's own reports, notes and records as well as those prepared by others and received by the psychological associate/psychologist.

Members are advised that on receipt of a properly executed consent, they may be obliged to allow an individual or another party who is authorized by the individual, to examine his or her client record or obtain any information from or a copy of the record. Members receiving such requests should consider the implications of agreeing or not agreeing to the disclosure. In making this decision, it may be prudent to contact the client or, with the appropriate consent, the lawyer or other authorized individual, to obtain a fuller understanding of the purpose of the request. As the obligation to disclose is not absolute, non-disclosure may be warranted if the member is satisfied on reasonable grounds there is a serious potential for harm in the disclosure, either to the client or a third party. As circumstances vary from case to case, each request must be judged on its own merits.

Principle 7.9 of the Standards of Professional Conduct states that, *a member shall provide within a reasonable time the original or raw results or data of a psychological assessment to a member or to a provider of psychological services in another jurisdiction when requested to do so by a client or the legal representative or guardian of a client*. Upon receipt of such a request, the member is expected to release the specified information to another psychologist/psychological associate within a reasonable time. This principle requires prompt release of the requested materials to an identified psychological services provider when the client duly authorizes such a request.

Principle 7.9 is not a prohibition against releasing raw test data or results to someone other than a member of the College or a provider of psychological services in another jurisdiction. Where the request is for disclosure to someone other than a provider of psychological services, the member may exercise discretion in considering the appropriatness of releasing the requested information. The considerations set out in Principle 7.5(2) should be applied in making this decision. The psychologist/psychological associate should make reasonable efforts to protect the test data from misuse or misinterpretation and to protect the integrity and security of test materials. Having made these efforts, a member may release their clinical reports, notes and records, including raw test results or data when provided with appropriate client consent.

As noted above, the member may wish to directly contact the client or, with appropriate consent, the lawyer or other authorized individual to more fully understand the purpose of the request. The client may wish to meet with the member to discuss the raw test data and this may satisfy his or her need without actually requiring a copy of the materials. Similarly, a lawyer may require more information than is contained in a psychological report but not necessarily all test data and results. Often, the client or lawyer has retained

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the services of a psychological associate or psychologist whom they wish to have review the raw test materials. In this case, consent may be obtained to release the information directly to this member.

Usually psychologists/psychological associates are reluctant to release raw data other than to another member of the College due to a concern for the potential misinterpretation or misuse of such test scores. When such concerns exist, it would be prudent to send an accompanying letter outlining the member's concerns regarding improper use of the information and the dangers of misinterpretation by unqualified personnel.

If the psychologist/psychological associate refuses disclosure of some or all of the file, the client may initiate proceedings in court to compel disclosure. In such a proceeding, the onus would be on the psychologist/psychological associate to justify his or her decision not to disclose the requested information, a decision which may or may not be confirmed by the courts. Legal counsel is advised when non-disclosure is being considered.§

Tricky Issues Feature II

CD-ROM Storage of Data: Further Advice

Electronic storage of data is a continuing issue for organizations with any kind of information that is personal or otherwise confidential, as FIPPA and MFIPPA provide for relatively high standards of security. This is especially true for records that fall within the psychological or medical domain, as professional responsibility requires an additional level of duty. It is important, however, to distinguish between records that are current and active, and those that are being retained for archival purposes.

Many organizations and individuals in the health-care fields are considering, or beginning, the use of electronic records as one of the primary ways of recording and retaining current client information. In these matters, they are simply following an irreversible trend in the broader community. Advantages of electronic storage are multiple, including immediate searchable access to the records, reduced paper storage, convenience for practitioners who have reduced support staff, etc. Use of electronic storage for current data access (typically on some form of computer hard drive) produces a number of security-related issues. Several of these are identified in the article on CD-ROM storage (the Bulletin, Vol. 22, No. 4), but may be more properly applicable to this context. In particular, it is important that the integrity of the data be protected, through restricted (and recorded) write access, and the maintenance of properly secure back-up data. Issues of read-only access are similar to those that apply to paper files.

The use of permanent electronic storage media for archival data is a somewhat different situation. At present, this mainly involves the CD-ROM format, although other technologies are being introduced and will probably overtake CD-ROMs because of greater capacity and lower unit cost.

Data recorded on CD-ROMs is permanent. It cannot be altered. In most cases, data is transferred to a CD-ROM only once, although there are mechanisms for incrementally adding data to a CD-ROM on multiple occasions. In any event, once the data is recorded, it cannot be altered.

For this reason, CD-ROM storage of data is usually for archival purposes. Paper records may be scanned and stored as graphic images; on-line data may be archived to a CD-ROM after a certain period, then deleted from the computer's hard drive. In some cases, the data stored on a CD-ROM may be actively available to a user through a computer network, when the data may be of current value. In most cases, the data will probably be purely archival, and will be stored in some secure, off-line, location. In either case, access to the information should be controlled through policies similar to those through which access is controlled to paper records. The same principles apply, but the mechanisms may differ.

Since the data may not be altered, there is no particular issue of "tampering" with respect to CD-ROM data. The issue is more properly one of ensuring that the data transferred to the CD-ROM is complete and accurate. In a sense, the issue is not unlike maintaining the integrity of data that is being photocopied for transmission or storage. §

Complaints Committee

Following its meeting on May 1, 1996, the Complaints Committee issued decisions in three new cases and two reinvestigations referred to the Complaints Committee by the Health Professions Board.

Disposition of New Cases: The following summary describes the disposition of these cases:

In three cases, the Committee dismissed the complaint.

In one case, the Committee dismissed the complaint and provided advice to the member.

In one case, the Committee issued a written caution to the member.

Nature of New Cases: The following summary provides a brief description of the nature of these cases:

One case dealt with the issue of whether a member's intervention with the client met professional standards and whether the member was in a supervisory relationship with staff interacting with a client.

One case dealt with confidentiality and the propriety of the procedures used in handling unsolicited calls from members of a client's family.

One case dealt with the issue of whether the procedures utilized and the report prepared in the context of neuropsychological assessment met professional standards.

Two cases involved reinvestigations of previous complaints where the Health Professions Board ordered the Complaints Committee to reconsider certain issues.

Note: In each case where the Complaints Committee investigates a complaint, the member and the complainant receive a written Decision setting out the Committee's findings and the reasons for the Committee's findings. However, as complaints are confidential, no information about a complaint or about the Committee's Decision with respect to a complaint can be provided to anyone other than the member and the complainant. The College therefore regrets that it cannot respond to requests for further details with respect to any of the above cases.§

DISCIPLINARY HEARING - DR. X

THE DECISION AND REASONS FOR THE DECISION

The following is a summary of a disciplinary proceeding in which the panel authorized publication of an educational article without identifying the parties.

THE CHARGES

All other allegations having been withdrawn in the context of a jointly agreed Statement of Admissions, Dr. X was charged with professional misconduct for violating the standards of practice.

Specifically, it was alleged that:

a) Dr. X provided therapy to Ms. Y that did not meet professional standards including:

i) Telling Ms. Y that her mother did not care about her, that her mother had never cared about her and that her mother would never care about her.

ii) Pressing Ms. Y to discuss details of her past abuse in a manner which made her uncomfortable.

b) Dr. X did not take appropriate steps to protect Ms. Y's confidentiality in that he conducted therapy with her in an office which had a faulty door latch when he was aware that if people were in the outer office they would be likely to overhear what was being said in his office.

c) He failed to maintain appropriate therapist-patient boundaries when conducting psychodynamic psychotherapy with Ms. Y by:

i) Giving Ms. Y money at the conclusion of some sessions with him to pay for her taxi home.

ii) Permitting Ms. Y to return to his office and to have further contact with him after the conclusion of her regular session.

iii) Rubbing one of Ms. Y's shoulders when she was upset in his office, in an effort to console her.

>>>

iv) Offering to share his lunch with Ms. Y.

v) Permitting Ms. Y to use the telephone in his office.

It was alleged that Dr. X failed to maintain records of treatment for Ms. Y in a manner consistent with professional standards, including:

a) Not maintaining adequate records of the particulars of all of Ms. Y's therapy sessions.

b) Not maintaining adequate records of all his telephone conversations with Ms. Y.

c) Not including in his records information that would reasonably be considered to be relevant to his treatment of Ms. Y, including but not limited to the following:

i) Ms. Y's relevant medical history.

ii) Ms. Y's medical status at the time she was his client.

iii) The opinion of Ms. Y's physician, Dr. A, as to whether Ms. Y was suffering from clinical depression, and whether Ms. Y required medication.

iv) The opinion of Ms. Y's physician, Dr. A, as to the nature of the treatment that Ms. Y required.

v) The reason for his referral to Ms. Y to another physician, Dr. Z.

vi) Information pertaining to Dr. Z's diagnosis of Ms. Y and Dr. Z's decision to prescribe medication to Ms. Y.

vii) Dr. Z's opinion as to the nature of the treatment that Ms. Y required and the recommendations pertaining to Ms. Y's treatment that Dr. Z provided to the agency funding Ms. Y's treatment.

THE PLEA

Dr. X entered a plea of guilty to the charges listed above.

THE DECISION

It is the decision of the Panel that Dr. X is guilty as charged under the Psychologists Registration Act R.S.O. 1990, Chapter P36, with respect to the charges as listed above.

REASONS FOR THE DECISION

There are three sets of reasons for the decision:

1. Dr. X entered a plea of guilty to the charges as listed. This is a sufficient reason for the decision.

2. The Statement of Admissions by Dr. X provides substantiating evidence for the decision with respect to all charges except those having to do with the maintenance of proper records (charge #5 in the Amended Notice of Hearing).

3. The charge concerning Dr. X's failure to maintain proper records is substantiated by an exhibit (exhibit #5: Dr. X's notes concerning Ms. Y) and by the verbal testimony of the expert witness, Dr. B, who testified that the standards of practice in this case would have required comprehensive notes, at least weekly, with all dates when the client was seen, including mention of such items as moods, emotional reactions, session themes, plans for next session, and referrals to another professional.

THE PENALTY

The penalty imposed on Dr. X as decided by the Panel, is precisely as proposed to the Panel in the Joint Submission With Respect to Penalty, with the exception that item #6 was amended to read as follows:

Dr. X shall provide a letter to the Complainant, previously vetted by the Registrar, acknowledging his mistakes and apologizing for the distress which she has suffered.

In summary, there are four components to the penalty:

a. Supervision of Dr. X with respect to his entire practice for one year, contingent on the Supervisor's provision of a favourable report acceptable to the Registrar. If the Supervisor's report is not satisfactory to the Registrar, supervision of Dr. X's practice will continue for a second year.

b. Provision to Dr. X's clients of official information regarding his restricted status.

c. Recording in the public register and publication in the College's annual report of the fact that Dr. X is practising under supervision.

d. At the discretion of the College, publication of an article based on the matter but without names or identifying details for the cautionary education of the profession.

REASONS FOR THE PENALTY

The members of the Panel relied upon the following considerations in determining the penalty:

1. The severity of the penalty is appropriate in relation to the charges for which there was a guilty plea and a decision.
2. The nature of the penalty is such that it may be expected to lead an amelioration of Dr. X's practice, in full conformity with the standards set by the College, and the penalty is therefore considered to be in the public interest.
3. The penalty recognizes and takes into account the distress experienced by the client by requiring that Dr. X provide a letter to the complainant, acknowledging his mistakes and apologizing for causing her distress.
4. The penalty is precisely as proposed by Counsel for the College and Counsel for Dr. X, in their Joint Submission With Respect to Penalty.§

The Public Register

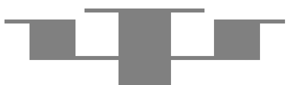
One of the functions of the College of Psychologists of Ontario is to verify registration and to provide callers with current public information regarding members.

The most common types of call received by the College regard verification of membership by members of the public or insurance companies processing claims and requests for a current business address.

Callers can be provided with the following information about a member upon request:

- name and business address and telephone number (this is the address indicated by the member to be the "Directory listing")
- title
- date until which fees are paid
- any term, condition or limitation currently imposed on the Certificate of Registration
- notice of any suspension in effect
- information on current disciplinary action
- information on the member's practice that the member has indicated as public (is published in the Directory)

The College does not release any information to callers that is not designated as public information by the regulations such as academic background, birth date, how long a member has been registered or home address (unless the home address has been designated as a business address by the member). §



Survey on Delegation of the Controlled Act of Diagnosis

The College of Psychologists is asking for the co-operation of all members in conducting a survey on delegation of the controlled act of diagnosis. Members will find a copy of a survey on delegation enclosed with this Bulletin and are asked to please fill out and either fax or mail it to the College. Replacement copies are available from the College. Results of the survey will be published in a future Bulletin. Your assistance is appreciated.§

Council Meetings:

Council meetings have been scheduled for the following dates:

November 29 and 30, 1996
March 21 and 22, 1997

Members of the College as well as the public are welcome to attend. Please contact the College to ensure that space is available.§

Committee Appointment

Wendy Cope, M.A.,C.Psych.Assoc. has been appointed to the Fitness to Practice Committee. The response to the call for a psychological associate to participate in this committee was enthusiatic. We would like to thank all members who expressed interest.§

Changes to the Register

The following persons have advised us of their resignation from the College and their names have been removed from the register:

Allan J. Brenman
Rose T. Doherty

Additions to the Temporary Register since July, 1996 - Psychologists

D.Lynn Andrews
Angela Biason
Lise Bisnaire-Poirier
Elizabeth Bolger
Mavash Elmpak
Sylvie Fortin
Maria Giordano-Beech
Soula Homatidis
Linda Lindsay
Ghislaine Marcotte
Sandra Mendlowitz
Jeremy Mills
Shulamit Mor
Anne-Siri Oyen
Erin Picard
Lyne Prud'honne
George Renfrey
Ann Robson
Douglas Saunders
Guiseppe Spezzano
Ewa Ostoja-Starzewska

The College would like to congratulate and welcome 2 new psychological associate members and 6 new psychologist members.

Additions to the Permanent Register since July, 1996 - Psychological Associate:

Emanuela Cianfronga
Joy Strachan

Additions to the Permanent Register since July, 1996 - Psychologists

Timothy Baker
Lucia Bohorquez
Mary Buell
Ayse Unsal
Denise Vallance
David Vollick

What Happens When I Call the College With a Query?

The College has become aware that some members of the profession are concerned about contacting the College for assistance in interpreting the regulations and standards with respect to practice issues. Apparently some members are concerned that making such an inquiry will reflect badly upon them and form a part of their record with the College.

Is there a record of my inquiry?

Yes, staff do document inquiries. Just as members of the College make notes during any contact with a client, College staff make a note of any communication with a member of the College or with a member of the public. The information noted includes the name of the caller (if provided), the date of the call, the subject of the inquiry and any advice or information given by the staff person.

What if I do not wish to be identified?

Most callers identify themselves. Some do not and that is their choice. The College does not have call display services so a caller may remain anonymous if he or she wishes.

The potential for anonymity is especially important for members of the public who may be tentative about coming forward to report unprofessional conduct by a member, particularly in cases where sexual abuse may have occurred. It allows the caller to learn more about the role of the College, the standards of professional conduct and the College's procedures for handling complaints before taking the step of identifying himself or herself and lodging a formal complaint.

Anonymity may also be reassuring for a supervisee uncertain about appropriate professional conduct but concerned about vulnerability should the supervisor be mentioned by name.

Some members prefer to remain anonymous when inquiring about the procedure to be followed in circumstances where they believe that they may have an obligation to provide a mandatory report on the conduct of a colleague or on their own conduct, possible incapacity or legal circumstances.

The College will provide whatever information it can to anonymous callers. College staff do not provide an opinion about whether or not a particular behaviour constitutes professional misconduct; that is a matter for the statutory committees of

the College to determine through appropriate procedures. However, staff can provide general information about the expectations of the College as formalized in statute, regulations and standards.

What action is taken on anonymous complaints about a member?

It is important to emphasize that the College cannot investigate anonymous complaints or reports. A complainant must be identified, specify his or her concerns in writing or in a recording and give written permission for the College to provide this information to the member and commence an investigation. Similarly any person providing a mandatory report under the requirements of the Regulated Heath Professions Act must be identified before the College can proceed; no action can be taken on an anonymous report.

Why do staff document queries?

As you might imagine, the College often receives queries which are complex or detailed. In order to ensure that adequate detail is obtained and that consideration is given to all of the relevant information in providing advice, staff take notes and may require some time to review the relevant standards or legislation before giving advice to the caller.

It is not infrequent for College staff to receive queries from two parties to a situation. Careful documentation assists staff in considering the circumstances described by both inquirers and then providing appropriate advice to both. Callers are not advised of each others calls. Confidentiality is maintained.

Occasionally, the College will receive a follow-up call to a matter dealt with previously. Typically the caller expects that the staff member has access to a record of the earlier discussion. The staff member can refer to his or her notes to ensure that the details of the previous discussion are considered in responding to the renewed inquiry.

Why do staff sometimes request that I put my query in writing?

When a query is complex and detailed, staff may request that the query be submitted in writing. As the response to an inquiry is necessarily based on the specifics provided by the caller, it is important that the details be as clear as possible. Staff may then prepare a response addressing the issues raised in a manner which is most relevant and helpful to the caller.

What happens to the notes on my inquiry?

Notes on telephone queries are filed separately in temporal order with a cover sheet identifying the date, the name of the caller and the general subject of the query. This permits ready access in order to follow up on any further inquiries on the same situation.

Statistics are kept on the number of queries received from members and non-members as well as on the number of queries received on various general subjects. This informs the preparation of relevant Bulletin articles and the identification of policy issues for referral to the Council.

In order that your query may be appropriately directed when you call the College, please advise the receptionist whether your call concerns an ethical question, a possible complaint or mandatory report, a registration matter or some other subject.§

QUERIES RECEIVED BY THE COLLEGE BETWEEN JUNE 1, 1995 AND APRIL 30, 1996 - BY SUBJECT

ISSUES IN ORGANIZATIONS	
Professional conflict	17
Adminstration vs. professional supervision	1
ISSUES IN PRIVATE PRACTICE	
Advertising and annoucements	52
Partnerships and incorporation	17
Billing and collection	45
Title of a practice	1
Individual vocational designation	3
Selling/moving a practice	6
INTERPRETATION OF STANDARDS	
Complaints and discipline	9
Supervision	112
Testing/report writing	43
General	9
Records and confidentiality	151
Consent, release of information	6
Obligation to parents	2
Right of client ot see report	8
Retention of files/record keeping	17
Obligation to provide raw data/member's right to retain	6
Closing a practice	8
Dual relationship/conflict of interest	25
LEGAL QUESTIONS	
Psychologists Registration Act or RHPA - General	9
Psychologists Registration Act or RHPA - Section 2	49
Freedom of Information or PrivacyAct	1
Reporting child abuse/sexual abuse	21
Subpoena to testify	6
Professional Regulation	89
(Professional misconduct, Specialty designation	
Renting office space/fee splitting, Psychological services)	
Liabitlity insurance, Consent to Treatment Act	
Other	83
TOTAL	796

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COLLEGE HIGHLIGHTS

Reciprocity Agreement

On August 12, 1996, the Board of Directors of the Association of State and Provincial Psychology Boards approved the College's application to enter the ASPPB Agreement of Reciprocity. This is an agreement among jurisdictions in Canada and the United States which share the same specified requirements for the registration or licensure of doctoral level psychologists. Currently in the agreement are Iowa, Kentucky, Maine, Manitoba, Missouri, Nevada, Oklahoma, Ontario and Texas.

Under the agreement, Ontario psychologists registered for at least five years and in good standing with no history of disciplinary action against their certificate of registration may apply for registration in any of the other jurisdictions under a process which is more streamlined that the regular registration process. Specifically, the applicant will not have to produce original transcripts, letters of reference or supervisors reports and will not have to take or retake the Examination for Professional Practice in Psychology. However, the applicant will be required to attend an oral interview and to pass any jurisprudence examination required by the jurisdiction where he or she is seeking licensure or registration.

The same provisions would apply to a registrant or licensee from one of the other member jurisdictions seeking registration in Ontario.

Quality Assurance

Council will be considering a revision of the proposed regulation on quality assurance at its meeting of November 29 and 30, 1996. It is anticipated that the regulation will then be approved for submission to the Ministry for review and approval.

Council Elections

The next Council elections will take place at the end of March 1997. Elections will be held for Districts 5 (Central East), 6 (Metropolitan Toronto) and 7 (Academic). Members are encouraged to consider running for election to Council. Formal notice of the elections will appear in the December issue of the Bulletin together with the date for receipt of nominations. Additional information on election procedures may be found in the regulation on elections which has previously been distributed to all members.§