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Information Disclosure in the Practice of Social Work and Malpractice in Social Work

by

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FOREWORD

The Sophie Boyd Award is an annual award given to an individual who is an alumnus/ae of the Faculty of Social Work at the University of Toronto. This person is interested in further study, research, or a project of at least one month's duration which has potential value for the development of the Social Work profession.

Stephen R. Schenke received the Sophie Boyd Award in May 1982 for the following two-part document entitled "Information Disclosure in the Practice of Social Work/Malpractice in Social Work." The final submission is enclosed in the following published report.

Mr. Schenke received the following degrees: Bachelor of Arts (1978), University of Western Ontario; Master of Social Work (1981), University of Toronto; Law (1983), University of Western Ontario. In 1985 he was called to the Ontario Bar Association. He has practised social work at the Metro Toronto Children's Aid Society and the Queen Street Mental Health Centre. Stephen is currently employed at Cohen and Melnitzer, Barristers and Soliciters practising family law and civil litigation.

The Social Work Alumni Association of the University of Toronto felt the report was worthy of publication given its wide applicability to the Social Work community. The Alumni Association is pleased to have participated in this project and is appreciative of Stephen Schenke's efforts. Certainly the issues outlined herein: confidentiality, malpractice, interaction of social work and law, will be of interest to readers. Special thanks to the Faculty of the School of Social Work and especially to Prof. Ben Schlesinger for their assistance in publishing this document.

Linda H. Goldberger,
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INFORMATION DISCLOSURE IN THE PRACTICE OF SOCIAL WORK

Steve Schenke

INTRODUCTION

This paper discusses the topic of information disclosure in the practice of social work. The motivation for this paper comes from the writer's limited experience in the practice of social work wherein he observed that several of his colleagues had the following attitudes and beliefs regarding the disclosure of client information:

a) It is acceptable for a social worker to release client information to another agency involved in the care of the client without the authorization of the client, so long as the social worker believed that the agency requesting the information was legitimate and would in turn treat the information as "confidential".

b) A client cannot be properly and effectively helped if there is not a free exchange of information between all the agencies involved with the client, regardless of whether the client has expressly consented to such exchanges. The notion here is that any breach or invasion of the client's privacy is justified because such breach or invasion is in the client's best interests.

c) When a client enters into a helping relationship with a social worker, he has waived his right to privacy and confidentiality. Although this statement is true to a limited extent, it cannot be accepted as a blanket justification for all disclosures of client information. The writer is of the opinion that a client may waive his right to privacy in a limited manner when he enters into a helping relationship, however, he does so only in exchange for assurances of confidentiality.

The concerns of the writer are the potential abuse that can be made of client information. A social worker has a great deal of power over an individual, and at present there are very few guarantees that

this power will be exercised for the client's benefit.

It is important to stress that the above comments are directed at only a small minority of social workers. The writer is convinced that any breaches of privacy and confidentiality stem from a lack of awareness of the legal guidelines, rather than an intentional disregard for client privacy. In fact, in a recent study by Swoboda et al. in Nebraska, it was found that out of a group of social workers, psychiatrists and psychologists, the social workers had the greatest understanding of the law relating to privileged communications and child abuse reporting laws.[1] (These topics are discussed in this paper.)

The purpose of this paper is to provide guidelines for the practicing social worker in Ontario concerning the disclosure of client information. The majority of guidelines in this paper are directed at the case-worker, i.e., the social worker in a family service, child welfare, public welfare, probation or parole, or residential treatment centre programme.

This paper is divided into two major sections. The first section discusses the ways in which a social worker may legitimately disclose client information. The second section discusses the liabilities a social worker may incur for an unauthorized disclosure of client information.

For the purposes of this paper, the term "client information" refers to information that concerns a particular person and is unique to that person (as opposed to information that could be about any person).[2] The term "disclosure" refers to the release or transmittal of client information, whether orally or by written record.

SECTION I

There are two ways in which a social worker may legitimately disclose client information: with the consent of the client; and in certain circumstances, without the consent of the client. A social worker may (or must) disclose client information without the consent of the client if the disclosure is:

a) made pursuant to a statute; or

b) court ordered.

In regards to disclosures made pursuant to a statute, the statute may mandate the social worker to disclose information, or the statute may authorize the social worker to disclose information.

If one were to illustrate the circumstances under which client information could be disclosed, the following flow chart would result:

1) Can or must the disclosure be made pursuant to a statute?
   Is the disclosure (a) mandated by statute; or
   (b) authorized by statute

2) Has the disclosure been ordered by a court of competent jurisdiction?

3) If the disclosure the social worker desires to make does not fall within (1) or (2) above, has the client consented to the disclosure?

This section of the paper discusses the means by which a social worker may or must disclose information concerning a client. The section begins with (1) in the flow chart and proceeds down to (3).

I Disclosure of Client Information Without the Consent of the Client

In the situations discussed under this heading, it is not a legal requirement that the social worker obtain the consent of the client

or individual authorized to consent to the disclosure of information on behalf of the client before the disclosure is made. As a matter of law, with the exception of the doctrine of privilege, the fact that a client or individual authorized to consent to a disclosure on the client's behalf has not done so, is not the determinative factor in deciding whether the social worker may or must disclose client information.

1) Disclosure Made Pursuant to Statute

(A) Disclosure Mandated by Statute

The term "disclosure mandated by statute" is used in this section to denote the following two situations:

(a) legislation that requires a social worker to report information to a legal entity once that information comes to his attention; or

(b) legislation that requires a social worker to report information to a legal entity upon the request of that entity.

The statutes that fall within the term "disclosure mandated by statute" can be divided into four categories as follows:

(1) Statutes that require disclosure of records to inspectors or investigative bodies:

THE CORONER'S ACT, R.S.O. 1980, c. 93, s. 16(2)(b) authorizes a coroner when carrying out an investigation (not an inquest) to inspect information contained in any records. Section 55 provides a penalty for hindering, obstructing or refusing to furnish information to a coroner of a fine of not more than $1,000 and a term of imprisonment for not more than six months.

THE MENTAL HEALTH ACT, R.S.O. 1980, c. 262, section 5(2) authorizes advisory officers to inspect records and other documents relating to

patients. Section 64 provides a penalty for refusing to allow an advisory officer to inspect of a fine of not more than $10,000.

THE MINISTRY OF CORRECTIONAL SERVICES ACT, R.S.O. 1980, c. 275, section 22 authorizes inspectors to inspect information in connection with the administration of the act. Refusal to furnish an inspector with information may lead to dismissal.

THE OCCUPATIONAL HEALTH AND SAFETY ACT, R.S.O. 1980, c. 321, section 28(1)(c) authorizes an inspector under the act to require the production of any document, record or report. Section 37(1) provides a penalty for breach of that section of a fine of not more than $25,000 and a term of imprisonment not more than 12 months.

THE PRIVATE HOSPITALS ACT R.S.O. 1980, c. 389, section 23 authorizes inspectors under the act to inspect records. Section 26 provides a penalty of breach of that section of a fine between $25 - $500.

Section 4(4)(c) of Regulation 865 made under THE PUBLIC HOSPITALS ACT, R.S.O. 1980, c. 410 authorizes the College of Physicians and Surgeons of Ontario to inspect and receive information from medical records. Section 27 provides a penalty for breach of that section of a fine between $25 - $500. It is important to note that section 38(1)(c) of Regulation 865 defines a medical record as including a family history of the patient. Given that it is likely that a social worker would complete a social history, the social worker's record would be subsumed under the medical record, and therefore governed by the provisions relating to medical records.

THE WORKMEN'S COMPENSATION ACT, R.S.O. 1980, c. 539, section 53 authorizes the Board to require any person having the care of an employee to furnish reports to the Board as may be requested by the Board in respect of such employee.

(2) Statutes that require records to be handed over to the relevant Ministry upon the revocation of a licence to operate a facility:

THE CHILDREN'S RESIDENTIAL SERVICES ACT, R.S.O. 1980, c. 71, section 13(3).

THE NURSING HOMES ACT, R.S.O. 1980, c. 320, section 12(3). Section 19 provides a penalty for breach of that section of a fine not more than $2,000.

(3) If a social worker is the administrator or superintendant of a facility, he will be required to report the death of a resident of the facility in which he is the administrator or superintendant to the coroner as per the following statutes:

Section 12 of Regulation 95 made under THE CHARITABLE INSTITUTIONS ACT, R.S.O. 1980, c. 64.

Section 11 of Regulation 98 made under THE CHILDREN'S INSTITUTIONS ACT, R.S.O. 1980, c. 67.

Section 5(t) of Regulation 502 made under THE HOMES FOR THE AGED AND REST HOMES ACT, R.S.O. 1980, c. 203.

Section 77 of Regulation 690 made under THE NURSING HOMES ACT R.S.O. 1980, c. 320. Section 19 provides a penalty for breach of that section of a fine not more than $2,000.

Section 22 of Regulation 937 made under THE TRAINING SCHOOLS ACT R.S.O. 1980, c. 508.

(4) Statutes that require "other" information to be reported:

THE CHILD WELFARE ACT, R.S.O. 1980, c. 66, section 49 places a duty on social workers to report the suspected abuse of a child to the Children's Aid Society. Section 94(f)(iii) provides a penalty for breach of that section of a fine not more than $1,000. Section 52(2)

provides that verified information of suspected abuse reported to the Children's Aid Society under section 49 is to be reported to the Director.

THE CORONER'S ACT, R.S.O. 1980, c. 93, section 10 places a duty on a social worker to report the death of an individual under the listed circumstances. Section 55 provides a penalty for breach of that section of a fine not more than $1,000 and 6 months imprisonment.

THE MINISTRY OF CORRECTIONAL SERVICES ACT, R.S.O. 1980, c. 275, section 37 requires every person having information relevant to the suitability of an inmate to be paroled to report that information to the Parole Board when requested to do so.

THE PRIVATE SANITARIA ACT, R.S.O. 1980, c. 391, section 42 provides that, if a social worker is a member of the Board of a Private Sanitarium, he is required to indicate if a particular person is detained in a Sanitarium upon the request of any person.

Section 9(1) of Regulation 836 made under THE PUBLIC HEALTH ACT, R.S.O. 1980, c. 409 requires a social worker, if he is in charge of a child, to report to the medical officer of health, if the eyes of the child become reddened, inflamed or swollen. Section 150(2) provides a penalty for breach of that section of a fine not more than $2,000 and 6 months imprisonment.

THE VITAL STATISTICS ACT, R.S.O. 1980, c. 524, section 11 places a duty on a social worker to report information to the Registrar regarding a new born child found deserted.

Section 54 provides a penalty for breach of that section of a fine of not more than $100.

THE STATISTICS ACT, S.C. 1970-71-72, c. 15, section 12 authorizes the chief statistician or any person authorized by him to have access to records relevant to the objects of the act. Section 30 provides a penalty for breach of that section of a fine not more than $1,000 and six months imprisonment.

(B) Disclosure Authorized By Statute

Certain existing statutes authorize a social worker or other individual to disclose client information collected by a social worker without the apparent consent of the client or person authorized to consent to such a disclosure on behalf of the client. In the statutes listed below there appears to be a certain degree of discretion vested in the social worker or other individual to disclose or not disclose information. This discretion is however subject to the caveat that if there is a contract between the social worker and client containing express provisions regarding the confidentiality of client information, the terms of the contract will govern.

THE CHILD WELFARE ACT, R.S.O. 1980, c. 66, section 52(6) permits the Director or persons authorized by him to disclose information maintained in the abuse registry to:

a) a coroner

b) a medical practitioner

c) a police officer pursuant to an investigation under The Coroner's Act

d) the Official Guardian

e) the Ministry

f) the Society

g) a Children's Aid Society outside Ontario

h) a person providing services or treatment in bona fide research to inspect information in the abuse registry with the written approval of the Director.

THE EDUCATION ACT, R.S.O. 1980, c. 129, section 237(10) permits the contents of a pupil's record to be reported to any person as may be required in the performance of his duties. It is unclear to the writer as to whether the phrase "his duties" refers to the person who has knowledge of the record or to the person who wishes to obtain the record. It is also unclear whether this section gives the record holder discretion to disclose or not disclose the record.

THE MENTAL HEALTH ACT, R.S.O. 1980, c. 262: If a person has been charged with a criminal offence and appears to suffer from a mental disorder, a judge may order that person to attend a psychiatric facility for examination (section 15 and 16). Section 18 authorizes the senior physician to report any information compiled by the

psychiatric facility to any person where in the opinion of the senior physician, it is in the best interests of a person who has been ordered to attend a psychiatric facilty for examination.

Section 29(3) permits the officer in charge of a psychiatric facility to disclose the clinical record to:

d) another health facility that is currently involved in the direct health care of the patient;

e) a person currently involved in the direct health care of the patient in a health facility where delay in obtaining the consent of the patient or nearest relative would endanger the life, a limb or a vital organ of the patient.

f) researchers.

Section 49(6) of Regulation 865 made under THE PUBLIC HOSPITALS ACT, R.S.O. 1980, c. 410 permits the board to allow another hospital or researcher to inspect and receive information from a medical record.

THE VENEREAL DISEASES PREVENTION ACT, R.S.O. 1980, c. 521, section 13 indicates that if a social worker has knowledge that a person was dealt with under the act, he may report that knowledge to a medical officer, physician or superintendant or head of any place of detention.

THE CANADIAN HUMAN RIGHTS ACT, S.C. 1976-77, c. 33 section 52(2) provides that any information given by an individual to the federal government can be made available for a derivative use (a use of the information that is not inconsistent for which it was compiled) without the consent of the individual.

2) Court Ordered Disclosure

The courts[3] have power to order the disclosure of client information within the knowledge or possession of a social worker by the following means:

In civil matters, a social worker may be involved in the proceedings in one of two ways. He may be a party to the action, or he may be subpoenaed by one of the parties to the action.

If the social worker is a party to the action, for example, he is being sued for some wrongful act he is alleged to have committed, the party suing the social worker may attempt to obtain information within the knowledge of the social worker by the following means. First, the other party may require the social worker to produce documents that the social worker had or has in his possession relating to any matters in question in the action.[4] Second, the social worker may be required to give evidence in the proceedings. In civil actions a party may give evidence at two stages: on oral examination for discovery and at trial. On oral examination for discovery each party can examine the other party to find out what case he will have to meet at trial.[5]

If a social worker is not a party to the action, he may become involved in one of two ways. First, any party to the action may compel the social worker to produce any documents he has that are relevant to the issues before the court.[6] Second, a social worker may be subpoenaed and required to give evidence at the trial.[7]

In criminal matters, a social worker, assuming

he is not the accused, can be subpoenaed by the Crown Attorney or accused and required to give oral evidence at a preliminary hearing and at trial.[8] If there are documents in the possession of a social worker which may afford evidence with respect to the commission of an offence, those documents can be seized by a police officer pursuant to a search warrant issued by a Justice of the Peace.[9]

In addition to the above methods of obtaining information in the possession of knowledge of a social worker, the following statutes provide for court ordered disclosure of client information:

THE CHILD WELFARE ACT, R.S.O. 1980, c. 66. section 50 provides that a court may order any person to disclose documents that are relevant to determine whether abuse has or is likely to be inflicted on a child. In considering whether to order disclosure under this section, the court must consider the factors under THE MENTAL HEALTH ACT[10] and as well the health and safety of the child. Hence there is an additional element under THE CHILD WELFARE ACT which is not present under THE MENTAL HEALTH ACT.[11]

THE FAMILY LAW REFORM ACT, R.S.O. 1980, c. 152, section 26 provides that for the purpose of bringing an application for support, custody, or access, or to enforce such an action, the court may order any person or public agency to provide the court with the whereabouts of the respondent.

THE MENTAL HEALTH ACT, R.S.O. 1980, c. 262, section 29(5) provides that the clinical record of a patient shall be disclosed pursuant to a court order or subpoena.

Section 49(2) of Regulation 865 made under THE PUBLIC

HOSPITALS ACT, R.S.O. 1980, c. 410 provides that medical records may be released to a person with a process.

Given that the courts have such broad powers to order the production of documents or to compel a social worker to give evidence in a proceeding, the next issue to be considered is the steps, if any, that may be invoked by a client who wishes to prevent a social worker from producing documents or giving evidence concerning him.

The right to withhold relevant, reliable and trustworthy evidence from a court would deprive both an opponent and the court of available facts relevant to an issue, and would create a risk that justice may not be done.[12] However, a client may withhold such information from the court on the ground that it is privileged. As Elder has stated:

> ..."privilege" reflects a policy decision that the protection of confidential disclosures is of greater importance than having fact finding bodies and the general public gain the protected knowledge. Privileges inherently cut off sources of testimony on potentially relevant facts, and become less justifiable as the excluded evidence more closely relates to the centre of controversy.[13]

It is important to distinguish between the doctrine of privilege and confidentiality:

> Confidentiality refers to the duty to keep secret information obtained while acting in a professional capacity; privilege exists when, by general law or express legislation, such information may not be disclosed in a legal proceeding without the client's or a patient's prior consent.[14]

Lord Diplock in D v. National Society for the Prevention of Cruelty to Children made the following comments regarding these two doctrines:

> The fact that information has been communicated by one person to another in confidence, however, is not of itself a sufficient ground for protecting from disclosure in a Court of law the nature of the information...if... these matters would assist the court to ascertain facts which are relevant to an issue upon which it is adjudicating... The private promise of confidentiality must yield to the general public interest that in the administration of justice truth will out, unless by reason of the character of the information, or the relationship of the recipient of the information to the informant, a more important public interest is served by protecting the information from disclosure in a court of law.[15]

Therefore, in brief, privilege is a rule of evidence law that provides an individual with the right to withhold evidence in a court. The privilege belongs to the client, not the social worker, and only the client can waive it. A client will be deemed to have waived his privilege when he puts his own mental condition in issue at trial; when a mental examination is ordered by the court; or in proceedings against a therapist. The one exception to the rule that only a client can waive the privilege is that created under The Child Welfare Act which requires a social worker to report information concerning child abuse notwithstanding that the information is privileged.[16]

Confidentiality on the other hand, refers to a standard of conduct that obligates the social worker not to disclose information obtained in confidence. (The common law action for breach of confidence is considered in section II of this paper).

There are three basic types of privileges in Canada which may arise by the common law or by statute. They are as follows:

1. Topic privilege; examples of this are that a voter does not have to disclose how he voted; or a juror cannot disclose deliberations of the jury[17].
2. Privilege based on a relationship; examples of this are the common law privilege afforded to the solicitor-client relationship; or the statutory privilege between husband and wife.[18]
3. Crown or State privilege.

It is fairly obivious that "topic privileges" will not be relevant to the practice of social work.

The privilege afforded to the solicitor-client relationship is relevant to the practice of social work. This privilege has two aspects to it. The first aspect, which is not relevant to the practice of social work is that any communications made between a solicitor and client are privileged whether or not made in relation to litigation, if they are confidential and are made by or to a legal advisor in his professional capacity for the purpose of rendering legal advice or assistance.[19] Second, any communications by a third party with the client or solicitor are privileged if brought into existence for the purpose of litigation actual or contemplated.[20] Thus if a client consults a solicitor, and if the solicitor, before trial and in contemplation of litigation refers the client to a social worker for an assessment (assuming the assessment may be relevant to the litigation), any communications between the social worker and client, or any reports prepared by the social worker in conjunction with that assessment are privileged. It is again important to stress that this information is protected not because of the doctrine of confidentiality or social work ethics but because the communication falls under the solicitor-client

privilege.[21] If the social worker produces an unfavourable assessment, his findings cannot be introduced as evidence in court unless the client has waived the privilege.

If an individual makes an application under section 26 of The Family Law Reform Act,[22] (referred to earlier) a solicitor cannot refuse to provide the information on the ground that it is subject to the solicitor-client privilege.[23]

The third type of privilege referred to above, Crown or State privilege is also relevant to the practice of social work. In D. v. National Society for the Prevention of Cruelty to Children, the N.S.P.C.C. was not required to disclose in a court of law the name of a complainant who informed them of the potential abuse of a child.[24] The name of the complainant was protected by an application of the privilege that is afforded to police informants. This privilege provides that the identity of police informers is not to be disclosed unless it is necessary to show that an accused was innocent of the offence in a criminal charge. This case has recently been accepted in Canada.[25]

In addition to the three basic types of privilege discussed above, there are several additional privileges created by statute which are relevant to the practice of social work.

1) THE DIVORCE ACT, R.S.C. 1970, C. D-8, s. 21(2) indicates that any communications made by the parties to a divorce suit to an individual endeavouring to assist in their reconciliation are not admissable in any legal proceedings. This section has been interpreted in two different ways by the courts. Several cases have indicated that it is not a general statutory rule of evidence applicable to all endeavours to assist the parties to a marriage with a view to their possible reconciliation,

but rather the privilege is limited to endeavours following the nomination of a marriage counsellor under section 8(1)(b) of The Divorce Act.[26] On the other hand, several cases have ruled that the privilege applies notwithstanding that the counsellor has not been appointed under section 8(1)(b).[27] This line of reasoning is more compelling to the writer as it could be argued that the privilege created under The Divorce Act is an extension of the privilege attaching to communications made "without prejudice". "Without Prejudice" communications are those made in an effort to promote settlements between the parties and are not admissible in evidence in the event that a settlement is not reached.

2) THE WORKMAN'S COMPENSATION ACT, R.S.O. 1980, C. 539, s. 103 provides that reports submitted to the Board are privileged and can only be used for the Board. A similar provision is found in THE STATISTICS ACT, S.C. 1970-71-72, c. 15, s. 17 which states that returns made to Statistics Canada are privileged.

3) THE EDUCATION ACT, R.S.O. 1980, c. 129, s. 237(2) and (9) indicates that the pupil record is privileged, except for use in disciplinary proceedings (237(13)).

4) THE MENTAL HEALTH ACT, R.S.O. 1980, c. 262, s. 29 creates two potential bars to the admissibility of evidence in a court. First, subsection 29(6) provides that if the attending physician states that disclosure or transmittal of the clinical record is (a) likely to result in harm to the treatment or recovery of the patient; or (b) is likely to result in injury to the mental condition of or bodily harm to a third person, the clinical record is not to be disclosed or ordered to be produced by a court until a hearing is held under subsection 29(7). According to the unreported case of Catholic Children's Aid Society of Metropolitan Toronto

v. J.S. and J.S. the hearing under section 29(7) involves two stages.[28] First, the physician must satisfy the court that disclosure of the clinical record is likely to produce one of the conditions described above. If that test is not met, then disclosure will be ordered. If that test is met, then the party subpoeanaing the record must satisfy the court that its disclosure is essential in the interests of justice.

Thomson, J. has stated that subsections 29(6) and (7) go well beyond the traditional doctrine of privilege because with most privileges, the person for whose benefit it exists is entitled to waive it.[29] Under subsections 29(6) and (7) the patient may want the disclosure but the physician may prohibit it.

The second evidentiary bar created by section 29 is found in subsection 29(9) which prohibits disclosure by a person in any action or proceeding of any knowledge or information in respect of a patient unless the consent of the person authorized to consent to such a discloure is obtained. If such consent cannot be obtained, then disclosure may notwithstanding that still be made, if it is essential in the interests of justice. This subsection appears to create a qualified privilege for all those employed in a psychiatric facility.[30]

Until the Supreme Court of Canada decision in Slavutych v. Baker et al.[31] it could be stated with a fair degree of certainty, with a few isolated exceptions, that if an individual could not fit himself within one of the above privileges, none could be claimed. The reasons for this are the cases of Wheeler v. Le Marchant[32] and The Queen v. Wray[33] In Wheeler, it was stated that the only privilege that would be afforded to a confidential relationship was that between the solicitor and client,

In Wray, the court stated that if evidence is relevant to the issue before the court, the trial judge has no discretion to exclude it unless its admissibility is tenuous and its probative value in relation to the main issue would be trifling and the evidence would be gravely prejudicial to the party who it was to be used against.

Thus, in the case of Robson v. Robson,[34] a social worker from the John Howard Society was required to disclose to the court his assessment of a husband and wife who were engaged in a custody dispute over their child. The social worker was required to disclose that information despite the fact that he claimed it would be contrary to public policy for him to do so. In The Queen v. Burgess[35] a confession by an accused to a psychiatric social worker was held to be admissible despite the claim by the accused that his communications with the social worker were privileged.

Despite these cases, there have been several isolated lower court decisions that refused to admit relevant evidence on the ground that to do so would be contrary to public policy.

In Re Kryschuk and Zulynik[36] the issue before the court was whether the Respondent was the father of a child. The Respondent had made statements to a social worker that were relevant to that issue, however, the social worker was not allowed to disclose those statements because (a) that evidence would have been hearsay; and (b) the communications with the social worker were privileged.

In Shakotko v. Shakotko and Williamson[37] Grant, J. held that communications between spouses and a marriage counsellor were privileged and to be protected on the grounds of public policy. The public policy to be furthered was the prevention of marital breakdown.

Several other cases have also created a privilege based on relationship:

G. v. G. psychiatrist as a marriage counsellor and spouses;[38] Dembie v. Dembie - psychiatrist and patient;[39] Carter v. Carter - physician and medical records containing information regarding the venereal disease of patient;[40] The Queen v. Hawke - psychiatrist and patient in criminal proceedings.[41]

As indicated earlier, the case of Slavutych v. Baker has had a significant impact on the doctrines of confidentiality and privilege.[42] In the Slavutych case, The University of Alberta asked a professor for his confidential opinion upon a colleague who had applied for tenure. Slavutych furnished his opinion on the basis that it would be kept confidential, but then proceedings to discharge him were commenced due to the severe language he had used concerning his colleague. In the dismissal proceedings before an arbitrator, the University attempted to introduce into evidence the confidential tenure form that Slavutych had completed.

Spence, J., in speaking for the Supreme Court of Canada, held that the documents were not admissible into evidence because they were confidential and could not be used against their maker. The University, which promised confidentiality, was not allowed to renege on that promise and breach the confidence.

McLachlin has indicated, in her commentary on the case, that all authorities except Slavutych do not support the proposition that a statement given in confidence cannot be compelled to be disclosed in evidence if otherwise admissible.[43] Past cases have indicated that the public interest in the administration of justice is taken to outweigh the private understanding of confidence. Arvay has stated that the result of the case is that a privilege would be conferred on a communication on the sole basis that it was made in confidence.[44] The doctrine of confidence has however, traditionally

been used to restrain a person from breaching a confidence in an out of court situation.

Even post-Slavutych cases have been reluctant to create a privilege based on confidentiality alone.[45] Laskin, C.J. in a 1982 Supreme Court of Canada decision noted the following in regards to Slavutych:

> It is recognized that merely because information is confidential does not ordinarily preclude its disclosure in evidence when commanded in a judicial proceeding in which it is relevant...The recent judgment of this Court in Slavutych shows that confidence may be protected by denying resort to information against the person providing it.[46]

In Slavutych, the court made several obiter comments regarding the doctrine of privilege. In those comments, the court indicated that a new class of privileged communications could result if the four fundamental conditions established by Wigmore[47] were satisfied. The conditions are:

1) The communications must originate in a confidence that they will not be disclosed;
2) Confidentiality must be essential to the full and satisfactory maintenance of the relationship;
3) The relation must be one which in the opinion of the community ought to be fostered sedulously; and
4) The injury that might inure to the relation by the communication's disclosure must be greater than the benefit thereby gained for the correct disposal of the litigation.

Although only obiter, the Court in Slavutych held that the four conditions were met and therefore the tenure form could be excluded because it was privileged.

According to commentators, the court in Slavutych appears to have confused the doctrine of privilege and the doctrine of confidentiality.[48]

As indicated earlier, the result of the case appears to be that if a communication was made in confidence that would confer a privilege on the communication. Even Wigmore, who created the above test stated: "In general then, the mere fact that the communication was made in express confidence or on the implied understanding of a confidential relation does not create a privilege."[49]

Whatever the criticisms of the case are, it is clear that the courts have since Slavutych accepted the Wigmore test. For example, in Solicitor General of Canada et al. v. Royal Commission of Inquiry into Confidentiality of Health Records in Ontario et al., Laskin, C.J. stated:

> This Court, speaking through Spence, J. in the Slavutych case, was of the opinion that the four fold test propounded in 8 Wigmore Evidence para 2285 p. 527 (McNaughton rev. 1961), provided a satisfactory guide for the recognition of a claim of privilege.[50]

The Wigmore test has been applied in a number of lower court decisions since the Slavutych case. It is important to briefly review several of these cases in order to attempt to predict whether the social worker-client relationship will satisfy the test and thus confer a privilege on communications made in the context of that relationship.

In The Queen v. Littlechild,[51] Littlechild applied for legal aid in order to obtain counsel in criminal offences he was charged with. In his application for legal aid, Littlechild waived his solicitor-client privilege. However, Laycroft, J.A. held that any communications between Littlechild and his interviewer at legal aid were inadmissible in evidence because the conditions in the Wigmore test were satisfied and therefore the communications were privileged. In regards to the fourth condition in the Wigmore test the Court noted that the legal system could not function without this privilege.

In Smith et al. v. Royal Columbian Hospital, Feldman and Kennedy,[52] the Credentials Committee of a hospital made inquiries into the suitability of a physician to become a staff member. A report of the Committee was subsequently produced for the hospital board. In subsequent proceedings by Smith (the applicant) against the hospital, due to the fact that he was denied employment, the board refused to disclose the document submitted to it by the Committee on the ground that it was privileged. The court held that the document was privileged as the conditions in the Wigmore test had been satisfied. In regards to the fourth condition of the Wigmore test, the court stated that it was important to protect the relationship between the Committee and its "advisors". To do otherwise might injure the public because the screening of the Committee might not be adequate due to the fact that "advisors" might not make full and frank disclosures to the Committee regarding the suitability of potential staff physicians.

A similar result was reached in Re University of Guelph and Canadian Association of University Teachers et al.[53] where the court held that the inquiries of a university committee regarding tenure, merit increments or promotion of faculty members were privileged. The court stated that the effective working of "the system" required that any communications with the committee be privileged.

In Alberta Human Rights Commission v. Alberta Blue Cross Plan[54] a complaint of sex discrimination was made by an employee under The Individual's Rights Protection Act.[55] In response to the complaint, the Human Rights Commission attempted to obtain disclosure of personnel records from the complainant's employer. The employer refused to release the records. The court held that the records were privileged as the Wigmore

test had been satisfied. In regards to the fourth condition of the test, the court held that the injury to labour relations would be great if such personnel documents were released.

To date in Canada there have been no reported cases where the Wigmore test has been applied to the social worker-client relationship, or any similar helping relationship. It is important to address the issue of whether the doctrine of privilege would be beneficial to the social worker-client relationship. According to Green and Richardson, the social worker-client relationship should be privileged because total confidentiality is a prerequisite to establishing the necessary relationship with a client.[56]

If the social worker-client relationship is privileged, it is important to stress that it is the client's privilege, i.e., only he can waive it. This may create a dilemma for the social worker, as it is foreseeable that there will be as many situations where the social worker will want to disclose client information despite the fact that the client has not waived the privilege, as there will be situations where both the social worker and client will not want the information to be disclosed. The U.S. courts have on many occasions applied the Wigmore test to the social worker-client relationship and have dealt with the dilemma presented above. These cases are discussed below.

If the social worker-client relationship is to be privileged, the four conditions of the Wigmore test must be satisfied.

In regards to the first condition of the Wigmore test, no one would make revelations of a private nature to a social worker without the expectation that they would be held in confidence.[57]

In regards to the second condition of the test, Rozovsky and Akhtar have stated that it would have a "chilling effect on the flow of communication" if the social worker had to say to his client "Whatever you say to me is confidential, unless I am summoned by a court. In that case everything you tell me will have to come out in court."[58] It would seem fairly obvious that if the relationship is to be of benefit to the client, there must be a free and complete exchange of information between the social worker and client.

In regards to the third condition, given that social workers do perform a helping function in society, it is not hard to argue that the relationship should be fostered.[59]

The fourth condition of the test is the most difficult to establish in regards to the social worker-client relationship. It is fairly clear that if a social worker is forced to disclose client information without the client's consent, that that social worker-client relationship will be destroyed. However, as Blyn, J., in the New York State case of Yaron v. Yaron stated, it is equally important to assess the effect of the disclosure on the general relationship between all social workers and their clients.[60] As was aptly stated:

> How can such persons have faith in this process if they become aware that some court can subsequently find that the confidence in which such feelings were revealed can be betrayed?[61]

In view of the Canadian cases discussed above that have applied the Wigmore test, in order for the social worker-client relationship to meet the fourth condition of the test, it would have to be argued that by affording a privilege to that relationship one is protecting a "system". It could be argued that "the system" in the context of the practice of

social work is the process whereby clients seek out social workers for service, or vice versa, and subsequently engage in a helping relationship.

As indicated above, it is instructive to look at the U.S. cases to see how they have dealt with the fourth condition of the Wigmore test in regards to the social worker-client relationship. It is clear from an analysis of the U.S. cases that the application of the doctrine of privilege to the social worker-client relationship depends upon the nature of the proceedings before the court.

In criminal proceedings, U.S. courts have generally held that no privilege attaches to statements made by an accused to a social worker regarding the commission of an offence, as the ends of justice demand that such information be disclosed.[62]

In proceedings dealing with the welfare of a child, the U.S. courts have been reluctant to grant a social worker-client privilege. For example, in Re Clear,[63] Polier, J. held that the best interests of the child governed in crown wardship proceedings regardless of the negative effect on the social worker-client relationship. The court held that there was no privilege between social worker-client communications despite the fact that there was a statute in force which extended the doctrine of privileged communications to persons standing in the relation of a client to a certified social worker.[64] In Illinois, the same result was reached in the case of In the Interests of Pitts.[65]

In Perry v. Fiumano,[66] Dillon, J. held that in custody proceedings, the welfare and best interests of the child govern and hence there could be no privilege between the social worker-client communications. As in the above cases, a statute, which apparently granted a privilege to such communications was overlooked, and instead the Wigmore test was adopted.

The results of these cases are very interesting as they demonstrate the reluctance of the courts to create a social worker-client privilege. Once a privilege has been created by statute, the Wigmore test is no longer relevant. The Wigmore test is intended to apply only in cases where there is no statutory privilege in effect. Only in one reported U.S. case, Yaron v. Yaron,[67] did the court hold that the statutory social worker-client privilege must govern, and that the Wigmore test was not to be considered, despite the fact that the proceedings concerned a child custody matter. Although this appears to be the correct result in law, it is open to question as to whether it is the desirable result.

Finally, when considering the U.S. cases, it is necessary to discuss an exception that has developed in relation to the doctrine of confidentiality. In Tarosoff v. Regents of University of California,[68] the court held that if a therapist determines, or should determine that a warning to a third party is necessary to avert danger from the medical or psychological condition of his patient, then the physician has a legal obligation to give that warning to the third party. That duty overrides the duty of confidentiality. To date no similar cases have been reported in Canada.

II. Disclosure of Client Information With the Consent of the Client

If a social worker wishes to disclose client information, and does not fall within one of the categories discussed above, then he should not do so unless he follows the procedures as outlined below.

There are two major issues related to obtaining a consent to disclose client information:[69]

a) who must consent to the disclosure of client information; and

b) what does "consent" mean.

In Ontario, existing legislative directives indicate that records can be dislcosed with the consent of the following indviduals:

THE EDUCATION ACT, R.S.O. 1980, c. 129, section 237(10) indicates that pupil records can be disclosed to any person:

> b) with the written consent of a parent or guardian where the pupil is a minor;
>
> c) with the written consent of the pupil where the pupil is an adult.

Subsection 237(11) indicates that a guardian includes a person, society, or corporation that has custody of a pupil. Thus in Re Children's Aid Society of Belleville and M. et al.[70] the court held that the Children's Aid Society had power to consent to the release of pupil records pursuant to subsection 237(10), as the Children's Aid Society fell within the definition of "guardian" in subsection 237(11), despite the fact that the child was in the care of the Children's Aid Society pending a final hearing of the matter.

THE MENTAL HEALTH ACT, R.S.O. 1980, c. 261, section 29(3) indicates that the officer in charge of the psychiatric facility may disclose the clinical record of a patient to any person:

> a) with the consent of the patient where the patient has attained the age of majority and is mentally competent;
>
> b) with the consent of the nearest relative of the patient where the patient has not attained the age of majority or is not mentally competent.

THE OMBUDSMAN ACT, R.S.O. 1980, c. 325, section 20(4) indicates that in proceedings or investigations under the act, the complainant must consent in writing in order that documents relating to him be released and available for those proceedings or investigations.

Section 49(6)(c) of Regulation 865 made under The Public Hospitals Act, R.S.O. 1980, c. 410 indicates that any person may inspect or receive information from a medical record if that person presents a written request by:

i) the patient;

ii) the personal representative of a former patient;

iii) the parent or guardian of an unmarried patient under 18 years of age.

In situtations not covered by the above statutes it is necessary to look at the common law in order to determine who may consent to the disclosure of client information.

A competent adult has the capacity to consent to the disclosure of information concerning him.

An incompetent adult does not have the capacity in law to consent to the disclosure of information concerning him. If an individual has been found mentally incompetent under The Mental Incompetency Act,[71] the committee of that individual should consent to the disclosure of information concerning the incompetent individual. The committee may be the Public Trustee or any individual appointed by the court. A mentally incompetent person not so found is treated in law like a child,[72] hence the legal guardian of the individual could consent to the disclosure. In the absence of a legal guardian, it is unclear in law as to whether the nearest relative has the authority to consent on behalf of the individual.

A mature minor can give his consent, just as an adult can.[73] It is however, difficult to predict with certainty when a minor will be said to be "mature" enough to consent to the disclosure of information concerning him without the additional consent of his parents or legal guardian. Some guidance may be obtained from The Child Welfare Act[74] which indicates

that a child who is 12 or more must consent to his being placed in the temporary care of the Children's Aid Society. If there are doubts about the capacity of a minor to provide such consent, the court has the power to declare whether a minor has that capacity and power to dispense with parental consent.[75]

Information concerning a child who is not "mature" should not be disclosed without the consent of the minor's parents or legal guardian.

In all of the above situations, i.e., under statute and at common law, the consent must be given voluntarily, without constraint, compulsion, duress or coercion, and as well it must be "informed". Informed consent means that the individual who is consenting must understand "the purpose for which the information is being requested and the contents of the material to be shared."[76] In addition, the individual consenting should know how the information is to be communicated.

SECTION II

If information has been disclosed by a social worker not in accordance with a method described in Section I, the social worker may have committed an unlawful disclosure. As a result the social worker may find himself faced with a statutory penalty for the wrongful disclosure or with a common law action by the client. Although there are at present no internal professional discipline procedures which could be commenced against a social worker for professional misconduct, such as breach of confidence, the possibility of such proceedings is discussed at the conclusion of this section.

1. Statutory Penalties for Wrongful Disclosure

In Ontario and Canada certain legislative directives indicate that records are only to be disclosed to individuals referred to in the statute. These statutes have been considered in Section I of this paper where the circumstances under which authorized disclosures could be made was discussed. If an unauthorized disclosure has been made, the following statutes provide for the following penalties:

THE CHILD WELFARE ACT, R.S.O. 1980, c. 66, section 94(f)(iv) provides for a maximum penalty of a $1,000 fine and up to one year imprisonment if an unauthorized disclosure of information maintained in the abuse registry in section 52 is made. Section 94(f)(iii) provides a similar penalty if records obtained pursuant to a court order under section 50 are disclosed other than for the purpose of determining whether a child is in need of protection.

THE MENTAL HEALTH ACT, R.S.O. 1980, c.262, section 64 provides for a maximum fine of $10,000 if a clinical record is disclosed not in accordance with section 29.

THE PUBLIC HOSPITALS ACT, R.S.O. 1980 c. 410, section 27 provides for a fine of not less than $25 and not more than $500 if an individual not authorized by section 49 of Regulation 865 inspects or receives information from a patient's medical record.

THE CANADIAN HUMAN RIGHTS ACT, S.C. 1976-77, c. 33 provides that if a nonderivative use is made of information given by an individual to the federal government, the individual may report to the Privacy Commission who will investigate the complaint.

2. Common Law Actions by the Client Against the Social Worker

If a social worker has made an unauthorized disclosure of client information, the social worker may be faced with a common law action by the client. In Canada, there are five possible common law actions that a client may bring against a social worker for unauthorized or unwarranted disclosure of personal information. The actions are:

a) breach of confidence;

b) negligence;

c) breach of statute;

d) defamation;

e) breach of contract.

The elements necessary to establish each of these causes of action are briefly considered below.

a) Breach of Confidence

In order to establish an action for breach of confidence, the client must establish the following three elements:

i) The information was "imparted in circumstances imparting an obligation of confidence",[77] i.e., "that any reasonable man standing in the shoes of the recipient of the information would have realized that upon reasonable grounds that the information was given to him in confidence".[78]

ii) The information must not be public knowledge.

iii) There must be an unauthorized use of the information to the detriment of the person communicating it.[80]

b) Negligence

If a social worker makes a disclosure of client information "which he could reasonably forsee would be likely to injure" the client, he may be liable in a negligence action.[81]

c) Civil Action in Tort for Breach of Statute

In Ontario and Canada certain legislative directives indicate that information compiled or obtained pursuant to the statute is to be considered as confidential and/or is not to be disclosed to unauthorized individuals. Tort liability may be imposed on the social worker for a breach of such a statute on the ground that the court is enforcing the intention of the legislature.[82] The statutes that contain such provisions and that are relevant to the practice of social work and that do not contain provisions indicating that no action lies against any person acting under the authority of the act in good faith are:

i) THE CHILD WELFARE ACT, R.S.O. 1980, c.66, section 52- unauthorized disclosures of information contained in the abuse registry; section 81 unauthorized disclosure of information contained in the adoption registry.

ii) THE EDUCATION ACT, R.S.O. 1980, c. 129, section 237- unauthorized disclosure of pupil record.

iii) Section 10 of Regulation 441 made under THE GENERAL WELFARE ASSISTANCE ACT, R.S.O. 1980, c. 188- the identity of individuals who are receiving or are eligible for assistance shall not be made public.

iv) Section 24(1) of Regulation 502 made under THE HOMES FOR THE AGED AND REST HOMES ACT, R.S.O. 1980, c. 203- records of residents shall be maintained in confidence.

v) THE MENTAL HEALTH ACT, R.S.O. 1980, c. 262, section 29- unauthorized disclosure of clinical record.

vi) Section 49 of Regulation 865 made under THE PUBLIC HOSPITALS ACT, R.S.O. 1980, c. 410- unauthorized disclosure of medical record.

vii) THE PUBLIC SERVICE ACT, R.S.O. 1980, c. 418, section 10- oath of secrecy of public service employees.

viii) THE CANADIAN HUMAN RIGHTS ACT, S.C. 1976-77, c. 33, section 2(b)- principle of privacy of individuals; section 52(2)- consent of individual to be obtained prior to nonderivative use of information.

d) Defamation Action

Defamation is the dissemination of information, whether by oral word, by written word, or by any other type of conduct, that tarnishes the good name of a person, causing his standing in the community to be impaired, or causing him to be pitied.[83] Defamation may be divided into the two categories of libel and slander. Libel has basically been associated with the written word and a slander is generally conveyed by the spoken word.

e) Breach of Contract

In situations where there is a contractual relationship between the social worker and client, there may be an express or implied contractual duty of confidence.[84]

It is important to note that the client receiving care or service does not have to be paying for the services before a term of confidentiality will be implied into the contract.[85]

If a social worker is faced with any or all of the common law actions referred to above, he would have a defence to such action or actions if he made the disclosure pursuant to a method described in Section I of this paper. In addition, the defence of "just cause" or "public interest" is recognized as a defence to actions for breach of confidence,[86] negligence[87] and defamation.[88]

There is unfortunately a lack of relevant case law defining the scope of the "just cause" or "public interest" defence when an unauthorized disclosure of personal information has been made. It is interesting to speculate as to whether the following disclosures of client information, if unauthorized

would fall within the scope of this defence.

i) Disclosure of a child's record to a parent or legal guardian.

Does a parent or legal guardian of a child receiving assistance from a social worker have the right to receive information about the child without the child's consent? The proposed Children's Act recommends that parents of a child under 16 could have access to the child's record without the consent of the child so long as the disclosure would not be harmful to the child.[89]

ii) Disclosure to the next care or service provider receiving the client.

Does the next care or service provider have the right to receive client information without the consent of the client? As indicated earlier, there are two statutes relevant to the practice of social work in Ontario, The Public Hospitals Act[90] and The Mental Health Act[91], that specifically allow the next care or service provider to receive client information without the consent of the client. It is interesting to note that under The Nursing Homes Act,[92] the administrator of another nursing home to which a resident has been transferred may receive information from a resident's medical or drug record, but not his personal record. In situations not governed by those statutes, it is necessary, in the opinion of the writer, to divide this issue into two categories: those clients voluntarily receiving service from a social worker, and those clients who are involuntarily receiving services. Only in the later case is the writer of the opinion that disclosure to the next care or service provider should fall within the just cause exception.

iii) Disclosure in emergency situations.

What type of emergency would justify a disclosure in the public interest? As indicated earlier, The Mental Health Act[93] provides that where the health of the patient is directly threatened, the clinical record may be released to anyone involved in delivering health care to the patient under circumstances where the withholding of such information would endanger the life, limb, or vital organ of the patient. Also, as mentioned earlier, in the Tarosoff[94] case, a disclosure would be justified if it was necessary to warn a third party to avert danger resulting from the psychological condition of a patient. Canadian commentators have agreed in principal with the Tarosoff case, as their comments indicate that any social worker should be allowed to disclose information without the consent of the client to the police or any institution that the social worker has reasonable grounds to believe would help prevent the client or some other person from suffering serious bodily harm.[95]

iv) Disclosure to researchers.

Most commentators agree that the benefits that accrue to society because of research are greater than the client's right to privacy.[96] In other words it would appear that commentators would be in favour of allowing a just cause defence to prevail when a social worker discloses records to a researcher that may personally identify a client. It is instructive to look at the statutory provisions that provide for the disclosure of information for the purpose of research. There are seven statutes

currently in force in Ontario which provide for disclosure of physical, social or mental health information for the purpose of research. Three of those statutes, The Child Welfare Act,[97] The Health Insurance Act,[98] The Mental Health Act,[99], indicate that no information shall be provided to a researcher that has the effect of identifying the client. Four of those statutes, The Cancer Act,[100] The Ministry of Health Act,[101] The Public Health Act,[102] and The Public Hospitals Act,[103] provide that information may be disclosed to researchers, but make no reference to the removal of information that may identify the client.

From this analysis, it is apparent that there is no clear answer to the question as to when disclosure to researchers will be seen to be in the public interest. It would appear that any court dealing with this issue would have to balance the nature of the information involved and the nature of the research to determine which interest should prevail.

REMEDIES

In the event that a client is successful in establishing one of the above causes of action, he may find that the nature of the wrong he has suffered may fall within the domain of damages poorly compensated, or simply not compensated at all.

For example, the only practical remedy available for a breach of confidence is an injunction. However, if the disclosure has already been made, an injunction will not issue.[104]

In regards to the remedy for negligence or breach of statute, the client must show that he has suffered some physical symptom as a result of the wrongful disclosure, such as a psychiatric illness.[105] Tort law will not allow compensation for general emotional upset.[106]

In an action for libel, general damages are presumed and therefore do not have to be proved.[107] However in an action for slander, the client must show that he suffered a material loss.[109]

Given these deficiencies in the law, it is apparent that a client will be faced with many hurdles while attempting to establish a claim for wrongful disclosure of information concerning him. Given this state of law it is necessary, in the opinion of the writer, for the profession of social work to establish internal disciplinary procedures to deal with complaints of unauthorized disclosures of client information. To do so would be a clear statement by the profession that a client's right to privacy is viewed as essential. Such internal disciplinary procedures are already in existence for the professions of medicine, dentistry and optometry under The Health Disciplines Act.[110] In that act, professional misconduct in the practice of medicine is defined as "giving information concerning a patient's condition or any professional services performed for a patient to any person other than the patient without the consent of the patient unless required to do so by law."[111] A similar provision is found with respect to the practice of dentistry,[112] and optometry.[113]

If, upon investigation of a complaint of professional misconduct under The Health Disciplines Act, the Discipline Committee finds the professional guilty of professional misconduct, it may reprimand, revoke the licence, or suspend or restrict the licencee.[114] It should also be noted that the disciplinary body investigating a complaint under the act has the power to

examine a client's file;[115] however, there are also provisions whereby such bodies are under a duty to preserve secrecy with respect to all matters that come to their knowledge in the course of their duties.[116] In the opinion of the writer, The Health Disciplines Act provides a good model which the profession of social work should consider adopting.

NOTES

1. J. Swoboda, A. Elwork, B. Sales and D. Levine, "Knowledge of and Compliance with Privileged Communications and Child Abuse Reporting Law" (1978), 9 Professional Psychology 448. The following results were obtained:

	Percentage Unfamiliar With Law	
	Privileged Communications	Child Abuse Reporting
Psychologists	32	32
Psychiatrists	23	18
Social Workers	23	3

2. Adapted from L. Everstine, D. Everstine, G. Heymann, R. True, D. Frey, H. Johnson and R. Seiden, "Privacy and Confidentiality in Psychotherapy" (1980), 35 American Psychologist 828.

3. This includes commissions set up under The Public Inquiries Act, R.S.O. 1980, c. 411.

4. Supreme Court of Ontario Rules of Practice, R.R.O. 1980, Regulation 540, rule 347; The Small Claims Court Act, R.S.O. 1980, C. 476, s. 96 and 97 and s. 33 of Regulation 917 made thereunder.

5. Supreme Court of Ontario Rules of Practice, R.R.O. 1980, Regulation 540, rule 326. In proceedings under The Small Claims Court Act there is no provision for oral examination for discovery.

6. Supreme Court of Ontario Rules of Practice, R.R. O. 1980, Regulation 540, rule 349; The Small Claims Court Act, R.S.O. 1980, c. 476, section 96 and 97.

7. Ibid., rule 274.

8. The Criminal Code, R.S.C. 1970, c. c-34, as amended, section 627, 628, 629,630, 633, and 636.

9. Ibid., section 443.

10. R.S.O. 1989, c. 262, section 29.

11. Re Clarke Institute of Psychiatry and Catholic Children's Aid Society of Metropolitan Toronto (1981), 31 O.R. (2d) 486 (H.C.).

12. J. Judge, Confidentiality: Evidentiary and Procedural Developments, in Studies in Civil Procedure, edited by E. Gertner (Toronto, Butterworths, 1979), p. 125-166.

13. J. Elder, "Evidence: The Physician patient privilege: Alternatives to the rule as it now exists in Okalahoma" (1971), 24 Okalahoma Law Review 380 at 382.

14. B. Dickens, "Legal Protection of Psychiatric Confidentiality" (1978), I International Journal of Law and Psychiatry 255 at 258.

15. [1977) 2. W.L.R. 201 at 207 (H.L.).

16. R.S.O. 1980, C. 66, section 49(3).

17. The Criminal Code, R.S.C. 1970, c. c-34, section 576.2.

18. The Canada Evidence Act, R.S.C. 1970, C.E-10, section 4(3); The Ontario Evidence Act, R.S.O. 1980, c. 145, section 11.

19. Cook v. Cook and Kelterbourne, [1947] O.R. 287; The Queen v. Ben Cardino and de Carlo [1947] 2. O.R. (2d) 351 (C.A.).

20. Re Goodman and Carr and Minister of National Revenue, [1968] 2 O.R. 814 (H.C.).

21. See note, supra 14, at p. 269.

22. R.S.O. 1980, c. 152.

23. Re Matson v. Matson (1981), 30 O.R. (2d) 468.

24. See note, supra 15.

25. Solicitor General of Canada et al. v. Royal Commission of Inquiry into Confidentiality of Health Records in Ontario et al. (1968), 62 C.C.C. (2d) 193 (S.C.C.).

26. Robson v. Robson, [1969] 2 O.R. 857 (H.C.); Cronkwright v. Cronkwright [1970] 3. O.R. 784 (H.C.).

27. Shakotko v. Shakotko and Williamson (1977), 27 R.F.L. 1 (H.C.); Ferguson v. Ferguson (1980) 16 R.F.L. (2d) 207 (P.E.I. S.C.F.D.); Hillesheim v. Hillesheim and Wicklin (1975), 19 R.F.L. 42.

28. Decided July 28, 1980 per James, J. Excerpts reported in: H. Kelly, "When is the law not the law?" (1981), 2 Health Law in Canada 42.

29. Judge G. Thomson, "Confidentiality and Compulsory Reporting of Child Abuse" (1981), 2 Health Law in Canada 15; 23.

30. B. Mazer, Procedures Under the Mental Health Act of Ontario (Canadian Mental Health Association Windsor/Essex County Branch, 1982), p. 61.

31. (1975), 55 D.L.R. (3d) 224; [1976] 1 S.C.R. 254.

32. (1881), 17 Ch. D. 675 (C.A.) This case has been followed and accepted in Canada in : G. v. G., [1964] 1 O.R. 361 (H.C.), Unger v. Sun Alliance and Canada Assurance Comp. Ltd., [1977] 3. W.W.R. 569 (Alta. S.C.); Reference re Legislative Privilege (1978), 18 O.R. (2d) 529 (C.A.); Halls v. Mitchell, [1928] S.C.R. 125.

33. [1977] S.C.R. 272; 11 D.L.R. (3d) 673.

34. [1969] 2 O.R. 857 (H.C).

35. [1974) 4 W.W.R. 310 (B.C. Co. Ct).

36. (1958), 14 D.L.R. (2d) 676 (Sask. Police Magistrate Court).

37. (1977), 27 R.F.L. 1 (H.C.).

38. [1969] 1 O.R. 361 (H.C.).

39. (1963), 21 R.F.L. 46 (S.C.).

40. (1975), 6 O.R. (2d) 603 (S.C.).

41. [1974] 3 O.R. (2d) 210 (H.C.).

42. See note, supra 31.

43. B. McLachlin, "Confidential Communications and the law of Privilege" (1977), 11 University of British Columbia Law Review 266.

44. J. Arvay, "Privilege, Confidence and Illegally obtained evidence" (1977), 15 Osgoode Hall Law Journal 456.

45. Reference Re Legislative Privilege (1978), 39 C.C.C. (2d) 226 (C.A.); MacMillan Bloadel Ltd. v. Assessors of Assessment Areas of West Vancouver et al. (1982), 34 B.C.L.R. 111 (S.C.).

46. Solicitor General of Canada et al. v. Royal Commission of Inquiry into Confidentiality of Health Records in Ontario et al. (1982), 62 C.C.C. (2d) 193 at 207.

47. 8 Wigmore Evidence para 2285 p. 527 (McNaughton rev. 1961).

48. See notes, supra 43 and 44.

49. See note, supra 47, at para 2286, p. 528.

50. See note, supra 46, at p. 207.

51. (1980), 11 L.R. (3d) 390 (Alta. C.A.).

52. (1980), 29 B.C.L.R. 99 (S.C.).

53. (1981), 29 O.R. (2d) 312 (H.C.).

54. (1981), 16 Alta. L.R. (2d) 205 (Q.B.).

55. R.S.A. 1980, C. I-2.

56. D. Green and R. Richardson, "The Social worker-client relationship and privileged communications" (1965), Washington University Law Quarterly 362.

57. R. Delgado, "Underprivileged communications: extension of the psychotherapist - patient privilege to patients of psychiatric social workers" (1973), 61 California Law Review 1050.

58. L. Rozovsky and S. Alchtar, "Should Psychiatric communications be privileged?" (1977), 1 Legal Medical Quarterly 115 at 117.

59. See note, supra 56.

60. (1975), 372 N.Y.S. 2d 518.

61. Ibid., p. 524-525.

62. State v. Halleck (1970), 263 N.E. 2d 917 (Court of Appeals of Ohio); State v. Driscoll (1972), 193 N.W. 2d 851 (Supreme Court of Wisconsin); State v. Roberts (1976), 544 p. 2d 754 (Washington C.A.).

63. (1969), 296 N.Y.S. 2d 184.

64. C.P.L.R. Section 5408.

65. (1976), 357 N.E. 2d 872.

66. (1978), 403 N.Y.S. 2d 382 (N.Y.S.C.).

67. See note, supra 60.

68. (1979), 529 P. 2d 553; (1976), 551 P. 2d 334; see also McIntosh v. Milano (1979), 403 A. 2d 500 for a similar result.

69. The Children's Act - A Consultation Paper (Ontario Ministry of Community and Social Services, 1982).

70. (1980), 28 O.R. (2d) 795.

71. R.S.O. 1980, c. 264. s. 12(1).

72. W.B. Williston and R.J. Rolls, The Law of Civil Procedure (Toronto, Butterworths, 1970), Volume 1, p. 154.

73. Johnston v. Wellesley Hospital, [1977] 2. O.R. 103(H.C.)

74. R.S.O. 1980, c. 66, section 25(8).

75. W. Bowker, "Minors and Mental Incompetents: Consent to Experimentation, gifts of tissue and sterilization" (1981), 26 McGill Law Journal 951.

76. Consultation Paper on Case Information Disclosure (Ontario Ministry of Community and Social Services, Children's Services Division, (1979), p. 25.

77. Coco v. A.N. Clarke (Engineers) Ltd., [1969] R.P.C. 128 at 47-48 per Megarry, J.

78. Ibid.

79. Saltman Engineering Co. Ltd. v. Campbell Engineering Co. Ltd. (1948), 65 R.P.C. 203 per Lord Greene M.R.

80. See note, supra 77 at p. 48.

81. Furniss v. Fitchett, [1958] N.Z.L.R. 396 (N.Z.S.C.).

82. A. Linden, Canadian Tort Law 3rd. ed. (Toronto, Butterworths, 1982).

83. Ibid., p. 675 and 677.

84. Parry Jones v. Law Society, [1969] Ch. 1 (H.C.); Damien v. O'Mulvenny (1982), 19 C.C.L.T. 48 (Ont. S.C.).

85. See note, supra 81.

86. Fraser v. Evans, [1969] 1 Q.B. 349.

87. See note, supra 81.

88. In an action for defamation, this defence is known as "qualified privilege". The essence of this defence is that the person who made the communication, i.e., the social worker, says he did so without malice, i.e., in the honest belief that his statements were true, and that his actions were in good faith, and in so doing had a legal, social or moral duty or interest to make the statements to whom it was made, and the person to who it was made had a corresponding interest or duty to receive it. Note that "truth of the statement" is an absolute defence to an action for defamation. A. Linden, Canadian Tort Law, 3rd ed. (Toronto, Butterworths, 1982), P. 702 and 697.

89. See note, supra 69, at p. 161-162.

90. Section 49(6)(b) of Regulation 865 made under R.S.O. 1980, c. 410.

91. R.S.O. 1980, c. 262, section 29(3)(d).

92. Section 94 of Regulation 690 made under R.S.O. 1980, c. 320.

93. R.S.O. 1980, c. 262, section 29(3)(e).

94. See note, supra 68.

95. See note, supra 89, at p. 106.

96. H. Krever, Report of the Commission of Inquiry into the Confidentiality of Health Information (Toronto, Ontario Government, 1980), Volume III, p. 15-52.
The Children's Act - A Consultation Paper (Ontario Ministry of Community and Social Services, 1982), p. 166.
K. Younger, Report of the Committee on Privacy (London, Her Majesty's Stationary Office, 1972).
J. London, Privacy in the Medical Context, in Aspects of Privacy Law, edited by D. Gibson (Toronto, Butterworths, 1980), p. 281-294.

97. R.S.O. 1980, c. 66, section 52(7).

98. R.S.O. 1980, c. 197, section 44(3).

99. R.S.O. 1980, c. 262, section 29(4)(b).

100. R.S.O. 1980, c. 57, section 7.

101. R.S.O. 1980, c. 280, section 6(2)(d).

102. R.S.O. 1980, c. 409, section 89.

103. Section 49(d)(ii) of Regulation 865 made under R.S.O. 1980, c. 410.

104. Malone v. Metropolitan Police Commissioner, [1979] Ch. 344.

105. Hinz v. Berry, [1970] 1 ALL E.R. 1074.

106. Duwyn v. Kapriellian (1978), 7 C.C.L.T. 121.

107. See note, supra 82, at p. 687.

108. See note, supra 82, at p. 691.

109. Elder v. Koppe (1974), 53 D.L.R. (3d) 705; Newell v. Can. Pac. Airlines Ltd. (1976), 14 O.R. (2d) 752.

110. R.S.O. 1980, c. 196.

111. Section 27. 22 of Regulation 448 made under R.S.O. 1980, c. 196.

112. Section 37. 30 of Regulation 447.

113. Section 26. 21 of Regulation 450.

114. R.S.O. 1980, c. 196, section 37(5) - dentistry, section 60(5) - medicine; section 105(5) - optometry.

115. R.S.O. 1980, c. 196, section 40 - dentistry; section 61 - medicine; section 108 - optometry.

116. R.S.O. 1980, c. 196, section 41 - dentistry; section 65 - medicine; section 109 - optometry.

MALPRACTICE IN SOCIAL WORK

Steve Schenke

INTRODUCTION

This paper discusses malpractice in social work. The paper is divided into two major sections. The first section discusses the elements necessary to establish a cause of action in negligence and the second section discusses the application of those principles to the practice of social work. Cases relating to malpractice in psychiatry and psychotherapy are considered as well.

SECTION I: Negligence Law

A client may bring a civil action against a social worker in regards to professional services rendered by the social worker under two major branches of law: contract law and tort law.

If there is a contract between the client and social worker, any breach of the terms of that contract will give rise to an action for damages. Actions for breach of contract are not considered in this paper.

A tort is a civil wrong other than a breach of contract for which one may have a remedy in the form of an action for damages. There are two major types of torts: intentional torts and negligence. Examples of intentional torts are assault, battery, false imprisonment and breach of confidence. Intentional torts are not considered in this paper.

Negligence, in the narrow sense, is conduct that falls below the standard of care required by society.[1] Negligence in its wider meaning refers to a cause of action for negligence.[2] Malpractice is a special form of negligence that is limited to professionals. The terms malpractice and negligence are used interchangeably

throughout this paper. The focus of this paper is malpractice in social work.

A cause of action for negligence arises if the following elements are present:[3]

1. The defendant must be under a duty recognized by the law to avoid harm to the plaintiff.
2. The defendant's conduct must be negligent, that is, in breach of the standard of care set by the law.
3. The claimant must suffer some damages.
4. The damages suffered must be caused by the negligent conduct of the defendant (factual connection).
5. The conduct of the defendant must be the proximate cause of the loss, or in other words, the damage should not be too remote a result of the defendant's conduct (legal connection).

Each of these elements are discussed below:

1. Duty

Mr. Justice V.C. MacDonald gave the following explanation of the concept of duty in Canadian negligence law:

> In every case the judge must decide the question: Is there a duty of care in this case owing by the defendant to the plaintiff and, if so, how far does that duty extend? ...The common law yields the conclusion that there is such a duty only where the circumstances of time, place and person would create in the mind of a reasonable man in those circumstances such a probability of harm resulting to the other persons as to require him to take care to avert the probable result... The existence of a legal duty of care by a defendant depends upon whether the hypothetical Reasonable Man would foresee the risk of harm to a person in the situation of the plaintiff vis-a-vis himself and his activities.[4]

2. Standard of Care

If a person, such as a social worker, holds himself out as possessing special skill and knowledge, then the law will hold him to a standard of care higher than that of the reasonable man.

The standard of care required in the practice of social work is to use such reasonable and ordinary care, skill and diligence that a reasonable and prudent social worker in the same community in the same general area of practice would ordinarily have exercised in a like case.[5] It is not required that a social worker should use the highest degree of skill; for there may be persons who have higher education or greater advantages than he has.[6] Nor does the standard require the social worker at all times to exercise his best skill and ability.[7] The standard does not require that a social worker's intervention result in a successful outcome.[8]

If a social worker holds himself out as being a specialist within the field, a higher degree of skill is required of him than one who does not so claim.[9] A specialist must exercise that degree of care and skill which would reasonably be expected of a like specialist.[10]

Thus, in evaluating the standard of care in social work, the test is whether the social worker, in the performance of his service, either did some particular thing that a social worker of ordinary skill, care and diligence in the same or similar circumstances would not have done, or, failed to do some particular thing that a social worker of ordinary skill, care and diligence would have done in the same or similar circumstances.

The "locality rule" has been used in assessing the standard of care. In other words, a social worker must have the same skill

ordinarily possessed by practitioners in similar communities in similar cases. In Canada this distinction is based mostly on rural/urban centres.[11]

If a social worker makes an "error of judgment", that will not necessarily mean that he has breached the standard of care required of him.[12] Lord Fraser in Whitehorse v. Jordan explained the concept of "error of judgment" as follows:

> ...an error of judgment is not necessarily negligent. But in my respectful opinion, the statement as it stands is not an accurate statment of the law. Merely to describe something as an error of judgment tells us nothing about whether it is negligent or not. The true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that a man acting with ordinary care, might have made, then it is not negligent.[13]

The standard of care is determined by the following means:

a/ The state of social work knowledge at the time of the intervention.

b/ Custom or established modes of practice within the profession. It should however be noted, that a social worker will not be deemed to have breached the standard of care because he tried a new technique. If a novel or exceptional intervention was used, the social worker must be prepared to justify it before the court.[14]

c/ The system or school the social worker belongs to - provided it is accepted within the profession.

3. Damages

The plaintiff must prove that he has suffered damages as a result of the defendant's conduct.

4. Causation

There must be some factual connection or link between the wrongful act or omission and the damage. The most commonly employed technique for determining causation-in-fact is the "but for" test. If the damage would not have occurred but for the defendant's negligence, then his conduct is the cause of the damage.[15]

5. Remoteness of Damage and Proximate Cause

The loss or injury incurred by the plaintiff must not be too remote a consequence of the defendant's act. The basic test for determining remoteness of damages is that the defendant will only be liable for damages that are reasonably foreseeable to the reasonable man.[16] The defendant does not have to foresee the precise way in which the injury occurred, so long as one could reasonably foresee in a general way the class or character of injury which occurred.[17] There has been some retreat from the "foreseeability" test in The Wagon Mound (No. 2.) where the court held that liability may be imposed even though a loss is not reasonably foreseeable, if there is a real risk of damage.[18]

Generally, damages in negligence law can only be recovered for physical injury to body or damage to tangible property. If the plaintiff's sole damage as a result of the defendant's wrongful act or omission is nervous shock or economic loss, he will not generally be compensated for those losses unless such damages flowed from or can be linked to personal injury or damage to property.[19]

Damages can be obtained for negligent infliction of nervous shock if the following two conditions are met:

a) The emotional upset is accompanied by some physical symptom, such as a recognizable psychiatric illness.[20] Thus, a plaintiff cannot obtain damages for general emotional upset.[21]

b) The nervous shock must be a foreseeable consequence of the negligent conduct.[22]

Liability for Negligent Statements

If the negligent statement of the defendant led to personal injury or property damage, then the plaintiff can recover those losses.[23] According to Linden,[24] liability may follow from negligent statements causing nervous shock, despite a Supreme Court of Canada case which denied compensation to a wife who suffered shock when she read an erroneous report in a newspaper of the death of her husband and three children.[25]

The case of Hedley Byrne and Co. Ltd. v. Heller and Partners Ltd. established new liability for negligent statements which cause economic loss.[26] The case stands for the proposition that if in the ordinary course of business or professional affairs, a person seeks information or advice from another, who is not under a contractual of fiduciary obligation to give the information or advice, in circumstances in which a reasonable man so asked would know that he was being trusted, or that his skill and judgment was being relied on, and the person chooses to give the information or advice without clearly so qualifying his answer to show that he does not accept responsibility, then the person replying accepts a legal duty to exercise such care as the circumstances require in making his reply.[27]

The defendant's subjected to this duty include "persons holding themselves out in a calling or situation or profession..[who]... take on a task within that calling or situation or profession."[28]

SECTION II: Application of Negligence Law to Social Work

One would postulate that the practice of social work would involve many situations where a social worker could be found negligent. The practice of social work in the field of child welfare provides many illustrations that could potentially amount to negligence. For example, in the Popen case, an infant was placed back in her home by the Children's Aid Society without an adequate investigation of the mother's history of abuse of the child.[29] The child was killed by the mother two and one half months later. Was the Children's Aid Society negligent for having placed the child back in the home? In the Savoie case, three children were returned to the care of their mother who had previously given them up to the Catholic Children's Aid Society to go out West with her boyfriend.[30] Ten days after the children were returned to the mother's care, a social worker visited the home and concluded that everything was in order. The following morning, the mother strangled one of her children. A psychiatrist who examined the mother the day of the killing indicated that the mother's symptoms of major depression should have been obvious. Was the social worker negligent in this case? What if a social worker apprehends a child from his parents only to later discover that the allegations which led to the apprehension were unfounded? Should the social worker be responsible for any emotional

harm caused to the family as a result of the temporary involuntary separation of the family?

The social worker in a mental health setting may also encounter situations where his conduct may amount to negligence. For example, assume that a social worker, who is the primary therapist for a patient, fails to recognize suicidal symptoms of the patient. If the patient subsequently injures himself or commits suicide, should the social worker be liable? If a social worker recommends a patient for discharge, and shortly after discharge the patient injures a third party, should the social worker be liable? Assume that in the course of counselling, a client advises a social worker that he will kill or injure a third party. Does the social worker have a duty to warn the third party of the potential danger?

Assume that a social worker advises a client in the course of counselling that his situation would improve if he divorced his spouse, or sold his business. If the client follows through on that advice and his situation does not improve, is the social worker liable? Assume that in pending custody proceedings, one of the spouses (who is a party to the proceedings) contacts a social worker, and the social worker advises the client to act in a certain manner to ensure that he will obtain custody of his child. If the spouse follows the social worker's advice and does not obtain custody of the child, should the social worker be liable?

On a more general level, studies have suggested that a client's condition can deteriorate due to the intervention of a therapist.[31] (Note that this is not a continuation of the deterioration of the client's condition, but a deterioration attributable

to the intervention). Should a social worker be liable for damages in this case?

In all of the foregoing illustrations, before legal liability is imposed on the social worker, the elements of a negligence action, discussed in Section I, must be satisfied. Many commentators have discussed the application of these elements to the practice of psychiatry and psychotherapy, and most would agree that in the majority of cases, it is difficult to establish a malpractice action against a psychiatrist or psychotherapist.[32] Following is a summary of the difficulties one would encounter when attempting to establish a cause of action for negligence against a social worker.

One of the most difficult elements to establish is the standard of care in social work. Commentators have suggested that because of the imprecision and vagueness of social work, it would be difficult to establish a standard of care.[33] For example, in the field of mental health, there is no consensus concerning the cause of mental illness and therapeutic procedures best suited to treat those illnesses.[34] Also, as indicated earlier, there is no guarantee that the intervention of a social worker will result in the desired outcome, and thus is not sufficient to establish that the standard of care has been breached by showing that the desired outcome was not obtained.

Another difficult element to establish is the causative link between the act, omission or statement and the damage suffered. To prove malpractice against a social worker, it must be established that the intervention of the social worker caused the injury for which damages are sought. There are many variables that effect the outcome of a social worker's intervention:[35]

a) therapist characteristics, for example experience, education, skill and attitude;

b) client characteristics;

c) therapeutic characteristics, for example mode of treatment, time spent in counselling;

d) relationship between social worker and client.[36]

To establish liability on the part of the social worker it is necessary to distinguish the damage incurred by a client from his pre-existing condition and the likely course it might have taken with or without the intervention of a social worker. Using the field of mental health as an illustration again, because little is known about the causes and progressions of mental illness, it would be difficult to establish that the injury flowed from the negligent conduct of a social worker, and not from the course of any illness.

Finally, it may be difficult for a client to establish that he has suffered damages which are recoverable in law. The majority of damages arising out of the negligence of a social worker would fall under the head of emotional suffering. As indicated previously, in the absence of any physical symptoms, such damages are not recoverable.

There are no reported Canadian, English or U.S. cases that deal directly with the alleged negligence of a social worker in his professional capacity. The cases that relate to the "helping professions" primarily involve psychiatrists and psychologists. The following reasons may be postulated for the lack of cases dealing with the alleged negligence of social workers:

a) The nature of the social worker-client relationship might head off conflicts that might otherwise motivate malpractice claims.[37] A client who has exposed his personal history to a social worker may find it difficult to change his position and attack his confessor. Studies have demonstrated that there is an inverse correlation between contact between health professionals and malpractice actions.[38] In other words, health professionals such as psychiatrists and general practitioners who have more contact with their patients have lower malpractice rates, whereas surgeons, who have littler interaction with their patients, have higher malpractice rates.

b) Social workers traditionally interact with clients in lower economic classes who may not have the means to seek legal assistance.

c) Clients do not want their personal history brought out in court proceedings.

d) The difficulty in establishing all the elements of the action.

The majority of cases dealing with the malpractice of psychiatrists and psychotherapists are U.S. and relate to the following areas:

a) Wrongful committal to a psychiatric institution.[39] (A false imprisonment action is then brought against the psychiatrist or institution).

b) Treatment with medication or electroshock therapy.[40] The main issue in these cases is generally whether the patient has been adequately informed of the risks associated with the treatment,

so that he can be said to have consented to the treatment. An assault and battery action is generally brought against the psychiatrist who ordered the treatment.

c) Injury or death to the patient because of the alleged failure to restrain, supervise or control the patient.

d) Injury or death to a third party because of the alleged failure to restrain, supervise or control the patient.

e) Duty to warn a third party of impending harm threatened by a patient.

f) Psychotherapy.

As social workers do not have the authority to commit an individual to an institution, or to order treatment with medication or electroshock therapy, the cases relating to those areas are not considered here. The cases relating to the other areas are considered below as they are relevant to the practice of social work.

Duty to Prevent Suicide of Patient or Injury to Patient From Self Inflicted Acts

It is necessary to distinguish between the duty of a hospital to safeguard a patient and the duty of a therapist to safeguard the patient. It is also necessary to distinguish between those individuals receiving in-patient care and those receiving out-patient care.

If a patient commits suicide or harms himself while an in-patient in a hospital, the failure ordinarily claimed is one of lack of watchfullness over the patient in the hospital. This is the general duty of the hospital and not the therapist.[41] The general rule is that the hospital has a duty to exercise reasonable care to safeguard the patient against known or foreseeable damages that result from the patient's physical or mental incapacity.[42] Hospitals are not,

however, insurers of safety - thus because a suicidal patient enters a psychiatric hospital does not mean that the hospital guarantees his safety from self inflicted acts.

It is the duty of the therapist to recognize suicidal tendencies in a patient under his treatment.[43] A failure to recognize a suicidal patient on the part of the therapist, when there are obivious indications, and a failure to consult, refer, restrain or supervise such a patient may lead to liability on the part of the therapist if the patient subsequently injures himself or commits suicide.[44]

In Villemure v. L'Hospital Notre Dame et al., decided by the Supreme Court of Canada, a patient was admitted on an emergency basis to a psychiatric ward of a hospital because of an attempted suicide.[45] On the recommendation of a physician he was transferred to the medical ward of the hospital. No precautions were taken to prevent the recurrence of the attempt and no surveillance was made. After the patient made unanswered pleas to return to the psychiatric ward he committed suicide. The physician and nursing staff of the hospital were held to have been negligent and liable to the patient's widow and children.

In the Saskatchewan case of Stadel v. Albertson, a negligence action was brought against a psychiatrist after his patient committed suicide by jumping out of a hospital window.[46] The psychiatrist was not found negligent, as the symptoms of the deceased did not suggest that he was a danger to either himself or to anyone else.

When the individual is an out-patient of a hospital, the major problem in establishing liability on the part of the therapist is the lack of control of the therapist over the individual. In

the Ontario case of Haines v. Bellismo, the court failed to find liability on the part of a psychiatrist and psychologist when an out-patient of theirs committed suicide.[47] In the case, the deceased was treated as an out-patient by a psychiatric hospital. Due to the deterioration in his condition, he was subsequently admitted to the hospital as a voluntary patient. A psychologist was his primary therapist on the multi-discipline team. The deceased was discharged one month later and continued on out-patient treatment. Three months later, while still receiving out-patient care, the deceased's wife discovered that the deceased had purchased a gun. On the suggestion of the psychologist, the deceased gave the gun to him. Three days later, the deceased obtained a new gun and shot himself to death. The deceased's wife brought an action against the psychologist and psychiatrist of the hospital team, claiming that they were negligent in failing to hospitalize the deceased and thereby protect him from the reasonably apprehended danger of suicide.

The court held that the psychologist was in the best position to assess the deceased's suicidal tendencies and that the psychiatrist had delegated his responsibility to him. No negligence was found. In his reasons for judgment, Griffiths, J. stated the following:

> Having undertaken to treat Robert Haines, the defendant's owed to him a duty to exercise that degree of reasonable skill, care and knowledge possessed by the average of like professionals. If the patient's mental condition and actions were such that a reasonably prudent psychiatrist or psychologist would under the circumstances have anticipated a suicide attempt, then the concept of "reasonable care" in treatment requires the therapist to take all reasonable steps including hospitalization of the patient, if necessary, to prevent or reduce the risk of self-destruction. To this should be added the fundamental principle of law that governs all professionals, that a psychiatrist or psychologist who makes a diagnostic mistake or error in judgment does not incur liability whatever the harm, provided he

> exercised reasonable care and skill and took into consideration all relevant factors in arriving at his diagnosis or judgment. Psychology and psychiatry are inexact sciences and the practice thereof should not be fettered with rules so strict as to exact infallability on the part of the practitioners which they could not humanly possess.[48]

Injury or Death to Third Party

The following U.S. cases deal with claims by individuals who are injured or killed by a patient who has recently been released from an institution. The claims generally maintain that the patient was prematurely discharged from the institution, or alternatively, that the patient should have been provided with follow up services. Although these claims are primarily against the physician who has discharged the patient, often a social worker was involved in the assessment which led to the discharge.

In Hasenei v. U.S., the plaintiffs sued a Veteran's Administration hospital after a recently discharged patient had been involved in an automobile accident with them.[49] Four months prior to the accident, the patient was discharged from a VA hospital. Two weeks prior to the accident he was assessed by a psychiatrist and social worker from the hospital. He was diagnosed as schizophrenic and alcoholic. At the time of the accident the patient was intoxicated. The plaintiffs unsuccessfully claimed that the hospital was negligent in discharging the patient or alternatively, that the patient should have been provided with follow up services.

In Milano v. State, a mental patient killed a four year old child one and one half months after he was discharged from a mental hospital.[50] The patient had a schizoid personality and had demonstrated suicidal behaviour and assaultive behaviour toward his younger brother. The parents of the deceased child were unsuccessful in their action

which alleged that the hospital had failed to properly diagnose the patient's assaultive propensities, or alternatively, that they did not provide follow up services.

In Merchants National Bank and Trust Company of Fargo v. U.S., the wife of a mental patient on leave from VA hospital was shot and killed by him.[51] Prior to his discharge, the patient indicated to his therapist, a psychologist, that he would injure his wife. The patient was discharged to a nearby ranch, but the psychologist did not provide the ranch owner with enough background about the patient and with specific instructions as to what he should do if the patient left the ranch. The psychologist was found negligent. A psychiatrist was also found negligent in ignoring warning signals that the patient would kill his wife.

Duty to Warn Third Party

An individual is not normally under an obligation to warn a third party of a possible danger from another. However, there is U.S. authority to the effect that where there is a special relationship between the parties, as between therapist and patient, and where a therapist determines, or should determine that a warning to a third party is necessary to avert danger to the third party arising from the medical or psychological condition of his patient, then the therapist has a legal obligation to give that warning to the third party.[52] In Tarosoff v. Regents of University of California, a tort action was brought against a psychotherapist for failing to warn a third party who was murdered by his patient after the patient had threatened to do so in the presence of the psychotherapist.[53]

The Tarosoff duty has been limited to situations where there are specific threats of harm directed at a specific victim. Thus, in Thompson v. County of Alameda, a therapist was not held liable when a juvenile offender client of his was released from confinement and killed a child 24 hours later.[54] Prior to his release, the juvenile indicated that he would kill some child in the neighbourhood. The court held that there was no duty to warn the community in that case, as the threats were nonspecific and directed at unspecified victims.

In Tarosoff duty presents a dilemma to the therapist. He faces liability for an action for breach of confidence if the potential victim is warned and there was insufficient evidence that the patient intended to fulfill his threats, and on the other hand he faces potential liability if the potential victim is not warned and is subsequently injured.

Psychotherapy

The following cases arise out of situations where a psychiatrist and patient are engaged in a psychotherapeutic relationship and subsequently become socially and sexually involved with each other. All of the cases are U.S. with the exception of one English case.

In Anclotte Manor Foundation v. Wilkinson, a psychiatrist told his patient that he would marry her after he (the psychiatrist) divorced his wife.[55] The patient then divorced her husband, and when the psychiatrist would not marry her, committed suicide. The court, in an action by the husband, held that this conduct of the psychiatrist fell below acceptable standards and was malpractice.

In the English case of Landau v. Werner, a psychiatrist engaged in psychotherapy with his patient for five months.[56] During that time the patient fell in love with the psychiatrist. The patient then decided to discontinue treatment. The psychiatrist continued to see her socially for the following nine months as he felt she was not yet better. After the nine months, the patient's condition had deteriorated and formal treatment began again, but was soon abandoned because it was of no help. The patient's mental condition deteriorated to such an extent that she became incapable of work. In an action against the psychiatrist, the patient claimed that her illness was due to the negligence of the psychiatrist. The court found that the psychiatrist was negligent and that his "departure from the recognized standard had resulted in gross deterioration of the patient's health, and on the evidence it would also amount to negligence in treatment".[57]

In a similar U.S. case, Zipkin v. Freeman, a psychiatrist treated a patient who subsequently fell in love with him.[58] The psychiatrist advised the patient that she should contiue social and personal contacts with him under the pre-text that that was part of her therapy. As a result, the patient "suffered remorse, humiliation, mental anguish, loss of respect of friends and family, was made nervous and unable to sleep, suffered headaches and was irritable and suffered financially".[57] The court found that this was unacceptable treatment for neurosis.

In Roy v. Hartogs, sexual acts between a psychiatrist and patient as part of the treatment were held to be unacceptable deviations from acceptable standards of treatment of the mentally disturbed.[60] Had this action arisen in Canada, it probably would have been litigated as intentional tort of battery.

In brief, these cases appear to stand for the proposition that a therapist should not abuse his position of power to serve his own needs.

Summary of Cases

As indicated above, there have been a number of cases relating to the malpractice of psychiatrists and psychologists in specific areas of those practices. Had a social worker been the therapist in one of the above situations, he may have been found to have been negligent in his practice. It is however important to stress the following:

a) No actions have been brought against a social worker alleging malpractice on his part.

b) The cases dealing with the liability of a therapist when his patient kills or injures a third party; or when a therapist has failed to warn a third party of threatened danger; or those dealing with psychotherapy, are all U.S. cases with the exception of one English case.

Although it is possible that a social worker practicing in Ontario may be found negligent if such acts or ommissions occurred in Canada, to date there have been no such reported cases in Canada.

It is also interesting to note that there have been no reported Canadian cases imposing liability on a psychiatrist under the Hedley Byrne principle discussed earlier.[61] Hedley Byrne has been applied to surgeons,[62] lawyers,[63] accountants,[64] architects,[65] engineers,[66] insurance agents[67] and car salesmen[68]. Perhaps Hedley Byrne has not been applied to a psychiatrist or related profession because the cases to date have dealt with damage resulting from an act or ommission

on the part of the therapist as opposed to damage incurred by a negligent statement of the therapist.

NOTES

1. C. Wright and A. Linden, Canadian Tort Law, 6th ed. (Toronto Butterworths, 1975), p. 147.

2. Ibid.

3. A. Linden, Canadian Tort Law, 3rd ed. (Toronto, Butterwoths, 1982), p. 85.

4. Nova Mink v. Trans Canada Airlines, [1951] 2 D.L.R. 241 at 254 (N.S.C.A.).

5. Challard v. Bell (1959), 18 D.L.R. (2d) 150; 61 Am Jur 2d Physicians and Surgeons para 205.

6. Challard v. Bell (1959), 18 D.L.R. (2d) 150.

7. Ibid.

8. See note, supra 6, and Johnston v. Wellesley Hospital (1971), 2. O.R. 103; 17 D.L.R. (3d) 139 (H.C.).

9. See note, supra 3.

10. Johnston v. Wellesley Hospital (1971), 2. O.R. 103; 17 D.L.R. (3d) 139 (H.C.).

11. See note, supra 3, at p. 142

12. See note, supra 10.

13. [1981] 1 ALL E.R. 267 at 281.

14. Landau v. Werner (1961), 105 Solicitor's Journal 1008 (C.A.)

15. See note, supra 3, at p. 90.

16. The Wagon Mound (No. 1), [1961] A.C. 388 (P.C.).

17. The Queen v. Cote (1974), 51 D.L.R. (3d) 244 (S.C.C.).

18. [1974] 1. A.C. 617 (P.C).

19. See note, supra 3.

20. Hinz v. Berry, [1970] 1 ALL E.R. 1074.

21. Duwyn v. Kaprielian (1978), 7 C.C.L.T. 121.

22. See note, supra 3, at p. 401.

23. Robson v. Chrysler Corp. (Canada) (1962), 32 D.L.R. (2d) 49 (Alta. C.A.).

24. See note, supra 3, at p. 433.

25. Guay v. Sun Publishing Co., [1953] 2 S.C.R. 216.

26. [1963] 2 ALL E.R. 575 (H.L.).

27. From Lord Reid's judgment.

28. See note, supra 26, at p. 616 per Lord Pearce.

29. Judge H. Allen, Judicial Inquiry into the care of Kim Anne Popen by the Children's Aid Society of the City of Sarnia and the County of Lambton (Ontario Government Publications, 1982).

30. Reported in The London Free Press, October 2, 1982.

31. Harty and Horowitz, "Therapeutic Outcome as Rated by Patients, Therapist and Judges" (1976), 33 Archives of General Psychiatry 957; Luborsky, Singer and Luborsky, "Comparative Studies of Psychotherapies" (1975), 32 Archives of General Psychiatry 995; A. Stone, "Suicide Precipitated by Psychotherapy: A Clinical Contribution" (1971), 25 American Journal of Psychotherapy 18.

32. M. Harris, "The Liability of Psychotherapist" (1973), 8 University of San Francisco Law Review 405; U. Fink, "Medical Malpractice: The Liability of Psychiatrists" (1973), 48 Notre Dame Lawyer 693; 99 A.L.R. 2d Malpractice Liability with Respect to Diagnosis and Treatment of Mental Illness 599; T. Daley, "Negligent Statements and the Social Worker" (1979), 10 R.F.L. (2d) 1; H. Rothblatt and D. Leroy, "Avoiding Psychiatric Malpractice" (1973), 9 California Western Law Review 260; J. Sauer, "Psychiatric Malpracitce: A survey" (1972), 11 Washburn Law Journal 461; H. Morse, "The Tort Liability of the Psychiatrist" (1967), 16 Buffalo Law Review 649; C. Tarshis, "Liability for Psychotherapy" (1972), 30 University of Toronto Faculty Law Review 75; P. Cassidy, "The Liability of Psychiatrists for Malpractice" (1974), 36 University of Pittsburgh Law Review 108; 38 A.L.R. 3d Liability of one releasing institutionalized mental patients for harm he causes 699; 11 A.L.R. 3d Civil Liability for Death by Suicide 751; D. Dawidoff, "The Malpractice of Psychiatrists" (1966) Duke Law Journal 696; R. Cohen, Malpractice: A Guide for Mental Health Professionals (New York, The Free Press, 1978); S. Halleck, Law in the Practice of Psychiatry (New York, Plenum Medical Book Comp., 1980); B. Furrow, Malpractice in Psychotherapy (Toronto, Lexington Books, 1980); D. Dawidoff, The Malpractice of Psychiatrists (Illinois, Thomas, 1973).

33. See note, supra 32, Daley and Fink articles.

34. See note, supra 32, Fink article.

35. See note, supra 32, Furrow book.

36. See note, supra 32, Harris article.

37. See note, supra 32, Furrow book.

38. See note, supra 32, Cassidy article.

39. See for example: Beaumont v. Segal 283 N.E. 2d 858 (Massachusetts, 1972); Cawthon v. Coffer 264 So. 2d 873 (Florida, 1972).

40. See for example: Hirschberg v. State 398 N.Y.S. 2d 470 (New York, 1977); McDonald v. Moore 323 So. 2d 635 (Florida, 1976); Wilson v. Lehrman 379 S.W. 2d 478 (Kentucky, 1964); Aiken v. Clary 396 S.W. 2d 668 (Missouri, 1965).

41. See note, supra 32, Morse article.

42. See note, supra 32, Furrow. Meir v. Ross General Hospital 445 P. 2d 519 (California, 1968).

43. See note, supra 32, Furrow book.

44. See note, supra 32, Harris and Rothblatt articles.

45. (1973), 31 D.L.R. (3d) 454.

46. [1954] 2 D.L.R. 328 (C.A.).

47. (1978), 18 O.R. (2d) 177; 82 D.L.R. (3d) 215 (H.C.).

48. Ibid., p. 190-191.

49. 541 F. Supp. 999 (Maryland, 1982).

50. 253 N.Y.S. 2d 662 (1964).

51. 272 F. Supp. 409 (1967).

52. Tarosoff v. Regents of University of California 529 P. 2d 553 (1974); 551 P. 2d 334 (1976).

53. Ibid. For a similar result see: McIntosh v. Milano 403 A. 2d 500 (New Jersey, 1979).

54. 614 P. 2d 728 (California, 1980).

55. 263 So. 2d (1972).

56. (1961), 105 The Solicitor's Journal 257; affirmed on appeal at (1961), 105 The Solicitor's Journal 1008.

57. Ibid., p. 257 per Berry, J.

58. 436 S.W. 2d 753 (Missouri, 1969).

59. Ibid., p. 755-756.

60. 381 N.Y.S. 2d 587 (1976).

61. See note, supra 26.

62. Smith v. Auckland Hospital Board, [1965] N.Z.L.R. 191 (C.A.).

63. Bruman's Beauty Supplies Ltd. v. Kempster (1974), 4 O.R. (2d) 626.

64. Harg v. Bamford, [1976] 3 W.W.R. 331 (S.C.C.).

65. Saxby v. Fowler (1977), 2 C.C.L.T. 195 (Alta. C.A.).

66. Carl Halvorson Inc. v. Robert McLellan and Co., [1973] S.C.R. 65.

67. Myers v. Thompson, [1976] 2 O.R. 335 (C.A.)

68. Reid v. Traders General Insurance Co. (1963), 41 D.L.R. (2d) 148 (N.S.).