

Working as a Member of a Multidisciplinary or Interdisciplinary Team within the Health and Social Services Network

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INTRODUCTION

In Quebec, members of professional orders are all regulated by the *Professional Code*. This document defines in detail the nature of the organization that has been put in place to guarantee the protection of the public with respect to services provided by professionals. It also sets out the operating rules of the 45 existing orders, as well as the role of the different authorities entrusted with this mission. However, it does not deal with the issue of multidisciplinary or interdisciplinary practice. Therefore, there is no regulatory framework defining collaborative work procedures while taking into account the ethical obligations specific to each discipline.

However, the *Act to amend the Professional Code and other legislative provisions as regards the health sector* (Bill 90, passed in June 2002) provides for the sharing of fields of practice in the health sector. Obviously, the changes brought by this act affect professionals belonging to a number of different orders. To ensure better harmonization of the practices of the professions concerned, the Office des professions has published an explanatory guide on Bill 90, aiming to describe its scope and facilitate its understanding. Furthermore, the report of the committee of experts on the modernization of professional practices in mental health and human relations envisages, particularly for

psychologists and some other orders concerned, that certain professional acts be either reserved or shared.

Unfortunately, there has not yet been any legislative follow-up on the committee of experts' work. This fact may impact the work of psychologists who are already involved in providing joint treatment with other professionals without the benefit of clear legislative guidance.

Clearly, the establishment of multidisciplinary practices is an indication of evolution in the health and social services network. It demonstrates a desire to promote a collaborative approach, the sharing of expertise, and an organizational style that serves to decompartmentalize the work done by different professionals. There is an evident desire by the legislator to avoid the "silo" approach to the treatment of clients. In addition, the *Act to amend the Act respecting health services and social services and other legislative provisions* (Bill 83) shows a willingness to implement a mechanism facilitating the delivery of services to users by focusing on interprofessional work processes that promote the achievement of the organization's objectives, quality of treatment and respect for the client, while maintaining a concern for efficiency.

Through the Comité des chefs de service de psychologie et représentants professionnels des psychologues en milieu

hospitalier (Committee of heads of psychological services and professional representatives of psychologists working in a hospital environment) – a committee of the Order – a task force¹ was established to assist in the preparation of this Ethics Guidelines. This task force helped us clarify the existing situation and illustrate, through reference to real-life experiences, how the vision of multidisciplinary work in different hospital environments is being turned into reality.

The major structural changes occurring in the public network have given rise to "local authorities"², responsible for defining a clinical and organizational project for the territory they serve³. The legislator states that they must act within "regional agencies," entrusted with the coordination of financing, human resources and specialized services⁴. All institutions are part of "a local health and social services network"; therefore, there needs to be an integration of resources. Moreover, professionals and other service

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providers must mobilize to ensure access and continuity of services to the population of a given territory⁵. According to the psychologists concerned, these substantial changes have not been accompanied by measures supporting the organization of professional work. Many psychologists working in the field believe that the absence of a consensus on treatment methods within multidisciplinary teams impedes their effectiveness. As other changes may be implemented in 2007 that could have an impact on work organization, some members of the Order have expressed apprehensions which, in the circumstances, appear quite justified.

In institutions, treatment programs favour a multidisciplinary approach for the treatment of certain types of problems. But in the context described above, concerns arise, especially for psychologists, about the issue of professional identity. In a multidisciplinary team, each member makes a contribution based on his discipline. But in terms of ethics, psychologists are subject to particular requirements that may be difficult to integrate into jointly provided treatment. In the absence of legislative guidelines, these psychologists must reflect on each question and take a position in compliance with the ethical framework. Attention must be paid to the values underlying the professional actions of psychologists, including respect for the client and quality of the treatment provided.

This Ethics Guideline provides some clarifications to help psychologists working in institutions. The issues discussed include record keeping, report preparation, consent and professional secrecy, as well as the psychologist's professional liability in a multidisciplinary context.

RECORD KEEPING

The Regulation respecting the keeping of records and consulting-rooms by psychologists requires that all information be documented in the client's file. In a multidisciplinary context, there is a need

to clarify issues related to progress notes and report content. The same is true of processing of raw data and record keeping, which will be discussed in the next point.

The psychologist cannot delegate to another professional responsibility for the treatment he provides. The present practice of co-signing, with the other professionals concerned, a note in the record, so long as the content is deemed appropriate by the psychologist, is compliant with the regulations. However, this approach is not a substitute for the psychologist's obligations. As recommended by the Order⁶, the progress note should contain: a summary of topics discussed, a summary of treatment provided, information on the client's progress in relation to the treatment plan and recommendations. It may also include professional interpretations which are understandable to potential readers and accessible to the client, and, as needed, a reference to theoretical considerations of which the content and form are also understandable to the client

In the absence of a specific rule adopted by the Bureau of the Order stipulating new requirements, the currently recommended practice is for the psychologist to personally prepare the progress note and mention the names of the other professionals involved. This practice is preferable to merely having the psychologist's name mentioned as a co-provider of services, without the psychologist being able to verify the content of the note. Also, the psychologist must reserve the option of writing and signing a separate progress note, if necessary, to indicate his disagreement when the progress note written by another professional fails to reflect his understanding of the treatment or observations he considers important to record, regardless of any discomfort that this might create within the team.

At the end of the assessment of a client by a psychologist, the opinion the psychologist expresses in the report must be based on sufficient professional and scientific information, and the process must be recorded – information that is normal for a psychologist to provide. Therefore, it is hardly imaginable that a

psychologist would be willing to give the impression, by signing a report, that he shares an opinion obtained through an assessment made by a professional from another Order, when he does not possess that professional's skills or have his professional title. Any report produced at the end of an assessment by several professionals must show the specific contribution made by the psychologist and the other parties concerned. In other words, who says what and based on what process. This can be clarified right at the start under the heading "Assessment Methodology". It may be clearer for the reader if the report bears the signatures of all those involved in its preparation. It is prudent to avoid, when submitting a report in a multidisciplinary context, the appearance that the psychologist was involved in determining a medical diagnosis or preparing recommendations which do not qualify as activities belonging to a psychologist under the *Professional Code* (section 37).

If it is impossible for the psychologist to reconcile his comments with those of the other members of the multidisciplinary team, an *addendum* should be included in the multidisciplinary report or a separate report should be prepared that adequately reflects his opinion, including his conclusions and recommendations. The psychologist should not hesitate to express his disagreement, or even to withdraw from the multidisciplinary treatment, if necessary, although this should be only a last resort. The best solution, if possible, is for the psychologist to include his contribution, under his signature, in a multidisciplinary report that complies with the institution's procedures and needs. This demonstrates a consensus and sets the basis for authentic multidisciplinary treatment. Incidentally, the Ordre des psychologues has prepared for its members a guide on record keeping⁷, which may be helpful to psychologists working on a multidisciplinary team.

RAW DATA

The existence of centralized records does not make it permissible to enter raw data⁸ in a central record, particularly material collected during the assessment.

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For example, direct observations found in interview notes⁹ and notes relating to psychometric tests¹⁰ are data that must not be accessible in a central record because they could be subject to false interpretation or misunderstanding by a reader who is not a psychologist (*Code of Ethics*, section 77). However, it should be noted that these are nominative data; they are an integral part of the client's record, but must be kept separate from the central record to which other service providers have access. They should be kept either in the Psychology Department or the psychologist's office. A note of their existence should be made in the central record, for example, in the report itself¹¹ or in the note accompanying the filing of the report into the record, if this is the preferred procedure.

Any other information relating to a client, for example, personal notes written by a psychologist, or subjects or questions to be discussed in supervision, is not part of the client's record. These notes may not be retained; there can be no record other than the client's record. More precise information on the content of the psychological record can be found in the above-mentioned guide on record keeping.

Under the *Regulation respecting the keeping of records and consulting-rooms by psychologists*, records must be kept for five years. However, it would be useful for the psychologist to synchronize the retention period of test protocols related to the assessment reports contained in the central record with the record retention period of the institution where he works, if this period is longer than five years. Information on the effective directives must be obtained from the institution.

PROFESSIONAL SECRECY AND CONSENT

The changes made to the legislation governing the organization of health services and social services favour wider dissemination of information on clients within the institution. Without the user's consent, information contained in his

record can be provided to different individuals and even organizations to ensure the continuity or complementarity of services. Given the Quebec legislator's choice to make information required for the organization of services available, there is a need to explain the psychologist's role with respect to consent, so that the client clearly understands the impact of his decision to receive psychological services. In addition, the limits to professional secrecy must be clarified given the context of a multidisciplinary team.

Sometimes psychologists choose to implement a procedure where the client is asked to provide written consent. This allows the client to fully understand the purpose and nature of the treatment, the advantages and risks involved in receiving or not receiving treatment, and the implications concerning professional secrecy and record keeping, given that the work is done through a multidisciplinary approach in the institution where he receives the services. Such an approach has merit. However, it is not required under the *Act respecting health services and social services* (AHSSS) once consent to the provision of care to a client in an institution has been given. It is the ethics of our profession that stress the obligation to obtain consent to psychological treatment. This consent does not necessarily have to be in writing. It is far preferable to obtain free and informed consent after taking the time to verbally explain all the issues to the client and note in the record that this was done, than to obtain a signature at the bottom of a consent form without the client taking the time to read it and appreciate the significance of his act.

With respect to exchanges of information, under the *Code of Ethics* (section 46), the client's written authorization must be obtained before any information is divulged. This requirement must now be qualified due to the changes introduced by Bill 83. These changes allow information contained in a client's record to be released – in certain circumstances and without the user's consent – by the institution to various persons or bodies if there is continuity or complementarity of services. For ex-

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ample, consent would no longer be required for communications concerning the assumption of care of the user, during his transfer or placement, or when services are provided between institutions under an agreement related to a treatment plan. Henceforth, a community organization could be included on the list of resources having access, if there is an agreement, to information about a user (AHSSS, section 108).

Therefore, it is all the more important that the psychologist explain the scope of these changes to the client. Within the same institution, written authorization for the release of information cannot be made compulsory, so it is very important that this be understood by the client and that he consent to receiving services in full awareness of the situation. Once the step of obtaining consent is completed, the psychologist has a clear mandate permitting him to work in his accustomed environment providing the expected services.

However, in all circumstances, it is up to the psychologist to assess whether information revealed by the client during treatment should be disclosed, bearing in mind its relevance, the scope of the consent, the nature of the treatment plan and the importance of not causing harm to the client.

PROFESSIONAL LIABILITY

Requirements by employers that a psychologist automatically comply with a request made by a doctor are contrary to ethics because this interferes with the psychologist's independence (*Code of Ethics*, section 31). The employer may not enact rules that contravene the psychologist's professional obligations. The Professions Tribunal has held that [Translation] "an employer cannot require that a professional behave in a

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manner contrary to that prescribed by his Code of Ethics, the Professional Code or, if applicable, the particular legislation and regulations governing his professional order"¹². However, by agreeing to work for an institution in the health and social services network, the psychologist recognizes his employer's right of management. Therefore, he cannot systematically ignore the directives he is given. The Syndic's Office recommends, in such situations, discussing the matter with the decision-makers with emphasis on mutual interests in order to establish mutually-accepted objectives and standards. This is in the interest of the services provided to clients. The psychologist always remains responsible for the treatment he provides. The fact that the treatment was delivered through a multidisciplinary approach

does not mitigate the psychologist's liability. If a psychologist acts as advisor to a treatment team, his client is the treatment team itself. If he is asked for advice related to a client's case, he does not need to note this fact in the client's record. However, if he previously treated the client, he should note in the client's record the treatment team's request and the recommendation he made. The psychologist should keep in mind his obligation to use caution, as he is making a hypothesis without having been in contact with the client concerned. Psychologists may be concerned about the consequences of potential errors made by the team. On the ethical level, the Order's Office of the Syndic may conduct an inquiry on the psychologist's actions. Furthermore, based on existing legal principles¹³, the psychologist could

be obliged to compensate a client in the event of malpractice in which he was involved with other professionals. This hypothetical situation should not discourage the psychologist from engaging in multidisciplinary work, but rather, make him aware that he remains fully liable towards his clients. In future, developments in multidisciplinary or interdisciplinary practice will likely lead to new reflections about modes of practice and the introduction of new guidelines arising from the ethical framework and, possibly, various courts or tribunals. Information on these matters will, of course, be provided to members as soon as they are known so that they may take them into account in their practice.

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1. We wish to thank the following psychologists: Suzanne Spénard of Centre hospitalier Jean-Talon, Terry Zaloum of Centre hospitalier Rivière-des-Prairies, Marcel Courtemanche of CHUM-Notre-Dame, Andrée Deschênes, of Centre hospitalier universitaire de Québec, Steve Balkou of Centre hospitalier universitaire de Sherbrooke, and Marie-Josée Lemieux, of Centre hospitalier Maisonneuve-Rosemont.
2. Section 99.4 of the *Act respecting health services and social services* (AHSS) explains that this is "a multivocational institution operating a local community service centre, a residential and long-term care centre and, where applicable, a general and specialized hospital centre."
3. See the explanatory notes in the introduction to Bill 83, *An Act to amend the Act respecting health services and social services and other legislative provisions*.
4. Ibid.
5. See sections 99.2, 99.3 and 99.5 of the AHSS.
6. See note 1, p.7
7. See *A Guide to Record Keeping* (2006). Ordre des psychologues du Québec.
8. See Ethics Guideline. "Données brutes et dossier du client." Vol. 2, no. 1. *Psychologie Québec*, vol. 18, no. 1, p. 1, and the article by Desjardins, P. "Divulgence du QI: éviter le préjudice." *Psychologie Québec*, vol. 24, no. 2, pp. 10 and 11.
9. Generally speaking, the interview notes used to prepare an assessment report are destroyed after the report is written. Likewise, notes taken by the psychologist during an interview, which are used to write a progress note, must also be destroyed.
10. These notes are related to testing and must be kept.
11. It could be indicated on the cover page, either in handwriting or using a stamp, that the test protocols used for the assessment are stored in the psychologist's office.
12. Bich, M.-F. (1994). *Le défi du droit nouveau pour les professionnels. Les journées Maximilien-Caron*. Montreal, Thémis, p. 66. Cited by the Professions Tribunal in Decision no. 500-07-000167-977, p. 12, February 5, 1999.
13. There have been no court decisions dealing with this issue so far.

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